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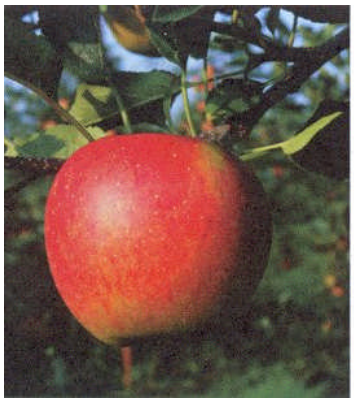
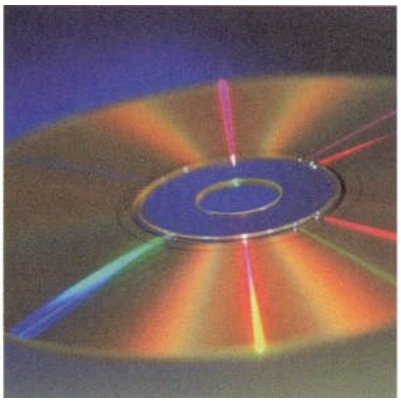
Centre for Health Services Studies

Thanet and Deal Early Intervention Scheme Pilot Projects

Interim Report

Centre for Health Services Studies
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1 Introduction

This report provides an overview of the progress of the two Early Intervention Pilot Project sites established in 2004. It will

- outline staff and site profiles,
- describe the different interagency and interprofessional process issues that occurred as part of the project development, including how challenges were overcome,
- provide a statistical description of referral source, the client group and the outcomes of interventions at the Thanet pilot project, based on the database developed as part of the evaluation
- give recommendations based on lessons learned and future aspirations

2 Background and Project Aims

Strategies to tackle health and social inequalities have been at the forefront of health policy in recent times, and there is a growing body of literature supporting schemes that intervene before major problems occur. Especially for young families, when interventions are started during the antenatal period or at birth, they can have long-lasting outcomes for children and high-risk mothers (Warr-Leper 2001)[1]. Using that evidence and with a focus on vulnerable families, these pilot projects were established to provide timely help and support from an integrated health and social care team operating from two GP practices, in two areas in East Kent. Such a service was seen as unique, in that it brought health and social care staff together for the first time to share preventive work.

The aims of the projects are to identify and support low-level vulnerable families with children 0-4 years through a single assessment process with a focus on:

- establishing an antenatal and preschool family intervention service through home visiting
- developing appropriate referral pathways
- promoting health development
- prevention of referrals to social services

[1] Warr-Leper GA (2001) A Review of Early Intervention Programs and Effectiveness Research for Environmentally Disadvantaged Children. Journal of Speech-Language Pathology and Audiology 25 (2) 89-102.

- supporting families to meet the needs of their children

3 Project Evaluation

The project commissioned an independent researcher from the University of Kent to facilitate the development of the project from the onset, and to undertake an evaluation. The evaluation consists of three facets, the first two of which have been completed and the last is due to commence in February 2006:

(i) Construction of an electronic database. This has been set up with project staff using information extracted from project documentation about the clients' demographic and social profiles, referral reasons and routes, the nature of any intervention, and outcomes (see appendices for data fields). Data are recorded by the project administrator.

(ii) An assessment of team working, revealing the processes and events that contributed towards and hindered the development and successful running of the project. This data has been collected through regular meetings with project staff, and will be used here to underpin the progress report.

(iii) A total population survey of clients who have used/are using the early intervention scheme that will elicit their views about their experiences with the service.

4 The Project Profiles

A project requirement was for the sites to be closely linked to a GP practice serving a disadvantaged population. The pilot projects have been established in **Thanet** and **Deal**. It was originally intended to target a primary care setting in Dover, however a host practice was not found. These two different sites have provided the opportunity of seeing how service models could be set up in contrasting areas.

4.1 Thanet Site

In Thanet, the project was set up in Newington Surgery in Ramsgate and became operational in April 2004. The catchment population of this area of approximately 8,000 includes a disadvantaged estate with young vulnerable families and therefore was considered ideal. The surgery houses the team. Constituting the health input is a health visitor, a health visitor assistant and two job-share midwives. As this type of work does not constitute a new role and is part of their general responsibilities, no discrete designated hours have

been committed to the project; instead their role had become integrated. Unlike health, the social care input to the team has been deemed a new role and therefore has designated hours attached to it. It is provided by a social worker (2.5 days per week) and two social work assistants, both working three days per week. Both projects share a part-time administrator whose support function is intrinsic to the smooth running of the service.

From an early stage the team created a service identity through the title 'NEST' – Newington Early Support Team and promoted themselves through leaflets, posters and word of mouth. They also organised to have a group facilitator from CAMHS (Child and Adolescent Mental Health Service) to enhance team building (see 5.1 for further details). Potential clients are able to access the service through either self-referral or via a professional worker. Other people can make a referral into the project provided the family is registered with Newington Road Surgery.

