Livewell Southwest

Health Visiting 0-5 within Plymouth Operational Policy.

Version No. 2.7

Review: September 2018

Notice to staff using a paper copy of this guidance

The policies and procedures page of LSW intranet holds the most recent version of this document and staff must ensure that they are using the most recent guidance.

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Asset Number: **852**

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Document review history

Version no.	Type of change	Date	Originator of change	Description of change
0.1	New document	17/7/13	Team Manager - Plym Locality - Health Visiting.	New document
1	Ratified	4/9/13	Policy Ratification Group	Minor amends.
2	Update	5/7/15	Team managers Health Visiting Service	Updated to include SystmOne and ASQ. Ending of Call to Action and organizational re-structure into 4 localities
2.1	Update	29/9/15	Team Manager East Locality	Addition of Family Nurse Partnership to the Policy
2.2	Update	11/11/15	Team Manager East Locality	Hyperlink updated.
2.3	Update	23/3/16	Team Manager East Locality	Updated to include SystmOne Pathways and new locality base for East Team.
2.4	Update	12/5/16	Team Manager East Locality	Minor amendment to correct appendix F - external transfer in process
2.5	Update	21/6/16	Team Manager East Locality	Minor amendment to S1 antenatal process
2.6	Update	19/7/16	Team Manager East Locality	Minor amendment to Health Visitor to School Nurse transition pathway.
2.7	Update	6/12/16	Team Manager East Locality	Closure of one of the HV bases in the West Locality.

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Health Visiting 0-5 within Plymouth. Operational Policy.

1 Introduction

1.1 Specialist Community Public Health Practitioners - Health Visitors lead teams that are based in 4 localities within Plymouth, providing a service to children aged 0-5 years and their families leading the Healthy Child programme.

1.2 Health Visitors have a public health role and are committed to the concepts of prevention, protection and promotion. The outcomes identified within the Healthy Child Programme (2009) and Every Child Matters (2013) represent key areas for health visitors to work with individuals, families and communities.

1.3 Health Visitors work closely with primary and secondary health services, social care, children's centres and the voluntary sector to identify vulnerable children, reduce inequalities and improve the future health outcomes for children and their families across the city.

1.4 Family Nurses deliver the Family Nurse Partnership Programme across the city and work alongside Health Visiting. FNP is offered to first time expectant mothers aged 19 or under (where capacity allows). If engaged with FNP, the Mother will not be allocated a Health Visitor on the arrival of her infant, instead, the Family Nurse will deliver the Healthy Child Programme till the child is two years old, when care will be transferred back to the Health Visitors.

2. Purpose

2.1 The purpose of this document is to provide clarity regarding the role and function of the Specialist Community Public Health nursing team for the staff within the team, staff within Livewell Southwest (LSW), service users, and other stakeholders.

2.2 The policy provides an outline of health visiting practice and objectives and the key services delivered.

3. Duties & Responsibilities

3.1 The **Chief Executive** is ultimately responsible for the content of all policies, implementation and review.

3.2 **Directors - LSW -** are responsible for identifying, producing and implementing Livewell Southwest policies.

3.3 **Locality Managers -** are responsible for ensuring that the relevant policies are effectively implemented within the relevant team or service.

3.4 **Team Manager / FNP Supervisor -** is responsible for ensuring that all team members are aware of the policy and implement it effectively.

3.5 **Line Managers / or Specialist role** within Team e.g. Community PracticeTeacher (CPT), Child Protection Supervisor (CPS), Family Nurse (FN) are responsible for implementing the policy as part of induction of new staff.

3.6 **Staff within the team** – are expected to have read, understood and adhere to the operational policy and any policies and protocols referenced within the document.

4. Definitions

4.1 CAF – Common Assessment Framework – is a multidisciplinary model of assessment in partnership with parents to offer early intervention and support.

4.2 CAMHS – Child and Adolescent Mental Health Services.

4.3 ICPC – Initial Child Protection Conference, - Multidisciplinary meeting to ascertain whether a child is at significant risk of harm.

4.4 NICE – National Institute of Clinical Excellence. Providing evidenced based guidance for clinical work.

4.5 LSW - Livewell Southwest - policies available on the intranet and accessible through- (www.plymouthcommunityhealthcare.co.uk/).

4.6 MECSH – Maternal Early Childhood Sustained Home Visiting.

4.7 MARAC – Multi Agency Risk Assessment Conference.

4.8 SCPHN- Specialist Community Public Health Nurse.

4.9 FNP – Family Nurse Partnership.

4.10 Great Expectations – City Wide Ante- Natal programme.

4.11 SystmOne – IT system used within Livewell Southwest.

4.12 ASQ (SE) – Ages and Stages Questionnaire (Social and Emotional).

4.13 ASQ3 – Developmental review tool.

4.14 TAC – Team Around a Child.

4.15 CP – Child Protection.

4.16 CIN – Child In Need.

4.17 QUESTT - Quality, Effectiveness and Safety Trigger Tool

4.18 CHID – Child Health Information Department

4.19 VDU – Visual Display Unit

4.20 KLOE – CQC Key Lines of Enquiry

5. Structure and Demographics

5.1 The Health Visiting Teams are based within 4 locality teams within Plymouth. These are:

West Locality Team
Beacon Hub
50 & 52 Foliot Road
North Prospect
Plymouth
PL2 2LP

Tel: 01752 434008

East Locality Team

Plymstock Clinic
Horn Cross Road
Plymouth
PL9 9BU

Tel: 01752 435370

South Locality Team
First Floor
Beauchamp Centre
Mount Gould
Plymouth
PL4 7QD

Tel: 01752 435169

North Locality Team
Estover Health Centre
Leypark Walk
Estover
Plymouth
PL6 8UE

Tel: 01752 434118

Hours of Business: Staff will be expected to work on an agreed rota basis to cover the hours 8.00am-8.00pm Monday to Friday and by prior agreement to cover occasional hours on Saturdays.

Family Nurse Partnership
Jan Cutting Healthy Living Centre
Scott Business Park
Beacon Park Rd
Beacon Park, Plymouth
PL2 2PQ

Tel: 01752 434314
Hours of Business: Monday – Friday 09:00 – 17:00

5.2 Client group: Children aged 0-5 yrs. and their families.

The staff members are divided into 4 localities – North, South, East and West. Locality Map: available on LSW website. Plymouth has a population of over 260,000 of this number approximately 13,635 are families with children under 5 years of age. (Public Health: Plymouth 2013).

FNP works across all 4 localities.

5.3 The Health Visiting Team has incorporated a skill mix model to address the varying nature of the identified work in partnership with families.

All **Health Visitors** will have completed the **Specialist Community Public Health Nursing** (SCPHN**)** qualification at degree or masters level following their original registration as a 1st level nurse. (NMC Standards 2009).

Community Public Health Nurses (CPHN) are qualified 1st level nurses (NMC 2004) who will complete and maintain competencies to work in the community, supporting health visitors and improving outcomes for children and young people.

Family Health Workers – Support SCPHN, and CPHN's in delegated planned episodes of care with families and support at child health clinics, breastfeeding workshops and latch on groups. There grade can range from Band 2-4 dependent on experience and qualifications.

The **Team Manager** will hold a SCPHN qualification and will have completed further training in management and leadership skills.

The **Child Protection Supervisor** will hold a SCPHN qualification and have completed specific training at Level 3 Safeguarding and in supervision skills.

The **Community Practice Teacher** (CPT) will hold a SCPHN qualification and have completed a further teaching qualification at Degree or Masters Level.

The **Clerical Officer** provides support to the team in the administration of the service.

The FNP Supervisor will have a nursing or midwifery qualification and be registered with the NMC. They will have completed the FNP National Unit Training and be educated to both degree and masters level or hold a professional qualification that is equivalent.

Family Nurses will have a nursing or midwifery qualification and be registered with the NMC. They will have completed the FNP National Unit Training and be educated to degree level or hold a professional qualification that is equivalent.

Quality Support Officer provides support to the team and the Supervisor in the administration of the service and maintaining the quality and data analyses needs of the service.

5.4 Within the Universal service all children under the age of 1 will have a named lead practitioner (SCPHN). All children will have a health needs assessment by the SCPHN to determine the level of service provision.

5.5 There is a lead SCPHN for each GP surgery, Children's Centre, and a representative sits on each of the Children Centre Advisory Boards.

5.6 The delivery of the service will take place in a variety of settings including family homes, child health clinics, and Children's Centres.

5.7 Access to the Health Visiting service is universally available to all children under 5. Notification of new clients will come via Child Health Information Service, GP notification, the Midwifery Service or via families themselves.

Access to the Family Nurse Partnership is based upon capacity at time of referral to the programme and that criteria are met. The criteria being, first time mother aged 19 or under at the time of booking with the midwife. Notifications can be received by any means and any service or via the woman herself.

5.8 All appointments will be generated for Developmental reviews or health needs assessments. Those appointments not attended will be followed up in accordance with organisational policy.

6. Service Delivery

6.1 The Health Visiting Service delivers a progressive universal service based upon the Healthy Child Programme: Pregnancy and the first five years of life (DOH 2009). This supports the philosophy of early intervention, Frank Field's (2010) Independent Review on Poverty and Life Chances and Graham Allen's (2011) Independent Review on Early Intervention highlight the importance of good, joined-up support for children and families at the start of life.

7 Model of Service Delivery

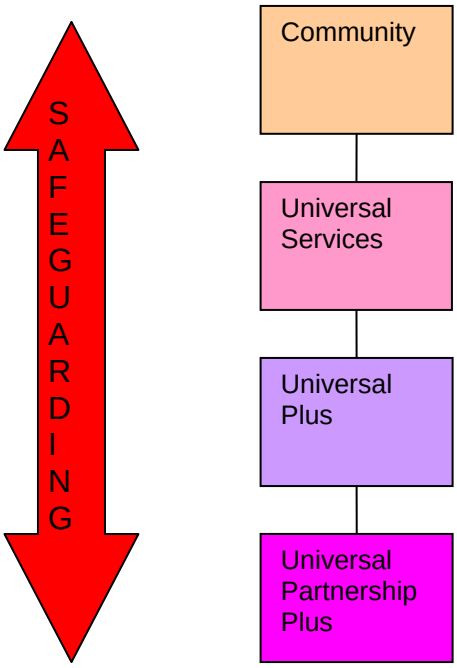


FIG 1.

