A Pathway of Care for Vulnerable Families (0-3)

Baby

Toddler

Assessment

er (27–41 weeks)

Indicator (HPI)

Birth

6 months

1 Year

2 Years

3 Years

34–36 weeks

37–38 weeks

39–40 weeks

41 weeks

First 24 hours

10–28 days*

6–8 weeks*

3 months*

4 months*

12–13 months*

24–30 months (review)

health nurse – health visitor

Pre and post birth for both mother, child, family

necessary along the pregnancy journey and becomes the named person after handover from the midwife

healthier scotland

SCOTTISH GOVERNMENT

A Pathway of Care for Vulnerable Families (0-3)

Guidance

The Scottish Government, Edinburgh, March 2011

Feedback

If you have any comments on this guidance or the resources please email vulnerablepathways@scotland.gsi.gov.uk

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Contents

1. Introduction

1. Introduction

All children and young people have the right to be cared for, protected from harm and abuse and to grow up in a safe environment in which their rights are respected and their needs met. A large number of children in Scotland, however, are born into, and live within, families that can be considered "vulnerable".

Twenty-one per cent of all children in Scotland live below the poverty threshold, which can affect not only their material well-being, but also their physical and emotional well-being. By the age of 3, a disadvantaged child's development is already up to a year behind that of their peers.[1] There is also evidence that pregnancy and the first years of life have a huge influence on the future mental health of the child. In one long-term follow up of children suffering abuse in the first years of life, 90% had at least one psychiatric diagnosis by age 17. And it is widely recognised that the teenage pregnancy rate in those under 16 years in the most deprived areas of Scotland is more than four times that found in the least deprived.[2]

Disadvantage takes many forms and is not just measured in socioeconomic terms. It can arise as a result of many causes, including parental substance misuse. Between 41,000 and 59,000 children in Scotland have at least one parent who is a problem drug user and around 70,000 have at least one parent who is a problem drinker.[1]

The Scottish Government's overarching purpose is to create a more successful country with opportunities for all of Scotland to flourish,[3] and it has committed to strengthen support for vulnerable children and families.

Improving outcomes for children and young people is a fundamental objective for all services and organisations. Ensuring that they and their families get the help they need, when they need it, will give all children and young people the opportunity to flourish. Agencies can improve outcomes for Scotland's most vulnerable by adopting common frameworks for assessment, planning and action that help them to identify needs and risks and work together to address them appropriately.[3]

A continuum of support from **universal provision** (the **universal pathway**) through to **specialist targeted provision** most effectively meets the needs of children and families at different ages and stages across the life course. A variety of different services and interventions are required to address the often very different needs of families and the multiple risk factors that impact on children's outcomes. The ultimate aim for services is **to support children and families to remain within the universal pathway whenever possible**, bringing in targeted or specialist provision where appropriate.

1 Scottish Government, 2008
2 Information Services Division, 2006
3 National Child Protection Guidance 2010: http://www.scotland.gov.uk/Publications/2010/12/09134441/2

1.1 What children and families can expect from health care services

Every child and adult is entitled to register with a local general practitioner to access primary health care services. They will also have access to support from a midwife in the antenatal period and a public health nurse/health visitor in the early years of a child's life. Secondary and tertiary support from health services, following identification of need, is coordinated and provided by a range of health care practitioners.

The *Healthcare Quality Strategy for NHSScotland*[4] has been built around what people in Scotland said they wanted from health care services, which was:

- caring and compassionate staff and services
- clear, effective communication and explanation about conditions and treatment
- effective collaboration between clinicians, patients and others
- a clean and safe environment
- continuity of care
- clinical excellence.

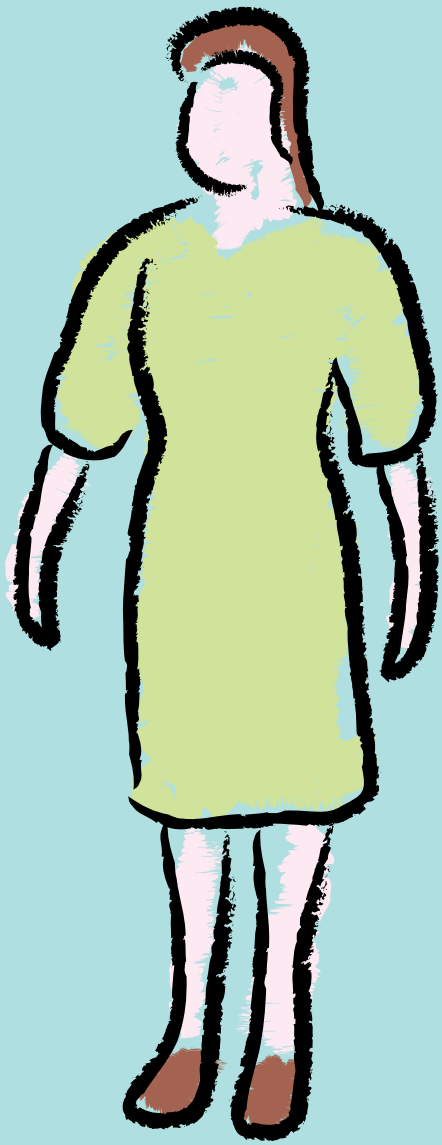
The *Quality Strategy* sets out the internationally recognised six dimensions of health care quality – health care that is: person-centred, safe, effective, efficient, equitable and timely. The three Quality Ambitions set out in the strategy to which all NHSScotland staff and its partners are aligned are:

- **person centredness** – mutually beneficial partnerships between patients, their families and those delivering health care services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making
- **safety** – there will be no avoidable injury or harm to people from the health care they receive, and an appropriate, clean and safe environment will be provided for the delivery of health care services at all times
- **effective** – the most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.

These Ambitions are relevant to the delivery of care to children and their families in the early years. They describe the care they should receive as being safe, relevant and delivered in partnership with children and their families.

4 The Healthcare Quality Strategy

2. This guidance



2. This guidance

The Scottish Government asked NHS Quality Improvement Scotland (NHS QIS)[5] to lead the development of a national multi-agency, multidisciplinary programme of work to support vulnerable children and families from conception to age 3 as part of the implementation of the *Early Years Framework*.[6]

The guidance has been developed as part of that work. It is intended primarily for service managers across all agencies to use with their teams to support the specific aims of the *Early Years Framework* implementation.

The guidance draws on key Scottish Government publications launched between 2008 and 2011 to reinforce key messages around reducing inequalities, building capacity in individuals, families and communities and taking a holistic approach to meeting the needs of all children.

