Service name	Community Children's and Young People's Service
Service specification number	CCYPS01

Introduction

This specification incorporates the following elements of community service provision for children and young people with acute and additional health needs, including disability or complex needs and those requiring palliative or end of life care:

Community children and young people's healthcare service – this element of the specification is applicable to all clinical discipline specific elements detailed in the sub-specifications as listed below. Following provider engagement with families, this service is now called the Community Children and Young People's Service (CCYPS) and shall be referred to as such within this specification.

CCYPS sub-specifications:

A – Children and young people's community physiotherapy and occupational therapy
B – Speech Language and Communication Needs service for preschool children (Early Intervention)
C – Children and young people's community speech and language therapy
D – Children and young people's community nursing
E – Children and young people's community phlebotomy

The Community Children and Young People's Healthcare (CCYPS) service will be delivered for children and young people registered with GPs in the Nottingham and Nottinghamshire Integrated Care System i.e. the Place Based Partnership areas of: Mid Nottinghamshire (Mansfield and Ashfield, Newark and Sherwood), South Nottinghamshire (Rushcliffe, Nottingham North and East and Nottingham West) and Nottingham City. If a child has school-based needs and attends a Nottinghamshire school but lives out of area, the local service will deliver the support in school, but the local ICB where the child lives will cater for their broader care. The provider is to have a case-by-case conversation with other provider parties to ensure that this is agreed and operationalised. Any issues with this should be escalated to commissioners.

This specification requires the provider(s) to commit to continual improvement, transformation and innovation by working collaboratively across interfaces, including but not limited to acute health services, community and universal health and social care services, adult health and social care services, education, third sector services and commissioners with the aim of integrating care for children and young people.

The vision is to enable children and young people with acute and additional health needs, including disability and complex needs, to have their health needs met wherever they are.

The services will support the child's life choices rather than restrict them and improve the quality of life for children and their families and carers.

This includes the following overlapping and interrelated groups:

Children and young people with...

- Life limiting and life-threatening conditions and illness, including those requiring palliative and end of life care.
- Disabilities and complex conditions including those requiring continuing care and neonates.
- Long term conditions (this excludes the activity delivered by condition specific Clinical Nurse Specialists based within Acute Trusts).
- Acute and short-term conditions (requiring interventions over and above those provided by universal and primary care services, to avoid hospital admission and/or reduce length of stay).

In Nottinghamshire, a child or young person is considered to special educational needs (SEN) or disability if they need extra help with for a range of needs in the four areas of SEND described in the SEND Code of Practice: 0 to 25 years (2014):

- Communicating and interacting
- Cognition and learning
- Social, emotional and mental health difficulties

- Sensory and/or physical needs

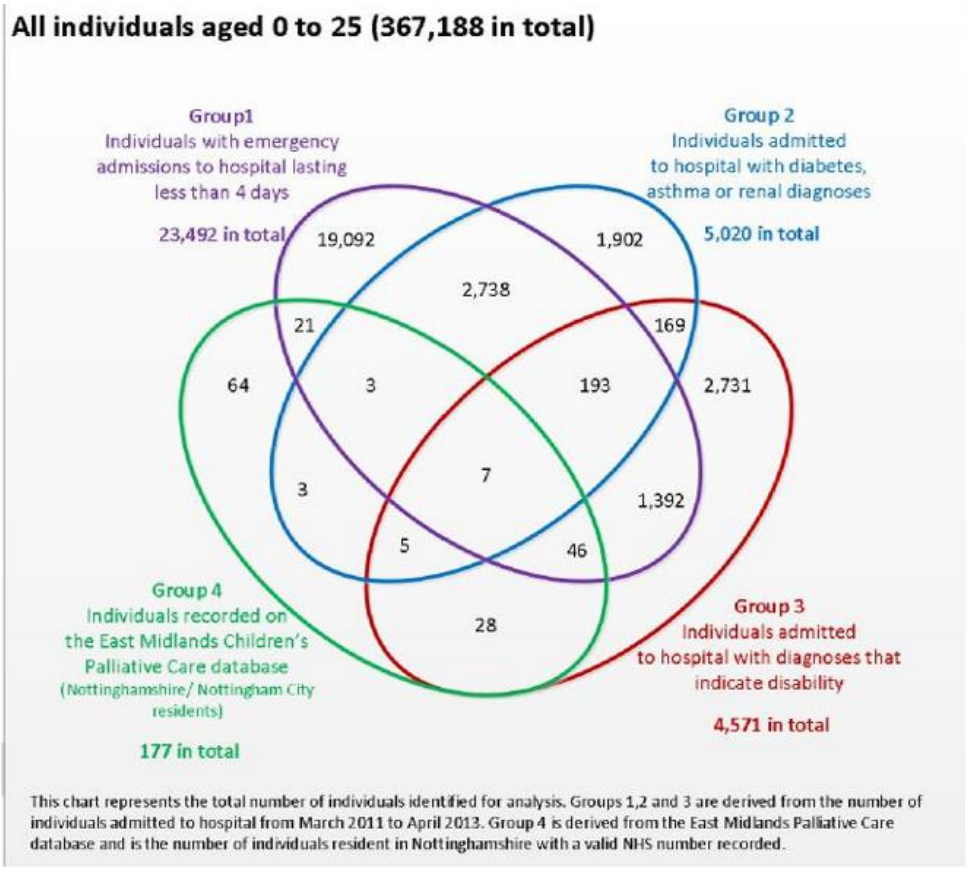
During their development and/or the progression of their condition or illness individual children and young people may and often do move between and overlap these groups. Equally there are children and young people who require input from only one clinical discipline within the coordinated service.

The vision reflects the Nottinghamshire Families' Statement of Expectations (see appendix 1), developed with young people and families in Phase 1 of the Nottinghamshire Integrated Children and Young People's Healthcare Programme (2013), which provides guiding principles for developing, commissioning, delivering and reviewing the service.

1. Population Needs

1.1 National and Local Context and Evidence Base

Data surrounding the number of children and young people who will have a need for this service is very difficult to define, as can be seen by the diagram below (from Phase 1 Report) which illustrates the overlap between the different groups of children and young people who will have a need for this service.



Within this context the estimates of those children experiencing some form of disability is outlined below.

Estimated numbers of children and young people experiencing some form of disability in Nottinghamshire County (Nottinghamshire JSNA 2014):

Thomas Coram Research Unit (2010) Based on 2014 population and a prevalence of 3-5.4% Child and Maternal Health Observatory (2000) Census (2011) CYP with life limiting long term health problems	6598-11882 (0-24 year olds) 7,615 (0-19 year olds) 7891 (0-15 year olds)

In November 2018, there were 7,080 children and young people aged 0-18 living in Nottinghamshire and 3,050 living in Nottingham City who were claiming Disability Living Allowance. 43% of school age children and young people in the city are from black and minority ethnic groups and 35% are living in poverty. There has been increased demand for places in special schools, increased numbers of children and young people with special education needs and increased referrals and contacts with specialist children and young people's community therapy services.

The table below shows the number of pupils with special educational needs in state funded primary, secondary and special schools in Nottinghamshire and Nottingham City (Local Authority school census data, January 2019).

	City		**County**	
	Total pupils with SEN	**Pupils with EHC Plans**	**Total pupils with SEN**	**Pupils with EHC Plans**
Primary School	4,134	103	7,830	261
Secondary School	2,342	111	3,866	273
Special School	620	611	1,071	1,068
Total	7,096	825	12,767	1,602
% of total state funded pupil population	15%	1.8%	10%	1.3%

NB – what these figures cannot show is what proportion of these children have clinical needs which may be associated with this service.

Across the population of children and young people with additional needs the following needs have been identified:

- There is a lack of co-ordinated support for children and young people with complex needs and disability and their families as shown in recent engagement work done.
- There is an increase in need and an ongoing requirement to demonstrate value for money as well as ensuring equity of access and service provision, taking account of population needs, geography and finances.
- More children with a severe disability and complex needs are living longer (Healthy Lives, Brighter Futures 2009), owing to new interventions and technology.
- Disabled children/young people and those with complex needs often have higher safeguarding needs.
- There are multiple providers/teams working to different processes (e.g. assessments, care plans), policies and procedures and different IT systems, which on occasion may result in duplication / lack of efficiency and effectiveness (resulting in a negative impact on children, young people and families).
- There are too many acute and emergency attendances and admissions for conditions and illness that could be treated at home or admission avoided. Evidence suggests peak times are weekends and during the after-school period.

2. Outcomes

The local CCYPS Service Outcomes and Quality Framework has been developed to reflect and support the delivery of the Families Statement of Expectations (see appendix 1). This framework sits within the context of the South Notts and Mid-Notts transformation programmes.

3. Scope

3.1 Aims and objectives of the Service

The CCYPS will provide high-quality evidence based coordinated service that anticipates and responds to the needs of specific groups of children and young people (see introduction above).

CCYPS will support the delivery of the recommendations from the Joint Nottinghamshire CCYPS Programme Phase 1 recommendations (Appendix 2). As such the objectives of the service are to:

- Minimise duplication, ensure effective use of resources, and optimise the collective benefit to children/young people and families from services and informal carers (e.g. family and friends) involved in their care – the child's "circle of support".
- Work with commissioners and partners to ensure high quality, clinically and cost effective, evidenced based and value for money services are delivered within agreed care pathways.

- Enable children and young people with acute and additional health needs, including disability and complex needs, to have their health needs met.
- Deliver care that 'follows the child/young person' to any location where they would reasonably be expected to be.
- Provide co-ordinated community healthcare services to improve the health, wellbeing and life chances of children, young people and their families.
- Reduce length of acute stay, facilitate discharge and/or avoid admission where clinically appropriate.
- Deliver a seamless service that is centred around children, young people and their families, contributing to maximising independence and quality of life including pro-active support and planning for transition.
- Empower children and young people to be actively involved in making decisions about their care, evaluation and co-production of the service, including but not limited to, deciding who to have present at consultations.
- Provide streamlined access and equity of care provision for children, young people and their families.
- Offer choice wherever possible, including access to Personal Health Budgets
- Ensure a sustainable and motivated workforce with the right skills in the right place at the right time, every time
- Ensure effective safeguarding is embedded across the provision.
- Provide early intervention, prevention and treatment that aims to reduce avoidable admissions and/or exacerbations.
- Contribute to improved emotional and mental health and wellbeing of children, young people their parents/carers and the wider family.
- Develop and implement pathways to ensure effective and supported transition to adulthood/adult services in collaboration with health, social care, education and third sector partners and commissioners.
- Proactively offer provision in a clear and transparent way to ensure families do not have to ask for the care and support that they need.

3.2 Service Description / Care Pathway

3.2.1 Service Overview

The service will provide coordinated and sustainable specialist children/young people's care delivered via a flexible and agile network of community-based services, including nursing care and therapies.

The service will provide streamlined access and coordinated assessment, treatment and review, supported by personalised care plans, shared records and communication across coordinated care pathways so that families experience a seamless service that is centered around the child / young person and family promoting privacy and dignity, independence and quality of life.

Care will 'follow the child/young person' and will include in-reach into hospital and out-reach to any location where the child/young person would reasonably be expected to be e.g. school.

The service will deliver a streamlined service consisting of:

- Children and young people's community occupational therapy
- Children and young people's community physiotherapy
- Children and young people's community speech and language therapy
- Children and young people's community nursing
- Children and young people's community phlebotomy
- Care co-ordination
- Transfer of care (facilitating discharge and avoiding admission)
- Training and competency assessment
- Information, advice and support

The service will be provided within a life-course, multi-disciplinary, multi-agency whole system approach, illustrated in Appendix 3, working with and alongside other services including, but not limited to, paediatricians, acute services, health visitors, midwives, school nurses, GP's, social care and education, third and independent sector services, including adult services during transition.

The service will proactively deliver support in line with the Equality Act 2010 and other relevant legal frameworks.
The coordinated service will be underpinned by:

- Effective leadership and a streamlined management structure, including appropriate specialist clinical leadership.
- A culture of continual improvement and innovation.
- Open and transparent collaborative relationships and co-production with commissioners, partners, children, young people and families.
- A multi-skilled and multi-sector workforce.
- Streamlined assessments, reviews and clinical activity.
- Best practice and evidence-based care
- Shared information and records and effective use of systems and processes e.g. administration tasks.
- Regular and effective communication with GPs
- Innovative use of technologies.
- Streamlined and consistent performance and outcome monitoring and reporting
- The family's statement of expectations (see appendix 1) and a child centred, family focused approach

3.2.2 Transformation and Continual Improvement
This specification requires the provider to commit to continual improvement, transformation and innovation by working collaboratively across interfaces, including but not limited to acute health services, community and universal health and social care services, adult health and social care services, education, third sector services and commissioners with the aim of integrating care for children and young people.

The provider will:

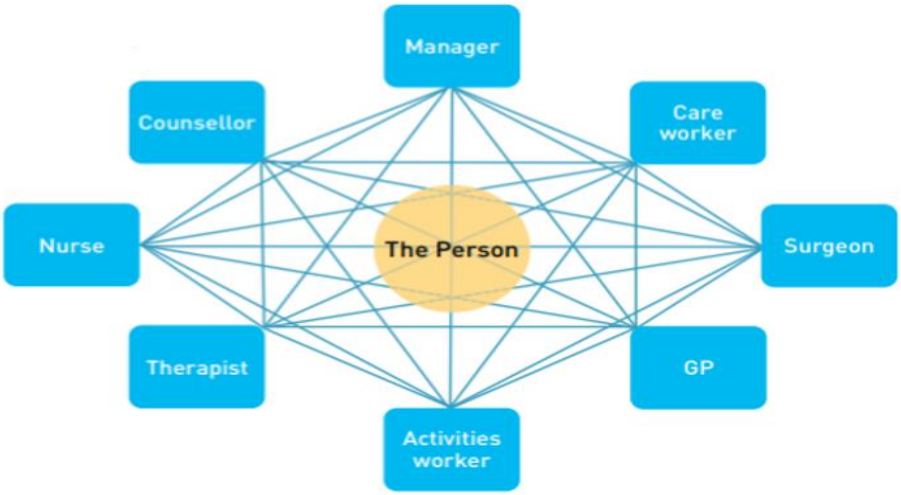
- Continually work towards improvement and development across the whole system to achieve better experience and outcomes for children, young people and their families.
- During the term of this specification fully co-operate in reviewing and improving/re-designing care delivery at the request of and with the involvement of the Commissioners, partners and children, young people and parents/carers. This will inform future service requirements.
- Ensure that there are effective systems and processes to support the collection, analysis and timely reporting (to commissioners) of high quality accurate and meaningful data and information to demonstrate effective care delivery and outcomes and to build an evidence base to inform future assessment of need and commissioning arrangements.
- Continually improve the quality of care delivery, for example, in response to audit (undertaking and completing the audit cycle), user and staff feedback (complaints, compliments, suggestions) and incidents.
- Continually review and be aware of relevant new and emerging guidance and recommendations and developments (e.g. local care pathways) and take the appropriate steps to assess and improve care delivery to achieve current evidence based best practice.
- Work with commissioners to implement the palliative care funding currency.
- Produce and implement plans that demonstrate how it will improve performance in achieving outcomes and meet increasing needs within its resources.

