0-19 Healthy Together:
Delivery of the 5-19 offer across Leicester City

Report overview

On October 1st 2019, a new model of delivery of the 5-19 years offer was rolled out across Leicester City. The current report will detail the journey of the development and roll out of the new offer.

Why was the change needed-

The development of the new model aims to ensure that as a workforce, Healthy Together can commit to delivering the public health/health promotion agenda as set out in our Standard Operating Guidance (2020), whilst also meeting the statutory safeguarding commitments as per the LSCB Guidance and Working Together to Safeguard Children (2018). In the previous model, each public health nurses was responsible for delivering both elements of the role. However, it was becoming increasingly evident that the quality and consistency of the delivery of public Health element of the service was becoming more frequently compromised. The service therefore, needed to develop and implement a model for the 5-19 workforce to manage the increased demands and commitments of statutory safeguarding responsibilities in Leicester City, whilst also providing a safe and effective public health service for young people and their families.

What was done-

In the new model practitioners, on a rotation basis, are assigned to either focus on safeguarding or public health related activities.

The current report will provide details of the background to the change, an overview of the new model and the impact it is having on the Service's ability to support young people.

1 Background

Safeguarding is the underpinning responsibility of all child health programmes. As the only group of health practitioners who engage with school aged children and young people at universal level, public health nurses (school nurses) are recognised for the significant impact they have on keeping children safe from harm, supporting health and wellbeing and improving outcomes for children, young people, families and communities. They have a unique perspective and relationship with young people and can provide essential information to contribute to the safeguarding of young people.

The primary commissioned role of Healthy Together is to support the school aged population in the following high

impact areas: resilience and wellbeing, keeping children and young people safe, healthy lifestyles, maximising learning and achievement and supporting complex and additional health and wellbeing needs.

Each school nurse is responsible for supporting approximately 7000 school aged young people. Over the past 12 months, approximately 470 young people were on Universal Plus, Partnership Plus and Safeguarding caseloads. To support this population, there were only 9 whole time equivalent Band 6 Specialist Community Public Health Nurses –School Nurse (SCPHN-SN) and 12 whole time equivalent Band 5 Healthy Child Programme Nurses. As such, the responsibility to deliver both the public health and safeguarding elements of their role were becoming increasingly difficult to balance.

The main areas of concern were the ability to manage strategy calls, initial child protection and children in need invitations and an increase in the volume and complexity of safeguarding cases (including an increase in the number of cases involving sexual and criminal exploitation). These increasing demands and depletion in the number of school nurses meant that team members were not always able to commit, respond and deliver public health services to their school aged populations. Safeguarding commitments across the 0-19 team were, and continue to increase across Leicester City.

It was becoming increasingly apparent that Healthy Together Safeguarding responsibilities were restricting the ability to deliver a proactive public health role, for which our service is commissioned. Therefore, to ensure our service was able to be more proactive, rather than reactive, and forward plan in relation to managing the safeguarding and public health commitments, the service needed to think differently about how to meet the service offer and support staff to provide a quality driven service with the current workforce.

As there is no proposed increase in the 5-19 workforce it was essential that the service meets these demands whilst ensuring that staff are not placed under increased stress caused by the increase of safeguarding demands.

2 Change idea

Given the background detailed in Section 1. the service aimed to design and implement a sustainable, safe and effective response to safeguarding work whilst also being able to provide a responsive and quality public health offer to young people aged 5-19 years old across Leicester City.

To design and deliver the new model, a task and finish group of practitioners including, School Nurses, Service leads and Quality leads formed and followed the NHS model for improvement to support the design, implement and evaluation of the new model. An outline can be seen below in table 1.