The team also have a close working relationship with the Nurse Practitioner and the community midwives, who identity and refer clients in need to the project. With community midwives, a particularly efficient system is in operation to include capture of the most vulnerable groups. Midwives refer all parents under the age of 19, with referrals being made at the first booking visit where they are placed in a 'holding' file. Letters are sent to clients informing them of the project, and contact is made around 20 weeks into the pregnancy. With respect to the resident GPs, input tends to be more peripheral and less involved.

Documentation particular to the requirements of the project was developed, such as referral and outcome forms and individual plans. Suitability for the service is assessed using established vulnerability criteria (see appendices for referral and outcome forms, and criteria). Cases put forward for referral are discussed at weekly meetings, and on-going cases reviewed. The aim is to provide focused relatively short-term intervention work with clients based on the achievement of mutually agreed goals, and refer on to other agencies if necessary. Cases are allocated between team members according to skills and available hours, there is no formal delegation. The social work assistants provide much of the 'hands-on' support and advice, and joint visits with health and social care staff are made when necessary. A social work assistant has set up self-esteem groups, as further support for some of the clients.

In September 2004, six months into the project, a recommendation was put to the team to expand to another surgery, as referral rates were slow. It was felt however that the potential scope of the projects had not yet been fully realised. Time was needed to build up community trust and there was more to do to encourage participation and referral. This recommendation was therefore resisted.

At the time of this report, the Thanet project has had more than 100 referrals. Now that the project has been established for more than a year, there is an increasing trend for clients to re-refer themselves, having had previous positive contact with team members.

The project has generated considerable interest among other agencies, who attend project meetings to observe how the project functions. This is seen as helpful in promoting the project externally with the community, encouraging other referrals into the project from different sources, and increasing knowledge of available resources. Strong links have also been made with the Primary Intervention Project which works with school age children, and the Play and Learn Scheme. NEST supports their weekly joint sessions for parents and children in Newington Community Centre.

4.2 Deal Site

The site at Deal started in September 2004, and so was able to capitalise on the experiences of colleagues in Thanet. Consisting of one health visitor, one health visitor assistant, one social worker and one social work assistant (both 1 day per week), the project was originally linked with the Cedars GP practice. However, this did not have a large enough population of vulnerable families and referral rates were low, so it expanded to include all five GP practices in Deal earlier this year.

Unlike Thanet, the Deal team do not share the same accommodation but hold meetings together at Deal Clinic. Although the meetings have not been held on a regular basis, health visitors from all practices are invited to refer cases and discuss them. This arrangement is still developing, however from December 2005, all health visitors in Deal will be based together and it is anticipated that the pilot project will also operate from this site. This will provide the opportunity for weekly contact with all the team and will fill the gap for informal contact, which is a contributory factor in team building, information sharing and the generation of referrals.

Relationships with community midwives are still developing and the project has yet to receive a referral from this professional group. This project shares the same referral system as the Thanet site. At the time of this report, 32 clients have been referred and the view among staff is that those clients entering the project with short specific aims have been successful in achieving them.

5 The Process of Project Development: Challenges and Solutions

At the start of the project, an ‘Away Day’ was organised to determine the aims and structure as well as an implementation plan. Following on from this, a steering group of senior representatives from health and social services was formed, also attended by a team member from each site. In addition to this, teams from both projects formed a support and advisory working group and have met eight times to discuss progress. A second Away Day took place six months after commencement to review progress and discuss challenges. This

provided the opportunity for staff to celebrate achievements and air concerns to a senior health representative.

There is an overwhelming perception among teams that the project is successful, and able to reach and respond in a timely way to those families in need, avoiding a social services referral. This is particularly so in Thanet where the service has been running longer. It must be stated that this is a staff view and challenges to measuring this from the client's perspective are recognised by the team. However efforts to capture such perceptions will be attempted in the client evaluation.

The following outlines main areas of development, highlighting the challenges and efforts to overcome them.

5.1 Developing the Team

In general, teams feel that they have established a good working relationship and are working well together. There has always been the perception in Thanet that working in the same surgery has done much to promote good quality prompt communication to the benefit of client outcomes. There have however been some difficulties encountered along the way. Due to the different professional backgrounds and differences in agency culture, problems emerged in relation to team roles and how project work was negotiated within the team. The social care workers felt for example that work was being delegated to them, rather than discussed in partnership. This has been particularly evident in Deal, where health visitors from all practices are referring to the service. This is being overcome by providing clear referral guidelines.

A further issue concerned the difference between the two agencies with dedicated project hours. While social service team members have designated hours, health personnel did not and this created a sense of unease within the teams. Health personnel had some difficulties in recording project activity, as it was integrated into their role and it remained largely unknown. This indistinct demarcation between 'normal' work and 'project' work caused a blurring of roles and responsibilities that was felt by some to weaken the project as a discrete entity.

