

HEALTH VISITOR GUIDELINES

Implementation of the Healthy Child programme

Introduction

This guideline relates to the Healthy Child programme, National Service Framework for Children Young people and maternity services and the Service Specification for Health Visiting and early years services 2009- 2012 as commissioned by North of the Tyne Commissioning PCT. This guidance applies to the Health Visitor and Nursery Nurse role within the programme.

The Healthy Child Programme ensures that under fives and their families receive a universal evidence based preventative programme that protects and promotes the health of all children.

The Healthy Child Programme is led by the health visitors and delivered by health visitors in partnership with early years practitioners working with parents and their children and co-ordinated by the NSF implementation multiagency group.

Reference documents

- Healthy Child programme (2008);
- Health for All children David Hall (2006);
- Routine Postnatal care of Women and Babies; NICE guidance (2007);
- Improving the nutrition of pregnant and breastfeeding mothers and children in low income households NICE (2008);
- Every Child Matters;
- The Common Assessment Framework (2006);
- Delivering Health Services through Sure Start Children's Centres;
- Northumberland's Children's and Young People's Plan (2008-2011);
- NSCB page <http://www.northumberland.gov.uk/default.aspx?page=3808>
- The Health of Gypsies and Travellers in the UK. A race equality Foundation briefing Paper 2008

Summary of the Core Contacts

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General Responsibilities

- From the health visitor contacting the parents for the antenatal contact it is suggested that where teams are fully staffed that each family should have a named health visitor until the child is one years old. Families with children receiving targeted interventions should have also have a named health visitor for the period of the intervention.
- The health visitor should complete a Common Assessment (CAF) in partnership with the family where there are a number of professionals involved with the family and a child is in need of additional services. The health visitor may take up the role of the lead professional.
- Communication and sharing information across agencies is essential to protect vulnerable children and provide an integrated service to families. Families expect information to be communicated and clear procedures are available to support staff sharing information as directed by regulations (see Information sharing guidance for HV's in appendix 13)
- It is expected that health visitor follows the NSCB safeguarding procedures in their working practice.

Mobile Children young people and their families

Gypsy Roma and Travelling families, refugee, or homeless children require specific consideration by the health visitor to ensure that services are accessible to them and that services are provided in a manner which addresses their needs and facilitates engagement.

Families experiencing problems

HV's working with children and their families' who are experiencing personal problems such as domestic abuse, mental illness, substance misuse and learning disability should ensure the needs of the children are assessed and appropriate services are delivered to these children and their families.

Where parents or carers have problems that result in them not being able to respond to their children's needs, the safeguarding of children (including the unborn child) is a priority. An assessment of the children's needs and parents' capacity should be undertaken in partnership with the FACT team.

Safeguarding

Ensuring services are accessible to all children and families will prevent children and young people from being harmed, safeguarding those who are likely to suffer significant harm and facilitating optimal outcomes for those children who have been harmed.

Health visitors are part of the FACT integrated services and will respond, in accordance with both the Trust and NSCB policy, in a co-ordinated manner to the assessed needs of children and their families where they consider a child at risk of being abused or neglected

Families with disabled children

The early support programme for parents of disabled children who need more frequent contact can provide extra help, support and information for families (DCATCH, Aiming High etc).

Core Programme

Ante natal contact

Antenatal screening is offered to every family by named HV (where possible) around 36 weeks onwards and is completed as per Tynedale Health Needs Assessment training. Earlier contact may be made if required following information received from midwife or other professional working with the family.

All parents receive Birth to Five Book (as per NICE guidance), leaflets as recommended in the leaflet list(appendix 11) may be given

Smoking cessation pathway followed at every contact with any smoking assessment and intervention recorded in the THNA.

Introduction of the childhood immunisation programme.

The health visitor will provide information about feeding especially the benefits of breast feeding as per breast feeding policy.

The health visitor will provide information about local services in the area in particular Children's Centres. A discussion around the integrated team members and circumstances you would be sharing information.

The Parent Held Record Book is given out by the midwife in hospital

Primary Visit (ref; CPHVA Professional Briefing 'The new Birth Visit' Nov 2008)

The HV offers the family a home visit convenient to the family.

An assessment of the baby's growth and development is made.

HV assesses woman's/ families' reaction to the birth, further support re breast-feeding, local children's centre groups and child health clinics.

The health visitor may offer relevant leaflets to support any verbal information given and complete the PHR book.

Gain consent to share information with Children's Centres, and Connexions, if teenage parents (registration leaflet signed and returned to the relevant Children's Centre).

Agree further home visits on assessed need; offer invitations to child health clinic, information about 6 week check and immunisation appointments. If the child fits into a high risk group it should have received its BCG prior to discharge from hospital. A pathway is being developed for those who get missed.

Vitamin K guidelines are followed.

Follow perinatal mental health pathway.

The Health Visitor will check with the parent that the blood spot has been done. Results should be received in approx 3 weeks and the HV will take appropriate action as per pathway (appendix 10)

HV's record breast feeding at 10 days and smoking and send a copy to Child health

6-8 weeks

Either GP or HV assess mother's emotional wellbeing as per Mental health prediction and detection pathway (appendix 4). Baby's growth and development is assessed.

The GP will complete the assessment as per local team arrangements.

The child should have received the first immunisation appointment.

Accident prevention issues highlighted re car seats, low cost safety scheme, hot drinks and baths.

If the family fail to attend this appointment on 2 occasions this must be followed up and the baby seen by the HV either at home or clinic by 10 weeks (as per Safeguarding guidance document for criteria for home visit follow up).

Ensure the parent has received the bloodspot result.

If PHR has HV 6 week check form return copy to Child health, if not ensure breast feeding is recorded on GP form

3 to 4 month contact

Record babies weight and assess growth using the immunisation visit as an opportunity if possible. Encourage parents to take up any parenting groups re support and introduction of solids routines etc. Target those families in Level 2 and 3 who do not access groups re home visits.

Introduce Low cost Safety scheme, reinforce previous safety messages, introduce messages re baby walkers and mobile baby etc.

Ongoing breast-feeding support if required.

Introduce Bookstart Pack to all families including hard to reach groups for example; teenage parents, homeless families, refugees, Gypsy Roma and Travellers families and asylum seekers. Discuss the importance of communication and interaction baby and parent re bonding, play, talking and listening.