7.1 The provider will ensure that the Health Visiting Service delivers the core offer described in A Call to Action (DoH 2011). The core offer is set out below, without limitation:

7.2 **Community** – Health Visitors and FNP work to develop and build community capacity (for example local Children's Centres and local voluntary groups) and use that capacity to improve health outcomes, leading the Healthy Child Programme for a population.

7.3 **Universal services for all families** – Leading the Healthy Child Programme for families with children under the age of 5, working with GPs and midwives, building strong relationships in pregnancy and early weeks and planning future contacts with families. This ensures a healthy start and support for all families (for example health and developmental reviews), and encourages access to a range of community services and resources.

7.4 **Universal plus** – ensuring families receive additional packages of support, working in partnership with other services (e.g. Children's Centres) that any family may need some of the time (for example care packages for peri-natal mental health, parenting support, and baby/toddler sleep problems) where the health visitor may provide, delegate or refer. This enables access to early intervention, to prevent problems developing or worsening.

7.5 **Universal partnership plus** – extra services for vulnerable families requiring on going additional support for a range of special needs. This includes, but is not limited to, families at a social disadvantage, families with a child with a disability, teenage mothers, adult mental health problems or substance misuse. The MECSH programme is an enhanced service available for families assessed in need of additional support commencing in the ante-natal period and up to the child reaching the age of 6 weeks and lasting until the child is 2 years of age.

The Family Nurse Partnership is an intensive strength based, home visiting programme offered to vulnerable first time expectant Mothers aged 19 or under. It is a structured programme that the women enter into on a voluntary basis and it offers support during the pregnancy and until the child becomes two years old. The Mother retains her midwife for clinical care however she will not be allocated a Health Visitor on the arrival of her infant. The Family Nurse develops a therapeutic relationship with the client enabling them to work through complex family situations. The programme domains concentrate on Personal Health, Environmental Health, Life Course Development, Maternal Role, Family and Friends and Health and Human Services. The overall aims are to improve pregnancy outcomes, improve child health and development and improve maternal life course development. This work is underpinned by the theories of Attachment, Human Ecology and Self Efficacy. As the programme is entered into on a voluntary basis, the woman can leave at any time and transfer care to the Health Visiting Service. Graduating when the programme is completed takes place when the child is 2 years old.

8 Children and Young People Safeguarding

8.1 Livewell Southwest has a Safeguarding Children Policy and this policy should be consulted and followed whenever harm to a child or young person is considered or identified. The following relates only to the specific Safeguarding responsibilities of the Health Visiting Service / FNP and which are not applicable to other services within LSW. It should be read in conjunction with the children's safeguarding policy. FNP will follow LSW guidelines along with the safeguarding guidance from the FNP National Unit.

8.2 The policy for review health assessments for children and young people who are looked after by the local authority can be found on healthnet. http://LSWnet.derriford.phnt.swest.nhs.uk/LinkClick.aspx?fileticket=bgIhUMxacyo%3d&tabid=411&portalid=3&mid=6162

8.3 It is a specific safeguarding role within this service that the health visitor will offer health assessment to any child at risk of significant harm, prior to, or having been made subject to a child protection plan. (Safeguarding Children Policy).

8.4 It is a specific safeguarding role within this service that the health visitor team will make Local transfers of care of vulnerable children aged 4-5 years, to the School

Nursing team where there are present or past concerns of welfare or child protection. The process is described on a flowchart that can be found at Appendix A (Transfer of Records from Health Visiting to school nursing within Plymouth). http://LSWnet.derriford.phnt.swest.nhs.uk/Portals/3/Safeguarding%20Children%20Policy%20v%201_4_1.docx

- It is necessary for the paper records (and paper copies of electronic records if transferring out of area) relating to the child to be collated in a chronological order and be secure and complete.

- The Safeguarding Office will be notified by Health Visitor and the safeguarding office will update the child health system.

- A handover of records will take place between the transferring and receiving practitioner and this will be clearly documented within the client record.

- When a child is subject to a Child Protection Plan or there are safeguarding issues moves to another area in Plymouth, the transfer of the case must be inthe best interests of the child. (See Appendix D) The Child Protection Supervisor and health professional must ensure:-

    a) The history and current assessment and plan have been discussed and agreed with the receiving health practitioner.
    b) The receiving area Child Protection Supervisor is aware of the transfer.
    c) Where there is a history of frequent family movement or change in health professional which has resulted in an inability to complete a comprehensive child and family assessment, every effort should be made to ensure consistency of health practitioner.
    d) The receiving health practitioner should ensure that practitioners in health and other agencies are aware of the transfer.
    e) The episode of care open to supervision will be transferred to the new supervisor.
    f) On receipt of the transfer form the safeguarding team will update Child Health.
    g) If families with children (including unborn babies) move in to temporary accommodation, the responsibility for the pre-school child remains with the Health Visitor from the original area in Plymouth.

8.5 It is a specific safeguarding role within this service that the health visiting teams will accept national transfers via the safeguarding children team where there are present or previous child protection concerns. The process is described in a flowchart that can be found at Appendix B (Transfer of Records of Vulnerable Children to Health Visiting in to Plymouth).

8.6 It is a specific safeguarding role within this service that the health visiting teams will transfer the records for children in their care where there are child protection

concerns and who move out of Plymouth. A flowchart that describes this process can be found at Appendix C (Transfer of Records of Vulnerable Children to Health Visiting out of Plymouth).

- If the child transfers out and the address is unknown and unobtainable through colleagues in other services, advice to be sought of the Safeguarding Children Team as a missing children alert may need to be circulated, either locally or through custodian of the list of children who are the subject of a child protection plan.

8.7 It is a specific safeguarding role within this service that the health visiting teams will respond to information received from partnership agencies where there is a level of concern which is likely to impact upon the child e.g. attendances at Emergency department and notified instances of domestic abuse.

9 The Lead Practitioner

9.1 It is a specific responsibility within the service to take a Lead Practitioner role for children subject to Child/ young people Protection Plan or where there are Child/ young people welfare concerns.

9.2 Health visitors will negotiate with school nursing colleagues in regard to who should take the lead for work with vulnerable children or those subject to a safeguarding plan if they are attending school but still under 5years. Best interests of the child will be considered to maintain a consistent and cohesive process for the child and family.

9.3 The Team Manager of the Health Visiting Team, in consultation with the Health Visitor and School Nurse practitioners will decide who is best placed to meet the presenting health and development needs of a child and family (for example if a family have a child attending an early years setting and siblings at school with identified health needs then the School Nurse will in most instances be best placed to be the Lead Practitioner).

9.4 Where there are families with extensive chronic child welfare, health and development issues which require periods of intensive input, the Team manager in consultation with the Health Visitor/ School Nurse, will decide if a separate Lead Practitioner for the 0-4 Years and the 5-19 Years children/ young people is required. This will be dependent on number of children, complexity of the situation and identified health needs.

9.5 The Lead Practitioner will be a Specialist Community Public Health Nurse or Family Nurse in with the FNP Programme.

9.6 The Lead Practitioner will be responsible when children are subject to child protection plans and/or where there are child welfare concerns for***:***

- Ensuring Child and Family Health Assessments are up to date and reflect any changes that may impact on the child.

- Ensuring that planned interventions by other practitioners and grades of staff within the team are completed and records written as per LSW clinical records and note keeping policy.

- The Lead Practitioner is identified on the electronic child record.

9.7 Attending and Preparing for Child Protection Meetings

- The Lead Practitioner is the person who will attend meetings and prepare reports as described in the LSW Safeguarding Children Policy. Two reports will be provided one to the Chairperson, and one to the family 48 hours prior to the meeting and a copy will be given to the social worker at the meeting. The Health Visitor will assess the number of additional copies of reports required for the meeting and will ensure that these additional copies are collected in before the meeting closes. The reports provided at the meeting to other agencies are to be collected in and taken back to base for shredding.

- Where the issues are very complex/ large families and more than one Lead Practitioner is identified each practitioner will submit a report to Chairing and review team 48 hours prior to the meeting and may attend.

10 Referral / Eligibility Criteria

10.1 Health Visiting service users are all children and their families, 0-5 years living within the Plymouth catchment area. Included in this are the children that live in surrounding areas, where the Plymouth Health Visitors include these families who are registered with GP's in Plymouth.

10.2 Health Visitors offer a universal service for all children from the 28th week of pregnancy (antenatal period) up to five years of age. Referrals are accepted from primary and secondary health services; families'; schools, children's centres and nurseries (with parental consent).

10.3 The Health Visiting service will deliver to all children and families aged 0-5 years registered with a Plymouth GP, as well as all children and families that the provider is notified of living within the city of Plymouth (e.g. children and families who transfer in to the city and traveller families).

10.4 FNP eligibility and referral criteria is that, capacity allowing, an offer of FNP can be made to first time expectant mothers aged 19 and under at time of booking with the midwife. The woman has to be enrolled on the programme before 28 weeks gestation to be eligible, with a fidelity goal of enrolment earlier than 16 weeks where possible.

11 Referral Method

11.1 Referrals can be made directly to each of the locality health visiting team bases or FNP office.

11.2 Referrals into Locality teams can be made by parents, primary and secondary care, nursery/educational settings, and statutory and voluntary agencies with parental consent.

11.3 Referrals into the service are disseminated and allocated on a weekly basis to staff.

12 Communication

12.1 Staff working in the community are required to follow the lone working policy for LSW. Each member of staff will be allocated a mobile phone for use during working hours.

12.2 Staff will offer clients who have English as a Second Language - access to translators and translated information as per LSW guidance.

12.3 Individual clients with specific communication needs will be offered appropriate support to access the Health Visiting service and/or FNP.

