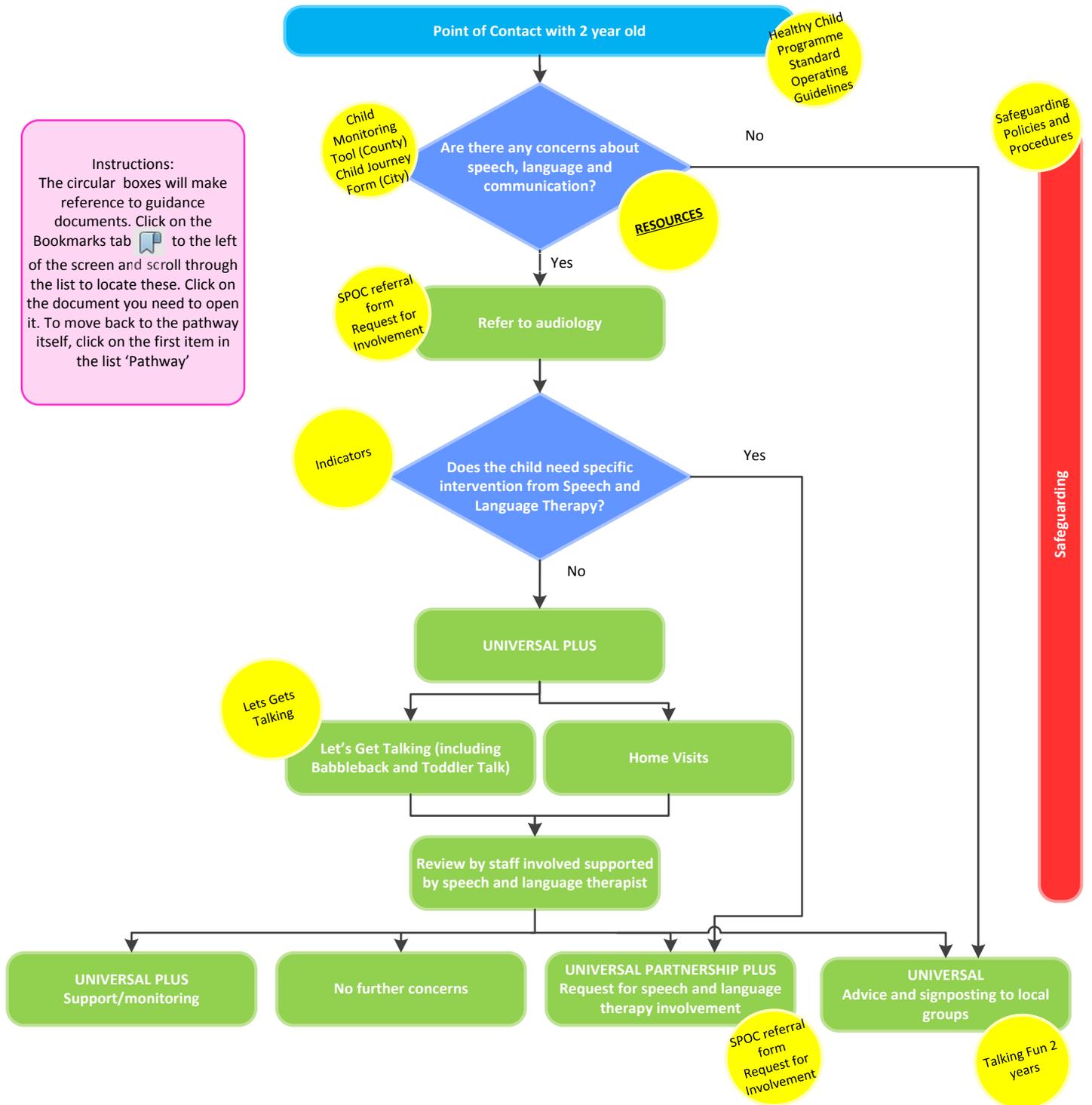


Families, Young People and Children's Services

'Late Talkers'

Speech, Language and Communication Needs at Two Years Care Pathway

Instructions:
The circular boxes will make reference to guidance documents. Click on the Bookmarks tab  to the left of the screen and scroll through the list to locate these. Click on the document you need to open it. To move back to the pathway itself, click on the first item in the list 'Pathway'



Families, Young People and Children's Services 'Late Talkers' Speech, Language and Communication needs at Two Years Care Pathway

Guidance Notes

The pathway for Speech, Language and Communication needs (SLCN) at 2 years is a tool for all professionals who come into contact with 2 year olds.

The pathway helps you to decide which children can be supported by their Health Visiting Team in collaboration with Local Childrens Centre's and a neighbourhood Speech and Language Therapist and which children require specific intervention from the Speech and Language Therapist.

This Universal Plus intervention is part of delivery of the Healthy Child Programme. Children and their families may be supported through 'Lets Get Talking' groups, home visits from their Community Nursery Nurse or Childrens Centre team or groups within Leicestershire's Childrens Centres by Speech and Language Therapists.

The pathway contains 'Guidance Documents' and other resources/information/links to help you in supporting the child and their family. These can be accessed via the pathway bookmarks.

Implementation of this pathway is supported by training and workforce development.

ELKLAN training is a 10 week accredited course covering all aspects of Speech, Language and Communication and how to support children with SLCN. This course is being run for Community Nursery Nurses across the City and County three times per year. A one day course for Health Visitors: Communication from the Start, is also being run every 3 months and covers information about the new pathway as well as key messages for parents to help support their children.



Internet Links

Early Interventions

<http://www.leicspart.nhs.uk/slcn-earlyinterventions>

Every Child a Talker (ECAT)

http://www.leics.gov.uk/index/education/childcare/early_years_service/foundationstage/ecat.htm

Talk to your baby

http://www.literacytrust.org.uk/talk_to_your_baby

Talking point – milestones

<http://www.talkingpoint.org.uk/en/Parent.aspx>

‘Talk Matters’ Video

families.leicester.gov.uk/talkmatters

‘Development Matters’

<http://www.foundationyears.org.uk/wp-content/uploads/2012/03/Development-Matters-FINAL-PRINT-AMENDED.pdf>

LPT Discharge Policy

<http://www.leicspart.nhs.uk/Library/LPTDischargePolicyFYPC.pdf>

FYPC Health Visiting Standard Operating Guidelines

<http://www.leicspart.nhs.uk/Library/HVStandardOperatingGuidance2015finalversion1952015.pdf>

Early Interventions

Speech, Language and Communication

Resources



[Introduction](#)

[Evaluating Early Language Development](#)



[Listening and
Attention](#)



[Understanding](#)



[Talking and
Expressive Language](#)



[Social
Communication](#)



[Parents](#)



[Speech Sounds](#)



[Stammering](#)



[English as an
Additional Language
\[EAL\]](#)

[Useful Websites and 2 year Pathway](#)

[Acknowledgements](#)



Let's Get
Talking

Who is it for?

All **professionals working with children under 5.**

“Practitioners are a child’s most valuable resource in an Early Years setting”

This tool packed full of ideas and activities for practitioners to use to support children’s speech, language and communication development.

What is it for?

This interactive tool helps you **find information** and is linked to the EYFS **Development matters.**

It includes simple practical tips to use while playing with children. One practitioner commented:

“I used the tip of just naming the objects the child is looking at and playing with. It made a big difference, we realised that although the children knew what to do with the tools they didn’t know what they were called”

Benefits?

Practitioners can **feel confident that they are giving targeted support at the right level for the child.**

As soon as the child’s communication and language needs are identified then practitioners can give them the help they need straight away.

How to use it?

Using the tool, you can see what stage a child is at in the areas of attention and listening, understanding, talking and social communication. From here, with a simple click, you can open up ideas and activities to help in any of these areas.



1. Click on ‘Evaluating Early Language Development’ box to identify area of concern
2. Click on area that needs support, eg ‘Listening and Attention’
3. Click for information and ideas to help and specific activities to support the child at their developmental level.
4. Click for more information when needed:
 - 2 year pathway
 - Stammering
 - Speech sound development
 - EAL
 - Ideas to give to parents
 - Useful websites

Healthy Child Programme

*Pregnancy and the first
five years of life*



DH INFORMATION READER BOX

Policy HR/Workforce Management Planning/Performance Clinical	Estates Commissioning IM&T Finance Social Care/Partnership Working
Document purpose	Best Practice Guidance
Gateway reference	12793
Title	Healthy Child Programme – Pregnancy and the first five years
Author	Dr. Sheila Shribman, Kate Billingham
Publication date	27 October 2009
Target audience	PCT CEs, NHS Trust CEs, SHACEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, GPs, Directors of Children's SSs, Health Visitors and Sure Start Children Centres
Circulation list	
Description	HCP is the early intervention and prevention public health programme that lies at the heart of all universal service for children and families. This updated version has been produced to strengthen delivery in pregnancy and the first five years of life.
Cross reference	National Service Framework for Children Young People and Maternity, gateway ref 3779
Superseded documents	Child Health Promotion Programme – Pregnancy and the first five years of life
Action required	N/A
Timing	N/A
Contact details	Jennie Mullins Partnerships for Children, Families and Maternity Area 212, Wellington House 133–155 Waterloo Road London SE1 8UG www.dh.gov.uk
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www.dh.gov.uk/publications

Healthy Child Programme

*Pregnancy and the first
five years of life*

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

Foreword by Dr Sheila Shribman

An effective and high-quality preventive programme in childhood is the foundation of a healthy society. This is as true today as ever. For more than 100 years we have provided a preventive health service that has protected and promoted the health of children. As an experienced paediatrician I have watched the Healthy Child Programme (HCP) change and develop over the years as it has adapted to new knowledge, changes in public expectations and changes in the way in which services are delivered.



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

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

This update has been written for a number of reasons.

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

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

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

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

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



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

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

Dr Sheila Shribman

National Clinical Director for Children,
Young People and Maternity Services
Department of Health

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Introduction

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

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

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

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

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

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

The importance of the Healthy Child Programme (HCP)

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



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

Effective implementation of the HCP should lead to:

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

- early detection of – and action to address – developmental delay, abnormalities and ill health, and concerns about safety;
- identification of factors that could influence health and wellbeing in families; and
- better short- and long-term outcomes for children who are at risk of social exclusion.

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

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

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

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

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

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



¹ www.hm-treasury.gov.uk/media/5/A/pbr_csr07_psa18.pdf and www.hm-treasury.gov.uk/media/3/A/pbr_csr07_psa19.pdf

What is new and different in this update of the HCP?

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



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

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

A major emphasis on parenting support

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

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

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

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

The application of new information about neurological development and child development

Rapid scientific advances are taking place in the study of neuroscience and child development, and in our understanding of the effectiveness of early childhood programmes. The HCP reflects this new knowledge by:

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

- building a progressive universal programme that responds to the different risk factors for children's future life chances, including the effects of multiple parental risk factors;
- integrating guidelines from NICE on promoting changes in the behaviours that affect health, maternal mental health, and antenatal and postnatal care; and
- incorporating interventions (where emerging evidence shows that they can help) to build resilience and improve outcomes, such as the Family Nurse Partnership programme (see page 30).

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

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

The use of new technologies and scientific developments

These include:

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

The inclusion of changed public health priorities

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

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

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

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

An emphasis on integrated services

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

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

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

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

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

- The HCP includes activities that require clinical and public health skills and knowledge.
- Health professionals are notified of all pregnancies and births, and are responsible for this registered population.

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

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

The HCP is a progressive universal service, i.e. it includes a universal service that is offered to all families, with additional services for those with specific needs and risks. The section on the HCP schedule (beginning on page 31) includes both the universal service to be offered to every family and the progressive services for children and families with additional needs and risks. A progressive universal HCP is one that offers a range of preventive and early intervention services for different levels of risk, need and protective factors.



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

Inequalities in early learning and achievement begin to become apparent in early childhood, with a gap opening up between the abilities of poor and prosperous children at as early as two or three years of age. Children who come from families with multiple risk factors (e.g. mental illness, substance misuse, debt, poor housing and domestic violence) are more likely to experience a range of poor health and social outcomes. These might include developmental and behavioural problems, mental illness, substance misuse, teenage parenthood, low educational attainment and offending behaviour.



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

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

The core requirements of the HCP

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



Early identification of need and risk

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

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

- identify the risk factors that make some children more likely to experience poorer outcomes in later childhood, including family and environmental factors;
- include protective factors as well as risks;
- be acceptable to both parents;
- promote engagement in services and be non-stigmatising;

- be linked to effective interventions;
- capture the changes that take place in the lives of children and families;
- include parental and child risks and protective factors; and
- identify safeguarding risks for the child.

A variety of different processes have evolved locally, and more needs to be done to provide the service with validated tools. We will be producing further guidance, in particular to support the PSA maternity indicator. The aim will be to enable and encourage earlier access to maternity care, with women having the opportunity by the 12th week of pregnancy to see a midwife or maternity healthcare professional for a health and social care assessment of their needs, risks and choices. This assessment will form the starting point for the HCP.

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

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

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

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

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

It can be difficult to identify risks early in pregnancy, especially in first pregnancies, as often little is known about the experience and abilities of the parents, and the characteristics of the child. Useful predictors during pregnancy include:²

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

2 www.dcsf.gov.uk/rsgateway/DB/RRP/u015301/index.shtml



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

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

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

Protective factors

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

Health and development reviews

The core purpose of health and development reviews is to:

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

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

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

- by the 12th week of pregnancy;
- the neonatal examination;
- the new baby review (around 14 days old);
- the baby's six to eight-week examination;
- by the time the child is one year old; and
- between two and two-and-a-half years old.

One of the HCP's core functions is to recognise disability and developmental delay. This includes a responsibility to provide information, support, referral and notification to others, and in particular there is a duty to inform the local education authority if it is suspected that a child may have special educational needs. Practitioners carrying out the HCP health and development reviews are expected to have knowledge and understanding of child development, and of the factors that influence health and wellbeing. They need to be able to recognise the range of normal development.

Growth is an important indicator of a child's health and wellbeing. Where parents or health professionals have concerns, the child's growth should be measured and plotted on appropriate charts. New growth charts (based on World Health Organization standards³ covering infants aged between two weeks and two years) were introduced in May 2009 following a pilot programme.

Regular monitoring of growth continues to be reviewed as new evidence emerges and concerns regarding obesity increase.

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

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



3 www.who.int/childgrowth/en



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

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

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

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

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

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

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

Antenatal and postnatal promotional interviews

Antenatal and postnatal promotional interviews (see the Centre for Parent and Child Support website for further information⁴) provide practitioners with a proactive and non-stigmatising approach to promoting the early psychosocial development of babies and the transition to parenthood. They provide a structured way of working with mothers and fathers during pregnancy and the postnatal period, helping them to explore their situation and to make more informed decisions about their family's needs.

Promotional interviews involve:

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

Screening

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

UK National Screening Committee

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

Childhood screening programmes are under continual review, and this update reflects the current evidence. Further information on screening is provided on the National Screening Committee website.⁵

4 www.cpcs.org.uk

5 www.nsc.nhs.uk/ch_screen/child_ind.htm

Summary of the screening schedule for the HCP

Antenatal

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

Antenatal screening for fetal conditions to be carried out according to NICE guidelines. See the guidelines on antenatal care from NICE⁶ for more information.

Newborn

Immediate physical external inspection after birth.

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

By 72 hours

Physical examination:

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

At five to eight days (ideally five days)

- bloodspot screening;
- biochemistry – hypothyroidism, phenylketonuria, cystic fibrosis, medium chain acyl-coA dehydrogenase deficiency; and
- haematology – haemoglobinopathies.

At six to eight weeks

Physical examination:

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

By five years

To be completed soon after school entry:

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

Immunisations

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

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

The current routine immunisation schedule, together with additional vaccines recommended for some groups, can be found at www.immunisation.nhs.uk.

At every contact, members of the HCP team should identify the immunisation status of the child. The parents or carers should be provided with good-quality, evidence-based information and advice on immunisations, including the

⁶ www.nice.org.uk/CG62

benefits and possible adverse reactions. Every contact should be used to promote immunisation. In addition, those immunising children should use the opportunity to promote health and raise wider health issues with parents.

Promotion of social and emotional development

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

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

Support for parenting

One of the core functions of the HCP is to support parenting using evidence-based programmes and practitioners who are trained and supervised. The new National Academy for Parenting Practitioners will build on our knowledge of what works best.

Core features of successful parenting programmes include:

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

Keeping the family in mind

Those delivering the HCP have always recognised the importance of the family in influencing outcomes for children. The HCP needs to look beyond the child to their family context, reviewing family health as a whole, working in partnership with adult services and building family strengths and resources (Social Exclusion Task Force, 2007).

Good practice for engaging fathers in the HCP

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

For further information, see the Fatherhood Institute website at www.fatherhoodinstitute.org and Including New Fathers (Fathers Direct, 2007).

Effective promotion of health and behavioural change

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

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

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

Prevention of obesity

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

The following factors will help to prevent obesity:

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

Promotion of breastfeeding

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

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

There are many examples of successful local breastfeeding initiatives, and of voluntary organisations and community groups playing an important role in promoting and supporting breastfeeding. However, more needs to be done to increase the initiation and continuation of breastfeeding – especially among young,

disadvantaged mothers (Scientific Advisory Committee on Nutrition, 2008).

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

- adopting UNICEF's Baby Friendly Initiative⁷ in all hospital and community providers;
- raising awareness of the health benefits of breastfeeding – as well as the risks of not breastfeeding;
- raising the topic of breastfeeding whenever possible during antenatal consultations;
- developing the skills of health professionals so that they are able to support mothers;
- making sure that there is easy access to professional advice at times of need;
- providing peer support – especially during the early weeks – to establish and continue breastfeeding;
- routinely informing fathers about the health benefits of breastfeeding, giving them advice and encouraging them to be supportive about breastfeeding – the father's involvement is a key predictor of breastfeeding initiation and maintenance;
- using Sure Start children's centres to make antenatal and postnatal services more accessible to hard-to-reach groups;
- increasing awareness of breastfeeding among young and low-income mothers by discussing breastfeeding during pregnancy and providing support to tackle the barriers;
- raising the profile of the Healthy Start initiative, whereby mothers receive advice on healthy eating and breastfeeding; and
- avoiding the use of inappropriate commercially sponsored promotional material.

⁷ www.babyfriendly.org.uk

Additional preventive programmes for children and families

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

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

The Commissioning Toolkit⁸ developed and maintained by the National Academy for Parenting Practitioners will help commissioners of parenting interventions to choose programmes based on information about their degree of success with different groups of parents.

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

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

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

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

This way of working with parents underpins a number of evidence-based services in the middle range of need and risk, such as the Family Partnership Model,⁹ the Solihull Approach¹⁰ and promotional interviewing – as well as intensive programmes such as the Family Nurse Partnership programme (see page 30).

8 www.parentingacademy.org/knowledge/toolkit.aspx

9 www.cpcs.org.uk

10 www.solihull.nhs.uk/solihullapproach/



Families with higher levels of risk or need

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

One of the most promising such programmes is the Family Nurse Partnership programme (Olds, 2006), which is being tested in England. This is a nurse-led, intensive home-visiting preventive programme for the most at-risk young, first-time parents. The programme begins in early pregnancy and continues until the child is two years old. It recognises the importance of pregnancy and the first years of life in influencing children's life chances, and is offered to first-time at-risk parents. The programme capitalises on the receptiveness of parents in early pregnancy and on their willingness at this stage to protect and do the best for their child.

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



The HCP schedule

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



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

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

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

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

HCP – an overview

Universal

- Health and development reviews
- Screening and physical examinations
- Immunisations
- Promotion of health and wellbeing, e.g.:
 - smoking
 - diet and physical activity
 - breastfeeding and healthy weaning
 - keeping safe
 - prevention of sudden infant death
 - maintaining infant health
 - dental health
- Promotion of sensitive parenting and child development
- Involvement of fathers
- Mental health needs assessed
- Preparation and support with transition to parenthood and family relationships
- Signposting to information and services

Progressive

Higher risk

- High-intensity-based intervention
- Intensive structured home visiting programmes by skilled practitioners
- Referral for specialist input
- Action to safeguard the child
- Contribution to care package led by specialist service

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

Promotion of health and wellbeing

- A full health and social care assessment of needs, risks and choices by 12 weeks of pregnancy by a midwife or maternity healthcare professional.
- Notification to the HCP team of prospective parents requiring additional early intervention and prevention (see page 17).
- Routine antenatal care and screening for maternal infections, rubella susceptibility, blood disorders and fetal anomalies. Health and lifestyle advice to include diet, weight control, physical activity, smoking, stress in pregnancy, alcohol, drug intake, etc. See NICE guidance on antenatal care CG6 (National Collaborating Centre for Women's and Children's Health, 2003).
- Distribution of *The Pregnancy Book*¹¹ to first-time parents; access to written/online information about, and preparation for, childbirth and parenting; distribution of antenatal screening leaflet.
- Discussion on benefits of breastfeeding with prospective parents – and risks of not breastfeeding.
- Introduction to resources, including Sure Start children's centres, Family Information Services, primary healthcare teams, and benefits and housing advice.
- Support for families whose first language is not English.

Preparation for parenthood

To begin early in pregnancy and to include:

- information on services and choices, maternal/paternal rights and benefits, use of prescription drugs during pregnancy, dietary considerations, travel safety, maternal self-care, etc.; and
- social support using group-based antenatal classes in community or healthcare settings that respond to the priorities of parents and cover:
 - the transition to parenthood (particularly for first-time parents); relationship issues and preparation for new roles and responsibilities; the parent–infant relationship; problem-solving skills (based on programmes such as Preparation for Parenting, First Steps in Parenting, One Plus One¹²);
 - the specific concerns of fathers, including advice about supporting their partner during pregnancy and labour, care of infants, emotional and practical preparation for fatherhood (particularly for first-time fathers);
 - discussion on breastfeeding using interactive group work and/or peer support programmes; and
 - standard health promotion.

¹¹ www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107302

¹² www.oneplusone.org.uk/

Progressive (including Universal)

Ambivalence about pregnancy, low self-esteem and relationship problems

Problems should be addressed using:

- techniques to promote a trusting relationship and develop problem-solving abilities within the family (e.g. promotional/motivational interviewing; the Family Partnership Model;¹³ and the Solihull Approach¹⁴):
 - establish what each parent's individual support needs are;
 - provide one or two structured listening support contacts;
 - work in partnership with families to develop problem-solving skills;
- support to access antenatal care; and
- preparation for parenthood (which could include separate sessions for fathers only).

Women experiencing anxiety/depression in addition to the problems above

- If no previous episode of depression or anxiety: social support (individual or group-based, including antenatal groups and parenting classes); assisted self-help (computerised cognitive behavioural therapy; self-help material presented to a group or individuals by a health worker/paraprofessional).
- For women with previous episodes of non-clinical symptoms of depression and anxiety: brief (four to six weeks), non-directive counselling delivered at home

(listening visits¹⁵) by skilled professionals, and access to local social support; or referral for brief psychological treatments (such as cognitive behavioural therapy or interpersonal therapy).

Women who smoke

Women who smoke should be offered:

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

Women who are overweight or obese

Women who are overweight or obese should be offered:

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

Breastfeeding

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

¹⁵ Listening visits are defined as unstructured, client-led discussions involving the counsellor in: active listening; reflection; providing empathic responses; encouraging the expression of experiences and accepting the emotions expressed; and not offering information or advice.

¹³ www.cpcs.org.uk/

¹⁴ www.solihull.nhs.uk/solihullapproach/

For parents at higher risk

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

At-risk first-time young mothers

- Intensive, evidence-based programmes that start in early pregnancy, such as the Family Nurse Partnership programme.¹⁶
- Multimodal support combining home visiting, peer support, life skills training and integration within social networks recommended for pregnant adolescents.

Parents with learning difficulties

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

Drug abuse

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

Alcohol abuse

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

Domestic violence

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

Serious mental illness

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

¹⁶ Currently being piloted in England.

Universal

Promotion of health and wellbeing

- Ongoing identification of families in need of additional support using criteria identified above (see page 33).
- As for pregnancy up to 28 weeks.