Table 1. NHS improvement model for change template

What are we trying to achieve?	• Reduce the use of reactive strategies by creating proactive processes to address the known needs of the population • Enable all team members to organise, plan, commit and provide a public health service that is sustainable, safe and effective • Reduce the time taken to respond to referrals from parents, education,

	partner agencies and children and young people. • Enhance safeguarding expertise and quality and consistency of delivery for families.
How will we know the change is an improvement?	• All children/young people to be offered a baseline health assessment and completed within 10 working days following the safeguarding meetings. • No cancellations or rescheduling of public health activities in schools due to capacity to deliver safeguarding commitments • For staff to report a manageable balance of delivering the safeguarding and public health elements of the service. • For staff to report increased confidence to support safeguarding cases • Improved communication between Healthy Together, schools and Social Care • A representative from Healthy Together at all 0-19 safeguarding meetings
What changes can we make that will result in an improvement	Changing the current delivery model so that there is a dedicated group of practitioners focusing specifically on safeguarding, allowing the remaining workforce to focus on delivering the public health element of the offer (for further details see section 3 below).

3 The new Leicester City School Nursing model

The new model was originally based upon the school nursing service in Reading (as outlined in The Westminster Briefing 2019 – The Future of School Nursing), where they faced similar staffing and service dilemmas. However, it is important to recognise that the population in Leicester City is larger, more diverse and the number of safeguarding cases is higher than that experienced in Reading. Therefore the model is not a direct replica, but used the principles of 'The Reading Model'.

To deliver the commissioned service offer as well as safeguarding commitments, the new model involves dividing the workforce into two strands, focusing on the two elements of the service delivery. Staff will work on a rotation basis, in the two strands (rotation time still under discussion). The strands are-

- The Public Health Practitioners (80% of our workforce)
- The Safeguarding Practitioners (20 % of our workforce).

The following sections will outline the new model.

3.1. Public Health-

Pathways to support the management of secondary school and primary school caseloads have been developed. New, clear processes have also been developed to manage referrals into the service using an evidenced based 'Traffic light process' (Public Health England, 2016).

The 'School Health Profile' has been redesigned to make it easier for the schools and staff to complete whilst outlining a clear 'school agreement' detailing what Healthy Together can provide. This Agreement also reinforces

the value of the Digital Years 7,9 & 11 Health and Wellbeing questionnaire; for which there has been an increase in uptake across the whole of Leicester City.

Our SystmOne Patient Electronic Health records have been streamlined to ensure that our assessments not only remain holistic and child/young person focused, but also allows the service to capture data to evidence contacts, outcomes and outward referrals of young people.

3.2. Safeguarding-

To support those staff working within the safeguarding team, clear pathways have been developed to reinforce the current safeguarding processes.

The safeguarding team has-

- A duty day rota – this allows safeguarding administration team to cover telephone strategy meetings in a timely manner, as the service now only has one telephone number that they need to ring instead of the previous six numbers.
- Weekly allocation meetings- to ensure that any new safeguarding cases are allocated equally amongst safeguarding staff.
- Safeguarding supervision- to ensure that staff supporting complex and often emotionally difficult cases are supported and so that the families receive the right referrals and support as needed.

Below are examples of the changes to practice.

Case 1: Managing strategy calls

Previous model

Getting cover for strategy calls could often be time consuming, leaving practitioners with insufficient time to read a child/young person's record before the call. The process of supporting a child or young person after the call was also proving inefficient.

Prior to the delivery of the new model, if a strategy call came into the safeguarding administration team they would contact the child or young person's allocated school nurse to request that they contribute to the call. However, this process was often complicated when the allocated practitioner was unable to support due to other commitments in the service. The administration team would then leave a message with the locality team to request the support of another practitioner (often the person who picked up the phone message first would be the one to cover). If the admin team received no response, they would then inform the Clinical Team Lead for that locality area, who would then find and allocate cover for the strategy call. This process could often be time consuming, reducing the amount of time a school nurse would have to read each child's SystmOne medical records and prepare for the strategy call.
Once on the call, the majority of staff would take hand written notes to then transcribe onto the child or young person's medical records and they would task the allocated school nurse to share the information with the relevant people and follow up with Social Care.

Current model

The request for support with strategy calls now comes through to one number for the safeguarding staff and staff

are allocated in a timely fashion. This allows the staff covering the call adequate time to check each child's medical records and prepare to feed into the conference call. All the safeguarding staff now use a Word Document to record the strategy meetings, which they then can copy and paste straight onto the child/young person's medical record. On average this saves approximately 20- 30 minutes record keeping per child.