In Thanet, team members organised some professional group facilitation using Child and Adolescent mental health workers (CAMHS) to address the issues of roles and responsibilities, which has proved worthwhile. This has been replicated in Deal. Some initial obstacles regarding the suitability of the facilitation were overcome. The fact that the project in Deal has expanded and also developed a different configuration means that there has been limited opportunity to develop a team ethos. This has meant that communication between team members has at times been at issue, such as informing health visitors when project interventions with clients have ended. Difficulties with team building have been compounded by the fact that the group facilitator

provided by CAMHS has not been replaced. Moves are being made to improve communication in this area.

Recent reflections from the Thanet team in October 2005 highlight the positive aspects of working in the project, and in particular working together creatively in a team. For example, opportunities that the project has provided in discussing and sharing complex, often extreme cases has reduced anxieties often associated with this type of work.

In addition, the team feels it has a formula for success, and these criteria are regular formal and informal communication and information sharing brought about by being based together, supervision, administrative support, and weekly meetings with full attendance. Added to this, the small, 'compact' and stable nature of the team is seen to promote a cohesive and rapid response. There is a view that expanding the service to an environment where teams are larger with more 'floating' members, creating less stability and reducing opportunities for optimal information sharing, might not have the same outcome. To some extent the Deal structure bears witness to this.

5.2 Leadership

From the onset, the day-to-day running of the project has been organised through operational staff members, and management support has been peripheral, usually present at progress meetings. If difficulties arose, these were resolved within the team or at supervision. There has been the perception that the projects lacked senior leadership, especially in the early months. This left the teams feeling isolated and unable to find clear pathways through problems. This perception was compounded by the fact that the steering group function has met infrequently due to other commitments. With the subsequent lack of decision-making capacity, identified problems were not initially being fully resolved as they arose. This was a key issue raised at the six month review Away Day, when it was agreed to establish a middle management steering group, but this has also failed to meet.

Now that projects are established, this 'steer' is not so urgent, but concerns about the future of the project do exist, with team members feeling they are working 'with an axe' over their heads and unable to plan ahead. This could be improved with better communication and attendance at strategic meetings.

5.3 Funding and Resources

There were initially no identified monies attached to the projects, which was causing difficulties with the supply of basic requirements such as stationary and refreshments. Importantly, planning for team facilitation was impeded by this factor, as mentioned. While some money and resources have now been allocated this is managed elsewhere and not fully controlled by the projects.

The lack of a discrete budget owned by the teams to finance project affairs has raised other concerns around control of recruitment to additional support groups, set up to enhance the scope of the project. Requests from funders to include clients with more complex needs has altered the manageability and dynamic of the groups. Teams from both sites feel that a budget managed by themselves is urgently needed to create a sense of autonomy and control.

As mentioned, the project has an administrative officer attached to it who supports the running of the project and inputs data for the project evaluation. Technologically however, there is limited access to email at both sites, which reduces the communication methods.

6 Achievements

As a testimony to the hard work of team members and the innovative and responsive nature of the projects, there are some achievements to report.

- In February 2004, the Projects were short-listed for the Guardian Public Service Awards and came runner-up.
- Two project team members from NEST have been awarded Best Practice Awards
- NEST gave a presentation to the Thanet Healthy Minds Forum in April 2005
- The NEST project in Thanet celebrated its first 'birthday' with a party in May 2005

7 Analysis of Activity from NEST

This section provides a statistical description of NEST activity, derived from database headings developed by teams to capture service activity. Areas captured relate to client characteristics, referral source, reason for referral, and outcome of intervention. The statistics are based on a total of 89 referrals, consisting of children, parents or carers, or a combination of these. For some sections, the greater numbers are due to the fact that some clients had more than one reason for referral, and more than one goal-related outcome. At the time of this report, data from the Deal site was not available.

As the data provided a relatively superficial overview of activity only, a group discussion was conducted with team members in an effort to supplement the statistics with some explanation and commentary. This has not only given more depth to the data but has highlighted areas where additional information needs to be collected.

7.1 Characteristics of Client Population

The main client characteristics are summarised as follows:

- The average age of the child referred was 1 year 3 months, with 34 females and 38 males.

- The mother was the main carer in all cases, with an average age of 24 years

- Regarding ethnicity, of the 83 completed entries, 79 were classed as White, 1 as Chinese and 3 as 'other'.

- All referrals were for Newington Road Surgery clients.

- The average number of weeks with the project was 11

With respect to the average number of weeks with the project, this is measured from the time that the case is allocated to a team member to discharge. While response is usually rapid with most first contacts made within a week, this can vary according to ease of accessibility to the client.

Table 1 provides an indication of the predominant referral focus and the average reasons for each referral. These were categorised according to physical or psychological issues manifest in the parent and/or child (such as substance abuse or behavioural problems respectively), as well as environmental factors (such as housing) that impacted upon the health and welfare of the child.

Table 1: Referral focus and average number of reasons for referral

Referral	Total	Average Number of Reasons per Referral
Both parent and child	26	3
Parent only	46	1
Child only	7	1
Environmental referral only	10	1
Total	**89**	

Most referrals were for parents, this includes a total of 16 antenatal referrals (as mentioned teenage mothers are automatically referred to the team by the midwife). Environmental referrals were for isolation/cultural difficulties (6) and housing problems/homeless (4).

