Service specification for lead provider and health and well-being services

Child House Pilot

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Developed by NHS England for the pilot

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1 INTRODUCTION

1.1 Purpose of this document

1.1.1 This specification sets out the services to be commissioned for London's Child House pilot project. It describes the expectations of the lead provider as the overall co-ordinator of services, together with the health and well-being services which are to be provided.

1.1.2 It outlines activities and outputs which need to be delivered and the outcomes to be achieved over the course of the contract period. The nature of the Child House pilot is one of promoting innovation, and ongoing co-design and co-production is encouraged.

1.1.3 The Provider will ensure that the Service is provided at all times in accordance with the principles, values and standards referred to in this document, other requirements within the Contract and all relevant national legislative requirements.

1.1.4 The specification should be read in conjunction with the terms and conditions section of the contract and other supporting information provided as part of the tender pack.

1.2 Background to the Child House

1.2.1 The Mayor's Office for Policing and Crime (MOPAC) and NHS England (London region) have been successful in gaining funding from the Home Office for the Child House project. The bid was based on a pilot operating for two years with the intention of evaluating its success to determine the benefits and feasibility of establishing more units across the capital and/or elsewhere. MOPAC and NHS England (London region) have also identified resources to invest in the pilot.

1.2.2 The scheme aims to radically improve support to children, young people and their non-offending families following incidents of child sexual abuse including exploitation. In 2014/15 a review of child sexual abuse pathways was commissioned by NHS England (London region) and undertaken by experts from Sexual Assault Referral Centres (SARCs). This showed that only 1 in 4 children who have been abused come to the attention of statutory services. The child is then subjected to a prosecution based process with multiple police interviews. Many cases do not have enough evidence to proceed to trial and those that do can take up to 2 years before they reach court. Conviction rates are low leaving suspected perpetrators free to re-offend.

1.3 The vision

1.3.1 The concept is simple and in line with best practice, the European PROMISE agreement and evidence from abroad. The aim is to provide a service which is centred around the child. Rather than the child/ young person having no choice other than to go to numerous agencies and buildings to access different services the Child House will provide support 'under one roof'. The environment will be reflective of the circumstances with an emphasis on being safe, secure and focused around the needs of the child/young person.

1.3.2 During the pilot all acute Forensic Medical Examinations (FMEs) will continue to be undertaken at the Children and Young People's Havens i.e. where the alleged abuse has taken place within the window for collection of DNA. The Child House will act as the central point for overseeing all historic FME provision i.e. where the alleged abuse has taken place beyond the window for collection of DNA. In some instances it may be appropriate for the Children and Young People's Haven to see people in the first instance even where they would normally be eligible to be seen by the Child House, e.g. referrals taking place out of hours, individuals in particular crisis etc. The specific protocol governing the referral arrangements between the Children and Young People's Haven and the Child House will need to be worked up during the implementation phase.

1.3.3 Some key services will be located at the Child House premises particularly the initial investigations, but ongoing support may well be accessed closer to the child's home e.g. individual counselling and therapeutic groups. The particular circumstances will be informed by the child/young person's needs and wishes, together with those of their non-offending families.

1.3.4 It is intended that the Child House will be a single point of access for the delivery of all the support children and young people need including Health and Well-being Services, Social Care, and Criminal Justice Services. Specifically, this will include:

- Comprehensive medical examination including holistic paediatric assessment
- Sexual health follow-up and aftercare
- Emotional, mental health and well-being assessments
- Top quality psychological and counselling services, including group therapy and 1:1 sessions
- Specialist advocacy and support
- Achieving Best Evidence (ABE) interviews conducted by trained clinical psychologists

Our aspiration is also to provide pre-trial cross examination interviews and/or live links to court all overseen by a presiding judge, for which we are waiting judicial approval.

1.3.5 It is intended that during the pilot the Child House will develop and establish a reputation for its expertise and be in a position to share learning arising from the project, including the most effective ways of working with / engaging children and young people. Our long-term ambition is that more Child Houses will be established, becoming centres of excellence serving as a place for the advancement of child protection, safety and security as well as family supportive practices. In time, the aim is for the Child Houses to contribute to the international body of literature on all matters relating to child sexual abuse, help change societal attitudes, tackle and support the prevention of sexual abuse in its broadest sense.

1.4 Expected outcomes

1.4.1 Commissioners are supporting an outcome based approach to service design and delivery, with the goals for the Child House pilot being:

- Improved referral pathways into and out of the Child House
- Improved CYP, family and carer experience of support received post disclosure
- Improved CYP experience of the criminal justice process post disclosure
- Improved mental health and well-being outcomes for CYP
- Improved professionals' awareness, competence and confidence in working with CSA/CSE
- Increased likelihood for CYP who received a Child House service to have cases charged by CPS
- Increased likelihood for CYP who received a Child House service to have their case end in conviction
- Improved partnership working

1.4.2 There are also some longer-term outcomes which have been identified. Due to the timescales around the Child House pilot, it is unlikely that they will be measurable, but they are aspirations which commissioners would like to achieve:

- Providing CSA victims care and support to reduce the long-term impact of victimisation;
- Organisations are committed to being victim focused in their support of CSA victims.