Case 2: Initial Child Protection and Child In Need invitations

Previous model

The administration team would place a task into the school caseload as a notification of an invitation to a meeting. It would then be left to each practitioner to check their allocated school's caseloads and action the invitation. This often led to a disproportionate workload for some staff; as some locality areas in Leicester City have higher safeguarding cases than others. Due to this, some would not have the capacity to complete a baseline health assessment pre conference and the voice of the child would often only be reflected through the social workers report. This also impacted on their ability to deliver public health activities.

Current model

Safeguarding invitations are now placed directly into a safeguarding allocation caseload and this is checked at least three times a day by a member of the team who is on a duty day. That practitioner would then contact the parents of the child/young person and where possible, obtain consent for a baseline health assessment to be completed pre conference. They would then allocate the safeguarding meeting to a member of the team who has capacity. As consent for the baseline has been given, this allows the team to complete the baseline pre conference and share the voice of the child/young person as part of the decision making process in the safeguarding meetings. The Service has not only seen an increase in pre-conference assessments rise from below 5% to an average of 65%, but the voice of the child has changed the decision of the plan in some cases. As an example, service has seen cases where the voice of the child/young person has raised the initial perception of the risk and identified the need to protect them through a Section 47 plan (compared to the Social Care proposal which was for Early Help support or a voluntary Section 17 plan).

4 Impact

Throughout the implementation, review points were scheduled to collate feedback from staff and from the patient electronic record system, to assess the impact of the new model.

4.1. Impact on Public Health promotion

The new model has facilitated teams across Leicester City to work more cohesively as one team rather than six individual teams. As of January 2020 the impact of the new model on the public health team has been evident by the amount of contacts documented using the staff's SystmOne Ledgers. The ability to identify the activity being carried out has been facilitated by significant updates to the patient electronic record system during this period.

As an example of the activities carried out, across Leicester City North and South, there are-

- 19 mainstream secondary schools (each requiring a weekly school nurse Health Shop)
- 9 schools for children with additional needs (require a bi-weekly health shop)
- 83 primary schools (which although do not have a weekly commitment from our service does generate

individual referrals for targeted support).

During the period of the 01.10.2019 – 03.01.2020 our public health team completed 614 contacts. These ranged from Triage appointments, full baseline health assessments as well as review appointments (this period also included three weeks where the schools were closed due to school holiday breaks).
These figures do not include contacts for Healthy Bladder, Healthy Bowel or any parent workshop for Sleep, Behaviour or anxiety. Prior to the new model, a number of these contacts would be cancelled in order to prioritise safeguarding commitments; now these do not need to be cancelled.

The service has seen an increase in the completion of the 'school agreement' (previously known as the 'School Health Profile') across Leicester City and there has been an increase in the number of schools and year groups booking to complete the digital years 7,9 & 11 Health and Wellbeing questionnaire.

Planning for Public Health events is currently underway, in line with the annual public health calendar, where previously this planning was effected by safeguarding commitments.

Weekly allocation meetings are now held to look at the Leicester City 5-19 caseloads to aid the decision making processes, ensure work is equally distributed and meets the needs of the children/young people and their families. A traffic light triage system is in place to support teams during their weekly allocation meetings to ensure that children and young people who are in need are prioritised to be seen, where possible reduce the waiting time for an appointment and or redirected to a more appropriate service to support them.

A further modification to the service delivery is the opportunity to offer young people an initial 10 minute triage appointment, rather than completing a full baseline health assessment, which takes around an hour in the first instance, and is not always necessary. The triage appointment allows the practitioner to offer health and wellbeing information and assess whether a full baseline health assessment is needed. Triage templates have been developed to aid this process.

4.2. Impact on safeguarding practice

For those on the Safeguarding caseload a full baseline health assessment is needed. Prior to the implementation of the new model less than 5% of young people had a baseline health assessment prior to conference. However, as of January 2020 the number of baseline health assessments completed pre-conference rose to over 65%.

