Public Health England

Department of Health

Health Visiting Programme: Pathway to support professional practice and deliver new service offer:

Health visiting and midwifery partnership – pregnancy and early weeks

About this pathway

Parents want joined up services with consistent professional advice throughout pregnancy and the early weeks of life. Commissioners are increasingly seeking to integrate services to provide joined up care and improved health outcomes at best value. Midwives and health visitors working together can enable improved parent experience of services and contribute to improved health outcomes and reduction of child health inequalities.

Recent evidence on pregnancy and infancy on a baby's neural development and the impact this has throughput childhood and into adult life shows the important of effective preventative services and those which promote and support positive mental health and early attachment. Midwives and health visitors working together to deliver universal services and 'early intervention' for women and families needing more help will make a difference to individual life chances which also translates into wider economic benefits.

This pathway is guidance to support midwives and health visitors to build on existing joint work and to provide an outline for commissioners on maximising the roles of midwives and health visitors in pregnancy and the first days of life using best evidence on giving all children the best start. It builds on existing policy and guidance set out in the Healthy Child Programme (the national public health programme for children and families), NICE guidance, Professional Bodies standards and 6 High impact Areas for health visiting services for children aged 0-5 years.

It describes the rationale for the health visiting and midwifery partnership pathway and outlines the challenges and potential opportunities for development. The pathway builds on good joint working already in place, and aims to enhance and extend joint working practices and improve outcomes for children, mothers, fathers and families and the wider community.

As local authorities start to commission Healthy Child Programme services for children aged 0-5 and their families, the pathway will support commissioners in developing locally tailored services (working with commissioners of maternity services) and to commission the mandated antenatal, new birth and 6-8 weeks reviews and the health visitor High Impact Areas of transition to parenthood and the early weeks, maternal (perinatal) mental health and breastfeeding.

Healthy Child Programme delivered by midwives and health visitors in pregnancy and early weeks of life

Antenatal

- Promoting positive maternal mental health.
- Promoting the importance of involvement of the father.
- Preparing families for transition to parenthood.
- Promoting the importance of parent and baby mental health/ attachment.
- Promoting breastfeeding and the support available.
- Providing safe infant feeding information.
- Signposting parents to Parent Education.
- Promoting Healthy Start (vitamins) for all women.
- Promoting the neurological development of the child, the negative impact of stress and the importance of attachment.
- Providing smoking cessation support.

Post natal

- Observing and promoting the importance of parent and baby mental health/attachment.
- Promoting attuned, sensitive parenting that supports the baby's early development and positive mental health.
- Assessing maternal mental health.
- Promoting the importance of father/partner involvement.
- Supporting mothers with postnatal exercise.
- Promoting home safety.
- Promoting steps to take to prevent Sudden Infant Death Syndrome (SIDS).
- Providing information on smoking cessation, development and growth.
- Providing information on, and registration with, local Children's Centres.

Outcomes for effective midwifery and health visiting partnerships

Public Health Community

- Improved health outcomes; leading to a reduction in health inequality for children.
- Improved maternal, antenatal and postnatal mental health in women leading to a reduced incidence of future mental health problems.
- Increased numbers of individuals making healthy lifestyle choices, leading to reduced obesity, reduced hospital admissions, reduced smoking and substance misuse and long term conditions, increased breast feeding rates, etc.
- Improved planning of local services to reduce health inequalities for children and families.

Universal Services

- Increased numbers of children and their families reporting a high level of satisfaction with services provided.
- Increased coverage of the Healthy Child Programme 0-5 and universal health visiting contacts.
- Increased numbers of families having improved access to support for emotional health and wellbeing.

Universal Plus

- Improved services tailored to the needs of families through evidence-based programmes which focus on the 6 High Impact Areas, making the biggest difference to children and families' public health.
- Improved mental health and wellbeing of children and families.
- Improved early identification of child and family need and appropriate response to meet need.
- Improved effective use of resources to benefit children and families.

Universal Partnership Plus

- Improved early and ongoing help for vulnerable children and families.
- Improved consistent approach to meeting the needs of children and families with complex needs.
- Reduced number of formal safeguarding referrals.

