



# **‘Helping parents to enjoy their under 5’s’**

Practice Handbook for Health Visiting Team Members  
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## Introduction

This document is to be used by all health visiting team members and key stakeholders (providers and commissioners) as a means of describing current service delivery. This is the 5<sup>th</sup> revision of the Practice Manual and the first to incorporate health visiting service delivery for both the former NHS Telford and Wrekin and Shropshire County PCT now operating as Shropshire Community Health NHS Trust (SCHNT)

### **The Vision:**

**The Health Visiting service works in Partnership to enable children in Shropshire to fulfil their health potential.**

**Health Visitors are the Lead Professional for all families with children under 5 years of age and are responsible for co-ordinating health and social care interventions for this client group.**

The National Health Service Act provides the frame work for the provision of preventative health services. Health Visiting services are delivered within a framework of professional accountability (NMC 2002) and are underpinned by evidence based practice, equity and accessibility of service provision and service user involvement.

The Integrated governance underpinning the service ensures that all Health Visiting practitioners abide by their professional code of conduct and maintain guidelines on record keeping [www.nmc-uk.org](http://www.nmc-uk.org).

For guidance on the management of records see Records Management Policy [www.shropscommunityhealth.nhs.uk](http://www.shropscommunityhealth.nhs.uk)

All activities undertaken as part of the care package follow best available evidence.

Our vision has been informed by the national and local agenda on children and families, Health Visitor Implementation Plan: A Call to Action 2009 and by SCHNT Vision 2008-2018.

**We aim to ensure that:**

- All parents have knowledge of how to access local services including the health visiting team.
- Babies and children are in the best possible health at birth, have good nutrition and maintain a healthy weight
- Babies and children have a positive attachment with their parents
- Babies and children live healthy lifestyles and have a positive sense of wellbeing
- Babies and children develop and achieve their potential
- Babies and children are protected from ill health, injuries and physical and mental health problems
- The impact and causes of health inequalities for babies and young children are reduced.

The overall purpose of the service is to achieve the best health and well-being outcomes for children from birth up to the age of 5 years through identifying health needs, promoting healthy lifestyles and influencing the broader context which affects health and well-being. This will include delivery of health and development reviews, health promotion and parenting guidance tailored to individual risks and protective factors.

## Health Visitor Implementation Plan – A Call to Action 2011

In presenting this framework there is recognition that this is a critical time for the regeneration of preventative early intervention services for children and a time of key investment in the establishment of a robust evidence based health visiting service. Ongoing investment till 2015 will see a significant uplift in Health Visitor numbers across our County. Implementation of a full service offer to families commenced in January 2010 and using a phased approach incorporated the 5<sup>th</sup> and final localities in November 2012. Although the growth in our workforce is far from complete the service is on target to deliver the full core offer across all localities by March 2013.

Shropshire Community Health NHS Trust has an agreed overall target for workforce growth of 28.63 WTE between 2011 and 2015. To support this growth and to provide for natural loss of staff through resignation and retirements it has been necessary to increase the number of SCPHN commissions facilitated by the organisation until 2015. To ensure that quality mentorship and effective learning environments can be maintained a new system of community practice education has been implemented.

A roving long arm mentoring model with a 1:5 Practice teacher/students ratio is currently in operation.

Each locality team is managed by a Band 7 Health Visitor Co-ordinator, supported by a Band 7 Community Practice Teacher (CPT). The CPT in each area takes overall responsibility for the educational functions within the locality team co-ordinating placements of all pre and post registration learners, monitoring the suitability of mentors and the progress of learners, and with managerial and clinical lead support ensuring that appropriate procedures are followed where there is concern that standards are not being met. Use of this model has enabled the Trust to significantly increase the training capacity for Health Visitor students. We have in addition alongside local Universities supported several Return to Practice Health Visitors with bespoke programmes of education and practice to enable their re-registration as practising health visitors.

Securing a permanent sustainable workforce through SCPHN recruitment processes has historically proved difficult in Shropshire. With a tendency for applicants from outside the County to apply and complete programmes of education but then seek employment closer to home. In 2010 we therefore implemented a Grow our own system of offering 1 year fixed term development contract to Staff Nurses interested in working within Health Visiting teams to determine their suitability for specialist practice training. These recruits tend to be local applicants who being required to commit to 2 years working within the County tend upon completion of SCPHN training to seek long term employment within our service.

A Health Visiting service Specification one for Telford and Wrekin and one for Shropshire County identifies the contractual agreement for delivery of the service and can be seen at Appendix 1 and 2 respectively. NB: A separate specification covers the work of the Family Nurse Partnership which currently only operates in the Telford localities.

## **The Solihull Approach:**

The Solihull Approach is the chosen model to support Health Visiting practice in SCHNT enabling Health Visitors to conduct more in-depth, holistic assessments of families on which therapeutic interventions can be based. The Solihull Approach is a highly practical way of working with families within a robust theoretical structure, to increase a family's capacity to deal with emotional and behavioural difficulties. This integrated psychodynamic and behavioural approach model has been successfully used by a range of professionals working with children and families since 2001 [www.solihull.nhs.uk/solihullapproach/](http://www.solihull.nhs.uk/solihullapproach/)

The model has been developed from three concepts.

- Containment
- Reciprocity
- Behaviour Management

These concepts can be useful to practitioners in three ways:

- to help parents process any emotions and anxieties that are overwhelming , which in turn both restores the parents ability to think and enables them to help the baby or child cope with his emotions and anxieties
- to help practitioners and parents see how the parents and child interact – this can then provide the basis for feedback in order to facilitate the relationship
- to help parents work with their child's behaviour

### **Training:**

All health visiting staff are trained in Solihull approach. New staff are required to attend the Solihull Approach 2 day foundation course – 'The First Five Years'.

Access to the Solihull Approach Resource Pack – 'The First Five Years'

Optional academic accreditation (honours degree level) from the University of Central England in Birmingham is available for practitioners who can demonstrate working through the resource pack in a final assessment.

## **Clinical Supervision**

All members of the Health Visiting Service within SCHNT are required to engage in Clinical Supervision.

The Trust definition of supervision based on the Department of Health (2003) definition states, ..... a formal process of professional support, self learning, development and reflection. This enables individual practitioners to develop the knowledge and competence to assume responsibility for their own practice, enhance patient care and the safety of that care provided in complex clinical situations. Clinical supervision is a means of encouraging individual learning through self assessment, analytical and reflective skills as part of the clinical governance process.

The chosen model for supervision in our service is that of Restorative supervision based on the Solihull Approach and more specifically developed by Sonya Wallbank and her team working within NHS West Midlands. 'Restorative supervision is a more formal way of delivering support to the professional. It contains elements of psychological techniques including listening, supporting and challenging the supervisee to improve their capacity to cope especially in managing difficult and stressful situations. This method of supervision has been shown to reduce stress within professionals, helping to restore their capacity to think and generalise their learning to future situations'. [www.restorativesupervision.org.uk](http://www.restorativesupervision.org.uk)

## **Information Sharing:**

The guidance for information sharing in this handbook is taken from HM Government information sharing package 2008 information Sharing Guidance for practitioners and managers and can be viewed at [www.everychildmatters.gov.uk/informationsharing](http://www.everychildmatters.gov.uk/informationsharing)

For guidance on the transfer of electronic patient identifiable data see Advisory Notice – Information Governance Interim Guidance [www.shropscommunityhealth.nhs.uk](http://www.shropscommunityhealth.nhs.uk)

Information sharing is key to delivering more effective public services that are co-ordinated around the needs of the individual. It is essential to enable early intervention and preventative work, for safeguarding and promoting welfare and for wider public protection. It is important to remember there can be significant consequences to not sharing information as there can be to sharing. Professional judgement should be used to decide whether to share or not, and what information is appropriate to share. The flowchart of key questions for information sharing will assist you and can be found at [www.everychildmatters.gov.uk/informationsharing](http://www.everychildmatters.gov.uk/informationsharing)



## **7 Golden rules for information sharing**

1. Remember that the Data Protection Act is not a barrier to sharing information
2. Be open and honest with the person or family
3. Seek advice if you are in any doubt
4. Share with consent where appropriate
5. Consider safety and well-being
6. Necessary, proportionate, relevant, accurate, timely and secure.
7. Keep a record of your decision and reasons

## **Telephone Triage - Health Visitor Advice Line**

Since 2008 the Shrewsbury central team have been operating a Health Visitor advice line to give rapid response/access to clients during normal working hours. Always staffed by a qualified Health Visitor families can get access to the advice and support they need right away.

