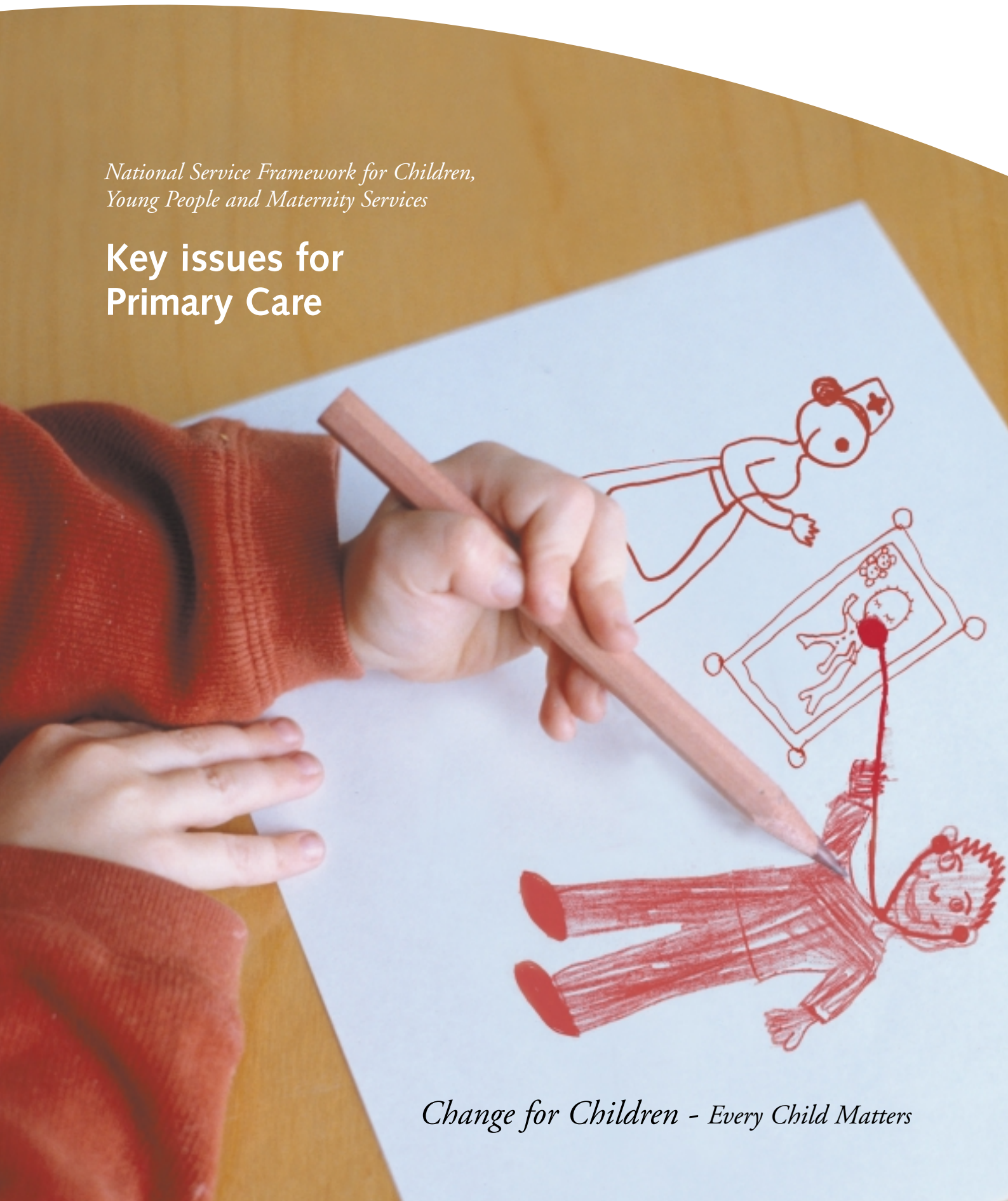


*National Service Framework for Children,  
Young People and Maternity Services*

## Key issues for Primary Care



*Change for Children - Every Child Matters*

<b>Policy</b>	Estates
HR/Workforce	Performance
Management	IM & T
Planning	Finance
Clinical	Partnership Working

<b>Document Purpose</b> Best Practice Guidance	
<b>ROCR ref:</b>	<b>Gateway ref:</b> 3779
<b>Title</b>	Primary Care Version, National Service Framework for Children. Young People and Maternity Services
<b>Author</b>	DH
<b>Publication date</b>	04 Oct 2004
<b>Target audience</b>	PCT CEs, NHS Trusts CEs, SHA CEs, PCT PEC Chairs, Special HA CEs, GPs, SHA Children's Leads, NHS Trusts Children's Leads, A&E Departments, Ambulance Trusts, Children's Hospices CEs, Local Authorities, Other Government Departments
<b>Circulation list</b>	
<b>Description</b>	This is the Primary Care Version of the National Service Framework for Children, Young People and Maternity Services.
<b>Cross ref</b>	
<b>Superseded docs</b>	
<b>Action required</b>	
<b>Timing</b>	
<b>Contact details</b>	Claire Phillips, Children's NSF Team, 526 Wellington House 133-155 Waterloo Road, London SE1 8UG. Telephone: 0207 9724908. <a href="http://www.dh.gov.uk">www.dh.gov.uk</a>
<b>For recipient's use</b>	

# Key Issues for Primary Care

*“It seems so obvious it hardly needs to be said: just as children differ from adults in terms of their physiological, psychological, intellectual and emotional development, so they differ in their healthcare needs. They experience and see the world differently.*

*Children are in a constant state of growth and development which creates particular needs and demands which are of a different order from those affecting adult patients.*

*Their relative physical and emotional immaturity, in comparison with adults, has implications both for the treatment which they receive and the physical environment in which they are cared for.”*

*Professor Sir Ian Kennedy, Report into children’s heart surgery at Bristol Royal Infirmary*

This part of the National Service Framework for Children, Young People and Maternity Services (Children’s NSF) is for general practitioners, practice nurses, practice managers, administrative staff, and all members of the Primary Health Care Team. It has been developed as a tool to assist them in implementing the parts of the Children’s NSF standards that are relevant to their daily work and delivering high quality care for pregnant women, children, young people and their families.



### Setting the Scene

The Children's, Young People's and Maternity NSF is a 10 year strategy that sets the direction of travel to improve the health and well-being of the nation's children and improve maternity services. Full implementation will take time; organisations, and the individuals within them, are at different starting-points; but changes will be needed in order to achieve the aims of the Children's NSF.

The key messages are that the Children's NSF:

- > Sets national standards for the first time for children's health and social care, which promote high quality, women and child-centred services and personalised care that meets the needs of parents, children and their families.

The standards require services to:

- > Give children, young people and their parents increased information, power and choice over the support and treatment they receive, and involve them in planning their care and services.
- > Introduce a new Child Health Promotion Programme designed to promote the health and well-being of children pre-birth to adulthood.
- > Promote physical health, mental health and emotional well-being by encouraging children and their families to develop healthy lifestyles.
- > Focus on early intervention, based on timely and comprehensive assessment of a child and their family's needs.
- > Improve access to services for all children according to their needs, particularly by co-locating services and developing managed Local Children's Clinical Networks for children who are ill or injured.
- > Tackle health inequalities, addressing the particular needs of communities, and children and their families who are likely to achieve poor outcomes.
- > Promote and safeguard the welfare of children and ensure all staff are suitably trained and aware of action to take if they have concerns about a child's welfare.
- > Ensure that pregnant women receive high quality care throughout their pregnancy, have a normal childbirth wherever possible, are involved in decisions about what is best for them and have choices about how and where they give birth.

