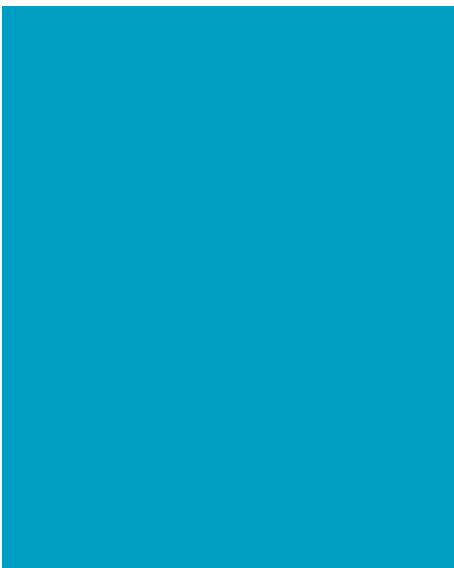


National Health Visiting Service Specification 2014/15



2014 – 15 National Health Visiting Service Specification

Publication date: March 2014

NHS England INFORMATION READER BOX

Directorate		
Medical	Operations	Patients and Information
Nursing	Policy	Commissioning Development
Finance	Human Resources	

Publications Gateway Reference: 01242

Document Purpose Resources

Document Name National Health Visiting Service Specification

Author NHS England

Publication Date 03 March 2014

Target Audience NHS England Regional Directors, NHS England Area Directors

Additional Circulation List Directors of PH, Directors of Nursing, , Directors of Children's Services, NHS Trust CEs

Description This is an updated and revision of the National Health Visiting Service Specification for commissioning of health visiting services in England.

Cross Reference 2013/14 National Health Visiting Service Specification and Health Visiting Service Specification Engagement Questionnaire

Superseded Docs (if applicable) 2013/14 National Health Visiting Service Specification

Action Required Use in commissioning of Health Visiting Services for 2014/15

Timing / Deadlines (if applicable) **NONE**

Contact Details for further information Sandra Anglin
NHS England
s.anglin@nhs.net

<http://www.england.nhs.uk/ourwork/qual-clin-lead/hlth-vistg-prog/>

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet

SCHEDULE 2 – THE SERVICES

A. Service Specifications (B1)

Service Specification No.	
Service	Health Visiting Service
Commissioner Lead	NHS England: ** Area Team (in partnership with local authority-led children’s health and wellbeing partnerships).
Provider Lead	
Period	1st April 2014 to 31st March 2015
Date of Review	February 2014

1. Population

1.1. National/local context and evidence base

1.1.1. The Health Visiting Service is a workforce of specialist community public health nurses who provide expert advice, support and interventions to families with children in the first years of life, and help empower parents to make decisions that affect their family’s future health and wellbeing. This service is led by health visitors and supported by a skill mix team. The service is central to delivering public health outcomes for children as listed in [section 2](#).

1.1.2. Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are set in place in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being, educational achievement and economic status. Universal and specialist public health services for children are important in promoting the health and wellbeing of all children and reducing inequalities through assessment and intervention as and when need is

identified and on an ongoing basis for more complex or vulnerable children and families. Successive reviews have demonstrated the economic and social value of prevention and early intervention programmes in pregnancy and the early years.

1.1.3. During pregnancy and in the first 2 years of the child's life the baby's brain and neurological pathways are being laid down for life. It is the most important period for brain development, and is a key determinant of intellectual, social and emotional health and wellbeing. Infancy is a time of rapid growth when three quarters of a baby's brain development takes place after birth. Research studies in neuroscience and developmental psychology have shown that interactions and experiences with caregivers in the first months of a child's life determine whether the child's developing brain structure will provide a strong or a weak foundation for their future health, wellbeing, psychological and social development¹.

1.1.4. The Government, NHS England, Public Health England (PHE), Royal Colleges, local government organisations and others signed up to the '[Pledge for better health outcomes for children and young people](#)' in February 2013. The Pledge sets out shared ambitions to improve physical and mental health outcomes for all children and young people. It commits signatories to putting children, young people and families at the heart of decision-making and improving every aspect of health services - from pregnancy through to adolescence and beyond.

1.1.5. Detailed references for the evidence base that supports this specification are set out in [Appendix 1](#).

1.1.6. This specification should be delivered in the context of the transition of 0-5 services to local authority commissioning from October 2015. This will be supported by co-commissioning with local authority-led children's health and wellbeing partnerships from April 2014, in many cases

¹ [Allen, G. \(2011a\) Early Intervention: The Next Steps. HM Government: London](#)

building on existing arrangements.

1.1.7. For providers this will involve further progress through a change process leading to an integrated approach to meeting the needs of young children and their families and the delivery of improved outcomes, particularly in working with in partnership with local authority provided or commissioned early years and children's social care services. In addition health visiting services should continue to work in close partnership with primary care and with CCG commissioned services, public health programmes and local authority commissioning from October 2015.

2. Outcomes

2.1. The health visiting service will deliver the full Healthy Child Programme (HCP) 0-5 years with a focus on working across services for 0-5s and their families to improve the following public health outcomes:

- The Public Health Outcomes Framework (PHOF) and the NHS Outcomes Framework include a range of outcomes which it is expected will be improved by an effective 0-5 years public health nursing team.
- Improving life expectancy and healthy life expectancy
- Reducing infant mortality
- Reducing low birth weight of term babies
- Reducing smoking at delivery
- Improving breastfeeding initiation
- Increasing breastfeeding prevalence at 6-8 weeks
- Child development at 2-2.5 years
- Reducing the number of children in poverty
- Improving school readiness
- Reducing under 18 conceptions
- Reducing excess weight in 4-5 and 10-11 year olds

- Reducing hospital admissions caused by unintentional and deliberate injuries in children and young people aged 0-14
- Improving population vaccination coverage
- Reducing tooth decay in children aged 5.

2.2. Family focussed provision

2.2.1. The Health Visitor Implementation Plan states: “The government believe that strong and stable families are the bedrock of a strong and stable society”².

2.2.2. It sets out what all families can expect from their local health visiting service under the following service levels:

Level 1 Communities Offer: To empower all families within the local community with children up to school entry age, through maximising family resources and development of community resources via involvement of local agencies and community groups as appropriate.

‘Health visitors will signpost and support access to a range of services already available in the community and work with partners to develop services including services communities can provide for themselves and they will make sure families know about them.’

Level 2 Universal Offer: Working in partnership with parents and carers to lead and deliver the full HCP from ante-natal care through to school entry.

‘A universal service from health visitors and their teams, providing the full HCP to ensure a healthy start for children and family, support for parents and access to a range of community services/resources.’

Level 3 Universal Plus Offer: To identify vulnerable families, provide, deliver and co-ordinate evidence based packages of additional care, including maternal mental health & wellbeing, parenting issues, families at risk of poor outcomes

² Health Visitor Implementation Plan “A Call to Action” 2011-2015, Department of Health (DoH).

and children with additional health needs.

'Rapid responses from the health visitor team when parents need specific expert help, for example with postnatal depression, a sleepless baby, feeding or answering any concerns about parenting.'

Level 4 Universal Partnership Plus Offer: To work in partnership with parents and agencies in the provision of intensive multi-agency targeted packages where there are identified complex health needs or safeguarding needs.

'On-going support from the health visiting team, plus a range of local services working together and with families, to deal with more complex issues over a period of time. These include services provided by Sure Start Children's Centres, other community providers including charities and, where appropriate, the Family Nurse Partnership (FNP).'

2.2.3. This plan was revised in June 2013 (DH and PHE) to take into account progress made, and changes in the health and care commissioning landscape.³

3. Scope

3.1. Aims and Objectives of the Service

3.1.1. The overarching aim of public health services for children under 5 is to protect and promote the health and wellbeing of children in the early years.

3.1.2. The key objectives of the health visiting service are to:

- a. Improve the health and wellbeing of children and reduce inequalities in outcomes as part of an integrated approach to supporting children and families;
- b. Ensure a strong focus on prevention, health promotion, early identification

³ <https://www.gov.uk/government/publications/health-visitor-vision>

- of needs and clear packages of support;
- c. Ensure delivery of the HCP to all children and families, starting in the antenatal period;
 - d. Promote secure attachment, positive maternal mental health and parenting skills using evidence based assessments and effective interventions - specifically NBO and NBAS, evidence based groups to promote parenting e.g. Webster-Stratton and language e.g. Hanan, effective home visiting using Solihull approach and motivational interviewing;
 - e. Identify and support those who need additional support and targeted interventions, for example, parents who need support with their emotional or mental health and women suffering from postnatal depression;
 - f. Work with families on positive parenting through motivational interviewing and evidence based approaches, and to support behaviour change leading to positive lifestyle choices;
 - g. Develop ongoing relationships and support as part of a multi-agency team where the family has complex needs e.g. a child with special educational needs or disability, or where there are identified safeguarding concerns;
 - h. Improve services for children, families and local communities through expanding and strengthening health visiting services to respond to need at individual, community and population level.

