NHSScotland

Child Health Surveillance Programme
Pre-School

Clinical Guidelines

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PREFACE

Welcome to the 2009 revision of the Clinical Guidelines for Pre-School Child Health Surveillance in Scotland (CHSP P-S). These guidelines are specially designed for health professionals who use the CHSP P-S system.

Seventeen years have passed since the first pilot of a child health surveillance system for Scotland. Today, almost all Scottish NHS Boards are using CHSP P-S, along with CHSP -S and SIRS.

It is also eight years since the last edition of the Clinical Guidelines to accompany the system. The main reason for revising the user guidelines at this time is the introduction of the Child Health Programme described in the 4th Edition of Health for All Children\(^1\) - known forever by the catchword Hall\(^4\) – and more specifically, the guidance on implementing the Programme in Scotland. It isn’t just the frequency of surveillance reviews and the concentration on families with the greatest need that has changed. During the same time we have seen the expansion in newborn blood-spot screening, newborn hearing screening, changes in the way in which we control TB in children, a great expansion in the core immunisation programme, and the commitment to introduce orthoptic led vision screening in the pre-school year.

We are fortunate to have a universal child health information system in Scotland. A consequence is that we know much more about the health of our children and are able to compare different geographical areas with different demographic characteristics. This has enabled us to chart the progress of new threats to health – overweight and obesity in particular - and to monitor the impact of health campaigns – such as infant feeding. Our understanding of the impact of income inequality on children’s health has been particularly important and helped to shape the Scottish Government’s Early Years Framework. The creation of a new child health information team (CHIT) within ISD was, at least in part, due to the need to provide good quality analyses from all the data collected in the child health information systems. See the CHIT site at http://www.isdscotland.org/isd/182.html.

The child health information systems have never been more important. Massive efforts are being made in Scotland to implement Getting it Right for Every Child – a whole new approach to assessing, planning and intervening for children across agencies – particularly health, education and social work. The child health surveillance information is a key part of this process.

The Child Health Programme is constantly changing as new evidence comes forward and new working practices evolve. So, too, we intend that the CHSP P-S system will change to reflect the demands of those changes and modifications to the clinical guidelines will be issued as addenda and corrigenda.

I would like to thank all the members of the Pre-school system national user group for their continuing support, particularly those who made up the subgroup developing these guidelines. I am particularly indebted to Linda Kerr, manager of the child health systems in Lothian, who has chaired the guideline revision group. These changes would have been much harder to carry through without the faithful assistance of the development team at ATOS Origin Alliance and the support of the contract team in NHS National Services Scotland.

Charles Clark
Consultant in Public Health
Chairman, CHSP P-S National User Group
1. INTRODUCTION

The purpose of this manual is to outline the processes of the Child Health Surveillance Programme, Pre-School (CHSP) to reflect changes in examination and review forms, new clinical and coding practice and documentation. The changes are the result of the implementation of *Health for all Children 4: Guidance on Implementation in Scotland* in consultation with clinicians and practitioners. The national guidelines should promote consistency of practice throughout Scotland and therefore improve clinical care and data quality at both a local and national level.

The recommendations in Hall 4 reflect a move away from a predominantly medical model of screening for disorders, toward greater emphasis on health promotion, primary prevention and targeting effort on active intervention for children and families at risk.

1.1 The Child Health Surveillance Programme

The principles of surveillance are:
- to identify and treat both physical problems and developmental delay as early as possible;
- to minimise disability and impairment by early and effective intervention;
- to provide support and resources for children with identified conditions;
- to offer health information to promote physical and mental health and well being;
- to identify and support vulnerable children and their families.

<table>
<thead>
<tr>
<th>SURVEILLANCE CONTACTS</th>
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<tbody>
<tr>
<td>Birth Details*</td>
<td>28 days</td>
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<tr>
<td>Newborn Hearing Screening</td>
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<td>Public Health Nurse (PHN) First Visit Report</td>
<td>28 days</td>
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<td>6 – 8 Week Assessment</td>
<td>12 weeks</td>
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<td>2 Year Assessment</td>
<td>28 months</td>
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<td>Pre-school Orthoptist Vision Screening (POVS)**</td>
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<td>Recall Review</td>
<td>5.5 years</td>
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<td>Unscheduled Review</td>
<td>5.5 years</td>
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* Birth Details Forms are not used by all NHS Boards
** POVS is not yet fully implemented in all NHS Boards

NB:
Children born more than 28 days premature (with EDD recorded) will be scheduled for the 6-8 week assessment by gestational age

1.2 Information Systems

The Scottish Birth Record (SBR) is being rolled out in maternity units across Scotland.

The Pre-School Surveillance system is one of a family of interlinked satellite systems of the Community Health Index (CHI). These interlinked systems are:
- SIRS (Scottish Immunisation and Recall System);
- CHSP-S (Child Health Surveillance Programme - School);
- SNS (Support Needs System).
2. PROGRAMME OVERVIEW

Child Health / Screening Departments notified of birth. Child registered on systems (e.g. SBR, CHI, SIRS). CHI number created.

Birth Details Form is completed

Newborn Hearing assessment and form is completed

PHN 1st Visit Report is completed

Child seen at 6-8 week Assessment and form completed

Between 8 weeks and school entry a recall review can be requested at any time

At 22 months, 2 Year Check List is sent to PHN so that information can be updated

At 2 Years

Child on Core Programme
Mailer sent to parent/carer inviting them to contact PHN if they have any concerns

Child with Additional or Intensive needs
The PHN will receive a Letter, Assessment Form and Attendance Register for children with HPI A or I and assessed as per Hall 4

Child invited for pre-school Orthoptic Vision Screening and form completed

Prior to school entry, Check List sent to PHN so that information can be updated
3. **BIRTH DETAILS (A5 Yellow)**

The birth details form gathers information about the birth, neonatal examination and indicators for targeted immunisation. The form should be completed in the maternity unit and updated by the community midwife before postnatal discharge. The Birth Details form must be forwarded to the PHN who will return the computer copy with the PHN First Visit Report to the local administration base.

