



2015 – 16 National Health Visiting Core Service Specification

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2015 – 16 National Health Visiting Core Service Specification

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Provider Lead	
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Date of Review	September 2014

NOTES FOR LOCALISATION:

If you require local additions to the Core Specification, this document has been set up with ‘Styles’ to enable you to easier keep the formatting consistent.

Within the top ‘bar’ there is a section ‘Styles’ these are used as follows:

- For a new header for a new section – Use heading 1
- To add to the numbering use:
 - Body Copy 1 for first level
 - Body Copy 2 for second level
 - Body Copy 3 for third level
 - Body Copy 4 for fourth level
 - All ‘fifth level’ information should be added as Bullet Point Body Copy 4
 - All bullet points should use the correct Bullet Point Body Copy level.

1 Introduction

- 1.1 The 2015/16 National HV Core Service Specification is an update of the 2014/15.
- 1.2 This document has been updated and developed in conjunction with key stakeholders including the Local Government Association (gaining input from SOLACE, ADPH, ADCS), the Department of Health, Public Health England, Health Education England and post an engagement process involving other key organisations and partners such as CHPVA, IHVA and NHS England Area Teams, CCGs and the Health Visiting Taskforce.
- 1.3 It is a core specification detailing the core elements for the commissioning of Health Visiting Services. Local needs and partner arrangements will shape any additions to this specification as required.
- 1.4 This specification should be delivered in the context of the transition of commissioning responsibility for 0-5 public health services, including the commissioning of health visiting services, to local authorities from October 2015.
- 1.5 This will be supported by joined up commissioning arrangements in partnership with local children's partnerships, children's trusts and health and wellbeing board strategies, local authority commissioner from April 2014, in many cases building on existing arrangements.
- 1.6 For providers this will support an integrated approach to meeting the needs of young children and their families and the delivery of improved outcomes. HVs will lead delivery of the HCP and work in partnership with maternity services, local authority-provided or commissioned early years services, voluntary, private and independent services, primary and secondary care, schools, health improvement teams, Family Nurse Partnership (FNP) colleagues and children's social care services.



2 Context and Evidence Base

- 2.1 The Health Visiting Service workforce consists of specialist community public health nurses (SCPHN) and teams who provide expert information, assessments and interventions for babies, children and families including first time mothers and fathers and families with complex needs. Health visitors (HVs) help to empower parents to make decisions that affect their family's health and wellbeing and their role is central to improving the health outcomes of populations and reducing inequalities.
- 2.2 The four contemporary principles of health visiting were first published in 1977. They are:
- Search for health needs;
 - Stimulation of an awareness of health needs;
 - Influence policies affecting health;
 - Facilitate health enhancing activities.
- 2.3 The Health Visiting Service works across a number of stakeholders, settings and organisations to lead delivery of the [Healthy Child Programme 0-5](#) (HCP), a prevention and early intervention public health programme that lies at the heart of the universal service for children and families and aims to support parents at this crucial stage of life, promote child development, improve child health outcomes and ensure that families at risk are identified at the earliest opportunity.
- 2.4 This includes safeguarding children and working to promote health and development in the '6 high impact areas' for early years – which can be found at <https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children>
- Transition to parenthood and the early weeks
 - Maternal mental health (perinatal depression)
 - Breastfeeding (initiation and duration)
 - Healthy weight, healthy nutrition and physical activity
 - Managing minor illness and reducing hospital attendance and admission
 - Health, wellbeing and development of the child age 2 – 2.5 year old review (integrated review) and support to be 'ready for school'.
- 2.5 The service is led by HVs and supported by skill mix teams. HVs are qualified nurses or midwives who have an additional diploma or degree in specialist community public

health nursing enabling them to practice autonomously and exercise professional judgement to improve outcomes for children and families.

- 2.6 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 early years practitioners, voluntary organisations, peer supporters, Family Nurse Partnerships, GPs and primary and secondary care providers as well as children's centres and early years staff to ensure a holistic service and focused on improving health outcomes, reducing inequalities at individual, family and community level.

2.7 The Evidence

- 2.7.1 Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are set in place during pregnancy and in early childhood. What happens during these early years has lifelong effects on many aspects of health and wellbeing, educational achievement and economic status. Universal and specialist public health services for children are important in promoting the health and wellbeing of all children and reducing inequalities including:
- Delivery of the HCP;
 - Assessment and intervention when a need is identified; and
 - On-going work with children and families with multiple, complex or safeguarding needs in partnership with other key services including early years, children's social care and primary care.
- 2.7.2 Successive academic and economic reviews have demonstrated the economic and social value of prevention and early intervention programmes in pregnancy and the early years. In fact, the evidence-base for improved health, social and educational outcomes from a systematic approach to early child development has never been stronger and has been described as a powerful equalizer which merits investment (Irwin et al 2007, Marmot 2010).
- 2.7.3 During pregnancy and in the first 2 years, a baby's brain and neurological pathways are being laid down for life with 80% of a baby's brain development taking place during this time. It is therefore the most important period for brain development, and is a key determinant of intellectual, social and emotional health and wellbeing. Research studies in neuroscience and developmental psychology have shown that

interactions and experiences with caregivers in the first months of a child's life determine whether the child's developing brain structure will provide a strong or weak foundation for their future health, wellbeing, psychological and social development¹.

- 2.7.4 The Government, NHS England, Public Health England (PHE), Royal Colleges, local government organisations and others signed up to the ['Pledge for better health outcomes for children and young people'](#) in February 2013. The Pledge sets out shared ambitions to improve physical and mental health outcomes for all children and young people. It commits signatories to putting children, young people and families at the heart of decision-making and improving every aspect of health services - from pregnancy through to adolescence and beyond.
- 2.7.5 Detailed references for the evidence base that supports this specification are set out in Appendix 1.

3 Public Health Outcomes

- 3.1 The Health Visiting Service will lead on the delivery of the full HCP 0-5 years with a focus on working across services and organisational boundaries for babies and children 0-5 and their families to improve public health outcomes. The [Public Health Outcomes Framework](#), the [Guide to Early Years Profile](#) and the [NHS Outcomes Framework](#) include a range of outcomes which will be improved by an effective 0-5 years' public health nursing service:
- 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;
 - Improving child development at 2-2.5 years;
 - Reducing the number of children in poverty;
 - Improving school readiness;
 - Reducing under 18 conceptions;
 - Reducing excess weight in 4-5 and 10-11 year olds;
 - Reducing hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14;
 - Improving population vaccination coverage;

¹ [Allen, G. \(2011a\) Early Intervention: The Next Steps. HM Government: London](#)

- Disease prevention through screening and immunisation programmes;
- Reducing tooth decay in children aged 5.

3.2 Benchmarked outcome data for local areas supported by guides for effective intervention to improve outcomes can be found at

<http://atlas.chimat.org.uk/IAS/dataviews/earlyyearsprofile>

3.3 A public health outcome measure of child development at age 2-2½ is under development, as set out in the Public Health Outcomes Framework. It is expected that data will be collected via the Children and Young People's Health Services data set from July 2015. More detailed information on the data items that will be required is included in 5.13.7.

3.4 The Health Service Delivery Metrics in Appendix 6 are planned for inclusion in Children and Young People's Health Services Secondary Uses Data Set, which integrates the Maternity and Children's dataset led and to be published by the HSCIC from July 2015 – for further information consult <http://www.hscic.gov.uk/maternityandchildren>

3.5 Health Visiting Services are required to prepare for collection of service delivery metrics and dashboards at the level of local authority resident population (date to be advised).

3.6 A Framework for Personalised Care and Population Health for Nurses, Midwives, Health Visitors and Allied Health Professionals can be found at: <https://www.gov.uk/government/publications/framework-for-personalised-care-and-population-health>

4 Aims and Purposes of the HV Service [previously Family Focused Provision]

4.1 [The Health Visitor Implementation Plan](#) states: "The government believe that strong and stable families are the bedrock of a strong and stable society"².

4.2 It sets out what all families can expect from their local Health Visiting Service under the following service levels:

- **Community:** health visitors have a broad knowledge of community needs and resources available e.g. Children's Centres and self-help groups and work to develop these and make sure families know about them.

² [Health Visitor Implementation Plan "A Call to Action" 2011-2015](#), Department of Health (DoH).

- Universal: health visiting teams lead delivery of the HCP. They ensure that every new mother and child have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation.
- Universal Plus: families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children.
- Universal Partnership Plus: health visitors provide ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition.

4.2.1 **Universal services for all families**: will include individual level interventions and programmes that will motivate and support people to;

- Understand the short medium and longer term consequences of their health related behaviour for themselves and others;
- Feel positive about the benefits of health enhancing behaviours and changing their behaviours;
- Plan change in terms of easy steps over time;
- Recognise how their social context and relationships may affect their behaviour, and identify and plan for situations that might undermine changes they are trying to make;
- Plan explicit 'if/then' coping strategies to prevent relapse;
- Make a personal commitment to adopt health enhancing behaviours by setting and recording goals to undertake clearly defined behaviours in particular contexts over a specified time;
- Share their behaviour change goals with others (NICE 2014).