Families getting access to quicker health visiting advice means that they don't have to make use of another NHS service – such as GP consultations or treatment and care from Emergency Departments as frequently. This helps reduce demand on other services. Through triaging of family concerns, those that need access to a face-to-face consultation with a health visitor can be booked into a clinic straight away, or, if appropriate can be booked in for a home visit or provided with advice to access other NHS services as appropriate. The scheduling of appointment-only clinics means families do not have long waiting times, unlike the old system of drop-in clinics.

Since introducing the Advice Line, the team have received an increase in the volume of enquiries, they have also seen an increase in the actual range of topics being enquired about – it seems that clients often feel more comfortable asking someone on the phone about something, rather than face-to-face. Other partner agencies that visit hard-to-reach groups are also making use of the Advice Line whilst they are with the client – helping to show that it is easy to use and encouraging good behaviour change in these groups. Following the success of this pilot the service has been extended to two more localities and will be implemented in the final

two in 2013. A texting service has also recently been added so that clients can text in, which raises an alert message at the triage desk and the Health Visitor will return the call to the mobile number displayed.

### **Health Visitor Service Model** (see Page 12)

The service is one of “Progressive Universalism” delivering levels of care based on assessed need in a variety of settings, underpinned by evidence using a skill mixed team.

Assessed levels of need can and do change for individual families across the early years period. Health Visitors will in consultation, following requests from families or referral from partner agencies, re assess the level of service being offered at any time to address identified needs/concerns.

Contacts carried out as part of the Universal core offer will enable practitioners to determine which level of service delivery is indicated for each family

The four levels of service provision as identified in The Health Child Programme framework are:

- Community
- Universal
- Universal Plus
- Universal Partnership Plus

### **Community Capacity**

It was recognised as part of the original brief in the Health Visitor Implementation Plan 2011-15: A Call to Action, that many frontline practitioners had become disempowered to undertake community public health work due to reduced workforce, increased capacity pressures, fragmentation of service and a changing landscape of the commissioning of children’s services. The Building Community Capacity (BCC) programme was developed to support practitioners in revisiting community public health practice and re-establishing skills and opportunities to make a difference to families and communities.

SCHNT has eight front line practitioners currently engaged in delivering Community projects as part of the BCC programme. In addition Health Visiting teams within Shropshire have historically delivered a County wide annual public health campaign as part of main stream health visiting services. In 2011/12 the campaign was ‘Change to Cup’ revisiting a previous successful campaign of 2004 where parents were supported to introduce early cup feeding, to prevent obesity, dental abnormalities and carries and promote early speech development. The 2011 campaign focused more on educative sessions to formal carers in children’s day care settings and health in and out patient settings where it had been identified that best practice around introduction of feeding cups was not being adhered to.

Our 2012/13 campaign is an Accident reduction programme for under 5's where using data from local accident referrals via A&E departments, the project team will structure and deliver a series of public information events targeting the specific highest causes of accidents in localities across the County.

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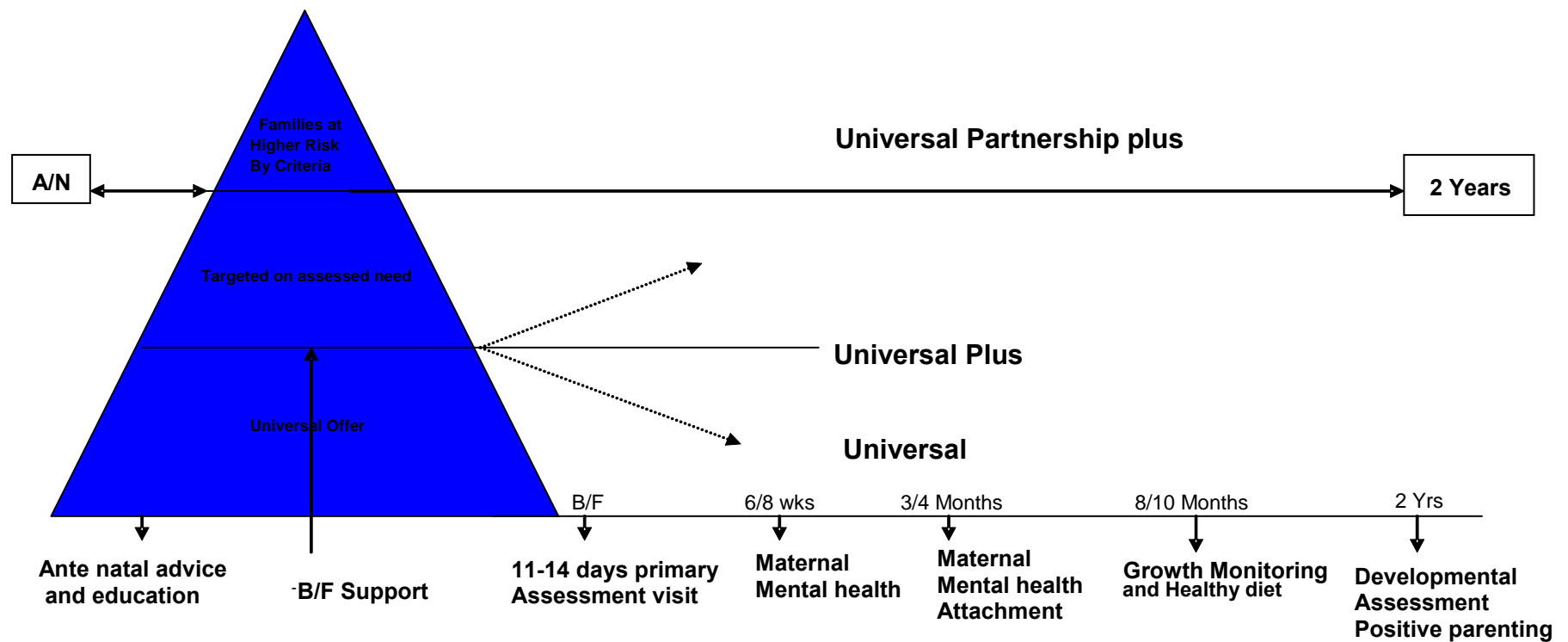
Contacts carried out as part of the Universal core offer will enable practitioners to determine which level of service delivery is indicated for each family

The following assessment tools are identified as appropriate for use within current Health Visiting practice within the context of the range of interventions identified in this manual.

### **Assessment Tools:**

- Edinburgh Postnatal Depression Score (EPDS)
- Whooley Questions – [www.sreening.nhs.uk/policydb\\_download.php](http://www.sreening.nhs.uk/policydb_download.php)
- European Early Promotion Project Postnatal interview (EPPP1)
- 3-4 Months European Early Promotion Project Postnatal interview (EPPP2)
- World Health Organisation Growth Assessment Guidelines [www.growthcharts.rcpch.ac.uk](http://www.growthcharts.rcpch.ac.uk)
- Baby Friendly Initiative Breast Feeding assessment form (BFIP/N CHECKLIST) [www.babyfriendly.org.uk](http://www.babyfriendly.org.uk)
- Framework of Assessment of Need (FAN)
- Domestic Abuse risk indicator tool (DART)
- Ages and Stages Questionnaire ASQ3 [www.agesandstages.com.uk](http://www.agesandstages.com.uk)
- Hospital Anxiety and Depression Score (HADS)