Measuring Impact and Outcomes

Data collection: The pathway provides a framework to support measurement of outcomes and quality assurance. Local Child Health Information Systems should support the delivery of child health services and collection of outcome data. The Maternity and Children's Dataset has been developed as a key driver to achieving better outcomes of care for mothers, babies and children. The dataset will provide comparative, mother and child-centric data that will be used to improve clinical quality and service efficiency; and to commission services in a way that improves health and reduces inequalities. The dataset also provides secondary information to patients and service users enabling them to make informed decisions about care.

Public Health England is hosting the interim data solution pending full use of Maternity and Children's Dataset enable progress to be monitored on service priorities within this pathway (including mandated service elements) and links to the Public Health Outcomes framework and local information through early year profiles.

	ANTENATAL* Please note that NICE guidelines relate to subsections of the work described only.						BIRTH	**POSTNATAL**	
When	**Booking in (8-12 weeks)**		**16-28 Weeks**		**32-36 weeks**			**Birth visit to 10-14 days**	
Who	Midwife	Health visitor	Midwife	Midwife/Health visitor	Midwife	Midwife/Health visitor		Midwife	Midwife/Health visitor
Where	Home, Health Centre, Children's Centre (CC), GP Surgery – (dependant on family need and local provision)							Obstetric/Midwifery unit/ Home/Children's Centre	Home
Action Proposals you may wish to consider developing	Antenatal screening. There is a need to address the consent issues of the mother and father for further notification. There needs to be recognition that the midwife is responsible for the mother, unborn child and father during the antenatal period and is responsible for ensuring all appropriate services are in place. Midwifery team to notify health visiting team of pregnancy, and Family Nurse Partnership if appropriate. Notification to include assessment of need, including needs of the father, and referrals to other agencies and action plan. This should be a particular consideration for women and fathers with complex social factors (NICE 110). 12 weeks health needs assessment.	Health visitor/health visiting team to inform midwife of named health visitor for every woman.	Ongoing review of action plan. Midwife to communicate any change in the pregnancy status and/or changes in risk to the family or child to the named health visitor/health visiting team. Health promotion review. Midwifery team to notify health visitor within one working day of any significant changes to maternal or child wellbeing, for example, miscarriage, still birth, congenital abnormality, serious illnesses and admission to NICU.	Possible further health needs assessment, including father's needs. Where a woman or father is identified as vulnerable the midwife and named health visitor should work collaboratively to assess the needs of the woman and it is recommended that they consider a joint meeting with the family (NICE 110). Information exchange between health visitor and midwife. Early identification of need.	Birth plan, including father's needs and place of birth. Shared with health visitor. Postnatal care choices and needs. Midwifery team to notify health visitor within one working day of any significant changes to maternal or child wellbeing, for example, miscarriage, still birth, congenital abnormality, serious illnesses and admission to NICU.	Health visitor universal contact. Supported emotional transition to parenthood in vulnerable groups. Offer of a holistic assessment of unborn child and family risk and resilience factors, using a strengths-based partnership approach to support transition to parenthood, if appropriate (the timing of this is variable between trusts but should be completed pre-birth). Women with identified vulnerability to be considered for a joint antenatal meeting. All women with identified vulnerability (e.g. maternal mental health, learning disability, fetal developmental issues, obstetric issues, domestic violence etc.) or need to have received an 'individualised postnatal care plan' prepared in conjunction with midwife and health visitor (NICE 37).		Midwife to update the health visitor on the health and social status of both mother and baby. Midwife to explain to all women the purpose of the parent-held personal child health record and how it will be used by midwife and health visitor (NICE 37). Day 5-7 midwife to complete appropriate sections of the parent-held personal child health record to facilitate handover to the health visitor. Midwifery team to notify health visitor within one working day of any significant changes to maternal or child wellbeing, for example, still birth, congenital abnormality, serious illnesses and admission to NICU.	Child and family needs assessment, including father's needs. It is recommended that by day 14 all women, particularly those with identified vulnerability or need, have received a joint handover/contact visit with their midwife and health visitor; it is recommended that this be a home visit. At discharge of vulnerable women and women who require midwifery input after day 14, the midwife and health visitor to have completed and recorded a verbal handover in addition to a written handover (NICE 37).
HCP Key Messages and Actions	• Promoting the health and emotional wellbeing of the mother. • Promoting positive mental health of the mother. • Promoting Healthy Start for all women. • Preparing families for transition to parenthood. • Promoting breastfeeding and the support available. • Promoting the importance of the involvement of the father. • Promoting the neurological development of child, the negative impact of stress and the importance of attachment. • The Healthy Child Programme also promotes good liaison between midwife and health visitor to benefit early intervention.		• Promoting the health and emotional wellbeing of the mother. • Promoting positive mental health of the mother. • Providing information on local Children's Centre services and consent to contact. • Providing smoking cessation support. • Promoting breastfeeding and the support available. • Providing information on screening and immunisations, child development, maternal nutrition e.g. folic acid and other dietary or lifestyle advice as required. • Preparing families for transition to parenthood. • Promoting the importance of the involvement of the father.		• Promoting the health and emotional wellbeing of the mother. • Promoting positive mental health of the mother. • Preparing families for transition to parenthood. • Promoting the importance of parent and baby mental health/attachment. • Providing safe infant feeding information. • Promoting breastfeeding and the support available. • Signposting parents to Parent Education. • Promoting the importance of the involvement of the father. • Delivering the Pregnancy, Birth and Beyond programme in partnership.		• Providing safe infant feeding information. • Promoting breastfeeding and the support available. • Observing and promoting the importance of parent and baby mental health/attachment. • Promoting attuned, sensitive parenting that supports the baby's early development and positive mental health. • Assessing maternal mental health. • Promoting the importance of father/partner involvement. • Supporting mothers with postnatal exercise. • Promoting home safety. • Promoting steps to take to prevent Sudden Infant Death Syndrome (SIDS). • Providing information on smoking cessation, development and growth. • Providing information on, and registration with, local Children's Centres. • Delivering the Preparation for Birth and Beyond programme in partnership.	
Your Community	Targeted to meet the identified needs of the community. Your community has a range of services including some Sure Start services and the services families and communities provide for themselves. Health visitors and midwives work together to develop and promote community based support for expectant and new parents, such as transition to parenthood groups and activities that meet the needs of local families.								
Universal Services	Universal services are for all families. Health visitors deliver the Healthy Child Programme to ensure a healthy start for children and families, for example immunisations, health and development checks, support for parents and access to a range of community services/resources.								
Universal Plus	Targeted according to assessed or expressed need, universal plus gives a rapid response from the health visiting team when families need specific expert help, for example with postnatal depression, a sleepless baby or answering any concerns about parenting.								
Universal Partnership Plus	Targeted according to identified need, universal partnership plus provides ongoing support from the team plus a range of local services working together with families to deal with more complex issues over a period of time. These include services from Sure Start Children's Centres, other community services including charities and, where appropriate, the Family Nurse Partnership.								

