Birmingham Community Healthcare NHS
NHS Trust

Guidance for communication between Health Visiting Teams and GP practices in Birmingham

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Subject category of document:	Non Clinical
Summary	This document provides the background to the development of guidance for communication between health visiting and general practice and information about the Healthy Child Programme in Birmingham.

Consultation History:
The following Committees, groups or individuals have been consulted in the development of this policy:

Name:	Date:
The Healthy Child Programme Service Delivery Group, consisting of Health Visitors, Practice teachers, Operational Managers, FNP, Clinical Lead, Head of Service	February-June 2013
Head of Safeguarding, GP practices via CCG Local Medical Committee Dr R Morley and Dr M Allen, named Dr for safeguarding children, Local Area team NHS England	April-November 2013
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Version History

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1. Introduction

This guidance document is for GPs, practice staff and members of the health visiting (HV) service. The health visiting service, which serves caseloads aligned to GP practices, is provided by Birmingham Community Healthcare NHS Trust. The service is commissioned by the local area team of NHS England for the GP registrant population of families with babies and children up to school age. When commissioning of health visiting transfers to Birmingham City Council in 2015, it is envisaged the service will be commissioned to be provided to the resident population. The significant issues this will raise for GPs who have patients registered outside Birmingham is being explored with Birmingham City Council and the Birmingham Local Medical Committee.

The HV service is commissioned to provide key elements of the Healthy Child Programme, in accordance with the **Healthy child programme maternity and the first 5 Years (DH 2009). See section 7 of this guidance**. In 2011 the Department of Health recognised that in order to provide the Healthy Child Programme (HCP), the workforce required almost doubling of the HV capacity to manage the caseloads of children in Birmingham. In 2011, average caseloads were 600-700 per WTE HV, and this should reduce to around an average of 350 by April 2015. Caseloads will be weighted to account for deprivation, safeguarding and other elements which impact on workload. This will be achieved through the Health Visitor Implementation programme (HVIP), whereby sufficient HV students will be trained to take up employment with the service and provide the HCP offer.

This guidance sets out the priorities and methodology for communication for children and families between HVs and GPs. It is recommended to HVs that these priorities and methodology are reviewed and agreed at an annual meeting between practice staff and the link HV, with their team leader and operational manager if required. However, practices may propose alternative mechanisms to achieve these aims. A suggested communication agreement format for this annual meeting is provided (appendix 1).

The guidance has been written in consultation with HV teams, HV Practice Teachers, Clinical Leads, Managers, Named GP and Head of Safeguarding, and in consultation with CCG and Local Medical Committee leads.

Within BCHCs service specification for the HV service, commissioners have identified how important principles of continued collaboration and effective systems of communication with GPs are. This is endorsed by Learning from Serious case reviews (Department for education 2012) and Working together to safeguard children (2010 and 2013)

In 2012 a benchmark audit in respect of information-sharing between the HV service and general practice showed the need to improve communication. A re-audit (part of the safeguarding programme of audits - feedback will be to safeguarding sub-committee and then to service) will be conducted in partnership with the safeguarding team to assess the effectiveness of the communication agreement, once it has been implemented for approximately one year.

The HV service recognises that, due to national and local commissioning changes, the role of the HV as a member of practice teams has changed into one which, while continuing to be closely aligned and linked to GP practices, is now also linked more

closely with other partners such as children's centres. The service considers it important that systems of communication with GPs are enhanced and strengthened throughout these periods of commissioning transition.

Many different forms of communication between GPs and HVs existed prior to the development of the guidance, so by agreeing and standardising communication systems an improved, safer service for children and families is anticipated. The HV service values effective reciprocal communication from GPs. This is consistent with Care Quality Commission requirements and best practice and recommended in the RCGP/NSPCC (2011) toolkit. Nevertheless, it is recognised that all practices have their unique circumstances and that whilst certain principles must be maintained there may inevitably be some variation in specific communication arrangements agreed between individual practices and HV teams, to ensure that the needs of patients, practices and HV teams are best met.

2. Purpose

The purpose of the guidance is to improve and standardise communication systems and approaches between HVs and GP practices. This is in response to recommendations of serious case reviews and the knowledge that effective communication is vital in order to safeguard and protect children as well as manage their health needs efficiently.