Books are available in other languages, for visually impaired and hearing impaired children through the librarian as required.

It is appropriate to offer the 'Tasty Treats' weaning programme at this age.

Ensure follow up as appropriate if parents failing to attend immunisation appointments.

The health visitor will complete a mental health assessment as per NICE guidelines and provide follow up or referral if indicated.

NB No slips to go back to Child Health

5 to 8months BabyCheck

Parents should be signposted to or facilitated to access the 5 to 8 month Babycheck on line; www.nhs.uk/lifecheck

1 Year Review

Offer a contact between 11 months and 13 months (could be combined with GP contact for immunisation)

Review general health and immunisation status.

Deliver Bookstart plus at this contact and make the link for the parent with good communication and speech and language development.

Check biographical details on the Child health Record. Refer back to the Tynedale health needs Assessment and any others plans or interventions. Evaluate them.

Is the child healthy? Record the developmental progress, review growth, immunisation and general progress.

Any dental health concerns? Encourage registration with a local dentist.

Is the child safe from harm? Can the parents/ carers support the child's development and respond to their needs.

Are there wider family and environmental elements that may impact on the child's ability to reach full potential?

Give anticipatory guidance regarding the Healthy Child Programme and future contact with the HV and Primary care services.

Record in the PHR.

Complete the Sure Steps to talking questionnaire as per training (Protocol and parents information attached)

The score determines the need for further action.

Speech review- statis/review- in the small space just below the data tick box write statis or review clearly (this is to enable the data in putters to quickly identify what they need to note without reading the body of the assessment).

Record breast feeding at 6 months on the assessment form and send a copy to Child health

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2yr 3 mths – 2yrs 6 mths Review

'An examination of the pattern of preschool referrals to speech and language therapy' Carolyn A. Anderson and Anna van der Gaag Child Language Teaching and Therapy 200:16:59 provided evidence for the optimum time for this contact.

<http://clt.sagepub.com/cgi/content/abstract/16/1/59>

All families are contacted between 2 yrs 3 mths and 2yrs 6 months. Not all families require a developmental assessment. Appendix 2 provides an aide memoir for a telephone contact. Children are identified for a targeted developmental assessment through;

- Concerns identified at the 1 year review
- Concerns identified at the telephone contact
- Parental request
- Professional request
- Automatic (see criteria below)

Criteria;

- Prematurity
- Multiple births
- Non immunised/not fully immunised
- Speech and language concerns identified at the 1 year review
- Obesity (>30 BMI: see clinical concerns)
- Parental anxiety/ mental health issues
- Young parent <20 with poor support networks
- Housing instability/ Lamb House, Refuge, no fixed abode.
- Ongoing behaviour difficulties
- Safeguarding issues/ allocated social worker/ level 2 concerns
- Multi agency working/plan
- Developmental delay
- Chronic health problem
- History of domestic violence
- Not engaging with the service
- English not a first language
- Problem drug user

The HV will assess the most appropriate person to complete the assessment. (nursery nurse, staff nurse, health visitor contact or both)

Complete the PHR

Tools developed by the NSF standard 1 Group are to be used as required (appendix 2)

Send a slip to Child Health stating telephone contact or full 27 month review

Nursery School Links

- Each first school will have a named HV.
- The HV team remain responsible for the child and family.
- Working with the school and families may offer opportunities for health promotion to be tackled in the schools either by the HV or NN.
- Information should be developed about the HV and NN team for nursery school staff.
- It is recommended that the HV /NN contact the nursery school at least once in every 6 months.

4-year transition

- HV team develop a leaflet pack for the practice nurse to give out to parents who attend with a child for a pre school booster (working group will consult parents to develop what should be in the leaflet pack)
- HV is responsible to arrange a meeting with the school health advisor to handover children in the year's cohort (September after the child's fourth birthday). There will be a written handover completed by the HV/ NN and filed in each continuous child health record.
- In level 2 and 3 cases there will be a planned handover to the school health advisor in partnership with parents at 4yrs and 11 months. Best practice would include a representative from school and integrated team.
- A 4 yr old already handed over to the SHA and requiring intervention will be discussed between professionals involved and a decision made about the best person to deliver the intervention.

Children not attending nursery/ pre school group

- Not attending nursery or pre school may increase the vulnerability of a child. If HV becomes aware the child is not accessing early education it is recommended that the HV would make a professional judgement based on the family and child's history/ previous contacts and offer an assessment.

APPENDICES

Appendix 1

Aide memoir; 1 year review

<u>Child development needs</u>	<u>Examples</u>
<p>Growth and Development, feeding, sleeping, general behaviour, identity and self-esteem. Immunisation status. Social presentation. Dental health Bookstart Plus Sure Steps to talking assessment</p>	<p>Sits well, reaching out. Walks holding on (coasting). Raking, pincer grasp. Plays peek aboo. Object permanency. Drinks from a cup. Chewing; eats family diet. Has visited dentist. Teeth brushed with fluoride paste.</p>
<u>Parenting Issues</u>	
<p>Basic care; home safety Safe from harm, protection. Emotional warmth and stability Guidance boundaries and stimulation</p>	<p>Age appropriate toys, use of safety equipment. Routines. Assessment of bonding and relationship. Good eye contact. Reassured by parents. Communication evident.</p>
<u>Family and environmental Factors</u>	
<p>Family functioning and wellbeing. Extended family. Social networks Housing, employment and financial considerations. Social and community elements and resources, including education.</p>	<p>Accesses age appropriate activities; toddlers, library, Children centres</p> <p>References; Sollihul, Denver, Infant Mental health. CAF Assessment.</p>

Appendix 2

Aide memoir; Telephone contact at 2yrs3 mths

Confirm speaking to parent.

- Do you have any concerns?
- Speech – how many words, joining words?
- Engage in pretend play
- Gross and fine motor skills
- Concentration
- Behaviour
- Lifestyle; Weight concerns
 - Diet (fussy eaters, promote 5 a day, avoid sugary foods and drinks at bedtime)
 - Level of Physical Activity
- Sleeping
- Toileting
- Happy with growth, eyesight, etc
- Dental health; has visited dentist?
 - Teeth brushed with fluoride toothpaste?
- Safety
- Nursery place?
- Invite to clinic for weight when passing
- Advise any local services

Appendix 3
Screening for TB risk factors.

