Family Nursing
& Home Care

Standard Operating Procedures
Health Practitioner Role

December 2024

Family Nursing & Home Care

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Introduction

These standard operating procedures outline the role and responsibilities of the Health Practitioner within the Family Nursing & Home Care (FNHC) Health visiting service.

The Health Visiting team has an important role in leading the delivery of the Healthy Child Programme (HCP) (Department of Health (DH), 2009) which is a universal prevention and early intervention programme.

Family Nursing & Home Care's (FNHC) Health Visiting Service aim to work in partnership with children, parents and carers and where necessary, specialist services, to deliver the (HCP). The HCP aims to give every child the best start in life by optimising child development and emotional wellbeing.

The Health Practitioner's role is unique to the Health Visiting team in Jersey. The Health practitioners are experienced midwives with a specific set of qualities and experience. They have worked within the community setting and have extensive experience in working with families with various needs, including mental health and safeguarding.

Their purpose is to support the health visiting team by delivering the HCP to Universal and Universal Plus service families, in pregnancy and through to the 6-8 week assessment.

The Health Practitioner will offer the following parts of the programme:

- Ante Natal Contact
- New Birth Review
- Support visits; mental health, breastfeeding, and social needs
- 6-8 week assessment

These standard operating procedures are based on current best practice guidance using a range of resources.

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SOP 1 Identification of Clients for Health Practitioner

Purpose

Identification of Clients

Scope

Core Requirements/Procedure

HV Duty triage HCP contacts from a Universal caseload for allocation to HP.

Universal and specific targeted clients will be identified such as issues of emotional wellbeing and supporting feeding issues, clients identified for MECSH.

Baby Steps will identify clients for targeting antenatal visits to HP, such as wellbeing and social need with short term outcomes.

Maternity Multi-Disciplinary Team Meeting will identify clients at a monthly meeting that HP triages need and liaises with HV Duty for allocation to HV or HP.

Fetal Medicine Meeting is monthly where needs are identified and liaised with HV Duty for triage and allocation to HV/HP/CCNT.

Jersey Neonatal Unit where needs are identified and liaised for allocation via HV Duty and Community Childrens Nurse Team.

MECSH Mental Health Practitioner may identify clients from Perinatal Mental Health Weekly Meeting to HV Duty and for allocation to HV/HP

SOP 2 Ante Natal Contact

Purpose

The Healthy Child Programme states that from 28 weeks of pregnancy, Health Visits should have a focus on emotional preparation for birth, carer-infant relationship, care of the baby, parenting and attachment, using techniques such as promotional interviewing. (Healthy Child Programme (HCP) Department of Health (DH), 2009)

The purpose of the HCP Ante Natal Contact is the:

- Promotion of health and wellbeing
- Ongoing identification of families in need of additional support.
- Preparation for parenthood.
- Involvement of fathers.
- Emotional preparation for birth, including career-infant relationship, care of the baby, parenting and attachment, using techniques such as motivational interviewing to identify those in need of further support during the post-natal period; and establish what their needs are.
- Sources of information on infant development and parenting and the HCP.
- Providing of information in line with Department of Health guidance on reducing the risk of SIDS.

Scope

To conduct an Ante Natal Assessment for all pregnant women from the period of 28 weeks gestation. This should be from 20 weeks if targeted MECSH or specialist level needs.

To assess parental mental health (NICE guidance CG192, CS115, and CG62)

To offer health promotion advice, guidance and support in accordance with the Healthy Child Programme (Department of Health (DH) 2009) and Institute of Health Visiting and Health for all Children – fifth edition (2019), NICE guidance CG NG 194 (2021) and the most relevant HIGH IMPACT AREAS (Appendix 1) – from Public Health England.

Core Requirements/Procedure

Where there is a universal level of need, the ANC should be from 28 weeks.

Where targeted or specialist level of need is identified, the Ante Natal Contact (ANC) should take place at 20 weeks.

Assess the health and social needs of the unborn baby with the context of their family. This should include identification of risk and resilience factors together with any changes to family composition.

Use **promotional/motivational interviews** as described in Appendix 2.

Undertake the Ante Natal Contact in accordance with the core requirements set out in Appendix 3.

The Health Visitor should use their professional judgement when undertaken the assessment, provided the approach is evidence based and a clear rationale for the decision-making and recorded/documented.

Service Provision: The Ante Natal Contact cannot be delegated to a Community Nurse or Staff Nurse.