3.1.3. The remit of the health visiting service will include:

- Working in full partnership with all early years services in the local area;
- Leading delivery of the HCP
- Delivery of the health visiting elements of the HCP in full
- Reviewing, in partnership with parents and carers, the health and development of babies at age 9 months, toddlers at 18 months (targeted) and 2 – 2.5 years (universal and integrated) and pre-school children using Ages and Stages questionnaires and involving the family in promoting optimum health and development of all children;
- Leading, with local partners in developing, empowering and sustaining families and communities' resilience to support the health and wellbeing of their 0-5 year olds by working with local communities and agencies to

improve family and community capacity and champion health promotion and the reduction of health inequalities;

- Through health visitors' use of their knowledge of the evidence base and skills as trained public health practitioners, this will entail:
 - Providing intelligence about communities' assets and needs to support the wellbeing of 0-5 year olds, to inform the Joint Strategic Needs Assessment (JSNA);
 - Use of the benchmarked child health outcome framework indicators for 0-5s to form a basis for setting shared priorities for action and contributing to the JSNA;
 - Advising on best practice in health promotion in the early years of childhood;
 - Responding to the Joint Health and Wellbeing Strategy;
 - Responding to childhood communicable disease outbreaks and health protection incidents as directed by Public Health England (PHE) or other authority;
 - Delivering parenting classes/groups e.g. Preparing for Pregnancy and Beyond and parenting groups;
 - Achieving and maintaining full accreditation of UNICEF Baby Friendly community initiative;
 - Working with parents, using well evidenced, strengths based approaches e.g. motivational interviewing and Solihull approach to promote positive lifestyle choices and support positive parenting practices to ensure the best start in life for the child;
 - Building family competency for example in parenting, providing a healthy diet and in managing minor illness;
 - Providing responsive care when families have problems or need support or preventative interventions in response to predicted, assessed or expressed need (through intervention using new evidence in developmental psychology and confident parenting);
 - Early identification of developmental and health needs early and signposting and/or referring for investigation, diagnosis, treatment, care and support;

- Identifying and working with complex or vulnerable children and families where additional ongoing support is required to ensure early intervention and early referral to targeted support. This includes utilising the Common Assessment Framework and health visitors undertaking the role of Lead Professional where appropriate);
- Ensuring appropriate safeguards and interventions are in place to reduce risks and improve future health and wellbeing of children for whom there are safeguarding and/or child protection concerns (*Universal Partnership Plus Offer*).
- Working with other agencies as part of a multi-agency intensive care package for children and families requiring intensive support, particularly children for whom there are safeguarding or child protection concerns (*Universal Partnership Plus Offer*). This includes the statutory duty to share information and communicate with other health professionals and agencies where there are safeguarding concerns.

3.2. Health Visiting Workforce Development Plan

3.2.1. The challenge of mobilising the profession requires due attention by all providers. It is expected that providers will develop a robust workforce development plan. This plan should demonstrate:

Service Transformation

1. Service development in response to client experience feedback from families and caregivers;
2. Alignment and weighting of the health visiting resource in line with the local population needs and local authority boundaries. This will include collection of information about service provision in order to inform the expansion of services;
3. Embedding learning from Early Implementer Sites and other evidence and good practice guidance;
4. Priorities for the service based on population indicators, Health and Wellbeing Board priorities and the Service Specification;
5. Learning needs analysis of the existing workforce;
6. Evidence based intervention audit and development plan in line with local authority Early Years and Troubled Families Strategies;

7. Staff development in Building Community Capacity, including the online module
8. CPD programme which supports delivery of the service specification particularly evidenced based assessments and interventions as well as multi-agency learning, leadership and supervision;
9. Resources allocated for the CPD requirements identified in the plan.

Service Monitoring

10. Routine collation of service user views to inform service development where possible using validated measuring tools including Friends and Family Tests;
11. Health visitor staff engagement and capturing of views;
12. Evidence that health visitors are accessing appropriate leadership training, clinical supervision and are competent in all aspects of safeguarding;
13. Evidence that health visiting practice teachers are maintaining competence to practice in line with national guidance;
14. Quality audit programme;
15. Organisation process for ongoing CPD, including appraisals and PDP.

Health Visitor Workforce Growth

16. Robust workforce analyses and plans to achieve set trajectories, which includes: numbers of new students needed; recruitment/retention plans; numbers of retirees; potential other leavers; numbers of student placements based on Health Education England (HEE) expectations;
17. Conversion of agency and bank staff to substantive contracts;
18. Support for return to practice staff;
19. Schemes supporting the retention of staff e.g. [‘Retaining your health visitor workforce’](#) – NHS Employers;
20. Organisational processes and managerial support in place to ensure that mentors and practice teachers are able to provide high quality placements for health visitor students in line with the NMC and HEI requirements;
21. Retention and supply of practice teacher roles to support trainees and latterly to support new staff and the development of the wider health visiting team, ensuring evidence based practice and research focus is maintained;
22. Provide high quality undergraduate and health visitor student placements in line with NMC Standards and the required HEE target; and development of plans to

support workforce development and retention, mobilisation of expanded services, service transformation and service monitoring;

23. FTE health visitor workforce numbers are reported using data from the Electronic Staff Record (ESR) and non ESR sources, in line with agreed definitions of the Health Visiting Minimum Data Set (HV MDS). The service provider will ensure ESR records are updated, including ensuring correct coding of all health visitors, on a monthly basis, based on the health and social care information centre workforce data collection and in line with the definition on [HSCIC website](#);
24. To demonstrate that the Government's workforce commitment has been met, accurate workforce data, service delivery and outcomes measures will need to be collated. Service providers will support NHS England in the collection and reporting of health visiting workforce and outcomes data as required.

Supervision

25. The provider will work with NHS England, HEE and Local Education Training Boards (LETBs) to ensure effective support for trainees and newly qualified health visitors. This will be delivered by ensuring the provision of: sufficient practice teachers; support through mentoring and supervision for students and newly qualified staff; and, placement capacity and high quality placements in line with NMC and HEI requirements;
26. The Provider will develop and maintain a supervision policy and ensure that all health visiting staff access supervision in line with the framework below:
- a. Clinical supervision
Health visitors should have clinical supervision according to their needs using emotionally restorative supervision techniques.
 - b. Safeguarding supervision
Health visitors must receive a minimum of 3 monthly safeguarding supervisions of their work with their most vulnerable babies and children. These are likely to include children on a child protection plan, those who are 'looked after' at home and those for whom the health visitor has a high level of concern. Safeguarding supervision should be provided by colleagues with expert knowledge of child protection to

minimise risk. For example, supervision must maintain a focus on the child and consider the impact of fear, sadness and anger on the quality of work with the family.

c. Management supervision

Health visitors should have access to a health visitor manager or professional lead to provide one to one professional management supervision of their work, case load, personal, professional learning and development issues;

d. All the above forms of supervision should have an emotionally restorative function and should be provided by individuals with the ability to:

1. Create a learning environment within which health visitors can develop clinical knowledge, skills and strategies to support vulnerable families. This will include experiential and active learning methods.
2. Use strengths based, solution focused strategies and motivational interviewing skills to enable health visitors to work in a consistently safe way utilising the full scope of their authority.
3. Provide constructive feedback and challenge to health visitors using advanced communication skills to facilitate reflective supervision.
4. Manage strong emotions, sensitive issues and undertake courageous conversations.

3.3. Responding to the new vision for nursing and the “Six C’s”, health visitors will:

1. Show **care** and **compassion** in how they look after families;
2. Find the **courage** to do the right thing, even if it means standing up to senior people to act for the child or parent’s best interests, in a complex and pressured environment;
3. **Communicate** well at all times and finally;
4. Demonstrate **competence**.