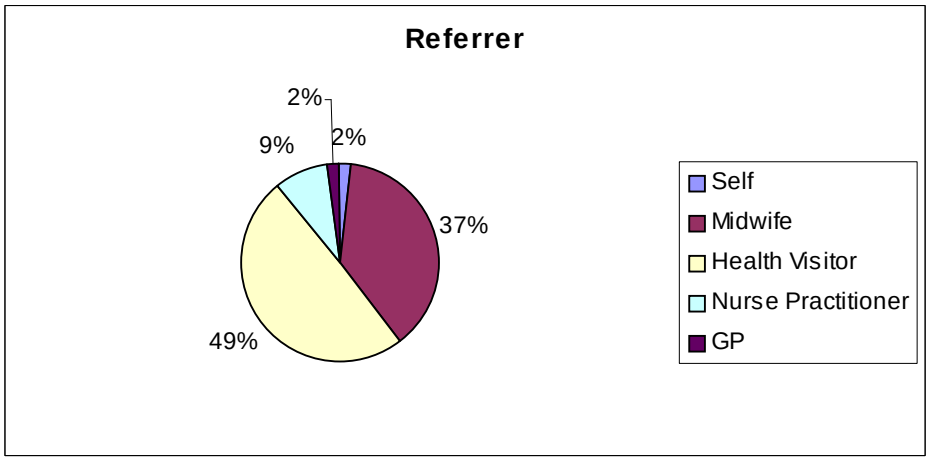
In practice, the primary reason for referral was often accompanied by other problems following assessment. It was uncommon for example for a child to be referred for behavioural problems without there being a supplementary contextual issue within the family. This highlights the importance of the project in the holistic nature of the work in identifying and addressing additional need.

7.2 Referral Source

As displayed by chart 1, the main referral source into NEST has been from health visitors, followed by midwives. This testifies to the close working relationships and good communication networks between team members that have been established. This is also evident with referrals from the nurse practitioner based at the surgery, who also has a close association with the project.

Although there are three GPs, only two referrals have been received during the 18 month history of the project. This supports the perceptions that GP engagement with the project remains peripheral.

Chart 1: Referral Source (n=89)



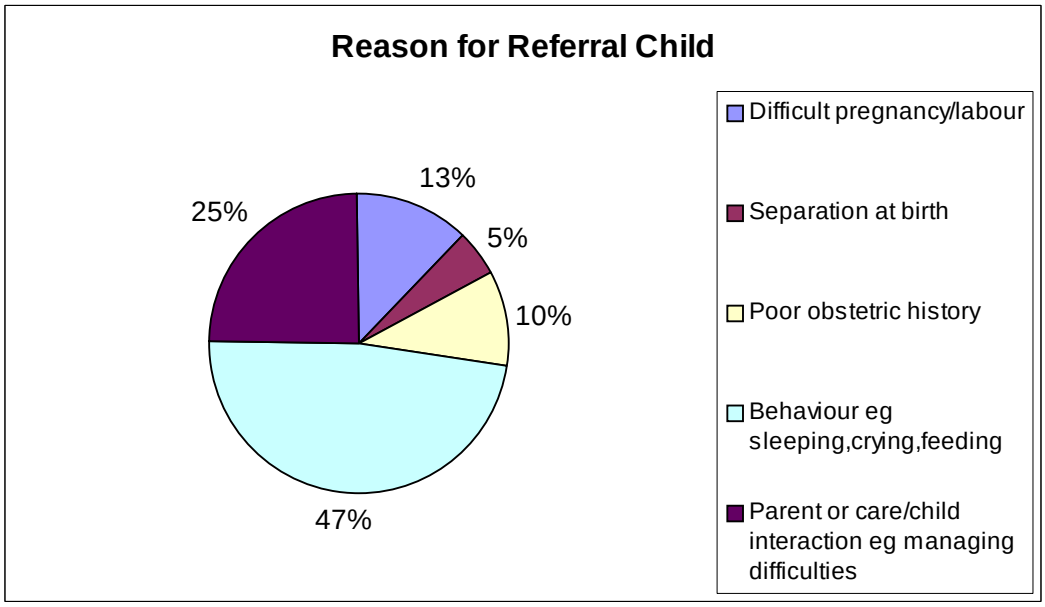
7.3 Reasons for referring a child

As reflected in chart 2, behaviour difficulties were the main reasons for referral into the team and therefore constituted the larger part of their work. Examples of this included challenges with bedtime routines or eating patterns, and general aggressive verbal and non-verbal behaviour.

Difficulties parents had in managing their children were also predominant in this category and were closely associated with behaviour problems manifest in their children. The majority of struggles here were concerned with loss of parental control, such as toddlers running off, and difficulties setting boundaries.