3.2.3 Care Pathway
The provider will be expected to develop/adopt specific clinical care pathways and guidelines to support evidence-based, cost and clinically effective service delivery and best practice.

The coordinated service will be delivered within a whole system approach.
Across the care pathway including but not limited to referral, triage, assessment, care planning, delivery of interventions, review and transition there will be effective communication with the child or young person, their parents/carers, the GP, the referrer and other appropriate professionals regarding progress, next steps and care delivery.

Interpreting services will be used wherever appropriate and communication with children, young people and families will be appropriate for individual's age and development, culturally sensitive and in a format that suits the individual child or young person and their family.

Model Pathway



3.2.4 Service Description

This section describes the care delivery of the coordinated service in which the following clinical discipline specific elements are embedded. Clinical detail for each element can be found in sub-specifications:

A – Children and young people's community physiotherapy and occupational therapy
B – Speech Language and Communication Needs service for preschool children (Early Intervention)
C – Children and young people's community speech and language therapy
D – Children and young people's community nursing
E – Children and young people's community phlebotomy

A) Access and referral management

- There will be a clear point/s for receipt of electronic, telephone and (where available) choose and book referrals, with specialist referral templates incorporating all relevant information.
- There will be an opportunity for supporting information, such as previous assessments, to be shared as part of this
- Appropriate referrals will be accepted from GP's, community and acute health and social care professionals, education, third sector services
- Self-referrals will be accepted where appropriate.
- Telephone advice to support referrals will be available.
- All referrals will be acknowledged, and information will be shared with the child or young person, their parent/carer, the GP and referrer regarding the referral and assessment processes. This will take place within a maximum of 7 working days (Monday-Friday, excluding bank holidays).
- The provider will advise and support the wider children and young people's workforce, including GPs, to make appropriate referrals.
- The provider will be expected to work collaboratively with Nottinghamshire County Council and Nottingham City Council to ensure the most appropriate services are accessible for disabled children and to constantly improve accessibility to services for disabled children.
- Where children and young people are declined at the point of referral the provider will support the family and the referrer to understand the reasons they are not eligible for this service and support them to access alternative services or support. This may include making a referral to these services on behalf of the child/young person as appropriate and/or supported access/signposting to the Local Offer/s.

B) Triage

- Referrals will be triaged by appropriately skilled professionals

- Additional information will be collected by the service, including copies of previous assessments, to complete triage.
- Triage will be supported by a clear governance process (such as detailed algorithms, clear assessment criteria and information sharing agreements).
- A Common Assessment Framework (CAF) or Early Help Assessment Form (EHAF) will be initiated where appropriate
- Triage will be available where appropriate within the working week to facilitate safe timely discharge from the acute setting and/or support avoidance of acute admission/attendance where clinically appropriate. The provider will prioritise assessment and provision of care based on clinical need.
- Core information will be recorded once and shared appropriately across referral, triage, care planning and delivery of interventions.

C) Assessment Process

- An appropriate holistic assessment will be undertaken, informed by information gathered at triage.
- Contact with the CYP and/or family will be made to assess and advise or offer treatment within the 13-week RTT. This will be prioritised based on clinical need. Same day assessment will be available where an immediate response is deemed necessary
- Coordinated assessments will be undertaken for children and young people who may require input from a range of disciplines/agencies and assessment will be carried out by multi-skilled professionals.
- Assessment will be carried out in conjunction with the multi-agency team wherever possible and the provider will be expected to pro-actively facilitate this.
- Interdependencies and links with paediatricians and acute services will be key to the effective delivery of the service, including assessment, treatment and review.
- The views and needs of the child/young person and their parents/carers will be at the heart of assessment.
- Assessment will be needs driven and not dependent on receipt of a specific clinical 'diagnosis'.
- The emotional and mental health of the child or young person, their parents/carers and the wider family will be considered across the pathway.
- Referrals and signposting may be made to other agencies and services with appropriate consent.
- Where children and young people are discharged at the point of assessment the provider will support the family and the referrer to understand the reasons they are not eligible for this service and support them to access alternative services or support. This may include making a referral to these services on behalf of the child/young person as appropriate and/or supported access/signposting to the Local Offer/s.

D) Personalised care plan

- A personalised care plan will be developed informed by the assessment, including assessment of risk.
- The care plan will ensure the needs and preferences of the child or young person, and their parents or carers are at the centre of care planning using 'support planning' principles.
- The care plan will use best practice and evidence-based interventions including use of validated evidence-based approach/tools to assess, identify and agree individual outcomes.
- The care plan will include clear outcomes using 'goal setting' principles, based on evidenced based tools.
- The care plan will be available to share electronically as appropriate with appropriate safeguards and compliance with information governance requirements and shall be owned by the child or young person and their parents/carers.
- The care plan will be shared with professionals and consent obtained where appropriate.
- There will be a case load holder for each child or young person available to contribute to multi-agency planning and review.
- The provider will contribute to Education Health and Care (EHC) plans within the mandated timescales when required.

E) Care delivery

- Interventions will be delivered by a multi-disciplinary workforce with multi-skilled individuals to use resources as effectively as possible and avoid multiple contacts for children/young people and their parents/carers.
- Coordinated interventions will be delivered for children and young people who may require input from a range of clinical disciplines, as detailed in the sub-specifications.
- Care delivery will aim to minimise disruption to the lives of the child/young person and their parents/carers and will be culturally sensitive. Care delivered will be flexible to respond to the emerging or changing needs of the child or young person and to have minimal disruptive impact on access to education, social and family activities.
- Provision of recommended equipment will be via the Nottinghamshire Integrated Community Equipment Loans Service (ICELS), children's continuing care and/or wheelchair services.
- Delivery of care will commence as clinically appropriate. Same day intervention will be available where this is deemed necessary

F) Transfer of Care (facilitated discharge and avoiding admission)

- Advice and clinical interventions will be provided to children and young people, parents/carers, acute and community health services and professionals with the aim of:
- Supporting discharge from acute services
- avoiding unnecessary admission or attendance at Emergency Department (ED)
- providing continuity of care during acute stays, ensuring good communication and information sharing
- The provider will develop care pathways to facilitate this, including working collaboratively with acute services to develop in-reach working to streamline handover of care to community services. This will include flexibility to deliver intensive interventions in the community to support step-down from acute services or prevent an avoidable admission, and the delivery of in-reach support to ensure delivery of interventions during hospital admissions.
- The service will establish strong relationships with General Practice and Healthy Family Teams.

<u>Children's continuing care</u>

The provider will proactively work with other services to refer children and young people with highly complex health needs for children's continuing care assessment in line with the Nottingham City and/or Nottinghamshire County children's continuing care pathways.

The provider will contribute to assessment and review of children and young people with continuing care needs and ensure interventions delivered under this service are coordinated with the delivery of packages of continuing care. This will include proactively supporting commissioners and providers of children's continuing care and working to integrate care pathways wherever possible.

<u>Children and young people's liaison</u>

The provider will:

- Facilitate all children/young people accessing health care provision to be safeguarded by effective communication between all healthcare providers and other agencies.
- Promote and support the transition of care between acute and community services to facilitate early discharge from hospital.

<u>Training provision</u>

The provider will establish, coordinate and deliver accredited training packages from the below embedded list of core offers, for a range of agencies and carers in the community, including parents and carers. The aim is to ensure that children and young people with additional health needs receive safe and effective care to meet their needs wherever they may reasonably be expected to be.

List of training subjects

- Administration of a Prefilled Subcutaneous Injection
- Anaphylaxis awareness and use of an AAI
- Anaphylaxis awareness and use of an AAI – Train the trainer
- Asthma awareness
- Attention Deficit Hyperactivity Disorder Awareness
- Autistic Spectrum Disorder Awareness

- Epilepsy Awareness
- Epilepsy Rescue Medication – Buccal Midazolam
- Gastromy Awareness including Blended diet
- Gastromy balloon water change Awareness – Delivered to residential areas only
- Gastrojejunal Awareness
- Medication Administration Awareness
- Medication Administration – Controlled Drugs
- Nasogastric Tube Awareness
- Oxygen Awareness
- Oral Suction Awareness
- Recognising Childhood Illness – delivered to residential areas only
- Tracheostomy Awareness
- Vagal Nerve Stimulation for paediatric epilepsies

Annual Refreshers

- Epilepsy Awareness
- Epilepsy Rescue Medication: Buccal Midazolam
- Gastromy Awareness including Blended Diet
- Medication Administration Awareness

The provider will develop and deliver accredited 'train the trainer' programmes where appropriate and manage and undertake competency assessment.

The provider will develop and deliver comprehensive training packages to ensure that the wider workforce have the skills and competency to meet the needs of children and young people. This may include staff in education settings, early years settings, short breaks services, youth and play services, leisure services, universal services, transport, direct payment/personal health budget providers and parents/carers and the extended family. Training may be delivered to individuals or groups.

Training will be delivered and assessed in line with an appropriate approved training framework. The training for some specific clinical tasks will be delivered by an appropriate clinician e.g. physiotherapist for deep suctioning.

Pathways will be established to other established training such as diabetes and asthma, where it is the responsibility of other providers or specialist services.

Where the training requested is patient specific, settings/ organisations will not be charged for this even those which are deemed to be profit making organisations (e.g. private early years settings). Profit making healthcare agencies will be charged. The operational management of this will be determined by the provider. The frequency and prioritization of subjects for generic training fall under the remit of the provider.

<u>Behavioural, emotional and mental health and wellbeing</u>
The service will support the emotional, mental health and wellbeing of the child/young person, their parents/carers and the wider family, including siblings via effective prevention, identification, support and referral to appropriate services.

Emotional, mental health and wellbeing will be embedded in service delivery in line with NHS England guidance regarding parity of esteem. The workforce will be appropriately skilled to recognise those at risk of developing emotional, mental health and wellbeing issues, the signs of emotional ill health, and know how to access specialist support. This will include effective liaison with emotional, mental health and wellbeing services e.g. child and adolescent mental health services, adult mental health services, the pathway for children and young people with behavioural, emotional and mental health needs (Nottingham City) and/or the concerning behaviours pathway (Nottinghamshire County).

<u>Patient engagement and participation</u>

Patient engagement and participation will be embedded in service delivery, design and co-production. The provider will ensure that continual review and evaluation of the service via effective two-way engagement with the children, young people, their parents/carers is embedded in the care delivery.

At all stages the provider will ensure communications about assessment and treatment are clear and timely and that the child or young person and their parents/carers have opportunity to feedback.

Promotion and support of self-care

Training and support for parents will be embedded in service delivery to skill parents and carers in identification, early intervention and prevention with the aim of avoiding exacerbation. Parents, carers and children and young people (where appropriate) will be skilled and competent to manage their own or their child or young person's condition.

To support parents and carers there must be appropriate communication and planning to enable them to manage conditions in the best way possible. To support this, information should be available and easy to access including access to appropriate electronic resources, care plans and records. Electronic resources may include self-care videos, recorded consultations and online trusted advice. Empowerment of the service users themselves and their parents/carers in the delivery of this self-care should be demonstrated with consideration given to the whole spectrum of those who provide this care.

Supporting Education

The provider will deliver high quality evidence-based care to:

- For children and young people attending a special needs school or a mainstream school (where the child or young person has additional health needs) assessment will be delivered prior to admission and support will be available to schools in the development of care plans, which the school will lead on and be responsible for. Pathways will be developed with education and social care to facilitate this, prevent delays to children and young people accessing educational placements and ensure the delivery of provision supports learning.
- Support the child or young person's health needs to enable them to access education and participate in family and social and leisure activities in settings of their choice.
- Work in a partnership with Public Health Nursing services to provide public health interventions for children and young people with complex and additional needs.
- Contribute to maximizing the child/young person's potential for independence, including pro-active support and planning for transition for those already known to the service and for those referred in for transition purposes (pathway to be developed with schools).

Education, Health and Care Plans (EHCPs)

The service will contribute/provide a written report to EHCPs wherever required. This may include assessment of needs and contribution to the development of plans with a clear focus on outcomes for children and young people. The provider will work within the agreed statutory timeframes for EHCPs and in line with the Nottingham City or Nottinghamshire County pathways. This may include providing support to the family and attending person centred review meetings/multi agency meetings (MAMs) to plan and review the child or young person's health and care needs and package of care.

EHCP Stage 2 Requests

When a request for health advice in relation to a child or young person's SEND is received from the local authority during stage 2 of the EHCP process, a response from the provider must be returned to the local authority within 6 weeks of receipt into the CCYPS SPA. A report must be produced for all cases seen by the service within the previous 12 months. For cases not seen by the service in the previous 12 months, the provider can respond through appropriate channels that they are no longer involved with the child or young person and giving the dates of any previous involvement. Any health provision recommended by the provider in their report must be specific and time limited where appropriate with specified outcomes.

EHCP Reviews

For children and young people known to the service with an EHCP in place, the provider has a duty to provide a report for any scheduled EHCP review 2 weeks prior to the review taking place. It is beneficial for practitioners to attend EHCP reviews wherever possible, however if they cannot attend a report must be submitted.

Extended Appeals
When notification of a SEND tribunal case comes through to the provider's nominated inbox, a report must be submitted prior to the deadline stated. This deadline may vary between cases dependent on the requirements of the Tribunal judge. The local authority will decide who needs to attend the Tribunal dependent on the needs of each case. It is the duty of the provider to offer support and appropriate guidance and training to all staff who may be reasonably expected to attend a Tribunal.