4.2.2 Additional services as part of Universal Plus and Universal Partnership Plus will include services:

4.2.2.1 **That any family may need some of the time**, for example, care packages for maternal mental health, parenting support and baby/toddler sleep problems – where the HV may provide, delegate or refer. Intervening early to prevent problems developing or worsening.

4.2.2.2 **For vulnerable families requiring on-going additional support** for a range of special needs, for example families at social disadvantage, families with a child with a disability, teenage mothers, adult mental health problems or substance misuse.

4.3 The overarching aim of SCPH nursing services for children under 5 is to protect and promote the health and wellbeing of children and their families. Responding to the new vision for nursing and the “Six C’s”, the national nursing strategy health visitors will:

- Show **care, compassion and commitment** in how they look after families.
- Find the **courage** to do the right thing, even if it means standing up to senior people to act for the child or parent’s best interests, in a complex and pressured environment.
- **Communicate** well at all times particularly with the children, families and communities they serve and demonstrate **competence** in all their activities and interventions.

4.4 As an overview, core elements of the HCP include:

4.4.1 **Health and development reviews** – Assessment of family strengths, needs and risks; providing parents with the opportunity to discuss their concerns and aspirations; assess child growth and development, communication and language, social and emotional development; and detect abnormalities. HVs should use evidence-based assessment tools and must use ASQ 3 for the 2 -2.5 year review. See Appendix 4 for the full list of universal assessments.

4.4.2 **Screening** – in line with the current and forthcoming updated HCP and the National Screening Committee recommendations.

4.4.3 **Immunisations** – Immunisations should be offered to all children and their parents. Health visiting teams should provide parents and young people with tailored information and support and an opportunity to discuss any concerns. They should check children and young people’s immunisation status during health appointments and refer to their GP if unvaccinated. General practices are the provider of immunisations through the section 7A agreement and child health record departments maintain a register of children under 5 years, invite families for immunisations and maintain a record of any adverse reactions in the Child Health Information System (CHIS).

- 4.4.4 **Promotion of social and emotional development** – The HCP includes opportunities for parents and practitioners to review a child’s social and emotional development using evidence-based tools such as ASQ 3 and ASQ SE and for the practitioner to provide evidence-based advice and guidance and decide when specialist intervention is needed.
- 4.4.5 **Support for parenting** – One of the core functions of the HCP is to support parenting using evidence-based programmes and practitioners who can work across different agencies who are trained and supervised.
- 4.4.6 **Effective promotion of health and behavioural change** – Delivery of population, individual and community-level interventions based on NICE public health guidance. Encourage the strengths within the family recognising that families have the solutions within themselves to make changes. Make every contact with the family a health promoting contact.
- 4.4.7 **Reducing hospital attendance and admissions** – Supporting parents to know what to do when their child is ill. This may include prescribing in line with legislation, providing information about managing childhood conditions and prevention of unintentional injuries.
- 4.4.8 **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 (see section 10 additional information).
- 4.5 **The key objectives of the health visiting service are to:**
- 4.5.1 Improve the health and wellbeing of children and reduce inequalities in outcomes as part of an integrated multi-agency approach to supporting and empowering children and families;
- 4.5.2 Ensure a strong focus on prevention, health promotion, early identification of needs, early intervention and clear packages of support;
- 4.5.3 Ensure delivery of the HCP to all children and families, including fathers, starting in the antenatal period;

- 4.5.4 Identify and support those who need additional support and targeted interventions, for example, parents who need support with parenting and women suffering from perinatal mental health issues including postnatal depression in accordance with NICE guidance;
- 4.5.5 Promote secure attachment, positive parental and infant mental health and parenting skills using evidence based approaches;
- 4.5.6 Promote breastfeeding, healthy nutrition and healthy lifestyles;
- 4.5.7 Promote 'school readiness' including working in partnership to improve the speech, communication and language of babies and toddlers and working with parents to improve the home learning environment;
- 4.5.8 Work with families to support behaviour change leading to positive lifestyle choices;
- 4.5.9 Safeguard babies and children through safe and effective practice in safeguarding and child protection. This will include working with other agencies to intervene effectively in families where there are concerns about parenting capacity, adult mental health, alcohol or substance misuse, domestic abuse or child abuse;
- 4.5.10 Develop on-going relationships and support as part of a multi-agency team where the family has complex needs e.g. a child with special educational needs, disability or safeguarding concerns;
- 4.5.11 Deliver services in partnership with local authorities to 'troubled families' and be 'lead professional' or 'key worker' for a child or family where appropriate. Link with work undertaken by FNP nurses to ensure seamless delivery of care to families;
- 4.5.12 Improve services for children, families and local communities through expanding and strengthening Health Visiting Services to respond to need at individual, community and population level.

5 Remit of the HV Service

- 5.1 Leading, with local partners, in developing, empowering and sustaining families and communities' resilience to support the health and wellbeing of their 0-5 year olds by working with local communities and agencies to improve family and community capacity and champion health promotion and the reduction of health inequalities.

- 5.2 Working in full partnership with all Early Years services in the local area and wider 0-19 services to ensure holistic seamless care to children and families.
- 5.3 Leading delivery of the HCP using a collaborative approach in partnership children, families and stakeholders.
- 5.4 Delivery of the health visiting elements of the HCP in full.
- 5.5 Reviewing, in partnership with parents and carers, the health and development of babies at age 9-12 months and 2 – 2.5 years (universal and integrated using ASQ 3) and involving the family in promoting optimum health and development of all children.
- 5.6 Assessing the development of babies and children, using the ASQ for the 2 -2.5 year review and using this or similar evidence-based assessment tools for other reviews.
- 5.7 **Meeting public health priorities through HVs' use of their knowledge of the evidence base and skills as trained public health practitioners** - including:
 - 5.7.1 Providing and developing intelligence about communities' assets in partnership with communities to support the health and wellbeing of 0-5 year olds, to inform the Joint Strategic Needs Assessment (JSNA);
 - 5.7.2 Use of the benchmarked child health outcome framework indicators for 0-5s to form a basis for setting shared priorities for action and contributing to the JSNA;
 - 5.7.3 Advising on best practice in health promotion in the early years of childhood;
 - 5.7.4 Responding to and supporting delivery of the Joint Health and Wellbeing Strategy;
 - 5.7.5 Responding to childhood communicable disease outbreaks and health protection incidents as directed by PHE or other;
 - 5.7.6 Ensuring immunisations are recommended as per The Green Book;
 - 5.7.7 Ensuring delivery of the health visiting aspects of the newborn screening programmes, for example, ensuring results are recorded and acted upon in line with UK NSC Programme Standards.
- 5.8 **Delivery of evidenced-based assessments and interventions:**

- 5.8.1 Prescribe medication as an independent/supplementary prescriber in accordance with current legislation (See Appendix 3 for additional information). Where HVs have not undertaken this module in training, it is a requirement of CPD for completion within the first 2 years of practice.
- 5.8.2 Promote parent and infant mental health and secure attachment e.g. through use of Neonatal Behavioural Observation and Neonatal Behavioural Assessment Scale.
- 5.8.3 Lead delivery of evidence based antenatal and post natal groups to promote attachment, for example, parenting classes/groups e.g. Preparing for Pregnancy and Beyond, CANparent quality marked parenting classes, and evidence-based groups for parents.
- 5.8.4 Lead delivery, in partnership with other agencies, of evidence-based parenting programmes for toddlers and pre-school children e.g. Incredible Years Pre-school basic programme and other evidence based programmes.
- 5.8.5 Achieve and maintain full accreditation of UNICEF Baby Friendly community initiative.
- 5.8.6 Work with parents, using well evidenced, strengths-based approaches e.g. motivational interviewing, Family Partnership Model and Solihull approach to promote positive lifestyle choices and support positive parenting practices to ensure the best start in life for the child.
- 5.8.7 Identify early signs of developmental and health needs and signpost and/or refer for investigation, diagnosis, treatment, care and support.
- 5.8.8 Provide responsive care when families have problems or need support or preventative interventions in response to predicted, assessed or expressed need (through intervention using new evidence in developmental psychology).
- 5.8.9 Ensure a family focus and safe transition into 5-19 services through close partnership working with services meeting the needs of children and young people aged up to 19.
- 5.8.10 Ensure a family focus and close partnership working with early intervention services such as troubled families including step up and step down transitions.

5.9 Child protection and safeguarding children:

5.9.1 The role of health visiting in child protection and safeguarding children are essential components of the service. Safeguarding children, which includes child protection and prevention of harm to babies and children is a public health priority.

