SERVICE SPECIFICATION

Service	Early Years
Commissioner	Carol McLoughlin
Lead Provider	City and Hackney GP Confederation
Provider Lead	Claire Lister
Period	1st April 2017 to 31st March 2018
Date of Review	

1 Population Needs

City and Hackney is a diverse inner London CCG. Hackney is the 10th most deprived local authority [1] in England (of 326 local authorities) in the 2015 Index of Multiple Deprivation (IMD). Of the nearly 260,000 people who reside in City and Hackney, just under 64,000 are children aged 0-19. The registered 0-19 year's population in City and Hackney is 75,051. Around 4,500 women deliver babies each year, with around 75% having their baby at the Homerton Hospital.

In City and Hackney forty-per cent of children live in poverty. This deprivation contributes to poorer health outcomes and perpetuates health inequalities such as life expectancy and life chances. It also contributes to families and children being vulnerable to poorer social outcomes such as isolation, abuse and homelessness. There are high rates of childhood obesity (27% of 4-5 years old's) and dental caries (mean number of 3.74 in children aged 5 years) and emergency admissions for lower respiratory tract infection in children under 1 year is higher than similar CCGs. In 2013/14 280 children (aged 0-4years) were admitted to hospital with unintentional and deliberate injuries. There are high levels of young people not in education or employment.

Pregnant women present with high levels of complexity (medical, obstetric, social and psychological needs); there are just over 8,000 women aged 20-45 years with one long-term condition (LTC) and 1,200 with two or more LTCs. In 2015/16 approximately fifty per cent of deliveries at HUH fell under the category 'with comorbidities and complications'. The trend has been upward rising from 31% in 2013/14 to 36% in 2014/15 with 51% forecast for 2015/16. The uptake of maternal flu and pertussis immunisations is low at 32.6% compared with the national average of 39.8% and London average of 35.9%.

In 2013/14 and 2014/15 an average of 165 women were known smokers at the time of delivery (168 and 163 respectively). While the rate (4.9%) is significantly lower than the national average of 11.9% it is higher than similar CCGs (4.5%).

The Infant mortality rate (i.e. infants dying before their first birthday per 1,000 live births) in Hackney is 5.7 which is higher than the national and London average. In the period 2011-2013, 26 infants died before their first birthday.

[1] Using the rank of the extent summary measure of deprivation

In the same period 2011-2013 there were 79 stillbirths (i.e. babies born after 24 completed weeks of pregnancy with no signs of life) in NHS City and Hackney, a stillbirth rate of 5.8 stillbirths per 1,000 births. The London rate was 5.5, and nationally the rate was 4.9.

The Marmot Review (2010) highlights the gradient of health inequalities associated with economic and social status. Central to the Review is the recognition that disadvantage starts before birth and accumulates throughout life. Marmot suggests that giving every child the best start in life is one of the key mechanisms for equalising the life-chances of children and reducing social adversity.

The aim of the Early Years contract is to enable early identification and intervention improving child and family outcomes. It will provide an enhanced primary care service to women and children. By commissioning and funding longer appointment slots we aim to support enhanced scrutiny and assessment of health and well-being concerns and enable proactive intervention utilising the range of services available locally.

2 Outcomes

Of the NHS Outcomes Framework the following will be supported through this contract.

1	Preventing people from dying prematurely	✓
2	Enhancing quality of life for people with Long term conditions	✓
3	Helping people recover from episodes of ill health or following injury	-
4	Ensuring people have a positive experience of care	✓
5	Treating and caring for people in safe environment and protecting them from avoidable harm	-

The service will contribute towards the CCG priority of reducing premature mortality. By supporting women to have healthier pregnancies we aim to reduce mortality and morbidity associated with high risk pregnancies and premature births. By offering and providing preconception advice and targeted care for women with long term conditions we aim to enable women to optimise their health before pregnancy to facilitate better outcomes.

Much of maternal and early years care is interdependent on Public Health strategy and this contract will support improvements in the four Public Health outcome domains:

- improving the wider determinants of health (by addressing school readiness, domestic violence, social isolation)
- health improvement (by addressing low birth weight, breastfeeding, smoking at delivery)
- health protection (by addressing antenatal and newborn screening, Immunizations)
- healthcare public health and preventing premature mortality (by addressing preventable ill health).

