

Public Health Nursing - Early Years Best Practice Guidance (North NHS Highland version)

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Purpose of Best Practice Guidance

This guidance has been developed to support practitioners to deliver their role and assist them to deliver best practice within the context of The Early Years Framework (Scottish Government 2008), Hall 4 (Scottish Executive, 2004) and Getting it Right for Every Child/GIRFEC (Highland Council 2010). It will provide the evidence base for the critical role of Public Health Nursing /Health Visiting (PHN/HV) services within Highland's children's services. The guidance will support new PHN/HVs and other practitioners working with children and their families and will also act as a reference for existing staff by providing links to supporting policies and research documents. Links will be made to the Highland Children's Services Practice Guidelines (GIRFEC) <http://forhighlandschildren.org/index.htm>.

This version of the document is for PHN/HV teams working within North NHS Highland area, an amended version is also available.

The role of PHN/HV's

PHN/HV's are recognised by the Nursing and Midwifery Council (NMC) as having a specialist qualification and are registered by the professional body as Specialist Community Public Health Nurses. There are standards set for practice which enable practitioner's to contribute safely and effectively in maintaining and improving the health of the public and communities therefore assuming the responsibilities and accountabilities necessary for public protection (NMC, 2005).

The standards of proficiency underpin the ten key principles of public health nursing practice. These standards can be accessed at - <http://www.nmc-uk.org/Documents/Standards/nmcStandardsOfProficiencyForSpecialistCommunityPublicHealthNurses.pdf>

PHN/HVs and those who work within Public Health Nursing Teams work with all children and families through the coordination and delivery of the core universal service as recommended in Hall 4. In order to ensure an effective service PHN/HVs must focus their skills and expertise on the areas where they can make the greatest impact:

- **Promotion;** of health and well being for young children and their families
- **Prevention;** through assessment, screening and surveillance, analysis and recognition of health and wellbeing needs
- **Early intervention;** improving outcomes by analysing and providing/coordinating support (early in the child's life, early in the spectrum of complexity or early in the life of a crisis) within a multi disciplinary/agency approach.

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PHN/HV Role as Named Person

All children within Highland will have Named Person; the responsibility within early years lies with PHN/HVs.

The role of the Named Person is fundamental to meeting children's needs. This ensures that children have one point of contact to enable universal provision of health and wellbeing needs and a starting point where any additional need can be identified, analysed and met through the coordination and delivery of early intervention.

The following time line demonstrates Named Person responsibility for all children within universal services:

Time Line	Named Person
Birth- 11 days	Midwife
11 days – entry to school	PHN/HV
Primary School Age	Primary Head Teacher
Secondary School Age	Secondary Guidance/ Depute Head teacher

The following information relates to the primary role of PHN/HVs and responsibilities as Named Person in the early years.

The PHN/HV has a critical role in coordinating and managing early identification of risk or need for children in the early years.

Role of Named Person:

1. Lead, coordinate and deliver the Hall 4 universal core programme
2. Point of contact for child, parent, other professionals and members of the community
3. Maintains the child's Record – ensures core information is up to date
4. Assessment of health and wellbeing needs.
5. Identification of support to meet needs
6. Partnership working
7. Plan, coordinate, support and deliver interventions for children and families
8. Ensure effective transfer of information about the child at points of transition to their new Named Person.

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Background

The vision for all of Scotland’s children is they can achieve their full potential to become successful learners, confident individuals, responsible citizens and effective contributors (Scottish Government, 2008). Evidence demonstrates that to achieve positive outcomes for all children the balance of care needs to shift from crisis management to an early intervention focus. This shift in focus is most successful in the early years;

“At age 3, children at higher risk of poor outcomes can be identified on the basis of their chaotic home circumstances, their emotional behaviour, their negativity and poor development”

(Scottish Government, 2008)

The Early Year’s framework (Scottish Government, 2008) has been published to support the implementation of integrated children’s services to best meet the needs of all children from pre –birth to eight years of age. The document is the key framework for developing integrated children’s services. The framework highlights the recognition that all children have the right to high quality relationships, environments and services which offer a holistic approach to meeting their needs. Early intervention (especially within the early years) is pivotal to achieving this outcome. The “Getting it Right for Every Child” practice model (GIRFEC) provides a framework for all practitioners working within integrated services to provide timely, proportionate and relevant care and support. PHN/HV’s provide a universal service for all children and families under the age of 5 or until entry into school through the Hall 4 core programme (Scottish Government, 2004).

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1. Health for all Children 4; Universal Core Programme

The NHS provides a universal service to all families with young children. Current policy recognises the need to target the service more effectively in order to ensure that those families with the greatest need receive the greatest level of support. Whilst aimed at the NHS, the Hall 4 programme recognises the need for inter-professional and multi-agency working, to deliver the best quality of care and support for children and their families in the vital early years (Scottish Government, 2011). The Hall 4 guidance on implementation (Scottish Executive, 2005) promotes a core programme of routine child health contacts which supports parents to have all the relevant information, skills and resources to help maximise their child's full potential.

PHN/HVs lead, coordinate and deliver the Hall 4 universal core programme in partnership with General Practitioners and other allied health professionals. The following section provides a brief summary of this programme.

The link to the full document is provided below.

Health for all Children 4: Guidance on Implementation in Scotland (Scottish Government, 2005) - www.scotland.gov.uk/Resource/Doc/37432/0011167.pdf

The Scottish Government have recently revised Hall 4 with a specific emphasis on the early years. The new guidance focuses on 3 main aspects of health service delivery to children and their families in the early years:

- The allocation of the Health Plan Indicator
- The 24-30 month review
- The delivery of health improvement information and advice.

The three aspects mentioned are reflected in this guidance; however developments regarding Health Plan Indicators and the Hall 4 core contacts are ongoing.

The link to the full document is provided below.

Scottish Government (2011) A New Look at Hall 4. The Early Years. Good Health for Every Child:

<http://www.scotland.gov.uk/Publications/2011/01/11133654/11>

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Universal/Core Programme

All children will receive the following reviews as a minimum:

Age	Review *	Practitioners involved
Antenatal Contact from 36 weeks gestation	Parental health and wellbeing	PHN/HV Midwife
Soon after birth	Full physical health check. Hearing Screen.	Paediatrician Midwife Audiologist
Within 10 days of birth	Health/development Blood spot test	Midwife
11 – 14 days after birth	Health/development assessment	PHN/HV
6-8 weeks after birth	Full physical health and development health assessment Childsmile Assessment	PHN/HV General Practitioner
2 months	Immunisation	General Practitioner Practice Nurse PHN/HV/Team
3 months	Immunisation Health Review Health Promotion	General Practitioner Practice Nurse PHN/HV/Team
4 months	Immunisation Health Review Health Promotion	General Practitioner Practice Nurse PHN/HV/Team
12 – 15 months	Immunisation Health and wellbeing assessment (inc Childsmile) Nutrition, growth & weight Health Promotion	General Practitioner Practice Nurse PHN/HV/Team
24 – 30 months	Developmental assessment including speech, language & communication. Nutrition, growth & weight Immunisation	PHN/HV
3- 5 years	Weight and Height (if not recorded at 24/30 months or if any concerns) Immunisation Health and Wellbeing review in partnership with preschool establishment	PHN/HV/ Team. GP/Practice Nurse Each Preschool establishment has a Link PHN/HV to support reviews.
4-6 years (school year P1)	Health Check including Vision, audiology, BMI and Dental check	PHN/HV/ Team Orthoptist

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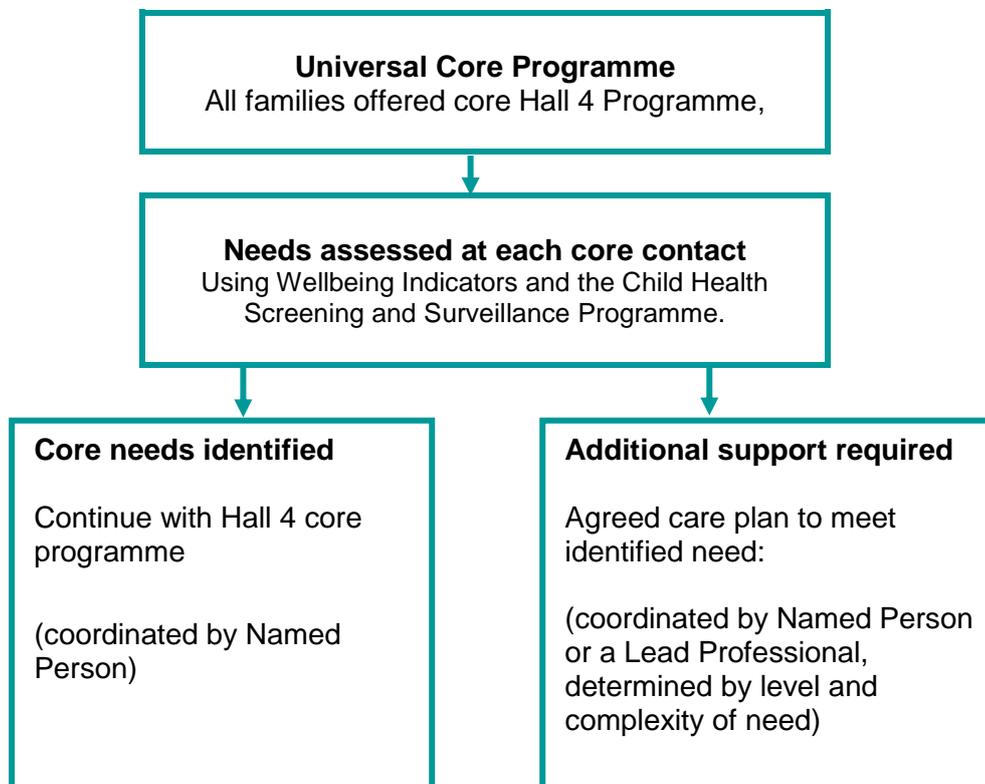
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The Hall 4 Core Programme

