# Children and Young People with Complex Health Needs, Disabilities, and Special Educational Needs Guideline

## Version: 1

### Summary:
This document defines the process and service offer by SHFT Specialist Community Public Health Nursing teams to children and young people with complex health needs, disabilities, and special educational needs.

### Keywords (minimum of 5): (To assist policy search engine)
Complex health needs, disability, special educational needs, children, young people, and families.

### Target Audience:
All members of health visiting and school nursing teams. All staff who directly or indirectly manage health visiting/school nursing teams.

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February 2020

### Approved and Ratified by:
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1. **Introduction and Purpose**

These guidelines are provided for use by health visiting (HV), school nursing (SN), children in care (CIC), and Family Nurse Partnership (FNP) teams to provide clarity regarding their contribution to the multi-agency team in supporting children and young people with complex health needs, disabilities, or special educational needs. It identifies how a health visiting/FNP/school nursing service can work in partnership with children, young people, parents, carers, education, and other key providers including social care and the voluntary sector, to improve outcomes. The guideline puts children, young people and families at the centre of decision making and care (no decision about me, without me) and recognises that children and their families will have differing needs and agreed outcomes, but will still require a universal public health offer.

1.1 Health visitors and school nurses have an important role in leading the delivery of the Healthy Child Programme (HCP); (Department of Health (DH) 2009). Supporting children and young people with complex health needs, disabilities, and special educational needs is an important part of this universal prevention and early intervention programme, which comprises child health promotion, child health surveillance, screening, immunisation, child development reviews, and health-led parenting support. All health visiting and school nursing interventions will focus on family strengths, whilst assessing and respectfully responding to needs.

1.2 Parents/carers are the experts in their child’s health and wellbeing. Health visitors, Family Nurses, and school nurses work in partnership with them to promote child development and identify problems at the earliest opportunity. The best outcomes for children and young people with complex health needs, disabilities, and special educational needs are achieved when all agencies work together with families using an integrated approach. Supporting the child and family is the core principle; this will require partnership working, and skilled staff from a range of agencies to collaborate to ensure the best outcomes. A skilled workforce will feel confident and competent – this will instil confidence in the child and family/carer.

1.3 The purpose of the HCP service offer for children and young people with complex health needs, disabilities, and special educational needs is:

- To enable an assessment of a child’s health, growth, and development at key intervals described in the universal HCP offer and when concerns are raised by parents/carers.
- To facilitate appropriate intervention, further assessment, and support for children and their families when complex health needs, disabilities, and special educational needs are suspected or diagnosed, as part of Hampshire’s integrated multi-agency support model (Appendix 3, Appendix 4).
- To reduce the number of children starting school with unrecognised disabilities, complex health needs, and special educational needs; to support a smooth transition between health visiting services, early years settings, and mainstream education.
- To enable appropriate and timely information sharing to safeguard children in accordance with Working Together to Safeguard Children (HM Government, 2015). This guidance must be used in conjunction with SHFT guidance on Safeguarding (SH CP 56), and Domestic Abuse (SH CP 78), to identify children and adults who may be at risk.
• To generate information to plan services and contribute to the reduction of inequalities in children’s outcomes; to ensure that parents/carers and young people are included in the co-design of new services.

2. Scope:
This document applies to all trust staff within the Children’s Business Unit who may be involved in the care of a child, young person, or their family when there is a diagnosis or suspected diagnosis of complex health needs, disabilities, and special educational needs in a child aged 0-19.

2.1 Support for children and young people with complex health needs, disabilities, and special educational needs forms part of a health visitor/school nursing led service model. Health visitors and school nurses (all qualified nurses) have a duty to comply with this guideline and report to their line manager if they are not able to fulfil this aspect of the HCP service delivery. The health visitor/school nurse may delegate aspects of this work to a community nursery nurse, but remains accountable for their decision to delegate tasks and duties to others in accordance with the NMC Code (NMC, 2015).

3. Definitions.

3.1 Healthy Child Programme: Pregnancy and the First 5 Years of Life (DH 2009) and Best Start in Life and Beyond: Improving Public Health Outcomes for Children, Young People and Families (PHE 2016) - These documents describe the provision of a transformed 4-5-6 health visiting universal preventative model which focuses on early life stages providing families with screening, immunisation, health and development reviews, with advice on health, wellbeing and parenting. The HCP is led by health visitors in partnership with parents and other agencies.

3.2 The Healthy Child Programme 5-19 (DH 2009) - Sets out the good practice framework for prevention and early intervention services for children and young people aged 5–19, and recommends how health, education, and other partners should work together in a range of settings to significantly enhance a child or young person’s life chances. It contains the recommended framework of universal and progressive services for children and young people to promote optimal health and wellbeing.