Reasons for the 35% who did have not a baseline health assessment completed pre conference were:

- Lack of parental consent – either parents refused to consent or it was not possible to get hold of them.
- Lack of notification of the meeting, as the reports have to be submitted 48 hours pre-conference the service did not have sufficient notification to complete the assessments in time.

The impact that completing a baseline health assessment can have on the outcomes for young people and their families can be seen in the case study found in Appendix 1. The skill of the Public Health Nurse (School Nurse) in reading a young person's body language identified that they and their siblings were subject to additional safeguarding issues at home, beyond the issue that had been initially presented. This could subsequently then be addressed at the Initial Child Protection Conference

Prior to the new model approximately only 25% of baseline health assessments post conference, within the 10 working day target, were completed. This has now increased to approximately 80%.

During a whole Leicester City school nurse team event on 22.01.2020 the qualified staff were asked to feedback on the impact on the new model. Due to the nature of the change and the short time that the model had been in place, the feedback largely related to the impact on the safeguarding work. The impact on safeguarding was identified as prompter responses and improved outcomes for both families and Social Care due to continuity from Healthy Together. In relation to public health, staff felt that schools were largely positive about the changes although some were adjusting to referrals being responded to by a team rather than a named nurse. It was recognised that the response to the public health work was improved by removing the unpredictable safeguarding workload.

Leicestershire Partnership NHS Trust safeguarding administration team report significant improvements for their team using this model, including a quicker response time for covering calls and clarity of responsibility within Healthy Together from the duty rota.

5 Conclusion

5.1. What is going well-

As demonstrated above, the new model is having a positive impact on the Service's ability to deliver the commissioned public health commitments and ability to deliver safeguarding duties with less impact on the public health element of the service.

5.2. Challenges and moving forward-

The service acknowledges that this is a new way of working and has been proactive in seeking out and addressing feedback. Although predominantly positive, there have been challenges to both strands of the service which the service is working through.

Schools across Leicester City are now being provided a service using a team approach; strong communication is being used in order to support schools with this change. There has been very little negative feedback regarding this change and schools continue to receive a consistent service from Healthy Together.

By creating two teams within the 5-19 team it has been recognised that staff confidence in managing safeguarding may be affected when they are not working within the safeguarding team. Staff will continue to receive regular safeguarding supervision and mandatory training and a regular rotation of staff in the teams will maintain skills.

Within the safeguarding work stream, the challenges largely relate to being able to meet the targets of completing baseline health assessment pre conference. Where the service has not been able to meet this target, this has been due to either lack of parental consent or lack of notification from social care. Timely notification of safeguarding meetings is required in order to be able to complete health assessments prior to safeguarding meetings.

It was thought on commencement of the model that staff would support work across teams. However, due to the high volume of work in the safeguarding team, particularly with strategy calls, this has not been possible.

The main challenge has been to ensure that the focus and purpose of this model is to allow the public health strand to meet the needs of the service users and not for it to solely focus on the safeguarding commitments. Working together as a whole, the Leicester City team is continually improving the quality of the delivered of the service across both public health and safeguarding. To support this, feedback continually being collated on the impact of the current Healthy Together offer to 5-19 year olds and their families across Leicester City.

Healthy Together have committed to completing a 12 month extended pilot due to the initial positive feedback of the model. At the end of this period further evaluation will take place in order to inform a decision on the future of the model.

6 Appendix

Appendix 1. Impact of the Baseline Health Assessment on inform the Initial Child Protection Conference

Impact of the Baseline Health Assessment on inform the Initial Child Protection Conference (ICPC)

Catherine Yeomanson – Lead practice teacher for school nursing in Leicester city

Case: 14 year old white British male reportedly raped younger sister

CONTACT TYPE / SETTING: Baseline health assessment – face to face in Secondary school and then an initial child protection conference (ICPC)

OTHER PROFESSIONALS INVOLVED: At ICPC: Social Services; Education; Police; Health; Parents and paternal grandfather.

REASON FOR CONTACT: Pre-conference assessment

INTERVENTION: Baseline health assessment

Child A understood why he was being seen and reported he had been accused of raping his little sister, which he then denied. He did not know who had reported him but he expressed that he was very angry towards them.