3. Scope

This guidance has been developed for the HV service to use with GPs and Practice Staff in Birmingham.

4. Objectives

HVs and GPs are to be clear on the priority areas which need reciprocal communication.

HVs and GPs are to be clear on the methodology for safe, effective communication to be implemented between the practice and the HV service; and frequency of formal meetings. It is recognised that this may vary according to practice needs, but that children with safeguarding concerns should generally be discussed at a minimum of the 3 monthly practice multi agency safeguarding meetings where these have been established by the practice. Where the 3 monthly meetings have not been established it should be agreed between the GP Practice and the HV on the meeting frequency. If a practice has no meetings to which the HVs are invited, HVs still have a responsibility to provide information to the GP about developments and changes for children subject to a safeguarding plan or children who have additional needs via written or verbal liaison

HVs and GP Practices are to use the communication agreement (appendix 1) to review communication arrangements annually and agree any required changes as appropriate.

5. Duties & Responsibilities

The Associate Director Universal Services, Children & Families Division is responsible for the development, approval and evaluation process of the guidance.

The Head of Universal Nursing Services 0-5, the Clinical Lead for Health Visiting, Operational Managers, and Head of Safeguarding are responsible for implementation and evaluation of the guidance with GP practices**.**

All Health Visitors are responsible for following the guidance for communication between Health Visiting Teams and GP practices in Birmingham.

The Clinical Governance Team (Children and Families Division) will monitor incidents related to the guidance. They will also monitor any actions implemented and this may require a change in practice or a review of the guidance.

Representatives from CCG and LMC, NHS England Area Team, and BCHC safeguarding services to continue to partner the HV service in developing, implementing and reviewing the guidance.

- Julia Neall NHS England
- Dr Morley, Executive Secretary, Birmingham Local Medical Committee
- Dr Allen, BSC Clinical lead
- Clare Edwards, Head of Service Safeguarding Children

6. Definitions

CCG – Clinical Commissioning Group
LMC – Local Medical Committee
HCP – Healthy Child Programme
HV – Health Visitor
HVIP- Health Visitor Implementation Programme
RCGP – Royal College of General Practitioners
NSPCC – National Society for Prevention of Cruelty to Children

7. Health Visiting Provision – Healthy Child Programme

7.1 Universal Offer

The HCP is the four-tier model which the service will be commissioned to provide by the end of 2015 in collaboration with GPs, and also with other partners such as children's centres, local authority and community organisations. The four levels are:

- Community
- Universal
- Universal Plus
- Partnership Plus

In summary, the Universal level of HV contacts will be an ante-natal contact at approximately 34 weeks of pregnancy, a birth visit offered at home at 10-14 days and a home visit at 6-8 weeks. There will be a HV team contact at 3-4 months, with health and development reviews at 9-12 months and 2 years 6 months. In some local areas, these contacts are already established, in others they are still developing but it is expected these will be fully offered by April 2015.

Commissioned Universal level activity includes promotion of, but not provision of, immunisations. By April 2015, antenatal contacts are expected to be offered, starting with a pilot of first-time mothers. This contact will focus on preparation for parenthood and promote parent-infant attachment.

Well baby clinics, and health and development review clinics are provided in various community settings, including GP practices, to make them as accessible for families as possible. A directory of clinics across Birmingham is provided from BCHC communications department and can be found on CCG websites. This also contains contacts for GP practice link HVs and team bases. This is updated quarterly. During the HVIP as the service expands, some re configuration of teams is taking place in order to make team a manageable size. GPs will be advised of any reconfigurations of HV teams providing a service to their local population.

7.2. New to Area Offer

A letter is sent by BCHC to all new-to-Birmingham families with preschool children from abroad or outside Birmingham, offering a home visit. For those moving home within Birmingham, a home visit is offered according to need.

7.3. Universal Plus Offer

Increased support and advice for parenting needs is provided through the Universal Plus offer, e.g. extra contacts for support with children's behaviour and sleep problems and support for post-natal depression.