5.9.2 The remit of the HV must include:

5.9.2.1 Provision of universal services including promotion of attachment and undertaking holistic assessments of children and families;

5.9.2.2 Provision of Universal Plus services for example, identifying and intervening with vulnerable babies and children where additional ongoing support is required to promote their safety and health and development e.g. CONI, providing interventions to improve maternal mental health;

5.9.2.3 Provision of Universal Partnership Plus:

- Ensuring early intervention, for example, parenting support and early referral to targeted support. This includes utilising the Common Assessment Framework or equivalent and health visitors undertaking the role of Lead Professional/key worker where appropriate.
- Ensuring appropriate safeguards and interventions are in place to reduce risks and improve health and wellbeing of children for whom there are safeguarding and/or child protection concerns (*Universal Partnership Plus Offer*). This includes maintaining accountability for babies and children for whom there are safeguarding concerns and working in partnership with other agencies to ensure the best outcomes for these children.
- Working with other agencies as part of a multi-agency intensive care package for children and families requiring intensive support, particularly children for whom there are safeguarding or child protection concerns (*Universal Partnership Plus Offer*).
- This includes the statutory duty to share information and communicate with other health professionals and agencies where there are safeguarding concerns and engagement of the health visiting service in multi-agency services e.g. MASH, 'troubled families' and MARAC.
- Communicating effectively with other agencies including contributing to initial and review case conferences and other safeguarding meetings as appropriate to the needs of the children.

- Working with the Looked After Children (LAC) nurse to contribute to and support assessments of Looked After babies and children aged 0-5 with timescales in line with national requirements and contribute to ensuring any action plans are carried out. Ensure provision of the HCP and additional services to meet their health needs.
- Having expert knowledge* about child protection and the skills* and qualities* to intervene to protect children.

**Knowledge needs to include domestic abuse, neglect, child and adult mental health issues, substance and alcohol misuse, physical, sexual and emotional abuse, female genital mutilation, fabricated and induced illness in a child.*

**Skills and qualities need to include high levels of communication and interpersonal relating, self-awareness, ability to challenge and to be challenged, understanding of barriers to safe practice e.g. collusion, adult focus, fear, burn-out. HVs need to receive expert supervision for child protection and safeguarding work they are involved in.*

5.10 Children with special needs

5.10.1 This includes families with children with special educational needs (SEN). The Children and Families Act (2014) introduces major changes to support for children and young people with 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 together more closely in supporting those with special needs or disabilities.

5.10.2 The Act includes the requirement that EHC plans will need to be reviewed regularly and cover people up to the age of 25 years old.

5.10.3 The role of HVs is to work in partnership with other services in supporting the assessment of the education health and care plans for children between 0-5 through sharing information about the child's and family's needs and reviewing in collaboration with other services what they can do to support the delivery of these plans and making sure the appropriate health visiting services form part of the high intensity multi-agency services for families where there are **safeguarding and child protection concerns**.

5.10.4 The Health Visitor Implementation Plan was revised in June 2013 (NHS England, DH and PHE) to take into account progress made, and changes in the health and care commissioning landscape.³

5.11 Supervision

5.11.1 The provider will work with NHS England, HEE and Local Education Training Boards (LETBs) to ensure effective support for trainees and newly qualified HVs. This will be delivered by ensuring the provision of: sufficient practice teachers; support through mentoring and supervision for students and newly qualified staff; and, placement capacity and high quality placements in line with NMC and HEI requirements.

5.11.2 The provider will develop and maintain a supervision policy and ensure that all health visiting staff access supervision in line with the framework below:

5.11.2.1 Clinical supervision

Health visitors will have clinical supervision according to their needs using emotionally restorative supervision techniques on a regular planned basis.

5.11.2.2 Safeguarding supervision

Health visitors will receive a minimum of 3 monthly safeguarding supervisions of their work with their most vulnerable babies and children. These are likely to include children on a child protection plan, those who are 'looked after' at home and others for whom the health visitor has a high level of concern. Safeguarding supervision should be provided by colleagues with expert knowledge of child protection to minimise risk. For example, supervision must maintain a focus on the child and consider the impact of fear, sadness and anger on the quality of work with the family.

5.11.2.3 Management supervision

HVs with a requirement to line manage in their roles will have access to a HV manager or professional lead to provide one-to-one professional management supervision of their work, case load, personal & professional learning and development issues.

³ <https://www.gov.uk/government/publications/health-visitor-vision>

5.11.2.4 Practice Teacher Supervision

HV Practice Teachers must have access to high quality supervision according to the requirements of their role.

5.12 All the above forms of supervision will have an emotionally restorative function and will be provided by individuals with the ability to:

5.12.1 Create a learning environment within which HVs can develop clinical knowledge, skills and strategies to support vulnerable families. This will include experiential and active learning methods.

5.12.2 Use strengths-based, solution-focused strategies and motivational interviewing skills to enable HVs to work in a consistently safe way utilising the full scope of their authority.

5.12.3 Provide constructive feedback and challenge to HVs using advanced communication skills to facilitate reflective supervision.

5.12.4 Manage strong emotions, sensitive issues and undertake courageous conversations.

5.13 Record keeping, data collection systems and information sharing

5.13.1 In line with contractual requirements, providers will ensure that robust systems are in place to meet the legal requirements of the Data Protection Act 1998 and the safeguarding of personal data at all times. Providers should also refer to 'Record Keeping: Guidance for Nurses and Midwives', NMC, 2009.

5.13.2 In line with the above and following good practice guidance, the provider will have agreed data sharing protocols with partner agencies including other health care providers, children's social care and the police to enable effective services to be provided to children and their families. Providers will ensure that all staff have access to information sharing guidance including sharing information to safeguard or protect children.

5.13.3 Providers must ensure information governance policies and procedures are in place and understood.

5.13.4 The Personal Child Health Record (PCHR) will be completed routinely by professionals supporting parents and carers to use proactively.

5.13.5 Appropriate records will be kept in CHIS or similar system to enable high-quality data collection to support the delivery, review and performance management of services.

5.13.6 Providers must ensure that staff are using and are trained to use suitable electronic record keeping equipment that includes data collection systems such as:

5.13.6.1 Ensure the HV service is accessible to all families with young children. This may require the use of appropriate technology e.g. health promoting apps, secure text messaging with clients, secure email facilities with clients and other agencies

5.13.6.2 The use, where necessary to meet needs and make the service accessible of remote access e.g. laptops and tablets, mobile phones, teleconference facilities, videoconferencing facilities.

5.13.7 *2-2.5 year review (Ages and Stages Questionnaire)* The PHOF indicator 2.5, development at age 2-2.5, will require the implementation of a data collection about the Ages and Stages questionnaire to be used in the 2-2.5 year review. The data items required are likely to include: date of birth of child, date of completion of ASQ-3 questionnaire, whether the questionnaire was completed as part of HCP 2-2.5 year review/integrated review, which questionnaire was used (eg24/27/30 month), ASQ domain scores (Communication/Gross Motor/Fine Motor/Problem-solving/Personal-Social), gestational age at birth, gender, postcode, ethnicity and date of birth of mother. Providers and Area Teams should make plans to ensure that the mechanisms for data collection of the 2-2.5 year review are in place in readiness for this collection.

5.14 Assessment of children and families

5.14.1 Initial assessments of children and families must be carried out by HVs. Certain re-assessments may be delegated according to the professional judgement of the HV.

5.15 HVs must respond to all referrals.

5.15.1 Referrals, from whatever source, (including families transferring in) will receive a response to the referrer within 5 working days, with contact made with the family within 5 working days.

5.15.2 Urgent referrals, including all safeguarding referrals, must receive a same day or next working day response to the referrer and contact with the family within two working days. While it is preferable that urgent referrals are dealt with by the named HV for

the family involved, to ensure these visits are prioritised, providers should have a process in place for when the named HV is not available.

5.15.3 When a child transfers into an area the HV must check newborn blood spot status and arrange for urgent screening if necessary.

5.15.4 Providers must develop their own local area newborn blood spot policies and pathways in partnership with local midwifery, CHIS and GP colleagues.

5.15.5 The HV must check status of, and record, all screening results including hearing, Newborn Infant Physical Examination (NIPE) and Hep B schedule, immunisation status and refer immediately for any follow up necessary.

5.16 Caseload holding

5.16.1 As a minimum there must be a named HV for every family up to 1 year of age and for all children 0-5 identified as having needs at the Universal Plus/ Partnership Plus levels.

5.17 Pathway into school nursing service

5.17.1 As a child approaches 4 years of age, transition to the local School Health Service will be initiated in accordance with local and national pathways. The provider must ensure that when the youngest child in the family reaches school entry age, the family file or adult records are transferred as per local procedure. The pathway from health visiting to school nursing should follow the DH published pathway for this transition. The pathway can be accessed via https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216466/dh_133020.pdf

5.17.2 Children being supported at Universal Partnership Plus must be formally identified to the School Nursing Service as per local procedure in order ensure continued targeted support.

5.18 Removals out of area

5.18.1 Where a child moves out of area the Health Visiting Service must ensure that the child's health records are transferred to CHIS for transfer to the receiving Health Visiting Service in the new area within 2 weeks of notification.