# Health Visiting Service Model



## Healthy Child Programme

# The Healthy Child Programme

## Universal Service

**Universal Offer:**

**Antenatal Assessment**

**5 core contacts and**

**Access to HV first response services Telephone Triage and Child Health Clinics**

Healthy Child Programme		
<p><b>Universal offer of an Antenatal assessment as per Pre-birth Pathway 28 – 34 weeks at home by the Health Visitor</b></p>	<p>All women and their partners will be offered a 1:1 contact with a Health Visitor at around 34 weeks gestation. This contact will serve as an introduction to the HV service and what the role entails. Every family will be provided with details of their local HV team and children’s centre.  <a href="http://www.chimat.org.uk/preview/evidence#analysis">www.chimat.org.uk/preview/evidence#analysis</a>                      Encouragement to attend Antenatal Preparation for Birth and Beyond Group <a href="http://www.dh.gov.uk/health/2011/preparation-for-birth-and-beyond-resource-pack-to-help-parenthood-groups/">www.dh.gov.uk/health/2011/preparation-for-birth-and-beyond-resource-pack-to-help-parenthood-groups/</a></p>	<p>Family well informed what services are available and how to access them.                      Family feel well supported at transition point from midwifery to Health Visiting services</p>
<p><b>Assessment tools EPPP1</b></p>	<p>Assessment of need using promotional interviewing techniques to identify difficulties/barriers that might need to be overcome and how  <i>Day C (2012) Antenatal &amp; Postnatal Promotional Guide Notes V4</i></p>	<p>Agree with parents the level of service delivery (see page 9)</p>
<p><b>Whooley questions HADS UNICEF B/F</b></p>	<p>Maternal mental health – NICE CG Antenatal and Postnatal mental health (2007) <a href="http://www.nice.org.uk">www.nice.org.uk</a></p> <p>Promotion of breast feeding – <i>Off to the best start DOH (2011)</i>                      The Baby Friendly Initiative <a href="http://www.unicef.org.uk/BabyFriendly">www.unicef.org.uk/BabyFriendly</a>                      Healthy Start <a href="http://www.healthystart.nhs.uk">www.healthystart.nhs.uk</a></p>	<p>Proceed as per PRD Pathway  <a href="http://www.dh.gov.uk/health/2012/08maternal-mental-health/">www.dh.gov.uk/health/2012/08maternal-mental-health/</a></p>
	<p>Reduce the risk of cot death DOH (2009)</p>	

	<p>Life style issues Parental alcohol, smoking and drug use –  Nice (CG620 (2008) Antenatal care  Nice (PH26) (2010) Quitting smoking in pregnancy and  childbirth  Housing and financial situation  Relationship conflict <i>Day C (2012) Antenatal &amp; Postnatal  Promotional Guide Notes V4</i></p>	<p>Proceed as per Domestic Abuse/MARAC  procedure</p>
<p><b>Initial  postnatal  assessment  visit 10-14  days at home  by the Health  Visitor</b></p> <p><b>Assessment  tools  EPP1  UNICEF B/F  Whooley  questions  Solihull  Approach</b></p>	<p>All women will be offered a home visit by a health visitor  between 11- 14 days following birth. Wherever possible the HV  will endeavour to arrange for the women’s  partner/husband/baby’s father to be present at this visit.</p> <p>The assessment will include:</p> <ul style="list-style-type: none"> <li>➤ Infant feeding/growth – infant cues  Off to the best start DOH (2011)  <a href="http://www.unicef.org.uk/BabyFriendly">www.unicef.org.uk/BabyFriendly</a></li> <li>➤ Guide to bottle feeding DOH (2011)  Healthy Start <a href="http://www.healthystart.nhs.uk">www.healthystart.nhs.uk</a></li> <li>➤ Prolonged jaundice – jaundice protocols –  <a href="http://www.childliverdisease.org.uk">www.childliverdisease.org.uk</a> <i>Nice (CG98) (2010)</i>  <i>Neonatal Jaundice</i></li> <li>➤ Maternal mental health -  <a href="http://www.dh.gov.uk/health/2012/08/maternal-mental-health">www.dh.gov.uk/health/2012/08/maternal-mental-health</a></li> <li>➤ Keeping safe (accident prevention)</li> <li>➤ Safeguarding</li> <li>➤ SIDS <a href="http://www.fsid.org.uk">www.fsid.org.uk</a></li> <li>➤ Health/development</li> <li>➤ Congenital Anomalies</li> <li>➤ Parents who smoke – CO monitoring and active  referral to H2Q <a href="http://www.smokefree.nhs.uk">www.smokefree.nhs.uk</a></li> <li>➤ Parents who are overweight</li> <li>➤ Promotion of immunisations <a href="http://www.nhs.uk/vaccinations">www.nhs.uk/vaccinations</a></li> </ul>	<p>Outputs</p> <p>Clear OAE result  Immunisation awareness  Clear understanding of HCP and the level of  service being offered  Contact numbers for local services/support –  HV triage information  Sign posting to Children’s Centre services</p> <p>Millennium Cohort Study (2010)  <a href="http://www.chimat.org.uk/preview/evidence#analysis">www.chimat.org.uk/preview/evidence#analysis</a></p>

	<ul style="list-style-type: none"> <li>➤ Assessment of mother/infant attachment</li> <li>➤ Sources of support</li> </ul>	<p>Media based self help tools</p> <p><a href="http://www.netmums.com">www.netmums.com</a></p> <p><a href="http://www.thechildren'sfoundation.co.uk">www.thechildren'sfoundation.co.uk</a></p> <p><a href="http://www.nhs.uk/parents">www.nhs.uk/parents</a></p>
<p><b>6-8 Week contact at home by the Health Visitor Assessment tools</b></p> <p><b>Whooley questions</b></p> <p><b>EPDS</b></p> <p><b>EEPP2</b></p> <p><b>UNICEF B/F assessment</b></p>	<p>All families will be offered a contact by a member of the health visiting team with the appropriate skills and competencies between 6-8 weeks to enable an assessment of maternal mental health to take place</p> <p>Infant weight and head circumference plotted – feeding guidance</p> <p>Advise about frequency of weighing as per WHO guidelines</p> <p><a href="http://www.rcph.ac.uk">www.rcph.ac.uk</a></p> <p>Healthy Start <a href="http://www.healthystart.nhs.uk">www.healthystart.nhs.uk</a></p> <p>Confirmation of Neonatal blood spot result and satisfactory hearing test <a href="http://www.newbornbloodspot.screening.nhs.uk">www.newbornbloodspot.screening.nhs.uk</a></p> <p>Age appropriate accident prevention advice <a href="http://www.capt.org.uk">www.capt.org.uk</a></p> <p>Assessment of infant/maternal attachment – reading infant cues</p> <p>Proactive sleeping advice</p> <p>Check BCG immunisation status for eligible children</p> <p>Offer next core contact and give contact date</p>	<p>Proceed as per PRD pathway</p> <p>Media based self help tools</p> <p><a href="http://www.netmums.com">www.netmums.com</a></p> <p><a href="http://www.thechildren'sfoundation.co.uk">www.thechildren'sfoundation.co.uk</a></p> <p><a href="http://www.nhs.uk/parents">www.nhs.uk/parents</a></p> <p>Sign post to Children's Centre services</p>
<p><b>3-4 Month at home by a Health Visitor Assessment tools</b></p> <p><b>EEPP2</b></p> <p><b>Whooley questions</b></p> <p><b>EPDS</b></p>	<p>All families will be offered a contact at home by a member of the health visiting team to repeat the mental health assessment and completion of European Early Promotion Project (EEPP2) interview</p> <p>Assessment of infant/maternal attachment behaviours – baby cues</p> <p>Introduction to Baby led weaning World Health Organisation</p> <p>Introducing solid foods (NHS 2011)</p> <p><a href="http://www.nhs.uk/start4life/Pages/babies-ontroducing-solid-food">www.nhs.uk/start4life/Pages/babies-ontroducing-solid-food</a></p>	<p>Proceed as per Pregnancy Related Depression (PRD) pathway</p>

