Oxfordshire Health Visiting & 0–5 Public Health Service (part of the New integrated child and young persons 0-19 integrated public health service) – Provider Report for HOSC (April 2026)

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HOSC Public Meeting: **16 April 2026**

CONTENTS

1. Introduction and purpose 3
2. Overview of the new service model (breadth of support) 3
   2.0 How the New Service Model Operates in Practice 4
   2.1 Estates and geographical delivery of the service 5
   2.2 Mandated contacts, universal offer, and escalation by need 6
   2.3 Episodes of Care (targeted interventions delivered through skill mix) 7
   2.4 Specialist Health Visiting roles and enhanced practice 8
   2.5 Family Nurse Partnership (FNP) 9
   2.6 Partnership with Home-Start – strengthening early help and community reach 10
   2.7 Workforce Sustainability and Development 13
3. Mandated reviews – performance overview, locality variation and improvement actions 14
   3.1 performance and trends 14
   3.2 Factors affecting target achievement and interpretation of performance 20
   3.3 Data Driven Improvement and Impact 24
4. Digital – how digital supports service delivery 25
   4.1 Digital principle: "supporting, not replacing" face-to-face 25
   4.2 ChatHealth / Parentline – rapid access and reduced barriers 26
   4.3 Website and digital information – improving health literacy and self-management 29
   4.4 AccuRx and appointment communication – reducing admin burden and improving reliability 31
   4.5 EMIS, templates, dashboards and system integration 32
   4.7 Next steps in digital development 34
5. Safeguarding – national guidance and current Oxfordshire practice 35
   5.1 National guidance and policy context 35
   5.2 Current Practice: Optimising Roles, Balance, and Demand Management 37
   5.3 Safeguarding processes: SPA triage, urgent timeframes and consistent recording 38
   5.4 Training, supervision and safeguarding competence 39
6. Surveys / Insight 39
   6.1 Service user insight (surveys, complaints, compliments) 39

6.2 Workforce survey / staff insight 43
7. Quality Assurance 45
7.1 Overview of the quality assurance framework 45
7.2 Supervision model and safeguarding supervision 46
7.3 Audit programme – completed activity and forward plan 48
7.4 Incident reporting, themes and learning (financial year to date) 49
7.5 Safeguarding processes and multi-agency interface 51
7.6 External assurance and inspection preparedness 53
7.7 Training, competence and compliance assurance 55
8. Workforce 57
8.1 Workforce overview and structure 57
8.2 Skill mix and workforce deployment 57
8.3 Workforce metrics and management oversight 58
8.4 Workforce Wellbeing, engagement and listening 59
8.5 Workforce risks and assurance 60
8.6 Workforce optimisation, demand and capacity review 61
8.7 Overall workforce assurance 62
9. System Collaboration 63
9.1 How the service works with system partners 63
9.2 Strategic system leadership and governance 64
9.3 Safeguarding and multi-agency working 65
9.5 Collaboration with the voluntary and community sector 65
9.6 Impact of system collaboration 65
10. Conclusion and assurance 66

1. INTRODUCTION AND PURPOSE

This report provides Oxford Health's written response to the HOSC themes relating to **Health Visiting and the 0–5 Public Health Service**, within Oxfordshire's integrated **0–19 Healthy Child and Young Person Public Health Service**. It focuses on (1) what the service delivers, (2) current performance and trends, (3) the quality and safeguarding arrangements that underpin delivery, (4) workforce capacity and sustainability, and (5) system collaboration and improvement actions.

The service model described in this report reflects the integrated 0–19 contract awarded in 2023 and the subsequent phased implementation across 2024, including the establishment of 11 integrated locality teams and a centrally based **Single Point of Access (SPA)**.

2. OVERVIEW OF THE NEW SERVICE MODEL (BREADTH OF SUPPORT)

Oxfordshire's current model is an **integrated 0–19 Public Health Nursing Service**, bringing together previously separate services—**Health Visiting (HV), School Health Nursing (SHN), and Family Nurse Partnership (FNP)**—into a single pathway, supported through the SPA. The service launch began on 1 April 2024 and reached full integration with SHN by September 2024, including the additional elements of Vision Screening and Protective Behaviours programmes.

2.0 HOW THE NEW SERVICE MODEL OPERATES IN PRACTICE

The integrated 0–19 Public Health Nursing Service in Oxfordshire functions through a coordinated pathway that begins with the Single Point of Access (SPA). Families and professionals can access support via the SPA via email or telephone call, which then provides initial triage and signposting, ensuring that needs are rapidly identified and directed to the most appropriate locality team or specialist service. Families can also access support and advice via the Chat Health confidential messaging service, offering a convenient digital route to communicate directly with health visitors and school nurses (described in further detail below).

Eleven locality teams operate across the county, each comprising Health Visitors, School Health Nurses, Family Nurses, and support staff, allowing for seamless transitions between universal, targeted, and specialist provision according to the child or family's needs. A map of the locality boundaries is described in Figure 1.

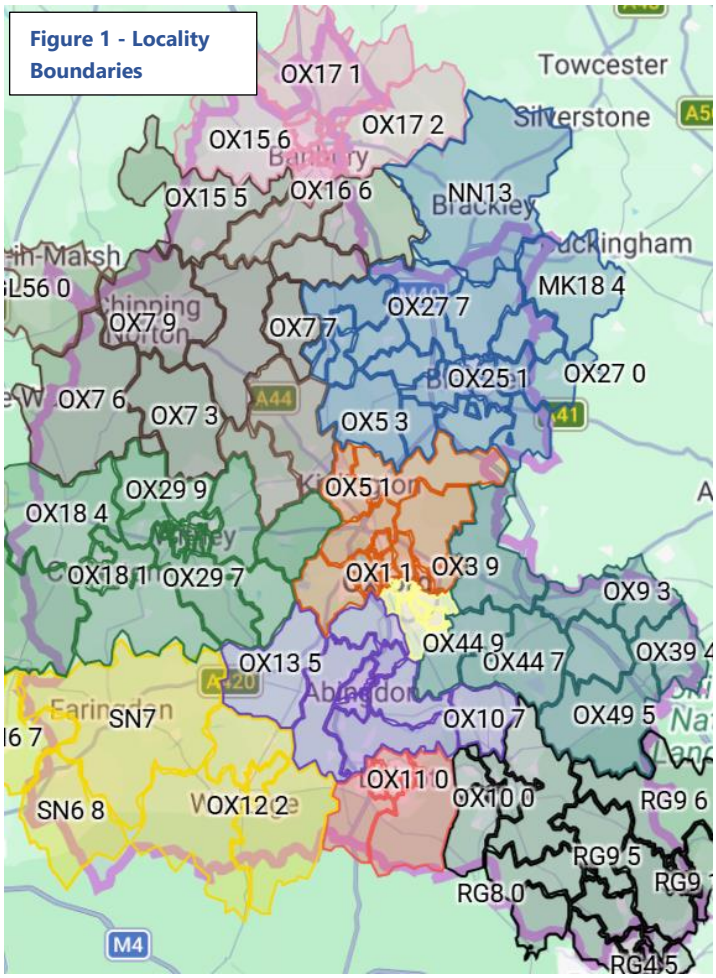


Figure 1 - Locality Boundaries

Routine contacts are scheduled as per the Healthy Child Programme, but the model's flexibility enables families to receive additional support through targeted Episodes of Care when specific concerns arise, such as sleep or behaviour issues (described in more detail below).

These episodes involve assessment, intervention, and—if needed—referral to wider services, promoting a holistic "Think Family" approach. The service utilises both face-to-face and virtual formats, adapting delivery to the family's circumstances and preferences while maintaining safety and quality standards. Close collaboration between locality teams and specialist practitioners ensures that pathways for complex needs (such as perinatal mental health or safeguarding) are robust, and escalation protocols are clear and responsive.

Regular multidisciplinary meetings within locality teams facilitate information sharing and joint decision-making, supporting integrated care planning and safeguarding. Workforce development is embedded in practice, with ongoing training and supervision to sustain professional expertise and service quality. Feedback from families and professionals is routinely captured and used to inform service improvement, ensuring the model remains responsive and effective in meeting the diverse needs of Oxfordshire's children and families.

2.1 ESTATES AND GEOGRAPHICAL DELIVERY OF THE SERVICE

The Oxfordshire 0–19 Public Health Nursing Service is delivered through a well-established network of community-based premises across the county, enabling local, accessible delivery while supporting countywide consistency. As the largest community services provider in Oxfordshire, Oxford Health utilises a combination of freehold and leasehold NHS premises, alongside co-located community settings, to deliver services within each of the 11 integrated localities. This includes clinical bases, protected space within secondary schools and colleges for school-aged pathways, and the use of GP practices and other community health settings where appropriate.

Importantly, families are not restricted to accessing services solely within their immediate local area. Contacts, clinics and group activity can be delivered across any suitable setting countywide, enabling flexibility, choice and continuity where this best meets family need or preference. This approach supports equitable access, reduces barriers linked to geography or travel, and allows the service to respond pragmatically to availability, capacity and individual circumstances.

The service also works in partnership with local authority and NHS partners through the One Public Estate approach, enabling flexible use of shared buildings such as Family Hubs, community centres, leisure centres and schools, particularly for group delivery and health promotion activity. This blended estate model allows services to be delivered close to where families live, supports outreach and group work, and enables the service to respond to population growth, housing developments and changing patterns of need.

However, it is important to recognise that community estates are subject to multiple competing system demands, including pressures from other health services, local authority functions and wider public use. As a result, 0–19 services are not always the priority user within shared premises, requiring ongoing negotiation, flexibility and adaptation to ensure continuity of delivery. Estate usage is therefore kept under regular review to ensure suitability, accessibility and value for money, while

maintaining the flexibility required to adapt to changing system pressures and future service need.

2.2 MANDATED CONTACTS, UNIVERSAL OFFER, AND ESCALATION BY NEED

Within Health Visiting, the service provides the mandated/core Healthy Child Programme contacts and a wider offer of targeted and specialist interventions where vulnerabilities are identified, aligned to a "Think Family" approach. The broader 0–19 service is delivered through a skill mix workforce with a range of contact formats ranging from face-to-face, virtual, groups and drop-in sessions used where safe and appropriate.

The Healthy Child Programme mandates a series of universal contacts for all families with children aged 0–5 years. These include:

- Targeted antenatal contact: Support and information for expectant parents, focusing on health, wellbeing, and preparation for parenthood.
- New birth visit (10–14 days): Assessment of the newborn and support for parents, including feeding, bonding, and safety.
- 6–8 week review: Monitoring infant development, maternal emotional health, and parental adjustment.
- 1 year review: Evaluation of growth, nutrition, development, and immunisations, alongside parental support.
- 2–2½ year review: Focused on the child's physical, emotional, and social development, school readiness, and early identification of additional needs.
- New 4 year universal review: Introduced as part of the integrated 0–19 model, this contact offers a universal assessment for children approaching school entry. It aims to review health, development, and wellbeing, reinforce school readiness, and identify any emerging needs or vulnerabilities, ensuring timely support and referral where appropriate.

In addition to these mandated contacts, Health Visiting teams facilitate group sessions for parents and carers, which may include:

- Infant feeding groups: Providing support and advice on breastfeeding, bottle feeding, and weaning.
- Baby Well drop in Clinics: Offering routine health checks, growth monitoring, and advice for infants, ensuring early identification of health issues and supporting parents with guidance on infant care.

- ‘Marvellous Me’ Groups: These health promotion groups specially target additional suggested HCP contacts points at 3-4 months, 6 months, 18 months and 3 years, providing sessions designed to boost children’s confidence, self-esteem, and emotional wellbeing, using age-appropriate activities and interactive play.

Where vulnerabilities are identified—such as concerns regarding safeguarding, parental mental health, or child development—the service provides targeted and specialist interventions, either individually or in groups, to address the specific needs of families. All contacts are delivered flexibly depending on family preference, safety, and appropriateness, ensuring accessibility and responsiveness across Oxfordshire’s diverse communities.

2.3 EPISODES OF CARE (TARGETED INTERVENTIONS DELIVERED THROUGH SKILL MIX)

A central component of the Oxfordshire 0–19 Public Health Nursing Service is the structured delivery of Episodes of Care. These episodes offer families defined, evidence-based packages of support, designed to address specific needs and facilitate early intervention. Each Episode of Care follows a clear protocol as outlined in the service standard operating procedure, encompassing assessment, intervention, and—when necessary—onward referral, all linked to integrated care pathways. Delivered through both the 0–5 and the broader 0–19 pathways, these time-limited episodes provide consistent advice and enable escalation to targeted or specialist support within locality teams, ensuring a coordinated and responsive approach.

The following Episodes of Care for early years are offered by the service:

- Sleep support
- Toileting support
- Behaviour management
- Social interaction and play
- Nutrition, healthy weight and infant feeding
- Early speech, language, and communication support (social communication and language)
- Child / Parent attachment
- Home safety & accident prevention
- Early childhood illnesses prevention and management
- SEND support

A review of 146 episodes of care in one month showed sleep (1), then speech/language/communication (2), behaviour (3), toileting (4), and nutrition (5) as the most requested interventions, and that many requests came via parental self-referral through ChatHealth (See section 4.2).

2.4 SPECIALIST HEALTH VISITING ROLES AND ENHANCED PRACTICE

The service model features a variety of specialist roles that support and strengthen universal HV and SHN provision in key priority areas. These roles offer countywide leadership for pathway development, promote effective collaboration across agencies, and provide workforce training across the 0-19 Public Health Service. Specialist Lead Practitioners also deliver clinical expertise for complex cases, contribute to service improvement, and ensure best practice is implemented in their areas. In addition, specialist support is provided via the two stand-alone Senior Lead Practitioners in Infant Feeding and Perinatal Infant Mental Health. This support can be offered through group sessions or direct 1:1 interventions, ensuring tailored guidance and care for families and children who require it. This integrated approach embeds specialist knowledge in daily practice, maintaining strong links with both universal and targeted services, and enhancing quality, consistency, and outcomes throughout early years and school-aged pathways.

Some Specialist Lead Practitioners also hold the role of Locality Team Leader, combining specialist leadership with operational management responsibility for a defined locality. In addition, Senior Lead Practitioners may take on the role of Clinical Education Lead, contributing to the development and delivery of clinical education and training across the service. Therefore, a Senior Lead Practitioner can operate as a standalone specialist, also serve as a Locality Team Leader, or fulfil the responsibilities of a Clinical Education Lead, depending on the needs of the service and their individual expertise. This blended model provides both depth of expertise and strong local oversight, supporting safe, effective and responsive services for children and families across Oxfordshire.