The overall aim is to ensure that vulnerable children (from conception to age 3) and families in all parts of Scotland receive support that is **equitable, proportionate, effective and timely**. Specific aims of the guidance are to:

- support a consistent approach to meeting the needs of pregnant women, children and families
- enhance local pathways for vulnerable children and families
- support implementation of the *Getting it Right for Every Child* (GIRFEC) approach.[7]

It is important to emphasise that the guidance seeks to build from existing best practice, in particular practice related to implementing the principles of GIRFEC, and to encourage professionals' critical reflection of existing practice. It reinforces key messages around service development and builds on *A Guide to Implementing Getting it Right for Every Child: messages from pathfinders and learning partners*, published in June 2010.[8]

The guidance is presented in three main parts:

- **the universal journey** from conception to age 3, with specific guidance on supporting children, women and families at each stage of the journey;
- **guidance on approaches within the antenatal period to enhance the universal pathway**, using the *GIRFEC National Practice Model* to aid continuous assessment;
- **guidance on approaches to enhancing the universal pathway in the immediate postnatal period up to age 3**, again using the *GIRFEC National Practice Model* and sharing information around the well-being indicators to promote a consistent continuum of support.

5 From April 2011, part of Health Improvement Scotland
6 Scottish Government 2008
7 http://www.scotland.gov.uk/Topics/People/Young-People/childrensservices/girfec
8 http://www.scotland.gov.uk/Publications/2010/07/19145422/0

It sets out a series of questions and issues that professionals from all agencies may want to consider as they explore potential concerns with children and families at different stages of the universal pathway.

The guidance is supported by two practical tools:

- a poster, *The Universal Pathway – what everyone needs to know*[9]
- *The Healthcare Pathway*, part of the *Keeping Childbirth Natural and Dynamic* (KCND) pathways of maternity care.[10]

2.1 Using the guidance

Professional leadership is central to ensuring not only that the guidance is used effectively to direct practice, but also to ensuring that children and families can gain access to the services and care they need.

The Scottish Government seeks to promote a shift from professional intervention for children and families only when a crisis happens to a position where prevention and early intervention are the norm. It aims to build capacity in communities and among children and families to help them tackle their problems. Strong professional leadership across health and social care services will be central to the achievement of both these aspirations. The Social Work Inspection Agency report for 2005 to 2009,[11] for instance, indicated that:

- leadership is of critical importance in the performance of social work services
- the quality of leadership impacts on outcomes for people who use social work services
- leadership of social work has a direct impact on staff morale and confidence.

Managers and teams will therefore gain maximum benefit from the guidance when its implementation is supported by strong and effective leadership. It will also be most effective where there is an ethos of team working, where communication between team members is strong and where there is an understanding of, and respect for, the contribution of other practitioners and agencies.

Managers and their teams consequently need to give some consideration to the **culture**, **systems** and **practice** within their organisations before using the guidance.

9 In Press
10 In Press
11 http://www.scotland.gov.uk/Publications/2010/03/24113359/0

2.2 Culture, systems and practice

Culture refers to the complex system of beliefs, values and behaviours displayed by a particular set of individuals, a group or organisation. Embedding the GIRFEC approach requires all agencies to work to a common aim and clear purpose. Roles and responsibilities should be clearly defined to enable the implementation or enhancement of local pathways of support for children and families with additional needs.

In relation to **systems**, embedding the GIRFEC approach requires agencies to ensure seamless, needs-led service provision to be developed and delivered within and between agencies.

And on **practice**, the GIRFEC approach calls for agencies to adopt a person and family-centred approach. Support and provision of care should be sensitive and responsive to needs and values, prioritising the health, safety and well-being of children and families.

Positive changes in culture, systems and practice are achieved through implementing the GIRFEC principles.

2.3 Questions and issues

When using the guidance to support the design and development of local pathways, agencies may wish to consider the following questions, each of which reflects elements of culture, systems and practice.

2.3.1. Are we thinking about the whole child and family, their safety and well-being?

- What models of assessment do you use within your designated area to identify individual needs of children and families?
- Are you aware of the assessment model your colleagues and partner agencies use?
- Do you have an individual plan of support for every child and family from conception to 3 years to identify their needs?
- Do you have an identified individual to facilitate the coordination of this plan?
- Do you use an agreed integrated assessment framework and planning model with your partner agencies?
- Are there models of assessment to determine parenting capacity for all families within your area and are they shared with your partner agencies?
- Do you work with families to anticipate their needs and support them to manage their needs where appropriate to do so?
- Do you think your agency always provides services with the needs of children and families at the centre?

2.3.2 Are practitioners and agencies working together and is it clear who is doing what?

- Do your individual agencies have a **common aim, clarity of purpose and defined roles and responsibilities?**
- If yes, how do you share them with your partner agencies?
- If no, do you feel that it is important for you and your partner agencies to have a common aim, clarity of purpose and defined roles and responsibilities?
- If there are concerns in relation to a child's safety, is it clear who takes responsibility for coordinating support prior to child protection being confirmed?
- Are you clear about exactly what each practitioner's and agency's contribution would be in supporting children and families to achieve better outcomes?
- Where there are no additional needs identified, do you know the services within your own and partner agencies that may be used to support children and families?
- When children and families have multiple and complex additional needs that require support from a variety of practitioners and agencies, how do the services you provide integrate within and across agencies, including adult services, from a child and family perspective?
- Do you think it is easy for children and families within your area to understand how services are provided and how they join together?
- Does your agency have clearly defined processes for managing information sharing, confidentiality, consent and documentation?

2.3.3 What is essential for responding to need and improving outcomes?

Practitioners and agencies have traditionally used a range of service models to provide consistent and responsive care and to engage parents, children and families. In health, pathways have been used to improve access and put patients at the centre of services. In local authorities and voluntary agencies, referral guidelines and processes have been used as a means to access the most appropriate service for clients.

During the development phase for this guidance, practitioners and agencies indicated that national pathways would not be helpful, however, support for the implementation or enhancement of local pathways would be welcomed.

2.4 The design of an effective local pathway.

2.4.1 Child and family centred

The local pathway should:

- outline the journey children and families travel within universal or targeted service provision
- reflect the involvement of children and families in the process of accessing support
- demonstrate the decision-making process through a shared commitment to effective communication, common understanding of expectations and understanding of benefits, depending on the level of need that has been assessed and planned using the GIRFEC *National Practice Model*[12]
- identify the most appropriate named person/lead professional to coordinate support.

