

IMMUNISATION

BUILDING
RELATIONSHIPS
WITH THE FAMILY

Guidance & Principles of Practice for Professional Staff

SURVEILLANCE

TARGETING
NEED



FAMILY
SUPPORT

SCREENING
SCREENING

HEALTH
PROTECTION

HEALTH
PROMOTION



Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

www.dhespsni.gov.uk



Date of publishing: 17th October 2006



CONTENTS

FOREWORD	4
ACKNOWLEDGEMENTS	5
BACKGROUND	6
INTRODUCTION	6
SECTION 1 HALL 4 CORE PROGRAMME AND OBJECTIVES IN NORTHERN IRELAND	7
1.1 Health promotion.....	8
1.2 Building relationships with the family.....	8
1.3 Health protection.....	9
1.3.1 Screening.....	9
1.3.2 Surveillance.....	10
1.3.3 Immunisation.....	10
1.4 Information sharing.....	11
1.5 Summary of Hall 4 programme.....	11
SECTION 2 TARGETED PROGRAMME	14
2.1 Assessing vulnerability.....	15
2.2 Children in special circumstances.....	16
2.2.1 Child Protection.....	16
2.2.2 Looked after children (LAC) / awaiting adoption.....	18
2.2.3 Maternal mental health.....	19
2.2.4 Domestic violence.....	21
2.2.5 Substance abuse by parent(s).....	22
2.2.6 Temporary residents / new to area.....	23
2.2.7 Children/young people with disabilities and special educational needs.....	24
2.2.8 Teenage pregnancy and parenthood.....	25
2.2.9 Child and adolescent mental health.....	26
2.2.10 Children educated outside school settings.....	27
2.2.11 Young people in community settings.....	27
SECTION 3 GUIDANCE TO THE UNIVERSAL CORE PROGRAMME FOR CHILD HEALTH SCREENING AND SURVEILLANCE – PRE-SCHOOL AND SCHOOL HEALTH	28
Antenatal visit/contact.....	30
Neonatal examination – first 72 hours.....	32
Postnatal visit/contact.....	34
Primary visit 10 - 14 days.....	36
8 weeks.....	38
3 months.....	40
4 months.....	41
12 months.....	42
15 months.....	43
2 year record review.....	44
4 years – school readiness assessment.....	45
Child Health Programme (School Health Flowchart)*Entry to Primary School (includes P1 and all other new school entrants).....	47
Entry to Primary School (includes P1 and all other new school entrants).....	48
Primary 2-7.....	49
Post-primary school.....	50
SECTION 4	51
Monitoring and quality assurance.....	51
Recommended reading list.....	52



APPENDICES	54
<i>Health promotion guidance at antenatal, neonatal examination and postnatal visit/contact</i>	55
<i>Health promotion guidance at primary visit/8 week, 3 and 4 month visit/contact</i>	56
<i>Health promotion guidance at primary visit at 15 months and 4 year school readiness assessment</i>	57
<i>Health promotion guidance at primary and post-primary school</i>	58
<i>Growth monitoring promotion</i>	59
<i>Centile Crossing</i>	59
<i>Faltering growth / failure to thrive</i>	60
<i>Criteria for referral</i>	60
<i>Growth Monitoring - Indicators for measurement of Length and Head Circumference</i>	60
<i>Recommendations for policy development</i>	61
<i>Scottish intercollegiate group network guidelines for postnatal depression</i>	62
<i>Hepatitis risk factors</i>	63
<i>Hepatitis B Immunisation Care Pathway in Neonates</i>	64
<i>Developmental dysplasia of hips (DDH) risk factors</i>	68
<i>Congenital heart disease risk factors</i>	69
<i>Hearing risk factors</i>	70
<i>Vision risk factors</i>	71
<i>Pneumococcal Immunisation risk factors</i>	72
<i>Visual screen pathway (Preschool)</i>	74
<i>Visual screen pathway – P1 (School Nurse)</i>	75
<i>Northern Ireland Pre-School Immunisation and Health Surveillance Programme</i>	76
<i>Northern Ireland Primary and Post-Primary School Health Immunisation and Health Surveillance Programme</i>	78
<i>The newborn blood spot screening pathway</i>	79
<i>Membership of Regional HFAC Group</i>	80



Foreword

The fourth edition of *Health for All Children* (Hall 4) provides a framework for connecting the range of different policies and spheres of activity that support children and young people's health and development in the early years and beyond.

Hall 4 is welcomed in Northern Ireland and offers a great opportunity to use the skills and expertise of a range of professionals to link effective child health promotion, prevention and care.

The Guidelines and Principles of Practice for Professional Staff set out a clear core programme of child health contacts that every family can expect, wherever they live in Northern Ireland, recognising that individual families are different and that there is a need to be flexible and innovative to ensure that all families are able to access and benefit from the advice, support and services that are available to them.

We are enormously grateful to all the professionals involved in the development of this guidance or who have commented on it. Their input has been invaluable.

Signed by

Angela McLernon
Chair of Regional Group

Dr. Margaret Boyle
Chair of Regional Group



Acknowledgements

This document has been endorsed by the Regional Health for all Children Working Group (Members detailed in appendix xvi) and endorsed by stakeholders at a regional multi-professional workshop April 2005.

The regional working group would like to take this opportunity to acknowledge the considerable contribution of the following members of the Regional Sub Committee who developed and edited the document for consultation.

Ms Avril Bassett, Nurse Education Consultant, The Beeches.

Dr Carol Beattie, Consultant in Public Health Medicine, EHSSB.

Mrs Patricia Blackburn, AHP Commissioner, SHSSB.

Mr Mike Dunne, Nurse Education Consultant, North West Consortium.

Mrs Maureen Griffith, Assistant Director of Nursing, NHSSB.

Ms Jackie Hamilton, Maternal and Child Health Project Manager, WHSSB.

Mrs Mary Maxwell, Midwifery Manager, NHSSB.

Mrs Jean McCracken, Health Visitor, SHSSB.

Mrs Siobhan McIntyre, Service Planner - Maternal and Child Health, WHSSB.

Ms Jo Taylor, Project Manager, Hall 4, NHSSB to June 05.

Mrs Deirdre Webb, Assistant Director of Nursing, EHSSB.



Background

In 1988 the Royal College of Paediatrics and Child Health established a joint working party to review existing services¹. The first edition of Health for All Children was published by this multidisciplinary working party in 1989. The emphasis then was on development of partnerships between parents, children and health professionals.

The fourth edition of Health for all Children (Hall 4)², published in December 2002 promotes the gradual shift from a highly medical model of screening, to one with a greater emphasis on health promotion, primary prevention and active intervention for children at risk.

Hall 4 reflects the current evidence base and is in line with recommendations from the National Screening Committee (NSC). The NSC assesses proposed new screening programmes against a set of internationally recognised criteria covering the:

- Condition;
- Test;
- Treatment options;
- Management of the condition.

Introduction

Guidance and principles of practice for professional staff has been developed to assist consistent implementation of the recommendations in the fourth edition of Health for All Children throughout Northern Ireland. It sets Hall 4 in the context of other local policies to promote the effective and integrated provision of universal and targeted services for children and families, and describes the activity needed for implementation at both regional and local levels.

The guidance provides an evidence-based framework to assess, monitor and support children's health and development throughout childhood and adolescence, based on staged intervention and underpinned by strong health promotion activities. The guidance will assist health care professionals who work with children and their families.

In circular HSS (MD) 15/04 the Chief Medical Officer and the Chief Nursing Officer commended that all Health and Social Services Boards and Trusts should commission and provide maternity and child health services in line with the Health for All Children report by April 2005.

1. British Paediatric Association and the Royal College of General Practitioners, the General Medical Services Committee of the British Medical Association, the Health Visitors' Association and the Royal College of Nursing.

2. Health for All Children, 4th Edition, David M. B. Hall & David Elliman, Oxford Medical Publications, 2003.



SECTION 1 HALL 4 CORE PROGRAMME AND OBJECTIVES IN NORTHERN IRELAND

The aim of the Hall 4 core programme is to work with families and communities to achieve optimum child health. The core programme will be made available to all children in Northern Ireland and is divided into three main sections:

1. Health promotion.
2. Building relationships with families.
3. Health protection.

Implementation and delivery of the core programme should be responsive to individual family, child and local community needs. Links, where appropriate, should be established with child-focused community based initiatives, for example, Surestart.

Additional services should be targeted at those who need them, based on assessments made by the professionals working with the family. Health professionals should also ensure that the initial family health needs assessment is regularly updated during the period of working with the family.

The screening programmes recommended by Hall 4 and the NSC should be offered to all children. The aim is to ensure that 100% of families/children are offered the recommended screening programmes.

Objectives of the Health for All Children core programme

- To ensure that all parents and children have access to, and understanding of all relevant health care messages that are evidence-based and shown to be beneficial.
- To arrange and deliver immunisations.
- To carry out the agreed screening procedures and ensure follow-up of abnormal results.
- To enable parents with worries about their child to locate the help they need promptly and efficiently.
- To support the local community in creating an environment at home and at school in which the child can be safe, grow, and thrive physically and emotionally.
- To identify vulnerable children and families who may benefit from additional support or services beyond the core programme and negotiate whatever is needed.
- To ensure that as far as possible children who have or may have special educational needs are identified and referred to the education services and to the appropriate voluntary and statutory agencies.



1.1 Health promotion

Hall 4 defines health promotion as *'any planned and informed intervention, which is designed to improve physical or mental health, or prevent disease, disability and premature death'*.

Health for All Children, 4th Edition, David M. B. Hall & David Elliman, Oxford Medical Publications, 2003

Health promotion should be integral to the day-to-day work of all health professionals engaged in caring for children. It should include information on antenatal care and early support after childbirth with particular reference to breastfeeding status, as well as providing information, advice and support to parent(s) as the child grows and develops.

Whilst health promotion should be tailored to the family's needs, the evidence in a number of areas is such that the health professional should ensure that parent(s) have the appropriate knowledge on prevention, for example, sudden infant death (SIDs), passive smoking and accidents.

There should be strong links and closer communication with community development programmes and other initiatives aimed at reducing inequalities, social exclusion, eliminating poverty and improving educational outcomes.

1.2 Building relationships with the family

'There should be sustained high quality and quantity input and importantly, sufficient continuity of input to develop a relationship with the individual client and family (in many cases this implies commencing a professional relationship during pregnancy rather than after the child is born).'

Health for All Children, 4th Edition, David M. B. Hall & David Elliman, Oxford Medical Publications, 2003, pg 50.

An assessment of need should be on an individual family basis. It is advised that health professionals should get to know the family in the antenatal period and use this information to assist in identifying those families and communities in need of greater support.

It is important that vulnerable children, including those with complex needs and special educational needs, are identified and provided with the necessary support. Parents should be provided with information on how to seek help if they have any concerns about their child.

'Families that need the most help are often the most difficult to reach and may not be known to the health services. They include the homeless, transient populations, refugees, asylum seekers, and people with chronic illness or disability (who may be cared for by their own children), substance abusers and people with communication problems such as the hearing impaired. Targeting these families and building a relationship needs more time and extra skills.'

Health for All Children, 4th Edition, David M. B. Hall & David Elliman, Oxford Medical Publications, 2003, pg 51.

Hall 4 promotes an approach that focuses on collaboration, information, empowerment, family support and education.



1.3 Health protection

There are three main strands to health protection in children: screening, surveillance and immunisation.

1.3.1 Screening

Screening is defined by the UK National Screening Committee as a '*public health service in which members of a defined population, who do not necessarily perceive they are at risk of, or are already affected by a disease or its complications, are asked a question or offered a test, to identify those individuals who are more likely to be helped than harmed by further tests or treatment to reduce the risk of a disease or its complications*'.

www.nsc.nhs.uk

The aim of screening is to identify children at risk of a particular condition. Screening is not diagnostic; it only identifies those who are likely to benefit from further investigation or treatment. A screening test may consist of a question identifying a child with a specific risk factor. Some of those identified by screening will be found not to be at increased risk when they have further investigations. These children are called 'false positives'. There will also be people who are at increased risk but are not identified by the screening programme. These are called 'false negatives'. Parents, where appropriate, should be made aware of the benefits and limitations of screening tests so that they can make informed decisions about whether or not to participate.

If children who screen negative present later with symptoms consistent with the condition screened for, they should be referred as appropriate. (For example, a negative neonatal blood spot screen for cystic fibrosis does not exclude cystic fibrosis in a 3-year-old child with multiple chest infections and failure to thrive). Parents should be made aware of the signs and symptoms of the specific conditions for which the child has been screened and advised to contact their GP or other health professional if they have any concerns, even if the screening test did not identify a problem. Health professionals should be equipped to advise and support parents who have concerns. They should also know when, where and how to refer the child.

Health visitors, school nurses, community paediatricians, allied health professionals and GPs are likely to be the first point of contact when parents have concerns. Parents may also raise their concerns with staff in their child's nursery, pre-school or school.

Population screening involves more than applying a screening test to an individual. To achieve its aims, a population based screening programme needs to be provided in a systematic way by appropriately trained staff. The target population needs to be defined, as does the timing of the test. The test needs to be applied in a uniform way with agreed positive or negative result. These parameters should be set according to the best available evidence. The referral pathway for screen positive individuals should be clearly defined.

Responsibility for ensuring appropriate referral and follow up of a 'failed' or 'not normal' screening test result lies with the health professional who carried out the screening test.



For a screening programme to be effective it should be undertaken:

- a. In a systematic way;**
- b. To the vast majority of the target population;**
- c. At the appropriate time;**
- d. By appropriately trained people.**

1.3.2 Surveillance

There should be ongoing surveillance of the general health and development of the child. Health professionals must listen to parental concerns and respond appropriately including onward referral and future assessment. They should work in partnership with parents to support them in making healthy choices for their children. That partnership should be based on trust. It is also essential that parents know where to go for advice when they have a concern about their child.

The development of a family-centred public health role for health professionals will support a more proactive approach to promoting child health with a reduced emphasis on routine systemised surveillance.

Where there is a concern about a child's development, formal assessment to confirm or refute these initial suspicions is essential. This should be undertaken as part of a more comprehensive assessment involving a network of child development services and should include consideration of referral to a community paediatrician.

Local care pathways and protocols should be monitored and evaluated on an ongoing basis to ensure their effectiveness.

1.3.3 Immunisation

Health professionals can contribute to improving the health and quality of life of children by promoting the uptake of safe and effective vaccines.

All children should be offered immunisation in line with the current national immunisation schedule. Contact with the family at the time of immunisation provides the health professional with the opportunity to provide relevant health promotion and carry out general health surveillance, including growth monitoring of the child (appendix ii).



1.4 Information sharing

From the antenatal period onwards and during the first few weeks of a baby's life, there must be an effective transfer of information between the midwife and the health visitor. The midwife should complete a transfer record for inclusion in the personal child health record (PCHR).

The health visiting record should be completed at the end of the pre-school period and passed onto the school health service. The transfer of information from the pre-school health visitor to the school nurse must be carried out in line with organisation protocols for transfer of information.

The transition from early years to primary school, primary school to post-primary school, and from post-primary school to employment or further education or training have been identified as vulnerable stages of development for children and young people. It is essential that there is an exchange of relevant information within, and between agencies to allow them carry out an integrated assessment of need and to meet the needs of these individuals, particularly for those who have special needs e.g. disability.

