**Referrals to the Bright Beginnings Pathway**

The Bright Beginnings pathway is part of the Evelina Health Visiting Service that provides rapid assessment and enhanced support to families who have complex health and social care needs in order to improve health outcomes for children and families. Referrals can be made any time between pregnancy and 2 years after birth. Children can be seen on this pathway until their 5th birthday as long as they continue to meet the necessary criteria.

All parents/ families that meet the pathway criteria will be triaged and allocated to an Early Intervention Health Visitor (EIHV). In addition to the five mandated Healthy Child Programme contacts, families on the pathway will receive more structured continuity of care, continuous assessment and individualised support through additional contacts at set points, as per the Bright Beginnings Contact Schedule.

Parents/carers/families can be referred to the service if they present one or more of the following risk criteria:

* Young parents aged 19 and under
* Significant mental health conditions (not issues of low mood alone)
* Domestic violence and abuse posing current risk or impact (including intimate partner violence, forced marriage, honour-based violence)
* Alcohol and substance misuse posing current risk or impact
* Parent with a learning disabilities or complex medical needs posing current risk or impact
* Parental history of safeguarding issues (Child Looked After, Child in Need or subject to a Child Protection Plan, gang affiliation, female genital mutilation, sexual exploitation, adverse childhood experiences) posing current risk or impact
* Concealed pregnancies posing current risk or impact

**New referrals onto the pathway will only be accepted if the child is under 2 years of age.** Referrals need to be made via email, using the attached referral form and can be made by any relevant professional/ agency, including:

* Perinatal Mental Health teams
* Children Social Care
* Maternity and Neonatal services
* Safeguarding Children teams/ MASH
* General Practitioners
* Liaison Health Visitor/ Specialist Health Visitors
* Universal Health Visiting teams

**Bright Beginnings Referral Form**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Details** | | | | | | | | |
| **First Name** | |  | | | | | | |
| **Family Name** | |  | | | | | | |
| **Date of Birth** | |  | | | | | | |
| **NHS Number** | |  | | | | | | |
| **Address** | |  | | | | | | |
| **Telephone/ mobile** | |  | | | | | | |
| **GP Name & Address** | |  | | | | | | |
| **Expected date of delivery** *(if applicable)* | |  | | | | | | |
| **Partner/ Significant Other Details** *(If applicable)* | | | | | | | | |
| **First Name** | |  | | | | | | |
| **Family Name** | |  | | | | | | |
| **Date of Birth** | |  | | | | | | |
| **NHS Number** | |  | | | | | | |
| **Address *(if not living with partner)*** | |  | | | | | | |
| **Telephone/ mobile** | |  | | | | | | |
| **Relationship with client** | |  | | | | | | |
| **Children’s Details** *(if applicable)* | | | | | | | | |
|  | **Name** | **DOB** | | | **NHS Number** | | | |
| **1.** |  |  | | |  | | | |
| **2.** |  |  | | |  | | | |
| **3.** |  |  | | |  | | | |
| **4.** |  |  | | |  | | | |
| **Other family members in household** | | | | | | | | |
|  | **Name** | | | **DOB** | | **Relationship to client** | | |
| **1.** |  | | |  | |  | | |
| **2.** |  | | |  | |  | | |
| **3.** |  | | |  | |  | | |
| **4.** |  | | |  | |  | | |
| **Reasons for Referral *(please include details of any initial assessments carried out):*** | | | | | | | | |
| Has a CAF/MARF been sent to Social Care? Yes □ No □ | | | | | | | | Date of referral: |
| Has the Safeguarding team been informed? Yes □ No □ | | | | | | | | Date of referral: |
| **Involvement of other agencies/ practitioners** | | | | | | | | |
| **Name** | | | **Agency/ Designation** | | | | **Contact details** | |
|  | | |  | | | |  | |
|  | | |  | | | |  | |
|  | | |  | | | |  | |

**Date of initial assessment:**

**Referral discussed with client: Yes □ No**

***Comments*** *(if applicable):*

**Eligibility Criteria for referral:**

|  |  |
| --- | --- |
|  | Please Tick MC900072629[1] |
| Young parents aged 19 and under |  |
| Significant mental health conditions (not issues of low mood alone) |  |
| Domestic violence and abuse posing current risk or impact (including intimate partner violence, forced marriage, honour-based violence) |  |
| Alcohol and substance misuse posing current risk or impact |  |
| Parent with a learning disabilities or complex medical needs posing current risk or impact |  |
| Parental history of safeguarding issues (Child Looked After, Child in Need or subject to a Child Protection Plan, gang affiliation, female genital mutilation, sexual exploitation, adverse childhood experiences) posing current risk or impact |  |
| Concealed pregnancies posing current risk or impact |  |

|  |  |
| --- | --- |
| **Has relevant information been sent to any other agencies/ practitioners:** | Please Tick MC900072629[1] |
| CAMHS |  |
| Safeguarding Children Team |  |
| GP |  |
| Health Visitor |  |
| Midwife |  |
| School Nurse |  |
| Social Worker/Children’s Social Care |  |
| Other professionals/ services (please specify): |  |

**Referrer Details**

**Name: Signature:**

**Designation: Telephone:**

**Email Address:**

**Please email your referral to*:*** [**gst-tr.earlyinterventionhealthvisitingservice@nhs.net**](mailto:gst-tr.earlyinterventionhealthvisitingservice@nhs.net)