2.4.2 Outcome focused

The local pathway should:

- identify the outcome(s) to be achieved in the short and longer term
- define the indicators and steps for practitioners and agencies to take, in partnership with children and families, in the process of achieving outcomes.[13]

2.4.3 Clarity for agencies working together

The local pathway should:

- demonstrate the use of a common language and appropriate utilisation of knowledge, skills, expertise and evidence to support practitioners and agencies in achieving better outcomes for children and families
- provide clarity in determining which agency/individual practitioner is best placed to support children and families who do not voluntarily access mainstream services.

2.4.4 Communication

The local pathway should:

- articulate systems and processes to support and protect children and safeguard their well-being in line with legislation[14] and professional codes of conduct.

12 www.scotland.gov.uk/gettingitright
13 Scottish Government 2008
14 For example: UN Convention on the Rights of the Child (1989); Human Rights Act 1998; the Data Protection Act 1998

- demonstrate integrated service provision and shared responsibility for early identification of concerns, sharing relevant information in a timely and accurate way and identifying gaps in information so that a full picture of the child and family can be established to accurately reflect additional need.[15]

2.4.5 The named person and five key questions

The guidance builds on the GIRFEC *National Practice Model* by promoting access to services on a multidisciplinary and/or multi-agency basis for children and families, with support coordinated by the most appropriate *named person/lead professional.*[16]

Responsibility for assessing, promoting and monitoring the health of children aged 0–3 years traditionally falls within the remit of universal health services. Midwives assume the role of *named person* for the child from conception until transfer to public health nurses/health visitors, who then assume the role.

Once a concern has been brought to the attention of the *named person*, he or she is responsible to take action to provide help, or arrange for the right help to be provided, to promote the child's development and well-being. To respond proportionately, the *named person* will ask five key questions.

- **What is getting in the way of this child or young person's well-being?**
- **Do I have all the information I need to help this child or young person?**
- **What can I do now to help this child or young person?**
- **What can my agency do to help this child or young person?**
- **What additional help, if any, may be needed from others?**

These key questions should be asked by **any professional** when faced with a concern regarding a child's health or well-being.

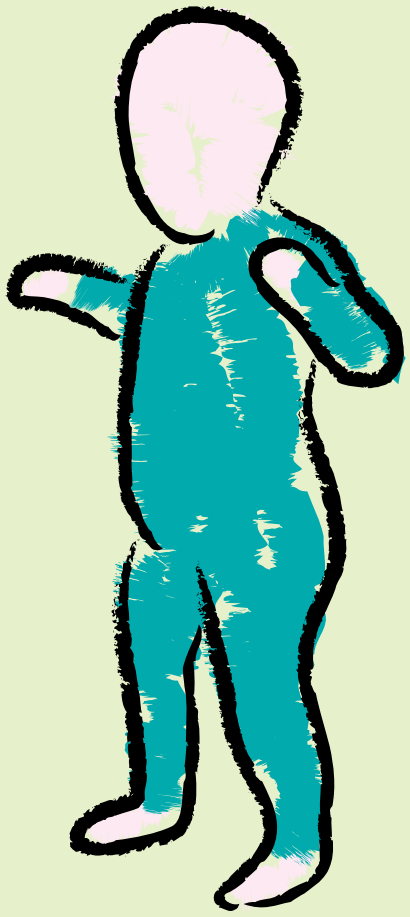
2.4.6 Development of the Child's Plan[17]

In a single agency plan, it may be enough to construct a plan from assessing concerns about a child's well-being, keeping in mind the whole of a child's world from the *My World Triangle*.

Where there is a multi-agency plan, it is likely that this will have involved the gathering of more complex information, using the *My World Triangle* and incorporating any specialist assessments from different professionals and agencies.

15 GIRFEC National Guidance
16 GIRFEC Practice briefing 1: the role of the named person
17 GIRFEC Practice briefing 6: the Child's Plan – one child, one plan

3. Universal journey for all children in Scotland

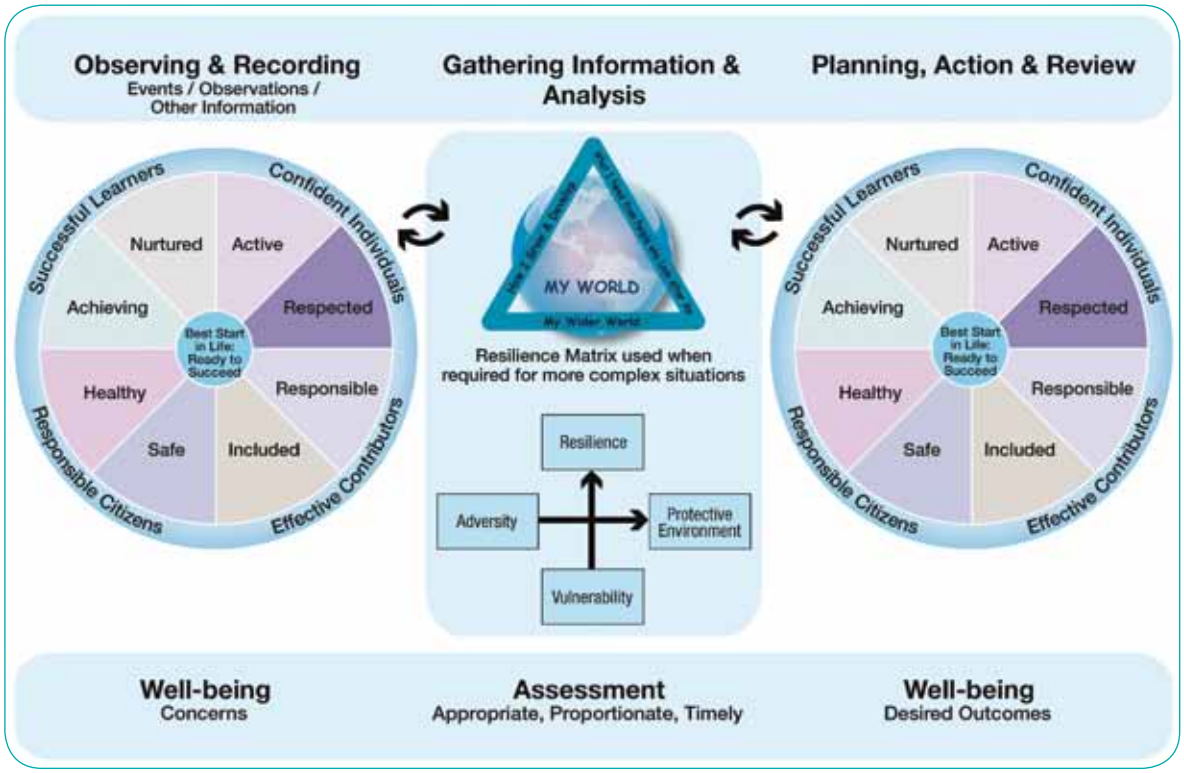


3.1 The universal journey

The universal journey defines the aspiration for all women, children and families in Scotland to access safe, effective and person and family-centred care and services. The aspiration of professionals is to support them through that journey, tailoring the intensity of support to meet need.

