Public Document Pack Shropshire Council

Date: Friday, 8 May 2015

Time: 9.30 am

Venue: Shrewsbury Room, Shirehall, Abbey Foregate, Shrewsbury, Shropshire, SY2 6ND

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HEALTH AND WELLBEING BOARD

TO FOLLOW REPORT (S)

9 Healthy Child Programme (Pages 1 - 16)

A report is attached.

Contact Lindsay McHardy.

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Agenda item 9

Shropshire Clinical Commissioning Group

Health and Wellbeing Board
8th May 2013

Healthy Child Programme: Discussion Paper

Responsible Officer Lindsay MacHardy
Email: shropshire.gov.uk Tel: Fax:

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1. Summary

1.1 The Healthy Child Programme (HCP) is the key universal public health service for improving the health and wellbeing of children through health and development reviews, health promotion, parenting support, screening and immunisation programmes. The current programme for 0-5 year-olds is based on the evidence available at the time of the last update of the HCP 0-5 years in 2009. As local authorities take on the commissioning of the HCP 0-5 years and its delivery via the universal health visiting service, it is important that it is underpinned by the latest evidence.

1.2 However, research recommendations suggest that further research is needed for all outcome areas, so we need to make decisions based on the best available evidence and what we understand to be important for our communities. (Please see Appendix A for the ChildHealthProfile2014-Shropshire)

1.3 Whilst acknowledging that we still have a long way to go in understanding how best to ensure the best possible start for our children, this paper sets out a strategic approach to commissioning services for 0 – 19 yr olds in Shropshire.

2. Recommendations

2.1 Whilst the Public Health Children &Young People Team is still developing and setting up governance structures through the newly established Healthy Child Programme Partnership Board reporting to the Health & Wellbeing Board and Children's Trust, there is scope to confirm priorities and new ways of working and map out a vision for the future of our children in Shropshire.

Key areas for discussion with the Health & Wellbeing Board include:

- Co-ordination of child-focused services within the Council and Shropshire CCG
- Delivering a child-centred approach across the County
- Ensuring the best start for every child in Shropshire.

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3.2 In April 2014, the Public Health Department took on responsibility for taking forward the Healthy Child Programme and TaMHs (Targeting Mental Health services for children and young people). Staff previously working within the Council's Health Development Team now makes up the Public Health Children & Young People's Team. Work is underway to produce a strategy and action plan, which will contribute to the priorities of the Children's Trust and Health & Wellbeing Board, for internal discussion and with key partners.

3.2.1 A Healthy Child Partnership Board has been set up, to provide a strategic steer, reporting to The Children's Trust and Health & Wellbeing Board and linking to the Safeguarding Board and other committees as appropriate (draft Terms of Reference for the Healthy Child Programme Partnership Board are attached in Appendix B - for information).

3.3 The original structure for the C&YP Team included two Programme Leads taking forward the Healthy Child Programme:

- 0 – 5's (including preconception), led by Anne-Marie Speke and
- 5 – 19's (including further education, the voluntary sector and TaMHs

3.4 Since the 1st April this year, however, the 5 – 19's Programme Lead has been recruited to a new position within the Council, to lead the Troubled Families Programme, so we are currently reconfiguring the C&YP Team and re-assessing priorities.

3.5 Developing Public Health through the PSHE curriculum is an important area of work led by Alice Cruttwell as the schools' Curriculum Advisor.

3.6 Encouraging young people to engage with health services has been developed through the 'You're Welcome' initiative, led by Val Cross who is also Project Officer working with pharmacies on the Condom Distribution scheme.

3.7 Lindsay MacHardy heads up the team.

3.8 The responsibility for commissioning of School Nursing services, including the National Child Measurement Programme (NCMP), was transferred from Primary Care Trusts to Public Health Departments within each local authority, effective from 1st April 2013. In Shropshire it was agreed that the contract for school nursing should be extended for an interim period, whilst we undertook a major review of the service which would then inform future commissioning priorities.
This extensive process was effective in engendering a shared vision across the local health economy. It was welcomed by the school nurses because it offered a real opportunity to analyse their work, their workloads, processes and systems and also to showcase some best practice. Schools and pupils participated well, with over 1,000 pupil responses and 167 responses from teaching staff and provided useful feedback.

3.9 The shared vision has been formalised as contractual recommendations and the school nursing service has developed an action plan to take these forward. They have also identified 3 key areas to pilot as a new approach:

- Increase in LAC/ not in mainstream education capacity

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- Providing a community drop in
- Offering a comprehensive school entry medical including NCMP

3.10 Public Health is currently engaged in developing a new school nursing contract specification, including a “core contract” for schools, taking into account the findings from the review and which is in line with national guidance.