The years from the early stages of post-primary school education and adolescence to adulthood are times of great change for young people. It is important that young people feel supported, maintain self-esteem and avoid a wide range of health damaging behaviours and other hazards. School health teams, working in partnerships with families and communities, can make a vital difference in this period.

1.5 Summary of Hall 4 programme

1. Every child and their parent(s) should have access to a universal core programme of preventive health care.

The content of this is based on three considerations:

- a) The delivery of agreed screening procedures;
- b) Evidence-based health promotion; and,
- c) The need to establish which families requires additional support.

2. The core programme includes:

Pre-school 0-5
• Antenatal visit / contact
• Neonatal examination
• Newborn hearing screening
• Newborn blood spot screening
• Primary visit
• 8 week developmental review
• The national immunisation programme and growth monitoring, 8 weeks, 3 months, 4 months, 12 months (immunisation only), 15 months and 4 years.
• Record review at 2 years.
• School readiness assessment at 4 years



Primary
• School entry health assessment (P1 and other new entrants)
• Vision screening
• Sweep hearing
• Growth monitoring
• P2 - P7 targeted reviews
Post-primary
• Yr 8 school entry health assessment (and other new entrants)
• Yr 8-14 targeted reviews
• Yr 11 school leaving immunisations

In addition:

- Support as needed in the first weeks with particular regard to breast-feeding
- Provision of health promotion advice.

Early detection can identify a large proportion of serious problems in one of five ways:

- *At the neonatal examination and 6-8 week examinations*
- *Follow-up of infants and children who have suffered various forms of trauma or illness affecting the nervous system*
- *Close observation of children with a strong family history of a particular disorder.*
- *Detection by parent(s) and relatives*
- *Detection by midwives, playgroup leaders, nursery nurses and teachers, health visitors, and GP's in the course of their regular work*
- *Opportunistic detection.*

*Health for All Children, 4th Edition, David M. B. Hall & David Elliman
Oxford Medical Publications, 2003 page 131*

3. Formal universal screening is not recommended for speech and language delay, global developmental delay or autism.
4. If parent(s) express concern, the appropriate health professional e.g. midwife / health visitor / school nurse / primary care practitioner should carry out a preliminary assessment or triage process to identify the child's needs with onward referral to appropriate services.
5. The personal child health record (PCHR) will provide the parent(s) with a comprehensive health record for their child. It will also provide a core child health data set.
6. Evidence is available to support health promotion activity in a number of areas including prevention of infectious diseases (by immunisation and other means), reducing the risk of sudden infant death, supporting breastfeeding, encouraging better dental care and informing and advising parent(s) about accidental injury.
7. The main healthcare needs of school age children will be identified from a range of interview studies held with teachers and children.



Additional programmes for school aged children will include:

- Support for children with additional and special needs.
- Participation in healthy schools programmes designed to improve the school environment and social ethos, promote emotional literacy, exercise opportunities and healthy eating and reduce bullying.
- Healthcare facilities for young people in line with their clearly stated and well-established requirements for privacy and confidentiality.
- Support at transition stages (pre-school – school, post-primary – work / college / university).

8. In each Trust, it must be clear who is responsible for screening programmes, maintenance and reporting of immunisation uptake, introduction of new immunisation programmes, health promotion, care pathways for children with health or developmental problems, socially excluded groups, child protection, looked after children, links with education, staff training and data management.



SECTION 2 TARGETED PROGRAMME

One important duty of the child health programme is to identify, assess and support families with identified needs and vulnerable families. Additional services / support should be targeted at those who need them, based on assessment made by the health professionals working with the family / school.

A targeted programme of support is one where the focus is on health and social support to those groups most at risk. This is an essential part of the public health approach.

Current guidance is that there should be a named health professional for every pre-school establishment. It is acknowledged that more and regular public health time in pre-school settings, including family centres, nurseries, parent and toddler groups, community and voluntary groups will enable effective liaison, support and early identification of problems within local communities.

The DHSSPS with health and social work professionals is currently developing a single assessment framework for vulnerable children and children in need.



2.1 Assessing vulnerability

A range of tools and checklists are in use to assist with the identification of vulnerable children or families (see recommended reading list Page 52). It must be emphasised that no one assessment tool or checklist will reliably identify all children at risk.

Assessment of vulnerability requires careful continuous gathering of information from formal assessment, observation and discussion with the family and / or child. Information about factors associated with risk or vulnerability should be balanced with information regarding the family's capacity to cope with stresses or problems. Availability of extended family support, good relationships with friends or neighbours and factors promoting personal resilience need to be taken into account. Available information should be analysed and interpreted on the basis of the professional's experience and knowledge, to inform their decisions about the family's need for additional help.

Implementation of the principles of the core programme will provide information systems and processes to enable health and social care professionals to identify the needs of children and ensure appropriate planning and referral for support when necessary.

No one agency can undertake a comprehensive assessment within and across all these domains without support from colleagues in other services and sectors.

Where a single agency is in touch with a child or family and identifies problems or stresses in any one of these areas, this should signal the need to involve others to accurately assess whether the child and family may be in need of additional support, and agree locally how this should best be provided.

Assessment of children and their needs should include consideration of:

The child's development needs:

Including health and education, identify family and social relationships, emotional and behavioural development.

Parenting capacity:

Including ability to provide good basic care, stimulation and emotional warmth, guidance and boundaries.

Ensuring safety and stability.

Wider family and environmental factors:

Including family and functioning, support from extended family and others.

Financial and housing circumstances, employment, social integration and community resources.



2.2 Children in special circumstances

2.2.1 Child Protection

Child protection is a shared responsibility. Co-operation between agencies and disciplines and working in partnership with parents must be the central focus.

'Child abuse occurs when a child is neglected, harmed, or not provided with proper care. Children may be abused in many settings, in a family, in an institutional or community setting, by those known to them, or more rarely by a stranger.'

There are different types of abuse:

- Physical
- Emotional
- Sexual
- Neglect

A child may suffer more than one of them.'

NI ACPC Regional Policy & Procedures 2005, Chp2, 2.3

Child protection must be viewed as high priority within caseloads that require enhanced service intervention above and beyond the core programme. Children categorised as 'in need' or 'in need of protection' is among the most vulnerable in the child population and has the highest levels of health needs. Collaborative working is essential if these children are to benefit from the processes designated to safeguard their welfare. Health and social care professionals are well placed to identify children in need of protection. They should be aware of the indicators of abuse (e.g. neglect, emotional, physical and sexual abuse) and the procedures to follow in the event of child care concerns.

The systems in place for child protection are primarily to protect the interests of children considered to be at risk / potential risk of significant harm.



The guidance and regulations accompanying the Northern Ireland Children Order 1995 states that:

- *The child's welfare must always be paramount – this overrides all other considerations.*
- *Children must be protected where they are at risk of 'significant harm'. This means ill treatment and / or impairment of health or development.*
- *All professionals caring for children and their families have a duty to protect children from abuse or neglect.*
- *Professionals must work together and share relevant information about children who may be at risk.*
- *Whenever possible, professionals must work in partnership with parents.*

NI ACPC Regional Policy & Procedures, 2005

All agencies should:

- *Be alert to potential indicators of abuse.*
- *Be alert to the risks which individual abusers or potential abusers, may pose to children.*
- *Share and help analyse information so that informed assessments can be made of each child's needs and circumstances.*
- *Contribute to whatever actions are required to safeguard the individual child and promote his/her welfare.*
- *Regularly review the outcomes for the child against specific shared objectives.*
- *Work in co-operation with parents unless this is inconsistent with safeguarding the child.'*

Co-operating to Safeguard Children DHSSPS 2003

“Each nurse, midwife and health visitor is required to act at all times in such a manner as to safeguard and promote the interests of individual patients and clients”

NMC Code of Professional Conduct 2004

The principles and guidance set out in the DHSSPS Co-operating to Safeguard Children (May 2003) should be adhered to when developing strategies, policies and procedures to safeguard children who are assessed to be at risk of significant harm.



2.2.2 Looked after children (LAC) / awaiting adoption

'Looked after children are amongst the most socially excluded of our child population. A series of Government reports have highlighted the extent to which health neglect, unhealthy lifestyle, and mental health needs characterise children and young people living in public care. Their health may not only be jeopardised by abusive and neglectful parenting, but public care itself may fail to repair and protect health and may even exacerbate damage and abuse.'

*Health for All Children, 4th Edition, David M. B. Hall & David Elliman
Oxford Medical Publications, 2003 page 300*

The term 'looked after children' was introduced by Children's (NI) Order 1995 and describes children in the care of a local Health and Social Services Trust:

- As a voluntary agreement between the Trust and those with parental responsibility (accommodated, Children's (NI) Order 1995, Article 21 and 25 Children Looked After Vol. 2)
- As a consequence of a court order where the threshold of 'significant harm' has been established, so that parental responsibility is granted to the Trust in partnership with birth parents (in care). Children's (NI) Order 1995, Article 25, 50 and 57 Children's (NI) Order 1995, Children Looked After Vol. 2.
- In Northern Ireland the number of children looked after is 54.3 per 10,000, rates vary across Boards and Trusts.

NISRA, 2003 Mid Year Estimates

Key recommendations for health professionals:

- The health visitors / school nurses should contribute to regular health assessments in a way that enables and empowers children and young people to take appropriate responsibility for their own health. (6 monthly assessments for under 5 year olds, and annual assessment for over 5 year olds).
- Assessments and services should be sensitive to age, gender, disability, race, religious beliefs, culture and language. They should be non-discriminatory and promote equality of access to services. Children should be given the opportunity, at all stages, to express their wishes and concerns and these should be listened to.
- Where possible and appropriate, the child or the young person's birth parents should be involved.
- The child or young person's informed consent to all healthcare and treatment should be actively sought and recorded.
- Assessments should be conducted with a standardised and systematic assessment framework (British Adoption and Fostering forms should be used in practice and should be adapted for local arrangements).



2.2.3 Maternal mental health

The mental health and well-being of women is pivotal to ensuring good clinical, social and other outcomes for both mother and baby and a healthy start to family life.

Ten per cent of new mothers are likely to develop a depressive illness, of whom, between one third and one half will be suffering from a severe depressive illness.

The majority of women who develop postnatal mental health problems will suffer from mild depressive illness, often with accompanying anxiety. Such illnesses are equally prevalent during pregnancy. However there is little evidence that mild depression is any more common during pregnancy or the postpartum period than at other times.

There is a growing awareness of the difficulties for women, their partners, and their children arising from perinatal mental ill health. The Confidential Enquiry into Maternal Deaths 'Why Mothers Die 2000-2002'³ highlighted the serious consequences of failure to address mental health adequately. Psychiatric illness is now the most common cause of maternal death.

The term 'postnatal depression' or PND should not be used as a generic term for all types of psychiatric disorder related to maternal health. Details of previous illness should be sought, and a psychiatrist should assess women who have a past history of serious psychiatric disorders post partum or non-partum.

The UK National Screening Committee does not recommend screening for depression, in the postnatal period. Screening in primary care began in the mid 80s with the development of a questionnaire specifically designed for pregnant and postnatal women - The Edinburgh Postnatal Depression scale (EPDS). The National Screening Committee, however, highlighted many problems with the **use of the EPDS tool**, which made it **unsuitable as a universal screening tool**.

The National Screening Committee issued a statement of clarification on the use of the EPDS.

'Until more research is conducted into its potential for routine use in screening for PND, the NSC recommends that the EPDS should not be used as a screening tool. It may serve as a checklist as part of a mood assessment of postnatal mothers, when it should only be used alongside professional judgement and a clinical interview. The professional administering it should have training in its appropriate use and should not use it as a pass / fail screening tool.'

Practitioners using it should also be mindful that, although it has been translated into many different languages, it could pose cultural difficulties for the interpretation, particularly when used with non-english speaking mothers and those from non-western cultures'.

UK National Screening Committee, 2003

3. Why Mothers Die 2000-2002 Report on confidential enquires into maternal deaths in the UK Gwyneth Lewis and James Drife, RCOG Press, London, 2004. Website: www.cemach.org.uk



4. DSM (IV) – Diagnostic Statistical Manual of Mental Disorders

Key recommendations for health professionals

- A local care pathway for the management of maternal mental health in the antenatal and postnatal period should be developed.
- Professionals must consider the risk factors that have a strong association with the development of mental health difficulties. (See Appendix iii).
- Puerperal psychosis is best managed by antenatal assessment of risk factors and close monitoring in the perinatal period.
- Raise awareness of maternal mental health with individuals, families and communities during the antenatal and postnatal period.
- The EPDS should never be used in isolation; it should form part of a full and systematic mood assessment of the mother supporting professional judgement and a clinical interview.
- The EPDS should only be used by professionals, who have had the appropriate training in the detection, and management of depression in the post natal period, use of the EPDS and conducting a clinical interview.



2.2.4 Domestic violence

Domestic violence and abuse is defined as ‘*threatening behaviour, violence and abuse (psychological, physical, verbal, sexual, financial or emotional) by one person on another where they are or have been intimate partners or family members irrespective of gender or sexual orientation.*’

Tackling violence in the Home, DHSSPSNI 2005

Domestic violence and abuse is essentially a pattern of behaviour, which is characterised by the exercise of control and the misuse of power by one person over another within an intimate relationship or a family. It is usually frequent and persistent. It knows no boundaries as regards age, gender, race, religion, sexual orientation, wealth or geography, but in the majority of reported cases women are the victims. It has wide adverse effects on children.

The impact of domestic violence on individuals’ health is substantial and people who are victims of domestic violence will often turn to a health professional for help. Health professionals should ensure that all health assessments are “child-centred, age appropriate, and allow participation of the child”.

Local policies should be in place to promote best practice for the identification and support of families experiencing domestic violence in partnership with local agencies / community and the voluntary sector. The response to disclosure may include the involvement of children’s social service professionals, local agencies and community and voluntary organisations. Only refer to those agencies that have specialist knowledge and skills in domestic violence. Multi-disciplinary / interagency training should be available locally.

Key recommendations for health professionals

- Raise awareness and routinely enquire about domestic violence with individuals, families and communities.
- Give information about where victims can go for help and assist families to make contact for support from voluntary and community agencies.
- Promote respect and validation when a client makes a disclosure.
- Carry out an assessment of risk and safety planning.
- Respond to physical injuries and make referrals for assessment and treatment.
- Support and follow-up victims of violence (including children who witness violence), monitor the situation and check for signs of escalating violence and increasing risk.
- Provide regular support to family refuges and their residents.
- Working closely with other agencies.
- Recognise that domestic violence in the context of a pregnant woman (with or without existing children) is a child protection issue, and the appropriate child protection policies should be followed.



2.2.5 Substance abuse by parent(s)

Addiction to drugs causes many problems for the child's home environment. There is a higher risk of poverty, criminal activity, chaotic lifestyles, poor nutrition, sexually transmitted diseases, missed appointments, unsafe individuals in the home and frequent parental absences. 'Babies born to opiate users tend to be of a lower birth weight and may have a smaller head circumference and are more at risk of Sudden Infant Death'.