Of the 11 standards in the Children's NSF, the first 5 (in Part 1) are applicable to all children (and cover health promotion, supporting parents, child-focussed services, growing-up and safeguarding children), while the next 5 standards in Part 2 relate to specific groups of children (the ill child, the child in hospital, disabled children, children with mental health problems, and medicines for children). Standard 11 (Part 3) highlights what needs to change within NHS Maternity services. If you need more information, please look at the relevant section of the full Children's NSF which is being sent to all practices and is also available on the website at: [www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation).

The vast majority of contacts with the health service for children are with primary health care teams. In a typical year, pre-school children will see their general practitioner about 6 times while school-aged children will visit 2 or 3 times. Most consultations in primary care are for minor illnesses that can be effectively dealt with by the general practitioner, practice nurse or health visitor - or, in some cases, the community pharmacist - together with the family. However, they have to decide when there may be a serious problem, when investigations need to be carried out or the child referred.

Families are the main providers of care for children and nothing matters more to parents than the health and well-being of their children. But a wide variety of factors, such as poverty and unhealthy lifestyles, can affect health outcomes for children and pregnant women. Primary care, through Primary Care Trusts, Children's Trusts and primary health care providers, has a key role in improving the health and well-being of the children in their local area and addressing health inequalities, both through local strategic partnerships, and through work with individual children, young people, families and communities.

The Children's NSF launches the new Child Health Promotion Programme, based on *Health for All Children 4*, which replaces the Child Health Surveillance Programme. Most of this will be carried out by members of the primary health care team. Primary Care Providers may choose to deliver this programme under GMS arrangements – it is an additional service. Midwives and health visitors see families with new babies; general practitioners, practice nurses and health visitors

provide immunisations for children under 5 and often check for physical abnormalities at 6-8 weeks. There are many opportunities for primary health care providers to promote the health of children and families. The main change in the programme is the shift away from limited routine developmental checks to much more holistic assessment of each child and family's needs, coupled with early interventions to address those needs.

Health visitors play a key role in the new Child Health Promotion Programme and each practice should have a named health visitor. General practitioners and practice nurses should liaise with, and consider offering a contact with the health visitor for a review of needs and possible interventions if:

- > They find immunisations are not up-to-date;
- > They see a child more frequently than most, particularly with potentially preventable injuries or infections;
- > They or the parents are worried about the child or parenting capacity, including the relationship between the parent and child;
- > They are aware that parents did not attend an important referral for their child, and
- > They suspect non-accidental injury, abuse or neglect (maltreatment) but, in addition, they must also follow the local protocol for safeguarding children (previously referred to as the child protection protocol).

Priority needs to be given to children, young people and families living in special circumstances (such as asylum seekers, those in temporary accommodation, looked after children or children of drug-misusing parents) who may need targeted health promotion interventions. Access for disabled children to both general and specialist care is another key priority. The importance of high quality, women-focussed, maternity services, to the ongoing health and well-being of all children should not be underestimated. Primary care providers can help to ensure early referral and continued contact to local maternity services with particular emphasis on those who do not currently access mainstream services.

There are some children, young people and families who are not registered with a general practice. It is intended that, as a result of this national service framework, PCTs will be more proactive about identifying and offering services to all the children and young people in its population including registration with a primary care provider to prevent children from falling through the net and missing out on a range of services such as immunisation. Primary care providers can help by encouraging patients with families to register with them. PCTs have a duty to improve the health of their whole population and this will require working in partnership with other key agencies.

Children's Trusts, which encompass health, education, and social care, will provide strategic leadership, commission services and raise standards of health for all children and young people. Health visitors and primary care providers will work with children, young people and families to improve their, and the community's, health and well-being.

### Clinical governance systems with a focus on children

Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence can flourish. Because it is an inherent part of the way services are planned and delivered, it spans all standards in this national service framework.

However, clinical governance systems do not always explicitly recognise children and young people as a separate and vulnerable client group. It is essential that the care of children is given a specific focus within the clinical governance arrangements in primary care. The components of clinical governance strategies in primary care will need to include arrangements for the safety of treatment and care; safeguarding; the use of evidence-based practice; clinical audit; effective prescribing and referrals, and continuing professional development (linked to revalidation for general practitioners).

### Exemplars

A series of exemplars are available to illustrate the Children's NSF, showing a child's journey with a particular condition or problem through community, primary, secondary and tertiary care and links with other agencies. The first of these are on asthma and autism. These are also available on the web at [www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation](http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/ChildrenServices/ChildrenServicesInformation)

### Terminology

The Children's NSF covers all babies, children and young people, and in it child/children is frequently used as shorthand to cover all under-19s. However, the agencies have different statutory responsibilities for children and young people of different age ranges, and services need to be commissioned and provided accordingly. The aim of this Children's NSF is to improve the age-appropriateness of services and base this around the needs of the individual young person and their family, planning appropriately for transition to adulthood. This may mean that some children receive services for a longer period than others.

Throughout the Children's NSF, parents is used as shorthand to include mothers, fathers, carers and other adults with responsibility for caring for a child or young person, including, for example, those with responsibilities for looked after children and young offenders.





## Children's and Maternity National Service Framework: Key Issues for Primary Care

### PART I

#### Standard 1: Promoting Health and Well-being, Identifying Needs and Intervening Early

The health and well-being of all children and young people is promoted and delivered through a co-ordinated programme of action, including prevention and early intervention wherever possible, to ensure long term gain, led by the NHS in partnership with local authorities.

#### Standard 2: Supporting Parenting

Parents or carers are enabled to receive the information, services and support which will help them to care for their children and equip them with the skills they need to ensure that their children have optimum life chances and are healthy and safe.

#### Standard 3: Child, Young Person and Family-centred Services

Children and young people and families receive high quality services which are co-ordinated around their individual and family needs and take account of their views.

#### Standard 4: Growing Up into Adulthood

All young people have access to age appropriate services which are responsive to their specific needs as they grow into adulthood.

#### Standard 5: Safeguarding and Promoting the Welfare of Children and Young People

All agencies work to prevent children suffering harm and to promote their welfare, provide them with the services they require to address their identified needs and safeguard children who are being or who are likely to be harmed.

**What this means for Primary Care Providers:**

The NSF introduces the new Child Health Promotion Programme - details are given in the box below:

**The core Child Health Promotion Programme (See Appendix 1) replaces the Child Health Surveillance Programme and encompasses:**

- > Childhood screening;
- > Immunisations;
- > A holistic and systematic process to assess the individual child's and family's needs;
- > Early interventions to address those needs, and
- > Delivering universal health promoting activities.

This Programme is:

- > Offered to all children throughout childhood and the teenage years;
- > In a range of settings including general practices, children's centres, early years providers and extended schools;
- > Provided as an additional service under the GMS contract; PCTs may also wish to build it into local PMS contracts;
- > A universal service which is individualised to meet the needs of the child and family;
- > Provides more support on a targeted basis to children and families that are vulnerable or have complex needs, and
- > Delivered in partnership with parents to help them to make healthy choices for their children and family.

Primary Care Providers (PCPs) are responsible for certain aspects of the Programme such as immunisations, and also for being proactive in promoting health at every opportunity within primary care.

### Preventing Infectious Diseases:

Primary care providers participating in the Child Health Promotion Programme:

- > Ensure that all children receive immunisation against major infectious diseases and that their carers receive appropriate advice about the nature and purpose of the programme (the current schedule of childhood immunisations can be found at [www.immunisation.nhs.uk](http://www.immunisation.nhs.uk));
- > Use contacts with children to check their immunisation status (based on the Personal Child Health Record or the child's medical record including, when established, the NHS Care Record Service) and refer them for 'catch-up' immunisation as required;
- > Check the immunisation history of children and young people who enter the country or who move into the area. Children who are un-immunised or whose history is unknown are offered a full course of immunisations and transferred to the routine schedule appropriate for their age, and
- > Follow-up failure to attend for a scheduled immunisation by triggering an assessment of the reasons.