If during a Tribunal the judge directs for an assessment to take place from one of the disciplines within CCYPS and the child or young person isn't known to the service, the provider will carry out this assessment or will explain why the child or young person does not meet the criteria for the service.

Clinicians/therapists and/or appropriate manager will prepare reports and attend SEND tribunals as per statutory legal process and when needed for children/young people who have or are receiving care from the service. This is particularly in relation to Extended Appeals; it is expected that the report will include expert advice; clinicians/therapists must respond to any request for information and evidence within the timeframe set by the Tribunal. In addition, if required, a representative from the respective clinical service must attend the hearing and give oral evidence.

<u>Location of service delivery</u>
Services will be locality based and the provider will ensure strong links with general practice to support appropriate use of GP services to avoid unnecessary paediatrician and ED attendances and hospital admissions and to support the development of seamless transition to adult services.

In Nottingham City Place Based Partnership, the locality-based hubs will integrate with the Primary Care Network model through which primary care services, community health services and social care services for adults are working to support the needs of Nottingham City patients.

Interventions will be delivered in a variety of locations and at times to meet the needs and choice of children, young people and families. The provider will use the Department of Health's "You're Welcome" quality criteria for young people friendly services as guiding principles to be accessible in age appropriate, child and young person friendly locations. Locations will include but are not limited to:

- Client's home
- Health centres
- Community clinics
- Education settings such as schools, colleges and nurseries
- Early years settings such as sure start and children's centres, playgroups
- Children's development centres
- Private day nurseries
- Short break settings
- Other sites as applicable

Where an intervention is largely delivered within school in term-time (including elements delivered by trained education staff) equivalent provision will be delivered during school holidays or during periods of absence such as illness to meet identified health needs.

<u>Response time and days/hours of operation</u>
The service will respond to the needs of children and young people and will deliver services appropriately to deliver the outcomes.

Responses times are as outlined above.

The service will deliver:

- Routine late afternoon/evening and weekend provision.
- Rapid response will be flexible wherever appropriate to meet individual needs
- End of life support available 24 hours a day, 7 days a week, 365 days a year.

The service provider must ensure that other activity delivered by the provider (i.e. commissioned by other organisations/agencies) does not have a negative impact on capacity to deliver the service commissioned under this specification.

G) Review

Review will be undertaken as appropriate to ensure that care provision for children and young people continues to meet their needs, including consideration of eligibility for Education, Health and Care plans and continuing health care.

H) Transition to adulthood and/or adult services

Proactive planning and care pathways will be developed in line with local and regional (Everybody's Business: East Midlands Best Practice Guidance for Young People Moving on from Children's Services November 2014 developed by the East Midlands Clinical Networks) transition guidance and the Together for Short Lives transition care pathway (http://www.togetherforshortlives.org.uk/professionals/care_provision/care_pathways/transition_care_pathway) which provides a generic framework for local adaption specifically for teenagers and young adults with life-threatening, life-limiting or complex medical conditions.

A transition plan will be developed for all children and young people from age 14 years. This will contain concise, consistent and clear documentation with all relevant information about the young person's transition for all those involved in the transition process.

Development of transition planning and processes will include the following:

- Workforce development to meet the needs of young people during transition
- Use of the Nottinghamshire CCYPS Programme Families' Statement of Expectations (see appendix 1) as guiding principles
- Support for the continuation of the personalisation approaches and systems used by the young person following transition to adulthood
- Statutory duty to contribute to and provide services to young people/adults within Education Health and care Plans (EHCP) in line with the Special Educational Needs and Disability (SEND) legislation https://www.gov.uk/government/publications/send-managing-changes-to- legislation-from-september-2014
- Reference to the recommendations within the Nottinghamshire Joint Strategic Needs Assessment Children's Chapter – Transitions http://jsna.nottinghamcity.gov.uk/insight/Strategic- Framework/Nottinghamshire-JSNA.aspx

The service will work in partnership with children's and adult's commissioners, adult community health and social care services, GPs and related services involved in the care of young people with additional health needs including disability and complex needs and those requiring palliative and end of life care to ensure seamless continuity of care during transition from children's to adult services.

Where a young person is at the end of life and would be expected to transition to adult services the CCYPS provider will continue to deliver a service, as appropriate, to ensure continuity of care and support close to the end of the young person's life.

I) Discharge

Where a child or young person's care is complete, transition out of the service will be made in line with appropriate guidance. Clear reasons for discharge will be discussed and communicated with the child or young person and their parents/carers, and information shared with the GP, the referrer and other appropriate professionals such as universal health services, community paediatricians and social care services. Processes/pathways will be in place to enable fast track access to the CCYPS should needs re-occur.

3.2.5 Information and Advice Services

The provider will ensure delivery of coordinated information and advice services, which may include co-location and shared branding with local authorities' information and advice services, delivered in line with best practice and the requirements of SEND legislation.

Information, advice and resources will be provided to children and young people with physical or learning disabilities and/or complex health needs and their parents/carers, professionals and circle of support. Strong links with acute and community health services will facilitate this. This will include the delivery of 'information prescriptions' requested by paediatricians. Information and advice will be readily available in venues, times and formats to best meet the needs of children, young people and parents/carers (e.g. available in a range of languages and formats suitable for the diverse population groups accessing the service) including on-line and face-to-face. The service will be widely promoted.

Information about and promotion of the CCYPS will be proactively shared and marketed in a wide range of settings including, but not limited to, disability hubs, schools, the local offer, and 111 services.

3.2.6 Information Management and Technology

Information management and technology (IMT) systems will support the principle that core information about children and young people will be recorded once and shared appropriately, supported by relevant levels of consent and choice, delivered in line with information governance policy and the safeguarding board guidelines. This will include but is not limited to:

- Shared or integrated electronic care records with access for all appropriate professionals including GPs.
- Access to a shared care plan for the child or young person and their parents/carers, which is centred around their needs and enables them to communicate information with the service.
- Mobile access with appropriate security and information management safeguards.
- Use of appropriate assistive technology to offer support and flexibility in the care delivered.
- Innovative use of technology to support improved contact and support e.g. teleconsultation.
- Compliance with relevant Information Governance, confidentiality and consent standards.

Further IMT requirements are detailed in Appendix 5.

3.2.7 Workforce

The workforce must have sufficient capacity, skills knowledge and behaviours in order to effectively deliver the service to meets the needs of the local population and achieve the outcomes identified. The provider will have a clear workforce development plan covering the whole workforce to demonstrate how the following will be achieved:

- Discipline specific professionals with specialist levels of skill to undertake assessment, care planning, interventions and management/supervision of multi-skilled colleagues
- Multi-skilled professionals and support workers/skilled carers, to support delivery of multidisciplinary interventions
- Administration and data management support
- Staff with specialist communication skills
- Staff with skills in peer support, key working, care co-ordination or advocacy
- Staff with appropriate skills in medicines management/prescribing, nutrition support and phlebotomy.

Development of the workforce will respond to the opportunities to develop new roles across traditional boundaries, recognising skills and competencies which require a specific professional registration and those which could be shared and developed across professional boundaries.

The provider will ensure that the workforce have the equipment and supplies to undertake their roles.

The provider will be actively engaged with the Local Education and Training Council (LETC) to ensure workforce risks and priorities have been identified and good practice in relation to workforce is shared accordingly.

3.3 Population Covered
The CCYPS will be delivered for children and young people registered with GPs in the Nottingham and Nottinghamshire Integrated Care System, namely:

- Mid Nottinghamshire Place Based Partnership (excluding paediatric phlebotomy)
- South Nottinghamshire Place Based Partnership
- Nottingham City Place Based Partnership

3.4 Any acceptance and exclusion criteria and thresholds
Any child or young person aged 0-18 years (or 19 years if in full time education) with a clinically indicated need for the service will be accepted by the service:

- SUB SPECIFICATION E: Children and young people's community phlebotomy provision
    - All children and young people aged 1-12 years AND children and young people with additional needs 1-18 (19 in education) registered with a GP in South Nottinghamshire (Rushcliffe, Nottingham North and East, Nottingham West) and Nottingham City Place Based Partnerships.

- Young people aged 19-25 will be supported for the following:
    - Respiratory physiotherapy with rapid response.
    - Areas of CCYPS provision on a case-by-case basis for young people with an EHCP where there is no adult provision to transition to.
    - Young people over the age of 25 that have previously been supported by the respiratory physiotherapy with rapid response service will be retained and will continue to be supported by the provider. New patients over the age of 25 will not be accepted.

- SUB SPECIFICATION C: Speech Language and Communication Needs (SLCN) service for preschool children
    - Home Talk for 2-2.5-year-olds
    - At 2 years: Children who have 0 to 30 words and have no social interaction or comprehension problems. 2 – 2 ½ year review
    - Closer to 2½ years: Children who:
        - have no social interaction or comprehension problems
        - are not using a wide range of single words (less than 50)
        - are only using single words and learnt phrase. A learnt phrase is one which the child may have learnt as if it is one word e.g.," thank you", "night night"
    - Closer to 3 years: Children who:
        - missed their 2-2.5 review and are found to have a language need identified by partners including early years settings, the Children's Centre Service, and Healthy Family Teams where the child does not meet the threshold for an immediate referral to the SSLT. This cohort will exclude who have already been referred for specialist SLCN support by other SSLT/SFSS/HT or relevant CC services.
        - Children aged 2.5 years who live in the defined area and did not achieve expected level in any ASQ area at 2-2.5 years and have not been referred onto other SSLT/SFSS/HT or relevant CC services.
    - The service is not expected to deliver SLCN's interventions to:
        - Children with complex needs and / or presenting with a clear indication of ASD.
        - Children with significant understanding difficulties such as not understanding single words or basic instructions at home.
        - Children with other SLCN such as stammering which require specialist Speech and Language Therapy.
        - Children over the age of 3.

The service will support children and young people with, but not limited to, physical health needs, learning disabilities, neuro-developmental conditions and emotional and mental health needs where there is a clinical need for this service.

Training will be provided to appropriate community staff and parents/carers supporting a child or young person registered with a GP within the boundaries of South Nottinghamshire (Rushcliffe, Nottingham North and East and Nottingham West) Place Based Partnership and Nottingham City

Place Based Partnership. This excludes Bassetlaw ICB except where the child/young person is accessing short breaks from Nottinghamshire County Council where the child/young person would be accessing as 'out of area'.

If a child has school-based needs and attends a Nottinghamshire school but lives out of area, the local service will deliver the support in school, but the local ICB where the child lives will cater for their broader care. The provider is to have a case-by-case conversation with other provider parties to ensure that this is agreed and operationalised. Any issues with this should be escalated to commissioners.

Where the provider supports children and young people from out of area the provider will ensure this does not impact upon the capacity of the commissioned service and re-charge the responsible commissioner/s for this provision. An annual report for CCYPS commissioners will be provided.

3.5 Interdependence with other Services / Providers

A number of partnership working opportunities are presented within the local health and social care community to enhance outcomes for children, young people and families

Integration across health and social care is high on both the national agenda (through the Children and Families Act 2014 and the Care Act 2014) and on the local Nottinghamshire agenda through the Children's Trust Board and Mid-Notts and South Notts Transformation programmes. The provider will be required to work in partnership with health, education and social care commissioners and providers towards greater integration. This may include working towards the integration or alignment of pathways, assessment, care planning and review processes, and/or co-location of services.

The service will liaise and work collaboratively with other agencies and services involved in the care of children and young people, including but not limited to:

111 emergency and urgent care services	Looked after children services
Acute Emergency Departments: (Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS Foundation Trust)	Maternity services
Acute sector	Nottinghamshire and Nottingham City Local Offers
Adult services (transition)	Optometry and hearing services
Bereavement services	Paediatric and neonatal intensive care units
Child and adolescent mental health services and professionals (including IMHA and IMCA)	Paediatricians in acute care settings
Children and adults continuing care services	Parent/carer/family
Children's Development Centres	Personal budgets and direct payments
Children's occupation therapy services	Primary Care Out of Hours services (NEMS and
Clinical support to appropriate panels and forums (e.g. communication aids panel)	Safeguarding and Multi Agency Safeguarding Hub (MASH)
Community paediatricians	School nursing/public health nursing services
Condition specific Clinical Nurse Specialists	Schools – teachers, teaching assistants
Dental services	Services for speech, language and communication needs
Early support pathways/programmes/targeted	Short breaks services
Family Nurse Partnership	Social care and Disabled Children's team
General Practitioners	Special education needs services (include key working services)
Health visiting services	Sure Start Children's Centres and Early Years
Hospices	Third sector providers
Information, advice and support services	Transport services for children and young people with additional needs and disability

Interpreting services	

3.5.1 Sale of Additional Provision

The provider will ensure that there is capacity and flexibility to enable the Commissioner and wider commissioners e.g. schools, Local Authorities, parents/carers/young people (via personal health budgets), to purchase additional provision outside of that which is described within this specification e.g. children's continuing care packages, response to tribunal recommendations.

The provider will ensure that there is capacity and flexibility to enable continuity of care from 1st April 2016 for children.

The provider will be expected to fully participate in any review, improvement and development during the life of the contract to ensure that continuing care provision best meets the needs of children, young people and their families.