2.1 Core Early Years contract

Our primary goal is to improve pregnancy outcomes, specifically reducing the number of infant deaths and stillbirths, as well as maternal morbidity and mortality.

As the numbers are small, measures of infant and maternal morbidity need to be viewed over longer time periods. In the shorter term the impact will be visible in reducing the number of babies requiring special care and neonatal intensive care.
In the medium and longer term pregnant women will be healthier and more likely to have a midwifery led birth thereby reducing the number of caesarean sections and births with intervention.
Over the next five years we aim to see increasing numbers of women having normal deliveries, from the current baseline of 39%.
By identifying vulnerable women support mechanisms can be mobilised through referral to partner agencies (e.g. Family Nurse Partnership, Perinatal Mental Health services).

2.2 Vulnerable children

The aim is to increase the number of vulnerable families accessing services. By maintaining a register identifying vulnerable children and through regular review of action plans with health visitors we aim to ensure on-going support and safety for children living in challenging social conditions / circumstances. The impact will be visible in reducing the number of hospital admissions caused by intentional or unintentional injuries in children under 5 years and a reduction in emergency admissions for children under 1 year.

2.3 Health Promotion / Health Checks for 16 year olds

The health promotion activities in the contract (pre-conception and 16 year old health check offer and information) are intended to better inform and support women and young people to make healthy life choices. The impact will be visible in increasing numbers of women presenting early (by 8 weeks) and in increasing numbers of women taking Healthy Start vitamins in pregnancy. Picking up possible adverse effects on the foetus of long term conditions or mental health issues in the mother should ensure early intervention and better outcomes for mother and baby.

3 Scope of Service

The service includes extended consultations for antenatal and postnatal appointments, case-finding/early identification and referral to support / treatment interventions, quarterly reviews of UPP action plans, and health promotion.

It includes elements of universal and targeted support for women, children and families. Some services such as those for pregnant women need to take a universal approach as the CCG is aiming to reach all pregnant women as early as possible in their pregnancy so that any medical, social, psychological or obstetric needs are identified promptly and allow care plans to be put in place in partnership with other agencies. Some services such as targeted appointments for women or children with vulnerability aim to support patients to better manage their health on a day to day basis via primary care input and without having to resort to crisis use of unscheduled care.

3.1 Service model

The model of care recognises the importance of primary care in providing continuity for patients, often across their lifetime and the unique position of being able to support women through the transition into parenthood.

The elements contained within this service specification aim to ensure that Primary Care can provide a seamless service for women, children and families in partnership with Midwives, Health Visitors and other key health professionals.

This service is available to all patients registered with a City and Hackney GP and is delivered by local GP practices supported by the GP confederation. This includes the Greenhouse Practice who may provide antenatal and postnatal care to homeless women. Unregistered women and families seeking access to services will be supported to register as per the GMS contract.

3.2 Care Pathways

GP registered women and children will be offered services under the contract and this will be coded by the GP practice. The service is supported by searches created by CEG and EMIS templates to prompt and record activity.

The commissioned services will form a key element of a number of care pathways for women, infants and children and will therefore need to link with other agencies including:

- Midwives, Obstetricians and Health Visitors at Homerton Hospital or other maternity departments.
- Community, general and acute Paediatricians at Homerton Hospital or other providers.
- Safeguarding Designated Doctors and Nurses at City and Hackney CCG, Homerton Hospital or other providers.
- Clinicians from local Mental Health and Child and Adolescent Mental Health (CAMHS) providers including East London Foundation Trust (ELFT) and Homerton Hospital.
- Other City and Hackney services provided to women and children as part of universal and care pathways including, but not limited to, Dietetics and adult and child obesity services, Family Nurse Partnership (FNP), Children's centres, antenatal class providers, breastfeeding services and Substance Misuse services.

