Families, Young People and Children’s Service Standard Operating Guidance for Health Visiting Teams delivering the Healthy Child Programme
The contents of the Standard Operating Guidance 2015 for the Health Visiting Team delivering the Healthy Child Programme will be reviewed annually.

This document has incorporated many relevant pathways, both service specific and integrated. For further pathways and the electronic version please go to: http://www.leicspart.nhs.uk/_Divisions-FamiliesYoungPeopleandChildrensService-CarePathways.aspx

For the electronic version of this document and all other health visitor related guidance please access: Health Visitor Staff Room on e-source: http://www.leicspart.nhs.uk/_Divisions-FamiliesYoungPeopleandChildrensService-ServiceStaffroom-HealthVisiting.aspx

April 2015
Assessment Framework

Working Together to Safeguard Children 2013 (page 20)

CHILD
Safeguarding & promoting welfare

Community Resources
Family's Social Integration
Income Employment Housing
Wider Family & Functioning

Family's Social Integration

Basic Care
Ensuring Safety
Emotional Warmth
Stimulation Guidance & Boundaries
Stability

Health
Education
Emotional & Behavioural Development
Identity
Family & Social Relationships
Social Presentation
Selfcare Skills

Child's Development Needs
Parenting Capacity

Family & Environmental Factors
CONTENTS

1. Purpose ................................................................................................. 5
2. Introduction .......................................................................................... 6
3. Overarching statement .......................................................................... 8
4. Roles and responsibilities ...................................................................... 8
5. Healthy Child Programme – Universal Offer ......................................... 11
6. Antenatal contact .................................................................................. 13
7. New Birth Review .................................................................................. 16
7.1 Completion of New Birth Review/Follow Up Contact ......................... 25
8. Six Week Universal Contact .................................................................. 25
9. Three to Four Month Review ............................................................... 30
10. Universal Health Review to be completed by One Year ...................... 32
11. Universal Two to Two and a Half Year Contact .................................... 37
12. Health Visitor remit Two and a Half to Five Years ............................. 43
13. The wider remit of the Health Visiting Service ..................................... 43

Tables
1  Traffic light system for identifying likelihood of serious illness .......... 48
2  Universal Plus Pathway ....................................................................... 49
3  Universal Partnership Plus Pathway ...................................................... 50
4  Vitamin D and Healthy Start ................................................................ 51
4a NICE Public Health Guidance 56 (Vit D) ......................................... 52

Appendices
1  Breastfeeding Assessment Form .......................................................... 53
2  Infant Feeding Conversations for HV Team .......................................... 54
3  Antenatal Contact – Communication with Your Baby ........................ 55
4a Management of Prolonged Jaundice in Infants – UHL letter 2014 ...... 56
4b Midwifery and Health Visitor Guidance for Jaundiced babies  
  between 13, 14 and 15 days ................................................................. 57
5  Blood Spot Screening Pathway ............................................................. 58
6a Movement In Pathway (Internal) .......................................................... 59
6b Movement In Pathway (External) .......................................................... 60
7  Discharge from Hospital Pathway .......................................................... 61
8  Perinatal Maternal Mental Health Pathway .......................................... 62
9  Speech and Language Communication Needs at 2 Year Pathway – 
    Late Talkers ....................................................................................... 63
10 MARAC Care Pathway ......................................................................... 64
11 Health Visiting Team – Behavioural Pathway 0 – 4 years .................. 65
12a Constipation Management for Children under 5 years ..................... 66
12b Constipation Management for Children under 5 years ..................... 67
13 Handover Pathway HV to SN – Universal Plus and Universal 
    Partnership Plus .............................................................................. 68
14 Children at Risk of Hearing Impairment .............................................. 69
15 Neonatal BCG Risk Assessment ........................................................... 70
16 Neonatal Hep B Immunisation Service ............................................... 72
17 Ages and Stages Recommended Tool .................................................. 73
18 Neonatal Care Pathway ....................................................................... 74
19 Oral Health ........................................................................................... 75
20 Transition to Parentood Pathway .......................................................... 76

References and recommended leaflets and websites .............................. 77
1. Purpose

This document replaces the Leicestershire Partnership Trust (LPT) Families, Young People and Children Service Standard Operating Procedure for Family Health Visiting Healthy Child Programme (2012). It has been produced in line with the new National Service Specification published in October 2014. It reflects current evidenced based practice in child health and the growing health improvement agenda.

The Healthy Child Programme (DOH 2009 HCP) is the guidance which underpins the work undertaken by the Health Visitor; it highlights the key role that Health Visitors and their teams play in improving the health and wellbeing of children, as part of an integrated approach to supporting children and families.

An effective, universal, preventative and early intervening service has a crucial role in working collaboratively to identify ‘at risk’ children and young people. The service aims to reduce the risk of this client group becoming the most vulnerable adults in the future. Early intervention and long term investment will support these children, young people and their families to reach their full potential.

This document gives clear guidance on the minimum standard expected of the Health Visitor and those members of staff she/he may delegate to:

- Community Nursery Nurse (CNN)
- Health Care Assistant (HCA)

It is expected that the Specialist Community Public Health Nurses (Health Visitors) employed by Leicestershire Partnership Trust uses their own professional judgement and have clear documented evidence of the rationale for their decision making. As nurses they should abide by the Nursing and Midwifery Council Code of Conduct (2015).

This document reflects the Health Visitor Implementation Plan; a Call to Action (2011-2015) and is to be delivered in the context of the transition of the 0 – 5 services to local authority commissioning in October 2015. Health visitors continue to work in close partnership with GPs, primary care and with the CCG commissioned services and public health programmes. This Implementation Plan sets out what the long term aspirations for implementing this commitment means for families, health visitors and their health, social care and voluntary partners.

The new expanded health visiting service will be delivered through home visits and within health centres, children centres and other convenient community settings.

The expectation is that from April 2015, in response to Call for Action, Health Visitors and their teams in LPT will undertake all the universal contacts laid down in the National Service Specification. It is expected that the Named HV in the City localities will undertake all the universal contacts except the 4 month contact which may be delegated to CNNs, whereas in the County neighbourhoods the 4 month and 2 year contact may be delegated to the CNN’s.
2. Introduction

Service

The service we offer in Leicestershire Partnership Trust (LPT) is laid out in this document setting out the minimum expected contact, assessment and delivery of care a Health Visitor (HV) and the Health Visiting team should deliver. The service offered will be dependent upon the generic assessment of need of the child and family which will determine whether the universal pathway is appropriate or further intervention is required. Health Visitors are Specialist Community Public Health Nurses (SCPHN) trained to lead the virtual HCP across a number of settings and organisations for children from birth to school entry age.

It is expected that the Health Visitor exercises professional judgement (following their assessment) in deciding whether or not a client/family should receive additional support and intervention. This document should be used in conjunction with the locally agreed procedures, Trust policies, CNN competencies and NMC codes of professional conduct (2015).

'The Offer'

Your community has a range of health services (including GP and community services) for children and young people and their families. Health Visitors should be aware of not only the health needs of the local community, but also relevant services available and develop preventative strategies.

Universal Services. The Healthy Child Programme offers every family a range of screening tests and assessments, the opportunity to receive the national immunisation programme, development reviews and information and guidance to support parenting and healthy choices (which families, young people and children need to receive if they are to achieve their optimum health and wellbeing).

Universal Plus. Health Visitors have a key role in ensuring that there are robust systems in place for identifying when families require further support, assessing need and delivering intervention. They operate within a social model of health that focuses on promoting resilience and building on strengths in both families and communities.

Universal Partnership Plus. Working together with other agencies from health, social and voluntary sectors for families with more complex needs.

To strengthen interactions at community level, building capacity to improve health outcomes and leading the healthy child programme (0-5) for a population.

Universal service for all:
- Antenatal
- New Birth Review at 10-14 days
- Six week
- Four month
- One year
- Two years

Packages of care in response to need eg.:
- Postnatal depression
- Weaning
- Sleepless baby
- Behaviour management
- Baby Discharged from NNU
- Feeding issues

Ongoing support and intervention for more complex needs, eg. children with disabilities or long-term conditions:
- Looked After Children (LAC)
- Family Nurse Partnership/Early Start
- New Adopted Children
- Pre-adoptive children (still LAC)
Safeguarding

All healthcare professionals have a duty to safeguard the welfare of those children (including child sexual exploitation) with whom they come into contact and to consider the needs of children in all relevant aspects of their work e.g. multi-agency working (http://www.lrsb.org.uk and http://www.lcitylscb.org)

Professionals must act in accordance with the Local Safeguarding Childrens Boards (LSCBs) for Leicester and Leicestershire and Rutland and organisational procedures if abuse or neglect is suspected.

Outcomes

The health visiting service will deliver the full Healthy Child Programme (HCP) 0-5 years with a focus on working across services for 0-5’s and their families to improve the following public health outcomes.

The Public Health Outcomes Framework (PHOF) and the NHS Outcomes Framework include a range of outcomes which it is expected will be improved by an effective 0-5 years public health nursing team:

- Improving life expectancy and healthy life expectancy
- Reducing infant mortality
- Reducing low birth weight of term babies
- Reducing smoking at delivery
- Improving breastfeeding initiation
- Increasing breastfeeding prevalence at 6-8 weeks
- Child development at 2 – 2½ years
- Reducing the number of children in poverty
- Improving school readiness
- Reducing under 18 conceptions
- Reducing excess weight in 4-5 years
- Reducing hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14
- Improving population vaccination coverage
- Disease prevention through screening and immunisation programme
- Reducing tooth decay in children aged 5.

High Impact Areas

Health Visitors can have a significant impact on health and well-being and improving outcomes for children, families and communities. These can be found at: https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children

The six high impact areas are:

- Transition to Parenthood and the Early Weeks
- Perinatal Maternal Mental Health (Perinatal Depression)
• Breastfeeding (Initiation and Duration)
• Healthy Weight, Healthy Nutrition (to include physical activity)
• Managing Minor Illness and reducing Accidents (Reducing Hospital Attendance/Admissions)
• Health, Well-being and Development of the Child Aged 2 – Two year old review (integrated review) and support to be ‘ready for school’

These areas are to be seen as a priority in addition to the work of the health visitor in delivering the Healthy Child Programme.


3. Overarching statement

The following statements apply to all contacts:

Advice and information should be offered where available in a format and language that is acceptable to families. Families whose first language is not English should be offered interpreted translation information as available.

Clarity regarding demographic information should be sought at each contact and any changes i.e.:
• phone number
• change in main carer
• new household member and new relationships should be documented on the SystmOne the HV electronic record.
• new name after adoption

Only information leaflets from the recommended approved list (see ‘Recommended Leaflets and Websites’ at back of SOG) should be offered to parents/carers, providing standardized, good quality, evidence based information. Parents should also be sign posted to websites and other areas of social media which has evidenced based approved resources.

For those practitioners who wish to use a leaflet not on this list or a new website please contact your Clinical Team Leader who may proceed through the Trust’s approved information process.

4. Roles and Responsibilities

The Named Health Visitor is responsible for ensuring that the Healthy Child Programme (HCP) universal service is offered to all children and families within Leicester, Leicestershire and Rutland. If this offer does not result in a child contact then clear rationale should be documented e.g.:
• No access visit
• Did not attend
• Service declined

The Health Visitor is responsible for coordinating the delivery of this programme and any actions that are required as a result of that contact. **The Named Health Visitor is also responsible for liaising with the GP to inform them of any children who have not had a universal HCP contact.**

From the first contact with the family during the ante-natal period, the new birth review, or when a family transfers into the Health Visiting caseload, the Named Health Visitor is the **accountable** practitioner. This accountability remains with the Named Health Visitor until there has been a safe transfer of care either:
• Through transfer to school nursing services
• Change of General Practitioner
• Change of area dependant on local working arrangements.

**See Movement In Internal and Movement In External Pathways (appendix 6a/6b) See Health Visitor to School Nurse Pathway and Protocol (appendix 13)**

The Named Health Visitor remains accountable for the delegated work undertaken by members of the Health Visiting Team, ensuring that the work is appropriate for the competencies of the team member to whom the work is delegated. There is only one Named Health Visitor any one time for an individual child or family. Any ambiguity about who is accountable in active case must be discussed and then documented (see LPT Corporate Working Guidelines V2 2012).

Within a corporate team a second Health Visitor may take responsibility for assessing and coordinating a specific episode of care, for example, a Health Visitor who undertakes the weighing of a child at an advice clinic is accountable for that episode of care, but the overall responsibility of the case remains with the Named Health Visitor. This person should ensure that the delegation of work is to a team member with the appropriate skills to deliver, and also that a robust system is in place for supervision and guidance as needed. For further guidance refer to the local policy on the process of delegation of tasks and NMC Standards (www.nmc-uk.org.uk www.nmc.org.uk).

Any contact must be documented within the National Personal Child Health Record (PCHR/Red book) and Leicestershire Partnership Trust Health Visiting electronic record system as appropriate, in line with the current record keeping policy.

**Community Nursery Nurses (CNN)** have undertaken a national recognised nursery nurse qualification, to a minimum of level 3 (NVQ). Working with health visitor teams they undertake aspects of the HCP which have been delegated to them by the Named Health Visitor. They have specific child-focused expertise. These activities should be provided through shared packages of care.

The Community Nursery Nurse is based within the team and their work is delegated as such. Central to the CNN role is to deliver targeted packages of care (universal plus). The CNN is competent to deliver the HCP universal contact at 4 month and 2 year if delegated by the HV team. Their role with the universal HCP is required
in the county neighbourhoods where the number of qualified HVs is less per population than the city neighbourhoods. The expectation in the city is that HCP contacts should be undertaken by the HV and the universal plus interventions undertaken by the CNN either as one-to-one or in a group. These interventions include:

- Weaning
- Oral health
- Behavioural
- Let’s Get Talking
- Infant massage (targeted)

**Within the Health Visiting service there are also additional roles that enhance the service:**

- Health Care Assistants
- Health Visitor (Homeless Families)
- Health Visitor (Asylum Seekers)
- Health Visitors (Children with Additional Needs)
- Named Nurses
- LAC Team
- Family Nurse Partnership
- Early Start Charnwood
- Infant Feeding Co-ordinator

As public health practitioners Health Visitors also contribute to health needs analysis using tools such as the Early Years Profile. They also work alongside other health professionals including midwives early years practitioners, voluntary organisations, peer supporters, Family Nurse Partnership, Early Intervention Service, GPs, primary and secondary care providers as well as children centres and early years settings to ensure a holistic service that focuses on improving health outcomes, reducing inequalities at individual, family and community level.

**Service delivery**

The core service will operate standard hours of 9.00am to 5.00pm, Monday to Friday, but with flexibility from 8.00am to 8.00pm to meet the needs of families. Other working hours, such as Saturday mornings may be considered by neighbourhoods to meet the needs of families.
### 5. Healthy Child Programme Universal Offer – Content Guidelines

<table>
<thead>
<tr>
<th>Universal</th>
<th>Ante Natal Contact</th>
<th>Initial Contact/ New Birth Review</th>
<th>Six Week Contact</th>
<th>4 Month Group Session</th>
<th>Health review by One Year</th>
<th>Two Year Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can the contact be delegated?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No (City) Yes (County)</td>
</tr>
<tr>
<td>* Recommended Contact Setting</td>
<td>Home</td>
<td>Home</td>
<td>Home/ Clinic setting</td>
<td>Community or Clinic</td>
<td>Clinic setting</td>
<td>Clinic setting</td>
</tr>
<tr>
<td>Growth</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Nutrition</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Development</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Parenting</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Environment/Family/ Social Network</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Maternal Mental Health Assessed</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Bookstart Distribution</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety Assessment/ Advice</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Oral Health</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

- Antenatal contact and 6-8 week contact should ideally be delivered jointly to both parents (Promotional Guide Training).

* Preferred contact setting and approach. This is the recommended approach for Universal Contacts. It is acknowledged that Health Visitors may use their professional judgement and a contact may be undertaken in a different venue or approach but the rationale documented.

HV = Health Visitor, GP= General Practitioner, CNN = Community Nursery Nurse.
Tools used in the delivery of HCP

Health visitors are Specialist Community Public Health Nurses and study at post graduate level. When employed within Leicestershire Partnership Trust they receive further training so they are competent to offer a high standard and evidence based service. This training includes the use of Promotional Guides and the use of Ages and Stages questionnaires to support the assessment of the family, parent and child. Although both have been advocated as the tools of choice, it is acknowledged that for the diverse cultural mix of clients we visit, where English is not their first language, a pragmatic approach must be adopted.

The HV should use their professional judgement as to how they undertake the HCP assessment (provided the approach is evidence based and a clear rationale for the decision making is documented).

See ASQ Guidelines (Appendix 17).
## 6. Antenatal Contact

Prospective parents will be offered an antenatal contact by a Health Visitor between 28-36 weeks gestation within their home setting following Health Visitor liaison with the Midwife. This should be a promotional narrative listening interview including preparation for parenthood. This should be done face to face in a confidential setting. This guided conversation should include talking about attachment, interacting and talking with baby to encourage development. The contact should be delivered to both parents where appropriate. (Transition to Parenthood and Early Years pathway).

