

# The Child Health Promotion Programme

*Pregnancy and the first five years of life*



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**Author** Dr. Sheila Shribman, Kate Billingham

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**Contact Details** Deborah Jamieson  
Children, Family & Maternity Partnerships  
Area 213, Wellington House  
133-155 Waterloo Road, London  
SE1 8UG  
0207 972 4353  
www.doh.gov.uk

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# The Child Health Promotion Programme

*Pregnancy and the first five years of life*

Update of Standard One (incorporating Standard Two)  
of the National Service Framework for Children,  
Young People and Maternity Services (2004)

# Foreword by Dr Sheila Shribman



An effective and high-quality preventive programme in childhood is the foundation of a healthy society. This is as true today as ever. For more than 100 years

we have provided a preventive health service that has protected and promoted the health of children. As an experienced paediatrician I have watched the Child Health Promotion Programme (CHPP) change and develop over the years as it has adapted to new knowledge, changes in public expectations and changes in the way in which services are delivered.

This is a critical moment in the development of the CHPP. The advances taking place in neuroscience and genetics – and our understanding of how early childhood development can be both promoted and damaged – create an imperative for the CHPP to begin in early pregnancy. At the same time, the development of Sure Start children's centres gives us an opportunity to make more of a difference to children – across a wider set of outcomes – than we have been able to in the past.

However, it is disappointing to hear that the CHPP is being given a low priority in some parts of the country. Health visiting and paediatric colleagues have reported that it is proving difficult to provide a universal CHPP, and to meet the needs of vulnerable children and families.

This update has been written for a number of reasons.

To raise the profile of the CHPP and to highlight its importance in addressing some of the serious problems that we are facing as a society.

To set out how the CHPP can deliver a universal preventive service at the same time as focusing on vulnerable babies, children and families.

To provide more detail on the programme that was set out in the *National Service Framework for Children, Young People and Maternity Services* (DH, 2004), and to give clearer direction on what needs to be done – and when.

To establish the CHPP within joint commissioning and integrated children's services across general practice and children's centres.



This document sets out the standard for the CHPP. The detail of how the programme is implemented will be decided by the local partners who commission and provide the service. It is the beginning of a process to strengthen the CHPP and to support local delivery. The world will keep changing and new evidence will emerge that may challenge some of the content of today's programme. This means we need to make sure that we have a skilled and flexible workforce, local leadership and an infrastructure that is capable of innovating, adapting and responding to the changing needs of children and families. This must include strategic monitoring, evaluation and quality improvement by the primary care trust and local authority.

Our success will be measured by the future health and wellbeing of children, and how the CHPP is seen by families – in particular, the most disadvantaged families.

I would like to thank the many people who have contributed to this publication, in particular the members of the CHPP Working Group.

**Dr Sheila Shribman**  
National Clinical Director for Children,  
Young People and Maternity Services  
Department of Health

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# Introduction

This guide is for primary care trusts (PCTs), local authorities, practice-based commissioners and providers of services in pregnancy and the first years of life. It highlights the key role that the Child Health Promotion Programme (CHPP) plays in improving the health and wellbeing of children, as part of an integrated approach to supporting children and families. This document is a first step: further work is planned to support services to build a CHPP that is fit for the future, and that meets the needs of children and the aspirations of families. The CHPP will be taken forward in the forthcoming government Child Health Strategy, which will have a strong focus on prevention in the first years of life.

This publication sets out the recommended standard for the delivery of the CHPP and demonstrates how the programme addresses priorities for the health and wellbeing of children (such as Public Service Agreement (PSA) indicators). Delivery of the CHPP depends on services for children and families being fully integrated, and this guide will inform joint strategic plans to promote child health and wellbeing across all agencies. Partnership working between different agencies on local service development – increasingly through children's trust arrangements – will be the key to the CHPP's success.

The CHPP begins in early pregnancy and ends at adulthood, and will be commissioned as one programme covering all stages of childhood. The focus of this update is pregnancy and the first five years of life – because this is where significant change has

taken place in the last few years, and where we wish to see a strengthening of current provision. The health of older children, in particular during adolescence, remains a priority: an integrated CHPP from pregnancy to adulthood is essential. The learning from this update will be used to strengthen the CHPP for other age groups in the future.

We are fortunate to have a strong evidence base for the CHPP, as set out in *Health for All Children* (Hall and Elliman, 2006). This update continues to adopt the recommendations of *Health for All Children* as the underpinning universal programme. This has been supplemented by guidance from the National Institute for Health and Clinical Excellence (NICE) and a review of health-led parenting programmes by the University of Warwick. The evidence base is less clear for some public health interventions (such as obesity prevention). However, there is no doubt about the importance of these public health issues; therefore, we have taken a pragmatic approach and included recommendations that are based on expert consensus (Cross-Government Obesity Unit 2008).

There are plenty of examples of high-quality, evidence-based CHPP services across the country, and many practitioners will already be working in the ways recommended in this update. However, given the range of people now involved in delivering the CHPP and the variability in standards and provision across the country, it is important to outline what good practice should look like rather than making assumptions.

# The importance of the CHPP

The CHPP is the early intervention and prevention public health programme that lies at the heart of our universal service for children and families. At a crucial stage of life, the CHPP's universal reach provides an invaluable opportunity to identify families that are in need of additional support and children who are at risk of poor outcomes.

The CHPP offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices – all services that children and families need to receive if they are to achieve their optimum health and wellbeing.

Effective implementation of the CHPP should lead to:

- strong parent–child attachment and positive parenting, resulting in better social and emotional wellbeing among children;
- care that helps to keep children healthy and safe;
- healthy eating and increased activity, leading to a reduction in obesity;
- prevention of some serious and communicable diseases;
- increased rates of initiation and continuation of breastfeeding;
- readiness for school and improved learning;
- early recognition of growth disorders and risk factors for obesity;
- early detection of – and action to address – developmental delay, abnormalities and ill health, and concerns about safety;



- identification of factors that could influence health and wellbeing in families; and
- better short- and long-term outcomes for children who are at risk of social exclusion.

Pregnancy and the first years of life are one of the most important stages in the life cycle. This is when the foundations of future health and wellbeing are laid down, and is a time when parents are particularly receptive to learning and making changes. There is good evidence that the outcomes for both children and adults are strongly influenced by the factors that operate during pregnancy and the first years of life. We have always known this, but new information about neurological development and the impact of stress in pregnancy, and further recognition of the importance of attachment, all make early intervention and prevention an imperative (Center on the Developing Child, 2007). This is particularly true for children who are born into disadvantaged circumstances.

Providing a high-quality CHPP that is visible and accessible to families with children is a core health responsibility contributing to the goals of *Every Child Matters* (HM Government, 2004) and services provided in Sure Start children's centres (DH, 2007a). The CHPP, led by health visitors, is increasingly being delivered through integrated services that bring together Sure Start children's centre staff, GPs, midwives, community nurses and others. Children's centres are a way of delivering community-based services, and are visible and accessible to families who might be less inclined to access traditional services.

The CHPP will continue to make sure that children receive appropriate referral to specialist services, and to signpost families to wider support. The programme will ensure that each family receives support that is appropriate for their needs – with the most vulnerable families receiving intensive interventions and co-ordinated support packages. Working in partnership with other agencies, the CHPP sits at the heart of services for children and families.

The CHPP is key to delivering the 2008–11 PSAs<sup>1</sup> for improving the health and wellbeing of children – specifically the indicators for breastfeeding, obesity prevention, and improving emotional health and wellbeing. The CHPP will have an impact on safeguarding and promoting the welfare of children, contributing to achieving the 'improving children and young people's safety' PSA (see page 64). By incorporating the maternity PSA indicator, the updated CHPP recognises the vital contribution that maternity services make to a child's future health and wellbeing.

In establishing the foundations of good health, the CHPP makes a crucial contribution to the Every Child Matters outcomes (and to delivering the legal duties to promote these), as well as to the *National Service Framework for Children, Young People and Maternity Services* (DH, 2004). The CHPP feeds directly into *The Children's Plan* (DCSF, 2007), which includes strengthened support for all families during the formative early years of children's lives, and helps parents to ensure that children are ready for early years education, school and later life.

It is important that PCTs make use of children's trust arrangements to work closely with local authorities to jointly plan and commission services to deliver the CHPP locally. Monitoring, evaluating and improving the quality of the CHPP will be a key aim.



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1 [www.hm-treasury.gov.uk/media/5/A/pbr\\_csr07\\_psa18.pdf](http://www.hm-treasury.gov.uk/media/5/A/pbr_csr07_psa18.pdf) and [www.hm-treasury.gov.uk/media/3/A/pbr\\_csr07\\_psa19.pdf](http://www.hm-treasury.gov.uk/media/3/A/pbr_csr07_psa19.pdf)

# What is new and different in this update of the CHPP?

Since the National Service Framework for Children, Young People and Maternity Services was published in 2004, there have been significant changes in parents' expectations, in our knowledge about neurological development, in our knowledge about what interventions work, and in the landscape of children's policy and services. At the same time, we are facing pressing public health priorities such as the rise in childhood obesity, an increase in emotional and behavioural problems among children and young people, and the poor outcomes experienced by children in the most at-risk families.

The CHPP needs to adapt to this changing environment, and it is expected that local programmes will provide:

- a major emphasis on parenting support;
- the application of new information about neurological development and child development;
- the use of new technologies and scientific developments;
- the inclusion of changed public health priorities;
- an emphasis on integrated services; and
- an increased focus on vulnerable children and families, underpinned by a model of progressive universalism.



## A major emphasis on parenting support

- Supporting mothers and fathers to provide sensitive and attuned parenting, in particular during the first months and years of life.
- Supporting strong couple relationships and stable positive relationships within families (in accordance with *The Children's Plan* (DCSF, 2007)).
- Ensuring that contact with the family routinely involves and supports fathers, including non-resident fathers.
- Supporting the transition to parenthood, especially for first-time mothers and fathers.

PCTs and local authorities will need to develop a joint strategy for the design and delivery of parenting support services in their area.

The contribution that fathers make to their children's development, health and wellbeing is important, but services do not do enough to recognise or support them. Research shows that a father's behaviour, beliefs and aspirations can profoundly influence the health and wellbeing of both mother and child in positive and negative ways.

Maternity and child health services are used to working mainly with mothers, and this has an impact on their ability to engage with fathers. Fathers should be routinely invited to participate in child health reviews, and should have their needs assessed.

### The application of new information about neurological development and child development

Rapid scientific advances are taking place in the study of neuroscience and child development, and in our understanding of the effectiveness of early childhood programmes.

The CHPP reflects this new knowledge by:

- stressing the importance of attachment and positive parenting in the first years of life in determining future outcomes for children;
- introducing a greater focus on pregnancy;
- recognising the specific impact that mothers and fathers have on their children, as well as their combined influence;

- building a progressive universal programme that responds to the different risk factors for children's future life chances, including the effects of multiple parental risk factors;
- integrating guidelines from NICE on promoting changes in the behaviours that affect health, maternal mental health, and antenatal and postnatal care; and
- incorporating interventions (where emerging evidence shows that they can help) to build resilience and improve outcomes, such as the Family Nurse Partnership programme.

The CHPP needs to reflect new evidence that has emerged about neurological development and the importance of forming a strong child-parent attachment in the first years of life. It should also incorporate the information that we have about the adverse effect that maternal anxiety and depression in pregnancy can have on child development.

A child's brain develops rapidly in the first two years of life, and is influenced by the emotional and physical environment as well as by genetic factors. Early interactions directly affect the way the brain is wired, and early relationships set the 'thermostat' for later control of the stress response. This all underlines the significance of pregnancy and the first years of life, and the need for mothers and fathers to be supported during this time.

## The use of new technologies and scientific developments

These include:

- new vaccination and immunisation programmes;
- new tests, such as newborn hearing screening and expanding newborn bloodspot screening programmes;
- maximising the potential of the internet, digital TV, helplines and text messaging services to provide parents with information and guidance, and to offer them more choice over how to access the CHPP, such as the online NHS Early Years Life Check<sup>2</sup> available on the NHS Choices website; and
- improved data collection systems and electronic records.

## The inclusion of changed public health priorities

- To increase the proportion of mothers who breastfeed for six to eight weeks or longer.
- To focus on the early identification and prevention of obesity in children through an emphasis on breastfeeding, delaying weaning until babies are around six months old, introducing children to healthy foods, controlling portion size, limiting snacking on foods that are high in fat and sugar, and encouraging an active lifestyle.
- To take a proactive role in promoting the social and emotional development of children.
- To support parents to get the balance right between encouraging play and physical activity, and minimising the risk of injury, as set out in *Staying Safe: Action plan* (DCSF, 2008).

Obesity and being overweight represent a profound public health challenge that is comparable with smoking in its significance and scale. According to the latest UK statistics, just under 10 per cent of under-19s are obese and 20 per cent are overweight. Around 25 per cent of adults are obese and 40 per cent are overweight.

If no action is taken, by 2050 it is suggested that 25 per cent of children will be obese and 30 per cent will be overweight. Children who are obese in childhood are likely to remain obese into adulthood.

Only 3 per cent of overweight or obese children have parents who are not overweight or obese: it is vital to work with parents, taking a whole-family approach (Cross-Government Obesity Unit, 2008).

## An emphasis on integrated services

- To build the CHPP team across general practice and Sure Start children's centres.
- To be led by a health visitor and delivered by a range of practitioners across the health service and the wider children's workforce.
- Health practitioners supporting early years staff in their role to promote the health of children.
- Identifying when children and their families need access to additional services, and using the Common Assessment Framework to assess their needs holistically.
- To work with and as part of developing local children's trusts.

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<sup>2</sup> Currently under development

Sure Start children's centres are being developed across the country. There are now over 2,500 centres, with plans for 3,500 by 2010 – one for every community. Children's centres provide a range of integrated services, such as health and family support, as well as childcare and early years education. Children's centres offer significant opportunities for improving children's health and are a key vehicle for delivering the CHPP. Many health services will either be located in children's centres or will work very closely with them.

The National Audit Office's impact evaluation of Sure Start children's centres (NAO, 2006) found that these are more effective when they work in partnership with health services. For example, centres that are successful at reaching disadvantaged groups use outreach and home visiting in co-operation with health and community groups to reach excluded families.

The team delivering the CHPP will include a range of health professionals and children's practitioners within children's centres, general practice and the wider children's workforce.

The responsibility for delivering the CHPP in the first years of life should lie with health professionals – in particular health visitors – for the following reasons:

- The CHPP includes activities that require clinical and public health skills and knowledge.

- Health professionals are notified of all pregnancies and births, and are responsible for this registered population.
- Health professionals are trusted and listened to by the public – especially during pregnancy and around the time of childbirth.
- Health professionals are able to address primary, non-stigmatising, physical health issues that are of concern to all pregnant women, expectant fathers and parents of newborn babies.
- The NHS has a skilled workforce that is used to working with different levels of need and in a range of settings, including the home.
- Health visitors have the necessary skills to co-ordinate the CHPP.
- GPs and practice nurses are ideally placed to offer opportunistic health promotion and to identify children and families who are in need of support.

### **An increased focus on vulnerable children and families, underpinned by a model of progressive universalism**

The CHPP is a progressive universal service, i.e. it includes a universal service that is offered to all families with additional services for those with specific needs and risks. 'The CHPP schedule' section (beginning on page 29) includes both the universal service to be offered to every family and the progressive services for children and families with additional needs and risks. A progressive universal CHPP is one that offers a range of preventive and early intervention services for different levels of risk, need and protective factors.