3.3 6 High Impact Areas (HIA) for the early years.

1) Transition to parenthood and the early weeks.
2) Maternal mental health (perinatal depression).
3) Breast feeding (initiation and duration).
4) Healthy weight, healthy nutrition, and physical activity.
5) Management of minor illness, accident prevention, and reducing hospital attendance and admission.
6) Health, well-being, and development of child aged 2–2.5 year old review (integrated review), and school readiness.

3.4 6 High Impact Areas (HIA) for the school-age years

1) Resilience and emotional wellbeing.
2) Keeping safe: Managing risk and reducing harm.
3) Improving lifestyles.
4) Maximising learning and achievement.
5) Supporting complex and additional health and wellbeing needs.
6) Seamless transition and preparation for adulthood.

The areas do not describe the entirety of the role and work of the health visitor or school nurse. There is still an expectation to deliver all elements of the Healthy Child Programme within the service model; Community, Universal, Universal Plus, and Universal Partnership Plus.

3.5 Health visiting team: A team of Specialist Community Public Health Practitioners - health visitors (HV) and associate practitioners who deliver a transformed 4-5-6 model of preventative public health services to all children and families who are resident in Hampshire, from pregnancy until school entry. Each GP practice, Children Centre, and Birth to Three Networks has a named link HV, to ensure optimal information sharing across the children's workforce.

Team members include the following practitioners:
- Health visitor clinical team lead (CTL) - A qualified Specialist Community Public Health Nurse who leads a health visiting team, and coordinates the delivery of the Healthy Child Programme pre-birth to 5 within a defined locality.
- Practice teacher – A qualified Specialist Community Public Health Nurse with an additional recognised teaching qualification.
- Health visitor (HV) – Specialist Community Public Health Nurse (SCPHN) – A qualified nurse or midwife with an additional specialist public health qualification and skills and expertise of assessing community health needs and working with children and young people from pre-birth to 5 years of age.
- Community nursery nurse (CNN) – Trained in child development and skilled in delivering parenting interventions, and healthy lifestyle advice as delegated by the SCPHN.
- Administrator – Provide SMART clerical processes to support the delivery of the Healthy Child Programme within the HV teams.

3.6 School nursing teams: A team of practitioners who work with a defined population to deliver services that promote the health and well-being of children, young people, and their families. School nursing services are delivered across Hampshire in schools, client’s homes, and community settings. Each school or college has a named Specialist Community Public Health Nurse to ensure timely access to information and support.

Team members will include all or some of the following practitioners:
- School nurse clinical team lead (CTL) - Leads a school nursing team and coordinates the delivery of the Healthy Child Programme 5-19 within a defined locality.
- Special/Specialist school nurse (SSN) – Registered nurses who work in identified special schools and have skills and training to work with children with profound and multiple disabilities, and complex health needs.
- Specialist Community Public Health Nurse (SCPHN) – Qualified nurse with an additional specialist public health qualification, and skills and expertise of assessing community health needs, and working with children and young people aged 5-19.
- Community staff nurse (CSN) – Qualified nurse who has skills and expertise of working with children and young people aged 5-19.
- Community nursery nurse (CNN) – Trained in child development, and skilled in delivering parenting interventions and healthy lifestyle advice, as delegated by the CSN or SCPHN.
• Health care support worker/ school nurse assistant (HCSW/SNA) – Trained to carry out specific health screening, and health promotion activities as delegated by the SCPHN.
• Clerical support worker/ admin assistant – Supports all practitioners in the school nurse team and ensures smooth processes are in place.

3.7 **Family Nurse Partnership (FNP):** The Family Nurse Partnership team consists of a supervisor, Family Nurses, and a quality support officer. The supervisor is responsible for the leadership of team learning, providing weekly supervision and team management, as well as a small clinical caseload. Family Nurses work with a maximum of 25 families and receive specialist training to deliver the FNP programme, and record data as part of the license. The team is supported by a quality support officer in terms of data collection, and general administrative and office support.

Family Nurse Partnership is a voluntary, home visiting programme for first time young mums aged 19 years and under. A specially trained Family Nurse visits the mum regularly from early pregnancy until their child is two.

The FNP programme aims to enable young mums to:
• Have a healthy pregnancy.
• Improve their child’s health and development.
• Plan their own futures and achieve their aspirations.

The FNP programme is underpinned by a robust evidence base. This demonstrates that if delivered well, it has the potential to change the life chances of some of the most vulnerable parents and babies, with long-term positive impacts on health and educational outcomes.

