Midwifery / Health Visitor & FNP Ante-natal - Early Intervention/Help Pathway Guidance

This pathway has been developed for health visiting teams and individual Health Visitors who are employees of South Tyneside NHS Foundation Trust (STFT). The aim is to clarify Health Visitor’s response to receiving Antenatal Vulnerability Assessments completed by the Midwifery Service and to ensure communication pathways are established and effective.

The objective of this guidance is to ensure that Health Visitors / FNP are aware of their roles and responsibilities in relation to antenatal vulnerable women, and their unborn child. Receipt of this information will provide the Health Visitor / FNP the opportunity to appropriately manage vulnerabilities they are being made aware of; and ensuring early intervention is provided to women and families where required. This guidance should be used in conjunction with the Department of Health guidance “Enhancing the care pathway: Strengthening the health visiting and midwifery partnership contribution to maternity care” 2012.

The rationale for these guidelines results from:

- A recommendation from a South Tyneside Serious Case Review 2014 (Child X)
- Department of Health guidance (2012)

Following the women being seen by the Midwife at her booking-in appointment the Health Visiting teams will receive the Antenatal Notification.

(The Midwifery service will notify the family nurse partnership (FNP) of all clients under 20 years with their first pregnancy).

The Ante-natal notification is required to record the health and social care needs assessment undertaken by the Midwife. The Antenatal Notification information and additional communication between the Midwife and Health Visitor / FNP will support the timeliness for the Health Visitor to become involved with the family. The following steps should be followed:

- It is envisaged that on completion of the ante-natal assessment by the Midwife the Antenatal Notification will be sent to the Health Visiting Teams. For all 1st time mothers under 20 years – the notification must go to the FNP Service. For those clients, under the age of 20 years who are booking with a subsequent pregnancy, an Early Help (Referral to Children’s Centre) is form forwarded to the Children’s Centre, with consent. A copy will be shared by the Midwife with the women’s named GP.

  Early Intervention – any pregnant woman is eligible for Children’s Centre notification
  The midwife must gain consent from the client at booking for notification to Children’s Centre. Children’s Centre will contact the client to introduce them to the services available.
If specific support is required by clients’ Midwifery Services and the Children’s Centre should work in partnership and a joint home visit considered agreeing support required by clients. Children Centre worker will liaise with referrer to discuss client specific information regarding the uptake and engagement of clients.

1. On receipt of the Antenatal Notification by the Health Visiting team the information will be entered onto the antenatal database. The allocation Health Visitor will review sign and date all Antenatal Notifications. The review would include consideration of any past history and vulnerability information held by the Health Visitor, which should be shared with the midwife. The allocation Health Visitor will then ensure that each woman is allocated to a Named Health Visitor whose name will be recorded appropriately on the antenatal database.

2. The Named Health Visitor details will be sent to the midwifery service by the allocation Health Visitor/administrator support. A list taken from the antenatal database will be sent to the: -
   - Identified Midwifery Team / Named Midwife

3. The Named Family Nurse details will be sent to the midwifery service by the allocation FNP administrative support. The list taken will be sent to the: -
   a. Identified Midwife / Named Midwife

4. In the event of any changes of allocated Midwife/Health Visitor/Family Nurse this information will be appropriately communicated to the appropriate practitioner. Significant changes will result in prompt sharing of information by the midwifery service; updating of the antenatal assessment should be considered by the Midwife where the woman has a new partners or risk to the family have been identified.

5. All Antenatal Notifications forms which identify vulnerabilities will result in Individual Child Health Records being established. All communications and contacts with the women, Midwife and other practitioners must be recorded. Women who have been identified as vulnerable should routinely be discussed during supervision with the safeguarding nurse advisor.

6. For women who are identified as vulnerable the Midwife and Health Visitor/Family Nurse should work collaboratively to enable effective early intervention which may result in the Health Visitor having contact prior to the recognised core service antenatal visit between 28 - 32 weeks. The Family Nurse has a structured programme which will be followed.

7. Early Help / Children Centre will work proactively to target and engage clients not allocated to FNP. If Early Help is not accepted and professionals have concerns the Generic Health Visitor must be informed to enable a visit prior to the routine 28-32 weeks ante-natal visit (this could be a joint visit with the Midwife).

8. The Midwife and Health Visitor/Family Nurse will ensure that by 32-36 weeks there is an individualised care plan (birth plan) in place for all women; which has been shared with the woman and other relevant parties e.g. GP’s (NICE 2006). This will be achieved by the Midwife recording the care plan in the hand - held
maternity record which is retained by the woman. For those women who have been identified as vulnerable the Health Visitor will undertake an antenatal home visit prior to the expected date of delivery, usually between 28 – 32 weeks if contact has not already been established. The care plan (birth plan) and necessary support should be discussed by the Health Visitor during the antenatal visit. A record of this will be documented in the *Individual Child Health Records*, i.e. routine care plan.

9. Unborn babies who are subject to a child protection plan or those where there are multi-agency meetings (Child in Need/Early Help) will have an agreed birth plan/arrangements, which will have been developed prior to the birth of the unborn baby as per local LSBC procedures. It is the responsibility of Children’s Services and the Midwife to ensure that this has been appropriately shared prior to the expected date of delivery e.g. with the woman, Health Visitor/Family Nurse and GP. The Health Visitor/Family Nurse must ensure they have a copy of the birth plan/arrangements prior to expected date of delivery.

10. Where a woman has been identified as vulnerable the proposed care plan (birth plan) should clearly be discussed with the woman by both the Midwife and Health Visitor/Family Nurse and appropriately documented in their corresponding records.

11. The Midwife will ensure that they promptly notify the Health Visitor/Family Nurse and other relevant professionals of any significant issues and of the birth details.

12. Up to 14 days post-natal all women as indicated through the Antenatal Vulnerability Assessment will have a written or verbal handover from the Midwife to the Health Visitor/Family Nurse. Written notification will be achieved by the Midwife completing the Midwifery discharge documentation held within the Parent Held Record. Where there are complex vulnerabilities the Midwife and Health Visitor/Family Nurse will have either a verbal or face to face handover.

Link with Board Priorities: Data of client engagement and outcomes is held with the Children’s centre Lead. This data can be made available to the Early Help Board and LSCB Board.

**If at any time there are safeguarding concerns which meet the Threshold for CP referral, early CP referral must be made.**

Tel: 0191 424 5010 (office hours) 0191 456 2093 (out of hours)

LSCB CP Procedures / referral form
http://www.stscb.org.uk/documents.asp