*Health for All Children, 4th Edition, David M. B. Hall & David Elliman
Oxford Medical Publications, 2003 page 47*

Alcohol misuse is also an associated problem. Problem drinking can severely affect the well-being of families through its association with child abuse and neglect, domestic violence and sudden infant deaths (SIDs). Drinking during pregnancy may give rise to foetal alcohol syndrome, and babies are more at risk of sudden infant death.

Key recommendations for health professionals

- Treat the issue of alcohol intake in a non-stigmatising way, as part of a family health assessment.
- Develop skills in brief intervention and motivational interviewing to help people think about reducing their substance abuse.
- Ensure that parents who abuse alcohol have access to local agencies and programmes to help people with substance abuse problems.
- Identify the risks to the children and consider parental capacity to meet the children's needs. Seek cooperation and work in partnership with other key agencies.
- Advice for prevention of sudden infant death.



2.2.6 Temporary residents / new to area

The link between temporary residents (e.g. refugees, asylum seekers,) and poor health is well established. Acute and chronic infections and accidents have been shown to be more common. Temporary accommodation is often cramped and opportunities for children to play are severely impaired. Mental health problems are common amongst homeless children and their families. The high incidence of mental health problems in both mothers and children can persist even after they have been re-housed.

In some circumstances, families that move into an area may do so because of family break-up, domestic violence or unemployment. Hall acknowledges that *“finding such families and supporting them can be difficult and time consuming, but they are a high-risk group and should be targeted. Often the family is reluctant to establish social links and as a result the child/children may not benefit, as the family is not familiar with services available in the area”*.

Health for All Children, 4th Edition, David M. B. Hall & David Elliman Oxford Medical Publications, 2003 Ch 2, page 36.

Key recommendations for health professionals

- Good liaison arrangement should be set up with Northern Ireland Housing Executive.
- Good cooperation between agencies and district councils working in partnership with support groups.
- Effective midwife and health visitor liaison arrangements should be in place with temporary accommodation and homeless hostels.
- Provision of additional support beyond the period of homelessness.



2.2.7 Children/young people with disabilities and special educational needs

'One child in six has learning difficulties at some time in his / her school career and one child in 60 has severe and persistent needs'

Health for All Children, 4th Edition, David M. B. Hall & David Elliman, Oxford Medical Publications, 2003, Chpr 13

A learning difficulty is defined in three ways. A child has a learning difficulty if he/she:

- Has a significantly greater difficulty in learning than the majority of children of the same age.
- Has a disability, which prevents or hinders the child from making use of educational facilities of a kind generally provided for children of the same age in schools within the area of the local education board.
- Are under 5 and falls within the definition of (a) and (b) above or would do so if special educational provision were not made for the child.

Children with special educational needs may include those with sensory, physical, emotional and behavioural difficulties. Between 3% and 5% of children in Northern Ireland are classified as having a disability.

NISRA, 2003

For children with disabilities or special educational needs, child health services should work in partnership with others to:

- Strengthen human rights for disabled people.
- Promote the inclusion of disabled children in society in order to enable them to achieve their full potential.
- Reduce health inequalities.
- Offer more support and greater choice for disabled children and their families.
- Reduce poverty among families with disabled children.

It is noted that not all disabled children have special needs, neither are all special needs due to disability.

- Support the setting up of support groups or networks for disabled children and young people and their families that are client-led.



2.2.8 Teenage pregnancy and parenthood

Teenage pregnancy and early motherhood are associated with poor educational achievement, poor physical and mental health, unemployment, social isolation and poverty.

Targeting of teenage mothers is vitally important due to the health consequences, which include low birth weight babies, higher infant mortality rate, and low incidence of breastfeeding status, high childhood accident rate, and higher rate of postnatal depression.

The DHSSPS Teenage Pregnancy and Parenthood Strategy and Action Plan 2002 – 2007 is currently being progressed by a multi-agency group chaired by the DHSSPS.

The strategy comprises a number of actions grouped under the following areas:

- Policy.
- Information and education.
- Parent(s) / child communication.
- Improving services.
- Confidentiality.
- Training.
- Providing support.
- Research.

Key recommendations for health professionals

- Work with others to initiate innovative ways of preventing teenage pregnancy and supporting teenage mothers eg links with Surestart, Health Action Zones.
- Empower, and support parents in their role as educators.
- Enable young people and teenage parents to participate in planning services.
- Each school should have a personal social and health education programme for all pupils. School nurses should work in partnerships with the parents, pupils and schools in the delivery of this program.
- A local strategy group for teenage pregnancy and parenthood, which must include midwifery services and child protection advisors should be in place. This framework should include a communication strategy, which engages the key stakeholders.



2.2.9 Child and adolescent mental health

The prevalence of mental health problems amongst children and adolescents is currently estimated at 20%. In the pre-school years, problematic childhood behaviours include waking and crying at night, over-activity, food refusal and difficulty settling at night.

Promoting mental health is a core component of all health professionals' work. They have an important role to play in supporting parent and children and developing community provision to prevent mental health problems.

Key recommendations for health professionals

- Provide support at vulnerable times, such as birth of a new baby or bereavement; increase self-esteem and problem solving skills.
- Use evidence-based approaches in individual and group work with parents and children (e.g. parent programmes).
- Work with others to ensure a co-ordinated approach to the planning and delivery of family support.
- Help parents to access community facilities, e.g. Surestart (where available).
- Run groups for children and young people to develop self-esteem, trusting relationships and social skills.
- Work with children and adolescent mental health services to provide integrated care for families.
- Assist schools to manage the issue of suicide / self-harm amongst young people.



2.2.10 Children educated outside school settings

Children may be educated outside the school setting for a number of reasons including:

- Chronic illness.
- Parental choice.
- Disciplinary measures (behaviour problems).

When children/young people are educated outside the school setting they may miss out on access to screening programmes, immunisations and health promotion. The impact of this life situation on an individual's mental health and family relationships may also be compounded by isolation, reduced self-esteem and missed education.

Systems should be in place to ensure communication links are established with local Education and Library Boards.

2.2.11 Young people in community settings

It is recognised that peer group pressure is particularly significant in early adolescence. Health professionals should avail of every opportunity to promote the mental and physical well-being of young people outside of the school setting. This should include partnership working with voluntary and private sector organisations in the community.

All agencies working with young people should be able to recognise those young people at risk of suicide and self-harm and mobilise appropriate help and onward referral to child and adolescent mental health services.



SECTION 3 GUIDANCE TO THE UNIVERSAL CORE PROGRAMME FOR CHILD HEALTH SCREENING AND SURVEILLANCE – PRE-SCHOOL AND SCHOOL HEALTH

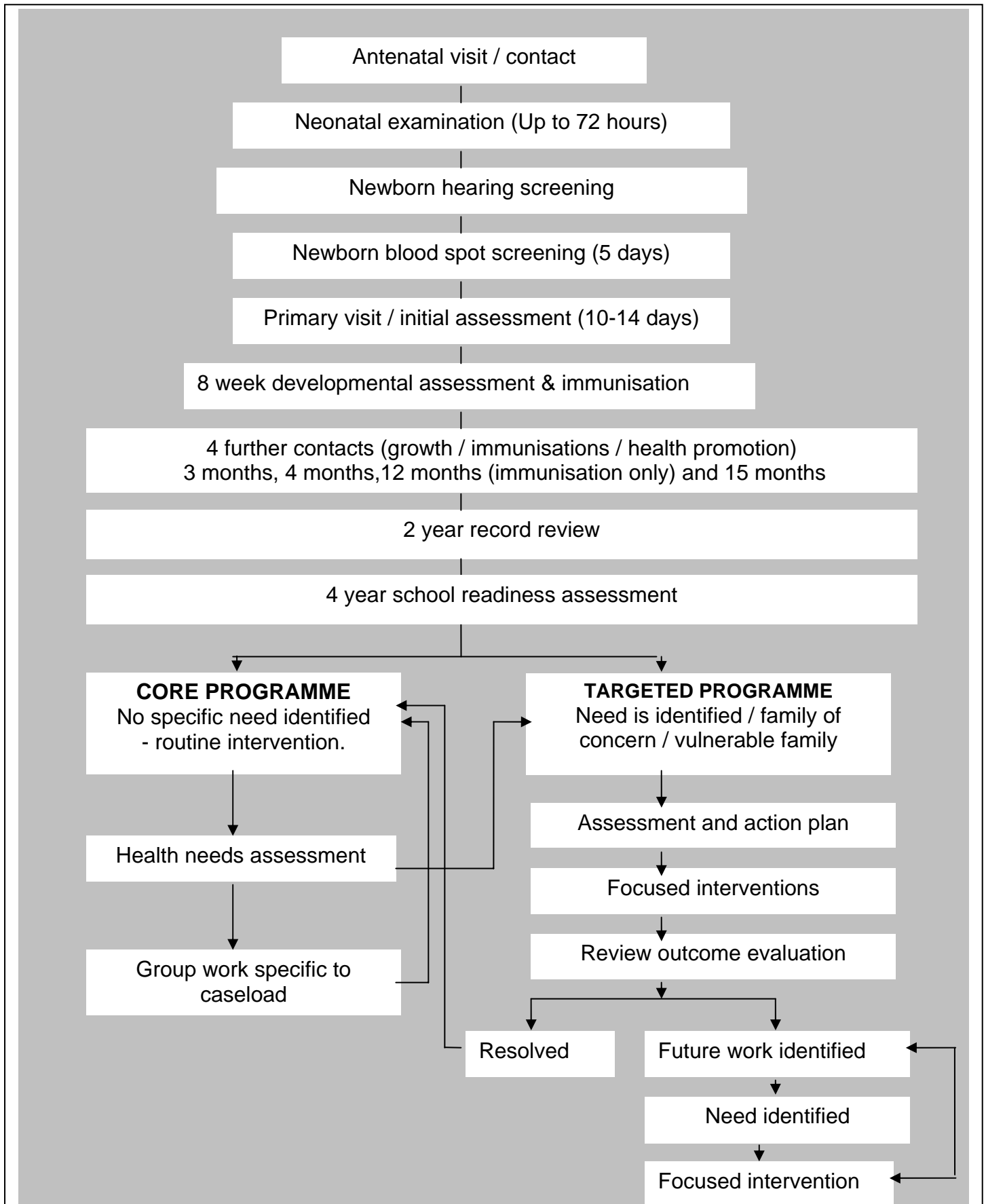
Please note:

The guidance in this section on the schedule of contacts is not intended to be prescriptive and does not over-ride the individual health professionals' responsibility to make judgements appropriate to the circumstances of individual families and children where additional support is required.

Opportunities for skill mix at local level should be encouraged within a robust framework of accountability and clinical governance.



Child Health Screening & Surveillance Programme (Pre-school Flowchart)*



* see appendix xiii – NI preschool immunisation and health surveillance programme



Antenatal visit/contact

Action: Midwife & Health visitor	Venue: Home / other
<p>An antenatal contact will be made by the midwifery service to all pregnant women. Further antenatal visits may be required at the discretion of the midwife based on clinical and social need.</p> <p>Health visitors will provide antenatal visits to all primigravida women and targeted to other women based on local agreement and health needs assessment.</p> <p>The midwife and health visiting service should agree locally how best to deliver antenatal care and have practice standards in place according to National Institute of Clinical Excellence (NICE) guidelines.</p> <p>There should be evidence of close liaison between HV and midwife.</p>	
<p>Review, discuss and record: midwife Identify risk factors for postnatal maternal mental health; domestic violence, Hepatitis B, Tuberculosis (TB), Developmental Dysplasia of Hips (DDH), congenital heart disease, hearing, vision, substance abuse and ability to parent. Refer as per locally agreed protocols. <i>This is not an exhaustive list. See appendices iii- xii.</i></p>	<p>Health visitor Review maternal health record. Commence family health needs assessment (FHNA).</p>
<p>MIDWIFE'S ROLE IN THE ANTENATAL PERIOD INCLUDES:</p> <ul style="list-style-type: none"> • Diagnosis of pregnancies and monitor normal pregnancies. • Carry out examinations necessary for the monitoring and development of normal pregnancies. • Advise on examinations necessary on the diagnosis of pregnancies at risk. • Identify and prevent pregnancy complications and refer to appropriate professionals. • Provide a programme to advise on issues such as nutrition, preparation for parenthood and make lifestyle changes e.g. smoking/alcohol cessation. • Identification of past and current history of mental health/physical health and domestic violence problems. • Carry out agreed screening procedures. • Recognise social circumstances that may affect the parent's ability to provide optimal care for the infant. • Inform parent(s) about the birth and options available. • Develop a relationship between the family and the primary healthcare team involved in the care of the mother and local community support networks. • Discuss role of midwife. • Discuss confidentiality and consent. • Carry out agreed screening and monitoring procedures. • Provide newborn hearing screening parental Information leaflet and promote the NHS programme (hospital / community midwife). • Liaison with health visitor and share maternal health record. 	



HEALTH VISITOR'S ROLE IN THE ANTENATAL PERIOD INCLUDES:

- Liaison with midwife – review maternal health record.
- Commence family health needs assessment.
- Discuss role of health visitor.
- Develop a relationship between the family, the primary healthcare team, and local community support networks.
- Discuss confidentiality and consent.
- Recognise social circumstances that may affect parental capacity and need of support.
- Awareness of the personal child health record (PCHR).

Health promotion.

Health promotion should be targeted towards the individual family's needs and agreed with them how best to deliver the programme. Health promotion should fit with regional and local strategies to improve the health and well-being of children. See appendix i.

Risk Factors:

- Identify risk factors: Hepatitis B, TB, DDH, congenital heart disease, hearing and vision. and refer as per locally agreed protocols. It is important that risk factors are reviewed and any new risk factors identified at this stage to ensure a targeted programme of review, e.g. vision - risk factor of 1st degree relative with potentially heritable eye disorders of amblyopia, squint or high refractive error. See appendices iii-xii.
- Identify parent who may require additional support (e.g. domestic violence, alcohol and substance abuse, learning difficulties, and mental health).

Note: Refer to National Institute of Clinical Excellence (NICE) antenatal guidance endorsed by DHSSPS.