This evidenced based approach is represented in the diagram below:



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2. Delivering Integrated Children's Services

“The Named Person is likely to be among the most dependable sources of information available to decision-makers at any given time. It is a critical role in integrated service delivery and at the heart of the *Getting it right* protocols for ensuring that the additional support to be provided for a child is actually delivered.” (Scottish Government, 2009)

The PHN/HV has a critical role in coordinating and managing early identification of risk or need for a child in the early years. This involves being the key point of contact for the child, family and other professionals involved in both universal and targeted services for all children. To achieve this best practice in both collaborative working and information sharing is essential.

2.1 Information Sharing, Responding to Children's Needs

A fundamental principle of *Getting it Right for every child* is that there are clear and transparent ways for children and families to access advice and help, that is appropriate, proportionate and timely.

Children and families should feel able to talk to practitioners – often the Named Person will be the first point of contact – in order to make sense of their worries and do something about them. This will demand sensitivity and awareness of practitioners of any cultural issues that might influence children's and families perspectives. Children and families should also know that, if appropriate, action will be taken and help provided.

When considering information that should need recorded or shared with another agency the following questions regarding the child's identified need will always be considered:

1. What is getting in the way of this child's well-being?
2. Do I have all the information I need to help this child?
3. What can I do now to help this child?
4. What can my agency do to help this child?
5. What additional help, if any, may be needed from others?

Information sharing and consent will be discussed at the earliest time possible with the family/child, key points:

- Antenatal contact
- New Birth Visit
- Starting school
- Transfer into area.

Further information on sharing data (including pathway) can be found in Practice guidance:

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<http://www.forhighlandschildren.org/5-practiceguidance/>

Procedures for data sharing across all agencies in Highland:

http://www.forhighlandschildren.org/2-childprotection/publications_13_2070083751.pdf

Where it is considered that a child or young person is at risk of significant harm, information must be shared between agencies to enable an assessment to be undertaken. In such circumstances, consent from the child or the parent is not required and should not be sought.

It is nevertheless, good practice to inform the child and parent of any actions you are going to take. There can though be circumstances where it is considered that this could place a child or others at risk, or compromise any investigative enquiry, PHN/HVs will contact CPA within their locality for advice, and assistance can also be sought from social work or police.

2.2 Essential Partnerships

Midwives

Midwives work as part of the wider maternity team and are the main professionals responsible for providing care to low risk women. They also provide support to women where additional need is required and provide a co-ordinator role for all pregnant women.

Community midwife caseload holders are the Named Person for all pregnant women and their babies in line with recommendations from NHS QIS (Keeping Childbirth Natural and Dynamic (KCND), 2009) that every pregnant woman will have a named midwife.

Assessment of risk and need is made at every contact with women in pregnancy and they are allocated to the correct pathway of care. This is achieved through the use of the KCND pathways and using Health Plan Indicators (HPI) to determine additional support for social aspects of maternity care.

Sharing of assessments and information gathered during antenatal contacts with women and their families is fundamental when planning ongoing care. Midwives and PHN/HVs will work closely together during pregnancy to ensure that women and babies needs are met as early as possible. This will be achieved through using opportunities for pre-birth planning when issues are identified by the midwife or other members of the wider maternity team. This will ensure effective transition and handover of care between the midwife and PHN/HV.

Information on Antenatal Plan in section 3.3 page 19

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General Practitioners (GPs)

Working with General Practitioners is crucial to meeting the needs of children and families.

Key Roles include:

- Child Health Screening and Surveillance
- Early Detection and support of the children's health and wellbeing needs
- Early Detection and support of families needs e.g. Post natal depression
- Health Promotion
- Immunisation

Each GP practice should have an allocated PHN/HV.
Sharing information and working together will ensure continuity for children and their parents. Analysis of health plan indicator may depend on information from GP.

Link PHN/HV- Preschool

PHN/HVs working with preschool centres are in a prime position to influence the health and wellbeing of children and families.

Every preschool centre will have a named PHN/HV (not necessarily Named Person for individual children). Best practice is to visit each centre at least once per term.

Core responsibilities in the role as link PHN/HV involve:

- Working in partnership with the preschool centre, the family and the Named PHN/HV to identify health and wellbeing needs for children. A discussion around each individual child including the Health Plan Indicator must take place (preferably near the beginning of term).
- Providing the preschool centre with relevant information regarding existing identified needs for individual children before entry to centre.
- Working in partnership to identify any extra help children may need to reach full potential (see assessment section 4).
- Working in partnership to help deliver current Health Promotion priorities or identified priorities from individual centres. .

Best Practice Guidance available from Childcare and Early Education Service – 01463 711176.

Further guidance – Promoting Health and Wellbeing in 0-5 year's settings: A Guide.

Oral Health Improvement Coordinators

The role of Oral Health Improvement Coordinators is to support, develop and facilitate oral health improvement for all children and young people, including the roll out of the Childsmile programme.

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Contact details:

North CHP 01955 609940
Mid CHP 07818 002388
South East CHP 01463 253665

Further information on oral health improvement and Childsmile can be found in section 8.8 page 47.

Integrated Service Officers (ISO)

The ISO is a Qualified Social Worker and a member of the local social work team. The ISO operates at the interface between social work and universal services. They should ensure there is constant dialogue across social services, health, and education and with the Integrated Services Co-ordinator. They are line managed by the social work team manager.

The ISO's role is to ensure that assessment and planning systems are working appropriately, proportionately and safely in each area. They will ensure effective assessment and planning for early intervention and offer advice and support to the Named Person and Lead Professionals in universal services. The ISO will monitor the assessments in place and that early intervention resources are being appropriately deployed.

The ISO is responsible for the supervision of the Children's Service Workers (CSW's) and will offer them professional support and development. ISO's are not case holders.

The ISO will assist the Named Person/Lead Professional in ensuring that appropriate Child Plans that require to be discussed at the area Liaison Meeting are presented.

PHN/HVs will work in partnership with their designated Integrated Service Officer to support opportunities for all children to reach their full potential.

Social Workers

The term Social Worker is a title reserved for professionally qualified workers who hold current registration with the Scottish Social Services Council. The Children and Families Social Worker's role is to work with children and families, assessing need in complex cases, and making plans, along with families and partner agencies, to address these needs. Social workers provide a targeted, specialist service to children with high levels of need who are often at risk of harm, or are looked after under a legal order by the Local Authority.

For further information and contacts: www.forhighlandschildren.org/2-childprotection/

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Children’s Service Workers, (Early Years) = CSWEY

Children’s Service Workers, (Early Years) offer early intervention and support to children, young people and their families. They can work within family homes and in group situations and provide support to both PHN/HVs and Social Workers to assess, promote and support child health and wellbeing.

Examples of support –

- supporting parents to stimulate children through play
- parenting support

CSWEYs are supervised by Integrated Services Officers (ISO); however work can be planned and coordinated through the PHN/HV (with the family).

To implement support and early intervention the “My World Triangle assessment form” (Child’s Plan) will be shared with the CSWEY and ISO so that identified needs and goals for the individual child are clear.

Police - Public Protection Units Northern Constabulary

Northern Constabulary has 3 Public Protection Units (PPU) throughout Highland. East Division covering Inverness, Badenoch, Strathspey and Nairn, Central Division covering Wester and Easter Ross, Lochaber and Skye and North covering Sutherland and Caithness. These units discuss child concern matters on a daily basis with Social Services and there is a daily discussion between Social work Managers to review child concern forms received. A decision is then made as to the necessary course of action and then the information is shared with the Named Person or Lead Professional. The units also investigate Child Protection enquiries in conjunction with Social Services.

In addition to this the PPU also deal with Domestic Abuse, Adult Support and Protection, Mental Health, Youth Offenders and the management of Sex Offenders in the community. Contact Northern Constabulary Headquarters – 01463 715555. Ask for local area PPU.

Community Children’s Nursing Team

The Community Children’s Nursing team provide nursing support for children with complex health needs and their families. Support is provided to children with a wide range of health and wellbeing needs including children with urology, cardiac, gastroenterology, respiratory, endocrine and palliative care needs. The team also provide training to other health care professionals, school personnel, respite carers and family members.