The recommended setting for the contact is the client's home.

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SOP 3 New Birth Review

Purpose

The Healthy Child Programme states that by 14 days a face-to-face New Baby Review with mother and father should be carried out by a Health Professional. Health Visitors should have a focus on infant feeding, promoting sensitive parenting, promoting development, assessing maternal and infant mental health, safer sleep (risk of SIDS, keeping safe and safeguarding. (DH), 2009)

The purpose of the New Birth Review is to:

- Identify the child's progress, strengths and needs at this age in order to promote positive outcomes in health and wellbeing.
- Offer the Healthy Child Programme (Department of Health (CH), 2009) to all infants within the designated age range.
- Ensure clear and consistent evidence-based practice resulting in quality and equity of delivery of the Healthy Child Programme 0-5 Years.
- Generate information for care planning and contribute to the reduction of inequalities in children's outcomes.
- Offer The MECSH Programme if eligible.
- Facilitate appropriate intervention and support for children and their families, especially those for whose progress is less than expected.
- Enable appropriate and timely information sharing to safeguard children in accordance with Working Together to Safeguard Children (HM Government, 2018) and in line with FNHC Safeguarding Policy, Jersey's Safeguarding Partnership Board guidance and Statutory Guidance Jersey and Children and Young People's Law (Jersey) 2022.

Scope

To conduct a Health and Development Assessment for all children aged between 10 and 14 days old.

To review maternal/paternal and infant mental health. NICE guidance CG192, QS115 and NG194.

To offer health promotion advice, guidance and support in accordance with the Healthy Child Programme (Department of Health (DH) 2009) and Institute of Health Visiting and Health for all Children – fifth edition (2019), NICE Guidance – NG194 (2021) and the most relevant HIGH IMPACT AREAS (Appendix 1). (Healthy Child Programme (HCP), Department of Health (DH), 2009)

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Core Requirements/Procedure

The New Birth Review should be undertaken when the baby is between 10-14 days old.

An Assessment of the child's health and social needs should be undertaken within the context of their family. This should include identification of risk and resilience factors together with any changes to the family composition.

The New Birth Review should include the core requirements as sent out in Appendix 4.

The Health Visitor should use their professional judgement when undertaken the Assessment, provided the approach is evidence based with a clear rationale for the decision making recorded/documented.

Use **promotional/motivational interviews**, as described in Appendix 2.

NOTE – weight and head circumference for preterm infants born 32 – 36 weeks should be plotted on the preterm page of the Parent Held Childhood Record (PHCR) until two weeks after the EDD. Subsequent measurements should be plotted on the 0-1 chart using gestationally corrected age which adjusts the plot for the number of weeks before 40 weeks a baby was born. Gestational correction should be continued until corrected age 1 year for babies born 32 – 36 weeks.

Infants less than 32 weeks should be plotted on the Neonatal Infant Close Monitoring Chart which has a larger scale and can be used up to the age of 2 years corrected age. After this time, gestational correction can cease.

Head circumference should be measured shortly after birth for all babies and then again at 8 weeks but not again unless there are worries about the child's head growth or development. If the initial head circumference measurement is not completed following birth then consideration of measurement by the midwife at day 5 visit or HV at New Birth Visit at 10-14 days. On going monitoring and/or referral should be considered where concerns are identified.

It is often difficult to get an accurate measurement of length or height in an uncooperative baby or toddler so not sought as a matter of routine. However, length should always be measured if there are concerns about a child's weight gain, growth or general health. Length should be measured up to 2 years and height thereafter. Length/height should be measured in any child whose weight is above the 99.6th centile or where there is very rapid weight gain.

All measurements should be taken with appropriate equipment, techniques, skills and knowledge (Emond 2019)

Service Provision: The New Birth Review cannot be delegated to a Community Nursery Nurse nor to a Staff Nurse. It is recommended that the New Birth Review takes place in the baby's home.

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SOP 4 6-8 Week Health and Development Review

Purpose

The 6-8 Week Health and Development Review is one of the key mandated reviews within this universal prevention and early intervention programme. The GP will have responsibility for ensuring the 6-8 week new-born infant physical examination is completed for all registered babies.