3.8 **Children in care teams (CIC):** A team of practitioners who work with a defined population, (Children in Care), to deliver services that promote the health and well-being of children, young people and their families.

Children in care services are delivered across Hampshire in schools, client’s homes and community settings. Children in care nurses are based at various locations throughout Hampshire each with a defined caseload.

Children in care nurses work in partnership with health visitors but do not lead the HCP one year health review.

Team members will include all or some of the following practitioners:
• Specialist Nurse/Team Lead - Leads the children in care team for Hampshire delivering children in care services for children in care accommodated by Hampshire County Council.
• Specialist Nurse for Children in Care – A qualified nurse with an additional specialist public health qualification, or skills and expertise of working with children and young people in care aged 0-19.
• Secretary to children in care team.

3.9 **Child Health Information Services (CHIS):** Child Health Information Services are a commissioned service that plays a key role in the scheduling, recording, and monitoring of Public Health programmes including immunisations, Newborn Infant Physical Examination (NIPE), newborn hearing Screening, newborn bloodspot screening and the National Child Measurement Programme (NCMP).

The CHIS team are responsible for the start of creating the electronic patient record (EPR) and will maintain this record until age 19. CHIS work in partnership with staff from across the children’s division to maintain the trust website pages which support the Healthy Child Programme 0-19, detailing information about each service and offering health information and advice to service users and stakeholders.
3.10 Complex health needs, disability, and special educational needs inclusion criteria: Children with complex health needs are defined as those who have or are at increased risk of having chronic physical, developmental, behavioural, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally. The aim of any care intervention is to optimise each child’s health and function whilst minimising recurrent or prolonged hospitalisation.

3.11 Disability: Definition of disability under the Equality Act 2010: You’re disabled under the Equality Act 2010 if you have a physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on your ability to do normal daily activities. [https://www.gov.uk/definition-of-disability-under-equality-act-2010]

3.12 Special educational needs: The Children and Families Act 2014 defines a child or young person as having special educational needs, if they have a learning difficulty or disability, which requires special educational provision to be made for them.
A child or young person is defined as having a learning difficulty or disability if they have a significantly greater difficulty in learning than the majority of others of the same age, or if they have a disability which prevents or hinders them from making use of facilities provided for other children of the same age in mainstream schools, or post -16 institutions.
The current commissioned service applies to all children and young people within the 0-18 age group, however there is recognition that the Education Health Care Plan provision is for 18–25 year old cohort and this would need to be addressed in future planning cycles.

3.13 Exclusions to the definition of complex health needs, disabilities and special educational needs:
- Children with long term conditions, asthma, diabetes, cystic fibrosis, cancer and epilepsy within main stream school and no associated co morbidities.
- Looked after children without complex health needs and disability.
- Children with an allocated social worker who do not have a disability or special educational needs.
- 19-25 year in the first phase, recognition that the Education Health Care Plan provision is for 19-25 year old cohort and this would need to be addressed in future planning cycles.

3.14 Ages and Stages Questionnaires (ASQ-3) and ASQ:SE-2 – British English Versions:
The ASQ: SE-2 was developed to complement the ASQ-3 by providing information specifically addressing the social and emotional behaviour of children. It covers eight domains of child social emotional development: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, interaction with people and general concerns. It supports the identification of those that may need further evaluation to determine if referral to intervention services is required.
In the UK, neither the ASQ-3, or ASQ: SE-2 are being used as screening tools and neither are diagnostic tools.

3.15 Children with complex health needs and disabilities under 5 years:
The ASQ-3 and ASQ: SE-2 should be offered to all children as part of their universal health review and both are helpful tools for identifying children with additional needs. However, where a child already has an identified complex health need, disability, or special educational need, health visiting teams will need to agree with parents/carers whether they wish to complete the ASQ-3/ASQ: SE-2 questionnaires as part of their child’s universal health review. Much rests on health visitors’ professional judgement
and their skill in working sensitively and collaboratively with families to agree the best approach; it may be appropriate to complete all or part of the ASQ-3/ASQ SE-2 in these instances.

Health visitors should work collaboratively with other professionals in the multi-disciplinary team to ensure a personalised approach to developmental assessment is provided to these children. Where the parent/carer wishes to use the ASQ-3 / ASQ: SE-2 questionnaires, the practitioner should use the appropriate age questionnaires and not an earlier age interval, unless the child was born pre-term. Children with complex health needs and disabilities should be offered all remaining components of the universal health reviews (SH CP 68; SH CP 90).