7.4 Community and Partnership Plus Offer

The Community and Partnership Plus levels of service represent a spectrum of support from signposting to community support, to partnership working with, and referral to, local authority and voluntary organisations, as well as specialist health services.

7.5 Link HVs

The HV service provides each GP practice with contact details for a HV, who is the designated lead link between the service and the practice. The link HV may not be the caseholder for all children on the local HV team caseload but will liaise with other team members. The frequency of which the link HV will communicate with the practice will be agreed at the annual review of communication with the practice (see appendix 1). Practices will also be provided with contact details of the HV team leader on the communication agreement (appendix 1). The link HV, with agreement of the team leader, will provide updates of changes to clinic arrangements for the local families.

GP practices are asked to identify one or more representatives to act as lead contact, to be easily accessible by the HV team. This would normally be a member of the practice managerial/admin team (with a named deputy in their absence); they would be responsible for ensuring contact is made with the most appropriate clinician within the practice. The safeguarding lead for the practice may be the most appropriate clinician.

Examples of topics the Link HV, HV Team member, Team Leader, and or operational manager will communicate with the GP or practice representative, with parental consent where possible and appropriate.

- Unmet maternal health problems the HV becomes aware of which indicate the need for a GP appointment during pregnancy or post-natally e.g. for signs of depression, particularly when the woman requires support to make an appointment.

- Safeguarding concerns e.g. the presence of domestic abuse, alcohol or substance misuse, neglect or unmet mental health needs within the family which may impact on the child or children.

- Parental learning or physical disability impacting on parental capacity.

- Unmet health or developmental concern for a baby or pre-school child, indicating the need for a GP appointment; particularly when the parent or carer has not followed advice to make an appointment.

- Difficulties in engaging or accessing a family for planned appointments.

- When an assessment under the Family Common Assessment Framework or social care referral is being undertaken.

- When a child is subject to a new or ongoing safeguarding plan. Communication to include the health contribution to the plan, and changes in the plan, to take place at frequency of intervals to be agreed between the GP and HV. Some practices are commissioned through CCG Local Improvement Scheme and host 3 times per year multi agency meetings. The HV service will be represented unless exceptional circumstances prevent this, in which case additional appropriate communication will take place as required.

- It should be decided at the annual review how routine growth measurements and other observations made at Universal contacts are shared if required by the GP.

- HV prescriptions written for minor conditions.

- Changes to well baby or development clinic times and locations.

- Changes in configurations or bases of HV teams who are providing a service to the practice population.

- News of HV or community health promotion or public health activities, posters and leaflets relevant to the practice and children and families.

Examples of topics the GP or practice representative is asked to communicate with the HV. (This section has been developed in consultation with the Local Medical Committee)

- Details of new-to-area families with pre-school children.

- Relevant information known in the antenatal period and significant information which the GP feels is required to be shared with the HV team and with patient consent wherever appropriate. E.g. history of postnatal depression, disability, mental health problems, late bookings, previous child or infant death.

- Updates on relevant GP contacts with families with safeguarding concerns, or where issues exist which may compromise the parenting of the child, particularly in relation to parental mental health, disabilities, substance or alcohol abuse or significant self harm/suicide attempts in parents which the GP feels is required to be shared with the HV team, and with patient consent wherever appropriate. The HV service should be invited to the three times a year multi agency practice meetings, where these are hosted by the practice, or to which ever other meetings are agreed between the practice and HV team. If no formal meetings are arranged HVs are still responsible to liaise with GPs about children with concerns as above using the HV to GP liaison form (appendix 3).

- Health concerns for the child if this indicates the need for HV contact. This could include GP concerns about children's sleep, breastfeeding, weaning, healthy eating, delayed toilet training or behaviour problems, or listening visits and support for mothers with postnatal depression.

- Significant non-attendances to GP or other health appointments, or a significant number of, or inappropriate, attendances at out-of-hours services or A&Es, if the GP decides that discussion with the HV is appropriate.

- Outcome of referrals made by HV to the GP at the request of the HV. This will be, limited to information the GP decides is appropriate and relevant to feedback, and taking into consideration issues of consent and confidentiality.

- Any other issues of concern the GP decides it is appropriate to discuss with the HV.