If we are to reduce inequalities in children's health, wellbeing and achievement, we need to focus on the most vulnerable children and families, and allocate resources accordingly. One of the CHPP's key roles is to identify children with high risk and with low protective factors, and to ensure that these families receive a personalised service. Poverty is one of the biggest risk factors linked to poorer health outcomes. Poorer children are less likely to be breastfed, more likely to be exposed to tobacco smoke, and more likely to be injured at home and on the roads.

Inequalities in early learning and achievement begin to become apparent in early childhood, with a gap opening up between the abilities of poor and prosperous children at as early as two or three years of age. Children who come from families with multiple risk factors (e.g. mental illness, substance misuse, debt, poor housing and domestic violence) are more

likely to experience a range of poor health and social outcomes. These might include developmental and behavioural problems, mental illness, substance misuse, teenage parenthood, low educational attainment and offending behaviour.

In a diverse country such as England, a one-size CHPP will not fit all. The use of interpreters, understanding different childcare practices, and taking services to the homeless and to travelling families will all be key features of local programmes.

<b>Moving the CHPP from</b>	<b>... to</b>
Commissioning a minimum core programme	Commissioning a universal core programme, plus programmes and services to meet different levels of need and risk (progressive universalism)
Variation of provision according to local investment	Variation of provision according to need and risk
A focus on post-birth	An increased focus on pregnancy
A focus on children's services	Greater integration and information sharing with family services – including adult services
A focus mainly on mothers and children	Working routinely with both mothers and fathers (whether they are living together or not)
A programme that looks for problems, deficits and risks	One that looks for and builds on strengths and protective factors – as well as risks
A non-specific approach to emotional issues	The proactive promotion of attachment and the prevention of behavioural problems
A focus on surveillance and health promotion	A greater focus on parenting support, as well as on surveillance and health promotion
A focus on 'contacts'	Health reviews using consultation skills and tools to support behaviour change. Supplementing face-to-face contact with new media and other channels where appropriate
A schedule that is determined by physical developmental stages and screening tests	A schedule that is also determined by social and emotional developmental stages, parental receptiveness and parents' priorities
The assessment of current needs	The assessment of future risks as well as current needs
An emphasis on professionally identified needs	A greater focus on mothers' and fathers' goals and aspirations for their children
Delivered by health practitioners	Led by health visitors, drawing on a range of practitioners, and delivered through general practice and children's centres
The separation of maternity and child health services	Better integration and information sharing between maternity services and the CHPP team, school health teams and adolescent services, including child and adolescent mental health services
A lack of clarity about who is responsible for the quality and outcomes of the CHPP	Health visitors lead the delivery of the CHPP for a defined population across a range of services and locations. The CHPP is commissioned, monitored and evaluated locally, and overseen by the PCT or children's trust in partnership with general practice, including population outcomes
Minimal supervision of staff or focus on outcomes or quality improvement	Regular supervision, and monitoring of quality and outcomes of teams and individual practitioners
Delivered through the primary healthcare team	Delivered by the primary healthcare team and Sure Start children's centres

# The core requirements of the CHPP

This update builds on the revised fourth edition of *Health for All Children* (Hall and Elliman, 2006), which will assist in determining what should be commissioned to meet government standards. The following requirements are intended to strengthen – and not to replace – those set out in *Health for All Children*.

## Early identification of need and risk

At population level, commissioners need a systematic, reliable and consistent process for assessing needs. At an individual level, families need a skilled assessment so that the programme is personalised to their needs and choices.

The CHPP health reviews provide the basis for agreeing with each family how they will access the CHPP over the next stage of their child's life. Any system of early identification has to be able to:

- identify the risk factors that make some children more likely to experience poorer outcomes in later childhood, including family and environmental factors;
- include protective factors as well as risks;
- be acceptable to both parents;
- promote engagement in services and be non-stigmatising;
- be linked to effective interventions;
- capture the changes that take place in the lives of children and families;
- include parental and child risks and protective factors; and
- identify safeguarding risks for the child.



A variety of different processes have evolved locally, and more needs to be done to provide the service with validated tools. We will be producing further guidance, in particular to support the PSA maternity indicator. The aim will be to enable and encourage earlier access to maternity care, with women having the opportunity by the twelfth week of pregnancy to see a midwife or maternity healthcare professional for a health and social care assessment of their needs, risks and choices. This assessment will form the starting point for the CHPP.

Generic indicators can be used to identify children who are at risk of poor educational and social outcomes (for example, those with parents with few or no qualifications, poor employment prospects or mental health problems). Neighbourhoods also affect outcomes for children. Families subject to a higher-than-average risk of experiencing multiple problems include:

- families living in social housing;
- families with a young mother or young father;
- families where the mother's main language is not English;
- families where the parents are not co-resident; and
- families where one or both parents grew up in care.

There is a clear relationship between the number of parent-based disadvantages and a range of adverse outcomes for children (Social Exclusion Task Force, 2007).

It is estimated that around 2 per cent of families in Britain experience five or more of the following disadvantages:

- Neither parent in the family is in work.
- The family lives in poor-quality or overcrowded housing.
- Neither parent has any educational qualifications.
- Either parent has mental health problems.
- At least one parent has a longstanding limiting illness, disability or infirmity.
- The family has a low income.
- The family cannot afford a number of food and clothing items.

It can be difficult to identify risks early in pregnancy, especially in first pregnancies, as often little is known about the experience and abilities of the parents, and the characteristics of the child. Useful predictors during pregnancy include:<sup>3</sup>

- young parenthood, which is linked to poor socio-economic and educational circumstances;
- educational problems – parents with few or no qualifications, non-attendance or learning difficulties;
- parents who are not in education, employment or training;
- families who are living in poverty;
- families who are living in unsatisfactory accommodation;
- parents with mental health problems;
- unstable partner relationships;
- intimate partner abuse;
- parents with a history of anti-social or offending behaviour;
- families with low social capital;
- ambivalence about becoming a parent;
- stress in pregnancy;
- low self-esteem or low self-reliance; and
- a history of abuse, mental illness or alcoholism in the mother's own family.

<sup>3</sup> [www.dcsf.gov.uk/rsgateway/DB/RRP/u015301/index.shtml](http://www.dcsf.gov.uk/rsgateway/DB/RRP/u015301/index.shtml)



As well as generic social and psychological indicators, there are specific risk and protective factors for particular outcomes. These include:

- an underlying medical or developmental disorder and temperamental characteristics, some of which may be genetic;
- low birthweight and prematurity;
- obesity in parents (a child is at greater risk of becoming obese if one or both of their parents is obese);
- poor attachment and cold, critical or inconsistent care (this can result in emotional and behavioural problems);
- smoking in pregnancy (this has multiple short- and long-term adverse effects on both the foetus and child, and can be a wider indicator of a pregnant woman's self-esteem); and
- smoking by partners (this also has both a direct and an indirect impact on children, and is the most powerful influence on the mother's smoking habit).

Some of the indicators listed above are more difficult to identify than others. Health professionals need to be skilled at establishing a trusting relationship with families and be able to build a holistic view.

#### **Protective factors**

- Authoritative parenting combined with warmth, with an affectionate bond of attachment being built between the child and the primary caregiver from infancy.
- Parental involvement in learning.
- Protective health behaviours, such as smoking cessation in pregnancy.
- Breastfeeding.
- Psychological resources, including self-esteem.

## Health and development reviews

The core purpose of health and development reviews is to:

- assess family strengths, needs and risks;
- give mothers and fathers the opportunity to discuss their concerns and aspirations;
- assess growth and development; and
- detect abnormalities.

Universal health and development reviews are a key feature of the CHPP. This updated CHPP keeps to the key ages set out in Standard One of the National Service Framework, in line with the Personal Child Health Record. However, this guide provides greater detail and places an increased emphasis on the review at two to two-and-a-half years.

The following are the most appropriate opportunities for screening tests and developmental surveillance, for assessing growth, for discussing social and emotional development with parents and children, and for linking children to early years services:

- By the twelfth week of pregnancy.
- The neonatal examination.
- The new baby review (around 14 days old).
- The baby's six to eight week examination.
- By the time the child is one year old.
- Between two and two-and-a-half years old.

One of the CHPP's core functions is to recognise disability and developmental delay. This includes a responsibility to provide information, support, referral and notification to others, and in particular there is a duty to inform the local education authority if it is suspected that a child may have special educational needs. Practitioners carrying

out the CHPP health and development reviews are expected to have knowledge and understanding of child development, and of the factors that influence health and wellbeing. They need to be able to recognise the range of normal development.

Growth is an important indicator of a child's health and wellbeing. Where parents or health professionals have concerns, the child's growth should be measured and plotted on appropriate charts. New growth charts (based on World Health Organization standards<sup>4</sup> covering infants aged between two weeks and two years) will be introduced at the end of 2008, following a pilot programme.

Regular monitoring of growth continues to be reviewed as new evidence emerges and concerns regarding obesity increase. Measuring and assessing the growth of young children is a particularly skilled task, and needs to be carried out by appropriately trained practitioners. From birth to two years of age, infants should be weighed without clothes on modern, electronic, self-zeroing scales that have been properly maintained and are placed on a firm, flat surface. Length (up to two years) and height must be measured on suitable equipment designed for the purpose.

Competent physical examinations should be undertaken for all newborn infants and at six to eight weeks, and thereafter whenever there is concern about a child's health or wellbeing. New guidelines on the physical examination of babies soon after birth and again at six to eight weeks will shortly be published by the National Screening Committee (<http://nipe.screening.nhs.uk>).

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4 [www.who.int/childgrowth/en](http://www.who.int/childgrowth/en)



The CHPP health and development reviews provide the opportunity to assess the strengths and needs of individual children and families, to plan for the next stage of childhood and to evaluate the services received so far. The topics covered and the depth of each review will depend on the experience and confidence of mothers and fathers, as well as their choices. This will also be subject to professional judgement.

Most children do well and, when given information, most parents are good judges of their child's progress and needs. Others may need more support and guidance, and a small minority will need intensive preventive input. Reviews can provide an opportunity to plan a package of support using local services (such as those provided in a children's centre) or for referral to specialist services.

Many children will have contact with a variety of early years practitioners, all of whom need to be alert to possible concerns. The Common Assessment Framework should be used where there are issues that might require support to be provided by more than one agency. It is important that professionals who are involved in assessing the child's and the family's needs work in partnership, and share relevant information as required.

The following table gives examples of the sorts of topics that might be covered during a health and development review.

	<b>Examples of topics</b>
<b>Pregnancy</b>	<ul style="list-style-type: none"> <li>• Assessment of the overall health and wellbeing of the mother</li> <li>• Screening for any conditions that may have an impact on mother or baby</li> <li>• Smoking in either parent</li> <li>• Folic acid and other dietary or lifestyle advice as required</li> <li>• Breastfeeding (including both parents' attitudes)</li> <li>• Mental health</li> <li>• Feelings about pregnancy</li> <li>• Assessment of risks and protective factors</li> <li>• Couple relationship</li> <li>• Assessment of the father's health and wellbeing</li> </ul>
<b>The child</b>	<ul style="list-style-type: none"> <li>• General physical health</li> <li>• Emotional, behavioural and social development</li> <li>• Physical development</li> <li>• Speech and language development</li> <li>• Self-care skills and independence</li> <li>• Evaluation of the attachment between the child and its mother and father</li> <li>• Vision and hearing</li> <li>• Immunisations</li> </ul>
<b>Parenting</b>	<ul style="list-style-type: none"> <li>• Emotional warmth/stability</li> <li>• Caregiving</li> <li>• The father's contribution</li> <li>• Ensuring safety and protection</li> <li>• Guidance, boundaries and stimulation</li> </ul>

	<b>Examples of topics</b>
<b>Parenting (continued)</b>	<ul style="list-style-type: none"> <li>• Supporting the child's cognitive development through interaction, talking and play</li> <li>• Factors that have an impact on the parents' ability to parent (problems such as mental ill health, poor housing, domestic violence, substance misuse, low basic skills, learning difficulties, physical health problems or experience of poor parenting as a child)</li> <li>• The need for parental support and/or access to formal parenting programmes for both parents</li> <li>• Provision of care that promotes and protects the health of the child, including feeding and diet, home and travel safety, and smoking</li> <li>• Provision of contraceptive advice to avoid unplanned second pregnancies</li> <li>• The benefits of taking up free early childcare for three- and four-year-olds</li> </ul>
<b>Family</b>	<ul style="list-style-type: none"> <li>• Family and social relationships</li> <li>• The family's health and wellbeing</li> <li>• The wider family, including carers such as grandparents</li> <li>• Housing, employment and financial considerations</li> <li>• Social and community elements and resources, including education</li> <li>• Separated parents, relationships and domestic abuse</li> <li>• Identification of risk factors for health and wellbeing (smoking, diet, activity level, alcohol consumption, drug taking, a family history of mental health, etc.)</li> <li>• Identification of familial and cultural issues that influence lifestyle</li> <li>• Access to support from extended family and friends, and cultural support networks (e.g. faith networks)</li> <li>• Housing, safety and community resources</li> <li>• Signposting to services and resources</li> <li>• Referral to specialist services if required</li> </ul>

It is important to avoid a 'tick box approach' when undertaking a health and development review, and it should always be undertaken in partnership with the parents. Parents want a process that recognises their strengths, concerns and aspirations for their child. Health professionals need to use consultation skills, purposeful listening skills and guiding questions to ensure that the goals of the CHPP are aligned with the goals of the parents – while not losing the focus of the review. Promotional interviewing, motivational interviewing and strength-based approaches are emerging as useful methods.

### **Antenatal and postnatal promotional interviews**

Antenatal and postnatal promotional interviews (see the Centre for Parent and Child Support website for further information<sup>5</sup>) provide practitioners with a proactive and non-stigmatising approach to promoting the early psychosocial development of babies and the transition to parenthood. They provide a structured way of working with mothers and fathers during pregnancy and the postnatal period, helping them to explore their situation and to make more informed decisions about their family's needs.

Promotional interviews involve:

- using a respectful and flexible approach to explore the mother and father's feelings, attitudes and expectations in relation to the pregnancy, the birth and the growing relationship with the baby;
- listening to mothers and fathers carefully, encouraging them as necessary to find solutions for themselves;

- empowering parents to develop effective strategies that build resilience, facilitate infant development and enable them to adapt to their parenting role; and
- enabling parents to recognise and use their own strengths and those of their informal networks, as well as formal services if appropriate.

## **Screening**

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

UK National Screening Committee

Screening is an integral part of the universal CHPP. All the screening programmes in the CHPP have met the criteria laid down by the National Screening Committee. Screening programmes require local implementation of an agreed pathway, including clear guidelines on referral to assessment and differential diagnostic services. Data and information systems should be capable of supporting the pathway, delivering a fail-safe service and performance management of the screening programme. A nominated lead of the local screening programme should be responsible for access to screening, diagnosis and appropriate management of cases. The lead should also facilitate arrangements for quality

assurance and improvement of these services, which is key to delivering improvements in outcomes through an equitable and universal service.

Childhood screening programmes are under continual review, and this update reflects the current evidence. Further information on screening is provided on the National Screening Committee website.<sup>6</sup>

## Summary of the screening schedule for the CHPP

### Antenatal

The first opportunity will be the assessment of the mother by 12 weeks of pregnancy.

Antenatal screening for fetal conditions to be carried out according to NICE guidelines. See the guidelines on antenatal care from NICE<sup>7</sup> for more information.