12.4 Health Visiting teams will meet on a minimum of a monthly basis to disseminate, updates, locality information, professional group feedback, and to discuss operational issues both at service and team level. Minutes of the meetings will be kept in the team G Drive in an electronic folder.

12.5 Family Nurses will meet on a weekly basis to disseminate updates, locality information, professional group feedback, and to discuss operational issues both at service and team level. There is also a requirement to partake in reflective meetings, psychological consultations, tripartite supervision and team supervision with the named nurse for safeguarding children. Minutes of the meetings will be kept in the team G Drive in an electronic folder.

13 Training Implications

13.1 Each member of staff attends the corporate mandatory induction training.

13.2 Each member of staff will have an identified line manager who will monitor and support their personal and professional development. Sickness absence and annual leave will be managed in accordance to LSW policies.

13.3 Each member of staff will maintain and update their required mandatory and safeguarding training specific to their role.

13.4 Staff will through the process of Line management and IPR undertake training and assessment specific to their role. For e.g., MECSH, ASQ 3, Solihull, breastfeeding, and newborn hearing screening training. It is the responsibility of staff members to ensure that they comply with their professional body recommendations, for re-validation.

13.5 Each member of staff will complete competencies specific to their role within a time frame agreed with their line manager.

14 Monitoring Compliance and Effectiveness

14.1 The Health Visiting service in order to demonstrate an effective quality service will utilise the following:-

- Annual record keeping and child protection audits.
- Patient information surveys - i.e. Meridian.
- CQC Key Lines of Enquiry document (Kloe's).
- Monthly QUESTT reporting.
- Health and Safety and VDU assessments annually or as required.
- A risk register is maintained and updated regularly.
- Incident reporting.
- Completing Compliments paperwork for reporting.
- Concerns and complaints as per LSW policy will generally be managed by the Team Manager for the locality team.
- Feedback and action plans from audits will be disseminated via team meetings and line Management.
- ESR - Electronic Staff Register reports will be utilised to monitor training and Appraisal compliance.
- Electronic data can be accessed to review locality performance.
- FNP Advisory Board
- FNP Annual Review

14.2 The Health Visiting Service and FNP are committed to delivering quality care to all their clients and feedback from service users and stakeholders is encouraged. Staff are expected to highlight any concerns or incidences which can be addressed to improve the service through the appropriate channels.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

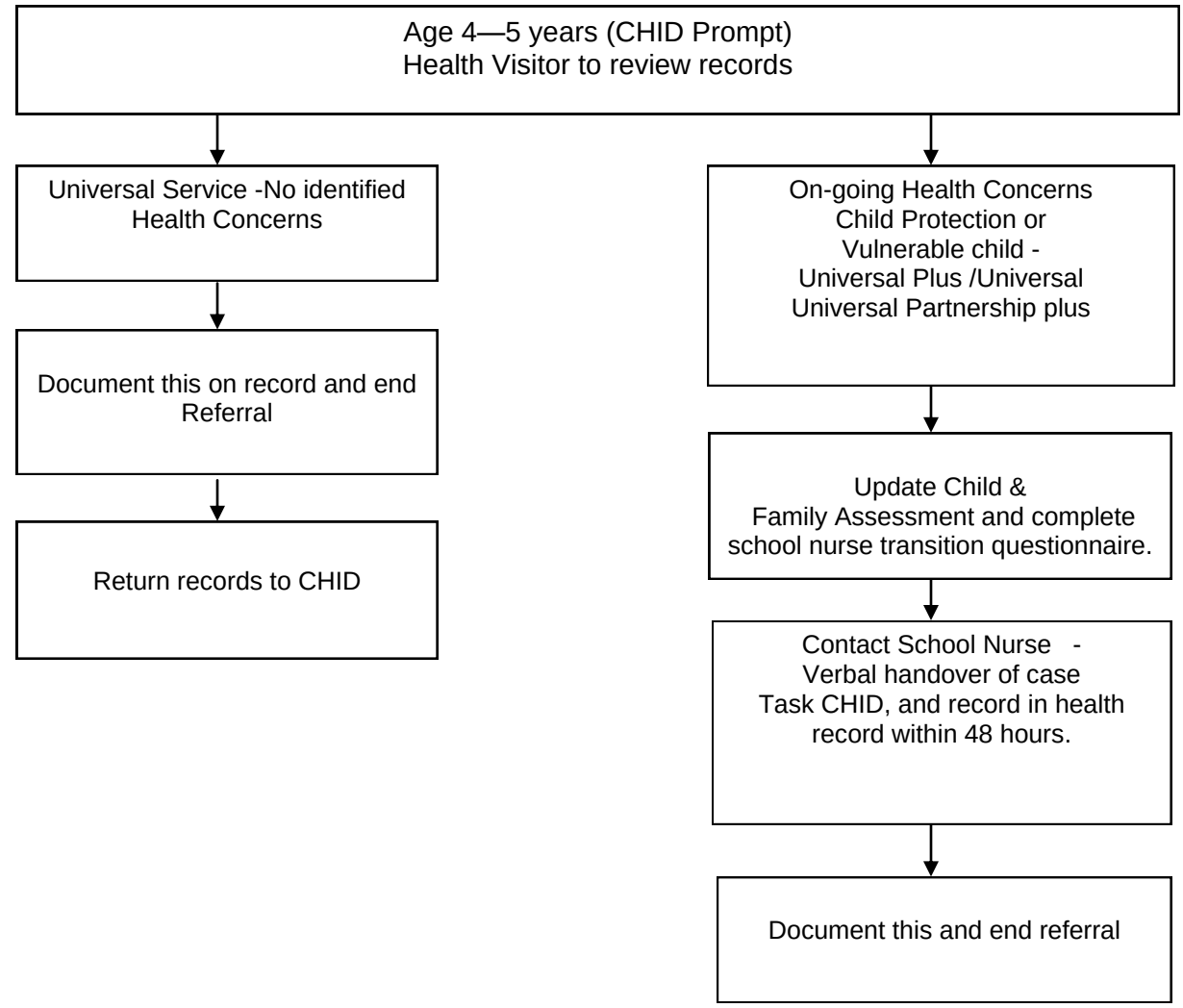
The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

Date: 17th September 2015

Appendix A

Transfer of Records from Health Visiting to School Nursing within Plymouth

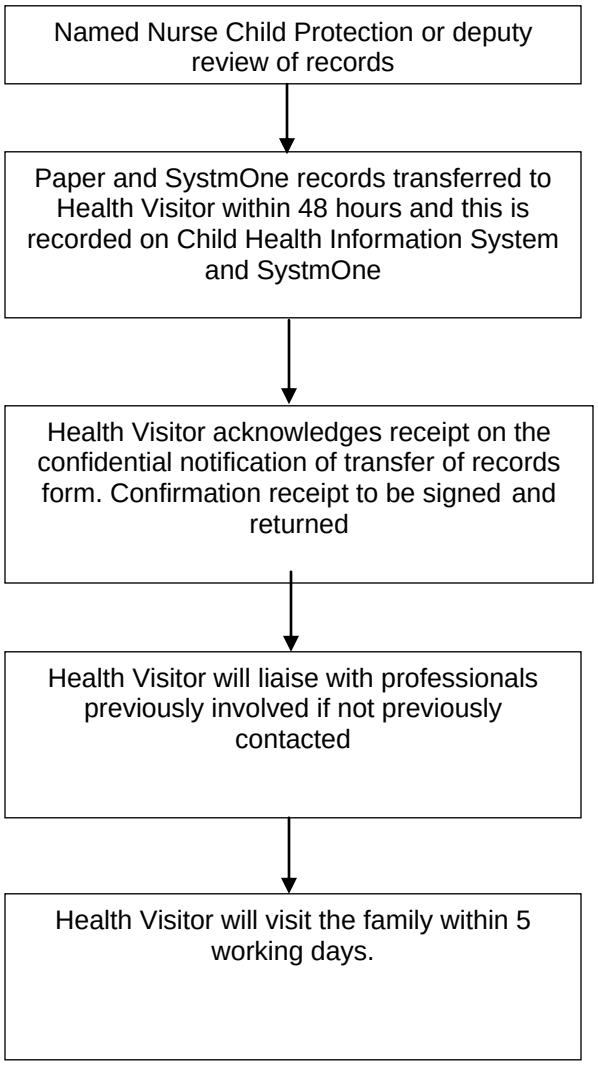


When considering handover of case consider the best interests of the child – see section 9