Highland area contact: Tel 01463 701384

Community Paediatricians

Community Paediatricians provide a secondary, specialised health service to children with a range of additional support needs, development disorders and disabilities.

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The service has a statutory responsibility to all children up to the age of 16 years (or 19 if still in full time education) through the Education and Children's Acts. It provides assessment, diagnosis and follow-up as appropriate of children with additional support needs. This also includes assessment and diagnosis of Autistic Spectrum Disorder (ASD), Attention Deficit Hyperactivity Disorder (ADHD) and Developmental Co-ordination Disorder (DCD).

Referral forms are available in local PHN/HV bases.

Contact Tel; 01463 701311.

Child and Adolescent Mental Health Services

Child & Adolescent Mental Health Services (CAMHS) are provided centrally and locally.

The referral process and referral criteria are designed to help you decide how to refer to the Child and Adolescent Mental Health Service. Children and young people from 0 to 16 years, or until they leave secondary education (aged 17-19), are eligible for referral.

This guidance includes information regarding primary mental health workers.

<http://intranet.nhsh.scot.nhs.uk/Org/DHS/ChildrensServices/CAMHS/Pages/Default.aspx>

If you require an emergency referral (severe risk of suicide/ self harm or mental illness, e.g. psychotic behaviour) please contact the service directly on 01463 705473/ 705597.

The Psychological Service

The Psychological Service includes Educational Psychologists and Pre-School Home Visiting Teachers.

Educational Psychologists (EPs)

EPs work with children and young people from 0 – 24 in partnership with parents or carers, teachers, other services and voluntary organisations. EPs have prescribed core functions which include: Consultation; Assessment; Intervention; Training; Research and Development. These five core functions are delivered at three levels: the child and family; the school or establishment; and the local authority.

Requests for the involvement of an Educational Psychologist are prioritised according to need and in consultation with schools/ settings and parents. Requests may be received in the form of a single or multi-agency plan; may arise from a solution focused multi-agency meeting or be received directly from parents or professionals. Educational Psychologists tend to work closely with other professionals in determining additional support needs and in planning interventions. The approach used is a solution focused one.

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With regard to Pre-school and early years, Educational Psychologists work closely with Pre-School Home Visiting Teachers.

Pre-School Home Visiting Teachers

This teaching service works with pre-school children with additional educational support needs and families. The service is offered to children whose needs may adversely affect their educational progress and development.

During visits made to homes and pre-school settings, parents and staff are given advice and support to help or manage their child's difficulties. This service aims to work in close partnership with parents, teachers, playgroup leaders and other related professionals.

Requests for involvement come from:

- Parents
- Medical services (GP; Community Paediatrician; Health Visitor; Community Nurse)
- Through Child Plans
- Educational Psychologist

After consultation with the parents the child's name is put forward for home teaching and contact is made as soon as there is a place available.

Pre-School Teachers and Educational Psychologists are very aware of the significance of times of transition for example from nursery to Primary 1 and work to ensure these are as smooth as possible for children, parents, settings and schools.

Further details can be found on our website

<http://www.highland.gov.uk/learninghere/psychologicalservice>

2.3 The Lead Professional

There are some circumstances where children's needs involve two or more agencies working together delivering services to the child and family, in this case a Lead Professional will be required.

The Lead Professional should be the person best placed to coordinate meeting the needs of the child and family. This will depend on:

- If the child is subject to a multi agency child protection plan, or is looked after at home or away from home under a statutory order, the Lead Professional will be a social worker:
- The kind of help the child/family needs and therefore the core roles of the practitioners involved.

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- Previous contact or where a good relationship with the child/family has already been established.

Any change of Lead Professional must be documented in the child's chronology.

For further guidance on the role of the Lead Professional, please go to:

www.forhighlandschildren.org/5-practiceguidancecp21

2.4 Multi Agency Practitioner Forums

Practitioner Forums are in place throughout the Highland area. The forums are for practitioners working within integrated children's services and will be implemented and coordinated by local service area managers.

Purpose of forums; to improve children and families outcomes by enhancing effective integrated children's services by:

- Providing a forum to promote reflective practice and shared learning
- Encouraging strong effective collaboration among staff and agencies
- Identification of further multi agency training needs
- Sharing and cascading information at individual team level

Representation at the forums is expected from all agencies.

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3. Transition

PHN/HVs as the child's Named Person are responsible for ensuring that information regarding children's health and wellbeing needs is acquired and transferred at points of transition.

This ensures the provision of safe, consistent, timely and effective care at points of transition and fulfils governance requirements through the implementation and practices of GIRFEC.

3.1 Key Points of Transition

Antenatal contact	If appropriate e.g. when an <i>Antenatal Plan: Additional support for mother and unborn child</i> is in place
11 days old	Midwife to Health Visitor handover
2.5-3 years Before entry into Pre-school	If a child is likely to require additional support or a parent may need advice on enrolment
4.5-5 years Entry to Primary School	Health Visitor to School Nurse handover
At any point	Movements of a child in or out of area

3.2 Midwife to Health Visitor Handover

Antenatal care offers an opportunity for assessment of risk and need which is a core role of maternity services. Each pregnant woman will have a named midwife who will provide much of her antenatal care and following assessment at each contact will allocate her to the correct pathway of care (NHS QIS, 2009). Social aspects of care are further assessed through the use of health plan indicators for maternity services which have been developed to assist midwives undertaking their assessments. Risk is dynamic and changes in the woman's pathway of care at any stage in her pregnancy, during delivery or her postnatal care.

The named midwife will communicate and share any concerns with the wider maternity team, including the PHN/HV. Concerns raised during pregnancy will alert the PHN/HV to the need for an antenatal contact with the mother, and joint planning of care should occur in line with the midwife to health visitor handover procedure which all staff will follow. Handover of information particularly where additional needs or risks are identified should begin as early as possible so that pre-birth planning processes are in place (NHS Highland, 2010)

Link to midwife to health visitor handover –

[http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Communication%20and%](http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Communication%20and%20)

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When there is a need identified for additional support from another agency for mothers and their unborn babies, midwives will complete an Antenatal Plan to enable the assessment they make to focus on the strengths and pressures for mum, the impact this is likely to have on her and her unborn and the desired outcomes for them both. This is required because at present the Scottish Woman Held Maternity Record (SWHMR) which summarises a woman's care does not reflect the required assessment in line with the recommendations of GIRFEC. The Antenatal Plan does not contain any health information which would be unsuitable to share with other agencies which the SWHMR does.

The named midwife will share the Antenatal Plan as required but always with the PHN/HV, GP and obstetrician.

Further details around the use of the Antenatal Plan and other developments to support assessment and planning of care in pregnancy can be found in the *Guidelines for Maternity Services Getting it Right for every Mother and Child NHS Highland, 2011*. Link – (available on intranet early 2011)

3.3 Antenatal Plan

When there is a need for additional integrated support for mothers and their unborn children an antenatal plan will be completed by the named midwife.

The plan is:

- similar to the Childs plan, focusing on strengths and pressures, My World Triangle and an action plan to support needs
- will be shared with the named PHN/HV in the antenatal period
- should be discussed at midwife to PHN/HV handover (if discussion has not already been had)
- will inform ongoing assessment and support for the child and family
- should be stored in the family section of the child and family PHN/HV record along with mothers chronology of significant events if applicable

Further information (Antenatal Plan) - www.forhighlandschildren.org/5-practiceguidance/ appendix iiid.

3.4 Before Entry to Pre-School

A PHN/HV is likely to be aware of children who will require additional support when they begin pre-school education sessions e.g. children with a diagnosed condition or who are vulnerable for some other reason.

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For a successful transition for the child, the centre needs be alerted early on so that appropriate preparations are made to meet additional needs e.g. if a child will require medication or special equipment or would benefit from the centre using a particular strategy.

Advance notice by the PHN/HV will enable the centre to be ready to help the child from the start.

Sometimes a parent, particularly one who is vulnerable or a first-time parent may be unaware that their child must be registered with a centre well in advance of the entry date. In this situation, Public health nurse teams can encourage parents either directly or through advertising enrolment dates.

Information about enrolment is available from:

Highland Childcare & Early Education Service Tel. 01463 711176

3.5 Entry to Primary School: Health Visitor to School Nurse Handover (NHS Highland)

The Public health nurse/health visitor, together with pre-school education centres are able to pass on valuable information to the primary school teacher and school nurse which will enable forward planning to meet the child’s needs.

Link –

www.nhshighland.scot.nhs.uk/forms/library/Documents/NewformslistOctober.xls

3.6 Movements of a Child in or out of area

When it is known that a child aged 3-4 years old who the PHN/HV has assessed as having additional needs has moved into an area, it is helpful if the PHN/HV alerts the pre-school education centre. However if the PHN/HV feels it appropriate they may contact the preschool education centre from the age of 2.

PHN/HVs/PHN/HVs as Named Person are responsible to ensure that information regarding children’s health and wellbeing needs is acquired and transferred at points of transition.

