Sharing Practice – Harlow Families First Service

This change in practice initiative is part of the Essex Family Innovation Project, working with Harlow Essex Family (HEF) key workers and a small number of specific families to help improve "the promoting good health" aspect of the whole family assessment and action planning. The service is a pilot under the Essex Family banner and is an effort to exemplify community budgeting in practice.

Families accepted on the service have been allocated one named Key Worker who works with the family throughout accesses all additional specialist support required. A mixture of statutory and voluntary organisations have come together to provide this service.

Current organisations involved:

- Harlow District Council (HDC)
- Harlow Education Consortium (HEC)
- Safer Places
- Harlow Children's Centres
- Health

So What's different?

Families in need are able to work with the Key Worker to gain access to all the support services required-this may be housing, employment, education or health. This is not a sign posting programme. Using health expertise the HV role works intensively with the Key Worker and principle family members in identifying the health improvements required, drawing up programmes and interventions to meet these and supporting (along with the Key Worker) the delivery of these. This programme identifies the benefits of close multiagency working with swift referral mechanisms between agencies and inputting to a whole family evaluation process by use of the "Family Star".

Some benefits already achieved include earlier referrals reducing waiting times, and the ability to manage mental health issues in the antenatal period which reduced postnatal support requirements.

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Community Engagement – The Travelling Community in South West Essex

As a skill mix 0-19 team of health visitors, community nursery nurses and school health practitioners we have one of the largest and most controversial traveller sites on our caseload. The community has high mobility and health needs with historical poor access to health services.

Initiatives in the past were short term, delivered in isolation from the health visiting team with caseload responsibility and lacked sustainability.

Following some informal collection of women's views we have focused on delivering the universal health visiting offer promoting increased visibility and access. We have worked with colleagues through a multi-agency community engagement group to deliver relevant services that address the communities identified needs.

The site was subject to huge media attention due to the evictions in 2011, during this period

we continued to maintain our links with the community and the group was successful in ensuring the reinstatement of health professionals visiting the site. During this difficult period we gained the trust of the community through continued multi-agency work which included the local Roman Catholic priest, police, traveller education service, youth service, children's centre, voluntary services and local council.

As a team we worked together on a mobile clinic (bus) on the site every Wednesday to signpost families to local services. Delivering a Child Health Clinic on the bus for six months raised the health visiting profile resulting in increased attendance at developmental checks and local clinics. We identified needs such as oral health promotion, benefit advice and cultural awareness training for professionals that have been addressed through the group.

We continue to meet monthly and are actively engaging with the community to ensure that we continue to proactively address their health and welfare needs, addressing service delivery issues together.

Gaye Picton
Health Visitor/Team Leader

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Anglian Community Enterprise Community Interest Company Children's Community Services: Breastfeeding Support.

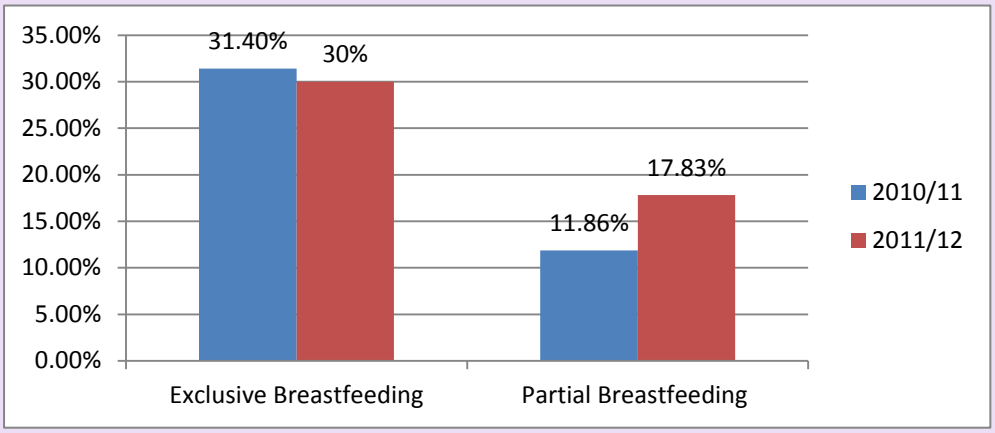
ACE is committed to supporting the UNICEF Baby Friendly Initiative and in April 2011 Breastfeeding Supporters were integrated into each of the 8 Children's Community Services Teams to assist the Health Visiting service with breastfeeding management and performance as recommended by NICE best practice guidelines.

