SCHEDULE 2 – THE SERVICES

A. Service Specifications

Mandatory headings 1 – 4. Mandatory but detail for local determination and agreement
Optional headings 5-7. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement

Service Specification No.	
Service	Children and Young People's Community Health Services
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

1. Population Needs

1.1. Introduction

This specification has been written at a time when all public services are facing the challenge of managing rising demand within a difficult financial climate. However, we know that health and wellbeing during childhood and teenage years significantly impacts life chances and outcomes as an adult, including young people's ability to work, to learn, and to engage with their community, and to nurture and support their own children. Providing the right support for our children and young people, at the right time and in the right place is crucial to the future health and wellbeing of our whole population. Effective investment now can have both immediate and long term impact and our community services are a vital element in the delivery of this support.

Our vision for the delivery of children and young people's community health services is set out below; "Children and Young People's Community Health Services within Northamptonshire will put the needs and voice of children, young people and their families at the centre. Over the next 3 years and beyond, we will continue to improve services collaboratively with our partners to ensure they are responsive, equitable and inclusive and are available where and when they are needed the most. By working together we aim to ensure children and young people are happy, healthy, safe and resilient, enabling a positive transition into adulthood." The Provider of the Service within this specification will play a key role in enabling this vision to be delivered.

1.2. National Context (and evidence base)

In January 2012, the Secretary of State for Health launched the development of a Children and Young People's Health Outcomes Strategy by establishing a Forum composed of individuals with a wide range of expertise and a shared commitment to improving health care for children and young people. The Forum was asked to identify the health outcomes that matter most for children and young people and make recommendations to improve care.

The Forum stated that "the NHS and social care have been designed around the system, rather than the individual. To children, young people and their families, that system feels fragmented and often means they have to tell their story repeatedly, striving unsuccessfully to be heard and get the properly joined up care they need. Designing and planning health and healthcare round the needs of the individual child or young person, taking account of their changing needs over time, will improve their experience of the service and their health outcomes – not just at a point in time, but for the longer term – and improve their lives enormously." The Forum also stated that "Children, young people and their families really struggle to get their voices heard and to be involved in decisions about their own health. This makes it difficult for them to take responsibility for their treatment and care. They know what needs to be done to improve the services they use. Their voices must be heard throughout the health system".

The 2013 Government response to the report, "Improving Children and Young People's Health Outcomes: a system wide response", sets out evidence and recommendations for change under the key themes set out below and this specification is set out to ensure services respond to those recommendations.

Also key to informing this specification is the national policy drive towards a joint NHS and Social Care approach to commissioning and delivery. National policy guidance expects CCGs to demonstrate that they will deliver strong arrangements for joint commissioning with local authorities, align commissioning budgets, integrate provision and show how they will achieve better use of combined health and local government resources. Local Authorities are also strongly encouraged to seek opportunities for integration and this specification has been developed in collaboration with local partners.

In May 2013 the Government published "Integrated Care and Support: Our Shared Commitment", setting out its intentions to integrate health and social care services and specifically referencing children and young people with long term and complex conditions and special educational needs and people with physical and mental health needs and The Children and Families Bill, February 2013, due to be implemented from 1st September 2014, provides for a new single assessment process, leading to an integrated Education, Health and Care (EHC) Plan for children with special educational needs and disability specifying all the services that a child would require between age of

0 and 25. The responsibilities for delivering statutory health elements of that plan have been developed with Local Authority colleagues and are set out in this specification.

In addition, national, regional and local data and guidance has provided the evidence base for service planning, highlighting where young people in the county have better or poorer health outcomes than elsewhere, good practice and gaps in service provision or areas where we need to make improvements.

The Provider shall be required to demonstrate that the service they provide delivers measurable improvement against national and local policy and guidance, including the Health Outcomes Forum themes set out below

1.3. Health Outcomes Forum Themes for improvement

1.3.1. Putting children young people and their families at the heart of what happens

The Provider shall be required to commit to service delivery that puts the users of the Services at the centre of such delivery. To do this the provider shall engage with service users in both the design and delivery of services and the Provider shall evidence how the voice of children, young people and parents and carers is captured and listened and responded to at all levels of the contracted service. This shall include demonstrating commitment through engagement of young people and families with individual needs assessment and care plans, operational service planning and design, recruitment and training of staff and strategic planning. The Provider shall demonstrate that:

- Children, young people and their families are at the centre of care planning
- Care is delivered as close to home/school/community as possible and safe to do so
- Care is provided by the right people with the right skills at the right time.

The Provider shall have in place an Engagement and Communication Strategy and evidence how the views of children, young people and their families are sought, recorded and used to inform workforce and service development, including feedback from complaints and Serious Incidents and how changes in services resulting from feedback are communicated to service users. The Communication Strategy shall set out how the Provider shall work collaboratively and creatively with young people and families to develop effective communication channels that reduce demand reduce missed appointments and increase compliance with treatment and care.

The Provider shall use age and cognitive ability appropriate resources, tools and methods throughout all aspects of the Service and at all stages of the pathways of care.

1.3.2. Acting early and intervening at the right time

Early intervention can reduce mortality and morbidity for children and young people. The

Provider shall be expected to deliver a single point of access for all referrals and to assess clinical and other needs and offer evidence based clinical response within timescales agreed with the Commissioner. Where the needs identified are not best met by the Provider, for example social care or housing needs, the Provider shall co-operate with the local arrangements to initiate and deliver the Common Assessment for Families (commonly referred to as "The CAF") in line with the Northamptonshire Thresholds and Pathways Guidance.

1.3.3. Integration

An integrated approach to health and social care will be increasingly be needed. The basis for such integration will be one where the Services from the Provider and from other providers (e.g. the County Council) will be co-ordinated around, and tailored to, the needs of the child or young person and their family, so as to improve fundamentally their health & wellbeing outcomes. Integration means the joins between services and commissioning responsibilities are invisible because organisations and individual services are working in partnership to deliver the best care across whole pathways and life stages. It means children, young people and parents don't have to keep repeating their information, that records are not lost or duplicated, that individuals and their needs do not fall between gaps and that resources are focused on the same goals, and provide value for money.

The Provider shall develop and provide a single Children's Community Health Service to deliver this service specification equitably to the population served, with a single point of access to the full range of clinical and professional disciplines and care pathways set out in this specification. The Provider shall demonstrate a "No wrong door 'approach to referrals received and ensure that the Service User is directed to the most appropriate discipline and care pathway.

The population to be served is set out in section 3.22

Staff recruitment, training and management across all aspects of the service will be integrated where this delivers benefits. Children, young people and their families will experience a single coherent service and they will only need to "tell their story" once.