This ensures the provision of safe, consistent, timely and effective care at points of transition and fulfils governance requirements through the implementation and practices of GIRFEC.

3.7 Transition of Children and Young People with Additional Support Needs

Not all young people have additional support needs as a result of disability and/or complex health, however the following joint policies and procedures are available to improve transition planning for those with greatest need and who require concerted effort and specific planning to achieve a positive outcome from transition to adulthood.

Integrating Services for Young people and Young adults with additional support needs as a result of Disability and/or Complex health. Joint Transitions Procedure:

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<http://www.highland.gov.uk/NR/rdonlyres/D79AD91C-68A8-4F34-A8F4-2DD62DF63D8C/0/JointTransitionsPlanningProcedure.pdf>

My Transitions Guide.

This guide is for parents, professionals and partner services who support children and young people who are going through transition:

<http://www.knowledge.scot.nhs.uk/media/CLT/ResourceUploads/11891/transitionguideppp.pdf>

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4. Assessment of Health and Wellbeing

The promotion of children’s health and wellbeing involves consideration of their developmental needs, the quality of parental care and the circumstances in which they grow up (Hall & Elliman, 2003). As quoted in Aldgate et al (2006), “we cannot begin to improve the lives of disadvantaged and vulnerable children unless we identify their needs and understand what is happening to them in order to take appropriate action”.

Highland Children’s Services have adopted the “Getting it Right for Every Child” approach to assessment of health and wellbeing which incorporates a developmental and ecological approach. The ecological approach places the child at the centre of his or her own world and takes consideration of all the influencing factors surrounding that individual child including parental and environmental influences. The ecological approach will be achieved by the universal use of the My World Triangle assessment. Needs are identified for children by using a solution focused approach which seeks to determine and assess possibilities rather than problems. (see page 30)

4.1 Assessment Tools

The following information will summarise assessment tools to be used in practice for all children and other tools that may be required depending on individual needs of children.

For full information on the GIRFEC Practice Model, tools for assessment see: www.forhighlandschildren.org/5-practiceguidance/ Section 2 page 9-16.

The Wellbeing Indicators

“Children’s wellbeing is at the heart of *Getting it right for every child*. To achieve our aspirations for all Highland’s children to develop into “Confident Individuals, Effective Contributors, Successful Learners and Responsible Citizens”, every child and young person needs to be Safe, Healthy, Achieving, Nurtured, Active, Respected & Responsible, and Included”, (For Highland’s Children Practice Guidance,2010).

The wellbeing indicators will be used as an ongoing “trigger” to identify health and wellbeing needs and enable identification of Health Plan Indicator (HPI).

My World Triangle

The My World Triangle assessment tool should be used at any appropriate time when a health/wellbeing need has been identified and there is a requirement for further assessment and support for the child/family.

The My World Triangle assessment can help to identify areas of constraints and support and can function as the child’s plan (when support is primarily from within

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universal services) for example; when support is provided to the child/family by a children's service worker.

The My World Triangle is included in the Personal Child Health record (red book). The purpose and use of the Triangle should be discussed with all parents as early as possible e.g. primary visit or new introductions to the child and family.

Further information on using the triangle for preschool children is in the Appendix and full information can be found in: Practice Guidance appendix i "*using the my world triangle*" - <http://www.forhighlandschildren.org/5-practiceguidance/>

Resilience Matrix

A major advantage of the GIRFEC practice model is that it not only helps to identify risks for a child but also looks at protective factors that can lessen those risks. The resilience matrix can be used to further analyse strengths and pressures Identified from the "My World Triangle".

Resilience Matrix should be used when needs are identified as complex.

Look at Resilience matrix with child and family. Further information <http://www.forhighlandschildren.org/5-practiceguidance/>

4.2 Schedule of Growing Skills

The Schedule of Growing Skills (SOGS) is an objective, evidence based developmental screen for use by medical and health practitioners. The tool is for developmental assessment of children 5 years and under.

It is a requirement to undertake a SOGS for all children if they are:

- Looked After Children (LAC) or Looked after and Accommodated Children (LAAC);
- Child Protection concerns

It is at the discretion of the PHN/HV to undertake SOGS:

- Where there are parental/professional concerns.

Communicating the outcome:

A copy of the "profile" should be given to the parent/carer; GP and any other relevant health professional.

The outcome of the SOGS assessment should be analysed and presented within the My World Triangle assessment form.

A copy of the SOGS should be included with any referral to AHP/paediatric services.

4.3 The Child's Profile 3-5 years (Pre- School Assessment)

This profile is used for all children within preschool establishments. Continual observations of the child's developmental skills linked with ability to communicate

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learn and socialise. The profile along with the individual review helps build up a very detailed picture of a child's developmental stage. Observations are analysed as to the child reaching specific milestones.

PHN/HVs should work with Pre School Centre Staff to identify and support needs for children. The Childs Profile can be used to inform The My World Triangle.

“This information provides a sound basis for PHN/HVs and pre-school practitioners to use in their assessment of a child's needs. It also offers valuable evidence towards any other assessments that may be necessary.”

Link PHN/HV and Pre-Schools Good Practice Guidance, 2009.

For further information contact Childcare and Early Years – 01463 711176

4.4 Edinburgh Post Natal Depression Scale

The Edinburgh Post natal Depression scale is a universal tool for the assessment of maternal mental health. Please see the following link to NHS Highland perinatal mental health best practice guidelines:

<http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Perinatal%20Mental%20Health%20Good%20Practice%20Guidelines.pdf>

4.5 Health Plan Indicators (HPIs)

Health Plan Indicators are fundamental in the planning of care and support for children and families. By identifying the level of need, support can be prioritised for the children and families who need it most and implemented as early as possible.

PHN/HVs are responsible for the assessment and identification of HPIs in partnership with children and families.

HPIs are:-

- identified according to the child's assessed health and wellbeing needs.
- assessed at every contact with the child/family.

The revised Hall 4 guideline (Scottish Government, 2011) stipulates that HPIs will now be core and additional. Children identified as 'Core' will receive the universal PHN/HV service, this means that any support offered through the Hall 4 core programme is regarded as core business of PHN/HVs, for example support for infant feeding.

Those children allocated an 'Additional' HPI will receive additional PHN/HV support and/or support from other disciplines or agencies for example support for post natal depression.

Identification and allocation of HPI will be a shared decision making process with the child and family. Information gathering and sharing around identification of need may require involvement from partner disciplines or agencies for example General

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Practitioners or Pre School Establishments. Assessment will be carried out using the “Getting it Right for Every Child” Practice Model.

HPI will be identified by the time the child reaches 6 weeks old and may be identified earlier:

Midwives begin the process of assessment at booking through the use of the Scottish Woman Handheld Maternity Record (SWHMR). Collecting this detailed history allows the woman to be allocated to a pathway of care in line with NHS QIS Keeping Childbirth Natural and Dynamic pathways (KCND) (NHS QIS, 2009). These pathways – green, amber and red can alter at each assessment or contact with the woman and are dynamic.

Midwives will follow the ‘Revised procedure for the communication and handover of health and social information between midwife and health visitor’ (NHS 2009) to ensure that joint working and sharing of information and assessments occur timeously between midwives and PHN/HVs. Therefore by the time the baby is due additional needs will have on many occasions already been identified and the PHN/HV informed by the midwife of the assessment. The use of HPIs by midwives has enabled a more thorough understanding of social risks for the mother, unborn and newborn baby which the KCND pathways do not detail (REF GIRFEC and Maternity services guidance – 2010). This assessment should then be shared with the PHN/HV.

When children move into the area it is essential that health and wellbeing needs are identified as soon as possible so that their health plan can be identified and appropriate support can be initiated.

Evidence and rationale in relation to the decision making process (identification and allocation of HPI) must be recorded in the child and family PHN/HV record. Evidence will be recorded in the appropriate assessment and planning documentation i.e. Well being Indicators, My World Triangle Assessment Child’s Plan and Resilience Matrix (when suitable).

Health and Wellbeing Needs are rarely static therefore HPI is never static. Changes in HPI will take place according to children’s levels of need. For example the completion of an episode of care and support may have reached the outcome aimed for and the child may no longer have additional need. This would lead to HPI changing back to core. This needs to be recorded along with any changes to Lead professional in the PHN documentation, including the chronology.