Neonatal examination – first 72 hours

Action: Maternity Service Provider (Hospital doctor/ GP / trained midwife) - by local arrangement	Venue: Hospital / community
<p>Review, discuss, record and refer onwards (where appropriate):</p> <ul style="list-style-type: none"> • Ethnicity. • Length of pregnancy in weeks. • Any problems ongoing or suspected from antenatal screening, family history, labour / birth and mode of delivery. • Review history and identify risk factors for congenital heart disease, developmental dysplasia of hips (DDH), vision/hearing problems, Hepatitis B and TB. • Feeding method at birth and at discharge. • Ask the mother re: concerns / baby's progress / issues / feeding. • Discuss confidentiality and consent. • Additional support required. • Provide Newborn Hearing screening parent information leaflet and promote hearing screening. • Parent(s) should be provided with information regarding community midwifery services. • Inform parent(s)/person with parental responsibility of the importance of the Personal Child Health Record (PCHR). 	
<p>Physical examination/growth monitoring:</p> <p>It is recommended that the following evidence-based core components of the physical examination are assessed:</p> <ul style="list-style-type: none"> • Cardiovascular system for congenital heart disease. • Femoral pulses. • Examination of eyes and red reflex. • Newborn hearing screening • Hip test for DDH – Ortolani & Barlow manoeuvres/ check for talipes. Identify risk factors <ul style="list-style-type: none"> - If the exam is other than normal refer for expert assessment and ultrasound screening (USS). - If the exam is normal and a risk factor is present refer to USS. • Check for signs of neonatal jaundice. All babies with jaundice persisting after 2 weeks of age should be assessed and investigated as per local protocol • Genitalia (undescended testis(es), hypospadias, other anomalies). <ul style="list-style-type: none"> - Where testis (es) are undescended advise mother of need for follow-up and record advice given. Highlight on the newborn examination form for review by health visitor at the primary visit. • Check vitamin K has been administered. • Colour and other signs of jaundice, e.g. stools. • Growth monitoring: weight, length and head circumference. Plot, interpret centile and take appropriate action. (See appendix ii) 	
<p>Health promotion:</p> <p>Health promotion should be targeted towards the individual family's needs and agreed with them how best to deliver the programme. Health promotion should fit with regional and local strategies to improve the health and well-being of children. See appendix i.</p> <p><i>Record advice given</i></p>	
<p>Risk factors:</p> <ul style="list-style-type: none"> • Identify risk factors: Hepatitis B, TB, DDH, congenital heart disease, hearing and vision, and refer as per locally agreed protocols. It is important that risk factors are reviewed and any 	



new risk factors identified at this stage to ensure a targeted programme of review, e.g. vision - risk factor of 1st degree relative with potentially heritable eye disorders of amblyopia, squint or high refractive error. See appendices ii-xii.

- Identify parent(s) who may require additional support (e.g. domestic violence, substance abuse, learning difficulties, and mental health).



Postnatal visit/contact

Action: Midwife	Venue: Home
<p>The midwife will provide professional midwifery care, based on individual needs of the mother, for not less than 10 days and for such longer as the midwife considers necessary.</p> <p>Postnatal visits are usual on several occasions within the first ten days of the baby's life. There is no defined or fixed frequency of visits – some mothers may need to be seen twice in one day, whereas others may be visited only once every two or three days.</p> <p>In addition to monitoring the mother's health and well-being, these visits provide an opportunity to observe the baby's health, feeding and progress. There should be evidence of close liaison between midwife and HV.</p> <p>This must include a written handover document.</p>	
<p>Review, discuss and record:</p> <ul style="list-style-type: none"> • Identify risk factors for postnatal maternal mental health, domestic violence, Hepatitis B, TB, DDH, congenital heart disease, hearing, vision, substance abuse and ability to parent, and refer as per locally agreed protocols. <i>This is not an exhaustive list.</i> See appendix iii – xii. • Review documentation associated with maternal and neonatal discharge. • Additional support required. <p>MATERNAL HEALTH AND WELLBEING:</p> <ul style="list-style-type: none"> • Enquire re: mother's health. Identify warning signs re: life threatening post delivery maternal conditions (as per CEMACH/CESDI Guidelines). • Encourage mother and her family to report any concerns in relation to their physical, social or emotional health, discuss issues and ask questions. Document any specific problems and follow-up. • Provide emergency contact information. • Review past history of mental health/physical health problems and assess maternal mental health. • Assess for risks, signs and symptoms of domestic abuse (Follow-up for advice/management) <p>BABY'S HEALTH, FEEDING AND PROGRESS:</p> <ul style="list-style-type: none"> • Review documentation associated with newborn exam and under take or arrange this examination if not carried out before baby's discharge. • Enquire re: concerns / baby's health / progress. • Provide support and advice on feeding. • Offer information and guidance to enable mother to assess her baby's general condition and identify warning signs to look for if baby is unwell. • Check Vitamin K status, and if on oral Vitamin K, advise on importance and timing of further doses where indicated. Administer oral Vitamin K where appropriate. • Growth monitoring (see appendix ii) • Carry out PKU / TSH and IRT bloodspot test at Day 5 regardless of prematurity, medical condition or feeding status. Refer to newborn blood spot screening pathway, premature babies should have a repeat test taken when they reach the equivalent of 36 weeks gestation unless they have reached 36 weeks equivalent gestation at the time the first test was taken (see appendix xv) • Arrange / carry out 2nd TSH testing (if required) at 36 weeks gestation for all pre-term infants with a bloodspot sample taken before 36 weeks equivalent gestation. • Assess for jaundice and arrange for SBR testing at 14 days if jaundice is still present. • Liaison with health visitor – share maternal physical and mental health information as well as infant's progress and screening information. 	

**Health Promotion:**

Should be targeted towards the individual family's needs and should fit with regional local strategies to improve the health and well-being of children. See appendix i.

Note: This is not a core component of the Health for All Children programme but has been recognised as an existing model of good practice. Guidance on the postnatal visit/contact should be updated as appropriate e.g. adoption of NICE guidelines in Northern Ireland.



Primary visit 10 - 14 days

Action: Health visitor	Venue: Home
Preparation for primary visit: review family health needs assessment (if commenced in the antenatal period)	
<p>Review, discuss, record and refer onwards (where appropriate):</p> <ul style="list-style-type: none"> • Review and update family health needs assessment. • Update additional support. • Review and discuss mother's physical and mental health well-being history and current status. • Review documentation associated with newborn examination, neonatal discharge outcomes in the PCHR. • Review maternal discharge outcomes. Check Vitamin K status and if on oral regime advise on importance and timing of further doses where indicated. Arrange for administration of 3rd oral dose, where appropriate. • Review and discuss risk factors, Hepatitis B, TB, DDH, congenital heart disease, hearing, vision, and refer as per locally agreed protocols. (See appendices (iii - xii)) • Record TB risk status (for targeted population). • Review newborn hearing screening results. • Review and update risk factors for permanent childhood hearing impairment. Any new risk factors noted must be submitted to the child health system for update. Refer as locally agreed protocols if parental or professional concern regarding hearing, even if child passed newborn hearing screening. • Confirm that the newborn blood spot sample has been taken. If the blood spot sample has not been taken, arrange for test to be carried out as soon as possible. • Review and discuss feeding method - (record breastfeeding status: totally/partial/not at all). • Additional support required. • Review and discuss smokers / smoking in household. • Review developmental progress. • Confirm birth registration and parental responsibility for the purposes of informed consent. • Discuss confidentiality and consent for immunisations and developmental assessments. . • Record preferred treatment centre / GP registration. • Promote oral health. 	
<p>Physical examination/growth monitoring:</p> <ul style="list-style-type: none"> • Observe parent(s) infant interaction. • Carry out Cephalo-caudal examination (to remain under review). • Repeat check of genitalia. (undescended testis(es), hypospadias, other anomalies). - Where testis (es) are undescended advise mother of need for follow-up and record advice given. Highlight for review by GP / HV at 8 week assessment in PCHR documentation. • Hip test for DDH – Ortolani & Barlow manoeuvres/ check for talipes. Identify risk factors - If the exam is other than normal refer for expert assessment and ultrasound screening (USS). - If the exam is normal and risk factor is present refer to USS. DO NOT TEST HIPS IF BABY HAS BEEN PREVIOUSLY REFERRED. • Colour and other signs of jaundice, e.g. stools. All babies with jaundice persisting at 2 weeks of age should be assessed and investigated as per local protocol. 	



- Measure: weight, length and head circumference.
Plot, interpret centile and take appropriate action. See appendix ii.

Health promotion:

Health promotion should be targeted towards the individual family's needs. Health promotion should complement regional and local strategies and targets to improve the health and well-being of children. See appendix i.

Record advice given.

Risk factors:

- Review and update risk assessment.
- Identify parent(s) who may need additional support (e.g. domestic violence, alcohol and substance abuse, learning difficulties, and mental health).

Note:

- **HV should inform parent(s)/person(s) with parental responsibility of guidance on developmental milestones in the PCHR**



8 weeks

Action: GP & health visitor / Other	Venue: Clinic / home / hospital inpatient
<p>Review, discuss, record and refer onwards (where appropriate):</p> <ul style="list-style-type: none"> • Review and record any parental concerns / review baby's progress. • Review and discuss maternal and family mental health and well-being history and current status. • Review documentation associated with newborn examination, neonatal discharge and primary visit outcomes in the PCHR. • Review maternal discharge outcomes. • Review and discuss risk factors, TB, DDH, congenital heart disease, hearing, vision, and refer as per locally agreed protocols (appendices iii-xii). • Review and record TB risk status (for targeted population) • Review and update family health needs assessment. • Update additional support. • Review and record breastfeeding at 6 weeks (record breastfeeding status: totally/partial/not at all). • Additional support required. • Review newborn hearing screening results. • Inform parent(s) of newborn blood spot screening results and record results in PCHR (if not already actioned). • Discuss confidentiality and consent (as required). 	
<p>Physical examination/growth monitoring</p> <ul style="list-style-type: none"> • Observe colour & signs of jaundice. Review Vitamin K status. • Observe parent(s) & baby interaction. • Measure: weight, and head circumference (length if indicated). Plot, interpret centile and take appropriate action. See appendix ii. • Repeat inspection of eyes and examination of red reflex. • Repeat check of cardiovascular system/femoral pulses. • Repeat check of genitalia (undescended testis(es), hypospadias, other anomalies). Refer immediately to children's surgical outpatients for undescended testis(es) • Hip test for DDH – Ortolani & Barlow manoeuvres/ check for talipes. Identify risk factors <ul style="list-style-type: none"> - If the exam is other than normal refer for expert assessment and ultrasound screening (USS). - If the exam is normal and a risk factor is present refer for USS. <p>DO NOT TEST HIPS IF BABY HAS BEEN PREVIOUSLY REFERRED.</p> <p>Hearing and communication</p> <ul style="list-style-type: none"> • Response to sudden sound. • Response to unseen mother's voice. <p>Social awareness</p> <ul style="list-style-type: none"> • Intently regard mother's face. • Following dangling object past midline. • Social smile. <p>Gross motor</p> <ul style="list-style-type: none"> • Pull to sit. • Ventral suspension. • Check moro reflex and muscle tone 	
<p>Immunisation:</p> <ul style="list-style-type: none"> • As per JCVI National Immunisation Schedule given by GP, practice nurse, treatment room nurse or health visitor. • Identify and follow-up on incomplete immunisations. 	

**Health promotion:**

Health promotion should be targeted towards the individual family's needs. Health promotion should complement regional and local strategies and targets to improve the health and well-being of children. See appendix i.

Risk factors:

- Review and update risk assessment.
- Identify parent(s) who may need additional support (e.g. domestic violence, alcohol and substance abuse, learning difficulties, and mental health).
- Children suspected of having special educational needs or child's development deviated from the normal, refer to community paediatrician or other relevant health professional.
- Continue with, and update family health needs assessment and plan future support and contact (if required).

See appendix ii for specific indications for length and head circumference measurement after 8 week assessment



3 months

Action: Health Visitor Led Service	Venue: Clinic/other
<p>Review, discuss, record and refer onwards (where appropriate):</p> <ul style="list-style-type: none"> • Review and discuss any parental concerns/ review baby's progress. • Review and discuss maternal and family mental health and well-being history and current status. • Review and discuss risk factors, TB, DDH, congenital heart disease, hearing, vision, and refer as per locally agreed protocols. Record TB risk status (for targeted population) • Review and update family health needs assessment. • Update additional support. • Review and record breastfeeding status. • Review newborn hearing screening results. • Discuss confidentiality and consent (as required). • Additional support required. 	
<p>Physical examination/growth monitoring:</p> <ul style="list-style-type: none"> • Observe parent(s) infant interaction. • Growth monitoring: weight (length and head circumference, if indicated). See appendix ii. Plot, interpret centile and take appropriate action. 	
<p>Immunisation:</p> <ul style="list-style-type: none"> • As per JCVI National Immunisation Schedule given by GP, practice nurse, treatment room nurse or health visitor. • Identify and follow-up on incomplete immunisations. 	
<p>Health promotion: Health promotion should be targeted towards the individual family's needs. Health promotion should complement regional and local strategies and targets to improve the health and well-being of children. See appendix i.</p>	
<p>Risk factors:</p> <ul style="list-style-type: none"> • Review and update risk assessment. • Identify parent(s) who may need additional support (e.g. domestic violence, alcohol and substance abuse, learning difficulties, and mental health). • Children suspected of having special educational needs or child's development deviated from the normal, refer to community paediatrician or other relevant health professional. • Continue with, and update family health needs assessment and plan future support and contact (if required). 	

See appendix ii for for specific indications for length and head circumference measurement after 8 week assessment



4 months

Action: Health Visitor led Service	Venue: Clinic/other
<p>Review, discuss, record and refer onwards (where appropriate):</p> <ul style="list-style-type: none"> • Review and discuss any parental concerns/ review baby's progress. • Review and discuss maternal and family mental health and well-being history and current status. • Review and discuss risk factors, TB, DDH, congenital heart disease, hearing, vision, and refer as per locally agreed protocols. Record TB Risk status (for targeted population) • Review and update family health needs assessment. • Review and record breastfeeding status. • Review newborn hearing screening results. • Discuss confidentiality and consent (as required). • Additional support required. 	
<p>Physical examination/growth monitoring</p> <ul style="list-style-type: none"> • Observe parent(s) infant interaction. • Growth monitoring: weight (length and head circumference, if indicated). See appendix ii Plot, interpret centile and take appropriate action. • Review risk factors for DDH. • Assess regarding limited abduction of hips, asymmetry of leg length or deep skin creases and identify any parental concerns 	
<p>Immunisation:</p> <ul style="list-style-type: none"> • As per JCVI National Immunisation Schedule given by GP, practice nurse, treatment room nurse or health visitor. • Identify and follow-up on incomplete immunisations. 	
<p>Health promotion</p> <p>Health promotion should be targeted towards the individual family's needs. Health promotion should complement regional, local strategies and targets to improve the health and well-being of children. See appendix i.</p>	
<p>Risk factors:</p> <ul style="list-style-type: none"> • Review and update risk assessment. • Identify parent(s) who may need additional support (e.g. domestic violence, alcohol and substance abuse, learning difficulties, and mental health). • Children suspected of having special educational needs or child's development deviated from the normal, refer to community paediatrician or other relevant health professional. • Review and update family health needs assessment and plan additional support and contact (if required) over the next 8 months. 	