Specifically the practices within the GP Confederation will:

- Offer an extended (i.e. 20-minute) GP consultation at pregnancy presentation, 16-week antenatal check, 6-week postnatal check allowing time to complete a comprehensive assessment.
- Record details of the clinical consultation on templates developed by CEG.
- Proactively identify women (20-45 years) with a long-term condition and invite for a pre-conception consultation.
- Invite newly registered children aged 5 to 17, for a health check (within one year of registering).
- Promote the opportunity of a health check and provide information about local services including mental health help to all registered 16-year olds.
- Maintain a register of vulnerable children.
- Liaise with the designated / assigned Health Visitor to agree actions plans for children coded as

Universal Partnership Plus.

- Liaise with the designated / assigned Health Visitor to review actions plans quarterly for children coded as Universal Partnership Plus.
- Maintain a register ofchildren identified as carer's.
- Mobilise support and intervention mechanisms by onward referral to other agencies.
- Promote pre-conception consultation and early booking.
- Ensure women who do not attend scheduled 16-week appointment are followed-up and re-invited.

It is recognised that there are many support structures, services and facilities available and that referral pathways may need defining and more clearly promoted to GP practices via the Confederation. The CCG is committed to reviewing and clarifying relevant referral pathways. Recruitment is underway for clinical leads who, it is anticipated, will assist with this work.

3.3 Service Description

3.3.1 Pre-conception health promotion

The GPC is commissioned to produce promotion materials (e.g. poster, leaflet) to advertise the availability of a pre-conception consultation. The consultation will include advice on weight management, smoking, alcohol, healthy start vitamins and early booking and provide information on psychological and social aspects of planning a pregnancy. The appointment is covered under the GMS contract and will not attract additional payment through this contract. Women with long-term conditions (LTCs) can avail themselves of a targeted pre-conception consultation.
To support the Confederation to implement this, the CCG will launch a series of pre-conception guidelines, based on current antenatal guidelines. This will include who to refer to obstetric medical clinics, guidelines signposting people to help for good mental health (e.g. 5 ways to stay well emotionally and mindfulness apps) and the importance of accessing antenatal classes.

3.3.2 Targeted Preconception Care

The GPC is commissioned to provide targeted pre-conception care to women with long-term conditions. To facilitate optimum health before and during pregnancy women with LTCs will be offered a health check to review their condition and medication prior to conception. Diseases requiring pre-conception care include: diabetes, hypertension, asthma, epilepsy, thyroid disease, rheumatological conditions, chronic kidney disease, cardiac disease and pre-existing mental health illnesses (women who are on SMI QoF and depression registers). Full details of the recommended clinical assessment are contained in appendix 2. Women with a complex medical / obstetric history or with more than one chronic disease can be referred to the Homerton pre-conceptual clinic.
A template has been developed by CEG to capture the required clinical details to support reporting and payment.

3.3.3 Pregnancy Presentation

The GPC is commissioned to provide an extended consultation for women presenting pregnant. This is to enable a more comprehensive social, psychological and medical risk assessment including being screened for depression where appropriate and referred on for further care if necessary. Full details of the recommended clinical assessment are contained in appendix 3.
A template approved by the CCG clinical lead for Maternity has been developed by CEG to capture the required clinical details to support reporting and payment.

3.3.4 16-week antenatal appointment

The GPC is commissioned to provide an extended consultation to women for the 16-week antenatal review. A template developed by CEG is in place to capture the required clinical details to support reporting and payment. Full details of the recommended clinical assessment are contained in appendix 4. To improve uptake it is recommended that women are given an appointment date at the time of pregnancy presentation. The Practice is expected to follow-up and re-invite women who do not attend.

3.3.5 6-week postnatal maternal appointment

The GPC is commissioned to provide an extended consultation to women for the 6-week postnatal review. The enhanced appointment aims to facilitate detection of early indications of vulnerability affecting the mother and baby. Specifically it will include a debriefing about pregnancy and birth; any outstanding medical issues (e.g. anaemia, stitches or issues that will impact on future pregnancies), depression screening and promotion of healthy start vitamins for the baby.
A template developed by CEG is in place to capture the required clinical details to support reporting and payment.