Health Visiting Services

3.11 In 2011, The Department of Health produced a Health Visitor Implementation Plan to put in place a new health visiting service across the country, by 2015, to increase health visitor numbers and ensure that all families can expect access to:

- Universal services

  The Health Visitor (HV) and team provide the Healthy Child Programme to ensure a healthy start for children and families (for example immunisations, health and development checks), support for parents and access to a range of community services/resources.
- Universal plus

  Rapid response from HV team providing specific expert help, for example, with postnatal depression, a sleepless baby, weaning or answering any concerns about parenting.
- Universal partnership plus

  Ongoing support from the HV team plus a range of local services working together to deal with more complex issues over a period of time. These include servicesfrom Sure Start Children’s Centres, other community services including charities and, where appropriate, the Family Nurse Partnership (FNP).

3.12 The service must be available in convenient local settings, including Sure Start Children’s Centres, GP practices and health centres, as well as through home visits.

3.13 From 1st April 2015, additional health visitors are now in post in the Community Trust, taking HV numbers to 105.6 staff working across Telford & Wrekin and Shropshire. In addition to this, Shropshire has also been provided with extra recurrent funding (£258K) for the establishment of Family Nurse Partnership (FNP) nurses who work with first time parents under the age of 20 and provide support during the first 2 years after the birth. 4 WTE nurses plus a supervisor have been in post since October 2014, based in Shrewsbury (Crowmore Children’s Centre), as the majority of teenage mothers are in the Shrewsbury area. However, it is recognised that there are teenage parents across the county and we will monitor to see whether additional FNP staff may be required elsewhere.

3.14 We are also looking at other models of support, including Homestart, and whether alternative models of support which work with and complement existing and statutory services could be appropriately developed for Shropshire. Despite the increase in Health Visitor (HV) numbers, the size of the County means that HV services will still be stretched. We are investigating a model of ‘community parenting’ which has been developed elsewhere in the country providing pre-birth support, to see if it could be adapted to support rural and relatively isolated communities. If we can take forward this mix of services for families with children under 5 and provide appropriate ante-natal support too, it would be anticipated that we could increase access to support and have an impact on inequalities.

3.15 From 1st October 2015, the commissioning responsibility for HV services will transfer from NHS England to Public Health Departments within local authorities. During the last year, work has been ongoing with NHS England to ensure the smooth transfer of arrangements and commissioning responsibilities. Public Health staff have also been working closely with the

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Community Trust to ensure a shared understanding of workforce plans, services, processes and relationships with other services particularly Children's Centres, School Nurses and maternity services.

Children's Emotional Health and Wellbeing: Think Good Feel Good (TaMHS)

3.16 The core aim of the Think Good Feel Good programme is to develop a whole school approach on emotional health and well-being through the delivery of an evidence based training programme across all Shropshire schools. There are 130 primary schools, 20 secondary schools, 2 special schools and Tuition Medical Behaviour and Support Service units (TMBSS). To date the programme has been aimed at school age children 5-16 years as well as their families and the whole range of school based staff. All of the training programmes that are delivered are evidence based, either nationally or internationally.

3.17 A PHSE curriculum resource has also been developed and further work on the analysis of data is being done with colleagues from public health and local schools on the data within schools. Plans are in place for the evaluation of this model and analysis of the data.

3.18 From April 2013 the programme extended its reach to cover 0-19 year olds with a renewed vision for the future based on a sustainable model. Work has started with FE colleges to identify what training can be implemented. Close working with the Health Champions has been established.

Self Harm

3.20 Adopting a 'self-harm pathway', producing guidance and a risk assessment framework was identified as a need following a reported increase in the prevalence of self-harm across the county. It was identified that there are currently no standardised guidelines to support practice in managing the needs of these young people, and inconsistencies in confidentiality and approaches to support were found. The self-harm pathway was developed in consultation with parents and young people who self-harm: evidence tells us that young people seek support from their peers before family members or professionals.

3.21 The information, advice and guidance leaflets were seen as particularly valuable for young people who are supporting their friends who self-harm. The feedback has ensured the information reflects what they say would be helpful to know and has in the process, increased practitioners' understanding of what their thoughts and needs are.
A self-harm toolkit and training package has been developed through an Early Help Advisory Group – this covers three key elements:

- information to dispel the myths on self-harm
- information for parents
- a risk assessment tool for school staff for referrals - schools do not have to do a separate EHAF (Education and Health Assessment Framework).