Appendix B

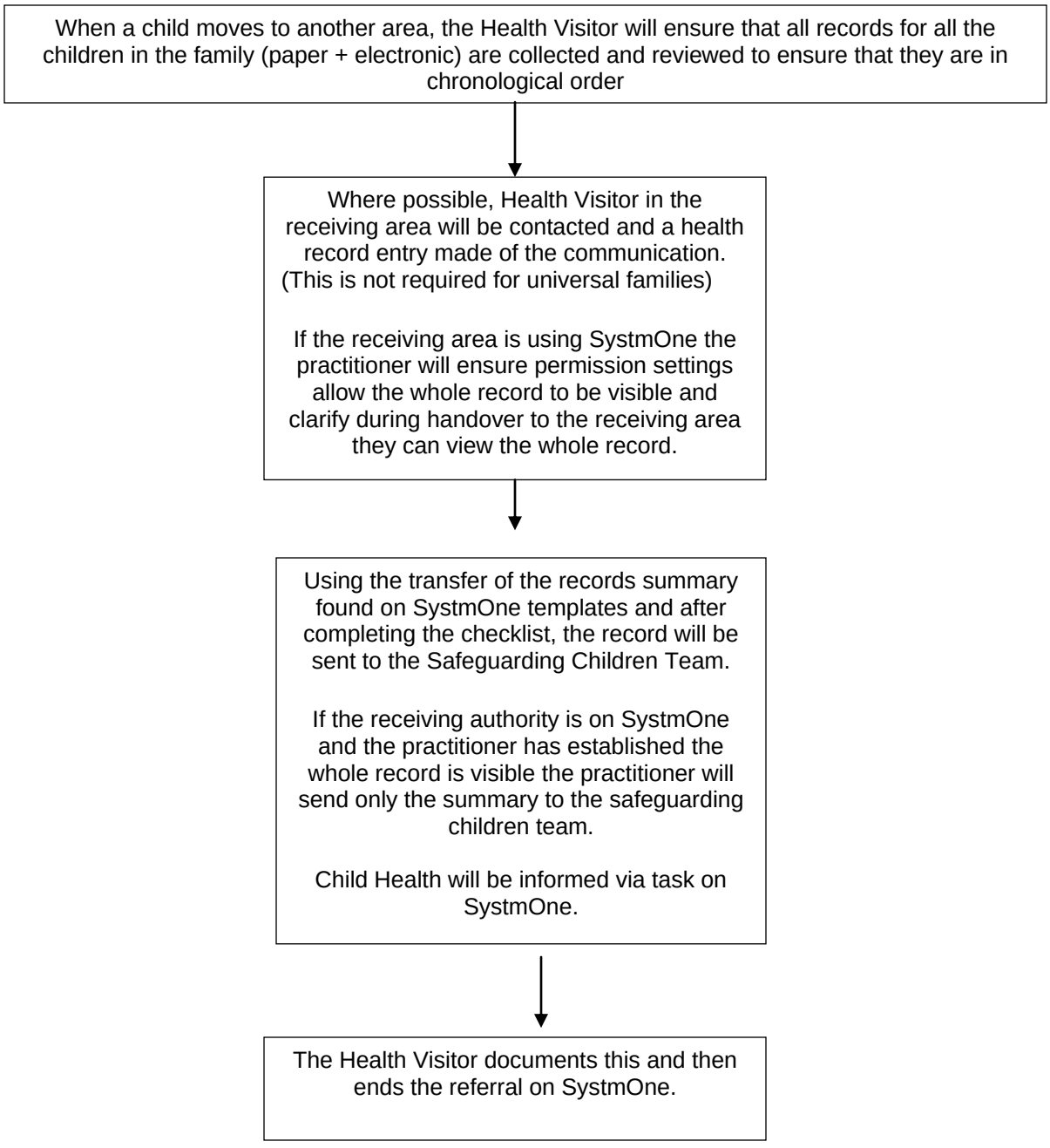
Transfer of Records of Vulnerable Children to Health Visiting in to Plymouth

Notice of transfer from the Safeguarding Team



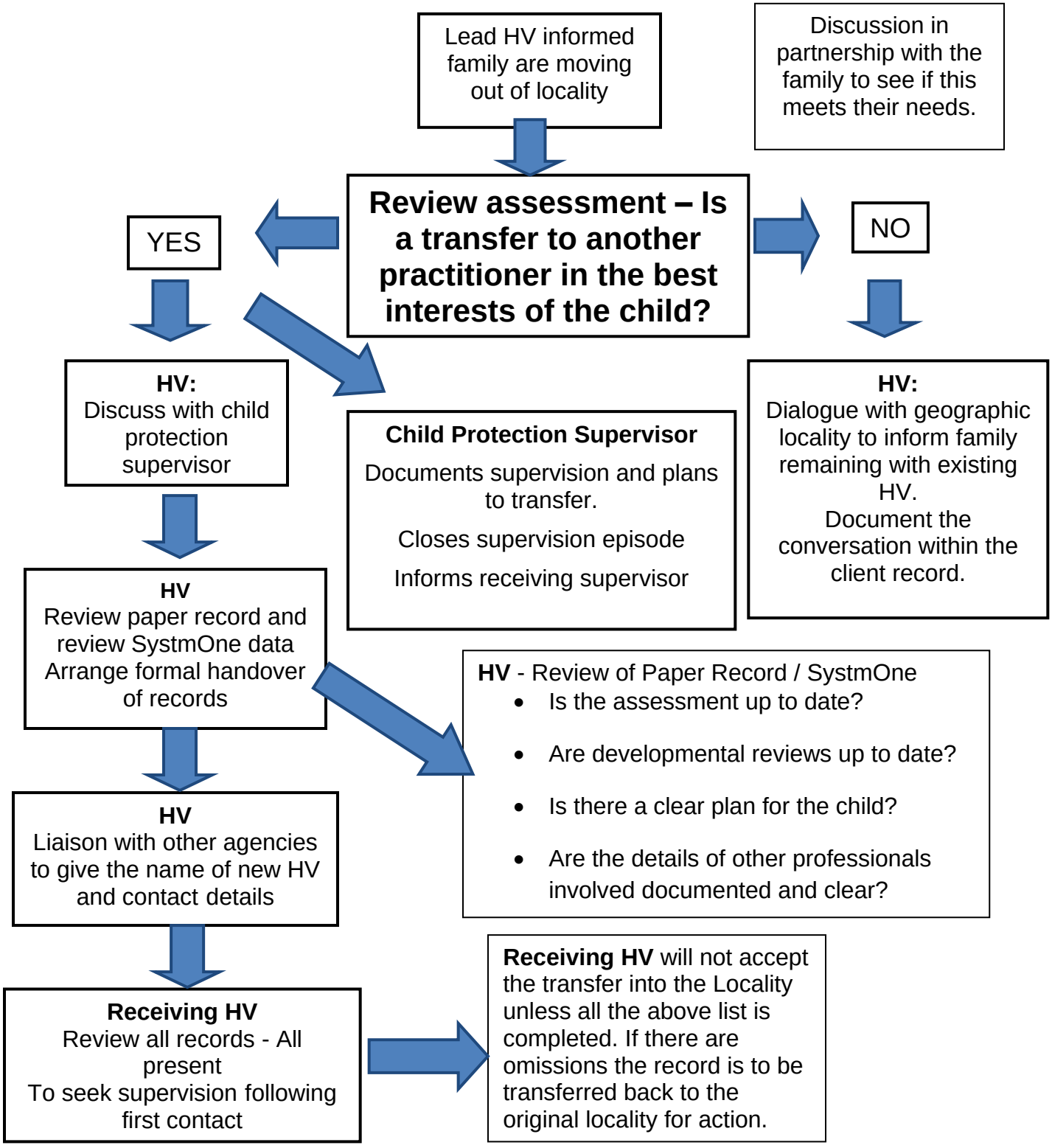
Appendix C

Transfer of Records of Vulnerable Children to Health Visiting out of Plymouth



Appendix D

Universal Partnership Plus internal transfer across the 4 localities within Plymouth.



Appendix E

Health Visiting – Best Practice Pathways

Antenatal Pathway

Universal Pathway

The Universal pathway is the core which supports the delivery of the Healthy Child Programme offered by the Health Visiting Service to all families

Contact Type	Description of Intervention
UNIVERSAL	
Antenatal before 28 weeks	
Liaison with Midwife following notification of pregnancy.	Following Midwifery assessment, the Health Visitor will receive notification of pregnancy with information relating to issues such as: • Actual or potential vulnerability of the family • Previous sudden infant deaths • History of physical and mental health problems • Safeguarding issues and any child protection concerns • Domestic abuse
Antenatal 28 weeks optimum	
Antenatal Visit.	*Meet with mother and father wherever possible. Discover the pregnancy journey so far and progress to date. Review with parents their hopes and worries for family life, their family's strengths and areas for behaviour change if necessary. Consider with parents their attachment to their baby and family's current level of engagement with Midwifery and other services* (indicator of ability to prioritise child). *Introduce the Health Visiting Service and highlight partnership approach working with midwifery services, children centres and other relevant professionals in the best interests of the child and family.* Use of **antenatal well –being plan** to prompt discussion that contributes to the family health needs assessment completed in partnership with the family. Using the Framework for the Assessment of Children In Need and Their Families (DH 2000). (Encourage attendance at Antenatal Preparation for Birth & Beyond –Great Expectations Group.) • Advise on sources of information on infant development and parenting, the HCP and Healthy Start. Also Baby Buddy App and Born to Move App. • Provide information in line with Department of Health guidance on reducing the risk of Sudden Infant Death Syndrome (SIDS). • Discuss new-born screening leaflet. • Introduce personal child health record • Delivery of Public Health messages with a specific focus on the 6 high impact areas for e.g. ➢ Stop Smoking

- Diet - obesity
- Safety
- Parenting
- Dental health

Particular consideration should be given to the following areas:

Early Childhood Development

- Introduce the Healthy Child Programme with specific reference to developmental screening and immunisations.
- Advice and support with multiple births.
- Promote parental understanding of baby brain development. and the importance of communication and stimulation

Infant Mental Health

Discuss with parents the:

- Importance of early attachment and brain development and highlight the importance of speaking to unborn baby
  - Identify those in need of further support during the postnatal period; and
  - Establish what their support needs are.
- Awareness of the impact of stressors on the unborn
- Environmental factors and determinants on the health of the unborn.

Parental Mental Health

- *Discuss with parents* their community support networks
- *Consider with both parents historic and current mental health issues and uptake specialist services*
- Promotion of the Health and wellbeing of the mother and its potential impact on the unborn.
- Domestic abuse questions - routine questioning at every visit.
- Work in partnership with the family to identify changes in the family dynamics, assess and record these.
- Identify depression or previous Mental Health condition treated by primary care team for either parent.

Undertake:

- Professional assessment of protective factors.
- Incidence of domestic abuse past and potential risk.
- Preparation for the birth: both physical and psychological.
- Identification of potential risk factors for attachment disorders.

Parenting support

- Promote parenting capacity and support parents-to-be
- Promote parents aspirations for themselves and their child
- Discuss parental support available and encourage father/partner involvement and participation.
- Assess emotional availability of the parents.

Assessment and consideration of MECSH Programme.

- Support transition to parenthood by identifying appropriate services available for help and support, such as Children's Centres, infant massage, antenatal and postnatal support groups, and use of social network sites (e.g. use of;

netmums).

Vulnerable families
Identify potential vulnerable families and level of support required Universal, Universal Plus or Universal Partnership Plus.

If there are concerns about the immediate safety and welfare of a child a referral must be made to Children's Social Care.