3.3.6 6-8 week baby check

A 6-8 week baby check is provided through the GMS contract. A template developed by CEG is in place to ensure that details of the 6-8 week baby check are captured consistently. It includes details of a baby check complying with NIPE NHS screening standards and an assessment of attachment between the mother and baby. Practices are required to continue to use and complete the 6-8 week baby template.

3.3.7 Vulnerable Children Register and Action Plans

The GPC is commissioned to ensure that practices maintain a register of vulnerable children and carry out regular reviews of actions plans with the designated Health Visitor. In 2015/16 the GPC was commissioned to compile a register of vulnerable children (categorised as Universal Partnership Plus) cross-checked with records held by the Homerton University Hospital (HUH) Health Visiting team. This register is to be maintained in 2017/18 and the emphasis is on the review of joint action plans for children registered as UPP. For the term of this contract action plans should be reviewed at least once. Going forward it is expected that action plans be reviewed quarterly. Further details and definitions are contained in appendix 7.

3.3.8 Carer's Register

The GPC is commissioned to ensure that practices that have children known or opportunistically identified to have caring responsibilities are coded as such on the electronic patient record (Code 'Is a carer' may be used). A children's carer register was established as part of the 2015/16 vulnerable children's contract and in addition to maintaining this register the GPC is expected to develop guidelines for the primary care management of children with caring responsibilities.

3.3.9 New patient health checks for children aged 5 – 17 years

The GPC is commissioned to ensure that practices provide a health screening check for newly registered children aged 5 to 17 years. This screening check may be carried out by a healthcare assistant or nurse and should be supported by a pre-check questionnaire developed by the practices to include height, weight, immunisation status (and offer further immunisations as appropriate), medication and allergies.

Healthy lifestyle advice, including information about CHYPS should be provided as appropriate. Full details of the recommended clinical assessment are contained in appendix 8.

3.3.10 16th Birthday Health Check

The GPC is commissioned to develop and display promotion materials (e.g. a poster) to advertise and invite all 16-year olds for a health check.

3.4 Structural Support

City & Hackney GP Confederation is contracted to ensure that all practices engage with the aspiration to improve pregnancy outcomes by providing extended appointments and mobilising referral pathways where indicated. The GPC will support practices to deliver the service and oversee quality and governance. Where the volume of enhanced appointments is lower than expected the GPC is asked to produce a report, calling on the assistance of CEG if needed, outlining what action has been taken to improve the situation.

4 Applicable Service Standards

- Better Outcomes for Young People pledge
- NICE Antenatal and Postnatal guidelines
- Locally agreed care pathways and action plan templates
- Early Intervention the Next steps, Allen G (2011)
- The Children and young people Outcomes Strategy, DH (2011)
- Working together to safeguard Children (2015)
- Healthy Child Programme
- CEG guidelines

5 Key Performance Indicators

5.1 Core Early Years contract

As per NICE guidance (2015) the 16-week antenatal appointment is a scheduled appointment in routine antenatal care. In 2015/16 2,725 had a 16-week check with their GP of which 2,437 qualified for an enhanced payment as per the GPC contract in place. Based on 4,500 births this represents 57% of women having an extended / enhanced 16-week appointment.

For 2017/18 this number will increase to 70% or 3150 women. To facilitate this it is recommended that women who attend for a pregnancy presentation / first contact appointment are given an appointment for their 16-week check at that time.

5.2 Vulnerable children

100% of children on the UPP register have an agreed joint action plan with the health visitor.
In 2015/16 the GPC was commissioned to compile a register of vulnerable children (categorised as Universal Partnership Plus) cross-checked with records held by the HUH Health Visiting team. This register is to be maintained in 2017/18 and the emphasis is on the review of joint action plans for children registered as UPP. For the term of this contract action plans should be reviewed at least once.

5.3 Health Promotion

A Pre-pregnancy consultation is advertised in each Practice.

Advertising will encourage women to present at 8 weeks to enable booking by 10 weeks as recommended in NICE guidance. Early booking is key to ensuring women have timely access to antenatal screening programmes and receive support intervention where indicated.

To check the effectiveness of this indicator the percentage of all bookings by 10 weeks will be monitored. These data will be provided on the HUH Maternity dashboard.