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Method of Assessment and support</th>
<th>Expected Outcome/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction to the Health Visiting Service</strong></td>
<td>Discuss the role of the Health Visitor; provide contact information and signpost to resources and services offered at the Children’s Centers.</td>
<td>Establish a positive relationship between HV and parents.</td>
</tr>
<tr>
<td>To support parents and give anticipatory guidance.</td>
<td></td>
<td>Parents will have clear understanding about the role of HV services.</td>
</tr>
<tr>
<td>To advise families of the local support network within the area from multiagency working.</td>
<td></td>
<td>Early signposting or referrals to other appropriate services.</td>
</tr>
<tr>
<td><strong>Parent Assessment</strong></td>
<td>Discuss family health history, e.g. existing health issues/conditions, previous obstetric history, physical, psychological, social, environmental needs.</td>
<td>NICE CG192 (2014) <a href="http://www.nice.org.uk">www.nice.org.uk</a></td>
</tr>
<tr>
<td>To identify any predisposing factors including vulnerability factors that may influence a parent's ability to parent safely and effectively.</td>
<td></td>
<td>See UNICEF re conversation on feeding.</td>
</tr>
<tr>
<td><strong>Health Promotion</strong></td>
<td>Possible discussion points: Discuss feeding choices to help pregnant women prepare for feeding and caring for their baby's well-being, including oral health. Discuss the value of breastfeeding as a way to comfort, nurture and protect. Vitamin D supplements and a Healthy Start. All pregnant and breast feeding mothers in the first year should take a vitamin D supplement and are entitled to the vitamins if they meet Healthy Start criteria. If</td>
<td>See UNICEF re conversation on feeding.</td>
</tr>
<tr>
<td>To promote the principles of early intervention and the contribution it makes to positive outcomes.</td>
<td>Liaison with midwife.</td>
<td></td>
</tr>
<tr>
<td><strong>Advice re vitamin supplements and uptake of Healthy Start.</strong></td>
<td></td>
<td>Maternal and Child Nutrition (NICE 2008 updated 2011) PH 11</td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
• Developing relationship between parents and unborn child.  
• Safe sleeping/reducing risk of sudden infant death.  
• Emotional preparation for birth, carer and infant relationship. Importance of secure attachment. (Infant mental health) using the promotional guides.  
• Ascertain smoking status of family members. Offer current information on the current evidence of risks to a child related to passive smoking and the benefit of quitting. | Responsive parenting.  
Promotional guides.  
Quitting smoking in pregnancy and childbirth (NICE 2010) PH26.                                                                                                                                                                                                                                                                                                                                                                                                  |
| Oral Health Assessment                        | Reminder of entitlement to free NHS Dentistry while pregnant.  
How to find their nearest NHS Dentist.                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | See Oral Health Pathway. Appendix 19.                                                                                                                                                                                                             |
<table>
<thead>
<tr>
<th>Rationale</th>
<th>Method of Assessment and support</th>
<th>Expected Outcome/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Social Integration</strong></td>
<td>Expected/anticipated changes in family life and relationships.</td>
<td>Discussion of family health and identify any pre-disposing factors.</td>
</tr>
<tr>
<td>Expected family support.</td>
<td>Early detection of identified risk/concerns. (Impact of DV on the unborn infant, baby and children).</td>
<td>Discuss how family integrates into local community/integration e.g. friendships and social networks.</td>
</tr>
<tr>
<td>Finance and environment.</td>
<td>To identify any concerns about housing, private renting, risk of eviction etc.</td>
<td>Discuss issues about financial situation and how parents are going to manage.</td>
</tr>
<tr>
<td>The prospective parent’s feelings about pregnancy. Life events.</td>
<td>For first-time parents having a baby is a major “life event”.</td>
<td>Discussion with parent/carer regarding any stressful situations including relationship issues, domestic violence (be alert to forced marriages and so called ‘honour’ based violence issues).</td>
</tr>
<tr>
<td>If a mother or father has experienced a previous cot death.</td>
<td>Please refer family to locality CONI Lead.</td>
<td>Early identification and documentation of any risks or actual safeguarding needs relating to the unborn child and/or parent.</td>
</tr>
<tr>
<td><strong>Safeguarding</strong></td>
<td>To identify any safeguarding concerns.</td>
<td>Observation throughout assessment/discussion to indicate any safeguarding concerns.</td>
</tr>
<tr>
<td></td>
<td>To identify risk/stressors to prevent escalation of safeguarding concerns and sign post to early intervention support services.</td>
<td>Discussion with parent/carer regarding any stressful situations including relationship issues, domestic violence (be alert to forced marriages and so called ‘honour’ based violence issues).</td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Timely communication with Line Manager, Safeguarding supervisors and Named Nurses and referral to other agencies e.g.:</td>
<td>Discussion around relationships issues including domestic abuse. See MARAC PATHWAY (Appendix 10).</td>
<td></td>
</tr>
<tr>
<td>Multi-agency practice guidelines – Female Genital Mutilations (HMG, 2014).</td>
<td>See Decision making pathway.</td>
<td>Follow guidelines if a woman or child identified – information must be shared with GP.</td>
</tr>
</tbody>
</table>

### 7. New Birth Review (NBR)

All parents will be offered a face to face contact with a Health Visitor in a home environment, between 10-14 days after the birth of their baby. If it is not undertaken at this time CLEAR rationale as to why it has not been undertaken must be documented. Appointments will be negotiated with families to maximise the possibility of fathers attending. This assessment should be undertaken by a Health Visitor or Specialist Community Public Health Nurse (SCPHN) student.

If this contact is either refused or there are **two no access** contacts then the Named Health Visitor is expected to advise the parents either verbally or in writing that the Health Visitor is required to liaise with Children & Young People Services and the family’s GP regarding any current/previous concerns within the family household and that Health Visiting services are being declined. It is recommended practice to encourage parents who decline the HV service to put this in writing.

Parental refusal of Health Visiting service is clearly documented within LPT Health Visiting records along with the agreed action plan and the Family Service Manager informed.

If a baby is in the Neonatal Unit (NNU) during this time the HV should offer the parents a new birth visit at the NNU. In addition a Looked After Child (LAC) in the City will be visited by the LAC Nurse. See Neonatal Care Pathway (Appendix 18)
In complex cases, where mother and baby move temporarily out of their neighbourhood but remain within Leicestershire Partnership Trust, the New Birth Review should be carried out by the named Health Visitor wherever possible. If this is not possible the Health Visitor carrying out the New Birth Review should have access to all the SystmOne records for that family.

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Method of Assessment and support</th>
<th>Expected Outcome/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Infants on Neonatal Unit (NNU).</strong> Appointment to be offered on the NNU.</td>
<td>See LLR Neonatal Care Pathway (appendix 18) and e-Source HV page for all FYPC Care Pathways.</td>
<td>Link between the hospital and the community. <a href="http://www.leicspart.nhs.uk/_Divisions-FamiliesYoungPeopleandChildrensService-CarePathways.aspx">http://www.leicspart.nhs.uk/_Divisions-FamiliesYoungPeopleandChildrensService-CarePathways.aspx</a></td>
</tr>
<tr>
<td><strong>Holistic assessment of baby and family’s wellbeing. This is the initial assessment of the infant.</strong></td>
<td>The baby should be assessed during the visit, even if sleeping.</td>
<td>If baby is not weighed or assessed at the NBR a clear rationale should be documented. If not undertaken a new date to complete the weight and assessment should be arranged within 7 days. This should be undertaken by a HV or SCPHN Student.</td>
</tr>
<tr>
<td><strong>To support parents and give anticipatory guidance.</strong></td>
<td>Discuss birth history with mother. To discuss any concerns parents may have.</td>
<td>Promotion and empowerment of parenting skills.</td>
</tr>
<tr>
<td><strong>To identify any abnormalities.</strong> To gain baseline measurement in which future growth can be measured, but interpretation should be compared with birth weight.</td>
<td>Complete physical assessment of baby. • Weigh naked baby. If birth weight not regained at 14 days calculate percentage weight loss. If more than 10% see growth monitoring guidelines – a referral to GP may be required. • Head circumference. • Fontanelles – tension, cranial abnormality, birth injury. • Eyes – signs of infection, fixed squint, jaundice, conjunctival haematoma. • Mouth – signs of infection, comment on visually observed abnormality. • Breasts – presence of swelling/infection.</td>
<td>Check results of NIPE (Newborn and Infant Physical Examination) document if not received. <a href="http://www.newbornphysical.screening.nhs.uk">www.newbornphysical.screening.nhs.uk</a> Early identification of any abnormalities. Refer to GP/advise or treat. If Tongue Tie suspected refer to Infant Feeding Co-ordinator for guidance.</td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>To establish an accurate assessment and record of body markings.</td>
<td>All birthmarks, Mongolian blue spots or unusual marks must be clearly documented on <a href="#">a body map</a> at primary birth review or when first identified.</td>
<td>Copy of body maps to be placed in the Personal Child Health Record (PCHR) and within electronic record. If concerned regarding body markings, follow local and LPT safeguarding procedures.</td>
</tr>
<tr>
<td>Feeding support/advice: The method of feeding should be ascertained and documented. Any difficulties should be discussed.</td>
<td>Refer to Infant Feeding conversation for health visiting team key points (Appendix 2).</td>
<td>Support given for feeding method.</td>
</tr>
</tbody>
</table>

- Umbilicus – state of healing.
- External genitalia observed for normal appearance.
- Muscle tone – range of movement, hyper or hypotonic.
- Evidence of Primitive Reflexes e.g. Moro.
- Observe alertness.
- Spine – observe for abnormalities.
- Sacral dimple – if present assess patency.
- Assess skin condition.
- Jaundice – any increased or prolonged jaundice.
- Check that newborn bloodspot taken.
- Check vitamin K given.

Umbilical Granuloma guidance (see e-source HV Staffroom).

Follow NICE guidelines.

To assess this, handling the baby is essential. Poor muscle tone must be referred to GP.

If sacral dimple noted and has not already been checked refer to GP to confirm patency.

If signs of infection refer to GP.

Advise on skin care.

See guidance and pathway (Appendix 4a, 4b)
Management of Prolonged Jaundice in Infants Day 13, 14, 15.

Hearing screening outcome.

Refer to Newborn hearing screening service on 01162586629 as soon as possible if assessment not completed.

Refer to Blood Spot Screening Pathway 2014. (Appendix 5).

Refer back to midwife/GP.
<table>
<thead>
<tr>
<th>Rationale</th>
<th>Method of Assessment and support</th>
<th>Expected Outcome/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For breastfed babies:</strong> Individual support and access to advice to promote exclusive breastfeeding to be offered. Advice given to fathers to encourage their support for breastfeeding.</td>
<td>Breast feeding assessment form completed. Advice re vitamin supplements and Healthy Start. (Table 4).</td>
<td>To meet national and local targets to: Promote/support &amp; protect breastfeeding and to increase breastfeeding rates at 6-8 weeks. <a href="http://www.babyfriendly.org.uk">www.babyfriendly.org.uk</a> <a href="http://www.leicspart.nhs.uk/infantfeeding">www.leicspart.nhs.uk/infantfeeding</a> (app Meals on Heels). Reinforcement of the Healthy Weight strategy. LPT Intranet/pathways. Maternal and Child Nutrition (NICE 2008 updated 2011) PH 11. <a href="http://www.healthystart.nhs.uk">www.healthystart.nhs.uk</a> • If concerned regarding breastfeeding additional contact within 1 week by HV team. • An individual plan of care is created. • Contact Information given for Health Professional. Local community based breastfeeding support. National support numbers. Off to the best start breastfeeding information given (<a href="http://www.nhs.uk/start4life">www.nhs.uk/start4life</a>) Advice re best beginnings: <a href="http://www.bestbeginnings.org.uk">www.bestbeginnings.org.uk</a></td>
</tr>
<tr>
<td><strong>For formula fed babies:</strong>  • Guidance offered regarding current advice on the sterilisation of bottles.  • Guidance offered regarding current advice on the preparation and storage of formula feeds.  • Guidance offered on the volume of formula to be offered at a feed.</td>
<td>Guidelines of infant formula intake 150-200ml/Kg per 24 hours divided between 4-8 feeds (DOH 2011).</td>
<td>To promote safe feeding practice as per current Department of Health guidelines (2011). If concerned regarding feeding practice and/or weight remains below birth weight then a follow up visit is required. Timing or delegation of this visit should be made using the Health Visitor’s professional judgement.</td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>• Importance of whey based formula milks in the first year (First stage milks).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccinations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To promote uptake of vaccinations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To ensure parent/carer have information regarding benefits/side effects of vaccinations to ensure informed choices and promote understanding of appointment procedure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss with parent/carer childhood vaccinations and discuss any concerns raised by parents and any contraindications that may arise.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess whether meets criteria for BCG.</td>
<td>Refer to Neonatal BCG Risk Assessment (Appendix 15). Refer to BCG Co-ordinator if any concern (0116 258 3767).</td>
<td></td>
</tr>
<tr>
<td>Adherence to vaccination schedule for babies born to women who are hepatitis b positive.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess maternal rubella status and follow up of two MMR vaccinations to protect future pregnancies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management of baby born to HIV positive mother.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check all status of all screening results and take prompt action to ensure appropriate referral and treatment pathways are followed in line with UK NSC standard.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signpost to GP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>See pathway – Appendix 16. Signpost to GP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A child born to an HIV mother requires special care, including specialist breast feeding and immunisation advice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenting Capacity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support and guidance (basic care and developmental needs).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify parent/carers ability to respond and understand baby's physical, emotional and developmental needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promoting sensitive parenting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observation of parent/carer behaviour, interaction and handling of baby using promotional guides.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early identification of parents requiring additional support.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promotion of parenting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Identify parent/carer ability to provide basic care. Including an assessment of the infant’s mental health.</td>
<td>Discuss registration of birth and advise if required to register child with GP.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discuss Health Visiting service and agree pathway following contact.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Give contact details for Health Visiting team.</td>
<td></td>
</tr>
<tr>
<td>Promote safety. Raise parent/carer awareness of accident and avoidable injury prevention.</td>
<td>Anticipatory guidance regarding safety issues for example safe sleeping, hot water, baby bouncers, pets, general safety around the house, toy safety, fire safety, smoke and carbon monoxide monitors, medication, car safety.</td>
<td>Raised awareness of locally available resources and initiatives – signpost if necessary.</td>
</tr>
<tr>
<td>Current advice guidelines to prevent Sudden Infant Death (SIDS) outlined to parents and the association with co-sleeping.</td>
<td>In order to reduce the incidence of SIDS using current evidence from the Lullaby Trust. Greater risk:</td>
<td>Refer to CONI supporter if applicable.</td>
</tr>
<tr>
<td></td>
<td>• Drug use.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Low birth weight or premature infant.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Household smoking.</td>
<td></td>
</tr>
<tr>
<td>Parental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To assess maternal general and mental health and promote the well-being of the mother.</td>
<td>general health, changes in relationships, family planning and contraception.</td>
<td>To empower parents and carers and raise their awareness of local/national support groups and initiatives for example family planning clinics, baby massage classes etc. Support and information to be offered regarding reflective birth experience where available.</td>
</tr>
<tr>
<td></td>
<td>Discuss health following birth e.g.:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Breast care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lochia.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Wound care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Appetite.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bowels/urine.</td>
<td></td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td></td>
<td>Questioning should take place relating to:</td>
<td>Recognition and timely intervention/referral of women with post-natal depression or any other significant mental health problems.</td>
</tr>
<tr>
<td></td>
<td>• Pregnancy.</td>
<td>Support given to women suffering post-natal depression.</td>
</tr>
<tr>
<td></td>
<td>• Delivery.</td>
<td>• Refer to GP/specialist services.</td>
</tr>
<tr>
<td></td>
<td>• Family history of congenital diseases/allergies.</td>
<td>See pathway (Appendix 8).</td>
</tr>
<tr>
<td></td>
<td>Assess maternal mental health e.g. history of any past/present mental illness and emotional changes, include family history of mental illness in first degree relative, i.e. mother, siblings. Observe mother’s general mood and further assess in accordance with NICE Antenatal &amp; Postnatal Mental Health CG192 (2014).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Domestic violence leaflet discussed (if appropriate and safe to do so and left within Personal Child Health Record (PCHR)).</td>
<td>This is a non-stigmatising, proactive approach for information giving regarding domestic violence.</td>
</tr>
<tr>
<td></td>
<td>Family health needs assessment e.g. parent with disability.</td>
<td>Living Without Abuse (LWA).</td>
</tr>
<tr>
<td></td>
<td>Questioning in relation to alcohol/substance misuse, consumption levels within the household.</td>
<td>City Domestic Violence Support Scheme (SAFE).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LPT Domestic Violence Policy (2014).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DASH Assessment Tool (if appropriate and safe to do so).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MARAC pathway (Appendix 10).</td>
</tr>
<tr>
<td></td>
<td>To promote early intervention and management of any identified family health issue.</td>
<td>To discuss any family health issues raised and promote awareness of health related issues and empower individuals to make positive lifestyle choices e.g.</td>
</tr>
<tr>
<td></td>
<td>To discuss any family health issues raised and promote awareness of health related issues and empower individuals to make positive lifestyle choices e.g.</td>
<td>To empower parents and carers and raise their awareness of local/national support groups and initiatives for example family planning clinics, baby massage classes etc.</td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------</td>
<td>-------------------------</td>
</tr>
</tbody>
</table>
| To promote early intervention and management of identified health issues. | • Breast awareness.  
• Testicular awareness.  
• Sexual health.  
• Contraception.  
• Drugs/alcohol.  
• Mental health.  
• Family nutrition.  
• Exercise.  
• Oral Health. | Remind parents that NHS dental care is free for 12 months after giving birth. |
| Reduce risks of passive smoking and smoking related conditions. | Identify parents, carers and any other members of the household who smoke. | Reduction of smoke related conditions e.g. Cancer, Heart disease and Respiratory conditions.  
Encourage smoke free environment.  
To give information regarding local/national support groups.  
Refer to local smoking cessation services. |
| Discussion about the baby:  
To promote the parents/carers understanding of their baby’s individual behaviour e.g. unsettled baby. | Discuss impact of new baby on partner and family relationships.  
Introduction to sensory and perceptual capabilities of their baby. | To allow parents to think about, and understand individual infants behaviour and individual childcare strategies.  
Refer to other local support services:  
• Childrens centre.  
• Postnatal groups. |
| Family & Environment | To identify any significant others within the family  
Discuss who is in the household e.g.:  
1. Significant other relationships with family.  
2. Absent family members.  
3. Relationship if separated parents. | Timely referral to appropriate support agencies.  
Early help assessment may be required and should be considered. |

**Family & Environment**

**History, Functioning and family social integration.**

Early identification of any risks or support required.