See appendix ii for specific indications for length and head circumference measurement after 8 week examination



12 months

Action: Community/Primary Care Health Professional	Venue: Clinic / other
Immunisation: <ul style="list-style-type: none">• As per JCVI National Immunisation Schedule given by GP, practice nurse, treatment room nurse or health visitor.• Identify and follow-up on incomplete immunisations	



15 months

Action: Health visitor-led service	Venue: Clinic/other
<p>Review, discuss, record and refer onwards (where appropriate):</p> <ul style="list-style-type: none"> • Review and discuss any parental concerns/ review infant's progress. • Review and discuss maternal and family mental health and well-being history and current status. • Review and discuss risk factors, TB, DDH, congenital heart disease, hearing, vision, and refer as per locally agreed protocols. Record TB Risk status (for targeted population) • Review and record breastfeeding status (at 6 months and 12 months). • Review and update family health needs assessment. • Review family's health plans with them for support and contact until the child's 4-year school readiness assessment. • Additional support required. • Record additional visits required between 15 months and 4 years. • Discuss confidentiality and consent (as required). 	
<p>Physical examination/growth monitoring</p> <ul style="list-style-type: none"> • Observe parent(s) & baby interaction • Growth monitoring: weight (length and head circumference, if indicated*). See appendix ii Plot, interpret centile and take appropriate action. 	
<p>Immunisation:</p> <ul style="list-style-type: none"> • Identify infants requiring extended pneumococcal programme and arrange for immunisations to be given (see Appendix for risk groups). • As per JCVI National Immunisation Schedule given by GP, practice nurse, treatment room nurse or health visitor. • Identify and follow-up on incomplete immunisations 	
<p>Health promotion</p> <p>Health promotion should be targeted towards the individual family's needs. Health promotion should complement regional and local strategies and targets to improve the health and well-being of children. See appendix i.</p>	
<p>Risk factors:</p> <ul style="list-style-type: none"> • Review and update risk assessment. • Identify parent(s) who may need additional support (e.g. domestic violence, alcohol and substance abuse, learning difficulties, and mental health). • Children suspected of having special educational needs or child's development deviated from the normal, refer to community paediatrician or other relevant health professional. • Identify and follow up incomplete immunisations. 	
<p>NOTE:</p> <p>The health visitor 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(s) how the 2-year review is carried out.</p>	

See appendix ii for specific indications for length and head circumference measurement after 8 week examination



2 year record review

Action: Health visitor as per locally agreed arrangements	Venue/contact: Professional judgement
<p>Contact between 15 months and 4 years – 2 year record review:</p> <p>At the 15 month review, the health visitor in partnership with the parent(s) should agree the schedule for future contact and subsequent reviews.</p> <p>At 2 years the health visitor will exercise his/her professional judgement to decide if a contact is required.</p> <p>The health visitor is responsible for reviewing the child's record (<i>family health needs assessment, child's health record, risk factors, hospital A & E referrals, hospital correspondence, paediatric referrals, outcomes of referrals, and child health system summary record (if available)</i>).</p> <p>A formal contact may not be necessary for all families. When no formal face-to-face contact is planned the health visitor should ensure that there is liaison with other members of the primary care team and other agencies as required. Local arrangements within Trusts should be in place to ensure effective liaison between early years services and health visiting teams to ensure that no new problems have emerged.</p> <p>In other cases contact by telephone, letter or email may be sufficient, whereas some families may require face-to-face contact.</p> <p><i>Record action taken.</i></p>	
<p>At 2 year record review, the health visitor should assess children with risk factors for congenital heart disease, vision, hearing – refer to appendices (iii- xii).</p>	



4 years – school readiness assessment

Action: Health visitor-led service	Venue: Clinic/other
<p>Review, discuss, record and refer onwards (where appropriate):</p> <ul style="list-style-type: none"> • Review and discuss any parental concerns/ review child's progress <i>e.g. family health needs assessment, child's health record, hospital correspondence, outcomes of referrals, and child health system summary record</i>). • Review and discuss maternal and family mental health and well-being history and current status. • Additional support required. • Review and discuss risk factors for TB, hearing, vision, and refer as per locally agreed protocols. Record TB Risk status (for targeted population). • Review and update family health needs assessment. • Observe parent(s) child interaction. • Discuss involvement with local support networks. • Discuss confidentiality and consent (as required). 	
<p>Physical examination/growth monitoring:</p> <ul style="list-style-type: none"> • Growth monitoring: weight and height – see appendix ii • Plot, interpret centile and take appropriate action. • Age appropriate vision screening for those children with risk factor (<i>1st degree relative with amblyopia, squint, high refractive error or nystagmus and act according to locally agreed protocols</i>). See appendix x – xi. 	
<p>Immunisation:</p> <ul style="list-style-type: none"> • Identify infants requiring extended pneumococcal programme and arrange for immunisations to be given. • As per JCVI National Immunisation Schedule given by GP, practice nurse, treatment room nurse or health visitor. • Health professionals should take this opportunity to ensure that the preschool immunisation schedule is complete. • Identify and follow-up on incomplete immunisations. 	
<p>Health promotion: Health promotion should be targeted towards the individual family's needs. Health promotion should complement regional and local strategies and targets to improve the health and well-being of children. See appendix i.</p>	
<p>Risk factors:</p> <ul style="list-style-type: none"> • Review and update risk assessment. See appendix ii-xii. • Identify parent(s) who may need additional support (e.g. domestic violence, alcohol and substance abuse, learning difficulties, and mental health). • Children suspected of having special educational needs or child's development deviated from the normal, refer to community paediatrician. • Identify and follow up incomplete preschool screening. • Identify and follow up non-compliance with reviews and referrals. • Review family health needs assessment and arrange for transfer of files to school health department. • Record any additional health visitor visits. 	



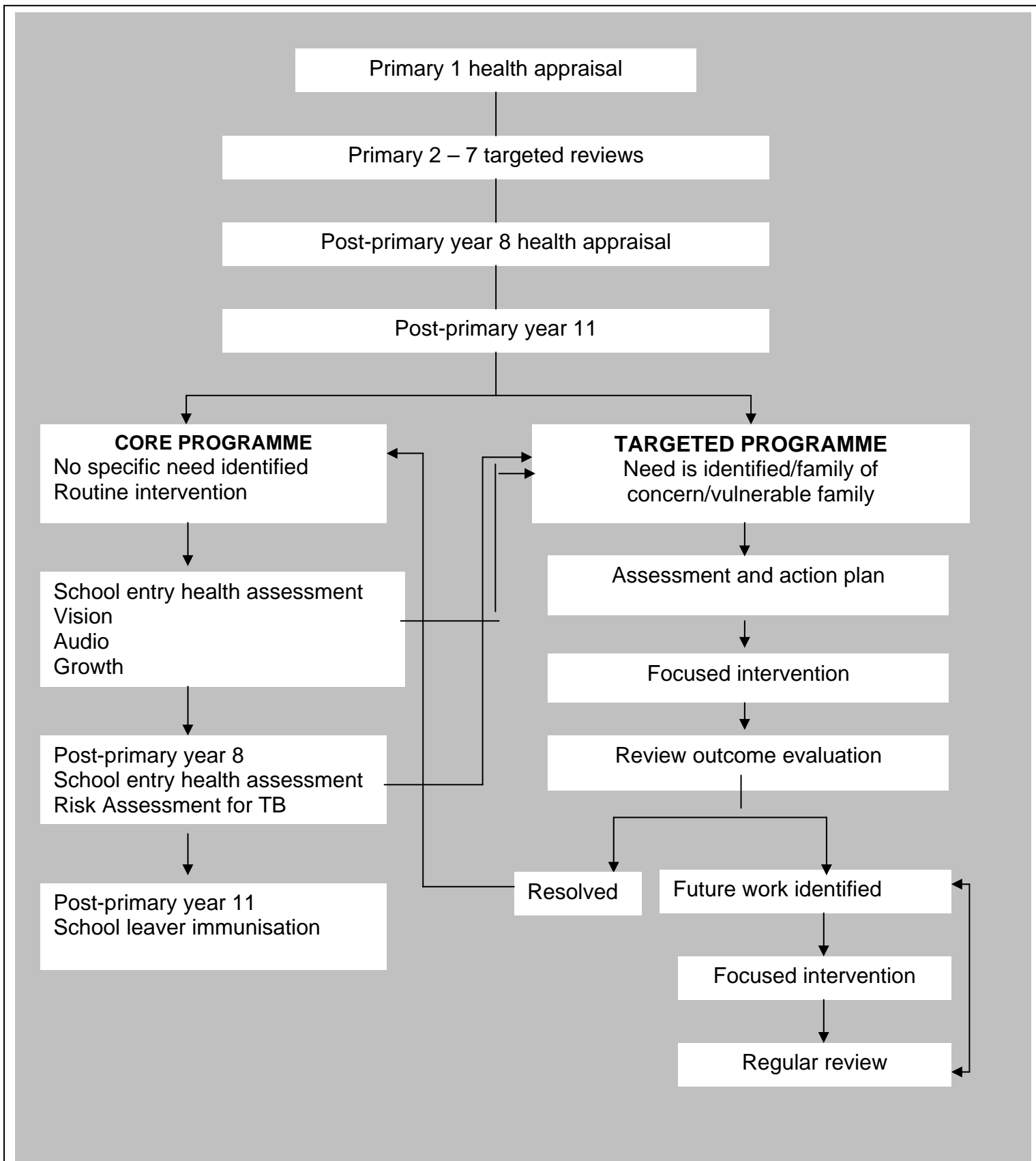
Preparation;

The health visitor should prepare records for transfer to school health. Arrangements should be in place to ensure a smooth transition from the health visiting service to the school health service, i.e. health visiting record and/or summary report. The health visitor must highlight to the school nurse children/families who require an enhanced service intervention from the school health team e.g. vulnerable families, looked after children, child protection register. If the health visitor is retaining a child protection file, the school nurse should be informed.

** See appendix ii for specific indications for length and head circumference measurement after 8 week examination*



Child Health Programme (School Health Flowchart)*



See appendix xiv NI primary and post primary school health surveillance and immunisation programme.



Entry to Primary School (includes P1 and all other new school entrants)

<p>Action: School nursing team</p>	<p>Venue: School</p>
<p>Information gathering: <i>Review and record:</i> On entry each child will receive a health check. The school nurse team should review the health appraisal questionnaire and exercise his/her professional judgement to decide if contact with the person with parental responsibility is required. From this contact appropriate referrals should be made.</p> <ul style="list-style-type: none"> • Discuss with the parent(s) the role of the school health team. • Identification of children who require individual health care plans. • Development of the school health profile and agreed health improvement plan. 	
<p>Screening/growth monitoring</p> <ul style="list-style-type: none"> • Growth Monitoring (height and weight), plot and interpret on centile chart. • Vision screening P1. The service should work towards orthoptists carrying out all vision screening in special needs schools. Health professionals providing visual screening need to be appropriately trained with regular updates. Training programmes should be regional and delivered locally. (See appendix xii) – P1 school nurse visual screening pathway • Sweep hearing test for hearing (continue pending further review). • Assess for TB Risk (if not already carried out at the school readiness assessment) 	
<p>Vision referral criteria: If a child does not achieve 0.2 (Linear Logmar) or 6/9 (Snellen based linear chart) in either eye (age appropriate vision test) despite good co-operation, referral is indicated.</p>	
<p>Immunisation: refer child back to primary health care team if primary immunisation programme has not been completed.</p>	
<p>Health promotion Health promotion should be targeted and fit with regional and local strategies to improve the health and well-being of children. See appendix i</p>	
<p>NOTE: The person with parental responsibility should complete the health appraisal. Health professionals must inform the person with parental responsibility of the results of the health check.</p>	



Primary 2-7

Action: School nursing team	Venue: School
Information gathering: <i>Review and record:</i> Review individual child's health care plans. Review school health profile and health improvement plan.	
Review P2-7: <ul style="list-style-type: none">• Where parental concern is expressed.• Follow-up as appropriate to individual child's needs. Review at primary 7 <ul style="list-style-type: none">• Referrals should be made according to locally agreed protocols.• Review individual health care plans and transition arrangements to post-primary school.	
Health promotion: Health promotion should be targeted and fit with regional and local strategies to improve the health and well-being of children. See appendix i. .	
NOTE: Health professionals must inform the person with parental responsibility of the results of the health check.	



Post-primary school

Action: School nursing team	Venue: School
<p>Information gathering: Public health programmes should be developed which are responsive to local need reflecting partnerships with schools, education boards and community voluntary groups.</p> <p>The school nurse team should undertake the Entry to Post Primary Health Appraisal Questionnaire (Form 1(Year 8) and all other new entrants) and exercise his/her professional judgement to decide if contact with the child or the person with parental responsibility is required. Vision information leaflet should be included in the Health Appraisal Questionnaire pack. From this contact appropriate referrals should be made.</p> <ul style="list-style-type: none"> • Identification of children who require individual health care plans. • Development of the school health profile and agreed health improvement plan. • All new school entrants should be assessed for TB Risk. 	
<p>Immunisation: Year 11: As per JCVI National Immunisation Schedule</p>	
<p>Health promotion/advice Health promotion should be targeted and fit with regional and local strategies to improve the health and well-being of children. See appendix i.</p>	
<p>NOTE: Health professionals must inform the person with parental responsibility of the results of the health check.</p>	



SECTION 4

Monitoring and quality assurance

All child health screening programmes should be provided to a level which meets nationally agreed quality assurance standards (where they exist). Every child and their parent(s) should have access to a core programme of preventative preschool care. Trusts should ensure that appropriate arrangements are in place for co-ordinating the management, delivery and monitoring of the core programme of preventative pre-school and school care.

The core programme, including the screening programmes contained within it, should be subject to local performance management and audit at Trust level.

Each Trust should identify who is responsible for screening programmes, maintenance and reporting of immunisation uptake, introduction of new immunisation programmes, health promotion, care pathways for children with health or developmental problems, socially excluded groups, child protection, looked after children, links with education, staff training and data management.

All staff in contact with children should be appropriately trained and take part in regular continuing professional development. Appropriate arrangements should be in place for monitoring the above.

To enable monitoring of the screening programmes, a minimum dataset should be collected by each Trust.