Consider completion of Pre-CAF/CAF or referral to other specialist services.
Safeguarding
The Health Visitor will demonstrate a level of professional authority/curiosity and ask questions to establish parental responsibility.
These will include questions that:

- Identify potential indicators of abuse or neglect
- Develop an awareness of the risks of harm that individual abusers or potential abusers may pose.
- Develop an awareness of the risk to the unborn child where domestic abuse is a feature in the antenatal period.

Advise parent on appropriate handling of infant and in particular the danger of Shaken Babies Syndrome.

Antenatal Preparation for Birth and Beyond Group.

Antenatal (Preparation for Birth & Beyond) Great Expectations Group
HV will work in partnership with the midwife and/or other providers to deliver Preparation for Birth and Beyond sessions.

- Raise parental awareness of childhood development and milestones to promote appropriate parental expectations.
- *Discuss with parents the significance of their relationship with their growing baby* brain development and highlight the importance of speaking to unborn baby
- Infant feeding – promotion of breast feeding (linked to nutritional pathway)
- Promote awareness of Social Baby information and attachment theory, transition to parenthood.
- Environment, social issues, financial issues, family and community networks, English as a second language
- Physical preparation for baby arrival.
- Sudden Infant Deaths Syndrome (SIDS) prevention information/Care of the Next Infant (CONI) support information.

Universal Plus and Universal Partnership Plus

The following pathway should not be read as stand-alone and MUST be read in conjunction with the Universal section, and the transfer to health visitor

- During the antenatal period the Midwifery Service is the accountable professional and lead for the care of the mother and the unborn / newly born child(ren) and works as part of the Healthy Child Programme (HCP) team.
- The Health Visitor will work collaboratively with the Midwife to provide continuity of care between the Antenatal and postnatal period. The Healthy Child Programme places greater emphasis on the antenatal period and for preparation to parenthood.

Contact Type	Description of Intervention
Universal Plus	
From 28 weeks to New Birth	
Follow-up Antenatal Visit	• Provide further advice and support relating to parental health issues or parenting issues • Promote parental understanding of baby brain development and an awareness of attachment theory using Solihull approach • Offer CAF assessment if Partnership+ is required. **Partnership collaboration** • Health Visitor to work in partnership with Children's to promote attendance at Centre and groups. • Work with midwifery team through local networks.). **Referrals and signposting** • Make referrals with consent to appropriate services (dependent on parent's wishes) • Liaison with other services as required. • Negotiate additional Health Visitor contacts with parents as appropriate. Consider MECSH.
Conduct Listening Visits **Facilitate attendance at antenatal topic based groups.**	Using PHQ2 / Whoolley questions, progress assessment using Edinburgh postnatal depression scale. As these assessments do not consider anxiety levels a separate assessment may need to be undertaken. • To identify and support: • Emotional and psychological problems • Parental mental health history including antenatal depression / emotional well being • Need for referral to antenatal counselling / CBT • Intervention for factors that could underlie poor parental mental health, for example, CONI • Low intensity therapeutic intervention (listening visits) offered. Liaison and referral to GP's and as appropriate

	Provide additional support to encourage attendance at antenatal groups.
Contact Type	Description of Intervention
Universal Partnership Plus	
28 weeks to New Birth	
Follow-up Antenatal Visit	• Enhanced partnership working with Midwife and other appropriate agencies to further establish therapeutic relationship and provide support ready for postnatal period. • Multi-professional / agency action planning, liaison and information sharing to provide additional early support and intervention to: ➢ reduce the risk to the child. ➢ promote positive physical and mental health and development of the child. ➢ identify at an early stage any parental mental health issues. • Provide further advice and support relating to issues such as: ➢ Domestic Abuse, parent who is a Looked After Child (LAC), vulnerabilities of the family. ➢ Foetal abnormalities and parenting concerns. • Promote parental understanding of baby brain development and an awareness of attachment theory using Solihull approach.
Additional Visit	• Support and education for parents with a range of complex needs • Support with accessing other services and sources of information and advice • Environmental issues addressed where appropriate • Emotional and psychological problems addressed • Support for parents in prison / refuge • Crisis and safety planning for victims of domestic abuse.
Conduct Listening Visits	Using PHQ2 / Whoolley questions, progress assessment using mood assessment tool. As these assessments do not consider anxiety levels a separate assessment may need to be undertaken. To identify and support: • Emotional and psychological problems • Parental mental health history including antenatal depression / emotional well being • Need for referral to antenatal counselling / CBT • Intervention for factors that could underlie poor parental mental health for example CONI • Low intensity therapeutic intervention (listening visits) Liaison and referral to GP's and as appropriate.
Multi-agency Meetings	• Liaison, information sharing, risk assessment, communicating with partner agencies. • Plan care in conjunction with parents, specialist services and local initiatives. • Liaise with CAF/TAC/CP/CIN service providers. • Liaise with Named Nurse Safeguarding re Social Care involvement especially if

non-engaging, hostile or uncooperative
- Referral and on-going partnership working with appropriate specialist services.

Contact Type	Description of Intervention
MECSH (Universal Partnership Plus)	
28 weeks to New Birth	
Follow-up Antenatal Visit	Women are classified as eligible if they have any one or more of the following: 1. A positive response to any of 12 psychosocial questions routinely asked. These questions assess expected lack of practical and emotional support, stressors in the past 12 months, personality, mental health, history of abuse in the mother's childhood, and family violence. In addition, the presence of any one of the following: maternal age under 19 years, late antenatal care after 20 weeks gestation, and current substance misuse. 2. Current probable distress. This is assessed using the Edinburgh Depression Scale (EDS). An EDS score of 10 or more may approximate the subgroups labelled in other trials as 'psychologically vulnerable' or 'low psychological resources'. The health visitor should aim to visit monthly until the baby is born the visit should be conducted in the family home. Visits will most commonly be of 30-60 minutes duration. Topics that could be expected to be covered at visits for every family include: • maternal health • maternal mood • maternal physical activity • maternal nutrition • expectations of having a baby • pregnancy/childbirth terminology • social support • care planning • housing issues • budgeting • community services Topics that could be expected to be covered at most visits for most families include: • infant sleeping/settling including SIDS prevention • infant feeding • contraception/conception/sexual activity • relationships with extended family • aims for the following week • mother's aspirations for the baby • mother's aspirations for herself Topics that could be expected to be covered at some visits for some families in response to needs include: • smoking cessation for mothers who smoke • drugs, alcohol, domestic violence particularly for higher risk mothers • maternal coping, parentcraft, partner health and management of other children's health

	(particularly for teenaged mothers, unsupported mothers and mothers with a history of mental health issues) • household and car safety (particularly for first time mothers) • cultural issues • dental health • partnership issues • partner coping • relationship with other children • child care services • family law • referral to other service

0 to 6 weeks

0 – 6 weeks	
Notification of birth – From Child Health Dept. **Handover from Midwife services.** **New Birth Visit - Optimal 10 – 14 days.**	Meet with mother and father; if at all possible, continue the review of the journey so far. Review with parents whether their hopes and worries for family life are any different from what they thought ante natally. Consider with parents their attachment to their baby and family's current level of engagement with Midwifery and other services (indicator of ability to prioritise child). Complete/review family health needs assessment using the Framework for the Assessment of Children In Need and Their Families (DH 2000). Particular consideration should be given to the following areas: **Early Childhood Development** • Use of the "From Birth to Five" Book (only available via internet) and the Personal Child Health Record • Family history for medical conditions • Discussion about labour, delivery and pregnancy related health issues and how they have impacted on life style and environmental factors • Education regarding stages of childhood development and advice regarding associated risks. • Discuss baby sleep patterns, settling and why babies cry • Advice and support with multiple births • Promotion of age appropriate development, play and stimulation. • Revisit the role of the Health Visiting Team and the Healthy Child Programme with specific reference to developmental screening. • Promote the uptake of childhood immunisations • Signpost and encourage attendance at appropriate groups such as Children's Centres • Distribution of Bookstart packs for babies (if not given in the antenatal period). **Infant Mental Health** • Observation of parent/ baby interaction • Offer breast feeding support • Promotion of infant massage where appropriate • Further discussion on the importance of baby brain development and highlight the importance of speaking to baby/promotion of social baby interaction. • Discuss the impacts of physical health on attachment.

Nutritional Healthy Start

- Healthy weight management and promotion of optimal nutritional status and growth - following WHO growth charts guidance.
- Check blood-spot screening has been undertaken and all results to be documented in personal child health records and electronic records.
- Identification of jaundice according to World Health Organisation (WHO) guidance / Department of Health (DH) Healthy Child Programme (HCP) and jaundice protocols.
- Use of:
  - Breast feeding assessment tool – UNICEF Baby Initiative
  - Formula feeding assessment tool which would include bowel and urine function
  - Baby Friendly initiatives to promote continuation of breast feeding
  - Feeding support using national and local services, advice regarding infant formulas and prescriptions.

Contact Type	Description of Intervention
0 – 6 weeks continued	

- Introduction to Peer support schemes

Reminder for Mothers regarding need to take vitamins - Healthy Start

- Introduction to Healthy Start vitamins programme. Healthy start vitamins should be encouraged for all infants less than 6 months of age who are breast fed and whose mother is not taking vitamins. Identify issues associated with allergies and intolerances (not just ask if baby is unsettled after feeds).

Advice given regarding appropriate feeding including choking prevention and prop feeding and the inappropriate introduction of weaning.

Diagnosis of Tongue Tie / Cleft Lip and palate / any other disorders that could affect feeding.

Parenta Parental Mental Heath

- Promote family and community support networks
- Assessment of parental mental health and wellbeing, identifying issues and any wider family mental health issues.
- Observe parents interaction with baby and attribution (comments made by parents about baby)
- Domestic abuse questions - routine questioning at every visit.
- Discuss with family any change in dynamics, make assessment and record.
- Identify depression or previous Mental Health condition treated by primary care team.