### Intervening Early:

The Child Health Promotion Programme provides a framework for a formal planned assessment of children's and families' needs, normally undertaken by the health visitor with the parents. These assessments (see paragraph below) enable the health visitor to:

- > Refer a child or parent to PCPs to identify early health problems (physical, emotional or developmental), and
- > Identify families who may require additional input, including support in the parenting role.

Many children will receive more contacts, with a variety of primary health care professionals, than the minimum outlined in Appendix 1, and PCPs need to be alert to possible concerns about the child's well-being.

Children's and young people's access to therapy services is inconsistent across regions, with long waits in some areas. Waiting long periods for therapy can harm the educational attainment and wider development of individual children and young people. Additional funding has been made available to increase overall capacity in the NHS. This will enable PCTs which identify this as a priority area to increase the capacity of the allied health professionals' workforce to help meet identified need and reduce waiting times. Primary care providers, as well as health visitors, have a crucial role in identifying problems early and referring them for specialist assessment, including diagnosis and treatment, and supporting parents who may be anxious about their child's development.

#### Assessments:

Where there are concerns about a child, a comprehensive assessment is key. Health visitors and PCPs need to ensure that children and young people can participate actively in their own assessments. The assessments should identify a child or young person's and their family's abilities as well as their needs and difficulties. Summaries should be recorded in the Personal Child Health Record as well as the primary care record whenever possible.

#### Non-attenders:

Children or young people failing to attend clinic appointments following referral from their general practitioner or other professional may trigger concern, given that they are reliant on their parent or carer to take them to the appointment. Failure to attend can be an indicator of a family's vulnerability, potentially placing the child's welfare in jeopardy. It can equally be an indicator that services are difficult for families to access or considered inappropriate, and need reviewing.

A system should therefore be in place to identify children or young people who do not attend an appointment following a referral for specialist care, so that the referrer is aware they have not attended and can take any follow-up action considered appropriate to ensure that the child's needs are being met (which may include a home visit or telephone contact to find out, for example, whether the appointment is no longer necessary). All practices may therefore need to review their DNA rates for children and young people regularly to ensure their services are meeting need.

### Positive Mental Health of Children and Young People:

Ten per cent of children aged 5-15 have a diagnosable mental health disorder. Effective prevention and early intervention could help reduce the burden on primary care and Child and Adolescent Mental Health Services and improve outcomes for children and families. PCPs should identify those at greatest risk and be aware of early signs of mental health problems, including emotional problems, which can be less evident than behavioural difficulties, and take appropriate action.

### Health Promotion:

Primary health care providers should take every opportunity to promote the health and well-being of pregnant women, parents or carers, babies, children and young people. This should include discussion of a child's physical and emotional development during consultations or during immunisation clinics or well-baby clinics. These consultations should also be used to promote smoking cessation for all family members, as well as healthy diets and active lives. School nurses will have a key role in promoting healthy lifestyles to school-aged children.

### **Areas where healthy choices make a big difference in children's and young people's lives**

There are several areas in children's and young people's lives where being able to make healthy choices will make a real difference to their life chances and/or health, social and economic outcomes. These include:

- > Breastfeeding;
- > Healthy diet and exercise for children and young people;
- > Social and emotional well-being;
- > Keeping children and young people safe;
- > Avoiding smoking, using volatile substances and other drugs and minimising alcohol intake, and
- > Reducing the risk of teenagers getting pregnant or acquiring sexually transmitted infections.

### Healthy Diets and Active Lives:

The Royal College of Paediatrics and Child Health and the National Obesity Forum have published guidance on weight management in children and adolescents (available at [www.rcpch.ac.uk](http://www.rcpch.ac.uk)). PCPs should provide parents with advice and support on the growth of their children, promote - for the whole family - physical activity and healthy diets with plenty of fruit and vegetables and limited sugar, salt and animal fats, as well as managing those identified as overweight or obese.

### Promoting the health of teenagers:

The needs of young people in primary care are not always addressed specifically. There is much that practices can do to meet their additional needs in terms of confidentiality, reassurance and support during adolescence, and health promoting activities which address risk-taking in sexual health, drugs and alcohol misuse and smoking. PCPs contribute to targets for the reduction of teenage pregnancy, smoking, substance misuse, sexually transmitted infections and suicide through the provision of targeted and sensitive care. PCPs:

- > Support other health and education services in providing young people with ongoing information and support to enable them to make healthy choices and instigate a 'culture' change in the way they think about and approach issues in relation to health and food;
- > Can recognise inappropriate eating habits such as the development of anorexia nervosa or bulimia and are able to make appropriate referrals if specialist help is required;
- > Provide access for young people to confidential contraceptive and sexual health advice services which are tailored to meet their needs, as set out in Best Practice Guidance on the Provision of Effective Contraceptive and Advice Services for Young People - Department of Health, 2000 ([www.dfes.gov.uk/teenagepregnancy](http://www.dfes.gov.uk/teenagepregnancy)). This can be provided in a range of settings, including extended schools (where additional services are provided). For the provision of contraception to under sixteen year olds, health professionals follow revised guidance (2004) ([www.dh.gov.uk/assetRoot/04/08/69/14/04086914.pdf](http://www.dh.gov.uk/assetRoot/04/08/69/14/04086914.pdf)). This should include providing young people with rapid access to testing and treatment for sexually transmitted infections including blood borne viruses, rapid access to emergency contraception, early and easy access to free pregnancy testing, unbiased advice, and speedy referral for NHS funded terminations of pregnancy or ante-natal care;

- > Recognise the early signs and symptoms of distress which could lead to or indicate mental health problems in a young person and are competent to support and refer them when necessary; and
- > Consider whether the practice meets the criteria set out by the RCGP for an adolescent friendly practice (see below).

The publication '*Getting it Right for Teenagers in Your Practice*', drawn up by the Royal College of General Practitioners and the Royal College of Nursing, April 2002, suggests the following steps to make your practice more teenage-friendly:

- > Ensure confidentiality;
- > Organise a practice meeting with the whole team to discuss how you can all make your practice more teenage-friendly;
- > Train members of the practice in teenage health issues;
- > Audit the 10-18 year olds in your practice;
- > Let young people know what your practice provides;
- > Consider running a "young persons' clinic" in your practice or with other practices;
- > Involve parents;
- > Make sure that the practice advice is directed to boys and young men as well as girls and young women;
- > Make sexual health and contraceptive advice in your practice teenage-friendly, and
- > Offer advice and support for teenagers who get pregnant.

For more information, see  
[www.rcn.org.uk/members/downloads/getting\\_it\\_right.pdf](http://www.rcn.org.uk/members/downloads/getting_it_right.pdf)

### Supporting parents

The NSF emphasises the importance of supporting parents before birth and, subsequently, through all stages of the child's life. Primary care has an important contribution to make given that, for many families, their main contact with health services will be with the primary care team. PCPs need to be alert to the need to support parents and are able to refer them to appropriate agencies.

The role of fathers in parenting their children is frequently overlooked. Their contribution to their child's development and well-being is important. All PCPs should be able to support fathers and have the skills for engaging with fathers as well as mothers.

Parents need information to help them make informed decisions about the needs of their children. Efforts should be made to ensure that consistent advice and information is given to parents across different care settings, including primary care. PCPs have a role in providing information to parents.