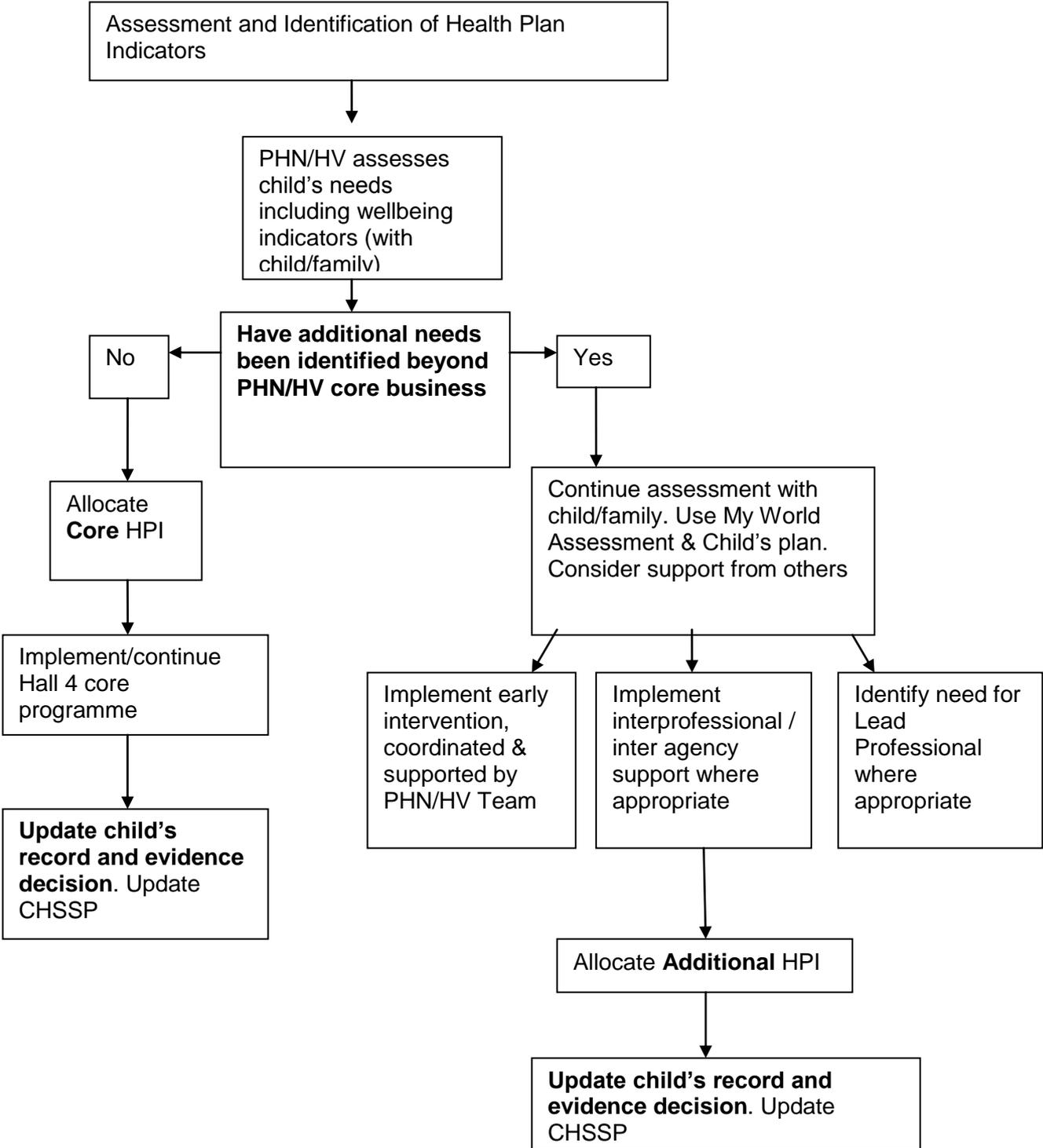
Any changes to Lead Professional must also be recorded in the chronology

The Child Health Screening and Surveillance Data Collection System (CHSSP) must be informed of alterations in identification and allocation of HPI.

Please see HPI pathway on the next page:

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Health Plan Indicators Pathway



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4.6 Child Health Surveillance Programme Data Collection System (CHSSP)

All NHS Boards in Scotland provide a Child Health Surveillance Programme where children are offered routine reviews at various stages of their life. Assessment and planning are part of the everyday processes practitioners employ to help children and families (GIRFEC, 2007). The aim is to help all children achieve their full potential by offering a planned programme of assessment and screening activities in order to identify and meet needs at the earliest possible time. CHSSP helps to provide information for public health intelligence and the information gathered should highlight health and social inequalities.

Information gathered will provide local information for targeting resources and priority setting at Board, Community Health Partnership and individual caseload level i.e. - breastfeeding, smoking prevalence and trends in obesity.

PHN/HVs can request reports for the above information through Professional Lead. Reports will be released through the child health department at the discretion of Professional Lead. Report requests should include rationale for receiving report and any service provision/project plans. Best practice would suggest demonstration of how provision/project will be evaluated.

Example – Request for breastfeeding figures within a local area to set up peer support group for breastfeeding.

Link to guidelines –

<http://intranet.nhsh.scot.nhs.uk/Org/DHS/ChildrensServices/ChildHealthSurveillance/Pages/Default.aspx>

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5. Record Keeping

5.1 Principles of Good Record Keeping (NMC)

Good record keeping is an integral part of nursing and midwifery practice and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow. (NMC, 2009)

Good Record keeping is fundamental for the following important functions:

- Helping improve accountability
- Showing how decisions related to patient care were made
- Supporting the delivery of services
- Supporting effective clinical judgements and decisions
- Supporting patient care and communications
- Making continuity of care easier
- Providing documentary evidence of services delivered
- Promoting better communication and sharing of information between members of the multi-professional healthcare Team
- Helping to identify risks, and enabling early detection of complications
- Supporting clinical audit, research, allocation of resources and performance planning
- Helping to address complaints or legal processes

NMC Principles of good record keeping -

<http://www.nmc-uk.org/Documents/Guidance/nmcGuidanceRecordKeepingGuidanceforNursesandMidwives.pdf>

5.2 Public Health Nursing Child and Family Record (PHNCFR)

All children in Highland have a universal health record. The record is designed to record information gathered during a child's pathway through universal services.

The record underpins the Hall 4 framework and GIRFEC approach to enable practitioners to plan, implement and evaluate care to meet the needs of children and families.

Link to PHNCFR guidance -

<http://intranet.nhsh.scot.nhs.uk/FormsLibrary/Pages/Default.aspx>

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5.3 Audit of Records

Audit should be integral to good record keeping practice. A cyclical process for audit should be established within each PHN/HV team to allow continuous improvement. Each individual should audit sample files as directed by Team Leader (approx 3 monthly) and follow up with an action plan. These results are managed locally. Annual audits are directed by the Clinical Effectiveness Department. These results need to be sent there.

5.4. PHNCFR Transfers

Guidance regarding the transfer of records can be found in the PHNCFR guidance.

5.5 Children and Families Missing from Known Address

PHN/HV's are responsible for prompt transfer of the PHNCFR, so that identified needs and support can be established as early as possible in their new location. PHN/HVs should inform families regarding the responsibility so that families will inform them when planning to move. PHN/HV's should seek advice at any time from your CPA when you have concerns about missing children and families. The following section provides information regarding children missing from known address.

Definition of Missing Family	<p>This is a family who has disappeared from a known location within a Health Board Area. This includes unborn children.</p> <p>Urgent concerns may need to be referred immediately to social work and police colleagues.</p> <p>It is the responsibility of the Keeper of the Register to trace "missing" children whose names are on the Child Protection Register. However if information about such children comes to the attention of health professionals in the first instance, contact with other agencies, such as social work or police should be made promptly.</p>
Concerns that a Family May Be Missing	<p>All reasonable and practical efforts should be undertaken to locate the family and this should include discussion with other health professionals; interrogation of IT systems such as Community Health Index (CHI), Standard Immunisation Recall Systems (SIRS) and Patient Administrative System (PAS).</p> <p>Contacts in other statutory agencies may also be able to assist, e.g. housing, social work, police and education.</p> <p>NHS personnel with concerns that a family are missing should also advise the Child Protection Advisor (Health) with responsibility for their locality/area of work.</p>

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Concerns that a family is missing

If a family remain missing the Child Protection Advisor should advise the Lead Child Protection Advisor for Child Protection within the Health Board Area. Where there are concerns regarding vulnerability or child in need/child in need of protection issues an NHS Scotland Missing Family Alert Template (MFA1) will be completed in agreement with the Caldicott Guardian and circulated within Scotland and other countries as appropriate.

5.6 Children Unexpectedly Absent from Pre-School Education

If a child has been absent for prolonged period of time without explanation the pre-school centre may contact the link PHN/HV for assistance and advice.

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6. Vulnerable Children and Families

Health inequalities continue to exist in Scotland today. Those most at risk of poor health outcomes remains those individuals influenced by the key determinants of health including the environment and the communities in which they live. The key principle to tackling health inequalities is by engaging children and families in the early years and supporting them through universal services (Scottish Government, 2008). Hall 4 (2004), states that PHN/HV's should focus their support and care on children who are most vulnerable and at risk of poor health and wellbeing outcomes. This includes children on the child protection register, looked after children, homeless children and children from the Gypsy and Traveller community.

Child Protection

6.1 Highland Child Protection Policy Guidelines

Children have the right not to be abused, and to be protected from abuse and neglect (Child Protection Policy Guidelines, 2009).

Child Protection is the responsibility of everyone, and agencies must collaborate to support the protection of children.

