

Health Visiting and School Nursing Programmes: supporting implementation of the new service model:

# Health visiting and school nursing partnership – pathways for supporting health visitor and school nurse interface and improved partnership working



## Context and rationale

This pathway is guidance to support professionals to deliver improved outcomes, and outlines our aspirations for service delivery. Local services will be at differing points of development and can use this pathway to benchmark their progress. The pathway builds on good practice and evidence drawn from the professions.

This document sets out the rationale for the partnership pathway and outlines the challenges and potential opportunities for development. Key principles and core components required to enhance outcomes, including options for service delivery, are detailed together with a comprehensive timeline. Delivery of the pathway requires the skills, knowledge and leadership of a qualified Specialist Community Public Health Practitioner for both health visiting and school nursing. The delivery should be led by the appropriate Specialist Community Public Health Nurse (SCPHN) and supported by an appropriately determined skill mix based on local need.

The overarching rationale for the partnership pathway is to achieve consistent, seamless support and care. Enhanced partnership working will ensure the delivery of the Healthy Child Programme 0-19 and achieve quality outcomes for children and parents. Underpinning this is:

1. Evidence from the collaborative children's workforce showing that there is no single profession or organisation that can ensure the best outcomes for children and families. This reinforces the need for a partnership pathway.
2. The specialist public health roles, skills and knowledge of both health visiting services and school nursing services emphasises these professionals as the knowledgeable leaders for children's health.
3. A clearer understanding and evidence base of the impact of early intervention and the economic savings that can be achieved through the provision of early help and therapeutic support through leadership, joint working and appropriate referral.
4. The recognition that the pathway needs to consider not only infant mental health but also the neuroscience of the brain through all stages of development.
5. The Munro review that identifies the importance of 'early help' throughout childhood and focuses on transition as being key.

## Why do we need a pathway?

The pathway provides a structured approach to addressing the common issues identified by both professionals associated with the transition of a family and child from health visiting to school nursing services. The pathway builds on good practice and provides a systematic, solution focused approach on which to base future local practice.

The partnership pathway will focus on addressing the integrated support required for children primarily aged between three and six years, whilst recognising that each child and family may have differing needs.

## Examples of anticipated outcomes

### Your Community

- Improved health outcomes and a reduction in health inequalities.
- Improved access to, and influence over, the wider community, allowing the promotion of healthy lifestyles and social cohesion.
- Improved planning of local services to reduce health inequalities.

### Universal Services

- Improved user satisfaction.
- Improved outcomes through the delivery of the Healthy Child Programme.
- Supported and empowered children, young people and families, resulting in the ability to make positive changes to their health and wellbeing.

### Universal Plus

- Supported children, young people and families resulting in the ability to address specific concerns on health issues.
- Services tailored to the needs of families through evidence-based programmes.
- Improved early identification of child and family needs, allowing timely and appropriate responses.

### Universal Partnership Plus

- Improved seamless multi-agency support for pupils with complex health and/or additional needs.
- Improved early and ongoing help for vulnerable children and families.
- Improved and consistent approach to meeting the needs of children and families with complex needs and/or additional health needs.
- Improved and appropriate safeguarding referrals.

## Achieving seamless transition

Ensuring the best possible local services for families means addressing service challenges.

Local service configuration, delivery and resourcing needs to be addressed through local partnership working between midwifery, Family Nurse Partnership, health visiting and school nursing service leads, commissioners and health and social care practitioners as part of the adoption of the partnership pathway principles.

This pathway is a tool that can be adapted to meet the needs of local mothers, fathers, children and families, taking into account local health priorities, health needs and resource deployment. To achieve seamless transition and integrated support, both professions need to work together and develop an understanding of each other's roles to ensure the early identification of need and support. This will ensure readiness for school and improve health and wellbeing. The use of a partnership pathway will support effective delivery and provide solutions to address local challenges including:

- **Partnership working:** Addressed through formalised liaison, joint training and regular meetings.
- **Financial constraints and lack of investment:** Partially addressed through the identification of appropriate skill mix within teams and measuring efficiency or impact, and through service redesign/planning/evidence based practice.
- **Workforce issues, lack of training opportunities and an aging workforce:** Addressed through the identification of joint training opportunities, and greater visibility of health visiting and school nursing as a career.
- **Communication systems fragmented within health and partner organisations:** Addressed through sharing learning and best practice and developing seamless sign posting between the professions. Standardisation of procedures for handover of records from health visitor and school nursing services.
- **Service fragmentation and variation of services provided to 0-5 and 5-19 year olds:** Addressed through clear identification of the different yet complimentary contributions of professionals throughout the transition timeline.
- **Evidence base is limited and often under-utilised:** Addressed through the identification and promotion of supporting policy and evidence.