4. Applicable Service Standards

4.1 Applicable National Standards (eg. NICE)

National standards, policy and drivers applicable to the CCYPS include but are not limited to

- Children and Families Act 2014 http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted
- Health and Social Care Act 2012 http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted
- The Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
- Special Educational Needs (SEN) Code of Practice: for 0 to 25 years Statutory guidance for organisations who work with and support children and young people with SEN June 2014
- The Health and Social Care (Safety and Quality) Act 2015
- DH (2010) Achieving equity and excellence for children
- DH (2010) National Framework for Children and Young People's Continuing Care
- NHS at Home: Community Children's Nursing Services DH March 2011
- Framework 15 - Health Education England Strategic Framework 2014-2029
- Together for Short Lives transition care pathway
- Care Certificate and standards (2015)
- HM Government (2013) Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children
- Code of Practice for Disability Equipment, Wheelchair and Seating Services - A Quality Framework for Procurement and Provision of Services (2015)
- CQC (2010) Essential standards of quality and safety
- Legislation.gov.uk (2010) Equality Act 2010 http://www.legislation.gov.uk/ukpga/2010/15/contents
- Department for Education (2009) Common assessment Framework for Children and Young People, guidance.
- DH (2009) Reference guide to consent for examination or treatment Second edition
- DH (2007) Mental Health Act http://www.legislation.gov.uk/ukpga/2007/12/contents
- HM Government (2004) The Children Act 2004 http://www.legislation.gov.uk/ukpga/2004/31/contents
- Multi-agency working (2012)
- 'You're Welcome': quality criteria for young people friendly health services
- DH (2001) Seeking consent: working with children
- Children and Young People's Outcomes Forum Pledge for better outcomes
- Children and Young People's Health Outcome Forum 2014

https://www.gov.uk/government/publications/responses-from-children-and-young-peoples-health-outcomes-forum

- Coventry and Warwickshire's Children and Young People's Teaching and Assessment Framework http://covandwarkschildcomps.org.uk/
- Children and Young People's Health Services Data Set

Clinical practice and interventions will be delivered in line with relevant evidence-based pathways, guidance, standards and resources e.g. as published by the National Institute of Health and Care Excellence (NICE) and Together for Short Lives and/or relevant locally developed resources derived from these.

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

Standards set out in Guidance and/or issued by a competent body include but are not limited to:

- The Health and Care Professions Council Standards of conduct, performance and ethics
- British Association of Occupational Therapists and College of Occupational Therapists professional standards, codes of conduct and professional guidelines
- Royal College of Paediatricians and Child Health
- Chartered Society of Physiotherapy – Quality Assurance Standards (2012) and Code of Professional Standards and Behaviour http://www.csp.org.uk/professional-union/professionalism/csp-expectations-members/quality-assurance-standards
- Chartered Society of Physiotherapy (2007) Information to guide good practice for physiotherapists working with children
- Royal College of Speech and Language Therapist Professional Standards
- DCSF (2008) Bercow Report Review of services for Children and Young People (0-19) with Speech, Language & Communication Needs.
- Royal College of Speech and Language Therapists (RCSLT) Communicating Quality 3 (2006) – clinical guidelines and recommended best practice in service organisation and provision
- RCSLT – Clinical Standards documents
- Supporting children with speech, language and communication needs within integrated children's services Position Paper, Marie Gascoigne, January 2006
- Nursing and Midwifery Council Standards of conduct performance and ethics http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/
- Royal College of Nursing Best Practice Guidance – Delegated Tasks List (RCN, 2008 – Appendix three)
- The BNF for Children (England/Wales/Scotland)
- Medicines Standard: National Service Framework for Children, Young People and Maternity Services
- Royal College of Paediatrics and Child Health – guidance and standards
- Department of Health – Every Child Matters 2003

4.3 Applicable local standards, policy and drivers

Local standards, policy and drivers applicable to the CCYPS include but are not limited to:

- Joint Nottinghamshire Integrated Community Children and Young People's Healthcare Programme, phase 1 report and recommendations. September 2013 - key driver for the CCYPS service
- Nottinghamshire County Joint Strategic Needs Assessment for Children and Young People 2014
- Nottingham City Joint Strategic Needs Assessment for Children and Young People with Learning Difficulty and Disabilities (2014)
- The Nottingham Children's Partnership Early Support Pathway (2011)
- Nottinghamshire County Pathway to Provision (2014)
- Nottingham City Council - Nottingham City Early Intervention Programme
- Nottinghamshire and Nottingham City Safeguarding Children Boards' Safeguarding Children Procedures June 2012 (Re-published September 2012)
- Nottingham and Nottinghamshire Safeguarding Adults Procedures and Practice Guidance
- Nottinghamshire County Health and Wellbeing Strategy 2014 – 2017
- Nottingham City Health and Wellbeing Strategy (2013 - 2016) – draft
- Nottinghamshire Children and Families Plan 2014 -2016
- Integrated Commissioning Group SEND Joint Commissioning Strategy

The following clinical discipline specific elements or 'sub-specifications' embedded within the CCYPS will be delivered as coordinated services so that children, young people and their families experience seamless provision and have their health needs met wherever they are.

Please note: The sub-specifications are not stand-alone specifications. They form part of and should be read and used in conjunction with the CCYPS specification above and accompanying appendices below.

Sub-specifications:
A – Children and young people's community physiotherapy and occupational therapy
B - Speech Language and Communication Needs service for preschool children (early intervention)
C – Children and young people's community speech and language therapy
D – Children and young people's community nursing
E – Children and young people's community phlebotomy

SUB SPECIFICATION A: Children and Young People's Community Physical and Occupational Therapy

Please note: This is not a standalone specification. It forms part of and should be read and used in conjunction with the CCYPS specification above and accompanying appendices below.

Purpose

The core purpose of the children and young people's occupational therapy (OT) and physiotherapy (PT) element of the CCYPS is, through assessment, treatment, management, education and evaluation, to respond to the needs of children and young people who have disabilities or disorders of movement or function which may be improved or maintained by therapeutic input and use of equipment by providing interventions to facilitate the child/young person to reach their maximum functional potential.

Physiotherapy

Children's physiotherapists work in partnership with the child, family and other professionals from health, education and social care settings to maximise a child's physical abilities and independence. Their goal is to work closely with the family and the wider team of carers, so they understand the child's physical difficulties and empower them to be able to support and enable the child to achieve their best.

Children's physiotherapists assess the child's abilities and analyse how they move. From this assessment an individual physiotherapy plan will be formulated. This will typically involve teaching parents and carers specific activities to practice with their child and how best to manage their physical needs throughout their daily routine. This may also include the provision of specialist therapy equipment to support standing, walking and position at night when sleeping.

Occupational Therapy

Children's Occupational Therapists work with children and young people to provide intervention, support and/or advice to children and young people and their families, where there is disability or impairment which significantly impacts on their performance and participation in everyday activities of life.

Advice and strategies are offered to the child/young person, their family, education staff and other professionals working closely with the child/young person; this provides them with the information they need to improve the child/young person's wellbeing. Adaptations to the environment, tasks and equipment will be recommended to enable the child or young person to be as independent as possible.

In addition to those listed in the Scope, see 3.1, the objectives for Physiotherapy and Occupational Therapy are to:

- Provide a comprehensive picture of the child/young person's physical, developmental and functional needs and to explain the benefits of therapeutic intervention to the child/young person and their parents/carers.
- Provide therapy intervention through assessment, treatment, management, education and evaluation for children and young people who have disorders of movement and posture,

disabilities or illness which may be improved or controlled by therapeutic skills and use of specialist equipment
- Enable the child/young person and their parents/carers to make an informed decision on issues relating to sensory motor and motor development and skill acquisition and provide clear communication to children, parents, carers and professional colleagues.
- Achieve/develop/maintain/restore functional and physical skills to a developmentally appropriate level for the child/young person to reach their full potential.
- Maximise the child's or young person's potential to connect with their physical and social environment.
- Promote effective quality of life in a range of settings by managing/compensating for the physical/functional difficulties as appropriate to the needs of the child or young person
- Promote the child's or young person's sense of purpose/value/role/self-esteem within the parameters of their functional/physical difficulties
- Develop and implement joint and coordinated working and care delivery across health and social care occupational therapy services, to reduce duplication for children, young people and parents/carers and ensure optimum utilisation of resources e.g. coordinated/joint assessments.
- Provide/recommend appropriate specialist equipment/orthotics to maximise ability and facilitate function and physical ability to enable the child/young person to access their environment

Categories of need

The provider will support children and young people who have disabilities or disorders of movement or function which may be improved or controlled by therapeutic input and use of equipment. This includes but is not limited to children and young people with:

- Neurological conditions e.g., Cerebral Palsy, Developmental Delay
- Neuromuscular conditions e.g., Muscular Dystrophy
- Congenital disabilities e.g., Rett's – exchange for "genetic syndromes"
- Acquired disability e.g., Head injury, spinal cord injury, oncology, amputation, rheumatology, burns and plastics which impact on functional and life skills
- Orthopaedic conditions – life-long orthopaedic condition which have a long-term functional impact on life skills
- Significant motor and functional difficulties as part of a physical disability
- Diagnosis of Development Coordination Disorder (DCD), inc. ASD with functional co-ordination delay
- Motor and function performance not in-line with cognitive ability
- Disability, illness or physical health need which may be improved or controlled by therapeutic skills and use of specialist equipment
- Respiratory conditions (rapid response)

The provider will develop coordinated clinical pathways to provide appropriate therapeutic interventions.

Exclusions

- A child or young person with a neuro-muscular condition who only needs specialist monitoring
- A child or young person with an acquired disability who needs
  - Acute rehabilitation
  - Specialist monitoring only
  - Management related to pain
- Short term or acute orthopaedic conditions
  - Fractures
  - Sports injuries
  - Back pain
  - Anterior knee pain / tight hamstrings
  - Toe walking or in toeing without a neurological diagnosis
  - Pain management
  - Talipes
  - Specialist monitoring only
- A child or young person with pain due to hypermobility

- A child or young person with a learning disability and not attaining physical skills due to the limitations of their LD
- CG and hyperventilating
- CAMHS related diagnosis ed. FND, POTS and chronic fatigue
- Long covid and chronic fatigue
- Sensory Modulating and processing difficulties
- Attachment and Trauma

Workforce
Care packages will be tailored to individual needs and will be delivered by therapists from a broad skills and knowledge base, to meet a broad spectrum of needs and degrees of complexity/specialty, enabling flexible and responsive delivery by the multi-disciplinary workforce supported by multi-skilled individuals.

The provider will deliver high quality evidence-based care to:

- Provide needs led occupational and physiotherapy interventions through assessment, advice, intervention, management, review, education and evaluation.
- Increase understanding of the child/young person's condition, level of ability and potential for change, for the child, their parents/carers and others working with them.
- Ensure the child/young person reaches their maximum physical potential by aiming to achieve/develop/maintain/restore functional and physical skills to a developmentally appropriate level for the child or young person.
- Provide training to parents/carers and a range of staff, to enable children to continue to access other activities, including education and short breaks.
- Provide interventions and packages of care incorporating graded and purposeful activity, that enable the child/young person to connect with their physical and social environment, optimise motor skills and achieve effective quality of life in a range of settings by managing/compensating for the physical/functional difficulties as appropriate to the needs of the child or young person.
- To provide advice and information to optimise functional skills of children/young person with everyday tasks and activities. Interventions will meet individual assessed need and incorporate robust goal setting actively involving the child or young person and their parents/carers
- Provide training to parents/carers and a range of staff, to enable children/young people to continue to access other activities, including education and short breaks.
- Recommend appropriate equipment/orthotics/wheelchairs to maximise ability and facilitate function and physical ability and to enable the child/young person to access their environment. Order and review equipment provided establishing appropriate care pathways with equipment providers. Support any review of wheelchair provision across Nottinghamshire.
- Contribute to maximising the child/young person's potential for independence, including proactive support and planning for transition. The provider will ensure provision of orthotics for children and young people as per assessed need.
- Work in partnership with local authorities to streamline provision of occupational and physiotherapy services across health and social care e.g., co-location, streamlined assessment and further transformation
- Contribute to maximising the child/young person's potential for independence, including proactive support and planning for transition.

Respiratory physiotherapy with rapid response:

- Provide specialist respiratory physiotherapy with rapid response (across 7 days per week) for urgent care needs and advice including management of emergencies in the community. Care will be delivered to children and young people with severe disability, life limiting, and life-threatening conditions identified as being at risk of admission due to acute respiratory episodes and infections.
- Where appropriate deliver the prescription of certain respiratory medications including antibiotics, nebulisers and inhaled treatment by an extended scope physiotherapist (an independent accredited prescriber) in liaison with the child/young person's lead doctor.

- Provide appropriate training on respiratory physiotherapy interventions to parents/carers and a range of staff, to enable children to continue to access activities, including but not limited to education and short breaks. This will include education and information to parents/carers on when to access their GP rather than ED.

SUB SPECIFICATION B: Speech Language and Communication Needs service for preschool children (Early Intervention)
Please note: This is not a standalone specification. It forms part of and should be read and used in conjunction with the CCYPS specification above and accompanying appendices below.

1. Introduction
NHT will provide a seamless service and pathway for children aged 2 upwards to help identify and address SLCN from universal to specialist provision.
The Early Intervention SLCN service will need to work closely with the Children's Centre Service, Healthy Family Teams, and specialist speech and language therapy services in Bassetlaw, as well as supporting targeted early years settings across Nottinghamshire.
The work is supported by Public Health commissioners with a view that future contracting arrangements meet the requirements of commissioners across Nottinghamshire County Council and Clinical Commissioning Groups.

1.1. Background
Ensuring children get the best from education is vital; education is central to improving life chances for children and young people and yet not enough children are starting school with the range of skills they need to succeed. Educational attainment is one of the main markers for wellbeing through the life course and so it is important that no child is left behind at the beginning of their school life.

Research shows that access to high quality early learning experiences, together with a positive learning environment at home, is a vital combination to ensure that children reach a Good Level of Development (GLD) at the start of compulsory school age, helping to close the gap between children with vulnerabilities and their peers.

The early years are a critical time for all children to develop strong cognitive, social and emotional foundations. Early language acquisition impacts on all aspects of young children's development. It contributes to their ability to manage emotions and communicate feelings, to establish and maintain relationships, to think symbolically, and to learn to read and write. Speech, language and communication is both an essential building block for a range of cognitive and social and emotional skills, and predictive of a range of later-life issues.

The term speech, language and communication needs (SLCN) describes difficulties across one or more aspects of communication, including:
- problems with producing speech sounds accurately
- problems understanding language (making sense of what people say)
- problems using language (words and sentences)
- problems interacting with others. For example, difficulties understanding the non-verbal rules of good communication or using language in different ways to question, clarify or describe things
- stammering and voice problems

Speech, language and communication skills are crucial for
- brain development in the early years and our attachment to others
- expressing ourselves and understanding others
- thinking and learning
- social interaction and emotional wellbeing.

Language difficulties predict problems in literacy and reading comprehension, but they may be indicative of problems in children's behaviour and mental health as well. Once children enter school, language skills remain a strong predictor of their academic success. Evidence shows that children with poor vocabulary skills at age 5 are more likely to have reading difficulties as an adult, more likely to have mental health problems, and more likely to be unemployed.