The guidance forms the operational procedures for multi-agency working. The guidance has been recently updated to incorporate the GIRFEC approach.

PHN/HVs should have easy access to the guidance at all times.

PHN/HVs should contact their local child protection advisor when they have any concerns of escalation of risks to a child.

Child Protection Guidelines:

<http://forhighlandschildren.org/2-childprotection/publications.htm>

Child Protection Link (For Highlands Children) –

www.forhighlandschildren.org/2-childprotection/

6.2 Child Concern Forms

Effective practice to protect children requires agencies to share information. To this effect, Northern Constabulary and other agencies share information about concerns that have come to their attention with Named Persons.

Receipt of Child Concern Forms

As Named Person, PHN/HVs will receive all child concern forms related to preschool children. Where a child is not known to Social Work Services and there is no indication of the risk of significant harm, the PHN/HV will be the only recipient of the child concern form and is expected to take appropriate action.

At this stage it is critical that The Named PHN/HV takes careful account and considers any subsequent actions that are required:

- Consider information

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- Asses identified need and take subsequent action
- Record Important details in PHN record (usually extraordinary events)
- Update Child's Chronology – including reference details of child concern form
- Update Health Plan Indicator
- Child Concern Form should then be stored in the child's record with any third party information removed.

Sharing concerns about the wellbeing and protection of children

Child concern forms should be completed when PHN/HV's have concerns about the wellbeing and protection of children, and forward to those professionals who need to know you have concerns, and to social work and/or police when there is concerns about significant harm or immediate harm to children. As the Named Person PHN/HVs have the responsibility to collate concerns and share when these increase. Advice can be sought for completion of the forms from local CPA.

All significant events including sending/receiving concern forms should be recorded in the child chronology within their record.

Full information regarding child concerns see Practice guidance page 28-31 and child protection guidance.

<http://www.forhighlandschildren.org/5-practiceguidance/>

6.3 Child Protection Advisors

The Child Protection Advisor (NHS Highland) is the Designated Person for health. The CPA is a specialist professional within each locality and is a resource for all health personnel, whose patients/clients are children, or adults who have involvement with children.

The Child Protection Advisor will:

- Provide information on the systems and processes of Child\Protection Guidelines
- Support, advise and guide all personnel through the HCPC processes including the roles and responsibilities of health professionals
- Advise on referrals to social work, police and children's reporter;
- Ensure relevant attendance at child protection plan meeting and other meetings
- Assist with providing information and preparing reports as appropriate for the purpose of assessment and investigations
- Advise on record keeping
- Facilitate transfer in/out of records where children are of concern or on the CP register
- Advise on training relevant to profession

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- Deliver induction, single agency and interagency training
- Initiate and disseminate Missing Family Alerts
- Support through legal processes and in consultation with the central Legal office (in Edinburgh) as appropriate
- Supervise practice, and peer review as appropriate

Link to CPA contacts:

www.forhighlandschildren.org/2-childprotection/ (bottom of page) or:

<http://intranet.nhsh.scot.nhs.uk/Org/DHS/ChildrensServices/ChildProtection/Child%20Protection%20Contacts/Forms/AllItems.aspx>

6.4 Child Protection Training

PHN/HVs should attend child protection training every 3 years. Training Courses can be sourced through local CPA, details are within the intranet.

Child protection Training Page-

<http://intranet.nhsh.scot.nhs.uk/Training/ChildProtection/Pages/Default.aspx>

www.forhighlandschildren.org/2-childprotection/

6.5 Child Protection Document Links

National Guidance for Child Protection in Scotland 2010

<http://www.scotland.gov.uk/Publications/2010/12/09134441/0>

HMIE inspection

www.hmie.gov.uk/documents/publication/hwcpnm-03.html

Protecting Children and Young People: The Charter (2004)

The Children's Charter sets out what children and young people feel they have a right to expect from those with responsibilities to protect them.

www.scotland.gov.uk/library5/education/ccel.pdf ISBN 0-7559-4087-3

Protecting Children and Young People: Framework for Standards (2004)

builds on the Children's Charter. A framework for all agencies to progress effective measures to protect children and young people.

www.scotland.gov.uk/childprotection ISBN 0-7559-4087-3

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Getting Our Priorities Right (2003)
Good practice guidance for working with children & families affected by substance misuse.
www.scotland.gov.uk/library5/education/gopr.pdf ISBN 0-7559-0716-7

Children (Scotland) Act 1995
www.opsi.gov.uk/acts/acts1995/Ukpga_19950036_en_1.htm

Protection of Children (Scotland) Act 2003
www.opsi.gov.uk/legislation/scotland/acts2003/20030005.htm

Young people, Sexual Health, Confidentiality and the Law

<http://intranet.nhsh.scot.nhs.uk/Org/DHS/ChildrensServices/HospitalPaediatrics/Documents/child%20protection/Young%20People,%20Sexual%20Health,%20Confidentiality%20and%20the%20Law.doc>

6.6 Looked After Children (LAC) & Looked After and Accommodated Children (LAAC)

Looked after children can stay either at home, or away from home and the Lead Professional is usually the Social Worker. The health partner to the multi agency Childs Plan is usually the Health Visitor or School Nurse. The Public Health Nurse (School Nurse) continues to be the health partner to the Childs Plan, even when the child is not attending their allocated school.

The PHN/HV has a responsibility to:

- Assess the child's health needs when they become Looked After (using the My World Triangle assessment tool)
- Ensure all children age 5 have their development assessed using a Schedule of Growing Skills2
- Co-ordinate the health action plan and information.
- Ensure that "core health information" (see PHNR Guidance Appendix) is reflected on the multi agency plan
- Support the carer/parent – including foster carer and residential care staff.

The Clinical Specialist for LAC & LAAC is available for clinical supervision, support and training on request.

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7. Supporting and Delivering Early Intervention

“The period before birth and in the early months and years of life has a profound impact on a child’s life, on their physical, mental and emotional development and, in turn, their life chances.” Deacon, (2011). As mentioned in the background (page 6), the focus of care and support for children and young people requires to shift from crisis management to early intervention, (whilst recognising crisis management will still be needed where appropriate). Early intervention is defined as early in the child’s life, early in the spectrum of complexity or early in the life of a crisis. The approach to integrated children’s services within Highland is central to supporting and delivering early intervention; by all children having a Named Person to identify needs at the earliest possible time and any identified needs will be planned and delivered through one child’s plan.

7.1 The Child’s Plan

Interventions should be planned on the basis of assessment and coordinated by using the My World Triangle and The Child’s Plan (if more than one agency involved).

<http://www.forhighlandschildren.org/5-practiceguidance/> page 41-45.

Interventions should be outcome focused by analysing strengths and pressures around the My World Triangle. Core health information should be recorded in the child’s plan; this information is detailed in PHNCFR guidance - <http://intranet.nhsh.scot.nhs.uk/FormsLibrary/Pages/Default.aspx>

Interventions that promote resilience are most effective to achieving good outcomes for children.

7.2 Solution Focused Approach

The solution focused approach has been recognised as being effective in involving children, families and all key partners to child’s plans to enable generation of solutions and interventions to support identified health and well being needs (Highland Children’s Services, 2010). A solution focused approach is about looking forward to the outcomes to be achieved for children rather than focusing on problems. Solution focused meetings can be held at any time when there is a need for professionals to get together with children and families. Meetings can be held when there is only one agency involved therefore the Named Person may convene or facilitate the meeting. Solution focused training can be accessed through Educational Psychologists.

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Key Principles (solution focused approach)

- The past is the past. What matters now is the future.
- All participants' contributions are equally welcomed.
- Participants are encouraged to step out of role and view the concerns from the perspective of all partners to the plan.
- The Named Person/Lead Professional may facilitate meeting. The engagement of the Integrated Services Officer can be sought for preparation and support. Meetings should always be facilitated by a practitioner trained in solution focused approaches.
- The Named Person/Lead Professional will compile a detailed action plan to ensure that solutions that are generated are followed through

The following link provides helpful information for practitioners to help children and young people identify their goals:

Helping children and young people identify their goals:

<http://www.highland.gov.uk/learninghere/psychologicalservice/information-professionals/Goals.htm>

Further guidance on solution focused meetings can be found:

www.forhighlandschildren.org/5-practiceguidance

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7.3 Key resources

This section provides information on key resources and Professionals who can help support children and young peoples' health and wellbeing needs.

Childcare and Early Education Service Tel: 01463 711176

Childcare and family Resource Officers

Each Childcare and Family Resource Partnership is a multi-agency group which usually includes:

Local service providers, e.g. representatives of childminders, pre-schools, after-school clubs, family support organisations

- The Highland Council's elected member who is the local Children's Champion
- NHS representative
- SWS representative

Childcare and Family Resource Officers (CFRO) cover each of the three Highland Council administrative areas. There are four in post (one for each area plus one who lends extra support where required).

One CFRO has been seconded to develop 'wraparound care'.