### Newborn

Immediate physical external inspection after birth.

Newborn Hearing Screening Programme (within four weeks if a hospital-based programme or five weeks if community-based).

### By 72 hours

Physical examination:

- cardiac;
- all babies should have a clinical examination for developmental dysplasia of the hips. Those with an abnormality of the hips on examination or a risk factor should, in addition, have an ultrasound examination;
- eyes;
- testes (boys);
- general examination; and
- matters of concern.

### Five to eight days (ideally five days)

- Bloodspot screening.
- Biochemistry – hypothyroidism, phenylketonuria, cystic fibrosis, medium chain acyl-coA dehydrogenase deficiency.
- Haematology – haemoglobinopathies.

### Six to eight weeks

Physical examination:

- cardiac;
- developmental dysplasia of the hips;
- eyes;
- testes (boys);
- general examination; and
- matters of concern.

### By five years

To be completed soon after school entry:

- Pre-school hearing screen – commissioners must ensure that there is easy access for children of all ages to audiology services throughout childhood.
- All children should be screened for visual impairment between four and five years of age by an orthoptist-led service.

## Immunisations

Immunisations should be offered to all children and their parents. General practices and child health record departments maintain a register of children under five years, invite families for immunisations and maintain a record of any adverse reactions on the GP record.

Where necessary, local planning should aim to target excluded or at-risk families (including refugees, the homeless, travelling families, very young mothers, those not registered with a GP and those who are new to an area). The current routine immunisation

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<sup>6</sup> [www.nsc.nhs.uk/ch\\_screen/child\\_ind.htm](http://www.nsc.nhs.uk/ch_screen/child_ind.htm)

<sup>7</sup> [www.nice.org.uk/CG006](http://www.nice.org.uk/CG006)

schedule, together with additional vaccines recommended for some groups, can be found at [www.immunisation.nhs.uk](http://www.immunisation.nhs.uk).

At every contact, members of the CHPP team should identify the immunisation status of the child. The parents or carers should be provided with good-quality, evidence-based information and advice on immunisations, including the benefits and possible adverse reactions. Every contact should be used to promote immunisation. In addition, those immunising children should use the opportunity to promote health and raise wider health issues with parents.

### Promotion of social and emotional development

More is known today than ever about the neurological development of infants, and the impact of poor attachment and negative parenting on a child's physical, cognitive and socio-emotional development – not only in childhood, but also as a key determinant of adult health.

The CHPP includes opportunities for parents and practitioners to review a child's social and emotional development, for the practitioner to provide evidence-based advice and guidance, and for the practitioner to decide when specialist input is needed. Practitioners need to listen well, observe carefully, understand when things are going wrong and be able to deal with this sensitively.

### Support for parenting

One of the core functions of the CHPP is to support parenting using evidence-based programmes and practitioners who are trained and supervised. The new National Academy

for Parenting Practitioners will build on our knowledge of what works best.

Core features of successful parenting programmes include:

- practitioners establishing a relationship with both parents based on trust and respect;
- recognising parents' knowledge about their own child, and adapting the CHPP to make sure that it is in line with their goals and aspirations for themselves and their child;
- considering the whole family and the impact of wider family issues on the child;
- focusing on parents' strengths;
- focusing on empowering parents – understanding that self-efficacy is an essential part of behavioural change;
- the ability to promote attachment, laying the foundations for a child's trust in the world, and its later capacity for empathy and responsiveness;
- involving fathers, ensuring that they are well informed and making them feel welcome;
- monitoring the effectiveness of local services at engaging with and supporting fathers, including those in socially excluded groups;
- an understanding of family relationships and the impact of becoming a parent;
- an appreciation of the factors that affect parenting capacity and health, and an understanding of the interplay between risk and resilience;
- recognising and addressing mental health problems in either parent; and
- ensuring that practitioners have consultation skills and the ability to assess risk and protective factors.

## Keeping the family in mind

Those delivering the CHPP have always recognised the importance of the family in influencing outcomes for children. The CHPP needs to look beyond the child to their family

context, reviewing family health as a whole, working in partnership with adult services and building family strengths and resources (Social Exclusion Task Force, 2007).

### Good practice for engaging fathers in the CHPP

- From the beginning, promote the father's role as being important to his child's outcomes.
  - Make it explicit that the CHPP is there for the whole family – including the father – and demonstrate this by providing suitable seating for him as well as for the mother. Address him directly, encourage him to speak and make it clear that you are listening.
  - Arrange meetings, services, groups and reviews to maximise the possibility of fathers attending. Stress the importance of their presence to both them and the mother.
  - Include positive images of fathers from different ethnic groups and of different ages in the literature that you produce and display.
  - Record fathers' details – including those of non-resident fathers. Most mothers will give this information willingly, and two in three pregnant women who are not living with the father of their child describe him as 'a good friend' or as their partner.
  - Include an assessment of the father's needs as well as the mother's, as these will have a direct impact on both the mother and the child.
- Include an assessment of the father's health behaviours (e.g. in relation to diet, smoking, and alcohol or drug use), asking him directly wherever possible. These behaviours have a direct impact on both the mother and the child, and specifically on the mother's own health behaviours.
  - Signpost fathers to all of the relevant services.
  - Make sure that fathers (as well as mothers) are in possession of information about, for example, the benefits of stopping smoking and strategies for doing so. Where possible, provide fathers with this information directly (rather than second-hand, via the mother) and ensure that it also incorporates information on their role in relation to their child.
  - Offer antenatal preparation to fathers, including at times that will be convenient for working fathers (e.g. evenings). This will also make it easier for working mothers to attend.

For further information, see the Fatherhood Institute website at [www.fatherhoodinstitute.org](http://www.fatherhoodinstitute.org) and *Including New Fathers* (Fathers Direct, 2007).

## Effective promotion of health and behavioural change

The CHPP should be based on NICE's public health guidance on behavioural change at the population, individual and community level (NICE, 2007).

NICE recommendations for the delivery of individual-level interventions and programmes include selecting interventions that motivate and support people to:

- understand the short-, medium- and longer-term consequences of their health-related behaviour for themselves and others;
- feel positive about the benefits of health-enhancing behaviours and changing their behaviours;
- plan their changes in terms of easy steps over time;
- recognise how their social contexts and relationships may affect their behaviour, and identify and plan for situations that might undermine the changes they are trying to make;
- plan explicit 'if/then' coping strategies to prevent relapse;
- make a personal commitment to adopt health-enhancing behaviours by setting (and recording) goals to undertake clearly defined behaviours, in particular contexts, over a specified time; and
- share their behaviour change goals with others.

## Prevention of obesity

The Government's obesity strategy (Cross-Government Obesity Unit, 2008) sets out a comprehensive action plan to tackle the rise in obesity at every level – from action by individuals to action by the Government itself. The strategy includes guidance on preventing obesity in pregnancy and the first years of life, as well as obesity in adults.

The following factors will help to prevent obesity:

- An assessment at 12 weeks of pregnancy, and advice on healthy weight gain during pregnancy.
- Making breastfeeding the norm for parents – evidence shows that breastfeeding reduces the risk of excess weight in later life.
- Delaying weaning until around six months of age, introducing children to healthy foods and controlling portion size.
- Identifying early those children and families who are most at risk (e.g. where either the mother or the father is overweight or obese, or where there is rapid weight gain in the child).
- Encouraging an active lifestyle.
- For some families, skilled professional guidance and support is needed. The health professional should work in partnership with the family – setting small goals, using strength-based methods and exploring family relationships and past life experiences.

## Promotion of breastfeeding

- Breastfeeding initiation in England and Wales has increased from 71 per cent in 2000 to 77 per cent in 2005.
- In 2005, 78 per cent of all mothers began breastfeeding. But by the time their babies were six weeks old, the rate was only 50 per cent.
- The prevalence and duration of breastfeeding has increased across the UK, with the greatest increases among older mothers, mothers from higher socio-economic groups and mothers with higher educational levels.
- In England in 2005, 46 per cent of mothers were exclusively breastfeeding at one week. At six weeks, only 22 per cent were exclusively breastfeeding.
- Young women in low-income areas with lower educational levels are least likely to initiate and continue breastfeeding.
- Many young mothers lack access to key sources of advice and information – such as antenatal classes, peer support programmes, friends, family and other support networks.

Breastfeeding is a priority for improving children's health: research continues to emphasise the importance of breast milk as the best nourishment for babies aged up to six months. Breastfeeding can play an important role in reducing health inequalities.

There are many examples of successful local breastfeeding initiatives, and of voluntary organisations and community groups playing an important role in promoting

and supporting breastfeeding. However, more needs to be done to increase the initiation and continuation of breastfeeding – especially among young, disadvantaged mothers (Scientific Advisory Committee on Nutrition, 2008).

The Government has introduced a new PSA indicator for breastfeeding, and will monitor continuation at six to eight weeks. The CHPP can support delivery of this by:

- adopting UNICEF's Baby Friendly Initiative<sup>8</sup> (or similar) in all hospital and community providers;
- raising awareness of the health benefits of breastfeeding – as well as the risks of not breastfeeding;
- raising the topic of breastfeeding whenever possible during antenatal consultations;
- developing the skills of health professionals so that they are able to support mothers;
- making sure that there is easy access to professional advice at times of need;
- providing peer support – especially during the early weeks – to establish and continue breastfeeding;
- routinely informing fathers about the health benefits of breastfeeding, giving them advice and encouraging them to be supportive about breastfeeding – the father's involvement is a key predictor of breastfeeding initiation and maintenance;
- using children's centres to make antenatal and postnatal services more accessible to hard-to-reach groups;

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<sup>8</sup> [www.babyfriendly.org.uk](http://www.babyfriendly.org.uk)

- increasing awareness of breastfeeding among young and low-income mothers by discussing breastfeeding during pregnancy and providing support to tackle the barriers;
- raising the profile of the Healthy Start initiative, whereby mothers receive advice on healthy eating and breastfeeding; and
- avoiding the use of inappropriate commercially sponsored promotional material.

### Additional preventive programmes for children and families

In addition to the core universal programme, the CHPP schedule includes a number of evidence-based preventive interventions, programmes and services that make up a progressive universal service. It will be for local children's commissioners (working with local parenting commissioners) to determine which of the progressive services are offered locally – and by whom.

The progressive services have been selected following a systematic review (by the University of Warwick) of health-led parenting interventions during pregnancy and the first three years of life.

The Commissioners' Toolkit<sup>9</sup> that is currently being developed and maintained by the National Academy for Parenting Practitioners will help commissioners of parenting interventions to choose programmes based on information about their degree of success with different groups of parents.

The additional support needed by some parents will depend on their individual risks, needs and choices. For the 'middle range' of need, the additional support may consist of access to groups, access to practical support or a small number of additional contacts with one of a number of primary care or children's practitioners.

The University of Warwick's review of the evidence highlighted the partnership between practitioners and parents as being key to delivering the CHPP effectively. If this partnership is in place, the practitioner can take advantage of other effective techniques for promoting sensitive parenting, maintaining infant health or supporting health promotion more generally.

In addition, the University of Warwick review provides evidence for:

- an assessment of need that explores with the parents their views and feelings about their current situation, with the practitioner listening in a respectful and non-judgemental manner;
- supporting both parents to develop problem-solving strategies that enable them to address any issues that they have identified;
- empowering approaches in which mothers and fathers recognise and use their strengths, developing effective strategies that build resilience; and
- enabling families to identify informal networks of support to develop their self-efficacy.

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<sup>9</sup> [www.parentingacademy.org/napcontent.aspx?page=commstoolkit](http://www.parentingacademy.org/napcontent.aspx?page=commstoolkit)



This way of working with parents underpins a number of evidence-based services in the middle range of need and risk, such as the Family Partnership Model,<sup>10</sup> the Solihull Approach<sup>11</sup> and promotional interviewing – as well as intensive programmes such as the Family Nurse Partnership programme.

### **Families with higher levels of risk or need**

Evidence from experimental studies of early childhood programmes suggests that intensive structured programmes delivered by skilled nurses (such as health visitors) can improve the outcomes of the most at-risk children and families. These programmes can also produce significant cost benefits – especially when supported by high-quality early education, access to universal healthcare and reductions in poverty (Center on the Developing Child, 2007).

One of the most promising such programmes is the Family Nurse Partnership programme (Olds, 2006), which is being tested in

England. This is a nurse-led, intensive home-visiting preventive programme for the most at-risk young, first-time parents. The programme begins in early pregnancy and continues until the child is two years old. It recognises the importance of pregnancy and the first years of life in influencing children's life chances, and is offered to first-time at-risk parents. The programme capitalises on the receptiveness of parents in early pregnancy and on their willingness at this stage to protect and do the best for their child.

The Family Nurse Partnership programme has achieved impressive results in the US, where it has been developed over 30 years, backed up by a rigorous programme of research. It is too early to assess what the impact of the programme will be in this country, but early learning looks promising. As well as helping the most vulnerable, the Family Nurse Partnership principles and methods have wider application for universal services.

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<sup>10</sup> [www.cpcs.org.uk](http://www.cpcs.org.uk)

<sup>11</sup> [www.solihull.nhs.uk/solihullapproach/](http://www.solihull.nhs.uk/solihullapproach/)

# The CHPP schedule

The following schedule sets out both the core universal programme to be commissioned and provided for all families, and additional preventive elements that the evidence suggests may improve outcomes for children with medium- and high-risk factors. The detailed content of the programme will always be 'work in progress', as research and social changes continue to suggest new priorities for the CHPP.

The intensity of preventive intervention will depend on assessment at family level. The purpose is to promote the health and wellbeing of children – from pre-birth through to adulthood – using a co-ordinated programme of evidence-based prevention and early intervention. Family circumstances may change over time, risks will impact differently, and categories need to be flexible in the real world. Professional assessment of risk and protective factors will underpin decision making.