At this point of contact, the method of infant feeding should be based on the previous 24 hour period.

4. **NEWBORN HEARING SCREENING (A5 White)**

This form has been designed to be completed by an audiology screener. Once a result has been recorded on CHSP, the computer copy will be forwarded to the PHN. Some areas may use an alternative form for recording results. The most recently recorded result will be pre-printed on the 6-8 week assessment.

5. **PUBLIC HEALTH NURSE FIRST VISIT REPORT - PHNFVR - (A4 Yellow)**

This visit continues the assessment process and the responsibility of care is transferred from the midwife to the PHN. Completion of this form confirms the child’s details on CHSP and ensures that future reviews are generated.

All boxes should be completed but note the following points:
- Demographic information should be checked and updated as appropriate;
- Indicate Caseload PHN and Treatment Centre details;
- Schedule for immunisation; this is to schedule child for routine immunisations through SIRS, this is not consent;
- TB Risk Status is determined by the countries of birth of the parents/carers and grandparents. Where information is unavailable indicate ‘unknown’. Babies at risk will be offered BCG immunisation. Practitioners should adhere to local policy;
- Is the child exposed to passive smoking? The answer to this should be recorded as ‘Y’ if the child is cared for in an environment where adults are acknowledged smokers;
- Record concerns raised by carer. Do not use this section as a checklist of issues discussed;
- Method of infant feeding should be based on the previous 24 hour period;
- Diagnoses, social issues or other concerns to be recorded – see section 14;
- Health Plan Indicator (HPI) – see section 15;
- Support Needs System (SNS) – local policy determines how CHSP links with the national SNS;
- The summary comments are aides mémoire and are not recorded on the system;
- The PHN must sign and date the form.

6. **6-8 Week Assessment (A4 White)**

The 6-8 week examination is the only universal screening offered until the pre-school year. Thereafter screening is targeted depending on the child’s need. During screening it is important to distinguish between history and observation.

All boxes should be completed but note the following points:
- Demographic information should be checked and updated as appropriate;
- Children born more than 28 days premature (with EDD recorded) will be scheduled for the 6-8 week assessment by gestational age;
- This form will come with pre-printed information. Review and update if required;
- Method of infant feeding should be based on the previous 24 hour period;
- BCG - TB Risk Status is determined by the countries of birth of the parents/carers and grandparents; Babies at risk should be offered BCG immunisation. Adhere to local policy;
- Hep B immunisation – if indicated ensure the child completes the course;
- Record concerns raised by carer. Do not use this section as a checklist of issues discussed.
6.1 Development: To record your findings;

In the boxes for each field, enter one of the following:
- O – direct successful observation;
- H – history of carer's report;
- X – not achieved.

In the summary boxes, enter one of the following:
- N – normal;
- A – abnormal;
- D – doubtful or uncertain;
- I – not done/incomplete.

6.1.1 Gross motor skills – The neurological status of the baby is assessed with particular note taken of posture and evidence of asymmetry of movements or reflexes. Diminished muscle tone is evidenced by poor head control and would also be revealed when the baby is held in ventral suspension.

Supine the baby’s head should be mainly to one side, but not fixed, elbows flexed, hands loosely closed, hips partly flexed and externally rotated. The jerky movements of the limbs noted in one month old babies are becoming smoother and more continuous, and the baby may kick vigorously with legs alternating.

Prone at 6 weeks the head is turned to one side and by 8 weeks is intermittently in the mid-line with the baby's head raised off the couch, and the face at an angle of 45° to the couch. At 6 weeks the buttocks are high with the hips partly extended and by 8 weeks the buttocks are flat with hips mainly extended.

Primitive reflexes such as the grasp, placing, Moro and asymmetrical tonic neck reflex (ATNR) are likely to be present.

6.1.2 Hearing and communication - The baby will be startled by sudden noises. He/she may stiffen, quiver, blink, screw up his/her eyes, fan out fingers and toes, or cry. Loud noises still distress the baby at 3 months, by which time he/she may turn away.

Between 6-8 weeks the baby will quieten and smile, turning to the sound of the unseen carer’s voice, but not when crying.

By 8 weeks the baby will be ‘talking’ back when spoken to or pleased. Little guttural noises or cooing sounds are produced.

All areas offer universal newborn hearing screening. Note, this only screens for congenital sensori-neural hearing loss. Hearing difficulties may arise at any time later. If the carer suspects a hearing loss, immediate referral should be made to appropriate local services.

6.1.3 Vision and social awareness – The baby will regard the parent’s face directly, follow a dangling object past midline and demonstrate a social smile.

6.2 Physical Examination:

6.2.1 Length: Ideally, two examiners are needed but most parents are able to offer the required assistance. Babies should lie supine with the external angle of the eye in line vertically with the external auditory canal, knees flat, ankles gently pulled to stretch the child and feet aligned vertically. A measuring mat should be used.

6.2.2 Weight: The baby should be weighed naked on a modern, electronic, self-zeroing scale, properly maintained and placed on a firm surface.

6.2.3 Head Circumference: A re-usable plastic or fibreglass insertion lasso tape should be used, measuring the maximum circumference around the supraorbital ridges anteriorly, and that part of the occiput giving the largest
circumference posteriorly. The tape is pulled tight and measured to the nearest millimetre.

6.2.4 **Cardiovascular:** The examiner should enquire for symptoms suggestive of Congenital Heart Disease (CHD) for example sweating, tachypnoea (especially during feeding), feeding problems, failure to thrive and recurrent chest infections. The main screening test for CHD is the physical examination. The examiner should look for central cyanosis and tachypnoea and pay particular attention to palpation of the femoral pulses and the praecordium with auscultation for murmurs and the characteristics of the second heart sound.

6.2.5 **Hips:** All babies with risk factors (e.g. breech presentation, family history, abnormalities of the lower limbs, and torticollis) should have an ultrasound examination of the hips. Asymmetry of skin creases is looked for and simple hip abduction is carried out. The hips should be checked using the Ortolani and Barlow manoeuvres. Beyond three months of age the abduction test is used with the infant lying on his/her back with hips flexed to 90°. Both hips are abducted at the same time with any limitation noted in one or both hips (left being most common). Thighs normally abduct to 75° on both sides. Where there is doubt, refer to an appropriate specialist.