The current Specialist Lead Practitioner roles within the service are each linked to a healthy child programme high impact area and include three stand-alone roles of Perinatal, Infant and Family Mental Health; Infant Feeding, Healthy Weight and Nutrition and SEND plus the following joint roles:

- Maternity and Care Of Next Infant (extra support for families who have previously experienced the sudden or unexpected death of a baby).
- School Readiness
- Neglect and Early Years Safeguarding
- Early Help and 0–19 Supervision
- Minor Illness, Emergency Department (ED) and Minor Injury Units (MIU)
- Healthy Lifestyles and PSHE
- Sexual Health (including contraception prescribing)
- Education Safeguarding and Attendance
- Mental Health Support Teams (MHSTs) and CAMHS interface
- Protective Behaviours and Substance Misuse
- Transition to Adulthood
- Clinical Triage and ChatHealth
- Digitalisation (EMIS)
- Website, Communications and Digital Engagement
- Co-production and Patient Experience
- Domestic Violence and Abuse (DVA)

Together, these roles strengthen clinical governance, support workforce capability, and ensure that evidence-based interventions are delivered consistently across the county, while enabling timely escalation and specialist support where additional need is identified.

2.5 FAMILY NURSE PARTNERSHIP (FNP)

FNP is embedded within the integrated model and provides an intensive, evidence-based programme for eligible young parents. FNP is an evidence-based, preventative programme designed to support young first-time mothers, aged 19 or under (or 21 and under if a care leaver), from early pregnancy through to their child's second birthday. The programme aims to improve maternal health, child development, and family self-sufficiency by providing regular, structured home visits from specially trained family nurses. These visits cover a range of topics including health, parenting, and personal development, fostering strong relationships and empowering young parents to make informed choices.

FNP operates under a national licence, which requires participating organisations to adhere to strict fidelity criteria, including staff training, programme delivery standards, and data collection protocols. Only qualified nurses who have completed

accredited FNP training are permitted to deliver the programme, ensuring consistency and quality. Additionally, services must maintain compliance with the licence, participate in national evaluations, and submit regular data returns to monitor outcomes and maintain programme integrity.

As part of the new service model a new, integrated young parent pathway has been implemented within the Service to ensure early identification, continuity and proportionate support for young parents from pregnancy through the early years.

The pathway operates alongside, and is closely aligned with, FNP, with Family Nurses providing specialist oversight, clinical leadership and expertise in supporting young parents with complex or multiple needs. Eligible young first-time parents are offered the evidence-based FNP programme, while those who do not meet FNP criteria or who graduate from the FNP programme are supported through the wider young parent pathway by locality Health Visiting teams.

Family Nurses play a central role in advising on pathway thresholds, contributing to multidisciplinary decision-making, supporting safe transitions between FNP and universal services, and providing consultation and supervision to locality practitioners. This approach ensures that all young parents in Oxfordshire receive a consistent, equitable and needs-led offer, with intensive support targeted where it will have the greatest impact, while maintaining continuity of care as families' needs change over time.

2.6 PARTNERSHIP WITH HOME-START – STRENGTHENING EARLY HELP AND COMMUNITY REACH

As part of the integrated 0–19 Public Health Nursing Service, Oxford Health holds a formal contractual partnership with **Home-Start**, a national charitable organisation that provides volunteer-led peer support to families with young children under 5. This partnership is a key component of the service's early help and prevention offer, complementing statutory health visiting and public health nursing provision.

Home-Start volunteers offer practical, emotional and non-judgemental peer support, typically through regular weekly contact, which may include home visits or community-based support. This frequency and continuity of support provides an offer that would not be possible through statutory services alone and enables families to build confidence, routines and resilience over time. Volunteers are carefully

recruited, trained and supported by Home-Start, and work alongside Health Visitors rather than replacing professional input.

Referrals into Home-Start are made through Health Visiting teams, ensuring that families are identified early and supported through a coordinated and proportionate pathway.

This partnership offers several important benefits within the Oxfordshire model:

- **Peer support that builds trust and engagement**
  Evidence from national and international studies demonstrates that peer support can be as effective as, and for some families more effective than, professional-only support in building trusting relationships, improving engagement and supporting positive outcomes, particularly for families experiencing isolation, low confidence or early vulnerability. Shared lived experience enables volunteers to connect with families in a way that reduces stigma and supports honest, open conversations.
- **Extending reach into communities**
  Home-Start's volunteer model enables support to be offered to families who may be less likely to engage with formal services, including those experiencing social isolation or practical barriers to access. This extends the reach of the 0–19 service beyond traditional clinical contacts and helps address inequalities in access.
- **Strengthening prevention and early intervention**
  Regular, relationship-based peer support helps prevent escalation of need by addressing issues early, supporting parental confidence and coping, and reinforcing key health and developmental messages. This reduces pressure on targeted and specialist health visiting capacity and supports families before concerns become more complex.
- **Enhancing outcomes through complementary support**
  Home-Start does not replace statutory services. Instead, volunteers work alongside Health Visitors to reinforce advice around parenting, routines, child development and emotional wellbeing. This layered approach strengthens outcomes through consistent, trusted relationships while ensuring that clinical oversight and escalation remain in place where required.
- **Supporting proportionate universalism**
  The availability of a voluntary-sector peer support offer enables Health Visiting teams to provide a graduated response, ensuring families receive the right

level of support at the right time, without over-medicalising need or defaulting to statutory intervention where this is not required.

- **Strengthening system collaboration**
  The partnership reflects a strong and mature relationship between the NHS and the voluntary and community sector, supporting shared ownership of early years outcomes and contributing to a more sustainable, system-wide approach to supporting families.

Illustrating impact: family and professional perspectives

The impact of the Home-Start partnership is evidenced not only through activity and outcome reporting, but also through direct feedback from families and professionals working within the integrated 0–19 pathway. These perspectives provide qualitative assurance of the value of structured, regular peer support alongside statutory public health nursing.

Family experience

Feedback captured within Home-Start annual reporting highlights the difference that sustained, relationship-based peer support can make for families experiencing vulnerability, isolation or low confidence. One parent described the impact of the support as follows:

> *"Having someone come regularly who understood what it was like, without judgement, helped me feel more confident as a parent. The support helped me get back on my feet, build routines, and feel less alone. It made a real difference to our family."*

Professional and system impact

From a professional perspective, Home-Start's contribution is recognised as strengthening early help pathways and supporting families with increasing complexity, complementing health visiting input. In contract review correspondence, Home-Start's Chief Executive highlighted the impact of the partnership with Oxford Health, noting:

> *"The security of the contract has enabled us to plan longer-term, increase capacity and take on more complex cases. Working closely with health visiting teams has improved referral quality and helped ensure families receive the right support earlier."*

Together, these perspectives reinforce the role of Home-Start as a trusted voluntary sector partner within the Oxfordshire 0–19 service model. By providing consistent,

non-judgemental peer support alongside professional public health nursing, the partnership enhances engagement, strengthens prevention and helps reduce escalation into more intensive statutory services.

Overall, the Home-Start partnership is a valued and integral part of the Oxfordshire 0–19 service model. By combining professional public health nursing with structured, regular peer support, the service is able to increase reach, build trust with families, and improve outcomes through a preventative, strengths-based approach aligned with national evidence and local need.

2.7 WORKFORCE SUSTAINABILITY AND DEVELOPMENT

Oxford Health is committed to ensuring workforce sustainability through a robust strategy of growing its own talent, underpinned by structured induction, ongoing development, and clear pathways for career progression. This approach not only maintains service continuity but also enhances the capability and morale of the workforce, ensuring that evidence-based interventions are delivered consistently across the county.

The organisation offers an extensive career progression framework that supports all staff bands, fostering professional growth from entry-level roles through to specialist positions. Staff are encouraged to pursue further qualifications and development opportunities, with dedicated sponsorship pathways available for those seeking to advance into Specialist Community Public Health Nursing (SCPHN), particularly within Health Visiting. This framework includes mentorship, regular appraisals, and tailored learning plans, ensuring that every team member has access to the resources and guidance required to progress in their career.

To become a qualified health visitor, practitioners must obtain the SCPHN qualification, which is recognised nationally as the essential credential for this role. Oxford Health actively sponsors eligible staff to undertake this qualification, typically recruiting candidates from its existing pool of community public health nurses.

During the SCPHN training period, staff are employed by the Trust, maintaining continuity of income and service engagement while developing their skills. Throughout the SCPHN training, trainees benefit from a comprehensive support structure designed to maximise their learning and success. Clinical Education Leads provide hands-on supervision, guidance, and feedback in practice settings, ensuring

trainees can apply theoretical knowledge effectively and safely. Academic support is delivered in partnership with local universities, most notably Oxford Brookes University and Bucks New University, where trainees receive expert tuition, access to research resources, and opportunities for academic enrichment. This dual support system ensures that trainees are well-equipped both academically and clinically to meet the demands of modern health visiting.

By investing in internal recruitment and supporting existing staff to achieve the SCPHN qualification, Oxford Health ensures a steady supply of new health visitors. This 'grow your own' model reduces reliance on external recruitment, promotes organisational loyalty, and facilitates the development of a highly skilled, locally embedded workforce. As a result, the Trust is able to maintain workforce stability and deliver high-quality, needs-led services to children and families in Oxfordshire. This is also evidenced by the level of vacancy currently within the service which stands at 0.77% (1.77twe) as of March 2026.

3. MANDATED REVIEWS – PERFORMANCE OVERVIEW, LOCALITY VARIATION AND IMPROVEMENT ACTIONS

This section summarises Oxfordshire's performance against mandated Healthy Child Programme contacts and associated follow-up activity. It presents (1) **timeliness and trends** over the year to date, (2) **locality variation** to identify places/groups with lower coverage or poorer outcomes, and (3) the **impact of targeted actions** (including SPA booking changes, outreach, and place-based approaches) and what has changed as a result. Performance is monitored through near real-time dashboards and commissioner reporting, with learning and improvement actions overseen through operational and clinical governance routes.

3.1 PERFORMANCE AND TRENDS

Table 1 below provides the headline position for key mandated contacts. Oxfordshire continues to deliver strong overall coverage, with the most significant improvement opportunity being achievement of the *tighter mandated windows* (particularly NBV within 14 days and the 6–8 week review within the 42–56 day window).

Table 1 - Headlines of Mandated Contacts

Contact / measure	Q3 2025/26 position	Target	Trend / Year to date position	Locality ranges in performance (Q3 2025/26)
New Birth Visit (NBV) within 14 days	**82.24%** (1486/1807 babies)	90%	**Improving**: 79.8% (Q1) → 81.0% (Q2) → 81.8% (Q3); YTD **80.9%** (4330/5354)	75% → 92%
NBV within 30 days	**94.96%** (1716/1807 babies)	95%	YTD **94.5%** (5064/5354) – consistently high coverage	90% → 95%
6–8 week review (42–56 day window)	**84.52%** (1518/1796 babies)	93%	Stable with improving timeliness; YTD approx. **87%**	78% → 92%
Breastfeeding prevalence at 6–8 weeks	**62.53%** (1123/1796 babies)	60%	Stable and above target across year; YTD above target	N/A (countywide metric)
12-month review by 12 months	**86.57%** (1566/1809 children)	90%	Improving when extended window of 15 months applied; YTD **90.25%** (1657/1836)	83% → 91%
2–2½ year review (within 691–914 days)	**81.20%** (1529/1883 children)	90%	Locality variation is the key driver for targeted improvement. YTD **81.0%**	76% → 89%

The tables below show the performance of each of the universal contacts, providing a detailed breakdown of how well the service is meeting its key targets across different review periods. These tables include data on the new birth review, the 6–8 week review, the 1-year review, the 2-year review, and the 4-year review.

For each stage, the tables display both the percentage of reviews completed within the recommended timeframe and the actual number of cases achieved versus the total eligible population. This enables a clear assessment of progress towards annual targets and facilitates the identification of areas requiring focused improvement.

The data also illustrates where performance is close to or exceeds set targets, as well as where there are shortfalls. For instance, the 12-month review by 12 months achieved 86.7% completion in Q3, slightly below the 90% target, but improved to 90.25% when extended to 15 months. Similarly, the 2–2½ year review reached 81.70% against a 90% target.

Table 2 - New Birth Review Performance

New Birth Review	(Blank) Current Qtr. % completed within 8-14d	(Blank) Current Qtr. % completed within 8-30d	90.0 % 8-14d 95.0 % 8-30d Qtr. Target Yr2	(Blank) Current Qtr. % completed within quarter

Financial Year	Total completed within 8-14d	% completed within 8-14d	Total completed within 15-30d	% completed within 15-30d	Total completed within 8-30d	% completed within 8-30d	No. of children 30d within quarter	Total completed before 8d	Total completed after 30d	Total completed within quarter	Total declined	Total DNA	Total no review	Total completed after 30d after quarter end
2025/2026	4,330	80.9 %	734	13.7 %	5,064	94.6 %	5,354	2	48	5,114	103	89	26	22
Q1	1,413	79.8 %	268	15.1 %	1,681	95.0 %	1,770		19	1,700	26	23	14	7
Q2	1,425	81.0 %	232	13.2 %	1,657	94.1 %	1,760	1	10	1,668	43	29	10	10
Q3	1,492	81.8 %	234	12.8 %	1,726	94.6 %	1,824	1	19	1,746	34	37	2	5
Total	4,330	80.9 %	734	13.7 %	5,064	94.6 %	5,354	2	48	5,114	103	89	26	22

Table 3 - 6-8 Week Performance

6-8wk Review	84.5 % Current Qtr. % completed within 42-56d	93.0 % Qtr. Target Yr2	91.2 % Current Qtr. % completed within quarter

Financial Year	% of 6-8wk reviews completed: Total completed within 42-56d	% completed within 42-56d	No. of children 56d within quarter	Total completed before 42d	Total completed after 56d	Total completed within quarter	Total declined	Total DNA	Total no review	Total completed after 56d after quarter end
2025/2026	4,393	83.7 %	5,248	118	329	4,840	157	134	73	44
Q1	1,425	83.2 %	1,712	41	117	1,583	47	33	36	13
Q2	1,458	83.0 %	1,757	45	113	1,616	51	44	28	18
Q3	1,510	84.9 %	1,779	32	99	1,641	59	57	9	13
Total	4,393	83.7 %	5,248	118	329	4,840	157	134	73	44

Table 4 - 1yr Review Performance

1yr Review	(Blank) Current Qtr. % completed within 270-366d	90.0 % Qtr. Target Yr2	(Blank) Current Qtr. % completed within quarter