3.4. Service Description

- 3.4.1. The health visiting service should provide the elements of the HCP as outlined in [section 2.1](#)
- 3.4.2. The universal elements of the HCP will be delivered by a team led by health visitors working in a way that is most appropriate to local public health needs. The team will work across a range of settings and organisations including general practice, maternity services and children’s centres (except where families are accessing the FNP, in which case the FNP family nurse will take on this role until the child is two years old).
- 3.4.3. The current HCP includes an emphasis on integrated services (see [Section 3.9](#)). As a part of this, health visiting services should be working toward increasing their engagement with early years staff in children centres and early years settings, in particular by exploring ways of bringing together the HCP review at age 2-2.5 with the Early Years Foundation Stage assessment undertaken in early years settings at age 2 using ASQ 3 and ASQ SE.
- 3.4.4. As an overview, core elements of the HCP include:
1. **Health and development reviews** – To assess family strengths, needs and risks using ASQ (3) and ASQ (SE); provide parents with the opportunity to discuss their concerns and aspirations; assess child growth and development, communication and language, social and emotional development; and detect abnormalities.
 2. **Screening** – in line with the current and forthcoming updated HCP.
 3. **Immunisations** – Immunisations should be offered to all children and their parents. General practices are the provider of immunisations and child health record departments maintain a register of children under five years, invite families for immunisations and maintain a record of any adverse reactions in the Child Health Information System. Members of the HCP team should identify the immunisations status of the child and work with families to encourage and support uptake.
 4. **Promotion of social and emotional development** – The HCP

includes opportunities for parents and practitioners to review a child's social and emotional development using ASQ 3 and ASQ SE, and for the practitioner to provide evidence based advice and guidance and decide when specialist intervention is needed.

5. **Support for parenting** – One of the core functions of the HCP is to support parenting using evidence based programmes and practitioners who are trained and supervised. See [section 3.5.2](#) for more evidence based pathways.
6. **Effective promotion of health and behavioural change** – Delivery of population, individual and community-level interventions based on NICE public health guidance.
7. **Sick children** – Supporting parents to know what to do when their child is ill.
8. **Children with additional needs** – Early identification, diagnosis and help.

3.4.5. In addition to the core programme, the HCP schedule includes a number of evidence based preventive interventions, programmes and services. Providers will work with Commissioners, local authority partners, local safeguarding and children's boards, Health and Wellbeing Boards, Clinical Commissioning Groups (CCGs), to determine which services are offered locally and by whom. See more detail on evidenced-based pathways in [section 3.5.2](#).

3.5. Service delivery and Care Pathways

3.5.1. The health visiting service will work to develop, implement, monitor and review multi-agency care pathways for priority needs for children and their families, ensuring clarity of roles and responsibilities, reducing duplication and eliminating gaps. These will be based on evidenced based assessments and interventions with a clear role for health visitors underpinned by training in the relevant competencies. These should be in line with national pathways and guidance where these have been developed.

3.5.2. Multi-agency, evidence based pathways expected to be in place would

include:

1. Safeguarding children including a focus on prevention, early help, targeted support, early intervention and sharing of information. (See [Working Together to Safeguard Children](#) HM Govt 2013).
2. Post natal maternal mental health ([NICE CG 37](#)).
3. Young parents including [Family Nurse Partnership](#).
4. [Substance and alcohol misuse](#).
5. [Domestic abuse](#).
6. Perinatal mental health and early attachment (for best practice see [Tameside & Glossop Early Attachment Service](#)).
7. Breastfeeding ([UNICEF baby friendly in the community](#)).
8. Nutrition and healthy weight including failure to thrive (NCMP and PHE via www.noo.org.uk)
9. [Children with additional needs and disabilities](#)
10. [Transition from midwife to HV](#)
11. [Transition from HV to School Nurse \(see DH website 2013\)](#)
12. [Seldom heard communities](#) including families with young children from traveller, asylum seeker and refugee communities and homeless families.

3.6. Response time and prioritisation

3.6.1. The provider must ensure that:

- 1) The four levels of service offers listed in the service delivery and care pathways are to be provided in full unless specifically agreed with local commissioners due to insufficient service capacity in the interim period of teams reaching capacity.
- 2) All initial assessments should be carried out by health visitors. All referrals from whatever source (including families transferring in) will receive a response to the referrer within 5 working days, with contact made with the family within 10 working days.
- 3) Urgent referrals, including all safeguarding referrals, must receive a same day or next working day response to the referrer and contact with the family within two working days.

- 4) As a child approaches 4 years of age transition to the local School Health Service will be initiated in accordance with local and national pathways.
- 5) Where health visitors are responsible for undertaking Looked After Children Health Assessment/ Review and care plans these must be done to national standards and within the statutory timeframe.
- 6) The provider must ensure that when the youngest child in the family reaches school entry age, the family file or adult records are transferred as per local procedure.
- 7) Children being supported with interventions at Universal Plus or Universal Partnership Plus must be formally identified to the School Nursing Service as per local procedure in order ensure continued targeted support.
- 8) Where a child moves out of area the health visiting service must ensure that the child's health records are transferred to the health visiting service in the new area within 2 weeks of notification, if known. Procedures must be in place to trace and risk-assess missing children. Direct contact must be made to handover all child protection cases.
- 9) The provider must audit compliance to the response time and prioritisation as agreed with commissioners.

3.7. Population covered

- 3.7.1. Geographic coverage/ boundaries - All families with a child aged 0-5 years and pregnant women currently resident in the local authority area should receive the HCP. Data collection will enable reports on activity for both the GP registered and the resident population.
- 3.7.2. The service will ensure that any coverage/ boundary issues that may arise will be dealt with proactively in collaboration with neighbouring providers. Delivery of a service that meets the needs (including safeguarding) of the child or family must take precedent over any boundary discrepancies or disagreements.

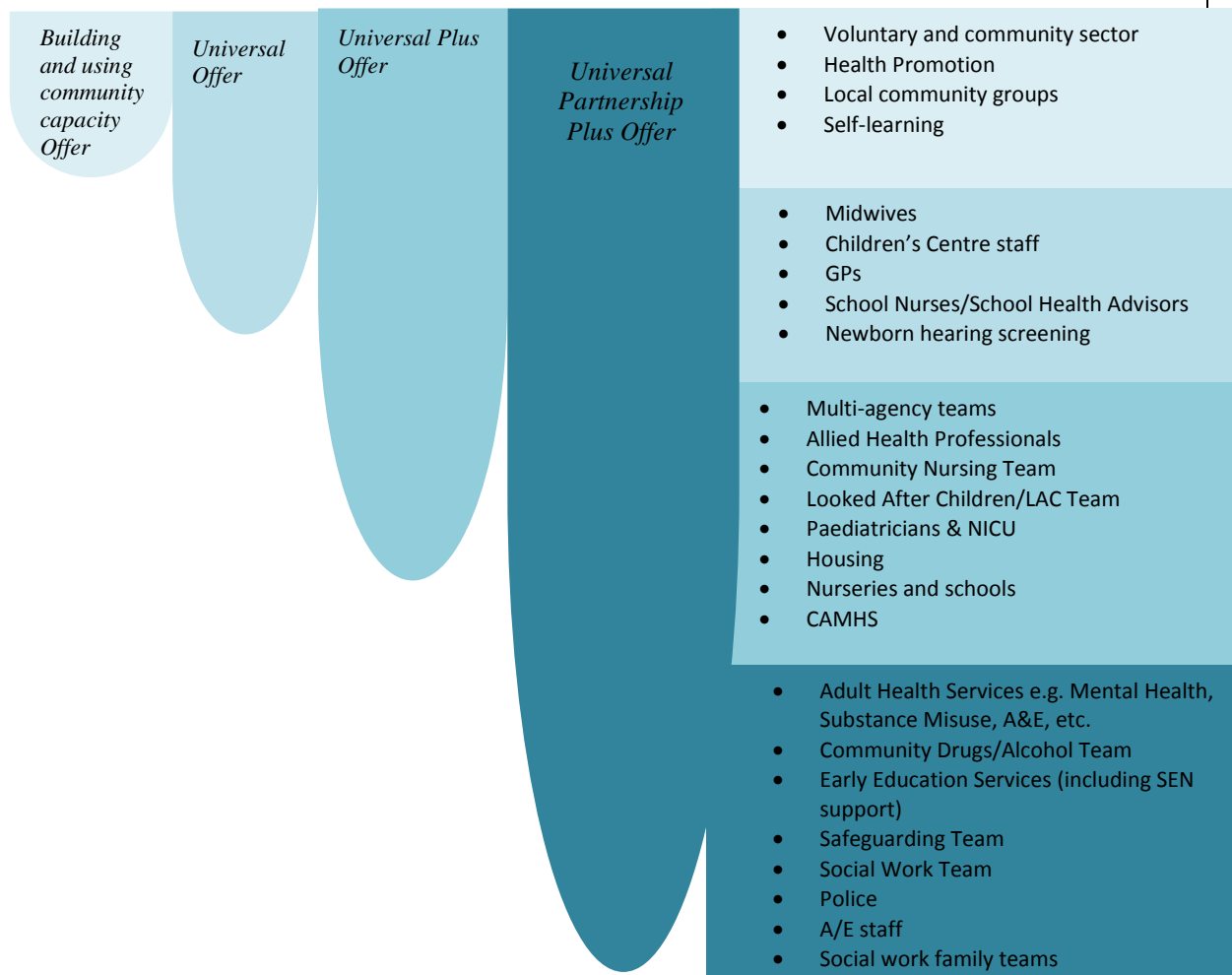
3.8. Acceptance and exclusion criteria

- 3.8.1. The service must ensure equal access for all children up to school entry and

their families, irrespective of age, disability, gender reassignment, marriage and civil partnership and race – this includes ethnic or national origins, colour or nationality, religion, lack of belief, sex or sexual orientation.