**Classical signs of dislocation:**
- an audible or palpable “clunk”;
- limitation of hip abduction;
- shortening of the leg on the affected side;
- asymmetrical skin creases over the thighs and/or buttocks.

6.2.6 **Genitalia:** Examination of the external genitalia of male and female children is an essential part of screening and any abnormalities should be recorded. The commonest problems in boys are incompletely descended or undescended testes. Testicular descent in boys should be recorded in the appropriate box. If there is doubt about testicular descent then the infant should be recalled and reviewed around the time of the first birthday. If full testicular descent cannot be confirmed refer to an appropriate specialist, following local pathways. Other abnormalities of male genitalia should be recorded (e.g. hypospadias, hydrocoele).

6.2.7 **Eyes:** The carer should be asked whether they think the child sees. Eyes are examined by checking for the red reflex. The ophthalmoscope is set at +3 and at a distance of 30cm from the child to look for a cataract seen as a silhouette against the red reflex. Look for nystagmus, squint, structural abnormalities and abnormal visual behaviour. The child should be able to fixate on an object 30cm away and follow through an arc of 45° from the midline. This is best observed using an object on a string (red is probably better than white) or the examiner’s head. Remember that movement should be slow. Any suspicion of poor vision requires urgent referral to an ophthalmologist. Referral criteria may vary.

If A (abnormal) is entered, a diagnosis/concern MUST be recorded, which will then be Read Coded at the administration base and pre-printed on subsequent forms.

The remainder of the boxes should be completed noting the following points:
- Diagnoses, social concerns or other issues to be recorded – see section 14;
- Recall section - to enable future reviews, indicate number of weeks until recall and reason for recall, which will then be pre-printed on recall review form;
- Health Plan Indicator – this should only be changed in discussion with the PHN - see section 15;
- Support Needs System (SNS) – local policy determines how CHSP links with the national SNS;
- Information Report - to request a printout of all surveillance and immunisation data for a child enter “Y”;
- The summary comments are aides mémoire and are not recorded on the system;
- All professionals involved in this assessment must sign and date the form.
7. **2 YEAR CHECK LIST (22 MONTH) - LIST OF CHILDREN ELIGIBLE FOR 2 YEAR CONTACT (A4 Blue)**

The checklist is to prompt practitioners to review all children and their families, identify their needs, update information and ensure appropriate planning for additional or intensive support. This information may be obtained from records, knowledge of family or information from other professionals/agencies. **A contact/visit is not required to complete the checklist.**

The top copy of the checklist must be returned to the administration base by the 21st of the month to enable the child to be scheduled appropriately at the age of two. The bottom copy should be filed in the child health record.

**Note the following points:**
- Demographic information should be checked and updated as appropriate;
- HPI should be updated – **see section 15**;
- Problem status should be updated and any new concerns recorded;
- Children on core programme with an identified need can be recalled. Indicate number of weeks and reason for recall, which will subsequently be printed on Recall Review form;
- The comments are aides mémoire and are not recorded on the system;
- Sign and date the form.

8. **2 YEAR CONTACT – CHILD ON CORE PROGRAMME (Mailer)**

Mailer sent directly to parent/carer by the administration base. The mailer includes the updated immunisation status and advises them of booster immunisation and orthoptic screening. It invites parent/carer to contact PHN if they have concerns about their child.

As PHN’s contact details are pre printed on the mailer, inform the administration base of any changes.

9. **2 YEAR ASSESSMENT – CHILD WITH ADDITIONAL or INTENSIVE SUPPORT NEEDS (A4 Blue)**

The PHN will receive an assessment form, attendance register and letter for children in need of additional or intensive support.

**Additional support** – The primary care team should assess and review the child’s progress usually in their home. A full developmental examination should be offered only if indicated by parental or professional concerns.

**Intensive support** - Where children have intensive support needs, chronic illness or disability, or are vulnerable because of other factors, the health professional should review available child health data and information from other agencies. Thereafter he or she should arrange a home visit with the parent and child for a discussion about the child’s progress and a full developmental examination. This should form the basis of discussion and action planning and should be recorded.

The PHN should ensure the letter is given to the parent/carer as this includes the updated immunisation status.

**All boxes should be completed but note the following points.**
- Demographic information should be checked and updated as appropriate;
- Record concerns raised by carer. Do not use this section as a checklist of issues discussed.
9.1 **Development**: To record your findings;

In the boxes for each field, enter one of the following:

- O – direct successful observation;
- H – history of carer’s report;
- X – not achieved.

In the **summary boxes**, enter one of the following:

- N – normal;
- A – abnormal;
- D – doubtful or uncertain;
- I – not done/incomplete.

For a child to perform an apparently simple task, such as building a tower with bricks, successful integrated functioning of several areas of development are involved. Children must first comprehend what is expected of them by understanding the language or other method of communication (e.g. demonstration) you have used in asking them to do the task. They must also have the attention span required to settle down to do the task. If a child does not have a particular skill then it is important to consider whether this relates to a specific developmental difficulty or is part of a wider general delay.

9.1.1 **Gross motor skills**: A two year old child can run safely on the whole foot, stopping and starting with ease and avoiding obstacles. The child walks upstairs and down holding on to a rail or the wall, usually two feet per step. In terms of ball skills, a two year old tends to walk into the ball when trying to kick it. An assessment of the child’s gait must be made.

9.1.2 **Fine motor or manipulative skills; vision**: The child should be able to build a tower of 5 or 6 bricks and imitate a circular scribble and/or a straight line. Pages in a picture book are turned singly.

9.1.3 **Communication skills; hearing**: Two or more words are put together to form simple phrases, and children are beginning to refer to themselves by name. Three to five pictures in a simple book can be identified by name. Children are able to vocalise their needs such as asking for food or drink, or indicating toilet needs. They may correctly identify several body parts on request. Non-verbal communication such as eye contact and gesture should be evident.