3.22 A self-harm, peer support, targeted intervention 10 week programme 'Signature Strengths' has been developed. Professionals and school staff are being trained to deliver the programme at Tier 2 level, to prevent needs escalating and requiring support from Tier 3 specialist services. In addition an Emotional and Mental Health PHSE curriculum resource is in development from KS1-KS4; whole class lesson plans will include helpful and unhelpful coping strategies and self-harm

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will be included within this. This work has been endorsed through the Safeguarding Board and with the advisory sub group consisting of local head-teachers. The training programme is being trialled at the moment with schools and will continue to be rolled out across the next six months. The package has been developed by a primary mental health worker with guidance and input from the advisory group.

Public Health outcomes for Children & Young People

Children & Young People make up 20% of the population

- Breastfeeding – initiation/at 6-8 weeks
- Children killed or seriously injured on roads
- Children in poverty (both dependent children under age 20 and all under 16's)
- Chlamydia prevalence in 15-24 year olds
- Domestic abuse
- Emotional wellbeing in Looked After Children (LAC)
- Excess weight in 4-5 year olds and 10-11 year olds
- First time admissions to youth justice
- HIV pregnant women
- Hospital admissions
- Immunisations
- Infant mortality
- Low Birth Weight (LBW) babies
- NEETs
- Neonatal screening (CCG commissioned)
- Outdoor space/exercise
- Percentage of children achieving expected level of development at the end of Year 1
- Percentage of children achieving good level of development at the end of reception
- Pupil absence
- School readiness levels
- Self-reported wellbeing and the number of people with increased anxiety
- Smoking – in pregnancy, at delivery and in 15 year olds (both regular and occasional)
- Teenager conceptions under 16 and under 18
- Tooth decay at age 5

3.23 The C&YP Team will be working towards achieving all of these Public Health outcomes. Recent communication with Public Health England indicates that 'school readiness' should be a particular focus of effort, because those children who 'lag' behind from the start of school, are likely to always struggle to make up this difference.

A Strategic Approach

3.24 Achieving the best start in life for our children can only be realised by taking a strategic approach to commissioning and we have been working with colleagues across the Council and with the CCG to identify how best we can co-ordinate, streamline and integrate services, intelligence and contracts. There is still a way to go, but by working together we aim to ensure

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that we can co-ordinate and complement activity, avoid duplication and provide the best quality services to communities, where and when they need them.

3.25 We already offer services in relation to parenting, breastfeeding, mental health, smoking, weight reduction and obesity, attachment, child development and physical activity, but more needs to be done to address social and economic inequalities and the bringing together of services dedicated to supporting children and families in Shropshire.

3.26 Whilst the Public Health C&YP Team is still developing and setting up governance structures through the newly established Healthy Child Programme Partnership Board reporting to the Health & Wellbeing Board and Children's Trust, there is scope to confirm priorities and new ways of working and map out a vision for the future of our children in Shropshire.

Key areas for discussion with the Health & Wellbeing Board:

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Conclusion

3.27 A discussion session has been planned for June 2015 to consider further some of the issues raised in this paper.

4. Risk Assessment and Opportunities Appraisal

(NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)

To be ensured through commissioning and performance monitoring of contracts for School Nursing, Health Visiting, Family Nurse Partnership service etc..

5. Financial Implications

Resource allocations for Health Visiting are based on national guidance and School Nursing on historic local allocation. Additional funding is provided for FNP.

6. Background

Incorporated in paper

7. Additional Information

Child Health Profile for Shropshire 2014
Draft Terms of Reference for Healthy Child Programme Partnership Board

8. Conclusions

A discussion session has been planned for June 2015 to consider further some of the issues raised in this paper.

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List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)
Cabinet Member (Portfolio Holder) **Cllr Karen Calder**
Local Member
Appendices Appendix A: ChildHealthProfile2014-Shropshire Appendix B: Shropshire HCP Partnership Board TOR (3)

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Public Health England

Child Health Profile

March 2014

Shropshire

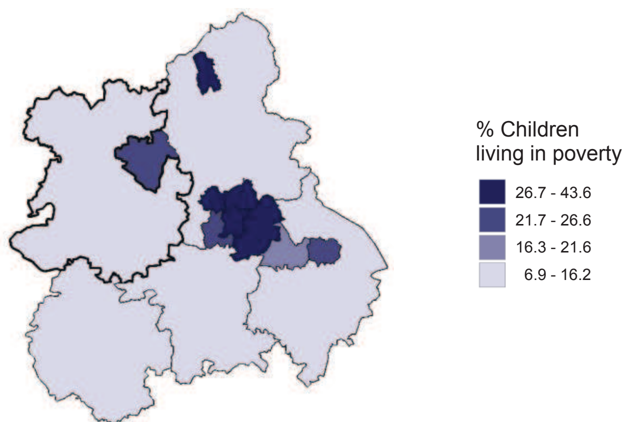
This profile provides a snapshot of child health in this area. It is designed to help the local authority and health services improve the health and wellbeing of children and tackle health inequalities.