This visit is crucial for assessing the baby's growth and wellbeing alongside the health of the parent, particularly looking for signs of postnatal depression. It is a key time for discussing key public health messages, including continuing with breastfeeding, immunisations, sensitive parenting and for supporting on specific issues such as sleep. The Health Practitioner will agree future contact with the family depending on Universal, Targeted or Specialist Service (HCP, DH, 2021)

The purpose of this review is to:

- Facilitate appropriate intervention and support for children and their families, especially those for whose progress is less than expected.
- Enable appropriate and timely information sharing to safeguard children in accordance with Working Together to Safeguard Children (HM Government, 2018) and in line with FNHC Safeguarding Policy, Jersey Statutory Guidance and Jersey's Safeguarding Partnership Board guidance.
- Ensure clear and consistent evidence-based practice resulting in quality and equity of delivery of the Healthy Child Programme 0-5 Years.
- Generate information which can be used to plan services and contribute to the reduction of inequalities in children's outcomes.
- Offer the Health Child Programme to all infants within the designated age range.

Scope

To conduct a Health and Development Assessment for all children aged between 6 and 8 weeks of age.

To review maternal/paternal mental health

To support sustainment of breastfeeding or/and responsive bottle feeding.

To support the uptake of immunisations using evidence-based discussion.

To offer health promotion advice, guidance and support in accordance with The Healthy Child Programme (Department of Health (DH) 2021). Institute of Health Visiting, NICE guidelines Post-Natal Care (NG194), Health for all children – fifth edition (2019 and the most relevant HIGH IMPACT AREAS (Appendix 1)

Core Requirements/Procedure

Undertake the 6-8 week review in accordance with the core requirements set out in Appendix 5.

Assess the child's health and social needs within the context of their family. This should include identification of risk and resilience factors together with any changes to family composition.

The Health Practitioner should use their professional judgement when undertaking the Assessment provided the approach is evidence based and a clear rationale for the decision making is recorded/documented.

Use **promotional/motivational interviews** as described in Appendix 2.

Consider the option for MECSH as the window of offer closes at 8 weeks post discharge from hospital.

Service Provision: The 6-8 week Health and Development Review **can be delegated to a Community Nursery Nurse or to a Staff Nurse.**

It is recommended that the 6-8 week Health and Development Review takes place in the baby's home.

SOP 5 Health Practitioner Support Visits and Calls

Purpose

Health Practitioner support for visits and calls.

Scope

Ante-natal to 6-8 weeks post-natal

Core Requirements/Procedure

Where there are identified mental or emotional health needs the EDOS, GADS tools are offered. Referral to the Perinatal Mental Health Team, MIND, Brighter Futures, Talking Therapies and Listening Lounge self-referral.

- Where birth trauma is identified then offer referral to maternity debrief.
- Listening Visits
- Where feeding support is required at home, excluding Breastfeeding Buddies, such as where there has been a ‘C’ Section.
- Where babies’ health needs require assessment before 6-8 weeks HCP contact, such as slow weight gain, prolonged jaundice, feeding issues where medical assessment is not indicated.
- Clients socially isolated

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SOP 6 Where Health Practitioners Identify Targeted or Specialist Level Client Need

Purpose

Where Health Practitioners identify targeted or specialist level client need.

Scope

Ante-natal to 6-8 weeks post-natal

Core Requirements/Procedure

Where the Health Practitioner has completed a HCP or client support contact and identified needs beyond Universal level and/or scope of Practitioner knowledge and skill or timescales of service delivery then: -

- Liaise with HV Duty, MECSH Lead, FNHC Safeguarding Lead, Operational Lead as required.
- Liaise with multi-agency partners/professionals HCS and CYPES
- Sign posting and referrals to relevant Agencies or Professionals.
- Handover to allocated Health Visitor.
- Consider joint visit to client with newly allocated Practitioner.

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Appendices

Appendix 1 High Impact Areas

High impact areas identified by Public Health England (2021) include:

- Supporting transition to parenthood
- Supporting maternal and family mental health
- Supporting breastfeeding
- Supporting health weight and nutrition
- Improving health literacy – managing minor illness and reducing accidents
- Supporting health, wellbeing and development and ready to learn.

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Appendix 2 Promotional/Motivational Interviews

Promotional/motivational interviews should involve:

- Using a respectful and flexible approach to explore the mother's 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.