The Provider shall also develop and maintain partnership arrangements with other service providers at strategic, tactical and operational levels, developing an integrated approach to service development and delivery wherever this will improve access, efficiency, effectiveness and/ or and service user experience. Partnership arrangements shall include but are not exclusive to :

- Joint needs assessments (population and individual level)
- Co-location for the provision of services

- Jointly delivered services in single locations
- Clear pathways for access to services that all partners understand
- Joint training and workforce development
- Information sharing agreements
- Joint Care Planning (including Education , Health and Care Plans)
- Joint Transition Planning
- Active engagement, including providing an identified function responsible for engagement with local partnership arrangements to deliver Early Help such as the Early Help Fore.
- An identified function responsible for Safeguarding, management of the CAF process within the service and liaison with partners.

1.3.4.Safe and sustainable service

Patient safety is a priority across the whole healthcare system and it is vital that the particular patient safety needs of children and young people are fully embedded in the health services delivered through this specification. The Provider shall follow national and local policy and guidance regarding clinical safety and have in place the full range of policies and procedures to protect staff and service users as set out in the contract , auditing implementation at least annually and evidencing how they use learning to inform workforce and service development. The Provider shall strike a balance between specialisation/centralisation of services versus care closer to home to ensure safe and effective clinical delivery.

The Provider shall adhere to the requirements of Working Together 2013 (and/ or any subsequent National requirements) and the Safeguarding Vulnerable People in the Reformed NHS Accountability and Assurance Framework 2012 produced by NHS England and provide evidence of annual audit of Safeguarding arrangements against Section 11 of the Children Act 2004 and subsequent Service improvements made. The Provider shall co-operate with, and support any statutory inspections of local services, including partnership inspections, and engage fully in any improvements required as a result of these inspections.

The Provider shall deliver the Service in line with the Data protection Act and Information Governance requirements and ensure all children and their families understand the extent and limits of confidentiality in terms of disclosure where there are safeguarding concerns and the importance and benefits of sharing information where this will improve access to services and outcomes.

1.3.5. Workforce, education and training

The Provider shall be responsible for delivering a safe and effective Service and shall have in place a workforce development strategy and a detailed workforce development programme , setting out a framework of expected professional development for all staff, and clearly defining mandatory training, essential to role qualifications and training and arrangements for continual professional development and monitoring . The workforce development programme for the Service shall deliver the requirements of National Policy and Professional bodies relevant to the Service, including the principles set out in *Fulfilling and Rewarding Lives, which* recommends that as a minimum autism awareness training should be included within general equality and diversity training programmes for all front line staff involved in delivering this commissioned Service. The Provider shall have a clear Supervision Policy which evidences arrangements for clinical supervision and safeguarding supervision for all clinical staff and professional supervision for all non-clinical staff. The Provider shall evidence annual audit of the workforce development programme and supervision policy and improvements to Service.

1.3.6. Knowledge and evidence

The Provider shall have information technology, systems and processes in place that are able to digitally collect and report real time data, and deliver performance and other reports as set out in the Performance schedule and as required by the commissioner. This will include the facility to collect data and information remotely and to provide data by single age bands and CCG localities, tracking data for individual children and families, and risk stratification.

The Provider shall offer evidence based interventions, adhering to models of care where evidence relates to specific client groups and or methods of delivery and where licensing requires this.

1.3.7. Leadership, accountability and assurance

The Provider shall have in place a named lead, with delegated responsibility for the delivery of this service specification as a whole, which will be the first point of contact for Commissioners and respond to, and co-ordinate, all initial requests for information and will represent the Service on Strategic Partnership Fora.

The Provider is accountable to the Commissioner for the delivery of this service specification through the contractual arrangements and shall provide performance and other reports against the contract requirements as requested by the Commissioner. To support the culture of integration and joint working to improve outcomes for children and young people the Provider shall also provide reports to local Strategic Partnerships such as, but not exclusive to, the Children and Young People's Partnership Board, Health and

Well Being Board and the Healthier Northamptonshire Programme.

The Provider shall also have in place a named lead who will act as the first point of contact for partner organisations on operational matters and co-ordinate effective representation of the Service at partnership operational fora.

1.3.8. Developing Innovation

The Provider shall develop innovative approaches to manage and, where possible, safely reduce the rising demand for more specialist services and acute provision. This will include developing models of delivery to care for children and young people outside of hospital, including early help and targeted support to reduce hospital admission, and supporting early hospital discharge and crisis intervention to manage sudden escalation of need. The Provider shall monitor and evaluate innovation to determine effectiveness, efficiency, safety and value for money and evidence impact to the Commissioner.

The Provider shall engage in research, at the request of and / or with the agreement of the Commissioner, where this may benefit local workforce development, knowledge and skills or improve client outcomes. Where such engagement is funded outside of this service specification the Provider shall deliver assurance to the Commissioner that commissioned capacity is not negatively affected.

1.4. Local Context –

1.4.1. "Healthier Northamptonshire"

The Healthier Northamptonshire Programme is a partnership programme that aims to ensure a strong partnership committed to planning and delivering the best possible services and wellbeing for the people of Northamptonshire and underpins the approach adopted within this specification and the overarching direction of travel is reflected within this specification. More information can be accessed via www.neneccg.co.uk .

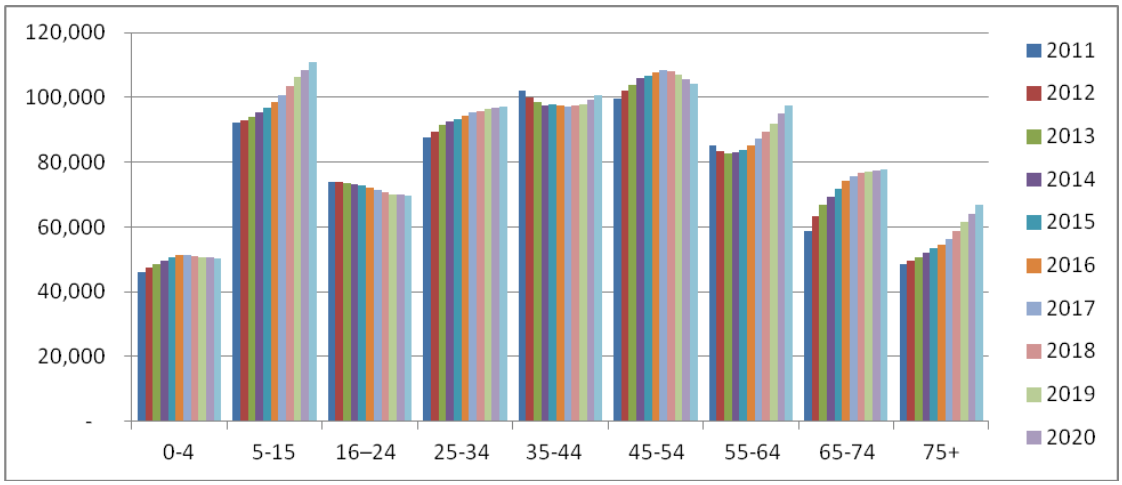
In line with the Healthier Northamptonshire Programme aims, this specification has been informed by commissioners and providers of local NHS services, Local Authority commissioners and providers, the NHS Commissioning Board, community and voluntary sector partners, children, young people and families and the Police. Partners want the Provider to offer a Service that is innovative and outward looking, creative and open to facing the challenges public sector providers are experiencing.