#### **Useful information provided locally to parents might include:**

- > What becoming a parent might be like and what it will involve;
- > The importance of pre-conceptual folic acid, and promoting health during pregnancy;
- > Not smoking during pregnancy and having a smoke-free atmosphere;
- > How to breastfeed and, where this is not possible, how to bottle feed safely; healthy weaning at the appropriate age;
- > Reducing the risks of sudden infant death; accident prevention, reducing non-intentional injury and first aid and basic life-saving skills for children;
- > The importance of parents communicating with their babies from birth;
- > How to nurture babies and children, set appropriate boundaries and manage behaviour effectively;
- > Healthy lifestyles, including skills and knowledge of the purchase and preparation of food to form a balanced diet, the importance of an active lifestyle and of maintaining a healthy weight;



- > What to expect at different ages, including emotional development, growth, puberty and child development;
- > The importance of creating play opportunities for learning;
- > How to create an effective learning environment at home from the early years, and how to engage effectively in a child's cognitive, emotional and social development and their education;
- > Common allergies and how to manage allergic reactions;
- > A range of other health issues, including emotional health and well-being, bullying, sex and relationships, and alcohol, tobacco and volatile substance misuse and other drug use;
- > Services to support parents and children through disrupted relationships and bereavement;
- > How to promote and support independence as young people grow up;
- > How to access services for their children, how to discuss and/or respond to health and well-being issues such as sex and relationships, and alcohol, tobacco and drug use with their children and how to set boundaries effectively;
- > Health, leisure/sports facilities, education and social care services and how to access them;
- > How mainstream or additional services meet the needs of disabled children, children with special needs and children in special circumstances;
- > The safe storage of medicines and volatile substances within the home, and
- > The legal concept of 'parental responsibility', and information which explains the rights of both the parent and the child.

See *Birth to Three Matters*

(Department for Education and Skills. 2002. [www.surestart.gov.uk](http://www.surestart.gov.uk))

Some of this information may be included in the Personal Child Health Record  
See [Standard 3](#). Guidelines and protocols based on evidence are available to support parents dealing with common problems and illnesses, including signposting local services.

### Supporting parents who have special needs:

The Children's NSF emphasises the importance of healthcare professionals recognising and identifying where their patient has a role as a parent or carer. Primary care practitioners are ideally placed to do so given that they generally know all members of the family. They should consider the impact of a parent's condition or behaviour on family functioning and their parenting capacity with a view to sign-posting them to services to provide additional support where needed. This may include referral to the health visitor for a comprehensive family needs assessment to understand and address the impact of the parent's needs on the children's health and development. In particular, PCPs should consider the needs of children of parents with substance misuse, mental health or domestic violence problems, teenage mothers and those with severe chronic or short term conditions which affect their capacity to parent their children; some may need referral for multi-agency assessment and support services.

PCPs, working with Primary Care Trusts, may need to be more proactive to engage with those families who do not regularly use services, particularly preventive services, and encourage them to make use of these services.

Where professionals working with adults have concerns about a parent's capacity to care for a child and consider that the child may consequently have additional needs, they should refer the child and family to social services. This may include a child who is believed to be, or is at risk of, suffering significant harm (*What To Do If You're Worried a Child is Being Abused, Department of Health, 2003*). In addition to social services, the police and the NSPCC have powers to intervene when there are concerns about a child suffering, or likely to suffer harm. Referrals should be made following the local ACPC (or its successor, the Local Safeguarding Children Board) procedures.

### Supporting parents whose children have special needs:

Parents whose children have special needs (e.g. due to disabilities or challenging behaviour) need to receive early support and evidence-based interventions; the key role for PCPs is to respond to concerns, undertake a preliminary medical assessment and refer on to appropriate services and support.

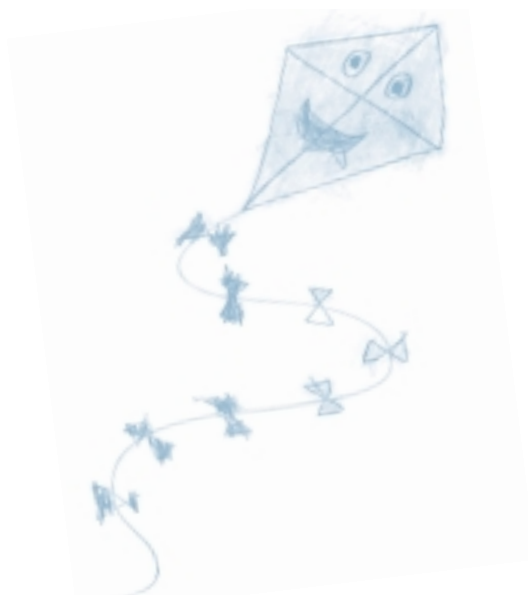
### Supporting adults caring for Looked After Children:

PCPs should ensure that foster carers and residential workers have fast track access for themselves and the children and young people they care for, to specialist parenting support services including child and adolescent mental health services.

### Supporting parents of teenage children (11-19 year olds):

PCPs should be aware of the particular needs of this age group and the pressures that managing teenage children can present for families, particularly those who are vulnerable or in special circumstances. Support for parents provided by primary care providers can include:

- > Written guides on parenting teenagers;
- > Web-based materials;
- > Counselling and psychological support when indicated;
- > Signposting local services including those provided by the voluntary sector, and
- > Making appropriate referrals to child and adolescent mental health services, drugs misuse or other appropriate specialist services.



### **Recording information:**

All PCPs understand and use the PCHR and, where available, the young person held health record. In addition, PCPs are responsible for ensuring that children and young people who move out of the area have all necessary records transferred promptly.

Where there is any concern for a child's welfare, all staff should maintain an accurate record of their involvement with a child and family on a routine basis. The record should be clear, accessible and comprehensive with judgements made and decisions carefully recorded. It should be dated, signed and the person's name legibly written at the end of the record entry or have appropriate equivalent electronic markers. All decisions and any disagreements about specific decisions are recorded in the child or young person's health record.

### **Rights, responsibility and confidentiality:**

PCPs working with young people have policies and procedures which ensure that confidentiality and rights are respected.

PCPs consider the role they can play in assisting young people to take on increasing responsibility for their own lives. They enable young people to spend part of a consultation without their parents present, and offer encouragement to discuss lifestyle and psychological issues.

All PCPs consider the needs of young people, addressing issues of confidentiality, copying young people in on clinical correspondence or writing to the young person; and, where appropriate, by the holding of personal health records by young people.

All services for young people produce and clearly display an explicit confidentiality policy, which sets out the duty of confidentiality and care to young people, including those under 16, as set out in the Royal College of General Practitioners' Confidentiality and Young People Toolkit ([www.dfes.gov.uk/teenagepregnancy/dsp\\_Content.cfm?PageID=129](http://www.dfes.gov.uk/teenagepregnancy/dsp_Content.cfm?PageID=129)) and staff are able to explain the implications of these policies, during consultations to children, young people and their parents.

### Information, choice and decision-making:

Every child, young person and parent should be actively involved in decisions about the child's health and well-being, facilitated by appropriate information. Formal working arrangements are in place for the provision of link workers, advocates to support children and young people, interpreters and/or support workers for children in special circumstances and children and families from minority ethnic groups, to represent their needs during individual consultations with PCPs. Children and young people are offered choices wherever possible, for example, in the location of care or treatment, treatment options or the gender of the professional that they see.

### Consent:

Consent policies that follow government guidance and address specifically the needs of children and young people are made explicit. PCPs are familiar with the concept of 'competence' in giving consent and understand what to do when there is disagreement between a competent young person and their parent. In line with statutory guidance in the context of safeguarding children (child protection), the child's interests are paramount.

(See *Seeking Consent: Working with Children* at [www.dh.gov.uk/assetRoot/04/06/72/04/04067204.pdf](http://www.dh.gov.uk/assetRoot/04/06/72/04/04067204.pdf) and see *Reference Guide to Consent for Examination or Treatment* at [www.dh.gov.uk/assetRoot/04/01/90/79/04019079.pdf](http://www.dh.gov.uk/assetRoot/04/01/90/79/04019079.pdf).)



### Sharing Information:

PCPs seek consent to share personal data, and explicit written consent to share sensitive personal data, as standard practice. They also have guidance on when they may share information without having sought or obtained consent.

Information sharing policies are clearly visible and PCPs are able to discuss the issues with children, young people and families, and to assess when information may appropriately be disclosed or kept confidential.

### Safeguarding children:

Staff (at all levels) understand their roles and responsibilities regarding safeguarding and promoting the welfare of children and young people and are appropriately trained to undertake these effectively.