➤ When to screen for risk factors.

In the table below are screening opportunities and the actions to be taken should an indication for vaccination be identified.

Screening opportunity	Health Professional	Action to be taken if risk factor identified.
Antenatal check - screening questions.	Midwives	Mark mothers notes and give leaflet 'BCG and your baby' to parents.
At Birth - check mother's notes and repeat screening questions.	Midwives	Alert staff on PNW of need for vaccination and document in yellow baby notes.
At Newborn Check - screening questions.	Doctor/ Midwife/ ANNP performing check	Proceed to complete BCG proforma and vaccinate baby.
At 10 days - screening questions.	Health visitor/ community midwife	Refer to TB clinic.*
At 6-8 week postnatal check. - screening questions and consider additional question.	GP/ health visitor.	Refer to TB clinic.*

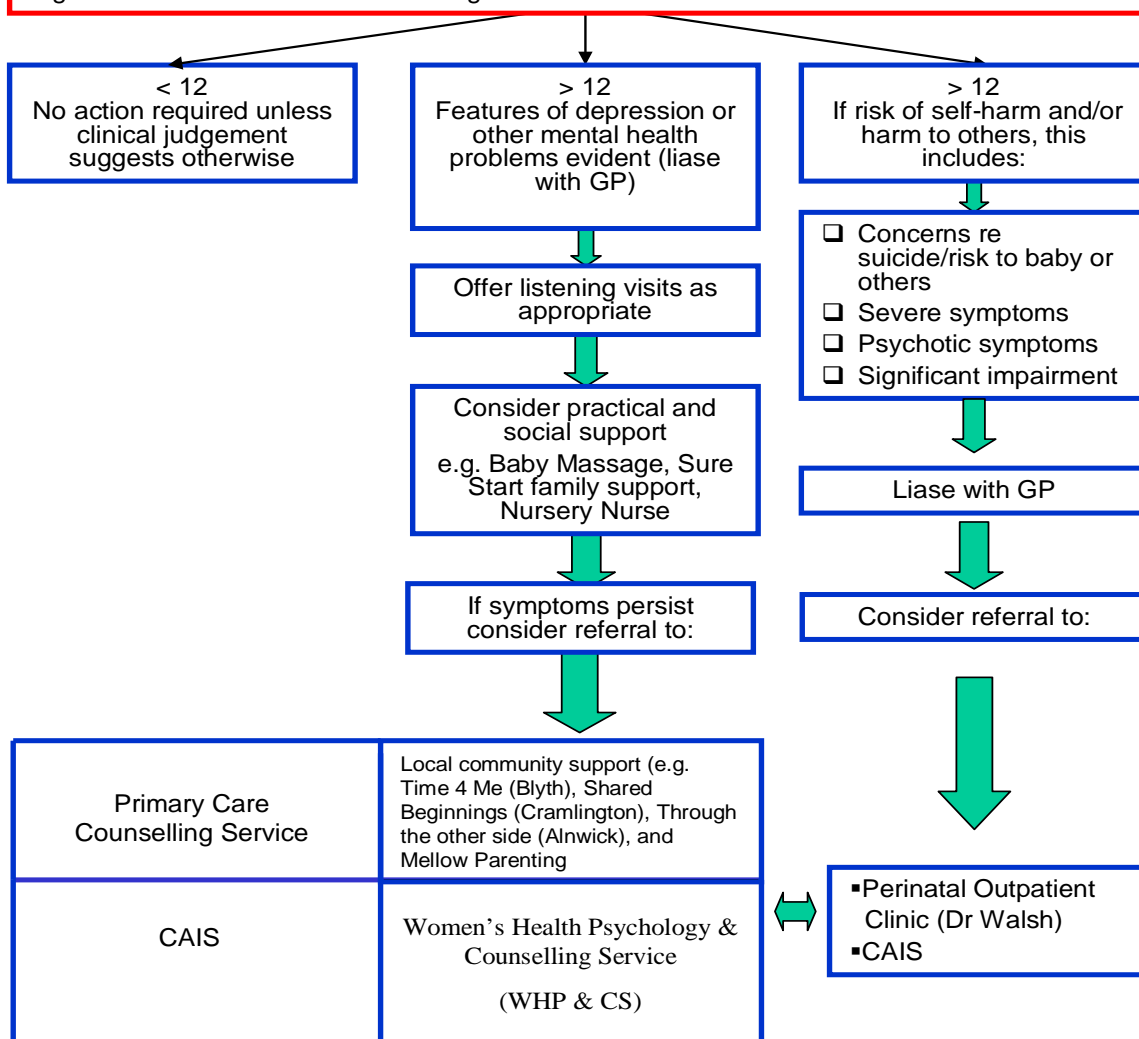
Appendix4

NORTHUMBERLAND HEALTH VISITOR MENTAL HEALTH PREDICTION & DETECTION PATHWAY

At each 4-6 week and 12-16 week visit the following mental health questions are to be asked:

1. During the past month have you often been bothered by feeling down, depressed or hopeless?
2. During the past month have you often been bothered by having little pleasure in doing things?
3. If yes to any of these questions is this something you feel you need or want help with?
4. Have you or any members of your family had any serious mental health problems, e.g. Bi-Polar Disorder, which have required hospital admission or referral to a Psychiatrist?

If mental health concerns are raised the Health Visitor should complete further assessment together with the EPDS. The following are then to be considered:



INFORMATION ABOUT MENTAL HEALTH SERVICES IN NORTHUMBERLAND

Community Mental Health Teams

These teams provide assessment of mental health difficulties and allocation to appropriate clinician for psychological treatment. The service is available to adults aged between 16 – 65 years. Referrals in writing can be made by any health professional. There is a single point of entry for all referrals.

Telephone:

Blyth Valley and Cramlington,	Beacon Hill, Cramlington 01670 593600
Ashington.	Greenacres, Ashington 01670 396609
Morpeth	Howard Centre, Morpeth 01670 395830
Alnwick	Hawkhill Business Park, Lesbury 01665 608040
Berwick	Anderson Court, Berwick 01289 356915
Tynedale	Fairnington Centre, Hexham 01434 656221.