Problems related to pregnancy and childbirth were also apparent. The team have worked with mothers who had great anxieties in relation to being pregnant and giving birth, often through a poor previous experience, and have also supported a mother through voluntary adoption. Teenage parents have also needed support and guidance, often related to immaturity and a mismatch in expectations.

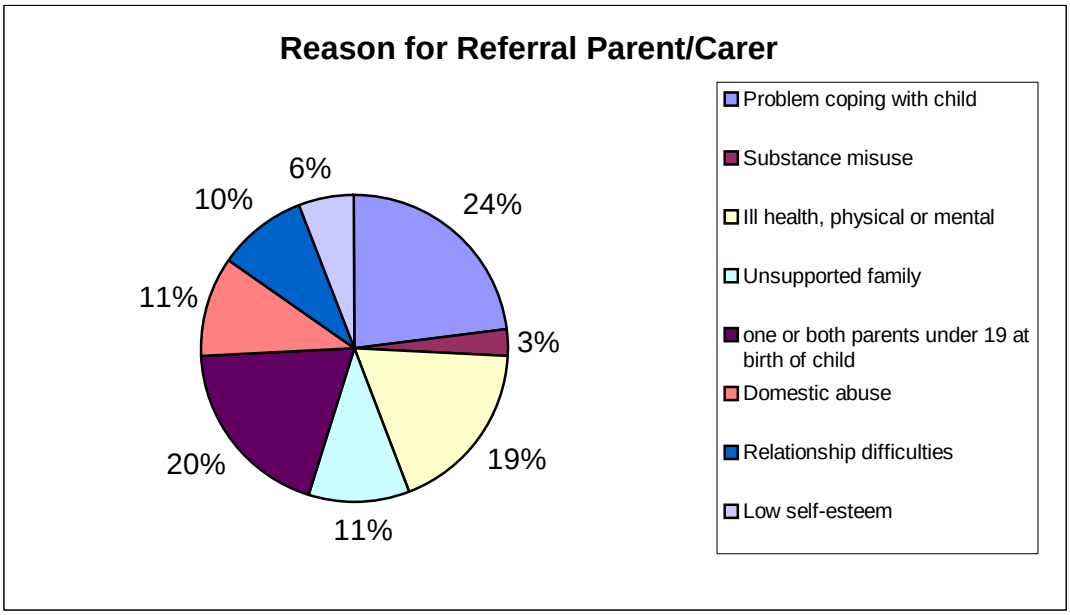
Chart 2: Reasons for referring a child (n=40)



7.4 Reasons for referring a parent or carer

As chart 3 below illustrates, there appear to be a spread of reasons for referring parent or carers to the team. Predominant causes relate to difficulties in coping with parenthood, and this again is often linked with the prevalence of behavioural problems among referred children. In addition, some parents are from families with poor dynamics and have been in care themselves.

Chart 3: Reasons for referring a parent or carer (n=93)



Young parenthood also appears to be a principle reason; this may be due to the aforementioned system of automatic referral by midwives in place. Regarding ill health, examples of problems were predominantly mental health issues such as depression, substance misuse and bereavement.

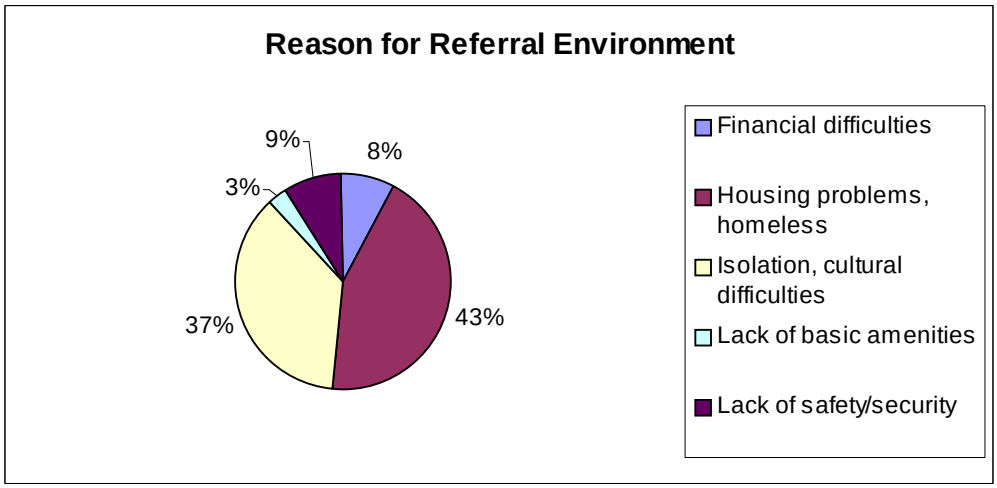
Within the data it is notable that a relatively high number of clients (11%) are victims of domestic abuse. This mirrors the average for Thanet (13%).

7.5 Environmental reasons for referral

This section is concerned with highlighting contextual problems that clients may have as a reason for referral. A total of 54 referrals in this area were received. Chart 4 indicates that the chief reasons were related to housing problems and isolation difficulties.