2 SCOPE

2.1 What is required?

2.1.1 The role of the lead provider will be twofold - one of co-ordination and local leadership and another as the provider of health and well-being services.

2.1.2 In its co-ordination role, the lead provider will be required to bring together a range of services under the umbrella of the Child House – health, social care, the police, criminal justice and the voluntary sector. The lead provider will have a key role in co-ordinating criminal justice and social services involvement in the support offered to children and young people alongside the health and well-being services which it will have a responsibility to deliver.

2.1.3 The lead provider will be required to provide the health and well-being services either directly, work in partnership or sub contract with other providers, including the voluntary sector.

2.2 Overall approach

2.2.1 This is very much a pilot project where the intention is to learn and develop through implementation. The lead provider is expected to deliver clinical and managerial leadership to promote the concept as well as the service. The lead provider will need to be proactive in managing local tensions and challenges and will need to exhibit strong clinical leadership in the context of multi-agency working and multi-disciplinary case discussions.

2.2.2 The specification is based on the best evidence available at this time and accommodates a process of ongoing co-production and co-design. The lead provider will be integral to this role and is expected to play an active part in supporting continuous improvement and delivering a robust evaluation of the service.

3 SERVICE PRINCIPLES, STANDARDS, LEGISLATION AND GUIDANCE

3.1 EU PROMISE project

3.1.1 The EU PROMSE Project was launched in 2015 and draws on UN, EU and Council of Europe law and good practice to establish child friendly justice and welfare services. The PROMISE Project has since published a set of quality standards which set out pan-European guidelines for Child House Services. They are underpinned by four key principles whereby measures are taken to ensure that:

- re-victimisation and/or re-traumatisation of the child is avoided at all times
- there is no undue delay; with interviews, assessments and all other interventions taking place on a timely basis
- the best interest of the child is the primary consideration in all actions
- the child has a right to be heard and receive information throughout the process

3.1.2 It is expected that the lead providers establish services in line with these standards as well as other practice and recommendations arising from the PROMISE Project. It is also a requirement for the lead providers to audit the service against these standards and practices.

3.1.3 Further details of the EU PROMISE Project and the published standards are available via the following links:
http://www.childcentre.info/promise/
http://www.childrenatrisk.eu/promise/european-barnahus-quality-standards/

3.2 UK legislation policy and practice

3.2.1 'Working together to safeguard children' (March 2015) sets out the legislative requirements and expectations of individual services to safeguard and promote the welfare of children. In this context,

it maps out the essential elements for the lead providers and other stakeholders involved in provision via the Child Houses. There are two key principles:

- Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their part; and
- A child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

3.2.2 The guidance must be adhered to as part of the Child House development, this being in accordance with the duties set out within the following legislation:

- Children Act 2004
- Education Acts (Section 175 of the Education Act 2002 and Sections 94(1) and (2) of the Education and Skills Act 2008 and Section 342 of the Education Act 1996)
- Children Act 1989
- Legal Aid, Sentencing and Punishment of Offenders Act 2012
- Police Reform and Social Responsibility Act 2011
- Childcare Act 2006
- Crime and Disorder Act 1998
- Housing Act 1996

3.3 London Child Protection Procedures

3.3.1 The London Child Protection Procedures are underpinned by 'Working together to safeguard children' (March 2015). They set out how agencies and individuals should work together to safeguard and promote the welfare of children and young people. The target audience is professionals (including unqualified staff and volunteers) and front-line managers who have particular responsibilities for safeguarding and promoting the welfare of children.

3.3.2 Where there are concerns about sexual abuse, it is likely that the case will meet the statutory child protection threshold. The majority of cases referred to the Child House are likely to be subject to a s47 investigation in accordance with the Children Act 1989.

3.3.3 The lead provider and all partner agencies are expected to comply with London Child Protection Procedures and Practice Guidance details of which are available via the following link http://www.londoncp.co.uk/

3.4 NICE guidance

3.4.1 There are numerous NICE documents which provide guidance for services related to Children and Young People, a key selection of which are listed in the tender supporting information. Only a few of these are directed to those who have experienced abuse, and those that are have a restricted scope e.g. NICE Quality Standard 'Domestic Violence and abuse' (QS116) covers adults and young people aged 16 and over but excludes those under 16 years. Similarly, NICE Clinical Guidance 'Child maltreatment: when to suspect maltreatment in under 18s' (CG89) focuses on the symptoms and signs of maltreatment rather than the response.

3.4.2 This gap in the available guidance has been recognised and the Department of Health and Department for Education asked NICE to develop further documentation on child abuse and neglect. This has recently been published: NG76 Child Abuse and Neglect (https://www.nice.org.uk/guidance/ng76).