3.16 **Children born pre-term:** (This is defined as all children born at less than 37 weeks gestation):

The appropriate age-adjusted ASQ-3/ASQ: SE-2 questionnaire should be used for all children born pre-term, rather than the chronological age, under the age of 2 years. The ASQ-3 app provides a quick means of calculating the correct questionnaire to be used and guidance is contained within the ASQ-3 user guide located in each team.

3.17 **Personal Child Health Record (PCHR):** Individualised record of a child’s health from birth, held by parent/carer, also known as the “red book”.

3.18 **Open RiO Standard Operating Procedure (SOP):**

A comprehensive guide to using the Open RiO electronic patient record (EPR) system.

4. **Duties and Responsibilities**

4.1 **Southern Health Board:** Southern Health Board has the responsibility to ensure that the health contribution to health visiting, Family Nurse Partnership, children in care, and school nursing services are discharged across Southern Health through the commissioning process.

4.2 **Director for Integrated Services Division (ISD):** The Director for the ISD has the overall strategic and operational accountability for delivery of the Children’s 0-19 Public Health Service within Business Unit 4.

4.3 **Senior Management team:** Lead in all aspects of the 0-19 services and will ensure there is adherence to relevant clinical policies.

4.4 **Clinical team leaders:** Clinical team leaders have the daily operational management of the 0-19 service and are required to ensure all staff are suitably trained and competent to deliver this role and that relevant policies are adhered to. Compliance to the guideline will be audited annually and exceptions to service delivery will be raised to the senior management team.

4.5 **Professional leads and practice teachers:** Professional leads and practice teachers support the high quality delivery of the HCP, and service/workforce development.

4.6 **All Staff:** All staff must follow trust policies and professional codes and guidelines relevant to their qualification and role e.g. Nursing and Midwifery Council: The Code – Professional Standards of Practise and Behaviours for Nurses and Midwives (2015). The health visiting and school nursing teams advocate and lead for children and young people’s public health, they work with a range of partners including paediatricians, GPs, education, and social care.
Health visitors have a legal duty to ensure all children with special educational needs and disabilities that they come into contact with under the age of 5 are brought to the attention of the local authority (Hampshire Inclusion Service).

5. **Main Policy Content**

5.1 The definition of children with complex health needs, disabilities and special educational needs has been agreed with Hampshire County Council to support an integrated approach and is contained in section 3.8. The RIO care plan for children and young people with complex health needs, disabilities and special educational needs should only be used for these children and young people.

5.2 All children will receive universal HCP health reviews in accordance with the SHFT Commissioned Service Specification and SHFT guidelines (SH CP 72). The universal 0-5 year health reviews for children with complex health needs, disabilities, and special educational needs should be carried out as a face to face contact by a qualified Specialist Community Public Health Nurse (SCPHN). The 0-5 year health review should include a strengths-based assessment of the child’s physical, emotional and social needs in the context of the family, including predictive risk factors. Health reviews for children aged 0-5 will use the ASQ-3 and ASQ-SE, unless contraindicated (see 3.14-3.16 and SH CP 68, SH CP 90).

5.3 The practitioner should work in partnership with parents/carers and young people to reach a shared understanding of health needs, taking into account parenting preferences, needs, and capacity to agree a core support offer to ensure that parents/carers receive information, service, and support to help make informed choices that optimise life chances for their child and support them in their parenting role. The impact of complex health needs, disabilities, special educational needs, and/or vulnerabilities identified must be discussed with the parents/carers/young people using a sensitive, individualised approach that ensures that their needs and preferences are at the heart of decision making and service delivery, and that they are supported to achieve positive health and educational outcomes.

5.4 For HV/FNP teams to ensure that every child 0-5 with complex health needs, disabilities, and special educational needs that the team are aware of, has a personalised and integrated evidence based care plan with established regular review dates (minimum every 6 months - this may be a telephone contact), devised in partnership with parents/carers who should receive a written copy. School nurses will work in partnership with families, schools, and social care to ensure that children and young people aged 5-19 years have an Education Health and Care Plan (EHCP).

5.5 To ensure that children who are awaiting formal diagnosis do not fall between the gaps between services; all children referred to other services who are suspected of having complex health needs, disabilities, or special educational needs, but have not received a formal diagnosis should be monitored in Universal Partnership Plus (only returning to Universal or an alternative HV/SN care plan, when resolution has been achieved or confirmation received that they do not fit the criteria for children with complex health needs, disabilities, or special educational needs).

5.6 The practitioner should document the future action plan, including timeframe for future contact and any agreed appointments in the progress note, care plan, PCHR and family and child assessment form.