3.8.2. The service must ensure they provide appropriate staff allocation according to population need whilst maintaining the universal offer.

3.9. Interdependencies - Whole System Relationships (list not exhaustive)



3.9.1. The provider must establish:

1. Good working relationships with all of the above, including effective joint working at transition points (e.g. from midwife to health visitor and health visitor to school nurse).
2. Representation of the health visiting service on local Children’s Health

and Wellbeing Partnerships and ensure links to feed in appropriately to local Health and Wellbeing Boards, Local Children Safeguarding Boards and Children's Trusts, developing services in line with the Board/Trust's priorities.

3. An area-based health visiting service structured in line with local children's services, working together to deliver integrated, evidence based services for children and their families, with a focus on prevention, promotion and early intervention.
4. As a minimum, a named health visitor for every family up to 1 year of age identified as having needs for Universal Plus/ Partnership Plus.
5. A named health visitor linked to each GP practice and facilitate an agreed schedule of regular contact meetings for collaborative service delivery.
6. A named health visitor on each Sure Start Children's Centre management advisory board to work in direct partnership with children centres to:
 - a. Provide improved access and delivery of the HCP and, through this, the children's centre core offer.
 - b. Integrated working with children's centres in their delivery of evidence based interventions to improve outcomes for families.
 - c. Promote and describe the wide range of early years provision that children and their families are entitled to, and as part of that process encourage all families to register for access to a wider range of provision.
7. Information sharing arrangements with local integrated services.
8. Service user engagement preferably using established tools such as the NHS Friends and Family test or other validated tools, and that results will be fed back into service design, performance monitoring and evaluation of provision.

4. Applicable Service Standards

4.1. Applicable national standards - please see [Appendix 1](#)

4.2. Record keeping, data collection systems and information sharing

- a. In line with contractual requirements, providers will ensure that robust systems are in place to meet the legal requirements of the Data Protection Act 1998 and the safeguarding of personal data at all times. Providers should also refer to 'Record Keeping: Guidance for Nurses and Midwives', NMC, 2009.
- b. In line with the above and following good practice guidance, the provider will have agreed data sharing protocols with partner agencies including other health care providers, children's social care and the police to enable effective services to be provided to children and their families. Providers will ensure that all staff have access to information sharing guidance including sharing information to safeguard or protect children.
- c. The Personal Child Health Record (PCHR) will be completed routinely by professionals supporting parents and carers to use proactively.
- d. Appropriate records will be kept in the Child Health Information System (CHIS) or similar system to enable high – quality data collection to support the delivery, review and performance management of services

4.2.1. 2-2.5 year review (Ages and Stages Questionnaire)

The PHOF indicator 2.5, development at age 2-2.5, will require the implementation of a data collection about the ages and stages questionnaire to be used in the 2-2.5 year review. The data items required are likely to include: date of birth of child, date of completion of ASQ-3 questionnaire, whether the questionnaire was completed as part of HCP 2-2.5 year review/integrated review, which questionnaire was used (24/27/30 month), ASQ domain scores (Communication/Gross Motor/Fine Motor/Problem-solving/Personal-Social), gestational age at birth, gender, postcode, ethnicity and date of birth of mother. Providers and Area Teams should make plans to ensure that the mechanisms for data collection of the 2-2.5 year review are in place in readiness for this collection.

5. Quality Requirements

5.1. The provider must deliver a comprehensive high quality health visiting service

which meets the standards, pathways and guidance set out in this service specification. The service must be safe, effective and customer focussed.

- 5.2. The provider service must be quality assured against CQC and all applicable quality standards, key performance indicators and service delivery metrics. The Provider Performance Framework ([Appendix 7](#)) must be completed on a quarterly basis, in line with other required data collections as notified.
- 5.3. Providers must provide the commissioner with a robust plan to implement electronic record keeping and data collection for health visiting services (also [see 4.2](#)).
- 5.4. The provider should highlight to commissioners where there is an absence of local services to refer families onto so that future commissioning plans can include mitigation for/provision of these; this is particularly urgent where need is identified but NICE guidance pathways are truncated at the onwards referral stage because local services do not currently exist.

6. Location of Provider Premises

6.1. Provider's Premises

- 6.1.1 Parents should be offered a choice of locations for visits which best meet their needs, e.g. GP surgeries, children's centres, community health services, the home, health centres, etc. Locations must be easily accessible for all children and families who live in the local vicinity (including access by public transport and at times appropriate to the user), children and young family friendly, suitable for multi-disciplinary delivery of services in both individual and group sessions and be conducive to flexible availability (e.g. early mornings, lunchtimes, after school, evenings and weekends).
- 6.1.2 Specific locations are to be agreed locally following engagement with relevant interested parties and feedback from users. Reviews should be taken periodically to ensure the locations are suitable to local needs.

6.1.3 Joint contacts should be provided in partnership with other agencies where this reduces inconvenience for families, for example integrated 2-2.5 year review.

6.2 Days/Hours of operation

The core service will operate standard hours of 9am – 5pm but will offer flexibility from 8am – 8pm to meet the needs of families.

Appendix 1

Evidence Base, Applicable National Service Standards and Suite of Evidence Based Interventions/Pathways

Evidence Base

- [Healthy Child Programme – Pregnancy and the first five years of life](#) (DH, 2009 – amended August 2010)
- [Better health outcomes for children and young people](#) Pledge
- [The Children and Young People’s Health Outcomes Strategy \(DH, 2012\)](#)
- [Allen, G. \(2011a\) Early Intervention: The Next Steps. HM Government: London](#)
- [Allen, G. \(2011b\) Early Intervention: Smart Investment, Massive Savings. HM Government: London](#)
- [Field, F. \(2010\) The Foundation Years: preventing poor children becoming poor adults. HM Government: London.](#)
- [Health visitor implementation plan 2011-15: A call to action](#) (DH, 2011)
- [The National Health Visitor Plan: progress to date and implementation 2013 onwards](#) (DH, 2013)
- [The Operating Framework for the NHS in England 2012/13](#) (DH, 2011)
- [The NHS Outcomes Framework 2012/13](#) (DH, 2011)
- [Improving outcomes and supporting transparency, Part 1: A public health outcomes framework for England, 2013-2016](#) (DH, 2012)
- [Improving outcomes and supporting transparency, Part 2: Summary technical specifications of public health indicators](#), (DH, 2012)
- [The Marmot Review \(2010\) Strategic Review of Health Inequalities in England, post-2010](#)
- Dame Clare Tickell (2011) [The Early Years: Foundations for life, health and learning – An Independent Report on the Early Years Foundation Stage to Her Majesty’s Government](#)
- [Hall D and Elliman D \(2006\) Health for All Children \(revised 4th edition\). Oxford: Oxford University Press.](#) (Please note: this link opens to the bookstore for purchase of copies of this edition).