1.4.2. Population and geography

Northamptonshire has a population of 700,576 (ONS MYE 2012: http://tinyurl.com/owvo98k), of which 173,973 (24.83%) are aged 0-19 Northamptonshire has a diverse population and landscape, the county has large rural areas, where 14% of the

population live. The majority of the population (65%) live in the major urban areas, with around 30% in Northampton (JSNA, 2009; http://www.northamptonshireobservatory.org.uk/publications/document.asp?documentid=1647&projectid=133).

The number of children and young people in the county is expected to increase by approximately 1,000 children annually until 2020.



Label and source:?

There is a well-established link between levels of deprivation amongst children and poor health. The 2012 Indices of Multiple Deprivation lists 20 Northamptonshire wards amongst the top 10% of the most deprived in the Health Deprivation and Disability domain as shown in the table below.

Label and source?

LSOA CODE	LA NAME	SCORE	RANK (where 1 is most deprived)
E01027153	Northampton District	2.35	99
E01026968	Corby District	1.70	908
E01027257	Northampton District	1.65	1012
E01027150	Northampton District	1.53	1363
E01026966	Corby District	1.38	1876
E01026957	Corby District	1.37	1887
E01027226	Northampton District	1.35	2017
E01027083	Kettering District	1.30	2253
E01026965	Corby District	1.29	2293
E01027244	Northampton District	1.26	2451
E01026950	Corby District	1.26	2464
E01026960	Corby District	1.26	2473

E01026961	Corby District	1.25	2477
E01027224	Northampton District	1.25	2480
E01027110	Kettering District	1.24	2538
E01027214	Northampton District	1.24	2550
E01027161	Northampton District	1.24	2581
E01027235	Northampton District	1.18	2919
E01026954	Corby District	1.16	3068
E01027198	Northampton District	1.14	3176

The Provider shall understand and respond to the needs of children and young people in deprived communities and shall have in place processes and infrastructure to "track" and model the changing needs of our children and young people, evidencing how they move through the Service and where improvement or increased capacity is needed.

Additional information on demographics, inequalities and health and social care outcomes is available from Northamptonshire Analysis - hyper link here - and the Northamptonshire Joint Strategic Needs Analysis. The Provider shall use this and other information to inform service design and delivery, ensure equity of service provision and address issues of access. The Provider shall also contribute to the Joint Strategic Needs Assessment, sharing data within local information sharing agreements and Information Governance arrangements

1.4.3. Local Policy Context

A number of local policies have informed this service specification. The Provider shall be familiar with, and deliver services in line with current local policies as agreed with the Commissioner. This includes:

Northamptonshire County Councils Early Help and Prevention Strategy (2012) which sets out plans to *'Enable individuals and families to access appropriate support as early as possible, to help them maintain their quality of life, prevent any problems getting worse and reduce the demand for specialist support services'.* The Provider shall work with partners in line with this Strategy, engaging with partnership fora and arrangements established to improve communication and service delivery, including designing service delivery in line with the geographical areas that provide the basis of Local Authority children's services such as Children's Centres and Supporting Services

1.4.4. Northamptonshire Thresholds and Pathways (2013)

The Service delivered through this specification shall operate in line with the Northamptonshire Thresholds and Pathways and Common Assessment for Families (CAF) arrangements. The Service shall deliver treatment and care across 3 levels of need and the Provider shall evidence those pathways and plans are in place to ensure effective 'step up' and 'step down' at each level.

2. Outcomes

2.1. NHS Outcomes Framework Domains & Indicators

The following are the outcomes defined with in the NHS outcomes Framework.

Domain 1	Preventing people from dying prematurely	
Domain 2	Enhancing quality of life for people with long-term conditions	
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	

The Provider shall deliver services in line with the nationally defined outcomes set out above in order that children and young people:

- Have local access to care, delivered within the home or local community when appropriate, to meet needs
- Receive timely care and support that best meets their needs
- Remain at the centre of all that we do
- Benefit from environments where staff, parents and carers have the right skills knowledge and competencies and know when and how to seek help
- Have access to appropriate coordinated support particularly when transitioning into adulthood
- Receive services that are safe and that ensure the child's welfare is paramount

2.2. Locally Agreed Outcomes

The monitoring arrangements related to this service specification are set out in the associated Performance and Quality Schedule

The Provider shall deliver:

- A reduction in the number of children and young people admitted to hospital for self-harm
- A reduction in the number of children and young people admitted to hospital for mental health problems
- A reduction in the number of children and young people admitted for Alcohol and drugs – Terry Pearson to write.
- An increase (?) in elective referral in the number of children and young people for Alcohol and drugs – Terry Pearson to write.
- A reduction in the number of children and young people with Zero length of stay admission to Acute Care
- A reduction in admissions for children and young people with long term conditions
- A reduction in admissions for children and young people with continuing care packages.

3. Scope

3.1. Aims and Objectives

The Provider shall deliver an integrated equitable Children's Community Health Service across Northamptonshire which includes the specific treatment and care pathways set out in this specification.

3.1.1. Aims

The aim of the service is to provide high quality advice, information, support and intervention to ensure all children and young people obtain the support needed to meet their emotional, physical and medical health needs.

3.1.2. Objectives

- Receive and acknowledge referrals (to both the referring agency and the child/ family) for the full range of health issues set out in this document within agreed timescales
- Assess individual and family need
- Identify a named lead professional , responsible for case management
- Develop and review, working with the child/ young person and family and partners where appropriate, an evidence based care plan with timescales and expected outcomes
- Deliver the commissioned elements of the Care Plan to a high quality and monitor progress and outcomes
- Initiate the Common Assessment for Families process where appropriate in line with Thresholds and Pathways guidance and contribute to CAF assessments when requested
- Review progress against agreed outcomes and where necessary, make referrals to other services.

3.2. Service Description

The Provider shall deliver an integrated Service offering a range of treatment and care pathways through:

- Clear referral processes and systems in a format that reduces delay and promotes the use of the CAF by the referring agency where a child has complex needs and / or where families may benefit from additional help.
- A single point of access with initial multi-disciplinary assessment of all referrals within agreed timescales.
- An identified professional lead for every child and young person known to the Service , who is responsible for case management, ensuring high quality assessment and development and delivery of care plans across all aspects of treatment and care.

- A full range of high quality evidence based clinical treatment and care pathways to deliver all aspects of this specification.

- Local management and delivery structures that reflect and relate to the ten geographical areas around which Local Authority Children's services are arranged (Appendix .....) and which demonstrate effective links to those services and to other Health Providers including but not exclusive to; Children's Centres, Health Visitors, GP practices, School Health Nurses.