Primary Care Counselling Services

Some practices have counsellors in the Health Centres. This service is appropriate to patients who are experiencing psychological distress or dissatisfaction with life, or going through a period of adjustment. Their difficulties can be related to stress at work, home, relationships and/or as a response to loss or bereavement. Contact patient's GP for possible onward referral to a counsellor.

Crisis Assessment and Intervention Service (CAIS)

This service provides urgent and immediate assessment and offers contact or home treatment to anyone aged 16 years and over in mental health crisis and to those individuals who are not able to guarantee their own safety. Medical and mental health professional referrals only are accepted (other health professionals can refer via patient's GP).

Telephone: 07740698182

Women's Health Psychology and Counselling Service

The Women's Health Psychology and Counselling Service (WHP&CS) aims to promote good mental health in women who are pregnant and post partum. It provides a specialist service to women (and their partners) for mental health difficulties arising during pregnancy or as a result of childbirth. The WHP&CS offers psychological assessment and treatment of difficulties including ante-natal anxiety and depression, post traumatic stress, bereavement and adjustment to parenthood. Referrals can be made by any health professional.

Telephone: 01670 564150

Outpatient Psychiatry

This service is available to pregnant women and women with babies up to the age of one year. Appropriate referrals include women

- Who have had a previous history of Bipolar Disorder or other serious mental illness.
- Who have a first degree relative with history of Bipolar Disorder (particularly on the maternal side of the family).
- Who have a previous history of inpatient or out patient psychiatric care.

Advice about medication is also offered. Medical referrals only.

Telephone 01670 501863

The Perinatal Community Mental Health Team

This team provides a specialist community psychiatric nursing service for women with mental health problems such as anxiety/depression or puerperal psychosis. These problems are related to pregnancy, childbirth and early motherhood. Referrals from Dr Walsh, St George's Hospital only.

Telephone number: 01670 501863

NB There is an overlap between these services with potential for cross referral. Discussion by telephone is offered to health professionals considering referrals.

Speech Language and Communication Surveillance in the Healthy Child Programme

At the One Year Review:

Carry out the Sure Steps to Talking questionnaire on ALL children.

Give every family a copy of the 'Talking and Eating: What I can do' leaflet

Give the 'Early Communication' leaflet to families where the child scores 14 or below

At the 2y 3m to 2y 6m review

Use the Referral Guidelines as usual for this.

If you have any queries about this please contact me.

Kath Frazer
Speech and Language Therapist
Brockwell Clinic
Northumbrian Road
Cramlington
NE23 1XZ

Tel: 01670 392754

Email: Kath.Frazer@gp-a84043.nhs.uk

Sure Steps To Talking

This is a screening test carried out at about 1 year which looks at children's communication behaviours.

The aims are twofold:

- To identify those children who might be at risk of having speech and language delay and/or disorder
- To offer early support to prevent the development of delay /disorder

It was first designed by a Speech and Language Therapist called Liane Smith when it went under the title of Screen 10. It was trialled on a small number of children and therefore, although the results were interesting, it needs a bigger sample to be significant.

Two Sure Start SLTs in Northumberland and North Tyneside adapted Screen 10 and it then became known as Sure Steps To Talking (SSTT); they trialled it on children in Bedlington and Howden. Taken all together, the results were disappointing. However, the Bedlington results alone are very promising in that SSTT seems to be predictive for speech and language delay and/or difficulties.

The current project is to look at a large sample of children (approx 3,000) and will yield significant results.

We are hoping to run this project in conjunction with the University of Newcastle upon Tyne, Department of Speech.

Kath Frazer
Speech and Language Therapist
Clinical Lead: Community Paediatrics



Sure Steps To Talking questionnaire: Information for Parents

Approximately 1 in 10 children experience speech and language delay or difficulty.

The SSTT questionnaire is designed to:

- Identify those children who may be at risk of having speech and language difficulties
- Offer some early support which may help to prevent these difficulties developing

All children are different and we do not expect your child to be doing all the things on the questionnaire

All families will be given the 'Talking and Eating: What I can do' leaflet. This explains what to expect in Speech, Language and Eating development at different ages. Your Health Visitor will also be giving you a Book Start pack. Using this will create opportunities to talk with your child.

If your child is identified as one who would benefit from support:

- You will also receive the 'Early Communication' leaflet
- You may be offered some extra support from your Health Visiting Team
- You may be given information about Children's Centre activities and/or Mother and Toddler groups
- Your Health Visitor will arrange to see your child again at about 2 years of age

You are asked to sign the questionnaire to give permission for the Speech and Language Therapy department to store and evaluate the information. This will help us to plan better services in the future.

Kath Frazer
Speech and Language Therapist
Clinical Lead: Community Paediatrics

Appendix 6

Primary Clinical Assessment of the Overweight or Obese Child

The aim of this questionnaire is to identify those children who may need investigations and/or referral to a paediatrician for evaluation of underlying cause of obesity and to identify/treat associated complications

Consider possible underlying medical problems:

- Cushing Syndrome
- Prader Willi syndrome
- Eating disorders
- Polycystic ovarian syndrome
- Hypothyroidism

1.	Is the child's height less than the 50 th centile?	YES/NO
2.	Is there a history of excessive hunger / always eating / seeking food?	YES/NO
3.	Is there a history of obesity since early childhood? (Specifically in early 3 years of life)	YES/NO
4.	Any unusual facial appearance? (Dysmorphic features)	YES/NO
5.	Any history of significant learning difficulties?	YES/NO
6.	Any history of significant visual problems? (Registered visual impairment, partially sighted or retinitis pigmentosa)	YES/NO
7.	Any family history (1 st degree relative) of type 2 diabetes / Ischaemic heart disease / hypertension?	YES/NO
8.	Any history of menstrual disturbance (Consider polycystic ovarian syndrome) - menstrual cycle – regular / irregular - length of cycle - pattern of bleeding – heavy / light	YES/NO
9.	Any history of sleep problems? (Heavy Snoring, sleep apnoea, excessive daytime sleepiness)	YES/NO
10.	Any history of mobility problems / joint pain? (Consider slipped upper femoral epiphysis).	YES/NO
11.	Is there extreme obesity? (over 99 th centile)	YES/NO

If Answer 'Yes' to 1 or more of above questions + BMI plots on or > International Obesity Taskforce obese centile, consider referral to paediatrician

Appendix 7 Dental health

Good oral health is an essential part of general health and well-being.