6 Reporting Requirements

To inform and support the on-going development of maternal, early years and vulnerable children care and intervention pathways the GPC is asked to report on quantitative and qualitative aspects of the service delivery. It is anticipated that this data will be available from information captured on the supporting clinical templates that have been developed with CEG. Where this is not in place a shared commitment is expected to enable this. In addition to the data reporting to secure quarterly payments the following is requested via the CEG (at year end):

- The number of women presenting before 10 weeks gestation
- The number of women referred for smoking cessation support
- The number of women with a BMI of >30
- The number of eligible women referred to FNP service
- The number of women taking healthy start vitamins at pregnancy presentation
- The number of pregnant women given flu vaccination
- The number of women given pertussis vaccination
- The number of children recorded as carer's referred for support.

6.1 Audit requirements

To be confirmed for 2017/18

7 Financial and Procurement Summary

The total budget available is £567,000 for the contract term 1 April 2017 to 31 March 2018. This is made up of £260,000 recurrent funding and £307,000 non-recurrent funding. This includes £24,000 assigned to the health visiting resource provided by HUH to support the development and review of UPP joint action plans.

The payment terms include elements of cost per case and one off payments as set out below:

Activity name	Eligible Cohort	Cap	Capped cohort	Cost per App	Activity sub-total
Targeted preconception			750	£ 40.00	£ 30,000.00
Pregnancy presentation	4500	65%	2925	£ 40.00	£ 117,000.00
16 week antenatal	4500	70%	3150	£ 40.00	£ 126,000.00
6 week postnatal	4500	85%	3825	£ 40.00	£ 153,000.00
UPP new - GP			300	£ 64.00	£ 19,200.00
UPP new - HV			300	£ 30.00	£ 9,000.00
UPP review - GP			1000	£ 30.00	£ 30,000.00
UPP review - HV			1000	£ 15.00	£ 15,000.00
New patient checks			1150	£ 40.00	£ 46,000.00
Maintenance of registers (UPP & Carer's)					£ 10,000.00
Publicising 16yr old health checks					£ 1,000.00
Development of health promotion materials*					£ 10,000.00
Total					**£ 566,200.00**

The available budget for Antenatal care is capped at £243,000
A payment of £40 per appointment is payable based on quarterly returns of data demonstrating enhanced appointments. The capped budget is based on 4,500 pregnant women per annum with 65% (2,925) having an enhanced pregnancy presentation appointment and 70% (3,150) having an enhanced 16-week appointment.

The available budget for Postnatal care is capped at £153,000
A payment of £40 per appointment is payable based on quarterly returns of data demonstrating enhanced appointments. The capped budget is based on 85% of women (3825) having an enhanced 6-8 week postnatal appointment.

The available budget for Pre-conception care is capped at £30,000. The capped budget is based on 750 women receiving a targeted preconception appointment. A payment of £40 per appointment is payable based on quarterly returns of data demonstrating enhanced appointments.

The available budget for practices for developing and reviewing Universal Partnership Plus action plans is capped at £49,200
The development and review of action plans for vulnerable children needs to be conducted with the designated Health Visitor. The available budget for the Health Visiting resource is capped at £24,000.

A payment of £64 is payable to practices for each new action plan. The capped budget is based on 300 new action plans.
A further payment of £30 is payable to Homerton University Hospital (HUH) for Health visiting service input.

A payment of £30 is payable to practices per reviewed action plan. The capped budget is based on 1000 action plan reviews.
A further payment of £15 is payable to HUH for Health visiting service input.

A payment of £10,000 will be provided to support the maintenance of the Carer's register and development of care pathways.

The available budget for new patient checks is capped at £46,000 based on a cap of 1150 checks.
A payment of £40 per appointment is payable based on quarterly returns of data demonstrating enhanced appointments.

A payment of £1,000 will be provided to support the development and display of promotional materials advertising a health check for 16-years old's.