To identify any literacy/numeracy needs of parents or carers.

| To identify any significant others within the family  
Discuss who is in the household e.g.:  
1. Significant other relationships with family.  
2. Absent family members.  
3. Relationship if separated parents. | Timely referral to appropriate support agencies.  
Early help assessment may be required and should be considered. |
<table>
<thead>
<tr>
<th>Rationale</th>
<th>Method of Assessment and support</th>
<th>Expected Outcome/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>To identify any cultural or religious needs.</td>
<td>Give programme of facilities of local Children Centres and details of Health Visitor advice in clinics. Complete registration form for Sure Start if applicable.</td>
<td></td>
</tr>
<tr>
<td>To identify how family integrates into local community.</td>
<td>Discuss integration, e.g. friendships and social networks.</td>
<td>Give information regarding local groups to aid integration.</td>
</tr>
<tr>
<td><strong>Housing/Environment:</strong> Early identification and concerns of any risks or support required e.g. Inadequate housing, risk of eviction. To identify amenities and facilities are appropriate.</td>
<td>Discuss any housing concerns the parent or carer may have. Identify type of housing e.g. Private rented.</td>
<td>Signpost appropriately.</td>
</tr>
<tr>
<td><strong>Employment and income.</strong> To assess the families financial status, including employment, benefit entitlements and childcare.</td>
<td>Establish employment and financial status. Discuss needs of child in relation to finance, e.g. equipment, clothes, food, and furniture.</td>
<td></td>
</tr>
<tr>
<td>To identify any impacts on income e.g. drug use, alcohol, mental health and disability.</td>
<td>Identify employment with parent/carer and financial situation regarding benefits and maternity leave.</td>
<td>Signpost to Welfare Rights/ Citizens Advice Bureau (CAB) and local support services.</td>
</tr>
<tr>
<td><strong>Safeguarding</strong> To identify any safeguarding concerns.</td>
<td>Observation throughout assessment/discussion to indicate any safeguarding concerns.</td>
<td>Early identification and documentation of any risks or actual safeguarding needs relating to the child and/or parent.</td>
</tr>
<tr>
<td>To identify risks/stressors to prevent escalation of safeguarding concerns and sign post to early intervention support services.</td>
<td>Discussion with parent/carer regarding any stressful situations. Discussion around relationships issues including domestic abuse.</td>
<td>Adhere to the safeguarding policies and procedures including Domestic Violence Policy (2014). Timely communication with line manager, safeguarding supervisors and named nurses and referral to other</td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>agencies e.g.</td>
<td></td>
<td>- Early Help.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Social care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Specialist Nurse Domestic Violence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- MARAC.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Health services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Surestart services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Domestic violence services.</td>
</tr>
</tbody>
</table>

### 7.1 Completion of New Birth Review/Follow Up Contact

Where all aspects of the new birth review were unable to be completed, a follow up visit should be undertaken by the Health Visitor. This may be necessary, for example, to further observe interaction between parents and baby, to offer further guidance and information or to ensure that assessment allowed sufficient information to be gathered for appropriate delegation within a team. If the follow up contact is delegated to another member of the Health Visiting team it is the Health Visitor’s or SCPHN Student’s responsibility to ensure delegation of work is to a team member with appropriate skills to deliver the episode of care. [www.nmc.org.uk](http://www.nmc.org.uk)

This contact may be within the home or clinic setting as appropriate. Examples of appropriately delegated tasks may be:
- Review of weight only to skill mix team member.
- Support with milk feeding.

### 8. Six week Universal Contact

All families will be offered a face to face review by the Health Visitor within the home or local community setting where possible prior to the GP medical examination at 6-8 weeks. It is the baby’s GP who is responsible for ensuring the 6 – 8 week NIPE (Newborn and Infant Physical Examination Programme) screen is completed for registered babies.
<table>
<thead>
<tr>
<th>Rationale</th>
<th>Method of Assessment and support</th>
<th>Expected Outcome/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>To monitor growth and identify any concerns.</td>
<td>Health Visitor to weigh baby naked, measure head circumference and plot on centile chart.</td>
<td>Early identification of any signs of growth and developmental delay or ill health. Referral to GP for further assessment if indicated.</td>
</tr>
<tr>
<td>To identify any abnormalities or health issues and promote early intervention and management of condition.</td>
<td>Health Visitor to handle the baby and assess muscle tone. To ask the questions in the Personal Child Health Record (PCHR) regarding development achievements e.g. smiling.</td>
<td>Remind parents to make the appointment for their baby’s medical examination with the GP.</td>
</tr>
<tr>
<td>To assess the well-being of the baby.</td>
<td></td>
<td><strong>The 6 week developmental examination is the responsibility of the GP.</strong></td>
</tr>
<tr>
<td></td>
<td>To assess feeding method and discuss with parents how this is progressing. Complete the infant feeding conversation for health visiting teams; key points.</td>
<td>Document feeding method on SystmOne.</td>
</tr>
<tr>
<td></td>
<td>To encourage and promote exclusive breastfeeding for the first six months as per Department of Health guidelines.</td>
<td>To meet national and local targets by increasing breastfeeding continuation rates. Any feeding difficulties resolved.</td>
</tr>
<tr>
<td></td>
<td>To support and guide parents in order to promote and sustain breastfeeding.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Follow up contact by Health Visiting Team if required or referral to local breastfeeding support groups.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not to introduce solids before 26 weeks.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Feeding status must be accurately recorded on SystmOne record.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To ensure safe formula feeding.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>To avoid early introduction of solid foods.</td>
<td>Anticipatory guidance offered in accordance with Department of Health Weaning Guidelines.</td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Newborn Screening Status.</td>
<td>Confirmation of newborn blood spot result.</td>
<td>Record result in PCHR and follow up any outstanding test results.</td>
</tr>
<tr>
<td></td>
<td>Confirmation neonatal hearing test completed.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Give Book Start pack.</td>
<td></td>
</tr>
<tr>
<td><strong>Vaccinations</strong></td>
<td><strong>Identify vaccination status and promote uptake.</strong> To ensure parent/carer has information regarding benefits/side effects of vaccination to ensure informed choice and promote understanding of appointment procedure.</td>
<td><strong>Discuss childhood immunisation. Identify missed appointments and respond to parental concerns.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Check status of all screening results and take prompt action to ensure appropriate referral and treatment pathways are followed in line with UK NSC standards.</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Assess maternal rubella status and follow up of two MMR vaccinations (to protect future pregnancies).</strong> <strong>Adherence to vaccination schedule for babies born to women who are hepatitis B positive.</strong></td>
<td><strong>Signpost to GP.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Assess whether infant meets criteria for BCG.</strong></td>
<td><strong>Signpost to GP.</strong> <strong>See Neonatal BCG/Risk assessment (Appendix 15/16).</strong></td>
</tr>
<tr>
<td><strong>Parental Capacity</strong></td>
<td><strong>To identify any family health issues including mental health.</strong> <strong>To promote early intervention and management of any identified family health issues.</strong></td>
<td><strong>Discuss general health of parents.</strong> <strong>Provide further health visiting support if required.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Reinforce current advice guidelines to prevent Sudden Infant Death (SIDS) outlined to parents/association with co-sleeping.</strong></td>
<td><strong>In order to reduce the incidence of SIDS using current evidence from the Foundation for Sudden Infant Death.</strong> <strong>Risk factors re-page 22.</strong></td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Promote safety. Raise parent/carer awareness of safety issues.</td>
<td>Anticipatory guidance regarding safety issues, reminding parent/carer of their responsibility to maintain safety and assess for hazards.</td>
<td>Reduce accidents to children and less hospital admissions. To meet local government targets to stay safe in the home and community.</td>
</tr>
</tbody>
</table>

**Parental Health**

To promote early intervention of any identified family health issues.

To assess parental physical, emotional and social health. (Use the promotional guides template).

To discuss any family health issues and promote awareness of e.g.:

- Sexual health and contraception.
- Breast and testicular awareness.
- Drugs and alcohol.
- Smoking.
- Nutrition and exercise/weight issues.
- Maternal recovery from delivery.
- Oral health (NHS dental care free for 12 month after birth).

Promotion and improved parental health and raised awareness of local support services e.g. Stop smoking service.

Achieving local and national targets relating to improved health outcomes.

Signpost to Birth Reflection Service.

If using dummy discuss dangers of dipping in sugary products.

Ref: NICE Guidelines CG192 (2014)
Maternal Mental Health Pathway (Appendix 8)
Recognition and timely intervention.
Referral of women with postnatal depression or any other significant mental health problems to GP/specialist/local community services.
Support given to women with mild to moderate depression and anxiety disorders. (Appendix 8).
<table>
<thead>
<tr>
<th>Rationale</th>
<th>Method of Assessment and support</th>
<th>Expected Outcome/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>To identify risk/stressors to prevent safeguarding issues.</td>
<td>Discuss with parent/carer regarding any stressful situations.</td>
<td>Adhere to the Safeguarding policies and procedures Including Domestic Violence Policy (2014).</td>
</tr>
<tr>
<td>To identify any safeguarding concerns.</td>
<td>Observation throughout assessment/discussion to indicate any safeguarding concerns.</td>
<td>Early identification and documentation of any risks or actual safeguarding needs relating to the child and/or parent.</td>
</tr>
<tr>
<td>To assess housing and environment and identify any inadequate situations that may affect the health, well-being and safety of the child.</td>
<td>Discuss with parent/carer any changes in their housing situation identifying any concerns they have about their amenities/facilities e.g.</td>
<td>Early identification of any risks to family and children and signposting to appropriate agencies. Early identification of any risks/support required. Signpost to Welfare Rights, benefit agencies and any charitable support.</td>
</tr>
<tr>
<td>To assess the family's financial status including employment and benefit entitlement.</td>
<td>Identify employment within the family and their financial situation, including maternity leave and eligibility for benefits.</td>
<td>Sign up for Healthy Start scheme, if eligible. Increase the uptake of the Healthy Start scheme.</td>
</tr>
<tr>
<td>To assess family history, functioning and social integration.</td>
<td>Identify any significant changes in the family situation to include:</td>
<td>Early identification of any risks or support required. Referral to appropriate support agencies. Signposting to community facilities/support networks and programmes within children centres.</td>
</tr>
<tr>
<td></td>
<td>• Who is living within the home. • Relationships within the family. • Significant others involved with family. Discuss integration into local community e.g. social and support networks and friendships.</td>
<td></td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------------</td>
<td>-------------------------</td>
</tr>
</tbody>
</table>
| Discussion around relationships issues including domestic abuse. | Timely communication with Safeguarding supervisors or named nurses and referral to other agencies e.g. | • Early Help.  
• Social care.  
• Specialist Nurse Domestic Violence.  
• MARAC  
• Health services.  
• Surestart services.  
• Domestic violence services.  
• Voluntary agencies. |

9. Three to Four Month Review
Families will be offered a review at this time in a group within a community setting or in a clinic setting if a group is not available.

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Method of Assessment and support</th>
<th>Expected Outcome/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Developmental and Health Needs</td>
<td>If weight undertaken, weigh naked and plot on centile chart. Measure length if indicated.</td>
<td>NICE/WHO guidelines from Healthy Weight Pathway. Timely referral to appropriate service(s).</td>
</tr>
<tr>
<td>To discuss the well-being of the baby. If parents request or if there is professional concern about the baby's growth or risk to normal growth (including obesity) an assessment should be carried out. The parent should be signposted to an advice clinic if this facility is not available at the group session.</td>
<td>Discuss with parents the recommendation for the introduction of solids at 6 months and the associated risk factors such as obesity, diabetes, allergies and food intolerance. Discuss family meals and identify particular diet e.g. vegetarian, vegan, coeliac.</td>
<td>Promotion of a healthy diet. Increased parental knowledge. Reduce diet related conditions e.g. rickets, anaemia, dental caries and diabetes.</td>
</tr>
<tr>
<td>Discuss weaning and introduction of appropriate food in accordance with DOH guidelines. To promote healthy eating and uptake of appropriate vitamin supplements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------</td>
<td>-------------------------</td>
</tr>
</tbody>
</table>
| Promote Oral Health. | To promote dental health.  
Discuss use of fluoride toothpaste and encourage use of free flow beakers.  
If using dummies discuss dangers of dipping into sugary products. | Offer a copy of the Healthy Teeth, Happy Smiles leaflet 6 months to 3 years and Oral Health Pack.  
Provide information on how to access dentists. Encourage all children to attend first dental check-up before first birthday. |

### Parental Health

The universal offer in a group setting of assessing mother’s mental health will vary and how it is delivered must be clinically led. The Lead Practitioner must consider venue, confidentiality and whether the CNN/HV delivering the group has established relationships with the mothers.

If a parent or health professional identifies concerns a more detailed maternal mental health assessment is undertaken – one to one in a confidential setting. Any parent that already has predisposed factors should be following Universal Plus Pathways and will be seen by their HV.

Maternal mental health assessed according to the protocol for predicting and detecting maternal mental illness by asking:

**During the past month have you often been bothered by feeling down, depressed or hopeless?**

**During the past month have you often been bothered by having little interest or pleasure in doing things?**

**Third question to be asked if a positive answer to either question – Is this something you feel or want help with?**

Further assessment using clinical skills and appropriate tool e.g. Edinburgh Postnatal Depression Score.

By the time of birth, a child is expected to:

- Understand the names of the family and other usual adults
- Say two words
- Play and have fun
- Dress and undress
- Eat solid food
- Sleep

See NICE Guideline CG192 Antenatal and Postnatal Mental Health.


### Assessing infant mental health.

Temperament based anticipatory guidance – practical guidance on managing crying and healthy sleep practices, bath, book, bed routines and activities and encouragement of parent – infant interaction using a range of media based interventions.

### Promoting development.

Encouragement of the use of books, music and interactive activities to promote development and parent infant relationship. Encourage reflective parenting styles.
<table>
<thead>
<tr>
<th>Rationale</th>
<th>Method of Assessment and support</th>
<th>Expected Outcome/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeping safe.</td>
<td>Raise awareness of accident prevention in the home and safety in cars.</td>
<td></td>
</tr>
<tr>
<td>Safeguarding</td>
<td>Discussion with parent/ carer regarding any stressful situations. Discussion around relationship issues including domestic abuse.</td>
<td>Adhere to the safeguarding policies and procedures Including Domestic Violence policy. Timely communication with Safeguarding supervisors or named nurses and referral to other agencies e.g. • Early Help. • Social care. • Specialist Nurse Domestic Violence. • MARAC. • Health services. • Surestart services. • Domestic violence services. • Voluntary agencies.</td>
</tr>
<tr>
<td>Vaccinations</td>
<td>Discuss childhood vaccinations and discuss any concerns raised by parents. Assess whether any family meets criteria for BCG and has not yet been signposted.</td>
<td>Refer to Neonatal BCG Assessment (Appendix 15).</td>
</tr>
</tbody>
</table>

10. Universal Health Review to be completed by One Year (10 months to 1 year)

All families will be offered a face to face contact with their Health Visitor by one year. The aim of the one year review is to holistically assess the child's general health, physical, social, emotional and behavioural, and language development. **This assessment should be undertaken by a Health Visitor or Specialist Community Public Health Nurse (SCPHN) student.** Contact should, where possible, take place in a Children's Centre or local community setting.