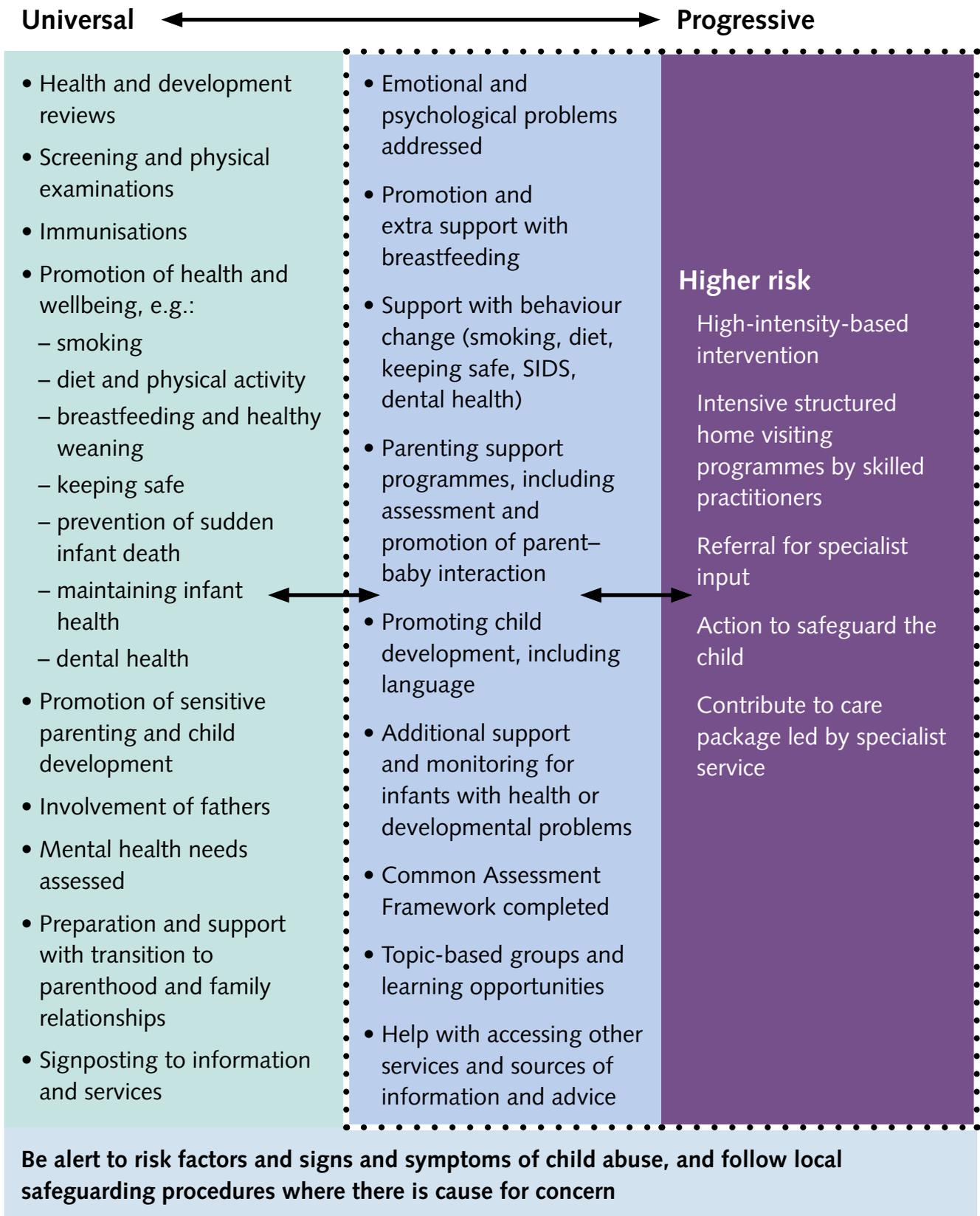
Commissioners and practitioners will want to offer services that are proven to make a difference and to be cost-effective. The services, programmes and interventions listed in the 'Progressive' sections below are based on the review carried out by the University of Warwick. They represent the range of 'best buy', evidence-based services that commissioners will wish to consider when making decisions about the range of services to be offered to families with young children. The services will be provided in a range of settings and increasingly in Sure Start children's centres, as well as in general practice.



Commissioners should endeavour to commission evidence-based programmes and to consider the following when making decisions:

- Is the programme well defined?
- Who is it for? Does it have a clear target group?
- Is it based on a well-tested theory, e.g. attachment theory, social learning theory?
- Is there a manual to ensure that it is delivered consistently?
- Is it explicit what parents will get, i.e. more than support?
- What are the workforce requirements that are needed to deliver the programme, i.e. training, competences and supervision?

## CHPP – an overview



### Promotion of health and wellbeing

- A full health and social care assessment of needs, risks and choices by 12 weeks of pregnancy by a midwife or maternity healthcare professional.
- Notification to the CHPP team of prospective parents requiring additional early intervention and prevention (see page 15).
- Routine antenatal care and screening for maternal infections, rubella susceptibility, blood disorders and fetal anomalies. Health and lifestyle advice to include diet, weight control, physical activity, smoking, stress in pregnancy, alcohol, drug intake, etc. See NICE guidance on antenatal care CG 6 (National Collaborating Centre for Women's and Children's Health, 2003).
- Distribution of *The Pregnancy Book*<sup>12</sup> to first-time parents; access to written/online information about, and preparation for, childbirth and parenting; distribution of antenatal screening leaflet.
- Discussion on benefits of breastfeeding with prospective parents – and risks of not breastfeeding.
- Introduction to resources, including Sure Start children's centres, Family Information Services, primary healthcare teams, and benefits and housing advice.
- Support for families whose first language is not English.

### Preparation for parenthood

To begin early in pregnancy and to include:

- information on services and choices, maternal/paternal rights and benefits, use of prescription drugs during pregnancy, dietary considerations, travel safety, maternal self-care, etc.; and
- social support using group-based antenatal classes in community or healthcare settings that respond to the priorities of parents and cover:
  - the transition to parenthood (particularly for first-time parents); relationship issues and preparation for new roles and responsibilities; the parent–infant relationship; problem-solving skills (based on programmes such as Preparation for Parenting, First Steps in Parenting, One Plus One<sup>13</sup>);
  - the specific concerns of fathers, including advice about supporting their partner during pregnancy and labour, care of infants, emotional and practical preparation for fatherhood (particularly for first-time fathers);
  - discussion on breastfeeding using interactive group work and/or peer support programmes; and
  - standard health promotion.

12 [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_074920](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074920)

13 [www.oneplusone.org.uk/](http://www.oneplusone.org.uk/)

### **Ambivalence about pregnancy, low self-esteem and relationship problems**

Problems should be addressed using:

- techniques to promote a trusting relationship and develop problem-solving abilities within the family (e.g. promotional/motivational interviewing; the Family Partnership Model;<sup>14</sup> and the Solihull approach<sup>15</sup>):
  - establish what individual support needs are;
  - provide one or two structured listening support contacts;
  - work in partnership with families to develop problem-solving skills;
- support to access antenatal care; and
- preparation for parenthood (which could include separate sessions for fathers only).

### **Women experiencing anxiety/depression in addition to the problems above**

- If no previous episode of depression or anxiety: social support (individual or group-based, including antenatal groups and parenting classes); assisted self-help (computerised cognitive behavioural therapy; self-help material presented to a group or individuals, by a health worker/para-professional).
- For women with previous episodes of non-clinical symptoms of depression and anxiety: brief (four to six weeks), non-directive counselling delivered at home (listening visits<sup>16</sup>) by skilled professionals, and access to local social support; or referral for brief psychological treatments (such as cognitive behavioural therapy or interpersonal therapy).

### **Women who smoke**

Women who smoke should be offered:

- smoking cessation interventions, including behavioural interventions combined with social support and incentives for achievement; and telephone counselling (NHS helplines);
- involvement of partners, if they agree, in the implementation of smoking-reduction/cessation programmes; and
- additional strategies, such as planning of smoke-free environments for children (e.g. areas within the home that are smoke-free).

### **Women who are overweight or obese**

Women who are overweight or obese should be offered:

- weight control strategies to reduce risks to both mother and baby;
- advice about healthy eating and physical activity; and/or
- referral to weight management services.

### **Breastfeeding**

- Discussion on infant feeding and support to tackle practical barriers to breastfeeding.
- Discussion of benefits and drawbacks for mother and child.
- Discussion with the prospective father.

<sup>14</sup> [www.cpcs.org.uk/](http://www.cpcs.org.uk/)

<sup>15</sup> [www.solihull.nhs.uk/solihullapproach/](http://www.solihull.nhs.uk/solihullapproach/)

<sup>16</sup> Listening visits are defined as unstructured, client-led discussions involving the counsellor in: active listening; reflection; providing empathic responses; encouraging the expression of experiences and accepting the emotions expressed; and not offering information or advice

### For parents at higher risk

Including at-risk first-time young mothers; parents with learning difficulties; drug/alcohol abuse; domestic violence; serious mental illness

#### At-risk first-time young mothers

- Intensive, evidence-based programmes that start in early pregnancy, such as the Family Nurse Partnership programme.<sup>17</sup>
- Multimodal support combining home visiting, peer support, life skills training and integration within social networks recommended for pregnant adolescents.

#### Parents with learning difficulties

- Information on support available to parents with learning disabilities, and assistance in interpreting information and accessing other sources of support.
- Specialist multi-agency support should include individual and group-based antenatal and parent education classes, and home visiting.
- Further support designed to address the parent's individual needs might include speech and language and occupational therapy.

#### Drug abuse

- Referral of one or both parents to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.
- Doula programmes (a combination of home visiting, role modelling and community supports) may also help to prevent attrition and increase sensitivity of mothers who are in recovery.

#### Alcohol abuse

- Referral of one or both parents to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.

#### Domestic violence

- Follow local guidelines.
- Following assessment, provision of a safe environment in which victims of domestic violence can discuss concerns.
- Provision of information about sources of support for domestic violence.
- Referral to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.

#### Serious mental illness

- Referral of one or both parents to specialist mental health/perinatal mental health service.
- CHPP team to contribute to care package led by specialist service.

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<sup>17</sup> Currently being tested in England

### Promotion of health and wellbeing

- Ongoing identification of families in need of additional support using criteria identified above (see page 31).
- As for pregnancy up to 28 weeks.

### Preparation for parenthood

- As for pregnancy up to 28 weeks (see page 31).
- Distribute the *Parent's Guide to Money* information pack, designed to help expectant parents plan their family finances.<sup>18</sup>

### Involvement of fathers

- As for pregnancy up to 28 weeks (see page 31).

### Antenatal review for prospective mother and father with CHPP team

- Focus on emotional preparation for birth, carer–infant relationship, care of the baby, parenting and attachment, using techniques such as promotional interviewing (see page 21) to:
  - identify those in need of further support during the postnatal period; and
  - establish what their support needs are.
- Inform about sources of information on infant development and parenting, the CHPP and Healthy Start.
- Distribute newborn screening leaflet.
- Provide information in line with Department of Health guidance on reducing the risk of sudden infant death syndrome (SIDS).
- Distribute and introduce Personal Child Health Record.

### Progressive (including Universal)

- As for pregnancy up to 28 weeks (see page 32).

### For parents at higher risk

- As for pregnancy up to 28 weeks (see page 33).

<sup>18</sup> Information on the *Parent's Guide to Money* is available at [www.fsa.gov.uk](http://www.fsa.gov.uk)

### Infant feeding

- Initiate as soon as possible (within one hour of delivery) using support from healthcare professional, or peer unless inappropriate; 24-hour rooming-in and continuing skin-to-skin contact where possible. Ongoing, consistent, sensitive, expert support about infant positioning. Provide information about the benefits of colostrum and timing of first breastfeed. Support should be culturally appropriate and should include both parents.
- Use the Baby Friendly Initiative<sup>18</sup> or a similar evidence-based best practice programme to promote breastfeeding.
- Provide information about local support groups.
- Parents and carers who feed with formula should be offered appropriate and tailored advice on safe feeding.
- Provide information on vitamin supplements and Healthy Start.
- Provide information and advice to fathers, to encourage their support for breastfeeding.

### Health promotion

- Distribution of Personal Child Health Record, if not already done antenatally.
- Distribution of *Birth to Five*<sup>19</sup> to all mothers.
- Injury prevention.

### Maintaining infant health

- Anticipatory, practical guidance on reality of early days with an infant, healthy sleep practices and bath, book, bed routine to increase parent–infant interaction, using a range of media (e.g. *Baby Express* newsletters<sup>20</sup>).

### Birth experiences

- Provide an opportunity for the father, as well as the mother, to talk about pregnancy and birth experiences, if appropriate.

### Promoting sensitive parenting

- Introduce parents to the 'social baby', by providing them with information about the sensory and perceptual capabilities of their baby using a range of media (e.g. *The Social Baby* book/video (Murray and Andrews, 2005) or *Baby Express* age-paced newsletters<sup>21</sup>) or validated tools (e.g. Brazelton<sup>22</sup> or Nursing Care Assessment Satellite Training – NCAST<sup>23</sup>).
- Promote closeness and sensitive, attuned parenting, by encouraging skin-to-skin care and the use of baby carriers.
- Provide information and support to fathers, as well as mothers, that responds to their individual concerns and involves active participation with, or observation of, their baby – over several sessions, if possible.

### Hearing screening

- Newborn hearing screening soon after birth (up to four weeks if a hospital-based programme, and five weeks if community-based).

18 [www.babyfriendly.org.uk/](http://www.babyfriendly.org.uk/)

19 [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_074924](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074924)

20 [www.thechildrensfoundation.co.uk/](http://www.thechildrensfoundation.co.uk/)

21 [www.thechildrensfoundation.co.uk/](http://www.thechildrensfoundation.co.uk/)

22 [www.brazelton.co.uk/](http://www.brazelton.co.uk/)

23 [www.ncast.org](http://www.ncast.org)

## Universal

### SIDS

- Reduction of the risk of SIDS – advice about sleeping position, smoking, co-sleeping, room temperature and other information in line with best evidence.<sup>24</sup>

### By 72 hours

- Comprehensive newborn physical examination to identify any anomalies that present in the newborn. This includes screening of the eyes, heart and hips (and the testes for boys), as well as a general examination. Where a woman is discharged from hospital before the physical examination has taken place, fail-safe arrangements should be in place to ensure that the baby is examined.
- Following identification of babies with health or developmental problems: early referral to specialist team; advice to parents on benefits that may be available; and invitation to join parent groups.
- Additional support and monitoring, as assessed by health professional.

### At five to eight days (ideally five)

- Screening for hypothyroidism, phenylketonuria, haemoglobinopathies and cystic fibrosis.
- Screening for medium chain acyl-coA dehydrogenase deficiency (MCADD) is already offered in half the country and will be universal from March 2009.
- Ongoing review and monitoring of baby's health, to include important health problems, such as weight loss.

### Within the first week

- Administration of vitamin K in accordance with protocol.

### Health protection – immunisation

- BCG is offered to babies who are more likely than the general population to come into close and prolonged contact with someone with tuberculosis.  
See [www.immunisation.nhs.uk](http://www.immunisation.nhs.uk)
- Hepatitis B vaccine is given to all babies of mothers who are hepatitis B carriers or where other household members are carriers of hepatitis B. The first dose is given shortly after birth.

For guidelines on postnatal care see *Routine Postnatal Care of Women and their Babies* (NICE, 2006).

### **Babies with health or developmental problems or abnormalities**

- Early referral to specialist team; advice on benefits that may be available; invitation to join parent groups.
- Package of additional support and monitoring as assessed by health professional.

### **Problems such as conflict with partner and lack of social support**

- Techniques to promote a trusting relationship and develop problem-solving abilities within the family (e.g. promotional/motivational interviewing; Family Partnership Model;<sup>25</sup> the Solihull approach;<sup>26</sup> and One Plus One Brief Encounters<sup>27</sup>) should be used to:
  - establish what individual support needs are;
  - provide one or two structured listening support visits;<sup>28</sup> and
  - work in partnership with families to develop problem-solving skills.

### **Promoting sensitive parenting**

- Assessment of parent–baby interaction using validated tools (e.g. NCAST).
- Sensitive, attuned parenting (by both mothers and fathers) should be promoted, using media-based tools (e.g. *The Social Baby* book/video (Murray and Andrews, 2005) or *Baby Express* newsletters<sup>29</sup>) or validated tools (e.g. Brazelton<sup>30</sup> or NCAST<sup>31</sup>).
- Information and support to the father, including opportunities for direct observation and interaction with the child.
- Individualised coaching (by a skilled professional) aimed at stimulating attuned

interactions at one day, two days and seven days and involving both fathers and mothers where possible.

### **Infant feeding and children at risk of obesity**

- Additional individual support and access to advice, to promote exclusive breastfeeding.
- Provide information about local support groups.
- Information on Healthy Start and vitamin supplements.
- Information on delay in introducing solids until six months.

