# Children’s Division

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

**Version: 2**

## Summary:
This guideline is designed to define the process and service offered to children and young people identified 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:
This guideline applies to all staff who work within the Public Health 0-19 Children and Family Service within Southern Health NHS Foundation Trust.

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February 2020

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Children’s Division Quality and Safety Meeting Board.  
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## Author:
Jane Levers, Professional Lead for School Nursing  
Members of HV Policy Group.

## Sponsor:
Liz Taylor (Associate Director of Nursing and Allied Health Professionals, Children and Family Services)
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Children’s Division

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

All staff within Southern Health NHS Foundation Trust (SHFT) are personally responsible for complying with Trust policies, guidelines and professional codes relevant to their qualification and role e.g. Nursing and Midwifery Council: The Code – Professional Standards of Practice and Behaviours for Nurses and Midwives (NMC 2015).

1. Introduction

This guideline must be read in conjunction with the Children’s Community Public Health 0-19 Service Overarching Policy (SH CP 72)

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.

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.

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.

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 1, Appendix 2).
- 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 staff within the children and family services business unit within SHFT 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.

Support for children and young people with complex health needs, disabilities, and special educational needs forms part of a health visitor/school nurse 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.**
For the full list of definitions please see Children’s Community Public Health 0-19 Service Overarching Policy (SH CP 72).
For specific definitions pertaining to this guideline please see below:

3.1 **Corporate Safeguarding Children Team**
This team comprises of Specialist Nurses, Professionals and Practitioners working under the guidance of Named Nurses. They provide advice and expertise to those within the Trust who are working with children or adults who have contact with children. They have specific expertise in children’s health and development, child maltreatment and local arrangements for safeguarding and promoting the welfare of children. They represent health in the Multiagency Rapid Response Process.

3.2 **Personal Child Health Record (PCHR)**
Individualised record of a child’s health from birth, held by parent/carer.

3.3 **Electronic Patient Record (EPR) and Family and Child Assessment Form**
Practitioners are required to keep clear and accurate records as detailed in the NMC Code (2015):
• Complete all records contemporaneously, at or as soon as possible after an event (ideally within 24 hours)
• Records should clearly identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
• Complete all records objectively, accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
• Attribute any entries made in the EPR to the named practitioner, complying with the RiO Smartcard user requirements, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation.
The Family and Child Assessment Form is contained within the EPR as a record of the assessment of health, wellbeing and wider factors that may impact on outcomes for parent/unborn child at the Antenatal Contact. It provides a summary of information gathered, risk analysis and plan for future level of care provided within the 4, 5, 6 health visiting model.

3.4 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.

3.5 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](https://www.gov.uk/definition-of-disability-under-equality-act-2010)

3.6 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.

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.

3.7 Ages and Stages Questionnaires (ASQ-3) and ASQ: SE-2 – British English Versions

The ASQ-3 and ASQ: SE-2 are parent-led assessments of child's physical and social emotional development respectively and are the mandated tools within the HCP. The questionnaires are designed for specific ages and it is important that the correct questionnaire is used. The evidence based ASQ-3 covers five domains of child development: communication, gross motor skills, fine motor skills, problem solving and personal-social development. It can help identify need, promoting a discussion between the health professional and the parent/ carer.

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 nor ASQ: SE-2 are being used as screening tools and neither are diagnostic tools.

Children with complex health needs and disabilities: The ASQ-3 and ASQ: SE-2 should be offered to all children as part of their one year review and both are helpful tool for identifying children with additional needs. However, where a child already has an identified disability or complex developmental delay, health visiting teams will need to agree with parents/careers whether they wish to complete the ASQ-3 / ASQ: SE-2 questionnaires as part of their child’s one year 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 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 one year health review.

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. 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.

3.8 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).

3.9 Children and young people who were born preterm:
National Institute for Health and Care Excellence [NICE] (2017) Developmental follow-up of children and young people who were born preterm covers the developmental follow-up of babies, children and young people under 18 years who were born preterm (before 37+0 weeks of pregnancy). It explains the risk of different developmental problems and disorders, and specifies what extra assessments and support children born preterm might need during their growth and development. Practitioners should be aware of this guidance so that they are able to support parent/carers and preschool/school staff who care for children who were born preterm and ensure that children are referred for further assessment using local pathways and offered educational support should issues be identified. Children who are born preterm are at increased risk of developmental problems and disorders, which include: speech and language and communication difficulties; attention and hyperactivity issues; emotional problems; special educational needs; learning disability and motor difficulties. 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.

4. **Duties and Responsibilities**
   In addition to those identified in the Children’s Community Public Health 0-19 Service Overarching Policy (SH CP 72)

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 3.4.
   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 babies that are born pre-term [Born 36 +6 weeks or earlier] staff should add a SNOMED alert at the new birth or transfer in visit to indicate prematurity [NICE 2017].
   Practitioners should clarify with the parent/carer the follow-up that the child is receiving or that is planned. Support should be offered to meet the parent/carer individual needs and a care plan should be commenced.

   5.5 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).

   5.6 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).

5.7 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.

5.8 The practitioner should consider referral to other agencies, including members of the wider multi-disciplinary health care team, Early Help Hub /Supporting Families, Children’s Safeguarding as needed. All referrals and information sharing must be completed with consent from the parent/carer as required in accordance with the Information Sharing Policy (SH IG 46), Information Sharing Staff Guidance (SH IG 48) and the Safeguarding Children’s Policy (SH CP 56).

5.9 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.

5.10 The practitioner should promote and support uptake of early years education offer for 2 year olds.

5.11 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).

5.12 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 1, Appendix 2). The Hampshire County Council area inclusion coordinator, Early Years advisory teacher, and specialist teachers are available to support parents with transition.

5.13 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.