Financial Year	Percentage of 12-month development reviews completed by the time the child turned 12 month: Total completed within 270-366d	% completed within 270-366d	No. of children 366 days within quarter	Total completed before 270d	Total completed after 366d	Total completed within quarter	Total declined	Total DNA	Total no review	Total completed after quarter end
2025/2026	4,595	84.4 %	5,445	6	287	4,888	165	243	65	84
Q1	1,540	84.2 %	1,830	4	88	1,632	57	91	27	23
Q2	1,494	82.3 %	1,815	2	121	1,617	57	85	21	35
Q3	1,561	86.7 %	1,800		78	1,639	51	67	17	26
Total	4,595	84.4 %	5,445	6	287	4,888	165	243	65	84

Table 5 - 2yr Review Performance

2yr Review	(Blank) Current Qtr. % completed within 691–914d	90.0 % Qtr. Target Yr2	(Blank) Current Qtr. % completed within quarter

Percentage of 2 to 2 1/2 year reviews completed

Financial Year	Total completed within 691–914d	% completed within 691–914d	No. of children 914d within quarter	Total completed before 691d	Total completed after 914d	Total completed within quarter	Total DNA	Total declined	Total no review	Total completed after quarter end
2025/2026	4,479	81.0 %	5,531	4	225	4,708	406	259	94	64
Q1	1,531	82.1 %	1,864	3	81	1,615	100	86	45	18
Q2	1,422	79.0 %	1,799		95	1,517	149	85	22	26
Q3	1,526	81.7 %	1,868	1	49	1,576	157	88	27	20
Total	4,479	81.0 %	5,531	4	225	4,708	406	259	94	64

Table 6 - 4yr Review Performance

4yr Review	(Blank) Current Qtr. % completed F2F	(Blank) Current Qtr. % completed records review	70.0 % Completed records reviews Qtr. Target

No. of 4yr old children who have had a school readiness transition review

Financial Year	Total completed F2F	% F2F completed	Total completed school readiness transition review	% completed school readiness transition review	No. of children 50m within quarter
2025/2026	2,425	40.3 %	5,536	92.1 %	6,011
Q1	615	32.0 %	1,724	89.6 %	1,924
Q2	760	38.1 %	1,879	94.1 %	1,996
Q3	1,050	50.2 %	1,933	92.4 %	2,091
Total	2,425	40.3 %	5,536	92.1 %	6,011

To support scrutiny, a summary of **variation in localities** for each mandated contact is provided below.

New Birth Visit (NBV) within 14 days

- Best performing localities: achieved approximately 89-90% NBV completion within 14 days in Q3.
- Lowest performing localities: recorded completion rates in the region of 62-75% within the 14-day window.
- Despite this variation, NBV completion within 30 days remained consistently high across all localities, with all localities above 90%, and several exceeding 95%.

6–8 week review (42–56 day window)

- Best performing localities: achieved around 92-93% completion within the mandated window.
- Lowest performing localities: were in the range of 68-79% within the 42–56 day window.
- Locality variation reflects differences in parental choice, Did Not attend/ Was Not Brought, and workforce availability rather than completion of the review overall, which is higher when measured outside the strict window.

12-month review (by 12 months)

- Best performing localities: achieved over 93% completion by 12 months.

- Lowest performing localities: recorded completion rates of approximately 78-85% by 12 months.
- When the reporting window is extended to 15 months, all localities exceed 90%, demonstrating that the issue relates primarily to timing rather than access or engagement.

2–2½ year review (within 691–914 days)

- Best performing localities: achieved approximately 86-88% completion within the mandated window.
- Lowest performing localities: recorded completion rates of around 73–78%.
- This review shows the greatest locality variation and is therefore the main focus of targeted improvement activity described below in Section 3.3. This metric is particularly influenced by factors such as the return of mothers to work and other availability constraints, which can impact attendance and timely completion of reviews as further described below.

4-year universal review

- This is a new contact introduced as part of the new integrated 0–19 model.
- Best performing localities: are already achieving over 97% completion of school-readiness transition reviews.
- Lowest performing localities: are in the range of 85%.
- Performance is improving quarter-on-quarter as the pathway becomes fully established across all localities but overall performance remains high.

Non-Mandated Activity

Across Q1–Q3 2025/26, the service recorded 121,958 attended contacts, of which 93,734 were face-to-face, 22,104 telephone, 4,726 email and 1,396 video. In Q3 alone, there were 42,280 attended contacts (32,547 face-to-face; 7,907 telephone; 1,340 email; 486 video). This demonstrates that, alongside mandated reviews, the service is delivering substantial volume of ongoing follow-up contacts and support (Table 7).

Table 7 - Number and Type of Contacts by the service. *NB this is the whole 0-19 service not just that of 0-5 ages.*

Back to report | NUMBER OF ATTENDED CONTACTS

Financial Year	Consultation via video consultation	E-mail consultation	Face to face consultation	Other consultation medium used	Telephone consultation	Total
2025/2026	1,396	4,724	93,734	0	22,104	121,958
Q1	474	1,773	30,628	0	7,843	40,718
Q2	436	1,611	30,559	0	6,354	38,960
Q3	486	1,340	32,547	0	7,907	42,280
Total	1,396	4,724	93,734	0	22,104	121,958

Caseload profile and implications for demand and capacity

Table 8 below summarises the current caseload profile for children aged 0–4 years within the Oxfordshire 0–19 Public Health Nursing Service. The majority of children are supported at a **universal level**, with a smaller but significant proportion requiring **targeted** or **specialist** input based on identified need. This distribution reflects a proportionate universalism model, where support is escalated according to vulnerability and complexity rather than applied uniformly.

At Q3 2025/26, approximately 80% of the 0–4 caseload is supported at a universal level, with around 14–15% receiving targeted support and approximately 5–6% receiving specialist support. Universal support includes delivery of the mandated Healthy Child Programme contacts and routine health promotion activity for children and families without identified additional needs which includes weekly well-baby drop-in clinics available in all localities. Demand at this level is primarily driven by population size and birth rates and is relatively predictable.

Families move from universal to **targeted support** where vulnerabilities or emerging concerns are identified through routine contacts, assessment or self-referral. Targeted support is typically delivered through **time-limited Episodes of Care**, as described above. While targeted cases represent a smaller proportion of the overall caseload, they generate **disproportionately higher contact activity**, requiring additional visits, follow-up and coordination, and therefore have a greater impact on workforce capacity.

A smaller proportion of children are supported at a **specialist** level, reflecting more complex, enduring or multi-agency needs, including safeguarding, significant developmental concerns, long-term conditions or SEND. All specialist intervention or support is delivered by a health visitor and cannot be undertaken by skill mix staff, although cases may also be escalated to Specialist Lead Practitioners where additional expertise is required. Specialist input often involves enhanced clinical oversight, multidisciplinary working and liaison with partner agencies, and may be delivered by Senior Lead Practitioners or practitioners with further specialist training. Although numerically limited, specialist cases are resource-intensive and contribute significantly to demand on practitioner time and system coordination.

Movement between levels of support is dynamic and needs-led. Families may step up from universal to targeted or specialist support as needs emerge, and step back down following effective intervention. This fluidity is central to the service model but

creates variability in demand that is not fully visible when considering headline caseload numbers alone. Periods with a higher proportion of targeted and specialist cases can therefore place additional pressure on capacity, even where overall caseload size remains stable.

Overall, the caseload profile in Table 8 provides important context for interpreting performance and capacity. High volumes of targeted and specialist work increase contact intensity and practitioner workload, which in turn can affect the timeliness of universal contacts in specific localities or periods. Understanding this balance is critical to workforce planning, performance interpretation and the targeted improvement actions described elsewhere in Section 3.

able 8 - Caseload Numbers by Level of Service

Back to report | NUMBER OF CASELOAD RECORDED AS UNIVERSAL; TARGETED; SPECIALIST IN 0-4 YEARS

Financial Year	Universal	% Universal	Targeted	% Targeted	Specialist	% Specialist	Denominator - Caseload
2025/2026	89,333	80.0 %	16,060	14.4 %	6,289	5.6 %	111,682
Q1	29,825	80.0 %	5,281	14.2 %	2,195	5.9 %	37,301
Q2	29,800	80.0 %	5,377	14.4 %	2,078	5.6 %	37,255
Q3	29,708	80.0 %	5,402	14.6 %	2,016	5.4 %	37,126
Total	89,333	80.0 %	16,060	14.4 %	6,289	5.6 %	111,682

3.2 FACTORS AFFECTING TARGET ACHIEVEMENT AND INTERPRETATION OF PERFORMANCE

The performance data presented in **Table 1-6 above** should be interpreted alongside an understanding of how national measures are defined, locally agreed reporting arrangements with commissioners, and the operational realities of delivering community-based services at scale. Together, these factors explain why some mandated targets are not consistently achieved despite high overall coverage and improving trends.

National time-window measures versus locally agreed quarterly reporting

As shown in **Table 1**, Oxfordshire performs strongly against broader completion measures (for example, New Birth Visits within 30 days) while performance against tighter national windows (such as NBV within 14 days and 6–8 week reviews within the 42–56 day window) remains below target.

National KPIs measure delivery strictly within defined day ranges, whereas local reporting agreed with commissioners considers performance **across the whole quarter**, recognising that families may choose appointments just outside the

mandated window while still receiving timely and clinically appropriate care. This explains the visible gap in Table 1 between "within window" performance and overall completion, and is a recurring theme discussed through Contract Review Meetings.

Impact of parental choice, declines, Did Not attend/ Was Not Brought and practitioner consistency

Variation observed in **locality performance** is partly driven by parental choice, including families declining reviews or requesting appointments outside mandated windows due to work commitments, family circumstances or personal preference this is particularly relevant for the 2-2.5yr review.

For the New Birth Visit (NBV), several factors contribute to visits falling outside the national timeframe. For example, some families may still be under the care of the midwife, with the health visitor visit intentionally deferred until midwifery discharge to avoid duplication and ensure a smooth transition of care. Additionally, there are cases where the baby remains in hospital for an extended period following birth—such as admissions to neonatal units—meaning the NBV cannot take place at home within the prescribed window. Occasionally, families may temporarily relocate to stay with relatives or move out of area for additional support during the early postnatal period, making it impractical to deliver the NBV within the original timeframes. These scenarios, alongside individual family choices and practitioner consistency considerations, collectively influence service performance against mandated targets.

Did Not Attend (DNA) rates and declines also disproportionately affect reported performance. These factors sit largely outside the provider's direct control but materially reduce the percentages shown in the performance tables. This is why some localities with otherwise strong engagement show lower headline KPI performance, despite high levels of contact activity overall.

In addition, practitioner consistency is a significant but often underemphasised factor influencing whether reviews are completed within target timeframes. In some instances, the service may intentionally prioritise continuity of practitioner—such as waiting for a part-time health visitor who already knows the family and carried out the antenatal contact—to deliver the New Birth Visit, even if this means missing the strict KPI window, particularly this would be the case for families under the specialist level of service.

The relationship and trust built through consistent practitioner involvement is considered to have a greater long-term benefit for family outcomes than rigidly meeting a reporting metric. This approach reflects the service's commitment to meaningful engagement and high-quality care, recognising that the value of practitioner-family continuity may outweigh the short-term impact on headline performance figures.

Workforce capacity, Locality variation and access factors

Locality variation and access factors, demonstrate that performance across Oxfordshire is not uniform. These differences stem from a blend of population characteristics, geography, transport and access issues, and variations in service configuration, rather than any single systemic problem. The proactive use of these variations enables targeted locality improvement plans, focusing action where performance is lowest instead of applying a uniform response. In this way, the locality performance data used internally serves as diagnostic tools to inform improvement.

Further, certain localities have experienced staffing pressures due to maternity leave and long-term sickness—factors not always visible when considering headline vacancy rates alone. Such pressures significantly impact the ability to meet targets, as teams that appear fully staffed on paper may still face operational challenges if key personnel are absent for extended periods. Recognising these subtleties is essential for understanding the true capacity and resource limitations in each locality, ensuring that improvement plans address the root causes of performance variation.

As well as long term, short-term workforce capacity pressures, including sickness absence and staff turnover, can affect the timeliness of service delivery in specific areas. Additionally, performance data in Tables 1–6 is sensitive to the timing of recording and coding: if a review is completed but not fully documented within the reporting period, this can temporarily suppress performance figures. Such factors are within the provider's control and are actively addressed through ongoing operational and administrative improvement efforts.

Deep dive into "no review" cases – explaining the residual gap

To support interpretation of the locality variation shown in Tables 2–6, a focused deep-dive analysis was undertaken in Q3 2025/26 for the **2–2½ year review**. This review was selected to better understand the drivers behind the residual gap between overall completion and achievement within the mandated national window

as it is also an Oxfordshire target of improvement as part of the national good level of development government standard.

The deep dive examined all cases recorded as **"no review"** at the point of extraction and categorised the reasons for non-completion, distinguishing between factors **within the provider's control** and those **outside the provider's control**. This analysis provides important context for understanding both the scale of improvement potential and the realistic limits of performance improvement based on provider action alone.

Key findings from the analysis were as follows:

- **Total 'no review' cases identified:** 58 cases (3% of 1,883 reviews due).
- **Factors not within Oxford Health's control:**
    - 31 cases (approximately 1.64% of reviews due).
    - These primarily related to parental choice, families declining the review, repeated DNAs, or child/family sickness.
- **Factors within the provider's control:**
    - 27 cases (approximately 1.4% of reviews due).
    - These related mainly to administrative or capacity-related issues, such as booking delays or recording lag.
- **Quantified improvement potential:**
    - If all cases within the provider's control had been completed within the mandated window, Q3 performance would have increased from **81.70% to 82.63%**.
- **Interpretation:**
    - Even full resolution of all 'within gift' cases would result in a **modest overall uplift**, demonstrating that DNAs, declines and parental choice have a disproportionate impact on headline KPI performance.

This analysis reinforces that locality variation and under-achievement against the national window are not driven by systemic access failure, but by a combination of timing, family choice and a relatively small number of administratively resolvable cases. It also supports the service's proportionate improvement approach, focusing effort where it can have the greatest impact without over-medicalising families who have actively chosen not to engage.

3.3 DATA DRIVEN IMPROVEMENT AND IMPACT

Performance improvement within the Oxfordshire 0–19 Public Health Nursing Service is driven through a structured, data-led approach that combines countywide operational changes with targeted locality-level actions. The performance tables and locality breakdowns presented in Sections 3.1 and 3.2 are actively used as improvement tools rather than solely as reporting outputs, enabling the service to prioritise action where variation is greatest and to monitor the impact of changes over time.