Educational attainment
Nationally, at school entry just 26% of children with SLCN's made the expected level of progress; at the end of primary school only 15% of pupils with SLCN's achieved the expected standard in reading, writing and maths; and at GCSE 20% of pupils with SLCN's achieved grade C or above in English and Maths.

Social, emotional and mental health
Children and young people with communication difficulties are at increased risk of social, emotional and behavioural difficulties and mental health problems:

- 80% of all children with emotional and behaviour disorders have unidentified language difficulties.
- young people referred to mental health services are three times more likely to have SLCN.
- 5-year-olds with poor vocabulary are 3 times as likely to have mental health problems as adults 2
- two-thirds of 7–14-year-olds with serious behaviour problems have a language impairment5

Life chances
Children with poor vocabulary skills are twice as like likely to be unemployed when they reach adulthood; and 60% of young offenders have low language skills.
Nationally, more than 10% of children and young people have long term speech, language and communication needs that persist throughout childhood and beyond, and 7.6% will have a developmental language disorder (i.e., a SLCN that affects that way children understand and express language).

Children's vocabulary skills are linked to their economic backgrounds. Children living in areas of socio-economic disadvantage are at much higher risk, with around 50% of children starting school with delayed language or other speech, language and communication needs. By 3 years of age, there is a 30-million-word gap between children from the wealthiest and poorest families. One study shows that the vocabulary gap is evident in toddlers and by 18 months, children in different socio-economic groups display dramatic differences in their vocabularies. By 2 years, the disparity in vocabulary development has grown significantly. Tackling this gap in early language acquisition is complex and requires a system-wide approach.

The Government's priority to improve social mobility includes a priority to 'close the word gap' in the early years, they identified that word gaps are particularly pronounced in the early language and literacy. By age 3, there is already a 17-month income-related language gap, with children from disadvantaged groups twice as likely to experience language delay.

Bercow: Ten Years On – An independent review of provision for children and young people with speech, language and communication needs in England sets out the state of provision for children's SLCN in England in 2018. Currently, poor understanding and insufficient resourcing for SLCN mean too many children and young people receive inadequate, ineffective and inequitable support, impacting on their education, their employability, and their mental health. The report found that:

a) Communication is crucial to children's life chances. Yet awareness of its importance among the public and decision makers is not sufficient.
b) Strategic system-wide approaches to supporting SLCN are rare; very often SLCN does not feature in national or local policies.
c) Services are inaccessible and inequitable. Too often support for children's SLCN is planned and funded based on the available resources, rather than what is needed, leading to an unacceptable level of variation across the country.
d) Support that makes a difference is based on the evidence of what works. However, service design and cuts frequently do not take account of the evidence we have.
e) Too many children with SLCN are being missed and are not getting the vital support they need.

Home learning is one of the biggest influences on early year's outcomes. The home learning environment refers to the physical characteristics of the home, but also the quality of learning

support received from parents and carers. Everyday conversations, make-believe play, and reading activities have particular influence, although daytime routines, trips to the park and visits to the library have also been shown to make a positive difference to children's language development. The early communication environment in the home provides the strongest influence on language development at 2, even more so than social background. This includes things like the number of books available, being read to by a parent, being engaged in a range of activities and the number of toys.

The Department for Education and Public Health England have formed a cross-government partnership to improve speech, language and communication in the early years for disadvantaged children.

1.2. Aims

The aim of the required intervention is to:

- improve speech, language and communication skills amongst preschool children
- intervene early, reducing the need for specialist speech and language intervention
- improve the knowledge of skills of local practitioners to help identify and address SLCN
- narrow the attainment gap between children who are eligible for Free School Meals (FSM) and their peers.

1.3. Objectives

The provider will not just deliver evidence-based interventions and services to children and families but will also increase the skills of the local Children's Centre Service and Early Years workforce and improve parental confidence and effectiveness in supporting their child's SLCN.

Improved SLCN outcomes could therefore be achieved through a range of methods including direct delivery of evidence-based interventions and services for children and families, training and supporting local practitioners, active promotion of home learning and SLCN campaigns.

Improvements in speech, language and communication skills should be reflected in the annual Early Years Foundation Stage Profile (EYFSP) and data stemming from the Department of Health's mandated health and development reviews for 2-2.5year olds, as well as the Provider's own evaluation and outcomes frameworks.

The provider will be required to work alongside the Nottinghamshire Children's Centre Service which is managed by Nottinghamshire County Council, and Healthy Family teams provided by Nottinghamshire Healthcare NHS Foundation Trust, as part of Nottinghamshire's multi-agency approach to speech, language and communication development and the Nottinghamshire Best Start Strategy.

1.4. Scope

The SLCN intervention will be required to cover all of Nottinghamshire with a key priority to target children eligible for Free School Meals and those living in low-income areas.
We know there are children and families who are more likely to experience a range of poor outcomes during pregnancy and the first 5 years of life. As the early years are critical in building child development, it is paramount that we understand who we need to target and why. Many children and families face several poor outcomes and share several risk factors which are often interlinked so a family in poverty may be destined for poor educational outcomes as well as poor health and well-being outcomes.

Nearly 50% of children from disadvantaged backgrounds have not secured the essential skills and understanding expected for their age by the time they finish Reception Year. Around 25% are unable to communicate effectively, control their own feelings and impulses or make sense of the world around them to ensure they are ready to learn. Many have reduced opportunities for home learning and parental engagement.

Children from more deprived backgrounds are more likely to experience Speech Language and Communication problems, with 23% of five-year olds eligible for FSM not meeting the expected levels in speech, language and communication at the end of Reception, compared to 13% of those not eligible for FSM across England. Progress in Nottinghamshire however is better than national

progress, although it is still evident that children eligible for FSM are less likely to achieve outcomes in comparison to their peers with 64.8% of children eligible for FSM achieved expected goals compared to 84.9% for their peers.

Within Nottinghamshire we know we have some key priority groups of vulnerable children, as defined in the Early Years and School Readiness Joint Strategic Needs Assessment (JSNA). Successful providers will need to ensure that efforts are made to engage preschool children and their families from these target groups:

- Children living in economic deprivation/low-income families.
- 2, 3- and 4-year-olds not accessing their childcare entitlements.
- Looked After Children and children known to Social Care.
- Children from some Black and Minority Ethnic Groups.
- Children with English as an Additional Language.
- Children with Special Educational Needs and Disabilities.
- Children with delayed language and specific speech, language and communication needs.
- Boys and Summer births with additional risk factors.
- Teenage Mothers and their Children.
- Children with mothers with mild to moderate mental health needs.
- Children and parents affected by Adverse Childhood Experiences (ACEs).
- Gypsy, Roma and Traveller (GRT) Families.
- Children with a family history of language or reading difficulties, or low adult responsiveness and interaction.
- 2–3-year-olds with expressive language delay.

2. Strategic Relevance

Nottinghamshire County Council has prioritised addressing the needs of families with preschool children as a key element of the County's early help approach.

2.1 A Local Priority

School readiness is a strong indicator of how prepared a child is to succeed in school cognitively, socially and emotionally. To assess how 'school ready' a child is, we use a measure called the good level of development (GLD). A child with a GLD at the Early Years Foundation Stage (EYFS) (from birth to five years old) will have reached the expected level in all the prime areas of learning which includes communication and language. Evidence shows that those who do not reach a GLD by age five, will go on to struggle with key skills such as communication, language, literacy and mathematics.

In 2018, 69.7% of Nottinghamshire pupils achieved a GLD compared to national data which shows that 71.5% of children achieved this measure. Data for statistically similar local authority neighbours shows that Nottinghamshire is ranked 13th out of 16 councils indicating that more needs to be done to improve children's development in Nottinghamshire. When examining 2018 data for children who are eligible for FSM, children from low-income households do less well than their peers. In 2018, 49.9% of children eligible for FSM in Nottinghamshire achieved a GLD. More information is available in the Early Years and School Readiness Joint Strategic Needs Assessment.

Nationally in 2018, 72.4% of children achieved at least the expected level of development across all the early learning goals within the Communication & Language and Literacy areas of learning. Locally, 82.6% of children achieved their expected level of above in all learning goals which comprise communication and language, however this reduces to 64.8% for children eligible for FSM.

We also know that about 4% of all primary school children are on the SEN register because of identified speech, language and communication needs, although other studies have shown that there are likely to be even more children than this who are having difficulties.

Most children develop typically, including those who grow up in disadvantage. There is, however, strong evidence to suggest that the achievement gap is underpinned by income-related gaps in children's language and communication skills, which are already detectable during the second year of life. Early intervention has an important role to play in supporting children who are showing early signs of atypical development,

Difficulties in early language development can lead to:

- educational disadvantage resulting in reduced school readiness and poor academic achievement,
- emotional and behavioural difficulties such as increased risk of ADHD and anxiety disorders in adolescence,
- risky behaviours, for example more than 70% of young people in the youth offender's system have a communication disability,
- involvement in offending - 50% of the UK prison population have language difficulties, compared to 17% of the general population,
- economic disadvantage - 12% average lower earnings among those with inadequate literacy skills, who are also twice as likely to be unemployed at age 34,
- emotional disadvantage - a threefold increased risk of mental health problems in adulthood.

Local data and further information regarding local needs are included in the Early Years and School Readiness Joint Strategic Needs Assessment (JSNA).

2.2 Local Strategic Context

Addressing SLCN helps to contribute to several local Strategies and priorities:

- Nottinghamshire County Council Plan Your Nottinghamshire, Your Future: The service will support the council's ambition to ensure that families prosper and achieve their potential which includes a target to ensure that more children achieve a good level of development by the end of reception year.
- Health and Wellbeing Strategy - This service will support the ambition to give every child a good start in life, a key priority of the Nottinghamshire Health and Wellbeing Strategy; it is recognised that the earliest years of a child's life can have an important impact on his or her long-term development, as these are formative years, physiologically, cognitively, socially and emotionally.
- Best Start Strategy 2021-2025 – The service will actively contribute to the development of the new Best Start Strategy which focuses on improving outcomes for children and families from pregnancy to the age of 4. Giving Children the Best Start in Life | Nottinghamshire County Council
- Early Years Improvement Plan: The service will actively contribute to the Early Years Improvement plan and Early Years Attainment Group which works in partnership to ensure children are ready for school.
- Early Help Strategy 2021-25 – The Early Help Strategy aims to bring together all early intervention activities across Nottinghamshire. Early Years is a key element of the strategy with priorities to ensure children are ready for school and improving life chances for children. Document.ashx (nottinghamshire.gov.uk)

2.3 Local Provision

Nottinghamshire currently has two main providers of work to address SLCN for children and young people, Nottinghamshire Healthcare NHS Foundation Trust and Doncaster and Bassetlaw Hospital Trust who provide services in Bassetlaw.

3. Service Specific Requirements

3.1. What is the service?

To deliver a range of interventions to improve speech, language and communication in pre-school children in Nottinghamshire. The service will both directly deliver interventions to children with identified SLCN as well as training and support for Children's Centre services working with pre-school children to ensure they have the knowledge and skills to identify SLCN's, support children's speech, language and communication development, and/or deliver interventions to meet SLCN's.

Interventions will include:

- Evidence based SLCN interventions delivered in the home and in community venues.
- Efforts to improve attainment levels of children and those from low-income families, therefore closing the attainment gap, and helping to ensure that all children are ready for school.
- An approach that actively promotes home learning and embeds parental engagement.

- Provide support on a consultation basis to the Children's Centre service, for children from vulnerable families with assessed SLCN's where there is evidence of their difficulty accessing community services.
- Support the early years sector through the provision of network events, targeting settings who operate in areas of deprivation and where there are high numbers of children from low-income families, to be identified in partnership with commissioners.

The service will work in partnership with the Children's Centre Service, Healthy Family Teams, early years providers and specialist speech and therapy service in Bassetlaw, as part of Nottinghamshire's multi-agency, early intervention approach:

- The Children's Centre service provide a range of support for children at risk of language difficulties, and with identified speech, language and communication needs.
- Healthy Family Teams deliver health and development reviews to children and often first identify speech, language and communication needs.
- Early years providers deliver childcare and early education in line with the EYFS and work closely with children to maximise their speech and language development.
- Specialist speech and language services for children who require specialist speech and language therapy.

The financial, physical and human resources associated with this Contract should be used exclusively for the provision of interventions to address Speech Language and Communication Needs for preschool children as identified in this service specification.

3.2. When is the service required?

The service will offer flexible, year-round services to ensure children can access timely interventions local to them. Services will be available across weekdays including provision on weekday early evenings where required to meet the needs of the child and family.

- Home Talk intervention should begin within 8 weeks of acceptance of referral.

3.3. Service location

SLCN interventions will be delivered in the home and accessible local community venues across Nottinghamshire including Children's Centre premises. The service will actively target areas of the county with higher deprivation and/or prevalence of SLCN.

The service will be invited to run activities within Children's Centre buildings, but office accommodation will not be provided unless the provider contributes to a service charge.

The provider will be responsible for the office accommodation and ICT requirements for the service.

Guidance, support and networks will be delivered to a range of early years professionals working with preschool children in Nottinghamshire, including but not limited to early years providers, the Children's Centre service and Healthy Family teams. In some cases, networks, support and training may take place within Ofsted registered early years settings who agree to host meetings and events.

3.4. Capacity of service

Home Talk™

- Home Talk is an evidence-based targeted home visiting programme licenced to NHCFT to support children who have moderate to severe expressive language delay at 2-2.5 years of age but who have no comprehension or social interaction difficulties. It has been designed to be part of a SLCN pathway, with its criteria for entry complementing that of specialist SLT and targeted selective (e.g. Little Talkers) services (see section 7 for pathway diagram). The programme is made up of between 3-6 visits, depending on the need identified on the first few visits. Children identified as in need of Specialist SLT early in the programme are referred on immediately. Most children will receive 6 visits and then a 3-month review. Families are either discharged after the three-month review or referred on to other services such as Specialist SLT if required.
- Each WTE Home Talk Worker will maintain an average active caseload of 12 at any one time.