Although children are beginning to use simple speech and may have up to 20 or more recognisable words, they often have the habit of talking to themselves in long monologues as they play, much of which is incomprehensible to others.

9.1.4 **Social skills and behaviour**: Children can spoon feed and may indicate toilet needs. Toys are used meaningfully and symbolically.

9.1.5 **Physical examination**: No specific physical examination is required, but growth measurements should be taken where there are concerns. In those who can walk the child should stand barefoot with both feet together and heels, buttocks, shoulders and head in alignment. The external angle of the eye is lined up horizontally with the external auditory canal and with the examiner’s hands below the chin and mastoids. The child should be weighed on a modern, electronic, self-zeroing scale, properly maintained and placed on a firm surface. Head circumference is measured using a re-usable plastic or fibreglass insertion lasso tape, measuring the maximum circumference around the supraorbital ridges anteriorly, and that part of the occiput giving the largest circumference posteriorly. The tape is pulled tight and measured to the nearest millimetre.

If A (abnormal) is entered, a diagnosis/concern MUST be recorded, which will then be Read Coded at the administration base and pre-printed on subsequent forms.

The remainder of the boxes should be completed noting the following points:

- Recall section - To enable future reviews, indicate number of weeks and reason for recall, which will then be pre-printed on subsequent Recall Review forms;
10. PRE-SCHOOL ORTHOPTIC VISION SCREENING (A4 Yellow)

All children should have their vision screened by an Orthoptist between the ages of 4 and 5 years. There may be some local variation in practice.

11. RECALL REVIEW (A4 Green)

This form will be pre-printed by the system when a recall has been requested by a health professional at a previous examination. It should not be used for initial/ad hoc contacts.

Demographic information should be checked and updated as appropriate.

Face to face contact is not always necessary. The information can be updated by contact or review of case notes. Indicate the main method of review.

The reason for using the recall review form is to:
- record an assessment of current situation;
- prompt further contact / assessment;
- close an episode of care after review.

If the review is no longer required, the form should be returned to the administration base (e.g. child has moved)

Complete the sections relevant to the review taking account of the following:
- Record concerns raised by carer. Do not use this section as a checklist of issues discussed;
- Diagnoses, social concerns or other issues to be recorded – see section 14;
- Health Plan Indicator (HPI) – see section 15;
- Support Needs System (SNS) – local policy determines how CHSP links with the national SNS;
- Information Report - to request a printout of all surveillance and immunisation data for a child enter “Y”;
- The summary comments are aides mémoire and are not recorded on the system;
- Sign and date the form.

12. UNSCHEDULED CONTACT (A4 Purple)

This form should be used for initial/adhoc contacts and when a child is outwith the age range indicated on routine forms. These forms are held by health professionals and are never pre-printed. Only sections relevant to the age of the child should be completed.

Demographic information should be entered as appropriate. Indicate Caseload PHN and Treatment Centre details.

The reason for using the unscheduled contact form is to record:
- a transfer into caseload;
- a contact outwith the routine surveillance programme (e.g. recognition of additional problem/concern, the closure of an episode of care);
- a change of HPI outwith routine surveillance programme;
- a referral outwith routine surveillance programme.
Complete the sections relevant to the contact taking account of the following:

- TB Risk Status is determined by the countries of birth of the parents/carers and grandparents. Where information is unavailable indicate 'unknown'. Babies at risk will be offered BCG immunisation. Adhere to local policy;
- Record concerns raised by carer. Do not use this section as a checklist of issues discussed;
- Diagnoses, social concerns or other issues to be recorded – see section 14;
- Health Plan Indicator (HPI) – see section 15;
- Support Needs System (SNS) – local policy determines how CHSP links with the national SNS;
- Information Report - to request a printout of all surveillance and immunisation data for a child enter “Y”;
- The summary comments are aides mémoire and are not recorded on the system;
- Sign and date the form.

13. PRE-SCHOOL CHECK LIST - LIST OF CHILDREN ELIGIBLE FOR SCHOOL ENTRY (A4 Buff)

The checklist is to prompt practitioners to review all children and their families, identify their needs, update information and ensure appropriate planning for additional or intensive support. This information may be obtained from records, knowledge of family or information from other professionals/agencies. A contact/visit is not required to complete the checklist.

The top copy of the checklist must be returned to the administration base. The bottom copy should be filed in the child health record. (Local practice may vary).

Please note the following points:

- Demographic information should be checked and updated as appropriate;
- HPI should be updated – see section 15;
- Problem status should be updated and any new concerns recorded;
- Enter ‘Y’ in ‘Monitor in school’ box and ‘reason’ in order for a summary list to be produced (if requested);
- School may be pre-printed if information already recorded. Update as appropriate;
- If deferred entrant please indicate and recall to the PHN for contact prior to school entry;
- The comments are aides mémoire and are not recorded on the system;
- Sign and date the form.

14. RECORDING DIAGNOSES, SOCIAL ISSUES OR OTHER CONCERNS

Enter diagnoses, social issues or other concerns that are likely to be relevant to the continuing health and development of the child including congenital conditions in this section of the form.

Whenever an item has been recorded as “A – Abnormal” or the HPI is recorded as Additional or Intensive, a problem must be entered.

Print any problems giving a clear description. Do not use abbreviations (e.g. ASD, CHD).

14.1 Severity (Sev) and Laterality (Lat) codes enable a problem to be qualified. It is also possible to record an unconfirmed problem by using the ‘?’ in this field. Codes are on the reverse of the form.

14.2 Professional Code indicates the professional to whom the problem has been referred. When a problem is entered for the first time, a professional code must be entered. A problem can be entered more than once if several referrals are made. GPs and PHNs are regarded as professionals in this context. Codes are on the reverse of the form.

14.3 Problem Status must always be completed. Codes are on the reverse of the form.
14.4 **Read Codes** - have been developed for the purpose of recording clinical information in health information systems and are used in all the national child health systems. The structure of the coding system allows data to be analysed at various levels and has been adopted as a national standard within the NHS in Scotland.