Recommended reading list

1. ACPC Regional Policy & Procedures, NI 2005.
 2. Boards/Trusts Strategy on Teenage Pregnancy.
 3. Co-operating to Safeguard Children DHSSPS 2003.
 4. Control and prevention of Tuberculosis in the United Kingdom: Code of Practice 2000, British Thoracic Society, Thorax 2000, Vol55 Pgs 887-901.
 5. CPHVA (2002) Postnatal depression and maternal mental health; A public health priority OSBN: 184253 002 x.
 6. Domestic violence: a Resource Manual for Health professionals (Department of Health, 2000.)
 7. NICE Guideline sites: www.nice.org.uk or www.guideline.gov.
 8. Health for All Children, 4th Edition, David M. B. Hall & David Elliman, Oxford Medical Publications, 2003.
 9. Health Promotion, Foundations for Practice', 2nd edition by Jennie Naidoo and Jane Wills.
 10. Holman (1992) Something Old, Something New: Perspectives on Five 'New' Public Health Movements. Health Promotion Journal of Australia.
 11. NSC Child Health Subgroup Report – Dysplasia of the hip. September 2004.
 12. Postnatal Depression and puerperal psychosis: a National Clinical Guidelines Edinburgh 2002.
 13. The DHSSPS Teenage Pregnancy and Parenthood Strategy and Action Plan 2002 – 2007.
 14. The Chief Nursing Officer review of the Nursing, Midwifery, Health Visiting Contribution to Vulnerable Children and Young People, DOH, 2004 www.dh.gov.uk/publications and statistics.
- Why Mothers Die 2000-2002, 6th Confidential Enquiry into Maternal and Child Health, CEMACH, RCOG Press, London 2004 Why Mothers Die 2000-2002 Report on confidential enquires into maternal deaths in the UK Gwyneth Lewis and James Drife, RCOG Press, London, 2004. Website: www.cemach.org.uk
15. A Healthier Future: A 20-Year Vision for Health & Wellbeing in N. Ireland, DHSSPS 2005.
 16. A Healthier Future –20-year strategy 2005-2025.
 17. www.wiredforhealth.gov.uk.
 18. www.ich.ucl.ac.uk.
 19. Children's Perspectives on Domestic Violence: Audrey Mullender, Gill Hague, Umme F Imam, Liz Kelly, Ellen Malos, and Linda Regan, Sage Publications, 2002.
 20. Department of Health- The Health Visitor Practice Development Resource Pack, 2001.
 21. Department of Health- The School Nurse Practice Development Resource Pack, 2001.
 22. Domestic Violence, Crime and Victims act 2004
www.legislation.hmso.gov.uk/acts/acts2004.htm.
 23. Effective health care bulletins: www.york.ac.uk/inst/crd/ehcb.htm.
 24. Helping Hands Programme - Women's Aid: www.womensaid.org.uk/.
 25. Hitting Home – Domestic Violence: www.bbc.co.uk/health/hh/.
 26. Immunisation Against Infectious Disease, Salisbury D.M. & Begg N.T. (Eds) 1996, HMSO, London: www.immunisations.nhs.uk.
 27. Information for Midwives. Hepatitis B Testing in Pregnancy Department of Health, The Royal College of Midwives.
 28. National Services framework: www.doh.gov.uk/nsf/nsf.home.htm.
 29. Newborn Blood spot Guidance and Practice for Professionals, Boards, 2005.
 30. Newborn Hearing Screening Guidance and Practice for professionals, 2005.
 31. Promoting Child Health in primary Care, Anthony Harnden & Aziz Sheikh, Royal College of GPs 2002.
 32. Royal College of Speech and Language Therapists website: www.rcslt.org.uk



33. Safety and Justice: The Governments Proposals on Domestic Violence
www.homeoffice.gov.uk/docs2/violence.html
34. South & East Belfast Health and Social Services Trust: Domestic Violence Guidelines for Health Visitors, October 2003.
35. Speech & Language ICAN Talking Point: www.talkingpoint.org.uk
36. Speech & Language Information provided by Afasic: www.afasic.org.uk
37. The Health Visitor and School Nurse Innovation Network: www.innovate.org.uk
38. Tackling Violence in the Home DHSSPS, 2005.
39. Vitamin K - Local Board/Trust policy.



APPENDICES



Health promotion guidance at antenatal, neonatal examination and postnatal visit/contact.

Antenatal	Neonatal examination – first 72 hours	Postnatal visit/contact
<p>Suggested relevant topics are:</p> <ul style="list-style-type: none"> • Reducing the risk of sudden infant death syndrome (SIDS). • Parent craft. • Breastfeeding – benefits/ techniques/support. • Nutrition. • Oral health. • Physical, emotional and mental health • Substance abuse. • Vitamin K prophylaxis • Jaundice/management of neonatal jaundice. • Anti D prophylaxis. • Smoking cessation • Provide information about local support networks and contacts for additional advice or support when needed. 	<p>Suggested relevant topics are:</p> <ul style="list-style-type: none"> • Reducing sudden infant death syndrome (SIDS) risks. • Feeding/nutrition. • Baby care. • Jaundice/management of neonatal jaundice. • Vitamin K prophylaxis / management of jaundice • Hepatitis B & BCG vaccines. • Smoking cessation. • Provide information about local support networks and contacts for additional advice or support when needed. 	<p>Suggested relevant topics are:</p> <ul style="list-style-type: none"> • Reducing sudden infant death syndrome (SIDS) • Feeding/nutrition • Baby care • Jaundice/ management of neonatal jaundice • Vitamin K prophylaxis • Blood spot screening • Physical, emotional and mental health • Substance abuse. • Provide information about local support networks and contacts for additional advice or support when needed.



Health promotion guidance at primary visit/8 week, 3 and 4 month visit/contact.

Primary Visit 10 – 14 days	8 week	3 and 4 months
<p>Suggested relevant topics are:</p> <ul style="list-style-type: none"> • Reducing sudden infant death syndrome (SIDS) risks. • Feeding/nutrition. • Baby care. • Parenting skills/behaviour management (e.g. sleeping/crying) • Protecting babies heads • Crying baby/colic • Physical, emotional and mental health • Contraception / family planning. • Immunisation. • Safety / accident prevention. • Smoking cessation. • Provide information about local support networks and contacts for additional advice or support when needed. 	<p>Suggested relevant topics are:</p> <ul style="list-style-type: none"> • Reducing sudden infant death syndrome (SIDS) risks. • Feeding/nutrition. • Parenting skills/behaviour management. • Physical, emotional and mental health • Immunisation. • Oral Health • Safety / accident prevention (car/home). • Smoking cessation. • Provide information about local support networks and contacts for additional advice or support when needed. 	<p>Suggested relevant topics are:</p> <ul style="list-style-type: none"> • Reducing sudden infant death syndrome (SIDS) risks. • Weaning. • Feeding/nutrition. • Parenting skills. • Behaviour management. • Development. • Oral health (at 4 months). • Physical, emotional and mental health • Immunisation. • Safety/accident prevention. • Smoking cessation. • Provide information about local support networks and contacts for additional advice or support when needed.



Health promotion guidance at primary visit at 15 months and 4 year school readiness assessment.

15 months	4 year school readiness assessment
<p>Suggested relevant topics are:</p> <ul style="list-style-type: none">• Speech and language development.• Feeding/Nutrition.• Parenting skills.• Behaviour management.• Development.• Oral health.• Registration with a dentist.• Immunisation.• Safety/accident prevention (car/home).• Provide information about local support networks and contacts for additional advice or support when needed.• Smoking cessation.	<p>Suggested relevant topics are:</p> <ul style="list-style-type: none">• Speech and language development.• Nutrition.• Parenting skills.• Behaviour management.• Development.• Oral health.• Immunisation.• Communicable diseases.• Stranger awareness and personal safety.• Safety/accident prevention (car/home).• Provide information about local support networks and contacts for additional advice or support when needed.• Smoking cessation.



Health promotion guidance at primary and post-primary school.

Primary	Post-primary
<p>Suggested relevant topics are:</p> <p><u>Lifestyle and other</u></p> <ul style="list-style-type: none"> • Behaviour management. • Enuresis. • Sexual health/puberty. • Substance use. • Support for bullying. • Mental health and well-being including bullying. • Healthy eating. • Personal safety. • Physical activity. • Infectious conditions • Provide information about local support networks and contacts for additional advice or support when needed. <p><u>Health education programme for teaching Staff</u></p> <ul style="list-style-type: none"> • Health promoting school initiative. • Management of anaphylaxis. • Epilepsy. • Diabetes. • Asthma. • Other chronic and complex needs. • Infectious conditions. <p><u>Oral health</u></p> <ul style="list-style-type: none"> • Dental registration and attendance. • Twice daily brushing with fluoride toothpaste should be advised. • Reducing the frequency of sugary food and drink consumption. 	<p>Suggested relevant topics are:</p> <p><u>Lifestyle and other</u></p> <ul style="list-style-type: none"> • Behaviour management. • Enuresis. • Sexual health. • Substance use. • Support for bullying. • Mental health and well-being including bullying. • Healthy eating. • Personal safety. • Physical activity. • Infectious conditions • Provide information about local support networks and contacts for additional advice or support when needed. <p><u>Health education programme for teaching Staff</u></p> <ul style="list-style-type: none"> • Health promoting school initiative. • Management of anaphylaxis. • Epilepsy. • Diabetes. • Asthma. • Other chronic and complex needs. • Infectious conditions. <p><u>Oral health</u></p> <ul style="list-style-type: none"> • Dental registration and attendance. • Twice daily brushing with fluoride toothpaste should be advised. • Reducing the frequency of sugary food and drink consumption. <p><i>Drop-in sessions provide opportunity for health promotion.</i></p>



Growth monitoring promotion

Within Hall 4 (2003) the term to describe activity related to measuring and interpreting children's growth patterns is 'growth monitoring promotion'. This includes the important dimension of health promotion and nutritional support for all children during contacts with the primary care team. For example, impaired growth may be associated with faltering growth or obesity related to difficulties in weaning or a lack of parental knowledge on nutritional needs of children.

It is good clinical practice to measure and plot on an appropriate centile chart the height, weight and head circumference of any child where concern about growth or chronic health problems are a feature and in children requiring prolonged follow-up for any reason. Growth in early childhood is fundamental to health with implications for future health and morbidity. It is also highly pliant in early infancy and therefore requires that those who are involved with growth monitoring receive training on normal and abnormal growth and variations that may occur. Interpretation of centile charts requires skill and judgement, and is easier when several measurements are taken over a period of time. If a parent(s)/carer is concerned about a child's abnormal growth or unexplained long-standing health problems, the clinical assessment should routinely include measurement and plotting of height and weight. Parent's value growth monitoring as a focus for visits to clinics. These opportunities should be used to provide information and support on nutrition and development.

Recommendations are made within this guidance for measurements as part of the core programme. However, further measurements and assessment are required when there is any concern about a child's growth, health or development. There is no precise guidance in the literature on the threshold at which referral to specialist services should be made. It is therefore recommended that the following criteria be used as guidance along with referral criteria developed by Trusts and that discussion should take place with the general practitioner and other professionals involved in the care pathway. A written plan of action should be made between the health visitor and GP on how a child with faltering growth is to be managed and reviewed regularly. (Lewis Report, 2003)

Centile Crossing

- Few babies continue on exactly the same centile from birth onwards. About 50% cross at least one centile on the weight chart between 6 weeks and 12 – 18 months and 5% fall across 2 centiles. Babies who are large at birth are more likely to show falls of this level.
- Small babies tend to 'catch up' in their weight and large babies 'catch down', a phenomenon known as 'regression to the mean' where the majority but not all babies will move towards the median.
- Consider both length and weight when reviewing possible growth problems.
- There should not be a differential of more than 2 centiles between length/height and weight.
- Staff and parents should be aware that the pattern of weight gain differs between breastfed and bottle-fed babies. The breast from birth centile chart has been designed to reflect this.



Faltering growth / failure to thrive

- The term ‘faltering growth’ is used when the line of growth crosses downwards. This is preferable to ‘failure to thrive’, which has traditionally been used to imply some organic cause. This term should only be used following further assessment and consultation with the multi-professional team when there is evidence that the slow weight gain is abnormal for that baby.
- Faltering growth is a common problem in the early years of life and the majority of cases are due to under-nutrition. This may be related to weaning difficulties, interactional difficulties between parent(s) or carers and children, late weaning, minor illness, oromotor dysfunction, developmental delay, abuse and/or neglect, and family disturbances and may be associated with slow weight gain or temporary weight loss. The literature would suggest that approximately 5% of young children with inexplicable poor growth are found to have a previously undiagnosed illness, and only a small minority are failing to thrive because of abuse or neglect. (Wright & Talbot, 1996)
- Faltering growth occurs across all social classes, however; poverty and deprivation increase the risk that a child will grow at a rate below their genetic potential.

Criteria for referral

1. Refer any child about whom you or a parent(s) is concerned.
2. Refer any child whose height falls below the 0.4th centile or above the 99.6 centile or who falls outside the target centile range.
3. Refer any child whose weight / length centiles are over 2 centiles apart.
4. Refer any child whose relevant growth curves appear to be continuing to climb/fall through the centiles after 3 measurements have been taken at the intervals below: -

Birth – 6 months	Weight and H/C 14 days	Length – quarterly
6 months – 2 years	Weight – monthly	Length – quarterly
2 – 18 years	Weight – monthly	Length – half-yearly

(Child Growth Foundation 1996)

Growth Monitoring - Indicators for measurement of Length and Head Circumference

Length and head circumference should be measured in any infant who was of low birth weight (<2500g), if any disorder is suspected or present, and in any infant whose health, growth or feeding pattern is causing concern. It must be recorded on the chart.



Recommendations for policy development

All staff involved in the measurement of growth parameters should have access to, at a minimum, a locally developed and agreed policy and procedure / guidance document advising on the following issues:-

- Identify levels of growth monitoring required for:-
 1. All children.
 2. Children who require additional monitoring.

- The type of equipment to be used when measuring each growth parameter.
- The specific process to be followed when measuring each growth parameter.
- How to record in written form any growth measurements taken and in which document to record findings.
- The types of centile charts to be used when plotting growth parameters.
- The method of plotting any growth parameter.
- Calculation of body mass index, mid parental centile and centile ranges.
- Indicators for consultation / referral and advice concerning faltering or excessive growth patterns.
- Clearly established pathways for referral.

- A section to deal with specific issues, such as:-
 1. The maintenance of any equipment used, including calibration.
 2. The transportation of equipment.
 3. The replacement of worn or broken equipment.
 4. The recording of an explanation if advice on the measurement of growth is not followed e.g. the child who has a disability.
 5. Induction training.
 6. Arrangements to identify the training needs of staff, train new staff and up-date other staff in measurement technique, interpretation of growth charts and other issues.
 7. The arrangements for the auditing practice with regard to growth measurement and recording.
 8. The review period for the document.

An addendum containing specific information that can be up-dated on a regular basis as required, (i.e. name, address, telephone number) of:-

- Who is responsible for ensuring the regular calibration of equipment;
- Who may be approached for further advice on the interpretation of any centile chart;
- Who may be contacted for further advice and support;
- Who has responsibility for supervising staff;
- Who has training responsibility?



Scottish intercollegiate group network guidelines for postnatal depression

A

The SIGN guidelines highlight the following risk factors as having a strong association with the development of postnatal depression;

- Past history of psychopathology and psychological disturbance during pregnancy.
- Low social support.
- Poor marital relationship.
- Recent life events.
- Prolonged 'baby blues'.

Weaker association was found with:

- Obstetric complications.
- A history of abuse.
- Low family income.
- Lower occupational status.

B

The nine symptoms form the DSM IV clinical interview.

- Depressed mood.
- Diminished interest or pleasuring.
- Appetite.
- Sleep.
- Restlessness/slowed down.
- Fatigue/loss of energy.
- Feelings about self.
- Concentration/decision making.
- Recurrent thoughts of death.