5.18.2 Procedures must be in place to trace and risk-assess missing children and those whose address is not known with systems in place to follow up and trace children who do not attend for 9 month and 2 year assessments.

5.18.3 Direct contact must be made to handover all child protection cases.

5.19 Integrated working

5.19.1 The provider will establish:

5.19.1.1 Excellent working relationships with all stakeholders, including effective joint working at transition points (e.g. midwife/health visitor, health visitor/school nurse, health visitor/midwife/Family Nurse Partnership/Local Authority/GP/5-19 services/troubled families/early years providers’).

5.19.1.2 A named HV on every Children’s Centre Management Board.

5.19.1.3 Ensure appropriate senior nurse representation in local Health and Wellbeing Boards, Local Children Safeguarding Boards, Children’s Trusts, developing and supporting delivery of services in line with the Board/Trust’s priorities in the JNSA.

5.19.1.4 An area-based geographical Health Visiting Service structured in line with local children’s services, working together to deliver integrated, evidence-based services for children and their families, with a focus on prevention, promotion and early intervention.

5.20 Health visitor linked to each GP

5.20.1 The service will provide a named HV for each GP practice to facilitate liaison, information sharing and joint working in the best interests of families. There will be an agreed schedule of regular contact meetings for collaborative service delivery which must be audited and actioned on a regular basis.

5.21 Health visitor linked to each Children’s Centre

5.21.1 A named HV on each Sure Start Children’s Centre management advisory board to work in partnership with children centres to:

5.21.1.1 Provide improved access and delivery of the HCP and, through this, the children’s centre core offer.

5.21.1.2 Integrated working with children's centres in their delivery of evidence based interventions to improve outcomes for families.

5.21.1.3 Promote and describe the wide range of early years provision that children and their families are entitled to, and as part of that process encourage all families to register for access to a wider range of provision.

5.21.1.4 Work in a collaborative manner with Children's Centre teams to agree joint local children's service priorities based on local JSNA.

5.21.1.5 Work in a collaborative manner with Children's Centre teams to agree how both services will work together. An example of this is the development of a Partnership agreement between the Health Visiting Service and Children's Centres.

5.21.1.6 Both services will agree a method of data collection that encourages appropriate sharing of information with the families consent.

5.22 The service will develop close links with all local providers of services to children, for example, voluntary sector providers, childminders, early year's settings and schools.

5.23 In addition to the core programme, the HCP schedule includes a number of evidence-based preventive interventions, programmes and services. Providers will work with Commissioners, local authority partners, local safeguarding and children's boards, Health and Wellbeing Boards, Clinical Commissioning Groups (CCGs), to determine which services are offered locally and by whom. The next section sets out the evidenced based multi-agency pathways that should be developed and implemented.

5.24 Care Pathways [Previously under Service Delivery and Care Pathways]

5.24.1 The Health Visiting Service will work to develop, implement, monitor and review multi-agency care pathways for priority needs for children and their families, ensuring clarity of roles and responsibilities, reducing duplication and eliminating gaps. These will be based on evidenced-based assessments and interventions with a clear role for HVs underpinned by training in the relevant competencies. These should be in line with national pathways and guidance where these have been developed.

5.24.2 Multi-agency, evidence-based pathways expected to be in place are in Appendix 2. This has replaced the long list of pathways as Appendix 2 covers these.

5.25 Population covered

5.25.1 The Health Visiting Service must be delivered to a defined geographical population in line with Local Authority boundaries and localities. All families with a child aged 0-5 years and all pregnant women currently resident in the local authority area must be offered the HCP. If the intervention is refused this must be recorded and actioned as appropriate depending on the assessment made by the HV of any risks.

5.25.2 Data collection should enable reports on activity for both the GP registered and the resident population.

5.25.3 The service will ensure that any coverage/ boundary issues that may arise will be dealt with proactively in collaboration with neighbouring providers. Delivery of a service that meets the needs (including safeguarding needs) of the child or family must take precedent over any boundary discrepancies or disagreements.

5.26 Provider's Premises

5.26.1 Parents should be offered a choice of locations and times for visits which best meet their needs, e.g. GP surgeries, children's centres, community health services, the home, health centres, etc. Locations must be easily accessible for all children and families who live in the local vicinity (including access by public transport and at times appropriate to the user), children and young family friendly, suitable for multi-disciplinary delivery of services in both individual and group sessions and be conducive to flexible availability (e.g. early mornings, lunchtimes, after school, evenings and weekends).

5.26.2 Specific locations are to be agreed locally following engagement with relevant interested parties and feedback from users. Reviews should be taken periodically to ensure the locations are suitable to local needs.

5.26.3 Joint contacts should be provided in partnership with other agencies where this is appropriate and reduces inconvenience for families, for example integrated 2-2.5 year review.

5.26.4 The Health Visiting workforce needs suitable premises for office space and service delivery. The provider organisation must ensure that service delivery is not hampered by inappropriate premises and should work in partnership with local authorities and other providers to ensure that seamless and integrated service delivery is facilitated, for example, co-location of health visiting teams in Children's Centres.

5.27 Days/Hours of operation

5.27.1 The core service will operate standard hours of 9am – 5pm Monday to Friday but with flexibility from 8am – 8pm to meet the needs of families. This may be delivered through a range of workforce planning options such as flexible shift times. Other working hours may be considered by local agreement to meet the needs of families.

5.28 Acceptance and exclusion criteria

5.28.1 The service must ensure equal access for all children up to school entry and their families, irrespective of age, disability, gender reassignment, marriage and civil partnership and race – this includes ethnic or national origins, colour or nationality, religion, lack of belief, sex or sexual orientation.

5.28.2 The service must ensure it provides appropriate staff allocation according to population need whilst maintaining the universal offer (see Cowley & Bidmead 2009).

5.29 The service should provide an equality impact assessment where changes to the existing contract are proposed.

6 HV Workforce Development/ Plan

6.1 The challenge of mobilising the profession requires due attention by all providers. It is expected that providers will develop a robust workforce development plan. This plan should demonstrate:

6.1.1 Service Transformation

6.1.1.1 Service development in response to client experience, feedback from families and caregivers and staff.

6.1.1.2 Alignment and weighting of the health visiting resource in line with local population needs and local authority boundaries. This includes collection of information about population needs in order to inform the expansion and delivery of services.

6.1.1.3 Embedding learning from Early Implementer Sites (EIS), national and international research, other evidence and good practice guidance; and sharing good practice through development of local integrated Children's Services networks.

6.1.1.4 Priorities for the service based on population indicators, Health and Wellbeing Board priorities and the National Core Service Specification.

6.1.1.5 Learning needs analysis of the existing workforce including a plan to develop career progression and succession planning for all HVs and teams.

6.1.1.6 Evidence-based intervention audit with training and development plan in line with multi-agency Early Years and Troubled Families Strategies.

6.1.1.7 Staff development in Building Community Capacity, including the online module and examples of interagency approaches and training.

6.1.1.8 Staff development to enable innovative and creative health visiting to meet local needs and to add to the body of research evidence for the profession.

6.1.1.9 CPD programme which supports delivery of the National Core Service Specification particularly evidenced-based assessments and interventions as well as multi-agency learning, leadership and supervision.

6.1.1.10 Resources allocated for the CPD requirements identified in the plan and access to multi-agency training at every opportunity.

7 HV Workforce Growth

7.1 Robust workforce analyses and plans to achieve set trajectories, which include: numbers of new students needed; recruitment/retention plans; numbers of retirees;

potential other leavers; numbers of student placements based on Health Education England (HEE) expectations.

- 7.2 Conversion of agency and bank staff to substantive contracts.
- 7.3 Support for return to practice staff.
- 7.4 Schemes supporting the retention of staff e.g. [‘Retaining your health visitor workforce’](#) – NHS Employers; and Recruitment and Retention Premia guidance hosted on the NHS Employers website.
- 7.5 Organisational processes and managerial support in place to ensure that mentors and practice teachers are able to provide high quality placements for HV students in line with the NMC and HEI requirements including role descriptors for mentors and practice teachers.
- 7.6 Retention and supply of practice teacher roles to support trainees and latterly to support new staff and the development of the wider health visiting team, ensuring evidence-based practice and research focus is maintained.
- 7.7 Provide high quality undergraduate and HV student placements in line with NMC Standards and the required HEE target; and development of plans to support workforce development and retention, mobilisation of expanded services, service transformation and service monitoring.
- 7.8 FTE HV workforce numbers are reported using data from the Electronic Staff Record (ESR) and non ESR sources, in line with agreed definitions of the Health Visiting Minimum Data Set (HV MDS). The service provider will ensure ESR records are updated, including ensuring correct coding of all HVs, on a monthly basis, based on the health and social care information centre workforce data collection and in line with the definition on [HSCIC website](#).
- 7.9 To demonstrate that the Government’s workforce commitment has been met, accurate workforce data, service delivery and outcomes measures will need to be collated. Service providers will support NHS England in the collection and reporting of health visiting workforce and outcomes data as required.