- Clear Safeguarding arrangements within the Service including a Named Nurse for Safeguarding for each locality, responsible for ensuring the responsibilities of NHS Provider organisations set out in Working Together are delivered, that safeguarding needs are identified and addressed, Thresholds and Pathways are understood and adhered to, Early Help needs are identified and the Common Assessment for Families is initiated where appropriate and working with partners where necessary.

- Clear arrangements to support the wider Safeguarding agenda, including arrangements to contribute to and engage with the Local Safeguarding Children's' Board (LSCBN) and the associated Improvement Board and Multi Agency Safeguarding Hub, including co location of staff.

- Arrangements to provide timely medical assessment for children where physical and or sexual abuse is suspected, working with local police and the Sexual Assault Referral Centre (SARC).

- Arrangements to deliver advice and support on safeguarding issues to Northamptonshire GPs, including a Named Doctor.

- A clear Transition Policy, to be audited quarterly, setting out the arrangements for transition to other services, including in patient care and social care, transition for young people aged 19-25 with a learning disability, transition back to Primary Care and transition to adult community services. The Policy shall set out the agreed arrangements and timescales for liaison and information sharing with the Local Authority and clear arrangements for timely transfer of clinical information.

- The Transition Policy shall include a clear process to start Transition Planning when a child reaches 14 years and is expected to need services in adult hood, including notification to the Local Authority Transition Team, the development of a Transition Plan, co-produced with the young person and their family and in liaison with other service providers and arrangements to notify adult service providers of expected transition at age 16. The process shall also include clear arrangements to work with relevant Local Authority and Adult Service Providers to deliver the Transition Policy. The Policy shall include the arrangements for transition of all young people with Autism Spectrum Disorder to adult services.

3.3. Medication

3.3.1. Prescribing

The Provider shall prescribe evidence based medicines and other consumables which are NICE compliant and follow the principles of self-help and self-care. Medication shall be prescribed either to supplement therapeutic interventions or where the level of presenting need require pharmaceutical treatment. The Provider shall develop 'shared care protocols' with GP's and pharmacists which ensure that prescriptions are dispensed, reviewed and monitored safely and appropriately to meet the needs of the child, young person and their family. The Provider shall record and monitor the amount, type and ranges of medication prescribed and provide quarterly reports to commissioners. The Provider shall produce annual evidence of prescribing audits, outcomes and improvements made.

3.3.2. Training

Where young people receive care in educational and home settings the Provider shall deliver training, advice and information to both special and mainstream schools on safe storage of medicines and dispensing practice and provide annual evidence of audit of training and improvements made . (see Appendix 20 for list of NICE guidance applicable to C&YP)

3.3.3. Paediatric Liaison Function

Paediatric liaison function with Kettering General Hospital (KGH)

3.4. Assessment and Care Pathways

3.4.1. Overview

- Tier 1 (Universal Health Services) are delivered by GP practices, Health Visitors and the School Nurse Services. Libraries and Children's Centres are also a key provider of more general universal services. The Provider shall develop and maintain an information base of local Universal Services and make it available to all families. This may be achieved in collaboration with local authority partners.

- The Provider shall deliver pathways of care across Tier 2, 3 and 4 as described in Northamptonshire Thresholds and Pathways, using multi-disciplinary clinical and professional assessment via the Single Point of Access to determine need at the initial referral.

- A locality based named professional lead with the appropriate skill and knowledge base to arrange detailed assessment and manage the overall care pathway shall be identified for each referred child or young person. The professional lead will be responsible for developing and overseeing delivery of the Care Plan, which may involve a number of disciplines and care pathways.

3.4.2. Assessment and care pathways delivered within Non NHS settings

- Where this best meets the needs of the child, the Provider shall deliver therapeutic programmes of intervention such as SLT, OT and Physiotherapy within non NHS settings, including but not exclusive to education, home and short break settings. The Provider shall ensure that where assessment and/ or therapeutic programmes of intervention are delivered within the education, home or short break setting the Service standards set out in this specification are applied.

- Where the child has complex medical needs and/ or disabilities the Provider shall deliver training, advice and information to enable parents, carers and staff in education and short break settings to deliver safe care appropriate the each child's needs. The Provider shall assess the skills and competencies of parents and carers and deliver clinical oversight of care arrangements in home, educational and short break settings. The Provider shall formally review the competency of staff in educational settings to deliver health care interventions 6 monthly and provide written confirmation of competency of educational staff to undertake named procedures and shall evidence annual audit of these processes and improvements to the Service.

- In line with the principles within 'Including Me' (ref)the Provider shall have in place a policy that sets out:

    - A nominated special school nursing lead for each special school or unit provision, who works collaboratively with the school or SEN unit to ensure the wide ranging and complex needs of children are safely met within the school environment

    - Multi-agency protocols and procedures, developed collaboratively, to ensure that children and young people with complex health needs can access education and receive appropriate skilled care within the LA school setting

    - The process for comprehensive 'needs' and 'risk' assessments undertaken on all children within the special school setting

3.4.3. Integrated Assessment

The Provider shall deliver an integrated assessment process as set out below:

- The child and family shall have a named individual who is responsible for co-ordination of the process for all aspects of the process and all pathways of care and acts as the key contact point for the family ensuring children, young people and their families understand what the assessment will entail and why it is needed

- The assessment shall be delivered within agreed time limits as set out in the performance schedule and outcomes are recorded digitally

- The location , time and duration of the assessment shall be agreed with the child, young person and or family and are offered as close to home as possible where this clinically appropriate and the preferred option of the child and family

- All elements of the assessment shall be carried out in the same place and at the same time where this is clinically appropriate and the preferred option of the child and family
- The 'child's voice' is evident throughout the process, their views are recorded and inform care
- The parent/carer views and, where appropriate, the views of siblings are recorded and inform care
- The outcome of the assessment is shared fully and appropriately with the child and family
- The Integrated Health Plan that results from the assessment is child centred, family friendly and outcome focussed.
- The Integrated Health Plan is 'owned by' and follows the child.

3.4.4. Assessment as part of the Education , Health and Care Plan

- Children and young people who attend one of the counties special schools or unit provisions for complex disability are among the most vulnerable children and young people in the county. (See appendix 22 list and map of special school/unit provision). The Provider shall work closely with NCC to ensure that health provision as part of the EHC Plan is aligned with services delivered across the range of mainstream school provision, resourced provision, unit provision and special school provision within the county.
- The Provider shall deliver the health element of the Education, Health and Care (EHC) Plan assessment, in line with current national and local guidance and timescales and as part of the local offer which Local Authorities are required to publish, providing information for children and young people with special educational needs (SEND) and their parents or carers in a single place. The Provider shall work collaboratively with Local Authority provided and/ or commissioned services and schools, providing clinical assessment and advice and information to inform multi- agency EHC planning. The Provider shall include an estimate of financial costs of health interventions identified in the EHC plan and provide this to the Commissioner on request. Where the assessment identifies any health care that is commissioned through this specification the Provider shall deliver that treatment within this specification and at no additional cost to the Commissioner.