Problems recorded on forms will be Read coded centrally by clinical coders. The Read code and text will be pre-printed on subsequent forms. There is standardised terminology associated with Read codes which may differ from the text entered by the practitioner. If the text appears inappropriate please contact the administration base prior to meeting with the parent.

To assist coding staff and ensure accuracy, it is essential that entries are both defined clearly and are legible. A ‘Standard List’ of frequently used Read Terms for pre-school and school aged children is available - see Section 18.

14.5 **Example of use of Read Codes**

Charlie was born at term. Development was normal in the early months. There were no social issues or concerns. Parents receive a routine mailer at 2 years and subsequently contact the PHN expressing concerns about his speech and language development and behaviour. PHN assesses Charlie and finds a significant delay in his language and communication skills and refers him to Speech and Language Therapy and Audiology. PHN completes an **Unscheduled Contact form** and allocates an HPI of ‘A’. Recall is requested to discuss behaviour management.

PLEASE PRINT CLEARLY  

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<th>Problem Status</th>
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</table>

Recall to Dr in [ ] wks Appt – enter S,M,L [ ] Reason for recall [ ]

Recall to PHN in [ ] wks Appt – enter S,M,L [ ] Reason for recall – Behaviour Management

Health Plan Indicator/Updated HPI A

20 weeks later review form issued with problems illustrated in bold pre-printed and Read codes evident

PHN reviews Charlie with his parents and advises on behaviour management and continues to offer ongoing support to family. Audiology report normal.

Speech and Language Therapist assesses and recommends referral to Community Paediatrician. Recall review is requested in 26 weeks.

PLEASE PRINT CLEARLY  

<table>
<thead>
<tr>
<th>Sev</th>
<th>Lat</th>
<th>Professional Code</th>
<th>Problem Status</th>
<th>Read Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2 2</td>
<td>R 0 3 4 A</td>
<td></td>
</tr>
<tr>
<td>(1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 6</td>
<td>R 0 3 4 A</td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0 4</td>
<td>1</td>
<td></td>
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<tr>
<td>(3)</td>
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<tr>
<td></td>
<td></td>
<td>0 4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>(5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6)</td>
<td></td>
<td></td>
<td>9 9</td>
<td>1</td>
</tr>
</tbody>
</table>
26 weeks later review form issued with problems illustrated in bold pre-printed and Read codes evident

PHN reviews information and learns that Charlie has been referred to the Community Autism Team, Educational Psychologist and Social Work and then meets with Charlie and his mother to review his health and wellbeing.

Mother reports that Charlie’s behaviour has become more challenging, impacting on family dynamics. Father has left and she is struggling to cope with Charlie and his older and younger siblings and states she is no longer able to care for Charlie. PHN contacts relevant agencies to co-ordinate and deliver intensive support to the family, including respite care. Recall review is requested in 26 weeks.

<table>
<thead>
<tr>
<th>PLEASE PRINT CLEARLY</th>
<th>Sev</th>
<th>Lat</th>
<th>Professional Code</th>
<th>Problem Status</th>
<th>Read Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Communication skills – Dev delay</td>
<td>2</td>
<td>2</td>
<td>2 2</td>
<td>3</td>
<td>R 0 3 4 A</td>
</tr>
<tr>
<td>(2) Behavioural problems</td>
<td>3</td>
<td>0</td>
<td>0 4</td>
<td>3</td>
<td>1 B 1 X .</td>
</tr>
<tr>
<td>(3) Communication skills – Dev delay</td>
<td>3</td>
<td>0</td>
<td>0 1</td>
<td>3</td>
<td>R 0 3 4 A</td>
</tr>
<tr>
<td>(4) Parental Support</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>8 0 8 0 .</td>
</tr>
<tr>
<td>(5) Family circumstances NOS</td>
<td>9</td>
<td>9</td>
<td>9 9</td>
<td>3</td>
<td>1 3 W 2 .</td>
</tr>
<tr>
<td>(6) Specialist team, behavioural difficulties</td>
<td>3</td>
<td>9</td>
<td>9 9</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

As there are now more than 6 concerns present, an unscheduled form has been used to add the new concerns. (Please split and staple individual copies together before distributing to recipients)

| (1) Autistic Spectrum disorder | 3   | 0   | 0 1              | 1              |           |
| (2) Autistic Spectrum disorder | 3   | 0   | 0 4              | 1              |           |
| (3) Autistic Spectrum disorder - Education | 2   | 8   | 2 8              | 1              |           |
| (4) Single Parent               | 0   | 0   | 0 4              | 1              |           |
| (5) Support for Extended Family  | 3   | 0   | 3 0              | 1              |           |
15. HEALTH PLAN INDICATOR - HPI

The NHS provides a universal service to all families with young children. Current policy recognises the need to target that service more effectively in order to ensure that those families with greatest need receive the greatest level of support.

Information gathered in the early months should provide the basis for establishing the nature and frequency of contacts, based on assessed need, co-ordinated by the public health nursing team and agreed with the family and where necessary with other agencies. This should assign the child to one of the models of contact and support described below.

### Universal Core Programme
- All families offered core screening and surveillance programme, immunisation, information, advice on services

### Needs Assessment

<table>
<thead>
<tr>
<th>Universal Core Programme - no additional input needed</th>
<th>Additional support from public health nurse as agreed with family</th>
<th>Intensive support required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact or appointments on request</td>
<td>Structured support (e.g. first time mother, breastfeeding problems, mental health problems)</td>
<td>Structured inter-agency support for individual families or communities (e.g. child on child protection register, looked after or disabled child, parental stresses)</td>
</tr>
</tbody>
</table>

Refer to local guidance on models of assessment and allocation of the Health Plan Indicator (HPI)

- **C** The core programme
- **A** The core programme + structured additional support
- **I** The core programme + intensive inter-agency support
- **U** Unknown

On subsequent contacts with the child or the family, the HPI can be updated if the child's needs have changed using the appropriate form.