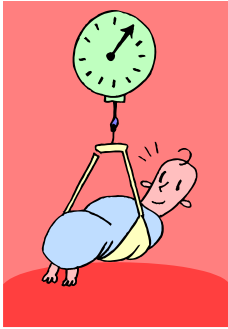
The core advice is :

- A. Cut down on foods, sweets and drinks that contain sugar, especially the frequency. Avoid them between meals, in the one hour before bedtime, at bedtime and during the night.
- B. Brush teeth every morning and every night using a smear of fluoride toothpaste for babies and a pea-sized amount for older children. Spit out afterwards but don't rinse with mouthfuls of water because some of the fluoride toothpaste needs to stay behind to strengthen the teeth.
- C. Visit a dentist for check-ups and advice.

Health Visitor contact within Northumbria Healthcare NHS Foundation Trust's oral health promotion team is Michelle Speed, Oral Health Promotion Officer. Tel No. 0191 237 4795. Her email address is michelle.speed@nhs.net

Assessment of Failure to Thrive (Growth Faltering)

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Most young infants are weighed regularly by their parents, often in the context of a health visitor clinic visit. Invariably, this process occasionally identifies children who are deemed to show sub-optimal gain in weight, with resulting parental and professional anxiety.

Since the completion of the Parkin Project in Newcastle in 2000, Northumberland has adopted the Parkin approach, which involves an initial careful assessment by a health visitor or other primary care professional. A standardized proforma and food diary are used. This approach has been useful in identifying relevant issues and potential for change, and often catch up growth follows this process without the need for further interventions. Failure of acceptable improvement has led to onward referral either to a dietitian or a paediatrician.

Given the updating of universal services to young children required by the implementation of Standard 1 of the NSF, it seemed sensible to review our response to failure to thrive at the same time, taking into account recent advances in knowledge and understanding.

However, a number of research projects and review articles published between 2003 and 2007, looking to identify evidence of best practice, have been unable to improve our understanding of failure to thrive. Problems remain with inconsistent definition, variable methods of identification, whether weighing infants is an acceptable form of screening and whether failure to thrive is ultimately significant in terms of long term outcome for the child.

This more recent research would suggest that both organic disease and neglect, though confirmed as important causes of failure to thrive, are only present in a very small proportion of children about whose weight gain there is concern. The role of poverty and deprivation has probably been overstated, and the long term sequelae in terms of IQ and emotional difficulties exaggerated. An important association with post-natal depression is probably only significant when failure to thrive occurs in very young infants.

Whatever the scientific evidence, there is no doubt that monitoring a child's weight is something parents find helpful and will wish to do, and health visitor clinics fulfill many functions apart from the weighing of infants. Though not qualifying as a screening procedure per se, this monitoring will continue to identify infants about whom there is concern. Problematical sub-optimal weight gain, irrespective of cause, is usually ultimately due to inadequate calorie intake, and therefore the approach, originally developed by the Parkin Project, which addresses in the first instance a child's nutritional intake, would appear to remain both practically and scientifically the best way of responding to the problem.

The Failure to Thrive Assessment Pack contains the following:

- Assessment Proforma and food diary
- Guidance notes on the Assessment Proforma
- Specialist weight monitoring charts for children with slow weight gain

Copies of the pack and spare charts etc. can be obtained from Ros Charlton 01670 564075

Appendix 9

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ADMINISTRATION OF VITAMIN K

Title: Administration of Vitamin K.		Unique Identifier: Postnatal No: 4
Issue Status: In Practice	Issue Date: 10th March 2008	Issue No: 2
Scope: All babies in the Postnatal Period.		Classification: Guideline
Replaces: No 1		
Authors Name: Guideline Group		Authors Title: Lead Consultant Obstetrician, Clinical Midwife Managers / Modern Matrons, Eugene Strehle, Consultant Pediatrician.
To be read in conjunction with the following documents:		
Authorised by: Obstetric & Gynaecology Governance Group		Authorisation Date: 13TH February 2008
Review Date: February 2011		
This document is no longer authorised for use after this date		

AIM & PRINCIPLE:

The Department of Health recommends that all babies are given a Vitamin K supplement at birth to avoid the rare but serious disorder called Vitamin K Deficiency Bleeding (VKDB)

RATIONALE FOR CHANGE:

To ensure that all babies North of Tyne receive the same administration of Vitamin K.

NeoKay is a nutritional food supplement therefore no prescription is required.

ADMINISTRATION:

Premature Babies

A single dose of 500 micrograms (0.05ml) IM Konakion MM Paediatric by intramuscular injection. This should be given as soon as possible after birth preferably in the delivery suite.

Other High Risk Babies

These are babies born to mothers who are taking carbamazepine, phenytoin, phenobarbitol, rifampicin or warfarin.

A single dose of 500 micrograms (0.05ml) Konakion MM Paediatric by intramuscular injection. This should be given as soon as possible after birth preferably in delivery suite this will be given by ANNP at Wansbeck.

If a delivery of a preterm baby or a baby in the above category occurs at a Midwifery Led Unit, the midwife will administer the above dose of Konakion as per the Patient Group Direction.

If a high risk delivery should take place at a Midwifery Led Unit the midwives will give the appropriate dose following the Patient Group Direction PGD.

No further supplements of Vitamin K will be necessary.

Low Risk Babies

All babies will require 1mg of Konakion MM Paediatric orally in the delivery suite, irrespective of the mothers intended method of feeding.

Breast Fed Babies

All babies of mothers who intend to breast feed will be given their own labeled bottle of Neokay, this will be given to the mother on the delivery suite.

Breastfeeding babies should receive a daily dose of Neokay 50mcg (0.25ml) until the bottle is completed (estimated around 14 weeks). Parental instruction on administration will be given by the midwives in the post natal ward and for early discharges mothers should be instructed before discharge, and documented in the care plan.

INFORMATION NOTES

In some cultures it is not the custom to give colostrum and early breast milk so babies may be formula fed on discharge from hospital but become fully breastfed within a few days. These babies should be supplied with NeoKay on discharge.