## Data collection

Collection of data pertaining to the Healthy Child Programme outcome measurements should be readily available locally. The pathway aims to build on local evidence to validate the success and quality assurance of the pathway.

## Suggested Collaborative timeline for services to support children and families from age two until settled into school

It is recognised that the circumstances and needs of the family must be taken into account when implementing this timeline. NB: GPs and Primary Care colleagues are essential partners throughout the pathway.

|                                   |   | Pre-school   |  |   |  |
|-----------------------------------|---|--|--|---|--|
| When                              | 2-2½ yrs  | 2½-5 yrs   | 5-7 yrs  | 7-10 yrs  |  |
| <b>Who</b>                        | Health visiting, universal contact, with support from other key professionals including Children's Centres as part of integrated review where eligible.   | Health visiting/school nursing<br>The health visitor remains the lead professional until the child is five years old, or until the child is in full time education with support from the school nurse.   | School nursing<br>The school nurse will be the lead professional with support from health visitor where there are ongoing or identified additional needs from the child or family  | School nursing with support from other key professionals.   |  |
| <b>Where</b>                      | Health Centre, Home, Children's Centres, Early years settings, GP surgery, School   |  | School, Home, Community, Primary Care, Education   |   |  |
| <b>Action Plan</b>                | Identify additional health needs and provision of early help.<br>Move towards an Integrated Health and Early Education Review.<br>Develop strong partnerships with early years settings to ensure targeted support.   | Review the general progress and delivery of key health messages re parenting and health.<br>Prepare for school entry and introduce school nursing service.<br>Identify additional health needs and provide early help where needed.<br>Identify concerns about safeguarding or promote welfare.<br>Ensure alignment of training for assessment between health professionals and educational providers.   | Facilitate a smooth transition into school setting.<br>Identify and support children with additional health needs.<br>Identify children with additional health needs and provide early help where needed. Identify concerns about safeguarding or promote welfare.   | Prepare children and families for transition to secondary school and transition into and out of school, e.g. excluded pupils, youth offenders, hospital education.<br>Support children with additional health needs and provide early help where necessary.<br>Identify children with additional health needs and provide early help where needed. Identify concerns about safeguarding or promote welfare.   |  |
| <b>Key messages and actions</b>   | <ul style="list-style-type: none"> <li>Complete child and family review.</li> <li>Complete the health component of the integrated 2-2½ year review including the use of Ages &amp; Stages Questionnaires®, Third Edition (ASQ-3™) as a population measure of child development.</li> <li>Promote healthy eating and exercise.</li> <li>Promote accident prevention.</li> <li>Promote social development.</li> <li>Complete relevant elements of the universal 2 year health review.</li> <li>Signpost and refer to appropriate services where necessary.</li> <li>Discuss immunisations and health protection.</li> </ul> | <ul style="list-style-type: none"> <li>Share information between professional groups regarding pre-school background and health needs.</li> <li>Use a parent questionnaire to establish additional needs.</li> <li>Complete the health assessment at school entry in reception and review with child and parent. Health assessment to include: <ul style="list-style-type: none"> <li>Immunisations and health protection.</li> <li>Promotion of healthy eating/lifestyle.</li> <li>Promotion of accident prevention.</li> <li>Promotion of oral health.</li> <li>Hearing and vision.</li> <li>Behaviour management.</li> <li>Promotion of physical activity.</li> <li>Continence.</li> <li>Accident prevention and road safety.</li> <li>Personal body safety.