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Method of Assessment and support</th>
<th>Expected Outcome/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Health and Development Needs</td>
<td>To discuss with parents any concerns they may have.</td>
<td>Promotion and empowerment of parenting skills.</td>
</tr>
</tbody>
</table>

To Contents Page
<table>
<thead>
<tr>
<th>Rationale</th>
<th>Method of Assessment and support</th>
<th>Expected Outcome/Action</th>
</tr>
</thead>
</table>
| To ensure growth along expected centile line and identify deviation from the norm. | To weigh the baby naked and plot on centile chart.  
To measure length, if indicated.  
To discuss outcome with parents/carers. | Reinforcement of the NICE/WHO guidelines and further guidance from the Healthy Weight Pathway. Timely referral to appropriate services. |
| To identify any abnormalities or health issues and promote early intervention and management of condition. | In partnership with parents carry out a general assessment of the development of the baby using Ages and Stages Questionnaires.  
To include fine and gross motor speech and cognitive development. Vision, hearing, speech & language. | If there are any concerns re: global development then a review should be undertaken by the Family Health Visitor. If either parent or practitioner has any concerns ASQ SE can be used at this contact.  
The timing of the review is subject to clinical judgement and the nature of the concerns, but in all cases should be completed within 1 month of original assessment. If concerns persist consider request for involvement of another service. This should be clearly documented in the child’s records. This action should also be communicated either verbally or written to the GP outlining the concerns.  
For concerns regarding vision refer to GP.  
For concerns regarding hearing refer to Audiology.  
**Refer parent to appropriate page of the PCHR**  
**A hip review is undertaken by a medical practitioner at birth and 6-8 weeks. Any parental concerns should be referred to the GP for further assessment.** |
<table>
<thead>
<tr>
<th>Rationale</th>
<th>Method of Assessment and support</th>
<th>Expected Outcome/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>To promote dental hygiene and reduce dental decay.</td>
<td>Oral health. Discuss use of fluoride toothpaste and encourage use of free flow beakers. If using dummies discuss dangers of dipping into sugar products.</td>
<td>Provide information on how to access dentists. Encourage all children to be registered with a dentist. (Oral Health pathway – appendix 19). Signpost to free bottle swaps at all Children Centres in the City.</td>
</tr>
<tr>
<td>To promote eating for good health.</td>
<td>To discuss diet management and identify any concerns e.g. • Meal time routines. • Prolonged use of bottles/dummies. • Healthy eating e.g. 5-a-day. Advice re vitamin supplements and healthy Start (Table 4).</td>
<td>Additional resources can be obtained from Leicestershire Nutrition and Dietetic Services <a href="http://www.inds.nhs.uk">www.inds.nhs.uk</a> To set good eating habits early to help a child grow into a healthy adult. Refer to Appendix F. <a href="http://www.healthystart.nhs.uk">www.healthystart.nhs.uk</a></td>
</tr>
<tr>
<td>Vaccinations</td>
<td>Discuss with parent/carer childhood vaccinations and identify missed appointments. Discuss any concerns raised by parents and re start appointments if necessary. MMR vaccination for women non-immune to rubella.</td>
<td>Increased knowledge of parent/carer. Increased uptake of childhood immunisations.</td>
</tr>
<tr>
<td>Parenting Capacity</td>
<td>Discussion with parent/carer throughout review. To listen to any parent/carer concerns expressed. Observation of parent/carer’s behaviour, interaction and attachment e.g. Verbal, handling, signs of affection and response and recognition of needs. Anticipating guidance around management of challenges including temper tantrums</td>
<td>Early identification of parents requiring additional support. Promotion of positive parenting and enhance cognitive development. Targeted support offered by professional. Signposting back to HV if necessary. Sleep management discussed.</td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>To promote safety. To raise parent/carer awareness of safety issues.</td>
<td>Anticipatory guidance regarding safety issues e.g. General safety around the house, car safety,</td>
<td>Reduce accidents to children and less hospital admissions to meet local Government targets to stay safe in the home and community.</td>
</tr>
<tr>
<td></td>
<td>toy safety, fire safety, smoke &amp; carbon monoxide detectors, garden, ponds, road etc.</td>
<td></td>
</tr>
<tr>
<td>To reinforce current advice guidelines to prevent Sudden Infant Death (SID's) outlined to parents.</td>
<td>In order to reduce the incidence of SID using current evidence from the Foundation for Sudden Infant Death. Greater risk.</td>
<td>Refer to CONI supporter if applicable. SIDS <a href="http://www.lullabytrust.org.uk/">www.lullabytrust.org.uk/</a> NICE CG37 p36 and p37.</td>
</tr>
<tr>
<td></td>
<td>• Parent/carer recent alcohol. • Drug use. • Low birth weight or premature infant. • Household smoking.</td>
<td></td>
</tr>
</tbody>
</table>

**Parental Health**

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Method of Assessment and support</th>
<th>Expected Outcome/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>To assess maternal general and mental health and promote the well – being of the mother.</td>
<td>To discuss mother’s general health, changes in relationships, family planning and contraception. To discuss mother’s mental health, in accordance with NICE Antenatal &amp; Postnatal Mental Health CG192 (2014).</td>
<td>Promotion of maternal health. Recognition and timely intervention/referral of women with post natal depression or any other significant mental health problem. See LPT Perinatal Maternal Mental Health Guidance to Support Health Visitors and their Teams (2014).</td>
</tr>
<tr>
<td></td>
<td>To give information regarding local/national support groups.</td>
<td>Raised parental awareness of local/national support groups and initiatives for example family planning clinics, play and stays.</td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>To promote early intervention and management of any family health issue</td>
<td>To promote early intervention and management of any identified family health issue</td>
<td>Offer appropriate advice/refer to GP.</td>
</tr>
<tr>
<td></td>
<td>To discuss any family health issues raised and promote awareness of health related issues e.g.:</td>
<td>Making Every Contact Count.</td>
</tr>
<tr>
<td></td>
<td>• Breast awareness.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Testicular awareness.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sexual health/cervical screening.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Contraception.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Drugs/alcohol.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Family nutrition.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Exercise.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Risks of passive smoking.</td>
<td></td>
</tr>
<tr>
<td>To complete an Oral Health Assessment.</td>
<td>Discuss use of fluoride toothpaste, oral pacifiers and encourage use of free flow beakers.</td>
<td>To promote dental hygiene and reduce dental decay.</td>
</tr>
<tr>
<td></td>
<td>Make sure the parents have a Healthy Teeth Happy Smiles pack for small teeth.</td>
<td>Provide information on local supervised tooth brushing sessions.</td>
</tr>
<tr>
<td></td>
<td>Go through the literature in the HTHS Pack with the parents picking up all the key points.</td>
<td>Provide information on how to access local NHS dentists.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage all children to see a dentist.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Remind mothers that NHS dental care is free up to 12 months after birth.</td>
</tr>
<tr>
<td>To identify parents/carers who smoke.</td>
<td>To encourage smoke free environments.</td>
<td>To refer to local smoking cessation services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduction of smoking related conditions e.g. Cancer, Heart disease and respiratory conditions.</td>
</tr>
<tr>
<td>Family and Environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>To identify predisposing factors and actual Domestic Violence issues.</td>
<td>Review and identify any environmental issues that may affect the health, well-being and safety of the child e.g. income, housing, drug and alcohol use.</td>
<td>Signpost to welfare rights and support services. Refer any safeguarding concerns. Early Health Assessment may be undertaken.</td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>To identify any predisposing factors, risks or concerns.</td>
<td>Discuss relationships. Identify further support in line with policy. Consider universal plus and universal partnership plus support.</td>
<td>Reduction in escalation of Domestic Violence incidents. Positive family interactions.</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>Observation throughout assessment/discussion to indicate any safeguarding concerns.</td>
<td>Early identification and documentation of any risks or actual safeguarding needs relating to the child and/or parent.</td>
</tr>
<tr>
<td>To identify any safeguarding concerns.</td>
<td>Discussion with parent/carer regarding any stressful situations. Discussion around relationships issues including domestic abuse.</td>
<td>Adhere to the Safeguarding policies and procedures including Domestic Violence policy. Timely communication with line manager, safeguarding supervisors or named nurses and referral to other agencies e.g.: • Early Help. • Social care. • Specialist Nurse Domestic Violence. • MARAC. • Health services. • Surestart services. • Domestic violence services.</td>
</tr>
</tbody>
</table>

11. **Two to Two and a half year Universal Contact**

There should be a named HV or CNN for all pre-school settings. 100% of families will be offered a contact with their child at two to two and a half years of age. The aim of the two year review is to holistically assess the child’s general health, physical, social, emotional, behavioural and language development using evidence based Ages and Stages questionnaire 3 and SE.

This review may be integrated with the Early Years Foundation Stage Two Year Old Summary from 2015. The health visitor should attempt to undertake this review with pre-school settings particularly for children who are Universal Plus and Partnership Plus. All integrated two year reviews should be recorded as such.
<table>
<thead>
<tr>
<th>Rationale</th>
<th>Method of Assessment and support</th>
<th>Expected Outcome/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>To identify any abnormalities or health issues and promote early intervention and management of condition.</td>
<td>Review with the parents the child’s general health, social, emotional, behavioural and language development.</td>
<td>Advise/refer to appropriate professional.</td>
</tr>
<tr>
<td>To assess and promote physical development.</td>
<td>To assess gross motor, fine motor, communication, problem solving and personal social using ASQ 3 and ASQ SE. Although ASQ is the tool of choice see guidance (appendix 17).</td>
<td>Refer to ASQ.</td>
</tr>
<tr>
<td>To ensure early identification of physical disability/difficulty in order to prevent further deterioration.</td>
<td>Promote physical activity/exercise. Signpost to local activities.</td>
<td></td>
</tr>
<tr>
<td>To assess and promote fine motor skills.</td>
<td>Promote play activities to encourage fine motor development. Refer to HV if any concerns identified. Identify children requiring universal plus intervention and timely referral. LAC children at 2 years should be offered 15 hours of child care as a priority. Refer to GP or request for Involvement of another service. Document the rationale If there is a concern regarding vision refer to the Orthoptic service via GP or signpost to local Optometrist.</td>
<td></td>
</tr>
<tr>
<td>To promote speech and language development and identify any concerns. Be aware of the child speaking in another language where the parents/carers first language is not English.</td>
<td>Use Speech and Language development guidelines with ‘Talking Fun’ leaflets to assess speech and language development. Discussion about dummy use.</td>
<td>If there are any concerns over limited use of words or an unusually quiet child refer to Speech and Language development guidelines as early identification and intervention is essential. Hearing problems can adversely affect children’s speech.</td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Social and Emotional development.      | Observations/questioning to be made on Social behaviour/play. ASQ SE. | Where there are concerns with speech and language, targeted support should be offered by the CNN (Let’s Get Talking intervention 4 week group or 2 home visits) and progress reviewed in 2 – 3 months.  
See Speech, language and communication needs at 2 year pathway.  
Use speech & language development guidelines with ’Talking Fun’ leaflets (www.leicschildhealth.nhs.uk)  
Signpost to speech and language services embedded within Children Centre Services where available.  
Referral to SALT if concerns persist after intervention.  
Children referred to SALT require evidence of hearing status within previous 6 months or referral for assessment along the audiology referral pathway.  
Any concerns regarding hearing refer to Audiology.  
If concerned regarding global developmental progress refer to Named Health Visitor for assessment if assessment undertaken by CNN. Referral or request for involvement with either verbal or written communication to GP outlining concerns.  
Information given to parents/carers regarding; structured play and developing secure attachment to parents.  
Referral back to Named HV for further assessment. |
<table>
<thead>
<tr>
<th>Rationale</th>
<th>Method of Assessment and support</th>
<th>Expected Outcome/Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure growth along expected centile lines in relation to growth potential and earlier growth measurements.</td>
<td>Unless refusal from parent or child, all children should be weighed in light clothing i.e. vest and pants and without shoes. Height should be measured using the standard height measuring equipment. See Healthy Growth Guidance.</td>
<td>Additional resources available through nutrition and dietetic services <a href="http://www.lnds.nhs.uk">www.lnds.nhs.uk</a> Signpost to local community resources/children centres activities where appropriate. Reinforcement of the NICE/WHO guidelines and further guidance from the healthy weight pathway. Timely referral to appropriate services. (Calculate or look up BMI centile if indicated).</td>
</tr>
<tr>
<td>To promote eating for good health.</td>
<td>Offer advice and information on healthy eating, portion sizes, meal time routines and promotion of physical activity for the child &amp; family.</td>
<td>Refer to Table 4.</td>
</tr>
<tr>
<td>To reduce static activities and encourage movement within play.</td>
<td>Advice re vitamin supplements and healthy Start.</td>
<td></td>
</tr>
<tr>
<td>To promote oral health.</td>
<td>Dental health. Discuss use of fluoride toothpaste and encourage use of free flow beakers. Make sure the parents have a Healthy Teeth Happy smiles pack for small teeth. Discuss the use of dummies and use of dipping in sugary products. Go through the literature in the HTHS pack with the parents picking up all the key points.</td>
<td>Provide information on local supervised tooth brushing sessions. Encourage all children to see a dentist. Provide information on how to access local dentists. Signpost to Childrens Centres for free bottle swaps (City Only).</td>
</tr>
<tr>
<td>Vaccinations</td>
<td>Discuss childhood immunisation. Identify missed appointments and respond to parental concerns.</td>
<td>To maximise immunisation uptake to meet national targets for and increase the proportion of children with a complete immunisation protection programme. Re-instate appointments if required.</td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>To identify parent/carer’s ability to respond and understand child’s needs.</td>
<td>To discuss any health concerns and promote early years developmental progress. Observe parent/child interaction e.g. verbal, handling, signs of affection and response and recognition of need.</td>
<td>If concerns identified, further HV assessment to identify need. Consider additional support e.g. practical parenting, behaviour, play and stimulation support from appropriate professional.</td>
</tr>
<tr>
<td>To promote positive reinforcement of good behaviour. Identifying, assessing and managing any behavioural difficulties prior to early year’s education.</td>
<td>Observation of child, discussion and anticipatory guidance should be offered regarding parenting and behavioural management support. e.g. • Tantrums. • Sleep. • Toilet training.</td>
<td>If behaviour problems identified, full assessment to be undertaken and referred to universal plus. Signposting/referral to appropriate group based parenting support if required. See new LPT Behavioural Pathways: (appendix 11).</td>
</tr>
<tr>
<td>To promote hazard awareness.</td>
<td>Anticipatory guidance to be offered regarding: • Injury prevention with an emphasis on supervision, toy safety, car safety and seasonal safety focus, e.g. sun safety, fire guards, radiators. • Security of dangerous substances and medicines in the home and also risk of burns/scalds. • Environmental hazards e.g. roads, ponds, falls from windows, smoke/carbon monoxide detectors. Check whether child has had admission to hospital due to injury.</td>
<td>Reduce accidents to children resulting in hospital admissions. Refer to safety schemes where appropriate and available. Increase parents/carers knowledge and awareness of safety. Follow up for those children who have had an admission to hospital. See hospital discharge flowchart (Page 64).</td>
</tr>
<tr>
<td>Rationale</td>
<td>Method of Assessment and support</td>
<td>Expected Outcome/Action</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Provide support and encouragement to take up Early Years Education. Provide information on: • Nursery Place funding from 2 yrs (for those eligible). • Family Information services. • School registration.</td>
<td>Provide information on: • Nursery provision. • Family Information service. • School registration.</td>
<td>Optimise uptake of early year’s education. When universal contacts are no longer required the adult record needs to be ended.</td>
</tr>
<tr>
<td>Family &amp; Environment</td>
<td>To review and identify any environmental issues that may affect the health, well-being and safety of the child.</td>
<td>To identify any predisposing factors, risks or concerns.</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>To identify any safeguarding concerns.</td>
<td>Observation throughout assessment/discussion to indicate any safeguarding concerns.</td>
</tr>
<tr>
<td>To identify risks/stressors to prevent escalation of safeguarding concerns and sign post to early intervention support services.</td>
<td>Discussion with parent/carer regarding any stressful situations. Discussion around relationships issues including domestic abuse.</td>
<td>Adhere to the Safeguarding policies and procedures, including Domestic Violence policy. Timely communication with line manager, safeguarding supervisors and named nurses and referral to other agencies e.g.: • Early Help. • Social care. • Specialist Nurse Domestic Violence. • MARAC. • Health services. • Surestart services. • Domestic violence services. • Voluntary agencies.</td>
</tr>
</tbody>
</table>
Health Visiting Remit 2½ to 5 Years

School Readiness

It is important that children are ready for school. Within health visiting teams this may be seen as a priority area for some health promotion parenting groups on child development, parenting, behavioural issues, and toileting. If a parent/carer has concerns around toileting then an appointment should be made to see a member of the HV team and a full assessment undertaken, using the ASQ tool, and a pre-toileting assessment undertaken (Continence Policy 2014 p20-22). This can be used as part of the child’s holistic assessment.