- Home Talk Workers will be supervised by Early Intervention Speech and Language Therapists (EISLTh) who may also undertake joint visits with them to support decision making and goal setting. The EISLTh's will also triage Home Talk referrals and line manage the HTWs
- Home Talk workers or EISLTh may also undertake joint visits with specialist SLT services, Healthy Family Teams and Children's Centre staff members to triage referrals within each other's services.
- The provider will deliver the Home Talk programme to all eligible children as outlined above. Performance reviews will monitor take up, completion rates and outcomes for children and families.
- The provider will deliver Home Talk interventions to at least 650 children where there is an identified speech, language and communication need for children aged 2-3 in the household. Performance reviews will help understand the take up and completion rates.

Training and Workforce Development:
The EISLTs will provide the following:

- Deliver Little Talkers networks for relevant Children's Centre staff which will include 6 x half-days per year. For this year some of these networks may be longer to incorporate refresher training for staff that require it.
- To provide 2 language Lead network meetings twice in the contract period for local Early Years settings (North and south) for early years providers or a model that is at least equivalent to this. Some of these networks may incorporate 'new to the role' sessions.
- Further training requirements will be discussed if need arises, and capacity/budget allows.

Consultancy and Advice about children with SLCN under the age of 5 years:
The EISLTs will provide the following:

- The Early Intervention Speech and Language Therapists will provide one-off advice on the phone to CC staff. The aim of this is to support early identification and intervention of children under 5 with SLCN.

Social Media:

- To maintain the Language for Life Facebook page and webpages.

Strategic Partnerships and Engagement

- The provider will ensure representation at relevant strategic and locality partnership meetings including the new Best Start Partnership subgroups (SLCN, Early Years Attainment) and Early Years Locality Networks on an ad hoc basis.

3.5. Staffing / Sub-Contractors
It is not anticipated that the provider will require sub-contracting arrangements to deliver the service.
There are no specific staffing requirements beyond the training, skills and knowledge set out in section 5, however the service must balance the priority for home based SLCN interventions with some training and consultancy provided by therapists.

3.6. Resources to be provided by the Client
The Client will provide access to Nottinghamshire Children's Centre's for the delivery of interventions. There will be no charge for use of Children's Centre's to deliver interventions; specific dates and times will require agreement with the Authority.

3.7. Resources to be provided by the Supplier
The Supplier will be required to provide all resources associated with the delivery of the service including office bases and ICT equipment as well as resources for the delivery of interventions and training.
The Supplier will be required to provide all resources associated with the delivery of the service, including but not limited to ICT, telephones, photocopying and other resources for the delivery of interventions, training and networks.
The Supplier is also responsible for the provision of office accommodation through the payment of a service charge to enable use of office accommodation owned by the Client. If the Supplier chooses to make alternative arrangements, this would also be at their own cost.

3.8. Record keeping

The provider will ensure a robust electronic client record management system in in place. As a minimum this will include demographic information, assessment and progress, and outcomes monitoring.

These will be General Data Protection Regulation (GDPR) compliant, and the provider will facilitate appropriate information sharing with key partners in line with GDPR. Agreed data sharing protocols and information sharing agreements will be established with partner agencies to enable holistic care to be provided to children, young people and families and information will be shared and received electronically with key partner agencies. An information sharing agreement with Nottinghamshire County Council is already in place.

The provider with have a confidentiality policy and comply with the requirements of the Data Protection Act 2018. Parents and carers will be made aware of confidentiality, consent and when information may be disclosed in line with best practice.

The Information Sharing Agreement enables the service to work closely with the Children's Centre Service and other Council teams such as the Schools and Families Specialist Service. This will include some joint work with families, engagement at allocations meetings and sharing data and information to ensure that the needs of the child and family are met.

4. Legislation, Policies and Procedures

4.1. Legislation

The Supplier/s must comply with all relevant legislation relating to the service, which includes any updates and amendments. It is the supplier's responsibility to keep up to date with any such developments.

Listed below is some of the relevant legislation that the Supplier is expected to comply with and is not meant to be exhaustive:

- The Childcare Act 2006
- The Child Poverty Act 2010
- Welfare and Work Reform Act 2016
- The Children and Families Act 2014
- The Children Act 1989 and 2004
- The Adoption and Children Act 2002
- Education Act 1996, 2002 and 2011
- Health and Social Care Act 2001, 2008 and 2012
- Safeguarding of Vulnerable Groups Act 2006
- Mental Health Act 1983 and 2007
- Mental Capacity Act 2005
- The Equality Act 2010
- National Health Service Act 2006
- Sex Offenders Act 1997 as amended by part 2 of the Sexual Offences Act 2003
- Police and Justice Act 2006

In addition, there are number of pieces of guidance or policy the provider is expected to be familiar with:

- Best start in speech, language and communication: Guidance to support local commissioners and service leads (PHE 2020)
- Early Intervention Foundation Maturity Matrix (2018)
- Early Intervention Foundation: Language as a child Wellbeing Strategy (2017)
- Statutory Framework for the Early Years Foundation Stage (2018)
- Healthy Child Programme: Pregnancy and the first 5 years of life (2015)
- Bercow: Ten Years On (2018)
- State of the Nation (2018-19)
- Children's Commissioner: We Need to Talk (2019)
- Nottinghamshire Health and Wellbeing Strategy (2018-2022)
- Nottinghamshire Strategy for Improving Education Opportunities for All
- Nottinghamshire Child Poverty Strategy
- The Best Start for Life: a vision for the 1,001 critical days

4.2. Business, Employment and Staffing Practices

The Supplier/s shall have in place and available for scrutiny, sufficient, robust and up to date written policies, procedures and codes of practices. This includes adequate instruction, guidance and support for staff in the function and delivery of the service outlined within the specification. These should be accessible and available to all stakeholders including customers; such policies and procedure documents should include:

- Equalities and Diversity Standards
- Recruitment and Selection Policy
- Staff Induction, supervision, appraisal, training and development
- Staff Code of Conduct, including professional boundaries
- Business Continuity Plan, to include; risk assessment and contingency in relation to interruption / closure of service i.e. power cut, inclement weather, unforeseen staff absence etc.
- Management & Risk Assessment
- Complaints; for all stakeholders i.e. service users, families, carers and staff
- Safeguarding Vulnerable Adults and Children
- General Data Protection Regulations
- Whistle Blowing
- Confidentiality and Data Protection
- Health and Safety (including lone working)
- Anti-Bullying
- Grievance
- Recruitment and use of Volunteers

Children and young people, their families and carers shall be given written information on the Service and the Supplier's complaints procedure. The complaints and representations procedure shall be compatible with the requirements of the Children Act 1989 and 2004.

5. Workforce

The provider will ensure the workforce is appropriately qualified and experienced, annually appraised and in receipt of appropriate ongoing training in order that they can best meet the objectives of this service and maintain knowledge, skills and competencies. This should include professional registration where required.

Clinical and safeguarding supervision will be provided for all appropriate staff supported by clear policies.

Home Talk workers will be required to have at least an NVQ 3 in a relevant field.
Qualified Speech and Language Therapists will be responsible for the line management of Home Talk workers in line with the local evidence base for the programme. Therapists will also lead on training and consultancy work.
Apprenticeships may be provided where appropriate.
The workforce will require an enhanced DBS check.

6. Referral, Access and Acceptance Criteria

6.1. Who will access the service?

The service will be provided for the following groups, as detailed:
Early identification and Early Help for Children with Speech Language and Communication Needs (Targeted Offer)

The Home Talk programme will provide an evidence-based targeted-indicated home visiting programme to support children aged 2-2.5 years who have moderate - severe expressive language delay i.e., have fewer than 30 words expressively at 2-2½ years of age but who have no comprehension or social interaction difficulties.

Home Talk will equip parents with strategies and techniques to effectively support their child to minimise the impacts of the early language delay on other areas of development.

The provider will work closely with and support the Children's Centre Service to help increase their understanding of SLCN, identify children with emerging SLCNs and enable them to provide initial and appropriate support to provide help as early as possible to address the delay and mitigate

against the impact on the rest of the child's development. This support will also enable timely referrals to be made to the most appropriate service, particularly following the 2-2½ year review.

The provider will actively target areas with greater levels of child poverty and 2–3-year-olds with characteristics linked to poor outcomes for school readiness. These groups are described in section 1.4.

As part of the Council's wider Early Help offer, the provider will deliver language lead networks for practitioners within CC the Early Years Sector (PVI and Schools) to enable them to understand the importance on speech, language and communication to ensure all children reach their speech, language and communication potential and to prevent language delays, identifying and addressing SLCN as early as possible.

The provider will be required to support early years settings (PVI and schools) to enable them to identify and provide early appropriate support for children with speech, language and communication needs. They will also support Early Years Practitioners to high quality communication environments and interactions to enable all children to reach their speech, language and communication potential. This will be carried out through Language Lead networks.

Children in Need of Specialist Speech and Language Therapy Services
The Early Intervention Speech and Language Therapists are not expected to work with children who meet criteria for the Specialist Speech and Language Therapy Service but to work through others to engage families as early as possible to mitigate against further speech, language and communication needs that impact on the child's GLD.

The provider will support appropriate referrals/pathways to the Specialist Speech and Language Therapy service (Nottinghamshire and Bassetlaw Services) to ensure that children with identified long-term persistent Speech, Language and Communication Needs are referred in a timely manner.

The provider will work in partnership with the Specialist Speech and Language Therapy service to ensure that families experience a streamlined care pathway.

The needs of the child should be central to decisions about transferring care. Children may access more than one service across the SLCN multi-agency pathway where it is identified to be of benefit to a child's language development, but children will not receive Home Talk and SLT simultaneously. If children meet criteria for Home Talk and Specialist Speech and Language Therapy Services, these services should be prioritised for access over other Early Intervention Services e.g., Little Talkers/Let's Play. The provider will work with other service providers to ensure the overall support pathway for families is streamlined and appropriate.

6.2. How will the service be accessed?
Children will be referred to Home Talk by Healthy Family Teams, the Children's Centre Service, and early years providers (PVI and schools). Any assessments carried out by referrers will need to be shared with the provider. Children may also be identified and referred by specialist speech and language therapy services, following triage or assessment.

As part of the 5 Department of Health mandated Healthy Child Programme reviews Healthy Families Teams will conduct a 2-2.5-year-old development review which includes a SLCN assessment. Children demonstrating a SLCN, that does not meet the threshold for specialist provision, will be referred for a Home Talk intervention as appropriate.

Parents can also self-refer to access the service if they have concerns about their child's speech, language and communication. Self-referrals will be supported by Children's Centre workers, and Healthy Family Teams. Assessments will be required for all children referred to the service by parents to ensure that SLCN interventions are appropriate.

The provider will be required to implement an assessment of SLCN needs, building on previous assessments made by Healthy Family Teams where available.

The Children's Centre case allocation meetings will invite Home Talk workers or Speech and Language Therapists if referrals are made to the CC service in relation to SLCN and wider home learning. Allocations meetings will ensure that families are referred appropriately and can access the right service or intervention.

Home Talk workers will be encouraged to work alongside Children's Centre staff to complete joint assessments, ensuring that the needs of children and families are identified, and effective support packages are in place.

Referral criteria for delivery of SLCN's interventions will be set by the provider, however, should include:
Home Talk for 2-2.5-year-olds
At 2 yrs: Children who have 0 to 30 words and have no social interaction or comprehension problems. 2 – 2 ½ year review
Closer to 2½ years: Children who:

- have no social interaction or comprehension problems
- are not using a wide range of single words (less than 50)
- are only using single words and learnt phrase. A learnt phrase is one which the child may have learnt as if it is one word e.g.," thank you", "night night"

Closer to 3 years: Children who:

- missed their 2-2.5 review and are found to have a language need identified by partners including early years settings, the Children's Centre Service, and Healthy Family Teams where the child does not meet the threshold for an immediate referral to the SSLT. This cohort will exclude who have already been referred for specialist SLCN support by other SSLT/SFSS/HT or relevant CC services.
- Children aged 2.5 years who live in the defined area and did not achieve expected level in any ASQ area at 2-2.5 years and have not been referred onto other SSLT/SFSS/HT or relevant CC services.

The service is not expected to deliver SLCN's interventions to:

- Children with complex needs and / or presenting with a clear indication of ASD.
- Children with significant understanding difficulties such as not understanding single words or basic instructions at home.
- Children with other SLCN such as stammering which require specialist Speech and Language Therapy.
- Children over the age of 3.

7. Partnership Working

A number of key services work in partnership to promote speech, language and communication development:

- The Children's Centre Service supports pregnant women and families with children under 5, with a key outcome to support children to achieve a good level of development, be ready for school, and close the attainment gap. Support provided by the Children's Centre Service includes evidence-based interventions and group programmes for children at risk of language difficulties. Moving forwards all Early Years roles in the Children's Centre service will be equipped with the knowledge and skills to both identify and address speech, language and communication needs with the children and families they work with.
- Healthy Family Teams are comprised of a range of practitioners, including health visitors and school nurses, who deliver public health nursing services to children and young people aged 0 to 19. Provided by Nottinghamshire NHS Foundation Trust, Healthy Family teams deliver health and development reviews using the Ages and Stages Questionnaire to 1 and 2-2.5 years, including the delivery of a language screen at 2-2.5 years.
- Early years providers in Nottinghamshire: in June 2019, there were 1,068 Ofsted registered providers delivering funded Childcare and Early Education across Nottinghamshire, including schools. All Childcare and Early Education providers are registered with Ofsted, and work towards the EYFS. Local data regarding childcare provision in Nottinghamshire is included in the annual Childcare Sufficiency Assessment available here Early Childhood Services. Early years settings provide good language environments and use appropriate strategies to support children's language development.

- Specialist speech and language therapy services: in Mid and South Nottinghamshire these are part of the Community Children and Young People's Service (CCYPS), provided by Nottinghamshire NHS Foundation Trust. In Bassetlaw these services are provided by Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

These partners work together to identify SLCN's in pre-school children and provide appropriate support by:

- supporting children to achieve expected levels of speech, language and communication development wherever possible
- identifying early children at risk of, or with suspected, speech, language and communication needs or delay
- delivering appropriate SLCN support and interventions, including speech and language therapy
- promoting early intervention and prevention
- ensuring children receive the right level of support, depending on their needs, and transition seamlessly between services or support as their needs change. Children may access more than one level of support at a time, for example a child accessing specialist support often benefit from a children's centre programme or group promoting language development.