</li> </ul> </li> <li>Signpost and refer to appropriate services where necessary</li> </ul> | <ul style="list-style-type: none"> <li>Promote healthy eating/lifestyle.</li> <li>Promote extended service provision.</li> <li>Discuss emotional health and wellbeing.</li> <li>Promote physical activity.</li> <li>Develop positive relationships.</li> <li>Signpost and refer to appropriate services where necessary.</li> <li>Promotion of oral health.</li> <li>Promote school routine.</li> <li>Discuss health protection, including immunisations.</li> </ul>   | <ul style="list-style-type: none"> <li>Promote healthy lifestyle.</li> <li>Promote involvement of father and wider family/carers.</li> <li>Discuss emotional health and wellbeing.</li> <li>Promote healthy eating and physical activity.</li> <li>Promote Personal, Social and Health Education (PSHE) and Economic Education.</li> <li>Promote school routine.</li> <li>Promote sun safety.</li> <li>Promote personal safety.</li> <li>Signpost and refer to appropriate services where necessary.</li> <li>Promotion of oral health.</li> <li>Discuss health protection, including immunisations.</li> </ul> |  |
| <b>Your Community</b>             | Your Community provides a range of health services, including some Children's Centres and the service families and communities provide for themselves. Health visiting services work to develop these and make sure families know about them.<br><br><b>← Potential for joined up Special Community Public Health Nurse led work</b>  |  | Your Community provides a range of health services (including GP and community services) for children, young people and their families. School nursing services develop and provide these and make sure children, young people and families know about them. Promotes family cohesion and family links, including the involvement of father and wider family/carers.<br><br><b>Potential for joined up Special Community Public Health Nurse led work →</b>  |   |  |
| <b>Universal Services</b>         | Universal Services from the health visitor provides the Healthy Child Programme to ensure a healthy start for children and family (e.g. prompts for immunisations, conducting health and development reviews). The health visitor supports parents and facilitates access to a range of community services/resources and refers to the GP where appropriate.  |  | Universal services from the school nursing service enables the Healthy Child Programme to ensure a healthy start for every child (e.g. National Child Measurement Programme, immunisations and health checks). School nurses identify the support that children may need when dealing with specific issues, e.g. bullying, emotional health, wellbeing and friendships, and provide support to teachers and school staff. School nursing services support children and parents with complex and/or additional health needs at school and ensure access to a range of community services and GP referral where appropriate. |   |  |
| <b>Universal Plus</b>             | Universal Plus delivers a rapid response from the health visiting team when specific expert help is needed, eg with parental mental health, attachment, toilet training, behaviour management, domestic violence.   |  | Universal plus provides a swift response from the school nursing service when specific expert help is needed (e.g. with weight management, enuresis, mental health concerns, long-term conditions and additional health needs. School nurses also provide support for parents and carers.  |   |  |
| <b>Universal Partnership Plus</b> | Universal Partnership Plus provides ongoing support from the health visiting team, bringing together a range of local services, to help families who have complex additional needs. These include services from Sure Start Children's Centres, other community services including voluntary and community organisations and, where appropriate, referral to the GP, social care or specialist services.   |  | Universal partnership plus provides ongoing support from the school nursing service, bringing together a range of local services working with families, to deal with more complex issues over a period of time (eg, with voluntary and community organisations, local authority and other key services such as the GP, Children and Adolescent Mental Health services (CAMHS), acute services and social care).  |   |  |