3.4.5. Autistic Spectrum Disorder (ASD) and Attention Deficit Disorder (ADHD)

The Provider shall assess children who present with behaviours indicative of ASD (including Asperger's) and Attention Deficit Hyperactivity Disorder (ADHD) within agreed timescales and confirm a diagnosis where appropriate. Whilst children are waiting for an assessment the Provider shall apply the Thresholds and Pathways guidance and use the CAF process to

enable access to support within the locality. Where the assessment identifies any treatment or health care that is commissioned through this specification the Provider shall deliver that treatment and care within this specification and at no additional cost to the Commissioner.

3.5. Care Pathway – Basic Generic Pathway

3.5.1. Overview

The assessment may indicate the need for a range of treatment and care pathways. The Provider shall deliver the following care pathways.

3.5.1.1. No health needs identified - Support Required

- Where the assessment has not identified a health need that can be addressed through this service specification, but has identified needs which could be met by an alternative service provider the Provider shall enable access to appropriate Early Help, Targeted Prevention Team, parenting support, support for challenging behaviour, sleep difficulties etc. contacting the local CAF co-ordinator to initiate the CAF process or inform an existing CAF.

3.5.1.2. Health need identified

- Where the assessment identifies that the child has a specific diagnosis/health need that can be met by this commissioned Service the Provider shall :
    - Deliver advice and information about the condition and advise on other sources of advice and support such as but not exclusive to NPFAG[1], asknormen[2] Talk out Loud[3] Family information Service and other websites
    - Provide advice on self-management and risk reduction.
    - Deliver evidence based treatment and care and monitor progress against expectations
    - Enable access to services delivered by other providers , including but not exclusive to NCC's Disabled Children Early Help Team, Voluntary sector providers
    - Initiation of a CAF in line with Thresholds and Pathways guidance.
- Where the assessment identifies that the child has a specific diagnosis/health need that can NOT be met by this commissioned Service, for example specialist treatment

[1] Northants Parent Forum Group www.northantspfg.co.uk

[2] www.asknormen.co.uk

[3] www.talkoutloud.co.uk

needs not included in this specification or in-patient care, the Provider shall liaise with the referrer and agree an alternative pathway.

- If the presenting need is urgent and requires services outside of the scope of this specification the Provider shall inform the referring agency and refer the child directly to emergency care services.

- Where a child does not respond to treatment and care within expected timescales the Provider shall, in liaison with the child and family, refer back to the GP for alternative action if this may improve outcomes.

3.6. Care Pathway 1 – Looked After Children (LAC) and Adopted Children

- The Provider shall deliver the Service in line with the statutory duties and guidance for health providers detailed in Statutory Guidance on Promoting the Health of LAC (2009) (see Appendix 1).

- The Provider shall deliver Initial and Review Health Assessments for Looked after Children who are the responsibility of Northamptonshire County Council, whether they are placed in or out of county and in line with the requirements of Working Together 2013. Where young people are placed out of county the Provider shall implement the Responsible Commissioner requirements for the provision of arrangements for children placed outside of the county of Northamptonshire and may arrange for other quality assured providers to undertake the Assessment and develop the Care Plan to deliver this element of this Specification.

- The Provider shall work directly with Northamptonshire County Council to establish and maintain a co-located, integrated administration and record keeping process that supports effective and timely notification from the Council of a child becoming looked after or requiring an Adoption medical, delivery of high quality health assessments within statutory time frames , and production of care planning and reporting processes across health , education and social care services. The Provider shall have in place recording arrangements that enable health histories to be recorded digitally and to be provided in hard copy to young people and/ or their carers. This administration and record keeping process shall be fully functional within 3 months of the contract start and health histories will be available for all young people coming into care from that point. The Provider shall provide evidence of annual audit of Health History's, Care Plans and improvements to Service.

- The Provider shall enable access to all other care pathways within the commissioned Service, integrating elements of service provision where this best meets the needs of Looked After Children and in particular providing:

    - access to appropriate emotional wellbeing and mental health support at all levels of the pathway including specialist mental health support when required;

    - collaborative working with the Complex and Continuing Care commissioning

team. The provider shall deliver or arrange clinical oversight for LAC children and young people placed outside of the county of Northamptonshire due to their highly complex needs.

- It is the responsibility of the local authority to make sure that every child it looks after has a health plan which forms part of the overall care plan. The provider shall deliver the Commissioner's responsibility to cooperate with the local authority to ensure that the health plan is effective. Where the child's health needs are complex the Provider shall co-ordinate the Health Plan and support delivery, including supporting registration with GP and dental services.

- NCC has a responsibility to support LAC for 3 years post adoption. The Provider shall expected work closely with NCC to ensure that the health needs of adopted children who have previously been adopted are effectively met within the adopted family

3.7. Care Pathway 2 – Children and Young People with Emotional Well Being and Mental Health (EWB&MH) Needs

3.7.1. Assessment

The Provider shall deliver a multi- disciplinary assessment for children and young people presenting with 'needs indicative of' the following;

- Emotional disorder
- Conduct disorder
- Eating disorder
- Psychotic disorders
- Deliberate and significant self-harm
- Habit Disorders
- Post-traumatic stress disorders
- Hyperkinetic disorders
- Autistic Spectrum Disorders (ASD)
- Developmental Disorders
- Attachment disorders
- Substance misuse

3.7.2. Treatment

The Provider shall deliver a range of evidence based treatments through either individual or group work sessions, and using Information technology to enable access where appropriate , including but not exclusive to:

- Cognitive Behavioural Therapy (CBT)
- Dialectical Behaviour Therapy (DBT)
- Family Therapy
- Systemic Therapy
- Psychotherapy
- Play therapy ?
- Theraplay
- Creative Arts Therapy
- Solution Focussed Therapy
- Post abuse therapy
- Video Interactive Guidance (VIG)

3.8. Counselling Support

I THINK THIS IS WHERE THE COUNSELLING SERVICES SHOULD LINK INTO THIS SPEC AND THEY WOULD FIT HERE. NEED TO THINK ABOUT LOTS AND SUB-CONTRACTS.