- [Service vision for health visiting in England \(CPHVA conference 20-22 October 2010\)](#)
- [Securing Excellence in Commissioning for the Healthy Child Programme 0 to 5 Years 2013 – 2015](#)
- [Equity and excellence: Liberating the NHS \(DH, 2010\)](#) and [Liberating the NHS: Legislative framework and next steps DH, 2011\)](#)
- [Achieving equity and excellence for children. How liberating the NHS will help us meet the needs of children and young people \(DH, 2010\)](#)
- [Getting it right for children and young people: Overcoming cultural barriers in the NHS so as to meet their needs \(DH, 2010\)](#)
- [Healthy lives, healthy people: our strategy for public health in England \(DH, 2010\)](#) and [Healthy lives, healthy people: update and way forward \(DH, 2011\)](#)
- [Healthy lives, healthy people: a call to action on obesity in England \(DH, 2011\)](#)
- [UK physical activity guidelines \(DH, 2011\)](#)
- [Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children \(HM Government 2013\)](#)
- [Fair Society, Healthy Lives. A strategic review of health inequalities in England post 2010 \(The Marmot Review, 2010\)](#)
- [The 1001 Critical Days: The importance of the conception to age two period. Wave Trust, 2013](#)
- [Conception to Age two: The Age of Opportunity. WAVE Trust and DfE](#)
- [Annual Report of the Chief medical Officer 2012. Our Children Deserve Better: Prevention Pays. Department of Health, 2013](#)
- [UNICEF UK Baby Friendly Initiative](#)

Applicable National Standards

Key NICE public health guidance includes:

Please note: For all reference see the [NICE website](#).

- PH3 Prevention of sexually transmitted infections and under 18 conceptions
- PH6 - Behaviour change at population, community and individual level (Oct 2007)
- PH8 Physical activity and the environment

- PH9 - Community engagement (July 2010)
- PH11 - Maternal and child nutrition
- PH12 - Social and emotional wellbeing in primary education
- PH14 Preventing the uptake of smoking by children and young people
- PH17 - Promoting physical activity for children and young people
- PH21 - Differences in uptake in immunisations
- PH24 Alcohol-use disorders: preventing harmful drinking
- PH26 - Quitting in smoking in pregnancy and following childbirth (June 2010)
- PH27 - Weight management before, during and after pregnancy (July 2010)
- PH28 - Looked-after children and young people: Promoting the quality of life of looked-after children and young people (October 2010)
- PH29 - Strategies to prevent unintentional injuries among children and young people aged under 15 Issued (November 2010)
- PH30 Preventing unintentional injuries among the under-15s in the home
- PH31 Preventing unintentional road injuries among under-15s
- PH40 Social and emotional wellbeing – early years: NICE public health guidance 2012
- PH42- Obesity working with local communities
- PH44 Physical activity: brief advice for adults in primary care
- PH46 Assessing body mass index and waist circumference thresholds for intervening to prevent ill health a premature death among adults from black, Asian and other minority ethnic groups in the UK.
- PH49 Behaviour change: individual approaches
- CG43 Obesity: Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children
- CG45 - Antenatal and postnatal mental health: clinical management and service guidance (February 2007)
- CG62 - Antenatal care: routine care for the healthy pregnant woman (March 2008)
- CG89 - When to Suspect Child Maltreatment (July 2009)
- CG93- Donor milk banks: the operation of donor milk bank services
- CG110- Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors

- QS22 Quality standards for antenatal care
- QS31 Quality standard for the health and wellbeing of looked-after children and young people
- QS37 Postnatal Care
- QS43 Smoking cessation: supporting people to stop smoking
- QS46 Multiple pregnancies
- QS48 Depression in children and young people

Suite of Evidence based pathways and interventions

[Svanberg P O, Barlow J & Tigbe W](#) The [Parent–Infant Interaction Observation Scale: reliability and validity of a screening tool](#). Journal of Reproductive and Infant Psychology, 2013: Volume 31, Issue 1, 2013

Milford R, Oates J. [Universal screening and early intervention for maternal mental health and attachment difficulties](#). Community Practitioner, 2009; 82(8): 30-3.

Appendix 2

Universal Offer - Assessments

Please note the Healthy Child Programme Schedule is currently under review. The schedule below is subject to change in accordance with the new schedule.

Universal Review	Description
Antenatal health promoting visits	Promotional narrative listening interview Includes preparation for parenthood
New Baby Review	Face-to-face review by 14 days with mother and father to include: <ul style="list-style-type: none"> - Infant feeding - Promoting sensitive parenting - Promoting development - Assessing maternal mental health - SIDS - Keeping safe - If parents wish or there are professional concerns: <ul style="list-style-type: none"> • An assessment of baby's growth • On-going review and monitoring of the baby's health • Safeguarding • Assessment of attachment using NBO before 8 weeks
6 – 8 Week Assessment	Includes: <ul style="list-style-type: none"> - On-going support with breastfeeding involving both parents - Assessing maternal mental health according to NICE guidance
By 9 months and 30 days	Includes: <ul style="list-style-type: none"> - Assessment of the baby's physical, emotional and social development and needs in the context of their family using Ages and Stages 3 and SE questionnaires - Supporting parenting, provide parents with information about attachment and developmental and parenting issues

	<ul style="list-style-type: none"> - Monitoring growth - Health promotion, raise awareness of dental health and prevention (ensuring that all children are accessing primary dental care services for routine preventive care and advice), healthy eating, injury and accident prevention relating to mobility, safety in cars and skin cancer prevention
By 2 – 2½ Years	<p>Includes:</p> <ul style="list-style-type: none"> - Review with parents the child’s social, emotional, behavioural and language development using ASQ 3 and SE - Respond to any parental concerns about physical health, growth, development, hearing and vision - Offer parents guidance on behaviour management and opportunity to share concerns - Offer parent information on what to do if worried about their child - Promote language development - Encourage and support to take up early years education - Give health information and guidance - Review immunisation status - Offer advice on nutrition and physical activity for the family - Raise awareness of dental care, accident prevention, sleep management, toilet training and sources of parenting advice and family information - This review should be integrated with the Early Years Foundation Stage two year old summary from 2015 as appropriate to the needs of children and families.
By 4 ½ years	<p>4½ years - Formal handover to School Nursing Service.</p> <p>Children on Universal Plus or Universal Partnership Plus Offer must have a written handover.</p>