All staff working with women and children are alert to the relationship between domestic violence and the abuse and neglect of children, and that witnessing domestic violence also constitutes harm to a child (*Children Act 1989*).

All PCPs, and the individual staff who work for them including those who do not have a specific role in relation to children, have a duty wherever possible, to:

- > Promote children's welfare;
- > Prevent the impairment of children's health and development;
- > Prevent children from being abused or neglected;
- > Identify those children who are or may be at risk of suffering significant harm and follow the local procedures for referral to social services or the police;
- > Ensure that where there are concerns about impairment to a child or young person's health or development, or where abuse or neglect is known or suspected, a timely and thorough multi-agency assessment is undertaken, led by social services;

- > Be confident and competent to contribute to child and family assessments, as appropriate, where there are concerns a child may be a child in need/or a child who has additional needs, including when it is considered they have, or may have, suffered significant harm;
- > Act to protect children from being harmed or from suffering further harm;
- > Provide services for children and their families where abuse or neglect has taken place or where action is required to prevent harm;
- > Ensure their staff use effective systems to record their work with children and families;
- > Have and use procedures to safeguard and promote the welfare of children, which are easily accessible by staff at all levels within each primary care organisation;
- > Contribute to serious case reviews where necessary and implement the relevant findings from serious case reviews to improve primary care services; and
- > Ensure that clinical governance arrangements cover all aspects of safeguarding children and young people.



### **Safeguarding disabled children and children in special circumstances:**

All staff are alert to the increased likelihood of harm being suffered by disabled children, or by those children 'in special circumstances', whose needs may not be recognised by staff in statutory agencies. Some children and young people may also be 'invisible' to the system.

All PCPs:

- > Who come into contact or work with disabled children or children in special circumstances are aware of their increased vulnerability to neglect and abuse, and respond to concerns about their safety and welfare;
- > Caring for, or working with children and young people living away from home have clear guidance and training to enable them to identify inappropriate and exploitative adult-child and/or peer relationships and take action to ensure children are protected from harm;
- > Working with adult parents or carers who are experiencing personal problems, should ensure that the needs of their children are assessed and that appropriate services are delivered to these children and their families; and
- > Are aware of and supported by a local multi-agency agreement on thresholds for referral to social services in cases where there is domestic violence, and include routine questions about domestic violence in all assessments, including ante-natal ones.

### **Listening to children:**

All staff are alert to the messages (verbal and non-verbal) children and young people are giving them about their safety and welfare and know how to respond and communicate with them to establish their wishes and feelings. This includes children who have specific communication needs and those for whom English is not their preferred language. Staff should be aware that children may be extremely fearful of communicating about their abusive experiences.



### Staff recruitment:

All agencies have in place safe recruitment practices for all staff in contact or working with children, including agency staff, students and volunteers. All PCPs ensure that all staff who come into contact with children or who handle information about children are checked by the Criminal Records Bureau.

### Training and Development:

All staff working with children and young people receive training and have the core skills, knowledge and competencies required to communicate with children and young people and their parents, and assist them to understand their health problems and treatment so that they are able to achieve their full potential (*see Appendix 2*).

Training to ensure that all staff recognise the particular needs of children and young people is an integral part of clinical governance and will make an important contribution to revalidation for general practitioners. The Royal College of General Practitioners (RCGP) and the British Association for Community Child Health (BACCH) have worked together to produce training materials for GPs in child health promotion and child development, available on the web at:

[http://www.rcgp.org.uk/education/chs\\_teaching\\_materials/index.asp](http://www.rcgp.org.uk/education/chs_teaching_materials/index.asp)

All PCPs need to ensure that they and all their staff are trained and competent to:

- > Be alert to potential indicators of abuse or neglect in children;
- > Know how to act on their concerns, and
- > Fulfil their responsibilities in line with the local ACPC (or its successor, the Local Safeguarding Children Board) procedures.

All PCPs ensure that they resource their responsibilities for safeguarding and promoting the welfare of children by providing ongoing staff training, guidance and supervision e.g. enabling staff to attend multi-agency, and other specialised training.

## Appendix 1

### Overview of the Child Health Promotion Programme

This table sets out health promotion services that will be offered to all pregnant women and children and for which there is evidence of effectiveness. Services may change as new evidence emerges, particularly in the area of adolescent health, and in response to new health concerns (including priorities that may be identified in the White Paper on public health). *See Standards 6 and 11 for pre-conception care.*

Age	Intervention
Ante-natal	Ante-natal screening and a preliminary assessment of child and family needs. Provide advice on breast-feeding and general health and well-being, including healthy eating and smoking cessation where appropriate. Arrangements are put in place, including sharing of information, to ensure a smooth transition from the midwifery to health visiting service.
Soon after birth	General physical examination with particular emphasis on eyes, heart and hips. Administration of vitamin K (if parents choose vitamin K drops, these are administered during the first week after birth). BCG is offered to babies who are more likely to come into contact with someone who has TB. The first dose of Hepatitis B vaccine is given to babies whose mothers or close family have been infected with Hepatitis B.
5 – 6 days old	Blood spot test for hypothyroidism and phenylketonuria. Screening for sickle cell disease and cystic fibrosis is also being implemented. See <a href="http://www.newbornscreening-bloodspot.org.uk">www.newbornscreening-bloodspot.org.uk</a>
Within 1st month of life	Newborn hearing screen now being rolled out to all areas. If Hepatitis B vaccine has been given soon after birth, the second dose is given.

New birth visit (usually around 12 days)	Home visit by the midwife or health visitor to assess the child and family health needs, including identification of mental health needs. Distribution of 'Birth to Five' guide and the Personal Child Health Record if not already given out ante-natally. Information/support to parents on key health issues to be available (eg. support for breastfeeding, advice on establishing a routine etc).
6 – 8 weeks	General physical examination with particular emphasis on eyes, heart and hips. First set of immunisations against polio, diphtheria, tetanus, whooping cough, Hib, and Meningitis C. Review of general progress and delivery of key messages about parenting and health promotion. Identification of post-natal depression or other mental health needs. If Hepatitis B vaccine has been given after birth, the third dose is given at 8 weeks.
3 months	Second set of immunisations against polio, diphtheria, tetanus, whooping cough, Hib, and Meningitis C. Review of general progress and delivery of key messages about parenting and health promotion, including weaning.
4 months	Third set of immunisations against polio, diphtheria, tetanus, whooping cough, Hib, and Meningitis C.  Opportunity to give health promotion and advice to parents and to ask about parents' concerns.
By the 1st birthday	Systematic assessment of the child's physical, emotional and social development and family needs by the health visiting team. This will include actions to address the needs identified and agree future contact with service.
Around 13 months	Immunisation against measles, mumps and rubella (MMR). Review of general progress and health promotion and other advice to parents. If Hepatitis B vaccine has been given soon after birth a booster dose and bloodtest are given.

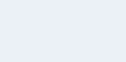
<p>2 – 3 years</p>	<p>The health visiting team is responsible for reviewing a child's progress and ensuring that health and developmental needs are being addressed. The health visitor will exercise professional judgement and agree with the parent how this review is carried out. It could be done through early years providers or the general practice or by offering a contact in the clinic, home, by post, telephone or email etc. Use is made of other contacts with the primary care team (e.g. immunisations, visits to the general practitioner etc).</p>
<p>3 – 5 years</p>	<p>Immunisation against measles, mumps, rubella (MMR) and polio and diphtheria, tetanus and whooping cough. Review of general progress and delivery of key messages about parenting and health promotion.</p>
<p>4 – 5 years</p>	<p>A review at school entry provides an opportunity to check that: immunisations are up-to-date, children have access to primary and dental care, appropriate interventions are available for any physical, developmental or emotional problems that had previously been missed or not addressed, to provide children, parents and school staff with information about specific health issues, to check the child's height and weight (from which the Body Mass Index can be derived for use as a public health indicator), and to administer the sweep test of hearing.</p> <p>National orthoptist-led programme for pre-school vision screening to be introduced.</p> <p>Foundation Stage Profile – Assessment by the teacher to include a child's:</p> <ul style="list-style-type: none"> <li>&gt; Personal, social and emotional development;</li> <li>&gt; Communication, language and literacy;</li> <li>&gt; Physical development, and</li> <li>&gt; Creative development.</li> </ul>

Ongoing support at primary and secondary schools      Access to school nurse at open sessions/drop-in and clinics by parents, teachers or through self-referral. Provision for referral to specialists for children causing concern. Children and young people with medical needs and disabilities may receive nursing care within the school environment according to their needs.