Useful evidenced pathways and tools to support this include:
Ages and Stages Questionnaires – Age Appropriate
Continence Policy (2014)
Behavioural (Solihull Training Manual)

Continence

Health visitors and their teams are trained to give key preventative messages around constipation at all stages of a child’s development, from milks, weaning to commencing more family foods, the importance of a healthy diet, and the importance of physical activity. Health visitors and their teams discuss toilet training at the 2 – 2½ year universal contact and give and sign post parent/carer for further information on toilet training. Between 3 – 5 years families/children can continue to access health visiting support from the HV team but this is on a universal plus and partnership plus basis. During this time the HV is competent to undertake a full assessment of the child’s developmental needs. (The ASQ tools can be used at all stages between 4 months and 5 years if either the HV or the parent/carer have concerns).

Universal Formal Handover to School Nursing Service by 4½ years

A formal handover from the health visitor to the school nursing service is required.

All children on universal plus or universal partnership plus must have a one to one contact between the HV/SN see guidance and pathway (Appendix 13).

For LAC children please refer to the LAC Practice Guidance

The wider remit of the Health Visiting Service

Delivering the Healthy Child Programme is only part of the health visitor’s role. The health visitor is also seen as a leader working with local partners in their neighbourhoods empowering and sustaining community’s resilience to support the health and well-being of 0-5 year olds by working with local communities and agencies to improve family and community capacity and champion health promotion.
The health visitor working in LPT can do this by evidence-based intervention delivered at Advice Clinics:

• **By promoting Immunisation** – these should be offered to all. The HV team should work with the family to encourage and support uptake.

• **Building Community Capacity** by raising the health needs and priorities in their neighbourhoods by health promotion events. The context and frequency of these is agreed within the team. One of the approaches adopted within FYPC (Families, Young People and Children) is Asset Based Community Development (ABCD). This approach is about creating action, not swapping information; it starts with a conversation in a community that ignites a passion that often leads to a commitment to action. ABCD is informal but not unstructured; it takes a positive approach asking what is ‘strong’ rather than what is ‘wrong’ and leads people into a commitment to participate in making changes. This approach could be utilized as part of the HV BCC work.

• **Pregnancy Birth and Beyond type classes** delivering parenting and health promotion classes to support families. These may be branded differently.

• **Prescribe medication** as a non-medical prescriber in accordance with current NMC Guidelines.

• **UNICEF Baby Friendly Community Initiative** – Achieving and maintaining full accreditation.

• **Supporting parents/carers to know what to do when their child is sick** (See Table 1).

• **Children with additional needs.** Early identification and assessment and help. Health visiting teams will provide assessment, care planning and on-going support for babies and children up to school entry with disabilities, long term conditions, sleep or behavioural concerns, other health or developmental issues. Within their caseload health visitors will have or may identify children with additional needs.

These children remain with the Named Health Visitor although advice and support can be received from the Health Visitor (Children with Additional Needs) who has additional knowledge in this area of practice.

The Children and Families Act (2014) introduces major changes to support for children and young people with Special Educational Needs (SEN) creating Education, Health and Care (EHC) plans to replace SEN statements. The basic goals are to give families a greater involvement in decisions about their support and to encourage social care, education and health services to work more closely in supporting those children with special needs and disability. The HV has a responsibility to notify the Local Authority Education Services as soon as they identify a child may have SEN. They may also need to refer to additional health education social care services.

• **Looked After Children.** The Looked after Children’s Team (LAC Team) comprises a Designated Nurse for Looked after Children, 9 Specialist LAC Nurses with administrative support. A named Dr for LAC also offers support to the team part time. The Looked after Children (LAC) across LLR have their health assessments on coming into care delivered by Drs these are Initial Health Assessments (IHA). Following the IHA the children have Review Health Assessments (RHA) completed by Health Visitors bi-
annually if they are under 5 years and annually by the Specialist LAC nurses if they are 5 – 18. LAC Nurses work geographically across LLR offering assessments and access to health services. There is a specific LAC/health visitor who offers specific advice to health visitors on LAC and the RHA.

**Family Nurse Partnership (City)**
The Family Nurse Partnership (FNP) is a voluntary, free, preventative programme offered to first time mothers aged 19 years or younger. The same Family Nurse works with the client from early pregnancy until the child is two years old. The programme’s primary focus is on the health and well-being of the child and mother. Family Nurses are all qualified nurses who come from a Health Visiting or midwifery background and they receive additional training to prepare and equip them for the role of Family Nurse.

Family Nurses help clients to:
- Increase chances of a healthy pregnancy.
- Help clients to manage their labour.
- Improve child development.
- Build a positive relationship between mother, baby and others.
- Help parents plan for their futures.
- Enable clients to make lifestyle choices that will give their child the best possible start in life.
- Enable clients to achieve their aspirations (such as finding a job or returning to education).

Family nurses also involve fathers in the programme if the client they are working with wants her partner involved in the programme. Visits take place either weekly or fortnightly and usually take place in the clients home and each visit lasts for an hour. The intensity of the work decreases in the last 3 months and then the client and child are transferred back to their Health Visitor.

**Early Start (County)**
Early Start is an early intervention programme that has been designed for first time parents who feel they would benefit from regular, consistent support from a named Health Visitor. The programme aims to prepare for parenthood and equip parents with skills and knowledge to overcome the challenges of parenting through the early years. Early Start is a service which provides support and education around pregnancy, parenting and relationships via home visiting and involvement in groups. Early Start support begins antenatally, ideally before 24 weeks of pregnancy until the baby’s 2nd birthday.

**Care Navigation**
A Care Navigator is a person who works within a neighbourhood and they can help with getting the right service for a child, sharing relevant information and appointment co-ordination. If more than one healthcare service is involved with a child then a Care Navigator can help in co-ordinating the care more effectively. They also facilitate practitioners to attend their local neighbourhood forums.

**Neighbourhood Clinical Forum**
These are multi-disciplinary meetings where there is discussion about the care pathway of children whose journey is more complex.

**Multi-Agency Information Sharing (MASH) – County only**
This process allows information sharing between organisations to improve outcomes for
children, young people and their families. It allows a practitioner to request information to find out who else is involved in supporting the family.

Following a request the practitioner will receive information which will include history of involvement from other agencies, a genogram of the family and contact details of the practitioners involved.

The information available varies across Local Authorities and health information is dependent on consent. The MASH team are able to access information from:

- NHS – System One, RIO (with consent), Local Authority – Framework I, CAPITA, social care – Safeguarding, Housing (in some areas) school attendance. Also currently negotiating information from probation (available in some areas).

**Did not attend or No Access Visits Guidance:**

- Professionals should be child focused and consider the child’s welfare even when Did Not Attend/No Access Visit relates to parent/carer. Health visitors should always use their professional judgement and document the rationale their decision making.

- Safeguarding children and young people is paramount.

- A maximum of two appointments should be offered before any other actions are considered. The content of any discussion with parents should be clearly documented along with any actions or outcomes within the child’s record.

- If a child did not attend or there were no access visits at both the universal 1yr and 2yr reviews, the Named Health Visitor should review the child’s records and refer to supporting policy for further guidance, recording action and outcome within the child’s record.

- This should include documented liaison with the GP.

**Movement into Health Visiting Caseload (Appendix 6a and 6b)**

**Rationale:**
To ensure that every child living in Leicester, Leicestershire & Rutland is known to Children’s Services, registered on child health system, health needs re-assessed, if required, and parents to be aware of how to access appropriate services and family support as required.

**Standard:**
All children prior to school entry will be contacted by the Health Visiting Team within documented time frames as outlined in the pathways referring to Safeguarding Children Practice Guidelines (2013) as appropriate.

**Notification:**
Health visiting teams can be notified through many different routes including GP surgery, Child Health services, family notifying local services, liaison from other professional or safeguarding named nurse.

Health Visitors are responsible for ensuring that systems are established within their named GP practices to identify new entrant information either via SystmOne or new entrant paperwork and that this is communicated within a timely period.
Where a Health Visitor is notified of a new entrant that has not yet registered with a GP practice it is their responsibility to take action as outlined in the appropriate transfer pathway or contact their Clinical Team Leader for allocation to a Health Visitor. The child will need to be registered into the appropriate SystmOne unit and an e-referral sent to child health services.

This process should also be followed for children who are not permanently living in Leicester, Leicestershire and Rutland but who are accessing the Health Visiting service, in order that any contact can be documented. If a child under 6 weeks old is in the area temporarily then universal contacts should be offered as per the Standard Operating Guidance. The Health Visitor should consider the most appropriate venue for the contact.

Rationale for any actions taken regarding contacts should be documented. Where doubts about residency in the area occur the Health Visitor should document the actions taken.

**Universal Plus Interventions**

The health visitor and her/his team are trained to identify families and children where there are additional needs which require intervention.

This is a rapid response from the health visiting team when parents need expert help for example with postnatal depression, a sleepless baby, feeding or answering concerns around parenting.
## Table 1: Traffic light system for identifying likelihood of serious illness

<table>
<thead>
<tr>
<th>Traffic light system for identifying risk of serious illness*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Green – low risk</strong></td>
</tr>
<tr>
<td>Colour (of skin, lips or tongue)</td>
</tr>
<tr>
<td>Activity</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Circulation and hydration</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**CRT**, capillary refill time; **RR**, respiratory rate

*This traffic light table should be used in conjunction with the recommendations in the guideline on investigations and initial management in children with fever. See [http://guidance.nice.org.uk/CG160](http://guidance.nice.org.uk/CG160) (update of NICE clinical guideline 47).
The health visitor team within LPT has a series of pathways cited in this guidance as appendices which documents clearly the package of care or intervention required.

**Table 2: Universal Plus Pathway**

<table>
<thead>
<tr>
<th>Pathway Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health visitors undertake comprehensive assessment, develop care plan and deliver evidence based interventions in line with local pathway.</td>
</tr>
<tr>
<td>May signpost family to other services such as groups, Children’s Centres, voluntary sector.</td>
</tr>
</tbody>
</table>

Ensure actions are recorded along with expected outcomes so progress can be monitored.

Share information as per local protocol.

If progress not made, re-assess and review interventions and plan with the family. Referral/request for involvement to additional and/or specialist services required.

Progress made, health need identified and met.

If needs increase this may require involvement of several services. The GP should be informed of all decisions and referrals relating to the child. May lead to Universal Partnership Plus pathway.

Universal Offer.

**Universal Partnership Plus Pathway**

This is where the health visitor works in partnership with parents and agencies in the provision of intensive multi agency targeted packages where there are identified complex needs or safeguarding needs.

Ongoing support from the health visiting team plus a range of local health and social care services working together and with families to deal with more complex needs over a period of time. For example, the looked after child, newly adopted child and the child with additional needs. Other services include Children Centres, other community providers including charities and, where appropriate, within Leicester City Family Nurse Partnership and, in Charnwood, the Early Start Project.
Table 3: Universal Partnership Plus Pathway

Identified health needs plus additional concerns:
* i.e. child with additional needs safeguarding, domestic abuse, alcohol/substance misuse, etc

<table>
<thead>
<tr>
<th>Step</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local assessment and identify health needs (physical, social and emotional) for children and parents/carers, and evaluate safeguarding concerns as per local procedures.</strong></td>
</tr>
<tr>
<td><strong>Identify /establish the team around the child/ family and attend/arrange child and family meeting, acting as Lead Professional as required. Communication with GPs is essential.</strong></td>
</tr>
<tr>
<td><strong>Work in partnership with other professionals/agencies involved and the family to develop an outcome centred child and family plan, clearly articulating responsibilities and timeframe. Attend multi-agency meetings e.g. core group, case conferences as appropriate.</strong></td>
</tr>
<tr>
<td>Health visitor will develop a care plan and deliver evidence based interventions in line with locally agreed partnership pathways.</td>
</tr>
<tr>
<td><strong>Throughout confirm and corroborate key information that parents/carers tell you, e.g. attendance at appointments; progress made with adult issues, e.g. drug &amp; alcohol problems; or if domestic abuse, whether violent partner still present.</strong></td>
</tr>
<tr>
<td>If adult issues, e.g. substance misuse, DV etc., record their impact on their parenting capacity and what it means for child to live in this situation. Provide written reports as necessary to local panels/procedures/court requests.</td>
</tr>
<tr>
<td><strong>Ensure continuous reviewing/updating/inputting to the child’s records in accordance with local guidelines with a clear action plan with outcomes recorded so progress can be monitored and plans for future visits agreed with client.</strong></td>
</tr>
<tr>
<td>Discuss families at clinical supervision/safeguarding supervision as per local policy and record actions in the child’s records.</td>
</tr>
</tbody>
</table>
| **IF concerns resolved**<br>Back to Universal Offer or Universal Plus Offer (if health needs remain).<br> | **Continue to deliver on Universal Partnership Plus Offer and escalate as necessary to avoid drift.**
Table 4: Vitamin D and Healthy Start

Please refer also to the leaflet ‘Vitamin D: an essential nutrient for all... but who is at risk of vitamin D deficiency? Important information for healthcare professionals’. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_115370

Healthy Start: Please make sure that women and families who may be eligible for Healthy Start know that they can apply for the benefit. Healthy Start vitamins are available free through this scheme. Visit: www.healthystart.nhs.uk

Best Practice Guidance Consider the following pathways when speaking to mothers and carers

<table>
<thead>
<tr>
<th>Supplementation of pregnant and breastfeeding women, infants and toddlers</th>
<th>Offer advice:</th>
</tr>
</thead>
</table>
| **Mothers-to-be and exclusive breastfeeding** | • about the benefits of taking vitamin D during pregnancy and breastfeeding  
• on the current UK Health Departments’ recommendations  
• to only take supplements recommended for consumption during pregnancy and breastfeeding |
| Ask them: Are you taking a supplement that contains vitamin D? | Mother took vitamin D during pregnancy | Advise vitamin D supplements* for baby after 6 months | Continue vitamin supplements until 5 years of age |
| | Mother did not take vitamin D in pregnancy | Consider use of vitamin D supplements* for baby after 4 wks | Advise vitamin supplements until 5 years of age |

**Mixed breastfeeding or formula feeding (birth to 12 months)**

<table>
<thead>
<tr>
<th>Ask them: Is your infant having more than 500ml of infant formula a day?</th>
<th>Taking more than 500ml of infant formula</th>
<th>No vitamin D supplement required</th>
<th>Continue vitamin D supplements until 5 years of age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Taking less than 500ml of infant formula</td>
<td>Advise use of vitamin D supplements*</td>
<td>Continue vitamin D supplements until 5 years of age</td>
</tr>
</tbody>
</table>

**Mothers and carers of 1-5 year olds**

<table>
<thead>
<tr>
<th>Ask them: Are you aware of the importance of continuing to supplement your child’s diet up until the age of 5?</th>
<th>Taking less than 500ml of infant formula per day, use vitamin D supplements* until 5 years of age</th>
<th>Offer advice:</th>
</tr>
</thead>
</table>
| | *The RNI of vitamin D for infants and toddlers is 7-8.5µg/280-340IU | • that children need sufficient vitamins to ensure healthy growth and development during the first five years when nutritional needs are highest  
• that vitamin D needs cannot be met by diet alone and supplements are advised  
• where/how vitamin supplements can be obtained  
• on foods rich in vitamin D  
• about fortified foods and their role  
• on the benefits of safe sun exposure |
Table 4A: NICE Public Health Guidance 56

Vitamin D: Increasing supplement use among at risk groups Issued November 2014

View the guidance at www.nice.org/guidance/PH56

A number of recommendations are relevant to, or make reference to Healthy Start vitamins.

The children’s drops and women's tablets each contain the recommended reference nutrient intake. They are suitable for people who avoid nuts, are vegetarian or have a halal diet.

<table>
<thead>
<tr>
<th></th>
<th>Children’s Drops</th>
<th>Women’s tablets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitamin A</td>
<td>233 micrograms</td>
<td>Nil</td>
</tr>
<tr>
<td>Vitamin C</td>
<td>20mg</td>
<td>70mg</td>
</tr>
<tr>
<td>Vitamin D (D3)</td>
<td>7.5 micrograms</td>
<td>10 micrograms</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>Nil</td>
<td>400 micrograms</td>
</tr>
<tr>
<td>One bottle</td>
<td>10ml (8 weeks supply)</td>
<td>56 tablets (8 weeks supply)</td>
</tr>
<tr>
<td>Daily dose</td>
<td>5 drops</td>
<td>1 tablet</td>
</tr>
<tr>
<td>Shelf life</td>
<td>10 months from manufacture</td>
<td>2 years from manufacture</td>
</tr>
<tr>
<td>Classification</td>
<td>General Sales List Medicine</td>
<td>Multivitamin Food Supplement</td>
</tr>
<tr>
<td>Suitable for vegetarian diets</td>
<td>Vegetarian Society Approved</td>
<td>Vegetarian Society Approved</td>
</tr>
<tr>
<td>Suitable for Halal Diets</td>
<td>Halal Monitoring Committee UK</td>
<td>Halal Monitoring Committee UK</td>
</tr>
</tbody>
</table>

Health professionals can recommend that breast fed babies under 6 months take the Healthy Start children’s vitamin drops if the mother did not take a supplement containing vitamin D throughout pregnancy.