The child population in this area

	Local	West Midlands	England
Live births in 2012			
	2,912	73,940	694,241
Children (age 0 to 4 years), 2012			
	15,700 (5.1%)	361,300 (6.4%)	3,393,400 (6.3%)
Children (age 0 to 19 years), 2012			
	67,600 (21.9%)	1,392,800 (24.7%)	12,771,100 (23.9%)
Children (age 0 to 19 years) in 2020 (projected)			
	69,300 (21.6%)	1,458,400 (24.5%)	13,575,900 (23.7%)
School children from minority ethnic groups, 2013			
	2,076 (6.3%)	216,695 (29.9%)	1,740,820 (26.7%)
Children living in poverty (age under 16 years), 2011			
	13.6%	23.2%	20.6%
Life expectancy at birth, 2010-2012			
Boys	79.8	78.7	79.2
Girls	83.8	82.7	83.0

Children living in poverty

Map of the West Midlands, with Shropshire outlined, showing the relative levels of children living in poverty.



Contains Ordnance Survey data

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Data sources: Live births, Office for National Statistics (ONS); population estimates, ONS mid-year estimates; population projections, ONS interim 2011-based subnational population projections; black/ethnic minority maintained school population, Department for Education; children living in poverty, HM Revenue & Customs (HMRC); life expectancy, ONS.

Key findings

Children and young people under the age of 20 years make up 21.9% of the population of Shropshire. 6.3% of school children are from a minority ethnic group.

The health and wellbeing of children in Shropshire is generally better than the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is better than the England average with 13.6% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average.

Children in Shropshire have average levels of obesity: 8.3% of children aged 4-5 years and 19.4% of children aged 10-11 years are classified as obese.

A similar percentage of mothers initiate breastfeeding compared to the England average, with 73.8% breastfeeding. By six to eight weeks after birth, the percentage of mothers who breastfeed their babies is lower than the England average, with 41.5% of mothers continuing to breastfeed.

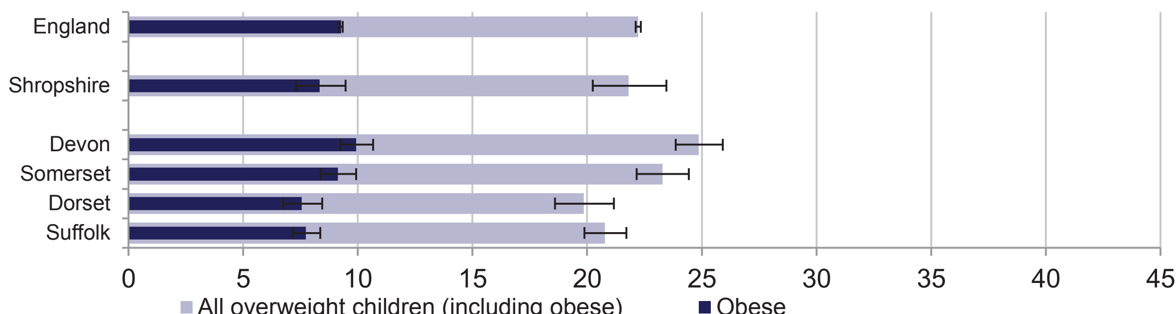
GCSE achievement is similar to the England average. 60.4% of young people gain five or more GCSEs at A* to C grade including maths and English.

Any enquiries regarding this publication should be sent to info@chimat.org.uk.

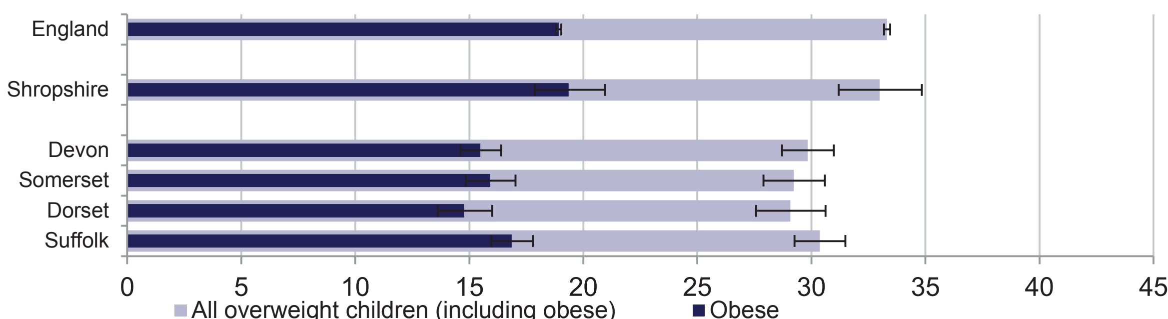
Childhood obesity

These charts show the percentage of children classified as obese or overweight in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) by local authority compared with their statistical neighbours. Compared with the England average, this area has a similar percentage in Reception and a similar percentage in Year 6 classified as obese or overweight.