SAFEGUARDING

Suggested collaborative timeline for midwifery and health visiting services* – *It is recognised that the circumstances and needs of the family must be taken into account when implementing this timeline e.g. the information needs and emotional experiences of first time parents differ to those of experienced parents (for further information follow this link)

Values underpinning care are often referred to as the 6Cs - this shows how the 6Cs underpin work in pregnancy and early weeks.

Compassion
- Recognising and understanding needs of children, young people and families in order to produce a care plan.
- Building trusting relationships.
- 'Normalising Life' Early Years Programme.
- Respecting dignity.
- Being open and non-judgemental.
- Supporting a whole family approach.

Commitment
- Demonstrate health and wellbeing.
- Improving joint working.
- Service user feedback, including the NHS Friends and Family Test should be collaged to inform service improvement.
- Improving delivery and sharing 'what works'.
- Supporting service improvement and changes.

Competency
- Develop skills through training.
- Acting as expert on children and young people.
- Ensuring appropriate referrals.
- Sharing evidence based practice.
- Standardising care.
- Recognising competencies and seeking new opportunities.
- Recognising specialist skills and skill mix within the team.

Care
- Health visitors and midwives to provide care in a range of settings.
- Seamless delivery of the Healthy Child Programme 0-19.
- Making time to understand the world of the baby, child and family.
- Promoting positive health and well-being.
- Using technology to improve access.