If the child is having 500ml or more of infant formula a day do not give the Healthy Start children’s vitamin drops as infant formula is fortified with vitamins.

All women who are trying to get pregnant or who are pregnant should take 400 micrograms of folic acid each day.
# Appendix 1: Breastfeeding Assessment Form

<table>
<thead>
<tr>
<th>What you and your health visitor can recognise that your baby is feeding well:</th>
<th>Care plan commenced: yes/no</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What to look for/ask about:</strong></td>
<td><strong>Date:</strong></td>
</tr>
<tr>
<td><strong>Attachment:</strong></td>
<td><strong>Health visitor signature:</strong></td>
</tr>
<tr>
<td>• Baby approaches nose to nipple, with chin leading, wide open mouth.</td>
<td></td>
</tr>
<tr>
<td>• More areola visible above the top lip than below.</td>
<td></td>
</tr>
<tr>
<td>• Baby held close to mum.</td>
<td></td>
</tr>
<tr>
<td><strong>Hold/position:</strong></td>
<td></td>
</tr>
<tr>
<td>• Head and body in a straight line, head free to tilt back, breasts hanging naturally.</td>
<td></td>
</tr>
<tr>
<td><strong>Your baby:</strong></td>
<td></td>
</tr>
<tr>
<td>• Has at least 8-12 feeds in 24 hours.</td>
<td></td>
</tr>
<tr>
<td>• Is generally calm and relaxed whilst feeding and content after most feeds.</td>
<td></td>
</tr>
<tr>
<td>• Will take deep rhythmic sucks and you will hear swallowing.</td>
<td></td>
</tr>
<tr>
<td>• Will generally feed for between 5 and 40 minutes and will come off the breast spontaneously.</td>
<td></td>
</tr>
<tr>
<td>• Has a normal skin colour and is alert and waking for feeds.</td>
<td></td>
</tr>
<tr>
<td>• Is offered both breasts.</td>
<td></td>
</tr>
<tr>
<td>• Has regained birth weight.</td>
<td></td>
</tr>
<tr>
<td><strong>Your baby’s nappies:</strong></td>
<td></td>
</tr>
<tr>
<td>• At least 6 heavy nappies in 24 hours.</td>
<td></td>
</tr>
<tr>
<td>• At least 2 dirty nappies in 24 hours, at least £2 coin size, yellow and runny.</td>
<td></td>
</tr>
<tr>
<td><strong>Your breasts:</strong></td>
<td></td>
</tr>
<tr>
<td>• Breasts and nipples are comfortable.</td>
<td></td>
</tr>
<tr>
<td>• Nipples are the same shape at the end of a feed as the start.</td>
<td></td>
</tr>
<tr>
<td>• How using a dummy/nipple shield/infant formula can impact on breastfeeding.</td>
<td></td>
</tr>
</tbody>
</table>

This assessment tool was developed for use in or around day 10-14.

- **Wet nappies:**
  - Nappies should feel heavy. To get an idea of how this feels take a nappy and add 2-4 tablespoons of water as this will help you know what to expect.

- **Stools/dirty nappies:**
  - By day 10-14 babies should pass frequent soft runny yellow poos every day with 2 being the minimum you would expect.
  - After 4-6 weeks when breastfeeding is more established this may change with some babies going a few days or more without pooping. Breastfeed babies are rarely constipated and when they do pass a poo it will still be soft, yellow and abundant.

- **Feed Frequency:**
  - Young babies will feed often and the pattern and number of feeds will vary from day to day. Being responsive to your baby’s need to breastfeed for food, drink, comfort and security will ensure you have a good milk supply and a secure happy baby.
  - Remember to keep your baby close and feed your baby as soon as they signal they are ready to feed. These may include signs such as becoming restless, rooting/sucking fingers, licking lips and eyes flickering.
  - Night feeds are important to ensure a good milk production – discuss ‘safer sleeping’ with your midwife, health visitor or breastfeeding support worker.

- **Date:**

- **Health visitor signature:**
Appendix 2: Infant Feeding Conversations for health visiting team: Key Points

Remember: explore what parents already know — accept — offer relevant information

All breastfeeding mothers should have a feeding assessment using the breastfeeding assessment form during the new birth visit and an appropriate plan of care made. This may include referral for additional/specialist support

<table>
<thead>
<tr>
<th>New Birth Visit</th>
<th>6 Week Contact/3-4 Month Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>All mothers are offered support and information on:</td>
<td>All mothers are offered support and information on:</td>
</tr>
</tbody>
</table>
| • The importance of closeness and responsiveness for mother-baby well being. | • Appropriate introduction of solid foods.  
| • How to hold their baby for feeding. | • Vitamin D supplementation.  |
| • Responsive feeding. |  
| • How to know their baby is getting enough milk. | • Feeding whilst out and about and signposted to the ‘mealsonheels’ phone app. to access information about breastfeeding friendly places and support groups.  |
| • Caring for their baby at night. |  
| • Managing feeding when out and about. | • Maximising breastmilk if other milks have been introduced. |
| • Where to access feeding and social support within the local area- signposted to: www.leicspart.nhs.uk/infantfeeding | • Management of breastfeeding on return to work.  |

All breastfeeding mothers are offered support and information on:

• Why hand expressing is a useful skill and how to do it.
• How to achieve and recognise an effective latch.
• Maximising breastmilk if other milks have been introduced.
• The need for vitamin D supplementation.

Mothers who formula feed (either exclusively or partially) are offered support and information to:

• Sterilise equipment and make up feeds.
• Feed their baby first milks.
• Limit the number of people who feed their baby.

Signature:  
Date:  
Comments:  

Signature:  
Date:  
Comments:
Appendix 3

Antenatal Contact – Communication With Your Baby

Key Messages to pass on to parents:

- **‘Talking to your bump’** – your baby can hear and feel before they are born, talk and sing to your bump and take turns with your baby (ie: when he kicks, rub your bump in that place, wait for baby to kick again and repeat – to encourage early ‘conversations’)

- **Saying Hello to your new baby** – your baby can focus at a distance of approx 12 inches (about the distance between your face and the baby’s face when you are feeding him or chatting with him); your baby will watch your face and may start copying your facial expressions. Try sticking your tongue out then waiting and watching. After a while your baby may start to copy! Your baby will recognise your voice and will be comforted by hearing, especially when you are holding your baby close to you.

- **Communication with your new baby** – your baby will communicate by eye contact, crying, facial expressions and body language – watch how your baby responds or his hands and legs move as you speak sing a song or talk in a tuneful voice. Babies find it easier to listen to tuneful voices with lots of ups and downs. When talking with your baby remember to wait and watch how he responds then say another word or sound. Take turns and have a little conversation!

- **Web links to information on early interaction, attachment and talking with your baby:**
  - Talk to your baby campaign – www.literacytrust.org.uk/talk to your baby
  - Free leaflet downloads: Quick tips in 13 languages
    - Eg: ‘Say hello to your new baby’
      - ‘Dummies and Talking’
      - ‘Talk to your baby in your own language’
      - ‘Playing with your baby’

- **Talk Matters:** www.leicester.gov.uk (or Google it)
  - Parent and carers section ‘Before baby is born’ free downloadable resource: Tips and resources – ‘Talk take off’.

- **Babble back:** www.leics.gov.uk
  - Downloadable leaflets for key messages eg ‘Talking time is any time’ ‘Get down to play’ and ‘Watch, wait and listen to me’.

- **Words for Life:** www.wordsforlife.org.uk/baby
  - Milestones section – baby to 3 months.
  - Information on ‘Make a difference from Day 1’. Tips for communication with your Baby.

NB: In the ‘Antenatal Promotional Topic Guide’ this information could be included under Topic 7 (what ideas do you have for when you meet your baby for the first time once s/he is born?) and under topic 8 (what do you feel about other aspects of caring for a young baby?)

(Neonatal Jaundice NICE 2010)

Referrals Of babies with Prolonged Jaundice
All Health Visitors
Dear Colleagues,

We wish to inform you that routine prolonged jaundice screens are being carried out by appointment only on the Children’s Day care unit located in Ward 11, level 4 Balmoral building in the Leicester Royal Infirmary.

Prolonged Jaundice screening is indicated in babies who are clinically jaundiced at:
14 days (if born after 37 weeks gestation)
21 days (if born preterm, before 37 weeks gestation)

If the baby is otherwise well, prolonged jaundice screens need not be done out of hours or at weekends and should be deferred until the next working day. Jaundiced babies who are under 2 weeks old, or any baby in whom there are other clinical concerns, should continue to be referred to the Children's Assessment unit, Ward 9, Leicester Royal Infirmary as before.

If you are seeing a baby with Prolonged Jaundice, please obtain and document information regarding the following:
- Frequency of feeds
- Type of feed (Breast/Formula)
- Baby’s weight
- Urine and stool colour

Please be aware, in babies with dark complexion, jaundice is often not noticeable on skin. Therefore, it is important to check these babies for jaundice in their sclera (white part of eyes) and gums.

If you wish to request a Prolonged Jaundice screen for a baby who is otherwise well, please contact the Children's Day Care unit on 01162586317. You will be allocated an appointment. Please advise parents to seek medical attention if baby’s jaundice gets worse before their appointment. Please note: babies who have had previous bilirubin levels checked will still require a prolonged jaundice screen if they are still jaundiced at 2 weeks of age, as this includes additional investigations.

On your arrival to the Children’s Day Care, a senior Paediatric nurse will review the baby and may take blood and urine samples. If there is any clinical concern a doctor may be asked to review the baby. All results are checked by a Consultant Paediatrician. A letter will be sent out to the parents and the GP with the outcome of the investigations. Provided the results are normal you do not need to repeat Bilirubin levels unless there is a clinical concern.

Thank you for your cooperation. If you need any further information the Children’s Day Care nurses will be happy to help you. Their contact number: 0116 2586317.

S Pande Consultant Paediatrician
Appendix 4b: Midwifery and Health Visitor Guidance for Jaundice Babies Between Day 13, 14 and 15

1. A midwife or health visitor visiting a baby that has previously been jaundiced and has previous reading – the midwife will recheck with a meter on Day 13/14 and if baby no longer appears jaundiced and the reading within normal – no action – discharged from midwifery care.

2. Visiting a baby that is still visibly jaundiced on day 14 – the Health Visitor will refer to Children’s Daycare for a Prolonged Jaundice Screen in accordance with the practice cited on Dr Pande’s letter (see appendix 4a)

3. If the HV does an early new birth review, eg 10 days and the baby is jaundiced, then the HV should liaise with the community midwife and request a bilirubin test. Document that this has been requested and review.

4. Please note Bilirubinmeter testing are not accredited for Prolonged Jaundice.
Appendix 5 – Blood Spot Screening Pathway

Pathway Author: Nicy Turney, Senior Nurse Professional Lead, Health Visiting

For the Ongoing Management of Babies Under 1 Year Old

Child Health Records (CHR) to undertake weekly checks to identify:
- Babies <32 weeks gestation with no record of repeat CHRIST screen
- All babies up to >1 year moving into the area from abroad or from within the UK with no documented record of all UK screens

Midwifery services for children under 28 days
Health visiting team for children over 28 days (*Babies >8 weeks do not test for CF)

Clinic to check own data systems before offering appointment to ensure that the test has not already been undertaken and that parents have received the leaflet ‘Screening Tests for you and your Baby’
*If there is any doubt a child has had a full screen of all conditions a retest must be offered. The family health visitor is accountable for telephoning the local blood spot tester and requesting a blood spot test. Once this has been confirmed it can be documented. This request is a priority contact because of the cut off date for a CF at 8 weeks or all tests before 1yr.

Appointment Offered

Parents accept
Blood spot taken and recorded in the PCHR (Red Book)

Unable to contact parents following 2 invitation letters and/or phone calls
Send standard no contact/discharge letter to the parent and GP (see SystmOne)
Record on SystmOne and task Child Health Records and Health Visitor
Child Health Records to stop reminder being sent to Health Visitor

Normal result
Health Visitor or midwife documents test result on the child’s record and in the PCHR (Red Book)
Normal result all conditions – Child Health Record Dept will send a letter of confirmation to parent

Inadequate sample
Repeat test

Abnormal result
LAB to inform Specialist Paediatrician and GP
Specialist Paediatrician to see parents and arrange appropriate follow up

Parents decline
Record verbal decline on SystmOne
Screening card to be completed if initial test is declined and sent LAB. *Not applicable for movements in
Record to be made in the PCHR (Red Book) *Not applicable to movements in
Scan onto child’s record and task Child Health Records

Child Health Records record the decline onto the system

To Contents Page
Appendix 6a: Movement in Pathway (Internal)

Families, Young People and Children’s Services
Internal Transfer Care Pathway – Movement In

Health Visitor made aware of movement in via Health Visitor to Health Visitor contact, Child Health Services, other agencies or e referral

LPT agreement to share record. Set share settings to ‘implicit consent’

Health Visitor to review records including confirmation of newborn blood spot. If the child is under 1 year old, check feeding status at 10 days and 6 weeks. Record if not documented

Blood Spot Screening Pathway

No previous health concerns or needs identified

Introductory letter and local information sent to the family within 2 working weeks

Universal service confirmed

Current health concerns or needs identified. Consider vulnerability factors below:

Is the child on a child protection plan?

No

Liaison with previous Health Visitor

New Health Visitor to arrange to see within 1 month or as per previous care plan

Contact made?

No

Assessment completed

Universal service

Universal Plus/Universal Partnership Plus

Yes

Yes

Contact made?

Contact line manager. Consider following safeguarding children’s practice guidance

Follow safeguarding children’s practice guidance. Contact within 5 working days of receipt of information

Copyright © 2014 Leicestershire Partnership NHS Trust. All rights reserved.
Appendix 7: Discharge From Hospital Pathway

Families, Young People and Children's Services
Health Visiting Hospital Discharge Care Pathway

Health visiting team receives hospital/WIC/MIU discharge notification

Follow up not routinely required
- Viral illnesses, infections, soft tissue injury
- Sign off hospital discharge notification by Health Visitor
- Scan hospital discharge onto patients electronic record

Follow up required within 7 working days of receipt
- The following is based on UHL’s follow up criteria and all require a follow up phone call by the Health Visitor
  - Burns
  - Scalds
  - Ingestions/self harm
  - Multiple attendances (4 or more in the last 12 months)
  - Fractures
  - Babies under 8 weeks
  - Special needs
  - Wheeze/Asthma
  - Febrile convolution
  - Admission to neonatal unit, HDU or children’s intensive care unit

Outcome of phone call
- Sign off hospital discharge notification by Health Visitor
- Scan hospital discharge onto patients electronic record

Child protection plan, special needs, early help or CAF
For initial Health Visitor follow up
- For any home visit identified, communication must be shared with the health visiting team and a decision made regarding the most appropriate health care professional to make the visit
- Following the home visit feedback the outcome of follow up and record on the patients electronic record

Patient Notes
It is not necessary to access notes for every hospital discharge, however it is essential that professional judgement is utilised, especially for those requiring a phone call or home visit follow up

*If the wrong Health Visitor is notified, that Health Visitor is accountable for tasking the family Health Visitor. Please do not return the request to UHL safeguarding team
Appendix 8: Perinatal Maternal Mental Health Pathway

Universal Healthy Child Programme Contacts
Assessment as per Standard Operating Guidance

Low Risk
(Universal)

Mild to Moderate Risk
(Universal Plus)

- Agreed package of care
- Up to 4-6 visits: to develop a therapeutic relationship (mother and HV). HV to use low intensity therapeutic interventions (NICE CG192)
- Liaise with GP
- Offer other support activities local to the neighbourhood

Monitor progress using professional judgement in line with Perinatal Mental Health Guidelines using Whooley questions, EPDS

No improvement:
Refer to GP/Health Visitors can refer to Perinatal Psychiatry Service using their professional judgement and a clear rationale. The GP should always be notified

Situation improved/
resolved:
Back to Universal Services

Non-Emergency Action:
Liaise with GP within 24 hours.
Liaise with Psychiatric services as required

Emergency action: Tel: 020 92020202
Assess the risk of suicide.
Get immediate specialist advice from GP or Crisis team.
Take appropriate action: Liaise with GP, CPN, CMHT, and Psychiatrist and agree Lead Professional

Liaising with Local Authorities

Safeguarding

LSCB Guidelines

Mother’s mental health should be assessed at all universal contacts in the perinatal period

Health Visitors can refer directly but GP must be informed.
Appendix 9: Speech and Language Communication Needs At 2 Year Pathway – Late Talkers

Families, Young People and Children’s Services
‘Late Talkers’
Speech, Language and Communication Needs at Two Years Care Pathway

Point of Contact with 2 year old

Are there any concerns about speech, language and communication?

Yes

Refer to audiology

Does the child need specific intervention from Speech and Language Therapy?