Babies who are partially breast and formula fed should receive daily Vitamin K supplements. However if the formula feed comprises greater than 50% of the total number of feeds supplementation will not be necessary.

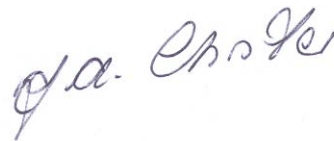
High risk babies who have received an intramuscular dose of Konakion MM paediatric will not require any further Vitamin K supplementation regardless of whether they are breast or bottle fed.

REFERENCES:

Routine postnatal care of women and their babies, NICE Clinical Guideline No: 37, (July 2006)



.....
Mr P Franks
Clinical Director
Midwifery



.....
Mrs J A Christer
General Manager / Head of

Appendix 10 Newborn Blood Spot Screening Health Visitor's Responsibilities

Introduction

Newborn screening aims to identify babies who are at high risk of having certain serious but rare conditions before they develop symptoms. Screening is not the same as diagnosis; instead it identifies which babies need to go to have diagnostic tests to determine whether or not they do have the condition. By detecting these conditions early it is possible to treat them and reduce their severity.

Newborn bloodspot screening is offered to all babies in the UK.

UK NBSSP

Procedure

1. At the primary visit, the HV will check the screening status of the infant and record in the Personal Child Health Record (PCHR) record whether testing is complete:

- Record date of testing in Health Visitor records, paper or electronic.
- If any part of the screening has been declined, record specific details.
- If screening has not been completed, discuss with parent whether screening has been offered. Explore other reasons why screening has not been completed.

For babies under one year of age who have moved into the area and are reported to have been screened, evidence of testing is required as per pathway (appendix 1).

2. On receipt of a request for a repeat sample record reason for repeat sample in HV1 and PCHR, ensure the parent is aware of the reason for repeat sample e.g.

- Identification of infant who has missed test (notification from Child Health Record Department (CHRD)).
- Laboratory request for repeat sample e.g. post transfusion
- Request from parent who previously declined test.
- Child moving into the area under 1 year of age.

If parental consent is given refer infant to local children's Out Patient Department (OPD) or Children's Assessment Unit (CAU) as per pathway for test.

3. Normal Results

It is an absolute requirement that the screening result is documented in the PCHR by 8 weeks. The HV receiving the results from the CHRD should

ensure that this is completed. Results to also be recorded in Health Visitor record (paper or electronic)

The health visitor should ensure that the same procedure is followed for a child under 1 years of age who has moved into the area.

4. Failure to attend

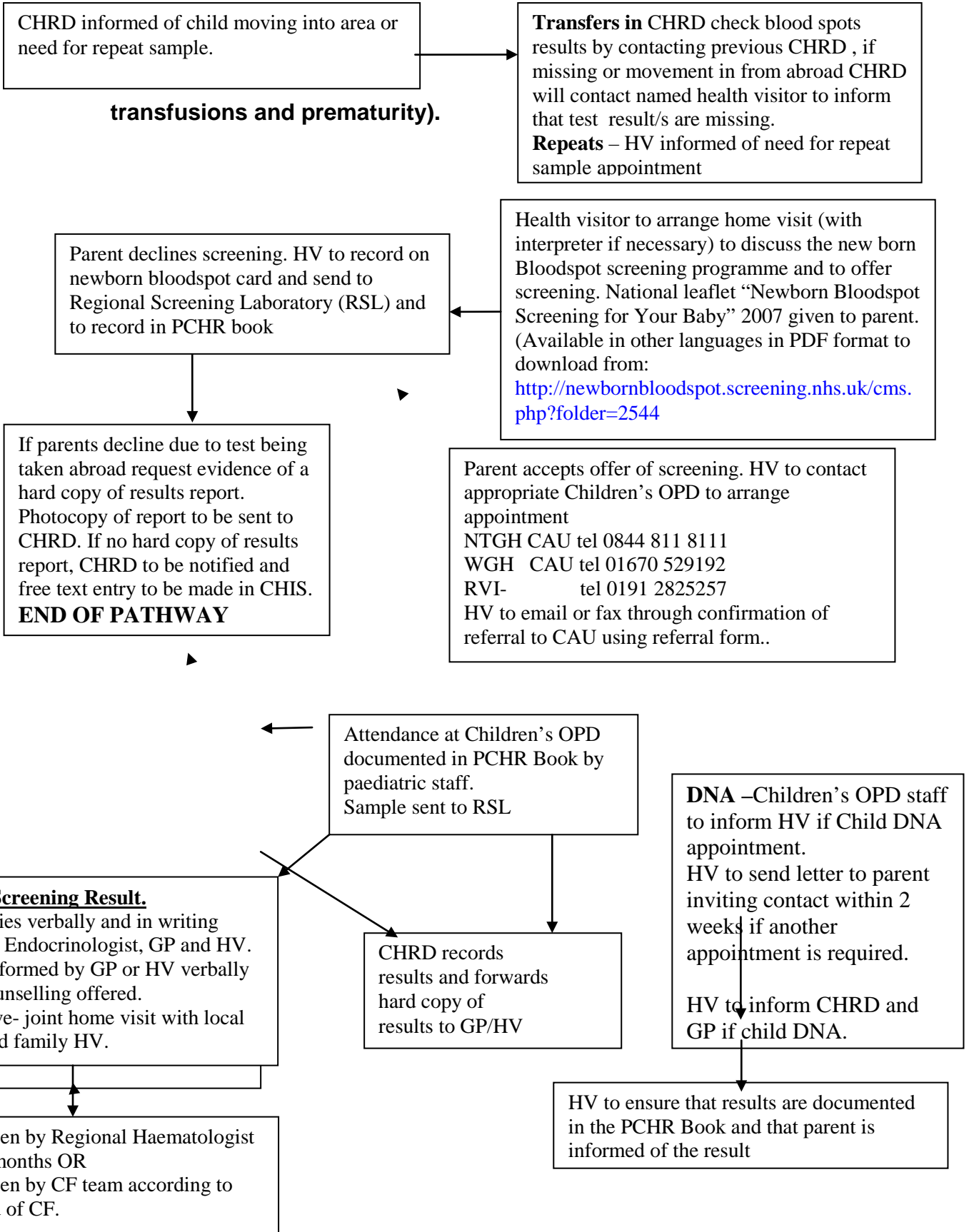
If infant fails to attend the OPD appointment the health visitor will be informed and this must be recorded in the HV record. It is the HV responsibility to inform the CHR and GP of the lack of attendance.