The Health Plan indicator should reflect the needs of the child within the family and not the professional capacity to meet these needs. (i.e. where professional resources are limited).

All professionals involved with the pre-school child have a responsibility to share information with the PHN regarding the child or family but should not change the HPI. The PHN is responsible for the caseload and keeping the HPI up to date. If the PHN is not in attendance, the HPI must not be changed without discussion with the PHN.

An HPI of 'U', Unknown indicates that a needs assessment has not been completed i.e. new births or transfer-ins. A child should not be on an HPI of 'U' for any longer than 6 weeks (local guidance may vary).

It is mandatory that the current HPI is recorded in the Updated HPI box on every form and check list even when there is no change.

If HPI is 'A' or 'I', one or more diagnoses, social issues or other concerns must be indicated in the appropriate section of the form.
15.1 Example of use of HPI

Charlie was born at term. Development was normal in the early months. There were no social issues or concerns. **HPI of ‘C’ is allocated.**

His parents receive a routine mailer at 2 years and subsequently contact the PHN expressing concerns about his speech and language development and behaviour.

He is assessed by the PHN who finds a significant delay in his language and communication skills and refers him to Speech and Language Therapy and Audiology.

PHN completes a full assessment, recording her findings on the Unscheduled Contact form and requests a recall in 20 weeks to discuss behaviour management. **HPI of ‘A’ is allocated.**

20 weeks later PHN reviews Charlie and advises on behaviour management and continues to offer ongoing support to family.

She learns that the Audiology report is normal and the Speech and Language Therapist has assessed and recommended referral to Community Paediatrician.

PHN completes scheduled review form and requests a recall review in 26 weeks. **HPI remains ‘A’.**

26 weeks later PHN reviews information and learns that Charlie has been diagnosed with severe autistic spectrum disorder and has been referred to Community Autism Team, Educational Psychologist and Social Work.

Mother reports that Charlie’s behaviour has become more challenging, impacting on family dynamics. Father has left and mother is struggling to cope with Charlie and his older and younger siblings and states she is no longer able to care for Charlie. PHN contacts relevant agencies to co-ordinate and deliver intensive support to the family, including respite care.

PHN completes scheduled review form and requests a recall review in 26 weeks. **HPI of ‘I’ is allocated.**

PHN will continue to review Charlie regularly and update problems and HPI.
16. **STANDARD LIST – READ TERMS**

This is a list of frequently used terms which will be Read coded centrally. DO NOT try and fit a ‘diagnosis, social issue or concern’ to the listed terms. If it is not listed, please give a clear description of the ‘diagnosis, social issue or concern’ and an appropriate code will be found from those available. When referring to a family member please use Family History (FH) terms. The list will be updated centrally, please ensure you are using the latest version.

Abbreviations used:  FH – Family History;  H/O – History of;  NOS – Not otherwise specified;  [D] – Working diagnosis, Symptom;  [X] – External causes of morbidity and mortality

*Note: THIS IS NOT AN EXHAUSTIVE LIST USE OF * INDICATES THAT SYNONOMOUS TERM HAS BEEN REQUESTED

<table>
<thead>
<tr>
<th>Term</th>
<th>Abbreviation</th>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td></td>
<td>COLOUR VISION DEFICIENCY</td>
<td>HAS SUPPORT WORKER</td>
</tr>
<tr>
<td>ADVICE TO CARER REGARDING CHILD'S SLEEP</td>
<td></td>
<td>CONTRACEPTIVE ADVICE – EMERGENCY</td>
<td>H/O: DELIBERATE SELF HARM</td>
</tr>
<tr>
<td>ADVICE TO CARER RE CHILD'S TOILET TRAINING</td>
<td></td>
<td>CONTRACEPTIVE ADVICE – GENERAL</td>
<td>HISTORY OF DOMESTIC VIOLENCE</td>
</tr>
<tr>
<td>ALLERGIC REACTION</td>
<td></td>
<td>CONVULSIONS</td>
<td>HISTORY OF SEXUAL ABUSE</td>
</tr>
<tr>
<td>ANXIOUS</td>
<td></td>
<td>CYSTIC FIBROSIS</td>
<td>HOMELESS FAMILY</td>
</tr>
<tr>
<td>[D] APPETITE LOSS</td>
<td></td>
<td>DELAYED MILESTONES</td>
<td>IMMIGRANT</td>
</tr>
<tr>
<td>ASPERGER'S SYNDROME</td>
<td></td>
<td>DEPRESSED</td>
<td>INADEQUATE HOUSING</td>
</tr>
<tr>
<td>ASTHMA</td>
<td></td>
<td>DEPRESSED MOOD</td>
<td>INAPPROPRIATE DIET AND EATING HABITS</td>
</tr>
<tr>
<td>ASYLUM SEEKER</td>
<td></td>
<td>DEVELOPMENTAL CO-ORD DISORDER</td>
<td>INFANT FEEDING ADVICE</td>
</tr>
<tr>
<td>ATTENTION DEFICIT DISORDER</td>
<td></td>
<td>DYSMENORRHOEA</td>
<td>* INFANT FEEDING PROBLEM</td>
</tr>
<tr>
<td>AUTISTIC DISORDER</td>
<td></td>
<td>Eczema NOS</td>
<td>INTE ntional SELF HARM</td>
</tr>
<tr>
<td>BEHAVIOUR PROBLEMS AT SCHOOL</td>
<td></td>
<td>[X] EMOTIONAL BEHAVIOURAL PROBLEMS</td>
<td>LEARNING DIFFICULTIES</td>
</tr>
<tr>
<td>BEHAVIOURAL PROBLEM</td>
<td></td>
<td>EMOTIONAL PROBLEM</td>
<td>[X] LEARNING DISABILITY NOS</td>
</tr>
<tr>
<td>BIPOLAR AFFECTIVE DISORDER, UNSPECIFIED</td>
<td></td>
<td>ENGLISH AS A SECOND LANGUAGE</td>
<td>LIVES IN A CHILDRENS UNIT</td>
</tr>
<tr>
<td>BULLIED AT SCHOOL</td>
<td></td>
<td>ENURESIS</td>
<td>LOOKED AFTER CHILD – CHILDREN (SCOTLAND) ACT 1995</td>
</tr>
<tr>
<td>CARRIES ADRENALINE INJECTION PEN</td>
<td></td>
<td>ENURESIS – DAYTIME</td>
<td>MENORRHAGIA</td>
</tr>
<tr>
<td>* CHILD ATTENDS SPECIAL SCHOOL</td>
<td></td>
<td>ENURESIS – NOCTURNAL</td>
<td>MIGRAINE</td>
</tr>
<tr>
<td>CHILD FOR ADOPTION</td>
<td></td>
<td>EPILEPSY</td>
<td>MOOD AFFECTIVE DISORDERS</td>
</tr>
<tr>
<td>CHILD HEAD CIRCUMFERENCE CENTILE</td>
<td></td>
<td>FAMILY BEREAVEMENT</td>
<td>MOOD SWINGS</td>
</tr>
<tr>
<td>CHILD HEIGHT CENTILE</td>
<td></td>
<td>FAMILY HISTORY OF LEARNING DIFFICULTIES</td>
<td>NO ANTENATAL CARE</td>
</tr>
<tr>
<td>CHILD WEIGHT CENTILE</td>
<td></td>
<td>FAMILY MEMBER ON PROTECTION REGISTER</td>
<td>NUTRITION PROBLEM IN CHILD</td>
</tr>
<tr>
<td>CHILD IN FOSTER CARE</td>
<td></td>
<td>FEEDING PROBLEM IN CHILD</td>
<td>OBESITY</td>
</tr>
<tr>
<td>CHILD IS CAUSE FOR CONCERN</td>
<td></td>
<td>FEEDING PROBLEM IN NEWBORN</td>
<td>PALLIATIVE CARE</td>
</tr>
<tr>
<td>CHILD IS UNHAPPY AT HOME</td>
<td></td>
<td>* FH OF ALCOHOL ABUSE</td>
<td>PARENT HAS PHYSICAL DISABILITY</td>
</tr>
<tr>
<td>CHILD LIVES WITH ANOTHER RELATIVE</td>
<td></td>
<td>FH: DEPRESSION</td>
<td>PARENTAL CONCERN ABOUT CHILD</td>
</tr>
<tr>
<td>CHILD ON PROTECTION REGISTER</td>
<td></td>
<td>FH: SUBSTANCE MISUSE</td>
<td>PARENTAL SUPPORT</td>
</tr>
<tr>
<td>CHILD ON SUPERVISION ORDER</td>
<td></td>
<td>FOOD ALLERGY</td>
<td>PASSIVE SMOKING RISK</td>
</tr>
<tr>
<td>CIGARETTE SMOKER</td>
<td></td>
<td>GLOBAL DELAY</td>
<td>PATERNITY DISPUTE</td>
</tr>
</tbody>
</table>
17. SYSTEM OUTPUTS