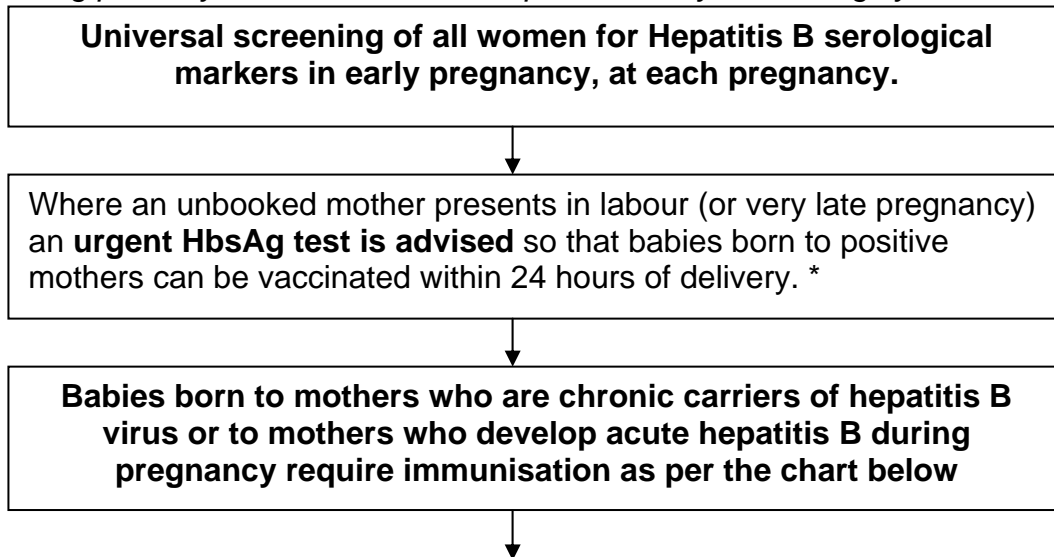
Hepatitis risk factors		
	Risk Factors	Risk factor description
1	Mother chronic carrier	Babies born to mothers who are chronic carriers of Hepatitis B virus or To mothers who have acute Hepatitis B in pregnancy
2	Parental drug mis-users	



Hepatitis B Immunisation Care Pathway in Neonates

Transmission of Hepatitis B infection may occur from mother to child (vertical transmission) around the time of delivery in the perinatal period. Development of the carrier state as a result of perinatal transmission can be prevented in over 90% of cases by appropriate vaccination of infants born to infected mothers, starting at birth.

The following pathway demonstrates the steps necessary for this highly effective intervention.



Vaccination of term babies according to hepatitis B status of the mother ¹:

Hepatitis B status of mother	Baby should receive	
	Hepatitis B vaccine	HBIG
Mother is HBsAg positive and HBeAg positive	Yes	Yes
Mother is HBsAg positive, HBeAg negative and anti-HBe negative	Yes	Yes
Mother is HBsAg positive where e-markers have not been determined	Yes	Yes
Mother had acute hepatitis B during pregnancy	Yes	Yes
Mother is HBsAg positive and anti-HBe positive	Yes	No

Use the accelerated Hepatitis B immunisation schedule for these babies:

- 1st dose within 24 hours of delivery (+/-HBIG as per chart)
- 2nd dose 1 month after the 1st dose (i.e. at 1 month old)
- 3rd dose 2 months after the 1st dose (i.e. at 2 months old)
- 4th dose (booster) at 12 months. This dose is preceded by collection of a blood sample for Hepatitis B serological markers.
- 5th dose with pre-school boosters and check child was appropriately followed up in infancy (at five years) if indicated by serological testing



****Where mother's Hepatitis B status is unknown at time of birth vaccination should be offered to the infant at birth, however, HBIG should NOT be offered.***

Arrangements should be made for administration of the course and blood sampling according to local arrangements with Primary Care/ Neonatology/ Paediatrics.

Mothers should not be discouraged from breastfeeding their babies.

The blood sample to check Hepatitis B serology (HbsAg) is taken prior to administration of the 4th dose of vaccine. This test identifies babies in whom immunisation has not been successful and who have become carriers. It also allows for referral for assessment and further management of such infants, as appropriate.

Where immunisation has been delayed beyond the recommended intervals, the vaccine course should be completed, but it is more likely the child may become infected, and therefore testing for HbsAg above the age of 12 months is particularly important.

There is evidence that the response to hepatitis B vaccine is lower in pre-term, low-birth weight babies (Losonsky et al., 1999). It is, therefore, important that premature infants receive the full paediatric dose of hepatitis B vaccine on schedule. For low-birthweight babies born to mothers infected with hepatitis B, HBIG should be given, in addition to vaccine, to babies with a birthweight of 1500g or less, regardless of the e-antigen status of the mother.

Where parent(s) or person(s) with parental responsibility, refuses to have the child immunised against Hepatitis B, health professionals should consider the very serious consequences of Hepatitis B infection.

Chronic Hepatitis B infection occurs in 90% of those infected perinatally.

About 20-25% of those with chronic hepatitis B infected progress to liver disease, and to cirrhosis in some.

Chronic hepatitis B carriers, particularly those with active inflammation, +/- cirrhosis, where there is rapid cell turnover, are at increased risk of developing hepatocellular carcinoma.

Development of the carrier state after perinatal transmission, can be prevented in >90% of cases, by appropriate vaccination starting at birth, of all infants born to infected mothers.

These facts need to be fully discussed with the parent(s) and very effort made to persuade them to have their baby immunised. In the event of continued refusal discussion should take place amongst all health professionals involved regarding the risk of the baby and consideration should be given as to whether any further action is needed.

Record the outcome of discussions regarding immunisation in the mother and child health records. Record refusal on the Child Health System and inform all relevant acute and primary care personnel.



Immunisation Information

HBIG = Hepatitis B Immunoglobulin. HBIG may be given at the same time as the vaccine **but at a different site.**

***In Northern Ireland HBIG is held by the Blood Transfusion Service, Belfast City Hospital, Belfast. Office Hours Tel: 02890 534637
Out of Hours Tel: 02890 329241, ask for the on-call NIBTS officer.**

*Immunisation should be commenced within 24 hours of delivery.

*Give a paediatric dose of the vaccine to infants. Check the summary of product characteristics of the Hepatitis B vaccine used, for the appropriate paediatric dose.

***The vaccine is given intramuscularly in anterolateral thigh in infants and in the deltoid in older children and adults.**

Children or other family members of any age, identified as close family contacts of a case or carrier should have their serology checked for hepatitis B markers, and offered immunisation if appropriate in line with the guidance provided in Immunisation Against Infectious Disease¹, Hepatitis B (Chapter 19 updated November 2005). Ensure correct dosage and schedule are followed

References

- (1) Ref: Salisbury, D. M. & Begg, N.T. (Eds) (1996), Immunisation Against Infectious Disease. HMSO, London Hepatitis B, Chapter 19.
- (2) Information for Midwives. Hepatitis B Testing in Pregnancy Department of Health, The Royal College of Midwives.



Tuberculosis TB risk factors*		
	Risk Factors	Risk Factor Description
1	Immigrants	Parent(s) or grandparents are immigrants from countries with a high prevalence of tuberculosis (40 cases or greater in 100,000 population)
2	Travel/migration	Infants or children travelling to countries with a high prevalence of tuberculosis (40 cases or greater in 100,000 population) for more than 1 month.
3	Contact	Member of infant's household/family circle is suspected of having TB, or has/has had TB in the past five years.

*Refer to National TB Guidance re contact tracing, treatment, immunisation and advice.

BCG should be offered where the country recorded has an incidence of TB of 40/100'000 or greater. This includes most of Eastern Europe, Asia, Africa, the Indian sub-continent, Central or South America and Portugal (December 2005), except where the mother is HIV positive when specialist advice is required.

(See HPA website <http://www.hpa.org.uk>)



Developmental dysplasia of hips (DDH) risk factors	
Risk factors	Risk factor description
Family history	1 st /2 nd degree relatives treated for DDH (i.e. mother, father, sibling, aunt, uncle, cousin and grandparent)
At delivery	Breech presentation
Lower limb malformation	e.g. fixed talipes
Torticollis	

Every baby should be reviewed in the first week of life to identify risk factors for DDH, and examined clinically through observation for visible abnormalities of the lower limbs and the Ortolani and Barlow tests as part of the newborn examination.

The hips must be examined again at the primary visit.

If examination is other than normal a baby must be referred for expert assessment and ultrasound screening.

If examination is normal but one or more risk factor is present a baby should be referred for ultrasound screening in accordance with local guidance.

The hips should be examined as part of the 8 week examination, including Ortolani – Barlow.

At 4 months:

- 1) Review risk factors for DDH
- 2) Assess regarding limited abduction of hips, asymmetry of leg length or deep skin creases (Do not use Ortolani – Barlow)
- 3) Identify any parental concerns

Hips should not be tested if the infant has been previously referred.

Parental concern is important and should be taken seriously. (NSC Child Health Sub Group Report: Dysplasia of the Hip, September 2004).



Congenital heart disease risk factors		
	Risk factors	Risk factor description
1	Related conditions	e.g. Down's syndrome, relevant extra cardiac defects, gastro intestinal malformations



Hearing risk factors		
	Risk factors	Risk factor description
1	Congenital infection	Proven or possible congenital infection due to Toxoplasmosis, Rubella, CMV or Herpes as determined by TORCH screen, and notified at any age.
2	Craniofacial anomalies	A (noticeable) craniofacial anomaly (excluding minor pits and ear tags) at any age, e.g. cleft palate
3	Amino glycoside administration for >48 hours	NNU child who had amino glycoside antibiotics for >48 hours
4	Bacterial Meningitis	Confirmed or suspected bacterial meningitis or meningococcal disease.
5	Family history of hearing loss (Parent(s)/siblings only)	Hearing loss in baby's parent(s) or siblings should be permanent (i.e. not glue ear) and present from childhood, irrespective of degree of loss.
6	IPPV >5 days	NNU child who had Intermittent Positive Pressure Ventilation (IPPV) >5 days
7	Jaundice at exchange transfusion level	Jaundice where bilirubin (normally unconjugated) reached a level indicating the need for exchange transfusion, taking into consideration other factors such as hypoxia, acidaemia, and prematurity.
8	Neurodegenerative or neurodevelopmental disorders	E.g. microcephaly, cerebral palsy.
9	Syndrome	Confirmed syndrome related to hearing loss e.g. Down's Syndrome
10	NNU protocol results	Bilateral clear response at otoacoustic brain response and the infant has not acquired a clear response in at least one ear at automated otoacoustic emissions.



Vision risk factors		
	Risk factors	Risk factor description
1	Prematurity	Prematurity (under 32 week gestation) and/or very low birth weight (is less than 1500g) VLBWB at risk of retinopathy of prematurity. Refer to Paediatric Ophthalmologist.
2	Family history	First-degree relative with inheritable eye disorder of e.g. congenital glaucoma, retinoblastoma, micro/anophthalmia or coloboma (Refer to Paediatric Ophthalmologist). First-degree relative with potentially heritable eye disorder of amblyopia, squint, nystagmus or high refractive error See relevant care pathway for referral to Orthoptist (appendix xi)
3	Dysmorphic syndrome/ neurodevelopmental disorders (learning disability)	Cerebral Palsy / Down's syndrome. (see relevant care pathway)
4	Children with sensory neural hearing impairment	(See relevant care pathway).
5	Children for "statementing"	Notes: Only refer children, who are not already attending, to an orthoptist where there is difficulty in assessing vision or if screening indicates the need to do so.



Pneumococcal Immunisation risk factors		
	Risk factors	Risk factor description
1	Asplenia or dysfunction of the spleen	This includes conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction.
2	Chronic respiratory disease	This includes chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema; and such conditions as bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis and bronchopulmonary dysplasia (BPD). Children with respiratory conditions caused by aspiration, or a neuromuscular disease (eg cerebral palsy) with a risk of aspiration. Asthma is not an indication, unless continuous or frequently repeated use of systemic steroids (as defined in Immunosuppression below) is needed.
3	Chronic heart disease	This includes those requiring regular medication and/or follow-up for ischaemic heart disease, congenital heart disease, hypertension with cardiac complications, and chronic heart failure.
4	Chronic renal disease	This includes nephritic syndrome, chronic renal failure, renal transplantation.
5	Chronic liver disease	This includes cirrhosis, biliary atresia, chronic hepatitis.
6	Diabetes (requiring insulin or oral hypoglycaemic drugs)	This includes type 1 diabetes requiring insulin or type 2 diabetes requiring oral hypoglycaemic drugs. It does not include diabetes that is diet controlled.
7	Immunosuppression	Due to disease or treatment, including asplenia or splenic dysfunction and HIV infection at all stages. Patients undergoing chemotherapy leading to immunosuppression. Individuals treated with or likely to be treated with systemic steroids for more than a month at a dose equivalent to prednisolone 20mg or more per day (any age), or for children under 20kg, a dose of ≥ 1 mg/kg/day. <i>Some immunocompromised patients may have a suboptimal immunological response to the vaccine.</i>
8	Individuals with cochlear implants	It is important that immunisation does not delay the cochlear implantation. Where possible, pneumococcal vaccination should be completed at least two weeks prior to surgery to allow a protective immune response to develop. In some cases it will not be possible to complete

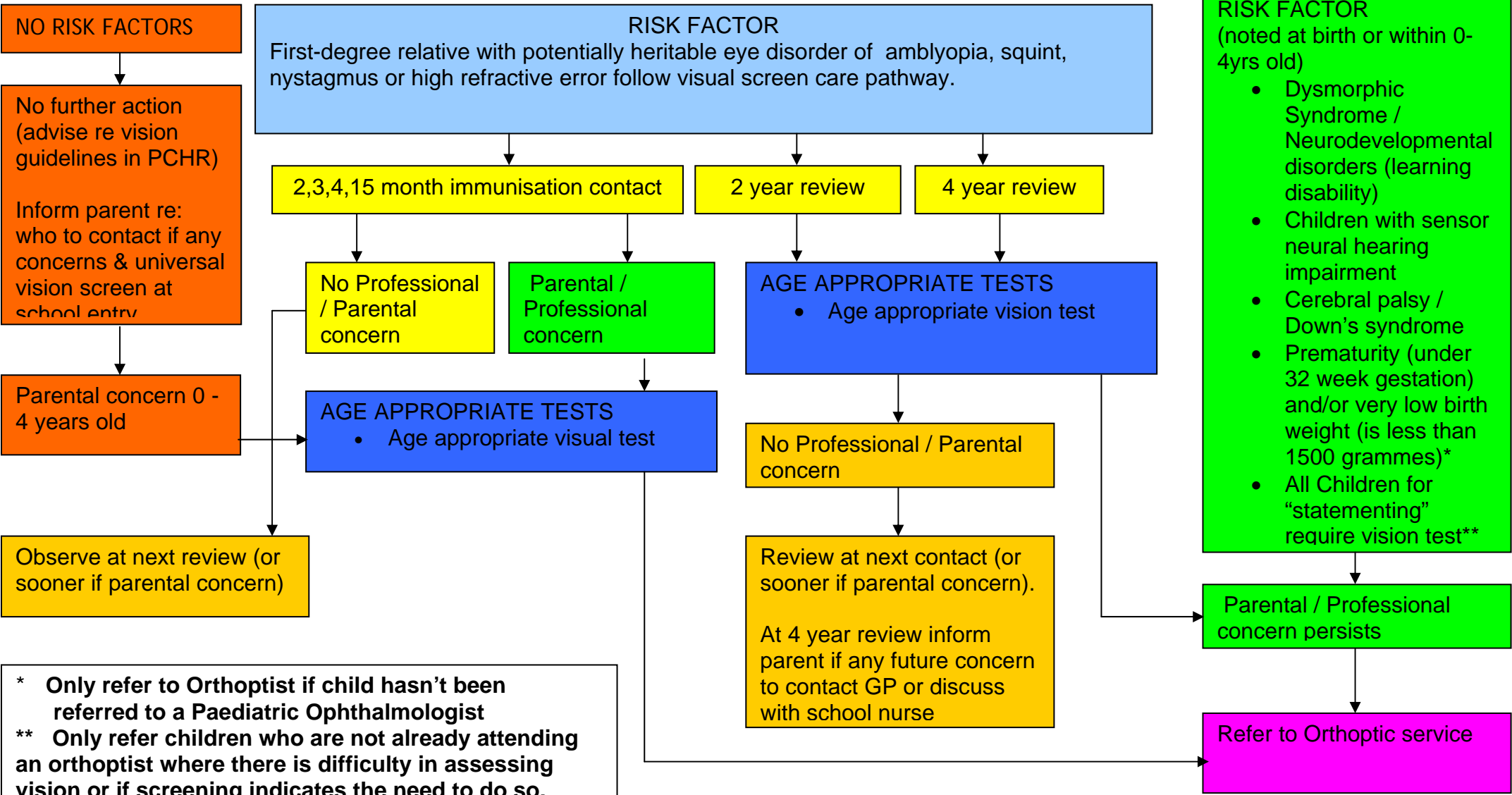


		<p>the course prior to surgery. In this instance, the course should be started at any time prior to surgery. In this instance the course should be started at any time prior to or following surgery and completed according to the immunisation schedule.</p>
9	Individuals with cerebrospinal fluid leaks	<p>This includes leakage of cerebrospinal fluid such as following trauma or major skull surgery.</p>