3.9. Parenting Programmes

- Where it is identified that the child, young person or parents may benefit from a 'parenting programme' or from a 'group work' programme the provider will work collaboratively with the 'Early Help' and 'Targeted' service providers to deliver this jointly and collaboratively wherever possible. This will avoid unnecessary duplication and ensure appropriate skills development and sharing between 'Specialist', 'Targeted' and 'Early Help' services within the defined localities.
- There may be some children and young people with enduring and complex levels of need who will benefit from a group work programme delivered by specialist services. Where this is the case the provider will work to step down to locally delivered programmes as soon as the young person's health needs indicate this is appropriate.
- (See Appendix 32 for detailed specification)

3.10. Children and Young People who Misuse Substances

Terry to do (See Appendix 37 for detailed specification)

3.11. Children who have a behavioural/mental health crisis

The Provider shall deliver an urgent response to children who have a rapid onset mental health need, presenting with sudden onset challenging and risky behaviours requiring an immediate and intense response (see Appendix 24). The response will liaise with GPs, local and out of county Acute Hospitals, and local and out of county Mental health in patient providers and deliver :

- An assessment of medical 'needs' and 'risks'
- Assessment of requirement for immediate or future clinical monitoring or treatment and care.
- Intensive home support
- "Step up" support where mental health in patient care is needed.
- "Step down " support where mental health in patient care ends

3.12. Care Pathway 3 – Children and Young People with a Disability and/or Long Term Condition

3.12.1. Assessment

The Provider shall offer assessment for children and young people presenting with a range of needs, including but not exclusive to:

- Speech, language and communication
- Deafness or hearing impairment
- Visual Impairment
- Specific language disorder
- Specific speech disorders (phonological disorders – including dyspraxia)
- Dysfluency, craniofacial and Velopharyngel disorders (cleft palate and related disorders)
- Voice Disorders
- Developmental feeding problems

- Complex Dysphagia
- Co-ordination difficulties/ Dyspraxia
- Cerebral Palsy and other neurological disorders
- Developmental disabilities
- Congenital or acquired Physical disabilities
- Conditions affecting respiratory function
- Lower extremity (hip, leg, foot) injuries
- Some upper extremity injuries (shoulder arm hand) including brachial plexus injuries
- Neuro muscular conditions
- Epilepsy
- Significant Behavioural needs
- Significant Learning difficulty/learning disability
- Acquired brain injury
- Sensory and motor disorders
- Delays in fine motor and visual motor skills affecting academic performance
- Behaviour indicative of Autistic Spectrum Disorder(ASD)
- Complex medical conditions e.g. Birth trauma , genetic disorder, acquired and congenital disorder
- Rheumatoid Arthritis
- Problems with feeding/eating
- Problems with sleeping

3.12.2. Therapeutic Intervention

The Provider shall deliver a range of evidence based therapeutic interventions to improve outcomes for children presenting with the needs described above including but not exclusive to:

- Occupational therapy (OT) intervention and management of specific disorders

i.e.: cerebral palsy

- Speech, language and communication interventions and interventions for children with swallowing difficulties
- Recommendation regarding the most effective use of Augmentative and Assistive Communication (AAC) aids when spoken communication is limited by physical condition
- Physiotherapy intervention and management of specific disorders i.e. cerebral palsy
- Prescribing and advising on the use of home and school based equipment needed to maintain mobility and keep children safe

- Development and clinical oversight of physiotherapy programmes to be undertaken by appropriate others
- Support for children with Learning Disability
- Sleep disorder
- Epilepsy management
- Behaviour management
- Equipment prescription for use at home and in the school setting where this will aid in functional independence , postural management and /or access to everyday living and to keep the child/young person safe
- Development and clinical oversight of any programmes to be undertaken by appropriate others such as family members including OT, Speech and Language Therapy[4]

3.13. Care Pathway 4 – Children and Young People with Complex Medical Needs

3.13.1. Assessment

The Provider shall offer assessment for children and young people presenting with any complex needs and with life limiting or life threatening conditions and children who need end of life care. This will include, but not be exclusive to children with:

- Cystic Fibrosis
- Complex Renal Conditions

[4] Appropriate others includes Learning Support Assistants (LSA's) in school and parents/carers

- Oxygen dependency
- Complex Cardiac Conditions
- Long Term Ventilation
- Cancer
- Conditions requiring immune suppressants.

3.13.2. Therapeutic Intervention

The Provider shall deliver a range of evidence based therapeutic interventions to improve outcomes for children presenting with the needs described above including but not exclusive to:

- Symptom management and control
- Administration of intravenous /complex drug regimes
- Specialist advice and support in relation to complex health needs, acute clinical episodes, long terms conditions and palliative care needs
- Nursing care and management of acute and short term needs including complex dressing regimes,
- End of life care and support for a child and their family.
- Case management and coordination for children and young people with long term conditions who may requires services through their transition into Adult services and beyond (See Appendix 34 for detailed specification)

3.14. Care Pathway 5 – Children and Young People with Continuing Care packages

- Some children with very complex, enduring, intense and unpredictable needs may be entitled to an individual care package to support them and their parent/carers to meet their health needs safely in the community. In such cases, a continuing care assessment will be carried out by the Commissioner's Continuing Care Team who will work jointly with NCC to determine whether a child/family is eligible for continuing care services and the level of care that they are entitled to.
- Where a package is agreed by Commissioners, the Provider shall deliver the health care element set out in each individual package, including the delivery of training to enable parents and carers to provide support in home, educational and short break settings and end of life care.
- This Care Pathway will be funded separately from the main commissioned

Service, with each package coasted and funded individually. The Provider may arrange sub contracts with quality assured care providers where it cannot respond to the requirements of Commissioners within the Provider's own resource.

3.15. Personal health Budgets (PHB)

- A personal health budget is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team.

- The vision for personal health budgets is to enable young people with long term conditions and disabilities to have greater choice, flexibility and control over the health care and support they receive. The Provider shall co-operate with, and support young people and families who choose to access a Personal Health Budget and work with them to develop and cost a Health Plan that meets their needs, providing clinical advice to, and liaising with, Local Authority partners to ensure that individual plans are clinically safe and meet individual health needs.

- Where the family wish to commission it, the Provider shall deliver the care set out in the plan, using the associated funding from the Personal Health Budget.

- The Provider shall deliver review health assessments and advise on progress towards outcomes and changes to the Individual Plan within timescales agreed with the Local Authority.

3.16. Care Pathway for children who become acutely physically unwell in the community

- The Provider shall have in place protocols and processes to receive and respond to referrals from general practitioners, ambulance services and urgent care settings

- The Provider shall deliver clinical management of the ill child at home with the aim of reducing hospital admission and / or length of stay where this is safe and in the child's best interest. This shall include delivery of "step up" support to local and out of county in patient care where admission becomes necessary and "step down" support from local and out of county inpatient care to enable, and following, discharge.

- The key to the effective delivery of this care pathway is parental confidence, and the Provider shall provide, in a range of formats, advice and information on self-management, risk assessment and responsive action, to all families receiving this pathway of care.

- Appendix 38 details the essential ingredients of the service model developed locally that the new provider will be required to implement

3.17. Specialist Substance Misuse

Specialist substance misuse services are currently being re- specified. This service will be jointly commissioned as part of this tender.