Preparation for parenthood

- As for pregnancy up to 28 weeks (see page 33).
- Distribute the *Parent's Guide to Money* information pack, designed to help expectant parents plan their family finances.¹⁷

Involvement of fathers

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

Antenatal review for prospective mother and father with HCP team

- Focus on emotional preparation for birth, carer–infant relationship, care of the baby, parenting and attachment, using techniques such as promotional interviewing (see page 23) to:
 - identify those in need of further support during the postnatal period; and
 - establish what their support needs are.
- Inform about sources of information on infant development and parenting, the HCP and Healthy Start.
- Distribute newborn screening leaflet.
- Provide information in line with Department of Health guidance on reducing the risk of SIDS.
- Distribute and introduce personal child health record.

Progressive (including Universal)

- As for pregnancy up to 28 weeks (see page 34).

For parents at higher risk

- As for pregnancy up to 28 weeks (see page 35).

¹⁷ Information on the *Parent's Guide to Money* is available at www.fsa.gov.uk

Infant feeding

- Initiate as soon as possible (within one hour of delivery) using support from healthcare professional, or peer unless inappropriate; 24-hour rooming-in and continuing skin-to-skin contact where possible. Ongoing, consistent, sensitive, expert support about infant positioning. Provide information about the benefits of colostrum and timing of first breastfeed. Support should be culturally appropriate and should include both parents.
- Use the Baby Friendly Initiative¹⁸ or a similar evidence-based best practice programme to promote breastfeeding.
- Provide information about local support groups.
- Parents and carers who feed with formula should be offered appropriate and tailored advice on safe feeding.
- Provide information on vitamin supplements and Healthy Start.
- Provide information and advice to fathers, to encourage their support for breastfeeding.

Health promotion

- Distribution of personal child health record, if not already done antenatally.
- Distribution of *Birth to Five*¹⁹ to all mothers.
- Injury prevention.

Maintaining infant health

- Anticipatory, practical guidance on reality of early days with an infant, healthy sleep practices and bath, book, bed routine to increase parent–infant interaction, using a range of media (e.g. Baby Express newsletters²⁰).

Birth experiences

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

Promoting sensitive parenting

- Introduce parents to the 'social baby', by providing them with information about the sensory and perceptual capabilities of their baby using a range of media (e.g. *The Social Baby* book/video (Murray and Andrews, 2005) or Baby Express age-paced newsletters²¹) or validated tools (e.g. Brazelton²² or Nursing Care Assessment Satellite Training – NCAST²³).
- Promote closeness and sensitive, attuned parenting, by encouraging skin-to-skin care and the use of soft baby carriers.
- Provide information and support to fathers, as well as mothers, that responds to their individual concerns and involves active participation with, or observation of, their baby – over several sessions, if possible.

Hearing screening

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

18 www.babyfriendly.org.uk/

19 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107303

20 www.thechildrensfoundation.co.uk/baby-express.php

21 www.thechildrensfoundation.co.uk/baby-express.php

22 www.brazelton.co.uk/

23 www.ncast.org

Universal

SIDS

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

By 72 hours

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

At five to eight days (ideally five)

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

Within the first week

- Administration of vitamin K in accordance with protocol.

Health protection – immunisation

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

For guidelines on postnatal care see *Routine Postnatal Care of Women and their Babies* (NICE Clinical Guideline 37, 2006).

²⁴ www.fsid.org.uk

Babies with health or developmental problems or abnormalities

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

Problems such as conflict with partner and lack of social support

- Techniques to promote a trusting relationship and develop problem-solving abilities within the family (e.g. promotional/motivational interviewing; Family Partnership Model;²⁵ the Solihull Approach;²⁶ and One Plus One Brief Encounters²⁷) should be used to:
 - establish what each parent's individual support needs are;
 - provide one or two structured listening support visits;²⁸ and
 - work in partnership with families to develop problem-solving skills.

Promoting sensitive parenting

- Assessment of parent–baby interaction using validated tools (e.g. NCAST²⁹).
- Sensitive, attuned parenting (by both mothers and fathers) should be promoted, using media-based tools (e.g. *The Social Baby* book/video (Murray and Andrews,

2005) or Baby Express newsletters³⁰ or validated tools (e.g. Brazelton³¹ or NCAST).

- Information and support to the father, including opportunities for direct observation and interaction with the child.
- Individualised coaching (by a skilled professional) aimed at stimulating attuned interactions at one day, two days and seven days and involving both fathers and mothers where possible.

Infant feeding and children at risk of obesity

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

Parents who smoke

- Smoking cessation interventions should be offered to women in the immediate postnatal period.
- Advice should include the prevention of exposure of infants to smoke and the creation of smoke-free areas within the home and cars.

SIDS

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

25 www.cpcs.org.uk/

26 www.solihull.nhs.uk/solihullapproach/

27 www.oneplusone.org.uk/

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

29 www.ncast.org

30 www.thechildrensfoundation.co.uk/baby-express.php

31 www.brazelton.co.uk/

For families at higher risk

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

At-risk first-time young mothers

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

Parents with learning difficulties

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

Drug abuse

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

Alcohol abuse

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

Domestic violence

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

Serious mental illness

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

³² Currently being piloted in England.

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

Infant feeding

- Use the Baby Friendly Initiative³³ or a similar evidence-based best practice programme to support continuation of breastfeeding.
- Individual support and access to advice to promote exclusive breastfeeding.
- Provide information and advice to fathers to encourage their support for breastfeeding.
- Provide information about local support groups.
- Information on Healthy Start and vitamin supplements.
- Information on delay in introducing solids until six months.
- Parents and carers who feed with formula should be offered appropriate and tailored advice on safe feeding.

Promoting sensitive parenting

- Introduce both parents to the 'social baby', by providing them with information about the sensory and perceptual capabilities of their baby using media-based tools (e.g. *The Social Baby* book/video (Murray and Andrews, 2005) or Baby Express newsletters³⁴) or validated tools (e.g. Brazelton³⁵ or NCAST³⁶).
- Promote closeness and sensitive, attuned parenting, by encouraging skin-to-skin care and the use of soft baby carriers.

- Invitation to discuss the impact of the new baby on partner and family relationships.
- Temperament-based anticipatory guidance³⁷ and listening to parents' concerns. Examples of topics that parents may wish to discuss include: interacting with baby (e.g. songs and music, books); feeding, diet and nutrition; colic; sleep; crying; establishing a routine; safety and car seats; the immunisation programme; prevention of SIDS; changes in relationships; sex and intimacy after birth; contraception; and division of domestic chores.
- Use of media-based materials to support sensitive parenting (e.g. Baby Express newsletters³⁸).
- Information about the HCP and roles of general practice, Sure Start children's centres and other local resources.

Promoting development

- Encouragement to use books, music and interactive activities to promote development and parent–baby relationship (e.g. media-based materials such as Baby Express newsletters and/or Bookstart³⁹).
- Referring families whose first language is not English to English as a second language services.

33 www.babyfriendly.org.uk/

34 www.thechildrensfoundation.co.uk/baby-express.php

35 www.brazelton.co.uk/

36 www.ncast.org

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

38 www.thechildrensfoundation.co.uk/baby-express.php

39 www.bookstart.co.uk/

Universal

Assessing maternal mental health

- Within 10–14 days of birth, women should be asked appropriate and sensitive questions to identify depression or other significant mental health problems, such as those recommended by the NICE guidelines on antenatal and postnatal mental health.⁴⁰

SIDS

- Reduction of the risk of SIDS – advice about sleeping position, smoking, co-sleeping, room temperature and other information in line with best evidence.⁴¹

Keeping safe

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

During the first month of life

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

Jaundice, if prolonged

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

Safeguarding

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

⁴⁰ Within the context of the visit, the professional should explore possible depression. The following questions may be helpful: 'During the past month, have you often been bothered by feeling down, depressed or hopeless?' 'During the past month, have you often been bothered by having little interest or pleasure in doing things?' A third question should be considered if the woman answers 'yes' to either of the initial questions: 'Is this something you feel you need or want help with?'

⁴¹ www.fsid.org.uk

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

- Early referral to specialist team; advice on benefits that may be available; invitation to join parent groups.
- Package of additional support and monitoring, as assessed by health professional, and drawing on the Early Support Programme.⁴²

Infant feeding

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

Parents who smoke

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

SIDS

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

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

Children at risk of obesity

- Promotion of breastfeeding using the Baby Friendly Initiative.⁴³
- Offer of additional support to feed their baby, including advice about the deferral of weaning.
- Advice on nutrition and exercise for the whole family.
- Invitation to group-based postnatal weight reduction programmes.

Keeping safe

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

Maintaining infant health

- Temperament-based anticipatory guidance⁴⁴ – practical guidance on reality of early days with an infant, managing crying and healthy sleep practices, bath, book, bed routines and activities, and encouragement of parent–infant interaction using a range of media (e.g. Baby Express newsletters⁴⁵).

⁴² www.earlysupport.org.uk

⁴³ www.babyfriendly.org.uk/

⁴⁴ Advice to help parents think about and understand individual infants' temperaments, and use of individualised childcare strategies, e.g. to address issues related to crying and sleeping.

⁴⁵ www.thechildrensfoundation.co.uk/baby-express.php

Progressive (including Universal)

Parenting support

- Techniques to promote a trusting relationship with both parents and to help them develop problem-solving abilities within the family (e.g. promotional/motivational interviewing; Family Partnership Model;⁴⁶ and the Solihull Approach⁴⁷) should be used to:
 - establish what each parent's individual support needs are;
 - provide one or two structured listening support visits; and
 - work in partnership with families to develop problem-solving skills.

Maternal depression

- Eight listening visits⁴⁸ or referral for brief cognitive behavioural or interpersonal therapy.
- Use of dyadic therapies⁴⁹ to increase maternal sensitivity, e.g. infant massage, interaction guidance.
- Postnatal parent–infant groups with enhanced components for fathers. Sessions should address and respond to the specific concerns of fathers, including support to partner, care of infants, and emotional issues arising from fatherhood. Enhanced postnatal support can include separate sessions with fathers and for fathers only.
- Recognition and referral of women with serious mental health problems.

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

- Assessment of parent–infant interaction using validated tools (e.g. Brazelton⁵⁰ or NCAST⁵¹).
- Media-based tools (e.g. *The Social Baby* book/video (Murray and Andrews, 2005) or Baby Express newsletters⁵²) or validated tools (e.g. Brazelton⁵³ or NCAST⁵⁴) should be used to promote sensitive, attuned parenting.
- Invitation to group-based parenting programmes (e.g. Mellow Parenting⁵⁵ or PIPPIN – the Parents in Partnership Parent Infant Network) or an infant massage group.
- Father–infant groups that promote opportunities for play and guided observation.

Parental relationships

- Parents in conflict should be offered access to parenting groups which address parental conflict using specially designed training resources (e.g. One Plus One First Encounters⁵⁶).

Promoting development

- Book sharing and invitations to groups for songs, music and interactive activities (e.g. PEEP⁵⁷ or Bookstart⁵⁸); Baby Express newsletters.⁵⁹

46 www.cpcs.org.uk

47 www.solihull.nhs.uk/solihullapproach/

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

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

50 www.brazelton.co.uk/

51 www.ncast.org

52 www.thechildrensfoundation.co.uk/baby-express.php

53 www.brazelton.co.uk/

54 www.ncast.org

55 www.mellowparenting.org/

56 www.oneplusone.org.uk/

57 www.peep.org.uk/

58 www.bookstart.co.uk/

59 www.thechildrensfoundation.co.uk/baby-express.php

For families at higher risk

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

At-risk first-time young mothers

- Intensive home visiting programmes by skilled practitioners beginning in early pregnancy and continuing for at least 12 months postnatally, such as the Family Nurse Partnership programme.⁶⁰
- Multimodal support combining home visiting, peer support, life skills training and integration within social networks.

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

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

Parents with learning difficulties

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

Drug abuse

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

Alcohol abuse

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

Domestic violence

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

Serious mental illness

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

⁶⁰ Currently being piloted in England.

Universal

Breastfeeding

- Ongoing support involving both parents.

Health review at six to eight weeks

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

Assessing maternal mental health

- Assessment of the mother's mental health at six to eight weeks and three to four months, by asking appropriate questions for the identification of depression, such as those recommended by the NICE guidelines on antenatal and postnatal mental health.⁶¹

At eight weeks

- Immunisation against diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenzae* type B, and pneumococcal infection. At every

immunisation, parents should have the opportunity to raise any concerns about caring for their baby and their health and development, and should be provided with information or sources of advice.

- If hepatitis B vaccine has been given after birth, the third dose is given at eight weeks.

At three to four months

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

⁶¹ Within the context of the visit, the professional should explore possible depression using the following questions: 'During the past month, have you often been bothered by feeling down, depressed or hopeless?' 'During the past month, have you often been bothered by having little interest or pleasure in doing things?' A third question should be considered if the woman answers 'yes' to either of the initial questions: 'Is this something you feel you need or want help with?'

Maintaining infant health

- Temperament-based anticipatory guidance⁶² – practical guidance on managing crying and healthy sleep practices, bath, book, bed routines and activities, and encouragement of parent–infant interaction using a range of media-based interventions (e.g. Baby Express newsletters⁶³).

Promoting development

- Encouragement to use books, music and interactive activities to promote development and parent–baby relationship (e.g. media-based materials such as Baby Express newsletters and/or Bookstart⁶⁴).

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.

⁶² Advice to help parents think about and understand individual infants' temperament and use of individualised childcare strategies, e.g. to address issues related to crying and sleeping.

⁶³ www.thechildrensfoundation.co.uk/baby-express.php

⁶⁴ www.bookstart.co.uk

Babies with health or developmental problems or abnormalities

- Early referral to specialist team; advice on benefits that may be available; invitation to join parent support group.
- Package of additional support and monitoring, as assessed by health professional, and drawing on the Early Support Programme.⁶⁵

Infant feeding and children at risk of obesity

- Additional encouragement and support to breastfeed exclusively.
- Ongoing communication with fathers about breastfeeding and their role in its maintenance.
- Peer support schemes (such as 'Best/Breast/Bosom Buddy') using local, experienced breastfeeders as volunteers; multimodal education/social support programmes combined with media campaigns.
- Promotion of Baby Friendly Initiative.⁶⁶
- Offer of additional support in feeding the baby, including advice about the deferral of weaning.
- Advice on nutrition and physical activity for the family.

Parents who smoke

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

SIDS

- Reduction of the risk of SIDS – advice about sleeping position, smoking, co-sleeping, room temperature and other information in line with best evidence.⁶⁷

Keeping safe

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

⁶⁵ www.earlysupport.org.uk

⁶⁶ www.babyfriendly.org.uk

⁶⁷ www.fsid.org.uk

Parenting support

- Techniques to promote a trusting relationship and develop problem-solving abilities within the family (e.g. promotional/motivational interviewing; Family Partnership Model;⁶⁸ and the Solihull Approach⁶⁹) should be used to:
 - establish what each parent's individual support needs are;
 - provide one or two structured listening support visits; and
 - work in partnership with families to develop problem-solving skills.

Maternal depression

- Eight listening visits⁷⁰ or referral for brief cognitive behavioural or interpersonal therapy.
- Use of dyadic therapies⁷¹ to increase maternal sensitivity, e.g. infant massage, interaction guidance.
- Postnatal parent–infant groups with enhanced components for fathers. Sessions should address and respond to the specific concerns of fathers, including support to partner, care of infants, and emotional issues arising from fatherhood. Enhanced postnatal support can include separate sessions with fathers and for fathers only.

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

- Assessment of parent–infant interaction using validated tools (e.g. NCAST⁷²).
- Media-based tools (e.g. *The Social Baby* book/video (Murray and Andrews, 2005) or Baby Express newsletters⁷³) or validated tools (e.g. Brazelton⁷⁴ or NCAST⁷⁵) may be used to promote sensitive, attuned parenting.
- Invitation to group-based parenting programmes (e.g. Mellow Parenting⁷⁶ or PIPPIN – the Parents in Partnership Parent Infant Network) or an infant massage group.
- Father–infant groups that promote opportunities for play and guided observation.

Parental relationships

- Parents in conflict should be offered access to parenting groups which address parental conflict using specially designed training resources (e.g. One Plus One Brief Encounters⁷⁷).

68 www.cpcs.org.uk/

69 www.solihull.nhs.uk/solihullapproach/

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

71 Dyadic therapies focus on both mother and baby and are aimed at improving the mother–infant relationship.

72 www.ncast.org

73 www.thechildrensfoundation.co.uk/baby-express.php

74 www.brazelton.co.uk/

75 www.ncast.org

76 www.mellowparenting.org/

77 www.oneplusone.org.uk/

Universal

Around seven to nine months

- Distribution of Bookstart⁷⁸ pack for babies.

Health review by one year

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

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

Dental health

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

⁷⁸ www.bookstart.co.uk/

Maintaining infant health

- Temperament-based anticipatory guidance⁷⁹ – practical guidance on managing crying and healthy sleep practices, bath, book, bed routines and activities, and encouragement of parent–infant interaction using a range of media (e.g. Baby Express newsletters⁸⁰).

Promoting development

- Book sharing and invitations to groups for songs, music and interactive activities (e.g. PEEP⁸¹ using the Early Learning Partnership Model, early years librarians or Bookstart⁸²).
- Encouragement to take up early years education.
- Referring families whose first language is not English to English as a second language services.
- Supporting parents returning to work to help their baby or young child make a smooth transition into childcare.

Keeping safe

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

⁷⁹ Advice to help parents think about and understand individual infants' temperament and use of individualised childcare strategies, e.g. to address issues related to crying and sleeping.

⁸⁰ www.thechildrensfoundation.co.uk/baby-express.php

⁸¹ www.peep.org.uk/

⁸² www.bookstart.co.uk

Babies with health or developmental problems or abnormalities

- Early referral to specialist team; advice on benefits that may be available; invitation to join parent groups.
- Package of additional support and monitoring, as assessed by health professional, and drawing on the Early Support Programme.⁸³

Infant feeding and children at risk of obesity

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

Parents who smoke

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

Keeping safe

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

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

Parenting support

- Health professional to facilitate access to Sure Start children's centre and early years services.
- Techniques to promote a trusting relationship and develop problem-solving abilities within the family (e.g. promotional interviewing; Family Partnership Model;⁸⁴ and the Solihull Approach⁸⁵) should be used to:
 - establish what each parent's individual support needs are;
 - provide one or two structured listening support visits; and
 - work in partnership with families to develop problem-solving skills.

Maternal depression

- As on page 49.

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

- As on page 49.

Parental relationships

- As on page 49.

83 www.earlysupport.org.uk

84 www.cpcs.org.uk/

85 www.solihull.nhs.uk/solihullapproach/

For families at higher risk

Keeping safe

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

At-risk first-time young mothers

- Intensive home visiting programmes by skilled practitioners, such as the Family Nurse Partnership programme.⁸⁶
- Multimodal support combining home visiting, peer support, life skills training and integration within social networks.

Seriously inadequate parent–infant interaction

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

Parents with learning difficulties

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

Drug and alcohol abuse

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

Domestic violence

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

Serious mental illness

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

⁸⁶ Currently being piloted in England.

Universal

At 13 months

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

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

- Review with the parents the child's social, emotional, behavioural and language development, with signposting to appropriate group-based parenting support (e.g. the Webster-Stratton Parenting programme).
- Review development and respond to any concerns expressed by the parents regarding physical health, growth, development, hearing and vision.
- Offer parents guidance on behaviour management and an opportunity to share concerns.
- Offer parents information on what to do if worried about their child.
- Promote language development through book sharing and invitations to groups for songs, music and interactive activities (e.g. early years librarian, PEEP⁸⁷ or Bookstart⁸⁸).
- Provide encouragement and support to take up early years education.
- Give health information and guidance (telephone helplines, websites, NHS Direct).

- Review immunisation status, to catch up on any missed immunisations.
- Offer advice and information on nutrition and physical activity for the family, and on healthy eating, portion size and mealtime routines.
- Raise awareness of dental care, accident prevention, sleep management, toilet training, sources of parenting advice.
- Offer information on Family Information Service, Sure Start children's centres and early years learning provision. Refer families whose first language is not English to English as a second language services.

Dental health

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

Keeping safe

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

87 www.peep.org.uk/

88 www.bookstart.co.uk

Children with health or developmental problems or abnormalities

- Early referral to specialist team; advice on benefits that may be available; invitation to join parent groups.
- Additional support and monitoring, as assessed by health professional, and drawing on the Early Support Programme.⁸⁹

Children at risk of obesity

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

Parents who smoke

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

Keeping safe

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

Parenting support

- As on page 52.

⁸⁹ www.earlysupport.org.uk

For families at higher risk

- Be alert to risk factors and signs and symptoms of child abuse, and follow local safeguarding procedures where there is cause for concern.
- Intensive programmes with skilled home visitors, such as:
 - Family Nurse Partnership⁹⁰ for first-time young parents until the child is two years old; and
 - Advanced Triple P Programme.⁹¹
- Maternal mental health problems/parent–infant relationship problems:
 - referral to specialist services; and/or
 - parent–infant psychotherapy.

⁹⁰ Currently being piloted in England.

⁹¹ www.triplep.net

At three to five years

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

By five years – to be completed soon after school entry

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

Progressive (including Universal)

- As under 'One to three years' (see pages 54–56).

Infrastructure requirements

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



Information for parents

Information for parents includes:

- *The Pregnancy Book*⁹² and *Birth to Five*,⁹³ which provide good-quality information for parents (in an accessible format) on the full range of child health, development and parenting issues;
- the personal child health record (PCHR) (often referred to as the red book), which provides a record of a child's health and development, including interventions received under the HCP;
- screening leaflets;
- Healthy Start;
- the NHS Choices website;
- Bookstart,⁹⁴ which promotes books and reading to people of all ages and cultures. It helps parents and carers to foster a nurturing relationship with the child, strengthening their emotional bond while aiding language development and having fun;

92 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107302

93 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107303

94 www.bookstart.co.uk

- immunisation information resources for parents and health professionals, available at www.immunisation.nhs.uk;
- the NHS Early Years LifeCheck on NHS Choices – currently being piloted for babies around six months; and
- locally developed information, such as the resources developed by Families Information Services and Sure Start children's centres.

Record keeping and data collection systems

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

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

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

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

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

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

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

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

Clinical governance

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

- monitoring outcomes;
- service improvement and evaluation;
- risk management and audit of the HCP;

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

Population needs assessment and resource allocation

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



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

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

Access to the HCP

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

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

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

At the same time, it is important that health visitors and other members of the team retain good links with the primary healthcare team. General practice delivers core aspects of the HCP, in particular the six to eight-week examination of all children and the immunisation schedule. In some areas,

general practice will be the focus for delivery of the programme. On average, a child under school age will see their GP six times a year, providing further opportunities to review children's health and support parents. New guidelines on the physical examination of babies soon after birth and again at six to eight weeks will shortly be published by the National Screening Committee.

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

Premises and equipment

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

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

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

Productivity and value

Offering universal services in different ways

The HCP is a universal service to be made available to all. Personal contact with mothers and fathers is important in helping to build up a relationship. For some families, though – especially those with a child already, for whom outcomes are likely to be good and who know how to access services – there are different ways of offering services that could free up resources for those requiring more intensive and skilled support and guidance. Examples include: web-based systems, such as NHS Early Years LifeCheck, Netmums and the NHS Choices website; the numerous valuable third sector local and national parenting support groups and organisations; and other interactive services, funded through Parent Know How, including Parentline Plus,⁹⁵ Young Minds⁹⁶ and Contact a Family.⁹⁷



95 www.parentlineplus.org.uk

96 www.youngminds.org.uk

97 www.cafamily.org.uk

Workforce flexibilities

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

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

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



Outcome measures

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

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

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

Annex A: Notes for commissioners

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

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

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

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

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

The NHS Operating Framework

The national NHS priority for 2009/10 is: 'keeping adults and children well, improving their health and reducing health inequalities' (DH, 2008). One of the four areas where primary care trusts (PCTs) are expected to make progress and where the HCP has an important contribution to make is in 'improving children's and young people's physical and mental health and wellbeing'.