The provider will build close working relationships with the above partners to ensure appropriate referrals are made, and children receive seamless care, moving between services as required to ensure that identified speech, language and communication needs are met by the most appropriate service.

The SLCN Pathway summarises Nottinghamshire's multi-agency response to SLCN's in pre-school children and provides an indication of the providers role within it. This is included in Appendix One.

8. Safeguarding / Child Protection

The provider will deliver the service in line with the policies and procedures of the Nottinghamshire Children's Safeguarding Children Partnership, Working Together to Safeguard Children (2018) and the Nottinghamshire Adults Safeguarding Board:
This will include:

- working in partnership with other key stakeholders to help promote the welfare and safety of children and young people
- contributing to reducing the number of children who enter the safeguarding system through preventative and early help work
- supporting safeguarding and access to early help and targeted family support, including engagement in the Troubled Families programme
- being aware of and supporting children with an early help assessment, child in need, child protection or Looked After Child plan
- contributing to multi-agency decision-making, assessments, planning and interventions, relating to children in need, children at risk of harm and Looked After Children
- contributing to individual case management issues, handling or crisis and emergency situations with other partners as required.

Referrals made to the MASH that are rejected should be signposted to the Children's Centre Service to access family support services. The provider will need to ensure that appropriate information and safeguarding concerns are shared with the Children's Centre Service.

The provider will work in line with best practice in relation to adult safeguarding set out in the Care Act 2014 and the Mental Capacity Act 2005.

The provider will work to identify children and young people at increased risk or need in line with these levels of support and refer as appropriate using Nottinghamshire's Pathway to Provision framework including the use of the Early Help Assessment Framework (EHAF) wherever appropriate, this pathway can be accessed via http://www.nottinghamshire.gov.uk/care/childrens-social-care/nottinghamshire-childrens-trust/pathway-to-provision

9. Expected Outcomes

The service will be expected to contribute to the delivery of these priority outcomes:

- Improving the proportion of children who have a good level of development in communication and language skills aged 5 years (EYFS).
- Improving the proportion of children at or above the expected level of development in communication skills aged 2-2.5 years (ASQ).
- Narrowing the attainment gap between children who are eligible for FSM and their peers.
- Children with speech, language and communication needs are identified early and supported to address their needs as soon as possible.
- Reducing the number of children starting school with unidentified speech, language and communication needs.
- Children achieve developmental milestones and are ready for school.

In addition, the provider will help achieve the following:

- Early Years Practitioners within the Children's Centre Service have the skills and knowledge to support parents to improve speech and language through interventions in the home.
- Early years practitioners in targeted early years settings are skilled and equipped to identify SLCN and to address emerging needs within their setting.
- Parents and carers of preschool children have the skills and tools to enable them to prevent speech, language and communication delays and support their child's language development.
- Children receiving interventions for SLCN's make sustained progresses following intervention.
- Children requiring specialist SLT support are identified and referred promptly.
- Parents and children experience a seamless pathway when transition is required between targeted and specialist SLCN services.

9.1. Monitoring Information

The provider will ensure that data collection and monitoring, effectively captures outcomes measures and measures impact against the outcomes listed above.

Measurement tools such as evaluation forms will be shared with commissioners during the mobilisation stage for review and approval to ensure outcome measures are reportable to evidence impact.
Reporting templates will be developed and agreed by the commissioner and provider during the mobilisation phase.

In addition to KPIs, commissioners require an impact report focusing on the training and consultancy elements of the service.
Commissioner will consider implementing 2 – 3 quality assurance visits for the duration of this contract.

The service will be required to report quarterly on a range of outcomes, key performance indicators and activity measures.

10. Social Value and Ethics

The 'Social Value' Act has been in force since 1 January 2013. It applies to services contracts only and places a statutory obligation on all public bodies in England and Wales to consider their Economic, Social and Environmental impact.
To this end each contracted Supplier should consider how its service contributes to social value, this could include the following:

- Supply chain opportunities advertised locally,
- Living wage,
- volunteering opportunities,
- offering of apprenticeships or over employment to local residents,
- making available facilities for local communities,
- undertaking additional activities for the benefit of local communities,
- specific and proportionate environmental requirements etc.

11. Equality & Diversity

The delivery of the service will be in accordance with the Council's Equality and Diversity Policy https://www.nottinghamshire.gov.uk/media/106673/equalitypolicy.pdf.
Services will be provided in an anti-discriminatory manner, including (but not limited to) taking into account gender, race, age, culture, religion, belief, language spoken, sexual orientation or disability.

The service will progress any requirements to promote accessible to certain communities.
The service will understand and address any community/culturally specific elements of service delivery including supporting children with English as an Additional Language (EAL) for example.

12. Health & Safety

The service will be delivered in line with Health and Safety legislation to ensure the health and safety of service users, staff and others including but not limited to:

- Lone working
- Fire safety
- COSHH
- Manual Handling
- First Aid
- H&S Audits

13. The total cost of the service will include:

The financial, physical and human resources available for this contract should be used exclusively for the delivery of the service as defined in this service specification.

Pay costs in this model at date of contract agreement relate to:

- 11.5 WTE Home Talk Workers to deliver the Home Talk model
- 2 WTE Therapists to deliver the Home Talk model, clinical supervision, one off advice for the CC service, line management, and networks.
- 0.4 WTW Administrator

13.3 Financial Information

The supplier shall ensure that any financial information supplied adheres to the principles of Open Book Accounting and should include the completion of a Cost Calculator Breakdown as a minimum showing:

- Direct staffing costs e.g. salary, NI/ Pension contributions, consultant costs etc.
- Indirect staffing costs e.g. travel, training, mobile phones etc.
- Non-staffing costs e.g. premises costs, rates, utilities, corporate overheads, contribution to surplus etc.
- Premises rental costs and/or service charges
- Premises repair and maintenance costs if appropriate

The provider may deliver a sold service aimed at improving speech, language and communication in pre-school and primary school aged children. This could consist of training, support and/or intervention aimed at supporting speech, language and communication development in pre-school and primary school age children. This however will need to be at neutral cost to the commissioner, and all expenditure (including staffing time) is offset by the income generated. Through open book accounting, the Trust will demonstrate that the financial resources available for this contract are used exclusively for the delivery of this service specification.

The service can apply for additional funding streams; however, the Provider will need to ensure this either ends at the end of this contract or is fully funded by an external grant after this contract ends. The council will not be able to subsidise any work that is funded through an external grant or other funding stream.

SUB SPECIFICATION C: Children and Young People's Speech and Language Therapy

Please note: This is not a standalone specification. It forms part of and should be read and used in conjunction with the CCYPS specification above and accompanying appendices below.

Purpose

The Children and Young People's Speech and Language Therapy (SLT) element of the CCYPS will provide specialist support for children/young people with speech, language and communication needs (SLCN) and/or swallowing and feeding difficulties (Dysphagia).

The Children and Young People's SLCN service will support a single pathway from early intervention through to the specialist service. It will deliver interventions based on assessment of an individual's need in conjunction with others who have a role in relation to the child's development and well-being e.g., parent, support worker, school staff, to improve or maintain speech, language and communication skills, including facilitating safe swallowing.

It will be provided within a multi-agency team approach recognizing that working through others to optimize and maintain a child/young person's communication skills requires partnership working with other service providers including health services, education services, social services and the voluntary sector.

In addition to those listed in the Scope, see 3.1, the objectives are to:

- Achieve a measurable improvement, where possible, in speech, language and communication for children with identified speech, language and communication needs/difficulties
- Support safe swallowing which reduces health risks – preventing choking, respiratory difficulties; reduces the risk of surgical intervention, poor nutrition and length of hospital stay associated with swallowing difficulties
- Improve participation in family, social, educational and occupational activities, and increase self-esteem and confidence
- Improve attainment at school through better access to the curriculum as a result of a therapeutic intervention, advice and recommended adaptations
- Enhance the communication and interaction of children for which assistive technology and augmentative communication systems are introduced

Categories of need
The provider will support children and young people with speech, language and communication needs who without speech and language therapy may not reach their full speech, language and communication potential. This includes but is not limited to children and young people with:

- Developmental Language Disorder
- Specific speech difficulties.
- Craniofacial and velopharyngeal disorders.
- Dysfluency/stammering.
- Learning disabilities.
- Voice disorders.
- Developmental delay.
- Neurological disorders.
- Pervasive developmental difficulties e.g., autism.
- Swallowing and feeding difficulties.
- Speech and language difficulties associated with severe and profound hearing impairment.

The provider will work collaboratively to develop coordinated or integrated clinical care pathways to provide appropriate therapeutic interventions.

Workforce:
Care packages will be tailored to individual needs and will be delivered by therapists and speech therapy support workers from a broad skills and knowledge base, to meet a spectrum of needs and degrees of complexity/specialty, enabling flexible and responsive delivery.
The provider will deliver high quality evidence-based care to:

- Assess, diagnose, design and deliver care packages specific groups of children and young people with speech, language and communication difficulties and/or swallowing difficulties.
- Deliver direct and indirect evidence-based interventions or packages of care based on assessment of an individual's need. Interventions will meet individual assessed need and incorporate robust goal setting actively involving the child or young person, their parents/carers and other key services or people.

- Ensure the child/young person reaches their maximum speech, language and communication potential.
- Provide training to key staff and carers that will support specific children and young people on the caseload with SLCN and/or swallowing difficulties achieving their SLC potential.
- Provide SLT specialist input as clinically appropriate to inform assessments for diagnosis of e.g., Autistic Spectrum Disorder (ASD), in line with local pathways.
- Contribute to maximising the child/young person's potential for independence, including proactive support and planning for transition.
- Recommend appropriate assistive technology and augmentative communication systems, support the introduction of these and establish appropriate care pathways with equipment providers.
- Work with SEND policy and provision colleagues to assess and provide expert opinion/advice for SEND tribunals for children who meet the criteria for the service as required and to assess and provide expert opinion/advice regarding provision based on need.

SUB SPECIFICATION D: Children and Young People's Community Nursing
Please note: This is not a standalone specification. It forms part of and should be read and used in conjunction with the CCYPS specification above and accompanying appendices below.

Purpose
"NHS at home: Community Children's Nursing Services" (DH March 2011) summarises the contribution community children's nursing services, as a key component of community children's services, can make to improving the outcomes for children, young people and their families. The guidance separates the needs of ill and disabled children and young people into four groups:

- Children with acute and short-term conditions (requiring interventions over and above those provided by universal and primary care services, to avoid hospital admission and/or reduce length of stay)
- Children with long-term conditions (this excludes the activity delivered by condition specific Clinical Nurse Specialists based within Acute Trusts)
- Children with disabilities and complex conditions, including those with continuing care packages in need of additional support from CCYPS
- Children with life-limiting and life-threatening illnesses and conditions, including those requiring palliative and end of life care

The children and young people's community nursing element of CCYPS service will provide high quality, responsive community-based nursing care, which includes holistic health needs assessments with the implementation of individual nursing care plans for children and young people with acute and additional health needs including disability and complex needs and those requiring palliative and end of life care.
In addition to those listed in the Scope, see 3.1, the objectives are to:

- Provide responsive nursing care and support when children and young people have community nursing needs wherever they may reasonably be expected to be.
- Support children and young people to achieve optimum health, reduce the impact of their illness and/or condition on their health and wellbeing and enhance quality of life.
- Support children and young people at the end of life (and their families) to have a positive experience wherever possible, including choice of place of care.
- Offer multi-agency support to enable others to provide care to this cohort of service users. This includes providing support to schools to develop care plans that will enable schools to ensure children and young people gain optimal benefit from the educational setting. This support should be led by the most appropriate professional within the service. This is in line with requirements from the Department for Education (2015) Supporting pupils with medical conditions in schools.

Categories of need
The provider will support children and young people with nursing needs that cannot be met by universal services and can be safely managed in the community.
Some examples of interventions and nursing support to be delivered by the service include, but are in no way limited to:

- Administration of medication (including intravenous medication, enteral medication and emergency medication)
- Administration of chemotherapy and taking oncology bloods, in partnership/liaison with the Paediatric Oncology Outreach Nurses (POONs)
- Central venous lines, portacath care including taking of bloods
- Wound care
- Enteral management and support (including re-siting of gastrostomy tubes/peg and nasogastric tubes)
- Eliminating, including continence support: working in partnership with the 0-19 Healthy Families Programme to provide tier one continence support for any child with a continence need over and above the universal service offer (including enuresis)
- Respiratory and tracheostomy care
- Home oxygen therapy and ventilation care
- Oral suction/nasal suction
- Newborn blood spot for babies who move into area

The service will use the Together for Short Lives 'A Core Care Pathway for Children/young people with Life- threatening and Life-limiting Conditions Framework' to support delivery using guidance from the Children's Act (2004).

Workforce:
Children's community nursing will be delivered by a team of nurses from a broad skills and knowledge base to meet a broad spectrum of needs and degrees of complexity/specialism. This will include an appropriate skill-mix of paediatric nurses and other NMC registered nurses supported by multi-skilled nursing associates, support workers and healthcare assistants.
Nursing care in the community, including schools
The provider will deliver high quality evidence-based care to:

- Undertake holistic health needs assessment with the implementation of individualised nursing care plans for children and young people with additional health needs.
- Provide timely assessment, treatment and nursing intervention, with an aim of providing care in the community; at home or in school (including all special schools).
- Provide ongoing clinical monitoring of children/young people who have an unstable medical condition, illness and/or a life limiting or life-threatening condition.
- Provide holistic, ongoing support from point of referral until discharge is appropriate, with a coordinated MDT approach.
- Provide long-term support for all children and young people known to the service with long-term conditions on a regular basis.
- Work in partnership with other agencies to provide services which address the child or young person's health, acute, social, educational and emotional needs throughout the period of their illness.
- Provide assessment and intensive nursing support and interventions to children and young people in community settings, including their home, for children and young people with acute episodes to avoid admission to hospital services where clinically safe and appropriate.
- Deliver prevention and earlier interventions for children and young people with needs that cannot be met by universal services to reduce risks, improve future health and well-being and/or prevent deterioration in health conditions
- Work in partnership with universal services to follow up repeat attendances and discharges from acute services and deliver appropriate intervention and support.
- Mechanisms will be in place to enable referrals to be triaged 7 days a week, 365 days a year to facilitate safe timely discharge from the acute setting and/or support avoidance of acute admission/attendance.