Appendix 1

Evidence Base, Applicable National Service Standards and Suite of Evidence Based Interventions/Pathways

Evidence Base

- [Healthy Child Programme – Pregnancy and the first five years of life](#) (DH, 2009 – amended August 2010)
- [Better health outcomes for children and young people](#) Pledge
- [The Children and Young People’s Health Outcomes Strategy](#) (DH, 2012)
- [Allen, G. \(2011a\) Early Intervention: The Next Steps](#). HM Government: London
- [Allen, G. \(2011b\) Early Intervention: Smart Investment, Massive Savings](#). HM Government: London
- [Field, F. \(2010\) The Foundation Years: preventing poor children becoming poor adults](#). HM Government: London.
- [Health visitor implementation plan 2011-15: A call to action](#) (DH, 2011)
- [The National Health Visitor Plan: progress to date and implementation 2013 onwards](#) (DH, 2013)
- [The Operating Framework for the NHS in England 2012/13](#) (DH, 2011)
- Strategic and Operational Planning 2014 to 2019 (NHS England 2014)
<http://www.england.nhs.uk/ourwork/sop/>
- NHS Outcomes Framework 2014 to 2015 (DH, 2013)
<https://www.gov.uk/government/publications/nhs-outcomes-framework-2014-to-2015>
- Public Health Outcomes Framework 2013 to 2016 (DH, 2014)
<https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency>
- [The Marmot Review \(2010\) Strategic Review of Health Inequalities in England, post-2010](#)
- Dame Clare Tickell (2011) [The Early Years: Foundations for life, health and learning – An Independent Report on the Early Years Foundation Stage to Her Majesty’s Government](#)
- [Hall D and Elliman D \(2006\) Health for All Children \(revised 4th edition\)](#). Oxford: Oxford University Press. (Please note: this link opens to the bookstore for purchase of copies of this edition).
- [Service vision for health visiting in England \(CPHVA conference 20-22 October 2010\)](#)
- [Securing Excellence in Commissioning for the Healthy Child Programme 0 to 5 Years 2013 – 2015](#)

- [Equity and excellence: Liberating the NHS \(DH, 2010\)](#) and [Liberating the NHS: Legislative framework and next steps DH, 2011](#)
- [Achieving equity and excellence for children. How liberating the NHS will help us meet the needs of children and young people \(DH, 2010\)](#)
- [Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs \(DH, 2010\)](#)
- [Healthy lives, healthy people: our strategy for public health in England \(DH, 2010\)](#) and [Healthy lives, healthy people: update and way forward \(DH, 2011\)](#)
- [Healthy lives, healthy people: a call to action on obesity in England \(DH, 2011\)](#)
- [UK physical activity guidelines \(DH, 2011\)](#)
- [Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children \(HM Government 2013\)](#)
- [Fair Society, Healthy Lives. A strategic review of health inequalities in England post 2010 \(The Marmot Review, 2010\)](#)
- [The 1001 Critical Days: The importance of the conception to age two period. Wave Trust, 2013](#)
- [Conception to Age two: The Age of Opportunity. WAVE Trust and DfE](#)
- [Annual Report of the Chief medical Officer 2012. Our Children Deserve Better: Prevention Pays. Department of Health, 2013](#)
- [UNICEF UK Baby Friendly Initiative](#)

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 includes:

NICE guidance summary for public health outcome domain (PHE 2013)
<https://www.gov.uk/government/publications/nice-guidance-summary-for-public-health-outcome-domain>

Please note: For all reference see the [NICE website](#).

- 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
<http://www.nice.org.uk/guidance/PH48>
- 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
<http://www.nice.org.uk/guidance/PH50>
- 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>
- QS22 Quality standards for antenatal care
- QS31 Quality standard for the health and wellbeing of looked-after children and young people
- QS37 Postnatal Care
- QS59 Antisocial behaviour and conduct disorders in children and young people <http://www.nice.org.uk/guidance/QS59>
- QS43 Smoking cessation: supporting people to stop smoking
- QS46 Multiple pregnancies
- QS48 Depression in children and young people
- QS51 Autism <http://www.nice.org.uk/guidance/QS51>
- Suite of Evidence based pathways and interventions
Svanberg P O, Barlow J & TigbeW The Parent–Infant Interaction Observation Scale: reliability and validity of a screening tool. Journal of Reproductive and Infant Psychology, 2013: Volume 31, Issue 1, 2013
Milford R, Oates J. Universal screening and early intervention for maternal mental health and attachment difficulties. Community Practitioner, 2009; 82(8): 30-

Appendix 2

Integrated 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).
- Post natal maternal mental health ([NICE CG 37](#)).
- 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
- Nurse Prescribing guidance: http://www.nmc-uk.org/Documents/Circulars/2009circulars/NMC%20Circular%2002_2009%20Annexe%2001.pdf

Appendix 3

Nurse Prescribing

Nurse prescribing enhances the clinician's ability to deliver high impact area on minor illness and reducing hospital admissions, not only from the point of view of managing symptoms but also from the medication knowledge that also enhances advice and support. There is a strong clinician view that health visitors welcome the ability to use their prescribing skills and that this is an important element of practice.

- Nurse prescribing has been shown to have a number of benefits ranging from increased compliance to reduced hospital and GP attendances
- Health visitors are in an ideal position to respond to common health concerns, discuss treatment options and wider management of conditions and then to prescribe as part of a holistic approach.

While prescribing is included as a deliverable within the Core Specification, it is understood that not all HVs will have taken this module as part of their training. Therefore where HVs have not undertaken this module in training, it is a requirement of CPD for completion within the first 2 years of practice.

For more information visit <http://www.nmc-uk.org/Nurses-and-midwives/Regulation-in-practice/Medicines-management-and-prescribing/>

Appendix 4

Assessments - Universal Offer

Universal Review	Description
<p>Antenatal health promoting visits</p>	<p>Promotional narrative listening interview</p> <p>Includes preparation for parenthood</p> <p>This should be done as a face-to-face, 1-2-1 interview in a confidential setting.</p>
<p>New Baby Review</p>	<p>Face-to-face review by 14 days with mother and father to include:</p> <ul style="list-style-type: none"> - Infant feeding - Promoting sensitive parenting - Promoting development - Assessing maternal mental health - SIDS prevention including promoting safe sleep - Keeping safe - If parents wish or there are professional concerns: <ol style="list-style-type: none"> 1. An assessment of baby's growth 2. On-going review and monitoring of the baby's health 3. Assessment of safeguarding concerns 4. Assessment of attachment using NBO before 8 weeks 5. Include promotion of immunisations specifically: <ol style="list-style-type: none"> a. Adherence to vaccination schedule for babies born to women who are hepatitis B positive b. Assess maternal rubella status and follow up of two MMR vaccinations (to protect future pregnancies). 6. Checking of the status of all screening results and take prompt action to ensure appropriate referral and treatment pathways are followed in line with UK NSC Standards, specifically: 7. Newborn blood spot; ensuring results for all conditions are present 8. Results of NIPE examinations 9. Hearing screening outcome.

<p>6 – 8 Week Assessment</p>	<p>Includes:</p> <ul style="list-style-type: none"> - On-going support with breastfeeding involving both parents - Assessing maternal mental health according to NICE guidance <ol style="list-style-type: none"> 1. The baby’s GP (or nominated Primary Care examiner) will have responsibility for ensuring the 6-8 week NIPE screen is completed for all registered babies 2. Include promotion of immunisations specifically: <ol style="list-style-type: none"> a. Adherence to vaccination schedule for babies born to women who are hepatitis B positive b. Assess maternal rubella status and follow up of two MMR vaccinations (to protect future pregnancies). c. Checking of the status of all screening results and take prompt action to ensure appropriate referral and treatment pathways are followed in line with UK NSC Standards as above in initial check.
<p>3 – 4 months</p>	<p>At three to four months</p> <ul style="list-style-type: none"> • Supporting parenting by providing access to parenting and child health information and guidance (telephone helplines, websites, NHS Direct, etc.), and information on Sure Start children’s centres and Family Information Services. • Checking the status of Immunisations at three months against diphtheria, tetanus, pertussis, polio, <i>Haemophilus influenzae</i> type B and meningococcus group C. • Checking the status of Immunisations at four months against diphtheria, tetanus, pertussis, polio, <i>Haemophilus influenzae</i> type B, pneumococcal infection and meningococcus group C. • If parents wish, or if there is or has been professional concern about a baby’s growth or risk to normal growth (including obesity), an assessment should be carried out. This involves accurate measurement, interpretation and explanation of the baby’s weight in relation to length, to growth potential and to any earlier growth measurements of the baby. <p>Assessing maternal mental health</p> <p>Assessment of the mother’s mental health at six to eight weeks and three to four months, by asking appropriate questions for the identification of depression, such as those recommended by the NICE guidelines on antenatal and postnatal mental health.⁶¹</p> <p>Maintaining infant health</p>