5.7 The HV/FNP Nurse/SN or CIC Nurse should consider referral to other agencies, including members of the wider multi-disciplinary health care team, Early Help Hub.
5.8 Families and children assessed as vulnerable according to SHFT safeguarding policy (SH CP 56) should be identified on the electronic patient record using the appropriate alert.

5.9 The HV/FNP nurse/ CIC nurse should promote and support uptake of early years education offer for 2 year olds.

5.10 The HV team should signpost parents to information that supports them in expressing their preference for a school and encourage them to visit schools to discuss their child’s needs and to apply for a school (all children are entitled to start school in the September after their 4th birthday).

5.11 In preparation for transition to school, transition between schools, and transfer in from an out of area school, the role of the HV/SN is to support the assessment of the Education Health and Care Plan in partnership with other services and ensure formal handover of all children receiving UPP services to the school nursing service. The health visitor/FNP nurse should ensure that the local authority Inclusion Service is notified of the child to support transition to early years’ settings and mainstream school at key transition points (Appendix 3, Appendix 4). The Hampshire County Council area inclusion coordinator, Early Years advisory teacher, and specialist teachers are available to support parents with transition.

5.12 To ensure that children and young people with complex health needs, disabilities and special educational needs are offered health promotion advice, guidance, and support in accordance with the HCP and the SHFT Overarching Policy (SH CP 72). At all universal contacts the practitioner will promote key public health messages as detailed in the service specification using an individualised approach that recognises that families will have differing needs, strengths, information requirements, and priorities.

5.13 To involve parents/carers and wider family and ensure that they are supported, particularly during the time of diagnosis and transition.

5.14 To support the child/young person and parent/carer and liaise with key professionals/educational settings as appropriate if the child/young person is requiring end of life care (NICE 2016).

5.15 At school entry parents/carers will be sent a school entry health review questionnaire to assess for health need, and will be sent information about the school nursing service. Where appropriate children will be encouraged to access aspects of the Healthy Child Programme such as vision and hearing screening and the National Child Measurement Programme.

5.16 School nurse teams will liaise with parent/carers and schools if unmet health needs are identified at school entry and will liaise with education providers with the parent/carer’s consent.

5.17 School nurse teams support schools to carry-out their statutory responsibility to support pupils with medical needs; this includes children with complex health needs and disabilities. School nurses will signpost schools to training provision or liaise with specialist health professionals to ensure that school staff are able to gain skills to care for individual children/young people’s complex health needs. There may be occasions...
where school nurses will liaise with children, young people, parents, health professionals and school staff to support the development of care plans.

5.18 School Nurses will offer 1 to 1 intervention as appropriate to children, young people and their parent/carers if they require specialist support i.e. sleep, puberty. If it is outside of their scope of practice or contracted service they can signpost or refer to other professionals/support. School nurses can support transition to adult health services as required as part of the multi-disciplinary team by acting as an advocate for the young person or parent/carer.

5.19 The HV/SN team will use the electronic patient record (EPR) system to identify all children that they are aware of aged 0-19 with complex health needs, disabilities and special educational needs. These children will have an open complex health needs, disabilities, and special educational needs care plan in accordance with the RIO Service Specific Guidance (SSG). A record of all health visiting and school nursing interventions will be recorded in the RIO progress notes/ family and child assessment form for the named child, and Personal Child Health Record (PCHR) for children under 5 when available. Engagement should be monitored in accordance with the Child and family was not brought and disengagement guideline (SH CP 105).

5.20 Safeguarding: All practitioners are trained to recognise the risks, signs and symptoms of child abuse maltreatment and should follow guidance contained within SHFT Safeguarding Children’s Policy (SH CP 56) and Domestic Violence and Abuse Policy (SH CP 78).

6. Record Keeping

6.1 All contacts will be recorded in accordance with the Southern Health record keeping policies and procedures, and the SHFT Standard Operating Procedure (SOP) and SSG.

6.2 The completed ASQ-3/SE questionnaire will be given to the parent/carer to be stored in the PCHR.

6.3 The ASQ-3/ASQ SE summary sheet will be used by the practitioner to inform data entry on the child’s EPR. All ASQ-3/ ASQ SE: 2 scores should be recorded on the RIO ASQ form. The summary sheet must then be shredded as per current SOP.

6.4 The HV will complete the PCHR and ensure that the parent/ carer/ young person is aware of and understands what is recorded within professional records as per the Standard Operating Procedure (SOP).