3.18. Children with multiple needs (MH, substance misuse , self-harm) who attend A&E – Partnership working

- Children who present at A&E with a range of needs often have chaotic lifestyles and behaviours that cannot be supported by one agency alone. This can include risky behaviour issues "Out of Hours" and/or alcohol and/or substance misuse and/or mental health crises
- The Provider will work closely with NCC out of Hours team and Northamptonshire Police to develop effective multi-agency responses for children and young people who present in crisis with risky behaviour issues "Out of Hours" and/or alcohol and/or substance misuse and/or mental health crises, and who often have no viable home base to return to.
- This service should ensure that young people are not held in police s.10 provision, acute or mental health inpatient units when their needs could be met within the community.
- The provider will develop an action plan to develop a fully integrated Out of Hours Crisis service within 1 year of the start date of the new service and will develop a fully integrated service by the 1st October 2017.

3.19. Discharge from Hospital

- The provider will need to make robust arrangements with local and tertiary acute providers to ensure that discharge planning following hospitalisation is timely and robust
- A range of providers have a responsibility to ensure that children can achieve a timely discharge once their medical needs have been met within the hospital environment. This includes providers of tertiary and local acute provision, local health providers and NCC who may have a responsibility to ensure social and/or educational support is in place to enable the child to return home.
- All of these providers are part of the 'network ' of care that needs to be in place locally to ensure the best possible outcomes for children and young people and all of these providers have acknowledged the part they need to play in this.
- There will be a collective responsibility upon the inpatient provision, NCC and the provider of this service specification to facilitate timely discharge. The provider will be expected to:
    - Liaise closely with all providers identified above to enable 'timely' and 'safe'

discharge;

- Ensure discharge planning 'processes' and 'protocols' are in place and working effectively;
- Flag any blockages to achieving effective discharge planning to the relevant senior management teams for resolution;
- Provide the specialist input required to enable full recovery or longer term management of needs

- Where a co-ordinated package of care is required the provider will:
  - Appoint a 'care co-ordinator' from the local multi – disciplinary team who will be the main point of contact for the family and who will ensure that discharge planning is well co-ordinated and effective;
  - The CAF should be initiated where the needs of the child and family are multiple and complex on discharge;
  - Ensure the child's discharge plan is child/ young person focussed;
  - Work closely with the nominated discharge coordinator from the hospital to ensure the child's discharge plan identifies all of the key people who will need to support discharge as well as their role and responsibility in this; and
  - Ensure the plan is outcome focussed and in many cases time limited.
- Where a child/young person's needs remain highly complex on discharge from hospital they may require an assessment for continuing care and the provision of a continuing care package of support. In this case the provider will need to ensure that the discharge planning includes notification to the continuing care team at the earliest opportunity.
- In these circumstances the Continuing Care assessor will take on the role of care co-ordinator to commission a care package of support to enable The child to be appropriately and safely discharged from hospital.(see Children and Young People with Complex and Continuing Care -Joint Practice Guidance)

3.20. Urgent Care Hours of Operation

3.20.1. Non-Urgent care

- The Provider shall deliver a single point of access to receive written electronic referrals 24/7 and shall review all referrals within timescales agreed with Commissioner. Where referral is urgent, for example in response to an urgent mental health need, arrangements for referral and response are set out below.

- The Provider shall deliver all Service pathways as a minimum between the hours of 8.30am and 5.30pm Monday to Friday, including/excluding Bank Holidays except where stated in this specification as exceptions

3.20.2. Urgent Care

Emotional and mental health pathway:			
Crisis and home intervention	08.30-10pm	Monday to Friday	
	9.00am to 5.00pm	Weekends and Bank Holidays	
On Call	10 pm – 0830	Monday to Friday Weekends and Bank Holidays	
Consultant Psychiatrist on call	10pm – 08.30 am	7 days a week including weekends and Bank Holidays	
Community Paediatrician on call	10pm – 08.30 am	7 days a week including weekends and Bank Holidays	
Physical ill health pathway			
Admission avoidance	Hours?	7 days a week including weekends and Bank Holidays	

- Crisis and home intervention service up to 10.00pm Monday to Friday
- Crisis and home Intervention service 9.00am to 5.00pm week-ends
- Crisis and Home Intervention service 'On call' advice and call out after 10.00 pm and at week-ends
- Consultant Psychiatrist 'On call' advice and call out after 10.00 pm Monday –

Friday and at week-ends

- Safeguarding medical assessment service flexible to operate up to 7.00pm Monday to Friday

- Consultant paediatrician 'on call' advice after 10.00 for sexual abuse cases- and at week-ends

3.21. IT Requirements

David / could you add this bit please JC

3.22. Population covered

- The Provider shall deliver the service to:

  - Children and young people up to the age of 19 who are registered with a General Practitioner(GP) within the county of Northamptonshire. This will include GP's who are part of Nene CCG, Corby CCG, and the Oundle and Wandsford practices

  - Young people aged 19 - 25 who meet the above criteria and who have a diagnosed learning disability such that transition to adult services would provide the most effective care.

  - Looked After Children up to the age of 19 who are the responsibility of NCC and who are placed both 'in' and 'outside' of the county Northamptonshire

  - Children who were previously 'Looked After' by NCC and who have been adopted within the previous 3 years irrespective of whether they are placed inside or outside of the county

  - Urgent care visiting Northants

- The provider will ensure the Service and individual pathways of care are accessible for young people who may be particularly vulnerable including , but not exclusive to:

  - Children and young people who may be Lesbian, Gay Bisexual or Trans (LGBT) (see Appendix 12 for details of service requirements)

  - Children and young people who attend Special Educational Needs (SEN) units due to the complexity of their behavioural, emotional and social needs (see Appendix 13 for details of service requirements)

  - Children and young people who attend Hospital and Outreach Education (HOE) Provision due to high level of emotional and/ or physical medical needs

- Children and young people who have experienced or will experience a bereavement within the family (see Appendix 15 for details of service requirements)
- Children and young people with long term medical conditions (see Appendix 16 for details of service requirements)
- Children and young people known to Youth Offending Service (YOS) (see Appendix 17 for details of service requirements)
- Gypsies and travellers who may not remain in the county for the duration of long term treatments.

3.23. Any acceptance and exclusion criteria and thresholds

- This specification does not include provision of treatment and care for children or young people who live within the county of Northamptonshire but are registered with a GP who is part of a neighbouring CCG **or** LAC who are placed within the county of Northamptonshire by neighbouring CCG's who require initial and review health assessments or specialist health care input. The Provider shall be responsible for putting into place charging policies with neighbouring CCG's for services provided outside this specification.
- The provider will be responsible for either providing or funding health care needs for children and young children who are placed outside of the county of Northamptonshire as detailed below
- LAC -initial and review health assessments
- LAC -specialist health care provision identified prior to placement
- Adopted children who were previously LAC and who have been adopted for less than 3 years -specialist health care provision identified prior to moving
- The provider will be expected to ensure that the income obtained by the above arrangements being in used appropriately to increase staffing capacity across the necessary areas
- The provider will be required to provide quarterly reports to commissioners which detail income and expenditure for the groups of children and services detailed above.(see Appendix *** reporting requirements)

3.5 Interdependence with other services/providers

This Service is interdependent with :

- General Practitioners ; for appropriate referrals and communication
- Local Authority : for timely notification and consent of LAC and Adopted

Children medicals and delivery of Health Care Plans, for co-operation re joint assessments , EHC Plan development and delivery and Transitions, access to NCC provided and Commissioned services including Disability Team and Early Help services including access to support with the CAF process.