	<p>Temperament-based anticipatory guidance⁶² – 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 (e.g. Baby Express newsletters⁶³).</p> <p>Promoting development</p> <p>Encouragement to use books, music and interactive activities to promote development and parent–baby relationship (e.g. media-based materials such as Baby Express newsletters and/or Bookstart⁶⁴).</p> <p>Keeping safe</p> <p>Raise awareness of accident prevention in the home and safety in cars. Be alert to risk factors and signs and symptoms of child abuse. Follow local safeguarding procedures where there is cause for concern.</p> <p>https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf 1</p> <p>https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209907/S9_Happy_Healthy_Families_First_Community_EISCS_V121210.pdf</p>
<p>9- 12 months</p>	<p>Includes:</p> <ul style="list-style-type: none"> - Assessment of the baby’s physical, emotional and social development and needs in the context of their family using evidence based tools, for example, Ages and Stages 3 and SE questionnaires; - Supporting parenting, provide parents with information about attachment and developmental and parenting issues; - Monitoring growth; - Health promotion, raise awareness of dental health and prevention (ensuring that all children are accessing primary dental care services for routine preventive care and advice), healthy eating, injury and accident prevention relating to mobility, safety in cars and skin cancer prevention; - Check newborn blood spot status and arrange for urgent offer of screening if child is under 1 year; - Adherence to vaccination schedule and final serology results for babies born to women who are hepatitis B positive; status of

	MMR vaccination for women non-immune to rubella.
By 2 – 2½ Years	<p>Includes:</p> <ul style="list-style-type: none"> - Review with parents the child’s social, emotional, behavioural and language development using ASQ 3 and SE; - Respond to any parental concerns about physical health, growth, development, hearing and vision; - Offer parents guidance on behaviour management and opportunity to share concerns; - Offer parent information on what to do if worried about their child; - Promote language development; - Encourage and support to take up early years education; - Give health information and guidance; - Review immunisation status; - Offer advice on nutrition and physical activity for the family; - Raise awareness of dental care, accident prevention, sleep management, toilet training and sources of parenting advice and family information; - This review should be integrated with the Early Years Foundation Stage two year old summary from 2015 as appropriate to the needs of children and families.
By 4 ½ years	<p>4½ years - Formal handover to School Nursing Service timed to meet the needs of the child e.g. if the HV is lead professional the handover may be delayed where this will improve outcomes for the child</p> <p>Children on Universal Plus or Universal Partnership Plus Offer must have a written handover.</p>

Appendix 5

Suggested activities at Communities Service Offer

(These are examples – it is expected that the Service will work in partnership with Children's Services to ensure that local innovation can flourish and appropriate developments grown.)

Peer support groups; support existing groups and develop and support 'role model' volunteers. Ensure local pathways for volunteers to progress towards paid work e.g. peer breastfeeding, community parents, asylum seeking families groups.

Community aspirations: use motivational interviewing to understand aspirations, dreams and assets and enable people to take their own steps to achieve this e.g. community credit facilities, food co-operatives. Act as communities' champion.

Building social networks; of families with similar interests, strengths or needs. Expansion of existing social networks to meet public health needs e.g. extended family, postnatal groups, faith groups, father's groups. Introduction and support of families into existing networks.

Influence other agencies and sectors to improve public health outcomes through supporting the application of best evidence-based practice in health improvement within and outside of health and early years settings, identifying local public health need and opportunity e.g. in housing, domestic abuse, teenage families, benefits system, schools, council planning/ neighbourhood improvement.

Use networks to improve public health; Signposting families to other services already existing locally, particularly early years but also adult education and training. Utilise local media opportunities for health promotion.

Appendix 6

Quality Assurance

The provider must deliver a comprehensive high quality health visiting service which can show evidence that it meets the standards, pathways and guidance set out in this service specification. The service must be safe, effective and customer focussed.

The provider must ensure delivery of the full Healthy Child Programme 0-5.

The provider service must be quality assured against CQC and all applicable quality standards, key performance indicators and service delivery metrics. The Provider Performance Framework (Appendix 8) must be completed on a quarterly basis, in line with other required data collections as notified.

Providers must provide the commissioner with a robust plan to implement electronic record keeping and data collection for health visiting services.

The provider should highlight to commissioners where there is an absence of local services or evidence-based pathways to refer families onto so that future commissioning plans can include mitigation for/provision of these; this is particularly urgent where need is identified but evidence-based pathways are truncated at the onwards referral stage because local services do not currently exist.

The health visiting service must report the KPIs and listed in the service specification and must provide evidence of compliance with CQC and other national applicable standards to assure commissioners and the public of the safety and effectiveness of the service. In order to do this the service must use suitable electronic record keeping and data collection systems.

The following items must be delivered:

- Routine collation of service user views to inform service development where possible using validated measuring tools including Friends and Family Tests;
- HV and team staff engagement and capturing of views;
- Evidence that HVs and teams are accessing appropriate leadership training, clinical supervision and are competent in all aspects of safeguarding;
- Evidence that HV practice teachers are maintaining competence to practice in line with national guidance;

- Ongoing quality audit programme;
- Organisation process for ongoing CPD, including appraisals and PDP for HVs and their teams. Evidence of a Health Visiting Training Needs Analysis to include action plan for ongoing professional development for the workforce with a focus on evidence-based practice and integrated training where possible. Evidence of a workforce plan which models both current and future workforce requirements in line with priorities for local area outlined in JSNA.

Appendix 7

Health Visitor Service Delivery Metrics

We request numerators and denominators for all indicators so that we can use these figures to evaluate the HV programme across Area Teams, regions and the country. This also allows us to validate these figures where possible to external sources.

If the specifications cannot be followed exactly please indicate how the information you provide differs from the specification.

Health Visiting Services are required to prepare for collection of service delivery metrics and dashboards at the level of local authority resident population (date to be advised).

Geographical Breakdown

This data should be reported by provider area of responsibility. Provider area of responsibility is defined as all those who the provider is responsible for providing HV services for. This should be defined on the basis of CCG footprints. CCG footprints are the CCG in which the infant is registered to a GP, or if they are not registered, the CCG of residence. All infants should therefore be included.

Timeframe

The data will be collected quarterly.

Data Specifications:

Guidance notes across all indicators

- All mothers and children are included in each indicator, this includes any being treated privately, or not registered with a GP. We realise that the occurrence of this may vary between areas.
- When families move, we have specified with which area/provider they should be included. It is recognised that this will involve some providers counting visits that were carried out by providers in other areas and/or visits that were not carried out in other areas. We have specified where the number of births should be counted and the number of babies should be counted.

Indicator C1 - Number of mothers who received a first face to face antenatal contact with a Health Visitor at 28 weeks of pregnancy or above.

Count of number of mothers who received a first contact with a health visitor when they were 28 weeks pregnant or later, before they gave birth.

Definition:

This should be a count of mothers who received a first contact with a health visitor when they were 28 weeks pregnant or greater, before they gave birth. Visits which occurred within the quarter should be counted (e.g. for Q1 2014/15, visits which occurred between 1st April and 30th June inclusive). The number of visits, not the number of children should be counted.

Notes:

This is defined as a count rather than a percentage because of the difficulty of defining a denominator to which antenatal visits can be linked within current data collection systems.

Indicators C2 & C3 - Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days by a health visitor (Indicator C2), or after 14 days (Indicator C3)

The information required is:

- The total number of infants who turned 30 days within the quarter (denominator C2 and C3).
- Total number of infants who turned 30 days within the quarter who received a face-to-face NBV within 14 days by a health visitor with mother (and ideally father) (numerator C2).
- Total number of infants who turned 30 days within the quarter who received a face-to-face NBV undertaken after 14 days by a health visitor with mother (and ideally father) (numerator C3).

Definitions:

The total number of infants who turned 30 days within the quarter is defined as all those infants within the provider area of responsibility who turn 30 days within the quarter.

This is to make sure that we are picking up most NBVs even where they occur after the recommended 10-14 days. The table below shows the ranges of birth dates which should be included in each quarter.

Quarter	Earliest birth date included	Latest birth date included
Q1	2nd March	1st June

Q2	2nd June	1st September
Q3	2nd September	2nd December
Q4	3rd December	1st March

NOTE: Count the number of children born, not the number of mothers.

The number of children who turned 30 days within the quarter who received a face-to-face NBV within 14 days is defined as the number of children defined above who also received an NBV within 14 days of their birth.

The number of children who turned 30 days within the quarter who received a face-to-face NBV after 14 days is defined as the number of children defined above who also received an NBV after 14 days after their birth.

We would expect that the vast majority of visits for those under 14 days will occur between 10-14 days as recommended, as midwives will be responsible for care prior to that. However there are occasions when an earlier visit is justified, so there is no lower limit for this indicator on how long after the birth the visit can occur.