Countywide improvement actions

The most significant countywide action to improve timeliness of mandated contacts has been the introduction of **SPA-led booking** for key reviews, including New Birth Visits, implemented from January 2026. This change was informed directly by performance data showing slippage against tighter national time windows despite high overall completion rates (as illustrated in Table 1). Centralised booking through SPA has improved consistency of offer, reduced variation in booking practice between localities, and strengthened oversight of appointments approaching the mandated window. Early data shows a continued upward trend in NBV delivery within 14 days, supporting the direction of travel seen across Q1–Q3.

In parallel, the service has strengthened **reminder and communication processes**, including increased use of AccuRx messaging (see section 4.4) and clearer appointment information, to reduce avoidable DNAs. These actions directly respond to the themes identified in the deep-dive analysis of "no review" cases and are intended to improve the figures presented in both the headline and locality-level tables.

Locality-specific improvement actions

Locality variation shown in Section 3.2 is used to trigger **local improvement plans**, which are reviewed through operational management and shared with commissioners via Contract Review Meetings. Rather than applying uniform solutions, locality teams are supported to tailor actions based on their specific population, geography and access challenges. Examples of locality-level actions include adjustments to clinic configuration, targeted follow-up of missed appointments, and flexible use of outreach approaches where clinic attendance is a barrier. These actions are designed to address the lower-performing localities identified in the tables, while sustaining performance in areas already performing well.

Focus on access, engagement and equity

Performance data is triangulated with service-user feedback and access insight to ensure improvement actions address underlying barriers rather than solely focusing on numerical targets. Feedback reviewed has informed changes such as improving clarity of appointment information, reviewing clinic locations where travel or parking is a barrier, and reinforcing messaging that families can attend alternative local clinics where appropriate. These actions support equitable access and are particularly relevant to localities where DNAs or declines contribute disproportionately to lower KPI performance.

Targeted follow-up of declines and DNAs

The Q3 deep-dive analysis of "no review" cases has provided a clearer understanding of which elements of under-performance are within the provider's control and which are not. This analysis has directly informed improvement actions, including prioritising earlier contact with families who initially decline or do not attend, refining escalation routes within SPA, and strengthening administrative oversight of follow-up activity. While the analysis demonstrates that resolving all "within gift" cases would result in a modest overall improvement, it has enabled the service to focus effort proportionately and avoid unintended consequences, such as over-medicalising families who have actively chosen to decline contact.

Monitoring impact and sustaining improvement

The impact of improvement actions is monitored through routine performance dashboards, locality reviews and Contract Review Meetings, ensuring that changes are tracked against the same measures presented in this report. This creates a clear feedback loop between data, action and oversight. Where improvement is demonstrated, actions are embedded as standard practice; where variation persists, further targeted intervention is considered. This approach ensures that the service continues to improve performance against national standards while maintaining a family-centred, proportionate model of care.

4. DIGITAL – HOW DIGITAL SUPPORTS SERVICE DELIVERY

4.1 DIGITAL PRINCIPLE: "SUPPORTING, NOT REPLACING" FACE-TO-FACE

Digital technology is increasingly utilised within the Oxfordshire 0–19 Public Health Nursing Service to enhance access, timeliness and consistency across service delivery. However, it remains fundamental that digital tools are designed to support—rather

than replace—the provision of face-to-face care. This guiding principle ensures that families continue to benefit from direct clinical interaction, with digital solutions complementing and expanding rather than substituting the traditional healthcare model.

The service's activity profile for Q3 25/26 demonstrates that face-to-face consultations continue to be the predominant method, accounting for 77.74% of all recorded contacts, whilst telephone consultations represent 18.91%, email 2.18%, and video 1.17%. These figures highlight the sustained prioritisation of in-person engagement, particularly for clinically mandated reviews, where direct assessment and support are essential.

The commissioned model is purposefully structured to allow a blend of delivery methods, ensuring flexibility and responsiveness to varying needs where it is considered both good and safe practice. Digital channels are harnessed to facilitate administrative efficiency, rapid communication, and improved reliability, such as through appointment reminders and information sharing.

At the same time, the service continually reviews feedback and performance data to ensure that digital approaches do not inadvertently create barriers or diminish the quality of clinical care. By maintaining a strategic balance between digital and face-to-face modalities, the service is able to optimise accessibility and consistency for families, while upholding the clinical standards and personalised support that underpin its model of care.

4.2 CHATHEALTH / PARENTLINE – RAPID ACCESS AND REDUCED BARRIERS

ChatHealth is an innovative digital messaging platform designed to provide families and young people across Oxfordshire with confidential access to timely health advice and support. The system allows users to communicate directly with Public Health Nursing staff via secure text messaging, facilitating early intervention and seamless escalation into face-to-face care pathways when necessary.
One of the key advantages of ChatHealth is its flexibility: messages can be sent at any time, 24/7, making it highly accessible for users regardless of their schedules. The service aims to respond to all messages within one working day, ensuring that timely support is provided. By offering a discreet and accessible means of engagement,

ChatHealth helps to remove barriers around seeking support, particularly for sensitive topics or when attending clinics in person may be challenging. The platform features clearly defined governance and quality assurance processes, including automated response messages, staff notifications, and robust authentication protocols, ensuring both the safety and reliability of communications. ChatHealth is available across a variety of age groups, supporting Parentline 0–5, as well as dedicated channels for children aged 5–11 and 11–19, thus catering to the distinct needs of different populations.

Figure 2 - Visual overview of ChatHealth Process

During Q3 25/26, ChatHealth facilitated a substantial volume of engagement, with 15,125 messages received through Parentline 0–5, 397 for the 5–11 age group, and 444 for the 11–19 channel. These figures are summarised in Table 9, which provides a detailed breakdown of ChatHealth activity and highlights the key role the platform plays in extending rapid access to advice, support, and feedback from families and young people throughout Oxfordshire.

Table 9 - Chat Health Messages Received

Financial Year	Number of messages received through digital platform Chat Health			
	a. Number of messages received through digital platform Chat Health for 0-5 years	b. Number of messages received through digital platform Chat Health for 5-11 years	c. Number of messages received through digital platform Chat Health for 11-19 years	Total
⊟ **2025/2026**	46,208	1,416	970	48,594
Q1	15,637	518	282	16,437
Q2	15,446	501	244	16,191
Q3	15,125	397	444	15,966
Total	46,208	1,416	970	48,594

Analysis of Q3 Parentline 0–4 activity confirms that the top three reasons for messages sent were appointment queries, constipation, and general development. These themes underline the service's role as a trusted first point of contact for parents seeking advice on both routine and more specific health concerns. Chat Health 0–4 Parentline continues to be the most widely accessed service of its kind across NHS Trusts nationwide, demonstrating its value in supporting families with young children.

Oxfordshire data demonstrates that the 0–4 and 5–11 Parentlines, as well as the 11–19 ChatHealth line, have all maintained performance levels consistently above the national average. This sustained high usage across all age groups highlights the platforms' growing relevance and effectiveness in addressing the evolving needs of parents, adolescents, and young people—offering timely support, reassurance, and expert advice when it is needed most. National benchmarking further underscores this success: using the ChatHealth standard metric of conversations per 100,000 service users (Oct 2024–Aug 2025), Oxfordshire's 0–4 Parentline averages 25.90 compared to the national average of 7.19 (over 3.6 times higher).

The 5–11 Parentline averages 0.801, nearly 2.7 times the national figure of 0.299, while the 11–19 service averages 0.462 compared to the national average of 0.267 (1.7 times higher). These results are consistent with local reporting which confirms that Oxfordshire's 0–4 Parentline is the most widely accessed ChatHealth service nationwide, and that the county's ChatHealth offer continues to outperform national averages across both the Parentline and young people's services.

In recognition of its innovative approach, the Oxford Health Chat Health team was nominated among the top three nationally for a digital innovation award in the past year. This accolade highlights the team's commitment to excellence and ongoing leadership in the development of accessible, responsive digital health solutions for families and young people.

The service is actively strengthening ChatHealth governance and quality assurance. Provider drafting describes ChatHealth away days and associated work to improve standard operating procedures and celebrate achievements (including recognition of the ChatHealth team). From a patient safety perspective, a formal ChatHealth clinical safety case describes inbuilt safety features including automated "bounce back" messages in and out of hours, staff notifications, unique staff logins and multi-factor authentication, with clear signposting to urgent services when the service is closed.

4.3 WEBSITE AND DIGITAL INFORMATION – IMPROVING HEALTH LITERACY AND SELF-MANAGEMENT

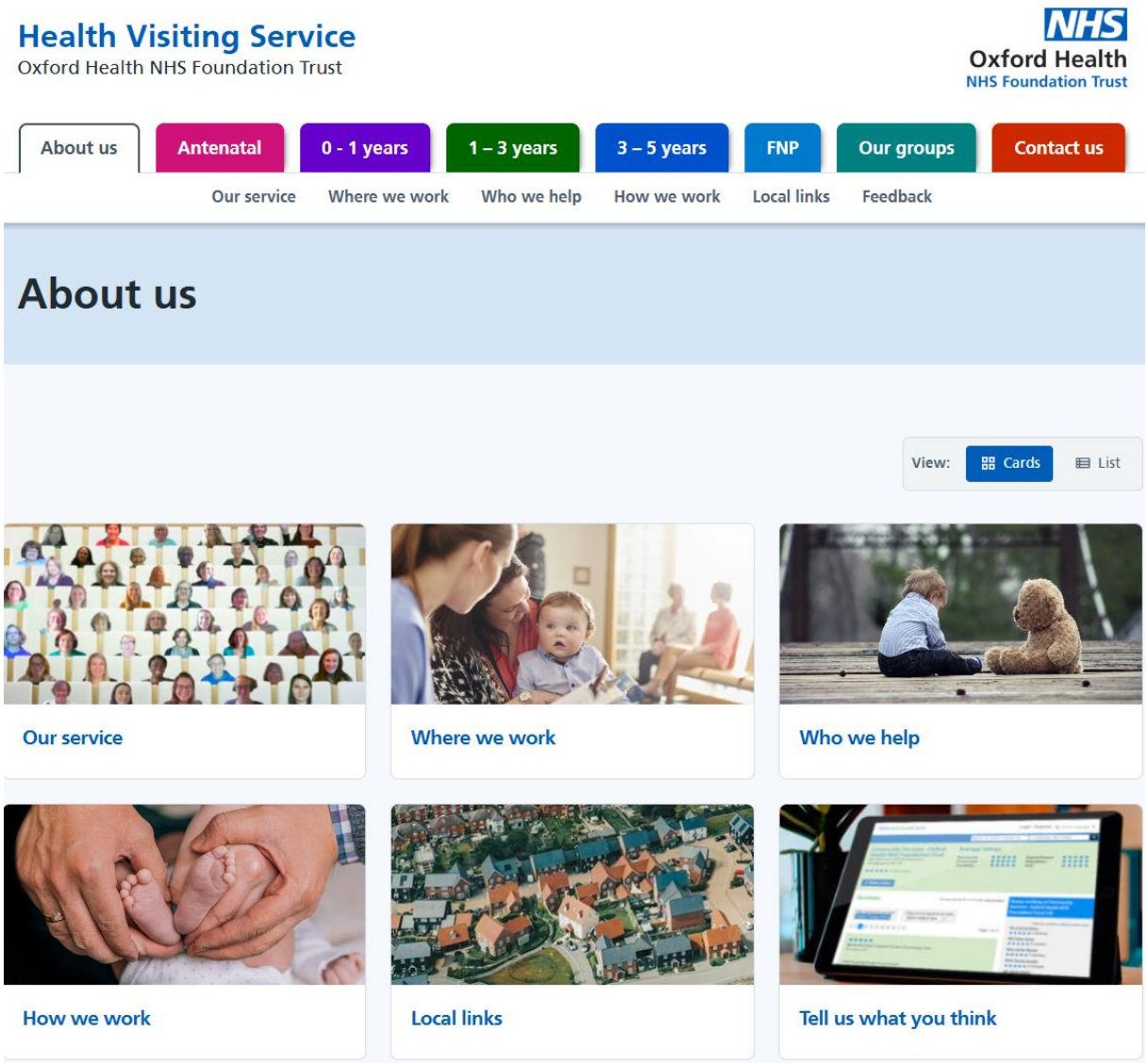
The Oxfordshire 0–19 website serves as a comprehensive digital hub, offering families and professionals a wide range of evidence-based resources and clear signposting to support health and wellbeing across childhood and adolescence. The site's Health Visiting section, in particular, has been prioritised for update to ensure that parents and carers of young children can easily access reliable advice on topics such as child development, feeding, sleep, and common health concerns. Regularly updated with the latest guidance, the section provides downloadable leaflets, interactive tools, and practical tips, enabling users to make informed decisions about their children's care.

Usage data for the website underscores its growing importance and reach: since January 2025, the Health Visiting pages have attracted 48,600 unique visitors—a substantial 40% increase compared to the previous period—while overall page views have soared by 48% to 136,000. These figures indicate not only heightened awareness and engagement with the service, but also confirm that families are turning to the site as a trusted first point of contact for health information and support. The rise in visitors and page views suggests successful efforts in promoting the website and improving its accessibility.

Recent enhancements to the site have further bolstered its usability and inclusivity. Multilingual functionality enables users who speak languages other than English to access key information, supporting Oxfordshire's diverse population. Improved mobile usability ensures that families can engage with the service on smartphones and tablets, reflecting modern digital behaviours and reducing barriers to access. Together, these advancements demonstrate a proactive commitment to digital inclusion and health literacy, ensuring that all families—regardless of background or device preference—can benefit from reliable, accessible health resources online.