The parent should then be informed in writing that if they still wish an appointment for repeat/missed testing than this must be requested within two weeks of receiving the letter. (see attached letter)

Audit

HV records may be audited for documentation of all screening results and information.

NHS North of Tyne Health Visitor Responsibilities
Pathway for Missing Newborn Bloodspot screening in babies aged > 28
days to age 1 year (Includes, transfers in, and repeats due to blood



Appendix 11

Below is a list of recommended resources for Health Visiting teams to use at contacts.

Resources for Health Visitor Team contacts

Breastfeeding leaflets (will usually be given out by midwives but if not can be given out at appropriate time)

Off to a good start (pink booklet)
Off to the best start (DH leaflet)
The first feed
From bump to breastfeeding DVD
Breastfeeding and work
Grandparents breastfeeding leaflet
Dads breastfeeding
Local peer support information

Antenatal Health Visitor contact.

Child Health Record – will be discussed but given out in Maternity unit
Birth to Five book (first time mothers only) ¹
Sure Start registration form (depending on local protocol)
Health Visitor Role (locally decided)
Baby bonding } Either of these, depending on reading skills
Infant Mental Health }
Bed sharing – Unicef } Either of these (Unicef one not currently available)
Bed sharing card (FSID) }
Reducing the risk of cot death
Northumberland Fire and Rescue home assessment and smoke alarm leaflet
Healthy Start (if not given by midwife)
Off to the best start - Breastfeeding (if not given by midwife)
Smoking cessation form ²
Protecting babies and children from second hand smoke (easy read version also available)
Domestic abuse card
Contraception – After you've had a baby
Meningitis – Meningitis trust card } Either of these
Don't ignore the signs ³ }
Lone parent guide *

Primary Visit.

As antenatal if not seen before birth

Immunisations up to 13 months.
I'm only a baby but... } Either of these depending on reading skills
Babies – top safety tips }
Accident prevention chart – vulnerable families only ⁴
Back to sleep front to play ³

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Local information, baby massage, clinic times, baby groups.

3 – 4 month visit

Weaning (DH)

Now I can crawl I can...

Toddlers and up – top safety tips

Baby Led Weaning DVD (if available)

Low cost safety equipment scheme information

Bookstart

Simple tips for healthier teeth

A guide to healthy teeth for your baby

} Either depending on reading skills

1 year visit

Bookstart plus

Talking and eating (What I can do) (comments on this leaflet needed for feedback to Kath Frazer)

Early communication. How you can help your child (if Sure Steps to talking score below 14)

Healthy start – vitamins (flag this up)

4 year contact (practice nurses could give out pack at pre-school booster)

Northumberland Parenting Handbook

Head lice

Step safely with a helping hand

Why your child's weight matters

Top tips for top kids

Artie Beats body book

Road safety activity book 1 (chicken on front)

Healthy lunchbox

A guide to healthy teeth for your school aged child

Transfer in visit.

Child Health Record

Birth to five (if relevant to age of child, or if one not already received)

Sure Start registration form

Local information, baby massage, clinic times, toddler groups.

Other leaflets as relevant to child's age from lists above.

Current gaps

Car seat safety – primary upwards

Road safety – 1 year

Feeding – 1 year

1 Limited stock from Epsom Drive2 Not available from Epsom Drive3 Being ordered4 Very limited stock – targeted groups only

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Janet Leigh

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Appendix 12

HEALTH VISITOR GUIDELINES Immunisation Role for HV's in Northumberland Care Trust

The Health Visitor Service Specification clearly states that Health Visitors **do not** give childhood immunisations. The delivery of childhood immunisation has been commissioned from Primary Care (immunisations for the Gypsy and Traveller community are dealt with separately).

The purpose of this guideline is to clarify the HV role and responsibility regarding immunisation.

Guideline

- HV's have a key responsibility in ensuring that parents are provided with the correct and up to date information about immunisations including; the risk of not being immunised, possible side effects and management of complications.
- HV's are responsible for following up of non-attenders and encouraging attendance for immunisations. This would include developing systems to ensure under 5's are immunised either through the birth book or in partnership with the GP practice.
- In all cases when an immunisation is given by a nurse there must be a Patient Group Direction signed by themselves and their manager.

A PDG is;

'a written instruction for the sale, supply and or administration of named medicines in an identified clinical situation. It applies to groups of patients who may not be individually identified before presenting for treatment'

A nurse must read the PDG, feel competent that he or she meets the requirements of the PDG before signing it and then ask the manager to sign it.

Reference;

NHS National Prescribing Centre Patient Group Directions (2004):*A Practical Guide and framework of competencies for all professionals using patient group directions.*

www.npc.co.uk/publications/pdg/pdg.pdf

Appendix 13

Confidentiality and Sharing Information within the NHS

The following comes from the NHS guidance on confidentiality, and is a reminder of the legal/ethical position with regard to the sharing of client/patient identifiable information with/without consent.

General Principle

“Patient information is generally held under ethical and legal obligations of confidentiality. Information provided in confidence should not be used or disclosed in a form that might identify a patient without his or her consent. There are a number of important exceptions to this rule, but it applies in most circumstances”

(Dept of Health 2003)

Confidential Information

Definition of confidential: Information which should not normally be in the public domain or readily available from another source, it should have a degree of sensitivity and value to be subject to a duty of confidence.

A duty of confidence arises when one person discloses information to another, in circumstances when it is reasonable to expect that the information will be held in confidence. It

1. Is a legal obligation derived from case law
2. Is a requirement within professional codes of conduct
3. Is included in NHS employment contracts as a specific requirement linked to disciplinary procedures

As a consequence of the above, information that can identify individual patients, must not be used or disclosed for purposes other than healthcare without the individuals **explicit consent**, some other legal basis or where there is a robust public interest or legal justification to do so.

In contrast anonymised information is not confidential and can be used with few constraints.