Include:

- Each child born, in the case of multiple births this will be more than 1.
- All children born privately, even if they are not seen by a health visitor.

Exclude:

- Babies who die before their NBV.

Notes:

- This definition is based on infants who should have received an NBV by the end of the quarter. There are infants who are neither born in the quarter referred to, nor receive an NBV in the quarter referred to. The definition has been set up so that those babies born towards the end of the specified period who receive an NBV later than 14 days are still counted as receiving a visit.
- There are cases where it is not possible for an NBV to take place within the recommended period. It is not expected that these indicators would total 100%, nor that areas would achieve 100% under 14 days.

Indicators C4 & C5 - Percentage of children who received a 12 month review by the time they were 12 months and percentage of children who received a 12 month review by the time they were 15 months.

The information required is:

- The total number of children who turned 12 months in the quarter (denominator C4).
- The number of children due a 12 month review by the end of the quarter who had received a 12 month review by the time they turned 12 months (numerator C4).
- The total number of children who turned 15 months in the quarter (denominator C5).
- The number of children who turned 15 months in the quarter who had received a 12 month review by the time they turned 15 months (numerator C5).

Definitions:

The number of children due a 12 month review by the end of the quarter is defined as all those who fulfil the following two criteria:

- Are under the responsibility of the provider at the end of the quarter (e.g. for Q1 2014/15 this would be on 30th June 2014).
- Were aged 12 months within the quarter (e.g. for Q1 2014/15 this would be those who were aged 12 months between April 2014 and June 2014, i.e. those who were born between 1st April 2013 and 30th June 2013 inclusive).

The number of children who turned 12 months within the quarter who had received a 12 month review by the time they turned 12 months is defined as the number of those who fulfil the criteria above and who have received a 12 month review by the time they turned 12 months. Note that children who received a review in a previous quarter should be included.

Include:

- All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

- Children who die before their 12 month review.

The total number of children who turned 15 months in the quarter is defined as all those who fulfil the following two criteria:

- Are under the responsibility of the provider at the end of the quarter (e.g. for Q1 2015/16 this would be on 30th June 2015).
- Were aged 15 months within the quarter (e.g. for Q1 2015/16 this would be those who were aged 15 months between April 2015 and June 2016, i.e. those who were born between 1st Jan 2014 and 31th March 2015 inclusive).

The number of children who turned 15 months in the quarter who had received a 12 month review by the time they turned 15 months is defined as the number of those who fulfil the criteria above and who have received a 12 month review by the time they turned 15 months. This includes children who received a 12 month review in previous quarters, and those who had it before they turned 12 months.

Include:

- All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

- Children who die before their 12 month review

Notes:

The numerator for indicator C5, percentage of children who have had their 12 month review by the time they have turned 15 months, should include all those who have turned 15 months who have received a 12 month review. This should include those who have had their review before the current quarter and also those who have had their review before they turned 12 months, as well as those who had their review between 12 and 15 months.

We would expect indicator C5 to have a greater percentage than indicator C4 (percentage of children who received a 12 month review by the age of 12 months) as it will include all those who have had their 12 month review by the time they were 12 months as well as those who had it between 12 and 15 months.

Indicator C6i - Percentage of children who received a 2-2.5 year review

The information required is:

- The total number of children due a 2-2.5 year review by the end of the quarter (denominator).

- The number of children due a 2-2.5 year review by the end of the quarter who received a 2-2.5 year review by the time they turned 2.5 years (numerator).

Definitions:

The number of children due a 2-2.5 year review by the end of the quarter is defined as all those who fulfil the following two criteria:

- Are under the provider's responsibility at the end of the quarter (e.g for Q1 2014/15 this would be on 30th June 2014).
- Were aged 2.5 years within the quarter (e.g. for Q1 2014/15 this would be those who were aged 2.5 years between April 2014 and June 2014, i.e. those who were born in Q3 2011/12, so between 1st Oct 2011 and 31st Dec 2011 inclusive).

The number of children due a 2-2.5 year review by the end of the quarter who received a 2-2.5 year review by the time they turned 2.5 is defined as the number of those who fulfil the criteria above and who have received a 2-2.5 year review by the time they turned 2.5. Note that this should include those who had a 2-2.5 year review in a previous quarter.

Include:

- All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

- Children who die before their 2-2.5 year review.

Indicator C6ii - Percentage of children who received a 2-2.5 year review using ASQ 3

The information required is:

- The total number of children who received a 2-2.5 year review by the end of the quarter (denominator).
- The number of children due a 2-2.5 year review by the end of the quarter for whom the ASQ-3 is completed as part of their 2-2.5 year review (numerator).

Definitions:

The number of children due a 2-2.5 year review by the end of the quarter is defined as all those who fulfil the following two criteria:

- Are under the provider's responsibility at the end of the quarter (e.g. for Q1 2014/15 this would be on 30th June 2014).
- Were aged 2.5 years within the quarter (e.g. for Q1 2014/15 this would be those who were aged 2.5 years between April 2014 and June 2014, i.e. those who were born in Q3 2011/12, so between 1st Oct 2011 and 31st Dec 2011 inclusive).

The number of children due a 2-2.5 year review by the end of the quarter **who received** a 2-2.5 year review by the time they turned 2.5 (the **denominator**) is defined as the number of those who fulfil the criteria above and who have received a 2-2.5 year review by the time they turned 2.5. Note that this should include those who had a 2-2.5 year review in a previous quarter.

Include:

- All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.
- All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

- Children who die before their 2-2.5 year review.

The number of children who received a 2-2.5 year review by the end of the quarter for whom the ASQ-3 is completed as part of their 2-2.5 year review (the **numerator**) is defined as the number of those who fulfil the criteria above and for whom the ASQ-3 is completed as part of their 2-2.5 year review by the time they turned 2.5. Note that this should include those who had a 2-2.5 year review in a previous quarter.

- Children who die before their 2-2.5 year review.

Indicator C7 - Number of Sure Start Advisory Boards/Children's Centre Boards with a HV presence

Information required:

- Numerator: Number of Sure Start Advisory Board/Children's Centre Board meetings with a HV presence.
- Denominator: Number of Sure Start Advisory Board/Children's Centre Board meetings.

Definitions:

The number of Sure Start Advisory Board/Children's Centre Board meetings is defined as the number of Sure Start Advisory Board/Children's Centre Board meetings which occur within the defined quarter. The number of meetings with a health visitor presence is defined as the number of those defined previously, which are attended by a health visitor.

Indicator C8 - Percentage of children who received a 3-4 month review

The information required is:

- The total number of children due a 3-4 month review by the end of the quarter (denominator).
- The number of children due a 3-4 month review by the end of the quarter who received a 3-4 month review by the time they turned 4 months (numerator).

Definitions:

The number of children due a 3-4 month review by the end of the quarter is defined as all those who fulfil the following two criteria:

- Are under the provider's responsibility at the end of the quarter (e.g. for Q1 2014/15 this would be on 30th June 2014).
- Were aged from 3 to 4 months within the quarter. For example, for Q1 2014/15 this would be those who were aged 3 to 4 months between April 2014 and June 2014, that is:
 - those who were born in Q4 2013/14, so between 1st January 2014 and 31st March 2014 inclusive;
 - and those who were born in December 2013, i.e., who turn 4 months in April 2014, and who had not yet received the 3-4 month review.

The number of children due a 3-4 month review by the end of the quarter who received a 3-4 month review by the time they turned 3-4 months is defined as the number of those who fulfil the criteria above and who have received a 3-4 month review by the time they turned 3-4 months.

Include:

- All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

- Children who die before their 3-4 month review.