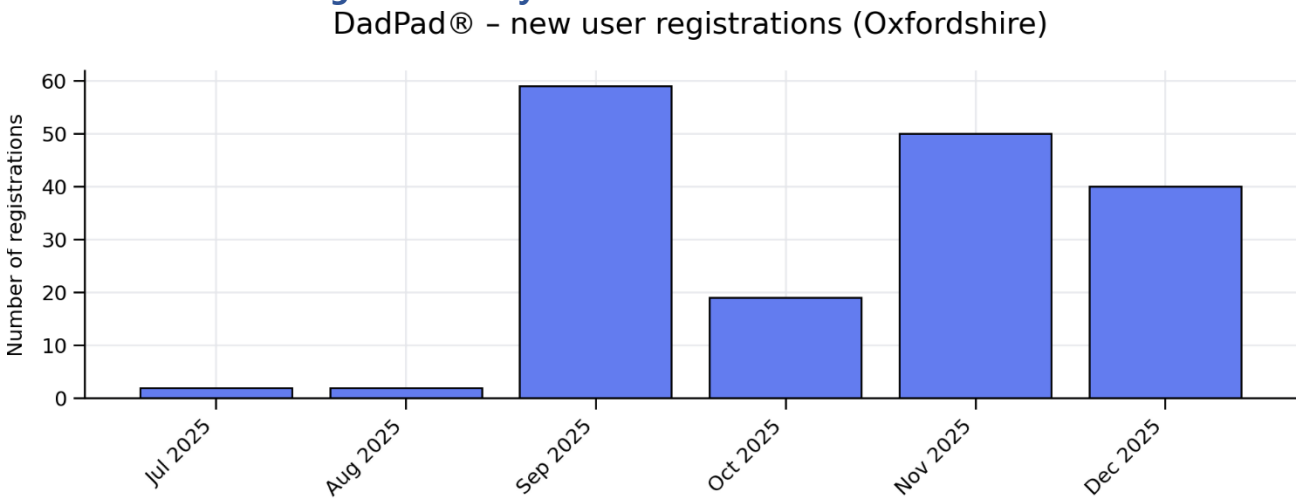
To ensure families have access to trustworthy information, the Oxfordshire 0–19 website provides direct links to national, reputable sources of health advice, such as the NHS website. In addition, the site is integrated with the Healthier Together platform, which offers evidence-based guidance specifically tailored for parents, carers, and young people of Oxfordshire. These partnerships and signposts reinforce the website's role as a gateway to reliable, up-to-date information, supporting families in making well-informed decisions about their health and wellbeing.

Figure 3 - Screenshot of the Website Homepage



The service also promotes father-inclusive digital support through **DadPad®**. Oxfordshire dashboard data shows 63 new registrations in Q3 2025 (Jul–Sep) and 109 in Q4 2025 (Oct–Dec) — 172 registrations across the two quarters — demonstrating growing utilisation of father-focused support.

Table 10 - DadPad Registrations by Month



The service's optimisation workstreams also recognise that digital content must be clear and accessible, with ongoing work to improve navigation and to strengthen how the service is described to families and professional stakeholders.

4.4 ACCURX AND APPOINTMENT COMMUNICATION – REDUCING ADMIN BURDEN AND IMPROVING RELIABILITY

AccuRx is a digital communication platform that is extensively utilised across the Oxfordshire 0–19 service to streamline appointment management and enhance the reliability of contact with families. Through the Single Point of Access, AccuRx facilitates the sending of appointment notifications, reminders, and clinician messages directly to parents and carers, making it easier for them to keep track of upcoming appointments and key information. All communications sent via AccuRx are seamlessly uploaded into EMIS (the Trust's electronic records system), ensuring that records are comprehensive and up to date, which supports continuity of care and robust documentation practices.

The system incorporates well-defined opt-in and opt-out procedures, allowing families to exercise choice over how they receive digital communications. This approach respects individual preferences and supports data protection requirements. Furthermore, there is a planned development to introduce further feedback mechanisms following appointments, enabling families to share their experiences and helping the service to continually improve its provision.

By automating routine appointment communications and facilitating secure clinician messaging, AccuRx significantly reduces administrative workload, minimises missed appointments, and improves overall service efficiency. Its integration with EMIS ensures that all interactions are accurately recorded, supporting audit capabilities and safeguarding. In addition, AccuRx enhances accessibility and engagement by providing timely, clear, and direct communication, enabling families to feel informed and supported throughout their care journey. These improvements ultimately contribute to better health outcomes and a more responsive, patient-centred service.

4.5 EMIS, TEMPLATES, DASHBOARDS AND SYSTEM INTEGRATION

EMIS is the core clinical record system used across the Oxfordshire 0–19 Public Health Nursing Service and plays a central role in enabling safe, efficient and optimised service delivery. The system supports consistent recording, clinical decision-making, safeguarding assurance and performance management across universal, targeted and specialist pathways.

Optimised service delivery through structured EMIS templates

Standardised EMIS templates are used across the service for mandated Healthy Child Programme contacts, safeguarding activity, Episodes of Care and outcome recording. These templates support practitioners to capture key information consistently at the point of care, reducing unwarranted variation in documentation and ensuring that clinical assessments, professional judgement and actions are clearly recorded. The use of structured templates improves data quality, supports audit and learning, and enables timely escalation where concerns are identified. Importantly, it also reduces duplication, supports skill-mix working, and ensures that information follows the child and family seamlessly as they move between levels of service or across the 0–19 pathway.

Access to the full GP record within EMIS

EMIS enables practitioners to view the full GP record directly within the clinical system, supporting safe, informed and joined-up care. Access to GP records allows Health Visitors, School Health Nurses and Family Nurses to understand the wider health context for children and families, including relevant medical history, long-term conditions, medications and recent primary care contacts.

This integration supports more effective clinical decision-making, reduces the need for families to repeat information, and strengthens collaboration between community

public health services and primary care. It is particularly important for safeguarding, complex needs and continuity of care.

Importantly, the integration with the GP record is reciprocal: not only can public health nursing practitioners access GP-held information, but GPs are also able to view relevant entries and updates made by the 0–19 service within EMIS. This two-way visibility ensures that both community and primary care professionals are kept fully informed, enabling truly joined-up and coordinated care for children and families.

To support understanding of the practical impact of EMIS integration on frontline delivery, the following anonymised feedback reflects themes consistently raised by practitioners through supervision, training sessions and service optimisation work:

> *"Having access to the full GP record within EMIS has made a real difference to how safely and confidently we work. We no longer rely on families repeating their story, and we can see medications, recent GP contacts and safeguarding flags immediately. It has reduced duplication, improved the quality of our assessments and helped us make clearer, quicker decisions about next steps for families."*

TOBI dashboards and performance oversight

TOBI (Trust Online Business Intelligence) provides near real-time dashboards that draw directly from EMIS data, enabling comprehensive oversight of service activity and performance. TOBI dashboards are used to monitor mandated review timeliness, caseload profiles, Episodes of Care, locality variation and commissioner-specific reporting requirements.

These dashboards support operational teams and senior leaders to identify emerging trends, understand variation, and target improvement action where it will have the greatest impact. The integration between EMIS and TOBI ensures transparency, supports routine governance and Contract Review Meetings, and enables the service to move from retrospective reporting to proactive, data-driven management.

Together, EMIS and TOBI form an integrated digital backbone for the Oxfordshire 0–19 Public Health Nursing Service. They support high-quality clinical practice, effective safeguarding, efficient use of workforce capacity and robust performance management, while enabling commissioners and the provider to share a consistent, trusted view of activity and outcomes across the system.

4.7 NEXT STEPS IN DIGITAL DEVELOPMENT

The Oxfordshire 0–19 Public Health Nursing Service will continue to develop its digital offer in a planned, proportionate and evidence-led way, aligned to clinical safety, information governance. A key underpinning of future digital development is a commitment to **co-production**, ensuring that digital solutions are shaped with families, young people and practitioners, rather than imposed upon them.

Co-production as a core design principle

Future digital developments will be informed through co-production with parents, carers and young people, alongside frontline practitioners. Feedback and insight gathered through ChatHealth, service-user feedback mechanisms, engagement events and routine governance forums will be used to test, refine and prioritise digital changes. This approach ensures that digital tools are accessible, inclusive and responsive to real-world need, and that they support trusted relationships rather than creating additional barriers to engagement.

Proactive digital communication and health promotion

Planned developments include extending the use of digital channels for proactive health promotion messaging, building on existing AccuRx and ChatHealth infrastructure. This includes the planned introduction of batch health-promotion messages from Spring 2026, targeted at key Healthy Child Programme milestones and seasonal priorities. Content will be co-produced where appropriate and clinically signed off, reinforcing evidence-based advice, signposting families to support, and reducing avoidable demand by providing timely and consistent information at scale. All messaging will operate within clear governance, with opt-out arrangements and safeguards to ensure communications remain proportionate and appropriate.

Strengthening digital engagement and reach

The service is also developing additional family-facing digital engagement routes, including a planned CYP 0–19 social media presence from Summer 2026. This work is intended to improve reach to families who may not routinely engage through traditional service routes, particularly around early years development, emotional wellbeing and school readiness. Content development will be informed through co-production and professional oversight, with clear moderation processes, safeguarding escalation routes and Trust governance in place to ensure safe and responsible use.

Continued optimisation of digital access routes

Ongoing work will continue to optimise existing digital access routes, including ChatHealth, AccuRx and the 0–19 website, ensuring information is clear, consistent and easy to navigate across platforms. Co-produced feedback from families and young people will be used to refine digital content, improve clarity around access routes, and reduce duplication or unnecessary contact. Digital developments will complement SPA processes, supporting earlier triage, clearer signposting and smoother transitions between universal, targeted and specialist pathways.

Data, oversight and continuous improvement

All digital developments will be supported by robust monitoring through EMIS and TOBI dashboards, enabling the service to track usage, understand variation and assess the impact of digital activity on access, demand and workforce capacity. Learning from implementation will be routinely reviewed through governance routes and used to refine digital approaches over time, ensuring continuous improvement. Together, these planned developments reflect a measured, co-produced and sustainable approach to digital innovation. They aim to strengthen prevention and early help, improve equity of access, and support staff to deliver high-quality care efficiently—while ensuring that digital tools enhance professional judgement, relational practice and partnership with families and young people.

5. SAFEGUARDING – NATIONAL GUIDANCE AND CURRENT OXFORDSHIRE PRACTICE

5.1 NATIONAL GUIDANCE AND POLICY CONTEXT

Safeguarding practice within the Oxfordshire 0–19 Public Health Nursing Service is underpinned by a clear and robust framework of **national statutory guidance, professional policy positions and local safeguarding arrangements**, ensuring that practice is lawful, consistent, proportionate and child-centred.

At a national level, safeguarding practice is governed by ***Working Together (2023)*** the statutory guidance that sets out how organisations and agencies must work together to help, support and protect children. This guidance places a clear expectation on health services, local authorities and police to work collaboratively, to share information appropriately, and to ensure that safeguarding responses are timely, proportionate and focused on the needs of the child. It also emphasises the importance of early help, multi-agency decision-making and clear accountability for

safeguarding arrangements. Practice within the Oxfordshire 0–19 service is aligned to this guidance, including expectations for attendance and contribution to strategy discussions, child protection conferences and multi-agency planning, where there is an identified health need.

Safeguarding practice is further informed by the Children Act 1989 and Children Act 2004, which establish statutory duties for agencies to safeguard and promote the welfare of children, and by the Healthy Child Programme (HCP), which embeds safeguarding as a core thread across universal, targeted and specialist public health nursing practice. The HCP reinforces the principle of proportionate universalism, ensuring that all children receive a universal offer, with additional support provided where vulnerability or risk is identified.

In recognition of the increasing complexity of safeguarding demand nationally, Oxfordshire's approach is also aligned to the Joint Policy Position: *The Safeguarding Role of Public Health 0–19 Services*[1] (November 2024), published by the Institute of Health Visiting (iHV), the School and Public Health Nurses Association (SAPHNA) and the Association of Directors of Public Health (ADPH).

This policy position provides important clarity on the role of Health Visitors and School Health Nurses in safeguarding, emphasising that safeguarding is a core responsibility of 0–19 services, but must be delivered in a way that does not displace their wider public health and preventative function. The position statement reinforces the principle that the "best placed practitioner" should contribute to safeguarding activity, and that health professionals should not default into roles where there is no identified health need.

At a local level, safeguarding practice operates within the arrangements of the Oxfordshire Safeguarding Children Partnership (OSCP), which brings together the local authority, health and police as statutory safeguarding partners. Local multi-agency procedures, thresholds and escalation routes are set through OSCP guidance and are embedded within Oxfordshire 0–19 service Standard Operating Procedures. These arrangements ensure consistency in how concerns are identified, escalated and managed, and provide assurance that safeguarding practice is aligned across agencies.

[1] The-Safeguarding-Role-of-Public-Health-0-19-services-FINAL-VERSION-28.10.24.pdf

Within Oxford Health NHS Foundation Trust, safeguarding practice is further underpinned by Trust-wide safeguarding children policies and supporting procedures, which set out expectations for information sharing, documentation, supervision, training and escalation. These policies are operationalised locally through 0–19 service SOPs, including safeguarding triage processes, SPA workflows and clear expectations for recording and professional accountability.

Together, these national and local policies and guidance provide a strong and coherent framework for safeguarding practice in Oxfordshire. They support a model that is child-centred, proportionate and multi-agency, balancing statutory safeguarding responsibilities with the delivery of effective public health and early intervention services, and providing clear assurance to partners and scrutiny bodies that safeguarding practice is both robust and evidence-based.

5.2 CURRENT PRACTICE: OPTIMISING ROLES, BALANCE, AND DEMAND MANAGEMENT

Safeguarding practice within the Oxfordshire 0–19 Public Health Nursing Service is delivered in a way that is safe, proportionate and focused on identified health need, in line with national guidance and local safeguarding arrangements. A key principle underpinning current practice is the allocation of the "best placed practitioner", ensuring that safeguarding activity is undertaken by the professional with the most relevant and current involvement with the child and family.

Safeguarding representation is determined through structured decision-making that considers the nature of the safeguarding concern, the child's health needs and the level of recent service involvement. Where there is an identified health need, a 0–19 practitioner contributes actively to multi-agency safeguarding processes, including strategy discussions, child protection conferences and core groups. Where there is no recent health involvement and no unmet health need, the service provides a standardised written response to multi-agency meetings, clearly setting out the rationale for non-attendance and the route for re-engagement should health needs be identified. This approach ensures statutory safeguarding responsibilities are met while avoiding unnecessary duplication of professional input.

Safeguarding demand and its impact on service capacity are explicitly recognised through the 0–19 risk register and governance processes. Increasing safeguarding

workload is acknowledged as having the potential to impact both universal service delivery and workforce wellbeing, particularly where health involvement does not add value to outcomes for the child. To support proportionate and consistent decision-making, the service maintains a safeguarding escalation log, which is used to record and track issues arising from multi-agency safeguarding processes that create operational risk or inefficiency.

The escalation log captures themes such as late or missing notifications of meetings, changes to meeting times without notice, absence of minutes or outcomes following meetings, and repeated follow-up required by health teams to obtain essential information. These issues are reviewed regularly through 0–19 safeguarding oversight arrangements and escalated where appropriate via senior operational and system-level forums. This provides a clear audit trail, supports constructive challenge within the partnership, and enables the service to highlight where safeguarding processes are impacting disproportionately on frontline capacity.

In parallel, the service operates regular 0–19 safeguarding oversight meetings to review requests for representation, agree the most appropriate practitioner to attend, and ensure safeguarding activity is allocated transparently and equitably across locality teams. The use of both the escalation log and structured oversight meetings enables safeguarding demand to be actively managed rather than absorbed informally by individual practitioners or teams.