Regarding housing, this data reflects the fact that for many years in Thanet there has been a shortage of adequate social housing, and private rented accommodation is often thought to be too expensive for many clients, and of poor quality. Overcrowding is seen to be a significant problem, especially for young mothers who have to live with extended families. The perception is that this will not change for the foreseeable future.

Chart 4: Environmental reasons for referral (n=54)

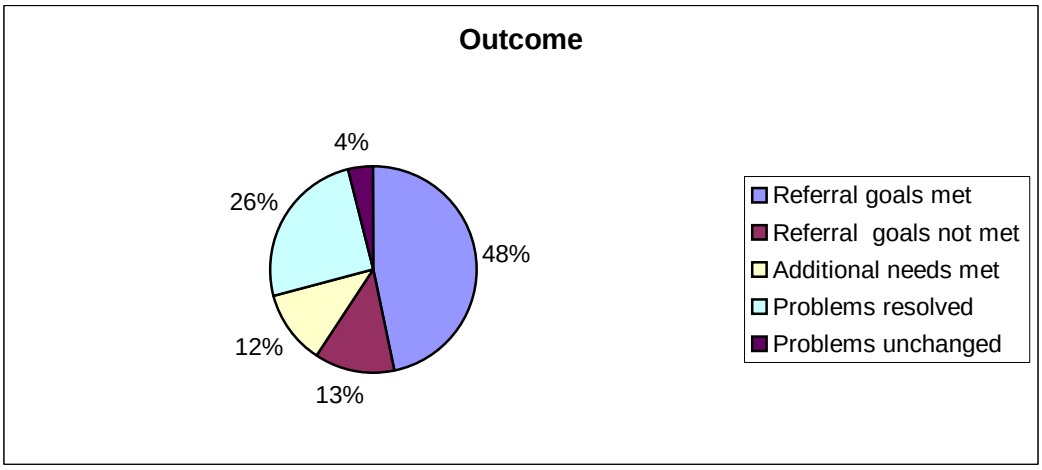


With reference to isolation, the higher numbers here are associated with the high mobility in the area and the initial difficulties becoming socially integrated. Some clients are also victims of domestic violence and therefore have the additional personal trauma associated with this, coupled with the ordeal of having to uproot the family. The team play a significant part in facilitating the process of community integration.

7.6 Outcomes of interventions

Chart 5 looks at the outcome of interventions with reference to goals that were set in partnership with the client and whether the initial problem (reason for referral) was solved. This distinction was made as solving the reason for referral was not always possible, but goals ameliorating the initial problem could be achieved. An example of this is 'overcrowding'; a client may not be rehoused, but through contact with NEST she will have acquired new skills in managing her environment.

Chart 5: Outcomes of interventions (n=93)



(nb some clients in this section had more than one goal or problem to resolve; also 19 clients did not have goals set/ problems identified - see next section)

It can be seen that most clients were able to achieve their goals. Perceptions from the team for this success centred on the importance of setting realistic goals, and the desire of clients to work with staff in overcoming their problems.

For eleven clients, additional needs were identified and met, again highlighting the benefits to clients of this service in resolving unmet need that might otherwise not have been addressed. These additional needs were largely concerned with budgeting and debt management, although the close relationship developed between staff and clients often resulted in more personal disclosures related to domestic abuse or relationship problems.

Some clients did however not appear to benefit from contact with the project. Sixteen clients either were unable to meet their goals or their problems were unchanged. The following section provides some insight into this.

7.7 Reasons for non-achievement of goals or problems

Table 2 includes 19 clients who did not have goals set or problems identified. It is of interest that only one client declined the service. Most people started with the service but did not continue, either terminating it themselves or only being able to take the service up in an irregular way.

One reason for this could lie with the universal visiting of all teenage parents. In a number of cases, following an initial visit, it became clear that the clients were coping well and not in need of the service. This could explain why goals were not set or problems identified.

Table 2: Reasons for non-achievement of goals/problems (n=41)

Reasons for non-achievement of goal/problem	Number of goals/problems
Client terminated service	23
Service declined	1
No visit made	1
Poor uptake of service	13
Plan renegotiated	1
Moved away	2
Total	**41**

The team was asked to reflect further on these statistics. Views about why the uptake seemed poor, or the service was terminated, are summarised as follows:

- It was felt that with some clients there was a mismatch of expectations relating to what the service was able to do for them. Clients terminated the service when they realised for example that NEST would not be able to rehouse them.

- There was the perception that some clients were reluctant to be linked with a Social Services project due to associated stigma.

- Staff felt that some clients may have agreed to have the service due to an obligation, or desire to please, which superseded a need. Subsequent ‘patchy’ uptake reflected misplaced commitment.

- For others, the crisis was either over before the team made the first contact, or clients were more in need of Social Services and more appropriate referrals were made.