Gaelic medium provision is assisted by a specialist CFRO. They focus on developing and sustaining childcare and family support services and supporting the local Childcare and Family Resource Partnership. Examples of their work are:

- Working with providers to maintain/improve the quality of service
- Encouraging inter-agency working;
- Working with the CFR Partnership members to decide on local priorities for funding;
- Identifying training needs and arranging courses;
- Producing regular newsletters

Voluntary Organisations

In addition to health, education and social work services, many voluntary organisations work in the highlands to support families and children. Some work in specific areas, others are Highland wide.

PHN/HVs should be aware of resources available in local areas, publicise contact information and build links with local organisations.

Families can contact organisations directly however PHN/HVs can request services in for children/families to the appropriate organisation in the role as Named

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Person/Lead Professional.

When requesting a service a completed My World Triangle/Child's Plan demonstrating the assessment, identified need and possible expectations from the voluntary service should be provided (or as soon after as possible)

Home Start

Operates in Ross and Cromarty and Caithness.

UK wide voluntary organization, with local projects managed by committees.

Paid staff recruit, train and support volunteers, who befriend with families and children. Support includes home visits, groups, crèches and outings.

Ross and Cromarty homestarc@btconnect.com telephone: 01349 883484

Caithness h-scaithness@btconnect.com telephone: 01955 606222

Action for children (formerly NCH)

Currently in Inverness, Alness and Lochaber.

UK wide organisation which provides a range of support to families using paid, trained staff. Services include home visiting, group work, crèches, and pre-school play sessions.

Project Manager – 01463 794404

Family First and Families in Focus

Currently in Golspie, Broadford and Portree

Support to families with at least one child 0-3 years of age.

Home visiting tailored to family need and facilitating groups.

Family First office@careandlearningalliance.co.uk

Families in Focus familiesinfocus@sky.com

Care and Learning Alliance

Umbrella group for voluntary pre-school groups, including playgroups and most parent and toddler groups and out of school clubs.

CALA - office@careandlearningalliance.co.uk tel. 01463 703033

Website www.careandlearningalliance.co.uk

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Direct Childcare

Currently in Caithness, Sutherland, Ross-shire, Skye and Localsh, Inverness and Nairn.

Innovative service that provides safe, professional crèche and sitter services through three mobile facilities.

Services can be provided for conferences, training programmes, education courses, family support groups and all types of meetings and seminars.

Direct Childcare info@directchildcare.co.uk

Website www.directchildcare.co.uk

HAPIS

Highland Ante/Post Natal Illness and Depression Support (HAPIS), is a voluntary group offering advice, information and opportunity to meet with others.

Individual and group work offered.

HAPIS www.hapis.org.uk

Helpline 0775 468 7423

One Parent Families Scotland

National organisation with helpline, useful publications and website.

www.opfs.org.uk Tel: 0131 556 3899

Other useful resources and contacts

Promoting Health and Wellbeing in 0-5 yrs settings: a guide.

Highland Children's Services – Easy Guide - http://www.forhighlandschildren.org/4-icspublication/index_12_597789979.pdf

7.4 Concerns about Meeting the Needs of Children (Liaison Meetings)

There will be times when early intervention has not addressed the child's needs within a reasonable timescale or where the circumstances for the child's health and wellbeing become more complex. Further analysis and assessment of health and wellbeing needs will be required.

The Liaison Meeting provides a mechanism for the Named Person or Lead Professional from universal services to discuss their concerns regarding an individual child. Liaison meetings are held on a regular basis within associated school group areas. Attendance at a Liaison Meeting will be arranged through the local ISO.

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The Child's Plan will be discussed by the Liaison Meeting where:

- Initial assessment suggests an acute level of complexity which requires the involvement of a targeted service and the child is not considered to be at risk of significant or immediate harm
- Complexity is increasing despite the provisions of an existing Child's Plan and advice is required.
- Concerns are not reducing – advice can be sought at any time, but must be sought where an early intervention service has been in place for 6 months.
- Referral to the children's reporter needs to be considered where concerns about the child's welfare or behaviour cannot be addressed on a voluntary basis, when parents/carers or the child are unable or unwilling to engage with services sufficiently to address the risks and needs for that child.
- Additional resources are required that cannot otherwise be met.

The Named Person or Lead Professional will ensure that the child (where appropriate) and family are;

- informed of the Liaison Meeting,
- have sight of the plan before it goes to the Liaison Meeting and
- are helped to understand and have their views included in good time.

(For Highland's Children, 2011)

For further information about Liaison meetings see Practice guidance page 38.

<http://www.forthighlandschildren.org/5-practiceguidance/> .

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9. Health Promotion and Prevention

Public health policy is designed to improve the public's health and in doing so focuses attention on key aspects of health and health improvement (Thornby, 2009). Positive health improvement information and support are key to the success of achieving a healthy nation. PHN/HVs are key to the delivery of these messages and to ensuring that the right messages are getting through. As part of the primary healthcare team, PHN/HVs should ensure that positive health improvement messages are provided as part of all universal contacts with children and their families (Scottish Government, 2011).

The following section illustrates the key target areas for promoting health within the Hall 4 core programme and targets set by Scottish Government to improve Public Health.

8.1 HEAT Targets

HEAT targets are priorities set by the Government to improve health care in Scotland. HEAT targets are set for a three year period and progress towards them are measured through local delivery plans. Targets are revised regularly and new targets are added as further evidence about population and public health becomes available. The following list explains HEAT:

- **Health Improvement for the people of Scotland** - improving life expectancy and healthy life expectancy;
- **Efficiency and Governance Improvements** - continually improve the efficiency and effectiveness of the NHS;
- **Access to Services** - recognising patients' need for quicker and easier use of NHS services; and
- **Treatment Appropriate to Individuals** - ensure patients receive high quality services that meet their needs

Current Priority Heat targets related to children and young people (Better Health Better Care, Scottish Government, 2008)

H	At least 60% of 3 & 4 year old children in each Scottish Index of Multiple Deprivation (SIMD) quintile to receive at least two applications of fluoride varnish per year by March 2014
H	Achieve agreed completion rates for child healthy weight intervention programme by 2010/11
H	Through smoking cessation services, support 8% of each NHS Board's smoking population in successfully quitting (at one month post quit) over the period 2008/09 – 2010/11

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H

Increase the proportion of newborn children exclusively breastfed at 6-8 weeks from 26% in 2006/07 to 33% in 2010/11

For further information about HEAT targets please see: Scotland performs (NHS Scotland, 2011) - <http://www.scotland.gov.uk/About/scotPerforms/partnerstories/NHSScotlandperformance>

8.2 The Personal Child Health Record (Red Book)

The new Personal Child Health Record (Red Book) has now been adopted for all children born on or after 1st January 2010. The Red Book will be used as a proactive tool to work in partnership with parents and carers to help them understand the expected health, wellbeing and developmental outcomes for their child. By using the Red Book in this way parents and carers will be helped to take the lead on discussions about any issues or concerns they may have for their child, for example, child development concerns. The following summary lists the key points noted in the recent summary of the new personal child health Record;

- The Red Book belongs to the child however is mainly completed by Health Professionals
- Should be given to the parent/carer on or as close to the 10th day after the baby is born (even if the baby is still in hospital)
- PHN/HVs should explain the purpose of the red book to parents/carers
- Should be used as a dynamic communication tool

Developmental Checklists are available –PHN/HVs are encouraged to share with Early Years Partners, to facilitate discussions with parents/carers if there are any aspects of a child’s developmental progress which are highlighted as being of possible concern in an early years setting.

Foster/kinship carers who are looking after a baby should be given the Red Book within 10 days of birth - This record should travel with the child across placements.,

Down’s syndrome – A 20 page insert, which contains additional information for parents and professionals, is available for babies born with Down’s syndrome. Inserts are available from the Child Health Department as and when required.

8.3 Highland Information Trail

[Intranet/Organisation/Public Health/phdept library](#)

PHN/HVs provide core health promotion & prevention support universally. Written core information is cascaded through the Highland Information Trail. The information trail covers preconception, pregnancy, infancy, toddler and preschool period. The trail covers information from a national and local perspective and

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signposts professionals to related services and resources to support parents and carers. Layout is organised to complement the Hall 4 core programme.

Central to the advice is the use of the following resources (Highland Information Trail):

- Ready Steady Baby – provided by midwives during pregnancy
www.readysteadybaby.org.uk
- Ready Steady Toddler – provided by PHNs, local CHP process
www.healthscotland.com/documents/2613.aspx
- Fun First Foods –Health Scotland resource evidence based information for healthy weaning. Provided by PHNs at age 3/4 months.
- Play @ Home – provides parents with guidance on safe and beneficial ways of handling an infant to improve family emotional ties, stimulate child development and promote a stimulating, nurturing environment. Provided by PHN's at primary visit, toddler version provided through local processes.

8.4 Health Information and Resources Service

Leaflets for the information trail can be ordered from the above service/library. The library also offers a wide range of health related materials for loan, free of charge. Materials consist of books, leaflets, videos, training packs, games and equipment. Health Information on a wide range of topics can also be sourced e.g. smoking.