	<p>Early activity guidelines/floor based play/'tummy time'  <a href="http://www.nhs.uk/start4life">www.nhs.uk/start4life</a></p> <p>Age appropriate accident prevention advice <a href="http://www.capt.org.uk">www.capt.org.uk</a></p> <p>Proactive sleeping advice  Gifting of the first Bookstart pack. <a href="http://www.bookstart.org.uk">www.bookstart.org.uk</a></p>	
<p><b>8-12 Month HV Led intervention with Band 5/ support worker input in CHC/CC/GP</b></p>	<p>All Families will be offered a contact by a member of the team with the appropriate skills and competencies. The contact will either be by invitation to a group or by appointment at a CHC/ CC/ GP surgery</p> <p>The prime objective for this contact is  Growth monitoring – prevention of obesity healthy weaning and mealtime routines <a href="http://www.nhs.uk/Start4life">www.nhs.uk/Start4life</a></p> <p>Age appropriate accident prevention advice <a href="http://www.capt.org.uk">www.capt.org.uk</a></p> <p>Proactive sleeping advice  Promotion of developmental interactive activities reading, music, singing  Check confirmation of newborn blood spot screening on all transfers into County up to 12 months of age</p>	<p>Proceed as per overweight children care pathway <a href="http://www.henry.org.uk">www.henry.org.uk</a></p> <p><a href="http://www.talkformeaning.co.uk/everychild">www.talkformeaning.co.uk/everychild</a></p> <p><a href="http://www.newbornbloodspot.screening.nhs.uk">www.newbornbloodspot.screening.nhs.uk</a>  Liaise with child health department</p>



<p><b>24 Month contact HV Led with /support worker input in CHC/CC/GP</b></p> <p><b>Ages and Stages (ASQ 3) developmental questionnaire</b></p>	<p>All children aged 24 months will be offered by letter a health review:  <i>Healthy Child Programme The Two year review DOH (2009)</i>          The prime objectives for this contact are          Detection of development delays          Promotion of positive parenting          Growth monitoring – prevention of obesity <a href="http://www.nhs.uk/start4life">www.nhs.uk/start4life</a>  <i>Nice Obesity (CG043) (2006)</i>  <i>Start active stay active (DOH 2011) <a href="http://www.dh.gov.uk">www.dh.gov.uk</a></i></p> <p>Age appropriate accident prevention advice <a href="http://www.capt.org.uk">www.capt.org.uk</a></p> <p>Immunisation status</p> <p>Professional or parental concerns identified at this review indicates progression to full developmental review using ASQ 3 / SE and referral on as indicated <a href="http://www.agesandstages.com">www.agesandstages.com</a></p>	<p>Proceed as per overweight children care pathway <a href="http://www.henry.org.uk">www.henry.org.uk</a></p> <p>Proactive assessment of parenting capacity and referral on to !! or group intervention as appropriate  <a href="http://www.publications.nice.org.uk/reducing-differences-in-the-uptake-of-immunisations-ph21">www.publications.nice.org.uk/reducing-differences-in-the-uptake-of-immunisations-ph21</a></p>
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<b>Clinics and Groups</b>	
<b>Descriptor clinic or Group</b>	<b>Descriptor of Clinic or Group</b>
<p><b>Child Health Clinic (CHCs): By appointment</b> CHCs provide opportunities to:</p> <ul style="list-style-type: none"> <li>• Review a child's growth and development in line with WHO Guidelines</li> <li>• Facilitate early identification of faltering weight gain, obesity and development delay</li> <li>• Offer opportunistically appropriate health promotion information and education for example on weaning</li> <li>• To provide a venue for parents to access information and possible referral to other health and social services.</li> </ul>	<p><b>Specialist Clinics/Groups</b></p> <p><b>Breast Feeding Support</b> Provision of professional and peer support to encourage the initiation and maintenance of exclusive breast feeding in line with UNICEF Baby Friendly Initiative <a href="http://www.babyfriendly.org.uk">www.babyfriendly.org.uk</a></p> <p><b>Sleep Clinics</b> Initially piloted in the Shrewsbury locality and based on the Millpond Sleep Training Programme these programmes are now being implemented across the other localities. The pathway provides for core promotion of good sleep routines at each of the core contacts. A rapid response via telephone triage services for parents of children with acute sleep issues and referral onto to be seen in specialist sleep clinics for children with more problematic sleep behaviours.</p> <p><b>Nutrition Service</b> Delivered in a variety of formats from formal invitation to weaning groups, attendance at identified clinics for specific eating problems, nutritional advice, obesity prevention/management (Utilising the HENRY approach) <a href="http://www.henry.org.uk">www.henry.org.uk</a></p>
<p><b>Transition into motherhood Group (TRIMS)</b> For women with mild to moderate pregnancy related depression (PRD) who following assessment and delivery of up to 8 supportive listening visits require ongoing support. Referral to a TRIMS group in each locality is followed by an assessment by the group leader to determine the client's suitability for the group and the need for referral on to other specialist mental health services and/or GP</p>	<p><b>Parenting Programmes</b> Based on Triple P model a range of multi level interventions for parenting support either in groups or 1:1 or where there are pre-existing adult behavioural or relationship problems <a href="http://www.triplep.net">www.triplep.net</a></p> <p><b>Freedom Programme</b> A structured programme of 10 sessions for women identified as at risk of or subject to domestic abuse.</p>
<p><b>Parent Education Programmes:</b> Preparation for Birth and Beyond Utilising this Department of Health A/N teaching pack and based on the Solihull Approach Antenatal Training Programme piloting of these Ante natal education programmes is set to commence in March 2014.</p>	

## **Health Visiting Care Packages**

Care packages initiated following a contact and assessment by a member of the health visiting team. The development of care packages emphasise the commitment to evidence based practice and an outcome based approach to service delivery with identified outcome and performance indicators. The value of explicit outcomes enables continual review and improvement of the service and demonstrates the value and effectiveness of health visiting.

The following identified packages of care are available at both Universal Plus and Partnership Plus levels of delivery dependent upon the specific requirements of the family

### **1: Accident Prevention**

#### **Descriptor of Contact:**

- To Promote child safety following identified need following an accident or incident
- To provide information, advice and future intervention strategies to families following a child's attendance at A&E

#### **Evidence /Rationale:**

- The health visitor and school nurse development programme health visitor practice development resource pack DH2001 [www.dh.gov.uk/en/publicationsandstatistics/Publications?publicationsPolicyAndGuidance/DH\\_4083498](http://www.dh.gov.uk/en/publicationsandstatistics/Publications?publicationsPolicyAndGuidance/DH_4083498)
- Preventing Accidental Injury-Priorities for Action Report to the Chief Medical Officer from the Accidental Injury Task Force DH 2002
- Prevention and reduction of accidental injury in children and older people Evidence briefing June 2003 Health Development Agency [www.nice.org.uk/page.aspx?o=502597](http://www.nice.org.uk/page.aspx?o=502597)  
Detecting Child Maltreatment guidance 2009 National Institute for Health and Clinical Excellence (NICE)  
Improvement review into Services for Children in Hospital. Commission for Healthcare Audit and Inspection. February 2007

#### **Activities:**

- Assess type of activity needed according to information on A&E notification sheets or verbal information from A&E Liaison Nurse
- Enter the attendance on significant events chronology
- Telephone contact with family – within 5 working days

- Home visit to family – safety assessment as indicated
- Provide relevant health information and advice, including referral to other agencies for example Children’s Centres
- Listing support
- Evaluation of intervention and reassessment

**Staff Group involved in delivering package:**

Main elements of this care package may be delegated to Band 4 and 5 staff recurring attendances or where there are safeguarding concerns Health Visitor input is indicated

**Outcome Indicator:**

- Reduction in A&E attendances for children 0-5 years

## 2: Antenatal Contacts

### Descriptor of contact:

Targeted pre birth assessment visit to women under 19 years of age referred by their GP, Midwife, TIMS or Stay Safe team or over 19 years of age and considered vulnerable by the following criteria:

- Domestic Abuse
- Homelessness
- Previous Safeguarding Issues
- Care Leavers
- Previous mental health issues or depression/ high levels of anxiety detected in the antenatal period
- Learning disabilities
- Substance misuse

### Evidence/Rationale:

- Working together to safeguard children (HM GOV 2006) [www.everychildmatters.gov.uk/socialcare/safeguarding](http://www.everychildmatters.gov.uk/socialcare/safeguarding)
- NSF for Children, Young People and Maternity Services  
[www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/ChildreServices/ChildreServicesinformation/index.htm](http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/ChildreServices/ChildreServicesinformation/index.htm)
- Reaching Out: An action plan on Social Exclusion 2006  
[www.cabinetoffice.gov.uk/social\\_exclusion\\_task\\_force/publications/reaching\\_out/](http://www.cabinetoffice.gov.uk/social_exclusion_task_force/publications/reaching_out/)
- Healthy Child Programme Pregnancy and the first five years of life [www.dh.gov.uk/publications](http://www.dh.gov.uk/publications)

### Activities:

- Pre-birth assessment in the home
- Determine level of service depending on assessment ie: targeted antenatal and/or postnatal care or referral for universal offer.
- Referral on to other specialist services, CAMHS, Substance misuse, GP, MARAC. referral to Children's Centres for social support

**Staff Group:**

The main elements of this intervention will be delivered by Band 6 Health Visitors with Support worker involvement as appropriate.