National priorities for local delivery

The HCP supports the delivery of:

- an increase in the percentage of women who have seen a midwife or a maternity healthcare professional, for assessment of health and social care needs, risks and choices by 12 completed weeks of pregnancy;
- an increase in the percentage of infants being breastfed at six to eight weeks;
- a reduction in the under-18 conception rate per 1,000 females aged 15–17;
- a reduction in obesity among primary school age children;
- an increase in the proportion of children who complete immunisation by the recommended ages; and
- a reduction in smoking prevalence among people aged 16 or over and in routine and manual groups.

PSA delivery agreements

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

- **PSA Delivery Agreement 12 – Improve the health and wellbeing of children and young people:** Indicator 1, Prevalence of breastfeeding at six to eight weeks; and Indicator 3, Levels of obesity in children under 11 years.
- **PSA Delivery Agreement 13 – Improve children and young people’s safety:** Indicator 3, Hospital admissions caused by unintentional and deliberate injuries to children and young people.

- **PSA Delivery Agreement 19 – Ensure better care for all:** Indicator 4, The percentage of women who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy.
- **PSA Delivery Agreement 10 – Raise the educational achievement of all children and young people:** Indicator 1, Early Years Foundation Stage achievement.
- **PSA Delivery Agreement 11 – Narrow the gap in educational achievement between children from low-income and disadvantaged backgrounds and their peers:** Indicator 1, Achievement gap at Early Years Foundation Stage.
- **PSA Delivery Agreement 18 – Promote better health for all:** Indicator 3, Smoking prevalence.
- **PSA Delivery Agreement 14 – Increase the number of children and young people on the path to success:** Indicator 4, Reduce the under-18 conception rate.

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

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

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



'The Children Act 2004 requires local authorities to prepare and publish an overarching plan setting out their strategy for discharging their functions in relation to children and young people. The Children and Young People's Plan (CYPP) is prepared by local authorities and their partners through the local children's trust co-operation arrangements, feeding into and informed by the Sustainable Communities Strategy. A key element of the CYPP is the requirement to carry out a comprehensive needs assessment, in partnership with all those involved in the planning process, and to review it on a regular basis. The needs assessment is based on the requirement to improve the five Every Child Matters outcomes for children, young people and their families: be healthy, stay safe, enjoy and achieve, make a positive contribution, and achieve economic wellbeing.'

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

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

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

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

Annex B: Core elements of the HCP workforce

Introduction

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

The HCP workforce

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

- multi-skilled teamworking involving a range of practitioners across general practice, maternity services and children's centre services;
- an agreed and defined lead role for the health visitor;
- a team with up-to-date knowledge and skills; and

- a team with competences to work in partnership with children, mothers, fathers and families to deliver the core elements of the HCP and to work effectively across service boundaries.

Multi-skilled teamworking

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

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

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

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

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

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

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

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

An agreed and defined lead role for the health visitor

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

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

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



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

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

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

A team with up-to-date knowledge and skills

This updated HCP identifies new priorities and advances in our understanding of child development and effective interventions. The knowledge and skills of the team delivering the HCP will need to reflect these changes and be open and flexible to future developments. In addition to existing public health and child development knowledge and skills, topics identified in this guide for greater focus are:

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

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

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

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



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

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

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

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

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

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

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

Competences required for the delivery of the HCP

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

The role of the health visitor

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

The review identified the core elements of health visiting as:

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

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

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

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

Possible roles in the HCP team

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

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

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

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

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

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

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

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

Effective teamworking for the HCP

- Clear information for families about the roles and responsibilities of each practitioner with whom they come into contact should be provided.
- There must be a core team, led by a health professional responsible for ensuring that all families receive a level of service and support relevant to their needs.
- There must be clear arrangements for engaging and drawing in support from services outside the core team.
- Regular meetings to discuss the HCP and individual children should be held.
- Decisions about what sort of practitioners are needed should be based on the competences required to deliver desired outcomes.
- There must be a clear description of the performance standards required within any particular role, and everybody should have access to regular supervision and an annual opportunity to review their sphere of practice and training needs.
- There must be clear lines of accountability and responsibility, especially when these transcend traditional organisational boundaries.
- There should be regular opportunities for communication across teams, to generate trust and understanding.
- Whenever possible, training should be designed for a multidisciplinary audience and should be of a high standard, with clear learning outcomes that can be assessed following attendance.
- Shared budgets and joint planning lead to co-ordinated service provision that makes best use of the available workforce and avoids duplication, confusion and the tendency to retreat into professional 'silos'.

Education and learning

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

The Children's Workforce Development Council⁹⁸ is involved in a pilot project to

develop induction standards for the children's workforce. The standards cover seven core areas:

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

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

98 www.cwdcouncil.org.uk



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

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

The use of competence assessment tools, such as the Coventry University Assessment,⁹⁹ should be encouraged, so that knowledge and skills deficits can be identified and addressed.

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

Opportunities for self-study should also be explored. For example, an online training programme is currently under development as part of the HENRY (Health, Exercise, Nutrition for the Really Young) programme, led by Professor Mary Rudolf.¹⁰⁰



99 www.healthbehaviourresearch.co.uk

100 For information, e-mail henry@rcpch.ac.uk

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Early Communication and Language

Stage	Listening & Attention	Understanding (Receptive Language)	Speaking (Expressive Language)	Social Communication (Strands from PSED, Communication & Language)
0-11 months	Turns toward a familiar sound then locates range of sounds with accuracy. Listens to, distinguishes and responds to intonations and sounds of voices. Quietens or alerts to the sound of speech. Fleeting attention – not under child's control, new stimuli takes whole attention.	Stops and looks when hears own name. (by 12 months ☒)	Gradually develops speech sounds (babbling) to communicate with adults; says sounds like 'baba', 'nono', 'gogo'. (by 11 months ☒)	Gazes at faces and copies facial movements, eg sticking out tongue. Concentrates intently on faces and enjoys interaction. Uses voice, gesture, eye contact and facial expression to make contact with people and keep their attention. (by 12 months ☒)
8-20 months	Concentrates intently on an object or activity of own choosing for short periods. Pays attention to dominant stimulus – easily distracted by noises or other people talking. Moves whole bodies to sounds they enjoy, such as music or a regular beat. Has a strong exploratory impulse.	Responds to the different things said when in a familiar context with a special person (eg <i>'Where's Mummy?', 'Where's your nose?'</i>) Understanding of single words in context is developing, eg <i>'cup', 'milk', 'daddy'</i> .	Uses single words. (by 16 months ☒) Frequently imitates words and sounds. Enjoys babbling and increasingly experiments with using sounds and words to communicate for a range of purposes (eg <i>teddy, more, no, bye-bye</i>).	Likes being with a familiar adult and watching them. Developing the ability to follow an adult's body language, including pointing and gesture. Learns that their voice and actions have effects on others. Uses pointing with eye gaze to make requests and to share an interest. (by 18 months ☒)
16-26 months	Listens and enjoys rhythmic patterns in rhymes and stories. Enjoys rhymes and demonstrates listening by trying to join in with action or vocalisations. Rigid attention – may appear not to hear.	Selects familiar objects by name and will go and find objects when asked, or identify objects from a group.	Beginning to put two words together (eg <i>'want ball', 'more juice'</i>). (by 24 months ☒) Uses different types of everyday words (nouns, verbs and adjectives, eg <i>banana, go, sleep, hot</i>). Beginning to ask simple questions.	Gradually able to engage in 'pretend' play with toys (supports child to imagine another's point of view). Looks to others for responses which confirm, contribute to, or challenge their understanding.
22-36 months	Singled channelled attention. Can shift to a different task if attention fully obtained – using child's name helps focus. (by 36 months ☒) Listens with interest to the noises adults make when they read stories. Recognises and responds to many familiar sounds, e.g. turning to a knock on the door, looking at or going to the door.	Identifies action words by pointing to the right picture, e.g. <i>"Who's jumping?"</i> (by 30 months ☒) Understands 'who', 'what', 'where' in simple questions (e.g. <i>'who's that/can?', 'What's that?' 'Where is?'</i>) Developing understanding of simple concepts (e.g. <i>big/little</i>)	Learns new words very rapidly and is able to use them in communicating. Uses action, sometimes with limited talk, that is largely concerned with the 'here' and 'now' (e.g. reaches towards toy, saying <i>'I have it'</i>). Uses a variety of questions (e.g., <i>(what, where, who)</i>). Uses simple sentences (e.g. <i>'Mummy gonna work'</i>). Beginning to use words endings (e.g. <i>going, cats</i>).	Uses language as a powerful means of widening contacts, sharing feelings, experiences and thoughts. Holds a conversation, jumping from topic to topic. Enjoys being with and talking to adults and other children. Interested in others' play and will join in. Responds to the feelings of others.
30-50 months	Listens to others in one to one or small groups, when conversation interests them. Listens to stories with increasing attention and recall. Joins in with repeated refrains and anticipates key events and phrases in rhymes and stories, Focusing attention – still listen or do, but can shift own attention. Is able to follow directions (if not intently focused on own choice of activity).	Understands use of objects (e.g. <i>'What do we use to cut things?'</i>). Shows understanding of prepositions such as 'under', 'on top', 'behind' by carrying out an action or selecting correct picture. Beginning to understand 'why' and 'how' questions.	Beginning to use more complex sentences to link thoughts (e.g. using <i>and, because</i>). Can retell a simple past event in correct order (e.g. <i>went down slide, hurt finger</i>). Uses talk to connect ideas, explain what is happening and anticipate what might happen next, recall and relive past experiences. Questions why things happen and gives explanations. Asks e.g. <i>who, what, when, how</i> . Uses a range of tenses (e.g. <i>play, playing, will play, played</i>).	Beginning to accept the needs of others, with support. Can initiate conversations. Shows confidence in linking up with others for support and guidance. Talks freely about their home and community. Forms friendships with other children.
40-60+ months	Maintains attention, concentrates and sits quietly when appropriate. Integrated – can listen and do in a range of situations with range of people; varies according to the demands of the task. Two-channelled attention – can listen and do for a short span. Sustains attentive listening, responding to what they have heard with relevant comments, questions or actions.	Understands humour, e.g. nonsense rhymes, jokes. Able to follow a story without pictures or props. Understands instructions containing sequencing words; first ... after... last and more abstract concepts – long, short, tall, hard, soft, rough. Demonstrates understanding of "how?" and "why?" questions by giving explanations.	Extends vocabulary, especially by grouping and naming, exploring the meaning and sounds of new words. Links statements and sticks to a main theme or intention. Uses language to imagine and recreate roles and experiences in play situations. Introduces a storyline or narrative into their play. Uses talk to organise, sequence and clarify thinking, ideas, feelings and events.	Has confidence to speak to others about their own wants, interests and opinions. Initiates conversation, attends to and takes account of what others say. Explains own knowledge and understanding and asks appropriate questions of others. Expresses needs/feelings in appropriate ways. Shows awareness of the listener when speaking. Works as part of a group or class, taking turns.

Notes of monitoring early communication and language

Observation and best-fit judgements

- Judgements of a child's stage of development are made through a process of ongoing observational assessment.
- Observation involves noticing what children do and say in a range of contexts, and includes information from the family about what children do and say at home.
- For children learning English as an additional language, it is important to find out from families about how children use language in their mother tongue and how they communicate at home.
- The assessment is a 'best fit' match to a stage band. This involves considering what is known about the child and matching it to the development described in the bands. This should be considered separately for each strand of communication and language.
- Within each band a judgement will be made in two levels – either 'Emerging' when a child shows some development at that level, or 'Secure' when most of the statements reflect the child's current development.
- Development of speech sounds need not be assessed specifically, but it is useful to be aware of typical development which is described in the table to the right.

Checkpoints

- Alongside the 'best fit' judgement, certain 'checkpoint' statements are included. Marked with a flag  and a specific age, these are particular statements which should be noted.
- Where a child has not reached a Checkpoint by the age indicated, this is not necessarily a sign of difficulty. The checkpoint statements serve as an alert for close monitoring, including discussion with the family and perhaps further assessment or support.

Guidance on typical development of speech sounds	
Stage	Speech Sounds <i>(Developing speech and being understood applies to all language. Order of acquiring specific sounds – here in English – may vary with other language)</i>
0-11 months	Babbles using a range of sound combinations, with changes in pitch, rhythm and loudness. Babbles with intonation and rhythm of home language ('jargon')
8-20 months	Speech consists of a combination of 'jargon' and some real words and may be difficult to understand
16-26 months	Many immature speech patterns, so speech may not be clear. May leave out last sounds or substitute sounds (e.g. 'tap' for 'cap'). Uses most vowels and <i>m, p, b, n, t, d, w, h</i> .
22-36 months	Speech becoming clearer and usually understood by others by 36 months although some immature speech patterns are still evident. May still substitute sounds or leave out last sound. Emerging sounds including <i>k, g, f, s, z, l, y</i> .
30-50 months	Speech mostly can be understood by others even in connected speech. Emerging use of <i>ng, sh, ch, j, v, th, r</i> – may be inconsistent. Sound clusters emerging (e.g. <i>pl in play, sm in smile</i>) though some may be simplified (e.g. 'gween' for 'green').
40-60+ months	Overall fully intelligible to others. May be still developing <i>r and th</i> . May simplify complex clusters (eg <i>skr, str</i>).

Making Good Progress

- The goal of monitoring children's development is to plan and provide more accurate support for each child to make good progress.
- How well a setting helps children to make good progress can be determined by analysing the proportion of children who are at risk of delay, as expected, or ahead of expectations in each strand of language and communication. If children are making accelerated progress the proportion of children at risk of delay should decrease over time.
- In considering whether a child is at risk of delay, as expected or ahead in each strand of language and communication, it is necessary to consider the child's actual age in months in relation to the overlapping age bands. If a child is within two months of the end of the age band and development is not yet within the band or is judged to be 'Emerging', then a judgement of 'risk of delay' would be appropriate.

NAME:		GENDER:		DOB:		EAL? Yes/No		KEYWORKER:	
SETTING:									
		Baseline		First Review		Second Review		Identified SEN?	
		Date:	Age:	Months:	Date:	Age:	Months:	Please circle Yes/No	
COMMUNICATION & LANGUAGE									
		PSED							
		Making relationships		Listening and attention		Understanding		Speaking	
0-11 months Baseline F	F1 Enjoys the company of others and seeks contact with others from birth F2 Gazes at faces and copies facial movements. F3 Vocalises in response to familiar voices F4 Likes cuddles and being held: calms, snuggles in, smiles, gazes at carer's face or strokes carer's skin. F5 Responds to what carer is paying attention to, e.g. following their gaze	F1 Turns toward a familiar sound then locates range of sounds with accuracy. F2 Quietens or alerts to the sound of speech F3 Listens to familiar sounds, words, or finger plays F4 Fleeting attention – not under child's control, new stimuli takes whole attention F5 Watches actions of others with interest	F1 Quiets to smile or mother's/carer's voice. F2 Displays excitement/anticipation of care routines F3 Recognises patterns of their day and may protest e.g. being placed in cot to sleep F4 Responds to 'no' and other inhibitive sounds. F5 Understands simple instructions with a gesture e.g. 'Give it to Mummy'	F1 Communicates needs & feelings in a variety of ways F2 Makes own sounds in response when talked to by familiar adults F3 Lifts arms in anticipation of being picked up. F4 Initiates conversations by vocalising and smiling F5 Vocal turn taking and babbling develops					
	Depends on close attachments with a special person within the setting and enjoys the company of others.	Turns towards a familiar sound then locates range of sounds with accuracy.	Pays attention to new sounds or events in the environment.	Communicates using a variety of sounds to initiate social interaction.					
8-20 months Baseline E	E1 Builds relationships with special people and is wary of unfamiliar people. E2 Explores new situations when supported by familiar person. E3 Shows interest in the activities of others and responds differently to children and adults E4 Reacts to an audience, repeats activity or action when encouraged. E5 May look concerned if hears crying or excited if hears a familiar happy voice.	E1 Moves whole body to sounds they enjoy, such as music or a regular beat E2 Has a strong exploratory impulse E3 Concentrates intently on an object or activity of own choosing for short periods E4 Recognises and responds to own name e.g. by turning or looking E5 Pays attention to dominant stimulus – easily distracted by noises or other people talking	E1 Recognises and responds to own name e.g. by turning or looking E2 Recognises some family names e.g. mummy, daddy or siblings names. E3 Shows understanding of at least 15 words by looking or pointing E4 Understands simple instructions from familiar adult without cue e.g. 'Get your cup' E5 Identifies three or four body parts on self, others and toys	E1 Uses voice or gesture to attract attention e.g. holds up a toy, wave arms E2 Enjoys babbling and increasingly experiments with using sounds and words to communicate E3 Uses sounds in play, e.g. 'brmm' for toy car E4 Uses pointing with eye gaze to make requests, and to share an interest E5 Uses single words (10-20),					
	Seeks to gain attention in a variety of ways, drawing others into social interaction.	Interested in music and singing. Easily distracted by noises or other people talking.	Understands simple phrases used by familiar people.	Creates personal words and takes pleasure in making a wide variety of sounds.					
16-26 months Baseline D	D1 Plays alongside others D2 Uses a familiar adult as a secure base from which to explore independently in new environments, D3 Plays cooperatively with a familiar adult, e.g. rolling a ball back and forth D4 Starts to 'give' and 'take' D5 Looks to others for approval.	D1 Likes to move from one activity to another. D2 Begins an activity with enthusiasm but needs support to keep concentrating D3 Enjoys rhymes and demonstrates listening by trying to join in with actions or vocalisations e.g. will clap hands D4 Rigid attention – may appear not to hear D5 Has favourite books	D1 Points to named object or picture D2 Understand simple sentences e.g. 'throw the ball' D3 Acts in response to action words. D4 Selects picture by use e.g. find me something to drink D5 Understands approximately 50 words e.g. toys, body parts,	D1 Attempts to join in with nursery rhymes, songs and jingles D2 Uses different types of everyday words, nouns, verbs and adjectives, e.g. banana, go, sleep, hot. D3 Beginning to put two words together e.g. 'want ball', 'more juice' D4 Beginning to talk about people and things that are not present D5 Uses 50 or more words appropriately					
	Can be caring towards each other and look to others for responses.	Starting to focus on an activity of their choice, although finds it difficult to be directed by an adult.	Is able to respond to simple requests and grasp meaning from context	Uses single-word and two-word utterances to express ideas.					
22-36 months Baseline C	C1 Interested in others' play and starting to join in. C2 Seeks out others to share experiences. C3 Shows affection and concern for people who are special to them. C4 Shows autonomy e.g. by defiance C5 May form a special friendship with another child	C1 Listens with interest to the noises adults make when they read stories C2 Recognises and responds to many familiar sounds e.g. a knock at the door C3 Shows an interest in play with sounds, songs and rhymes C4 Listens to a short story in 1 to 1 situation C5 Single channelled attention. Can shift to a different task if attention fully obtained – using child's name helps focus	C1 Understands more complex sentences, e.g. 'Put your toys away and then we'll read a book' C2 Understands 'who', 'what', 'where' in simple questions C3 Developing understanding of simple concepts e.g. big/little C4 Identifies action words by pointing to the right picture e.g. 'who's jumping?' C5 Understands simple oppositional concepts e.g. in/out, open/shut	C1 Learns new words rapidly and is able to use them in communication C2 Uses a variety of questions (e.g. what, where, who) C3 Uses simple sentences (e.g. Mummy gonna work) C4 Beginning to use word endings (e.g. going, cats) C5 Carries on a simple conversation with adult					
	Learns social skills and shares experiences with adults and other children.	Follows adult lead interaction for a short time.	Uses language and actions to show s/he understands and recalls past events, and emotions, of others.	Learns new words rapidly and uses them in communicating about matters which interest them.					
30 -50 months Baseline B	B1 Can play in a group, extending and elaborating play ideas, B2 Keeps play going by responding to what others are saying or doing B3 Demonstrates friendly behaviour, initiating conversations B4 Can modify behaviour to fit in with what others are doing B5 Understands that own actions affect other people	B1 Listens to others one to one or in small groups, when conversation interests them B2 Listens to stories with increasing attention and recall B3 Joins in with repeated refrains and anticipates key events and phrases in rhymes and stories B4 Can return to a task after an interruption B5 Focusing attention – still listen or do, but can shift own attention.	B1 Understands use of objects e.g. 'what do we use to cut things?' B2 Shows understanding of prepositions such as 'under', 'on top', 'behind' by carrying out an action or selecting correct picture. B3 Offers more than one object when asked using a plural form B4 Understands simple questions involving negatives e.g. 'which doll has no hat?' B5 Beginning to understand 'why' and 'how' questions	B1 Can retell a simple past event in the correct order. B2 Questions why things happen and gives explanations. B3 Uses a range of tenses. B4 Builds up vocabulary that reflects the breadth of their experiences B5 Uses talk in play, e.g. 'This box is my castle'.					
	Can adapt behaviour to different situations and changes in routine.	Enjoys listening to stories however can only focus on one thing at a time.	Uses language to think through and revise what they are doing.	Begins to use longer sentences to describe more complex ideas.					
40 - 60 months Baseline A	A1 Attends to and takes account of what others say Takes steps to resolve conflicts with other children, e.g. finding a compromise A2 Monitors others behaviour with a sense of right and wrong A3 Takes turns & shares resources with peers A4 Gets satisfaction from doing things with other children and adults A5 Aware that there are different ways to behave dependent on the situation	A1 Can tell what's missing when one object is removed from three e.g. when playing Kim's game A2 Recalls four objects seen in a picture A3 Attention is integrated for a short time e.g. plays with toy and answers adult question while playing. A4 Attention is integrated for sustained period of time. A5 Good attention skills evident across different situations and with different people.	A1 Understands all pronouns: 'they', 'he', 'she', 'him' and 'her'. A2 Understands and anticipates sequence of the day A3 Carries out two unrelated directions A4 Listens and responds to ideas expressed by others in conversation or discussion. A5 Understands humour e.g. nonsense rhymes, jokes.	A1 Extends vocabulary to include concepts and categories A2 Uses language to imagine, recreate roles and experiences in play A3 Links statements and sticks to a main theme or intention A4 Uses talk to organise, sequence and clarify thinking A5 Introduces a storyline or narrative into their play					
Early Learning Goal	Children play co-operatively, taking turns with others. They take account of one another's ideas about how to organise their activity. They show sensitivity to others' needs and feelings, and form positive relationships with adults and other children	Children listen attentively in arrange of situations. They listen to stories, accurately anticipating key events and respond to what they hear with relevant comments, questions or actions. They give their attention to what others say and respond appropriately, while engaged in another activity.	Children follow instructions involving several ideas or actions. They answer 'how' and 'why' questions about their experiences and in response to stories or events	Children express themselves effectively, showing awareness of listeners' needs. They use past, present and future forms accurately when talking about events that have happened or are to happen in the future. They develop their own narratives and explanations by connecting ideas or events					

SLCN Guidance Notes

The documents attached, will help you to identify whether the child can be supported at a Universal Plus level or whether they require specific intervention from a Speech and Language Therapist.

Children who have no words or are only using single words at age 2 may be described as 'late talkers' and should be supported at a Universal Plus level by Lets Get Talking groups. These children have delayed language in the absence of additional difficulties.

The following two year olds should be directed straight to Speech and Language therapy and therefore a request for involvement should be made.

- Eating, drinking and swallowing difficulties
- Voice difficulties
- Dysfluency
- Deterioration in skills
- Complex needs (additional needs in other areas of development)
- Severe social interaction difficulties (they are not secondary to delayed language)
- Children with good developing language but significant speech sound difficulties making them very difficult to understand

The attached documents provide information on each of the above areas and will help you to identify which children will need a referral to Speech and Language Therapy. Please discuss with your neighbourhood Speech and Language Therapist if you are unsure.

Indicators for referral to SALT – Cleft palate

Children diagnosed with a cleft will be referred to a specialist SALT at birth

Undiagnosed cleft (sub mucous cleft):

Indicators:

- Feeding difficulties – history of difficulty breast feeding and nasal regurgitation when feeding
- Nasal speech – using mainly m, n and vowel sounds (not using p,b,t,d)
- Visible cleft at back of palate when mouth open (bifid uvula)
- Persistent glue ear

These children should not be placed on Pathway for 2 year olds with SLCN. They need referral to SALT, including a description of difficulties (see above)

Stammering in two year olds.