Children aged 4-5 years classified as obese or overweight, 2012/13 (percentage)



Children aged 10-11 years classified as obese or overweight, 2012/13 (percentage)

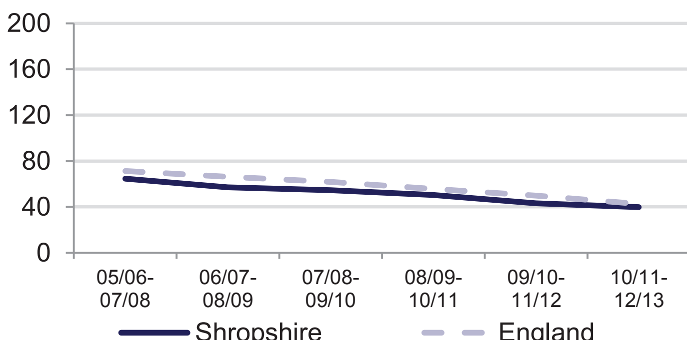


Note: This analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese.
I indicates 95% confidence interval. Data source: National Child Measurement Programme (NCMP), Health and Social Care Information Centre

Young people and alcohol

In comparison with the 2005/06-2007/08 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol such as alcohol overdose is lower in the 2010/11-2012/13 period. The admission rate in the 2010/11-2012/13 period is similar to the England average.

Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years)

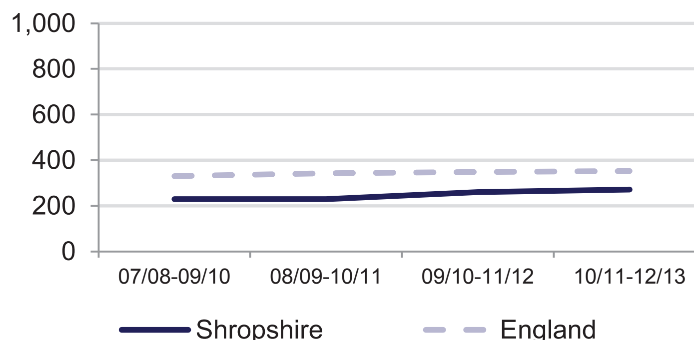


Data source: Public Health England (PHE)

Young people's mental health

In comparison with the 2007/08-2009/10 period, the rate of young people aged 10 to 24 years who are admitted to hospital as a result of self-harm is similar in the 2010/11-2012/13 period. The admission rate in the 2010/11-2012/13 period is lower than the England average*. Nationally, levels of self-harm are higher among young women than young men.

Young people aged 10 to 24 years admitted to hospital as a result of self-harm (rate per 100,000 population aged 10 to 24 years)

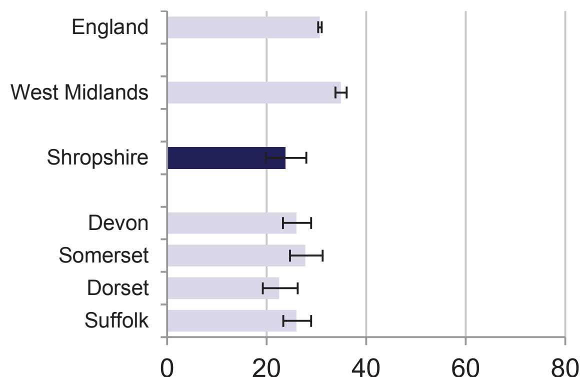


*Information about admissions in the single year 2012/13 can be found on page 4

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

These charts compare Shropshire with its statistical neighbours, the England and regional average and, where available, the European average.

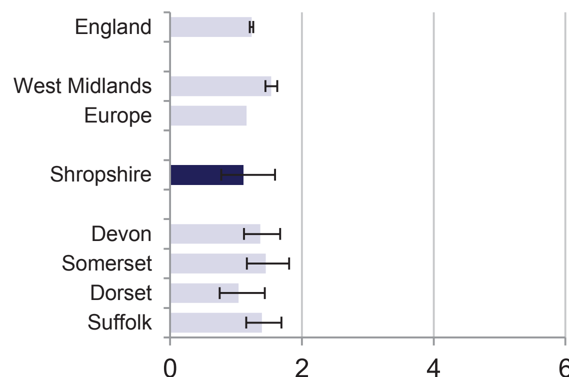
Teenage conceptions in girls aged under 18 years, 2011 (rate per 1,000 female population aged 15-17 years)



In 2011, approximately 24 girls aged under 18 conceived for every 1,000 females aged 15-17 years in this area. This is lower than the regional average. The area has a lower teenage conception rate compared with the England average.