Breastfeeding Supporters together with Health Visiting Team members contact all new mothers within 48 hours of discharge notification and soon after a home birth to ensure mothers are happy with their chosen feeding method. Contact continues to all breastfeeding mothers with the offer of weekly face to face home visits and additional telephone and texting contact to help them be successful.

Health Visiting Teams recognise the importance of supporting mothers to build close and loving relationships with their baby. Staff fully appreciate any breast milk a baby receives has benefits to both mother and baby. We support this by providing a free electric breast pump loan service which ensures mothers have access to suitable equipment to enable them in their decision to breastfeed.

Health Visiting teams and Breast Feeding Supporters work in partnership with Barnardo's Children's Centres to facilitate "Baby Beginnings" groups across North East Essex. These groups promote breastfeeding as the norm. Baby Beginnings Facebook and Twitter provide communities where mothers can link with each other and a specific Breastfeeding Supporter and or Nursery Nurse who are available to offer followers information and advice as well as respond to queries and signpost to Health Visitors.

Since the introduction of integrated Children's Community workforce in 2011 ACE annual breastfeeding percentage at 6-8 weeks increased by 4.47% from 43.26% in 2010/11 to 47.73% in 2011/12. This is illustrated in the graph below.



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Health Visiting Innovation - Improving Relationship and Communication with GPs Organisation : SEPT Community Health (Children's Services), South East Essex

Description:

To foster close relationship with GP colleagues, use face to face and or telephone contacts to communicate regularly with them so that we can share essential information about children and their families health needs, resources and other support services available locally for children and families, and, to work collaboratively to improve family needs assessments and agree a joined up care plan where appropriate for children 0 – 19 years on the practice caseload identified as vulnerable by both the GP or Children's services practitioners.

A term of reference was developed and agreed with GPs via the lead for safeguarding. Project presented at GP forums and information about the meetings published in the monthly GP newsletter. At least once a month face to face meeting between the GP and a Health Visiting and or School Nursing caseload holders is recommended to take place at the GP surgery with both parties bringing a list of cases for discussion to the meeting. The list of children should be shared before the meeting where possible. Each practitioner is responsible for ensuring that, and is required to inform the client that such meeting is taking place and information is being shared. A recording template was developed to record concerns shared at the meeting, potential impact of the concerns on the child / ren, action plan and review date for action plan. The template is then scanned on to the child / ren's electronic record - SystmOne used by most practices accessible to both the GP and Children's services staff.

Area of service vision or family offer this meets: Improve outcomes for children in the Safeguarding arena; improve communication between the leaders in Primary Care; Universal, universal plus and universal partnership plus.

Rationale behind Innovation: What clearly emerged from serious case reviews is a failure of system compounded by other factors, the greatest of which was lack of or ineffectiveness of, communication and liaison between health professionals.

Outcome of Innovation: Communication in its varied form – planned and ad hoc face to face, telephone, SystmOne notifications and tasks are now taking place more regularly between GPs and Children's services staff where essential information needs to be shared. Efforts are on-going to achieve cooperation with practices where this has not yet been implemented even though the need to have regular meeting has been identified. Primary Care Meetings has been incorporated in the standard / guidelines for managing Health Visiting caseloads.

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Hertfordshire Community NHS
NHS Trust

Reflection on ante natal and post natal promotional guide training.

Following a liaison with one of our midwives I was able to have contact with two mums and their partners both at different stages of pregnancy and was able to carry out a first interview implementing the antenatal promotional guide. Both sets of parents were very receptive to my contact and consented to a follow up home visit pre-birth 4 weeks later to complete the promotional guide programme with them. They are both aware that I intend to follow them through when their babies arrived.

The night before the above I was very excited about being able to take part in the antenatal promotional guide training. I feel very strongly about the delivery of the H/V service currently and the need to change our practice to incorporate the pre-birth contacts. Quite often at new birth contacts some of the issues that arise could have been avoided or anticipated with a pre-birth contact. It will also support interagency working with our midwife colleagues which is also currently very sporadic.