Visual screen pathway (Preschool)

VISUAL SCREEN CARE PATHWAY - PRESCHOOL

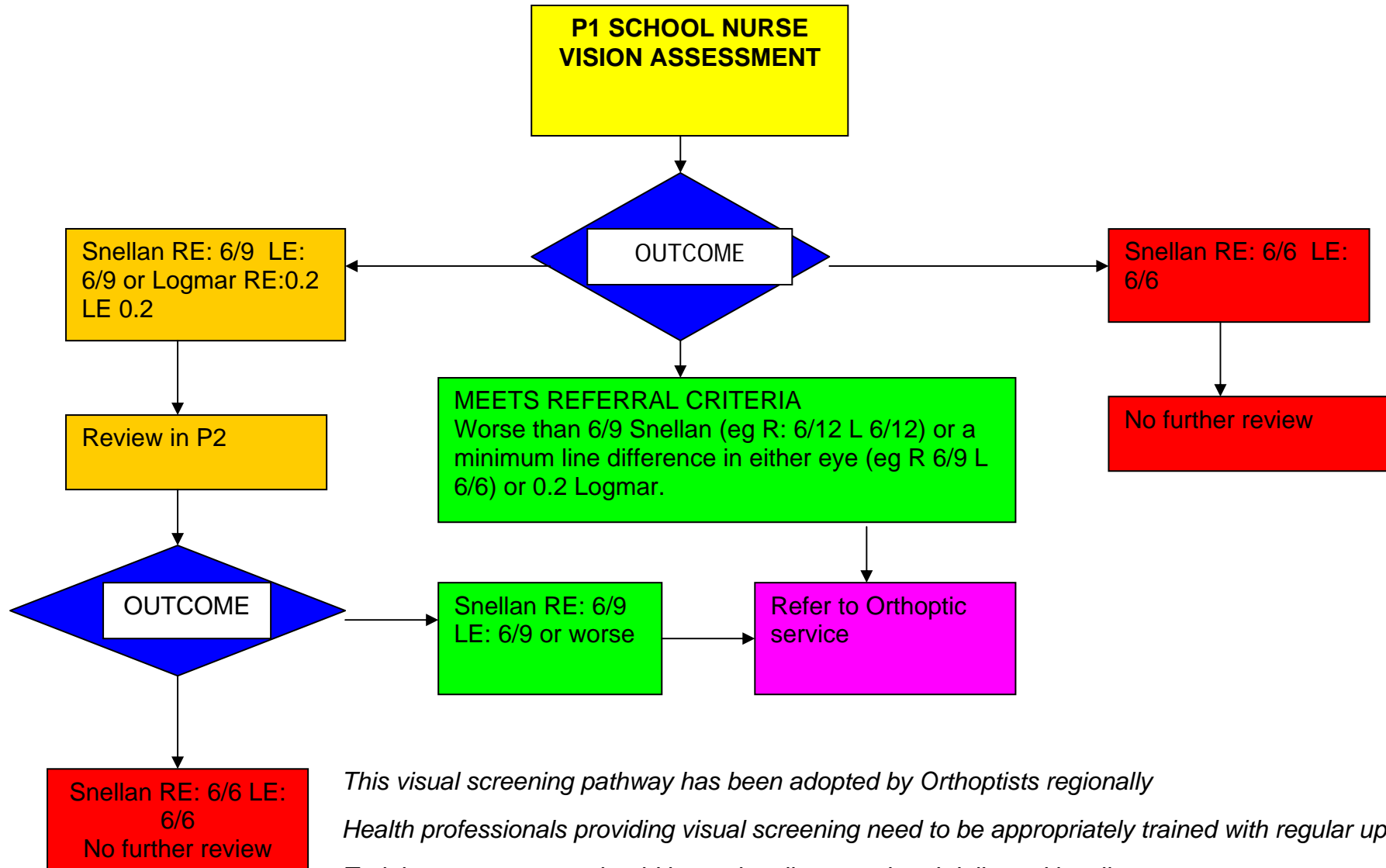


This visual screening pathway has been adopted by orthoptic professionals regionally.



Visual screen pathway – P1 (School Nurse)

P1 SCHOOL NURSE VISUAL SCREEN PATHWAY



*This visual screening pathway has been adopted by Orthoptists regionally
 Health professionals providing visual screening need to be appropriately trained with regular updates.
 Training programmes should be regionally agreed and delivered locally.*

Northern Ireland Pre-School Immunisation and Health Surveillance Programme				
Intervention	Timing	Health Professional	Details of Intervention	Venue
Antenatal review	Before 36 th week pregnancy	Midwife/health visitor (as per local arrangements)	Review core information from midwife/mother's notes. Commence health needs assessment, develop relationship with family. Identification of risk factors DDH, vision, hearing, Hep B, TB and mental health problems.	Home/clinic/ other appropriate Venue
Neonatal examination	Up to 72 hours	Doctor /midwife	Physical examination (to include eyes, hips, heart, testis(es), congenital malformations). Growth monitoring. Health promotion programme.	Hospital/home/ clinic
Newborn blood spot	5 days	Midwife	Phenylketonuria/hypothyroidism/cystic fibrosis/homocystinuria/ tyrosinaemia.	Hospital/communi ty
Primary visit	10- 14 days	Health Visitor	Health needs assessment and plan, growth monitoring, DDH examination. Permanent childhood hearing impairment risk factors, Identify any new risk factors for DDH, Health promotion programme.	Home
Newborn hearing screening	Up to 28 days	Screeener/ Co-ordinator	Semi-automated testing to detect hearing impairment. Detection of hearing screening risk factors.	Hospital/clinic (for mop-up)
Immunisation/ developmental surveillance	8 weeks	GP Health Visitor*	Physical examination (to include eyes, hips, heart, testis(es), congenital malformations including risk factors). Growth monitoring. Review & record breastfeeding status at 6 weeks. Health promotion programme. Local arrangements apply in relation to administration of immunisation.	Clinic/other
Immunisation review	3 months	Health visitor/ Practice Nurse*	Growth monitoring. Review & record breastfeeding status at 3 months, health promotion programme. Local arrangements apply in relation to administration of immunisation.	Clinic/other
Review	4 months	Health visitor/ Practice Nurse*	Growth monitoring. Review & record breastfeeding status at 3 months (if not already recorded), health promotion programme. Local arrangements apply in relation to administration of immunisation. Review for DDH.	Clinic/other
Immunisation review	12 months	Health visitor/Practice Nurse*	Local arrangements apply in relation to administration of immunisations.	Clinic/other



Intervention	Timing	Health Professional	Details of Intervention	Venue
Immunisation review	15 months	Health visitor	Review & record breastfeeding status at 6 & 12 months (if not already recorded). Health promotion programme. Growth Monitoring Local arrangements apply in relation to administration of immunisation. Review of children's records.	Clinic/other
2 year record review	2 year	Health visitor	The health visitor will exercise his/her professional judgement to decide if a face-to-face contact is required.	Clinic/home/telephone
School readiness review and immunisations	4 year	Health visitor/practice nurse	Growth monitoring. Health promotion programme. Local arrangements apply in relation to administration of immunisation TB risk assessment.	Clinic

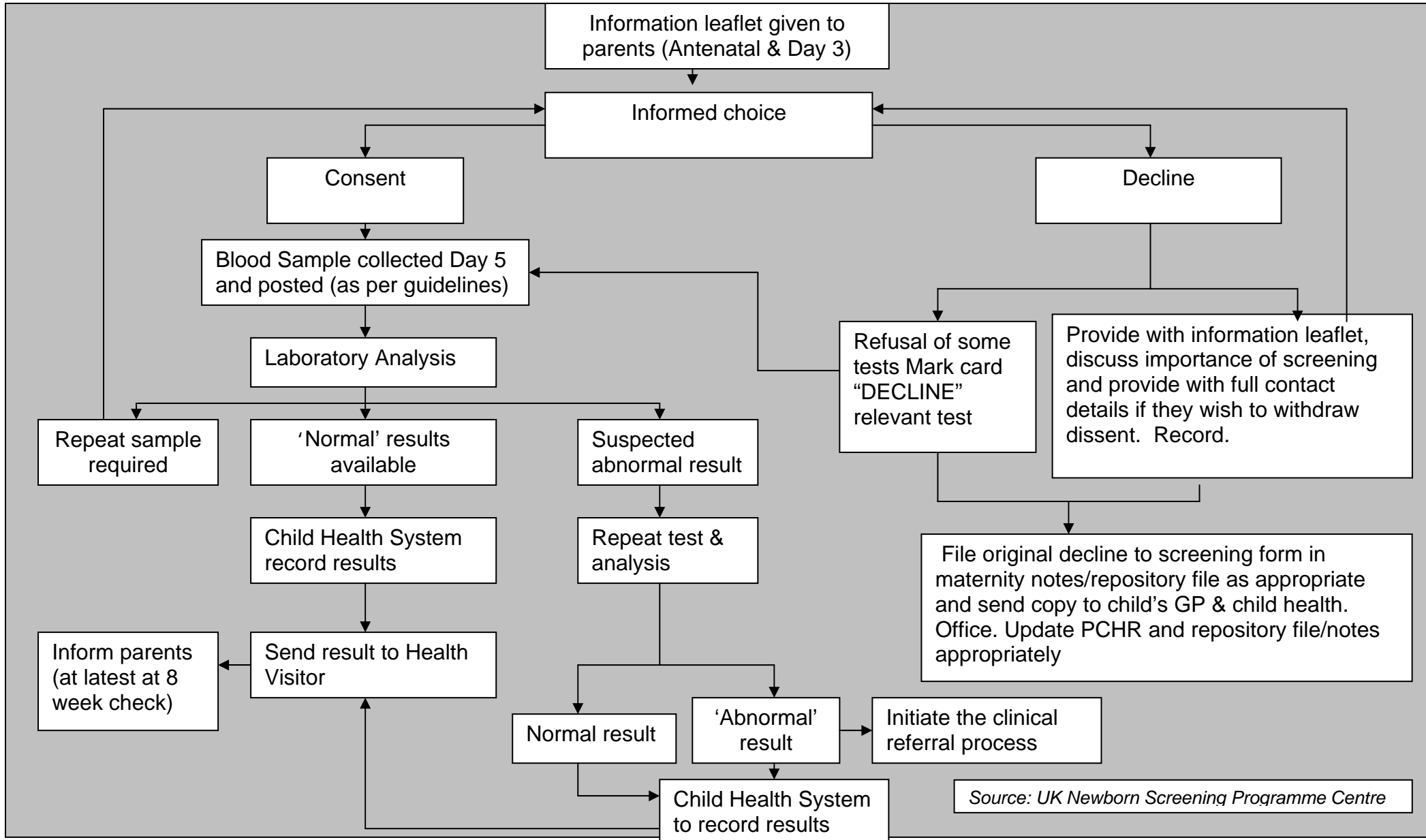
Local arrangements apply in relation to the administration of immunisations



Northern Ireland Primary and Post-Primary School Health Immunisation and Health Surveillance Programme				
Intervention	Timing	Health Professional	Details of Intervention	Venue
Entry to Primary School (plus new entrants)	P1	School nursing team	Health questionnaire and appropriate referrals Vision screening Sweep hearing Growth monitoring : height, weight, calculate percentiles & body mass index Health promotion TB risk assessment (if not already actioned at 4 years)	School/comm unity
Review	P2 – P7	School nursing team	Reviews Health promotion.	School/comm unity
Post-primary review (and new entrants)	Year 8	School nursing team	Health questionnaire and appropriate referrals. Reviews. Health promotion/drop in sessions. TB risk assessment	School/comm unity
Reviews (targeted)	Year 8-14	School nursing team	Reviews. Health promotion/drop in sessions.	School/comm unity
Immunisation/ review	Year 11	School nursing team	Health promotion/drop in sessions. Immunisations: School leaving booster. (Td/IPV) & 2 nd MMR (if required).	School/comm unity



The newborn blood spot screening pathway





Membership of Regional HFAC Group

Dr Carol Beattie, Consultant in Public Health Medicine, EHSSB.
Mrs Patricia Blackburn, AHP Commissioner, SHSSB
Dr Margaret Boyle, Senior Medical Officer, DHSSPS (Joint Chair).
Ms Georgie Clawson, Maternal & Child Health Project Manager, EHSSB.
Mrs Bridget Dougan, Maternal & Child Health Project Manager, NHSSB.
Mrs Valerie Doyle, Child Health Project Manager, SHSSB.
Dr Brid Farrell, Consultant in Public Health Medicine, SHSSB.
Ms Caroline Goldthorpe, Assistant Director of Nursing, Armagh & Dungannon HSST
Mrs Maureen Griffith, Asst. Director of Nursing, NHSSB.
Ms Jackie Hamilton, Maternal & Child Health Project Manager, WHSSB.
Mrs Mary Harkin, ISSM, Westcare Business Services.
Ms Glynis Henry, Chief nurse, SHSSB – from March 2006
Miss Ruth Johnston, Child Health System Manager, NHSSB.
Mrs Margaret Kelly, Nurse Manager, South & East Belfast HSST
Dr Fiona Kennedy, Consultant in Public Health Medicine, NHSSB.
Dr Tracey Owen, Consultant in Public Health Medicine, SHSSB.
Dr Caroline Mason, Senior Registrar Public Health, WHSSB
Dr Carolyn Mason, Nursing Officer- Public Health DHSSPS (Joint Chair) – to July 05.
Mrs Joan McCracken, Health Visitor, SHSSB.
Mrs Siobhan McIntyre, Service Planner Maternal & Child Health, WHSSB.
Mrs Angela McLernon, Nursing Officer – Public Health DHSSP (Joint Chair) – from April 06.
Mrs Angela McVeigh, Director of Health Care and Nursing Services, SHSSB.
Mrs Maria Monaghan, Child Health System Manager, EHSSB.
Mr Phelim Quinn, Nurse Commissioner, SHSSB. – to June 2005
Mrs Siobhan Rooney, Project Director of the Redesign of Community Nursing Project,
DHSSPS (Joint Chair) - from July 05 to April 06.
Mrs Jo Taylor, Maternal & Child Health Project Manager, NHSSB to April 05.
Mrs Deirdre Webb, Asst. Director of Nursing, EHSSB.