This approach is consistent with the Joint Policy Position on the Safeguarding Role of Public Health 0–19 Services, which emphasises that health professionals should not default into safeguarding roles where there is no identified health contribution, and that public health nursing capacity must be protected to sustain prevention and early intervention. By applying these principles in practice, the Oxfordshire 0–19 service seeks to balance its statutory safeguarding duties with its wider public health role, ensuring that safeguarding activity is purposeful, proportionate and focused on improving outcomes for children and families, while maintaining transparency about system pressures and partnership dependencies.

5.3 SAFEGUARDING PROCESSES: SPA TRIAGE, URGENT TIMEFRAMES AND CONSISTENT RECORDING

A dedicated safeguarding process standard operating procedure sets out how safeguarding communications are triaged through a separate safeguarding inbox,

prioritising Strategy Meetings and Initial Child Protection Conferences due to short timescales, requiring urgent forwarding to locality and Locality Team Leaders, and requiring documentation of actions in EMIS. This standard operating procedure also covers Red multi-agency safeguarding hub (MASH) referrals, uploading of outcomes/minutes, and escalation routes.

This provides assurance that safeguarding work is supported by structured administrative controls, escalation pathways and consistent recording expectations (rather than being dependent on informal processes).

5.4 TRAINING, SUPERVISION AND SAFEGUARDING COMPETENCE

Safeguarding competence is supported through training and supervision structures which are described in more detail below under the quality section.

6. SURVEYS / INSIGHT

6.1 SERVICE USER INSIGHT (SURVEYS, COMPLAINTS, COMPLIMENTS)

The Oxfordshire 0–19 Public Health Nursing Service gathers service-user insight through a range of structured and routine mechanisms, including **IWantGreatCare (IWGC)**, ChatHealth feedback, Microsoft Forms used following group sessions and targeted interventions, and direct feedback gathered during clinical contacts. These sources are triangulated with performance and safety data and reviewed through established governance arrangements to ensure that learning is translated into service improvement.

IWantGreatCare (IWGC) feedback and themes

IWGC feedback demonstrates consistently positive experiences of care across the 0–19 service. During the most recent reporting period of February 2026, **77 IWGC responses were received** (including Family Nurse Partnership), with the **overwhelming majority rated positively**. Only **three responses scored 2 or below**, relating to non-attendance at an appointment and delays in re-booking; these were reviewed and followed up locally by locality team leaders.

Qualitative feedback highlights strong themes around reassurance, professional relationships and feeling listened to. Illustrative examples include:

"I was so worried about my little boy, but no-one was listening. Then a health visitor walked through my door. It was like an angel had arrived. She listened, she knew our family, the history and my own difficulties. I immediately felt reassured."

"I want to thank my health visitor for the amazing support she gave me. She made me feel truly heard and understood at every visit and every tip she gave made a difference."

"The appointment was very relaxed and the health visitor very friendly – she put both me and my child at ease."

Feedback also reflects the value families place on group-based and preventative support:

"We really enjoyed the group development review. It was lovely to see my child play and interact with other children his age."

"The early days course was so informative, delivered in a relaxing environment and a good opportunity for networking with other new mums going through similar things."

'You Said, We Did' – learning and improvement

Where feedback has identified areas for improvement, this has been addressed through a structured **'You Said, We Did'** approach, providing transparency about actions taken. Examples include:

You said: "The appointment felt like a tick-box exercise, the person did not really engage with my child and the questionnaires were not properly explained."
We did: Reviewed Ages and Stages Questionnaire practice with Community Public Health Associate leads, introduced retraining and strengthened supervision to improve the quality and consistency of reviews.

You said: "We have always felt supported when coming to lunchbox, but the room where we weigh our baby is small and often there is someone else there."
We did: Relocated the drop-in clinic to a venue with more space, enabling greater privacy and improved opportunities for 1:1 discussion.

Where actions cannot be taken immediately, this is communicated transparently, with rationale recorded and reviewed through governance routes.

Complaints and concerns

Formal complaints relating to the 0–19 service remain very low. Between 1 April 2025 and 31 December 2025, the service recorded 1 formal complaint. Complaints within the Oxfordshire 0–19 Public Health Nursing Service are managed in line with the NHS Complaint Standards, which promote proportionate, timely responses and early resolution wherever possible. Concerns raised by families are categorised according to complexity and risk, with clear expectations for response timeframes.

Under this framework, concerns are handled as follows:

- **Rapid Resolution Concern**
  Concerns that can be resolved quickly through explanation, reassurance or immediate action are managed as rapid resolutions. These are typically responded to and closed within 3 working days, often through direct contact with the practitioner or locality team leader. This approach supports timely reassurance and prevents unnecessary escalation.

- **Early Resolution Concern**
  Where a concern requires some additional review or coordination but does not meet the threshold for a formal investigation, it is managed through early resolution. Early resolution responses are normally completed within 10 working days, with a focus on understanding the concern, providing a clear explanation and agreeing any immediate actions.

- **Formal Complaint**
  A concern is managed as a formal complaint where issues are more complex, involve multiple elements of care, or where early resolution has not been possible.
  Formal complaints are acknowledged promptly and responded to within an agreed timeframe, typically up to 25 working days, with extensions agreed with the complainant where required.

This structured approach ensures that concerns are addressed proportionately and compassionately, with the majority resolved quickly and close to the point of care. It also reflects national expectations that complaint handling should focus on learning

and improvement, rather than defaulting to lengthy investigative processes where these add little value.

Learning from all concerns and complaints—regardless of category—is reviewed alongside other sources of service user insight, including feedback, compliments and incident themes. This ensures that issues identified through complaints contribute to service improvement, while maintaining transparency and assurance for families and system partners.

Accolades and compliments

Positive experience is also reflected through formal accolades and compliments. In Q3 alone, the service received 23 accolades, including 12 recognising the wider 0–19 service and 11 relating specifically to the Family Nurse Partnership. These accolades consistently highlight compassion, professionalism and the impact of sustained support for families.

Examples of accolade feedback include:

- Praise for practitioners who "went above and beyond" to support families during challenging periods.
- Recognition of staff who provided calm, clear advice that helped parents feel confident and supported.
- Positive feedback about group sessions that increased parental confidence and peer support.

ChatHealth feedback

ChatHealth feedback provides additional insight into user experience across the 0–4 Parentline, 5–11 Parentline and 11–19 services. Feedback consistently highlights:

- Speed and reliability of responses
- Clear, reassuring advice
- Feeling listened to and supported, particularly for sensitive or anxiety-provoking concerns

Service users frequently describe ChatHealth as convenient and accessible, valuing the ability to seek advice discreetly and receive timely guidance that supports decision-making and, where needed, escalation into face-to-face care.

Overall assurance

Taken together, IWGC feedback, low complaint levels, high numbers of accolades and

positive ChatHealth experience provide strong assurance that families experience the Oxfordshire 0–19 Public Health Nursing Service as **supportive, responsive and professionally delivered**. Service-user insight is routinely reviewed at service and Children and Young People Senior Management Team level and is used to inform service development, reinforce good practice and support workforce recognition, demonstrating a culture of continuous learning and improvement.

6.2 WORKFORCE SURVEY / STAFF INSIGHT

Staff insight for the Oxfordshire 0–19 Public Health Nursing Service is gathered primarily through the **NHS Staff Survey**, supplemented by structured local engagement and listening activity. Together, these sources provide a rounded view of workforce experience, morale and engagement, and are used alongside workforce, quality and performance data to inform leadership focus and service improvement.

Staff survey overview and context

The March 2026 staff survey comparison for the 0–19 service demonstrates a mixed but improving picture. Across many domains, responses show positive movement compared to the previous year, reflecting increased stability following the major service reconfiguration and the embedding of the integrated 0–19 model. Staff continue to report a strong sense of purpose in their work, with consistently high scores relating to making a difference to children, young people and families, and positive relationships within teams. However, the data also highlights ongoing pressures associated with workload, pace of change and capacity, which are consistent with national findings across community services and with the wider context described elsewhere in this report.

Key themes from the staff survey

Engagement and commitment

Staff report high levels of enthusiasm for their roles and strong attachment to their teams. Many indicators relating to pride in work, teamwork and respect between colleagues show improvement year-on-year, suggesting that the integrated locality model has strengthened day-to-day team relationships and peer support.

Leadership and line management

Responses relating to immediate line managers are generally positive, particularly in relation to approachability, care for staff wellbeing and openness to challenge. This

aligns with the leadership visibility and locality-based management arrangements, including increased senior clinical presence in teams and regular engagement forums.

Workload and capacity

As reflected elsewhere in this paper, workload pressure remains a key challenge. Survey responses relating to staffing levels, time pressures and ability to meet conflicting demands remain lower than organisational averages. These findings reinforce the narrative that performance and workforce wellbeing are influenced not only by establishment numbers, but by caseload complexity, safeguarding demand and targeted work, which place disproportionate pressure on clinical time.

Wellbeing and fatigue

While there has been some improvement in measures relating to work–life balance and support for flexible working, indicators associated with emotional exhaustion and fatigue remain an area of concern. These findings are consistent with the period of sustained change and demand experienced over the past 12–18 months and are reflected in the workforce risks outlined later in this report.

Speaking up and safety culture

The majority of staff report feeling able to raise concerns and that colleagues treat one another with respect. However, confidence that concerns will always be addressed remains an area for continued focus. This aligns with the service's use of multiple feedback and escalation routes, including Freedom to Speak Up, listening events and direct leadership engagement.

Staff engagement and listening activity

The staff survey results are not considered in isolation, the service has invested significantly in workforce engagement and co-production, particularly during and following the implementation of the new integrated model.

Key engagement activity has included:

- A formal staff consultation and restructure process during 2023–24, supporting transition to the new locality model.
- A large-scale listening event in July 2025, with strong attendance and structured feedback on workload, systems and ways of working.
- Ongoing locality-based engagement, including leadership attendance at team meetings, open Q&A sessions and direct access to senior leaders.

- Use of **"you said, we did"** approaches to feedback, ensuring that staff input is visibly reflected in service changes and optimisation workstreams.

Feedback from these engagement activities has directly informed the **0–19 Service Optimisation Plan**, including priorities around workload management, role clarity, digital optimisation and workforce wellbeing. Staff representatives are embedded within the optimisation governance structure, ensuring that workforce voices continue to shape service development.

Overall assurance

Taken together, the staff survey data and wider engagement activity provide assurance that:

- Staff remain highly committed to the purpose and values of the 0–19 service.
- The integrated model has strengthened team working and professional relationships.
- Workforce pressures are recognised, understood and being actively addressed through targeted improvement and engagement.
- There is a clear line of sight between staff feedback, leadership action and service development.

This triangulated approach supports a learning culture and underpins the service's commitment to sustaining a resilient, engaged and supported workforce while continuing to deliver high-quality care to children, young people and families across Oxfordshire.

7. QUALITY ASSURANCE

7.1 OVERVIEW OF THE QUALITY ASSURANCE FRAMEWORK

Quality assurance within the Oxfordshire 0–19 Public Health Nursing Service is delivered through a layered and integrated framework that provides ongoing oversight of safety, effectiveness, experience and workforce practice. Assurance activity operates at three interconnected levels:

1. Day-to-day operational controls, embedded in service Standard Operating Procedures
2. Routine review and learning, through supervision, audit, incident review and performance oversight; and

3. Formal governance and escalation, through Trust quality structures and system-level forums.

This framework ensures that quality and safety are actively monitored throughout the year, enabling early identification of risk, timely intervention and continuous improvement, rather than relying solely on retrospective assurance.

7.2 SUPERVISION MODEL AND SAFEGUARDING SUPERVISION

Clinical, managerial and safeguarding supervision within the Oxfordshire 0–19 Public Health Nursing Service is delivered in line with the Trust Supervision Policy and the 0–19 Supervision Standard Operating Procedure, which define clear minimum frequency, format and accountability requirements. Supervision is delivered through a combination of scheduled supervision and live supervision, providing both planned reflective space and real-time professional oversight.

Managerial and clinical supervision (scheduled)

- All staff receive managerial supervision at least every 8 weeks, focusing on workload management, wellbeing, performance, and professional development.
- All clinically registered staff receive clinical supervision at least every 8 weeks, delivered separately from managerial supervision. Clinical supervision provides structured reflective discussion on clinical decision-making, safeguarding, professional judgement and complex cases, supporting safe, consistent practice across localities.

Safeguarding supervision

All staff participate in regular safeguarding supervision, delivered through a structured group model as set out in the 0–19 Supervision SOP. These supervision groups are facilitated by safeguarding named nurses, who are part of the Trust safeguarding team, ensuring expert guidance and consistency in safeguarding practice.

The safeguarding supervision model has been strengthened during the current financial year, including:

- defined supervision cycles,
- capped group sizes to enable meaningful discussion and challenge,
- senior clinical oversight to ensure consistency across localities, and

- explicit linkage to individual Safeguarding Passports, supporting ongoing competence assurance.

Safeguarding supervision provides focused review of complex cases, multi-agency decision-making and learning from practice and is a key mechanism for identifying emerging risk and supporting proportionate, defensible safeguarding practice.

Live supervision (in-practice oversight)

In addition to scheduled supervision, the service makes active use of live supervision, which provides real-time clinical oversight and support during day-to-day practice. Live supervision is embedded within service SOPs and is used to support safe decision-making at the point of care. Live supervision can also take the form of observed practice, where senior clinicians or team leaders directly observe practitioners as they carry out clinical duties. This enables immediate feedback, practical guidance, and reinforcement of best practice in real-world scenarios.

Live supervision operates through:

- immediate access to senior clinicians, Locality Team Leaders or Specialist Lead Practitioners for case discussion,
- real-time advice and challenge during safeguarding triage, complex assessments or escalation decisions,
- support for practitioners during contacts or follow-up activity where professional judgement is required,
- prompt guidance on thresholds, documentation and next steps in line with policy,
- direct observation of practice, allowing supervisors to provide immediate feedback and support within the clinical environment.

This approach ensures that practitioners are not making complex or high-risk decisions in isolation, particularly in relation to safeguarding, escalation, or multi-agency working. Live supervision complements scheduled supervision by providing timely support, reducing risk and reinforcing consistent practice.

Enhanced supervision for specialist roles

Staff working in high-intensity or specialist roles, including the Family Nurse Partnership, receive additional specialist and psychological supervision, in line with national programme requirements and Trust expectations. This reflects the complexity and emotional demands of the work and provides additional assurance around practitioner wellbeing and safe practice.