Between the ages of 18 months and 7 years, many children pass through stages of normal speech dysfluency associated with their attempts to learn how to talk. These are natural hesitations that do not require specific intervention.

Features of natural hesitations in the young child

1. One or two repetitions of syllables or words especially at the beginning of a sentence. Occurs about once in every ten sentences.
2. Dysfluencies may increase in frequency for several days or weeks and then be hardly noticeable for weeks or months, then return again.
3. Child shows no awareness of the normal dysfluencies showing no surprise or frustration.
4. Child under three years.

Developing Stammer

The following features can be an indication that the child has more difficulty with their talking and will need closer monitoring, advice given to the parent (smooth talking). Professionals should contact their local Speech and Language Therapist to discuss a referral.

Features of a mild stammer.

1. Four or five repetitions of a sound syllable or word.
2. Stretching out of a sound in word
3. Show signs of reacting to the stammer, e.g. blinking eyes, looking away or tensing their mouth when talking. Or show temporary signs of embarrassment or frustration at the moment of stammering.
4. Stammers appear more regularly

Risk Factors for developing a persistent stammer.

If one or more of the following risk factors are present it is advisable to have discussion with a Speech and Language Therapist.

1. Close family member who has a stammer.
2. Child over 3 and a half years
3. Stammer been present for longer than 6 months
4. Child is male; girls are more likely to outgrow a stammer.
5. Frequent Speech sound errors.

References

Guitar, B., & Conture, E. G. (Eds.) (2006). *The child who stutters: To the pediatrician. Fourth edition, publication 0023*. Memphis, TN: Stuttering Foundation of America.

RCSLT: Communicating Quality 3:

RCSLT: Clinical Guidelines.

Alison Blane

Specialist Speech and Language Therapist

Referral Guidelines for 2 year olds (Dysphagia)

Typically developing two year olds can eat independently and can tackle every kind of food and liquid that appeals to them. The types of food eaten vary because of personal taste and preference, not usually because of lack of coordination and skill (Evans-Morris and Klein 2000) and children of this age are mostly able to feed themselves independently.

As with other age groups, effective eating, drinking and swallowing is dependent on stability of the body systems involved and medical conditions that affect these systems can result in compromised swallow safety, inadequate intake of food or drink and / or distress associated with mealtimes.

The Speech and Language Therapy service accepts referrals for children with eating, drinking and swallowing difficulties where there is an impact in one or more of these areas due to their current or past medical conditions or to a significant delay in their development.

The following concerns would indicate that SLT referral is appropriate:

- Coughing or choking when feeding
- Noisy or gurgly breathing during feeding
- Gagging and or vomiting associated with eating or drinking
- Inability to manage a range of textures and a reliance on a diet or feeding method that is inappropriate for the child's age.

Food refusal, excessively long mealtimes, distress associated with eating and extreme parental anxiety may also be triggers for referral but usually only in the context of current or past medical or developmental issues as these frequently occur in 2 year olds when a degree of resistance and selectivity in eating is common.

KJH

April 2013

Indicators of 'complex needs':

The child may have a physical disability or significant health care needs often accompanied by a sensory impairment (hearing and/or vision). Communication may be at a pre-intentional or early intentional level, or may be difficult to assess (thus requiring specialist input to the assessment process)."

Indicators for referral to Speech and Language Therapy

Children presenting with difficulties in the following areas :

- **Communication**
- **Social interaction**
- **Play and imagination**
- **Unusual or restricted interests**

These signs of an Autism Spectrum Disorder may show as:

SPOKEN LANGUAGE

- regression in or loss of speech/language delay in comparison to peers
- unusual spoken language eg non speech like vocalisations, odd intonation, reference to self by name
- difficulties with speech clarity
- how does the child indicate they want something?
- how does the child indicate they want something again?
- repetition of words/phrases/sentences not in context
- reduced use of language for communication, for example use of single words although able to speak in sentences

RESPONDING TO OTHERS

- reduced or absent social smiling or response to name
- reduced or absent response to feelings or facial expressions
- negative responses to the requests of others
- rejection of cuddles from others, cuddles only on their terms

INTERACTING WITH OTHERS

- do they use others as a tool eg take them by the hand?
- are they aware or interested in others? do they show challenging behaviour eg hitting/pushing/kicking
- reduced or absent awareness of personal space
- reduced or absent imitation of others' actions
- reduced or absent initiation of play
- reduced or absent enjoyment of social situations

ATTENTION AND LISTENING

- does the child respond to their name?
- does the child blank out instructions given to them?
- does the child appear to be listening in group activities?
- does the child flit from one activity to another?
- does the child pace backwards and forwards in the setting?

UNDERSTANDING

- can they anticipate routines?
- can they understand words, phrases or questions?
- is the child's understanding more delayed than their spoken language?

- do they need the use of visual cues eg symbols/pictures to help them understand what is about to happen?

EYE CONTACT, POINTING AND OTHER GESTURES

- reduced or absent use of gestures and facial expressions or eye contact
- does the child look directly or use their peripheral vision? eg watch something from side glances
- does the child watch certain stimuli eg lights, shadows, reflections?
- reduced or absent joint attention eg difficulties following a 'point' or sharing and pointing to pictures in a book, pointing or showing objects to share an interest

IDEAS AND IMAGINATION

- reduced or absent pretend play
- can the child share and take turns?
- will they join in with others or is their play on their terms?
- when they get upset is this out of proportion to the activity eg meltdowns?

UNUSUAL/RESTRICTED INTERESTS

- repetitive hand movements eg spinning, hand flapping, rocking, finger flicking
- repeating actions eg opening and shutting doors/light switches
- over focused on parts of toys/objects/faces
- insistence on own agenda
- extreme emotional reactions to change
- over or under reaction to sensory stimuli eg textures, smell, sounds, touch
- excessive reaction to taste, smell and texture, crowds, noise, touch
- do they cover their ears with everyday sounds?
- do they smell and lick objects and people?

- **CQC 2, 21**
- **National Institute for Health and Clinical Excellence Autism- NICE Clinical Guidelines 2011**

Selina Wightman- Specialist Speech and Language Therapist (November 2012)

Voice Disorders in Children

Voice disorders in children under three are very rare. The largest percentage of children presenting with voice disorders are of primary school age.

Reason for referral to Speech and Language Therapy:

- Persistent significant hoarseness for 6 months or more
- Aphonic (no voice) for more than 2 weeks
- Significant physical reason e.g. vocal fold paralysis/papilloma/cyst/cleft palate
- Strained voice quality

Let's Get Talking Guidance Notes

Universal Plus intervention consists of 3 options.

The first is 'Let's Get Talking' groups.

Let's Get Talking is a 4 week intervention group for parents and children. It consists of 4 x 1.5 hour sessions. Ideal group size: 6 families. The groups are generally delivered from Children's Centres. In the initial stages groups will be run jointly by a Community Nursery Nurse (CNN) and Speech and Language Therapist (and Children's Centre colleagues where available). From September 2013 the groups will be led by the Community Nursery Nurses with support from the local Speech and Language Therapist and Children's Centre colleagues. A Let's Get Talking folder is available to CNN's including session plans, invitation letter, handouts and evaluation forms.

The groups aim to support parents/carers in using these key strategies with their children:

- Reducing background noise
- Being face to face
- Following the child's lead
- Naming
- Keeping it simple
- Commenting (and reducing questions)
- Using the 'traffic lights', stop, wait and respond

Each week focusses on 2 of these strategies through activities and discussion then the group practices using the strategies with their children during play.

The second option is county Children's Centre Speech and Language groups:

These groups are delivered by Speech and Language support within Children's Centres. They have the same content as 'Let's Get Talking' and are delivered in collaboration with Health Visiting and Speech and Language Therapy. But have different names.

Market Harborough – "Toddler Talk"

Hinckley and Bosworth – "Babble Back"

The third option is Community Nursery Nurse or Children's Centre staff support:

When a family does not attend a group then they are offered up to 2 home visits which aim to share the same key strategies from the group in a home environment.

Session 1: Face to Face, Following Your Child's Lead, Background noise

Aims:

- Parents/carers will recognise, embrace and respond to their child's attempts at communication.
- Parents/carers will understand the benefit of face to face play for their child and how to adapt activities and create opportunities for this.
- Parents/carers will understand the negative effect of background noise on their child's ability to listen and learn.
- Parents/carers will practice following child's lead during play.

What you will need:

Toys (using child's own toys where possible)

Hand-outs:

Face to face

Following your child's lead

Session Plan: (Sessions will last between 30-60 minutes)

Introduction

Explain to the parent that you will be carrying out 2 home visits during which you will be discussing ideas to help with their child's talking. During these visits you will practise the ideas together.

Explain the focus of this session – Getting down to child's level and following their lead.

Introduce Strategies:

Discuss: face to face

Practitioner stands behind parent or faces away from them and asks parent about what they did last night, family, interests. Feedback: discuss what it was like when not talking face to face. Talk about the impact of not having eye contact and of being at different levels.

Learning: Children learn to talk by listening to us talking but sometimes it's hard to 'tune in' to us as there is so much going on around them (back ground noise TV,

radio) Children's attention is developing but at 2 to 3 years old they may still find it difficult to focus on 2 things at once. Therefore if the child is absorbed in play they will find it much easier to listen to us if the TV is off and we are down at the same level.

It may be useful to make a comment to parents in relation to – 'Not shouting across the room' – point out that the child is not being lazy or intentionally ignoring them but they may have single channelled attention and need you to get down to their level , say their name and get eye contact before talking to them.

At this point if the tv/radio is on ask them to turn it off.

Discuss: Following your child's lead

Learning: We can sometimes have our own agenda about how to play with a toy e.g. want to build a tower with bricks – what we expect you should do with them, however the child may not be interested in playing with the toy in that particular way and will lose interest if you direct them in their play. If we get down to your child's level, follow what they are interested in and maybe join in, even if its just banging on the floor or pretending to cook, then they are more likely to look at us and listen to our comments.

Demonstrate getting down to the child's level and following the child's lead. Encourage the parent to get down on the floor opposite their child, to wait before jumping in and to closely observe what their child is doing with the toys. Point out what their child seems to be interested in/what their child likes doing with the objects. Encourage the parent to practice joining in with the play by following the child's ideas and interests and copying their child's play.

Give parent handouts and ask them to practise turning off the TV, getting down to the child's level and following their child's lead every day for 5 minutes over the next week/s.

Session 2: Traffic Lights, Naming and Commenting and reducing questions

Aims:

- Parents will begin to match their child language – modelling single words or short phrases when naming objects or actions
- Parents will understand how asking questions can put a child under pressure resulting in poor responses or avoidance and loss of interest
- Parents will be reminded to follow child's lead – stop and wait.

What you will need:

Toys (using child's own toys where possible)

Book

Hand-outs:

Naming

Commenting/reduce questions

Traffic lights

Session Plan: (Sessions will last between 30-60 minutes)

Introduction

Discuss how they found the previous advice given at the last home visit and if they had managed to practise them. Any challenges they came across.

Show the parent/carer the traffic light hand out to recap on last weeks strategies and to move on with next strategies.

Red: STOP- important to stop and get down to your child's level- face to face and really look to see what they are looking at and watch what they are doing before we 'barge in' with a question or want to take over the play.

Amber- WAIT- pause and even count to 10 in your head before you get involved. This will give you a chance to see what your child is interested in. Adults can then think how they can show an interest and gradually join in. Try waiting till the child involves you by offering to give you something, looking at you or just making a noise – then join in!

Tell the parent/carer that you will cover the **green** RESPOND during this session.

Introduce 'reducing questions':

Activity: Can they remember a time when they were asked lots of questions – an interview, an exam or test? Feedback: How did they feel if they couldn't answer the question or just didn't know the answer? Think about feelings - under pressure/ tested or examined. Talk about closed questions i.e. with only one correct answer – 'what's that?' 'what colour is it?'

Many children's first words are 'whats that?' because as adults we want them to speak so keep asking them questions (with the best intentions)

Activity: Demonstrate how you can share a book with a child without asking questions and instead commenting on what is on the pictures. Children learn better without the questions – they just need the words.

Learning: Children need to hear actual words to build up their vocabulary and this can be done when you are looking through a book or when playing with your child and using '**commenting**'. Describe what the child is doing using single words and simple phrases that relate to the objects and actions the child is doing. Whilst commenting on what the child is doing, remember to leave **pauses** (up to 10 seconds) to allow the child to process what has been said and possibly make a response.

Refer back to the traffic light handout and explain that commenting is one way of responding and using words. The other ways of responding are:

-Naming – if your child is playing with, exploring or just looking at an object – NAME it.

-Repeating- when your child makes a sound or says a word then repeat it back to them which will show that you are interested and passing back the turn without asking them a question.

-Add – if your child uses a word add another word and repeat it back to them e.g. Child- 'teddy' Adult- 'fluffy teddy'. This will expand their language without asking questions.

Encourage the parent to play with their child. Practitioner should model, offer further advice or facilitate interactions by using positive praise.

Give parent handouts and talk to them about the next steps i.e. follow up in 2-3 months with a phone call or home visit; referral to Speech and language therapy if needed; signposting to other groups such as children's centre, library services etc. and ask them to practise the strategies every day for 5 minutes with their child over the next weeks.

Let's Get Talking

Folder Contents

Notes for Practitioners

Session Plans

Session One - Face to Face

Session Aims and Resources
Session Plan
Parent Hand Outs

Session Two - Naming (and keeping it simple)

Session Aims and Resources
Session Plan
Parent Hand Outs

Session Three - Commenting

Session Aims and Resources
Session Plan
Parent Hand Outs

Session Four - Traffic Lights

Session Aims and Resources
Session Plan
Parent Hand Outs

Additional Information

References
Useful Websites
Pathway - SLCN at 2 years

Copyable Resources

Invitation
Parent Questionnaire – Think about your child
Practitioner Observation Sheets
Master copy of Handouts
Let's Get Talking Diary
Feedback and Evaluation forms

Notes for Practitioners

'Lack of positive communication between children and their parents could be harming their long term development. They need conversations with people, especially parents, with the adult making eye-contact and showing interest in order to acquire language to help them 'understand, think, communicate and learn.' (Sue Palmer, 'Toxic Childhood', 2006)

Encouraging parents and carers to understand their role in supporting their child's language development is essential for maximum impact and eventual success. Explaining what Let's Get Talking sessions are all about and giving them suggestions for how they can help to achieve those aims for their child is a critical part of future learning.

The parent invitation gives a brief and accessible overview of what parents can expect from the workshops.

The individual sessions contained in this booklet aim to enhance the adult and child interactions and therefore support the child's language acquisition and communication skills in the home learning environment.

The skills required during interactions include:

- Attention and Listening
- Non-Verbal Behaviour
- Receptive Language or Comprehension
- Expressive Language
- Speech and Gestures

Playing and having fun in a supported and structured session provides an environment for children, parents and carers to experience and practise new skills essential for successful social interactions and ultimately the development of speech, language and communication.

The following aspects of parent child interaction will be targeted throughout the workshop:

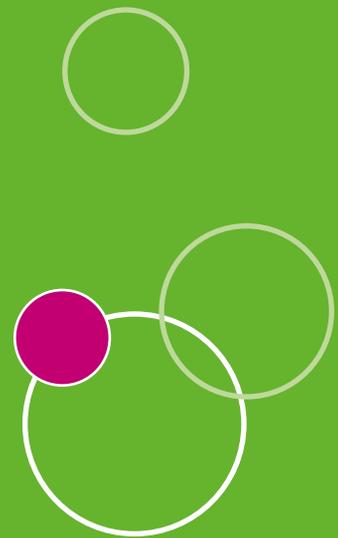
- Having Fun
- Face to face positioning
- Following the child's lead
- Naming
- Modelling
- Commenting
- Reducing questions
- Stop, wait and responding appropriately

Playing and interacting using the above strategies will support the following developmental skills:

- Attention and listening
- Waiting and anticipating
- Taking turns
- Joint interest
- Learning new vocabulary and grammar
- Speech sounds
- Confidence and self esteem

Session One

Face to Face



Information for Practitioners

Session 1 Face to Face

This session aims to inform parents/carers and intends to deliver the following learning outcomes:

- **Parents/carers will recognize, embrace and respond to their child's attempts at communication.**
- **Parents/carers will understand the benefit of face to face play for their child and how to adapt activities and create opportunities for this.**
- **Parents/carers will understand the negative effect of background noise on their child's ability to listen and learn.**
- **Parents/carers will practice following child's lead during play.**

What you will need:

Stickers and pens
Observation sheets
Spare questionnaires

Circle time

Ball, Song sheets/words and rhymes. Song board with pictures/symbols or objects such as finger puppets/toys

Activity

Play dough, stacking hoops or coloured blocks

Toys

Selection including large doll play and tea set, small world play, inset puzzles, tunnel, rolling objects (balls, cars etc.), books, posting toys, stickers, large pieces of fabric or scarves for pee-po and stacking hoops/small coloured blocks.

Hand-outs

Face to Face
Following your child's lead

Session Plan

Minutes

15 Introduction

As parents and children arrive introduce yourself and give out stickers and pens for names. Collect in questionnaires, explain the format of the weekly sessions (i.e. parents and children arrive, 'Hello Song' and circle time, children play while parents and practitioners discuss ideas to help with their child's talking (handouts provided), parents then join in their child's play and practice the ideas with support from the practitioners and finally the group convenes for song/story 'choosing' and 'Goodbye' song) and 'Ground rules' – this is an opportunity to discuss points such as group confidentiality and parents' expectations of the group.

Explain focus of this session – Getting down to child's level and following their lead.

15 Circle time (remind parents that the children are young and may not want to join in straight away, it is fine to let them do so in their own time)

Hello song – introduce each child by name.

Ball rolling game: Explain to the parents/carers that the aim of the game is for the children to listen for their name and to choose, by looking, pointing or saying the name of, who they want to roll the ball to. This game also encourages looking, listening and turn-taking skills. If a child finds this difficult the adults should choose a child to roll the ball to and then model saying the child's name.

Encourage the children to explore the toys provided whilst adults talk.

15 Introduce Strategies

Discuss - Face to Face

Activity: One parent stands behind another seated parent (both facing forwards) and they try to have a conversation - suggestions include introducing themselves and talking about family, talking about interests or what they did last night etc. Then ask parents to continue conversation facing each other. **Feedback** - focus discussion on the impact of not having eye contact and of being at different levels.

Learning: Children learn to talk by listening to us talking but sometimes it's hard to 'tune in' to us as there is so much going on around them (back ground noise – TV, radio, washing machine etc. and visual stimuli – TV, other people). Children's attention is developing but at 2 to 3 years old they may still find it difficult to focus on 2 things at once. Therefore if they are absorbed in play they will find it difficult to listen to us – they need to look at us to be able to listen which will be much easier if we are on the same level.

It may be useful to make a comment to parents in relation to – 'Not shouting across the room' – point out that the child is not being lazy or intentionally ignoring them but they may have single channelled attention and need help developing more advanced attention and listening skills.

Discuss - Following your child's lead

Activity (Optional):

Play dough – demonstrate how we all have different ideas hand a piece of dough to each parent and ask them to play with it in any way they like.

Learning: We can sometimes have our own agenda about how to play with a toy – comments on what parents have done with the play dough **OR** use the stacking hoops or bricks and discuss what we expect we should do with them but the child may not be interested in putting them in correct order or building and they will lose interest and not listen to what is being said. If we get down to the child's level, follow what they are interested in and maybe join in even if its just banging on the floor (exploratory play) or pretending to nibble (imaginative/symbolic play) then they are more likely to look at us and listen to our comments. We are not going to talk about specific words as this is covered in more detail in later sessions.

35 Interaction Activities

Encourage parents to play with their children moving around the available activities – reinforce the focus of 'face to face' and 'following the child's lead'. Practitioners should move around the pairs to model strategies and facilitate interactions using positive praise. Use this as an opportunity to discuss questionnaires as appropriate.

- Large doll & tea sets – watch what the children do with it and follow their lead.
- Tunnel – opportunities to be 'face to face' down the tunnel.
- Ready Steady Go Games – sitting opposite each other rolling a toy when you say "Go!"
- Inset puzzles – bring a piece up to your eyelevel when talking about it.
- Fabric and scarves (some transparent) – initially use transparent fabric to hide your face and play pee-po. Using thicker material hide your face or other objects so your child can reveal what's underneath to initiate conversation – naming, describing etc.

15 Circle time

Reconvene as a group and recap on the target strategies – distribute hand-outs.

Rhyme time - practitioner should encourage and support each child to make a successful choice from the picture song board or objects (finger puppets etc.). Encourage parents to sit facing their children whilst singing together.

Goodbye song

10 Finish

Healthy Child Programme

Face to Face

Get down on the floor to play with your child.
Change your body position as you play, so that you are face to face, and your child can more easily make eye contact with you.



Why do this?

- It is easier for you to join in with their play.
- It makes it easier for your child to show you, by looking and making eye contact, that they are enjoying the play.
- It makes it easier for you to understand, or respond, to any attempts they make to communicate.
- It allows your child to see your mouth when you are talking.

Further information is available at: www.wordsforlife.org.uk

Healthy Child Programme

Following Your Child's Lead

Let your child lead the play by following their own ideas. This will mean spending time to watch them closely to see what they are interested in.



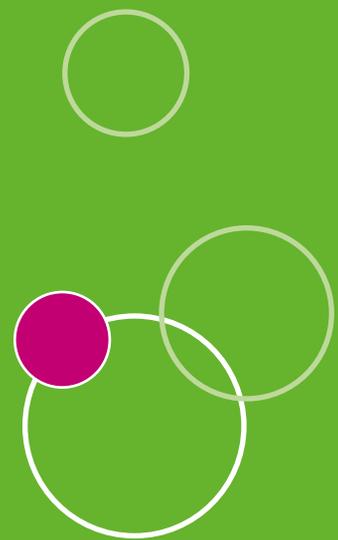
Why do this?

- It will be easier for your child to focus on things they enjoy. This will mean that they are more likely to play longer, let you join in and pay attention to the words you use.
- It will encourage them to make choices rather than always following your lead.
- It will encourage them to gain in confidence.

Further information is available at: www.wordsforlife.org.uk

Session Two

Naming (and keeping it simple)



Information for Practitioners

Session 2 Naming (and keeping it simple)

This session aims to inform parents/carers and intends to deliver the following learning outcomes:

- Parents/carers will begin to match their child's language – modeling single words or short phrases when naming objects or actions.
- Parents/carers will begin to label what the child is doing 'in the moment' for example, during a range of experiences such as playing and other everyday activities.
- Parents/carers will practice repeating keywords many times and will remember to pause after modeling and commenting to allow the child to respond (either in actions or verbally).
- To understand why they should not ask the child to repeat words that are pronounced incorrectly and the benefit of modeling back with the correct pronunciation.

What you will need:

Stickers and pens, Observation sheets, Feedback forms for Session 1

Circle time

Ball, Song sheets/words and rhymes. Song board with pictures/symbols or objects such as finger puppets/toys

Bubbles

Activity

Interlocking Stars or Stickle Bricks and a Guiro

Toys

A selection including large doll play and tea set, small world play, inset puzzles, toddler toys, trains and track, books, bricks and stickers for activity

Hand-outs

Keep it Simple

Listen and Respond

Session Plan

Minutes

10 Introduction

As parents and children arrive give out stickers and pens for names.

Use this opportunity to talk with parents/carers about how they got on with practicing the previous week's strategy and how their child responded. Explain that this week will follow the same format as the previous week but that the focus of this session will be Naming (objects and actions) and keeping adult's language simple.

15 Circle time

Hello song – introduce each child by name. Ball rolling to each child encourage naming and use positive language supporting social interaction including "my turn and now it's [child's name]'s turn" etc.

Encourage the children to explore the toys provided whilst adults talk.