A payment of £10,000 will be provided to support the development of health promotion materials for new families. These should take the form of leaflets or a booklet and include the following topics;

- Using local health services (when to access GP, out of hours, pharmacies, A&E)
- Immunisation schedule for children
- Local offer
- How to provide feedback on experience of Early Years' service

There are no penalties. However for the CCG to impact on infant mortality in the longer term and improve maternity outcomes maximum coverage is desirable for the extended antenatal and postnatal consultations. Our objective in the initial term of this contract is to increase the number of enhanced appointments and understand the level of need to inform pathway development.

The CCG will review activity levels with the GPC on a quarterly basis. Funding above the capped levels is not guaranteed however the CCG will review and consider the overall contract performance in the context of the full available budget.

8 Proposed Contractual Terms

- Type of contract proposed: NHS standard contract.
- Service Commencement date: 01.04.2017
- Initial term of service is: 12 months
- Option to extend the initial term? If so, on what basis? Extension may be granted for 2018/19 dependent on securing further non-recurrent funding.
- Details of proposed sub-contractors: GP practices in City and Hackney

Contractual interdependence with other existing services / providers:

- CEG for template development and reporting.
- Maternity and Health Visiting Services.

Appendices

- Opportunistic Preconception Care
- Targeted Preconception Care
- Pregnancy Presentation / First Contact
- 16-week Antenatal Appointment
- 6-week Postnatal Appointment
- 6-week Baby check
- Vulnerable Children register and action plan
- New patient health check
- 16 year old health check

Appendix 1. Opportunistic Preconception Care

The Confederation will develop pre-conception information materials and promote the availability of pre-conception appointments.

Pre-conception information materials will include information on:

- Folic acid/healthy start vitamins
- Healthy weight and physical activity
- Smoking, alcohol and drugs
- Medication(s)
- Mental health screening and support
- Chronic disease management
- Importance of early booking (before 10 weeks of pregnancy)
- Antenatal classes, preparation for parenthood, relationship counselling, advice on psychological and social aspects of planning a pregnancy, including discussion of any previous difficulties.

To support the Confederation to implement this, the CCG will launch a series of pre-conception guidelines, based on current antenatal guidelines. This will include who to refer to obstetric medical clinics, guidelines signposting people to help for good mental health e.g. 5 ways to stay well emotionally and mindfulness apps, and the importance of accessing antenatal classes.

Appendix 2. Targeted Preconception Care

Women (aged 20-45 years) with the following long term conditions will be invited to have their condition and medication optimised prior to conception:

- Diabetes
- Hypertension
- Asthma
- Epilepsy
- Pre-existing mental health illnesses (women who are on SMI QoF and depression registers)
- Thyroid disease
- Rheumatological conditions
- Chronic Kidney Disease
- Cardiac disease

The GPC will be required to deliver the following services and develop a template to record the following activities:

- Review of long term condition and any associated medication(s)
- Prescribing healthy start vitamins and folic acid or confirmation that own pregnancy vitamins are taken
- Taking blood pressure
- Weighing and measuring and calculating BMI
- Alcohol and smoking advice
- Medication review
- Mental health assessment
- Screening for rubella, hepatitis, syphilis and HIV if risk justifies, and Hb electrophoresis if

appropriate the template must allow for an exclusion code for patients not wishing to continue their family.

Appendix 3. Pregnancy Presentation

The GPC will ensure that patients who present to their GP when first pregnant and intend to continue their pregnancy will receive a 'first contact appointment' to include:

- Advice on diet, smoking, alcohol and healthy start vitamins.
- Recoding of BP and prescription of aspirin if indicated.
- Recording of BMI and referral to HUH dietetics if indicated.
- A social, psychological and medical risk assessment including being screened for depression where appropriate and referred on for further care if necessary.
- Have medical issues addressed including those related to asthma, epilepsy, hypertension, diabetes, thyroid disease (increasing levothyroxine if necessary), rheumatological diseases and mental illnesses and a full medication review.
- Referral to antenatal care using the pan-London referral form sharing all relevant information with maternity services.
- Referral to specialist services if indicated, e.g. perinatal mental health, primary care psychology, public health or specialist midwives, medical obstetric clinics, bump buddies, benefits advice, Family Action, relationship counselling, FNP, dietetics, targeted antenatal classes, children's social care.