Governance and assurance

Supervision arrangements, including frequency, uptake and themes arising from both scheduled and live supervision, are monitored through operational governance routes. Learning from supervision informs training priorities, audit focus and service improvement actions, ensuring that frontline learning feeds directly into the wider quality assurance framework.

Taken together, the combination of scheduled supervision, safeguarding supervision and live supervision provides strong assurance that staff are supported, risks are identified early, and clinical and safeguarding practice is consistently reviewed and strengthened in line with Trust policy.

7.3 AUDIT PROGRAMME – COMPLETED ACTIVITY AND FORWARD PLAN

Audit is a central component of the service's quality assurance approach and is used to provide assurance on practice quality, pathway compliance and safeguarding standards.

During the current financial year to date, audit activity has included (but not limited to):

- Safeguarding case file audits, reviewing identification, escalation, documentation quality and multi-agency working;
- Casefile audits as part of the SEND and Joint Targeted Area Inspection Child Sexual Abuse in the Family Environment Inspections;
- Pathway and documentation audits, focusing on mandated contacts and Episodes of Care;
- Targeted audits initiated in response to themes emerging from incidents, complaints or performance review.
- Ongoing temperature monitoring audits to ensure safe practice and compliance.
- Regular breastfeeding practice audits undertaken as part of our Baby Friendly Initiative (BFI) accreditation, supporting best practice and standards in infant feeding.

Findings from completed audits have been reviewed through service governance, shared with locality teams and translated into clear actions, including updates to guidance, targeted training and changes to local processes. Where audit findings

indicate potential risk, actions are tracked to completion through Trust quality governance arrangements.

The audit programme for the forthcoming year has now been finalised and builds on learning from audits already completed this year. It continues to prioritise:

- safeguarding practice,
- quality and consistency of recording,
- adherence to agreed clinical pathways, and
- areas of known system risk.
- continuation of temperature monitoring and breastfeeding practice audits to underpin safe care and maintain BFI standards.

This ensures continuity between retrospective learning and forward assurance.

7.4 INCIDENT REPORTING, THEMES AND LEARNING (FINANCIAL YEAR TO DATE)

Patient safety incidents within the Oxfordshire 0–19 Public Health Nursing Service are reported and managed in line with the Trust Incident Reporting Policy and the Patient Safety Incident Response Framework (PSIRF). Incident data is reviewed routinely through the Children and Young People Management Team, Service Management Team (SMT) quality reporting and Trust governance routes to ensure that learning is identified and acted upon in a timely and proportionate way.

Incident reporting volume and profile (2025/26 year to date)

During the current financial year to date, incident reporting volumes within the 0–19 service have remained low and stable, with incidents predominantly assessed as low-level and low-harm. Recent safety metric reporting shows that:

- incident reporting fluctuates month-to-month in line with service activity,
- there have been no Serious Incidents recorded during the year to date, and
- the majority of incidents relate to process, communication or documentation issues rather than direct harm.

For example, service data shows 14 incidents reported in December 2025, representing a reduction compared to the preceding month. Similar patterns have been seen across other months, with no upward trend in severity or harm.

Incident themes and learning

Themes identified through incident review during the year to date include:

- communication and information-sharing challenges, often at service interfaces with partner agencies,
- documentation or recording issues within clinical systems,
- coordination or timing issues linked to multi-agency working,
- isolated estates or environmental issues.

These themes are consistent with those identified through complaints, audit and staff feedback, and are therefore considered within a triangulated quality assurance approach rather than in isolation.

Application of PSIRF and just culture principles

The service now operates fully within the **Patient Safety Incident Response Framework (PSIRF)**, which represents a shift away from a one-size-fits-all investigation model towards a **proportionate, learning-focused approach**. Under PSIRF:

- not all incidents trigger formal investigation,
- the response is tailored to the level of risk, harm and learning potential, and
- the emphasis is on understanding what happened and why, rather than attributing blame.

Low-level incidents are typically reviewed through local management review, learning huddles or team discussion, while higher-risk incidents would be escalated through Trust patient safety routes using structured review methodologies where required.

How learning is embedded in practice

Learning from incidents is embedded through:

- learning huddles and team meetings, where themes and examples are discussed,
- updates to SOPs, templates or guidance where system issues are identified,
- targeted supervision or support for individuals or teams where appropriate,
- escalation of system-level issues through governance where learning requires wider action.

This approach ensures that incident reporting contributes directly to service improvement and risk reduction, rather than becoming a purely administrative process.

Assurance and oversight

Incident trends and themes are reviewed alongside audit findings, complaints and safeguarding intelligence to provide a rounded view of risk and quality. Where recurring themes are identified, these are escalated through governance and inform priorities for audit, training or service improvement.

Overall, the incident profile for the current financial year to date provides assurance that:

- incident reporting is being used appropriately,
- there is a strong learning culture aligned to PSIRF principles, and
- safety risks are identified early and managed proportionately in line with Trust policy.

7.5 SAFEGUARDING PROCESSES AND MULTI-AGENCY INTERFACE

Safeguarding quality assurance within the Oxfordshire 0–19 Public Health Nursing Service is underpinned by a clear set of Trust policies, service Standard Operating Procedures and local multi-agency safeguarding arrangements, which describe exactly how safeguarding concerns are identified, assessed, recorded and escalated in practice.

Identification, thresholds and recording

- All safeguarding concerns identified by practitioners are recorded on the clinical record within EMIS, using standardised safeguarding templates, regardless of whether the concern meets the threshold for referral to Children's Social Care.
- Where concerns do not meet statutory thresholds, the rationale for decision-making is clearly documented, ensuring transparency and continuity of care.
- Practice is aligned to the Oxfordshire Safeguarding Children Partnership (OSCP) threshold of need guidance, supporting consistent, proportionate decision-making and appropriate use of early help, targeted or statutory pathways.

Triage and escalation through SPA

- All incoming safeguarding communications are triaged through a dedicated safeguarding inbox within the Single Point of Access, in line with the safeguarding process SOP.

- Defined criteria are used to prioritise urgent activity, including strategy discussions, Initial Child Protection Conferences (ICPCs) and urgent safeguarding reviews.
- Standard operating procedures set out:
    - expected response timeframes,
    - escalation routes to senior clinicians and managers,
    - documentation standards within EMIS, and
    - processes for following up outcomes and minutes from multi-agency meetings.

This ensures safeguarding activity is managed consistently and does not rely on informal processes or individual practitioner judgement alone.

Use of local multi-agency protocols Safeguarding practice is informed by specific OSCP-approved protocols, which are embedded within training, supervision and SOPs. These include:

- the Protocol for the Management of Bruising in Pre-Mobile Babies and Children, which requires urgent assessment and escalation for any bruising in children who are not independently mobile, and
- the Guidance on Bruising in Independently Mobile Children and Young People, which supports proportionate assessment and decision-making based on developmental stage, presentation and context.

These protocols provide a shared, evidence-based framework across health, social care and partner agencies, supporting consistent responses and reducing variation in practice.

Safeguarding escalation log and system assurance

- The service maintains a safeguarding escalation log, which records system-level issues arising from multi-agency safeguarding processes, such as late notifications of meetings, changes to arrangements without notice, or missing documentation.
- This log is reviewed through safeguarding oversight meetings and escalated through Trust and partnership routes where required.
- The escalation log provides an audit trail, supports constructive system challenge, and ensures that operational risks arising from safeguarding processes are visible and managed.

Governance and assurance

- Safeguarding activity, themes and pressures are reviewed through routine governance routes alongside incident, audit and supervision intelligence.
- This enables safeguarding demand to be actively managed, learning to be identified and acted upon, and assurance to be provided that safeguarding practice is consistent, proportionate and aligned to both Trust policy and OSCP guidance.

Taken together, these arrangements provide assurance that safeguarding within the 0–19 service is robust, well-governed and fully integrated with local multi-agency safeguarding systems, while maintaining clear clinical oversight and accountability.

7.6 EXTERNAL ASSURANCE AND INSPECTION PREPAREDNESS

The Oxfordshire 0–19 Public Health Nursing Service maintains ongoing readiness for external scrutiny, accreditation and inspection, with assurance activity embedded within routine practice rather than treated as a standalone exercise.

CQC self-assessment and action planning

The service has completed CQC self-assessments aligned to the CQC quality statements, with associated action plans in place. These self-assessments are used to:

- identify areas of strength and improvement,
- track actions through service and Trust governance routes, and
- ensure that evidence remains current and reflective of day-to-day practice.

Progress against CQC action plans is monitored through established governance structures, providing assurance that learning is acted upon and improvements are sustained.

External accreditation and recognised standards

The Oxfordshire 0–19 Public Health Nursing Service is accredited by the Baby Friendly Initiative (BFI), reflecting its commitment to internationally recognised standards for infant feeding, parent-infant relationships and safeguarding. This accreditation demonstrates that the service has met rigorous criteria and consistently applies best practice, further strengthening its external assurance alongside other recognised standards.

Embedding these standards within clinical pathways, training and supervision provides an additional layer of external assurance and supports consistency, quality and improved outcomes for babies and families.

Recent Oxfordshire inspection activity and assurance

In 2026, the service has actively participated in both a SEND inspection and a Joint Targeted Area Inspection (JTAI) focusing on Child Sexual Abuse in the Family Environment (CSAFE). As part of these inspection processes:

- service leads and frontline practitioners were interviewed directly by inspectors, providing evidence of leadership oversight, clinical decision-making and operational practice;
- the service completed and submitted case file audits, demonstrating the quality of recording, safeguarding assessment and professional judgement;
- practitioners and leaders participated in multi-agency case tracking meetings with inspectors, evidencing how the service works collaboratively with partners to safeguard children and support families.

This level of engagement provides assurance that safeguarding and quality assurance arrangements are not only documented but are actively understood and applied in practice by staff at all levels of the service.

Embedding inspection and accreditation learning

Learning from inspection activity and external accreditation standards is reviewed through service and Trust governance routes and informs:

- audit priorities,
- supervision focus,
- training and development activity, and
- service improvement actions.

This ensures that external scrutiny and accreditation contribute to continuous improvement, rather than being treated as one-off or compliance-only exercises.

Overall assurance

The combination of routine CQC self-assessment, action planning, alignment to external accreditation standards such as BFI, and recent active participation in SEND and Joint Targeted Area Inspection focusing on Child Sexual Abuse in the Family Environment inspections provides strong assurance that the Oxfordshire 0–19 Public Health Nursing Service is:

- inspection-ready,

- quality-focused and evidence-informed,
- transparent in its practice,
- engaged in multi-agency safeguarding systems, and
- committed to learning and continuous improvement.

7.7 TRAINING, COMPETENCE AND COMPLIANCE ASSURANCE

Training and professional development within the Oxfordshire 0–19 Public Health Nursing Service are structured to ensure that staff are competent, confident and appropriately skilled to deliver safe, effective and evidence-based care across universal, targeted and specialist pathways. Training assurance operates across three levels: statutory and mandatory training, enhanced role-specific training, and ongoing professional development, with clear governance oversight.

Statutory and mandatory training

All staff are required to complete Trust-mandated statutory and mandatory training, including safeguarding level 3 for children and adults, information governance, basic life support, and other core requirements, in line with Trust policy. Compliance is monitored through routine reporting and reviewed through service and directorate governance routes. Where gaps are identified, actions are agreed with managers and followed up through supervision and performance processes.

Enhanced and role-specific training

In addition to mandatory training, the service delivers and commissions a wide range of enhanced role-specific training, reflecting the complexity of 0–19 public health nursing practice. This includes, but is not limited to:

- **Solihull Approach** training to support evidence-based practice in parent–infant relationships, emotional wellbeing and behaviour;
- Infant feeding and breastfeeding support training, aligned to national guidance and local pathways, to ensure consistent, high-quality support for families;
- safeguarding-focused training linked to specific risks and pathways, informed by OSCP guidance and learning from audits and incidents;
- training linked to specialist roles and pathways, delivered or supported by Specialist Lead Practitioners and Clinical Education Leads.
- All Health Visitors are trained in NSPCC Graded Care Pathway 2 assessments, which helps professionals measure the quality of care provided by a parent or

carer, ensuring consistent, developmentally informed assessment and decision-making across the service.

External training and professional development

The service supports ongoing professional development through access to external training and qualifications, including the use of Learning Beyond Registration (LBR) funding where appropriate. This enables staff to undertake accredited courses or specialist training that supports service priorities, succession planning and workforce sustainability. Access to external training is agreed through managerial processes and aligned to service need.

Monitoring, governance and assurance

Training compliance and professional development are monitored through a triangulated assurance approach, including:

- routine training compliance reporting through Trust systems;
- discussion and review of training needs and competence within supervision, including safeguarding supervision;
- incorporation of training and development objectives within Personal Development Reviews (PDRs);
- oversight through service and directorate governance forums, where themes from training, audit and incident learning are reviewed together.

Learning from audits, incidents, complaints and external inspections informs training priorities, ensuring that education and development activity remains responsive to emerging risks and service need, rather than static or compliance-driven alone.

Overall assurance

Taken together, the combination of mandatory training, enhanced role-specific education, access to external development opportunities and robust governance oversight provides assurance that the 0–19 workforce is appropriately trained, supported and competent to deliver safe, high-quality care. This structured approach supports workforce capability, underpins safeguarding assurance and contributes directly to improved outcomes for children, young people and families.

8. WORKFORCE

8.1 WORKFORCE OVERVIEW AND STRUCTURE

The Oxfordshire 0–19 Public Health Nursing Service is delivered by a large, multidisciplinary workforce, structured to support delivery of universal, targeted and specialist interventions across the county. The workforce includes Health Visitors, School Health Nurses, Family Nurses, Community Public Health Nurses, Community Public Health Associates, specialist practitioners and administrative staff, operating within integrated locality teams and a centrally based Single Point of Access.
The service is led through a clear clinical and operational leadership structure, with senior clinical leadership, operational management and professional leads providing oversight across health visiting, school nursing and Family Nurse Partnership pathways. Locality Team Leaders, Specialist Lead Practitioners and Clinical Education Leads (CELs) provide day-to-day operational management, clinical leadership and workforce development within and across localities, ensuring consistency of practice and appropriate escalation.

This structure supports both strong local leadership and county-wide standardisation, embedding specialist expertise within frontline delivery while maintaining clear lines of accountability.

8.2 SKILL MIX AND WORKFORCE DEPLOYMENT

The service operates a skill-mix workforce model, enabling high-volume delivery of the universal Healthy Child Programme alongside targeted and specialist support for families with additional or complex needs. Registered practitioners retain accountability for assessment, safeguarding and clinical decision-making, while Community Public Health Nurses and Associates support delivery of defined elements of care under clear delegation and supervision arrangements.