6.5 All parents/carers/young people should be given a written copy of their care plan which should be developed in partnership with them and contain a review date. Care plans should be reviewed every six months as a minimum. It is recognised that children and young people with complex health needs, disabilities, and special educational needs, have differing needs and these will change over time; the practitioner should work in partnership with the family and the multi-disciplinary team to decide the most appropriate mechanism of follow up, ensuring that the child/young person remains at the centre of this decision making process (follow up may be face to face or by telephone as appropriate). Care plans may require more regular review when a child/young person’s condition is changing, during the period of diagnosis and at key transition points.
7. **Training Requirements**

See TNA contained within SHFT Children’s Community Public Health 0-19 Overarching Policy (SH CP 72).

8. **Monitoring Compliance**

This guideline will be monitored by qualitative and quantitative data.

- Quantitative data will be collected via the Trust computer system Tableau (number of children identified as having additional/special educational needs at the universal 2 year review); number of children receiving additional support from the HV/FNP/SN service, identified with a complex health needs, disabilities and special educational needs care plan.

- Qualitative data will be collected through patient experience feedback, peer review and annual record keeping audit. (Every child or young person with complex health needs, disabilities, and special educational needs, that the team are aware of, has a personalised and integrated evidence based care plan with established regular review dates).

- All health visitors, school nurses, community nursery nurses and student health visitors/ school nurses who are newly appointed within the Trust will be signposted to this guideline and their competence assessed as part of the Trust induction/ HV/ SN Training Programme.

9. **Guideline Review**

This guideline will be reviewed in February 2020.

10. **Associated Documents**

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<td>SH CP 06</td>
<td>School Based “Drop-in” Sessions Guideline.</td>
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<td>SH CP 07</td>
<td>Continence Promotion for School-age Children and Young People Guidelines.</td>
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<td>Clinic Health Advice Clinic Contacts by Health Visiting Teams Guideline.</td>
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<td>SH CP 63</td>
<td>Healthy Start Guideline.</td>
</tr>
<tr>
<td>SH CP 64</td>
<td>Immunisation Procedure for School Nursing Teams.</td>
</tr>
<tr>
<td>SH CP 65</td>
<td>New Birth Contact Guideline.</td>
</tr>
<tr>
<td>SH CP 68</td>
<td>One Year Health Review Guideline.</td>
</tr>
<tr>
<td>SH CP 69</td>
<td>Transfer of Children In and Out of Health Visiting, Family Nurse Partnership &amp; School Nursing Teams Guideline.</td>
</tr>
<tr>
<td>SH CP 70</td>
<td>Long-term Health Conditions in Children and Young People aged 5-19 Guideline.</td>
</tr>
<tr>
<td>SH CP 72</td>
<td>Children’s Community Public Health 0-19 Service Overarching Policy.</td>
</tr>
<tr>
<td>SH CP 78</td>
<td>Domestic Violence and Abuse Policy.</td>
</tr>
<tr>
<td>SH CP 81</td>
<td>School Entry Health Review Guideline.</td>
</tr>
<tr>
<td>SH CP 88</td>
<td>Protocol for the management of actual or suspected bruising in infants who are not independently mobile.</td>
</tr>
</tbody>
</table>
Children and young people with complex health needs, disabilities and special educational needs Guideline
Version: 1
April 2017

11. Supporting References

Annual Report of the Chief Medical Officer 2012.


CQC (2015) From the pond into the sea: Children’s transition to adult health services.


Department of Health (2014) Children with special educational and complex needs Guidance for Health and Wellbeing Boards

Department of Health (2015) Universal Health visitor reviews: Advice for local authorities in delivery of the mandated universal health visitor reviews from 1 October 2015


https://www.nmc.org.uk/standards/code


Public Health England ChiMat National Child and Maternal Health Intelligence Network  
http://www.chimat.org.uk

Public Health Outcomes Framework 2013 to 2016  

Royal College of Paediatrics and Child Health (RCPCH) Early years - UK-WHO growth charts and resources.  
http://www.rcpch.ac.uk/improving-child-health/public-health/uk-who-growth-charts/early-years/early-years-uk-who-growth-char#0-4

Department of Health SAFER Communication Guidelines.  


The Marmot Review.  

Applicable National Standards:

CQC Essential Standards of Quality and Safety (2010).  

