APPENDIX 3

Gwent Early Years Integration Transformation Programme

Midwifery and Early Years Core Programme – accessible version

Date 17/01/2023 Version 8

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Purpose and summary of the document:

This document outlines the Gwent Midwifery and Early Years Core Programme which is delivered universally to all families across Gwent through an integrated team of local authority and health board staff.

Gwent Midwifery and Early Years Core Programme

Key:

- HV = Health Visitor
- SHN = School Health Nurse
- MW = Midwife
- FW = Family Worker (this is a generic title used to represent all those working with families in a family support type role and may include responsive feeding, early language, child development, parenting programmes, etc.
- EL = Early Language
- GP = General Practitioner
- HVCN = Band 5 Health Visitor Community Nurse
- PIMHS = Parent Infant Mental Health Service
- HCWP = Healthy Child Wales Programme mandatory / standardised contact
- a. = additionality offered based on need

Contacts:

1. MW at 8-12weeks in the clinic or home deliver the booking appointment. 'Healthier Together' information is sent via Text by Community Midwife prior to booking appointment. Antenatal booking is completed face to face.
    a. Community Midwife has a What Matters conversation at all contacts and links to Family Worker/wider team when appropriate.
2. MW at 11(+2)-14(+1) weeks in the hospital deliver a dating scan. Scan completed at hospital by Midwife / Sonographer. Estimate due date generated. Discussion and informed consent obtained for antenatal screening, routine bloods – FBC and Group and Antibodies., HIV, Hep B, Syphilis & Combined / Quad screening test offered. Whooping cough vaccine discussed & advised to make appointment for this vaccination at GP practise between 16-32weeks gestation. Advised to get flu vaccine, in season. Advised to take multi-vitamins/folic acid.
3. MW at 16 weeks in the clinic or home deliver an antenatal contact for all women. Appointment to provide results of AN screening blood tests taken at booking appointment. Also, give information to the family including support available antenatally.
4. MW at 18-20(+6) weeks in the hospital for all women to have an anomaly scan and diagnostics for physical development.
5. FW at 20 weeks virtual or home antenatal contact for all pregnant mums. Early Years registration form completed. Following discussion with midwife ensuring continued pregnancy, focus on responsive feeding and mental health, What Matters conversation, healthy start information, key public health messages.
    a. Antenatal programme online access or in 1-1 / small group (What Matters). PIMHS pull-in if needed.
6. MW at 24 weeks routine antenatal appointment for all women in clinic
    a. May need additional 1-1 work depending on issues / concerns raised. May need pull-in from wider team.

7. MW at 28 weeks routine antenatal appointment for all women in clinic. Routine blood screening offered GTT if applicable.
    a. May need additional 1-1 work depending on issues / concerns raised. May need pull-in from wider team.
8. HV (HCWP) at 28+ weeks virtual or home targeted antenatal contact for first time and vulnerable parents. Early Years Registration Form check. HV to assess family's needs - FRAIT, key public health messages. Parental expectation and preparation for parenthood. Promote group availability if not already accessed.
    a. May need additional 1-1 work depending on issues / concerns raised. May need pull-in from wider team.
9. MW at 31 weeks routine antenatal appointment for primigravidia in clinic
10. MW at 32 weeks routine antenatal appointment for multigravidia in clinic
11. MW at 34 weeks routine antenatal appointment for primigravidia in clinic. Information to prepare for labour and discussion about their birth plan.
12. MW at 36 weeks routine antenatal appointment for all women virtually or in clinic. Mode of delivery and birth plan discussed.
13. MW at 38 weeks routine antenatal appointment for all women virtually or in clinic
14. MW at 40 weeks routine antenatal appointment for all women in clinic. Discussion & options if pregnancy exceeds 41 weeks.
15. MW at 41 weeks routine antenatal appointment for all women in clinic. Antenatal appointment for pregnancy. Discussion & options available & plans made if pregnancy goes beyond 41 weeks.