Frequency and method of communication about children and families will be agreed at the annual review of communication using the communication agreement.

- Attendance at relevant part of practice meetings, or at one-to-one meetings with GP practice representative, to formally discuss cases, is the preferred method of communication where capacity allows, particularly where there are safeguarding concerns, as advised in the RCGP/NSPCC toolkit for Safeguarding Children and Young people for General Practice (2011). It is recognised that differing arrangements may be agreed between practice

and the HV team depending on circumstances of the practice, Link HVs or team leaders are asked to record the agreed arrangements on the annual review of communication form

- All referrals to or from the GP or the HV and all other principles of confidentiality and information governance must comply with Caldicott principles and BCHC policies in terms of confidentiality and information governance.

Methods of referral and liaison between GP and HV:

- The BCHC GP to HV liaison form (appendix 2) is the preferred formal method of written request for HV involvement rather than messages being left in notebooks, pieces of paper or informal conversations, when the GP is requesting a HV contact with a family.

- The HV to GP liaison form must always be completed when the HV is referring a matter to the GP or providing an update of HV involvement.

- If, however, the GP decides to make a referral by telephone, an informal discussion, a safe haven fax, or a secure NHS.net HV team email then a written record must be made by the HV and GP in the child's GP and HV records.

- If the GP practice requires the HV to input information or a message directly onto the GP practice electronic record where this has been requested by the practice, the HV must have received all appropriate training by the practice and have signed to comply with the practice's confidentiality and information governance policies. The HV must also record the information in the BCHC record.

7.6 Feedback

Compliments about the service are welcome and should be forwarded to the team leader or operational manager.

Concerns can often be managed by the team leader or operational manager, whose details will be found on the communication agreement or directory. However, if a formal complaint needs to be raised, it should be referred to:

- The Head of Service, Carol.Rogerson@bhamcommunity.nhs.uk or;
- Associate Director, Elizabeth.Webster@bhamcommunity.nhs.uk.

Following the previous methods, the Complaints Department can be contacted on 0121 466 7038.

8. Mental Capacity

Non clinical policy therefore not relevant

9. Implementation

HV Operational Managers and Team leaders will be responsible for the implementation of this guidance. GP Practices will manage implementation in line with their own practice procedures.

Following ratification the procedural document's author/lead will ensure (in discussion with the Committee's Secretary) that the document is forwarded to the Compliance and Assurance Team (C&AT). The C&AT will make final checks, amend the footer and forward to the Library for uploading to the intranet. Once uploaded to the intranet the Library will inform the Communication Team to ensure notification appears in the next Staff E-Newsletter.

The implementation of this guidance requires no additional training resource**.**

The implementation of this guidance requires no additional financial resource.

10. Training Implications

No additional mandatory / statutory training required.

11. Monitoring & Audit

The audit of communication in partnership between the HV and the safeguarding services will be repeated a year after implementation of the guidance. Complaints to the HV service where communication with GPs is a factor will be assessed for adoption and application of the guidance in preparation of the response.

The guidance will be reviewed 2 years after implementation

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Survey of HV perspective of HV/GP communication	Head of Safeguarding with Associate Director Universal Children's Services	Repeat of survey monkey audit undertaken in 2012	Bi annual, to start 12 months after implementation of the guidance	BCHC Safeguarding children subcommittee and Local Medical Council	BCHC Children and Families Division Health Visiting Service, Head of Service	Internally: team meetings and HV forum meetings
Complaints about to the HV service where HV/GP communication is a factor	Associate Director Universal Children's services with Clinical Governance Manager	Assessment of adoption and application of the guidance in responses to complaints where communication is a factor	continual to start once guidance is implemented	BCHC Children and Families Integrated performance committee	BCHC Children and Families Division Health Visiting Service, Head of Service	Internally: team meetings and HV forum meetings

12. Authorship & Consultation Process

Elizabeth Webster, Associate Director Universal Children's Services.

13. References/Evidence/Glossary/Definitions

The Healthy Child Programme Pregnancy and the First Five Years of Life (HCP) (Department of Health, October 2009).

RCGP/NSPCC (2011) **Safeguarding Children and Young People, a toolkit for General Practice toolkit.**

Department of Health, Home Office, Department for Education and Employment (2010) Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children.