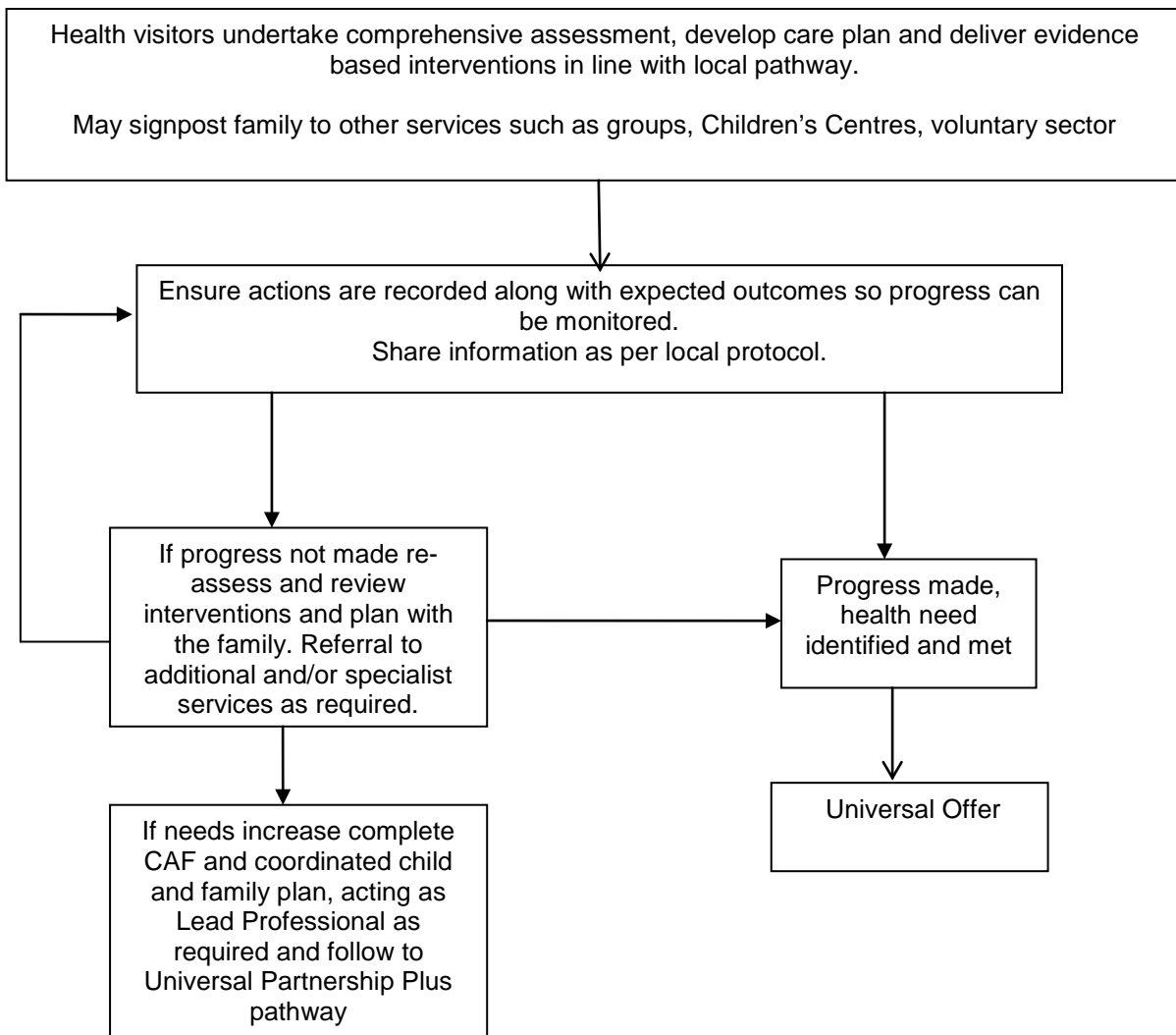
Appendix 3

Universal Plus Offer

Please note the Healthy Child Programme Schedule is currently under review. The schedule below is subject to change in accordance with the new schedule.

Universal Offer and any identified additional needs requiring intervention as per local procedure at any time.

Identified health needs such as *feeding, sleep, behaviour, toilet training, developmental, feeding, postnatal depression*



Note: CAF is the Common Assessment Framework or equivalent multiagency assessment processes in place in the local authority

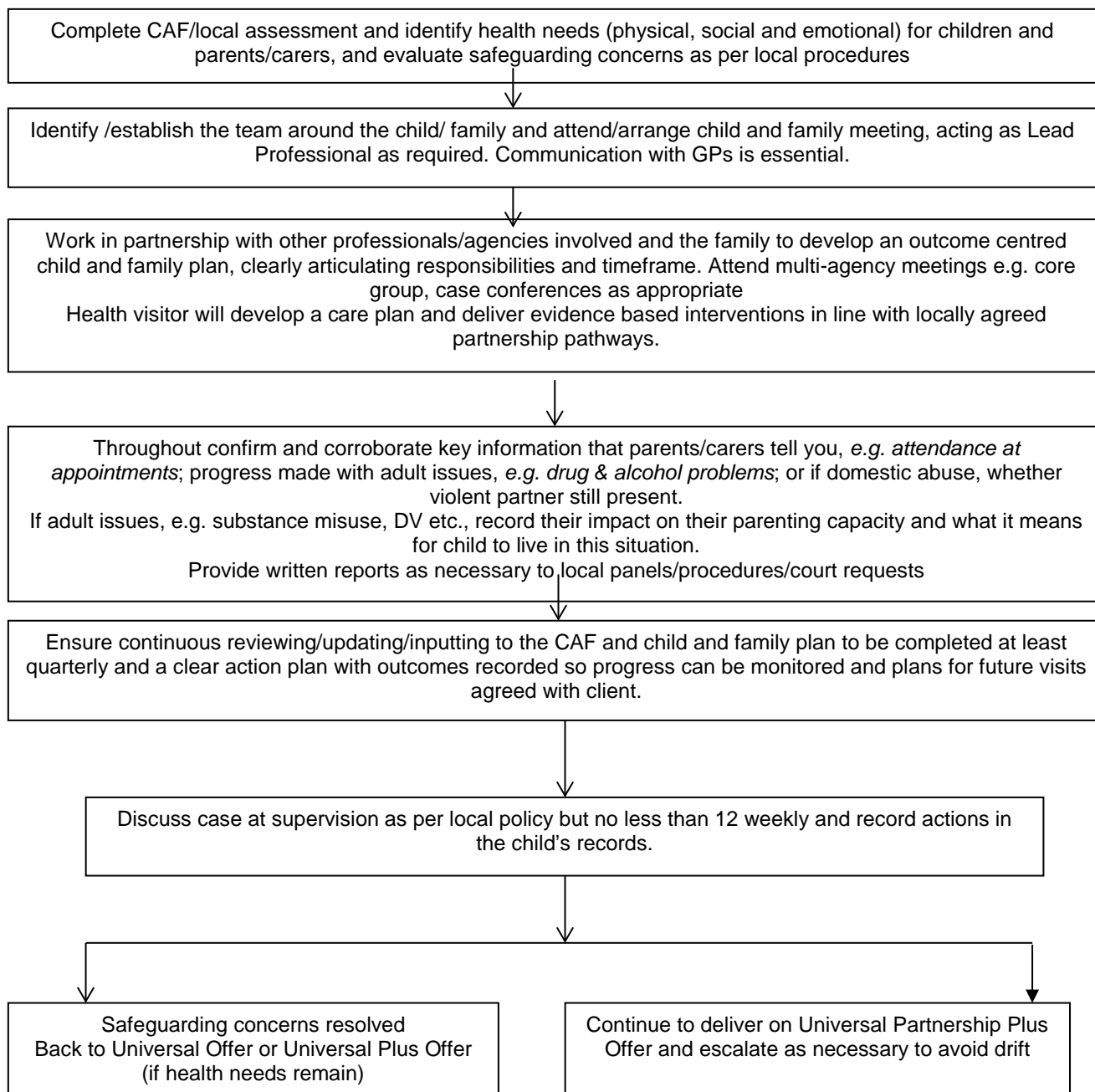
Appendix 4

Universal Partnership Plus Offer

Please note the Healthy Child Programme Schedule is currently under review. The schedule below is subject to change in accordance with the new schedule.

Identified health needs **plus** additional concerns

i.e. safeguarding, domestic abuse, alcohol/substance misuse, mental health problems, poor physical health etc



Appendix 5

Suggested activities at Communities Service Offer

Please note the Healthy Child Programme Schedule is currently under review. The schedule below is subject to change in accordance with the new schedule.

(These are examples – it is expected that the Service will work in partnership with Children’s Services to ensure that local innovation can flourish and appropriate developments grown.)

Peer support groups; support existing, develop and support ‘role model’ volunteers. Ensure local pathways for volunteers to progress towards paid work e.g. peer breastfeeding, community parents, asylum seeking families groups.

Community aspirations: use motivational interviewing to understand aspirations, dreams and assets and enable people to take their own steps to achieve these e.g. community credit facilities, food co-operatives. Act as communities’ champion.

Building social networks; of families with similar interests, strengths or needs. Expansion of existing social networks to meet public health needs e.g. extended family, postnatal groups, faith groups, father’s groups. Introduction and support of vulnerable families into existing networks.

Influence other agencies and sectors to improve public health outcomes through supporting the application of best practice in health improvement outside of health and early years settings, identifying local public health need and opportunity e.g. in housing, domestic abuse, teenage families, benefits system, schools, council planning/ neighbourhood improvement.

Exploit every opportunity for public health gain; develop group work with public health intention. Presence at community locations and events (supermarkets, markets, library, fetes, fun days). Signposting families to other services already existing locally, particularly early years but also adult education and training. Utilise

local media opportunities for health promotion. Link fatherhood skills into men's health community initiatives.

Appendix 6: Health Visitor Service Delivery Metrics

We request numerators and denominators for all indicators so that we can use these figures to evaluate the health visitor programme across Area Teams, regions and the country. This also allows us to validate these figures where possible to external sources.

If the specifications cannot be followed exactly please indicate how the information you provide differs from the specification.

Geographical Breakdown

This data should be reported by provider area of responsibility. Provider area of responsibility is defined as all those who the provider is responsible for providing health visitor services for. This should be defined on the basis of CCG footprints. CCG footprints are the CCG in which the infant is registered to a GP, or if they are not registered, the CCG of residence. All infants should therefore be included. From Q1 2014/15 we will additionally be collecting this information by local authority of residence based on postcode of the child. This is to facilitate working within the public health system to prepare for the transition of 0-5s commissioning to local authorities in October 2015.

Timeframe

The data will be collected quarterly. Note that from Q1 2014/15 we will also be collecting this data by local authority of residence.

Data Specifications:

Guidance notes across all indicators

- All mothers and children are included in each indicator, this includes any being treated privately, or not registered with a GP. We realise that the occurrence of this may vary between areas.
- When families move, we have specified with which area/provider they should be included. We realise that this will mean that some providers will count visits that were carried out by providers in other areas and/or visits that were not carried out in other areas. This should, in the long run, average out

across areas and encourage the responsibility of the new area to pick up children quickly into the health visitor service.