Courage
- Having difficult conversations.
- Advocating for baby or child.
- Knowing when to use professional challenge.
- Having intelligent conversations and empowering parents and carers.
- Embracing innovation and new ways of working.
- Working transparently with families.

Communications
- Using defined protocols and Information sharing.
- Communicating appropriate safeguarding concerns when they arise.
- Embracing modern technology and utilising new ways of communicating.
- Improving communication across same and other agencies.
- Supporting cross-agency working and communications.

Maximising Health and Well-being
- Communicating with family and other services and taking time to listen.
- Working at the family's pace.
- Identifying domestic violence and abuse or mental health issues.
- Supporting families in a way that is appropriate to that individual family.
- Making every contact count and using communication skills which promote behavioural change e.g. motivational interviewing, brief interventions, Family Partnership approach.
- Normalising the transition process for the family.
- Delivering the Public Health agenda through joint delivery of the Healthy Child programme 0 –5.
- Improving seamless support address to address public health priorities e.g. obesity, mental health etc.
- Improving support for parenting skills and family resilience.

Delivering care and measuring impact
- Working with the family and other services after identifying issues such as domestic violence and mental health.
- Sharing evaluation and the use of locally agreed assessments.
- Promoting family feedback.
- Using data to identify needs and outcome measures.
- Using evidence based care.
- Sharing information to improve outcomes.
- Increasing equality and quality of services for all, to deliver improved outcomes.

Working with families to provide a positive experience
- Promoting joint home visits for complex needs cases where appropriate.
- Ensuring accessible service provision.
- Keeping to commitments made.
- Building relationships and helping 'preparing for becoming a parent'.
- Clarity of professionals' roles for parents and the offer that they will be provided.
- Increasing opportunities to focus on enhanced priority for babies, mothers and families with complex needs.

Improved Health outcomes and reduced inequalities of families and children

Ensuring seamless transition through better care

Ensuring readiness for transition to parenthood through working with the mother, family and baby

Contributing to early help including intervention, support and referral

Comprehensively delivering the public health messages and the Healthy Child Programme 0-5 years

Maximising health and wellbeing | Delivering care and measuring impact | Working with families to provide a positive experience | Supporting staff to have a positive experience | Building and strengthening leadership | Ensuring the right staff, with the right skills, in the right place

Safeguarding is of paramount importance and local areas need to ensure there are clear protocols in place, which offer clarity regarding the roles and responsibilities of health visitors and midwives

Supporting positive staff experience
- Sharing best practice and what works.
- Recognising and utilising staff strengths.
- Providing peer support.
- Promoting good support and supervision from managers.
- Providing feedback to staff both positive and negative.
- Developing joint training.
- Improving technology and support delivery, linking to technology fund.
- Utilise social networking and social media for professional developing and networking.

Building and strengthening leadership
- Providing robust training.
- Sharing learning/best practice e.g. AIS.
- Ensuring managers/supervisors role modelling good practice.
- Standardising procedures and protocols.
- Linking to health and well-being boards and commissioners.
- Using systems to improve joint working.
- Facilitating working in new ways to provide for transition to parenthood activities and programmes.
- Developing frameworks to support flexibility to adapt quickly to changing needs and circumstances.

Ensuring the right staff, with the right skills, in the right place
- Ensuring role definition with other health professionals, social care and partners.
- Sharing responsibility.
- Providing clarity and responsibility.
- Using health and well-being boards to identify priorities.
- Accessing training.
- Using competency frameworks.
- Ensuring flexibility of services.
- Improving integration of services/multi-disciplinary communication/team visits.
- Releasing time to care through reducing duplication of visits.
- Providing peer review and joint training.
- Delivering co-ordinated and continuous care across different agendas