This approach supports efficient use of professional capacity, but also means that caseload complexity, safeguarding activity and targeted Episodes of Care have a disproportionate impact on workload and capacity. Workforce planning therefore considers not only headcount and whole-time equivalents but also caseload profile, safeguarding demand and service user need.

8.3 WORKFORCE METRICS AND MANAGEMENT OVERSIGHT

Workforce metrics for the Oxfordshire 0–19 Public Health Nursing Service are monitored through routine Trust governance arrangements, providing clear oversight of workforce capacity, stability and risk. These metrics are reviewed regularly through the Children and Young People Senior Management Team (CYP SMT), escalated through directorate performance and quality boards, and reported to Executive Board level where required.

The workforce metrics presented below are drawn from the Trust's operational management dataset and therefore exclude NHS Agenda for Change Band 8a and above roles, which are overseen through separate senior leadership reporting. The data reflects the frontline workforce delivering services day-to-day.

Current workforce position and performance against Trust targets (as of February 2026)

- **Substantive headcount: 288 staff**
- **Whole Time Equivalent (WTE): 226.1 WTE**
- **Vacancy rate: 0.77% (1.8 WTE vacancies)**
  Trust target: <5%
  → Significantly better than target, indicating a stable workforce and effective recruitment.
- **Agency usage: £0.00 (0%)**
  Trust expectation: minimal / zero agency use
  → Target met, supporting continuity of care and cost control.
- **Bank usage: 0.41% (0.77% of WTE)**
  Trust target: <5%
  → Well within target, demonstrating controlled use of temporary staffing.
- **Turnover (monthly): 9.57%**
  Trust target: <14%
  → Within target, though monitored closely due to the size and complexity of the workforce.
- **Early turnover: 9.07%**
  Trust target: <14%
  → Within target, indicating improving retention during early employment.
- **Sickness absence (current month): 4.20%**
  Trust target: <4.5%

→ Within target, with fluctuations managed through local absence management processes.

- **BAME representation: 8.0%**
  → Monitored through Trust equality, diversity and inclusion reporting and informs ongoing workforce development activity.

Trend and stability overview

Trend data over the past 12 months shows:

- **Sustained vacancy levels below Trust thresholds**, with vacancy WTE continuing to reduce;
- **Consistently low bank usage**, remaining well below Trust tolerance;
- **No reliance on agency staffing**;
- **Turnover and early turnover maintained within Trust targets**, with locality-level monitoring to identify emerging risk;
- **Sickness absence fluctuating month-to-month**, but remaining within Trust expectations for community services.

Governance and assurance

Workforce performance against Trust targets is triangulated with:

- staff survey feedback,
- caseload complexity and safeguarding demand,
- incident and quality intelligence, and
- locality management insight.

This triangulated approach enables **early identification of workforce risk**, supports targeted management action, and ensures that workforce performance remains aligned with Trust expectations. Where indicators approach or exceed tolerance, issues are escalated through Trust governance routes to ensure timely oversight and mitigation.

8.4 WORKFORCE WELLBEING, ENGAGEMENT AND LISTENING

Workforce wellbeing and engagement within the Oxfordshire 0–19 Public Health Nursing Service are monitored through a combination of quantitative and qualitative intelligence, including NHS Staff Survey results, structured engagement activity, supervision and routine management oversight. This information is reviewed alongside workforce metrics, quality data and caseload complexity to inform leadership focus and service improvement.

Staff feedback highlights a workforce that remains highly committed to the purpose and values of the service, with strong pride in supporting children, young people and families. Team relationships are generally positive, and staff report valuing visible leadership and locality-based management arrangements. These strengths support resilience and continuity of care across the service.

At the same time, staff feedback consistently identifies workload pressure, pace of change and emotional fatigue as ongoing challenges. These themes are consistent with national trends across community services and reflect the complexity of safeguarding demand, targeted work and the scale of service transformation delivered over recent years. These pressures are explicitly recognised within workforce planning and optimisation activity described elsewhere in this section.

The service places strong emphasis on listening to and engaging with staff, using a range of mechanisms to ensure workforce voices inform decision-making. This includes:

- locality-based team meetings with leadership presence;
- structured listening and engagement events;
- open Q&A sessions with senior leaders; and
- visible **"you said, we did"** approaches to feedback.

Feedback gathered through these routes has directly informed service development priorities, including workload distribution, digital optimisation, supervision models and workforce support arrangements. Engagement is treated as an ongoing process rather than a one-off exercise, with learning routinely fed back to teams and reflected in service improvement plans.

Together, this approach provides assurance that workforce wellbeing and engagement are actively monitored, understood and addressed, and that staff experience and insight are used to shape how the service continues to develop and improve.

8.5 WORKFORCE RISKS AND ASSURANCE

The service recognises ongoing workforce risks, including:

- workload pressure linked to safeguarding demand and targeted work;
- sickness absence and emotional fatigue;

- recruitment challenges in some registered and specialist roles.

These risks are actively managed through workforce planning, recruitment activity, supervision, wellbeing support and escalation through Trust governance routes.

8.6 WORKFORCE OPTIMISATION, DEMAND AND CAPACITY REVIEW

Alongside routine workforce monitoring and governance oversight, the service is undertaking a structured programme of workforce optimisation to ensure that the staffing model continues to align with demand following implementation of the new integrated 0–19 service model.

As a first stage, a Time in Motion study has recently been completed across the service. This work provides a detailed understanding of how staff time is currently being spent across universal, targeted and specialist activity, including direct clinical contacts, safeguarding activity, administrative tasks and indirect care. The study establishes a robust baseline of real-world activity and variation across localities and roles and is currently in the process of being analysed.

The Time in Motion study forms the initial phase of a wider demand and capacity review, which will:

- assess whether the current skill mix and staffing distribution appropriately reflects population need and service demand;
- identify variation in workload and activity across localities;
- support evidence-based decisions about the right balance of registered, non-registered and specialist roles in different parts of the county; and
- inform future workforce planning, recruitment and development priorities.

This work is being taken forward as part of the service's broader optimisation plan and is overseen through established governance arrangements, including the CYP Programme Board and directorate transformation board. Findings will be triangulated with workforce metrics, caseload data, safeguarding demand and staff feedback to ensure that changes are proportionate, transparent and focused on maintaining service quality and workforce wellbeing.

The purpose of this work is not to reduce capacity, but to ensure that the configuration of the workforce matches demand, supports safe and effective practice, and is sustainable over time as population need and service delivery models continue to evolve.

8.7 OVERALL WORKFORCE ASSURANCE

Taken together, the workforce structure, skill-mix model, routine performance metrics and governance oversight provide assurance that:

- workforce capacity and risk are actively monitored and managed;
- leadership structures support safe, consistent practice;
- staff engagement and wellbeing are recognised and addressed; and
- workforce intelligence informs decision-making at service, directorate and executive levels.

. In addition, robust assurance arrangements are in place to ensure that all staff working within the Oxfordshire 0–19 Public Health Nursing Service meet required employment, registration and safeguarding standards. All staff in regulated roles are subject to Disclosure and Barring Service (DBS) checks at the appropriate level prior to appointment, with ongoing oversight through Trust employment processes. Professional registration for regulated staff (including Nursing and Midwifery Council registration) is verified at appointment and monitored on an ongoing basis, including confirmation of revalidation in line with national professional requirements.

Compliance with DBS and professional registration requirements is overseen through Trust-wide workforce systems, routine management checks and internal assurance processes. Any concerns relating to registration status, safeguarding suitability or professional practice are escalated promptly through established HR, safeguarding and clinical governance routes.

These arrangements provide assurance that the workforce delivering the 0–19 service is appropriately vetted, professionally registered and safe to practise, and that safeguarding considerations are embedded within workforce governance alongside quality, supervision and training oversight. This supports the delivery of a sustainable, high-quality 0–19 Public Health Nursing Service across Oxfordshire

9. SYSTEM COLLABORATION

9.1 HOW THE SERVICE WORKS WITH SYSTEM PARTNERS

The Oxfordshire 0–19 Public Health Nursing Service operates as a core system partner, working collaboratively with health, local authority, education, justice and voluntary and community sector (VCS) organisations to improve outcomes for children, young people and families. Partnership working is integral to the service model and underpins delivery of early help, safeguarding, SEND support and population health improvement across the county.

The integrated 0–19 design, including locality teams and a central Single Point of Access, enables consistent engagement with partners while maintaining clear accountability for health-led contributions. Collaboration occurs at strategic, operational and frontline levels, ensuring alignment between system priorities and day-to-day practice.

At an operational level, the service works closely with a wide range of partners, including:

- **maternity and community midwifery services**, ensuring effective antenatal and postnatal pathways and smooth transitions of care;
- **GPs and primary care teams**, supporting shared information, continuity and joined-up management of health needs;
- **children's social care and early help services**, including regular interface with MASH and early help teams;
- **education and early years providers**, supporting prevention, school readiness and early identification of need;
- **CAMHS, Mental Health Support Teams and specialist perinatal services**, ensuring appropriate escalation and continuity;
- **voluntary and community sector organisations**, extending reach and supporting engagement with families.

Regular multi-agency meetings at locality level support shared understanding of need, coordinated planning and timely escalation where required. Health Visitors and School Health Nurses act as **key system connectors**, supporting information sharing, joint planning and continuity for families.

The SPA plays a central role in operational collaboration, providing a **consistent access point for professionals**, supporting triage, and ensuring referrals are directed appropriately across health and partner services.

9.2 STRATEGIC SYSTEM LEADERSHIP AND GOVERNANCE

The service provides active leadership and professional input across a wide range of multi-agency governance boards and programmes, ensuring that public health nursing expertise, safeguarding insight and health intelligence inform system decision-making. This includes representation on:

- the **Family Hubs Programme Board**, supporting delivery of the Start for Life agenda and ensuring health visiting and school nursing are fully embedded within the wider family support offer;
- the **Families First Programme**, aligning early help pathways and supporting coordinated, whole-family responses;
- the **Early Years Board**, contributing to system-wide priorities around school readiness, child development and prevention;
- the **Early Help and Early Intervention Board**, supporting shared thresholds, escalation routes and proportionate responses to emerging need;
- the **Neglect Strategy Group**, contributing health expertise to the development and oversight of the countywide neglect strategy;
- **Neglect Practitioner Forums**, supporting consistent practice, shared learning and multi-agency understanding at a frontline level;
- **SEND improvement governance**, including participation across all SEND improvement theme groups;
- the **SEND Assurance and Improvement Board (SAIB)**, providing health assurance and supporting oversight of SEND improvement activity;
- the **PAUSE Programme Board**, contributing health insight to intensive work with families experiencing recurrent care proceedings;
- the **Youth Justice Board**, supporting joined-up responses for children and young people involved with the youth justice system.

Through these forums, the service helps shape strategy, supports assurance activity, and ensures that health visiting and school nursing perspectives are fully integrated into system planning and improvement. In addition, Specialist Lead Practitioners participate in systemwide meetings relevant to their areas of expertise, such as those focused on attendance in education, supporting coordinated approaches in their

specialist fields, and contributing to wider multi-agency planning and improvement activities.

9.3 SAFEGUARDING AND MULTI-AGENCY WORKING

Safeguarding is a central element of system collaboration. The service works closely with **children's social care, multi-agency safeguarding hub, police and partner agencies**, contributing to strategy discussions, child protection conferences, core groups and multi-agency planning where there is an identified health need.

Clear thresholds, agreed through the Oxfordshire Safeguarding Children Partnership (OSCP), support consistent decision-making across agencies. The service's safeguarding escalation processes and oversight arrangements ensure that partnership challenges—such as late notifications, changes to meeting arrangements or missing information—are identified, recorded and escalated appropriately, supporting continuous system improvement.

9.5 COLLABORATION WITH THE VOLUNTARY AND COMMUNITY SECTOR

Partnership with the voluntary and community sector is a key strength of the Oxfordshire model. Alongside statutory partners, the service works with VCS organisations to:

- extend reach into communities,
- improve engagement with families,
- support prevention and early intervention.

These partnerships complement statutory provision and enable a **graduated, strengths-based response**, aligned with proportionate universalism. Clear governance arrangements ensure that VCS partnerships align with safeguarding standards, pathways and outcome monitoring.

9.6 IMPACT OF SYSTEM COLLABORATION

Effective system collaboration supports:

- earlier identification of need and timely intervention;
- reduced duplication and clearer pathways for families;
- shared ownership of safeguarding, neglect and early help;
- stronger coordination across health, education, social care and justice;
- improved assurance and inspection readiness at system level.

By maintaining strong relationships, clear governance and consistent operational processes, the Oxfordshire 0–19 Public Health Nursing Service acts as a **reliable, accountable and influential system partner**, contributing to improved outcomes for children, young people and families across the county.

10. CONCLUSION AND ASSURANCE

This report has set out how the Oxfordshire 0–19 Public Health Nursing Service operates, the breadth of support it provides to children, young people and families, and the systems in place to ensure safe, effective and high-quality delivery. It has described service performance against mandated contacts, the reasons for variation where targets are not consistently met, and the actions being taken to improve timeliness while maintaining a family-centred, proportionate approach.

The report has also provided assurance on quality and safeguarding arrangements, including supervision, audit, incident learning and inspection readiness, demonstrating that risks are actively identified, managed and escalated through established Trust governance structures. Recent inspection activity, alongside routine self-assessment and external assurance processes, provides further confidence that safeguarding and quality assurance arrangements are embedded in day-to-day practice.

Workforce capacity, wellbeing and sustainability remain a critical enabler of service delivery. The service has a stable workforce performing well against Trust workforce targets, supported by strong leadership, structured supervision, ongoing training and active engagement with staff. At the same time, the service recognises the ongoing pressures created by safeguarding demand, caseload complexity and the scale of the integrated model. Work underway as part of the optimisation plan, including the Time in Motion study and subsequent demand and capacity review, provides a robust, evidence-based approach to ensuring the workforce configuration continues to match population need.

Finally, the report has demonstrated the service's role as a core system partner, working collaboratively across health, local authority, education, justice and the voluntary and community sector. Through strong operational interfaces and active participation in strategic governance, the service contributes to shared system priorities around early help, safeguarding, SEND improvement and prevention.

Taken together, the information presented provides assurance that the Oxfordshire 0–19 Public Health Nursing Service is:

- delivering a comprehensive and proportionate offer to families;
- performing strongly overall, with targeted action where improvement is needed;
- operating within robust quality, safeguarding and governance frameworks;
- maintaining a stable and supported workforce; and
- working effectively with system partners to improve outcomes for children and young people.

The service remains committed to continuous improvement, transparency and partnership working, and will continue to use data, feedback and system learning to strengthen delivery and outcomes across Oxfordshire.