**Outcome Indicator:**

Improved access to co-ordinated programmes of care for the most vulnerable with early pre-birth identification and intervention.

### 3: Breastfeeding

#### **Descriptor of contact:**

To provide information, advice and intervention strategies to promote, protect and support breastfeeding in line with the UNICEF Baby Friendly Seven Point Community Plan [www.babyfriendly.org.uk](http://www.babyfriendly.org.uk)

#### **Evidence/Rationale:**

- Antenatal care: Routine care for the healthy pregnant woman [www.nice.org.uk/guidance/CG6](http://www.nice.org.uk/guidance/CG6)
- Postnatal care: Routine postnatal care for woman and their babies NICE 2006 [www.nice.org.uk/guidance/CG37](http://www.nice.org.uk/guidance/CG37)
- NSF for children, young people and maternity services standard 1  
[www.dh.gov/en/Policyandguidance/Healthandsocialcaretopics/ChildrenServices/Childrenservicesinformation/index.htm](http://www.dh.gov/en/Policyandguidance/Healthandsocialcaretopics/ChildrenServices/Childrenservicesinformation/index.htm)
- National Standards, Local Action: Health and Social Care Standards and planning Framework 2005/06-2007-08  
[www.dh.gov.uk/en/Publicationsandstatistics/PublicationsPolicyAndGuidance/DH\\_4086057](http://www.dh.gov.uk/en/Publicationsandstatistics/PublicationsPolicyAndGuidance/DH_4086057)
- Choosing Health: Making healthy choices easier 2004  
[www.dh.gov.uk/en/Publicationsandstatistics/PublicationsPolicyAndGuidance/DH\\_4094550](http://www.dh.gov.uk/en/Publicationsandstatistics/PublicationsPolicyAndGuidance/DH_4094550)
- UNICEF baby friendly initiative [www.babyfriendly.org.uk](http://www.babyfriendly.org.uk)
- Community Infant feeding policy [www.shropscommunityhealth.nhs.uk](http://www.shropscommunityhealth.nhs.uk)

#### **Activities:**

- To assess attachment and positioning, identifying any concerns and undertake specific interventions based on assessment
- To provide advice and/or information for example on expressing, safe storage of breast milk
- To sign post and/or refer on to appropriate services within the team or external, for example Baby Café, Voluntary groups
- To reassess following any specific intervention

#### **Staff group involved in delivering package:**

Some elements of this care package may be delegated to Band 4 and 5 staff by Health Visitor (Band 6 and 7)

#### **Outcome Indicator**

- All parents are supported to maintain breastfeeding for their desired duration

#### **Training**

In house training for all staff - 3 levels of UNICEF compatible training delivered by B/F Leads

## 4: CAF – Common Assessment Framework

### **Descriptor of contact:**

A multi-agency assessment process using a nationally standardised tool, carried out by a CAF trained practitioner, of the child's additional needs based on the five outcomes of Every Child Matters, aimed at providing early intervention and partnership working. CAF completed when identified needs using a solution focused approach are met by the family with support of the appropriate agencies

### **Evidence/Rational**

- Children act 2004 [www.opsi.gov.uk/acts2004/20040031](http://www.opsi.gov.uk/acts2004/20040031)
- Every Child Matters Change for Children [www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk)
- Every Child Matters The Children and Young People's Plan for Shropshire
- DfES. Working together to safeguard children: A guide to interagency working to safeguard and promote the welfare of children. Department of Education and Skills 2006

### **Activities:**

- Discussion with parents to gain consent for CAF process following identification of additional needs impacting on the child's ability to reach its full potential.
- Check with CAF database that no previous or current CAF exists
- Complete assessment with the family
- Enter CAF on central database using available technology and convene a multi-agency meeting
- Nominate a Lead Professional and agree an action plan and set review date
- Implement health visiting interventions
- Reconvene and assess progress against agreed action plan

### **Staff Group Involved in delivering package**

Some elements of this care package may be delegated to Band 4 and 5 staff by the Health visitor (Band 6 or 7) completion of the CAF is always completed by the Health Visitor

### **Outcome Indicator**

- Children under 5 years old achieve their full potential as identified in the Children Act 2004

### **Training**

Contact point training/ CAF training/refresher course



## 5. Care of the Next Infant (CONI)

### **Descriptor of contact:**

To provide a defined episode of intensive support to families affected by cot death upon the birth of a subsequent child  
Consultant only referral following Adverse Life Threatening Event (ALTE)  
Co-ordination of care to babies on the CONI programme is part of the remit of the Paediatric Liaison Health Visitor

### **Evidence/Rational:**

- Waite A McKenzie A et al 1988 Report on 5000 babies using the CONI programme SIDS [www.sids.org.uk](http://www.sids.org.uk)
- CONI co-ordinator Manual 2002

### **Activities:**

- CONI facilitator referral made following initial assessment
- CONI joint home visit with CONI facilitator and Named Health Visitor, including resuscitation demonstration and instruction
- Ordering monitoring equipment
- Weekly contact with family (symptom monitoring, weighing, listening), initially in the home. With the time frame and venue negotiated thereafter with the client
- Completion of appropriate documentation
- Liaison with GP, Paediatrician and CONI National Office

### **Staff Group involved in delivering package:**

Some elements of this care package will be delegated to a Health Visiting Team member by the CONI facilitator

### **Outcome Indicator:**

- All families where a previous Sudden Infant Death has occurred are offered the CONI Programme by a CONI facilitator

### **Training**

Attendance at CONI update sessions delivered in house by CONI Co-ordinators 3 yearly.

## 6: Child Health or Development Concern

### Descriptor of Contact

To provide information, advice and intervention strategies to families where there exists an identified child health or development concern, for example a child with cerebral palsy, faltering growth

### Evidence/Rational

- Every Child Matters The Children and Young People's Plan for Shropshire
- Postnatal care: Routine postnatal care of woman and their babies NICE 2006 [www.nice.org.uk/guidene/CG37](http://www.nice.org.uk/guidene/CG37)
- NSF for Children. Young People and Maternity Services Standard1  
[www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/ChildrenServices/Childreasureservicesinformation/index.htm](http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/ChildrenServices/Childreasureservicesinformation/index.htm)
- Guidelines for the Identification and Management of Faltering Growth and Failure to Thrive for All Children – based on WHO growth guidelines

### Activities

- Assessment of the child's health or development issue using Ages and Stages Questionnaire [www.agesandstages.com](http://www.agesandstages.com)
- Diagnosis of child's health problem or identification of development concern, for example eczema or speech and language concern
- Prescribe within Nurses Pharmaceutical Formulary
- To sign post and/or refer on to appropriate services, for example , GP, Child Development Centre (CDC)
- Listen, support and reassure parents and provide further information as relevant
- Evaluation of intervention and reassessment

### Staff Group involved in delivering package:

Named health visitor (Band 6 or 7) for formal assessment some aspects of care may then be delegated to other appropriately trained members of the team as part of a targeted intervention.