Parenting Support

- Identification of potential risk factors for attachment disorders
- Explore, promote and encourage appropriate parental expectations.
- Encourage father/partner involvement and participation.
- Explore availability of local provision including children centres, libraries and support groups.
- Promote understanding of parenting and emotional availability to baby
- Discuss safe parenting and accident prevention for example SIDS
- Discussion regarding family planning options.
- Discussion of Public Health messages for example:
  - Stop Smoking – Referral to smoking cessation initiatives and discussion regarding smoke-free environments for children (e.g. no smoking within the home, including cars.)
  - Diet – obesity
  - Safety
  - Parenting

Vulnerable Families

Identify potential vulnerable families as described in Antenatal section above.

Safeguarding

The Health Visitor will demonstrate a level of professional authority/curiosity and ask questions to establish parental responsibility.

See Antenatal Visit section above.

Contact Type	Description of Intervention
0 – 6 weeks AND available to all families and child age groups to 5 years.	
Child Health Clinic.	Introduction to the Health Visiting Team/service. To support growth and development, feeding support and any other parental concerns. Open access to all families. During clinic's particular consideration should be given to the areas identified during the New Birth Visit – see above.

Contact Type	Description of Intervention
6 weeks – 6 months	
6- 8 Week Developmental Assessment.	This assessment is undertaken according to local contracting arrangements by the GP and Health Visitor. Complete/review family health needs assessment using the Framework for the Assessment of Children In Need and Their Families (DH 2000). Delivery of public health messages and interventions. Particular consideration should be given to the following areas: **Early Childhood Development.** • 6-8 week developmental assessment (GP). • Promotion of age appropriate development, play and stimulation (HV). • Promote socialisation and development (HV) Mood review (HV) • **Infant Mental Health.** • Address parental questions and concerns • Assess: using MORS-SF ➢ Maternal wellbeing and early indicators for anxiety and depression. ➢ Reciprocity e.g. smiling and eye contact / turning to voices / In-tune with baby. ➢ Containment – the awareness of the parent and the needs of the child/assessment of parental care of baby. • Promote wider socialisation of baby and highlight the importance of singing, reading and talking with baby. . • Advice and support on sibling rivalry if required. • Advice on the promotion of baby led activities and flexible routines. **Nutritional Healthy Start** • Healthy weight management and promotion of optimal nutritional status and growth. • Identify faltering growth and refer as appropriate. • Advice given regarding appropriate feeding and weaning including choking prevention and prop feeding and the inappropriate introduction of weaning. • Use of the Baby Friendly initiatives to promote continuation of breast feeding

	and feeding support using local and national services. • Continued promotion of peer support schemes and feeding support services. • Advice to reduce the incidence of colic. • Identify issues associated with allergies and intolerances. • Healthy Start vitamins should be encouraged for all babies less than 6 months of age who are breast-fed and whose mother is not taking vitamin supplementation.
Contact Type	Description of Intervention
6- 8 Week Developmental Assessment continued	**Parental Mental Heath** • Assess parental mental health using Whoolley questions • Progress to mood assessment if indicated by score on MORS-SF and consider appropriate referral if required including listening visits, infant mental health team, GP, Options (post natal women prioritised up to 12 months) etc. • Discussion about parental support networks and community resources including postnatal education groups, children centres. • Continued discussion regarding attachment and attribution, transition to parenthood, family involvement and support • Observe parent interaction with baby and signs of attribution • Refer for counselling services as appropriate. • Promote importance of couple relationship • Domestic abuse questions - routine questioning at every visit. • Identify and discuss any change in family dynamics. • Identify and discuss depression or previous Mental Health condition treated by primary care team. **Parenting Support** • Support parental relationship if parental conflict. • Introduction of importance of parent's socialisation and their ability to prioritise baby's needs. Increasing parental understanding of child behaviour and promoting appropriate parental expectations. • Support routine and coping with tiredness. • Support regarding return to work for both parents / benefits where appropriate. • Promote importance of fathers as well as mothers in child development and well-being • Explore coping mechanisms and social support. • Discussion of Public Health messages for example: ➢ Stop Smoking – Referral to smoking cessation initiatives and discussion regarding smoke-free environments for children (e.g. areas within the home that are smoke-free), including cars. ➢ Diet – obesity ➢ Promotion of safe and sensitive parenting and environment factors. **Vulnerable Families** Identify potential vulnerable families as described in Antenatal section

	Safeguarding The Health Visitor will demonstrate a level of professional authority/curiosity and ask questions to establish parental responsibility. See Antenatal Visit section.
3- 4 Month Review.	This is a Needs Led review agreed in partnership with the family. Complete/review family health needs assessment using the Framework for the Assessment of Children In Need and Their Families (DH 2000), with particular attention to: • Parental mental health and wellbeing (including Wholley questions) • Public health messages appropriate to the needs of the family • Accident prevention • Dental health education • Infant nutrition.

Contact Type	Description of Intervention
6- 12 months	
9 month - 1 year Developmental Assessment.	Review with parents their aspirations for family life, their families' strengths and areas for behaviour change if necessary. Consider with parents their attachment to their baby and family's current level of engagement with other services (indicator of ability to prioritise child). Assessment of the infant's physical, emotional and social needs in the context of their family, including predictive risk factors. An opportunity for both parents to talk about any concerns that they may have regarding their infant's health. Complete/review family health needs assessment using the Framework for the Assessment of Children In Need and Their and Families (DH 2000). Opportunity for professionals to deliver public health messages and interventions. Particular consideration should be given to the following areas: **Early Childhood Development** • Promotion of age appropriate development, play and stimulation. • Promote socialisation and development. • Review immunisation status, encourage catch up on any missed immunisations • Dental care awareness (Brush for Life) **Infant Mental Health** • Provide parents with information about attachment and the type of developmental issues that they may now encounter (e.g. clinginess or anxiety about being separated from one particular parent or carer). • Provide temperament based anticipatory guidance. • Use of media to encourage parent infant interaction, such as; mums.net; Baby Buddy App and Born to Move App. **Nutritional Healthy Start** • Growth monitoring which involves accurate measurement, interpretation and explanation of the infant's weight in relation to height, growth potential and any earlier growth measurements of the infant.

- Support with the progression of weaning and other feeding issues e.g. use of cups.
- Advice on nutrition and physical activity for family.
- Advice to be given around frequency and amount of sugary food and drinks which should be as part of a meal.
- Healthy start vitamins should be encouraged for every child taking less than 500mls formula milk from 6 to 12 months of age until 4 years of age.

Parental Mental Health

- Assess parental mental health Whoolley questions.
- Progress to mood assessment if appropriate and refer to GP if required.
- Advise on self- help and coping skills
- Domestic abuse questions - routine questioning at every visit.
- Identify and discuss any change in family dynamics
- Encourage social networks to prevent social isolation and promote appropriate socialisation.
- Identify and discuss depression or previous Mental Health condition treated by primary care team.

9 month - 1 year Developmental Assessment continued.

Parenting Support

Support parental relationship if parental conflict (consider impact on child)

Encourage parents to maintain or develop appropriate levels of socialisation and their ability to prioritise infant's needs.

Increasing parental understanding of child behaviour and promoting appropriate parental expectations.

Promote consistency in setting of routines

Support around establishing routine and coping with tiredness

Support regarding return to work for both parents / benefits where appropriate

Explore coping mechanisms and social support.

Discussion of Public Health messages for example

Stop Smoking – Referral to smoking cessation initiatives and discussion regarding smoke-free environments for children (e.g. areas within the home that are smoke-free), including cars.

Diet – obesity

Discussion about safe and sensitive parenting and environment factors.

Reiterate accident prevention and use of safety equipment pay particular regard to thermal injuries.

Dental Health (Brush for Life)

Vulnerable Families

Identify potential vulnerable families as described in Antenatal Visit section above.

Safeguarding

The Health Visitor will demonstrate a level of professional authority/curiosity and ask questions to establish parental responsibility.

See Antenatal Visit section above.

1 – 3 years

2- 2.5year Developmental Assessment Liaison with Early Years Providers

Consider with the parents the child's social, emotional, behavioural and language development. Opportunity for integrated 2 to 2.5 year review with early year's provider.
Complete/review family health needs assessment using the Framework for the Assessment of Children In Need and Their Families (DH 2000).
Opportunity for professionals to deliver public health messages and interventions.
Particular consideration should be given to the following areas:

Childhood Early Development

- Promotion of age appropriate development, play and stimulation.
- Promote socialisation and development
- Discuss and encourage attendance for early year's education. Give health information and guidance (telephone helplines, websites).
- Review immunisation status, encourage catch up on any missed immunisations.
- Promote language development through book sharing and invitations to groups for songs, music and interactive activities (e.g. Bookstart).

Infant Mental Health

- Promote social interaction with peers.
- Observe attachment behaviour.
- Advice and support on sibling rivalry (if required).

Nutritional Healthy Start

- Growth monitoring which involves accurate measurement, interpretation and explanation of the child's weight in relation to height, growth potential and any earlier growth measurements.
- Advice on nutrition and physical activity for family.
- Advice to be given around frequency and amount of sugary food and drinks which should only be given as part of a meal.
- Healthy start vitamins should be encouraged for all children 1 – 4 years of age unless they are consuming 500mls formula milk
- Promotion of social eating and families eating together at mealtimes.

Parental Mental Health

- Advise on self- help and coping strategies–
- Domestic abuse questions - routine questioning at every visit.
- Identify and discuss any change in family dynamics
- Encourage social networks to prevent social isolation and promote appropriate socialisation.
- Identify and discuss depression or previous Mental Health condition treated by primary care team.

Parenting Support

- Support parental relationship if parental conflict (consider impact on child)
- Encourage parents to maintain or develop appropriate levels of socialisation and their ability to prioritise child's needs.
- Increasing parental understanding of child behaviour and promoting appropriate parental expectations including positive reinforcement, consistency and being aspirational for themselves.
- Support around establishing routine and coping with tiredness.
- Support regarding return to work for both parents / benefits where appropriate.
- Explore coping mechanisms and social support.
- Discussion of Public Health messages for example:
  - Stop Smoking – Referral to smoking cessation initiatives and discussion regarding smoke-free environments for children (e.g. areas within the home that are smoke-free), including cars.
  - Diet – obesity
  - Promotion of safe and sensitive parenting and environment factors.
  - Reiterate accident prevention and use of safety equipment pay particular regard to thermal injuries.
  - Dental Health (Brush for Life)

Vulnerable Families

Identify potential vulnerable families as described in Antenatal Visit section above.