Data source: ONS

Teenage mothers aged under 18 years, 2012/13 (percentage of all deliveries)

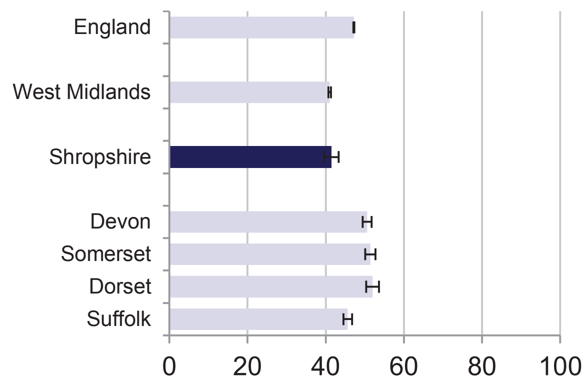


In 2012/13, 1.1% of women giving birth in this area were aged under 18 years. This is similar to the regional average. This area has a similar percentage of births to teenage girls compared with the England average and a similar percentage compared with the European average of 1.2%*.

Data source: Hospital Episode Statistics, Health and Social Care Information Centre

* European Union 27 average, 2009. Source: Eurostat

Breastfeeding at 6 to 8 weeks, 2012/13 (percentage of infants due 6 to 8 week checks)

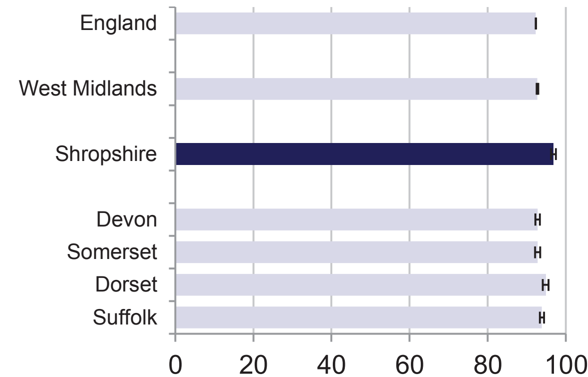


In this area, 41.5% of mothers are still breastfeeding at 6 to 8 weeks. This is lower than the England average. 73.8% of mothers in this area initiate breastfeeding when their baby is born. This area has a lower percentage of babies who have ever been breastfed compared with the European average of 89.1%*.

* European Union 21 average, 2005. Source: Organisation for Economic Co-operation and Development (OECD) Social Policy Division

Data source: PHE

Measles, mumps and rubella (MMR) immunisation by age 2 years, 2012/13 (percentage of children age 2 years)



Compared with the England average, a higher percentage of children (96.9%) have received their first dose of immunisation by the age of two in this area. By the age of five, 93.4% of children have received their second dose of MMR immunisation. This is higher than the England average. In the West Midlands, there were 95 laboratory confirmed cases of measles in young people aged 19 and under in the past year.

Data sources: Health and Social Care Information Centre, PHE

Note: Where data is not available or figures have been suppressed, no bar will appear in the chart for that area.

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which are shown as a grey bar. The red line indicates the England average. The key to the colour of the circles is shown below.

- Significantly worse than England average
- Significantly better than England average
- Not significantly different
- Regional average