Birth of Child

16. MW first postnatal visit at home. Physical examination of new born, Infant feeding conversation. Physical examination of the mother.
17. FW within 72 hours post discharge, phone call from responsive support. Phone call following birth – wellbeing and responsive feeding discussion with follow up calls at 7, 14, 21 days and then signpost to group support at 28 days.
    a. Family Worker to do further 1-1 work if needed and pull-in if needed form wider team.
18. MW at 4-6days in the home or clinic postnatal contact for blood spot screening.
19. HV at 10-14days (HCWP) contact in the home for the family health review. Birth visit – Assessment of family needs and infant feeding conversation. Health Visitor Observation and Assessment of the Infant (HOAI). Bespoke package of care planned by team based on "What Matters" conversation to understand needs / number of visits / by whom.
    a. HV to discuss bespoke package of care in What Matters meeting to ensure coordinated work of core team and wider team is pulled in as needed.
20. MW at 4weeks in hospital for a postnatal contact. New born hearing screening within 4weeks.

21. MW up to 28 days at home for the discharge visit where the mother is discharged from midwifery care and handover of care to health visiting.
    a. Families needing further interventions are brought to the What Matters meeting.
22. HV/FW bespoke follow up visit at clinic, virtual or home depending on need of family to follow up birth visit at 3 weeks.
    a. Support will depend on the What Matters conversation. Support may include 1-1 listening visit, wellbeing contact, PIMHS, housing, feeding, domestic violence, financial support including food parcels, changing benefits, and budgeting.
23. HV/FW bespoke follow up visit at clinic, virtual or home depending on need of family to follow up birth visit at 4 weeks.
    a. Support will depend on the What Matters conversation. Support may include 1-1 listening visit, wellbeing contact, PIMHS, housing, feeding, domestic violence, financial support including food parcels, changing benefits, and budgeting.
24. HV/FW bespoke follow up visit at clinic, virtual or home depending on need of family to follow up birth visit at 5 weeks.
    a. Support will depend on the What Matters conversation. Support may include 1-1 listening visit, wellbeing contact, PIMHS, housing, feeding, domestic violence, financial support including food parcels, changing benefits, and budgeting.
25. HV (HCWP) contact at 6 weeks at home to finalise the Family Health Resilience assessment paperwork. HV assessment of family need as per HCWP and evaluation of care packages delivered by FW & wider team where appropriate. Peri Natal Depression screening. Delivery of key public health messages. Introduction to baby massage.
    a. Living Life to the Full and/or peer support Peri Natal Depression group – PIMHS/FW
26. GP contact at the GP surgery for the 6-8week medical check-up by the GP.
27. FW contacts the family by phone at 8weeks – 6months to invite to Baby Club. Baby club open to all delivering key public health messages, baby massage, child development, Language development and promote peer support networks.
    a. Link to community provision for social isolation support. Link to wider team and pull-in as needed.
28. HV/FW/HVCN (HCWP) contact at 8 weeks will review the growth and developmental progress either in the home or clinic depending on the family needs. There is also postnatal depression screening.
    a. Living Life to the Full and / or peer support Perinatal Depression group through Parent Infant Mental Health Service PIMHS/FW.
29. GP at 8 weeks will deliver immunisations at the GP practice.
30. HV/FW/HVCN (HCWP) contact at 12 weeks will review the growth and developmental progress either in the home or clinic depending on the family needs. There is also postnatal depression screening.
    a. Living Life to the Full and / or peer support Perinatal Depression group through Parent Infant Mental Health Service PIMHS/FW.
31. GP at 12 weeks will deliver immunisations at the GP practice.