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

5.15 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).

5.16 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.
5.17 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.

5.18 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.

5.19 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 practise 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.

5.20 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).

5.21 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).

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

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

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.

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).

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.

6. **Training Requirements**
   See the Training Needs Analysis (TNA) contained within the Children’s Community Public Health 0-19 Service Overarching Policy (SH CP 72).

7. **Monitoring Compliance**
   Dependant on KPI, this guideline will be monitored by qualitative and quantitative data.
   - Quantitative data will be collected via the Trust data collection system (Tableau).
   - Qualitative data will be collected through:
     - Peer review
     - Annual record keeping audit
     - Patient experience feedback

8. **Guideline Review**
   This guideline will be reviewed in three years or earlier if necessary.

9. **Associated Trust Documents**

| SH CP 06 | School Based “Drop-in” Sessions Guideline. |
| SH CP 07 | Continence Promotion for School-age Children and Young People Guidelines. |
| SH CP 09 | Clinic Health Advice Clinic Contacts by Health Visiting Teams Guideline. |
| SH CP 53 | Neo-natal Jaundice Guidelines. |
| SH CP 54 | Perinatal Mental Health Guidelines. |
| SH CP 56 | Safeguarding Children’s Policy. |
| SH CP 60 | GP Communication Guideline. |
| SH CP 61 | Antenatal Contact Guideline. |
| SH CP 63 | Healthy Start Guideline. |
| SH CP 64 | Immunisation Procedure for School Nursing Teams. |
| SH CP 65 | New Birth Contact Guideline. |
| SH CP 68 | One Year Health Review Guideline. |
| SH CP 69 | Transfer of Children In and Out of Health Visiting, Family Nurse Partnership & School Nursing Teams Guideline. |
| SH CP 70 | Long-term Health Conditions in Children and Young People aged 5-19 Guideline. |
| SH CP 72 | Children’s Community Public Health 0-19 Service Overarching Policy. |
| SH CP 78 | Domestic Violence and Abuse Policy. |
| SH CP 81 | School Entry Health Review Guideline. |
| SH CP 88 | Protocol for the management of actual or suspected bruising in infants who are not independently mobile. |
| SH CP 89 | Infant Feeding Policy. |
| SH CP 90 | 2-2.5 Year Health Review Guideline. |
| SH CP 105 | Child and Family Was Not Brought and Disengagement Guideline. |
| SH CP 106 | Joint Working Protocol: Safeguarding Children and Young People Whose |
Parents/Carers have problems with Mental Health/Substance Misuse.

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10. Supporting References


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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 


http://www.eif.org.uk/publication/the-best-start-at-home/


Please note: this link opens to the bookstore for purchase of copies of this edition.

Healthy Child Programme: Pregnancy and the first five years, Department of Health 2009


Liberating the NHS: No decision about me, without me, Department of Health, 2012

Mental Capacity Act: making decisions.
https://www.gov.uk/government/collections/mental-capacity-act-making-decisions

NHS England (2016) the five year forward view for mental health.

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

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PH30 - Unintentional injuries: interventions for under 15s (2010).
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<td>• Community offer responsive to local needs developed in partnership with Barnardo’s eg. Andover 21special interest group</td>
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<td><strong>Universal (in addition to Community services)</strong></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</strong> identified as having additional/ special educational needs at the universal 2 year review (separate measures for hearing, vision) <strong>Method:</strong> Audit of ASQ 3 / ASQ:SE-2 scores / referrals to other services <strong>Outcome measure survey</strong></td>
<td>New Parent Talks School Entry Health Review Assessment and early identification of additional health needs Chat Health Signposting schools to generic training</td>
<td>Patient experience survey</td>
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<td>• Information sharing between agencies with appropriate consent eg. School Nurse handover, notification to Hampshire Inclusion Service</td>
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<td>• Working in partnership with other agencies as part of a multi-agency care package.</td>
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<td>• Ensuring early intervention and early referral to targeted specialist support/ Early Help Hub/ Supporting Families/ Children’s safeguarding team where appropriate.</td>
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| **Universal Partnership Plus (in addition to Universal and Universal Plus services)** | • Holistic assessment of need and personalised care plan                    | **Audit/ peer review:**  
  • Response to referrer within 5 working days following request for support.  
  • SNOMED codes recorded on Electronic Patient Record  
  • 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)  
  • Transition to school-Children with complex health needs, disabilities and special educational needs care plan  
  • Numbers receiving UPP service offer at handover to SN teams  
  • **Outcome measure** to be devised by HCC. Aim to reduce the number of children starting school with unrecognised disabilities, complex health needs and special educational needs. | Health Visitor Handover Liaison with parents to review health needs Timely and specific one to one support for the child/ young person/ family as required e.g. puberty, medication, transition Liaise with key professionals as part of a multi-disciplinary approach e.g. transition, care planning and identification of training needs Contribute as required to advanced care plans / end of life care. | Alerts / SNOMED codes. Care plans devised and shared with parent / carer |
|                             | • Timely response when expert help is needed e.g. Infant feeding, behaviour, sleep, supporting parents/ carers. |                                                                                  |            |                                                                                |
|                             | • Children referred to other services should be monitored in UPP (only returning to Universal when resolution has been achieved) |                                                                                  |            |                                                                                |
|                             | • Support with transition into early years provision / school               |                                                                                  |            |                                                                                |
|                             | • Working in partnership with other agencies as part of a multi-agency care package. |                                                                                  |            |                                                                                |
|                             | • Ensuring early intervention and early referral to targeted specialist support/ Early Help Hub/ Supporting Families/ Children’s safeguarding team where appropriate. |                                                                                  |            |                                                                                |
|                             | • 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 |                                                                                  |            |                                                                                |
Appendix 2: 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 needs.

**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.