There are two types of output: **Routine** and **Ad hoc**.

- **Routine outputs** are run at regular intervals by your local administration base for you.
- **Standard Ad Hoc outputs** are available on request from your local administration base.

Please note that all sample reports displayed below make use of ‘dummy’ data.

17.1 Routine Outputs

The following reports assist with the efficient running of the clinics and the follow-up of defaulters.

18.1.1 Attendance Register

This lists all children due to attend a specific clinic session. It will be sent to you in advance of the clinic date. It indicates the earliest and latest review date that the child should be seen. It should be completed as follows:

- **Circle C** - child attended for examination and the review form should be completed and returned to your admin base
- **Circle D** - child could not attend (reason given), will be re-invited providing child does not reach max age for review offered
- **Circle E** - child could not attend (no reason given), will be re-invited for one further appointment. If a three is circled on a second occasion, the ‘Missed Two Appointments’ report will be generated

The attendance register must be returned to your local admin base as soon as possible to ensure defaulters are rescheduled
17.1.2 Assessment / Review Forms

Sent to you with the Attendance Register in advance of the clinic date. These are coloured 3 part forms. Where applicable data may be pre-printed which has been recorded at previous reviews.

The computer copy should be returned promptly to your local admin base.

17.1.3 Missed Two Appointments Report

This is a list of children who have been invited twice and recorded as “defaulted - no reason given” (i.e. circled ⊗ twice). Child will not be re-invited unless you indicate in the comments column and return sheet to the local admin base.

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>CHI No</th>
<th>Sex</th>
<th>Address</th>
<th>TC No</th>
<th>Last Date Offered</th>
<th>Review Name</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cameron</td>
<td>12</td>
<td>F</td>
<td>12 Kirriemuir Rd Forfar Angus</td>
<td>1001</td>
<td>26/05/2008</td>
<td>Ophthalmic Vision</td>
<td></td>
</tr>
<tr>
<td>Fordham</td>
<td>27</td>
<td>M</td>
<td>27 HARD COURT ST DURRIDGE</td>
<td>1001</td>
<td>26/05/2008</td>
<td>Ophthalmic Vision</td>
<td></td>
</tr>
<tr>
<td>Green</td>
<td>10</td>
<td>M</td>
<td>1 HIGH ST DURRIDGE</td>
<td>1001</td>
<td>26/05/2008</td>
<td>Ophthalmic Vision</td>
<td></td>
</tr>
<tr>
<td>Smith</td>
<td>12</td>
<td>M</td>
<td>2 HIGH ST DURRIDGE</td>
<td>1001</td>
<td>26/05/2008</td>
<td>Ophthalmic Vision</td>
<td></td>
</tr>
<tr>
<td>Yates</td>
<td>03</td>
<td>M</td>
<td>2 HIGH ST DURRIDGE</td>
<td>1001</td>
<td>19/05/2008</td>
<td>Recall Review</td>
<td></td>
</tr>
</tbody>
</table>
17.1.4 Clinic Queue

This is a list of children due to be invited, but who cannot be given an appointment because the clinic session is full. This is sent with Attendance Registers and Review Forms. The system will prioritise the children on the clinic queue and schedule where possible. Particular attention should be paid to “the latest review” date - child will not be called for review after this date. If you wish to increase your clinic please contact your local admin base. The Clinic Queue is for your information only and does not have to be returned.