The universal journey is supported by the *GIRFEC National Practice Model* (Figure 1), *Pathways for Maternity Care – Keeping Childbirth Natural and Dynamic (KCND)*, *Health for all Children (Hall 4)* and the *Personal Child Health Record*.

Figure 1. *GIRFEC* National Practice Model



3.2 Universal pathway of core contacts

The universal pathway of core contacts has been included in this guidance at the request of practitioners and agencies. It provides a visual representation of how all children and families can expect to receive equitable support from health services.

Table 1. Universal Pathway pre-conception to 3

Time	Interaction
Pre-conception	
Up to 12 months before conception	There is currently no universal approach to managing pre-conceptual health. However, *Improving Maternal and Infant Nutrition – a Framework for Action*[18] and *A Refreshed Framework for Maternity Care in Scotland*[19] highlight areas of concern that can contribute to poor health outcomes for mother and baby, such as poor nutrition and obesity.
Antenatal – unborn baby	
First point of contact	• Sensitive enquiry as to whether or not the woman is accessing any other services such as substance misuse, social work and psychiatric services, and any history of domestic violence. • Information provided, scheduling of screening tests[20] and contacts, parent education sessions, locally available services to support pregnancy, birth and postnatal care and specialist services to support healthy lifestyle choices. • Families who wish termination of pregnancy are offered appropriate information and counselling.
10-13 weeks	• Maternity record updated (Scottish Women-Held Maternity Record (SWHMR)). • Care is planned with named midwife to meet identified needs. • Information given: *Ready Steady Baby*.[21] • The named midwife undertakes to support the maternal and family journey throughout the antenatal period using guidance from the KCND *Pathways for Maternity Care*.[22]

18 Improving Maternal and Infant Nutrition 2011
19 A Refreshed Framework for Maternity Care in Scotland 2011
20 PregnancyAndNewbornTimeline.pdf
21 Ready, Steady, Baby
22 Pathways for Maternity Care
23 A new look at Hall 4 – The Early Years 2011

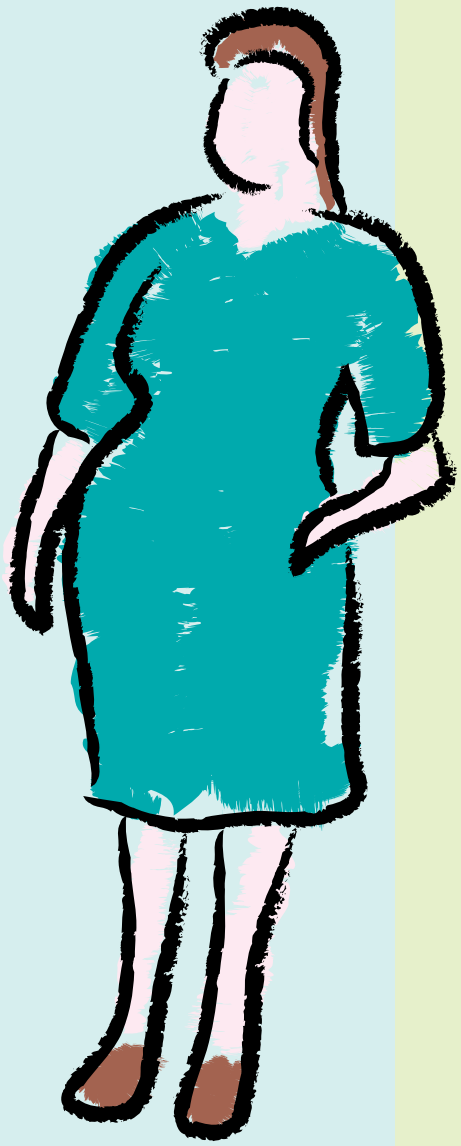
Time	Interaction
15-16 weeks	• Maternity record updated, refreshed and needs are recorded. • Consider engaging with the public health nurse/health visitor, family and other key professionals to allocate the Health Plan Indicator (HPI) antenatally.[23]
18-21 weeks	• Fetal anomaly scan.
22-41 weeks	• Maternity record is refreshed and needs are recorded. • Screening tests for height of uterus, blood pressure and urinalysis, oedema, fetal heartbeat, fetal movement and emotional well-being discussed and documented.
BIRTH	
Within first 24 hours	• Maternity record is refreshed and identified needs are recorded to reflect needs of parent and baby using guidance from *Pathways for Maternity Care* in relation to physical/mental health and well-being, including emotional attachment. • Infant feeding support is initiated and information on general care of baby is discussed. • Full neonatal examination is performed within 72 hours. • Within three days, screening tests of mother's mental health and well-being, blood pressure, temperature, respiratory rate, bladder and bowel function, perineum and pelvic examination/exercise are performed. • If appropriate, anti-D and any relevant blood tests are performed.
Around 10-14 days (within 28 days)	• The antenatal assessment and care plan, alongside what antenatal pathway of support has been followed, is discussed between the named midwife and the named public health nurse/health visitor. The first visit (notification visit) is conducted by the public health nurse/health visitor, assessment of child and family circumstances is refreshed and the care plan updated. • Information is provided on registration of the child with a GP, general child health surveillance and immunisation programmes and locally available services. • The personal child health record[24] is given to the family, if it has not already been issued. • The child is weighed. • Newborn hearing screening test is performed.

24 The Red Book

Time	Interaction
6-8 weeks after birth	• The public health nurse/health visitor record is refreshed and care plan updated. • The first physical health and development check, including weight for child, is performed. • The Edinburgh Postnatal Depression Score for maternal mental well-being is calculated.
3, 4, 12 and 13 months	• "Childsmile" dental assessment is conducted. • Weight check and immunisation performed. • The Health Plan indicator (HPI)[25] is allocated by the public health nurse/health visitor.
24-30 months	The 24–30 month review should cover the following as a minimum and may need to be expanded, depending on child and family circumstances and professional concerns:[26] • speech, language and communication • personal, social and emotional development (including behavioural issues) • nutrition, growth and weight • immunisations • parental concerns and issues • vision, hearing and oral health • physical activity and play.