### **Parents who smoke**

- Smoking cessation interventions should not be offered to women in the immediate postnatal period.
- Advice should include the prevention of exposure of infants to smoke and the creation of smoke-free areas within the home and cars.

### **SIDS**

- Advice on reducing the risk of SIDS when there are increased risks (e.g. smoking, co-sleeping) for demographically high-risk groups (e.g. first-time mothers, single mothers, families on low income).

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25 [www.cpcs.org.uk/](http://www.cpcs.org.uk/)

26 [www.solihull.nhs.uk/solihullapproach/](http://www.solihull.nhs.uk/solihullapproach/)

27 [www.oneplusone.org.uk/](http://www.oneplusone.org.uk/)

28 Listening visits are defined as unstructured, client-led discussions involving the counsellor in: active listening; reflection; providing empathic responses; encouraging the expression of experiences and accepting the emotions expressed; and not offering information or advice

29 [www.thechildrensfoundation.co.uk/](http://www.thechildrensfoundation.co.uk/)

30 [www.brazelton.co.uk/](http://www.brazelton.co.uk/)

31 [www.ncast.org](http://www.ncast.org)

### For families at higher risk

Including at-risk first-time young mothers; parents with learning difficulties; drug/alcohol abuse; domestic violence; serious mental illness

#### At-risk first-time young mothers

- Intensive evidence-based programmes that start in early pregnancy, such as the Family Nurse Partnership programme.<sup>32</sup>
- Multimodal support combining home visiting, peer support, life skills training and integration within social networks.

#### Parents with learning difficulties

- Information on support available to parents with learning disabilities, and assistance in interpreting information and accessing other sources of support.
- Specialist multi-agency support should include individual and group-based parent education classes, and home visiting.
- Further support designed to address the parent's individual needs might include speech, language and occupational therapy.

#### Drug abuse

- Referral of one or both parents to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.
- Doula programmes (a combination of home visiting, role modelling and community supports) may also help to prevent attrition and increase sensitivity of mothers who are in recovery.

#### Alcohol abuse

- Referral of one or both parents to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.

#### Domestic violence

- Follow local guidelines.
- Following assessment, provision of a safe environment in which victims of domestic violence can discuss concerns.
- Provision of information about sources of support for domestic violence.
- Referral to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.

#### Serious mental illness

- Referral of one or both parents to specialist mental health/perinatal mental health service.
- CHPP team to contribute to care package led by specialist service.

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<sup>32</sup> Subject to testing in England

**New baby review by 14 days with mother and father: face-to-face review by health professional, to include:**

### Infant feeding

- Use the Baby Friendly Initiative<sup>33</sup> or a similar evidence-based best practice programme to support continuation of breastfeeding.
- Individual support and access to advice to promote exclusive breastfeeding.
- Provide information and advice to fathers to encourage their support for breastfeeding.
- Provide information about local support groups.
- Information on Healthy Start and vitamin supplements.
- Information on delay in introducing solids until six months.
- Parents and carers who feed with formula should be offered appropriate and tailored advice on safe feeding.

### Promoting sensitive parenting

- Introduce both parents to the 'social baby', by providing them with information about the sensory and perceptual capabilities of their baby using media-based tools (e.g. *The Social Baby* book/video (Murray and Andrews, 2005) or *Baby Express* newsletters<sup>34</sup>) or validated tools (e.g. Brazelton<sup>35</sup> or NCAST<sup>36</sup>).
- Promote closeness and sensitive, attuned parenting, by encouraging skin-to-skin care and the use of soft baby carriers.
- Invitation to discuss the impact of the new baby on partner and family relationships.

- Temperament-based anticipatory guidance<sup>37</sup> and listening to parents' concerns. Examples of topics that parents may wish to discuss include: interacting with baby (e.g. songs and music, books); feeding, diet and nutrition; colic; sleep; crying; establishing a routine; safety and car seats; the immunisation programme; prevention of SIDS; changes in relationships; sex and intimacy after birth; contraception; and division of domestic chores.
- Use of media-based materials to support sensitive parenting (e.g. *Baby Express* newsletters).
- Information about the CHPP and roles of general practice, children's centres and other local resources.

### Promoting development

- Encouragement to use books, music and interactive activities to promote development and parent–baby relationship (e.g. media-based materials such as *Baby Express* newsletters and/or Bookstart<sup>38</sup>).
- Referring families whose first language is not English to English as a second language services.

33 [www.babyfriendly.org.uk/](http://www.babyfriendly.org.uk/)

34 [www.thechildrensfoundation.co.uk/](http://www.thechildrensfoundation.co.uk/)

35 [www.brazelton.co.uk/](http://www.brazelton.co.uk/)

36 [www.ncast.org](http://www.ncast.org)

37 Advice to help parents think about and understand individual infants' temperament and use of individualised childcare strategies, e.g. to address issues related to crying and sleeping

38 [www.bookstart.co.uk/](http://www.bookstart.co.uk/)

### Assessing maternal mental health

- Within 10–14 days of birth, women should be asked appropriate and sensitive questions to identify depression or other significant mental health problems, such as those recommended by the NICE guidelines on antenatal and postnatal mental health.<sup>39</sup>

### SIDS

- Reduction of the risk of SIDS – advice about sleeping position, smoking, co-sleeping, room temperature and other information in line with best evidence.<sup>40</sup>

### Keeping safe

- Home safety, especially the dangers of hot water and baby bouncers.

### During the first month of life

- If parents wish, or if there is professional concern, an assessment of a child's growth should be carried out. This involves accurate measurement, interpretation and explanation of the child's weight in relation to length, to growth potential and to any earlier growth measurements of the child.
- Ongoing review and monitoring of the baby's health, to include important health problems, such as weight loss and progressive jaundice.
- If hepatitis B vaccine has been given soon after birth, the second dose is given at one month of age.

### Jaundice, if prolonged

- Identification of prolonged jaundice and referral, when indicated, according to local protocol.

### Safeguarding

- Raise awareness of accident prevention, be alert to risk factors and signs and symptoms of child abuse, and follow local safeguarding procedures where there is cause for concern.

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<sup>39</sup> Within the context of the visit, the professional should explore possible depression. The following questions may be helpful: 'During the past month, have you often been bothered by feeling down, depressed or hopeless?' 'During the past month, have you often been bothered by having little interest or pleasure in doing things?' A third question should be considered if the woman answers 'yes' to either of the initial questions: 'Is this something you feel you need or want help with?'

<sup>40</sup> [www.fsid.org.uk](http://www.fsid.org.uk)

### **Babies with health or developmental problems or abnormalities, including prematurity and low birthweight**

- Early referral to specialist team; advice on benefits that may be available; invitation to join parent groups.
- Package of additional support and monitoring, as assessed by health professional and drawing on the Early Support Programme.<sup>41</sup>

### **Infant feeding**

- Additional encouragement and support to breastfeed exclusively.
- Peer support schemes (such as 'Best/Breast/Bosom Buddy') using local, experienced breastfeeders as volunteers; multimodal education/social support programmes combined with media campaigns.
- Ongoing communication with fathers about breastfeeding and their role in its maintenance.

### **Parents who smoke**

- Smoking cessation interventions should include: behavioural interventions combined with social support and incentives for achievement; and telephone counselling (NHS helplines).
- Partners should be involved in the implementation of smoking-reduction/cessation programmes.
- Additional strategies should include planning of smoke-free environments for children (e.g. areas within the home that are smoke-free), including cars.

### **SIDS**

- Advice to both parents on reducing the risk of SIDS when there are increased risks (e.g. advice about smoking, co-sleeping)

for parents from demographically high-risk groups (e.g. first-time mothers, single mothers, families on low income).

### **Children at risk of obesity**

- Promotion of breastfeeding using the Baby Friendly Initiative.<sup>42</sup>
- Offer of additional support to feed their baby, including advice about the deferral of weaning.
- Advice on nutrition and exercise for the whole family.
- Invitation to group-based postnatal weight reduction programmes.

### **Keeping safe**

- Home visits, including training on healthy sleep and correct use of basic safety equipment, and facilitating access to local schemes for the provision of safety equipment. Information about thermal injuries.
- Healthcare professionals should be alert to risk factors and signs and symptoms of child abuse, and should follow local child protection procedures where there is cause for concern.

### **Maintaining infant health**

- Temperament-based anticipatory guidance<sup>43</sup> – practical guidance on reality of early days with an infant, managing crying and healthy sleep practices, bath, book, bed routines and activities, and encouragement of parent–infant interaction using a range of media (e.g. *Baby Express* newsletters).

41 [www.earllysupport.org.uk](http://www.earllysupport.org.uk)

42 [www.babyfriendly.org.uk/](http://www.babyfriendly.org.uk/)

43 Advice to help parents think about and understand individual infants' temperaments, and use of individualised childcare strategies, e.g. to address issues related to crying and sleeping

#### Parenting support

- Techniques to promote a trusting relationship with both parents and to help them develop problem-solving abilities within the family (e.g. promotional/motivational interviewing; Family Partnership Model;<sup>44</sup> and the Solihull approach<sup>45</sup>) should be used to:
  - establish what individual support needs are;
  - provide one or two structured listening support visits; and
  - work in partnership with families to develop problem-solving skills.

#### Maternal depression

- Eight listening visits<sup>46</sup> or referral for brief cognitive behavioural or interpersonal therapy.
- Use of dyadic therapies<sup>47</sup> to increase maternal sensitivity, e.g. infant massage, interaction guidance.
- Postnatal parent–infant groups with enhanced components for fathers. Sessions should address and respond to the specific concerns of fathers, including support to partner, care of infants, and emotional issues arising from fatherhood. Enhanced postnatal support can include separate sessions with fathers and for fathers only.
- Recognition and referral of women with serious mental health problems.

#### Insensitive (i.e. intrusive or passive) parenting interactions

- Assessment of parent–baby interaction using validated tools (e.g. Brazelton<sup>48</sup> or NCAST<sup>49</sup>).
- Media-based tools (e.g. *The Social Baby* book/video (Murray and Andrews, 2005) or

*Baby Express* newsletters<sup>50</sup>) or validated tools (e.g. Brazelton<sup>51</sup> or NCAST<sup>52</sup>) should be used to promote sensitive, attuned parenting.

- Invitation to group-based parenting programmes (e.g. Mellow Parenting<sup>53</sup> or PIPPIN – the Parents in Partnership Parent Infant Network) or an infant massage group.
- Father–infant groups that promote opportunities for play and guided observation.

#### Parental relationships

- Parents in conflict should be offered access to parenting groups which address parental conflict using specially designed training resources (e.g. One Plus One First Encounters<sup>54</sup>).

#### Promoting development

- Book sharing and invitations to groups for songs, music and interactive activities (e.g. PEEP<sup>55</sup> or Bookstart<sup>56</sup>); *Baby Express* newsletters.<sup>57</sup>

44 [www.cpcs.org.uk](http://www.cpcs.org.uk)

45 [www.solihull.nhs.uk/solihullapproach/](http://www.solihull.nhs.uk/solihullapproach/)

46 Listening visits are defined as unstructured, client-led discussions involving the counsellor in: active listening; reflection; providing empathic responses; encouraging the expression of experiences and accepting the emotions expressed; and not offering information or advice

47 Dyadic therapies focus on both mother and baby and are aimed at improving the mother–baby relationship

48 [www.brazelton.co.uk/](http://www.brazelton.co.uk/)

49 [www.ncast.org](http://www.ncast.org)

50 [www.thechildrensfoundation.co.uk/](http://www.thechildrensfoundation.co.uk/)

51 [www.brazelton.co.uk/](http://www.brazelton.co.uk/)

52 [www.ncast.org](http://www.ncast.org)

53 [www.mellowparenting.org/](http://www.mellowparenting.org/)

54 [www.oneplusone.org.uk/](http://www.oneplusone.org.uk/)

55 [www.peep.org.uk/](http://www.peep.org.uk/)

56 [www.bookstart.co.uk/](http://www.bookstart.co.uk/)

57 [www.thechildrensfoundation.co.uk/](http://www.thechildrensfoundation.co.uk/)

### For families at higher risk

Including at-risk first-time young mothers; parents with learning difficulties; drug/alcohol abuse; domestic violence; serious mental illness

#### At-risk first-time young mothers

- Intensive home visiting programmes by skilled practitioners beginning in early pregnancy and continuing for at least 12 months postnatally, such as the Family Nurse Partnership programme.
- Multimodal support combining home visiting, peer support, life skills training and integration within social networks.

#### Seriously inadequate parent–infant interaction or child protection concerns (either parent)

- Referral to specialist services.
- Referral to attachment-oriented or parent–infant psychotherapy interventions.

#### Parents with learning difficulties

- Provision of information about the support available to parents with learning disabilities, and assistance in interpreting information and accessing other sources of support.
- Establishing ongoing community support network.
- Specialist multi-agency support should include individual and group-based antenatal and parent education classes, and home visiting.
- Further support designed to address the parent's individual needs might include speech, language and occupational therapy.

#### Drug abuse

- Referral of one or both parents to local specialist services as part of a multi-agency strategy.

- CHPP team to contribute to care package led by specialist service.
- Doula programmes (a combination of home visiting, role modelling and community supports) may also help to prevent attrition and increase sensitivity of mothers who are in recovery.

#### Alcohol abuse

- Referral of one or both parents to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.

#### Domestic violence

- Follow local guidelines.
- Following assessment, provision of a safe environment in which victims of domestic violence can discuss concerns.
- Provision of information about sources of support for domestic violence.
- Referral to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.

#### Serious mental illness

- Referral of either parent to specialist mental health/perinatal mental health service.
- CHPP team to contribute to care package led by specialist service.

### Breastfeeding

- Ongoing support involving both parents.

### Health review at six to eight weeks

- A comprehensive physical examination, with emphasis on eyes, heart and hips (and the testes for boys).
- Baby's feeding status to be recorded – breastfeeding, bottlefeeding or mixed feeding.
- Review of general progress and delivery of key messages about parenting and baby's health, including eating and activity, weaning and accident prevention. Information about play and appropriate activities.
- Baby's weight and length should be measured and plotted, where there are concerns.

### Assessing maternal mental health

- Assessment of the mother's mental health at six to eight weeks and three to four months, by asking appropriate questions for the identification of depression, such as those recommended by the NICE guidelines on antenatal and postnatal mental health.<sup>58</sup>

### At eight weeks

- Immunisation against diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenzae* type b, and pneumococcal infection. **At every immunisation, parents should have the opportunity to raise any concerns about caring for their baby and their health and development, and should be provided with information or sources of advice.**
- If hepatitis B vaccine has been given after birth, the third dose is given at eight weeks.

### At three to four months

- Supporting parenting by providing access to parenting and child health information and guidance (telephone helplines, websites, NHS Direct, etc.), and information on children's centres and family information services.
- Immunisations at **three months** against diphtheria, tetanus, pertussis, polio, *Haemophilus influenzae* type b and meningococcus group C.
- Immunisations at **four months** against diphtheria, tetanus, pertussis, polio, *Haemophilus influenzae* type b, pneumococcal infection and meningococcus group C.
- If parents wish, or if there is or has been professional concern about a child's growth or risk to normal growth (including obesity), an assessment should be carried out. This involves accurate measurement, interpretation and explanation of the child's weight in relation to length, to growth potential and to any earlier growth measurements of the child.

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<sup>58</sup> Within the context of the visit, the professional should explore possible depression using the following questions: 'During the past month, have you often been bothered by feeling down, depressed or hopeless?' 'During the past month, have you often been bothered by having little interest or pleasure in doing things?' A third question should be considered if the woman answers 'yes' to either of the initial questions: 'Is this something you feel you need or want help with?'