Link – www.informatics-scitech.co.uk/healthyhighlanders/IndexNoNews.asp

Library - 01463 704647

Health Information – 0845 757 3077

8.5 Growth Measurement Hall 4

Regular and accurate growth measurements and plotting on growth charts will identify rapid weight gain.

Current Hall 4 guidelines specify universal growth measurements at birth, within the first 10 days of life, 6-8 weeks, 3 months, and 4 months, between 12-15 months and between the ages of 3-5 years and at entry to school.

It is also recommended that where there is a concern that a child may be overweight, his/her height and weight should be measured and Body mass index (BMI) calculated and recorded. Further support to children and families should be offered as appropriate (Hall 4, 2005).

New WHO Growth charts have been introduced to be used for all infants (however they are fed) from January 2010. The charts are now inserted into all new Red Books. The new charts have been constructed using data from healthy breastfed

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babies from around the world who had no health or environmental constraints to growth (WHO, 2009).

New charts will be available from Harlow Printing and should be ordered as per previous procedures. The charts can be viewed at www.growthcharts.rcpch.ac.uk.

All practitioners involved in height and weight screening/surveillance should be able to accurately plot growth and analyse results (Hall 4, 2005).

Best practice suggests regular updating of knowledge and skills in this area.

Training on new growth charts is essential for all practitioners using the charts. Free educational materials to support use of new charts downloads are available from the above website.

The infant and Toddler Forum provides healthcare practitioners and parents with practical help and information on nutrition and development.

The website also provides a free online learning and development package on “a comprehensive, practical approach to monitoring the growth of infants and toddlers”
Link – www.infantandtoddlerforum.org

8.6 Infant Feeding and Nutrition

- *Improve the nutrition of women of child bearing age, women who are pregnant and children under the age of five in disadvantaged areas.*
- *Achieve agreed completion rates for child healthy weight intervention programme by 2010/11*

The Maternal and Child Nutrition Best Practice Guidance provides a co-ordinated, practical and evidence based framework for delivery of nutritional care. The guidance can be found at:

<http://intranet.nhsh.scot.nhs.uk/pages/Default.aspx>

Or

www.forhighlandchildren.org (publications and information)

8.7 Breastfeeding.

NHS Highland has committed to achieving full UNICEF Baby Friendly Accreditation and in doing so has ensured that mothers who chose to breastfeed will have the support and encouragement from staff that are competent in providing research based breastfeeding advice and support.

Breastfeeding Policy

NHS Highland has an integrated breastfeeding policy which has been ratified by UNICEF and covers both the hospital 10 steps and the 7 point plan of the

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community. Each member of staff should have their own copy of the policy and the policy can be found using this link - [NHS Highland Policy on breastfeeding](#)

New Birth Visit Breastfeeding Checklist

Breastfeeding requires on-going support, encouragement and promotion by all health care providers. Handover of care from midwifery to the public health nursing team is an important transition and one which requires careful assessment of breastfeeding. As part of the New Birth Visit Care Plan any woman who is breastfeeding her child should have the NHS Highland/UNICEF post-natal checklist completed, the checklist can be downloaded in the PHNR: [PHNR PSY1 New birth visit care plan Oct](#). As from January 2010 every PHN/HV within NHS Highland will have their own laminated copy of the checklist. A careful breastfeeding history will be taken via the use of the checklist and then this will be noted on the new birth care plan.

Peer Support

NHS Highland has worked closely with both the National Childbirth Trust and Breastfeeding Network and now has externally accredited breastfeeding peer supporters in the communities working with health professionals to ensure women receive the support and encouragement to breastfeed for as long as they wish.

These volunteer breastfeeding peers are there to support the health professionals. They have strict pathways and guidelines to adhere to. They have completed NHS Highland mandatory training in moving and handling, violence and aggression, child protection, hand hygiene and fire and have also completed the corporate induction programme. They have all achieved enhanced disclosure and have had occupational health screening. They offer a great service and women should be encouraged to take up the offer of this additional support network in your area. To get in touch with your local peer supporters please get in touch with the Infant Feeding Advisors on 01463 704842 and they will put you in contact with a peer in your area.

NHS Highland Excessive Weight Loss Guideline for Breastfed Neonates

It is very important that neonatal wellbeing is monitored in relation to breastfeeding. Urine and stool output are the most important markers to evaluating whether breastfeeding is going well, but weight gain should also be monitored. It is recommended that all babies are weighed by the PHN/HV during their new birth visit assessment.

All breastfed babies should ideally have achieved their birth weight by 2 weeks of age – if not clear objectives should be implemented to improve weight gain. The use of the NHS Highland policy following policy - [Prevention of Excessive Weight Loss in the Breastfed Neonate](#) should be integral to improving both the support and care given to mothers whose baby has lost or is slow to gain weight.

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8.8 Healthy Start Scheme –

Information/support for the uptake of healthy start is provided by midwives. PHN/HVs should continue this process by advising women and families about the scheme and encouraging anyone who may be eligible to uptake. Provide information on where to get a form and how to fill in. PHN/HVs will also need to sign part B of the form.

An online learning package on all aspects of the scheme is provided free to practitioners: www.healthystart.nhs.uk

Information on vitamin supply in Highland is in Maternal and Child Nutrition Best Practice Guidance.

Resources for Practitioners:

- Healthy Eating, Active Living: An action plan to improve diet, increase physical activity and tackle obesity.
www.scotland.gov.uk/publications/2008/06/20155902/0
- Nutritional Guidance for Early years: food choices for children aged 1-5 years in early education and childcare
www.scotland.gov.uk/publications/2006/01/18153659/0

8.9 Pre-school Orthoptic Visual Screening Programme

NHS Highland is working in partnership with Highland Council to offer all children a Pre-School Orthoptic Vision Screening (POVS) assessment in the year before they are eligible to start school.

The Scottish Government has recommended that children should be offered an eyesight test between their 4th and 5th birthdays. The report also recommended that the screening should be carried out by an Orthoptist in the child's pre-school centre.

This assessment will replace the routine eyesight check which PNH have carried out in P1 in the past. It is therefore the **only** vision test the children will have.

The assessment in the pre school centre follows national standards, but as with all screening tests, it cannot guarantee to pick up all problems. Parents are advised that if, after a normal result, they still have worries about their child's eye-sight, they should seek advice from a local Optometrist (optician) or their general practitioner (GP).

If a child has not been screened at pre-school by an orthoptist, this will be indicated on the P! Assessment Form. The visual acuity must then be tested by a PHN in P1, who has been trained in the use of Sunken LogMar Test.

Further training/updates will be ongoing and can be arranged by contacting jean.mcculloch@nhs.net

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8.10 Oral Health

- **80% of all three to five year old children to be registered with an NHS dentist by 2010/11**

Provision of free toothbrushes/toothpaste, free dental checks, promotion of healthy nutrition and about the relationship between sugary foods and tooth decay are all useful interventions. PHN/HVs (alongside oral health colleagues) are in a prime position to promote the above. The following local resources support this:

- First Teeth Healthy Teeth – oral health guide for practitioners, parents and carers, can be used for 1-1 health promotion or within group situation.
www.healthscotland.com/documents/3251.aspx
- Childsmile Core: The Childsmile Core programme is available throughout Scotland. Every child will be provided with a dental pack containing a toothbrush, toothpaste and regular information leaflets.
- Universal provision of a free-flow cup by six months.

The universal service will not always reach those most in need. NHS Highland has recently commenced the roll out of the Childsmile programme. The programme provides the opportunity to provide additional support to children and families most in need. Implementation of childsmile is via a phased roll out, a fully active programme across all of Highland is proposed for end of financial year 2011-2012. All children will be assessed for dental health support during the Hall 4 6-8 week core contact by PHN/HVs. The pathway for assessment and support of dental health needs can be found in the following link.

Childsmile: www.child-smile.org.uk

8.11 Smoking

- **Through smoking cessation services, support 8% of each NHS Board's smoking population in successfully quitting (at one month post quit) over the period 2008/09 – 2010/11**

All relevant information on supporting families through smoking cessation services-

Women, pregnancy and substance misuse Best practice guidance - Link

Useful resources:

Ash Scotland – briefing on children and second hand smoke -

http://www.ashscotland.org.uk/files/Smokinginhome_Briefing_Mar10.pdf

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9. Best Practice Guidance. Pathways

www.forhighlandschildren.org publications and information page:

- Women, Pregnancy and Substance Misuse – revised guidelines
- Domestic Abuse: Pregnancy and the Early Years – revised protocol for midwives, PHN/HVs, GPS and obstetricians
- Maternal and Child Nutrition; Best Practice Guidance
- Intimate care for children policy (Highland Council)

Preschool Health and Wellbeing – [LINK \(will be available in intranet early 2011\)](#)

Guidelines for Maternity Services Getting it Right for Every Mother:

<http://intranet.nhsh.scot.nhs.uk/PoliciesLibrary/Documents/Guidelines%20for%20Maternity%20Services%20Getting%20it%20Right%20for%20Every%20Mother%20and%20Child.pdf>

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