25 A new look at Hall 4 – The Early Years 2011
26 Ibid.

4. Guidance on approaches from the antenatal period to age 3



4. Guidance on approaches from the antenatal period to age 3

This section of the guidance presents the enhanced universal pathway from the antenatal phase to age 3, with suggestions for possible interactions at each core contact to support women, children and families where there is a concern about the child's well-being.

It should be emphasised that **these are not the only points where service providers will meet with the child or family**, and local pathways should reflect flexible contact points in addition to these core contacts.

4.1 Guidance on approaches within the antenatal period to enhance the universal pathway

This is about equipping and supporting professionals to think about the kinds of issues that are important to women, children and families throughout their universal journey. The guidance presents prompts that will enable professionals to identify where women, children or families are at higher risk of poor outcomes. Professional judgement should then be used to decide how any needs can be met, working with the family and engaging other professionals as appropriate.

The antenatal period is a critical time to engage with women and their families to identify additional needs and to support them to achieve the best possible outcomes for their child and family.

Pregnant women with complex social factors may need additional support. Examples of high-risk groups are:[27]

- women misusing substances (drugs and/or alcohol)
- women experiencing domestic abuse
- women under 20 years old
- women who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English.

Using the *GIRFEC National Practice Model* (see Figure 1, page 13) and placing the child at the centre of the assessment allows practitioners to consider their role in working with and supporting the family, whether through observation, practical support or involving other agencies as appropriate. The model focuses on key elements during the journey through consideration of the eight well-being indicators:

- safe
- healthy
- achieving

27 NICE (2010): Pregnancy and Complex Social Factors

- nurtured
- active
- respected
- responsible
- included.

As Scottish Woman-Held Maternity Record (SWHMR) is the national record for assessment used in maternity services, examples of strengths and needs have been mapped against the well-being indicators to show how the GIRFEC approach is reflected in the record.

Note that the examples are just that – **examples** that have been provided to support professionals to think about the kinds of issues they may want to address. Professionals and teams will also have to consider a wider range of issues, depending on individual needs.

4.1.2 Examples of questions to raise within SWHMR

Safe

Strengths/resources	Needs/worries
• Mother/family has stable relationships • Mother/family has good support network • Mother/family has suitable housing • Recognition and understanding of risks to the child • No concerns regarding previous children	• Abuse or neglect of previous children • Previous children removed/on child protection register • Poor impulse control • Mother/family experienced abuse in childhood • Domestic violence • Drug or alcohol misuse • Homeless and/or poor housing

Examples of questions to raise within SWHMR

When is your baby due?

- **How sure are you of this date?**

Is this a planned pregnancy? Be respectful of the decision the woman has made in ensuring the progression of a safe and healthy pregnancy.

Your previous pregnancy

- **Is your current pregnancy with a new partner?**

Consider the safety and well-being of other siblings as this may impact on the unborn baby. Are you aware of any child protection concerns?

Healthy

Strengths/resources	Needs/worries
• Mother keeps antenatal appointments • Mother develops and sustains good working relationship with professionals • Good self-care skills • Expresses an awareness of the unborn baby's needs and a desire for the baby • Ability to prioritise the baby's needs • Mother/family has good support network	• Drug/alcohol misuse • Domestic violence • Mental ill health • History of postnatal depression • Poor engagement with professionals • Learning disability • Very young parent/immature • Stressful relationships • Limited support • Unwanted/concealed pregnancy

Examples of questions to raise within SWHMR

Mother's health

The woman can make a significant difference to the unborn baby's/child's health by giving them the best start in life through, for instance, having adequate nourishment, sleep and physical activity.

Other health-related questions

- **Do you go to the dentist regularly?**

Consider referring the women to a dentist as part of the "Childsmile" programme if appropriate.

- **How many units of alcohol a week are you drinking now?**

Consider the impact of **all** substance misuse on the unborn baby, as well as the health and safety of the woman.

- **Current smokers: cigarettes smoked per day**

Consider the targets to reduce smoking and the programmes of local support available.

- **Substances used**

Is the well-being of the woman and unborn baby/child being compromised due to substance misuse? There is a need for skilled and sensitive enquiry to elicit information and to establish the additional support needed from other practitioner and partner agencies as appropriate.

- **Medication**

Is the woman compliant with prescribed medication and getting any additional help with problems?

Achieving

Strengths/resources	Needs/worries
• Mother demonstrates understanding of the developmental needs of a baby • Good early childhood experiences • Positive experience of professional relationships	• Lack of awareness of baby's needs • Unrealistic expectations • Poor physical and/or mental health • Learning disability • Poor experience of professional relationships

Examples of questions to raise within SWHMR

Information for mother

The named person (midwife) will be establishing the relationship with the pregnant woman and should support understanding of the desired outcomes and their shared responsibility to work with practitioners to make this happen.

Plan of care for pregnancy

The plan for care should be documented following the assessment undertaken using the pregnancy record. The pathways for maternity care (green/amber/red) will support the identification of the Health Plan Indicator appropriate for the unborn baby/child and family as part of the continuum of support.

Postnatal record

- **Problems identified during pregnancy, labour/birth**
- **Problems in the postnatal period/referrals, investigations or results pending**

Transition from antenatal to early years care will require that the assessment and plan for the unborn baby needs to be refreshed by the named person when the baby is born.

- **Postnatal care**

Transfer of the relationship-based care from, and to, a named person/lead professional as appropriate will need to be managed sensitively to achieve the best outcome for the child and family.

- **Feeling confident with the baby**

The support a child and family needs to achieve the desired outcomes can be developed through the well-being indicators of safe, healthy, achieving, nurtured, active, respected, responsible and included.

Examples of questions to raise within SWHMR *continued*

- **Formula feeding the baby**

Sensitivities around supporting informed decision-making to bottle feed may impact on the mother's bonding with the baby and create potential concerns regarding mental health issues and attachment as a result of feelings of failure/rejection. This will inform assessment and planning to support early intervention and prevention of problems.

- **Thinking about the pregnancy, labour and birth**

Sensitive enquiry should be considered to elicit health and social care needs which may affect the woman's decision to have another pregnancy or come to terms with the current pregnancy.