17.1.5 2 Year Checklist

This is sent to you two months in advance of child reaching 2 years old. All children in the age range are listed regardless of HPI. This is an opportunity to update known changes, demographics, HPI and problem status where appropriate. The list should be returned by the 21st of the month (the month printed, not month when child reaches two). Children who have an HPI of A or I will automatically be scheduled for a 2 Year Assessment.
17.1.6 2 Year Mailer

Children with HPI of core will receive a mailer which shows the child’s immunisation history and asks parents to contact their Public Health Nurse if they have any concerns.

Dear Parent/Carer,

As your child ZOE is now 2 years old, it is a good time to think about her health and development.

Our records show that ZOE has had the following immunisations:

<table>
<thead>
<tr>
<th>Immunisation</th>
<th>Date</th>
<th>Immunisation</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3RD Pneumo</td>
<td>27/11/07</td>
<td>MMR</td>
<td>27/11/07</td>
</tr>
<tr>
<td>Hib/Menc</td>
<td>20/09/07</td>
<td>2ND Pneumo</td>
<td>13/12/06</td>
</tr>
<tr>
<td>2ND MENC</td>
<td>13/12/06</td>
<td>3rd D TaP/PV/Hib</td>
<td>13/12/06</td>
</tr>
<tr>
<td>1ST MENC</td>
<td>09/11/06</td>
<td>2nd D TaP/PV/Hib</td>
<td>08/11/06</td>
</tr>
<tr>
<td>1ST Pneumo</td>
<td>03/10/06</td>
<td>1st D TaP/PV/Hib</td>
<td>03/10/06</td>
</tr>
</tbody>
</table>

If any of the above are incorrect or your child has had other immunisations that are not recorded here, please provide details to your Health Visitor.

Your child will not have any further routine examinations for her health or development. She will receive an appointment for pre-school immunisation and an eye test will be offered either in the pre-school year or in Primary 1.

Please keep this safe for future use, preferably in her Personal Child Health Record (Red book).

If you have anything you wish to discuss relating to your child or your family, please contact your Health Visitor at the address below.

Contract: MARY SMITH
Address: BLACKMOUNTT SURGERY 999 GREAT NORTH WAY EDINBURGH EH9 99XX
Tel. No: 0131 111 1111
17.1.7  2 Year Letter

The Public Health Nurse will receive a letter for children with an HPI of Additional or Intensive which shows the child's immunisation history which should be given to parents on contact. The letter has been designed with a blank box to allow the PHN to enter an update for the parent.

S. SMITH
3 ST MARTINS AVENUE
EDINBURGH
XX0989YY

Date of Birth / CHI No  99/99/99  9999

Dear Parent/Carer,

As your child STELLA is now 2 years old, it is a good time to think about her health and development.

Our records show that STELLA has had the following immunisations:

<table>
<thead>
<tr>
<th>Immunisation</th>
<th>Date</th>
<th>Immunisation</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>3RD Pneumo</td>
<td>27/11/07</td>
<td>MMR</td>
<td>27/11/07</td>
</tr>
<tr>
<td>Hb/Menc</td>
<td>13/09/07</td>
<td>2ND Pneumo</td>
<td>13/12/06</td>
</tr>
<tr>
<td>2ND MENC</td>
<td>13/12/06</td>
<td>3rd DTaP/IPV/Hib</td>
<td>13/12/06</td>
</tr>
<tr>
<td>1ST MENC</td>
<td>08/11/06</td>
<td>2nd DTaP/IPV/Hib</td>
<td>09/11/06</td>
</tr>
<tr>
<td>1ST Pneumo</td>
<td>03/10/06</td>
<td>1st DTaP/IPV/Hib</td>
<td>05/10/06</td>
</tr>
</tbody>
</table>

If any of the above are incorrect or your child has had other immunisations that are not recorded here, please provide details to your Health Visitor.

Contact:  MARY SMITH
Address:  SMITHFIELD SURGERY 11 NORT ROAD EDINBURGH EH0 0XX
Tel. No:  0131 999 9999
17.1.8 Attendance Register – Outstanding Pages

Please return Attendance Register page, if page is not available please complete the appropriate section on the list.

17.1.9 Examination Result – Overdue Report

This is a list of children for whom you indicated as having attended on the Attendance Register by circling ☑ but no Examination Form has been submitted. Check if computer copy has been filed in error, if not please supply a photocopy to your local admin base.
17.1.10 Information Report

This is a summary of a child’s surveillance and immunisation history, some of which may have been electronically transferred from other areas in Scotland. This can be requested by indicating a ‘Y’ on the appropriate box on the Review form.
17.2 Ad hoc Reports

Reports are available on request from your local administration base, e.g. a list of children with or without immunisation / surveillance details which can be produced in treatment centre or PHN order.

17.2.1 Check List (Ad Hoc)

The purpose of this check list is to:

- Review a caseload
- Inform workload and workforce planning
- Inform planning and development

The checklist enables practitioners to update information on individual children.

17.2.2 Statistical

Various statistical outputs are available:

1. HPI Analysis;
2. Breast Feeding;
3. Attendance rates;
4. Developmental results;
5. Analysis by Read Code.

These can be produced in treatment centre or PHN order and are available from your local administration base.

N.B. If you need any additional reports not listed here, please contact your local administration base, detailing specific requirements. Certain requests may need national approval.

17.2.3 General Forms

Other reports which ensure good housekeeping can be produced locally.

Please be aware when changing demographic details that this updates CHSP/SIRS and the Community Health Index (CHI) which is accessed /downloaded to many other systems.
### 18. BIBLIOGRAPHY - ADDITIONAL READING AND REFERENCES

<table>
<thead>
<tr>
<th>Title</th>
<th>Author</th>
<th>Published</th>
</tr>
</thead>
</table>