3.4.3 Compliance with existing and newly developed guidance will be key in the delivery of services within the Child Houses.

3.5 Care Quality Commission (CQC)

3.5.1 The successful lead provider will be responsible for registering the service with CQC as required. In anticipation of this it is expected that the services will be provided in accordance with the Care Quality Commission's five key domains, which are as follows:

- **Safe**: By safe, we mean that people are protected from abuse and avoidable harm
- **Effective**: By effective, we mean that people's care, treatment and support achieves good outcomes comparable with health outcomes in the general population, promotes a good quality of life and is based on the best available evidence.
- **Caring**: By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
- **Responsive**: By responsive, we mean that services are organised so that they meet people's needs.
- **Well-led**: By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture

3.5.2 The lead provider must ensure that services are delivered in accordance with CQC's standards of quality, access and effectiveness. Any formal or informal inspections / reports should be used to inform service improvements and developments

3.6 Office for Standards in Education Children's Services and Skills (Ofsted)

3.6.1 The lead provider needs to be mindful of Ofsted's responsibilities to inspect and regulate services, in particular those that care for children and young people.

3.6.2 Directors of Children's Services have a professional responsibility and a key leadership role within the local authority working with other agencies to improve services for children and young people, their families and carers. They have a responsibility to ensure that all functions are discharged with a view to safeguarding and promoting the welfare of children.

3.6.3 Ofsted has responsibility to assess the quality and effectiveness of services to ensure these obligations are fulfilled making recommendations and taking corrective action where necessary.

3.7 Service user involvement

3.7.1 Under the National Health Service Act 2006, the NHS has a legal duty to ensure that public, patient / service users and carers are involved in the design and delivery of healthcare services. For the purposes of the Child House the requirement for service user involvement should extend beyond the NHS to encapsulate all aspects of provision including health and well-being, social care, criminal justice and voluntary sector services.

3.7.2 It is expected that the lead provider will build on the engagement work undertaken by commissioners and establish a delivery framework that continues to promote co-design and co-production. This should include but is not restricted to activity such as:

- Further development of the service models
- The development of operational policies
- The recruitment of staff, including encouragement of applications from people with lived experience of CSA
- The management and review of the quality of the service, utilising peer review

- Involvement in the management / governance structures for the service e.g. via a Children's/Young People's Board
- Information on the service for children, young people and their families

3.7.3 The lead provider should provide appropriate and accessible means by which service users can express their views about and their experiences of services, making the best use of the latest available technology and social media as well as conventional methods. As well as capturing service users feedback the lead provider should demonstrate robust systems for analysing and responding to that feedback.

3.7.4 A number of papers are referenced below which help to set out standards and guidance for children and young people's and parents' participation in service design and delivery:

- NICE (2016) *NG44 Community engagement: improving health and wellbeing and reducing health inequalities,* (https://www.nice.org.uk/guidance/ng44)
- Department of Health (2011) *Quality Criteria for young people friendly health services ('You're Welcome'),* (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216350/dh_127632.pdf) [1]
- National Youth Agency (2006) *Hear by Right. Standards for young people's participation*, (http://www.tusla.ie/uploads/content/Hear-By-Right-2010.pdf)
- Health and Social Care Advisory Service (2008), *Turning what young people say into what services do*[2]
- NHS England (2014), *CYP IAPT principles in Child & Adolescent Mental Health services values and standards: "Delivering With and Delivering Well"* (https://www.england.nhs.uk/wp-content/uploads/2014/12/delvr-with-delvrng-well.pdf)[3]
- GIFT (2014), *The involvement of parents and carers in Child and Adolescent Mental Health Services.*
- Laves, P., Hewson, L. (2011) *How Many Times Do We Have to Tell You? A Briefing from the National Advisory Council about What Young People Think About Mental Health and Mental Health Services*, (National Advisory Council for Children's Mental health and Psychological wellbeing)
- Reilly, M., Vostanis, P., Taylor, H., Day, C., Street, C., & Wolpert, M. (2012*). Service user perspectives of multiagency working: a qualitative study with children with educational and mental health difficulties and their parents*.
- Royal College of Paediatrics & Child Health, Office for Public Management, and the NHS Confederation (2011), *Involving children and young people in health services*
- Street, C. Anderson, Y. Allan, B. e t al (2012) *"It takes a lot of courage" Children and Young People's experiences of complaints procedures in services for mental health and sexual health, including GPs*, (The Children's Commissioner).
- Street , C. (2014), *Children and young people's views of counselling: improving the tools to gather outcomes,* (Youth Access) *,* (http://www.youthaccess.org.uk/downloads/childrenandyoungpeoplesviewoncounselling-march20141.pdf)

3.8 Equality and diversity

3.8.1 Under the Equality Act 2010 public authorities must have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations between persons who share a protected characteristic and those who do not. The protected characteristics are defined as age, disability, gender re-assignment, race, religion and

[1] This document sets out principles to help commissioners and service providers to improve the suitability of NHS and non-NHS health services for young people

[2] Quality Standards for children and young people's participation in CAMHS is based on the Hear by Right standards above and adapted specifically for CAMHS

[3] This document was developed by young people, commissioners and providers to integrate the principles of the CYP IAPT programme into existing quality assurance and accreditation frameworks

belief, sex, sexual orientation, pregnancy and maternity, marriage and civil partnership. The impact of service changes on individuals with protected characteristics needs to be considered and action taken to promote access and reduce any negative effect.