In the event that this cannot be delivered in a single appointment the patient could be asked to come back for a second appointment if they are more complex.
The GPC will ensure GPs complete the enhanced template at all pregnancy presentation appointments.

Appendix 4. 16-week Antenatal appointment

The GP will deliver a 16-week appointment to pregnant women which will include the following care:

- Depression screening, using the Edinburgh depression score where appropriate.
- Review, discuss and document the results of all screening tests undertaken; reassess planned pattern of care for the pregnancy and identify women who need additional care. Results must be printed off and placed in the Maternity Blue Notes.
- Discuss the results of Down's syndrome screening and quadruple test offered if Down's syndrome screening has not yet been undertaken.
- Investigate a haemoglobin level of less than 11 g/dL and consider iron supplementation if indicated.
- Give information on the routine anomaly scan undertaken at 20 weeks.
- Check that aspirin has been prescribed to women at high risk of pre-eclampsia.
- Check the woman's BP and dipstick urine.
- Review of medication.
- Review of flu immunisation status, provide information and advice to promote and deliver immunisation as required.
- Review of pertussis immunisation status, provide information and advice to promote and deliver immunisation as required.
- Check whether the woman is taking healthy start vitamins or their own pregnancy vitamins.
- Address any medical concerns.
- Identification and referral of vulnerable families and safeguarding issues.

The GPC will ensure GPs complete the enhanced template at all 16-week antenatal appointments.

Appendix 5. 6-week Postnatal appointment

A postnatal appointment by the GP will be provided 6 – 8 weeks after delivery. This appointment is focused on maternal health and includes:

- A debrief about pregnancy and birth; any outstanding medical issues e.g. anaemia, stitches or issues that will impact on future pregnancies.
- Blood pressure check.
- Depression screening – Review how the woman is feeling e.g. relationships, bonding with the baby, sleep, mood, other children.
- Information and promotion of breastfeeding.
- Review of contraception.
- Review of smoking status.
- Examination and health promotion, including offering cervical screening in the practice.
- Ask and ensure that the woman has met a Health Visitor.
- Ensure that their baby has had their 6 week check (including Newborn Infant Physical Examination (NIPE).
- Identification and referral of vulnerable families and safeguarding issues.

The GPC will ensure GPs complete the enhanced template at all 6-8 week postnatal appointments.

Appendix 6. 6-week Baby check

At 6-8 weeks a baby check will be carried out by the GP with the following information captured on a template:

- Delivery of NIPE and early identification and referral for congenital cataracts, congenital heart disease, developmental dislocation of the hip and un-descended testes in males
- Promotion of BCG vaccination (by 6 weeks)
- Observation of good attachment between parent and child
- Promotion and signposting of children's centre services
- Identification and referral of vulnerable families and safeguarding issues;
- Referral for specialist services if indicated, e.g. perinatal mental health, specialist health visitors, breastfeeding, tongue tie, parenting services, bonding with baby, benefits advice, 3rd sector organisations etc.

The GPC will advise GPs to complete the enhanced template at all 6-8 week baby check appointments.

Appendix 7. Vulnerable children

Definition of vulnerable

To ensure consistency the definition of vulnerable will mirror that used 2015/16 in the national Health Visiting core specification**.**
https://www.england.nhs.uk/wp-content/uploads/2014/12/hv-serv-spec-dec14-fin.pdf

Universal:

Health visiting teams lead delivery of the Healthy Child Programme. They ensure that every new mother and child have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation.

Universal Plus:

Families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children.

Universal Partnership Plus:

Health visitors provide ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition.

Please refer to: City of London Threshold of Need document and The Hackney Child Wellbeing Framework for further information

The GPC is expected to maintain a register of vulnerable children. Siblings / other children aged 5 to 17 who are identified in the course of the 0-5 review, or opportunistically identified by the GP, should also be included on the vulnerable list.

The GPC is required to ensure that joint action plans are developed for children categorised as UPP on the vulnerable children register. This must be done with their named Health Visitor, (and where appropriate with other health professionals such midwives or a Family Nurse Partnership (FNP) practitioner).