Lack of emotional connection to the allegation

At no point through the assessment did Child A's presentation change – he maintained eye contact and sat with an open frame and his tone of voice was light and did not change when talking about his emotions.
He presented with no changes to his sleep, diet, self-caring or friendships and at one point discussed that his friends knew but they didn't believe it either. He also reported no low mood, suicidal thoughts, or being scarred/anxiety. The only time he reported he got angry was linked to whom ever had reported him.
He also denied ever being sexually active and had no concerns with his sexuality or gender. He discussed no risk taking behaviours.

No safety plan in place at home

Child A was not restricted in his contacts with his younger sister whilst at home, which indicated the family either did not have a safety plan to protect the younger sister or that they were not adhering to it.

My overall assessment of his risk of harm 'very high'. This was due to the validity of the assessment, as it raised concerns about his honesty as he showed no emotional connection to the allegation made against him.

Concern over parental behaviour

Child A did not report smoking, drinking or drug taking, but **lost eye contact when discussing this (which had been unusual**). I asked if he had a friend or family member who used alcohol, smoked or took drugs. Child A was silent for a while and then started to talk about his dad.

Child A reported that his dad drinks alcohol all the time and he is scared about it – he then stopped talking as he did not want his dad to find out he had shared this as part of the assessment. We agreed that it needed to be shared if he was scarred and confirmed I would only share it in the confidential slot of the meeting (I explained what this meant). Child A then shared that **he had been hurt by his dad when he was drinking before and nothing happened to stop him** – so he doesn't bother to tell anyone now.

Child A discussed that dads mood changes when he drinks, he may start play fighting with them (Child A inferred to all his siblings) but that dad doesn't stop when they want him too and he hurts them. **They are too scared to stop him as he also gets really angry when he drinks so they let him 'play'.** Child A reported that their mum knows and she can't stop him from drinking. Child A also shared that he is **scared this drinking will mean his dad will die and he doesn't want that.** We agreed that this is something the social worker can explore with mum and dad and see if dad would want some help.

OUTCOME / REVIEW:

During the ICPC the focus was on Child A and the allegation against him and his parents' ability to protect the younger females in the family. The recommendation was that the family be subject to a child in need plan (Section 17 of the Children's Act), with support to be in place to protect the family from Child A. The other recommendation was that Child A be subject to a CUAB plan (Child undertaking abusive behaviour).

During confidential slot, the practitioner shared Child A's disclosure about dad's alcohol misuse and the alleged impact on him and his siblings. Professionals also learnt that the person whom reported the alleged rape to social care was the paternal grandmother. Whom had alleged that dad had walked in on Child A raping the youngest sibling and stopped it and allegedly told mum about it. Neither parent reported it to the police or social care.

Social Care shared previous involvement with the family linked to dad physically hurting Child A, however their assessments at this time reflected dad play fighting and it being an accident.

When the parents returned to the conference following the confidential slot – Dad's alcohol use discussed. He admitted to drinking every day at set times and mum confirmed that this stopped dad from getting angry towards them, so she didn't mind him drinking. Dad also confirmed that he had completed an intense alcohol detox programme previously, so he knows he doesn't need help now as he isn't like he was before the programme. Mum reported she has to work and leaves the children in the care of their dad; for which he then has alcoholic drinks at set times to help him cope.

Mum and dad continued to deny any concerns around Child A and the rape allegations. However, Mum then discussed how she has talked to all the children about touching each other and what they can and can't do. But they did not agreed to any safety plan and it was confirmed there was no supervision of Child A with his siblings.

OUTCOME:

The outcome of the ICPC was that all children be subject to a child protection plan under the category of 'Sexual Abuse'; which is due to the risk Child A poses towards them. **By sharing the baseline health assessment in conference, the focus was also on the parents ability to protect and parent the children due to Dad's alcohol misuse, mum colluding with dad, neither parent reporting the rape and the parents not supervising contact between Child A and his siblings**. As a consequence social care also sought legal planning to ensure the family

engaged and that Child A received the correct support to help him have positive sexual experiences in the future and not be classed as a sexual predator.