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Appendix 3 Core Requirements – Ante Natal Contact

Core requirements	Tools and resources	Plan	Expected outcome
Prior research/screening/multi agency liaison undertaken by the practitioner using existing records and systems including sibling information where appropriate. Assessment of the overall health and wellbeing of the mother including mental health assessment Screening for any conditions that may have an impact on mother or baby Smoking, alcohol and substance misuse in either parent Domestic Abuse screening Folic acid and other dietary or lifestyle advice as required including Vit D Breastfeeding and relationship building(including both parents' attitudes) Mental health of parents	Standard antenatal assessment recording template Whooley questions GAD-7 EPDS FNHC antenatal/birth pack (white folder) Safeguarding Children's Policy; Domestic Abuse Strategy FNHC policy SPB guidance	Indicate the level of Healthy Child Programme intervention i.e. universal, targeted or specialist in the consultation/template on EMIS Document future action plan, including timeframe for future contact and any agreed appointments in the EPR/EMIS. If assessed as universal then follow HCP mandated visits. If targeted or specialist need then the HV should consider referral to other agencies in line with ensuring the right help is received at the right time, including Children and family Hub, as needed families and children assessed as vulnerable according to FNHC safeguarding policy should be identified on the	Signposting to services and resources Referral to specialist agencies if required. Comprehensive health needs assessment completed for child and family Level of need identified All parents are informed how to access HV services and other appropriate local services locally. For all babies to be as healthy as possible at birth. For all babies and parents to form positive attachment :

Core requirements	Tools and resources	Plan	Expected outcome
Feelings about pregnancy Assessment of risks and protective factors Parents' relationship Assessment of the father's health and wellbeing Family and Social relationships Community and Housing Immunisations To offer The MECSH Programme if eligible. Referral to Baby Steps as a universal offer. Parent and infant attachment Infant neuro-development	Jersey Children's First approach Links to UNICEF BFI, AN prompt sheet NHS Best Beginnings, NHS Choices, Institute of health Visiting (itemised in antenatal/birth pack)	electronic patient record using the appropriate alert liaison with midwife consider referral for antenatal MDT, if required - gain parental consent	

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Appendix 4 Core Requirements – New Birth Review

Core requirements	Tools and resources	Plan	Expected outcome
Review of maternity / delivery record and liaison with maternity services as required Results of new-born and infant physical examination Hearing screen outcome Oral health advice, breastfeeding assessment contraception, immunisations General health of new-born baby Neonatal jaundice Parental and infant mental health Safer sleep Smoking, alcohol and substance misuse in either parent Domestic Abuse screening Dietary and lifestyle advice as required including Vit D Assessment of risks and protective factors	Standard new birth visit assessment recording template (EMIS) Whooley questions GAD-7 EPDS FNHC birth pack if not provided antenatally (white folder) FNHC Safeguarding Policy for Adults and Children FNHC Domestic Abuse Practice Guidance JSPB guidance	Indicate the level of Healthy Child Programme intervention i.e. universal, targeted or specialist in the consultation/template on EMIS Document future action plan, including timeframe for future contact and any agreed appointments in the EPR/EMIS. If assessed as universal then follow HCP mandated visits. If targeted or specialist need then the HV should consider referral to other agencies in line with ensuring the right help is received at the right time, including Children and Family Hub, as needed. Families and children assessed as vulnerable according to FNHC safeguarding policy should be identified on the electronic patient record using the appropriate alert.	Signposting to services and resources Referral to specialist agencies if required. Comprehensive health needs assessment completed for child and family Level of need identified All parents are informed how to access HV services and other appropriate local services. For all parents to have support for feeding choices. For all babies and their parents to be as healthy as possible. For all babies and parents to form a positive attachment

Core requirements	Tools and resources	Plan	Expected outcome
Adherence to vaccination schedule for babies who are born to women who are hepatitis B positive New born blood spot screening Community and Housing To offer The MECSH Programme if eligible. Parent and infant bonding and attachment Infant neuro-development Completion of required sections in Personal Child Health Record (Red Book)	Jersey's Children First Approach FNHC Breast Feeding policy FNHC Slow weight gain pathway Jersey Breast feeding buddies Breastfeeding Network First Steps Nutrition NICE guidance on Jaundice in newborn babies Adult Patient/Client Experience Feedback Survey Interpreting service/ The Big Word	Liaison with midwife Consider referral for antenatal MDT, if required. Gain parental consent UNICEF Breastfeeding assessment to be completed in the PHCR	

Core requirements	Tools and resources	Plan	Expected outcome
	NICE guidance Vitamin D Links to UNICEF Baby Friendly Initiative Breast Feeding assessment form www.babyfriendly.org.uk First Steps Nutrition NHS Choices Institute of Health Visiting (itemised in antenatal/birth pack) World Health Organisation Growth Assessment Guidelines www.growthcharts.rcpch.ac.uk		