The action plan must include:

- a joint risk assessment of all vulnerable children aged 0 – 5
- a jointly agreed category level of support for each child
- named health agreed actions to support the child and family, including referrals to other agencies, who is responsible for actions and timescales.

In addition to agreeing the action plans, outcomes of decisions agreed at meetings between GPs and other health professionals for each child must be recorded to improve the recording of support for vulnerable children and families and multiagency working.

GP Practices should record notes from the meeting in the individual electronic patient record in EMIS – marking each entry with the code 'multidisciplinary review' – 6AE --- and health visitors must record this in Rio.

Appendix 8. New patient check

If a newly registered patient (within one year) has children (or is the main carer for a child) aged 5 to 17, the child should be offered a screening check by the Practice. This screening check may be carried out by a healthcare assistant or nurse and should be supported by a pre-check questionnaire developed by the Provider to cover the following minimum requirements:

- height
- weight
- immunisation status (and offer further immunisations as appropriate)
- medication and allergies
- healthy lifestyle advice, including information about CHYPS, as appropriate.

The healthcare professional is also expected to explore other elements of the full health check (see below), as seems appropriate, to determine if, for example, the child has or may have significant caring responsibilities or whether there is a personal or family history of mental ill health.

If following screening it is considered that the child or family require or may require further assessment or management (for example further exploration of family medical history, referral for blood testing or to other community or secondary care services), then the healthcare professional should refer the child/family member(s) to the GP for further assessment and management.

The elements of the full new patient check could include:

<table>
<tr><th>Child Health Check</th><th>Health Promotion</th><th>Vulnerable Family Assessment</th></tr>
<tr><td>Weighing and measuring</td><td>Check immunisation status including HPV for girls aged 12+</td><td>Child carer</td></tr>
<tr><td>Hearing</td><td>Offer testing for HIV, TB, Hepatitis B and C (for new entrants to the country)</td><td>Incidents of self-harm</td></tr>
<tr><td>+/- Blood pressure if clinically indicated (obese)</td><td rowspan="4">Appropriate healthy lifestyle advice. This should be tailored according to the age of the children and be culturally appropriate:
• Diet and exercise
• Dental health
• Sexual health
• Mental well-being
• Smoking
• Drugs and alcohol
• FGM</td><td>Parental mental health vulnerabilities or have learning disabilities</td></tr>
<tr><td>+/- Blood test for diabetes if indicated (obese)</td><td>Parental drug or alcohol misuse Domestic violence Asylum seeker family Highly mobile family
Past history of child being subject to a child protection plan</td></tr>
<tr><td>+/- Blood tests for anaemia
+/- thyroid function if indicated</td><td>Children over eight may speak to HP alone and be asked about mental wellbeing</td></tr>
<tr><td>Family history</td><td>Record school attended</td></tr>
<tr><td>Review of long term conditions or complex health needs</td><td>Provide information about CHYPS Plus (service for 11-19 year olds)</td><td></td></tr>
<tr><td>Medications and allergies</td><td></td><td></td></tr>
</table>

If it is identified that the child has caring responsibilities this should be coded and recorded on the child carer's register on the electronic patient record.

If the child is identified as vulnerable this should be coded and recorded on the vulnerable children's list on the electronic patient record.

Appendix 9. 16-year health check

The GPC will develop and display promotion materials (e.g. a poster) to advertise and invite all 16-year olds for a health check.

All health checks should be offered at an appropriate time that is suitable for the young person e.g. out of school hours. The health check will include:

Health Check	Health Promotion	Information & Signposting
Weighing and measuring	Provide brief interventions on healthy lifestyle factors including: • Drugs and alcohol • Smoking • Diet and exercise • Sexual health – sex and relationship information, family planning and safe sex advice • FGM • Intimate partner violence • Mental wellbeing including use of a Wellbeing questionnaire if appropriate	To all relevant services, including sexual health services CHYPs plus Carer's services Self-help programmes
Blood pressure if indicated		
Review family history	Review immunisation status and offer any missed vaccines	
Review of diagnosed long term conditions or complex health needs	Chlamydia screening & STI screening if sexually active	
Medications and allergies	Check HPV status and offer vaccine if unvaccinated or incomplete course	