HM Government (2006) Information Sharing Guidance for Practitioners.

Health Visitor Implementation Programme (2011) Department of Health.

Appendix 1

Communication agreement: For review at annual discussion between Link Health Visitors and GP Practices	
Discussion Topics	
1. General review of previous 12 months' communication	
2. Method for sharing Safeguarding concerns and updates in the next year	Frequency of meetings or visits to practice by HV
3. Method for sharing relevant maternal or child health information	E.g.; telephone call followed up by written liaison form
4. Method for receiving feedback on referrals	
5. Method for sharing routine information from Universal HV contacts e.g. growth, and development reviews with GPs	
6. Method for HVs receiving information on new to area families	
7. Update on HV and GP services, clinics or team changes	
8. Local health promotion /community activities	
9. Where and who to send referrals/liaison form to:(communication guidance appendix 2 and 3)	
GP to HV	
HV to GP	
10.AOB	

	Name	**Email Address**	**Base**	**Phone**	**Agreement Signatures**
GP Practice					
Link HV					
HV Team Leader					
HV Operational Manager					
Practice Manager					
Practice Safeguarding Lead					

Date of agreement…….
Review date: (12 months)……
Copies for Team Leader, Link HV &Practice

Appendix 2

GP to Health Visitor Liaison Form

GP to complete child's details below:-	
Full Name	
Address	
Date of Birth	
NHS Number	
Ethnicity	
GP Name	
Practice Address	

Issue which requires referral to the Health Visitor	
What action is being requested?	
Relevant medical history	
Are there any Safeguarding concerns? Details if yes.	
Relevant information on other agencies involved with the family	
Relevant information on family structure	
Will an interpreter be needed? If yes, which language?	
Date of request	Urgent or standard request?
Has a telephone referral already been made? …… Date if yes	
Please return form to Health Visitor	

Appendix 3

Health Visitor/School Nurse to GP Liaison Form

Birmingham Community Healthcare NHS
NHS Trust

Private & Confidential
Dr
Address
Postcode

Health Visitor/School Nurse Team Address

Date:

Telephone…….
Secure Team Email Address
……..

Dear Dr
This letter is for: (Health Visitor/School Nurse to tick)
1. Information only ☐ or 2. A request for the child to be seen by the GP. ☐

I am writing to inform you that the following child/ children and family are receiving additional support from the Health Visitor / School nursing team.

Name	Date of Birth	Address	NHS number

HV /School Nurse current involvement / concerns include:

☐ Referral to children's social care
☐ Child subject to child protection plan
☐ Looked After child
☐ Parental Learning Difficulties
☐ Domestic abuse
☐ Developmental Delay
☐ Frequent A&E attendances
☐ Minor ailments i.e…….
☐ Family support
☐ Behaviour problem
☐ Maternal history of FGM
☐ FCAF assessment initiated
☐ Core Group
☐ Child In need
☐ Parental mental ill health
☐ Parental substance/alcohol misuse
☐ Feeding issues/faltering growth
☐ Non attendance of health appointments
☐ Missing family/unable to locate
☐ Parental capacity
☐ No HV involvement as school age
☐ Transferred to School Nursing
☐ Referred to other service i.e……
☐ Other concern……

Relevant Information

It is recognised that GPs have responsibilities to all their patients, however children may be particularly vulnerable and their welfare is paramount. A recurring theme in Serious Case Reviews has been inadequate sharing of information about vulnerable children. Working Together to Safeguard Children 2010 and 2013 requires Health Visitors and School Health Nurse to liaise with GPs so that a full picture of risk factors and progress is obtained.

Information sharing discussed with Carer/Young Person Yes/No

The Safeguarding Children and Young People Tool Kit for General Practice guidance requires information provided by the Health Visitor/School Nurse to be recorded in the notes under a Read code. Information about vulnerable children will need to be recorded in the child's notes (significant events/summary) and where appropriate the notes of siblings and significant adults.

If you require any further information in regard to this family or have any information that is relevant to ensuring the well being and safety of the child/children please contact the health visiting/school health team on the above number

Yours sincerely

Signature

Print name
Job title