3.8.2 The lead provider together with its partner agencies is expected to promote services in line with its responsibilities under the Equalities Act. As part of the co-design process specific mention has been made on the need to consider the LGBT community in particular young boys/men, those in families where there has been arranged/forced marriage, as well as issues associated with some cultural and religious beliefs.

3.8.3 Some service users will have additional and complex needs that require staff with specialist skills e.g. to work with those with a learning disability and/or those who are non-verbal. The Lead Provider will need to make provision for these individuals to enable them to express and process their trauma fully and appropriately.

3.9 Information Governance

3.9.1 Due to the sensitivity of the information that will be handled by the Child House, the variety of the flows of personal data into and out of the health and well-being services, and the potential complexity of information sharing within the network of organisations working in the field, the lead provider will need to be committed to, and capable of demonstrating, the highest standards of information governance (including information security). It will need to be at Level 2 or 3 of the IG Toolkit, or to be able to provide an improvement plan showing how the relevant requirements at Level 2 will be met by the time of the letting of the contract, and readying itself to comply with the redesigned toolkit that is due to be rolled out in April 2018.

3.9.2 The lead provider will be a data controller for personal data processed in connection with the provision of health and well-being services, assuming all the obligations imposed by the Data Protection Act 1998, and fully responsible for its dealings with its data processors and other data controllers in the course of this activity. It will need to ensure the observance of other existing information law as necessary (such as the Access to Health Records Act 1990 and the Computer Misuse Act 1990). It should also be preparing to comply with the General Data Protection Regulation (which will apply from 25 May 2018) and the final legislation arising from the Data Protection Bill (which is currently before Parliament).

3.9.3 There will be a requirement for the lead provider to take account of the common law duty of confidentiality (particularly in respect of consent to the use of personal confidential data for a secondary purpose), the Caldicott Principles, and NHS codes of practice. The lead provider should, as necessary, adhere to statutory codes of practice issued by the Information Commissioner's Office (such as the Data sharing code of practice and the Anonymisation code of practice) and guidance issued by other relevant parties (such as the Information Governance Alliance and NHS Digital).

3.9.4 However, in its approach to information governance, the lead provider should also be mindful of the following statements included in a letter of 3 March 2015 from the (then) Secretaries of State for the Department of Health, Home Office, Department for Communities and Local Government, and Ministry of Justice following the "chronic failures to protect children from sexual exploitation in Rotherham":

> *There can be no justification for failing to share information that will allow action to be taken to protect children. Professional staff need to be able to make these crucial decisions on a day to day basis. They need clarity and simple guidelines about when and how personal information should be shared. […] Let's be absolutely clear - a teenager at risk of child sexual exploitation is a child at risk of significant harm. Nothing should stand in the way of sharing information in relation to child sexual abuse, even where there are issues with consent.*

4 THE SERVICES

4.1 Location

4.1.1 The pilot Child House is to be based in North Central London, a sector which includes the CCGs and boroughs of Barnet, Camden, Enfield, Haringey and Islington. It will operate from a location which has been identified in Camden Town. Further details of the premises are provided in the supporting information.

4.2 Who is the service for?

4.2.1 The service will cater for all children and young people where there is disclosed sexual abuse including exploitation. This includes contact and non-contact abuse. The Child House will also support non- offending family members / carers, in particular those with a parental responsibility and siblings of the children/young people who have indicated they are victims.

4.2.2 Referrals will fall into three broad client groups:

- Children aged 0 -12 years
- Young people aged 13 -17 years
- Young people aged 18 - 25 years who have additional needs and vulnerabilities such as a learning disability (where specific pathways have been agreed between the service, other local services and the Commissioners)

4.2.3 It is anticipated that the majority of referrals will be via the police or social services and the CYP Havens, although young people aged 13 years and over will also be able to self-refer. Equally they may be referred by associated local services e.g. sexual health or child and adolescent mental health.

4.2.4 Anyone aged 17 years who starts to receive support via the Child House will be able to continue doing so after they reach 18 years.

4.2.5 Children and young people eligible for the service will be those residing in or the under the care of (i.e. they may be children being fostered outside of the local authority boundaries) the Local Authorities within the sector in which the Child House is located. In exceptional circumstances, the service will cater for people who fall outside of this scope e.g. young people who are homeless. Such referrals will be considered by the provider in conjunction with the commissioners and reported on a case by case basis. Non-offending family members / carers will be supported irrespective of where they live, providing the child/young person is eligible to receive support from the Child House.