### Outcome Indicator

- Early intervention of health and development issues and prompt referral services if required

### Training

WHO Growth Chart training  
Prescribing pathways  
CDC referral pathway

## 7: Domestic Abuse Support

### **Descriptor of contact:**

To provide information, advice and intervention strategies to clients, enabling them to take appropriate measures in domestic abuse situations

### **Evidence/Rational:**

- Responding to domestic abuse: a handbook for health professionals DH2005
- National Service Framework for Children, Young people and Maternity Services Department of Health 2004: <http://www.dh.gov.uk/Policy>
- Shropshire Domestic Abuse strategy, flow chart and operational procedures.
- Protocol for documentation of Domestic Abuse incidents in client records

### **Activities:**

- Assessment of risk to clients experiencing domestic abuse using Domestic Abuse Risk indicator tool
- Assessment of risk to child in the household using Common assessment framework (CAF)
- Support client in current situation, including signposting and referral to support agencies
- To facilitate the development of the client's safety plan
- Discussion with client and referral when appropriate to the Multi Agency Risk Assessment Committee (MARAC)

### **Staff Group involved in delivering package:**

This care package is to be delivered by the Health Visitor (Band 6 or 7)

### **Outcome Indicator:**

- All clients feel enabled to take appropriate measures where domestic abuse is an identified issue

### **Training**

DA awareness training levels 1 and 2

## 8: Family and Social Support

### **Descriptor of contact:**

To support family members where difficulties have been identified for example recent bereavement, family relationship difficulties, problems with housing, debt

### **Evidence/Rational:**

- Choosing Health [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4094550](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550)
- NSF for Mental Health [www.dh.gov.uk/en/Publicationsandstatistics/PublicationsPolicyAndGuidance/DH\\_4009598](http://www.dh.gov.uk/en/Publicationsandstatistics/PublicationsPolicyAndGuidance/DH_4009598)
- NSF for Children, Young People and Maternity Services  
[www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/ChildreServices/Childrenservicesinformation/index.htm](http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/ChildreServices/Childrenservicesinformation/index.htm)
- Every Child Matters NICE Guidance for Depression and Depression in children and young people
- Reaching Out : An action Plan on Social Exclusion 2006  
[www.cabinetoffice.gov.uk/social\\_exclusion\\_task\\_force/publications/reaching\\_out/](http://www.cabinetoffice.gov.uk/social_exclusion_task_force/publications/reaching_out/)

### **Activities:**

- To provide or signpost information on appropriate support services
- To refer on to identified services if relevant
- To offer up to four 1:1 non-directional time limited visits
- Evaluation of intervention and reassessment

### **Staff Group involved in delivering package:**

Some elements of this care package may be delegated to Band 4 and 5 staff by the Health Visitor (Band 6 or 7)

### **Outcome Indicator:**

- Where difficulties have been identified families feel supported and enabled to take appropriate action

## 9: Infant Nutrition

### Descriptor of contact:

To provide information, advice and intervention strategies to parents ensuring children under 5 years old maintain adequate nutrition

### Evidence/Rational:

- Support the exclusive continuation of breast feeding up till 6 months of age [www.unicef.org.uk/BabyFriendly](http://www.unicef.org.uk/BabyFriendly)
- Provide access to advice and information to fathers to encourage support for breast feeding
- Promote Healthy Start vitamins and Vitamin D according to UK Health Department advice
- [www.healthystart.nhs.uk](http://www.healthystart.nhs.uk)
- Guide to bottle feeding DOH (2011) to ensure that carers adopt safe formula feeding practice
- Postnatal care: Routine postnatal care of woman and their babies NICE 2006 [www.nice.org.uk/guidance/CG37](http://www.nice.org.uk/guidance/CG37)
- Change4life [www.nhs.uk/Change4life](http://www.nhs.uk/Change4life)

### Activities:

- To assess nutritional intake, including feeding technique any concerns and undertake specific interventions based on assessment
- To provide advice and/or information for example on Healthy Start, safe storage of milks and foods
- To sign post and/or refer onto appropriate services within the team or external for example child health clinic, breast feeding support services, GP
- To reassess following any specific intervention

### Staff Group involved in delivering package:

Some Elements of this care package may be delegated to Band 4 & 5 staff by the Health visitor (Band 6 or 7)

### Outcome Indicators:

- All Children under 5 years old reach their optimum health
- All Children where significant weight gain or loss are identified are referred for further assessment from specialist services-  
To be determined

### Training

Nutritional update for all staff 3 yearly to be determined

## 10: Looked After Children (LAC)

'Looked after children' are children looked after by a local authority including those subject to care orders under section 31 of the Children Act and those looked after on a voluntary basis through agreement with their parents under section 20 of the Children Act 1989. The Designate Nurse, LAC is to assist the PCT in fulfilling their responsibility as commissioner of services to improve the health of LAC.

The statutory requirement is for LAC to have a review health assessment every 6 months for children under 5 and every year for those over 5. In Shropshire these review assessment for children under 5 are completed by the named Health Visitor using the Ages and Stages Questionnaire (ASQ3) assessment tool. Children registered with a Shropshire GP but accommodated out of county the assessments are completed by the Designate Nurse LAC and copies sent to the Health Visitor and GP.

### Descriptor of Contact

A high proportion of LAC who are under five have been subject to a plan. A Health Visitor will have therefore been involved with this process and is informed; or may be part of the decision making process when a child becomes 'looked after'. At this point care planning/management of the child transfers to the LAC case managing and planning processes and in most cases the child is no longer subject to a child protection plan. Occasionally a child is both looked after and subject to a child protection plan, in these circumstances 'safeguarding processes take precedence.

### Evidence/ Rationale

Children's Act 1989 [www.doh.gov.uk](http://www.doh.gov.uk)

Statutory Guidance on Promoting the Health and Wellbeing of looked after children DCSF DH2009 [www.dcsf.gov.uk](http://www.dcsf.gov.uk)

### Activities

- 6 monthly health assessment reviews. Responsibility for the co-ordination of the health review assessments remains with the LAC nurses. When a review is required the relevant documentation will be sent through to the named HV who then conducts the review and returns the assessment and any actions to the LAC nurse,
- The level of Health Visiting service is determined via the child protection plan/care plan.
- Attendance at LAC reviews/core groups and case conferences sits with the HV currently involved with the child.

### Staff group involved in delivering this care package

Band 6 Health Visitor. Some specific elements of this care package may be delegated to Band 4 and 5 staff. Formal Health reviews are always conducted by Band 6 or 7 Health Visitors

## 11: Maternal Mood

### **Descriptor of contact:**

To provide information, advice and intervention strategies to woman with identified mood changes following initial maternal mood assessment after child birth

### **Evidence/Rational:**

- NSF for Mental Health [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4009598](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009598)
- Antenatal and Postnatal mental health: Clinical management and service guidance NICE 2007 <http://guidance.nice.org.uk/CG45>
- Postnatal care: Routine postnatal care of woman and their babies NICE 2006 [www.nice.org.uk/guidance /CG37](http://www.nice.org.uk/guidance/CG37)
- Shropshire PRD Pathway

### **Activities:**

- Use of Whooley questions and if indicated EPDS
- Completion of maternal mood assessment Edinburgh Postnatal Depression Score (EPDS) based on NICE Guidance
- Programme of 4 - 8 listening visits and review of further action
- Delivery of other support programmes for example PRD support groups as per Shropshire Community Health NHS Trust pathway for PRD see Appendix
- Signposting to other services and agencies

### **Staff Group involved in delivering package:**

Delivered by Health visitor (Band 6 or 7)

### **Outcome indicator:**

- Women with identified postnatal mood changes will be enabled to seek help and support, developing personal interventions strategies

### **Training**

In house refresher training every 3 years.  
Introduction to CBT techniques

# Guidelines for the Health Visiting referral pathway for women identified with Pregnancy Related Depression

The Health Visiting care pathway for women experiencing Post Natal Depression has been developed in conjunction with the Shrewsbury and Telford Hospitals Maternity Guidelines for Antenatal and Postnatal Mental Health (2008) and has taken the research & evidence used as a basis for that document to produce this pathway.

## **Postnatal Depression**

Postnatal depression is a persistent and pervasive low mood of varying severity and duration.

It is experienced by 10-15% of women post delivery and symptoms include: clinical features similar to depression, loss of pleasure or interest, low mood, loss of energy, tiredness, psychomotor agitation or retardation, poor concentration, poor appetite and may have suicidal thoughts.