Safeguarding

The Health Visitor will demonstrate a level of professional authority/curiosity and ask questions to establish parental responsibility.

See Antenatal Visit section above.

Contact Type	Description of Intervention
3 – 5 years	
Liaison with Early Years Providers	Delivery (by early years services with health professional support) of key messages regarding: • Promoting child health and maintaining healthy lifestyles • Nutrition • Active play • Accident prevention • Dental health.
Handover to School Nursing	Professional handover and early identification of possible concerns at school transition. Lead Practitioner is responsible for advising school nursing in a timely way. All details documented in child record.
0 – 5 years	

Transfer In Visit	Initial assessment of any family moving into the area at any point pre-school entry using the relevant interventions from above dependent on age. Consider as part of transition to school any transfer in any families who may need support accessing a school place.
Telephone Contacts	Ad-hoc telephone contact from parents/families for a range of advice and support. The nature of advice and support provided will be dependent on the family's particular needs and age of the children.

KPI: Business Intelligence:
- Ensure that the correct EDD is on the waiting list as this is a read code.
- Tick box on Antenatal Template is a read code

Best Practice:
HV should attempt 2 Telephone calls to arrange an appointment; if unsuccessful an appointment letter should be sent. If no contact Exception report should be completed.

S1 Antenatal Process

Notified of pregnancy by Antenatal Booking Form, SCIF or professional

Fast Track Antenatals
Notified by professional of late antenatal booking, CP, CAF, CIN or Strategy Meeting

Register mother on SysmOne and Scan booking form on Communication and Letters

Register mother on SystmOne and scan on booking form if received

Put on antenatal waiting list and set EDD as due date. In Notes section of waiting list input amount of previous children if any and any SCIFS or alerts.

Place on Antenatal Waiting list (amend due date as EDD) and Allocation waiting list. Put in notes and activities the concerns with family

Antenatal Champion to triage antenatal forms minimum monthly prior to 28 weeks gestation and assess if U (Universal) or UPP (Universal Partnership Plus) and amend in notes section of waiting list and ensure that due date has been put as EDD. Booking forms can then be shredded.

Allocate to a Health Visitor

Allocate antenatals. The Lead Practitioner should be tasked and the family added to their caseload. Initials for LP to be added to waiting list.

HV to Liaise with Midwife and record information in Notes and Activities. If Child Protection mother should be placed on CP waiting list stating Unborn CP in notes section and CP Supervision waiting list.

Make contact with Mother and record in Notes and Activities. If contact has been made via attendance at Great Expectations Group the Great Expectations template needs to be completed for both dates.

Universal ← Check viability of pregnancy, either via list received from Maternity or telephone liaison with GP. This should be inputted on Notes and Activities on SystmOne. → **UPP**

HV to undertake visit and complete Antenatal Template, mother to remain on antenatal waiting list until baby is born. Tick box needs to be completed in template as shown below.

Non-viable pregnancy

Record information in Notes and Activities and end referral.

Make an appointment to visit family. (If unborn CP check risks for home visit)

HV to undertake visit and complete Antenatal Template (Child Welfare to be completed if CAF, CP or CIN). Notes section to be amended on waiting list stating if receiving CAF, MECSH, CP, CIN or if HV has identified risk factors.

HV to be allocated New Birth if possible

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Version 2.0

KPI: Business Intelligence:
- on COMS paperwork you need to select which visit this is if part of the Healthy Child Programme

Record Keeping:
- NOTES AND ACTIVITY to be completed for appointment letters and Telephone liaison.
- COMS paperwork to be completed for all face to face.
- Sharing Consent to be asked and filled in on maternal records.

New Birth Process

Notification received from Child health that baby has been born. Check locality is correct.

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Add name and address to Birth Book (If required by Locality). Register baby onto S1 and input birth details on Height and Weight Template at Birth on S1. Register mum (if not already registered) and check Careplus for any siblings and create reciprocal relationships on S1. Professionals involved in the child i.e GP or Social Worker need to be added as a textual relationship.

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Add baby to the 10-14 day waiting list, 6-8 week waiting list and the developmental waiting lists.

↓

Attach or Scan in Birth Notification Form. Check if seen antenatally by HV for continuity of care and put intials of allocated HV within the notes section on the new birth waiting list along with any relevant information i.e premature

↓

Once allocated, LP intials to be added to notes section of waiting list, baby to be assigned to lead practitioner's caseload and a task sent to LP.

↓

Communication from Midwife should occur on day 10 onwards. If Summary of Birth received by Midwife this should be scanned onto Child's records.

↓

Lead Practitioner to make an appointment to visit family to complete new birth visit within 10-14 day timeframe (birth to be counted as day 1). Input visit on S1 diary. Baby should stay in LP's caseload until 9-12 month developmental has been completed. Amend notes on 9-12 month developmental waiting list stating LP initials and if ASQ has been identified

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These steps should be completed by a clerical officer/ assistant family health worker.

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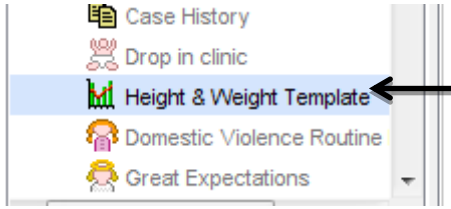
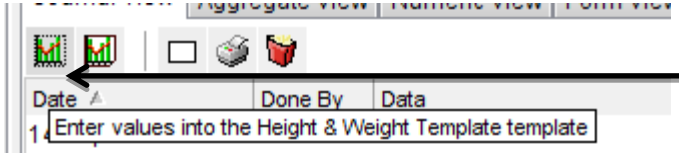
These steps should be completed by a Health Visitor.

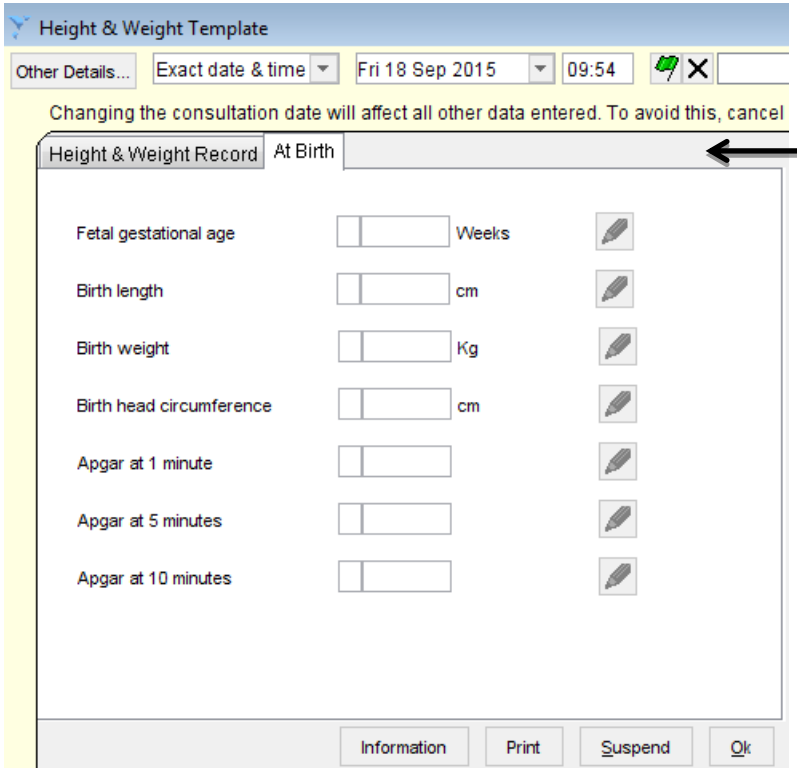
Where to input Birth Details



Click on Height and Weight Template on the Clinical Tree

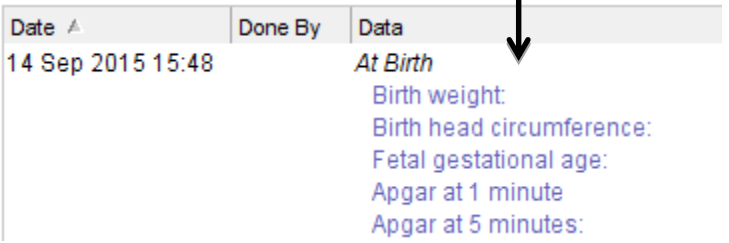


Click on new Height and Weight Template



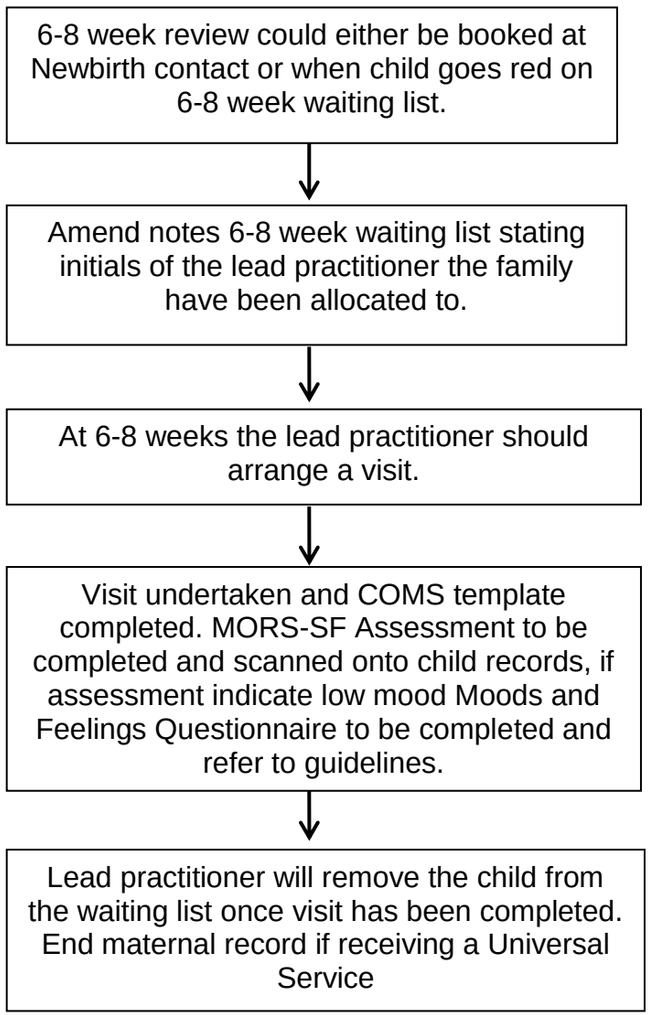
Input known birth details in the relevant boxes

This will appear as below in the tabbed journal



6-8 Week Review Pathway

This visit needs to be undertaken when the child is between 6-8 weeks of age.