Appendix 8

Provider Performance Framework Report

Provider Performance Report					
	Outcome	MEASURE	Additional information	Target	Data collection/Report
Delivering capacity	Health Visitor Growth	Health Visitors (FTE) in Post - ESR	Health Visitor: An employee who holds a qualification as a <u>Registered Health Visitor under the Specialist Community Public Health Nursing part of the NMC Register</u> and who occupies a post where such a qualification is a requirement. Not below Agenda for Change Band 6. Coded as occupation code N3H only in NHS Workforce information. (NHS IC, (2011) Occupation Code Manual Version 11)	* FTE by 31/3/15	Reported monthly to the HSCIC via Omnibus (Health Visitor Minimum Dataset)
		Health Visitors (FTE) in Post - Non-ESR		* FTE by 31/3/15	Reported monthly to the HSCIC via Omnibus (Health Visitor Minimum Dataset)
		Total Health Visitors (FTE) in Post - Calculation		* FTE by 31/3/15	Reported monthly to the HSCIC via Omnibus (Health Visitor Minimum Dataset)
		Leavers (FTE)	FTE of staff who have left the provider	*per agreed local trajectory	AT (monthly) - for local AT assurance
		Joiners (FTE)	Health Visitor joiners separated into newly qualified joiners direct from training, joiners from return to practice and other joiners	*per agreed local trajectory	AT (monthly) - for local AT assurance
		Number of vacancies (FTE)	Currently unfilled posts		AT (monthly) - for local AT assurance

	C2A Student growth delivered			* in 2014/15	AT (monthly) - for local AT assurance	
System Transformation		Workforce development plan in place with regular review and assurance	See service specification section 6		Quarterly Area Team Dashboard (NHS England)	
		Service specifications in place/agreed by commissioner and provider	Evidenced by having contracts signed off		Quarterly Area Team Dashboard (NHS England)	
		Performance targets against each service performance metric set for each Provider	Performance measures agreed based on the Providers performance to date and expectations regarding growth.		Quarterly Area Team Dashboard (NHS England)	
		Performance targets against each public health outcome for 0-5s metric set for each Provider	Performance measures agreed based on the Providers performance to date and expectations regarding growth.		Quarterly Area Team Dashboard (NHS England)	
		AT and LETB are in agreement that student placements are sufficient to support the growth target			Quarterly Area Team Dashboard (NHS England)	
		HV service equipped for delivery of C2A	Annual report compiled from HV service submissions on Patient Experience feedback from families and caregivers, using validated patient experience measures	In line with NHS Outcome Framework: Ensuring people have a positive experience of care		Quarterly Area Team Dashboard (NHS England)
			AT has agreed a plan with provider with milestones for comprehensive delivery of the HCP by March 2015	See service specification section 4.3		Quarterly Area Team Dashboard (NHS England)
			There is an evidence-based multi-agency maternal mental health pathway with a clear role for health visiting.	See service specification section 4.4		Quarterly Area Team Dashboard (NHS England)
			There is an evidence-based multi-agency early attachment pathway with a clear role for health visiting.	See service specification section 4.4		Quarterly Area Team Dashboard (NHS England)
			There is an evidence-based multi-agency healthy weight pathway with a clear role for health visiting.	See service specification section 4.4		Quarterly Area Team Dashboard (NHS England)
Service Delivery	Service offer metrics	Number of mothers who received a <u>first</u> face to face antenatal contact with a Health Visitor at 28 weeks or above	Due to the difficulties establishing a reliable denominator this is a count. Target count should be agreed based on average number of deliveries over the past three years.	*% target	Quarterly Area Team Dashboard (NHS England)	

Percentage of births that receive a face to face NBV within 14 days by a Health Visitor	Numerator: Total number of infants who turned 30 days in the quarter who received a face-to-face New Birth Visits (NBV) undertaken within 14 days from birth, by a Health Visitor with mother (and ideally father) Denominator: Total number of infants who turned 30 days in the quarter Formula: Numerator/Denominator x 100	*% target	Quarterly Area Team Dashboard (NHS England)
Percentage of face-to-face NBVs undertaken after 14 days, by a Health Visitor	Numerator: Total number of infants who turned 30 days in the quarter who received a face-to-face New Birth Visits (NBV) undertaken after 14 days from birth, by a Health Visitor with mother (and ideally father) Denominator: Total number of infants who turned 30 days in the quarter Formula: Numerator/Denominator x 100	*% target	Quarterly Area Team Dashboard (NHS England)
Percentage of children who received a 12 month review by the time they turned 12 months	Numerator: Total number of children who turned 12 months in the quarter, who received a review by the age of 12 months Denominator: Total number of children who turned 12 months, in the appropriate quarter Formula: Numerator/Denominator x 100	*% target	Quarterly Area Team Dashboard (NHS England)
Percentage of children who received a 12 month review by the time they turned 15 months	Numerator: Total number of children who turned 15 months in the quarter, who received a 12 month a review by the age of 15 months Denominator: Total number of children who turned 15 months, in the appropriate quarter Formula: Numerator/Denominator x 100	*% target	Quarterly Area Team Dashboard (NHS England)
Percentage of children who received a 2-2.5 year review	Numerator: Total number of children who turned 2.5 years in the quarter who received a 2-2.5 year review, by the age of 2.5 years of age. Denominator: Total number of children who turned 2.5 years, in the appropriate quarter. Formula: Numerator/Denominator x 100	*% target	Quarterly Area Team Dashboard (NHS England)

		Percentage of children who received a 2-2.5 year review using ASQ 3	Numerator: The number of children who received a 2-2.5 year review by the end of the quarter for whom the ASQ-3 is completed as part of their 2-2.5 year review. Denominator: Total number of children who received a 2-2.5 year review by the end of the quarter. Formula: Numerator/Denominator x 100	*% target	Quarterly Area Team Dashboard (NHS England)
		Percentage of Sure Start Advisory Boards with a HV presence	Numerator: Number of Sure Start Advisory Boards/Children's Centre Boards with an HV presence Denominator: Number of Sure Start Advisory Boards/Children's Centre Boards Formula: Numerator / Denominator x 100	*% target	Quarterly Area Team Dashboard (NHS England)
		Percentage of children who received a 3-4 month review	Numerator: The number of children due a 3-4 month review by the end of the quarter who received a 3-4 month review by the time they turned 4 months. Denominator: The total number of children due a 3-4 month review by the end of the quarter.	*% target	Quarterly Area Team Dashboard (NHS England)
Key Outcomes	Breastfeeding	Percentage of infants for whom breastfeeding status is recorded at 6-8wk check	Numerator: Number of infants where feeding status has been recorded at 6-8wk check Denominator: Total number of infants due 6-8wk check Formula: Numerator / Denominator x 100	*% prevalence target	Central collection (quarterly) Unify2
		Percentage of infants being breastfed at 6-8wks	Numerator: Number of infants recorded as being totally and partially breastfed at 6-8wks Denominator: Total number of infants due 6-8wk check Formula: Numerator / Denominator x 100	*% prevalence target	Central collection (quarterly) Unify2
Identificati	Health Visitors	No. of new CAFs completed by HV staff in the month	Number per FTE/% caseload	*target	AT - for local agreement

Quality Standards	identifying families at risk of poor outcomes	Percentage of mothers who received a Maternal Mood review in line with local pathway, by the time infant is aged 8 weeks, based on the quarter when the infant reached 8 weeks of age	Numerator: Total number of mothers with an infant who turned 8 weeks in the quarter, who received a Maternal Mood review by the time infant turned 8 weeks Denominator: Total number of mothers with infants who turned 8 weeks, in the quarter Formula: Numerator/Denominator x 100	95%	AT - for local agreement
	Safeguarding	Percentage of HV staff who have completed mandatory training at levels commensurate with roles and responsibilities (levels 1,2, 3) in child protection within the last three years.	Numerator: Number of staff who have received mandatory child protection training (as per local policy) in the last 36months Denominator: Total number of staff Formula: Numerator / Denominator x 100 expressed on a rolling 36mth basis	95%	AT - for local agreement
	Annual Audit of 50 randomly selected cases in each category	Annual audit of 50 randomly selected urgent referrals, including all safeguarding referrals	Numerator: Number of these 50 urgent referrals to HV who received a same day/next working day response to referrer. Denominator: 50 urgent referrals from whatever source (including families transferring in) to HV Formula: Numerator/Denominator x 100	95%	AT - for local agreement
		Percentage of urgent referrals, including all safeguarding referrals, who a) received a same day or next working day response to the referrer and b) received a HV contact with the family within two working days.	Numerator: Number of these 50 urgent referrals to HV who received a HV contact within two working days Denominator: 50 urgent referrals from whatever source (including families transferring in) to HV Formula: Numerator/Denominator x 100	95%	AT - for local agreement
	Annual audit of 50 randomly selected referrals from any source	Numerator: Number of these 50 referrals where referrer received a response within 5 working days. Denominator: 50 referrals from whatever source (including families transferring in) to HV Formula: Numerator/Denominator x 100	95%	AT - for local agreement	
	Percentage of all referrals from whatever source (including families transferring in) who a) received a response to the referrer within 5 working days and b) with contact made with the family within 10				

		working days.	Numerator: Number of these 50 referrals where contact was made with the family within 10 working days. Denominator: 50 referrals from whatever source (including families transferring in) to HV Formula: Numerator/Denominator x 100	95%	AT - for local agreement
		Annual audit of 50 randomly selected cases with a transfer request received	Percentage of cases where a transfer request was received where the records were transferred within 2 weeks. Numerator: Number of these 50 children where the health records were transferred to the HV service in the new area within 2 weeks of notification. Denominator: 50 children where HV service has been notified as moved out of the area Formula: Numerator/Denominator x 100	95%	AT - for local agreement
			Percentage of CP cases where there was direct contact with the HV team in the receiving area of these cases. Numerator: Number of these 50 children who were on a CP plan where there was direct contact to HV team in receiving area. Denominator: Number of these 50 children who were on a CP plan where HV service has been notified that child has moved out of the area Formula: Numerator/Denominator x 100	95%	AT - for local agreement
	CQC	Adherence with CQC standards	Evidence should be available to commissioners on request		For local agreement