### **Maintaining infant health**

- Temperament-based anticipatory guidance<sup>59</sup> – practical guidance on managing crying and healthy sleep practices, bath, book, bed routines and activities, and encouragement of parent–infant interaction using a range of media-based interventions (e.g. *Baby Express* newsletters<sup>60</sup>).

### **Promoting development**

- Encouragement to use books, music and interactive activities to promote development and parent–baby relationship (e.g. media-based materials such as *Baby Express* newsletters and/or Bookstart<sup>61</sup>).

### **Keeping safe**

- Raise awareness of accident prevention in the home and safety in cars
- Be alert to risk factors and signs and symptoms of child abuse.
- Follow local safeguarding procedures where there is cause for concern.

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<sup>59</sup> Advice to help parents think about and understand individual infants' temperament, and use of individualised childcare strategies, e.g. to address issues related to crying and sleeping.

<sup>60</sup> [www.thechildrensfoundation.co.uk/](http://www.thechildrensfoundation.co.uk/)

<sup>61</sup> [www.bookstart.co.uk/](http://www.bookstart.co.uk/)

### **Babies with health or developmental problems or abnormalities**

- Early referral to specialist team; advice on benefits that may be available; invitation to join parent support group.
- Package of additional support and monitoring, as assessed by health professional drawing on the Early Support Programme.

### **Infant feeding and children at risk of obesity**

- Additional encouragement and support to breastfeed exclusively.
- Ongoing communication with fathers about breastfeeding and their role in its maintenance.
- Peer support schemes (such as 'Best/Breast/Bosom Buddy') using local, experienced breastfeeders as volunteers; multimodal education/social support programmes combined with media campaigns.
- Promotion of Baby Friendly Initiative.<sup>62</sup>
- Offer of additional support in feeding the baby, including advice about the deferral of weaning.
- Advice on nutrition and physical activity for the family.

### **Parents who smoke**

- Smoking cessation interventions should include: behavioural interventions combined with social support and incentives for achievement; and telephone counselling (NHS helplines).

- Partners should be involved in the implementation of smoking-reduction/cessation programmes.
- Additional strategies should include planning of smoke-free environments for children (e.g. areas within the home that are smoke-free), including cars.

### **SIDS**

- Reduction of the risk of SIDS – advice about sleeping position, smoking, co-sleeping, room temperature and other information in line with best evidence<sup>63</sup>.

### **Keeping safe**

- Home visits, including training on healthy sleep and correct use of basic safety equipment, and facilitating access to local schemes for the provision of safety equipment. Information about thermal injuries.
- Healthcare professionals should be alert to risk factors and signs and symptoms of child abuse, and should follow local child protection procedures where there is cause for concern.
- Advice about reducing the risk of SIDS where there are increased risks (e.g. sleeping position, smoking, co-sleeping).

<sup>62</sup> [www.babyfriendly.org.uk/](http://www.babyfriendly.org.uk/)

<sup>63</sup> [www.fsid.org.uk](http://www.fsid.org.uk)

#### Parenting support

- Techniques to promote a trusting relationship and develop problem-solving abilities within the family (e.g. promotional/motivational interviewing; Family Partnership Model;<sup>64</sup> and the Solihull approach<sup>65</sup>) should be used to:
  - establish what both parents' individual support needs are;
  - provide one or two structured listening support visits; and
  - work in partnership with families to develop problem-solving skills.

#### Maternal depression

- Eight listening visits<sup>66</sup> or referral for brief cognitive behavioural or interpersonal therapy.
- Use of dyadic therapies<sup>67</sup> to increase maternal sensitivity, e.g. infant massage, interaction guidance.
- Postnatal parent–infant groups with enhanced components for fathers. Sessions should address and respond to the specific concerns of fathers, including support to partner, care of infants, and emotional issues arising from fatherhood. Enhanced postnatal support can include separate sessions with fathers and for fathers only.

#### Insensitive (i.e. intrusive or passive) parenting interactions

- Assessment of parent–baby interaction using validated tools (e.g. NCAST<sup>68</sup>).
- Media-based tools (e.g. *The Social Baby* book/video (Murray and Andrews, 2005) or *Baby Express* newsletters<sup>69</sup>) or validated tools (e.g. Brazelton<sup>70</sup> or NCAST<sup>71</sup>) may be used to promote sensitive, attuned parenting.
- Invitation to group-based parenting programmes (e.g. Mellow Parenting<sup>72</sup> or PIPPIN – the Parents in Partnership Parent Infant Network) or an infant massage group.
- Father–infant groups that promote opportunities for play and guided observation.

#### Parental relationships

- Parents in conflict should be offered access to parenting groups which address parental conflict using specially designed training resources (e.g. One Plus One Brief Encounters<sup>73</sup>).

64 [www.cpcs.org.uk/](http://www.cpcs.org.uk/)

65 [www.solihull.nhs.uk/solihullapproach/](http://www.solihull.nhs.uk/solihullapproach/)

66 Listening visits are defined as unstructured, client-led discussions involving the counsellor in: active listening; reflection; providing empathic responses; encouraging the expression of experiences and accepting the emotions expressed; and not offering information or advice

67 Dyadic therapies focus on both mother and baby and are aimed at improving the mother–baby relationship

68 [www.ncast.org](http://www.ncast.org)

69 [www.thechildrensfoundation.co.uk/](http://www.thechildrensfoundation.co.uk/)

70 [www.brazelton.co.uk/](http://www.brazelton.co.uk/)

71 [www.ncast.org](http://www.ncast.org)

72 [www.mellowparenting.org/](http://www.mellowparenting.org/)

73 [www.oneplusone.org.uk/](http://www.oneplusone.org.uk/)

### For families at higher risk

Including at risk first-time young mothers; parents with learning difficulties; drug/alcohol abuse; domestic violence; serious mental illness

#### At-risk first-time young mothers

- Intensive home visiting programmes by skilled practitioners, such as the Family Nurse Partnership programme.
- Multimodal support combining home visiting, peer support, life skills training and integration within social networks.

#### Seriously inadequate parent–infant interaction or child protection concerns

- Referral to specialist services.
- Referral to attachment-oriented or parent–infant psychotherapy services.

#### Parents with learning difficulties

- Provision of information about the support available to parents with learning disabilities, and assistance in interpreting information and accessing other sources of support.
- Establishing ongoing community support networks.
- Specialist multi-agency support should include individual and group-based antenatal and parent education classes, and home visiting.
- Further support designed to address the parent's individual needs might include speech, language and occupational therapy.

#### Drug abuse

- Referral to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.

- Doula programmes (a combination of home visiting, role modelling and community supports) may also help to prevent attrition and increase sensitivity of mothers who are in recovery.

#### Alcohol abuse

- Referral to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.

#### Domestic violence

- Follow local guidelines.
- Following assessment, provision of a safe environment in which victims of domestic violence can discuss concerns.
- Provision of information about sources of support for domestic violence.
- Referral to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.

#### Serious mental illness

- Referral to specialist mental health/perinatal mental health service.
- CHPP team to contribute to care package led by specialist service.

#### **Around seven to nine months**

- Distribution of Bookstart<sup>74</sup> pack for babies.

#### **Health review by one year**

- Assessment of the child's physical, emotional and social needs in the context of their family, including predictive risk factors.
- An opportunity for both parents to talk about any concerns that they may have about their baby's health.
- Supporting parenting – provide parents with information about attachment and the type of developmental issues that they may now encounter (e.g. clinginess or anxiety about being separated from one particular parent or carer).
- Monitoring growth – if there is parental or professional concern about a child's growth or risk to normal growth (including obesity), an assessment should be carried out. This involves accurate measurement, interpretation and explanation of the child's weight in relation to height, to growth potential and to any earlier growth measurements of the child. A decision should be made as to whether follow-up or an intervention is appropriate, and agreement with the family should be sought.
- Health promotion – raise awareness of dental health and prevention, healthy eating, injury and accident prevention relating to mobility, safety in cars, and skin cancer prevention.

- At 12 months – immunisation against *Haemophilus influenzae* type b and meningococcus C. Immunisation history should be checked and any missed immunisations offered.
- **At every immunisation, parents should have the opportunity to raise any concerns about caring for their baby and their health and development, and should be provided with information or sources of advice.**

#### **Dental health**

- Sugar should not be added to weaning foods.
- As soon as teeth erupt, parents should brush them twice daily.
- From six months of age, infants should be introduced to drinking from a cup; from one year of age, feeding from a bottle should be discouraged.
- Parents should be advised to use only a smear of toothpaste.
- The frequency and amount of sugary food and drinks should be reduced, and, when consumed, limited to mealtimes. Sugars should not be consumed more than four times a day
- Where possible, all medicines should be sugar-free.

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74 [www.bookstart.co.uk/](http://www.bookstart.co.uk/)

### Maintaining infant health

- Temperament-based anticipatory guidance<sup>75</sup> – practical guidance on managing crying and healthy sleep practices, bath, book, bed routines and activities, and encouragement of parent–infant interaction using a range of media (e.g. *Baby Express* newsletters<sup>76</sup>).

### Promoting development

- Book sharing and invitations to groups for songs, music and interactive activities (e.g. PEEP<sup>77</sup> using the Early Learning Partnership Model, early years librarians or Bookstart<sup>78</sup>).
- Encouragement to take up early years education.
- Referring families whose first language is not English to English as a second language services.
- Supporting parents returning to work to help their child make a smooth transition into childcare.

### Keeping safe

- Advice and information on preventing accidents and on use of safety equipment.
- Be alert to risk factors and signs and symptoms of child abuse, and follow local safeguarding procedures where there is cause for concern.

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<sup>75</sup> Advice to help parents think about and understand individual infants' temperament and use of individualised childcare strategies, e.g. to address issues related to crying and sleeping

<sup>76</sup> [www.thechildrensfoundation.co.uk/](http://www.thechildrensfoundation.co.uk/)

<sup>77</sup> [www.peep.org.uk/](http://www.peep.org.uk/)

<sup>78</sup> [www.bookstart.co.uk](http://www.bookstart.co.uk)

#### **Babies with health or developmental problems or abnormalities**

- Early referral to specialist team; advice on benefits that may be available; invitation to join parent groups.
- Package of additional support and monitoring, as assessed by health professional, and drawing on the Early Support Programme.<sup>79</sup>

#### **Infant feeding and children at risk of obesity**

- Advice and information to both parents on healthy weaning, appropriate amounts and types of food, portion size and mealtime routines.
- Advice on nutrition and physical activity for the family.

#### **Parents who smoke**

- Smoking cessation interventions should include behavioural interventions combined with social support and incentives for achievement; and telephone counselling (NHS helplines).
- Partners should be involved in the implementation of smoking-reduction/cessation programmes.
- Additional strategies should include planning of smoke-free environments for children (e.g. areas within the home that are smoke-free), including cars.

#### **Keeping safe**

- Provide information on correct use of basic safety equipment and facilitate access to local schemes for the provision of safety equipment. Information about thermal injuries.

- Be alert to risk factors and signs and symptoms of child abuse, and follow local safeguarding procedures where there is cause for concern.
- Advice about reducing the risk of SIDS where there are increased risks (e.g. smoking, co-sleeping).

#### **Parenting support**

- Health professional to facilitate access to children's centre and early years services.
- Techniques to promote a trusting relationship and develop problem-solving abilities within the family (e.g. promotional interviewing; Family Partnership Model;<sup>80</sup> and the Solihull approach<sup>81</sup>) should be used to:
  - establish what individual support needs are;
  - provide one or two structured listening support visits; and
  - work in partnership with families to develop problem-solving skills.

#### **Maternal depression**

- As on page 47.

#### **Insensitive (i.e. intrusive or passive) parenting interactions**

- As on page 47.

#### **Parental relationships**

- As on page 47.

79 [www.earlysupport.org.uk](http://www.earlysupport.org.uk)

80 [www.cpcs.org.uk/](http://www.cpcs.org.uk/)

81 [www.solihull.nhs.uk/solihullapproach/](http://www.solihull.nhs.uk/solihullapproach/)

### For families at higher risk

#### Keeping safe

- Be alert to risk factors and signs and symptoms of child abuse, and follow local safeguarding procedures where there is cause for concern.

#### At-risk first-time young mothers

- Intensive home visiting programmes by skilled practitioners, such as the Family Nurse Partnership programme.<sup>82</sup>
- Multimodal support combining home visiting, peer support, life skills training and integration within social networks.

#### Seriously inadequate parent–infant interaction

- Referral to attachment-oriented or parent–infant psychotherapy interventions.

#### Parents with learning difficulties

- Provision of information about the support available to parents with learning disabilities, and assistance in interpreting information and accessing other sources of support.
- Establishing ongoing community support networks.
- Specialist multi-agency support should include individual and group-based antenatal and parent education classes, and home visiting.
- Further support designed to address the parent's individual needs might include speech, language and occupational therapy.

#### Drug and alcohol abuse

- Referral of one or both parents to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.

#### Domestic violence

- Follow local guidelines.
- Following assessment, provision of a safe environment in which victims of domestic violence can discuss concerns.
- Provision of information about sources of support for domestic violence.
- Referral to local specialist services as part of a multi-agency strategy.
- CHPP team to contribute to care package led by specialist service.

#### Serious mental illness

- Referral of one or both parents to specialist mental health/perinatal mental health service.
- CHPP team to contribute to care package led by specialist service.

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<sup>82</sup> Subject to testing in England

### At 13 months

- Immunisation against measles, mumps and rubella (MMR) and pneumococcal infection. **At every immunisation, parents should have the opportunity to raise any concerns about caring for their child and their health and development, and should be provided with information or sources of advice.**
- Immunisation history should be checked and any missed immunisations offered.

### Two- to two-and-a-half-year health review

- Review with the parents the child's social, emotional, behavioural and language development, with signposting to appropriate group-based parenting support (e.g. the Webster-Stratton Parenting programme).
- Review development and respond to any concerns expressed by the parents regarding physical health, growth, development, hearing and vision.
- Offer parents guidance on behaviour management and an opportunity to share concerns.
- Offer parents information on what to do if worried about their child.
- Promote language development through book sharing and invitations to groups for songs, music and interactive activities (e.g. early years librarian, PEEP<sup>83</sup> or Bookstart<sup>84</sup>).
- Provide encouragement and support to take up early years education.
- Give health information and guidance (telephone helplines, websites, NHS Direct).
- Review immunisation status, to catch up on any missed immunisations.

- Offer advice and information on nutrition and physical activity for the family, and on healthy eating, portion size and mealtime routines.
- Raise awareness of dental care, accident prevention, sleep management, toilet training, sources of parenting advice.
- Offer information on family information service, children's centres and early years learning provision. Refer families whose first language is not English to English as a second language services.

### Dental health

- Sugar should not be added to foods.
- As soon as the child's teeth erupt, parents should brush them twice daily, using only a smear of toothpaste.
- From the age of one year, feeding from a bottle should be discouraged.
- The frequency and amount of sugary food and drinks should be reduced, and, when consumed, limited to mealtimes.
- Sugars should not be consumed more than four times a day.
- Where possible, all medicines should be sugar-free.

### Keeping safe

- Advice about use of basic safety equipment and facilitating access to local schemes for the provision of safety equipment. Information about thermal injuries.
- Be alert to risk factors and signs and symptoms of child abuse, and follow local safeguarding procedures where there is cause for concern.