4.2.6 Services must be made accessible to all children and young people regardless of race, ethnicity, gender, sexual orientation, disability, economic background, religion, culture, immigration status.

4.2.7 The Child House will provide support and intervention up to the 2-year duration of the pilot. If ongoing support is required thereafter individuals will be referred onto local services.

4.2.8 During the pilot period the Child House **will not** cater for:

- Children and young people requiring acute forensic medical examination
- Victims who are also perpetrators or at high risk of offending, without the prior agreement of commissioners
- Those where exploratory interview is required to determine whether or not sexual abuse has occurred and to provide an opportunity for disclosure

The potential for the Child House to extend into these other areas will be dependent on the success of the pilot and sustainability plans thereafter

4.3 Hours of operation

4.3.1 The Child House will initially operate Monday - Saturday 10am-8pm and 10am–1pm Sunday mornings. Evening and weekend opening is being supported so that people can attend the centre outside school/college hours and family members do not have to take excessive time off work to attend.

4.4 Lead provider as co-ordinator and local leader

4.4.1 The Provider will ensure strong leadership at sector and operational level e.g. by demonstrating overarching leadership and supporting robust clinical and information governance structures, overseeing the day to day management of the child house. They will demonstrate similar leadership with all subcontractors.

4.4.2 The lead provider is expected to establish the day to day operational arrangements and ensure that services are well co-ordinated once the Child House is open. A means needs to be established by which services come together so that the teams working in the Child House sees any child from any location within the sector, under a single governance process and a single record keeping system.

4.4.3 Timely and well-co-ordinated mobilisation will be essential. The lead provider will have overall responsibility for establishing and delivering a robust implementation plan. It is expected that this will include a series of milestones associated with 3 broad stages i.e. what will be achieved by the:

- Contract commencement date
- Opening of the Child House
- Within the first 6 months of operation

At an absolute minimum the mobilisation plan will need to consider:

- arrangements for recruiting staff and/or subcontracting services
- writing policies and protocols to be adopted in the Child House, drawing on good practice elsewhere e.g. CSA toolkit and the work at the Children and Young People's Havens.
- establishing MoUs between partners setting out the terms of agreement by which the Child House will be delivered
- establishing information sharing agreements to assist in ensuring that information is shared in accordance with information governance requirements
- establishing user engagement arrangements

4.4.4 The lead providers will have a key role in overseeing the business management aspects of the care pathway. This includes managing the day to day operational arrangements for which processes and protocols will need to be drawn up with partner agencies and associated services. Individual cases will need to be tracked, progress through the system will need to be monitored and good quality management reports will need to be produced. Cases will also need to be managed in aggregate and it is envisaged that the lead provider will be responsible for organising weekly caseload management meetings and daily 'hot issues' meetings.

4.4.5 The lead provider is required to recruit a dedicated Child House Service Manager who will be instrumental in overseeing this function. The postholder is expected to have a health or care professional qualification. An outline of the responsibilities and requirements for the postholder is summarised below:

- To provide leadership to the Child House and all staff working under the umbrella of the Child House
- To coordinate the day to day running of the service so that the child is always at the centre of the service and to ensure that the lead provider's role is fulfilled

- To ensure the effective operational functioning of the service and the management and monitoring of all sub-contracting and partnership arrangements
- To monitor partnership working and the effectiveness of the Multiagency MoUs
- To ensure that there is appropriate clinical and managerial supervision available to all staff working under the umbrella of the Child House
- To be responsible for ensuring that all staff working under the umbrella of the Child House have undertaken appropriate training and have in place a programme of professional development.
- To ensure that information sharing agreements are put in place, adhered to, and reviewed as necessary
- To ensure that the local care pathways for access to the service, care and treatment within the Child House and transfer/discharge to local services are adhered to
- To ensure that regular multi-disciplinary and peer review meetings are held and recorded to review cases and agree care plans
- To ensure that the property is managed in line with the agreed premises and lease arrangements
- To support the development and strengthening of a Service Manager's Network between the Child House, the CSA hubs, and the Children and Young People's Havens
- To support the monitoring and evaluation of the pilot by ensuring the correct and relevant data is collected and presented as required
- To ensure the timely return of contract performance data and development of any action plans as agreed with commissioners
- To work with MOPAC and NHS England (London) in hosting of visits from those interested in pilot from within the UK and abroad, and managing any media interest arising
- To work with NHS England (London) and MOPAC to ensure that the learning from the pilot is recorded and that it informs the consideration and development of a sustainability plan
- To represent the service at a senior level at partnership meetings, public meetings and other forums as required.