KPI: Business Intelligence: - on COMS paperwork you need to select which visit this is as part of the Healthy Child Programme

Visit needs to be between the 6-8 week timeframe. You will breach if the child is over 8 weeks i.e. 8 weeks and 2 days will require an exception report.

KPI: Business Intelligence: - on COMS paperwork you need to select which visit this is as part of the Healthy Child Programme

Universal 9-12 Month Developmental Pathway

Add child onto SystmOne and place on all relevant waiting list. Ensure that parameters are correct. For instance:
9-12 Month Developmental Waiting List – Goes red at 9 months
Lead Practitioners name to be put in amend notes section, if UP or UPP place in notes section and ASQ can be completed.

↓

Prior to 9 months, lead practitioner to be tasked and informed developmental is due.

↓

Appointment to be made for Child to attend developmental prior to going red on the waiting list.

Universal developmentals at home

↓

Booking of appointments to be agreed by local variation. For developmentals requiring Band 4+ booking diary should be checked for available dates and appointment made with family either by phone or letter sent. This appointment should be recorded in the Notes and Activities and visit to be placed in relevant staff S1 diary. Booked and initials of staff to be written on note section of waiting list.

↓

If child attends developmental, COMS paperwork should be completed and a clinical decision should be made as to whether assessment needs updating.

↓

Task Admin if family DNA appointment so that DNA process can commence and another appointment can be arranged. After 3rd DNA HV should review records and follow Safeguarding Children Policy.

↓

Remove from waiting list once visit has been completed.

Universal developmentals at clinic

↓

Admin to book child into available clinic slot on appointment ledger depending on geographical area. This appointment should be recorded in the Notes and Activities. Booking via appointment ledger will automatically remove child from the waiting list.

↓

If child attends developmental, COMS paperwork should be completed and a clinical decision should be made as to whether assessment needs updating.

↓

Task Admin if family DNA appointment so that DNA process can commence and another appointment can be arranged. Child to be added back onto 9-12 month developmental waiting list with correct parameters. After 3rd DNA HV should review records and follow Safeguarding Children Policy.

KPI: Business Intelligence: - on COMS paperwork you need to select which visit this is as part of the Healthy Child Programme

2-2 ½ Year Developmental Pathway

Add child onto SystmOne and place on all relevant waiting list. Ensure that parameters are correct. For instance:
2-2½ Developmental Waiting List – Goes red at 2 years
Lead Practitioners name to be put in amend notes section of waiting list

↓

Prior to 2 year, lead practitioner to be tasked and informed developmental is due.

↓

Appointment to be made for Child to attend developmental prior to going red on the waiting list.

UPP or UP developmentals

For developmentals requiring LP the LP should task admin advising them of date to book in the appointment.

↓

Admin will write in Notes and Activities when the appointment has been made either by phone or letter and then add the visit to LP S1 diary. Relevant ASQ questionnaires to be sent to family prior to appointment. Initials to be placed on waiting list notes stating booked.

Universal developmentals at home

For developmentals requiring Band 4+ booking diary should be checked for available dates and appointment made with family either by phone or letter sent. This appointment should be recorded in the Notes and Activities and visit to be placed in relevant staff S1 diary. Relevant ASQ questionnaires to be sent to family prior to appointment. Booked and initials of staff to be written on note section of waiting list.

Universal developmentals at clinic

Admin to book child into available clinic slot on appointment ledger depending on geographical area. This will remove the child automatically from the waiting list. Relevant ASQ questionnaires to be sent to family prior to appointment.

↓

If child attends developmental, COMS paperwork and ASQ template should be completed and a clinical decision should be made as to whether assessment needs updating. Score of ASQ should be written on child health slip and then forwarded to Child Health.

↓

Task Admin if family DNA appointment so that DNA process can commence and another appointment can be arranged. After 3rd DNA HV should review records and follow Safeguarding Children Policy. Child to be added back onto 2-2 ½ year developmental waiting list with correct parameters

↓

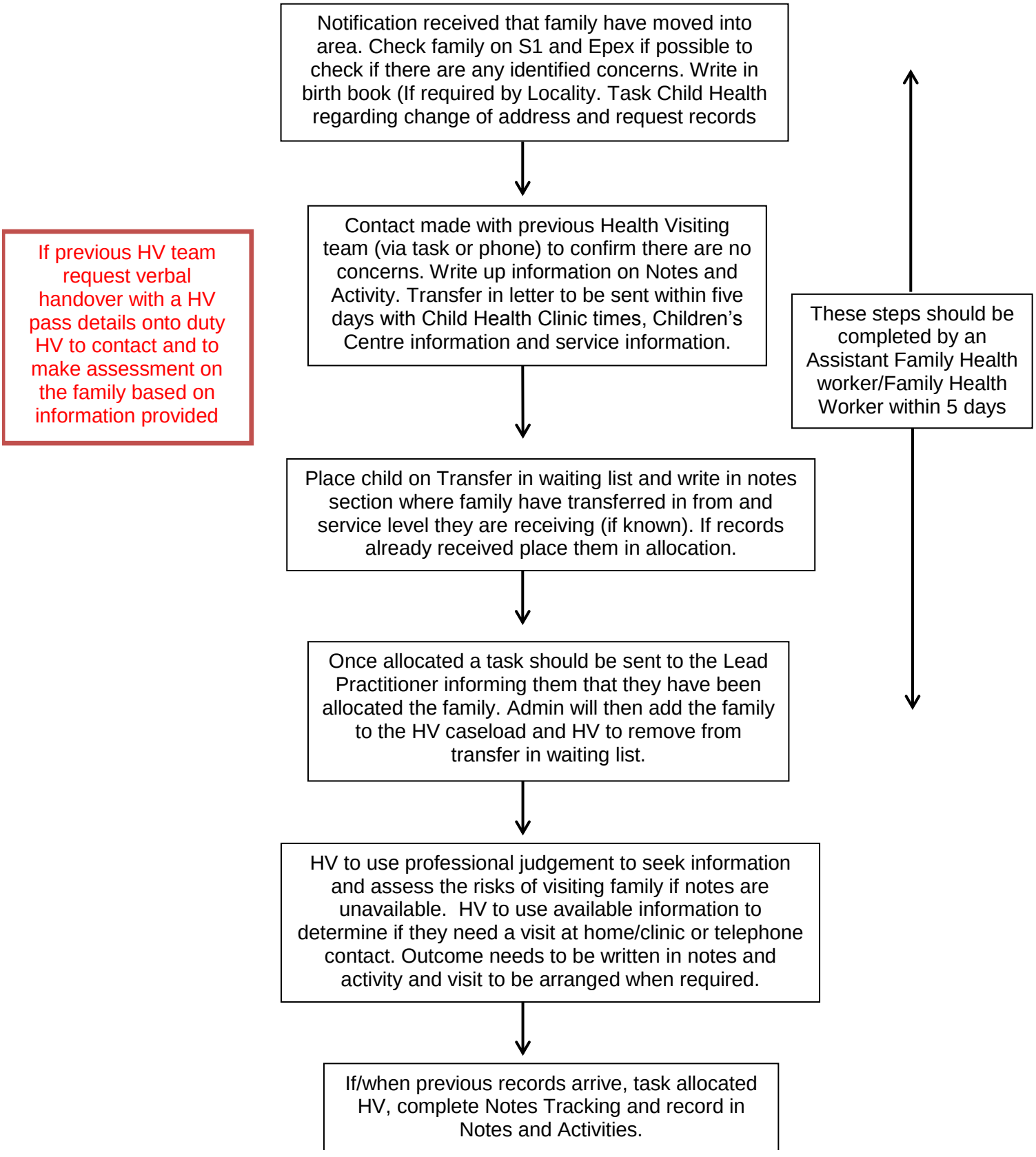
Remove from waiting list once visit has been completed.

To find out which Ages and Stages Questionnaire needs to be used you can use this online calculator.

http://agesandstages.com/free-resources/asq-calculator/

Version 2.0 January 2016

41 Internal Transfer in process



External Transfer in process

Notification received that family have moved into area. Write in birth book (If required by Locality. Task Child Health regarding change of address and request records

↓

Contact made with previous Health Visiting team via task or phone (if from within the U.K) to discuss any concerns. Write up information on Notes and Activity. If Universal Partnership Plus Family HV should take handover. Transfer in letter to be sent within five days with Child Health Clinic times, Children's Centre information and service information.

If previous HV team request verbal handover with a HV pass details onto duty HV to contact and to make assessment on the family based on information provided

↓

Place child on Transfer in waiting list and write in notes section where family have transferred in from and service level they are receiving (if known). If records already received place them in allocation.

↓

Once allocated a task should be sent to the Lead Practitioner informing them that they have been allocated the family. Admin will then add the family to the HV caseload and HV to remove from transfer in waiting list.

↓

HV needs to enquire about Neonatal Blood Screening and refer to day beds if required. This should appear as a tick box on SystmOne

HV to use professional judgement to seek information and assess the risks of visiting family if notes are unavailable. All families that have transferred in from outside of area with children under the age of 1 require a home visit. Outcome needs to be written in notes and activity and visit to be arranged when required.

↓

If/when previous records arrive, task allocated HV, complete Notes Tracking and record in Notes and Activities.

These steps should be completed by an Assistant Family Health worker/Family Health Worker within 5 days