Yes

UNIVERSAL PLUS

- Let’s Get Talking
- Let’s Get Talking (including Babbleback and Toddler Talk)
- Home Visits

UNIVERSAL PARTNERSHIP PLUS

Request for speech and language therapy involvement

No further concerns

UNIVERSAL PLUS Support/monitoring

No

Safeguarding Policies and Procedures

Healthy Child Programme Standard Operating Guidelines

Instructions:
The circular boxes will make reference to guidance documents. Click on the Bookmarks tab to the left of the screen and scroll through the list to locate these. Click on the document you need to open it. To move back to the pathway itself, click on the first item in the list ‘Pathway’

Copyright © 2014 Leicestershire Partnership NHS Trust. All rights reserved.
Appendix 10: Marac Care Pathway

**Case #1: Consider child protection with family**

- Outcome of contact
- The MARAC information
- To discuss:
  - HV action plan
  - Outcomes
  - Issues discussed
  - Known
  - Telephone contact and/or home visit
  - MARAC information needs to be re-assessed
  - Care plan
  - Child already known to have plans in place
  - Increased level of risk

**Case #2: Consideration of risk**

- Immediate DV and AGN discussed
- MARAC information from health visitor receives MARAC information
  - Community midwife in the case of new births
  - Specialist nurse domestic violence within 10 working days of MARAC for children already on caseload or
Appendix 11: Health Visiting Team – Behavioural Pathway 0–4 Years

Families, Young People and Children’s Services
Health Visiting Team Universal, Universal Plus Behavioural Pathway 0-4 Years

Specific behavioural issue identified
(requests for help may come in via phone, clinic, home visit etc)

Initial ‘triage’
Carry out assessment using ‘Framework for assessment’ (DoH 2003)

Appointment with HV (complex). In-depth assessment using Parenting Positively manual, Solihull Approach, or other assessment tools

Delegation to HV team member. In-depth assessment using Parenting Positively manual or other assessment tools

Can the issue be managed within HV service?

Implement behaviour management plan (up to 6 contacts). Review and evaluate progress

Dual responsibility between referrer and agency to ensure feedback on progress and outcomes of intervention

Consider referral to other agencies, eg. CAMHS professional advice line, Early Years and Clinical Forums

Yes

Has the issue been resolved?

No

Or new/more complex issues

Family made aware of ongoing support options available

Assessment tools

Yes

Can the issue be managed within HV service?

No

Assessment tools

Parenting Positively Manual

Delegation to HV team member. In-depth assessment using Parenting Positively manual or other assessment tools

Appointments with HV (complex). In-depth assessment using Parenting Positively manual, Solihull Approach, or other assessment tools

Immediate advice given
Offer follow-up if required. Consider signposting to Surestart/Homestart etc

Specific behavioural issue identified
(requests for help may come in via phone, clinic, home visit etc)

Initial ‘triage’
Carry out assessment using ‘Framework for assessment’ (DoH 2003)

To Contents Page
Appendix 12b: Constipation Management for Children Under 5 Years

Families, Young People and Children’s Services
Constipation Management for Children under 5 years Care Pathway

Child under school age referral received by Health Visiting Service

Box 1 HV assessment

Refer to GP for assessment and examination

Box 2 red flag/amber flag: GP refers

Specialist Service

Box 3 No red/amber flags: GP starts treatment and monitors

Box 4 HV review monthly

Behaviour Management

Box 5 3 months face to face review of assessment

No improvement refer to GP

Improvement continue monthly telephone support

HV return to Universal care

Normal bowel habit discharge

Instructions: The circular boxes will make reference to guidance documents. Click on the Bookmarks tab to the left of the screen and scroll through the list to locate these. Click on the document you need to open it. To move back to the pathway itself, click on the first item in the list ‘Pathway’

Continence Specialist Nurse can offer advice and support at all stages of the process

Failure to attend, follow DNA policy

Copyright © 2014 Leicestershire Partnership NHS Trust. All rights reserved.
Appendix 13: Handover Pathway Health Visiting to School Nurses – Universal Plus and Universal Partnership Plus

Universal Plus and Universal Partnership Plus

HV to identify through SystmOne, all Child Protection, Looked After Children, Universal Plus, Partnership Plus, and children with additional needs – on their caseloads on a monthly basis. The Handover between HV and SN includes decision about caseload responsibility and the rationale for care planning.

This recorded formal handover MUST be done before the child is 4 years, six months.

It is acknowledged that the Universal child becomes part of the School Nurse caseload on entry into school. It is an organisational reporting requirement where this is Safeguarding. LAC, Universal Plus, Partnership Plus care plan there must be a formal handover undertaken between Health Visitor to School Nurse and documented on SystmOne. **This MUST be done by the time the child is 4 years 6 months old.**

There are different approaches to caseload management. This can either be done on a month-by-month basis or quarterly. The decision and approach is up to the named health visitor who is accountable for the child until handover.

HV/SN's will have a face-to-face contact to decide who will carry out identified actions for this child, then document on child's electronic health records.

SN/HV to alert manager if handover has not taken place and document actions.

HV to identify children with Safeguarding/Child Protection Plan

- A consultation will take place between the HV and SN to work in partnership to identify who will best meet the needs of the child. This is recorded on SystmOne.
- On handover from the HV the SN must carry out a health needs assessment within one month.
- Following the health needs assessment and if there are no identified health needs, the SN must access supervision within ten working days to agree to make the child “inactive”.
- If health needs are identified, supervision will be accessed at the time of the next child protection conference. The case will, therefore, be “active” to the SN with a plan to care. (Safeguarding Children Supervision Policy, December 2012).
Appendix 14: Children At Risk of Hearing Impairment

Can your baby hear?
Checklist for Reaction to Sounds:

**Shortly after birth – a baby:** is startled by a sudden loud noise such as a hand clap or a door slamming. Blinks or opens eyes widely to such sounds or stops sucking or starts to cry.

**1 month – a baby:** starts to notice sudden prolonged sounds like the noise of a vacuum cleaner and may turn towards the noise. Pauses and listens to the noises when they begin.

**4 months – a baby:** quietens or smiles to the sound of familiar voice even when unable to see speaker and turns eyes or head towards voice. Shows excitement at sounds e.g. voices, footsteps etc.

**7 months – a baby:** turns immediately to familiar voice across the room or to very quiet noises made on each side (if not too occupied with other things).

**9 months – a baby:** listens attentively to familiar everyday sounds and searches for very quiet sounds made out of sight.

**12 months – a baby:** shows some response to own name. May also response to expressions like “no” and “bye bye” even when any accompanying gesture cannot be seen.

The following should be considered at ALL development assessments:

- **Parental or professional concern** (using p17 in Red Book “Can Your Baby Hear?” as guidance).

- **Concern about speech** (using p18 in Red Book as guidance). Repeated ear infections with pain or discharge.

- **All movements in from abroad need to be offered a referral for audiology/audiometry.**

- **Babies under 12 weeks who have not had a Newborn screen need to be referred urgently, directly to the Newborn Screening Programme at the LRI (0116 2586629, secure answerphone).**

Referrals for hearing test for other reasons are not the responsibility of the Health Visitor to identify (e.g. ototoxic drugs, syndromes associated with hearing loss, bacterial meningitis etc.), as there are already robust systems in place to ensure these are done.
### High Risk Countries – Incidence of TB >40/100,000

<table>
<thead>
<tr>
<th>A</th>
<th>Afghanistan</th>
<th>Algeria</th>
<th>Angola</th>
<th>Armenia</th>
<th>Azerbaijan</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Bangladesh</td>
<td>Belarus</td>
<td>Benin</td>
<td>Bhutan</td>
<td>Bolivia</td>
</tr>
<tr>
<td>C</td>
<td>Cambodia</td>
<td>Cameroon</td>
<td>Cape Verde</td>
<td>Central African Republic</td>
<td>Chad</td>
</tr>
<tr>
<td>D</td>
<td>Democratic People’s Republic of Korea</td>
<td>Democratic Republic of the Congo</td>
<td>Djibouti</td>
<td>Dominican Republic</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Equador</td>
<td>Equatorial Guinea</td>
<td>Eritrea</td>
<td>Ethiopia</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Fiji</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>Gabon</td>
<td>Gambia</td>
<td>Georgia</td>
<td>Ghana</td>
<td>Greenland</td>
</tr>
<tr>
<td>H</td>
<td>Haiti</td>
<td>Honduras</td>
<td>Hong Kong</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I</td>
<td>India</td>
<td>Indonesia</td>
<td>Iraq</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>Kazakhstan</td>
<td>Kenya</td>
<td>Kiribati</td>
<td>Kyrgyzstan</td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>Lao People’s Democratic Republic</td>
<td>Latvia</td>
<td>Lesotho</td>
<td>Liberia</td>
<td>Libya</td>
</tr>
<tr>
<td>L</td>
<td>Macao</td>
<td>Madagascar</td>
<td>Malawi</td>
<td>Malaysia</td>
<td>Maldives</td>
</tr>
<tr>
<td>M</td>
<td>Nambibia</td>
<td>Nauru</td>
<td>Nepal</td>
<td>Nicaragua</td>
<td>Niger</td>
</tr>
<tr>
<td>N</td>
<td>Pakistan</td>
<td>Palau</td>
<td>Panama</td>
<td>Papua New Guinea</td>
<td>Paraguay</td>
</tr>
<tr>
<td>O</td>
<td>Qatar</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Republic of Korea</td>
<td>Republic of Moldova</td>
<td>Romania</td>
<td>Russian Federation</td>
<td>Rwanda</td>
</tr>
<tr>
<td>Q</td>
<td>Sao Tome &amp; Principe</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Senegal</td>
<td>Sierra Leone</td>
<td>Singapore</td>
<td>Soloman Islands</td>
<td>Somalia</td>
</tr>
<tr>
<td>S</td>
<td>Tajikistan</td>
<td>Thailand</td>
<td>Timor-Leste</td>
<td>Togo</td>
<td>Turkmenistan</td>
</tr>
<tr>
<td>T</td>
<td>Uganda</td>
<td>Ukraine</td>
<td>United Republic of Tanzania</td>
<td>Uzbekistan</td>
<td></td>
</tr>
<tr>
<td>U</td>
<td>Vanuatu</td>
<td>Vietnam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>V</td>
<td>Yemen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W</td>
<td>Zambia</td>
<td>Zimbabwe</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Neonatal BCG risk assessment

Check your patient’s risk overleaf and if vaccination is indicated follow the checklist below:

Referral checklist
- Child meets criteria for vaccination (see flow chart)
- Parent/guardian aware of the risks/benefits and consents to vaccination (see table below)
- If the child has one of the following BCG should not be offered:
  - Individuals with generalised septic skin conditions (if eczema exists, an immunisation site should be chosen that is free from skin lesions)
  - Other causes of immune deficiency, e.g. ongoing cancer treatment (baby only – OK to give vaccine if someone else in the house is having cancer treatment)
  - High fever
  - HIV infection
- No close contacts with TB symptoms or active TB (chronic cough, weight loss, night sweats). If there are, refer to TB service.

Risks and benefits of BCG vaccination

<table>
<thead>
<tr>
<th>Risks</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain (common)</td>
<td>It provides protection from TB, particularly in young children</td>
</tr>
<tr>
<td>Local abscess 1/1000</td>
<td></td>
</tr>
<tr>
<td>Disseminated TB 1/1million</td>
<td></td>
</tr>
</tbody>
</table>

How to refer your patient 0-6 years of age

1. Send a task via SystmOne to Imm & Vac, stating user group Imm & Vac task heading ‘new referral’. Please include the preferred clinic venue
2. Advise parent to wait for an appointment letter

For urgent referrals, high-risk travel is imminent. Children over 6 and New Entrants, please complete an urgent referral form and send to BCG Coordinators 0116 2583767 Fax 0116 2563766

Contacts and information

Please contact the BCG Coordinators on 0116 2583767 with any queries or problems.
Further information about the TB programme, including leaflets in other languages, can be found at www.immunisation.nhs.uk
Appendix 16: Neonatal HEP B Immunisation Service

Neonatal Hepatitis B Immunisation Service – for babies born to hepatitis B positive mothers only

Universal antenatal screening for Hepatitis B infection
NICE guidelines recommend booking bloods to be undertaken at 8-10 weeks gestation
Women who present later in pregnancy should be screened ASAP (even at delivery)

Antenatal care: responding to a positive result

On receipt of a Hepatitis B positive (HBsAg +ve) result, UHL Maternity Services are required to:
- Inform the Trust’s designated Blood Born Infection Midwives, Obstetrician, GP, Health Protection Team HPT (PHE)
- Recall woman to give results and document results in notes within 10 working days
- Ensure the woman is referred for assessment (including confirmatory testing) and management by an appropriate specialist within 6 weeks of the screening results being received
- Refer household and sexual contacts for screening and vaccination
- Assess indications for HBIG and if required order from Colindale on standard form (see Appendix A)
- Consent mother for full vaccination schedule and dried blood spot test at 12 months

On receipt of Hepatitis B positive result, the Health Protection Team (PHE) is required to:
- Liaise with GP, and support screening and vaccinating of household and sexual contacts

On receipt of Hepatitis B positive result, the GP is required to:
- Arrange screening and vaccination of household and sexual contacts.

After delivery, UHL Maternity Services are required to:
- Explain implications of Hepatitis B and obtain consent for vaccination. Provide leaflet to parents.
- Ensure first vaccine +/- HBIG is administered within 24 hours of birth
- Record mother’s hepatitis status and baby’s vaccination status in midwifery notes, discharge letter, and PCHR

At discharge UHL maternity services are required to:
- Inform CHRD, GP, HV of mother’s hep B status and that first dose (+/-HBIG) has been given to the baby. Neonatal Hep B Notification (Form HB1)
- Ensure fail safe is in place for notifying CHRD and GP
- Explain the follow up process and check that mother’s address and phone number are accurate

On receipt of notification form (HB1) CHRD are required to:
- Commence scheduling/prompting and invitation for all subsequent vaccine doses
- Inform GP of scheduled appointments
- Inform HV of missed appointments
- Follow systems for rescheduling missed appointments
- Submit quarterly data on behalf of NHS England to COVER
- Coordinate Dried Blood Spot Testing to exclude infection at 12 months, and record the test result
- Follow local protocols when child moves in / out of area

The GP is required to:
- Identify newly registered ‘at risk’ babies. Inform HV and CHRD. If maternity services have been unable to give the first dose, arrange as soon as possible
- Order and administer the 2nd, 3rd and 4th doses of the vaccine at 1, 2 and 12 months respectively.
- Notify CHRD after each dose of vaccine is given
- Arrange dried blood spot test to exclude infection at 12 months, and report the result to the patient
- Assess need for a booster dose of vaccine at 3 years 4 months (see Green Book or contact HPT
- Follow up DNAs by contacting parents
- Referral to an appropriate specialist if child develops hepatitis B infection

Follow up with GP and Health Visitor (HV)

The Health Visitor is required to:
- Identify ‘at risk’ babies by checking mother’s hep B status at newborn visit
- Check that vaccination schedule is up to date at 10-14 days, 6 weeks and 10m - 1 yr
- Reinforce the need for vaccination and signpost parents at each routine visit
- Liaise with GP and contact the family when a child fails to attend for vaccination
- Check Hep B status for all children who move into the area

Delivery & transfer from maternity services to other providers

To Contents Page
## Appendix 17: Ages and Stages Recommended Tool

<table>
<thead>
<tr>
<th>CHILD’S AGE</th>
<th>USE THIS ASQ-3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 month 0 days – 2 months 30 days</td>
<td>2 months</td>
</tr>
<tr>
<td>3 months 0 days – 4 months 30 days</td>
<td>4 months</td>
</tr>
<tr>
<td>5 months 0 days – 6 months 30 days</td>
<td>6 months</td>
</tr>
<tr>
<td>7 months 0 days – 8 months 30 days</td>
<td>8 months</td>
</tr>
<tr>
<td>9 months 0 days – 9 months 30 days</td>
<td>9 months</td>
</tr>
<tr>
<td>10 months 0 days – 10 months 30 days</td>
<td>10 months</td>
</tr>
<tr>
<td>11 months 0 days – 12 months 30 days</td>
<td>12 months</td>
</tr>
<tr>
<td>13 months 0 days – 14 months 30 days</td>
<td>14 months</td>
</tr>
<tr>
<td>15 months 0 days – 16 months 30 days</td>
<td>16 months</td>
</tr>
<tr>
<td>17 months 0 days – 18 months 30 days</td>
<td>18 months</td>
</tr>
<tr>
<td>19 months 0 days – 20 months 30 days</td>
<td>20 months</td>
</tr>
<tr>
<td>21 months 0 days – 22 months 30 days</td>
<td>22 months</td>
</tr>
<tr>
<td>23 months 0 days – 25 months 15 days</td>
<td>24 months</td>
</tr>
<tr>
<td>25 months 16 days – 28 months 15 days</td>
<td>27 months</td>
</tr>
<tr>
<td>28 months 16 days – 31 months 15 days</td>
<td>30 months</td>
</tr>
<tr>
<td>31 months 16 days – 34 months 15 days</td>
<td>33 months</td>
</tr>
<tr>
<td>34 months 16 days – 38 months 30 days</td>
<td>36 months</td>
</tr>
<tr>
<td>39 months 0 days – 44 months 30 days</td>
<td>42 months</td>
</tr>
<tr>
<td>45 months 0 days – 50 months 30 days</td>
<td>48 months</td>
</tr>
<tr>
<td>51 months 0 days – 56 months 30 days</td>
<td>54 months</td>
</tr>
<tr>
<td>57 months 0 days – 66 months 0 days</td>
<td>60 months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHILD’S AGE</th>
<th>USE THIS ASQ-SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months – 8 months</td>
<td>6 months</td>
</tr>
<tr>
<td>9 months – 14 months</td>
<td>12 months</td>
</tr>
<tr>
<td>15 months – 20 months</td>
<td>18 months</td>
</tr>
<tr>
<td>21 months – 26 months</td>
<td>24 months</td>
</tr>
<tr>
<td>27 months – 32 months</td>
<td>30 months</td>
</tr>
<tr>
<td>33 months – 41 months</td>
<td>36 months</td>
</tr>
<tr>
<td>42 months – 53 months</td>
<td>48 months</td>
</tr>
<tr>
<td>54 months – 65 months</td>
<td>60 months</td>
</tr>
</tbody>
</table>
Appendix 19: Oral health

Oral Health Pathway

Ante Natal Contact
- NHS Dental care is free for all pregnant mothers and for 12 months after birth
- Discuss the importance of oral health as part of overall health.