School Entry

## High Level Principles and Partnership Working

**Compassion in practice: Nursing, Midwifery and Care Staff: Our Vision and Strategy** provides a platform to describe the core values of nursing and midwifery. It is based around six values, known as the 6 C's – care, compassion, courage, communication, competence and commitment. These are underpinned by the six fundamental values in the boxes below.

### High-level principles

- Safety of child and access to early help for children and families.
- Child and family centred approach to care, support and decision making process.
- Partnership working within the changing health and social care agenda and recognising core values of the family service.
- Early years are critical to setting out a child's life trajectory for physical and emotional health, learning and development.
- Local service provision taken into account in designing a collaborative shared pathway to identify the optimum points for partnership working.

### Principles of Health Visiting

- Search for health needs.
- Stimulations of an awareness of health needs.
- Influence on policies affecting health.
- Facilitation of health enhancing activities.

### Maximising Health and Well-being

- Seamless transition through early years to starting school.
- Joined up working.
- Communication between everyone involved in the family.
- Delivering public health outcomes through joint implementation of the Healthy Child Programme: pregnancy to the first five years of life.
- Incorporating the full public health offer within a family and community concept.
- Improving parenting skills and family resilience.

### Delivering care and measuring impact

- Using appropriate assessment tools to ensure the right intervention.
- Having intelligent conversations at points of contact.
- Robust data collection, including needs and outcomes.
- Increasing equality and quality of universal offer to all to deliver outcomes.
- Undertaking joint needs assessments.
- Utilising school entry questionnaires.
- Supporting clinical effectiveness, risk management and clinical audit.
- Utilising evidence based practice and following clinical guidelines.

### Working with children and young people to provide a positive experience

- Providing information on health visiting and school nursing services to children, young people and families.
- Participating in complex needs joint visits.
- Participating in care planning with schools, children, young people and families.
- Sharing information where appropriate.
- Improving information available for families about roles of professionals.
- Improving service user family satisfaction.
- Ensuring care is delivered by experienced and knowledgeable practitioners, with the skills to communicate effectively with children, young people and families.

### Compassion

- Recognising and understanding needs of children, young people and families in order to produce a care plan.
- Building trusting relationships.
- 'Normalising Life' Early Years Plan.
- Respecting dignity.
- Being open and non-judgemental.
- Using a whole family approach.

### Commitment

- Demonstrate health and well-being.
- Improving joint working.
- Ensure services meet 'You're Welcome' standards.
- Implementation of NHS Friends and Family test.
- Improving delivery and sharing 'what works'.
- Supporting service improvements and changes.

### Competence

- Develop skills through training.
- Act as an expert on the child or young person.
- Ensure appropriate referrals.
- Utilise evidence based practice.
- Standardising care.
- Recognising competencies and seeking new opportunities.
- Recognising specialist skills and skill mix within the team.

### Care

- Health visitors and school nurses provide care in a range of settings.
- Seamless delivery of Healthy Child Programme 0-19.
- Making time to understand the world of the child, young person and family.
- Promoting positive health and well-being.
- Using technology to improve access.