4.4.6 The lead provider needs an appropriate structure to support and deliver the information governance requirements set out in this specification and ensure that they are maintained in all aspects of service delivery. An example of this might be:

> *an Information Governance Advisory Group that will meet on a regular basis, involving a representative from each partner agency (and including stakeholder representation, if possible and where appropriate), to co-design any necessary information sharing agreement(s) between the organisations working with the Child House, to assist in the mapping of data flows, to co-ordinate the provision of fair processing information to service users, to contribute to Privacy Impact Assessments (as necessary) and to facilitate the discussion of any issues or risks. The discussions and recommendations of the Advisory Group should be fed into the lead provider's IG management framework.*

4.4.7 Due to the nature of the work to be carried out by the Child House, it seems highly likely that access to a Data Protection Officer will be required to ensure compliance with the General Data Protection Regulation from 25 May 2018. Where the lead provider has a Data Protection Officer in post or under a contract for service by then, due to its ongoing processing of personal data, that person should be able to advise on data protection matters affecting the Child House as part of their wider duties. However, were the lead provider to be a new entrant, it would be required to commission this function in accordance with the requirements of the GDPR and with reference to the existing, and any future, associated guidance. In carrying out their prescribed duties, a DPO will need to report direct to the highest management level of the lead provider.

4.5 Care pathway

4.5.1 The Lead Provider must ensure that there is a clear pathway into and out of the Child House and for the period of a child and their family's involvement in the service. This needs to give due consideration to:

- Self and professional referrals
- Whether there will be a triage process
- Initial response e.g. medical examination, investigative interview
- Multi-disciplinary assessment and reviews processes
- Allocation of specific roles e.g. case management, advocate
- Ensuring the separate assessment and care plan for a child/young person and their carer
- Transfer/discharge plans
- Interface between the health, care, child protection, education and criminal justice system aspects of the pathway

4.5.2 As well as coordinating the care pathway for an individual client the Lead Provider is responsible for managing the overall operation of all cases e.g. daily hot issue meetings, weekly case load management meetings, case tracking and production of case load/management reports.

4.5.3 Whilst much emphasis is placed on the successful delivery of health and well-being services it is expected that the lead provider will also have a proactive role in advancing the criminal justice agenda. For example, the lead provider is expected to work closely with the Metropolitan Police to ensure that ABE interviews are conducted on a timely and appropriate basis. Operational protocols for ABE interviews will need to be established during the mobilisation phase, building on the experience at the Children's and Young Peoples Haven where clinical psychologists are now involved.

4.5.4 Similarly, the lead provider will need to work with Her Majesty's Courts and Tribunals Service (HMCTS) on the roll out of Section 28 pre-trial cross examination of witnesses. HMCTS' plans for this are still in development but once established it is expected that the lead provider will have a pro-active role in supporting the use of video links to court within the umbrella of the Child House provision.

4.6 Lead provider of health and well-being services

4.6.1 The lead provider will have responsibility for securing the health and well-being services that operate from the Child House. This will include:

- Clinical leadership
- Paediatric services
- Mental health and well-being services including clinical psychology, family therapy, counselling, advice from child psychiatry (often remotely) and from CAMHS.
- Advocacy, including child advocates and young person's advocates (both include family therapy)
- Play

4.6.2 Set out below are the key roles, anticipated tasks and headline skill requirements for the health and well-being service. These are outlined as they are expected when the pilot Child House is fully operational. It is acknowledged that during the start-up period not all roles may be in place or carry out the full function.

4.6.3 Staffing numbers and the exact skill mix will be for the lead provider to propose and agree with the commissioner.

4.6.4 All core staff are expected to:

- support and participate in multi-disciplinary reviews of individual clients, of the service as a whole and contribute to the training and development of staff within the sector

- adhere to the child centred model and work flexibly when required to support a child and their family when at the Child House
- provide court reports and attend court as required

4.6.5 It is anticipated that all staff will record their intervention as per the agreement with the lead provider and others who employ staff working under the umbrella of the Child House and that all staff will complete an agreed common dataset.

4.7 Clinical leadership

4.7.1 To offer an effective service in line with the Barnahus standards and London Child Protection procedures strong clinical leadership within the Child House will be essential.

4.7.2 The clinical leader will be expected to:

- be a champion of the Child House ethos, culture and model
- have an overview of the whole service and play a key role in both strategic and operational review
- lead the development and application of the Child House clinical governance processes including audit of the service, service development needs, review of nationally agreed guidelines on best practice from a clinical and forensic medico-legal aspect, monitoring the quality and effectiveness of the interventions offered
- with the service manager ensure that all clinical and care staff have appropriate line management and are receiving the right level of individual and team support
- through their recognised professional competence –
    - ensure that the service operates in the best interests of the child
    - address and show leadership in the resolution of professional and personal challenges and ethical dilemmas
    - ensure that appropriate clinical/care pathways are in place to support the child and their family during and after their time in the Child House
    - ensure that there are adequate peer review arrangements in place, especially for new and less experienced staff.
    - ensure there is appropriate annual external peer review of complex cases
    - work with the Service Manager in reviewing the service with commissioners, ensuring the involvement of other health and wellbeing staff as required

4.7.3 Whilst there is no specific professional qualification for this role they will be a member of a regulated health profession, hold a senior position within their organisation and/or profession. They will be expected to demonstrate the attributes required to deliver the role. It is anticipated that they will be held in high regard within the sector and be well known with a demonstrable ability to work across organisations and professions.