	Indicator	Local no.	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	1 Infant mortality	9	3.1	4.3	7.7	1.3
	2 Child mortality rate (1-17 years)	6	9.8	12.5	21.7	4.0
Health protection	3 MMR vaccination for one dose (2 years)	2,843	96.9	92.3	77.4	98.4
	4 Dtap / IPV / Hib vaccination (2 years)	2,870	97.9	96.3	81.9	99.4
	5 Children in care immunisations	135	90.0	83.2	0.0	100.0
	6 Acute sexually transmitted infections (including chlamydia)	812	22.9	34.4	89.1	14.1
Wider determinants of ill health	7 Children achieving a good level of development at the end of reception	1,586	52.4	51.7	27.7	69.0
	8 GCSEs achieved (5 A*-C inc. English and maths)	1,967	60.4	60.8	43.7	80.2
	9 GCSEs achieved (5 A*-C inc. English and maths) for children in care	-	-	15.3	0.0	41.7
	10 16-18 year olds not in education, employment or training	500	5.4	5.8	10.5	2.0
	11 First time entrants to the youth justice system	126	423.1	537.0	1,426.6	150.7
	12 Children in poverty (under 16 years)	6,745	13.6	20.6	43.6	6.9
	13 Family homelessness	165	1.3	1.7	9.5	0.1
	14 Children in care	240	39	60	166	20
	15 Children killed or seriously injured in road traffic accidents	7	13.9	20.7	45.6	6.3
Health improvement	16 Low birthweight of all babies	174	6.0	7.3	10.2	4.2
	17 Obese children (4-5 years)	212	8.3	9.3	14.8	5.7
	18 Obese children (10-11 years)	491	19.4	18.9	27.5	12.3
	19 Children with one or more decayed, missing or filled teeth	-	22.1	27.9	53.2	12.5
	20 Under 18 conceptions	136	23.7	30.7	58.1	9.4
	21 Teenage mothers	29	1.1	1.2	3.1	0.2
	22 Hospital admissions due to alcohol specific conditions	24	40.0	42.7	113.5	14.6
	23 Hospital admissions due to substance misuse (15-24 years)	19	53.4	75.2	218.4	25.4
Prevention of ill health	24 Smoking status at time of delivery	-	-	12.7	30.8	2.3
	25 Breastfeeding initiation	1,879	73.8	73.9	40.8	94.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	1,166	41.5	47.2	17.5	83.3
	27 A&E attendances (0-4 years)	4,621	293.7	510.8	1,861.3	214.4
	28 Hospital admissions caused by injuries in children (0-14 years)	464	95.1	103.8	191.3	61.7
	29 Hospital admissions caused by injuries in young people (15-24 years)	397	112.1	130.7	277.3	63.8
	30 Hospital admissions for asthma (under 19 years)	143	221.5	221.4	591.9	63.4
	31 Hospital admissions for mental health conditions	38	62.8	87.6	434.8	28.7
	32 Hospital admissions as a result of self-harm (10-24 years)	160	299.7	346.3	1,152.4	82.4

Notes and definitions - Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box.

1 Mortality rate per 1,000 live births (age under 1 year), 2010-2012
2 Directly standardised rate per 100,000 children age 1-17 years, 2010-2012
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2012/13
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2012/13
5 % children in care with up-to-date immunisations, 2013
6 Acute STI diagnoses per 1,000 population aged 15-24 years, 2012
7 % children achieving a good level of development within Early Years Foundation Stage Profile, 2012/13
8 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2012/13
9 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2013 (provisional)
10 % not in education, employment or training as a proportion of total age 16-18 year olds known to local authority, 2012
11 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2012
12 % of children aged under 16 living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2011
13 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2012/13
14 Rate of children looked after at 31 March per 10,000 population aged under 18, 2013
15 Crude rate of children age 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2010-2012
16 Percentage of live and stillbirths weighing less than 2,500 grams, 2012
17 % school children in Reception year classified as obese, 2012/13
18 % school children in Year 6 classified as obese, 2012/13
19 % children aged 5 years with one or more decayed, missing or filled teeth, 2011/12
20 Under 18 conception rate per 1,000 females age 15-17 years, 2011
21 % of delivery episodes where the mother is aged less than 18 years, 2012/13
22 Crude rate per 100,000 under 18 year olds for alcohol specific hospital admissions, 2010/11-2012/13
23 Directly standardised rate per 100,000 (age 15-24 years) for hospital admissions for substance misuse, 2010/11-2012/13
24 % of mothers smoking at time of delivery, 2012/13
25 % of mothers initiating breastfeeding, 2012/13
26 % of mothers breastfeeding at 6-8 weeks, 2012/13
27 Crude rate per 1,000 (age 0-4 years) of A&E attendances, 2011/12
28 Crude rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2012/13
29 Crude rate per 10,000 (age 15-24 years) for emergency hospital admissions following injury, 2012/13
30 Crude rate per 100,000 (age 0-18 years) for emergency hospital admissions for asthma, 2012/13
31 Crude rate per 100,000 (age 0-17 years) for hospital admissions for mental health, 2012/13
32 Directly standardised rate per 100,000 (age 10-24 years) for hospital admissions for self-harm, 2012/13

Healthy Shropshire
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Shropshire Council

SHROPSHIRE HEALTHY CHILD PROGRAMME PARTNERSHIP BOARD

Background

From 1 October 2015, the commissioning responsibilities for the "0- 5 Healthy Child Programme" will transfer to local authority Public Health Departments. This includes:

- health visiting services (delivery of the service vision, four stage model including universal, community and targeted services) and
- Family Nurse Partnership services (targeted service for teenage mothers).

The Child Health Information System (CHIS) and 6-8 week GP check will remain the responsibility of NHS England (to be reviewed 2020).