7.8 Referrals from NEST to other agencies

An important function of the project was to ensure that clients received continued or additional assistance from other agencies that were able to extend the remit of what the team could provide. Table 3 indicates referrals to statutory and non-statutory agencies

The broad range of agencies that NEST refers to indicates the important role the project has in attempting to meet on-going family needs.

Table 3: Referrals to other agencies (n=19)

Referrals to statutory agencies	
CAMHS (Child and Adolescent Mental Health Service)	3
Social Services	3
Total Number	**6**
Referrals to non-statutory agencies	
Connexions (housing and sexual health advice, counselling)	4
Crowbridge Housing (outreach support for under 19's in their own homes)	1
Cruse	1
GP Counsellor	1
PALS (Play and Learn Scheme)	2
Parent and Toddler	1
PIP (Primary Intervention Project)	2
Playgroup	1
Total Number	**13**

7.9 Commentary

The statistical data have provided an interesting overview of NEST activity based on a total of 89 referrals. The analysis highlights that the referrals were suitable, that NEST is targeting the appropriate population, and that there seems to be a high level of engagement and goal achievement on the part of the client. The important function the team has in identifying and addressing additional need as revealed by the data cannot be overstated.

There are some obvious shortcomings to the data. Firstly, they do not reflect the actual work of the team, and some effort should be made in adding fields to the database that reflect the interventions and contact frequency that have brought about the outcomes. Key to the success of the project has been the ability of the team to provide valuable individualised attention. This includes escorting clients to community groups to facilitate much needed social contact; assisting with form-filling to maximise financial status; tackling low self-esteem, providing hands-on support in helping parents to set barriers with unruly toddlers and deal with behaviour; and being an advocate for clients with other agencies.

Secondly, the service is targeted at disadvantaged groups and team members feel they are reaching this population, however at present there is insufficient demographic data to measure this and additional fields are needed. Also, more evidence needs to be accumulated to reflect the rapid response nature of the project. Suggestions for these and other data field inclusions are put forward in the following section.

8 Conclusion and Recommendations

This report has provided an interim account of progress of the Early Intervention Pilot Projects from an organisational perspective. Although the client view is needed to give a more balanced opinion, some tentative conclusions about their overall success can be put forward here.

With respect to the aims of the project, it is clear that teams have established an antenatal and preschool intervention service that targets vulnerable clients, and so are providing a valuable, rapid and concentrated individualised service to at risk families. Appropriate referral pathways to and from the projects have been set up and are in operation, although greater GP involvement could be encouraged.

The teams are clearly promoting health development of parent and child, and supporting parents to meet the needs of their children. Greater exposure of interventions is needed to make evident the processes that contribute towards an outcome.

The extent to which teams have prevented referrals to Social Services is less easy to determine, and may become more apparent following the client evaluation. Anecdotal evidence from teams suggests that this is the case. What is clear is that vulnerable parents who re-refer themselves to the project (as seen in NEST) are demonstrating positive help-seeking behaviour that is preventive in nature. In addition, that the team is able to identify and deal with additional needs reveals a further important preventive aspect of service provision by reducing the multiple stresses that can precede Social Service referral. Given this, it could be argued that the projects are having an impact on this area, and additionally have a considerable cost-saving potential.

Although statistical information about the Deal site was not available, it is evident that the project is now gathering momentum with an increasing number of referrals. This site has however been handicapped by its relatively low numbers of vulnerable families, alongside environmental changes and group facilitation difficulties that have impeded team building.

Setting up a service of this nature is not a simple process, as evidenced by the volumes of literature that testify to the inherent difficulties of sustaining

multi-agency working (eg. Hudson 2002)[2]. Not only have the projects overcome testing problems, but have received recognition through a number of achievements including a practice award (see 6), and this is a significant testimony to their endeavours.

8.1 Recommendations

These recommendations have been developed in consultation with the teams and reflect project development so far. The intention is to put forward suggestions for improvement of existing sites, and aspects to consider for any future schemes.

- The structure of the project seems to be a fundamental component to its success; hence the continuation of small, compact multi-agency teams sharing the same accommodation will be an important ingredient to any future schemes.

- Projects of this nature would benefit from a distinct timescale to facilitate planning and evaluation, and clearer communication and guidance from senior management in the early stages.

- Multi-agency teams working within new ways of working need expert group facilitation from the onset, to address roles and responsibilities and reduce the potential for misunderstanding and tension.

- Teams should be allocated discrete funds to promote autonomy and control around project development.

- The projects would benefit from an improved technological infrastructure.

- If future projects are to be established, greater consideration needs to be taken when selecting the area to ensure that there are sufficient numbers of vulnerable families to sustain the project.