Secondary school      The Heaf test is carried out between 10 to 14 years, and BCG vaccine given to those requiring it. Tetanus, diphtheria and polio vaccines are given between 13 and 18 years. Check other immunisations are up to date.

### Key to relevant records

 NHS Care Record Service

 Personal Child Health Record

This schedule is underpinned by a health promotion programme, based on best available evidence, that focuses on priority issues such as healthy eating, physical activity, safety, smoking, sexual health and mental health, and is delivered by all practitioners who come into contact with children and young people, and in all settings used by this age group.

## Appendix 2

### Training and Development

All staff who come into contact with children in all agencies need to be competent in the following core areas:

- > Child and young person development (physical and psychological);
- > Safeguarding children/child protection, including risk and protection factors;
- > Effective communication and engagement (listening to and involving children and working with parents, carers and families);
- > Supporting transitions (maximising children's achievements and opportunities and understanding their rights and responsibilities);
- > Multi-agency working (working across professional and agency boundaries), and
- > Sharing information.

Depending on their role, staff working with children may also need training to ensure that they are competent in the following areas:

- > Assessing children and young people's developmental needs in the context of their family and environmental factors including school and community, and parenting capacity;
- > An understanding of the impact of disability on the child and family;
- > Understanding the key vulnerability factors for children in special circumstances and responding to their needs, including through referral and joint-working;
- > Identifying the early warning signs of mental health problems in children and young people such as attention deficit hyperactivity disorder, depression, eating disorders, substance misuse and self-harm;
- > Recognising inequalities and ethnic diversity and addressing them proactively;
- > Promoting healthy lifestyles and directing families to local services;
- > Issues of confidentiality and consent, and
- > Record-keeping.

## Children's and Maternity National Service Framework: Key Issues for Primary Care

### PART II

#### Standard 6: Children and Young People who are Ill

All children and young people who are ill, or thought to be ill, or injured will have timely access to appropriate advice and to effective services which address their health, social, educational and emotional needs throughout the period of their illness.

#### Standard 7: Children and Young People in Hospital

Children and young people receive high quality, evidence-based hospital care, developed through clinical governance and delivered in appropriate settings.

#### Standard 8: Disabled Children and Young People and those with Complex Health Needs

Children and young people who are disabled or who have complex health needs receive co-ordinated, high-quality child and family-centred services which are based on assessed needs, which promote social inclusion and, where possible, which enable them and their families to live ordinary lives.

#### Standard 9: The Mental Health and Psychological Well-being of Children and Young People

All children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders have access to timely, integrated, high quality multidisciplinary mental health services to ensure effective assessment, treatment and support, for them and their families.

#### Standard 10: Medicines for Children and Young People

Children, young people, their parents or carers, and health care professionals in all settings make decisions about medicines based on sound information about risk and benefit. They have access to safe and effective medicines that are prescribed on the basis of the best available evidence.





### What this means for Primary Care Providers:

The Children in Hospital Standard (Standard 7) was published in 2003. Although it is focussed on the child who is in hospital as an in-patient or an out-patient, there are some implications for primary care. These include the need for good discharge planning and identifying before referral or admission any additional needs for families who may need support in hospital including translation services or advocacy. The quality of referrals is also important in terms of optimising the use of secondary care. The long term aim is to reduce reliance on secondary care services, by delivering more services in primary care, through enhanced self-care and improving the management of long term conditions for all age groups.

### General information, advice and support:

PCPs ensure that parents or carers, children and young people receive information, advice and support to enable them to:

- > Manage minor illnesses themselves, using community pharmacists where appropriate;
- > Access appropriate services when necessary;
- > Participate in their own care planning and delivery;
- > Be routinely involved and supported in making informed decisions and choices about their treatment, care and support, taking into account their age and development, increasing autonomy with age, and the need for confidentiality balanced with the parents' need for have information, and
- > Young people and parents or carers receive copies of relevant letters about their health, if they want them. Health professionals may need to develop appropriate writing styles for this.

**Access:**

**PCPs ensure that:**

- > Appointment booking systems and drop-in sessions are in place to minimise the amount of time children and young people will be away from school awaiting appointments, and take into account the particular needs of disabled children (e.g. by offering double appointment times or first and last appointment times or those outside school hours);
- > They see urgently on request children and young people with complex health care needs who are prone to health crises, and
- > They fulfil their duties under the *Disability Discrimination Act 1995* to remove or alter physical features (incorporating specialist advice) which may make it difficult for disabled people to access their service.

**Take-up of mental health services**

Many children, young people and their families who could benefit from Take-up of mental health services for assessment and treatment are not accessing services. There are a variety of reasons for this:

- > A lack of recognition or agreement that a problem exists;
- > A fear of being teased and stigmatised;
- > A fear of confidentiality being broken, and
- > A belief that nothing can be done.

These can all affect the take-up of help. PCPs need to be sensitive to these concerns and to offer parents and children choices about how they access services.

“We want a choice where we get help, for instance in school and outside school in a place that isn’t medical” (a user of child and adolescent mental health services).

## Assessment of the Ill Child:

### All PCPs ensure that:

- > All children and young people presenting with undifferentiated illness in primary care are assessed by staff who are competent and trained in assessment of children. There is the facility for timely re-assessment of a sick or injured child within primary care;
- > Assessment considers the mental health needs of the child, and
- > Guidelines are available and used for the management of the common acute illnesses and injuries of childhood and for the assessment of children who re-attend. For example, see Advice on the Management of Common Medical Emergencies in Primary Care<sup>1</sup>. Adherence to such guidelines is audited.

To help PCPs achieve this, a DVD for updating health care workers on the diagnosis and management of acute illness in children is being distributed to all practices with this national service framework.

The Royal College of General Practitioners (RCGP) and the British Association for Community Child Health (BACCH) have worked together to produce training materials for GPs in child health promotion and child development, available on the web at [http://www.rcgp.org.uk/education/chs\\_teaching\\_materials/index.asp](http://www.rcgp.org.uk/education/chs_teaching_materials/index.asp)

### **Child and Adolescent Mental Health Epidemiology**

Ten per cent of 5-15 year olds have a diagnosable mental health disorder and more would benefit from specialist services than are currently seen. Similar numbers of children and young people with less serious mental health problems will need some help. In most cases, this will be provided by services in primary health care, social care, education (including early years) and the voluntary sector.

<sup>1</sup> (due to be published by Kingston PCT and the Modernisation Agency, Autumn 2004)

### Early identification:

- > All staff working directly with children and young people have sufficient knowledge, training and support to promote the psychological well-being of children, young people and their families and to identify early indicators of difficulty. They understand their responsibilities for supporting children in difficulty and are able to access support and advice from specialist CAMHS and CAMH workers in Primary Care;
- > All health visitors and general practitioners are competent and confident to identify health and developmental problems early and refer appropriately for formal diagnosis, and
- > PCPs respond quickly to concerns raised by parents, early years workers, teachers and others who are in close contact with the child or young person.

### Early Interventions:

Early intervention where there are problems identified in a child's development has a positive effect both in terms of promoting development, and minimising decline or regression among children with developmental disabilities. PCPs have access to, and use protocols for referral, support and early intervention, agreed between all agencies.