UK National Screening Committee  
https://www.gov.uk/government/groups/uk-national-screening-committee-uk-nsc#publications

Newborn Bloodspot Screening  
https://www.gov.uk/topic/population-screening-programmes/newborn-blood-spot

Newborn Hearing Screening  
https://www.gov.uk/topic/population-screening-programmes/newborn-hearing

Newborn Infant & Physical Examination  
https://www.gov.uk/topic/population-screening-programmes/newborn-infant-physical-examination

The Green Book- (Imms)  
Key NICE public health guidance includes:

NICE guidance summary for public health outcome domain.

https://www.nice.org.uk/advice/lgb22/chapter/introduction

https://www.nice.org.uk/guidance/ph6

NG44 - Community engagement: Improving health and wellbeing and reducing health inequalities (March 2016).
https://www.nice.org.uk/guidance/ng44

https://www.nice.org.uk/guidance/ph11

https://www.nice.org.uk/guidance/ph28

https://www.nice.org.uk/guidance/ph29

PH30 - Unintentional injuries: interventions for under 15s (2010).
https://www.nice.org.uk/guidance/ph30

https://www.nice.org.uk/guidance/ph40

PH48 - Smoking: acute, maternity and mental health services (2013).
https://www.nice.org.uk/guidance/ph48

https://www.nice.org.uk/guidance/ph50

https://www.nice.org.uk/guidance/cg145

https://www.nice.org.uk/guidance/ng61

QS140 – Transition from children’s to adult’s services (2016).
https://www.nice.org.uk/guidance/qs140

https://www.nice.org.uk/guidance/ng62

https://www.nice.org.uk/guidance/qs142
Appendix 1: Training Needs Analysis
If there are any training implications for your policy please complete the form below and contact the Learning, Education and Development department (LEaD) on 02380 774091 before the policy is approved.

<table>
<thead>
<tr>
<th>Training programme:</th>
<th>Infant Mental Health</th>
<th>Child Development/ASQ</th>
<th>Complex Health Needs</th>
<th>Safeguarding Children and Adults: level 1,2 and 3</th>
<th>Record Keeping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency:</td>
<td>Once</td>
<td>3 Yearly</td>
<td>3 Yearly</td>
<td>3 Yearly</td>
<td>Annual</td>
</tr>
<tr>
<td>Course length:</td>
<td>I full day plus 1 half day</td>
<td>Half day + 2 part e-learning module</td>
<td>1 day + 6 e-LFH learning modules</td>
<td>6 hours</td>
<td>Half day</td>
</tr>
<tr>
<td>Delivery method:</td>
<td>Face to face</td>
<td>Face to face + e learning on e-LFH</td>
<td>Face to face</td>
<td>Face to face and e-learning</td>
<td>Face to face</td>
</tr>
<tr>
<td>Trainer(s)</td>
<td>Specialist Practice Teachers/Infant Mental Health Champion HV (train the trainer programme from iHV)</td>
<td>Professional Leads and Practice Teachers</td>
<td>To be arranged</td>
<td>Corporate Safeguarding team</td>
<td>Practice Teachers Professional Leads</td>
</tr>
<tr>
<td>Recording attendance:</td>
<td>LEaD</td>
<td>LEaD/Print certificates</td>
<td>LEaD/Print certificates</td>
<td>LEaD</td>
<td>LEaD</td>
</tr>
<tr>
<td>Strategic and operational responsibility:</td>
<td>Senior Management Team</td>
<td>Senior Management Team</td>
<td>Senior Management Team</td>
<td>Senior Management Team</td>
<td>Senior Management Team</td>
</tr>
</tbody>
</table>
## Appendix 2: Target audience