Core requirements	**Tools and resources**	**Plan**	**Expected outcome**
	Lullaby Trust guidance including Baby Check App		

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Appendix 5 Core Requirements – 6-8 week review

Core requirements	Tools and resources	Plan	Desired Outcome
Assessment of progress from birth to 8 weeks- Check new born blood spot screening completed Check new born hearing screening completed Monitoring if physical examination scheduled or taken place with GP Breastfeeding Baby's feeding status to be recorded – breastfeeding, bottlefeeding or mixed feeding. (involving ongoing support for both parents) Health Review and promotion Review of general progress and delivery of key messages about parenting and baby's health, including eating and activity, weaning at 6 months and accident prevention. Information about play and appropriate activities. Baby's weight and length should be	Parent Held Child Record (PHCR, Red Book) FNHC breastfeeding policy and slow weight gain policy Whooley questions GAD 2/Gad 7 EPDS Safeguarding Children's Policy; Domestic Abuse Strategy FNHC policy SPB guidance,	Indicate the level of Healthy Child Programme intervention i.e. universal, targeted or specialist in the consultation/template on EMIS Document future action plan, including timeframe for future contact and any agreed appointments in the EPR/EMIS. (Electronic patient record) and PHCR. If assessed as universal then follow HCP mandated visits. If targeted or specialist need then the HV should consider referral to other agencies in line with ensuring the right help is received at the right time, including Children and family Hub, as needed. Families and children assessed as vulnerable according to FNHC safeguarding policy should be identified on the	Comprehensive health needs assessment completed for child and family Signposting to services and resources Referral to specialist agencies if required. Level of need identified All parents are informed how to access HV services and other appropriate local services. For all babies and parents to be as healthy as possible For all babies and parents to form positive attachments

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Core requirements	Tools and resources	Plan	Desired Outcome
measured and plotted, where there are concerns and referrals made where indicated, commencement of Slow Weight Gain Pathway* *Slow Weight Gain Pathway (see appendix 6) (where necessary) Oral health discussion Assessing maternal mental health (assessment of the mother's mental health at six to eight weeks by asking appropriate questions for the identification of depression) Discuss 8 week immunisations Parent-infant Interaction: promoting emotional attachment Safeguarding (to include screening for domestic abuse, drug and alcohol abuse and referrals to be made where necessary) Screening. Domestic abuse, alcohol and substance misuse, passive smoking risk Maintaining Infant Health (crying and healthy sleep practices, bath, book, bed routines and activities,	Jersey Children's First approach Links to UNICEF BFI, NHS Best Beginnings, NHS Choices, Institute of health Visiting (itemised in antenatal/birth pack) The social baby The baby check app- lullaby trust www.lullabytrust.org.uk Childrens and Family Hub FNHC Adult/patient feedback form	electronic patient record using the appropriate alert. Where CNN and CSN are visiting any concerns are highlighted to the allocated Health Visitor.	

Core requirements	Tools and resources	Plan	Desired Outcome
and encouragement of parent– infant interaction using a range of media-based interventions) Promoting Development (Encouragement to use books, music and interactive activities to promote development and parent–baby relationship, discuss forthcoming milestones) 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.) Safe sleeping (Reduction of the risk of SIDS – advice about sleeping position, smoking, co-sleeping, room temperature and other information in line with best evidence.) Parental relationships (parents in conflict should be signposted to local resources such as Relate) Parenting Support (establish what each individual parent's needs are)	Interpreting services including Big word As above		

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Core requirements	Tools and resources	Plan	Desired Outcome
Assessment of the father's health and wellbeing Family and Social relationships Community and Housing Signposting to services and resources			

Appendix 6 Slow Weight Gain Pathway

Weight gain	Management plan
Baby not back to birth weight at new birth visit	Plan 1, moving to plan 2 and 3 if necessary
Slow weight gain. (Crossing two centile spaces in one month for average baby, one centile space in one month for baby born below 9th centile, crossing three centile spaces in one month for a baby born above 91st centile)	Plan 1, moving to plan 2
Static or falling weight	Plan 1 moving to Plan 2 and then 3 if necessary