During the contacts that I was able to have they were very open and receptive and it was really exciting to initiate a conversation that I felt could identify both strengths and weakness for the prospective parents and for them to have a really good understanding our the H/V service.

The other important aspect of this new way of working is initially developing a relationship with parents pre-birth and if the worst case scenario happens and they have a still birth or a neonatal death you already know them to offer support following this difficult and painful experience. I am currently working with three families who have experienced some of these issues and it could have been less traumatising for them if the pre-birth contact had been available and I had had the opportunity to build a relationship with then prior to the traumatic event.

Following my second training day on 7/3/13 I am now working towards continuing to have a monthly contact at the midwife clinic for pre-birth visits and have identified some recent new births that I intend to start to use the postnatal guide with. I feel that my colleagues and I do deliver most things in the postnatal guide but these guides will reinforce what a fantastic service we can deliver to the families on our caseload.

Jane Ward
Health Visitor – Stevenage, Hertfordshire
March 2013

UNICEF Baby Friendly Accreditation

The 0-19 service along with Children's Centres for Bedford Borough and Central Bedfordshire Borough were accredited with the Baby Friendly Award on 28th March 2013. This means that the mothers and babies of Bedfordshire receive optimum care to enable them to breastfeed for as long as they want to. To achieve the UNICEF standards we have created Baby Brasseries and Breastfeeding Buddies (peer support) to support the 0-19 teams to deliver the required care at a standard designated by WHO and UNICEF.

Members of the assessment team spent 2 days with us and gave very positive feedback to the service on behalf of the mothers they interviewed. As part of the assessment they had a series of questions and either phoned or met with over 50 mothers over this period to understand how well they were being supported and advised. Our feedback included a detailed list highlighting how positive and welcoming the organisation is for breastfeeding mothers. Many of the strategies put in place also support the bottle feeding mothers to recognise the cues of when a baby needs feeding, attachment and safe sterilisation techniques.

Only one other Community Service in East of England has this award to date.

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Cambridgeshire and Peterborough NHS
NHS Foundation Trust

NEWS RELEASE

UNICEF inspectors give top honour to breastfeeding service

Health visitors from Cambridgeshire and Peterborough NHS Foundation Trust, who run a breastfeeding advisory service, have been praised by global health organisation UNICEF.

The service gives advice and support to pregnant women and new mums about the health benefits of breastfeeding.

After a lengthy inspection process conducted by officials from UNICEF, breastfeeding services in Peterborough, including the one run by CPFT, have now been awarded full accreditation to UNICEF's Baby Friendly Initiative. The application process was originally led by NHS Peterborough, which commissioned a number of breast feeding advisory services including the one run by CPFT.

The rigorous accreditation process ensures that the care given to pregnant women and breastfeeding mothers and babies, is of a high standard.

Angela Rees, CPFT Service Manager said: "This is a huge achievement and we would like to thank all of our team who have worked tirelessly to support breastfeeding mothers and their families in Peterborough.

"We are very proud of the significant part we have played in breastfeeding services gaining full accreditation."

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Case Study: Rolling out Ages and Stages Questionnaires across Norfolk Community Health and Care

Organisation: Norfolk Community Health and Care NHS Trust

Brief Description: Ages and Stages questionnaires are an affordable effective developmental assessment tool that provides a clear picture of a child's developmental strengths, through the ASQ-3 questionnaires, and a child's social and emotional strengths, through the ASQ-SE questionnaires. The packs compromise age specific questionnaires, that are strength based assessments completed with all families during the Health Visitors two year review.
Training has been provided to all Health Visitor, community nursery nurses and family support workers, in collaboration with the family nurse partnership and speech and language team. All 32 Health Visiting bases across Norfolk have been supplied with not only the ASQ packs but with a developmental assessment bag and a specific speech and language pack in order to fully assess and support a child with certain developmental areas/behaviours.

Area of the service vision or family offer this example meets:

- A universal service to all families.