4.8 Role of the paediatric clinical lead

- Provide phone consultation on child abuse cases
- Undertake medical examinations to assess the child's health and wellbeing/development to identify and document injuries and/or areas of concern that may indicate other forms of child abuse or neglect.
- Undertake medical and sexual health treatments at the Child House in conjunction with the local sexual health team and resident paediatric nurse
- Document and report on findings as appropriate to inform further health and well-being plans, child protection plans and criminal investigation and proceedings
- Where there is a need for further physical care the paediatric lead will refer the child to local health services as clinically required
- Offer follow up related to clinical need within the context of the Child House remit

- Report writing outlining findings of CSA examination and sexual health screening for submission to court ensuring that the report is clear, factual and provides the level and detail of information required
- Court attendances as needed (estimated to be approx. 5% of cases i.e. where there are physical findings but also dependent on the quality of reports submitted)
- Undertake joint case planning and reviews with multidisciplinary colleagues including liaison with social care and the police, attending strategy planning meetings and case conferences as determined by the complexity of the case
- Training / peer review to create a network of local expertise and to help grow new expert paediatric examiners
- Support creation of a centre of expertise in CSA/CSE including involvement in auditing and publishing findings
- Providing supervision and leadership to the team on matters relating to child protection

The clinical lead will be expected to have as a minimum, level 3 safeguarding training as described in "Safeguarding Children and Young People: roles and competencies for health care staff; Royal College of Paediatrics and Child Health"; March 2014

4.9 Role of the Paediatric Nurse

- Undertake medical examinations and follow up in conjunction with Paediatric clinical lead
- Undertake medical and sexual health follow up in conjunction with the local sexual health team and paediatric lead; providing results and outcomes of tests in line with agreed pathways
- Undertake joint case planning and coordinate all care including reviews with multidisciplinary colleagues
- Undertaking individual case management responsibilities in the context of fulfilling statutory duties with this being decided on a case by case basis
- Contribute to peer review of relevant aspects of the service
- Contribute to creating a centre of expertise in CSA/CSE including involvement in audit and research and publishing findings in academic journals in conjunction with the paediatric lead

All paediatric nurses to be qualified RCNs and have as a minimum, level 3 safeguarding training as described in "Safeguarding Children and Young People: roles and competencies for health care staff; Royal College of Paediatrics and Child Health"; March 2014

4.10 Role of mental health and well-being practitioners

4.10.1 A team of mental health experts with a skill mix which could include clinical psychology, social work, family therapy, counselling, advice from psychiatrist (often remotely) and from CAMHS, which together will:

- Undertake an initial assessment and development of evidence-based and trauma-informed treatment plan which meets the needs of the child and family at that time. The child/young person and non-offending family members / carers are to have separate care plans.
- Provide bespoke therapeutic intervention offered as per the needs of the child and their family at a time when they are ready to engage.
- Support for all children, young people and their non-offending families (after the forensic interview)
- Undertaking individual case management responsibilities in the context of fulfilling statutory duties with this being decided on a case by case basis
- Refer onto local or specialist services outside of the Child House if required
- Provide reports and attendance at court as needed
- Establish an ongoing relationship with local support networks including voluntary and community sector specialists

- Provide clinical supervision and training to enable the local support network to assist the child/young person outside of the Child House creating a 'team around the worker' including for example:
    - Voluntary and community sector agencies
    - School nurses and school counsellors
    - Youth workers
    - Youth Offending Team (YOT) officers

4.10.2 In addition to the therapeutic role described above, suitably trained clinical psychologists will lead the ABE interviewing of children and young people as agreed with the MPS and other CJS partners. Whilst clinical psychologists need to have the capacity and capability to undertake ABE interviews alongside their therapeutic work they cannot provide both functions for the same child. Where one clinical psychologist undertakes an ABE interview for a child another psychologist must provide the therapeutic support.

4.10.3 Mental health and well-being practitioners will be expected to adhere to 'Provision of Therapy for Child Witnesses Prior to a Criminal Trial: Practice Guidance' which is accessible via the following link https://www.cps.gov.uk/publications/prosecution/therapychild.html. The CPS is in the process of reviewing this and it is expected that therapy provision will be in line with any subsequent versions of the documentation