Four month contact
- NHS Dental care is free for all pregnant mothers and for 12 months after birth
- If Bottle fed, discuss and begin bottle to cup weaning.
- Signpost to free Bottle Swaps at Children's Centres (Leicester City only)
- Discuss the dangers of dummy dipping
- Stress the importance of the child's primary dentition
- Assess and identify risk factors for dental decay
- Distribute Healthy Teeth, Happy Smiles! resource packs (Leicester City only)
- Children born in the County to receive 'my first toothbrush and paste pack'

One Year Contact
- Remind that NHS Dental care is free until the age of 18
- Encourage taking child to their first dental check up before 1 year of age
- If Bottle fed, discuss and begin bottle to cup weaning.
- Signpost to free Bottle Swaps at Children's Centres (Leicester City only)
- Discuss the dangers of dummy dipping
- Stress the importance of the child's primary dentition
- Assess and identify risk factors for dental decay
- Distribute Healthy Teeth, Happy Smiles! resource packs (Leicester City only)

Two Year Contact
- Remind that NHS Dental care is free until the age of 18
- Check that child has been for a dental check up by one year. If not refer to OHP (Leicester City only)
- Check that the child has been weaned off baby bottle. Remind of free bottle swap at Childrens Centres (Leicester City only)
- Discuss benefits of fluoride varnish from age 3
- Check that child no longer uses baby bottles or dummies - if still in use refer to OHP (Leicester City only)
- Distribute Healthy Teeth, Happy Smiles! resource packs (Leicester City only)

Key Questions
There are few keys questions which need to be asked at the final two visits:

1. Has the child been for a dental check-up and if not why not?
2. When was the last dental check-up?
3. If required, signpost to the nearest NHS Dental Practice at www.nhs.uk/dentists or by calling Healthwatch on 0116 2574 999

Resources
1. Leicester City only:
   - Distribute Healthy Teeth, Happy Smiles! Oral health resource packs at 4 month, one year and 2 year contacts.
   - Signpost to free Bottle Swaps at Childrens Centres
   - For additional advice and guidance contact the Oral Health Promoters (OHP - details on: www.leicester.gov.uk/healthyteethhappysmiles)
2. County:
   - Distribute My first toothbrush and paste pack at 4 month contact.
   - Leaflets to enhance messaging around Oral Health to be distributed at one year and two year contact.

Universal Messages
1. NHS Dental care is free for all pregnant mothers and for 12 months after birth
2. NHS Dental care is free until the age of 18
3. After brushing teeth, it’s important to spit and not rinse
4. Discourage dummy dipping
5. Encourage stopping bottle feeding by one year of age
6. Discuss benefits of fluoride varnish
Appendix 20: Transition to Parenthood and the early weeks Pathway

Families, Young People and Children’s Services
Transition to Parenthood and the early weeks Care Pathway

Instructions: The circular boxes will make reference to guidance documents. Click on the Bookmarks tab to the left of the screen and scroll through the list to locate these. Click on the document you need to open it. To move back to the pathway itself, click on the first item in the list ‘Pathway’.

Box 1
Midwife completes Notification of prospective parent form (NPP) by 16 wks

Do parents need additional support?

Health Visitor and Midwife meet face to face locally, fortnightly to share concerns about vulnerable families

No

Yes

Box 2
Universal
No additional support needed

No

Yes

Box 3
Universal Plus
Some support needed

Box 4
Universal Partnership Plus
Support needed

Box 5
Safeguarding

Do parents meet criteria for FNP, Early Start or Early Help?

No

Yes

Midwife refers to Intensive Support Programme as appropriate by 16 wks

FNP Care Pathway

Early Start Charnwood Care Pathway

Box 6
Early Help/Think Family

Perinatal Maternal Mental Health Care Pathway

6 week contact

Potential Promotional Guide

Perinatal Maternal Mental Health Care Pathway

6 week contact

Potential Promotional Guide

Perinatal Maternal Mental Health Care Pathway

6 week contact

Potential Promotional Guide

Perinatal Maternal Mental Health Care Pathway

6 week contact

Potential Promotional Guide
References


2. All Party Parliamentary Group, Conception to Age 2. First 1001 Days. (February 2015)


19. DH, (2010) Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs (DH, 2010).


40. HM Government, Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children (HM Government 2013)


43. Leicestershire County Council (08) Family information Service, available at: www.leics.gov.uk/family


57. Pledge, Better health outcomes for children and young people.
58. PREview- investing in children’s services for a fairer future.
60. Reduce the risk of cot death (2009) (quote 292301/Reduce the risk of cot death).
69. Wave Trust, Conception to Age two: The Age of Opportunity. WAVE Trust and DfE
70. Wave Trust, The 1001 Critical Days: The importance of the conception to age two period. Wave Trust, 2013
Applicable National Standards

CQC Essential Standards of Quality and Safety 2010

UK National Screening Committee Standards and Guidelines

Newborn Bloodspot Screening
Newborn Hearing Screening
Newborn Infant & Physical Examination
The Green Book- (Imms)

Key NICE public health guidance (till 12/2014) includes:


Please note: For all reference see the [www.nice.org.uk](http://www.nice.org.uk)

PH3  Prevention of sexually transmitted infections and under 18 conceptions
PH6  Behaviour change at population, community and individual level (Oct 2007)
PH8  Physical activity and the environment
PH9  Community engagement (July 2010)
PH11 Maternal and child nutrition
PH12 Social and emotional wellbeing in primary education
PH14 Preventing the uptake of smoking by children and young people
PH17 Promoting physical activity for children and young people
PH21 Differences in uptake in immunisations
PH24 Alcohol-use disorders: preventing harmful drinking
PH26 Quitting in smoking in pregnancy and following childbirth (June 2010)
PH27 Weight management before, during and after pregnancy (July 2010)
PH28 Looked-after children and young people: Promoting the quality of life of looked-after children and young people (October 2010)
PH29 Strategies to prevent unintentional injuries among children and young people aged under 15 Issued (November 2010)

PH30 Preventing unintentional injuries among the under-15s in the home

PH31 Preventing unintentional road injuries among under-15s

PH40 Social and emotional wellbeing – early years: NICE public health guidance 2012

PH42 Obesity working with local communities

PH44 Physical activity: brief advice for adults in primary care

PH46 Assessing body mass index and waist circumference thresholds for intervening to prevent ill health a premature death among adults from black, Asian and other minority ethnic groups in the UK.

PH48 Smoking cessation: acute, maternity and mental health services

PH49 Behaviour change: individual approaches

PH50 Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively. NICE public health guidance

PH56 Vitamin D: Increasing supplements use among at risk groups. This replaces recommendation 3 in Maternal and Child Nutrition (PH11)

CG37 Postnatal Care (Dec 2014)

CG43 Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children

CG45 Antenatal and postnatal mental health: clinical management and service guidance (February 2007)

CG62 Antenatal care: routine care for the healthy pregnant woman (March 2008)

CG89 When to Suspect Child Maltreatment (July 2009)

CG93 Donor milk banks: the operation of donor milk bank services

CG110 Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors

CG170 Autism: the management and support of children and young people on the autism spectrum http://www.nice.org.uk/guidance/cg170

CG192 Antenatal and postnatal mental health: clinical management and service guidance (Dec 2014)

CG192 Antenatal and postnatal mental health: clinical management and service guidance (Dec 2014)
Integrated National Pathways

Safeguarding children including a focus on prevention, early help, targeted support, early intervention and sharing of information. (See Working Together to Safeguard Children HM Govt 2013).

Young parents including Family Nurse Partnership

Substance and alcohol misuse

Domestic abuse

Parental and infant perinatal mental health and early attachment (for best practice see Tameside & Glossop Early Attachment Service).

Parenting Programme Pathway (Social and Emotional Development (Greater Manchester Public Service Reform Early Years Programme)

Breastfeeding (UNICEF baby friendly in the community).

Nutrition and healthy weight including failure to thrive (NCMP and PHE via www.noo.org.uk)
Children with additional needs and disabilities

Transitions between midwifery, FNP and health visiting (DH)

Transition from health visiting to school nursing (DH)

Transition from HV to School Nurse (see DH website 2013)

Seldom heard communities including families with young children from traveller, asylum seeker and refugee communities and homeless families.

Families with complex and multiple needs including ‘troubled families’

Newborn Blood Spot Programme: http://newbornbloodspot.screening.nhs.uk/professionals

Newborn Hearing Screening Programme

Newborn Infant Physical Examination Programme


Recommended Leaflets, Websites and Apps

If leaflets are no longer available please signpost.

Antenatal and New Birth Review

• NHS Choices Website (Pregnancy and Baby Guide)

• Becoming Parent Leaflet Leicester Maternity Unit

• Step Right Out Stop Smoking Leicestershire Partnership Trust.

• NHS Information Service for Parents https://www.nhs.uk/InformationServiceForParents/pages/home.aspx


• Vaccines for Kids Online http://www.nhs.uk/Planners/vaccinations/Pages/Vaccinesforkidshub.aspx

• A guide to Immunisations up to 13 months (NHS 2013).

• Contraceptive Choices – after you’ve had your baby www.fpa.org.uk/helpandadvice/contraception/contraceptionafterbaby

• Lullaby Trust Safer sleep for your baby. The guide for parents. Safer Sleep for babies. Things you can do. www.lullabytrust.org.uk
• Emotional changes following childbirth (NHS, LPT) – all first time and targeted mothers.

• Off to the best start (NHS) 2011 www.nhs.uk

• Guide to Bottle feeding (NHS) 2011 www.dh.gov.uk

• NHS Stop Smoking Services – 0116 2954141 or 0845 0452828

• Healthy Start Application Pack www.healthystart.nhs.uk

• Free milk, fruit, vegetables and vitamins for you and your family. Healthy start NHS

• Vitamin D An essential nutrient


• The mothers and other guides – Caring for your new baby – Issue 11

• Oral Health in Pregnancy – produced by Leicester City Council

• Best Beginnings ‘Baby Buddy’ Mobile Phone App (Download from ‘App Store’)

• Meals on heels App.

For insertion in the PCHR

• Details of team, telephone number and clinic times

• NHS, LPT Customer Service – Here to Help (LPT)

• A Guide for parents and carers: Your child’s information- what you need to know. (NHS LCR)

• Health Visiting With You Every Step of the Way. :Leicestershire Partnership Trust

• Making Every Contact Count Leicestershire Partnership Trust

Six Week contact

• Smoking cessation – STOP Leicester City Tel: 0116 2954141. Stop Smoking service Leicestershire County and Rutland Tel: 0845 0452828

Four month Weaning Sessions

• Introducing Solid Foods (NHS 2011) www.nhs.uk/start4life

• Stage 1 Smooth textures and tastes. Updated Sept 2010 (Leicestershire Nutrition and Dietetic service intranet) http://www.lnds.nhs.uk/_HealthProfessionals-LifestyleDietaryManagementResources-NutritionforInfantsandChildren.aspx


• Tiny Teeth (Dairy Council) www.milk.co.uk/publications


• Now I can crawl (CAPT 2006) and other safety leaflets www.capt.org.uk

• Smoking cessation – STOP Leicester City Tel: 0116 2954141. Stop Smoking service Leicestershire County and Rutland Tel: 0845 0452828

• Eat Better. Do Better xxxx@xxxxxxxxxxxxxxxxxxx.xxx.xx

• I love my baby tooth. (Bookstart)

• Stopping the Bottle – Produced by LCC

One year contact

• Small Talk http://www.thecommunicationtrust.org.uk/resources/resources/resources-for-parents/small-talk.aspx

• Top Tips for developing talk http://www.thecommunicationtrust.org.uk/resources/resources/resources-for-parents/top-tips-leaflet.aspx

• Stage 3 Lumps, chopped foods and finger foods. Updated Sept 2010 (Leicestershire Nutrition and Dietetic service intranet) http://www.lnds.nhs.uk/

• 5 a day Made Easy http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4088835.pdf

• Tiny Tums (Dairy council) www.milk.co.uk/publications

• Tiny Teeth (Dairy council) www.milk.co.uk/publications


• Now I can crawl (CAPT 2006) www.capt.org.uk

• Smoking cessation – STOP Leicester City Tel: 0116 2954141. Stop Smoking service Leicestershire County and Rutland Tel: 0845 0452828

• Six Months – 3 years (oral health leaflet) LCC
Two year contact

• Toilet training- refers to Birth to Five, Chapter 6 Habits and behaviour, page 86. Online version http://www.dh.gov.uk/en/Publicationsandstatistics/


• Smoking cessation – STOP Leicester City Tel: 0116 2954141. Stop Smoking service Leicestershire County and Rutland Tel: 0845 0452828

• Family Information Service - www.leics.gov.uk/family; www.families.leicester.gov.uk

• Welcome to the school nurse service http://documents.lcrchs.nhs.uk/Library/13schoolnurseleaflet.pdf

• Healthy Tots Teeth, www.leicestershirehealthytots.org.uk

Other

• Good Practice Points for Health Visitors www.iHV.org.uk

• iHV Tips for Parent www.iHV.org.uk

• 3 – 6 years (Oral health leaflet) Produced by LCC

• Magic of Fluoride Varnish, Leicestershire County Council, Leicester City Council (2015)

• Change4Life, Department of Health. www.nhs/change4life

• Solihull Approach, www.solihullapproachparenting.com

• Newborn blood spot test, www.nhs.uk
Acknowledgements

Nicy Turney, Professional Lead Health Visiting would like to thank all Health Visitors and professional colleagues who have contributed and commented on this document. Special thanks to:

Louise Butchart  Speech and Language Therapist, LPT
Liz Jackson  Speech and Language Therapist, LPT
Ruth Pope  Lead Practice Teacher, LPT
Maureen Curley  Locality Manager, LPT
Claire Turnbull  Designated Nurse, LAC, LPT
Jill Phelan  Clinical Team Leader, LPT
Alison Timmins  Health Visitor, LPT
Sheila Gulley  Lead Practice Teacher, LPT
Carolyn Corbett  Acting Professional Lead, Safeguarding Children, LPT
Theresa Farndon  Locality Manager, LPT
Sally Clare  Specialist Nurse, Domestic Violence, LPT
Carole Fishwick  Breastfeeding Lead, LPT
Joanne Hackman  Senior Specialist TB Nurse and BG Co-ordinator, UHL
Kathryn Hammond  Lead Practice Teacher, LPT
Sarah Fenwick  Clinical Team Leader, LPT
Chris Davies  Locality Manager, LPT
Tejas Khatau  Lead Pharmacist, FYPC, LPT
Asha Day  Health Visitor, LPT
Collette Proctor  Perinatal Project Lead, LPT
Christina Brooks  Lead Practice Teacher, LPT
Jacqui Cooper  Clinical Team Leader, LPT
Liz Sampson  Health Visitor / LAC Specialist Nurse, LPT
Maggie Clarke  Professional Lead, School Nursing, LPT
Theresa Heffernan  Administrative Service Manager, LPT
Jasmine Murphy  Consultant in Public Health (CYP, Sexual Health, Dental Public Health) Leicester City Council
Jane Roberts  Senior Public Health Manager, Leicestershire County Council
Trish Crowson  Public Health Manager, Leicestershire County Council
Janis Young  Personal Secretary, LPT
Sharon Gregory  Clinical Team Leader
Jo Chessman  Clinical Team Leader LPT
Linda Mills  Lead Practice Teacher LPT
Jane Sansom  Locality Manager LPT
Deanne Rennie  Speech and Language Clinical Lead.