Rational behind the innovation: To provide a standardised approach to the 2 year review across Norfolk, although the tools supplied will be used for all developmental assessments at any time from birth to five. The ASQ is well researched and used in many countries since 1995. It is also referenced within the healthy child programme. This standardized approach the county will help when working with nursery setting that now also complete a two year review on children within nursery settings.

Outcome of innovation:

- To provide a standardised universal approach to developmental assessments across Norfolk
- Increased ability to identify children that may require additional support and services.
- Health Visitor, community nursery nurses and family support workers that have responsible for undertaking developmental assessments across the trust have been able to book onto a half day training session that allows time to run through the assessment tools, and come to grips with this new resource.

- Families feel supported. The activity sheets have been welcomed. Communication between professionals and families about realistic expectations and concerns has been found to be easier.
- Health Visitors, Nursery Nurses and family support workers have welcomed this new tool and can see the practicality of this tool when making referrals to others services. Feedback has been very positive.

Written by Amanda Wagg, HV EIS programme support

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Antenatal Healthy Child Collaborative Case Study
Jane England: Family Support Worker

Family: Family - Mum (K), Step-Dad (B), Son (E) 9yrs, Son (L) 2 ½ yrs, Unborn baby. B is the father of L and the unborn baby.

Original referrer and agency: Community Midwife referred to Antenatal Healthy Child Collaborative (AHCC) with clients consent.

Outline of initial referral reasons: Referred to AHCC with concerns around maternal low mood and possible recurrence of Post Natal Depression (PND) for this third pregnancy.

Outline of intervention plan: Following discussion by panel, an Initial home visit by Children's Centre Family Support Worker was done to assess the service needed and how Children's centre support and multi-agency working could benefit the family.

Home Visit: During the visit K explained that she was worried about suffering from PND again. K went on to say that during her first pregnancy she had suffered from very severe PND which has resulted in the end of her relationship with her first child's (E) father. During the conversation it became clear that there were complex issues between K and her 9 year old son E.

K's attachment issues could be traced back to the depression resulting in little attachment to E. E walked to and from school himself; made his own meals including his packed lunch for school. K's relationship with the school had broken down and she felt unable to attend parent's evenings for E.

K explained that she did not like her son. She said she felt she loved him and could care for him in a practical sense however she had never felt close enough to him to be able to help him emotionally or to show him love.

When K was born, again, with this experience K felt her PND was severe.
K was given medication; however, she felt that by this time she was struggling to bond with her newborn son. She did after a while feel able to love him.

K was anxious about her current pregnancy. She was fearful of PND and her perceived effects it has had on her relationships.

Progress made / Aims achieved: Following the home visit, the family agreed to a CAF assessment being carried out for both E and K. This resulted in a Team Around the Child (TAC) meeting being held for E at his school to look at his behaviour issues along with the relationship with K and B and looking at their relationship with E and helping to give him a more confident view of himself and his place within the family.

The school which E attended were invited to the TAC meeting in the hope that the relationship between parents and school could be improved. School also highlighted concerns around, E his behaviour in school and his lack of personal hygiene and parental intervention.

The CAF for L picked up issues with him not accessing early education and delayed speech and language development. A request was made for him to start pre-school. Speech and language difficulties where discussed and a referral for Speech Therapy has been made.

K and B also agreed to take part in a pilot project called 'Getting to Know You' which involves

the VIG (Video Interactive Guidance) process from as soon as an hour after the birth of the baby. The use of VIG helps the attachment process by promoting attunement, empathy and well-being. (Kennedy et al 2010)

The Health Visitor was also fully involved antenatally and will be aware of the family leading up to and after the birth of the new baby. This will enable referral to GP and/or Mental Health Services if necessary. Support through the Post-Natal Group will also be offered.

Reason(s) for closure to AHCC: The aims of the AHCC where fully met. K was offered a family support service by the Children's Centre which offered her weekly home visits with a plan of intervention which would be reviewed on a regular basis to ensure that positive outcomes for the family were being achieved.

Reference: Kennedy, H., Landor, M. & Todd. L. (2010) Video Interaction Guidance as a method to promote secure attachment Educational and Child Psychology Vol. 27 No. 3.

Edited by: Kim Joyce, Healthy Child Programme Lead, East coast Community Healthcare CIC. April 2013

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