Palliative and End of Life Care
The service will provide palliative and end of life care to children and young people who are 0 - 18. A multi-disciplinary team will provide high quality evidence-based care:

- To ensure that there is multidisciplinary person-centred working, and that the teams work in partnership with continuing care and other services who come into contact with the child.
- To consider implementing a package of care around the family prior to and following the death of the child or young person.

- To offer immediate bereavement support services.
- To sign post families to bereavement support services where appropriate.
- To ensure that there is parallel planning with continuing care providers for alternative outcomes whilst providing palliative and end of life care and support.
- To ensure that there is good communication and parallel planning with other community nursing services within the Trust for alternative outcomes whilst providing palliative and end of life care support.

Continuing Care: Oak Field School (Nottingham City)
All day one to one care in school for children and young people will have their individually assessed health needs met through the provision of children's continuing care (see 3.2.4 e) ii) Children's continuing care) and/or appropriately trained multi-skilled teaching assistants. This is undertaken via arrangements between health and education commissioners and falls outside of the direct provision within this contract (see 3.5.1 Sale of additional provision). An exception to this approach is for Oak Field School where there is an identified quantum of need for a small cohort of Nottingham City PBP registered children who have highly complex needs, see below.
The service will provide a pool of appropriately trained and skilled staff to support a small number of children and young people with continuing care needs attending Oakfield School, including dedicated 1:1 support delivered throughout the school day.
A multi-disciplinary team will provide high quality evidence-based care to:

- Deliver personal health care support throughout the school day (including specialist nursing care and interventions) to support children and young people who are continuing care funded to access education and support children and young people to fulfil their potential and manage any deterioration in health or impending health crisis by providing a named keyworker.
- When a child or young person is unwell and cannot access education, the service will ensure that the care is delivered within the home in conjunction with the child or young person's GP or paediatrician, on a short-term basis where appropriate.

The above will be supported by appropriately skilled health care practitioners for 7 identified children and young people funded through continuing care.

SUB SPECIFICATION E: Children and Young People's Community Phlebotomy
Please note: This is not a standalone specification. It forms part of and should be read and used in conjunction with the CCYPS specification above and accompanying appendices below.

Purpose
To provide a responsive community phlebotomy service for identified categories of children and young people
Categories of need:
The provider will support children and young people requiring phlebotomy services as follows:

- All children and young people aged 1-12 years registered with a GP in the South Nottinghamshire Place Based Partnership (Rushcliffe, Nottingham North and East, Nottingham West) and Nottingham City Place Based Partnership.
- Children and young people with additional needs* aged 1-18 (19 in education) registered with a GP in South Nottinghamshire and Nottingham City Place Based Partnerships.

*'Additional needs' is defined as a CYP on the caseload of the CCYPS service or CYP whose emotional, developmental, social or health needs mean they require additional support not available in alternative universal phlebotomy provision.

Workforce:
Interventions will be delivered by appropriately trained and skilled professionals to meet the needs of the children and young people who are eligible for the service.
The provider will deliver high quality evidence-based care to:

- Develop innovative solutions to deliver phlebotomy to best meet the needs of the identified populations (as a minimum this will include weekly phlebotomy clinics aligned to locality-based models of working across Rushcliffe, Nottingham North and East, Nottingham West and Nottingham City ICB areas).
- Take blood samples as required, based on medical need for investigations.
- Keep auditable electronic records of bloods taken.

- Safely store blood samples, ready for transportation to the pathology laboratory for analysis (the provider will align to the existing phlebotomy pathway(s) and provider supply chain
- Ensure that bloods are ready for pick up and processing from one of the existing collection locations to ensure that the rest of the pathway does not incur any further costs.

During the life of the contract the provider will participate fully with commissioners to evaluate and develop this element of the service. Following review of the services in Mid Nottinghamshire this service may be extended to offer additional provision in these areas.

APPENDIX 1: Families Statement of Expectations
CCYPS Programme Families Statement of Expectations
Our values are...
Respect
Collaboration
Continual improvement

1. "No decision about me without me".

We are consulted and listened to, heard and treated with respect as experts on our/our own child's condition and have our views taken into account at all times.

2. Access to information and supplies.

We can easily get information, advice and guidance, and the services and supplies that we need, when we need them, so that our family can enjoy the best possible health and fulfilling lives. This should enable and support our roles, lifestyle choices and aspirations.

3. Whole systems working.

There is collaborative, joined up and timely planning and service delivery, with all parts working as a whole across all organisations and agencies involved in every aspect of our children's care.

4. Child/young person-centred care.

Every child/young person is treated as an individual.

5. Communication and record sharing.

There is timely communication and shared documentation including core essential information about our children, their condition and their support between all those who need to be involved.

6. Capacity, competency and empathy.

We are confident that there are enough staff, who have the right knowledge, skills and expertise for what they are there to do, and they demonstrate this by empathy and understanding in all contacts.

7. Transition.

Children/young people are supported to achieve responsibility for themselves as adults and the family is supported during this period of transition to adulthood and reduced dependence on the family.

8. Continual improvement.

We can see that everyone involved in our children's care is committed to continually improving what they do.

9. Care environment.

Children/young people are seen in age-appropriate environments furnished and equipped to meet their needs, taking into account chronological and developmental age.

10. Safety. *

At all times our children are protected from harm.

*Please note this is wider than safeguarding - consider points such as moving and handling training for parents, safe use of equipment etc.

APPENDIX 2: Phase 1 Recommendations
The Joint Nottinghamshire CCYPS Programme Phase 1 Recommendations are:

1. The 'Families' statement of expectations' should be used as guiding principles in the design, commissioning and provision of services and to develop standards to measure service user experience against.
2. Involve parents and young people in the development phase and prototyping of proposed integration.
3. Promote 'Contact a Family' resources for general practice and encourage GP practices to complete the self-assessment to identify key areas of focus. This will support GPs to enable families with children and young people with disabilities to access GP services and to reduce hospital admissions.
4. Develop education and training opportunities for GPs and practices.

5. Identify GP champions to raise the profile of the CCYPS programme in phase 2
6. Develop a Practice Specific Objectives Target for 2014/15 (Nottingham City ICB) to update patient registers with specific categories (e.g. carers) and define some parameters of care which would help GPs to support children and young people with additional health needs and their families.
7. Develop and implement a mobile working system for children's community services.
8. Continue to monitor data to identify any further areas of work to focus on, in particular analysis of workforce data to assess competencies and skill mix to inform a workforce development plan.
9. Develop meaningful quality and outcome measures as key performance indicators, which can be reported without creating burdensome and unnecessary bureaucracy for providers or commissioners. This should include standard, comparable measures relevant to all services to facilitate ease of reporting and consistency and to enable benchmarking as well as key outcome measures appropriate to individual services.
10. Adopt/adapt the Family Friendly Framework (FFF) in phase 2 of the CCYPS programme to support the development of a coordinated network model of children's community health services and pathways designed around the needs of children, young people and families, to reduce duplication, achieve seamless flow between services and good experience and outcomes.
11. Prototype shared records, assessments and care plans in children's community nursing services.
12. Align the CCYPS programme with the SEND legislation development work in Nottingham City and Nottinghamshire County in phase 2
13. Develop ICT functionality and compatibility across organisations.
14. Invest in increased use of assistive technology to address the individual needs of children and young people as part of the development of coordinated services and support.
15. In developing a single point of access and multi-agency, multi-disciplinary hub ensure that the challenges and considerations identified in phase 1 are included.
16. Develop key working for families with children with additional needs in collaboration with SEND legislation development work in Nottingham City and Nottinghamshire County in phase 2.
17. Ensure that proactive transition pathways, planning and support, including personal health budgets, for all children with additional needs are included in the new service network.
18. Build mental health prevention, recognition and early support and access to mental health services for any member of the family into a coordinated model and service specifications, which considers the mental health needs of the whole family.
19. Embed the principles of good safeguarding and early intervention to meet the 'children's request for protection' ('Working together to safeguard children') within the design, development, specification and delivery of coordinated services.
20. Ensure all work of the Mid-Nottinghamshire NHS Integrated Care Transformation Programme (ICTP) and CCYPS Programme is aligned in phase 2 of the programme (County only).

APPENDIX 3: Coordinated model of children's service delivery
The essential interdependent elements of a coordinated model of children and young people's community health care delivery

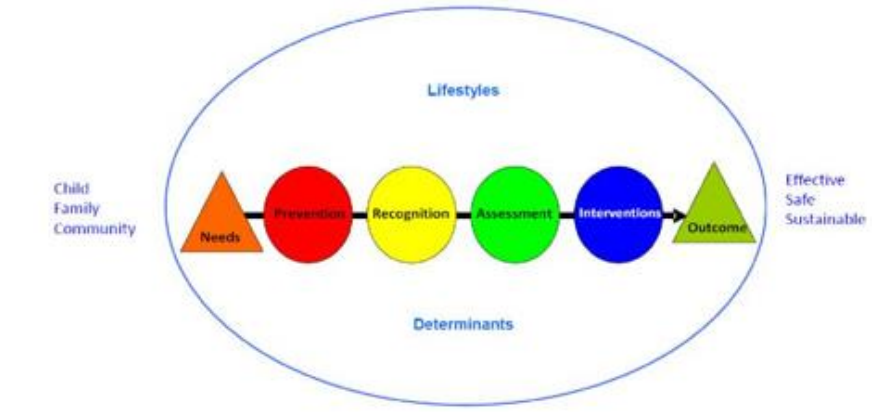
APPENDIX 4: Pathway and Network Definitions

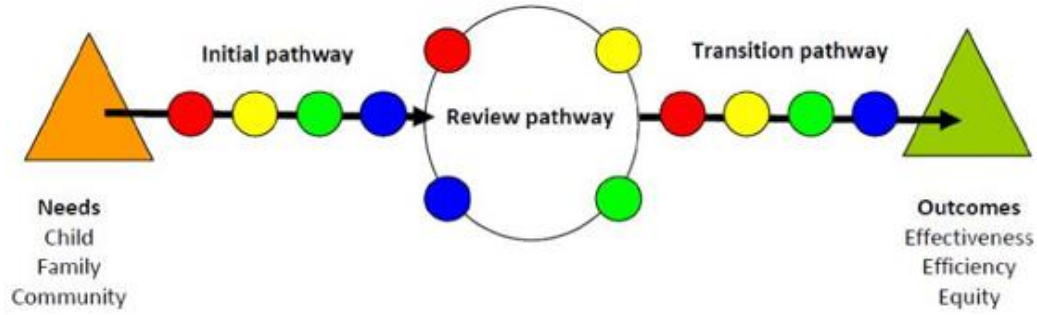
A pathway is a description of the best management of a concern/condition. For a short-term condition, it links four component parts: prevention, recognition, assessment and interventions. For a long-term condition these component parts are replicated into a programme of care consisting of the initial pathway (up to diagnosis and treatment), a review pathway (living with the condition) and transition pathway (back to normal, onto adult services or into end-of-life care/services) illustrated in Figure 2.

A network comprises all the teams that deliver component parts of the pathway and are involved with the management of a group of conditions which collectively strive for continuous improvement.

Pathway components:

Illustration of the FFF long-term pathway with 3 phases – the initial, review and transition phases, each with four component parts.





APPENDIX 5: Information Management and Technology (IMT) Requirements
To deliver the CCYPS it is anticipated that information management and technology (IMT) will be a key enabler. Whilst the specific information system functional requirement will vary across the spectrum of care there are several expectations that will be consistent.

Access to a shared or integrated record that allows the care provider/s to gain insight into the whole picture of care will be essential. Whilst it is important that this should conform to best practice Information Governance policy, including appropriate levels of consent and choice, this should not hinder the ability of care professionals to access all the information they need electronically. It is anticipated that this would be demonstrated through appropriate Data Sharing Contracts and Information Sharing Agreements supported by good policy and advice to care providers to ensure the right balance between choice and an unnecessary burden being placed on the service users and their carers. This will support transition from service to service and avoid unnecessary repetition for families when dealing with multiple services of care.

With more emphasis on supporting self-care and carers the provision of patient access to a shared care record will also improve communication with families and clarity on how care plans are to be delivered. Existing pieces of work to consider and align with in this field include: the Nottinghamshire Children's Wiki for Education, Health and Care Plans and the NHS England Patient On-line Access to GP Records Projects.

To ensure the safest, most effective and efficient service is provided, it is anticipated that care staff will have access to the necessary information contained in shared or integrated records whilst at the patient side, in the location that fits the patient's needs. This will require mobile access with appropriate security and information management to access and record information in a contiguous and contemporaneous manner (in line with professional records keeping best practice policies).

The National Information Board (NIB) has published its framework for action (2013) with a timeline (available at https://www.gov.uk/government/publications/personalised-health-and-care-2020/using-data-and-technology-to-transform-outcomes-for-patients-and-citizens) for clinicians

across primary, urgent and emergency care to be working without the need for paper records by 2018. By 2020, it is anticipated that all care records to be digital, real-time and interoperable and by April 2020, the entire health system will adopt SNOMED (Systematised Nomenclature of Medicine) clinical terminology. To support the delivery of these actions locally the provider/s of the CCYPS will be expected to participate in the Connected Nottinghamshire Programme – a programme of work facilitating information systems interoperability (across Health and Social Care) to support service transformation across Nottinghamshire.

With emphasis on keeping the children and young people out of hospital and avoiding unnecessary hospital visits it is anticipated that appropriate Assistive Technology will offer support and flexibility in the care delivered. Where appropriate, services users and their carers should have the ability to record and share information relating to the on-going management of their condition(s) with care professionals. The innovative use of technology to support improved contact and support through Teleconsultation is an emerging area and should be considered.

The CCYPS Provider will be expected to implement systems to collect and report on the national Children and Young People's Health Services Data Set:
http://www.hscic.gov.uk/maternityandchildren/CYPHS

Information Governance Requirements:
All providers will ensure that they meet the necessary assurance levels for the following:

1. PSN COCO
2. NHS COCO
3. IGT level 2
4. DPA
5. Caldicot 2 Principles