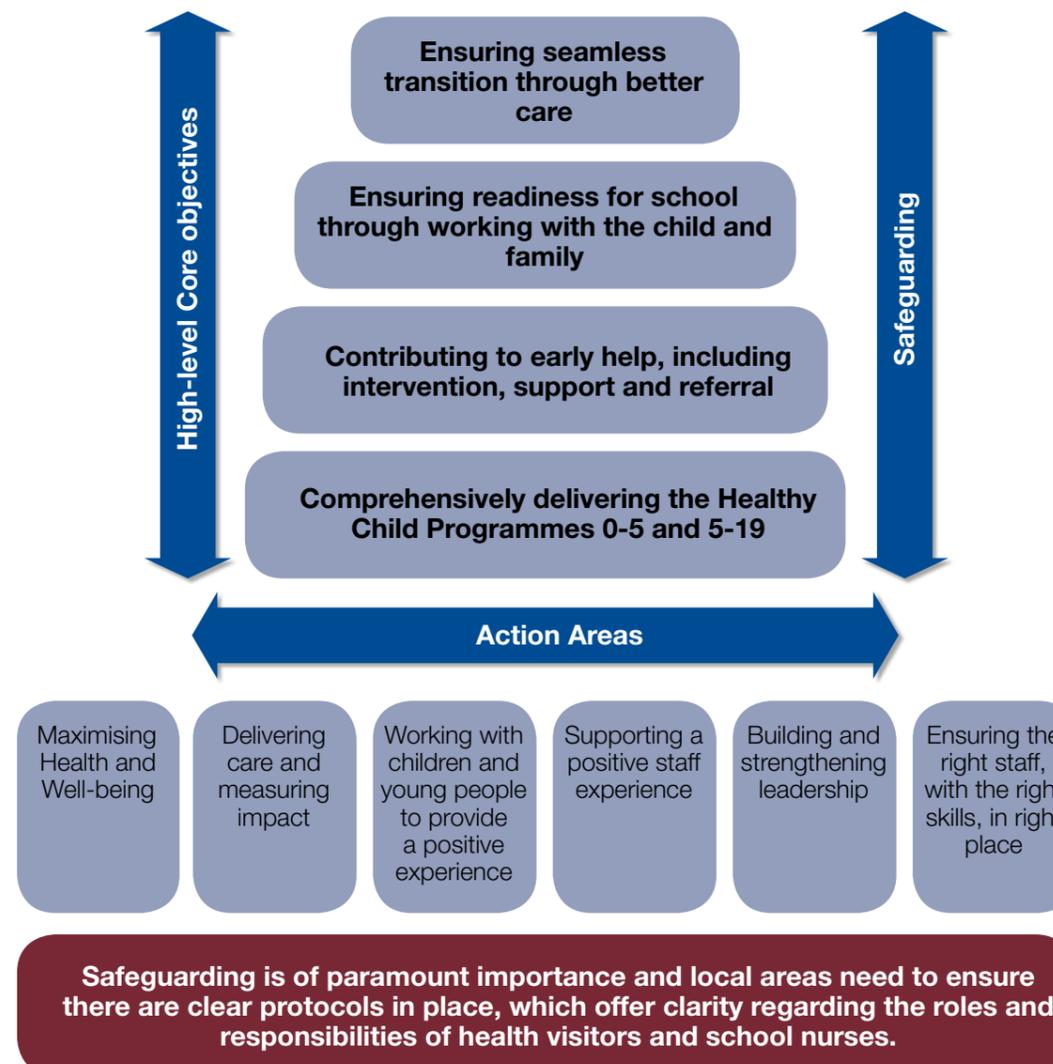
### Courage

- Having difficult conversations and empowering the child, young person and family.
- Advocating for the child or young person.
- Knowing when to professionally challenge.
- Having intelligent conversations.
- Embracing innovation and new ways of working.
- Working transparently with the child, young person and family.

### Communication

- Having robust protocols for information sharing.
- Communicating appropriate safeguarding concerns when they arise.
- Embracing modern technology and utilising new ways of communicating.
- Improving communication across own and other agencies.
- Supporting cross-agency working and communications.

**Figure 1: Improved health outcomes and reduced inequalities of family/child experience: illustrating the inter-connectivity between the 6 Action Areas and improving outcomes for children and young people**



### Supporting positive staff experience

- Joint training and supervision.
- Sharing best practice.
- Integrating broader learning into the health visiting and school nursing role, e.g. Family Nurse Partnership.
- Using case studies to improve service delivery, and disseminating good practice.
- Improving skill mix and specialist roles.
- Increasing peer support and integration.
- Inter-agency working between different professional groups.

### Building and strengthening leadership

- Provide live and updated access for tracking pupil movement in and out of schools.
- Formal dialogue taking place between health visitors and school nurses during transition phases.
- Ensuring leader professionals have strategic knowledge the for whole 0-19 pathway.
- Optimising management and efficiently deploying resources.
- Improving communications, team working and joint planning.
- Aligning IT Systems between health, education and social care.