Nurtured

Strengths/resources	Needs/worries
• Positive childhood experiences • Stable relationships developed and maintained • Mother shows maturity • Mother/family has good support network • Empathy and the ability to keep the unborn child in mind • Safe and secure family environment • Expectant mother happy about pregnancy	• Conflict and hostility in the family environment • Very young parent/immature • Poor relationship history • Poor physical and/or mental health • Lack of social supports • Inability to focus on the needs of the unborn child

Examples of questions to raise within SWHMR

Questions or concerns

Consider the impact on the child's health and development as a result of:

- living in a poor physical environment
- family tensions
- social and family networks.

Active

Strengths/resources	Needs/worries
• Keeping active during pregnancy • Taking advantage of local activities • Prepared for the baby's arrival • Attending antenatal education classes	• Social isolation • Physical or mental health problems that inhibit social activity • Inability to prepare for the baby's arrival

Examples of questions to raise within SWHMR

Breastfeeding the baby

- Raise topic of breastfeeding.
- Consider local community planning initiatives in relation to infant nutrition/healthy start food cooperatives and peer support groups to support ongoing breastfeeding.

Respected

Strengths/resources	Needs/worries
• Good self esteem • Positive relationships • Involved in decision-making • Makes positive choices	• Poor self care • Poor self esteem • Poor relationship history • Domestic violence

Examples of questions to raise within SWHMR

Postnatal record

Mother's progress

Ensure that needs are systematically assessed universally for all children and, for a small proportion of children with additional needs, on a multi-agency and/or multidisciplinary basis.

Mother's health after the birth

Managing transitions from the woman and unborn baby being at the centre to the child and family being at the centre by ensuring that the woman does not feel excluded and remains central to the well-being of the child.

Responsible

Strengths/resources	Needs/worries
• Able to make positive choices in pregnancy • Keeps all appointments and is proactive in self care • Acknowledges concerns • Able to prioritise the well-being of the unborn child • Able to budget – good practical skills	• Chaotic lifestyle • Unable to focus on, or prepare for, the baby • Poor antenatal care • Prioritising own and partner's wants above well-being of baby • History of offending

Examples of questions to raise within SWHMR

Mother's age

If the mother is a young woman, consider if she is actively playing a responsible part at home and in school. Is she a confident individual?

Postnatal care

Consider the transition from named person (midwife) to named person (public health nurse/health visitor). What aspects of well-being do you need to consider. How will the transfer of the relationship-based care to another practitioner impact on the woman? What process will you use if there are additional needs and a lead professional is responsible for coordinating the care?

Included

Strengths/resources	Needs/worries
• Good support from family and/or friends • Makes use of community resources	• Socially isolated family • Mother/family has poor social supports • Negative childhood experiences by mother/family • Housing and financial problems being experienced by the mother/family

Examples of questions to raise within SWHMR

Mother's partner/supporter for this pregnancy

Have all contact details for any health or social care agency the woman is in contact with been gathered? Sensitive enquiry to elicit wider health and social care needs.

Ethnic origin

Is the woman and her family accepted into the community without prejudice or tension and included in local supports and resources?

Referral needed

Consider if anyone else is involved with the care of the pregnant woman. Care and intervention may be required from other practitioners and agencies to determine the extent of the additional needs.

Additional needs identified here may require discussion with practitioners and partner agencies. An integrated assessment and core planning meeting may need to be called. Are you confident that you understand how this happens?

4.2 Guidance on approaches to enhancing the universal pathway in the immediate postnatal period up to age 3

The well-being of children and young people and their "well becoming" are at the heart of *Getting it Right for Every Child*. The eight indicators of well-being (safe, healthy, achieving, nurtured, active, respected, responsible and included) are the basic requirements for all children and young people to grow, develop and reach their full potential. Children and young people will progress differently depending on their circumstances, but every child and young person has the right to expect appropriate support from adults to allow them to develop as fully as possible across each of the well-being indicators.

Family circumstances may change over time. The additional needs that arose in the antenatal period will impact differently in the immediate postnatal period and beyond.

Families with additional needs may be able to manage their circumstances with little or no intervention from universal or specialist services. However, continuous assessment of need, at every contact, will enable the right level of support, in agreement with the family and other professionals, to be given at the earliest opportunity.

Examples of families at higher risk of poor outcomes include:

- first-time young mothers
- parents misusing substances
- those experiencing domestic abuse
- those with emotional or mental well-being issues
- parent or child with disabilities.

4.3 Protective and risk factors[28]

Protective factors are behaviours or characteristics for which there is research evidence that shows they make a difference in outcomes for children with complex or multiple needs. In addition to generic social and psychological indicators, there are specific risk and protective factors for particular outcomes.

4.3.1 Protective factors

Include:

- authoritative parenting combined with warmth, with an affectionate bond of attachment being built between the child and the primary caregiver from infancy
- parental involvement in learning

28 Healthy Child Programme, DH (2008)

- protective health behaviours, such as smoking cessation in pregnancy
- breastfeeding
- psychological resources, including self esteem.

The parent/carer may show evidence of understanding and appropriate action in some areas. These should be considered strengths and a measure of where to start building parental capacity, rather than focusing on areas that are not being met.

4.3.2 Risk factors

Include:

- an underlying medical or developmental disorder and temperamental characteristics, some of which may be genetic
- low birth weight and prematurity
- obesity in parents (a child is at greater risk of becoming obese if one or both of the parents is obese)
- poor attachment and cold, critical or inconsistent care (this can result in emotional and behavioural problems)
- smoking in pregnancy (this has multiple short and long-term adverse effects on both the foetus and child, and can be a wider indicator of a pregnant woman's self esteem)
- smoking by partners (this also has both a direct and indirect impact on children and is the most powerful influence on the mother's smoking habit).

Some of the indicators listed above are more difficult to identify than others. Health professionals need to be skilled at establishing a trusting relationship with families to enable them to build a holistic view.