83 [www.peep.org.uk/](http://www.peep.org.uk/)

84 [www.bookstart.co.uk](http://www.bookstart.co.uk)

### **Children with health or developmental problems or abnormalities**

- Early referral to specialist team; advice on benefits that may be available; invitation to join parent groups.
- Additional support and monitoring, as assessed by health professional, and drawing on the Early Support Programme.<sup>85</sup>

### **Children at risk of obesity**

- Advice and information on healthy eating, portion size and mealtime routines.
- Advice on nutrition and physical activity for the family.
- If there is parental or professional concern about a child's growth or risk to normal growth (including obesity), an assessment should be carried out. This may be in the first two years of life. It involves accurate measurement, interpretation and explanation of the child's weight in relation to height, to growth potential and to any earlier growth measurements of the child. A decision should be made as to whether follow-up or an intervention is appropriate, and agreement with the family should be sought.

### **Parents who smoke**

- Smoking cessation interventions should include behavioural interventions combined with social support and incentives for achievement; and telephone counselling (NHS helplines).

- Partners should be involved in the implementation of smoking-reduction/cessation programmes.
- Additional strategies should include planning of smoke-free environments for children (e.g. areas within the home that are smoke-free), including cars.

### **Keeping safe**

- Advice about use of basic safety equipment and facilitating access to local schemes for the provision of safety equipment. Information about thermal injuries.
- Be alert to risk factors and signs and symptoms of child abuse, and follow local safeguarding procedures where there is cause for concern.

### **Parenting support**

- As on page 51.

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<sup>85</sup> [www.earlysupport.org.uk](http://www.earlysupport.org.uk)

### For families at higher risk

- Be alert to risk factors and signs and symptoms of child abuse, and follow local safeguarding procedures where there is cause for concern.
- Intensive programmes with skilled home visitors, such as:
  - Family Nurse Partnership for first-time young parents until the child is two years old; and
  - Advanced Triple P Programme.<sup>86</sup>
- Maternal mental health problems/ parent–infant relationship problems:
  - referral to specialist services; and/or
  - parent–infant psychotherapy.

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<sup>86</sup> [www.triplep.net](http://www.triplep.net)

### At three to five years

- Support parenting – access for both parents to Family Information Services, children's centres, health information and guidance (telephone helplines, websites, NHS Direct, etc.).
- Monitoring of child's social, emotional and behavioural development and signposting to other services where appropriate (e.g. group-based parenting programmes).
- Promotion of child's development and use of early learning centres.
- Delivery (by early years services with health professional support) of key messages about:
  - promoting child health and maintaining healthy lifestyles;
  - nutrition;
  - active play;
  - accident prevention; and
  - dental health.
- Immunisation against measles, mumps and rubella (MMR), polio and diphtheria, tetanus and whooping cough is given between three years four months and three years six months. Check immunisation history and offer any missed immunisations. **At every immunisation, parents should have the opportunity to raise any concerns about their child's health and development, and should be provided with information or sources of advice.**

### By five years – to be completed soon after school entry

- Review immunisation status and offer any missed immunisations.
- Review access to primary care and dental care.
- Review appropriate interventions for any physical, emotional or developmental problems that may have been missed or not addressed.
- Provide children, parents and school staff with information on specific health issues.
- Measure height and weight for the National Child Measurement Programme.
- Hearing screening should be carried out using an agreed, quality-assured protocol in appropriate surroundings. Parental concern about hearing should always be noted and acted upon.
- Screen all children for visual impairment between four and five years of age. This should be conducted either by orthoptists or by professionals trained and supported by orthoptists.
- Assessment as part of the Foundation Stage Profile.
- Be alert to risk factors and signs and symptoms of child abuse, and follow local safeguarding procedures where there is cause for concern.

### Progressive (including Universal)

- As under 'One to three years' (see page 54).



# Infrastructure requirements

Successful delivery of the CHPP needs to be supported by the following systems, processes and tools. Some are already in place and others require local or national action.

## Information for parents

Information for parents includes:

- *The Pregnancy Book*<sup>87</sup> and *Birth to Five*,<sup>88</sup> which provide good-quality information for parents (in an accessible format) on the full range of child health, development and parenting issues;
- the Personal Child Health Record (PCHR) (often referred to as the 'red book'), which provides a record of a child's health and development, including interventions received under the CHPP;
- screening leaflets;
- Healthy Start;
- the NHS Choices website;
- Bookstart,<sup>89</sup> which promotes books and reading to people of all ages and cultures. It helps parents and carers to foster a nurturing relationship with the child, strengthening their emotional bond while aiding language development and having fun;
- immunisation information resources for parents and health professionals, available at [www.immunisation.nhs.uk](http://www.immunisation.nhs.uk);
- the NHS Early Years Life Check on NHS Choices – currently being piloted for babies around six months; and
- locally developed information, such as the resources developed by Families Information Services and Sure Start children's centres.



## Record keeping and data collection systems

Connecting for Health is developing an electronic child health record that will support the information needs of the CHPP.

The PCHR is the main system for collecting and recording CHPP data. At the same time, it promotes greater personal ownership and guardianship of the health and illness biography of each child. The PCHR should be the same in appearance and core content as advised by the national PCHR group, to ensure consistency and continuity into the school years.

Local organisations will need to work towards a system of information sharing across health services by the use of one record, in which children and families are aware of what information is collected and who has access.

87 [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_074920](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074920)

88 [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_074924](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074924)

89 [www.bookstart.co.uk](http://www.bookstart.co.uk)

Information should only be shared on a need-to-know basis. Where there are concerns in respect to safeguarding children, both parents should be aware that the child is paramount and that information may need to be shared to protect the child. The development of Contact Point, formerly known as the Information Sharing Index, will enable practitioners delivering services to children to identify and contact one another more easily.

More needs to be done to integrate maternity and child health systems.

The CHPP will be delivered across a range of settings, and where computerised data collection systems exist, this information should be used to inform the CHPP data systems, to avoid duplication of records.

Systems should be in place to collect records into both anonymised data records for outcome measurements and individual and family records.

Effective inter-professional communication systems are vital to the delivery of the CHPP.

### Clinical governance

Local commissioners and providers need to be confident that clinical governance arrangements and professional leadership are in place, to ensure protection of the public and safe practice. This will include processes for:

- monitoring outcomes;
- service improvement and evaluation;
- risk management and audit of the CHPP;
- safety and quality of screening programmes;
- parent feedback;

- safety and quality of the immunisation programme;
- safeguarding;
- access to specialist paediatric, psychological and other services;
- professional practice and regulation;
- assessment of competence of the workforce;
- clinical supervision;
- delegation and accountability;
- confidentiality and information sharing; and
- continuing professional development.

### Population needs assessment and resource allocation

The CHPP should be underpinned by a systematic assessment of population needs that provides a basis for configuring services and allocating resources. That assessment should be undertaken in partnership with local agencies as part of joint strategic needs assessment. The assessment will need to identify sub-populations in the community (e.g. teenage parents, travellers, refugees/migrants, black and minority ethnic communities, looked-after children, children with disabilities) and set out action required to address their specific needs. Looked-after children are known to have particularly poor health outcomes, and the CHPP needs to take account of their specific needs. Monitoring outcomes for sub-populations will help to ensure that the CHPP is making a full contribution towards addressing health inequalities.



Data should be collated to provide the epidemiological basis for health needs assessment and the determination of risk and predictive factors.

Information on uptake rates, weight and height measurements, smoking cessation, immunisation, breastfeeding, screening and other measures should be used for the strategic planning, monitoring, evaluation and quality improvement of the CHPP.

### Access to the CHPP

The CHPP needs to be highly visible, accessible, understandable and popular with all parents, particularly in disadvantaged communities. Improving access to services is a priority for achieving good outcomes for children. More co-located and multidisciplinary services are seen as key objectives for providing the integrated support that many families will need.

Depending on local circumstances, the CHPP will be available in a range of settings, such as GP surgeries, children's centres, health centres, schools, extended schools and other community venues. Parents need to be able to choose how they wish to access the service, which should be flexible and should include the use of new technologies, such as email and mobile phones. Services need to fit around the requirements of working parents and be proactive and systematic in engaging and supporting fathers.

In many areas, Sure Start children's centres are becoming the focus for integrated children's services, especially for early years learning and parenting support. It is expected that children's centres will provide a number of the services listed in the 'progressive' part of the schedule, for example breastfeeding support, smoking cessation and a range of parenting support programmes. Children's centres offer a way of delivering services in a community setting that makes them more visible and accessible to families that may be less inclined to access traditional services. Multi-agency teams in children's centres have been able to offer new and innovative services that are designed around the needs of the child and the family. They also have a strong track record of community engagement and user participation. Children's centres may be an ideal place from which to provide the CHPP, making full use of the children's centre workforce and services and of their role in promoting children's health and wellbeing.

At the same time, it is important that health visitors and other members of the team retain good links with the primary healthcare team. General practice delivers core aspects of the CHPP, in particular the six to eight week examination of all children and the immunisation schedule. In some areas, general practice will be the focus for delivery of the programme. On average, a child under school age will see their GP six times a year, providing further opportunities to review children's health and support parents. New guidelines on the physical examination of babies soon after birth and again at six to eight weeks will shortly be published by the National Screening Committee.

Every general practice needs to have regular contact with a named health visitor with whom to discuss individual children and families and the delivery of the CHPP.

### Premises and equipment

Accommodation needs to be suitable for clinical practice, and practitioners should be able to access IT and record-keeping facilities, for example growth monitoring equipment. Whatever setting the CHPP is delivered in, it should be appropriate for the task, with a room suitable for clinical practice and maintaining confidentiality, including record storage.

Any equipment required to undertake practice should be suitable for purpose and all safety measures maintained. A modern, electric, self-zeroing weighing scale, which is properly maintained, should be used to weigh children. It should be placed on a firm surface. Length and height must be measured on suitable equipment designed for the purpose.

Where immunisations are undertaken, staff should be trained and competent. Resuscitation equipment should be available in the event of anaphylactic reactions.

### Productivity and value

#### Offering universal services in different ways

The CHPP is a universal service to be made available to all. Personal contact with mothers and fathers is important in helping to build up a relationship. For some families, though – especially those with a child already, for whom outcomes are likely to be good and who know how to access services – there are different ways of offering services that could free up resources for those requiring more intensive and skilled support and guidance. Examples include: web-based systems, such as NHS Early Years Life Check, Netmums and the NHS Choices website; the numerous valuable third sector local and national parenting support groups and organisations; and other interactive services, funded through Parent Know How, including Parentline Plus,<sup>90</sup> Young Minds<sup>91</sup> and Contact a Family.<sup>92</sup>

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90 [www.parentlineplus.org.uk](http://www.parentlineplus.org.uk)

91 [www.youngminds.org.uk](http://www.youngminds.org.uk)

92 [www.cafamily.org.uk](http://www.cafamily.org.uk)

## Workforce flexibilities

As the core CHPP workforce, health visitors are leading and working with teams that include a wide range of practitioners working across general practice and children's centres. Information on the CHPP workforce is available in Annex B.

A number of options are available to improve efficiency in the delivery of the CHPP, including:

- administrative support, so that practitioners can use their time effectively;
- close alignment of staff, including co-location in general practice and children's centres, to share responsibility for a defined population of children and families;
- common systems (IT and record keeping) of information sharing, to map children's health and their contacts with the service;
- systematic methods of assessing the population and personalising services;
- developing new ways of working, new roles and career pathways; and
- developing a CHPP team approach, to make the best use of skills.



## Outcome measures

Key indicators for the CHPP will include PSA indicators for breastfeeding, obesity prevention, infant mortality and the 12-week antenatal assessment.

Additional impact measures, such as immunisation rates, programme coverage, smoking in pregnancy, father's engagement, feedback from parents, and the Foundation Stage Profile<sup>93</sup> at the age of five, are also useful measures of CHPP outcomes. These should be aggregated and used by joint commissioners to plan, evaluate and improve the quality of the CHPP.

Further work is being carried out to develop child health and wellbeing indicators in children under the age of three.

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<sup>93</sup> To be superseded by the Early Years Foundation Stage from September 2008

# Annex A: Notes for commissioners

This guide sets the standard for an evidence-based prevention and early intervention programme for children and families, to be led by the NHS and delivered through integrated children's services. It will be jointly commissioned by children's services commissioners and parenting commissioners.

The CHPP will be developed through children's trust arrangements and will involve:

- a joint strategic needs assessment, including a meaningful engagement with users about the services that they require;
- planning services, in particular preventive services, based on the joint strategic needs assessment and dialogue with potential providers from the public, private and third sectors;
- the development of delivery partnerships based on contracts, grants, service level agreements or other appropriate clear statements of the services to be delivered; and
- monitoring the impact of providers on the outcomes, and refining the service based on this information.

The CHPP is a core programme for delivering national priorities and statutory responsibilities on local partnerships, for example to promote the five Every Child Matters outcomes through children's trust arrangements and to reduce inequalities in outcomes for young children. It forms the basis for ensuring that national priorities are met, as set out in the 2008/09 *Operating Framework* (DH, 2007d),

Public Service Agreement (PSA) delivery agreements and operational plans:

- *Guidance on Joint Strategic Needs Assessment* (DH, 2007c); and
- *Joint Planning and Commissioning Framework for Children, Young People and Maternity Services* (DfES and DH, 2006).

## The NHS operating framework

The national NHS priority for 2008/09 is: 'keeping adults and children well, improving their health and reducing health inequalities' (DH, 2007d). One of the four areas where primary care trusts (PCTs) are expected to make progress and where the CHPP has an important contribution to make is in 'improving children's and young people's physical and mental health and wellbeing'.

## National priorities for local delivery

The CHPP supports the delivery of:

- an increase in the percentage of women who have seen a midwife or a maternity healthcare professional, for assessment of health and social care needs, risks and choices by 12 completed weeks of pregnancy;

- an increase in the percentage of infants being breastfed at six to eight weeks;
  - a reduction in the under-18 conception rate per 1,000 females aged 15–17;
  - a reduction in obesity among primary school age children;
  - an increase in the proportion of children who complete immunisation by recommended ages; and
  - a reduction in smoking prevalence among people aged 16 or over and in routine and manual groups.
- **PSA Delivery Agreement 11 – Narrow the gap in educational achievement between children from low-income and disadvantaged backgrounds and their peers:** Indicator 1, Achievement gap at Early Years Foundation Stage.
  - **PSA Delivery Agreement 18 – Promote better health for all:** Indicator 3, Smoking prevalence.
  - **PSA Delivery Agreement 14 – Increase the number of children and young people on the path to success:** Indicator 4, Reduce the under-18 conception rate.

### PSA delivery agreements

This updated CHPP has been designed to support delivery of a range of cross-government PSA indicators:

- **PSA Delivery Agreement 12 – Improve the health and wellbeing of children and young people:** Indicator 1, Prevalence of breast feeding at six to eight weeks; and Indicator 3, Levels of obesity in children under 11 years.
- **PSA Delivery Agreement 13 – Improve children and young people’s safety:** Indicator 3, Hospital admissions caused by unintentional and deliberate injuries to children and young people.
- **PSA Delivery Agreement 19 – Ensure better care for all:** Indicator 4, The percentage of women who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy.
- **PSA Delivery Agreement 10 – Raise the educational achievement of all children and young people:** Indicator 1, Early Years Foundation Stage achievement.

