Appendix 7 – Example pathway for infants requiring neonatal follow up

	ENHANCED	**TAILORED**	**UNIVERSAL**
	Consider for children born **<30weeks or 30-36+6 weeks with risk factors***	**Consider for children born** **30+0-33+6 weeks**	**All Children**
Birth through 2 years (corrected age)	Support at home should be provided by a neonatal liaison nurse or nurse with expertise in neonatal development with input from a neonatologist or paediatrician with relevant neonatal expertise. Consider providing support via: home visits, telephone helpline, text messaging service, leaflets or electronic communication. At discharge families should have a single point of contact within the neonatal service. Surveillance Face to Face Assessments Performed by the multidisciplinary team **A minimum of 2 in the first 12 months**. 1st visit between 3 and 5 months CGA 2nd visit by 12 months CGA.	Support tailored to the needs of the child and family should be delivered by a group of appropriately experienced professionals. This may include: neonatal liaison nurse or nurse with expertise in neonatal development, a neonatologist or paediatrician with relevant neonatal expertise, AHP, GP, or paediatric services. Consider providing support via: home visits, telephone helpline, text messaging service, leaflets or electronic communication. Robust links between Health Visitors and the neonatal team are essential. At discharge families should have a single point of contact within the neonatal service. Surveillance Face to Face Assessments Performed by appropriately trained professional (as above) at intervals and in a setting appropriate to the needs of the child.	Surveillance from the Child Health Programme Universal Health Visiting Pathway in Scotland - Pre-Birth to Pre-School The Scottish Child Health Programme: Guidance on the 27-30 month child health review

	Each assessment should include a discussion with parents about any concerns they have about their child's development; an assessment of the child's development including vision and hearing; a health assessment and measurement of weight, length and OFC. If developmental problems are found this should be discussed with the parents or carers and the child referred on to the appropriate local pathway. Results of each assessment should be communicated to the general practitioner, health visitor and any other professional involved in the child's care.	Continuous assessment of follow up needs is essential with additional input accessed as required. When discharged from hospital follow up, clinicians should provide families with information on 'red flags' in all main areas of development and encourage parents to seek advice if concerns.	
Age 2 (corrected age)	Face to face developmental assessment at 2 years CGA Provided by MDT to include as a minimum - Health and developmental assessment - Parent Report of Children's Abilities-Revised (PARCA-R) questionnaire (completed between 22 and 26 months CGA) - Ensure checks of vision and hearing have been carried out in line with national recommendations		

	A standardised developmental assessment (e.g Bayley, SGS, Griffiths) can be performed in addition to the above as per local policy. Record the outcome of the 2 year assessment for national audit. Communicate results with general practitioner, health visitor, neonatologist at hospital of discharge and any other professional involved in the child's care. Robust links between the Neonatal team and Health Visitors are essential.		
Age 2 to 4 years (Chronological Age)	Surveillance from the Child Health Programme (links as above)		
Age 4 years	**Children born < 28 weeks gestation**		
	<u>Face to Face Developmental assessment at 4 years</u> Provided by an educational or clinical psychologist or a paediatrician with expertise in neurodevelopmental assessment. Assessment should include; Parent questionnaire -Strengths and Difficulties Questionnaire (SDQ) or the Ages and Stages 48 month Questionnaire Standardised IQ test -Wechsler Preschool and Primary Scales of Intelligence 4th Edition (WPPSI) should be used (if the WPPSI is not suitable eg because of sensory or motor impairment use a suitable alternative) If cerebral palsy has been diagnosed, complete a GMFCS score.		

	A summary of the assessment, detailing the child's strengths, difficulties and any developmental problems identified should be discussed with the family. A management plan should be developed with the family. This information should be shared (with parental consent) with educational services, the neonatologist and any other professional involved in the child's care.
	** Risk factors include: a brain lesion on neuroimaging likely to be associated with developmental problems or disorders (for example, grade 3 or 4 intraventricular haemorrhage or cystic periventricular leukomalacia), grade 2 or 3 hypoxic ischaemic encephalopathy, neonatal bacterial meningitis, herpes simplex encephalitis, severe hypoglycaemia. Consider providing enhanced developmental support for children who do not have any of the above risk factors but who are thought, using clinical judgement, to be at risk, taking into account the presence and severity of risk factors.*