4.4 What questions to ask

Within the *National Practice Model*, the "My World Triangle" questions should prompt users about key areas to focus on, following identification of a need. Probing questions on areas that impact on "How I grow and develop" and that relate to "What I need from people who look after me" and "My wider world" are found within the GIRFEC guidance.[29]

Table 2 provides examples of families who may need additional support. The list is not exhaustive, but can be used as a guide to considering what the population-level needs might be within your local area.[30]

29 A Guide to Getting it Right for Every Child (2008)
30 Child and Young People Wellbeing indicators SCOTPHO

Table 2. Universal pathway (enhanced) – birth up to age 3

Example of family need*		Evidence of strength/asset in[31] relation to (or knowledge of):
Birth to around 10 days	• First-time parents • Mother recovering from a difficult delivery • New babies up to eight weeks • All children in neonatal unit until completion of SOGS assessment • Breastfeeding mothers depending on need	• Pram and cot safety • Sleeping pattern, bed sharing, position, temperature • Feeding preparation safety • SIDS (sudden infant death syndrome) • Animal safety • Carer's routine/lifestyle
Around 10–28 days (handover from midwife to public health nurse/ health visitor)	• Families new to area • Children whose main carer is isolated, unsupported partner • Previous history of child bereavement • Serious illness of parent/child • Children isolated from services due to geography, resources or parenting capacity • Children recently removed from child protection register	• Skin care – bathed and nappy changed regularly • Smoke-free home • Parent/carer expresses love and emotional warmth towards the baby • Parent/carer seeks appropriate help and advice if experiencing difficulties managing baby • Parent/carer calm and consistent when dealing with baby's distress

* Examples of HPI additional categories from a number of NHS Boards
31 Getting it right for every child in Lanarkshire

Example of family need*		Evidence of strength/asset in[31] relation to (or knowledge of):
From handover – 6 months	• Parents with complex needs • Significant life events, such as bereavement or homelessness • Children with disabilities, including communication disorders • Children with complex care needs, chronic ill health or terminal illness • Chronology frequent no access	• Baby is calm and comfortable with parent/carer • Siblings show obvious love and affection towards the baby • Physical needs of baby attended to by parent/carer • Appropriate play (singing, talking, reading, floor play etc.) • Parent/carer may attend local groups • Taken out to visit family/ friends/shops/local community • A limited number of safe adults deliver intimate care • Feeding appropriate for age and stage • Appropriate sleeping pattern

* Examples of HPI additional categories from a number of NHS Boards

Example of family need*		Evidence of strength/asset in[31] relation to (or knowledge of):
6 months to 1 year	• Children with emotional, behavioural, developmental or mental health issues • Families with literacy issues • Children whose development may be affected by a succession of carers • Specific behavioural problems such as sleep difficulties • Children in families where there is poor hygiene • Children subject to supervision requirement • Chronology indicating high mobility • Chronology failed health appointments	• Appropriate home safety precautions • Infant is normally well • Developmental milestones reached • Appropriate use of language and tone of voice (by parent/ carer) • Taking cues and responding appropriately • Support from family and friends • Gross motor skills age appropriate • Vision and fine motor skills age appropriate • Development of secure attachment • Child understands simple commands

* Examples of HPI additional categories from a number of NHS Boards

Example of family need*		Evidence of strength/asset in[31] relation to (or knowledge of):
1 year to 3 years	• Obesity and/or other weight issues (with parent/carer and/or child) • Children experiencing a crisis likely to result in a breakdown of care arrangements • Parents who self refer for additional support • Looked after and looked after and accommodated children • Young carers in the family unit • Children involved in contact/residence disputes • Failure to thrive/developmental delay • Children on child protection register	• Parent/carer ensures child has plenty of opportunity and encouragement to develop motor skills • Appropriate modelling of behaviour • Child expects to be liked by parents/carers • Child is outgoing, smiles and "talks" – responds appropriately to parents/carers • Child's sense of self begins to develop • Child explores their environment with parent/carer in close proximity • Child has a range of safe toys to play with • Accidental injuries appropriately dealt with by parent/carer • Parent/carer responds appropriately to any symptoms of illness • Infant has age-appropriate diet

* Examples of HPI additional categories from a number of NHS Boards

5. Developing skills and capacities within the workforce

5. Developing skills and capacities within the workforce

The person coordinating support needs to have relevant training, supervision and an overall picture of family needs. He or she also needs to have information on all services that are available to provide appropriate support. He or she will be accountable for coordinating the plan of support for the child.

Taking a strengths-based approach is key to developing parenting capacity and allowing families to find the best way to help their children grow and develop.

Engaging clients with support services and interventions is recognised as a key factor in ensuring their success in resolving problems and achieving positive change in the lives of families. The most effective approaches and methodologies are more likely to achieve their potential when parents are partners in the endeavour rather than being coerced. The overwhelming consensus is that power issues, meaningful opportunities to participate in, and challenge, decision-making and planning, to understand processes, "readiness to change" and worker style are crucial to effective engagement and the promotion of the role of parents as the real experts in their child's development.

Practice-related factors include the inherent power imbalance between client and worker, inadequate assessment of need, practitioner attitude and the pervasive gendered assumptions influencing both service development and practice.[32]

32 Support and Services for Parents: A review of the literature engaging parents 2007)

Acknowledgements

6. Acknowledgements

6.1 Steering group

The steering group and working groups, led by the NHS Quality Improvement Scotland project team, have provided great support and driven the work for this guidance.

More information on how this piece of work was developed and who sat on the steering group can be found at: **http://www.vulnerablefamilies.org/Default.aspx**

6.2 Useful websites

Maternal and Early Years (0-8)

This website is for everyone working in the early years workforce in Scotland. It covers a wide breadth of information relevant to practitioners at all levels and brings together a wealth of up-to-date information and support.

Access at: http://www.maternal-and-early-years.org.uk/

Early Years Information Pathway

The Early Years Information Pathway covers pre-conception, pregnancy, infancy, toddler, and the pre-school period up to the age of five. It provides information from a national and local perspective and signposts health professionals to related services and resources to support parents and carers.

Access at: http://www.healthscotland.com/documents/3708.aspx

Learning and Teaching Scotland – Early Years

The Early Years area of the Learning and Teaching Scotland website specifically aims to support quality early years provision by providing examples from practice, points for reflection and information to support and stimulate those involved in the care and education of Scotland's youngest children.

Access at: http://www.ltscotland.org.uk/earlyyears/index.asp

6.3 References

1 Early Years Framework; Scottish Government 2008 http://www.scotland.gov.uk/Publications/2009/01/13095148/10

2 Information Services Division, 2006

3 National Guidance for Child Protection in Scotland 2010: http://www.scotland.gov.uk/Publications/2010/12/09134441/20

4 http://www.scotland.gov.uk/Publications/2010/05/10102307/0 – The Healthcare Quality Strategy for NHSScotland, 2010

5 From April 2011, part of Health Improvement Scotland

6 As note 1

7 Getting it right for every child (GIRFEC): http://www.scotland.gov.uk/Topics/People/Young-People/childrensservices/girfec

8 GIRFEC: messages from pathfinders and learning partners: http://www.scotland.gov.uk/Publications/2010/07/19145422/0

6. Acknowledgements

[9] The Universal Pathway – What everyone needs to know (core contacts for women, children and families 0-3) – In press

[10] The Healthcare Pathway – In press

[11] Improving Social Work in Scotland: A report on SWIA's Performance Inspection Programme 2005-2009: http://www.scotland.gov.uk/Publications/2010/03/24113359/0

[12] Getting it right for every child, National Practice model

[13] As note 1

[14] For example: UN Convention on the Rights of the Child (1989); Human Rights Act 1998; the Data Protection Act 1998.