20 Introduce Strategies

Discuss – Naming - keep it simple

Activity: Get the full attention of the group and show everyone the musical instrument (the Guiro) DO NOT NAME IT. Pass it around and give everyone a chance to handle and play with it, talk about what it looks and sounds like. Then take another object for example construction toys such as interlocking stars or Stickle Bricks. This time give the group a piece and name it many times as each person passes it around or fixes it together.

Holding the construction toys ask the group "What is this called". They will be able to tell you because you used the word many times when talking to them. Now, holding the Guiro, ask them, "What is this called". The group will be unlikely to be able to name it because they didn't hear the practitioner name it. **Feedback** - focus discussion on what helps us to learn new words and remember meaning.

Learning: Draw out the importance of naming (through labeling and modeling) objects and actions 'in the moment' i.e. when it is in front of you, when you are holding it or doing it. Highlight the importance of repetition and pausing. In addition explain that words can get lost in a string of words so it is easier for a child to listen and remember if they keep it simple.

30 Interaction Activities

Encourage parents to play with their children moving around the available activities – reinforce the focus of 'naming and keeping it simple'. Practitioners should move around the pairs to model strategies and facilitate interactions using positive praise.

Use this as an opportunity to observe and assess children's developing skills - Are they listening? Making eye contact? Making sounds or using words spontaneously? Repeating words after the adult? Understanding single words? E.g. find the car.

- Large doll & tea sets – naming objects (cup, bed etc.) and actions (drinking, sleeping).
- Books – Parent says 'Can you see the,', pointing and naming or use simple lift the flap or picture books and talk about pictures rather than reading the story.
- Mediums such as Play dough, shaving foam etc. – describe texture (soft, sticky) and actions (roll, press) etc.
- Train and track – comment on child 'pushing' the train, 'train goes up, up, up' etc.
- Building bricks – naming 'brick', 'more bricks', 'on top', 'all fall down', 'again' etc.
- Physical activities – actions, 'clapping' 'shaking' concepts, 'slowly', 'quickly' etc.
- Singing – use familiar, short, repetitive songs with actions – 'Again?'

15 Circle time

Reconvene as a group and recap on the target strategies – distribute handouts.

Assess understanding of single words e.g. hands, nose and head etc. using bubbles.

Blow and catch a bubble on the wand, then say to each child, "pop on your ... tummy", "pop on your ... nose", "pop on your ... shoes".

Being careful not to give a clue by looking at their tummy, shoes etc. Pause after each statement and wait briefly to see if the child looks at or touches their tummy, shoes etc. showing that they recognize and understand the word. If they do not respond support their parent to help by tickling/touching the spot and saying target word.

Assess understanding of two word instructions using, coloured stickers, a doll, a teddy bear, and other adults.

Ask the children to put the sticker on, "Teddy's nose", "Dolly's hand", "Mum's shoes".

Practitioner should encourage and support each child to make a successful choice from the picture/symbol song board or objects such as finger puppets/toys.

Goodbye song

Finish

Healthy Child Programme

Keep it Simple

Keep your sentences generally at the level your child is at. If your child is not using any words or only a few single words, try to use mostly single words when you play together. If they are using lots of single words but not putting words together, you should use two words together.



Why do this?

- Your child will find it easier to learn words if you say the word that matches what the child is interested in.
- Lots of words said together can be just too much for your child to understand, they cannot pick out the important words so easily.

Further information is available at: www.wordsforlife.org.uk

Let's Get
Talking

Healthy Child Programme

Listen and Respond

When you hear your child say something, try to give it meaning by interpreting what they have said, and say the word for them to hear.



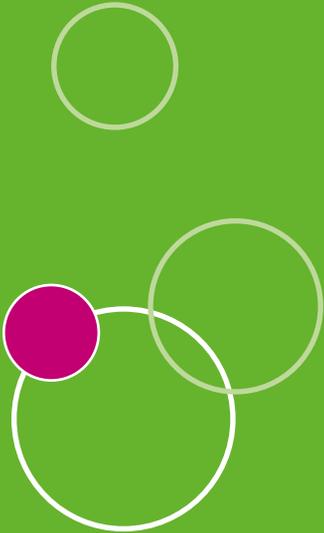
Why do this?

- Interpreting what you think your child might be trying to say lets them know you understand and encourages them to communicate.
- Copying actions as well as sounds lets your child know you are interested in communicating with them.

Further information is available at: www.wordsforlife.org.uk

Session Three

Commenting



Information for Practitioners

Session 3 Commenting

Comment and Pause – reducing questions

This session aims to inform parents/carers and intends to deliver the following learning outcomes:-

- Parents/carers will understand that children will learn more words and understand the world better if adults talk to them about things as they happen.
- Parents/carers will recognize that through commenting on what they and their children are doing they will show that they are interested in the child and that this builds confidence
- Parents/carers will practice pausing after commenting to provide opportunities for the child to respond
- Parent/carers will understand how asking questions can put a child under pressure resulting in poor responses or avoidance and loss of interest. (Refer back to Follow Child's Lead)

What you will need:

Stickers and pens

Observation sheets

Feedback forms for Session 2

Circle time

Ball, Song sheets/words and rhymes, Song board with pictures/symbols or objects such as finger puppets/toys

Activity

'Where's Spot' book

Toys

A selection including large doll play and tea set, small world play, inset puzzles, toddler toys, trains and track, books, drawing and mark making, play dough, shaving foam

Hand-outs

Commenting

Reduce Questions

Session Plan

Minutes

15 Introduction

As parents and children arrive give out stickers and pens for names.

Use this opportunity to talk with parents/carers about how they got on with practicing the previous week's strategy and how their child responded. Explain that this week will follow the same format as the previous week but that the focus of this session will be Commenting and reducing questions.

15 Circle time

Hello song – introduce each child by name.

Ball rolling to each child encourage naming and use positive language supporting social interaction including "my turn and now it's [child's name]'s turn" etc.

Encourage children to explore the toys provided whilst adults talk.

20 Introduce Strategies

Discuss - Commenting and Reduce Questions

Activity: Can they remember a time when they were asked lots of questions – an interview, an exam or test? **Feedback** How did they feel if they couldn't remember the answer or just didn't know the answer? Think about feelings - under pressure/ tested or examined. Talk about closed questions i.e. with only one correct answer - "What's that?", "What colour is it?", "How many are there?" or "Where's the ...?". Ask parents/carers to think about the words that children are hearing – What?, Where?, What colour?, How many?

Many children's first words are, "What's that?" because as adults we want them to speak so keep asking them questions (with the best intentions).

Activity: Demonstrate how you can share a book with a child without asking questions. The practitioner 'reads' the story 'Where's Spot?' to the children without asking any of the questions but commenting on what is on the pages, encouraging the children to join in by turning the pages, opening the flaps etc. Children learn better without the questions – they just need the words.

Learning: Children need to hear actual words to build up their vocabulary and this can be done both with books by talking about the pictures and using commentary. Our job is to be the 'commentator' for their play like a football match on the radio. Describing what the child is doing using simple words and phrases that relate to the objects and action the child is doing. Whilst commenting on what the child is doing though remember to leave pauses (up to 10 seconds) (Speaker counts to 10 in head and then continues speaking to demonstrate how long) to allow the child to process what has been said and possibly make a response.

25 Interaction Activities

Encourage parents to play with their children moving around the available activities – reinforce the focus of reducing questions and commenting. As practitioners move around the pairs they should offer individual advice and demonstrate commenting as a strategy leaving pauses and then facilitate the interactions between the parent/carers and child using positive praise.

Use this as an opportunity to observe and assess children's developing skills - Are they listening? Making eye contact? Making sounds or using words spontaneously? Repeating words after the adult? Understanding single words? E.g. find the car.

- Large doll & tea sets – naming objects (cup, bed etc.) and actions (drinking, sleeping).
- Animals (farm, zoo etc.) – naming, actions and concepts (in, on and maybe under).
- Books – Parent says 'Can you see the ...', pointing and naming or use simple lift the flap or picture books and talk about pictures rather than reading the story.
- Mediums such as Play dough, shaving foam etc. – describe texture (soft, sticky) and actions (roll, press) etc.
- Mark making/drawing – comment on what child is doing e.g. 'Round and round'.
- Train and track – comment on child 'pushing' the train, 'train goes up, up, up' etc.
- Building bricks – naming 'brick', 'more bricks', 'on top', 'all fall down', 'again' etc.
- Physical activities – actions, 'clapping', 'shaking' concepts, 'slowly', 'quickly' etc.
- Singing – use familiar, short, repetitive songs with actions – 'Again?', 'More?' and leave slight pauses to allow child to fill space but continue if this is not forthcoming.
- Rolling Toys – push toward child 'Ready, steady ...' Leave a slight pause for child to fill – if they don't adult says and pushes toy to child.
- Packing Away – 'In the box', 'Car in the box' etc.

15 Circle time

Reconvene as a group and recap on the target strategies – distribute handouts.

Practitioner should encourage and support each child to make a successful choice from the picture/ symbol song board or objects such as finger puppets/toys.

Goodbye song

2.30 Finish

Healthy Child Programme

Commenting

Comment on your child's play to introduce new words and practise ones they know.



Why do this?

- When your child is interested in something they are more likely to pay attention to the words you are using.
- The word will have more meaning, and be easier to remember, if it matches what your child is looking at, or doing.
- Even if you know your child knows the word it helps them to hear it repeated.

Further information is available at: www.wordsforlife.org.uk

Healthy Child Programme

Reduce Questions

With young children, a lot of questions are not helpful.
Try to comment rather than ask a question.



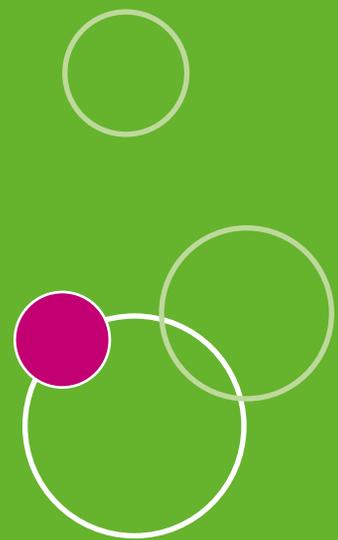
Why do this?

- If you say, 'What's that?' a lot to your child, it is more likely that that is what they will learn to say. It's much better to comment instead, as your child then hears new words.
- Using questions can feel like a test to your child, especially if they know the answer.
- Your child may not know the answer and this may decrease their confidence.

Further information is available at: www.wordsforlife.org.uk

Session Four

Traffic Lights



Information for Practitioners

Session 4 Traffic Lights

Stop, Wait and Respond

This session aims to inform parents/carers and intends to deliver the following learning outcomes:

- Parents/carers will be reminded to follow the child's lead – 'Stop and Wait' and gain information on different responses depending on the child's developing communication skills.
- Parents/carers will understand the benefit of using different responses such as naming, repeating and adding to (expanding on) what the child has said to support the child's developing speech and language skills.
- Parents/carers will revisit previous strategies – being face to face and following child's lead from session 1, the importance of pausing, modelling vocabulary (object, actions and descriptions) and stressing keywords from session 2, commenting and reducing questions from session 3.

What you will need:

Stickers and pens
Observation sheets
Feedback forms for session 3 and 4

Circle time

Ball, Song sheets/words and rhymes
Song board with pictures/symbols or objects such as finger puppets/toys

Activity Laminated Traffic Light

Toys

Selection including large doll play and tea set, small world play, inset puzzles, tunnel, rolling objects (balls, cars etc.), books, animals and farm or zoo, Duplo

Hand-outs

Traffic Lights
Feedback and Evaluation forms

Session Plan

Minutes

15 Introduction

As parents and children arrive give out stickers and pens for names.

Use this opportunity to talk with parents/carers about how they got on with practicing the previous week's strategy and how their child responded. Explain that this week will follow the same format as the previous week but that the focus of this session will be Traffic lights: stop, wait and respond.

15 Circle time

Hello song – introduce each child by name.

Ball rolling to each child encourage naming and use positive language supporting social interaction including "my turn and now it's [child's name]'s turn" etc.

Encourage the children to explore the toys provided.

15 Introduce Strategies

Discuss – Stop, Wait and Respond using the traffic lights.

Activity: Talk through the traffic lights as a way of reminding us to use all of the strategies from previous sessions. **Feedback** - focus discussion and involve parents in talking about the strategies and see what they remember.

Red: STOP – important to stop and get down to your child's level – face to face and really look to see what they are looking at and watch what they are doing before we barge in with a question or to take over their play.

Amber: WAIT – pause and even count to 10 in your head before you get involved. This will give you a chance to see what your child is interested in. Adults can then think how they can show an interest and gradually join in. Try waiting till the child involves you by offering to give you something, looking at you or just making a noise – then join in! Remember to pause and think of a comment rather than ask a question – try - 4 comments to each question.

Learning: Green: RESPOND – talk through the different ways in which adults can respond to what children say or do:

- Naming - if your child is playing with, exploring or just looking at an object – NAME it.
- Repeating – when your child makes a sound or says a word then repeat it back to them which will show that you are interested and passing back the turn without asking a question.
- Add – if your child uses a word add another word and repeat it back to them adding one more word e.g. Child – “Teddy” Adult – “Fluffy teddy”. This will expand their language without asking questions.

30 Interaction Activities

Encourage parents to play with their children moving around the available activities – reinforce the focus of 'stop, wait and respond'. Practitioners should move around the pairs to offer individual advice and model all strategies and facilitate interactions using positive praise.

Use this time to talk to parents/carers about next steps i.e. follow up in 2-3 months with a phone call or visit; referral to Speech and Language Therapy if needed; signposting to other groups such as children's centres, library services etc.

- Large doll & tea sets – naming objects (cup, bed etc.) and actions (drinking, sleeping).
- Animals (farm, zoo etc.) – naming, actions and concepts (in, on and maybe under).
- Books – Parent says, “Can you see the...?”, pointing and naming or use simple lift the flap or picture books and talk about pictures rather than reading the story.
- Mediums such as play dough, shaving foam etc. – describe texture (soft, sticky) and actions (roll, press) etc.
- Mark making/drawing – comment on what child is doing e.g. “Round and round”.
- Train and track – comment on child 'pushing' the train, “train goes up, up, up” etc.
- Building bricks – naming 'brick', 'more bricks', 'on top', 'all fall down', 'again' etc.
- Physical activities – actions, 'clapping', 'shaking' concepts, 'slowly', 'quickly' etc.
- Singing – use familiar, short, repetitive songs with actions – “Again?”, “More?” and leave slight pauses to allow child to fill space but continue if this is not forthcoming.
- Rolling Toys – push toward child “Ready, steady...” Leave a slight pause for child to fill – if they don't adult says and pushes toy to child.
- Packing Away – “In the box”, “Car in the box” etc.

15 Circle time

Reconvene as a group and recap on the target strategies – distribute hand-outs.

Practitioner should encourage and support each child to make a successful choice from the picture/symbol song board or objects such as finger puppets/toys.

Parents asked to complete feedback forms.

Goodbye song

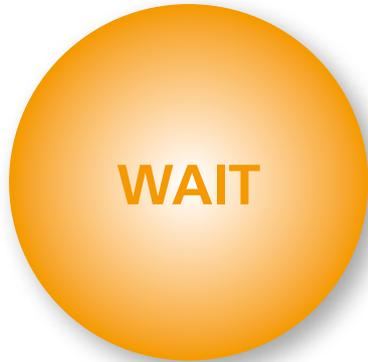
Finish

Healthy Child Programme

Traffic Lights



- Get down to your child's level
- Face to face
- Look at what they are doing



- Count to 10 in your head
- Try waiting for your child to involve you in the play



- Say the name of the thing your child is exploring
- Copy back their sounds or words
- If your child says a word, repeat it back and ADD a word

Healthy Child Programme

Let's Get Talking

Parent's Evaluation

Take a couple of minutes to give us your honest opinion on the sessions. Any comments or suggestions will help us to improve the service.

Please answer the following questions about how you felt about your skills before and after the group – indicate using the following scale.

A Little 1	2	3	4	A Lot 5
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1. How often do you join in and follow your child's lead in play?

Before:	1	2	3	4	5
After:	1	2	3	4	5

2. How often do you tell your child what things are called?

Before:	1	2	3	4	5
After:	1	2	3	4	5

3. How often do you talk to your child about what they are doing?

Before:	1	2	3	4	5
After:	1	2	3	4	5

4. How confident are you in knowing what to do to help your child's talking?

Before:	1	2	3	4	5
After:	1	2	3	4	5

Name (optional):

Thank you for completing this evaluation form

Healthy Child Programme

Let's Get Talking Parent's Feedback

Please take a couple of minutes to give us your honest opinion on the sessions. Any comments or suggestions will help us to improve the service.

1. Were you given enough information about what would happen at the groups before you came to the first week? (If 'no', what information would you have liked?)

.....

.....

.....

2. Has coming to the groups helped you to understand more about how your child is learning to play and talk?

.....

.....

.....

3. How have the sessions helped you when playing and talking with your child?

.....

.....

.....

4. What are you now doing differently when playing and talking with your child?

.....

.....

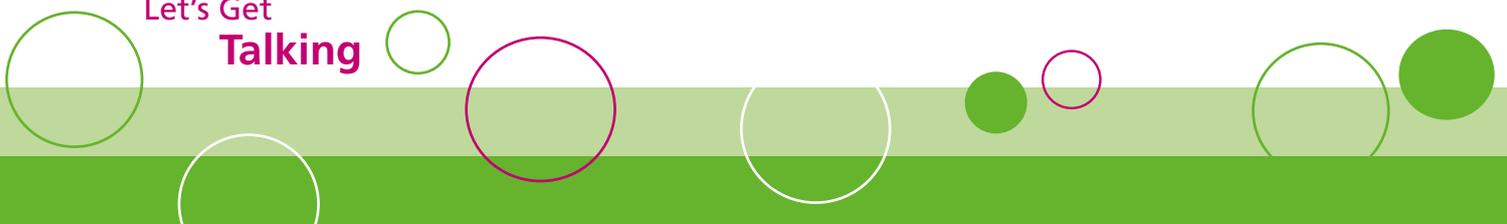
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5. What differences/changes have you noticed in the way your child is playing and talking since coming to the sessions?

.....

.....

.....



Parent's Feedback (continued)

6. How easy was it to carry out the daily play sessions?

.....
.....
.....

7. What specific advice was useful for you?

.....
.....
.....

8. Was there anything that was not useful?

.....
.....
.....

9. Any other comments?

.....
.....
.....
.....
.....

Thank you very much for your comments

If you need this information in another language or format please
telephone **020 7253 7700** or email: patient.Information@leicspart.nhs.uk



Useful References

Hamer, C. (2012) National Childbirth Trust (NCT) Research overview: Parent-child communication is important from birth. NCT's journal on preparing parents for birth and early parenthood.

Linsay, G., Dockrell, J., Law, J., Roulstone, S. and Vignoles, A. (2010) Better communication research programme: 1st interim report. Research Report DFE-RR070. Warwick: Department for Education.

Cable, A. L. and Domsch, C. (2011), Systematic review of the literature on the treatment of late language emergence. International Journal of Language and Communication Disorders, 46: 138-154. doi: 10.3109/13682822.2010.487883.

Law, J., Garret, Z. and Nye, Chad. (2003) Speech and Language Therapy Interventions for Children with Primary Speech and Language Delay or Disorder. Cochrane Database of Systemic Reviews 2003, Issue 3.

Useful Websites

www.leicspart.nhs.uk Information and advice for parents and practitioners in relation to Families, Young People and Children's Health Services in Leicester, Leicestershire and Rutland.

www.rcslt.org Royal College of Speech and Language Therapists.

www.wordsforlife.org.uk A useful guide for parents including developmental milestones for communication and language.

www.talktoyourbaby.org.uk Hosted by National Literacy Trust providing information and support for practitioners.

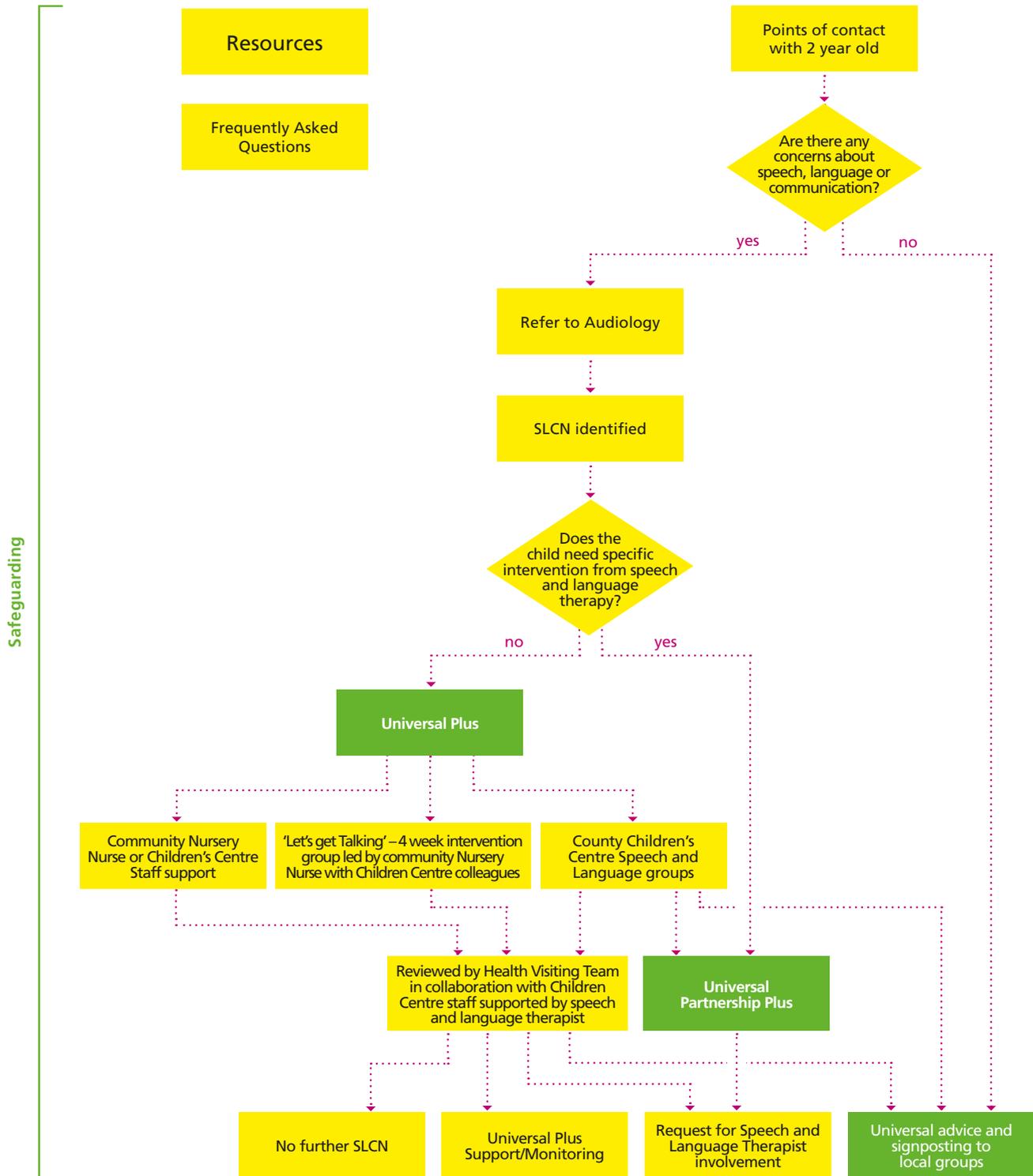
www.thecommunicationtrust.org.uk A coalition of nearly 50 voluntary and community organisations with expertise in speech, language and communication.

www.ican.org.uk Children's Communication Charity offering advice, resources and training for parents and practitioners.

www.talkingpoint.org.uk Advice and free resources for parents of children with SLCN.

Pathway - SLCN at 2 years

SLCN - Speech, language and communication needs



New care pathway for children with speech, language and communication needs

From the 1st April 2013, Families Young People and Children (FYPC) changed the way 2 year old children with speech, language and communication needs (SLCN) are supported, as part of our Service Development Initiative.