- The database needs to include the following headings:

    ◊ Time between allocation of client and first contact *(to measure the rapid response nature of the projects)*

    ◊ Number of contacts with client *(to measure degree of input to client)*

    ◊ Under 19's not needing service *(to record instances when the service is not required to this population group, differentiating*

[2] Hudson B. (2002) Interprofessionality in Health and Social Care: The Achilles' Heel of Partnership? *Journal of Interprofessional Care,* 16(1):8-17.

between those are not in need and those who refuse the service)

◊ A list of interventions *(to record process criteria that contribute towards the outcome)*

◊ Criteria that provide some measure of deprivation *(to ensure appropriate targeting).*

APPENDICES

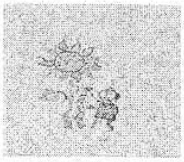
Fields for Database

1 Main carer name
2 Main carer first name
3 Joint carer surname
4 Joint carer first name
5 Antenatal - Expected date of delivery
6 Child's name
7 Child's date of birth
8 Gender of child
9 Post code
10 Main carer code – mother
– father
– foster parent
– other
11 Main carer date of birth
12 Joint carer date of birth
13 Ethnic group - White
Black Caribbean
Black African
Black - other
Indian
Pakistani
Bangladeshi
Chinese
Other ethnic group
14 Surgery – Newington
Cedars
Manor road
15 Self referral
Agency referral midwife
health visitor
nurse practitioner
GP
social services
Surestart
PALS
Homestart
playgroup/nursery
PIP
CAMHS
other
16 Referral reason child – unwanted pregnancy
17 Referral reason child – difficult pregnancy/labour
18 Referral reason child – separation at birth
19 Referral reason child – poor obstetric history

20 Referral reason child – mental health, special needs, developmental delay, failure to thrive
21 Referral reason child – behaviour eg sleeping, crying, feeding
22 Referral reason child – parent or carer/child interaction eg managing difficulties
23 Referral reason child – repeated attendances at A&E
24 Referral reason parent/carer – problems coping with child
25 Referral reason parent/carer – substance misuse
26 Referral reason parent/carer – ill health, physical or mental
27 Referral reason parent/carer – unsupported family
28 Referral reason parent/carer – one or both parents under 19 at birth of child
29 Referral reason parent/carer – reluctant to engage with services
30 Referral reason parent/carer – domestic abuse
31 Referral reason parent/carer – relationship difficulties
32 Referral reason parent/carer – low self-esteem
33 Referral reason environmental – financial difficulties
34 Referral reason environmental – housing problems, homeless
35 Referral reason environmental – isolation, cultural difficulties
36 Referral reason environmental – lack of basic amenities
37 Referral reason environmental – lack of safety/security
38 Outcome – referral goals met
39 Outcome – referral goals not met
40 Outcome – additional needs met
41 Outcome – problems resolved
42 Outcome – problems unchanged
43 Client terminated service
44 Client declined service
45 No visits made
46 Poor uptake of service
47 Plan renegotiated
48 Referral on to statutory agency
49 Referral on to non-statutory agency
50 Moved away
51 Number of weeks with service

NEWINGTON EARLY SUPPORT TEAM

REFERRAL FORM



Referred child:

Name:	DOB/EDD:	Gender M/F
	Ethnic Origin:	
Main Parent/carer:	D.O.B:	Relationship to Child:
Joint Parent/Carer:	D.O.B:	Relationship to Child:
Address:		
P/Code	Phone:	G.P.

Referrer:

Name:

Address:

Will your agency stay involved with referred person? YES/NO
In what way?

Reason for referral/Issues of concern:

Child

1. Unwanted pregnancy
2. Difficult pregnancy/labour
3. Premature birth
4. Poor perinatal history
5. Medical/health special needs, dev. delay, failure to thrive
6. Behaviour eg. feeding, crying, feeling
7. Parent or family social presentation eg. managing difficulties
8. Repeated attendances at A&E

Parent

1. Planned pregnancy with child
2. Substance misuse
3. Ill health, physical or mental
4. Unsupported family
5. Age of parents under 19 at birth of child
6. Reluctant to engage with services

Environment:

1. Financial Difficulties
2. Housing Problems, homeless
3. Isolation, cultural difficulties
4. Lack of basic amenities
5. Lack of safety/security

Desired outcome of referral:

Referrer's goals:

Parent/carer's goals (if known)

Services Used: Past – X Present – /

Social Services		Play & Learning Scheme		Primary Intervention Project		Playgroup/ Nursery	
Surestart		Child & Adult Mental Health Services		Homestart		Other	

Details:

Parent/carer:
I consent to N.E.S.T. working with my family
Signed

I agree to N.E.S.T. team members liasing and sharing information with other agencies as necessary. Signed

Referrers signature: Date:

Please return to:- N.E.S.T. Newington Road Surgery
100 Newington Road, Ramsgate,
KENT CT12 6EW

NEWINGTON EARLY SUPPORT TEAM
CLOSING REPORT

Name of referred person:	G.P.
Date of referral:	Date closed:
Outcome:	No. Weeks in Project:

1. Referral goals met
2. Referral goals not met
3. Additional needs met
4. Problems resolved
5. Problems unchanged
6. Client terminated service
7. Poor uptake of service
8. Plan renegotiated
9. Referral on to statutory agency
10. Referral on to non-statutory agency
11. Moved away

Any outstanding issues:

Closing Report:

Name of person completing closure summary.