[15] GIRFEC National Guidance

[16] GIRFEC: Practice briefing 1 (2010): the role of the named person http://www.scotland.gov.uk/Topics/People/Young-People/childrensservices/girfec/publications/practicebriefings

[17] GIRFEC: Practice briefing 6 (2010): The Child's Plan – one child, one plan

[18] Improving Maternal and Infant Nutrition, 2011: http://www.scotland.gov.uk/Publications/2011/01/13095228/0

[19] A Refreshed Framework for Maternity Care in Scotland 2011, http://www.scotland.gov.uk/Publications/2011/02/11122123/0

[20] Pregnancy and newborn screening timeline, NHSScotland: see http://www.healthscotland.com/uploads/documents/12614-PregnancyAndNewbornTimeline.pdf for further information

[21] Ready Steady Baby, NHSScotland http://www.readysteadybaby.org.uk/

[22] Pathways for Maternity Care, NHS QIS, http://www.nhshealthquality.org/nhsqis/5989.html

[23] A New Look at Hall 4 – The Early Years – 2011 http://www.scotland.gov.uk/Publications/2011/01/11133654/0

[24] The Personal Child Health Record (Red Book) 2010 http://shop.healthforallchildren.co.uk/pro.epl?SHOP=HFAC4&DO=USERPAGE&PAGE=DEC09

[25] As note 23

[26] Ibid.

[27] NICE (2010): Pregnancy and complex social factors. London: NICE http://guidance.nice.org.uk/CG110/Guidance

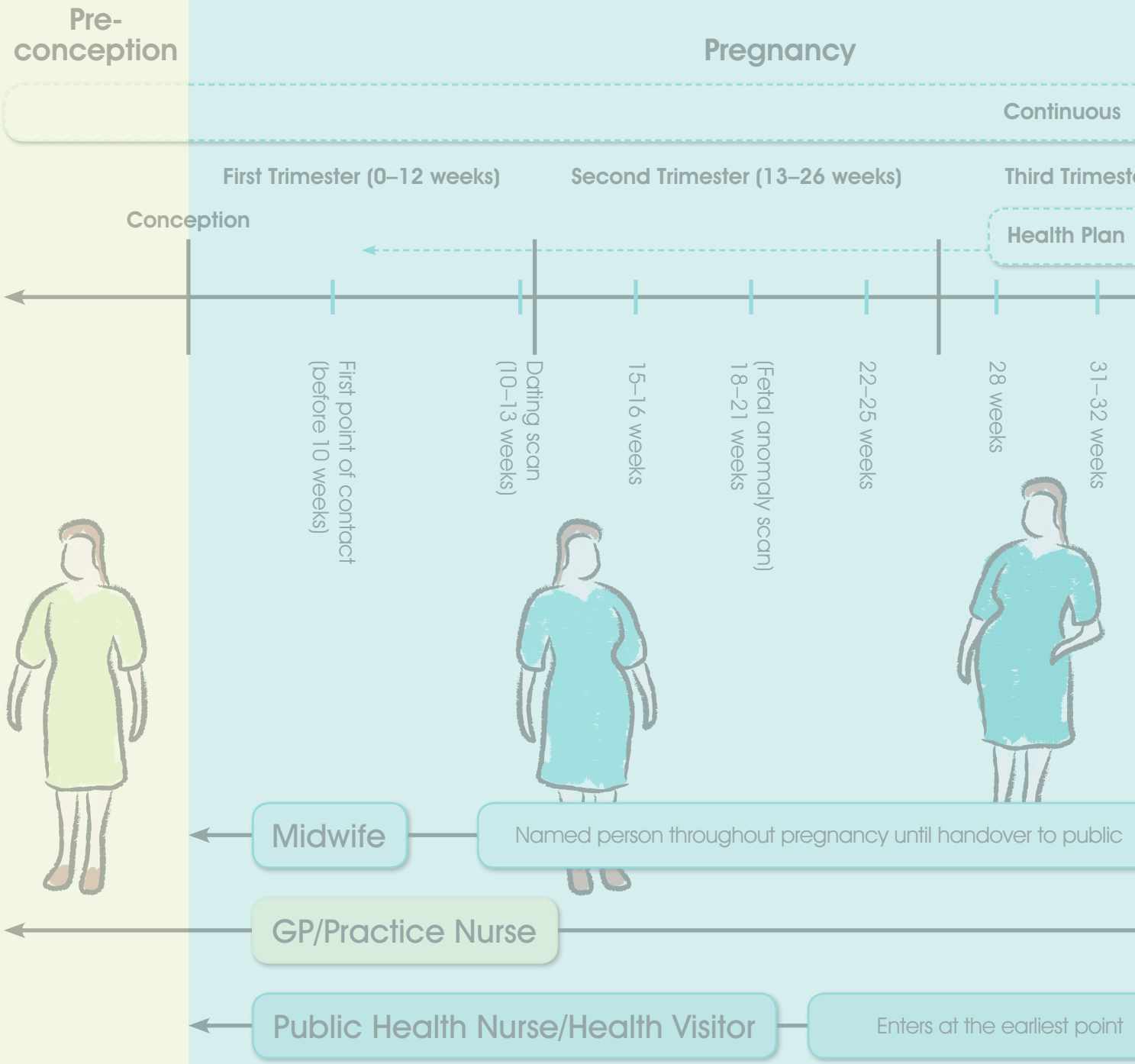
[28] Healthy Child Programme, DOH 2008 http://www.education.gov.uk/publications/standard/EarlyYearseducationandchildcare/Page5/DH-286448

[29] A Guide to Getting it right for every child http://www.scotland.gov.uk/Publications/2008/09/22091734/0/Q/ViewArchived/On

[30] Reference to Child and Young People Wellbeing indicators SCOTPHO http://www.scotpho.org.uk/home/Comparativehealth/Profiles/2010CHPProfiles.asp

[31] Based on Getting it right for every child in Lanarkshire

[32] Support and Services for Parents: A review of the literature engaging parents 2007) http://www.scotland.gov.uk/Publications/2008/04/07085557/0



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