Health Visiting and Speech and Language Therapy have worked together to develop a new pathway to make sure young children and their families receive the most appropriate support in their local neighbourhood.

The Pathway is a tool for all professionals who come into contact with 2 year olds.

The pathway supports you to identify which children need to be directed to the Speech and Language Therapy service. It also helps you to decide which children can be supported by their Health Visiting team in collaboration with local Children's Centres and a local speech and language therapist (known in the Healthy Child Programme as Support at a Universal Plus Level).

This Universal plus intervention may be delivered through 'Let's Get Talking' groups, home visits from their community nursery nurse or Children's Centre team, or groups run within Leicestershire's Children's Centres by speech and language therapists.

This pathway can be accessed from Leicestershire Partnership Trust website and intranet. Users will be guided through the steps involved and, with a simple click on each box, will have access to resources to support their decisions and their work with young children and their families.



Let's Get
Talking

Healthy Child Programme You and your child are invited to Let's Get Talking

Come along and pick up ideas to
encourage your child to get going
with talking



Where?
.....

When? (4 weeks)
.....

What time?
.....

Who will be there? *This is a small group of up to 6 children, their parents and your local Community Nursery Nurse*

Let's Get
Talking

LGT1

What to expect each week?

- Arrive, settle in and hello song with the children
- Simple game in a circle to help children get to know each other
- Hear about a new idea to help your child get talking more – for example did you know that for some children asking lots of questions means that they actually say less back to you?
- Time after this for you and your child to play together and try out some new ideas
- To finish, the children come together to join in singing and say goodbye

Each week you will be asked to practise the new idea when you play with your child at home and let us know how you get on.

Please complete the enclosed 'Think About Your Child' sheet and bring it along to the first session.

For more information please contact:

Your Community Nursery Nurse

Contact telephone number:

If you need this information in another language or format please telephone **020 7253 7700** or email: patient.Information@leicspart.nhs.uk

Think About Your Child

Please tick any words from this list that your child says (in any language).
The words do not have to be clear, as long as you know what your child is trying to say.

Mum	<input type="checkbox"/>	Car	<input type="checkbox"/>	Bath	<input type="checkbox"/>	Fish	<input type="checkbox"/>
Dad	<input type="checkbox"/>	Bus	<input type="checkbox"/>	Bed	<input type="checkbox"/>	Cat	<input type="checkbox"/>
Baby	<input type="checkbox"/>	Bike	<input type="checkbox"/>	House	<input type="checkbox"/>	Dog	<input type="checkbox"/>
		Outside	<input type="checkbox"/>			Bird	<input type="checkbox"/>
Juice	<input type="checkbox"/>	Ball	<input type="checkbox"/>	Down	<input type="checkbox"/>	Duck	<input type="checkbox"/>
Milk	<input type="checkbox"/>	Teddy	<input type="checkbox"/>	Up	<input type="checkbox"/>		
Drink	<input type="checkbox"/>	Book	<input type="checkbox"/>			Eyes	<input type="checkbox"/>
Biscuit	<input type="checkbox"/>			Cup	<input type="checkbox"/>	Nose	<input type="checkbox"/>
Banana	<input type="checkbox"/>	Bye	<input type="checkbox"/>	Spoon	<input type="checkbox"/>	Mouth	<input type="checkbox"/>
Toast	<input type="checkbox"/>	More	<input type="checkbox"/>	Bottle	<input type="checkbox"/>	Hands	<input type="checkbox"/>
Chocolate	<input type="checkbox"/>	Gone	<input type="checkbox"/>			Feet	<input type="checkbox"/>
Sweets	<input type="checkbox"/>	Hello	<input type="checkbox"/>	Hot	<input type="checkbox"/>	Shoes	<input type="checkbox"/>
Crisps	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Big	<input type="checkbox"/>	Socks	<input type="checkbox"/>
Dinner	<input type="checkbox"/>	No	<input type="checkbox"/>	Dirty	<input type="checkbox"/>	Hat	<input type="checkbox"/>
Tea	<input type="checkbox"/>						



As well as using words, children also learn to use their hands, faces and sounds to communicate. Please circle any of the following that your child does:

- Waves bye
- Points for what they want
- Reaches to get things
- Joins in songs with hand actions
- Makes sounds for things (cars, animals)
- Uses their own gestures
- Sometimes copies a new word

What type of things does your child like to play with?

.....

.....

What do you think about your child's understanding? (Do they understand what you say to them?)

.....

.....

Let's Get Talking Observation Sheet

Child's Name: Child's Age:

Date: Practitioner's Name:

Type of interaction/activity observed:

LISTENING AND ATTENTION: - Concentration on activity? - Listening to adults and children?
- Prompts needed to gain/ maintain attention?

.....

UNDERSTANDING: - understanding directions/ questions/ comments? (write examples of these and child's response). Does the child rely on context/situation for cues? How many pieces of information (key words) can the child understand at one time?

.....

TALKING: - Length of phrases/sentences the child is using? Use of vocabulary e.g: nouns, verbs, describing words? Write examples. - Other means of communication? e.g: pointing/ noises

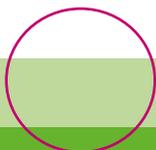
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SOCIAL COMMUNICATION: - Eye contact? Turn taking? Initiating conversation? Responding to peers?

.....

PLAY: - Examples of play? Symbolic play /pretend play? Cooperative play with adult/children? Listening to adults/peers during play? Repetitive play?

.....



Healthy Child Programme

Face to Face

Get down on the floor to play with your child.
Change your body position as you play, so that you are face to face, and your child can more easily make eye contact with you.



Why do this?

- It is easier for you to join in with their play.
- It makes it easier for your child to show you, by looking and making eye contact, that they are enjoying the play.
- It makes it easier for you to understand, or respond, to any attempts they make to communicate.
- It allows your child to see your mouth when you are talking.

Further information is available at: www.wordsforlife.org.uk

Healthy Child Programme

Following Your Child's Lead

Let your child lead the play by following their own ideas. This will mean spending time to watch them closely to see what they are interested in.



Why do this?

- It will be easier for your child to focus on things they enjoy. This will mean that they are more likely to play longer, let you join in and pay attention to the words you use.
- It will encourage them to make choices rather than always following your lead.
- It will encourage them to gain in confidence.

Further information is available at: www.wordsforlife.org.uk

Healthy Child Programme

Keep it Simple

Keep your sentences generally at the level your child is at. If your child is not using any words or only a few single words, try to use mostly single words when you play together. If they are using lots of single words but not putting words together, you should use two words together.



Why do this?

- Your child will find it easier to learn words if you say the word that matches what the child is interested in.
- Lots of words said together can be just too much for your child to understand, they cannot pick out the important words so easily.

Further information is available at: www.wordsforlife.org.uk

Healthy Child Programme

Listen and Respond

When you hear your child say something, try to give it meaning by interpreting what they have said, and say the word for them to hear.



Why do this?

- Interpreting what you think your child might be trying to say lets them know you understand and encourages them to communicate.
- Copying actions as well as sounds lets your child know you are interested in communicating with them.

Further information is available at: www.wordsforlife.org.uk

Healthy Child Programme

Commenting

Comment on your child's play to introduce new words and practice ones they know.



Why do this?

- When your child is interested in something they are more likely to pay attention to the words you are using.
- The word will have more meaning, and be easier to remember, if it matches what your child is looking at, or doing.
- Even if you know your child knows the word it helps them to hear it repeated.

Further information is available at: www.wordsforlife.org.uk

Healthy Child Programme

Reduce Questions

With young children, a lot of questions are not helpful.
Try to comment rather than ask a question.



Why do this?

- If you say, 'What's that?' a lot to your child, it is more likely that that is what they will learn to say. It's much better to comment instead, as your child then hears new words.
- Using questions can feel like a test to your child, especially if they know the answer.
- Your child may not know the answer and this may decrease their confidence.

Further information is available at: www.wordsforlife.org.uk

Healthy Child Programme

Traffic Lights



STOP

- Get down to your child's level
- Face to face
- Look at what they are doing



WAIT

- Count to 10 in your head
- Try waiting for your child to involve you in the play



RESPOND

Name
Repeat
Add

- Say the name of the thing your child is exploring
- Copy back their sounds or words
- If your child says a word, repeat it back and ADD a word

My child is learning to:

.....
.....
.....
.....
.....

I am helping by remembering to:

.....
.....
.....
.....
.....

This week I will remember to:

.....
.....
.....

Day 13 Date:

My child enjoyed playing? 😊 😐 😞

My child responded -

- Sounds Single words
 Words together Gestures/signs

Some examples are:

.....
.....

Day 14 Date:

My child enjoyed playing? 😊 😐 😞

My child responded -

- Sounds Single words
 Words together Gestures/signs

Some examples are:

.....
.....

Day 4 Date:

My child enjoyed playing? 😊 😐 😞

My child responded -

- Sounds
- Single words
- Words together
- Gestures/signs

Some examples are:

.....

Day 5 Date:

My child enjoyed playing? 😊 😐 😞

My child responded -

- Sounds
- Single words
- Words together
- Gestures/signs

Some examples are:

.....

Day 6 Date:

My child enjoyed playing? 😊 😐 😞

My child responded -

- Sounds
- Single words
- Words together
- Gestures/signs

Some examples are:

.....

Let's Get
Talking

Day 7 Date:

My child enjoyed playing? 😊 😐 😞

My child responded -

- Sounds
- Single words
- Words together
- Gestures/signs

Some examples are:

.....

Day 8 Date:

My child enjoyed playing? 😊 😐 😞

My child responded -

- Sounds
- Single words
- Words together
- Gestures/signs

Some examples are:

.....

Day 9 Date:

My child enjoyed playing? 😊 😐 😞

My child responded -

- Sounds
- Single words
- Words together
- Gestures/signs

Some examples are:

.....

Let's Get
Talking

Day 10 Date:

My child enjoyed playing? 😊 😐 😞

My child responded -

- Sounds
- Single words
- Words together
- Gestures/signs

Some examples are:

.....

Day 11 Date:

My child enjoyed playing? 😊 😐 😞

My child responded -

- Sounds
- Single words
- Words together
- Gestures/signs

Some examples are:

.....

Day 12 Date:

My child enjoyed playing? 😊 😐 😞

My child responded -

- Sounds
- Single words
- Words together
- Gestures/signs

Some examples are:

.....

Day 1 Date:

My child enjoyed playing? 😊 😐 😞

My child responded -

- Sounds
- Single words
- Words together
- Gestures/signs

Some examples are:

.....

Day 2 Date:

My child enjoyed playing? 😊 😐 😞

My child responded -

- Sounds
- Single words
- Words together
- Gestures/signs

Some examples are:

.....

Day 3 Date:

My child enjoyed playing? 😊 😐 😞

My child responded -

- Sounds
- Single words
- Words together
- Gestures/signs

Some examples are:

.....

Healthy Child Programme
**Let's Get
Talking**
Parent's Feedback

Please take a couple of minutes to give us your honest opinion on the sessions.
Any comments or suggestions will help us to improve the service.

1. Were you given enough information about what would happen at the groups before you came to the first week? (If 'no', what information would you have liked?)

.....

.....

.....

2. Has coming to the groups helped you to understand more about how your child is learning to play and talk?

.....

.....

.....

3. How have the sessions helped you when playing and talking with your child?

.....

.....

.....

4. What are you now doing differently when playing and talking with your child?

.....

.....

.....

5. What differences/changes have you noticed in the way your child is playing and talking since coming to the sessions?

.....

.....

.....



Parent's Feedback (continued)

6. How easy was it to carry out the daily play sessions?

.....
.....
.....

7. What specific advice was useful for you?

.....
.....
.....

8. Was there anything that was not useful?

.....
.....
.....

9. Any other comments?

.....
.....
.....
.....
.....

Thank you very much for your comments

If you need this information in another language or format please
telephone **020 7253 7700** or email: patient.Information@leicspart.nhs.uk

Healthy Child Programme

Let's Get Talking

Parent's Evaluation

Take a couple of minutes to give us your honest opinion on the sessions. Any comments or suggestions will help us to improve the service.

Please answer the following questions about how you felt about your skills before and after the group – indicate using the following scale.

A Little 1	2	3	4	A Lot 5
----------------------	----------	----------	----------	-------------------

1. How often do you join in and follow your child's lead in play?

Before:	1	2	3	4	5
After:	1	2	3	4	5

2. How often do you tell your child what things are called?

Before:	1	2	3	4	5
After:	1	2	3	4	5

3. How often do you talk to your child about what they are doing?

Before:	1	2	3	4	5
After:	1	2	3	4	5

4. How confident are you in knowing what to do to help your child's talking?

Before:	1	2	3	4	5
After:	1	2	3	4	5

Name (optional):

Thank you for completing this evaluation form

If you need this information in another language or format please
telephone 020 7253 7700 or email: patient.Information@leicspart.nhs.uk

Arabic

إذا كنت في حاجة إلى قراءة هذه المعلومات بلغة أخرى أو بتنسيق مختلف، يرجى الاتصال بهاتف رقم 020 7253 7700 أو إرسال بريد إلكتروني إلى: Patient.Information@leicspart.nhs.uk

Bengali

যদি এই তথ্য অন্য কোন ভাষায় বা ফরমেটে আপনার দরকার হয় তাহলে দয়া করে 020 7253 7700 নম্বরে ফোন করুন বা Patient.Information@leicspart.nhs.uk ঠিকানায় ই-মেইল করুন।

Traditional Chinese

如果您需要將本資訊翻譯為其他語言或用其他格式顯示，請致電 020 7253 7700 或發電子郵件至：Patient.Information@leicspart.nhs.uk

Gujarati

જો તમારે આ માહિતી અન્ય ભાષા અથવા ફોર્મેટમાં જોઈતી હોય તો 020 7253 7700 પર ટેલિફોન કરો અથવા Patient.Information@leicspart.nhs.uk પર ઇમેઇલ કરો.

Hindi

अगर आप यह जानकारी किसी अन्य भाषा या प्रारूप में चाहते हैं तो कृपया 020 7253 7700 पर हमें फोन करें या Patient.Information@leicspart.nhs.uk पर हमें ईमेल करें

Polish

Jeżeli są Państwo zainteresowani otrzymaniem niniejszych informacji w innym języku lub formacie, prosimy skontaktować się z nami telefonicznie pod numerem 020 7253 7700 lub za pośrednictwem poczty elektronicznej na adres: Patient.Information@leicspart.nhs.uk

Punjabi

ਜੇ ਤੁਹਾਨੂੰ ਇਹ ਜਾਣਕਾਰੀ ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੈਟ ਵਿੱਚ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 020 7253 7700 ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ ਜਾਂ ਇੱਥੇ ਈਮੇਲ ਕਰੋ: Patient.Information@leicspart.nhs.uk

Somali

Haddii aad rabto in aad warbixintan ku hesho luqad ama nuskhad kale fadlan soo wac lambarka 020 7253 7700 ama email u dir: Patient.Information@leicspart.nhs.uk

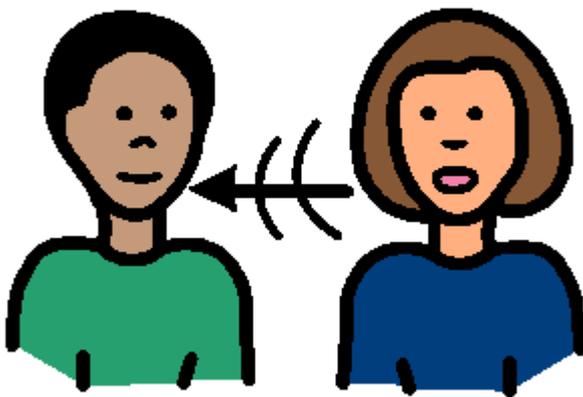
Urdu

اگر آپ کو یہ معلومات کسی اور زبان یا صورت میں درکار ہوں تو براہ کرم اس ٹیلی فون نمبر 020 7253 7700 یا ای میل پر رابطہ کریں Patient.Information@leicspart.nhs.uk

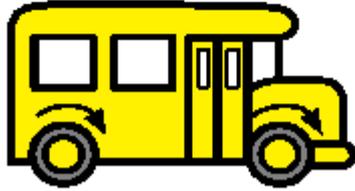
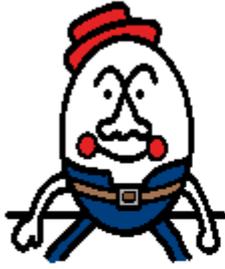
Hello Song



Discussing previous weeks strategies



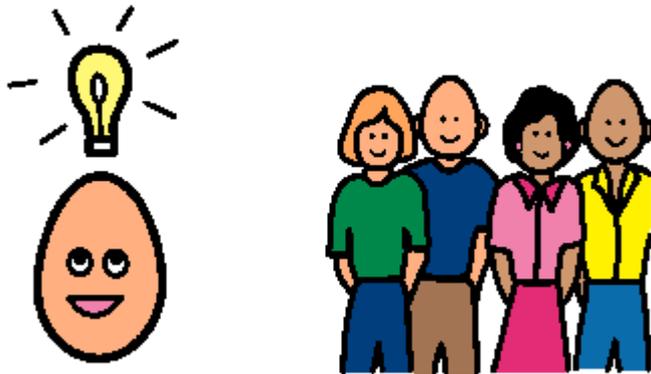
Sing-Songs



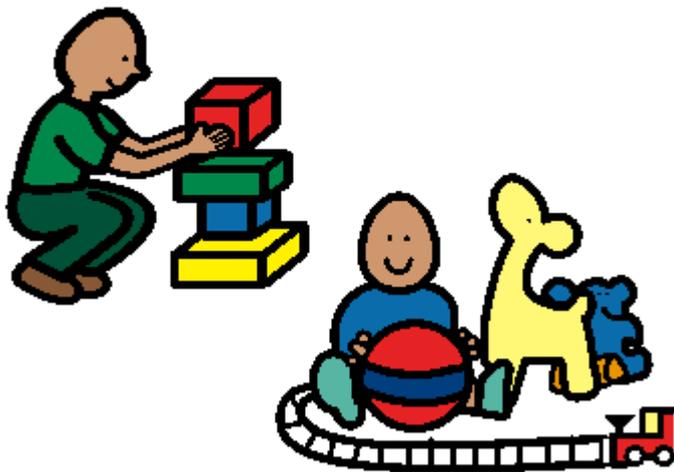
Circle Time



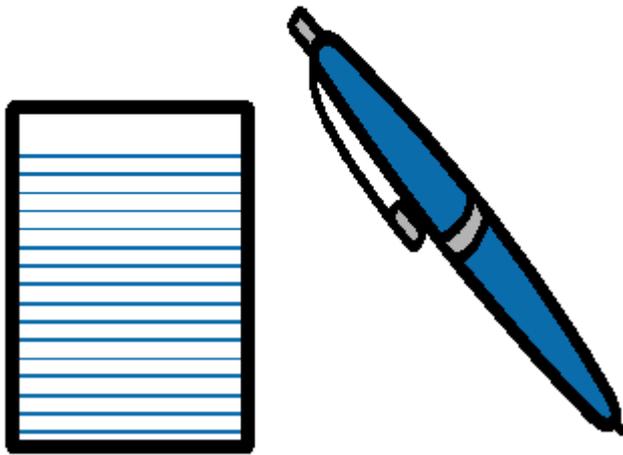
Introducing a new to idea to parents



Free play using the strategies



Hand-outs for parents



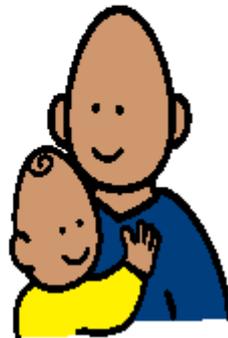
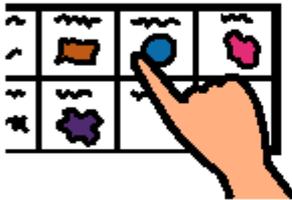
Home Time



Face to Face

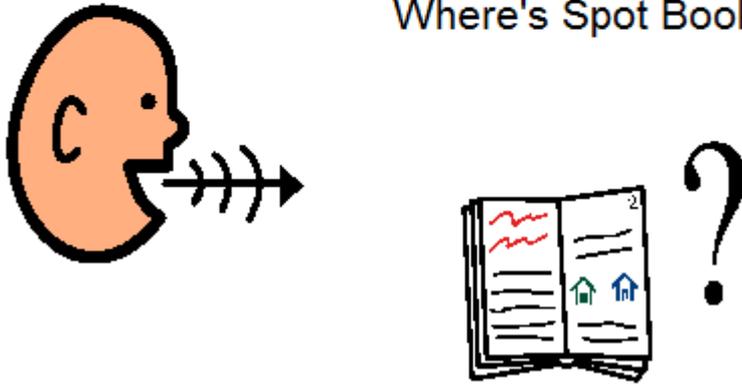


Naming



Commenting

Where's Spot Book



Traffic Lights



FAMILIES, YOUNG PEOPLE & CHILDREN'S SERVICE REFERRAL FORM

Key Information:

Title	Forename(s)	Surname	NHS number
Date of birth	Gender	Ethnicity	Religion
Address (including post code)			
Home telephone number	Mobile telephone number	Preferred contact number	
Home language spoken	Home language written	Interpreter required	
GP details		School/nursery attended?	

Family/Carer Information:

Surname	Forename	Date of birth	Gender	Relationship	PR? *

Who looks after this child/person? In what capacity?

Main family/carers address (if different)	Carer contact number (preferred)
	Carer contact number (secondary number)

Which other professionals \ services are involved with the family? (Please provide contact details)

Referral Information:

Principle reason for referral					
Nature of concern					
How long have these problems been evident?					
How do these difficulties affect the child/person in daily life?					
Medical history, including diagnostic screening, if undertaken					
Is the child/young person currently taking any medication? (if so please specify)			Does the child/young person have any known allergies? (if so please specify)		
Weight		Height		BMI	
Any additional information that you feel is relevant? (please attach relevant documentation & reports)					
If appropriate what equipment\supplies has the child been supplied with?					
Perceived level of urgency of current situation (e.g. routine urgent, planned discharge date)					
Does the child or family have any disability that requires support in accessing appointments?			Is the child/family aware of the referral and has given their consent to the referral?		
Is the referred an overseas visitor?			How long have they been resident in this country?		
Do you have any additional comments relating to the referral?			Do you feel that this referral needs input by specialist CAMHS?		

FAMILIES, YOUNG PEOPLE & CHILDREN'S SERVICE REFERRAL FORM

Safeguarding

Are any of the following in place for the child? (Please provide copies)

Common assessment framework (CAF)	Child in need support
Child protection plan	Is the child looked after by Local Authority?
Does the client or family have any safeguarding concerns? <i>(if yes please specify)</i>	
Are there any known home environmental concerns?	

Special educational needs

Does the Child\Young person have? (Please provide copies)

Identified Special Educational Needs	School Contract?
Statement\Education Health Care Plan?	

Referrer information

Referrer name	Profession
Address	
Address for response to be sent to <i>(if different to above)</i>	
Telephone number	Fax number
Signed	Date

Once completed please return form to us by:

Email fypc.referrals@nhs.net

Post FYPC Referrals.
 Families, Young People and Children's Services,
 Leicester Partnership NHS Trust,
 Bridge Park Plaza,
 Bridge Park Road,
 Thurmaston,
 Leicester, LE4 8PQ.

Fax 0116 2958302

Families, Young People and Children's Services Transformation Programme

Requests for Involvement

What is a 'request for involvement' as a feature of our transformation programme?

This is a request made by one FYPC practitioner to another through **direct discussion**. The purpose of the request is to secure either expert knowledge through consultation, or direct involvement in the care of a child or young person. **It is essential that from now on involving another member of the division in a child's care must always involve a discussion.**

Within this document the person requesting involvement is described as the case holder and the practitioner being asked to provide additional support is described as the expert. A request for involvement may be made between any of our services where support or advice is required.

Non System1 Users: We recognise that not all of our services use System1 for patient records. Where either the case holder or expert does not use System1 outcomes should be documented within the clinical record and any activity undertaken should be recorded within the services IT system eg. Maracis, TIARA.