Supporting Policy

- Healthy Child Programme (2009), is the preventive programme for all children and includes schedules for screening, immunisation and assessment. The Healthy Child Programme supports health, learning and development outcomes for children, and recognises that some will need higher levels of input to reach their potential. The Healthy Child Programme is led by health visitors and commences in pregnancy.
- Health Visitor Implementation Plan: A Call to Action (2011), sets out the revitalised universal offer of health visiting support for all children and their parents and challenges midwives and health visitors to articulate and recognise their different professional perspectives and collaborative contributions to ensure quality outcomes for children and parents.
- Supporting Families in the Foundation Years (2011), underlines and emphasises the importance of the foundations years, from pregnancy to age five, and the value of offering parents support, advice, and information antenatally and after birth.
- Midwifery 2020: Delivering Expectations (2010), sets the direction for midwifery and outlines that timely communication is 'crucial to the success of such partnership working'.
- Maternity and Early Years: Making a good start to Family Life (2010), sets out the government's ambition for better integrated care, responding to feedback from families that they would like 'stronger continuity of care after birth'.
- Good partnership working is seen as one of the key elements in responding to the recommendations of the Allen (2011), Munro (2010), Tickell (2011) and Field (2010) reviews.
- Public Health White Paper Update and Way Forward: (2011), outlines that professionals such as health visitors and midwives will have a role in helping to develop local approaches to public health, by providing links between public health and the NHS and displaying leadership in promoting good health and addressing inequalities.
- NICE Clinical Guideline 37. Routine postnatal care of women and their babies (2006).
- NICE Clinical Guideline 6. Antenatal Care: Routine care for the healthy pregnant woman (2008).
- NICE Clinical Guideline 110. Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors (2010).
- NICE Clinical Guideline 45. Antenatal and postnatal mental health: Clinical management and service guidance (2007).
- Supporting Families in the Foundation Years (2011).
- Parents' views on the maternity journey and early parenthood (2011), can be used in conjunction with the suggested timeline for advice as to how to deliver the messages to ensure a family and baby-centred approach.
- NHS Future Forum: Recommendations to government on NHS modernisation, Department of Health, 2011.
- E-Learning for Healthcare – Peri-Natal Mental Health – (2014).
- Early Years High Impact Areas: documents to support local authorities in commissioning children's public health services, Department of Health, 2014.
- 1001 Critical Days: The Importance of the Conception to Age 2 period, Wave Trust, 2014
- Public Health Outcomes Framework.

Acknowledgements

This pathway has been developed in partnership with a range of stakeholders across the NHS and other organisations. Thanks are extended to all contributors, specifically the following:

Task and Finish Group members

Members were experienced in working in inter-professional partnerships and were nominated by their professional bodies; the Royal College of Midwives and Community Practitioner Health Visitors Association/Unite.

Mary Griffiths
Family Nurse Partnership,
Department of Health

Carolyn Langrick
Senior Midwife, Derby NHS Foundation Trust

Terry McGinn
Health Visitor, Lancashire Care NHS Foundation Trust

Elizabeth Punter
Midwife, Dudley Group of Hospital NHS Foundation Trust

Pamela Shaw
Health Visitor, Mid Yorks Hospital Trust

Jane Teper
Health Visitor, Cumbria Partnership NHS Foundation Trust

Sarah Hughes
Health Visitor Harrogate and District Foundation Trust (HDFT), Staff side CPHVA/ Unite workplace rep, Health and Safety Rep. CPHVA/UNITE

Claire Matthews
Head of Midwifery/Assistant General Manager, Lincolnshire & Goole NHS Foundation Trust

Dave Munday
Professional Officer (in the Health Sector), Unite the Union

Sue Rowlands
Specialist Midwife Perinatal Mental Health and Domestic Abuse, Lancashire Teaching Hospitals NHS Foundation Trust

Carolyn Taylor
Health Visitor, South Tyneside Foundation Trust

Jill Withers
Health Visitor/Practice Educator Midyorks Hospital Trust

Obi Amadi
Lead Professional Officer, Unite the Union/CPHVA

Fiona Smith
Adviser in Children and Young People's Nursing
Royal College of Nursing

Alison Morton
Specialist Practice Teacher – Health Visiting, Southern Health NHS Foundation Trust

Jacque Gerrard
Director, Royal College of Midwives

Secretariat

Wendy Nicholson
Lead Nurse – Children, young people and families,
Public Health England

Pauline Watts
Lead Nurse – Quality,
Public Health England

Craig Hewitt
Professional Mobilisation Project Planning Lead, Department of Health

Fiona Hill
Project Support Officer Children, young people and families, Public Health England

Judy Walker
Project Support Officer, Quality,
Public Health England