The Healthy Child Programme is available to all families and aims to:

- help parents develop a strong bond with children;
- encourage care that keeps children healthy and safe;
- protect children from serious diseases, through screening and immunisation;
- reduce childhood obesity by promoting healthy eating and physical activity;
- encourage mothers to breastfeed;
- identify problems in children's health and development (for example learning difficulties) and safety (for example parental neglect), so that they can get help with their problems as early as possible;
- make sure children are prepared for school;
- identify and help children with problems that might affect their chances later in life.

Commissioning responsibilities for the "5-19" elements of the Healthy Child Programme, through school nursing, transferred to Public Health Departments on 1st April 2014.

In order to ensure an approach across Shropshire which is comprehensive, cost effective and also sensitive to local community needs, it is proposed that an overarching Partnership Board be set up. This Board would provide a link to regional networks; oversee the work of the 'Pregnancy to 5' and '5 to 19' Working Groups; and ensure appropriate governance through The Children's Trust and the Health & Wellbeing Board by providing timely updates against local priorities and national targets.

In the first instance, the Board would be tasked with developing a strategic approach to the commissioning of services encompassing health visiting, school nursing, nursery education and children's centres.

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Purpose

- To provide leadership for the Healthy Child Programme in Shropshire
- To develop a Shropshire "Healthy Child Programme" commissioning strategy.
- To oversee effective implementation of the Healthy Child Programme, encompassing pregnancy - 19 years.
- To maximise the delivery of the Healthy Child Programme through effective strategic partnership working, both within the local authority and other partners.
- To prioritise the plans and activities of the two Healthy Child Programme Working Groups': "Pregnancy – 5 years" Working Group and "5 to 19 Working Group".
- To ensure robust commissioning and monitoring processes are in place for the Healthy Child Programme.
- To oversee and ensure rigour in performance in relation to the Healthy Child Programme public health targets.
- To ensure effective delivery of the Healthy Child Programme within available resources.
- To ensure implementation of national and regional guidance/policy.
- To provide assurance and/or exception reports to The Children's Trust and Health & Wellbeing Board in relation to performance against national targets.

Accountability and Responsibility

- The Chair of the Shropshire HCP Partnership Board to provide regular reports on the strategic development and achievement of targets of the Healthy Child Programme to the Children's Trust and the Health & Wellbeing Board.
- Partnership Board members to align their organisation's activities to the Healthy Child Programme priorities, as appropriate.
- Partnership Board members to attend and actively contribute to meetings and act as champions for the Healthy Child Programme within their agency/organisation.
- To work in partnership to meet the needs of the Healthy Child Programme, including sharing (non-identifiable) information and data, as appropriate.
- To identify and agree co-commissioning or joint funding opportunities as appropriate, including bid funding opportunities.
- To attend quarterly meetings or provide alternative representation.

Chairing arrangements

Chair: Lindsay MacHardy: Associate Director, Public Health, Children & Young People Team Lead
Vice Chair: to be agreed.

Frequency of Meetings

Meetings will be held once every quarter from January/February 2015.

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Decision making
Decisions should be made on a consensual basis. Where consensus cannot be achieved, the matter will be referred to the Children's Trust and/or the Health & Wellbeing Board.

Support Arrangements
Public Health Administrator: to be identified.

Distribution of Minutes
Group Members
Children's Trust
Health & Wellbeing Board Executive Team
Health Portfolio Council Member
Children's Services, Transformation & Safeguarding Portfolio Council Member
Director of Public Health

Shropshire HCP Board (proposed) Membership:

NAME	ROLE	ORGANISATION
Lindsay MacHardy	Associate Director, Public Health, Children & Young People Team Lead	Shropshire Council
Fiona Ellis	Commissioner: Women and Children	Shropshire CCG
Karen Saunders		Public Health England
Andrea Westlake	Commissioner	NHS England
Elaine Griffiths	Voluntary Sector	Voluntary Sector
HV Manager	Nicki Ballard/Sara Ward	Shropshire Community Health Trust
Cathy Smith	Head of Midwifery	SaTH
Jane Randall-Smith	Chief Officer	Healthwatch
To be agreed	Children's Services	Shropshire Council
Stella Pugh	Early Help	Shropshire Council
Neville Ward	Early Years and Childcare	Shropshire Council
To be agreed	Children's Centre Co-ordinator	Shropshire Council
To be identified	FNP Supervisor	Shropshire Community Health NHS Trust
Jo France	School Nurse Co-ordinator	Shropshire Community Health NHS Trust
Tina Russell	Safeguarding	Shropshire Council
Audrey Ryan-Scott	Safeguarding	Shropshire Community NHS Trust
Mark Trenfield	Public Health Analyst	Shropshire Council
Anne Marie Speke	Healthy Child Programme Coordinator	Shropshire Council
Kay Smallbone	Programme Lead 5-19yrs	Shropshire Council

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