How is a request for involvement made in FYPC's transformation programme?

1. Discuss the need to involve another FYPC colleague with the parent/child. Explain this may only be a discussion but could also result in a referral/appointment for their child/them. The case holder will document this discussion in the record.
2. Make contact with an appropriate FYPC colleague within the neighbourhood team. Contact details can be found in the staff link, by contacting the admin team for the service or through the care navigator. If the person required is not available contact another member of the expert's team.
3. Discuss the child/young person's needs by phone, face to face or electronically.
4. The discussion between the case holder and the 'expert' focusses on the child/family's needs and assessment and interventions to date. This will enable new insights to be made to inform the plan of care and next steps. The outcomes of this discussion may result in one of the following scenarios:

Scenario 1: Signposting to other services that will provide advice and support. These services may be internal or external to FYPC.

Scenario 2: The expert provides advice and support so that the case holder can continue to support the child and family and meet the identified needs.

Record Keeping: The case holder will document the discussion and any agreed outcomes within the child's record. If the child is also known to the advising service then a record should also be made by the expert. A joint agreement may be made between the professionals regarding record keeping to prevent duplication within the records.

Scenario 3: The case holder and the clinician with expertise may undertake a brief assessment to determine the needs of the child or family without a full assessment being undertaken by the expert

Record Keeping: The case holder will document in the child's record as above and share the record. The expert needs to ask their admin team to open the child's record so they can document the visit and any outcomes and ensure that their contact is recorded for data purposes.

Scenario 4: The case holder and the expert agree that the child needs to have an appointment for a full assessment by the expert's service.

Record Keeping (SystemOne Users): The expert will inform the case holder of any specific information that needs to be included in the Referral Template in order to ensure the child is seen in the appropriate clinic/setting. The case holder will complete the Referral Template and include as a minimum name of expert spoken to, diagnosis if known, previous interventions, significant concerns and expected outcomes of requested intervention. It is essential that this information is included to ensure that the Request for Involvement is accepted. The case holder will then make an electronic referral to the appropriate service which states 'please see the referral template dated ...' so that referral information can be easily identified. If the template is to be sent to a non-SystemOne user then print off the template and forward it to the expert's service. Further information regarding use of electronic referrals/the Referral Template is available on the LPT Intranet.

(Non-SystemOne Users): The case holder should complete a hard copy of the Referral Template as above and forward to the destination identified by the expert.

Scenario 5: The case holder and expert may agree that the child/family require more support than is available from one service and that it would be beneficial to discuss within a neighbourhood clinical forum. The case holder will need to contact the relevant care navigator and arrange discussion.

Record Keeping: The case holder will document the discussion and any agreed outcomes within the child's record. If the child is also known to the advising service then a record should also be made by the expert. A joint agreement may be made between the professionals regarding record keeping to prevent duplication within the records.

Scenario 6: The expert may not feel comfortable that they can appropriately advise the case holder. The expert will then seek advice from their line manager or clinical lead and feedback to the case holder. When a course of action is agreed it should be documented as above.





Speech and Language Therapy Services

Talking Fun - 2 Years

A leaflet for parents and carers

Talking is learned through everyday activities. The following games will help your child to hear and use new words. As your child learns more words he/she will begin to join them together in short sentences.

Make sure there are quiet times in the day when you talk to your child. Turn off the television and music so that he/she child can concentrate and listen more easily.

While your child is learning to talk it is important for him/her to move his/her tongue and lips properly, so try to restrict the use of the dummy to bedtime only. Don't encourage your child to talk with the dummy in his/her mouth.

Talk about everyday activities as you do them, e.g. washing dishes, hoovering, shopping. Encourage your child to join in.

- T** Talk about everyday activities.
- A** Add a word when your child just says one.
- L** Listen to your child and give him/her time to talk.
- K** Keep playing with toys and looking at picture books with your child.

The games on the
reverse will help.



Speech and Language Therapy Services Talking Fun - 2 Years

- Play with your child for 10-15 minutes each day with their toys. You can play pretend games that relate to everyday life, for example, washing, eating, dressing. Talk about what is happening using short simple sentences.
- Enjoy simple books with your child. Point to and name different things on each page. Let your child point to the pictures he/she likes and you name them for him/her.
- Ask your child to follow simple instructions, e.g. "Give the ball to daddy", "Give dolly a drink". You may have to show your child what to do.
- Singing action rhymes and traditional songs can be enjoyable for your child. Encourage him/her to fill in missing words, e.g. "The wheels on the bus go round and _____".
- Expand what your child says by adding another word, e.g. if your child says "ball" you could say "kick ball" or "throw ball".
- Talking and playing with other children of the same age also helps develop language skills. Consider joining a mum and toddler group, playgroup or crèche.



If you have any concerns or would like further information about your child's talking skills, please contact your health visitor or Children's Speech and Language Therapy Service
Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester, LE4 8PQ
Telephone: 0116 225 5256



If you require help with understanding the contents of this document please telephone 0116 295 4743

এই ডকুমেন্ট এর কোন বিষয় বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয়, তাহলে অনুগ্রহ করে 0116 295 4743 নাম্বারে টেলিফোন করুন।

اگر آپ کو اس کے بارے میں کوئی سوال ہو تو براہ کرم 0116 295 4743 پر فون کریں۔

अगर आपको इस दस्तावेज़ में शामिल जानकारी समझने में सहायता चाहिए तो कृपया 0116 295 4743 पर फोन कीजिए।

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਵਿਸ਼ਾ ਵਸਤੂ ਸਮਝਣ ਲਈ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕ੍ਰਿਪਾ ਕਰਕੇ ਇਸ ਨੰਬਰ ਤੇ ਟੈਲੀਫੋਨ ਕਰੋ 0116 295 4743

Hadii aad u baahantahay in lagaa caawiyo fahmida qoraalka ku qoran documintigaan fadlan nagala soo xiriir telefoonkaan 01162954743.

Jeśli potrzebujesz pomocy w zrozumieniu treści tego dokumentu prosimy o telefon pod numer 0116 2954743.

اگر آپ کو اس کے بارے میں کوئی سوال ہو تو براہ کرم 0116 2954743 پر ٹیلیفون کریں۔

Published January 2012 by
Families, Young People and
Children's Services.

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ctd0619/LPT/2YR

Smooth Talking

Learning to say sounds smoothly without bbbb bumps takes time and practice.

Here's how you can help....



A leaflet for Parents and Carers of Preschool Children from the Speech and Language Therapy Service

Try to stay calm and relaxed—learning to talk takes time.



This will help your child see that he does not need to try and hide his difficulties.

Talk slowly and calmly to your child. Your child will learn from you they do not need to rush when they are talking.

Make sure that you are looking at your child when he is talking to you



This shows your child that you are listening and interested in what he has to say.

Talk about what you and your child are doing.



Describing what you can see instead of asking questions encourages more relaxed talking.

Be positive about your child's talking



This can help boost your child's confidence when talking

For more information contact:

Children's Speech and Language
Therapy Service
Bridge Park Plaza
Bridge Park Road
Thurmaston
LE4 8PQ
Tel: (0116) 2255256

Office Hours:

Monday – Thursday 9.00am - 5.00pm
Friday – 9.00am – 4.30pm

Accept what your child says, even if it doesn't sound quite right.



You can help by saying the word clearly after them.

Give your child plenty of time to talk.



Interrupting them or finishing off their sentences can cause frustration

Have times when the TV is switched off and you can play together or share a book



This time together can help your child relax.

Try to play face to face.



This way your child knows they have your full attention

DATE: December 2006

PISG: 68

FILE: s:\shared\leaflets\master copies\Smooth Talking



The Communication Trust
Every child understood

Universally Speaking

The ages and stages of children's communication development

From birth to 5 years





The Communication Trust
Every child understood

The Communication Trust

The Communication Trust is a coalition of 50 voluntary and community organisations with expertise in speech, language and communication. We harness our collective expertise to enable the children's workforce and commissioners to support all children and young people's communication skills, particularly those with speech, language and communication needs (SLCN).

We do this by raising awareness, providing information and workforce development opportunities, influencing policy, promoting best practice among the children's workforce and commissioning work from our members.

The Trust was founded in 2007 by Afasic, BT, Council for Disabled Children and I CAN.

www.thecommunicationtrust.org.uk



Pearson Assessment

This booklet, along with the rest of the suite of the Universally Speaking booklets, was originally produced with the support of Pearson Assessment. They are publishers of standardised assessments for a range of speech, language and communication needs.

www.pearsonclinical.co.uk

Universally Speaking is a series of 3 booklets for anyone who works with children and young people. To order further copies of the Universally Speaking booklets please go to

www.thecommunicationtrust.org.uk/universallyspeaking

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Children can all be great communicators

Communication is the way we connect with other people. It underpins learning and development in children of all ages and is a skill that can always be developed and improved.

Learning a language is the most important thing a child will ever do. Young babies and children need to learn how to:

Understand what people are saying

Use words and sentences properly

Speak clearly

Look, listen and take turns

People sometimes assume that speech, language and communication skills develop and flourish no matter what. This is not the case... children need adults to encourage and support development of their language and communication.

The Early Years Foundation Stage (EYFS) in England

One of the prime areas of learning in the EYFS curriculum in England is 'Communication and Language'. Within Communication and Language the three early learning goals are based around; 'listening and attention', 'understanding' and 'speaking'. The focus on these areas shows how important it is that children develop good foundation skills in communication and language early on in their life.

Universally Speaking provides information that will help you to support children to develop skills in line with their age, as well as help you to identify and support children who may be struggling.

Children's communication and language is 'everybody's business'. Parents and staff who see and work with children regularly are often the experts in knowing about a child's communication. With the right information and access to the right help at the right time early on, everyone can really make a difference.

NB Every effort has been made to align the content of this booklet with descriptions of ages and stages in the Early Years Foundation Stage (EYFS), Development Matters, Every Child a Talker and Healthy Child Programme guidance.

5 top reasons to understand more about communication

1

It doesn't happen by accident!

Children need adults to nurture and support their communication and language development. The more all people know and understand about language and how it develops, the better position they are in to help.

2

You can make the difference

Early years practitioners are in a unique position to support the development of communication and language skills in babies, toddlers and young children.

- Supporting communication development is easy when you know how. With communication and language at the forefront of your mind, you can support development of these skills during everyday activities.
 - Quality early years settings and quality interaction with children can have a big impact on their communication and language development.
 - You can share information with parents about the development of these skills.
-

3

It helps to know what happens and when

Many practitioners report that they are not confident in knowing what children should be doing at different ages and stages, how to support good language skills and how to spot those children who might be struggling. The information in this booklet may help to spot and support children who are struggling.

4

Being able to talk and listen well is important

At home, in the early years, at school and throughout life, language is vital in order to learn, make friends and feel confident. Poor language puts children at risk of poor reading and writing, poor behaviour, poor exam results and a lack of success in school.

5

The earlier we help the better

Lots of children struggle to develop their communication skills. About 1 million children in the UK will have long term difficulties and in areas of social deprivation more than 50% of children start school with delayed language.

Although there is some variation in the rate of learning to talk, there are key milestones for what children should be doing at different ages. It's important for practitioners to know what to expect, so they can check whether children are on the right track and identify those who might be struggling.

By six months...

Babies communicate from day one. As they develop, they begin to watch the adults around them and start making noises. They will communicate with adults by watching their faces and usually try to copy what they do. Being able to copy is important for young babies – it is how they learn.

By six months, babies will usually:

- make sounds, like cooing, gurgling and babbling, to themselves and with other people
- make noises to get your attention
- watch your face when you talk to them
- get excited when they hear voices coming, showing their excitement by kicking or waving their arms or making noises
- smile and laugh when other people smile and laugh
- make sounds back when talked to



How to check it out... babies are amazing!

Check out how the baby can communicate

Copy sounds the baby makes.

- Can they look at you and sometimes join in?
- Are they cooing and gurgling to themselves?

Check out how the baby can listen

Talk to babies about what is happening.

- Are they watching your face while you are talking?

Check out how the baby can take part

Spend time talking and playing – get down on the floor with babies and play.

- Do they enjoy the company of adults?
- Do the babies smile and laugh with you?

Some lovely things to do to encourage baby talk:

- Get close, let them see your face, get right down to their level, even lying down to make eye contact, talk in a sing song voice – babies respond really well to this.
- Talk to babies in your care – tell them what is happening and what you notice about them – they are listening and taking it all in.
- Listen to them. Leave little spaces in your talk for the baby to join in or start the ‘conversation’ – ask them questions, tell them what you see – you may get a gurgle for an answer.
- Sing songs and rhymes.
- Play ‘peek-a-boo’ or similar games.
- Look at and talk about picture books – it’s never too early to share books.

If you are worried that a baby in your care is not doing these things there is more information on www.talkingpoint.org.uk. Or, using your setting’s procedure, talk to the parents about your concerns.



By one year...

Babies communicate in more ways now – making noises, pointing and looking to get your attention. They start to understand routines, simple words and activities.

By one year, babies will usually:

- make talking noises - babble strings of sounds, like 'ma-ma-ma', 'ba-ba-ba' point and look at you to get your attention
- many, though not all 1 year olds, will be saying their first words and they may also use gestures
- start to understand words like 'bye-bye' and 'up' especially when a gesture is used at the same time
- recognise the names of familiar objects, things like 'cup' and 'bowl', 'teddy' and 'mummy'
- look at you when you speak or when they hear their name called
- take turns in 'conversations', babbling back to an adult



How to check it out... babies are amazing!

Check out how the baby can talk

Spend some individual time with the babies in your care.

→ Do they try and get your attention? E.g. If they want something they can not reach will they shout, point or make noises? (Naming the object that they request will help the baby to use the word in the future).

Check out how the baby can listen

Talk about everyday activities, like getting dressed, eating and bathing.

→ Does the baby respond to things you say a lot? E.g. You say “*arms up*” when you are taking off a jumper and the baby puts their arms up.

Have three or four familiar objects near the baby and ask for one of them.

→ Do they look at the object or point to it? They may even give it to you, E.g. Say “*Where’s teddy?*”

Check out how the baby can take part

Spend time with babies in your care, playing and talking. Talk to the baby and leave a space for them to answer back.

→ Do they make talking noises and join in the ‘conversation’?

→ Wait for them to make a sound or do something, then copy the baby, and wait again.

Some lovely things to do to encourage baby talk:

→ Write down and share with their parents the first words babies say – this is an exciting milestone.

→ Respond to the baby when they point, gesture or make noises. Interpret what they are saying and let them know in words, E.g. “*You want a spoon?*”

→ Use actions with words. Try waving as you say “*bye-bye*” or holding your hands out to the baby and saying “*up*” – this will help them understand the words and encourage them to join in.

→ Sing action songs like ‘This little piggy went to market...’ and play games like ‘peek-a-boo’ to encourage communication and concentration.

→ Get on their level to play, listen and talk with them.

→ Babies learn language through play, interaction and repetition, so anything that does this is good – E.g. ‘ready, steady, go’, with balls and ‘all fall down’ with brick towers.

→ Babies love treasure baskets, full of things they can explore and tell you about – let them show you what can be done and talk to them about what they are doing.

If you are worried that a baby in your care is not doing these things, there is more information on www.talkingpoint.org.uk. Or, using your setting’s procedure, talk to the parents about your concerns.

By 18 months...

This is a very exciting time – babies will be starting to talk now. Not everyone will understand but they are having a good try at saying a handful of words.

By 18 months, babies will usually:

- be talking! They will be able to say around 20 words. These are usually things they hear a lot at home or in the setting – such as ‘milk’, ‘doggy’, ‘hurrah’, ‘bye-bye’, ‘more’, ‘no’
- say words in a baby way, but the words are usually consistent in how they sound
- understand some simple words and short phrases. These are usually things they hear a lot during the day, such as ‘coat on’, ‘drink’, ‘shoes’, ‘bus’, ‘in your buggy’, ‘dinner time’, ‘all gone’
- recognise and point to familiar objects when you ask them
- enjoy games like ‘peek-a-boo’ and ‘pata-cake’ and toys that make a noise – they still like the comfort of a familiar adult near by
- be exploring their world and starting to enjoy simple pretend play, like pretending to talk on the phone



How to check it out... babies are amazing!

Check out how the baby can talk

Take some time to listen out for what the baby is saying.

- Are they saying words now in their own way?
- What do babies say at home? Write down the words you hear babies say – share these with their parents.

Check out how the baby can listen

Do babies in your care:

- Get excited when you mention things they enjoy? E.g. “dinner time”
- Look around when you ask questions or give instructions? E.g. Look round when you say “Where’s teddy?”
- When looking at a picture book: Can they point out some of the pictures you mention? E.g. The dog when you say “Where’s the doggy?”

Check out how the baby can take part

Talk while playing simple games with babies in your care – like ‘peek-a-boo’ or building a tower with bricks.

- Do they enjoy your company?
 - Do they like playing and exploring?
 - Do they join in with building and knocking bricks down?
- Give the baby a pretend phone and you have another one.**
- Do they pretend to talk?

Some lovely things to do to encourage baby talk:

- Get down to their level. Watch, listen and comment on what they are doing.
- Sing nursery rhymes with actions like ‘Incy-wincy-spider’.
- Talk to babies about what you are doing, such as “Let’s change your nappy”.
- When babies point to an object, tell them what it is, E.g. “Banana”.
- If they try to say a word, say it back to them so they can hear the name of the object clearly.
- Share picture books and talk about the pictures in short sentences.
- Play ‘ready, steady go’ with games using bubbles or rolling a ball – remember to be on their level.
- Spend time outside with babies, talking, listening and exploring.

If you are worried that a baby in your care is not doing these things, there is more information on www.talkingpoint.org.uk. Or, using your setting’s procedure, talk to the parents about your concerns. A referral to speech and language therapy may be needed.



By two years...

Toddlers are into everything and will be exploring the world around them much more actively. Their understanding of words and phrases grows really quickly during this time. They understand much more than they say. This can result in frustration when they don't get their message across.



By two years, toddlers will usually:

- use over 50 single words like 'juice', 'car', 'biscuit'
- be starting to put short sentences together with two to three words, such as "more juice" or "bye-bye daddy"
- be asking simple questions such as "what that?", "who that?". They might do this quite a lot!
- understand between 200 and 500 words
- understand simple questions and instructions like "where's baby", "go and get your coat", "mummy's turn"
- enjoy pretend play with their toys, such as feeding dolly or pretending to drive a car, usually making noises and talking while playing
- become very frustrated when they cannot get their message across. This is one reason for toddler tantrums



How to check it out... toddlers are amazing!

Check out how the child can talk

Make sure you have time every day when you can have a 'conversation'.

- You should notice toddlers using more single words, putting two or maybe three words together. Encourage them to use short sentences this by using 2 -3 word sentences when you are talking to the toddler.
- Comment on what they are doing and they may talk about it. This works better than asking questions, E.g. Adult: "Ah, you've got a baby" Toddler: "Shh, baby sleeping" Or wait and respond to what they say.

Check out how the child can listen

Toddlers do not always do what we want them to, but on a good day you can note toddlers' understanding.

- Do they understand simple questions? E.g. When putting the toys away, do they follow "find me the bricks."
- If you are looking at picture books, can they point out familiar objects when you say? E.g. "Where's the dog?" or "What's the boy doing?"
- Can they play a simple game in your setting? E.g. Place some different toys on the floor with a big box to throw them all into.

Check out how the child can take part

Watch how toddlers play and how they react to others. Toddlers enjoy adults' company and might even let you join in with their games.

- Do they enjoy simple pretend games? E.g. With cars and trains, shopping and cooking?
- Do they also enjoy shape sorting games or simple jigsaws?
- Toddlers are not great at being directed by adults, but you can set up different activities. Try to follow their lead, E.g. Do toddlers begin to pretend to go shopping or cook dinner?

Some lovely things to do to encourage toddler talk:

- Share books together; interactive books with flaps and different textures are great – one or two toddlers sharing a book with you is ideal.
- Have times when you wait for toddlers to initiate talking – don't feel that you have to fill the silences.
- Repeat and expand on what children say. If a child says "car" you can say "mummy's car", "blue car" etc. This shows children how words can be put together.
- Playing with children, follow their lead and building their language and thinking helps them learn and grow – young children really benefit from this approach.
- Finger rhymes and action songs help toddlers with the rhythms of language and makes talking and listening fun.

If you are worried that a child in your care is not doing these things, there is more information on www.talkingpoint.org.uk. Or, using your setting's procedure, talk to the parents about your concerns. A referral to speech and language therapy may be needed.

By three years...



Children will be saying lots more words during this time – you will notice that they use new words almost daily. This is a really exciting time and children will be asking endless questions to help them learn and find out about the world around them. They are often keen to have conversations with adults they know well.

By three years, children will usually:

- use up to 300 words. They will use different types of words to do different things, E.g. to describe what things look like
 - ‘big’, ‘soft’
 - where they are – ‘under’, ‘on’
 - what they are for – ‘eating’, ‘playing’
 - that say who they are – ‘me’
 - to describe how many - ‘lots’
- refer to something that has happened in the past
- put 4 or 5 words together to make short sentences, such as “*me want more juice*”, “*him want his coat*”
- ask lots of questions
- have clearer speech, although they will still have some immaturities such as ‘pider’ instead of ‘spider’. They often have problems saying more difficult sounds like ‘sh’, ‘ch’, ‘th’ and ‘r’. However, people who know them can mostly understand them
- listen to and remember simple stories with pictures

- understand longer instructions, such as “*put on your coat and get your bag*” or “*where’s mummy’s coat?*”
- understand simple ‘who’, ‘what’ and ‘where’ questions
- play more with other children and join in with play
- play more complex imaginative games
- be able to have a proper conversation, though they may flit around the topic a bit and be difficult to follow at times
- be able to recognise how other people feel and will try to do something about it, E.g. “*Ah, Josie sad. She need a hug.*”



How to check it out... children are amazing!

Check out how the child can talk

Spend some individual time with children and listen to what they are saying.

- Are they speaking in sentences, joining 4 or 5 words together? E.g. “*Me a big girl now*”
- Have they stopped relying on pointing or only using single words to get what they want?
- You should also be able to understand most of what they say at this age, though their speech might not be perfectly clear to everyone.

Check out how the child can listen

Three year olds understand a lot more of what is being said now. Check it out.

- Can they remember longer instructions and information? E.g. “*Teddy is in the box*”, “*find a big plate.*”
- Can they understand questions using ‘what’, ‘who’ and ‘where?’ (though not ‘why’) E.g. When out walking or looking at a book can they respond to “*What is that?*”, “*Where is Spot now?*”
- Three year olds should be able to understand these things by listening to adults talking without being shown.

Check out how the child can take part

Three year olds often enjoy the company of adults and of other children.

- They will watch other children playing and when they feel comfortable will join in.
- They might ask you to play with them and join in simple games.
- Check out 3 three year olds in your care. They should enjoy playing and talking with others.

Some lovely things to do to encourage toddler talk:

- Add words to children’s sentences to show how words fit together. For example, if a child says “*brush dolly hair*” you can say “*Lucy is brushing dolly’s hair. Lovely*”.
- Share books and talk about the story and characters. Have children join in with stories to make them more interactive, E.g. joining in with repetitive lines of stories.
- If children say words that are not clear, the best way to help is to repeat what they

have said using the right words and sounds. There is no need to make them say it.

- Songs and rhymes are good to use at this age as they help children to learn the patterns of speech and language, important skills when learning to read.
- Have conversations about real things with children. Let them start the conversation, listen carefully to what they say and follow their interests.
- Keep the talk going by, nodding, smiling, encouraging

them to tell more through comments “*really...*” “*wow...*” “*a spiderman outfit...*”, rather than asking questions.

If you are worried that a child in your care is not doing these things, there is more information on www.talkingpoint.org.uk. Or, using your setting’s procedure, talk to the parents about your concerns. A referral to speech and language therapy may be needed.

By four years...