## **Detection**

At a woman's first contact with the Health Visiting service in the antenatal and postnatal periods the health visitor should ask questions about:

- past or present severe mental illness including psychosis in the postnatal period and severe depression
- previous treatment by a psychiatrist/specialist mental health team including inpatient care
- family history of perinatal mental illness.

Postnatally at 4-8 weeks and/or 3-4 months health visitors should ask two questions to identify possible depression.

1. During the last month, have you been bothered by feeling down, depressed or hopeless?
  2. During the last month, have you been bothered by having little interest or pleasure in doing things?
- A third question should be considered if the woman answers yes to either of the initial questions.
3. Is this something you feel you need or want help with?



As part of subsequent assessment or when monitoring the effectiveness of outcomes use of the Edinburgh Postnatal depression Scale (EPDS) should be considered in combination with clinical judgement. ( EPDS Score 13+ indicates further intervention & support should be offered)

### **Referral and Initial care**

Having identified a possible postnatal depression consider the following options following discussion with the woman:

- Referral to the GP when there are significant concerns or when the management plan indicates an increasingly severe presentation of the illness.
- Offer supportive listening visits for up to 8 sessions
- Adopt a multi- professional approach to support the woman. This may include Community Mental Health Team (CMHT), Children's Centre Services or other community voluntary support e.g. Homestart.
- Offer a place on the local Transition into Motherhood (TiM) support group

### **Transition into Motherhood Support Group**

The TiM support group provides an evidence based support model for women experiencing postnatal depression based on Milgrom's model and is facilitated by a Health Visitor and wherever possible a member of the CMHT to provide mental health advice and support. The Health Visitor group facilitators have been trained to utilize simple Cognitive Behaviour Therapy interventions. The group lasts for 8-10 sessions and provides social as well as therapeutic support for group members. It may be used in conjunction with antidepressant or other medical treatment.

Referrals for the Transition into Motherhood group are accepted from

- the woman herself
- Health Visitor
- Midwife
- GP
- CMHT
- Children's Centre support worker.

On receipt of a referral the project health visitor will communicate with the woman's own Health Visitor to ascertain if listening visits have been offered. Where a group is due to commence this may be preferable to commencing listening visits. Individuals may refuse the offer of listening visits and prefer to attend a group.

Alternatively if listening visits have not commenced these should be offered by the Health Visitor for 4-8 sessions. A review using the two questions should be carried out after session 4 and 8 to assess current outcomes. Referral to GP and/or CMHT may be necessary at any stage if moderate/severe signs of illness indicate. A successful outcome at this stage will indicate no further interventions are needed and discharge possible. The TiM group will also be offered, if indicated, where listening visits are unsuccessful.

Women considered suitable for the Transition into Motherhood group will be offered a home visit by the group facilitator, ideally in conjunction with the referrer. Clinical assessment using clinical interview, the two questions and EPDS will be completed and documented by the health visitor .

Where the group is considered **inappropriate** the woman will be directed back to the referrer, her own Health Visitor, GP and/or third tier services as necessary.

Where the group is considered **appropriate** the project Health Visitor will offer as deemed most appropriate:

- a place on the TiM group

- one to one interim support

Information about the group and what is offered will be provided.

Telephone contact prior to commencing the group will confirm that a place is still required and is appropriate.

The Transition into Motherhood group comprises a 10 week programme, which may be reduced to 8 weeks depending on group numbers and dimensions. Individual progress will be assessed at weeks 5 and 10 using the EPDS. Group members will be given written material and handouts to support the programme. Missed sessions will result in contact by the facilitator. Further missed sessions will necessitate referral back to the referrer/GP/Health Visitor.

On completion of the TiM group the woman will be offered ongoing community support from Health Visitors, Children's Centres etc and may be signposted to other services such as AXIS, Women's Aid, Homestart etc as required. The referrer will be notified about an individual's progress and any outcomes.

Managers and senior professionals responsible for the project workers, Health Visitors, Midwives and Children's Centre workers should ensure that staff receive training and supervision, including appropriate knowledge of postnatal depression and CBT, assessment and referral routes to enable them to follow the care pathway.

## 12: Parenting Support

### **Descriptor of contact:**

To provide information, advice and intervention strategies to help parents maximise their parenting abilities

### **Evidence/Rational:**

- Every Child Matters: The children and young people's plan for Shropshire [www.shropscommunityhealth.nhs.uk](http://www.shropscommunityhealth.nhs.uk)
- NSF for Children, Young People and Maternity Services
- [www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/ChildreServices/Childrenservicesinformation/index.htm](http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/ChildreServices/Childrenservicesinformation/index.htm)
- Reaching Out: An action plan on Social Exclusion 2006  
[www.cabinetoffice.gov.uk/social-exclusion-task-force/publications/reaching-out/](http://www.cabinetoffice.gov.uk/social-exclusion-task-force/publications/reaching-out/)

### **Activities:**

- To undertake assessment of parenting abilities
- To provide advice and/or information to families on a range of parenting issues for example, temper tantrums eating problems etc.
- To sign post and/or refer on to appropriate services within the team or external for example parenting group, Children's Centre Support Worker
- To offer up to four 1:1 time limited contacts on specific parenting difficulties.
- To reassess following any specific intervention

### **Staff Group involved in delivering package:**

Some elements of this care package may be delegated to Band 4 and 5 staff by the Health Visitor (Band 6 or 7)

### **Outcome Indicator:**

- Parents will have increased confidence in dealing with parenting difficulties following health visiting support
- Each health visiting team will have a named practitioner to act as family support champion (parenting lead)

### **Training**

Triple P Positive Parenting Programme offering a range of training levels and specialities

## 13: Prescribing

### **Descriptor of Contact:**

- To assess, diagnose and prescribe products identified in the Nurses Pharmaceutical Formulary
- To observe identified prescribing pathways :
  - Prescribing of emollients
  - Prescribing in the treatment of oral thrush in infants and treatment of nipple thrush in B/F mothers
  - More pathways to be developed

### **Evidence/Rational:**

- Shropshire County Non Medical prescribing policy (2008) [www.shropscommunityhealth.nhs.uk](http://www.shropscommunityhealth.nhs.uk)
- Health Visitor Prescribing Pathways (2009) [www.shropscommunityhealth.nhs.uk](http://www.shropscommunityhealth.nhs.uk)

### **Activities:**

- Ordering of prescription pads from identified locality appointed person
- Practitioners should only hold 1 pad at a time
- Pads should be stored in a locked facility when not in use transported in the car boot when travelling but not left in vehicles overnight
- All items prescribed should be notified to the clients GP on the approved form

### **Staff group involved in delivering this care package**

Band 6 and 7 approved nurse prescribers

Staff are required to show evidence of their continued professional development in relation to prescribing at their annual review

### **Outcome indicator:**

Improved access to appropriate medications without access to GP services

## 14: Safe Guarding

### Descriptor of contact:

- To provide assessment, support and interventions to families with children within the Safeguarding framework
- To Share information within a multi-agency framework

### Evidence/Rational:

- Framework for the Assessment of Children in Need and Their Families (DOH 2000)
- Working Together to Safeguard Children (HM GOV.2006) [www.everychildmatters.gov.uk/socialcare/safeguarding](http://www.everychildmatters.gov.uk/socialcare/safeguarding)
- Every Child Matters: Change for Children Programme (DfES 2004) [www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk)
- National Service Framework for children, young people and maternity service Standard 5 (DOH 2004) [www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/ChildreServices/ChildreServicesinformation/index.htm](http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/ChildreServices/ChildreServicesinformation/index.htm)
- What to do if you're worried a child is being abused-Leaflet (DOH 2006)  
Hyperlink from SCHNT website to all safeguarding policies and procedures [www.shropscommunityhealth.nhs.uk](http://www.shropscommunityhealth.nhs.uk)  
The Protection of Children in England, Laming 2009  
Detecting Child Maltreatment Guidance 2009 National Institute for Health and Clinical Excellence (NICE)  
The SAFER tool was developed from another SBAR which originated from the US Navy and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA. Department of Health 2010.