Mental health problems in children are associated with educational failure, family disruption, disability, offending and antisocial behaviour, placing demands on social services, schools and the youth justice system. Untreated mental health problems create distress not only in the children and young people, but also for their families and carers, continuing into adult life and affecting the next generation.

### Co-ordination and continuity of care

PCPs have an understanding of how the local Children's Clinical Network operates and their role within it. While care for children and young people will often be co-ordinated and managed by a paediatrician or key worker in the community, PCPs should endeavour to keep up-to-date regarding significant management changes for their patients – and should at minimum know who to contact if they need further information when they see a child or young person.

There is continuity between care delivered in different settings supported by systems to share relevant information about children and young people in a timely way.

### Records and sharing Information:

For children with known significant medical disorders, there is a personal plan readily accessible to PCPs describing action to be taken in the event of deterioration. Copies of this should be held both by parents and filed in the medical notes.

### Prescribing

The use of medicines in children is based on the best available evidence of clinical and cost-effectiveness and safety, ideally derived from clinical trials, but also including, where appropriate, medicines that are not licensed for their age group or for their particular health problem ('off-label'), or those that do not have a licence at all ('unlicensed') in order to achieve the best possible health outcomes and minimise harm and side effects.

The British National Formulary for Children will provide authoritative and up-to-date advice on the use of medicines in children. It will be produced by an expert Formulary Committee, will take account of recent NICE and CSM guidance, will be revised annually, and will be distributed to doctors and pharmacists. Its format will resemble the adult BNF, and an electronic version is also planned.

### Concordance:

The concept of compliance (the extent to which the prescriber's instructions are followed) is now widely considered as outdated and instead the aim is to achieve concordance, where there is shared decision-making between parents or carers, children and young people, and professionals. Time and effort invested in a concordant discussion between the health care professional and the child or young person and their family in their treatment should result in more effective use of medicines.

Prescribing medicines for children can present particular problems, especially for those professionals who do not routinely work within children's services. To meet this standard, PCPs will need to take account of the following:

- > The doses of medicines prescribed need to take account of the age and weight of the child, their developmental stage and co-existing co-morbidities. The child's age, weight and intended dose in mg/kg is ideally included on all prescriptions for medicines of high risk, where available;
- > Oral syringes of appropriate size are used to administer all liquid medicines when the volume required does not correspond to a 5ml teaspoon. For babies and younger children, it may be appropriate to use oral syringes rather than spoons to facilitate administration of all liquid medicines;
- > There is prominent documentation of the allergy status in patient records;
- > To reduce avoidable problems when a child is transferring between secondary and primary care, clear and prompt written communication takes place between hospital specialists, general practitioners and, where appropriate, the community pharmacist, about the medicines and doses they have prescribed for a child, and
- > Personal Child Health Records are used as well as NHS-based records when medicines are unusual, or when the dose is changed frequently. Hospital pharmacists communicate directly with colleagues in other hospitals and in the community when a child or young person is transferred or discharged, when medicines are unusual, require special preparation or consideration, or are difficult to obtain.

### Information and decision support for professionals:

- > Health professionals who prescribe, dispense and administer medicines for children are able to access support and information from paediatric specialists who have the knowledge and expertise in medicines for children, and
- > In primary care, the use of unlicensed medicines is overseen by the Area Prescribing Committee (or equivalent).

### Information on medicines for patients:

- > Children, young people and their parents/carers receive consistent, up-to-date, comprehensive, timely information on the safe and effective use of medicines;
- > In all settings, professionals enable parents, young people and, where appropriate, children to be active partners in the decisions about the medicines prescribed for them, ensuring that the risks and benefits of treatment are discussed, taking into account their values and beliefs, as well as the effects of the proposed treatment on daily living;
- > The age at which children are ready to take care of, and be responsible for, their own medicine, varies. Healthcare professionals need to assess, with parents and children, the appropriate time to make this transition;
- > Tailored information is provided to young people and their carers, where available, for off-label or unlicensed medicines, to explain the use of the medicine for their particular condition. Two patient information leaflets (one for parents/carers and one for older children) have been produced by the Joint Standing Medicines Committee of the Royal College of Paediatrics and Child Health and the Neonatal and Paediatric Pharmacists' Group and are available on their website: [www.rcpch.ac.uk/publications/formulary\\_medicines.html](http://www.rcpch.ac.uk/publications/formulary_medicines.html);



- > Labels in larger type and braille are, where possible, provided for parents and children and young people who are visually-impaired, and
- > PCPs should be able to demonstrate that they have sought and acted on patients' and their parents or carers views and that patients' agreement was sought for the medicine regime they have jointly agreed, especially for children or young people with long term or complex medication needs.



### Medication review:

PCPs ensure that mechanisms are in place for regular review of medicines used to treat children and young people with complex, long term conditions, for children in all settings including children's homes and young offenders institutions.

Professionals taking medication histories ensure that the use of complementary therapies is taken into account.

### Medicine storage:

When prescribing, dispensing and administering medicines for either adults or children or young people who are at home, professionals alert parents or carers to the potential dangers of the medicines and advise them on appropriate storage.

### Clinical Governance:

Record-keeping systems allow appropriate monitoring and promote safe practice. PCPs should ensure that medication errors are reported through local systems as well as national reporting and learning systems.

Prescribing of antibiotics should be in line with best practice and monitored with a view to reducing antimicrobial resistance.

A large number of sugared medicines are still prescribed for, or dispensed to children and are a potential cause of tooth decay. In prescribing, dispensing or administering medicines to children, healthcare professionals should be aware of the availability of sugar-free alternatives and ensure that, where possible, these are prescribed or dispensed in preference.

### Medicines for children at school:

A range of options are explored to enable children and young people to receive their medicines during the school day; prescribers may wish to consider the following options:

- > The use of medicines which need to be administered only once or twice a day (where appropriate) for children and young people so that they can be taken outside school hours, and/or
- > Providing two prescriptions, where appropriate and practicable, for a pupil's medicine: one for home and one for use at school, avoiding the need for repackaging or relabelling of medicines by parents. School staff should follow

only the prescriber's labelled instructions.

#### **Training and development for medicines management in primary care:**

PCPs have the relevant competencies to prescribe, dispense and administer medicines for children and young people *see Box below*.

Staff involved in medicines management for children and young people have the appropriate common core skills, knowledge and competencies (including safeguarding/child protection) set out in Standard 3.

#### **Medicines management competencies for Primary Care Providers**

Health professionals who are prescribing or administering medicines for children and young people are competent in:

- > The safe and effective use of medicines in children;
- > Calculating drug doses, and administering medicines to children;
- > Understanding the risks and benefits of medicines in relation to children;
- > The needs of ethnic minorities, and cultural differences in beliefs about illness and the use of medicines;
- > Accessing best evidence on the effectiveness of medicines;
- > Giving information on medicines to children and parents in a clear way;
- > Concordance, including active listening and shared decision-making with children and parents, and
- > The recording of significant events and their use in multi-disciplinary and multi-agency audits.

## PART III

### Standard 11: Maternity Services

Women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies.

#### Primary care information, advice and support :

The majority of women and their partners will want to be active participants in their care. Most will want to be involved in decisions about which type of care or offers of screening best suits their needs and wishes, and to share responsibility for managing their pregnancy in partnership with professionals.

Ante-natal tests and screening are offered to women as options (with the purpose and consequence of each test explained), rather than as a routine part of the process of being pregnant. Where women request or decline services or treatment, their decision is respected.

#### Pre-Birth Care

The NICE Ante-natal Care Guidelines recommend that women have access to maternity services at 8 – 10 weeks of pregnancy to give them time to plan their pregnancy effectively and consider early screening options.

Delivering effective ante-natal care is dependent upon effective and sensitive provision of non-directive information and support.

Feedback from parents is that they want more information than is currently provided for them, particularly first-time parents, fathers, young parents, those from disadvantaged communities or groups, and minority ethnic groups.