32. HV/FW/HVCN (HCWP) contact at 16 weeks will review the growth and developmental progress either in the home or clinic depending on the family needs.
33. GP at 16 weeks will deliver immunisations at the GP practice.
34. HV/HVCN (HCWP) contact at 6months for a child and family health review in clinic, virtually or in the home depending on family needs. There is an assessment of family need and evaluation of care packages delivered by FW/ wider team through What Matters meetings. 6 month growth and developmental review of child as well as the delivery of key public health messages including home safety and oral health toolkits.
    a. Where there are concerns with Speech Language and Communication understanding or parent child interaction, FW will deliver key language messages or additional activities to support development.
35. HV/HVCN/FW contact at 9-12 months in clinic, virtually or in the home depending on family needs for the Health Toddler contact. An assessment of family need and evaluation of care packages delivered by FW/wider team through What Matters meetings. Delivery of key public health messages.
36. GP at 12-13months does the immunisation in the GP surgery.
37. HV/HVCN (HCWP) contact at 15months to complete the Child and Family Health review either in the clinic or the home depending on family needs. HV assessment of family need as per HCWP and evaluation of care packages delivered by FW/ wider team through weekly What Matters meetings. 15month growth and developmental and SLC review of child. Delivery of key public health messages.
    a. **FOR FS ADDRESS – discuss childcare entitlement. NON-FS ADDRESS – discuss childcare needs and appropriate advice. FW to support early child development and language interventions including use of PAFT etc.
38. HV (HCWP where family has identified issues) contact at 18months in the clinic or at home depending on family needs to complete the Development Assessment Review. Where a concern was identified in any two skill sets at 15 months, the Schedule of Growing Skills tool to be undertaken and referrals where appropriate.
    a. May need Emerging ALN or Early Language interventions.
39. FW contact at 20-23months in the clinic, virtually or in the home complete the family health review. Identified packages of care delivered by FW. Delivery of key public health messages and toileting information / support.
    a. **FOR FS ADDRESS - Discussion re childcare needs (FS or local provision and funding options). Remind parent to check when school / setting Nursery application dates open and deadlines for submission.
40. EL/FW contact at 21-24months deliver early language interventions following an assessment of early language in a community space or the home depending on family needs. Development of speech, language, and communications, and assessment if appropriate. FW to do early language intervention in the community or home if needed.
    a. More intense/prolonged early language interventions if needed.
41. GP at 2-3years deliver the Flu vaccinations in the GP surgery.

42. HV/HVCN/FW (HCWP) contact at 27months will deliver the Child and Family Health Review in the clinic, virtually, or at home depending on needs. HV Assessment of family need as per HCWP and evaluation of care packages delivered by FW/ wider team through What Matters meetings. 27month growth and developmental review of child. Delivery of key public health messages. Check for school readiness e.g., toilet trained and support toilet training with the family if needed. Check parent has submitted Nursery Application and if received notification from Admissions.
    a. Early ALN / Language interventions and referral to ISCAN if appropriate for Educational Psychology assessment prior to starting nursery. If no developmental delays and not toilet trained, FW will support rapid potty training to ensure transition to nursery is possible. If concerns for transition of parents, support listening visits to prepare parents to be school ready. Support transition information to Nursery School / Setting.
43. GP contact at 3.4years will deliver the Preschool immunisations in the GP surgery.
44. HV/HVCN/FW (HCWP) contact at 3.5years will deliver the Child and Family Review in the clinic, virtually or at home depending on needs. HV Assessment of family need as per HCWP and evaluation of care packages delivered by FW/ wider team through What Matters meetings. School readiness review of growth and developmental of child. Delivery of key public health messages.
    a. If early language development or family support needs remains, pull in relevant support and interventions including relevant professionals / specialists. Ongoing contacts may require pull-in from wider teams as needs change throughout transition into nursery and statutory school and on to KS2.
    b. *The 4-7year offer will be further developed*.
45. HV/HVCN (HCWP) will meet the School Nurser to complete a record review and handover in the office or on the phone. Review of records and handover from Health Visitor to School Nurses.
46. FW will continue to make contact 3-7years in clinc, virtually or at home depending on family needs and will be available to support school transitions and through any periods of challenge.
47. SHN (HWCP) contact at 5years in school or hub for Vision and growth screening, Hearing impairment screening and Child measurement programme. Flu vaccine will be delivered.

NB: the model is not about referring on (reserved only for those statutory services that sit outside of the wider team). The wider team will be pulled-in as needed based on the What Matters conversation and work alongside the key worker who will be either HV or FW to ensure core team is upskilled in delivery of specific support.