4.11 Role of the advocate

- Greet the child/young person and their non-offending family members/ carers the first time they enter the service and provide support and advocacy thereafter until they no longer need the Child House services.
- Key role will be to act as the main navigator for both the child/young person and their family throughout their contact with the Child House
- Be proactive in helping to problem solve issues for the child, young person and their non-offending family members and be the main point of contact in this respect
- Be aware of the nine domains of advocacy: (accessible, client-led, informed decision-making, empowering, emotionally and practically supportive, independence, criminal justice system supports, multiagency collaboration, complaints and feedback) and evidence them in daily practice and interactions with their clients.
- Ensure that there is continuous access to information about what to expect, especially about the criminal justice and social care systems and the roles of different staff within the Child House,
- Provide guidance in decision making, ensuring that children, young people, their families and carers are aware of their rights throughout the process
- Perform a safety assessment of the family and develop and recommend a safety plan for the child victim and their family/carers
- Support case management for all children and young people, monitoring the multidisciplinary response to ensure that the clients are receiving adequate levels of care and support
- Assist the family in accessing services recommended by the team
- Ensure that the child, young person and their family is settled into the follow up provision if referred out to community-based services in the family support network
- Undertake joint case planning and reviews with multidisciplinary colleagues
- Assist with community education and professional training on child abuse prevention.

The post holders will not be required to have any particular qualifications but need to have a suitable level of appropriate experience and have completed accredited training. They need to be assessed as being competent in the task, of high Integrity and good character.

It is expected that the advocacy role will be managed and delivered in line with recently published Home Office guidance on 'The Role of the Independent Sexual Violence Adviser: Essential Elements' (September 2017) This is particularly important in respect of maintaining strict boundaries when providing support to minimise the possibility of evidential information being shared inappropriately to the extent that it may give rise to a challenge by the defence. Where an advocate

provides support through the process of the ABE interview, ongoing support through the criminal justice process will need to be provided by a different advocate. Similarly, where an advocate takes the first account or is involved in initial crisis intervention a different staff member needs to provide ongoing support as the original advocate may have to appear in court as a witness.

4.12 Child support including play

4.12.1 This function is a key element of the Child House model. It could be a dedicated role or form part of the wider mental health and wellbeing team remit. The key tasks are:

- Using play to help a child understand what the physical examination will include, and as such prepare them for examination and possibly spend time with them afterwards
- Support the service to maintain a child focus in their general approach
- Provide general support for the child to help reduce traumatisation especially for those aged up to 12 years
- Support /play with siblings if required to enable the parent/carer to be seen alone or with the child who has been abused.

4.12.2 If a dedicated play worker is employed the good practice recommended by the National Association of Health Play Specialists should be upheld.

4.13 Associated services

4.13.1 In addition to the above there will be some other new functions established as part of the Child House initiative. These are:

- A social care liaison officer with responsibility for providing advice and co-ordinating cases between the Child House and the local social care teams.
- A police liaison officer with responsibility for providing advice and co-ordinating cases between the Child Houses and the CAIT and SAPPHIRE teams

4.13.2 Neither of these roles are being commissioned via this contract but are referred to here as the lead provider will be expected to liaise and bring together the functions in the context of its co-ordination role. Further information about these functions is provided in the supporting information issued with the tender.

4.14 Lead Providers role in supporting the evaluation

4.14.1 The Child House model has already been proven to achieve better outcomes for the victims of CSA and their families and is now an internationally recognised model. This project is about testing proof of practice within the English judicial and care system with the intention of extending implementation. Consequently, there is heavy emphasis on evaluation and continuous improvement.

4.14.2 MOPAC's Evidence and Insight team are conducting an evaluation of the pilot and a high-level evaluation plan has been produced. Funding has been secured from the Department for Education to help with the scaling up of the concept.

4.14.3 The lead providers are expected to have an integral role in helping implement the evaluation plans and it is expected that the lead providers will work with MOPAC's Evidence and Insight team to do so.

5 GENERAL ISSUES AND REQUIREMENTS

5.1 Demand management

5.1.1 Commissioners have undertaken some demand analysis, further details of which are included in supporting information for the tender. Once the services are operating the lead provider will have a role in collecting and comparing actual activity against that which was planned.

5.2 Information management

5.2.1 The Lead Provider and its partner agencies will be expected to use both their own information management systems together with an overarching case management system specifically for the Child House.

5.2.2 Commissioners have appointed a Project Manager to identify and support the implementation of the case management/data collection software for the Child House. The Lead Provider will be expected to help with the final development and application of the system to facilitate co-ordination and information sharing between agencies, and to underpin the management and evaluation of the service.

5.3 Complaints

5.3.1 The Lead Provider will be expected to have an easily accessible complaints procedure and be able demonstrate to users and commissioners how these have been dealt with and used to improve the service

5.4 Confidentiality

5.4.1 The Lead Provider will be expected to ensure that all practice is managed in accordance with NHS confidentiality requirements.

5.5 Risk Management/Incident Reporting

5.5.1 The Provider will ensure that there are robust policies and procedures relating to the identification and reporting of incidents and serious incidents.

5.6 Business Continuity

5.6.1 The Provider must have a business continuity plan covering a broad range of risks that may affect the delivery of services contained within this service specification.

5.7 Workforce development

5.7.1 The Lead Provider will have for workforce planning ensuring that staffing structures are in place based on the demand assessment, the realities of recruitment and retention, training and competence building and performance management.