<table>
<thead>
<tr>
<th>Division</th>
<th>Target audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Mental Health</td>
<td></td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td></td>
</tr>
<tr>
<td>Older Persons Mental Health</td>
<td></td>
</tr>
<tr>
<td>Specialised Services</td>
<td></td>
</tr>
<tr>
<td>TQtwentyone</td>
<td></td>
</tr>
<tr>
<td>Adult Physical Health</td>
<td></td>
</tr>
<tr>
<td>Children’s</td>
<td>x</td>
</tr>
<tr>
<td>Corporate (HR, Governance, Estates, etc.)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service Level</th>
<th>0-5 years</th>
<th>Outcome Measure</th>
<th>5-19 years</th>
<th>Outcome Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community</strong></td>
<td>Health Visiting (HV) website</td>
<td><strong>Narrative</strong> of how health visiting teams are identifying and meeting needs of 11 individual district/ borough local authorities</td>
<td>School nursing website</td>
<td>Patient experience survey</td>
</tr>
<tr>
<td></td>
<td>Local Resources eg. Hampshire Parent Carer Network; Hampshire Local Offer</td>
<td></td>
<td>Local resources</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community offer responsive to local needs developed in partnership with Barnardo’s eg, Andover 21 special interest group</td>
<td></td>
<td>Third sector organisations</td>
<td></td>
</tr>
<tr>
<td>Universal (in addition to Community services)</td>
<td>HV HCP Universal Contacts: Assessment and early identification of additional health needs. All children identified or suspected of having complex health needs, disabilities and special educational needs will be offered Universal Partnership Plus support from the HV/ FNP and SN team</td>
<td><strong>HCP KPIs</strong> for all children <strong>Number of children identified</strong> as having additional/ special educational needs at the universal 2 year review (separate measures for hearing, vision)</td>
<td>New Parent Talks School Entry Health Review</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Signposting to community resources</td>
<td><strong>Method</strong>: Audit of ASQ 3 / ASQ:SE-2 scores / referrals to other services</td>
<td>Assessment and early identification of additional health needs</td>
<td></td>
</tr>
<tr>
<td>Universal Partnership Plus (in addition to Universal and Universal Plus services)</td>
<td>Holistic assessment of need and personalised care plan</td>
<td><strong>Audit/ peer review</strong>:</td>
<td>Health Visitor Handover</td>
<td>Alerts / SNOMED codes. Care plans devised and shared with parent/ carer</td>
</tr>
<tr>
<td></td>
<td>Timely response when expert help is needed e.g. Infant feeding, behaviour, sleep, supporting parents/ carers.</td>
<td><strong>Response to referrer within 5 working days following request for support.</strong></td>
<td>Liaison with parents to review health needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children referred to other services should be monitored in UPP (only returning to Universal when resolution has been achieved)</td>
<td><strong>SNOMED codes recorded on Electronic Patient Record</strong></td>
<td>Timely and specific care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support with transition into early years provision / school</td>
<td><strong>Ensuring every child or young person has a personalised and integrated evidence based care plan with established review dates, devised in partnership with parents/ carers, who should receive a written copy (PCHR)</strong></td>
<td>e.g. puberty, medication, transition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Information sharing between agencies with appropriate consent e.g. School Nurse handover, notification to Hampshire Inclusion Service</td>
<td><strong>Transition to school- Children with complex health needs, disabilities and special educational needs care plan</strong></td>
<td>Liaise with key professionals as part of a multi-disciplinary approach e.g. transition, care planning and identification of training needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Working in partnership with other agencies as part of a multi-agency care package.</td>
<td><strong>Numbers receiving UPP service offer at handover to SN teams</strong></td>
<td>Contribute as required to advanced care plans / end of life care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ensuring early intervention and early referral to targeted specialist support/ Early Help Hub/ Supporting Families/ Children’s safeguarding team where appropriate</td>
<td><strong>Outcome measure</strong> to be devised by HCC. Aim to reduce the number of children starting school with unrecognised disabilities, complex health needs and special educational needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support transition to school- support the assessment of the Education Health and Care Plan in partnership with other services and ensure formal handover of all children receiving UPP services to the school nursing service</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4: Children and Young People with Complex Health Needs, Disabilities, and Special Education Needs Inclusion Support (Early Years and School entry).

Notification of a child / young person with actual or suspected complex health needs, disabilities, and special educational

0-2 years
- Holistic assessment of needs/universal HCP reviews.
- Complex health needs, disabilities, and special educational needs care plan
- Liaison/referral with relevant agencies (e.g. Community paediatrician, children’s therapies, Community children’s, nurses etc…).
- Support individualised integrated plan of care as per guideline – review as required/minimum every 6 months.
- Support parents/carers and signpost to relevant information and additional support e.g. Hampshire Parent Carer Network, Hampshire Local Offer, disability benefits.
- **Term before 2nd birthday** - promote 2 year nursery offer application and transition to Early Years setting, (support parents to access Hampshire Local Offer and Early Years SENCO for chosen setting).

3-5 years
- Complex health needs, disabilities, and special educational needs care plan.
- Liaison/referral with relevant agencies (e.g. Community paediatrician, children’s therapies, Community children’s nurses etc…).
- Support individualised integrated plan of care as per guideline - review as required/minimum every 6 months – support school readiness in partnership with other agencies.
- **Autumn term before school entry the following academic year** - promote application to school and signpost to HCC inclusion co-ordinator.
- **April before school entry in September** - ensure that HCC inclusion service are notified of all children with complex health needs, disabilities, and special educational needs due to start school in September. (If the child is in an Early Years setting this is normally completed by the Early Years SENCO). – The HV service are responsible for ensuring that all children that fit this criteria, that they are aware of, are notified to HCC.
- Liaison with school nursing service once school place is confirmed; coordinate handover to SN.
- Attend transition meeting to ensure that school are aware of the child’s health and developmental needs and any safeguarding needs, if applicable.