Plan 1	Plan 2	Plan 3
Observe a full breastfeed ensuring effective positioning and attaching, and milk exchange. **Evaluate** frequency/amount of urine and stools. **Complete** and document a full breastfeeding assessment. Consider if baby shows signs of being **unwell**. Ensure **at least** 8 feeds in 24 hours including night time feeds and if not	**Carry out plan 1 and liaise** with the BFI lead. Consider **switch feeding** for sleepy babies. **Express** breast milk after every feed (or as often as mum can manage) and offer this to the baby as a top up. **Massage** breast before expressing. **Consider** if a GP review is necessary. Contact parents to review in 2-3 days. **Reweigh in one week.**	**Carry out Plans 1 and 2 and liaise** with BFI lead. **Refer** to GP to exclude underlying illness. **Refer** through Complex Feeding Challenges Pathway. Consider introducing formula **ONLY IF** • expressed breast milk unavailable measures to improve milk supply and transfer have been tried for at least 10-14 days • baby's weight has been static or minimal increase for more than one week

Plan 1	Plan 2	Plan 3
advise parents to wake the baby so he gets 8 feeds. **Reiterate** early feeding cues. Consider any family/environmental **barriers to breastfeeding.** **Discourage** dummy use. Suggest **Skin to Skin** to encourage breastfeeding. **Signpost** to Breastfeeding Buddies group. **Reweigh in one week.** If weight increases, continue to offer support weekly until an ongoing upward trend is seen for at least two weights 2-4 weeks apart. **If no minimal weight gain, move to Plan 2.** **If the baby develops other concerning symptoms, review immediately and consider medical referral.**	If weight gain of less than 28g per day, move to plan 3. **If the baby develops other concerning symptoms, review immediately and consider medical referral.**	• Baby appears unwell/dehydrated. • Underlying illness has been excluded. Begin with one additional feed rather than a top up (formula or EBM) of 25-30mls/kg in 24 hours. Timing as convenient for parents. Contact parents in 2-3 days and weigh in One week. Continue to monitor effectiveness of baby's feeding through period of supplementation. Gradually reduce supplementation in line with number of wet/dirty nappies as appropriate for age. Weigh weekly until upward trend demonstrated.

Appendix 7 Ages and Stages Questionnaire

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

The ASQ-3 and ASQ: SE-2 are parent-led assessments of child's physical and social emotional development respectively and are the mandated tools within the HCP. The questionnaires are designed for specific ages and it is important that the correct questionnaire is used, taking into account prematurity. The evidence based ASQ-3 covers five domains of child development: communication, gross motor skills, fine motor skills, problem solving and personal-social development.

The ASQ: SE-2 was developed to complement the ASQ-3 by providing information specifically addressing the social and emotional behaviour of children. It covers eight domains of child social emotional development: self-regulation, compliance, communication, adaptive functioning, autonomy, affect, interaction with people and general concerns .It supports the identification of those that may need further evaluation to determine if referral to intervention services is required.

These tools are not diagnostic but are indicators of development at population level.

Children with complex health needs and disabilities: The ASQ-3 and ASQ: SE-2 should be offered to **all children** as part of their one/two year review and both are helpful tool for identifying children with additional needs. However, where a child already has an identified disability or complex developmental delay, health visiting teams will need to agree with parents/ carers whether they wish to complete the ASQ-3 / ASQ: SE-2 questionnaires as part of their child's one/two year review. Much rests on health visitors' professional judgement and their skill in working sensitively and collaboratively with families to agree the best approach; it may be appropriate to complete all or part of the ASQ-3/ ASQ; SE-2 in these instances. Health visitors should work collaboratively with other professionals in the multi-disciplinary team to ensure a personalised approach to developmental assessment is provided to these children. Where the parent wishes to use the ASQ-3 / ASQ: SE-2 questionnaires, the practitioner should use the appropriate age questionnaires - not an earlier age interval, unless the child was born pre-term. Children with complex health needs and disabilities should be offered all remaining components of the one-year health review.

Children born pre-term: (this is defined as all children born at less than 37 weeks gestation). The appropriate age-adjusted ASQ-3 / ASQ: SE-2 questionnaire should be used for all children born pre-term, rather than the chronological age. The ASQ-3 app provides a quick means of calculating the correct questionnaire to be used and guidance is contained within the ASQ-3 User Guide located in each team.

Record Keeping: The ASQ-3 and ASQ SE 2, including summary sheet, will be used by the practitioner to inform data entry on the child's electronic patient record- (EMIS) by completing the

relevant EMIS templates. The questionnaire is returned to the parent. The summary sheet must then be shredded.