- We have specified where the number of births should be counted and the number of babies should be counted.

Indicator C1 - Number of mothers who received a first face to face antenatal contact with a Health Visitor at 28 weeks of pregnancy or above.

Count of number of mothers who received a first contact with a health visitor when they were 28 weeks pregnant or later, before they gave birth.

Definition:

This should be a count of mothers who received a first contact with a health visitor when they were 28 weeks pregnant or greater, before they gave birth. Visits which occurred within the quarter should be counted (e.g. for Q1 2013/14, visits which occurred between 1st April and 30th June inclusive). The number of visits, not the number of children should be counted.

Notes:

This is defined as a count rather than a percentage because of the difficulty of defining a denominator to which antenatal visits can be linked within current data collection systems.

Indicators C2 & C3 - Percentage of births that receive a face to face New Birth Visit (NBV) within 14 days by a health visitor (Indicator C2), or after 14 days (Indicator C3)

The information required is:

- The total number of infants who turned 30 days within the quarter (denominator C2 and C3).
- Total number of infants who turned 30 days within the quarter who received a face-to-face NBV within 14 days by a health visitor with mother (and ideally father) (numerator C2).
- Total number of infants who turned 30 days within the quarter who received a face-to-face NBV undertaken after 14 days by a health visitor with mother (and ideally father) (numerator C3).

Definitions:

The total number of infants who turned 30 days within the quarter is defined as all those infants within the provider area of responsibility who turn 30 days within the quarter.

This is to make sure that we are picking up most NBVs even where they occur after the recommended 10-14 days. The table below shows the ranges of birth dates which should be included in each quarter.

Quarter	Earliest birth date included	Latest birth date included
Q1	2nd March	1st June
Q2	2nd June	1st September
Q3	2nd September	2nd December
Q4	3rd December	1st March

NOTE: Count the number of children born, not the number of mothers.

The number of children who turned 30 days within the quarter who received a face-to-face NBV within 14 days is defined as the number of children defined above who also received an NBV within 14 days of their birth.

We would expect that the vast majority of visits for those under 14 days will occur between 10-14 days as recommended, as midwives will be responsible for care prior to that. However there are occasions when an earlier visit is justified, so there is no lower limit for this indicator on how long after the birth the visit can occur.

Include:

- Each child born, in the case of multiple births this will be more than 1.
- All children born privately, even if they are not seen by a health visitor.

Exclude:

- Babies who die before their NBV.

Notes:

- 1) This definition is based on infants who should have received an NBV by the end of the quarter. There are infants who are neither born in the quarter referred to, nor receive an NBV in the quarter referred to. The definition has been set up so that those babies born towards the end of the specified period who receive an NBV later than 14 days are still counted as receiving a visit.
- 2) There are cases where it is not possible for an NBV to take place within the recommended period. It is not expected that these indicators would total 100%, nor that areas would achieve 100% under 14 days.

Indicators C4 & C5 - Percentage of children who received a 12 month review by the time they were 12 months and percentage of children who received a 12 month review by the time they were 15 months.

The information required is:

- The total number of children who turned 12 months in the quarter (denominator C4).
- The number of children due a 12 month review by the end of the quarter who had received a 12 month review by the time they turned 12 months (numerator C4).
- The total number of children who turned 15 months in the quarter (denominator C5).
- The number of children who turned 15 months in the quarter who had received a 12 month review by the time they turned 15 months (numerator C5).

Definitions:

The number of children due a 12 month review by the end of the quarter is defined as all those who fulfil the following two criteria:

1. Are under the responsibility of the provider at the end of the quarter (e.g. for Q1 2013/14 this would be on 30th June 2013).
2. Were aged 12 months within the quarter (e.g. for Q1 2013/14 this would be those who were aged 12 months between April 2013 and June 2013, i.e. those who were born between 1st April 2012 and 30th June 2012 inclusive).

The number of children who turned 12 months within the quarter who had received a 12 month review by the time they turned 12 months is defined as the number of those who fulfil the criteria above and who have received a 12 month review by the time they turned 12 months. Note that children who received a review in a previous quarter should be included.

Include:

- All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

- Children who die before their 12 month review.

The total number of children who turned 15 months in the quarter is defined as all those who fulfil the following two criteria:

1. Are under the responsibility of the provider at the end of the quarter (e.g. for Q1 2013/14 this would be on 30th June 2013).
2. Were aged 15 months within the quarter (e.g. for Q1 2013/14 this would be those who were aged 15 months between April 2013 and June 2013, i.e. those who were born between 1st Jan 2012 and 31th March 2012 inclusive).

The number of children who turned 15 months in the quarter who had received a 12 month review by the time they turned 15 months is defined as the number of those who fulfil the criteria above and who have received a 12 month review by the time they turned 15 months. This includes children who received a 12 month review in previous quarters, and those who had it before they turned 12 months.

Include:

- All children under the provider's responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

- Children who die before their 12 month review

Notes:

The numerator for indicator C5, percentage of children who have had their 12 month review by the time they have turned 15 months, should include all those who have turned 15 months who have received a 12 month review. This should include those who have had their review before the current quarter and also those who have had their review before they turned 12 months, as well as those who had their review between 12 and 15 months.

We would expect indicator C5 to have a greater percentage than indicator C4 (percentage of children who received a 12 month review by the age of 12 months) as it will include all those who have had their 12 month review by the time they were 12 months as well as those who had it between 12 and 15 months.

Indicator C6 - Percentage of children who received a 2-2.5 year review

The information required is:

- The total number of children due a 2-2.5 year review by the end of the quarter (denominator).
- The number of children due a 2-2.5 year review by the end of the quarter who received a 2-2.5 year review by the time they turned 2.5 years (numerator).

Definitions:

The number of children due a 2-2.5 year review by the end of the quarter is defined as all those who fulfil the following two criteria:

1. Are under the providers responsibility at the end of the quarter (e.g for Q1 2013/14 this would be on 30th June 2013).
2. Were aged 2.5 years within the quarter (e.g. for Q1 2013/14 this would be those who were aged 2.5 years between April 2013 and June 2013, i.e. those who were born in Q3 2010/11, so between 1st Oct 2010 and 31st Dec 2010 inclusive).

The number of children due a 2-2.5 year review by the end of the quarter who received a 2-2.5 year review by the time they turned 2.5 is defined as the number of those who fulfil the criteria above and who have received a 2-2.5 year review by the

time they turned 2.5. Note that this should include those who had a 2-2.5 year review in a previous quarter.

Include:

- All children under the providers responsibility at the end of the quarter. This includes children who live in the area but are not registered to a GP, and those who are having their paediatric care privately even if they are not seen by a health visitor or GP.

Exclude:

- Children who die before their 2-2.5 year review.

Indicator C7 - Number of Sure Start Advisory Boards/Children's Centre Boards with a HV presence

Information required:

Numerator: Number of Sure Start Advisory Board/Children's Centre Board meetings with a HV presence.

Denominator: Number of Sure Start Advisory Board/Children's Centre Board meetings.

Definitions:

The number of Sure Start Advisory Board/Children's Centre Board meetings is defined as the number of Sure Start Advisory Board/Children's Centre Board meetings which occur within the defined quarter. The number of meetings with a health visitor presence is defined as the number of those defined previously, which are attended by a health visitor.

Changes to the specification for Q3 2013/14:

None.