Primary care providers (PCPs):

- > Refer all pregnant women immediately for booking and not ask them to wait (PCPs need to make receptionists aware of the importance of this);
- > Inform women that they have the right to go directly to a midwife for their booking and ensure receptionists are aware of this to avoid delay;
- > Pass on relevant social and medical information to the midwife to ensure appropriate risk assessment and care is provided;
- > Support involvement of all women in planning their own care with information, advice and support from professionals, including choosing the place they would like to give birth and the professionals who will attend them throughout their pregnancy and after birth;
- > Are proactive in engaging all women with maternity services, particularly women from disadvantaged groups and communities, early in their pregnancy and encouraging them to maintain contact before and after birth;
- > Identify women with pre-existing medical or familial conditions who may become pregnant and ensure they have pre-pregnancy access to specialist advice should they plan to become pregnant, or appropriate contraception if they do not;
- > Ensure all pregnant women and their partners who smoke receive clear information about the risks of smoking and support to stop;
- > Who are working with women in the pre-conception and ante-natal period are competent in recognising, advising and referring women who would benefit from more specialist services;
- > In addition to providing support and advice for women, seek to engage and support fathers, where appropriate;
- > Offer women general and specific information about taking medicines during their pregnancy, and
- > Consider the welfare of the unborn baby and are aware of the importance of parental problems including domestic violence, substance misuse and mental health problems. They are competent in recognising the symptoms and presentations and are able to make a sensitive enquiry if concerned and can provide basic information about, or referral to, local services as required.

*See Standard 5 and Domestic Violence: a resource manual for Healthcare*

*Professionals DH (2000)* and [www.northbristol.nhs.uk/midwives/domesticviolence](http://www.northbristol.nhs.uk/midwives/domesticviolence).

### **Problems in Early Pregnancy**

A significant number of women develop problems in early pregnancy which require quick and sensitive assessment. Up to 20% of pregnancies miscarry and one in a hundred pregnancies will be ectopic pregnancies (outside the womb). The latter can be life-threatening unless diagnosed early and dealt with quickly. Successive Confidential Enquiries into Maternal Deaths Reports have highlighted delays in the diagnosis of ectopic pregnancy, sometimes with fatal results.

PCPs:

- > Refer all women with worrying symptoms in early pregnancy for rapid assessment and treatment as required, and
- > Offer women with three or more miscarriages a referral to a specialist recurrent miscarriage clinic;

### **Post-natal Ongoing Community Care:**

All PCPs involved in the care of women immediately following childbirth need to ensure that the care and support provided is tailored to meeting the individual needs of each woman. The mother's plan of care should be drawn up by the midwife or health visitor following a structured assessment of needs, using a recognised assessment tool and PCPs should be informed when there are particular problems. Post-birth care for the mother may need to be provided for 3 months, or longer, depending on need. All PCPs should be able to distinguish normal emotional and psychological changes from significant mental health problems and to refer women for support according to their needs.

### **Post-Birth Care for Babies:**

PCPs examining newborn babies have up-to-date training in neonatal examination techniques. Prompt referral for further medical investigation or treatment is provided through agreed clinical care pathways.

### **Infant Feeding:**

PCPs are aware of and, if appropriate, refer women to easily accessible breast-feeding support services e.g. community-based networks offering mother-to-mother support and trained breastfeeding counsellors working within, or closely with, the health care system. PCPs prescribing medicines to women who are breastfeeding ensure their safety, based

on best available current evidence and by consulting authoritative sources, if appropriate.

## Appendix 3:

### Further information on Maternity Services for Primary Care Providers

The Department of Health national target on improving the health of the population sets out some of the current challenges including the need to focus on:

- > Reductions in smoking in pregnancy;
- > Improving nutrition of women of childbearing age, particularly those who are pregnant or breastfeeding;
- > Increased breastfeeding initiation and duration rates;
- > Effective ante-natal care; and providing high quality midwifery, obstetric and neonatal services in a culturally sensitive way, together with
- > Effective family support, focussed on those with high needs.

#### Pre-Conception care

About half of pregnancies in the United Kingdom are unplanned and some women may delay seeking advice once they know they are pregnant, for a variety of reasons.

Prospective parents do not currently have easy access to information, such as the importance of folic acid supplementation prior to conception and ensuring rubella immunity as rubella infection in the first 8-10 weeks of pregnancy results in fetal damage in up to 90% of infants.

Some women and prospective parents need specialist pre-conception advice, information and support:

- > Women who have conditions treated with prescription drugs that may harm the unborn baby need advice about changes in their medications prior to pregnancy; such conditions include epilepsy, schizophrenia, hypertension and bi-polar affective disorders;
- > Women with a condition such as heart disease, a history of embolism, epilepsy or diabetes will need information and advice, to ensure that their treatment is optimised, about managing their health before conception and during pregnancy, and
- > Prospective or existing parents with a family history of a genetic disorder, and those who are concerned about familial disease or disabilities.



There are significant risks to the health, and life, of a baby if the mother smokes. These include the risk of miscarriage, premature birth and stillbirth, of placental abnormalities, low birthweight and, after birth, sudden infant deaths. It is estimated that about one-third of all perinatal deaths in the UK are caused by smoking.

### Pre-conception information for parents

Local health promotion arrangements include the provision of the information for parents on what becoming a parent might be like and what it will involve and the importance of:

- > Pre-conceptual folic acid;
- > Minimising intake of alcohol;
- > Not using recreational drugs;
- > Not smoking during pregnancy and having a smoke-free environment;
- > Pre-pregnancy rubella immunisation, and
- > Seeing a healthcare professional as early in pregnancy as possible.

See also the Department of Health/Dr Foster local maternity guides and *You're Pregnant*.

### Pre-Birth Care

Approachable and supportive ante-natal services in convenient and accessible settings encourage and enable women to engage with maternity services early in their pregnancy and maintain contact throughout the pregnancy, the birth and the early post birth period. It is recommended in the NICE Ante-natal Care Guidelines that women have access to maternity services at 8 – 10 weeks of pregnancy to give them time to plan their pregnancy effectively and consider early screening options.

Some women, particularly those from more vulnerable and disadvantaged groups, may require more support and access to social or other services, e.g. housing, benefits advice and relationship support.

Delivering effective ante-natal care is dependent upon effective and sensitive provision of non-directive information and support. Feedback from parents is that they want more information than is currently provided for them, particularly first-time parents, fathers, young parents, those from lower social classes and minority ethnic groups.

As pregnancy progresses women's information requirements change. Good antenatal care for all women and their partners will also involve access to parenting education, and preparation for birth as classes or through other means to enable them to make informed choices about the type of birth they would prefer.

Women need general and individual information about taking medicines during their pregnancy.

#### Pre-Birth Mental Health

The transition to parenthood is associated with psychological change and emotional upheaval. All those concerned with the care of women and their families at this stage in their lives need to be familiar with the normal emotional and psychological changes that take place during pregnancy and in the post-natal period. They also need to be familiar with the signs and symptoms of common crises, the likely causes of these crises, and the states of distress that arise in relation to obstetric and other events.

Mental health problems and mild non-psychotic psychiatric illnesses are common both in pregnancy and following birth. The incidence of serious mental illness is reduced during pregnancy but increased following delivery. A significant minority of women will have a psychiatric disorder during pregnancy which may continue following delivery and compromise their adjustment to motherhood.

Women who have substance misuse problems are at greater risk of problem pregnancies and their care should be provided by an integrated multi-disciplinary and multi-agency team.

Professionals should also consider the effect these problems may have on the woman's ability to meet the needs of her baby. Where there are concerns about the unborn baby's welfare, or the welfare of the baby after birth, a referral should be made to social services for an assessment of the mother and baby's needs, and for social care services to be provided as required.



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40620 1p 25k Sept 04 (STE)

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*40620/Key Issues for Primary Care - National Service Framework  
for Children, Young People and Maternity Services*

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