(P7 Para 9)

Consent is an agreement based on knowledge and understanding of likely consequences There are different types of consent:

Explicit consent: written or oral

Implied consent: agreement is signalled by behaviour rather than in orally or writing

Legislation

The following legislation is relevant to the management of information held by organisations;

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- The Data Protection Act 1998.
- The Human Rights Act 1998.
- Common Law Duty of Confidence
- The Freedom of Information Act 2000
- Health & Social Care Act 2001
- Education Act 1996 and 2002
- Children Act 1989 and 2004
- NHS and Community Care Act 1990
- Sex Offenders Act 1997

Patient consent

Patients have the right to object to the use and disclosure of confidential information that identifies them.

Where patients have been informed of the use or disclosure of their information associated with their healthcare and of the choices that they have, then explicit consent is not usually required to provide that healthcare, however where the purpose is NOT directly concerned with the healthcare of a patient, it would be wrong to assume consent.

(P8 Para 14,15,16)

Informing Patients

The Data Protection Act 1998 requires that patients be informed how their information will be used, who will have access to it and the organisations it will be disclosed to. This should take place prior to disclosure; unless there are exceptional circumstances (see below)

(P 11 Para 24)

Common Law and Disclosure in the Public Interest

The key principle of the duty of confidence is that information confided should not be used or disclosed further in an identifiable form, except as originally understood by the confider, or with his or her subsequent permission.

There are exceptions to the duty of confidence which may make the use or disclosure of confidential information appropriate. Case law has also established that confidentiality can be breached where there is an over riding public interest.

Public Interest

Under Common Law, staff are permitted to disclose personal information in order to prevent and support detection, investigation and punishment of serious crime and /or to prevent abuse or serious harm to others, where they judge on a case by case basis, that the public good that would be achieved by the disclosure, outweighs the obligation of confidentiality to the individual.

The disclosure should be recorded in such a way that there is clear evidence of the reasoning used and the prevailing circumstances. Disclosures should be proportionate and be limited to relevant details.

Whenever possible the issue of disclosure should be discussed with the individual concerned and consent sought, where this is not forthcoming the individual should be

told of the decision to disclose against his/her wishes. This will not be possible in all circumstances, e.g when there is a likelihood of a violent response or where informing a patient might allow them to evade a criminal investigation

Confidentiality Decisions

Disclosure for healthcare purposes

To NHS staff

Where information is shared widely to provide healthcare, additional efforts need to be made to ensure patients are effectively informed.

To Social Workers

The test of what would be required to effectively inform (see above) should be more demanding than where disclosure is limited to NHS staff, as the breadth of the information disclosure is not as obvious to patients and their consent cannot be assumed.

Disclosure may lead to confidential information being held outside the NHS in records of partner organisations. Patients need to be aware of this.

DoH 2002

Disclosure for non medical purposes

To Surestart teams

NHS bodies have a statutory gateway to support disclosure to Surestart teams under the NHS Act 1977 where the disclosure is to support healthcare.

For disclosures other than those made to support healthcare, explicit parental consent is necessary.

If confidential patient health information is to be held within the records of partner organisations, parents need to be made aware of this prior to any disclosure.

DoH 2002

The Northumberland Information sharing protocol and checklist will help staff in the decision making process and clarify whether the information should be shared.

For further guidance contact the safeguarding Children team or a clinical lead or manager.

Sharing Information as part of preventative services

Seeking consent should be the first option. Practitioners in universal, targeted and specialist services, including multi agency services, should proactively inform children, young people and families **when they first engage with a service**, about their services policy on how information will be shared, and seek their consent. (However remember that under the NHS Code of Practice, consent needs to be specific regarding the purpose of disclosure so there can not be “blanket” consent in advance, to disclose confidential information at a future, unspecified date)

The approach to sharing information should be explained openly and honestly. Where this is done young people and families will be aware how their information may be shared and experience shows that most will give consent.

Information that is not confidential may generally be shared where that is necessary for the legitimate purposes of preventative work.

Information Sharing: Practitioners Guide page 11 3.16 and 3.17

REFERENCES

Dept of Health (2003) "Confidentiality; NHS Code of Practice"

HM Govt (2006) "Information Sharing; Paractitioners Guide"

NMC(2004) "The NMC Code of Professional Conduct, Performance and Ethics"

GLOSSARY

TERM	MEANING
Anonymised Information	Information which does not identify an individual directly. Requires removal of all patient identifiable information
Common Law Duty of Confidentiality	The principle of the common law duty of confidentiality owed to the public. This requires that personal information given for one purpose cannot be used for another, and places restrictions on the disclosure of that information. This duty can only be broken if the public interest requires it.
Consent	Agreement, either expressed or implied, to an action based on knowledge of what that action involves, its likely consequences and the option of saying no.
Express Consent	Consent which is expressed orally, or in writing, (except where patients cannot write or speak, when other forms of communication would need to be considered).
Data	Essentially the same as “information”, but tends to be information recorded in a form, which can be processed by equipment automatically (usually electronically although manual records may also be kept), in response to specific instructions.
Data in the Public Domain	Any information, which is publicly available, whether, it relates to a living individual or not. For example, information found on the internet, television or local authority public records.
Data Protection Act 1998	Legislation, which regulates the processing of personal data. It embodies the eight basic principles of data processing, and gives guidance on data sharing.
Data Subject	An individual who is the subject of personal data.
Harm	The Children Act 1989 defines harm as “ill-treatment or the impairment of health or development” . “Development” is defined as “ physical, intellectual, emotional, social or behavioural development.” “Health” is defined as “physical or mental health” and “ill-treatment” is defined as including “sexual abuse and forms of ill-treatment which are not physical”.
Healthcare purposes	All activities that contribute to the diagnosis, treatment and care of an individual and the audit/assurance of the quality of healthcare provided. Does NOT include research, teaching, financial audit or other management activities.
Human Rights Act 1998	This Act requires the compliance to Article 8 of the European Convention on Human Rights. This prohibits interference with the right to respect for private and family life except when it is in accordance with the law, and pursues a legitimate public interest in a proportionate manner.
Patient Identifiable Information	Information, which relates to a living individual who can be identified from the data or any other information which, is in the possession of the data holder. This is the most restricted type of information and should only be used where there is no reasonable alternative.