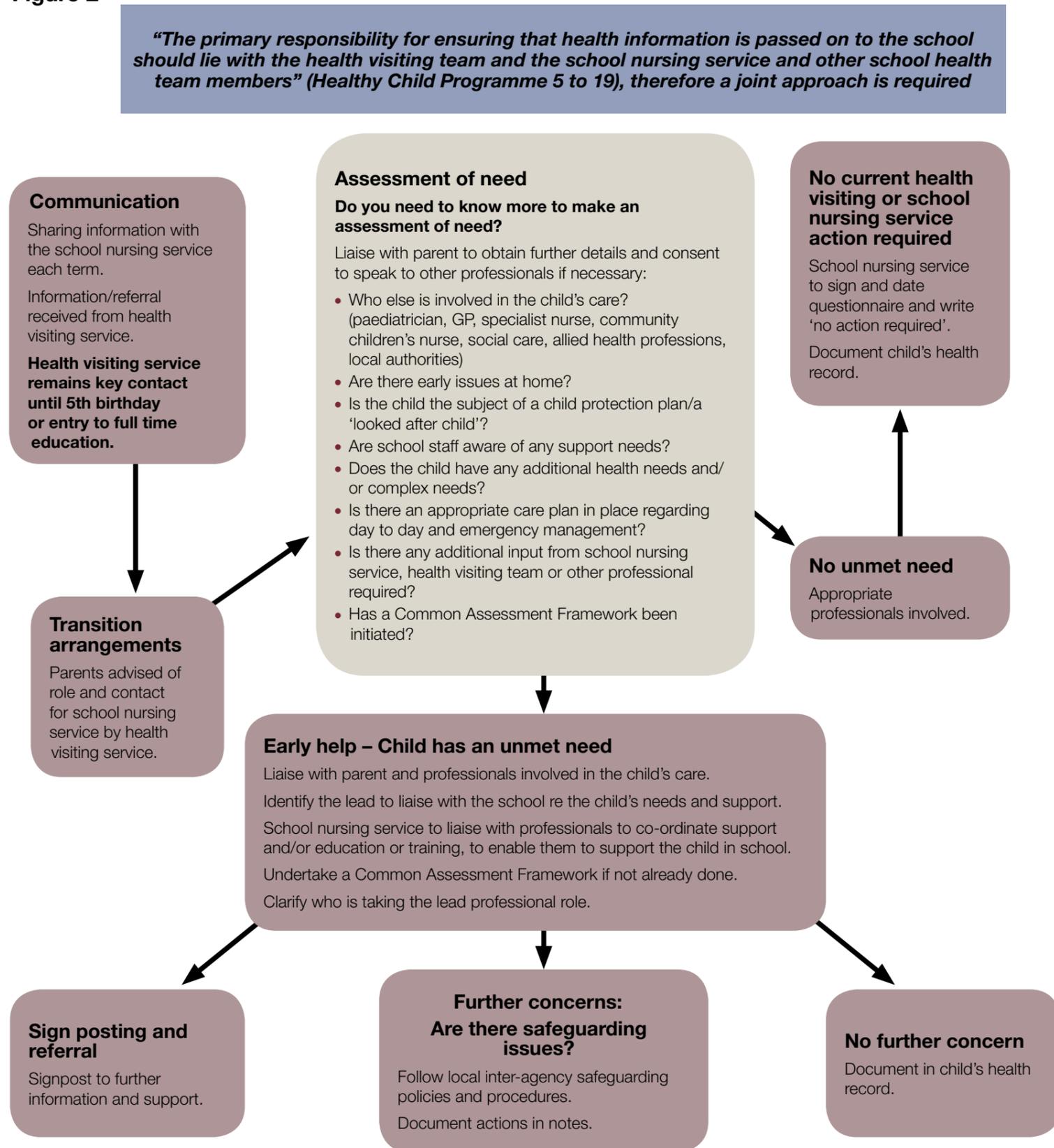
### Ensuring the right staff, with the right skills, in the right place

- Improving skill mix and team working.
- Using resources more efficiently, underpinned by joint commissioning.
- Having clarity regarding roles and responsibilities of the multi-disciplinary team.
- Identifying the lead professional at an early stage.
- Building on 'what works' and utilising evidence.
- Improving use of clinical skills and robust professional judgement.
- Improving multi-agency communication.
- Enhancing partnership working within a changing agenda, recognising the views of children and young people's services.

# Acknowledgements, Supporting Policy and Evidence

Local services need to develop their own pathways based on local needs and service provision. Figure 2 below offers an example of a pathway

Figure 2



## Acknowledgements

The pathway was developed collaboratively and in partnership with representatives drawn from health visiting and school nursing, a range of stakeholders across the NHS, and other organisation. Wider consultation has been facilitated through the professional organisations. Thanks are extended to all contributors, specifically the following:

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### Supporting policy and evidence

- [The Healthy Child Programmes 0-5](#) and [5-19](#) are the preventative programmes for all children and include schedules for screening, immunisation and assessment. The Healthy Child Programme supports health, and learning and development outcomes for children, and recognises that some will need higher levels of input to reach their potential. The Healthy Child Programme is led by health visitors and commences in pregnancy.
- The [Health Visitor Implementation Plan: A Call to Action](#) sets out the revitalised universal offer of health visiting support for all children and their parents, and challenges midwives and health visitors to articulate and recognise their different professional perspectives and collaborative contributions to ensure quality outcomes for children and parents.
- The [Supporting Families in the Foundation Years](#) document underlines and emphasises the importance of the foundations years (from pregnancy to age 5), and the value of offering parents support, advice, and information, antenatally and after birth.
- The [Munro Report](#) sets out proposals for reform which are intended to create the conditions that enable professionals to make the best judgments about the help to give to children, young people and families.
- Community Public Health, [Demonstrating and Measuring Achievement Community Indicators for Quality Improvement](#).
- Nursing and Midwifery Council, [Standards of Proficiency for Specialist Community Public Health Nurses](#).
- The [Mobile Health Worker Project Progress Report \(2011\)](#), which looks into the effectiveness of the use of mobile devices in clinical care has found that health professionals can work more productively with the tools than without.