- Hospitals for joint development of care plans for children with continuing care packages and complex needs, access to children attending Hospital education, notification of a child where supported discharge would be beneficial, and notification of children who may need end of life care.
- Parents and carers to bring their child to appointments, adhere to treatment and medication advice and develop self-care skills
- Availability of appropriately qualified and experienced staff.
- Adult services where the parent or carer needs services in order to achieve the safe and improved outcome for the child.
- CCG continuing care commissioners to share assessments of need and respond to change in a child's level of need
- Schools to allow access to children and young people during school days.
- Young people's sexual health services.

4. Applicable Service Standards

4.1. Applicable national standards (e.g. NICE)

The continuing care team are looking up all relevant NICE guidelines for C&YP

We have a list of relevant documents etc. within all other service specs.

Sharon and Kathryn are looking at those pertaining to LD

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

These can be taken from current specs

4.3. Applicable local standards

Would like us to put our locally generated standards from the values documents and from work with children and young people

5. Applicable quality requirements and CQUIN goals

5.1. Applicable quality requirements (See Schedule 4 Parts A-D)

Jane Bell should be working in this – would like to include the Your Welcome quality standards

5.2. Applicable CQUIN goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises are located at: tbc

7. Individual Service User Placement

B. Indicative Activity Plan

Not Applicable

This belongs in a separate additional info section just for the procurement exercise.

Staffing

Community health services are currently delivered by two main providers NGH in the south and NHFT in the north (who also provide some county wide services).
The services currently delivered are listed in Appendix 3. The role, grade and Whole Time Equivalent (WTE) for staff currently in post within each of the services areas are listed in Appendix 4. It is the expectation that all services currently delivered will be made available by the new provider and the staff listed in Appendix 4 will be subject to TUPE transfer.
Specialist substance misuse service is currently provided by ****. The role ,grade and WTE for staff currently in post are also listed in Appendix It is the expectation that all services currently delivered will be made available by the new provider and the staff listed in Appendix 4 will be subject to TUPE transfer.

Assets

Appendix 5 details the premises and assets currently in used by providers. It describes the terms of their usage and the future availability of the provision.
The new provider will be expected to ensure that adequate premises are made available to deliver the services in a way that meets the requirements described within this specification. Where the new provider requires the continued usage of premises and assets currently in use the expectation will be that negotiations as to terms and conditions of usage will be carried out directly prior to the submission of any bids for this specification.

IT systems/ Clinical Records

There are currently a range of record keeping systems in operation**.** These are detailed in Appendix 6. NHFT operate two main systems – System1 and EPEX. Both are used for clinical record keeping although not all current services are on the clinical system. NGH operate a range of bespoke databases and clinical records are held manually. The future IT and clinical record keeping requirements are detailed in section***.
The new provider will be expected to provide a detailed action plan to ensure the efficient, effective and safe transfer of records from the current providers into the new service.

Current Health Service Activity

Appendix 7 provides a broad outline of the current level of service activity across a range of services and within each of the 10 localities. The below samples the data in Appendix 7 highlighting the potential 10,000+ referrals handled by existing services, throughout the course of 2013/14.

	Community Children's Nurses: Specialist nurse practitioners	Community Children's Nurses: Generic Community nurses	Community Children's Nurses: Home Respite	Consultant Community Paediatrics	Children's Therapy Services - Occupational Therapy	Children's Therapy Services - Physiotherapy	Children's Therapy Services - S&LT	Looked After Children INITIAL ASSESSMENTS	Looked After Children REVIEW HEALTH ASSESSMENTS	Children's Dietetics	CAMHS Community (Whole Service)	CAMHS Crisis and Home Treatment Only
HIGHLY SPECIALISED												354
SPECIALIST SERVICES	734	202	15	1409	715	336	2179	158	609	941	3298	
ESTIMATED ACTIVITY BY LOCALITY BASED ON POPULATION												
Central/ Northampton Central	81	22	2	155	79	37	240	17	68	104	363	39
DSN North/ Daventry (North)	68	19	1	131	66	31	202	15	75	87	306	33
DSN South/ South Northamptonshire	77	21	2	148	75	35	230	17	85	99	347	37
East Northants/ East Northamptonshire	75	21	2	144	73	34	223	16	83	96	338	36
East/ Southern/ Northampton East	90	25	2	174	88	41	268	19	100	116	406	44
Kettering	105	29	2	202	102	48	312	23	116	135	473	51
Wellingborough	73	20	2	141	72	34	218	16	81	94	330	35
Western/ Northampton West	88	24	2	170	86	40	262	19	97	113	397	43
Corby	75	21	2	145	73	34	224	16	83	97	339	36

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Northamptonshire has been a pathfinder authority for implementation of the requirements for the Children and Families Bill and systems and processes have been developed to ensure that the requirements of the new Act will be implemented by the 1st September 2014.The new provider will be expected to build on the local arrangements developed to date and ensure the new requirements are implemented fully (see section**)

NCC review of Designated Special Provision

NCC has carried out a review of all Designated Special Provision (DSP's). This will lead to changes to the type and number of DSP's within the county. The timescale for implementation is;

- Formal consultation with stakeholders October – December 2013
- Cabinet – January 2014
- Implementation – May 2014 onwards
- September 2014 changes fully implemented

Follow the link for SEN PROVISION REVIEW CONSULTATION for consultation and full proposals (Need to refine this)

. Funding mechanisms will need to be put into place to ensure that schools are clear about what can be accessed free at the point of delivery and what services can be commissioned directly by schools.
Source: 2013/14 Part year performance extrapolated to full year equivalent

This is indicative information only – It is anticipated that the new requirements upon service delivery will ensure fewer inappropriate referrals and more effective pathways to support which in turn will lead to fewer referrals into specialist and highly specialist services.

The provider will also be required to work collaboratively with the post sexual abuse counselling service provider currently commissioned and accessed via the Sexual Abuse and Referral Centre (SARC) until 1st April 2015 in order to ensure clinical supervision and governance is in place and performance reporting is co-ordinated and delivered as part of this specification (see youth counselling reporting above).

The provider will make available a sum of money to allocate on a flexible basis to specials schools and SEN units to enable the recruitment of staff to work within the school environment to ensure schools have sufficient capacity to meet the full range of health need within the school environment.
On a yearly basis the Provider shall;

- Liaise with NCC to ensure that an audit of children's health needs is made as they move from one school to another.
- Ensure the funding allocation for the specials school/SEN Unit is adjusted to reflect the changed needs of the cohort of children in the school/Unit.
- Ensure funds are allocated in a timely fashion In order to ensure that schools are able to recruit and train staff in a timely way as the new academic term commences.