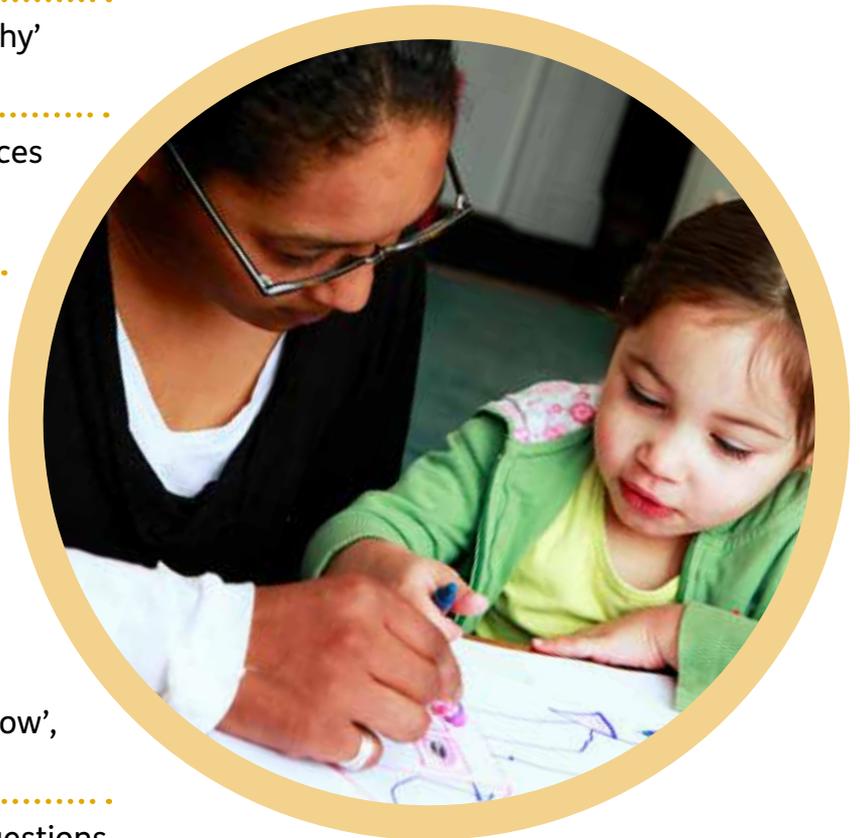


Children understand and say lots of words and sentences now. You can see them using their talking to meet new friends or to work out problems. They talk to find out new information by asking lots of questions. A massive amount of learning happens in this time.

By four years, children will usually:

- ask lots of questions using words like ‘what’, ‘where’ and ‘why’
- be able to answer questions about ‘why’ something has happened
- use longer sentences and link sentences together, E.g. *“I had pizza for tea and then I played in the garden”*
- describe events that have already happened, E.g. *“We got dressed up and we went to the hall and singed songs. All the mummies and daddies did watch”*
- have mostly clear speech, though will continue to have difficulties with a small number of sounds – for example ‘r’ – as in ‘rabbit’, ‘l’ – as in ‘letter’, ‘th’ as in ‘thumb’, ‘sh’ as in ‘show’, and ‘j’ as in ‘jam’
- listen to longer stories and answer questions about a story they have just heard, for example, simple questions such as *“Who did Cinderella dance with at the ball?”*, *“Were Cinderella’s sisters kind?”*

- understand and often use colour, number and time related words, for example, ‘red’ car, ‘three’ fingers
- enjoy make-believe play
- start to like simple jokes – though often their own jokes make little sense
- start to be able to plan games with others



How to check it out... children are amazing!

Check out how the child can talk

By four years, children can explain their ideas and talk in sentences and talk about things that have happened.

- Can they explain where they went and what happened? E.g. The child says *“Julie and Saria and me goed park and played on swings.”*
- Can they use longer sentences joined up with words like ‘because’, ‘or’, and ‘and’? E.g. *“I like ice cream because it makes my tongue shiver.”*
- Are they easily understood by others?

Check out how the child can listen

Four year olds are getting good at understanding more and more of what people are saying.

- Check this out by asking them to do a simple task as part of everyday activities.
- Are they able to follow simple two part instructions reasonably well? E.g. *“Go and get me the big scissors and some blue paper from the drawer.”*
- Are they able to understand simple ‘why’ questions?
- Talk about a story you have just read and ask a couple of questions.

Check out how the child can take part

Four year olds use talk in different ways.

- Do they use talk to organise themselves and their play? You might hear them saying things like *“let’s pretend we are in a jungle, you be theand I the”*
- They like make-believe play and dressing up.
- What about the four year olds in your care? Do they like to play and talk with others? Do they enjoy make-believe play?

Some lovely things to do to encourage child talk:

- Join children in pretend play. Play alongside them, let them take the lead. Listen and talk about what they are saying and doing rather than asking lots of questions.
- Give longer instructions for them to follow.
- Play around with words and sounds, E.g. think of words that begin with the same sound.
- Get the child to think of words that belong to the same category, for example as many different animals as they can think of.
- Make up a story together – think of a character, where does he live, where did he go today, what did he do, are there any mishaps, and what happens in the end.

If you are worried that a child in your care is not doing these things, there is more information on www.talkingpoint.org.uk. Or, using your setting’s procedure, talk to the parents about your concerns. A referral to speech and language therapy may be needed.

By five years...



By the age of five, almost all children will be in school.

At this stage, they need to learn how to listen, understand and share their ideas within the classroom. They also need to understand words and phrases used in school that they may not have heard at home – things like ‘line up’, ‘packed lunch’ and ‘talk to your partner’ etc.

They also still need to have conversations – to share information, to make friends and explain how they are feeling.

By five years, children will usually:

- take turns in much longer conversations
- use sentences that are well formed, for example, “*I had spaghetti for tea at Jamilia’s house*”
- be learning more words all the time as well as thinking more about the meanings of words, such as describing the meaning of simple words or asking what a new word means
- be able to re-tell short stories they have heard in roughly the right order and using language that makes it sound like a story
- use most speech sounds. However, they may have some difficulties with more difficult words such as ‘scribble’ or ‘elephant’ and some speech sounds such as ‘r’ and ‘th’ may still be difficult
- enjoy listening to stories, songs and rhymes and will start to make up their own

- ask relevant questions or make relevant comments in relation to what they have heard
- understand spoken instructions without stopping what they are doing to look at the speaker
- understand more complicated language such as ‘first’, ‘last’, ‘might’, ‘maybe’, ‘above’ and ‘in between’
- understand words that describe sequences such as “*first we are going to the shop, next we will play in the park*”
- choose their own friends
- use talk to take on different roles in imaginative play, to interact and negotiate with people and to have longer conversations
- use talk to help work out problems to organise their thinking and take part in activities



How to check it out... children are amazing!

Check out how the child can talk

By five years, children can have conversations; they know lots of words and can use longer sentences, though they still might make some little mistakes, which is fine.

- Can they organise their thoughts and put longer sentences together?
- Can you usually understand what they are saying?
- Do they regularly get frustrated or give up trying to tell you something?
- Do they regularly forget the words or miss out important pieces of information?
- Do they sound muddled and disorganised in their talking? If so, they may be struggling.

Check out how the child can listen

Check out children's understanding.

- Can they listen for instructions while they are busy with something else? E.g. Ask them to get their coat and shoes while they are playing (not TV or computer, they are too absorbing).
- Are they beginning to get the idea of time? E.g. "Mummy will be here after lunch."
- Do they understand a longer list of instructions? E.g. "First get your lunchbox, then sit at the red table." Note if they have to watch another child in order to know what to do, rather than understanding it themselves. This might indicate difficulties in hearing or understanding.

Check out how the child can take part

There will be times when five year olds will be happy to play alone, with adults, or with other children.

- Do they talk with other children and join in with group conversations and games?
- Are there any children who seem isolated? Check it out further.
- Talk to children about what they enjoyed most in a day – these conversations often include different games or activities they play with friends.

Some lovely things to do to encourage child talk:

- Playing board games that involve taking turns helps children to listen.
- Introduce new words and phrases to help them continue learning. Think of lots of different words that mean a similar thing – E.g. words that mean 'big'.
- Play around with rhyme, E.g. "cat, fat, hat, splat... any more?" it's an important skill for reading.
- Children may need time to think before responding to questions and instructions.

If you are worried that a child in your care is not doing these things there is more information on www.talkingpoint.org.uk. Or, using your setting's procedure, talk to the parents about your concerns. A referral to speech and language therapy may be needed.

Other important information

English as an additional language

Some estimates suggest that as much as two-thirds of the world's population speak more than one language. Speaking more than one language is a positive and beneficial skill and should be celebrated. There is no evidence to suggest that learning more than one language will delay the development of speech and language skills. In fact, learning more than one language at once can have many positive benefits for children.

For children learning English as an additional language:

→ it is important to recognise and value all languages.

→ accept and praise words and phrases used in home languages and give English equivalents where appropriate.

→ encourage parents of children learning English as an additional language to continue to talk to their children in their home language.

Different languages have different sound and grammatical systems; the ages and stages used in this booklet refer to English.

There is more guidance available at

<http://www.literacytrust.org.uk/assets/0000/0804/FAQsonbilingualism.pdf>

A word about boys

Boys can struggle more with developing aspects of language although the ages and stages in this booklet apply to both girls and boys. It is good to check that your provision includes things that boys like to do and talk about. It's useful to have a range of books and resources that boys are interested in exploring, this will help to develop their imagination and communication. Outside play and games to encourage language are also great for boys and often provide many opportunities to think about how to include and involve dads.

Children with speech, language and communication needs (SLCN)

Children with speech, language and communication needs may have difficulty in one or more of the following areas:

→ **Listening and attention** - children may have difficulties listening to what has been said to them and may struggle to concentrate on a game or activity for even a short period of time, flitting from one task to another without completing anything.

→ **Understanding language** - children may struggle to understand words or sentences that are being used or to follow instructions they hear.

→ **Spoken language** - children may use a limited number of words in their talking or be unable to put words together to form sentences. What they say may be very muddled and disorganised and difficult for someone to follow and understand.

→ **Speech sounds** - children may have speech that is difficult to understand. They may not say the right sounds for their age or may mix up and miss out sounds in words, making their speech unclear e.g. “a tup of tea”.

→ **Fluency** - children might have hesitations in their speech and may prolong or repeat sounds and parts of words or sentences. They may struggle to get their words out at all. Getting ‘stuck’ on words in this way is sometimes referred to as stammering.

Stammering can emerge at any childhood stage, but most commonly between the ages of 2 and 5 years. This coincides with the period of rapid development of learning complex language skills. It can be very difficult to tell if a child will recover naturally from their stammer, or if it might be more persistent. Discuss your concerns with parents and seek advice as soon as possible from a speech and language therapist – see www.stammering.org for more information.

→ **Social use of language** - children may have a good vocabulary and can put sentences together, but they may struggle to know how to use their language to have conversations, play and socially interact well with others.

Find out more

Your local offer

You could look up your local authority's 'local offer' which is published on their website. The local offer clearly sets out what services are available in your area for children from birth until they are 25 years old. The local offer also explains how these services can be accessed.

Talking Point

www.talkingpoint.org.uk

A website all about children's speech, language and communication, designed for parents, people who work with children, and children and young people themselves. It contains information about supporting children's speech and language development, and helps you to identify if a child is having difficulties or falling behind. If they are struggling, then it tells you what you could do to help or who you could get help from.

To find out more about the organisations involved in The Communication Trust please go to:

www.thecommunicationtrust.org.uk/partners

If your organisation would like to become a member of The Communication Trust's consortium please go to

www.thecommunicationtrust.org.uk/partners/consortium

for more information

or e-mail [enquiries@](mailto:enquiries@thecommunicationtrust.org.uk)

thecommunicationtrust.org.uk

Progression Tools from The Communication Trust

If you still have concerns about a child's speech, language and communication skills you could use a Progression Tool to help identify where children are at in relation to their age and how they are progressing with developing these vital communication skills.

Progression Tools are available for the following key ages of development in primary school: 3, 4, 5-6, 7-8 and 9-10 years old. Each tool covers different aspects of speech, language and communication where two types of information are gathered: one through direct questions with the child and one by capturing your own observations or knowledge of the child.

The Progression Tools will give information to help you decide whether a child would benefit from a targeted intervention or whether they may need more specialist assessment and support and need referring to a speech and language therapist.

If you would like further information about the progression tools please go to: www.thecommunicationtrust.org.uk/resources/resources/resources-for-practitioners/progression-tools-primary/

Frequently asked questions

What should I do if I am concerned about a child who has not been identified with speech, language and communication needs?

Talk to parents to gain further information. If together you decide it is appropriate to refer to Speech and Language Therapy, you can do so if you get parent's permission. Speech and Language Therapists can offer more detailed assessment and advice and support for children with speech, language and communication issues. Anyone can refer to a Speech and Language Therapist, including the parents. If you ring your local speech and language therapy department, they will be able to advise you on the best way to make a referral. Sometimes referrals can be taken over the phone. You don't have to go through a GP or Health Visitor. You **always** have to get permission from parents to refer their child to other services such as Speech and Language Therapy.

How can I find out if I need to improve my knowledge and skills in children's communication and where can I find out about further training?

You could complete the Speech, Language and Communication Framework (SLCF). The SLCF outlines what people who work with children and young people need to know and be able to do in order to support children's communication. For more information about the SLCF go to www.talkingpoint.org.uk/slcf

Your local Early Years advisory team, speech and language therapy team or children's centre may also be able to help.



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Every child understood

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Transfer to additional or alternative SLCN / Dysphagia or other Health Pathway

Quick Look Guide to Speech and Language Therapy Pathways

Speech Pathway

Meets the needs of children/young people with speech sound difficulties having an impact on well-being and/or learning. (e.g. could include a mild difficulty with severe impact).

The majority of children will come from 3 years. Only a very few will enter at 'rising three'.

Children with other difficulties e.g. language delay, ASD, learning disability can enter the pathway. They just need to have 'readiness' to respond to speech work.

Children with severe speech difficulties can receive help with AAC

Dysphagia Pathway

When a child or young person has any of:

Changes with breathing when feeding/eating, drinking, and swallowing (EDS).

E.g. coughing, choking, spluttering, gurgly sounds, gasping

Gagging or vomiting when feeding/EDS

Aversive behaviours when feeding/EDS

E.g. anxiety, distress, refusal

Limited or absent oral feeding experience

Intervention in hospital and requires community follow up

In conjunction with the above, there may also be an impact on:

Nutrition and hydration, growth, respiratory health, acquisition of feeding skills, mental health, social and educational attainment

Language Pathway

Child/young person's intervention will target language regardless of any other known diagnosis, e.g. ASD, Cleft, learning difficulty.

May also be on the speech pathway if both speech and language are being targeted at the same time

Up to 16 years old unless in statutory education (19 years)

Child/young person has one word level understanding or above

Stammering (Dysfluency) Pathway

Framework for providing appropriate referral, assessment and provision of early intervention for children/young people where there the main presenting concern is about a stammer.

Age of referral: 2 years up to 18 years

All dysfluency referrals to the service will be accepted for an initial screen.

Children where a co-existing disorder (ASD, Down's Syndrome, speech or language delay/disorder etc) is the primary concern, may receive advice but not be placed on the dysfluency pathway

Voice Pathway

Framework for providing appropriate referral, assessment and provision of early intervention for children/young people where the main presenting concern is about voice quality

Age of referral: 1 year up to 18 years

Type of difficulty: Persistent generalised hoarseness, structural/organic abnormality or sudden complete loss of voice that is significantly impacting on communication and well being

Nasal Speech Pathway

Criteria for entry onto Pathway:

Children presenting with nasal sounding speech either

in association with a cleft palate (+/- cleft lip) who will already be on a Cleft Pathway or with no known history of a cleft palate

PMLD Pathway

A child or young person with PMLD...

Will usually have a physical disability and significant health care needs often accompanied by a sensory impairment

Will communicate at a pre-intentional or early intentional level

Will require both formal and informal assessment

May be difficult to assess (thus requiring specialist speech and language therapy input to the assessment process)

The pathway is not appropriate for children and young people who have verbal understanding at or above the one word level.

2 Year Pathway – Late Talkers

Who for? – any other professional (eg CNNs, setting staff etc)

What for? – to help a professional decide if a child needs to be referred to SALT OR if they are a late talker

What then? – Late talkers are invited to Lets get talking (4 week parent/child) group, led by CNN and supported one week by SALT

Why have the pathway? - Many late talkers can 'catch up' with advice shared in the group

Autism Spectrum Disorder Diagnostic Pathway

If the child is a preschool child, and presenting with difficulties with play, communication and interaction, at neighbourhood level the Advanced Practitioner can provide a block of Parent Child Interaction Therapy before this is escalated to tier 3 services

If the child presents with difficulties with play, communication and interaction and referred into the Service the speech and language therapist will start the assessment process and refer to other appropriate agencies eg Paediatrician, Occupational Therapy, Educational and Clinical Psychology, CAMHS

The speech and language therapist will contribute to the diagnosis process

Evidence Base for 'Let's Get Talking' intervention

1. Delivery by other professionals
2. Key messages selected
3. Group intervention
4. Early Intervention

1. Effectiveness of trained non-SLT professionals & Parents delivering intervention

- ▶ “42% of SLTs deliver therapy regularly but others deliver it more frequently in between visits”, “29% of SLTs deliver it occasionally for the purpose of demonstrating to others how they should deliver the intervention on a more frequent basis”, “6% of SLTs reported that others deliver it following SLT advice”
 - **Department of Education (2011), *Better Communication Research Programme: 2nd Interim Report*, Research Report DFE-RR172**
- ▶ “The extent to which an intervention is delivered by a specialist practitioner or can equally well be delivered by an appropriately trained assistant or parent.”
 - **Department of Education (2011), *Better Communication Research Programme: 1st Interim Report*, Research Report DFE-RR070**
- ▶ “In general, the findings from parent training appear to be comparable to those from therapist intervention, potentially making the latter less expensive depending on the economic perspective adopted.”
 - **Department of Education (2011), *Better Communication Research Programme: 1st Interim Report*, Research Report DFE-RR070**
- ▶ “Well trained assistants and parents often have comparable outcomes to specialist direct work for language.”
 - **Department of Education (2011), *Better Communication Research Programme: 1st Interim Report*, Research Report DFE-RR070**
- ▶ “A parent-based model of language intervention embodies features of early language learning identified as important by previous research: use of language in familiar contexts; joint focus of attention; turn-taking, and following the child’s lead.”
 - **Gibbard, D. (1995). *Parental Involvement in Language Intervention: A Model. Paediatric and Educational Issues. 30 (S1), 205-211***
- ▶ “Parent-based language intervention was therefore found to be as effective as individual speech and language therapy.”
 - **Gibbard, D. (1995). *Parental Involvement in Language Intervention: A Model. Paediatric and Educational Issues. 30 (S1), 205-211***
- ▶ “Substantial language gains can be made in children’s language by working through their parents”
 - **McConkey, R et al (1979). *Involving parents in extending the language development of their young handicapped children. British Journal of Disorders of Communication. 17. 141-148***

- ▶ “Parent training addresses the child’s language needs in a naturalistic environment , thereby maximising communicative opportunities and participation”
 - **Royal College of Speech and Language Therapists (2005), Clinical Guidelines**
- ▶ “Parents have much more experience with their children than professionals, and their experience is more representative of their child’s experiences and interests.”
 - **Dale PS, Patterson JL. Early Identification of Language Delay. In: Tremblay RE, Barr RG, Peters RDeC, Bovin M, eds. *Encyclopaedia on Early Childhood Development* [online]. Montreal, Quebec: Centre of Excellence for Early Childhood Development; 2009: 1-6. Available at: <http://www.child-encyclopaedia.com/documents/Dale-PattersonANGxp-Learning.pdf>**
- ▶ “Well-trained, well-supported and well-motivated SLTAs can act as effective surrogates for SLTs in the delivery of services within primary schools to children with primary learning impairments who do not require the specialist skills of an SLT.” “There were no significant differences between direct and indirect modes of therapy, or between individual and group modes on any of the primary language outcome measures” “The data collected supports the adoption of indirect models of intervention delivered by trained SLTAs working under the direction of a qualified SLT, and also group models of intervention.” “The results from the economic evaluation further reveal that the costs of providing intervention could be considerably reduced by means of delivering therapy, where appropriate, via groups formed within a school and via SLTAs.”
 - **Boyle, J. McCartney, E. Forbes, J. O'Hare, A. (2007). A randomised control trial and economic evaluation of direct vs indirect and individual vs group mode of speech and language therapy for children with primary language impairment. *Health Technology Assessment*. 11 (25), 1-139.**

2.Key Messages

- ▶ “There is also evidence that children who are heavy television viewers have lower expressive language scores.” “Evidence suggests that children under 22 months acquire information, or learn first words, less effectively from television than from interactions with adults.” “Viewing by children of programming aimed at a general or adult audience is correlated with poor language development in pre-schoolers. Evidence suggests that children who are frequently exposed to such programmes tend to have a lower vocabulary, poorer expressive language and to engage in less TV-talk” “Carers should limit exposure for the under-twos in favour of other one-to-one language enhancing activities.”
 - **Close, R (2004). *Television and Language Development in the Early Years: A Review of the Literature*. London: National Literacy Trust**
- ▶ “38 programmes were specified with the most common being modelling (96%), repetition (84%) and reducing distractions (82%).”
 - **Department of Education (2011), *Better Communication Research Programme: 2nd Interim Report*, Research Report DFE-RR172**
- ▶ “In the absence of strongly evidence based programmes, practitioners are responding positively with adaptations based on experience.”
 - **Department of Education (2011), *Better Communication Research Programme: 2nd Interim Report*, Research Report DFE-RR172**

- ▶ “There is evidence that treatment improves vocabulary use and MLU in conversation, as well as the acquisition of specific target words” in children aged 24-36 months
 - **Cable, A & Domsch, C. (2011). Systematic review of the literature on the treatment of children with late language emergence. *International Journal of Language Communication Disorders*. 46 (2), 138-154.**
- ▶ “Several lines of research have documented that children producing their first words learn new words more effectively if they hear them in isolation with no grammatical context, demonstrating that simplified language may benefit these early language learners.” “By excluding the extraneous words and providing greater focus on the target words, children with ELD may be able to devote more processing resources to identifying and mastering the core content words that are not currently in their lexicons”
 - **Wolfe, D & Heilmann, J. (2010). Simplified and expanded input in a focused stimulation program for a child with expressive language delay (ELD). *Child Language Teaching and Therapy*. 26 (3), 335-346.**
- ▶ “There is evidence that the development of selective attention is considerably impaired in very noisy environments where the signal-noise ratio is not sufficiently high”
 - **Ward, S. (1999). An investigation into the effectiveness of an early intervention method for delayed language development in young children. *International Journal of Language & Communication Disorders*. 34 (3), 243-264.**
- ▶ “It has been suggested that an important function of the modification of the adult-child speech is in obtaining and maintaining attention to speech”
 - **Ward, S. (1999). An investigation into the effectiveness of an early intervention method for delayed language development in young children. *International Journal of Language & Communication Disorders*. 34 (3), 243-264.**
- ▶ “A large body of research suggests that the special properties of adult-child speech facilitate language development. Barnes et al. (1983), Snow (1977) and Fernald (1993) Ward suggest that these properties (short, simple utterances, exaggerated intonation with smooth contours, slow rate and repetition) assist in terms of arousal, attention, perception and comprehension.”
 - **Ward, S. (1999). An investigation into the effectiveness of an early intervention method for delayed language development in young children. *International Journal of Language & Communication Disorders*. 34 (3), 243-264.**

3. Group Work

- ▶ “There is evidence that group programmes are more cost-effective than those run on an individual basis.”
 - **Gibbs, J., Underdown, A., Stevens, M., Newbery, J. and Liabo, K. Group-based parenting programmes can reduce behaviour problems of children aged 3-12 years. *What Works for Children group Evidence Nugget* April 2003.**

4. Early Intervention

- ▶ “Early language delay is associated with a range of ongoing linguistic, educational and social difficulties.” “Population based studies found that children with early speech and language delays later presented with educational difficulties”

- **Roulstone, S. Peters, T, Glogowska, M. Enderby, P. (2003). A 12-month follow up of pre-school children investigating then natural history of speech and language delay. Child: Care, Health & Development. 29 (4), 245-255**