Appendix 7

Provider Performance Framework Report

Provider Performance Report					
	Outcome	MEASURE	Additional information	Target	Data collection/Report
Delivering capacity	Health Visitor Growth	Health Visitors (FTE) in Post - ESR	Health Visitor: An employee who holds a qualification as a <u>Registered Health Visitor under the Specialist Community Public Health Nursing part of the NMC Register</u> and who occupies a post where such a qualification is a requirement. Not below Agenda for Change Band 6. Coded as occupation code N3H only in NHS Workforce information. (NHS IC, (2011) Occupation Code Manual Version 11)	* FTE by 31/3/15	Reported monthly to the HSCIC via Omnibus (Health Visitor Minimum Dataset)
		Health Visitors (FTE) in Post - Non-ESR		* FTE by 31/3/15	Reported monthly to the HSCIC via Omnibus (Health Visitor Minimum Dataset)
		Total Health Visitors (FTE) in Post - Calculation		* FTE by 31/3/15	Reported monthly to the HSCIC via Omnibus (Health Visitor Minimum Dataset)
		Leavers (FTE)	FTE of staff who have left the provider	*per agreed local trajectory	AT (monthly) - for local AT assurance
		Joiners (FTE)	Health Visitor joiners separated into newly qualified joiners direct from training, joiners from return to practice and other joiners	*per agreed local trajectory	AT (monthly) - for local AT assurance
		Number of vacancies (FTE)	Currently unfilled posts		AT (monthly) - for local AT assurance

	C2A Student growth delivered		* in 2014/15	AT (monthly) - for local AT assurance
System Transformation	HV service equipped for delivery of C2A	Workforce development plan in place with regular review and assurance	See service specification section 3.2	Quarterly Area Team Dashboard (NHS England)
		Service specifications in place/agreed by commissioner and provider	Evidenced by having contracts signed off	Quarterly Area Team Dashboard (NHS England)
		Performance targets against each service performance metric set for each Provider	Performance measures agreed based on the Providers performance to date and expectations regarding growth.	Quarterly Area Team Dashboard (NHS England)
		Performance targets against each health outcome metric set for each Provider	Performance measures agreed based on the Providers performance to date and expectations regarding growth.	Quarterly Area Team Dashboard (NHS England)
		AT and LETB are in agreement that student placements are sufficient to support the growth target		Quarterly Area Team Dashboard (NHS England)
		Annual report compiled from HV service submissions on Patient Experience feedback from families and caregivers, using validated patient experience measures	In line with NHS Outcome Framework: Ensuring people have a positive experience of care	Quarterly Area Team Dashboard (NHS England)
		AT has agreed a plan with provider with milestones for comprehensive delivery of the HCP by March 2015	See service specification section 3.4	Quarterly Area Team Dashboard (NHS England)
		There is an evidence-based multi-agency maternal mental health pathway with a clear role for health visiting.	See service specification section 3.5	Quarterly Area Team Dashboard (NHS England)
		There is an evidence-based multi-agency early attachment pathway with a clear role for health visiting.	See service specification section 3.5	Quarterly Area Team Dashboard (NHS England)
		There is an evidence-based multi-agency healthy weight pathway with a clear role for health visiting.	See service specification section 3.5	Quarterly Area Team Dashboard (NHS England)

Service Delivery	Service offer metrics	Number of mothers who received a <u>first</u> face to face antenatal contact with a Health Visitor at 28 weeks or above	Due to the difficulties establishing a reliable denominator this is a count. Target count should be agreed based on average number of deliveries over the past three years.	*% target	Quarterly Area Team Dashboard (NHS England)
		Percentage of births that receive a face to face NBV within 14 days by a Health Visitor	Numerator: Total number of infants who turned 30 days in the quarter who received a face-to-face New Birth Visits (NBV) undertaken within 14 days from birth, by a Health Visitor with mother (and ideally father) Denominator: Total number of infants who turned 30 days in the quarter Formula: Numerator/Denominator x 100	*% target	Quarterly Area Team Dashboard (NHS England)
		Percentage of face-to-face NBVs undertaken after 14 days, by a Health Visitor	Numerator: Total number of infants who turned 30 days in the quarter who received a face-to-face New Birth Visits (NBV) undertaken after 14 days from birth, by a Health Visitor with mother (and ideally father) Denominator: Total number of infants who turned 30 days in the quarter Formula: Numerator/Denominator x 100	*% target	Quarterly Area Team Dashboard (NHS England)
		Percentage of children who received a 12 month review by the time they turned 12 months	Numerator: Total number of children who turned 12 months in the quarter, who received a review by the age of 12 months Denominator: Total number of children who turned 12 months, in the appropriate quarter Formula: Numerator/Denominator x 100	*% target	Quarterly Area Team Dashboard (NHS England)
		Percentage of children who received a 12 month review by the time they turned 15 months	Numerator: Total number of children who turned 15 months in the quarter, who received a review by the age of 12 months Denominator: Total number of children who turned 15 months, in the appropriate quarter Formula: Numerator/Denominator x 100	*% target	Quarterly Area Team Dashboard (NHS England)

		Percentage of children who received a 2-2.5 year review	Numerator: Total number of children who turned 2.5 years in the quarter who received a 2-2.5 year review, by the age of 2.5 years of age. Denominator: Total number of children who turned 2.5 years, in the appropriate quarter. Formula: Numerator/Denominator x 100	*% target	Quarterly Area Team Dashboard (NHS England)
		% of Sure Start Advisory Boards with a HV presence	Numerator: Number of Sure Start Advisory Boards/Children's Centre Boards with an HV presence Denominator: Number of Sure Start Advisory Boards/Children's Centre Boards Formula: Numerator / Denominator x 100	*% target	Quarterly Area Team Dashboard (NHS England)
Key Outcomes	Breastfeeding	Percentage of infants for whom breastfeeding status is recorded at 6-8wk check	Numerator: Number of infants where feeding status has been recorded at 6-8wk check Denominator: Total number of infants due 6-8wk check Formula: Numerator / Denominator x 100	*% prevalence target	Central collection (quarterly) Unify2
		Percentage of infants being breastfed at 6-8wks	Numerator: Number of infants recorded as being totally and partially breastfed at 6-8wks Denominator: Total number of infants due 6-8wk check Formula: Numerator / Denominator x 100	*% prevalence target	Central collection (quarterly) Unify2
Early Identification	Health Visitors identifying families at risk of poor outcomes	No. of new CAFs completed by HV staff in the month	Number per FTE/% caseload	*target	AT - for local agreement
		Percentage of mothers who received a Maternal Mood review in line with local pathway, by the time infant is aged 8 weeks, based on the quarter when the infant reached 8 weeks of age	Numerator: Total number of mothers with an infant who turned 8 weeks in the quarter, who received a Maternal Mood review by the time infant turned 8 weeks Denominator: Total number of mothers with infants who turned 8 weeks, in the quarter Formula: Numerator/Denominator x 100	95%	AT - for local agreement

Quality Standards	Safeguarding	Percentage of HV staff who have completed mandatory training at levels commensurate with roles and responsibilities (levels 1,2, 3) in child protection within the last three years.	Numerator: Number of staff who have received mandatory child protection training (as per local policy) in the last 36months Denominator: Total number of staff Formula: Numerator / Denominator x 100 expressed on a rolling 36mth basis	95%	AT - for local agreement
	Annual Audit of 50 randomly selected cases in each category	Annual audit of 50 randomly selected urgent referrals, including all safeguarding referrals	Numerator: Number of these 50 urgent referrals to HV who received a same day/next working day response to referrer. Denominator: 50 urgent referrals from whatever source (including families transferring in) to HV Formula: Numerator/Denominator x 100	95%	AT - for local agreement
			Percentage of urgent referrals, including all safeguarding referrals, who a) received a same day or next working day response to the referrer and b) received a HV contact with the family within two working days.	Numerator: Number of these 50 urgent referrals to HV who received a HV contact within two working days Denominator: 50 urgent referrals from whatever source (including families transferring in) to HV Formula: Numerator/Denominator x 100	95%
		Annual audit of 50 randomly selected referrals from any source	Numerator: Number of these 50 referrals where referrer received a response within 5 working days. Denominator: 50 referrals from whatever source (including families transferring in) to HV Formula: Numerator/Denominator x 100	95%	AT - for local agreement
			Percentage of all referrals from whatever source (including families transferring in) who a) received a response to the referrer within 5 working days and b) with contact made with the family within 10 working days.	Numerator: Number of these 50 referrals where contact was made with the family within 10 working days. Denominator: 50 referrals from whatever source (including families transferring in) to HV Formula: Numerator/Denominator x 100	95%

	Annual audit of 50 randomly selected cases with a transfer request received	<p>Percentage of cases where a transfer request was received where the records were transferred within 2 weeks.</p> <p>Numerator: Number of these 50 children where the health records were transferred to the HV service in the new area within 2 weeks of notification.</p> <p>Denominator: 50 children where HV service has been notified as moved out of the area</p> <p>Formula: Numerator/Denominator x 100</p>	95%	AT - for local agreement
		<p>Percentage of CP cases where there was direct contact with the HV team in the receiving area of these cases.</p> <p>Numerator: Number of these 50 children who were on a CP plan where there was direct contact to HV team in receiving area.</p> <p>Denominator: Number of these 50 children who were on a CP plan where HV service has been notified that child has moved out of the area</p> <p>Formula: Numerator/Denominator x 100</p>	95%	AT - for local agreement