### Joint strategic needs assessment: assessing the needs of children and young people

Joint strategic needs assessment is a process for identifying the current and future health and wellbeing needs of a local population, informing the priorities and targets set by local area agreements, and leading to agreed commissioning priorities that will improve outcomes and reduce health inequalities.

The CHPP (according to DH, 2007c) both informs, and is informed by, joint strategic needs assessment:

‘The Children Act 2004 requires local authorities to prepare and publish an overarching plan setting out their strategy for discharging their functions in relation to children and young people. The Children and Young People’s Plan (CYPP) is prepared by local authorities and their partners through the local children’s trust cooperation arrangements, feeding into and informed by the Sustainable Communities Strategy. A key element of the CYPP is the requirement to carry out a comprehensive needs assessment, in partnership with all those involved in the



planning process, and to review it on a regular basis. The needs assessment is based on the requirement to improve the five Every Child Matters outcomes for children, young people and their families: be healthy, stay safe, enjoy and achieve, make a positive contribution, and achieve economic wellbeing.'

### World-class commissioning: adding life to years and years to life

*World Class Commissioning* (DH, 2007e) sets out a new approach for health and care services. It is the underpinning delivery vehicle for many objectives of current health policy, and presents the vision and competences for world-class commissioning. PCTs will lead the work to turn the world-class commissioning vision into reality, applying it locally in a way that meets the needs and priorities of the local population.

The CHPP as set out in this publication fits well with commissioners wanting to demonstrate world-class commissioning, as it reflects many key competences. The CHPP is:

- **strategic** – taking an overview of children's and families' health and wellbeing;
- **long-term** – improving future outcomes for children and families through early intervention and prevention;
- **outcome-driven** – providing a clear set of outcomes for children that can be measured;
- **evidence-based** – it is based on meta-level reviews of evidence, including *Health for All Children* (Hall and Elliman, 2006), National Institute for Health and Clinical Excellence guidance, and a review of evidence-based, health-led parenting interventions;
- **partnership-focused** – the CHPP can only be delivered through joint commissioning of children's services in partnership with families and communities; and
- **clinically led and highly professional** – successful commissioning of the CHPP requires high levels of engagement by health professionals.

# Annex B:

## Core elements of the CHPP workforce

### Introduction

Successful delivery of the CHPP will depend on having the right workforce in place to deliver the programme. Significant changes are taking place in the children's workforce that are impacting on the provision of the CHPP. In producing this guide, we commissioned a review of national workforce developments impacting on the CHPP workforce and an analysis of the competences required to deliver the programme. This annex has been included to assist commissioners and local managers to ensure that they have the workforce needed to deliver the CHPP standard described in this guide.

### The CHPP workforce

Delivery of the programme relies on a team approach that includes children's centre staff and members of the primary healthcare team. An effective, competent and confident workforce, capable of delivering the CHPP during pregnancy and the first years of life, will have the following characteristics:

- multi-skilled teamworking involving a range of practitioners across general practice, maternity services and children's centre services;

- an agreed and defined lead role for the health visitor;
- a team with up-to-date knowledge and skills; and
- a team with competences to work in partnership with children, mothers, fathers and families to deliver the core elements of the CHPP and to work effectively across service boundaries.

### Multi-skilled teamworking

Delivering the CHPP relies on the contribution of a broad spectrum of practitioners, including GPs, practice nurses, midwives, health visitors, community nursery nurses, early years practitioners, family support workers and other practitioners employed by children's centres or working for voluntary organisations.

The primary care trust (PCT) will work within local children's trust arrangements in commissioning children's services. This should include accurate assessment of need and proportionate allocation of resources to deliver the CHPP, and work with partners to ensure that this service is integrated with wider provision, including children's centres.

The key to success is a shared understanding – both by parents and by all the practitioners involved – of the roles, responsibilities and potential contribution of the different practitioners and organisations.

The GP and primary care team provide child health surveillance, health protection and clinical care.

Sure Start children's centres and the CHPP share similar objectives. Just as children's centres rely on the contribution of health services, the health team relies on early years staff to provide proactive health-promoting interventions, as well as to assist in the provision of a range of targeted support for families in need. Children's centre teams have expertise in the delivery of high-quality early years provision and parenting support.

Teamworking can benefit from, but does not depend on, co-location. What matters is that people meet regularly to review the programme and discuss individual children. Teamworking across service boundaries requires practitioners to:

- develop trusting relationships, based on a shared purpose, values and language;
- know when and how to share information appropriately;
- make use of common processes, such as the Common Assessment Framework; and
- nominate a lead professional to co-ordinate activity.

Clear lines of accountability and responsibility must be defined, when practitioners from different organisations work together in integrated teams.

### **An agreed and defined lead role for the health visitor**

The CHPP is a clinical and public health programme led by, and dependent on, health professionals. Effective leadership is required to ensure that the various practitioners contributing to the CHPP communicate with each other and provide an holistic, co-ordinated service tailored to local needs.

It is recommended that responsibility for co-ordinating the CHPP to a defined population at children's centre and general practice level should rest with the health visitor. Having a public health nursing background, health visitors are ideally placed; they have a registered population of children from pregnancy to five years, they know how the health system works, and they bring knowledge and understanding of child and family health and wellbeing and skills in working with individuals and communities. They will need to work across general practice and children's centres, working closely with maternity services and other agencies concerned with children and families

This role is hands-on, working with children and families, overseeing and delivering the CHPP to a defined and registered population, involving local parents, co-ordinating and supporting the contribution of the team, quality-assuring the service and monitoring the outcomes and delivery of the programme. A pilot project is currently working with 10 sites to test this role and explore the training and support needs of health visitors to lead the CHPP.

The leadership model is one of distributed responsibility, whereby everybody has an equally important role to play in delivering the component parts of the CHPP. GPs and children's centre managers will have a key role in maximising the contribution made by their services.

Health professionals, such as midwives, health visitors and GPs, are the universal first point of contact for families during pregnancy and the first years of life. They have credibility when it comes to diagnosis, health information, guidance and decision making. Health professionals are trained and experienced in working with both adults and children, and are able to work with the whole family. They are ideally placed to identify and provide support for problems as soon as they arise, drawing in, where necessary, support from other services. Midwives have an important role in promoting the health of the child and the family.

Every registered health profession has a code of professional conduct, and an agreed body of knowledge, defined by specified competences and assessment frameworks. This provides assurance to the public of the standard of care they can expect.

### **A team with up-to-date knowledge and skills**

This updated CHPP identifies new priorities and advances in our understanding of child development and effective interventions. The knowledge and skills of the team delivering the CHPP will need to reflect these changes and be open and flexible to future developments. In addition to existing public health and child development knowledge and

skills, topics identified in this guide for greater focus are:

- the early identification and prevention of obesity;
- the promotion and support of breastfeeding;
- the impact of the early nurturing environment on the developing brain and interventions to promote optimal physical, social and emotional development;
- the important contribution of fathers;
- factors influencing health choices and behaviour change;
- parenting support using strength-based and promotional intervening skills and tools; and
- high-level skills to deliver an intensive programme to at-risk families in the home.

### **A team with the competences to work with children and parents, to deliver the core elements of the CHPP and to work effectively across service boundaries**

Competences are the knowledge, skills, behaviour and characteristics required to carry out an activity (or combination of activities) in a particular environment or organisational context, in a way that leads to effective and enhanced organisational performance. It is necessary to stipulate both the range and level of competences required across the available workforce, as well as the specific competences required to undertake specialist tasks.



With so many practitioners potentially involved in supporting children and families, it is essential that everybody is aware of their own areas of responsibility and those of others, how they interact and overlap with other roles, the skills and knowledge they require to do the job, and the limits to their competence.

Enhanced levels of competence are required where additional skills are needed to explore sensitive issues or establish and respond to varying levels of vulnerability, complexity and risk.

In addition to identifying and specifying skills and competences, arrangements need to be in place for appropriate training and continuing development, including joint cross-discipline training, particularly where new roles emerge or roles overlap. There should also be the opportunity for those skills to be recognised and accredited, to avoid duplication, improve joint working and support workforce and cross-sector mobility.

There are some higher-level competences that are health professional-specific (such as the clinical skill of listening for heart murmurs in six-week-old babies). This means that, while there is opportunity for flexibility in the workforce profile, some tasks and skills are non-transferable.

A competent, confident and effective practitioner is more than the sum of his or her competences; sensitive and appropriate decision making is often underpinned by professional insight grounded in a wealth of experience. A less-skilled practitioner can undertake aspects of care under the supervision and guidance of a more competent practitioner. However, investing in professionals with higher-level competences can be more cost-effective in terms of outcomes.

Support workers should be trained to the appropriate level of skill and competency for their role and should not work outside their job specification.

Practitioners working in multi-agency settings need the ability to work effectively across traditional service boundaries and to share information, as well as specific knowledge of what services are available locally and how to access them, including use of shared tools such as the Common Assessment Framework and lead professional role.

Besides the competences required to deliver the specific components of the CHPP, additional competences are required to lead a multidisciplinary team designing and delivering needs-based, outcomes-driven interventions across a range of settings.

### Competences required for the delivery of the CHPP

- All practitioners who work with children, young people and families should be able to demonstrate a basic level of competence in the six areas of *The Common Core of Skills and Knowledge for the Children's Workforce* (DfES, 2005b).
- Ideally, promoting health should be added to the Common Core of Skills and Knowledge as an essential prerequisite for all those working with children.
- Of particular relevance for practitioners working with families with young children is the capacity to build effective and sensitive relationships with the parents: all practitioners working with this client group are therefore expected to demonstrate compliance with the *National Occupational Standards for Work with Parents* (Lifelong Learning UK, 2005).
- Competences required for the delivery of specific aspects of the CHPP should be explicit in the job specifications of relevant practitioners. These competences should relate to the achievement of health outcomes identified during the joint strategic health needs assessment and specified in *The Children and Young People's Plan* (DfES, 2005a).
- Various frameworks and tools exist to help service planners to identify the competences required for the achievement of specific outcomes.

### The role of the health visitor

The health-visiting workforce is central to the delivery of the CHPP. This was recognised in the review of the future role of the health visitor, *Facing the Future* (DH, 2007b), which recommended that health visitors should focus on young children and families, where their public health nursing expertise can have greatest impact.

The review identified the core elements of health visiting as:

- public health nursing;
- working with the whole family;
- prevention and early intervention;
- knowing the community and 'being local';
- being proactive in promoting health and preventing ill health;
- progressive universalism;
- safeguarding children;
- working across organisational boundaries;
- teamwork and partnership;
- readiness to provide a health protection service; and
- home visiting.

The review concluded that there were two core roles for health visitors:

- leading the delivery of the CHPP to a defined population; and
- delivering intensive preventive programmes to the most at-risk families with young children.

Local workforce planning for the CHPP will need to ensure that the health visitor has a lead role in the CHPP and has the skills and knowledge needed to lead and deliver the programme as described in this publication.

### Possible roles in the CHPP team

**The health visitor.** The CHPP team is often a virtual team across a number of settings and organisations, requiring leadership skills to ensure that the universal and progressive needs of families and children are met. The CHPP health visitor will have a key role in ensuring that there are robust arrangements for identifying where families need extra support, assessing needs and co-ordinating multi-agency activity.

**The GP and practice nurse** are a core part of the CHPP team. Most children are seen by a GP up to six times a year in the first years of life. General practice has an important role to play in delivering the CHPP, through screening, surveillance and immunisations, as well as opportunistically promoting health.

**The midwife** role, in addition to assessing health and social needs, is to ensure that all screening tests are understood and available to all women. They make sure that pregnancy is monitored through to delivery of the baby. They may maintain contact for up to 28 days after delivery, as necessary.

**Community nursery nurses** have proved an invaluable asset to health-visiting teams.

**Community staff nurses** have a particular role to play in supporting children and families with healthcare needs.

Sure Start children's centre staff – such as **family support workers, parent engagement workers, early years practitioners, outreach workers and play leaders** – all have an important part to play in the CHPP. Not only do they provide many of the parenting support and child development and childcare services that are essential for children's health, but they also increasingly have a role in health promotion and public health. As the CHPP lead, it is expected that the health visitor will support and supervise children's centre staff to acquire the competences needed to support delivery of the CHPP.

With the growing emphasis on the importance of behavioural change in improving the health of the nation, and the need to spread the message more widely and engage with hard-to-reach families, **health trainers** may also provide a useful addition to the team.

**Administrative assistance** is vital to ensure cost-effective use of the team. Administrative support is needed to facilitate engagement with families, to provide and collect information, and to monitor and review the CHPP.

### Effective teamworking for the CHPP

- Clear information for families about the roles and responsibilities of each practitioner with whom they come into contact should be provided.
- There must be a core team, led by a health professional responsible for ensuring that all families receive a level of service and support relevant to their needs.
- There must be clear arrangements for engaging and drawing in support from services outside the core team.
- Regular meetings to discuss the CHPP and individual children should be held.
- Decisions about what sort of practitioners are needed should be based on the competences required to deliver desired outcomes.
- There must be a clear description of the performance standards required within any particular role, and everybody

should have access to regular supervision and an annual opportunity to review their sphere of practice and training needs.

- There must be clear lines of accountability and responsibility, especially when these transcend traditional organisational boundaries.
- There should be regular opportunities for communication across teams, to generate trust and understanding.
- Whenever possible, training should be designed for a multidisciplinary audience and should be of a high standard, with clear learning outcomes that can be assessed following attendance.
- Shared budgets and joint planning lead to co-ordinated service provision that makes best use of the available workforce and avoids duplication, confusion and the tendency to retreat into professional 'silos'.

### Education and learning

Competences relating to maternal and child health should be underpinned by a knowledge of relevant legislation relating to confidentiality, consent, record keeping and information sharing; children's rights; key government policies; relevant guidance; main issues and debates (relating to child and family health); factors affecting health and parenting capacity; the evidence base for practice; the art of communication; and an awareness of one's own sphere of competence and the roles of other practitioners.

The Children's Workforce Development Council<sup>94</sup> is involved in a pilot project to develop induction standards for the children's workforce. The standards cover seven core areas:

- the principles and values essential for working with children and young people;
- the worker's role;
- health and safety requirements;
- effective communication;
- development of children and young people;
- keeping children safe from harm; and
- personal and professional development.

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94 [www.cwdcouncil.org.uk](http://www.cwdcouncil.org.uk)



It is hoped that PCTs and local authorities will incorporate shared induction programmes to promote integrated early years provision.

Developing competence requires access to courses that are recognised, standardised, assessed and credible. Local authorities are responsible for delivering training to practitioners across the local area in the Common Assessment Framework, in the use of the lead professional and in information sharing.

Maintaining competence requires regular opportunities to apply knowledge, share experience, practise skills, review competence and identify training needs. Service managers should ensure that individual and service training needs are reviewed on an annual basis and that appropriate opportunities for developing knowledge and skills are provided.

The use of competence assessment tools, such as the Coventry University Assessment,<sup>95</sup> should be encouraged, so that knowledge and skills deficits can be identified and addressed.

Multidisciplinary training opportunities should be encouraged, to avoid conflicting advice, share perspectives, boost confidence and deliver more integrated, tailored support to service users.

Opportunities for self-study should also be explored. For example, an online training programme is currently under development as part of the HENRY (Health, Exercise, Nutrition for the Really Young) programme, led by Dr Mary Rudolf.<sup>96</sup>

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95 [www.healthbehaviourresearch.co.uk](http://www.healthbehaviourresearch.co.uk)

96 For information, email [henry@rcpch.ac.uk](mailto:henry@rcpch.ac.uk)

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