### Activities:

- To undertake an in-depth assessment of risk to the child based on the Framework of Assessment of Need, including completion of the significant event chronology
- Use of the failed contact protocol for children where there are concerns
- To make a referral to social services
- To undertake a pre-conference or review contact where considered appropriate ( giving due consideration to staff safety)
- Implementation of health visiting part of agreed Child Protection Plan
- Child Protection liaison with other agencies
- Attendance at Child Protection case conference, reviews or core groups
- Report writing

### Staff Group involved in delivering package:

Delivered by Health Visitor (Band 6 or 7), some specific elements of care packages may be delegated to Band 4 or 5 staff

**Outcome Indicator:**

- To identify and address need at all levels (vulnerable, complex, acute) to ensure ongoing safety and protection of children and young people

**Training**

Annual update at Level 2 on one of the following topics: Information sharing, Child Death Over panels/ serious case reviews, record keeping **Or** Any of the Safeguarding Board approved study days on topical issues. ie: Safeguarding and the Internet

**SAFER communication guidelines**

These are guidelines for communications between health and local authority children's social care teams using the SAFER process when a child may be suffering or is likely to suffer significant harm.

All verbal communications can be carried out using the SAFER process.

The use of SAFER will ensure a uniform approach to communicating the level of risk to a child/children.

**Section A: Prior to referral, ask yourself these questions:**

- Have I assessed the child and documented my findings?
- Have I documented existing risk factors or issues?
- Is there any evidence of substance abuse, domestic abuse, mental illness, a chaotic lifestyle or missed appointments?
- Has a Common Assessment Framework (CAF) been followed?
- Has the situation been discussed with the child's parent(s)?
- Who else is in the household?
- Has the situation been discussed with the child's GP?
- Have I updated myself on the child's recent health history?
- Do I have knowledge of any siblings? May they be at risk of harm too?
- Is there a social worker already allocated? Have I discussed this referral with that social worker?
- Has the situation been discussed with a named nurse/senior colleague for safeguarding?

Prior to making a call, have the following available:

- the child's health record
- a list of recent events
- the evidence triggering the call.

## **Section B: Aide-memoire to support efficient and appropriate telephone referrals of children who may be suffering, or are likely to suffer, significant harm**

### **S Situation**

- This is the health visitor (give name) for (give your area). I am calling about ... (child's name(s) and address).
- I am calling because I believe this child is at risk of significant harm.
- The parents are/aren't aware of the referral.

### **A Assessment and actions**

- I have assessed the child personally (and done a CAF) and the specific concerns are ... (provide specific factual evidence, ensuring the points in Section A are covered).
- Or: I fear for the child's safety because ... (provide specific facts – what you have seen, heard and/or been told and when you last saw the child and parents).
- A CAF has/hasn't been followed.
- This is a change since I last saw him/her (give no. of) days/weeks/months ago.
- The child is now ... (describe current condition and whereabouts).
- I have not been able to assess the child but I am concerned because ... .
- I have ... (actions taken to make the child safe).

### **F Family factors**

- Specific family factors making this child at risk of significant harm are ... (base on the Assessment of Need Framework and cover specific points in Section A).
- Additional factors creating vulnerability are ... .
- Although not enough to make this child safe now, the strengths in the family situation are ... .

### **E Expected response**

- In line with *Working together to safeguard children*, NICE guidance and Section 17 and/or Section 47 of the Children



Act I recommend that a specialist social care assessment is undertaken (urgently?).

- Other recommendations.
- Ask: Do you need me to do anything now?

### **R Referral and recording**

- I will follow up with a written referral and would appreciate it if you would get back to me as soon as you have decided your course of action.
- Exchange names and contact details with the person taking the referral.
- Now refer in writing as per local procedures and record details and time and outcomes of telephone referral.  
(NB: The intention is to make reasons for referral factual and informative to assist the duty team in taking appropriate action.)

**If a child is at risk of immediate, significant harm, the priority remains to move them to a place of safety. The police have the powers to remove a child to a place of safety without parental consent.**

## 15. Transfer into County

### **Descriptor of Contact**

To provide a contact to every child that transfers into Shropshire County in order that an assessment of need can be carried out.  
To ensure that children already subject to safeguarding procedures are identified and managed accordingly  
To ensure that children with existing care plans are identified and their care continued appropriately  
To inform new parents of the range and nature of services offered in Shropshire and how these can be accessed

### **Evidence/Rational:**

CP guidance April 2009

Neonatal screening guidance

Framework for the Assessment of Children in need and their families (DOH 2000)

Working together to safeguard children (HM GOV 2006) [www.everychildmatters.gov.uk/socialcare/safeguarding](http://www.everychildmatters.gov.uk/socialcare/safeguarding)

Routine Postnatal Care of Women and their Babies NICE 2006

### **Activities:**

- Make contact with the family to confirm child is resident in the area and verify the information that they have been given relating to the child. This contact may be via letter, phone call or invitation to a clinic – within one month following notification of transfer.
- Obtain details of where the child and family originated from and request records via Child Health within the same working day wherever possible.
- Upon receipt of record determine whether the family requires a face to face contact
- Upon receipt of confidential files analyse the information ensure chronological filing and date and sign the files to indicate they have been received and read. A 'significant event chronology' may need to be completed.
- Inform the Stay Safe team/Helpdesk of all children who transfer to Shropshire who have a child protection plan
- Parents of children, up to one year of age, transferring into the UK from Eastern European Countries, who are therefore unlikely to have received neonatal blood spot screening, need to be advised of the purpose of these screening tests and how they may access them

### **Staff Group involved in delivering package:**

Delivered by Health Visitors Band 6 or 7

### **Outcome Indicator**

All children resident in Shropshire will be known to the Health Visiting service in the locality in which they reside

## 16: Transfer to School Health Services

### Descriptor of Contact

Records for children aged 5 years and over are transferred automatically to School Health Services upon the child reaching the age of 5 years and 1 day. This procedure is negotiable for children where there are outstanding concerns/programmes of care currently in place or where the child/children are subject to safeguarding plans. The child's ongoing plan of care should in these instances be directly negotiated by the Health Visitor and School Nurse involved.

### Evidence/Rational:

- Framework for the Assessment of Children in Need and Their Families (DOH 2000)
- Working Together to Safeguard Children (HM GOV.2006) [www.everychildmatters.gov.uk/socialcare/safeguarding](http://www.everychildmatters.gov.uk/socialcare/safeguarding)
- Every Child Matters: Change for Children Programme (DfEs 2004) [www.everychildmatters.gov.uk](http://www.everychildmatters.gov.uk)
- National Service Framework for children, young people and maternity service Standard 5 (DOH 2004) [www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/ChildreServices/ChildreServicesinformation/index.htm](http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/ChildreServices/ChildreServicesinformation/index.htm)
- What to do if you're worried a child is being abused-Leaflet (DOH 2006)  
Hyperlink from SCHNT website to all safeguarding policies and procedures [www.shropscommunityhealth.nhs.uk](http://www.shropscommunityhealth.nhs.uk)  
The Protection of Children in England, Laming 2009  
Detecting Child Maltreatment Guidance 2009 National Institute for Health and Clinical Excellence (NICE)

### Activities

- Review of all child records entry of transference into school health records made, signed and dated by the discharging HV.
- For children with ongoing care plans full Transfer out documentation to be completed and verbal handover to receiving School nurse conducted. Hyperlink from SCHNT website to all safeguarding policies and procedures [www.shropscommunityhealth.nhs.uk](http://www.shropscommunityhealth.nhs.uk)

### Staff Group involved in delivering this package

Band 5 for children with no ongoing concerns

Band 6 for children with care packages/safeguarding plans.

### Outcome indicator

A timely and informed transference of information between Health Visiting and School Health services, identifying where appropriate, additional need and/or ongoing programmes of care for vulnerable children.

**Health Visiting Team Members Feedback Form**

This document is subject to regular consultation and review To help with this process your comments on the document are helpful:

**Comments:**

Name:

Contact Point:

Base:

Telephone:

Email:

Please return these forms to your Health Visiting Coordinator