CHILD HEALTH SURVEILLANCE PROGRAMME
PRE-SCHOOL

CLINICAL GUIDELINES

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PREFACE

Welcome to the 2013 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.

Twenty 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 four 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 a universal 27 month review 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 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 and the support of the contract team in NHS National Services Scotland.

Zelda Mathewson
Consultant in Public Health
Chair, CHSP P-S National User Group
1. INTRODUCTION

The purpose of the Clinical Guidelines is to outline the processes of the Child Health Surveillance Programme - Pre-School (CHSP-PS) to reflect changes in examination and review forms, new clinical and coding practice and documentation. The changes are the result of the implementation of a “New Look at Hall 4” in consultation with clinicians and practitioners with reference to The Scottish Child Health Programme Guidance on the 27-30 month child health review (Bibliography ref 3). 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.

1.1 The Child Health Surveillance Programme – Pre School

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>
<th>MAXIMUM AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth Details*</td>
<td>-</td>
</tr>
<tr>
<td>Newborn Hearing Screening</td>
<td>by day 28</td>
</tr>
<tr>
<td>Public Health Nurse (PHN) First Visit Report</td>
<td>as per statutory guidance</td>
</tr>
<tr>
<td>6 – 8 Week Assessment</td>
<td>12 weeks</td>
</tr>
<tr>
<td>27-30 month Review</td>
<td>32 months</td>
</tr>
<tr>
<td>Pre-school Orthoptist Vision Screening (POVS)</td>
<td>Primary 1</td>
</tr>
<tr>
<td>Recall Review</td>
<td>5½ years</td>
</tr>
<tr>
<td>Unscheduled Review</td>
<td>5½ years</td>
</tr>
</tbody>
</table>

*Birth Details Forms are not used by all NHS Boards

NB: Children born more than 21 days premature (with EDD recorded) will be scheduled for the 6-8 week assessment by gestational age.

1.2 Information Systems

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).

The Scottish Birth Record (SBR) is used by maternity units across Scotland.

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.
2. PROGRAMME OVERVIEW

- Child Health / Screening Departments notified of birth. Child registered on systems (e.g. SBR, CHI, SIRS). CHI number
- Birth Details Form is completed
- Newborn Hearing assessment and form is completed
- HV 1st Visit Report is completed
- Child seen at 6-8 week Assessment and form completed
- Child seen at 27-30 month Review and form completed
- Child invited for pre-school Orthoptic Vision Screening and form completed
- Prior to school entry, Check List sent to HV so that information can be updated
- Unscheduled (purple) Contact Forms may be used for initial or adhoc contacts
- Recall (green) Contact Forms may be used for recall reviews
3. ASSESSING CHILDREN’S NEEDS WITHIN CHILD HEALTH REVIEWS

Assessing children’s needs within the context of their family and wider environment is a fundamental part of child health reviews. The assessment process is ultimately aiming to provide a balanced view shared by the HV and parents of a child’s development, health, and wider wellbeing; the factors in their life that are likely to influence (positively or negatively) their future progress; and their need for additional support to attain good outcomes.

The Getting it right for every child (GIRFEC) approach provides a useful general framework for assessing children's needs, analysing the information obtained, and using it to plan how to address the needs that have been identified.

GIRFEC encourages practitioners to keep children's wellbeing, and what they can do to support and advance that, as their primary consideration at all times. The approach breaks down the concept of children’s wellbeing into eight indicators: safe, healthy, achieving, nurtured, active, respected, responsible, and included. Whenever practitioners come into contact with children, they are encouraged to consider the child's wellbeing and ask themselves five key questions, namely

- What is getting in the way of this child's or young person's wellbeing?
- Do I have all the information I need to help this child or young person?
- What can I do now to help this child or young person?
- What can my agency do to help this child or young person?
- What additional help, if any, may be needed from others?

Underpinning this general approach is the use of the national practice model (see below) to support more detailed assessment of children's circumstances when required, for example during child health reviews. The national practice model encourages practitioners to adopt a consistent approach to assessment and planning by:

- Initially considering a child's wellbeing holistically using the wellbeing indicators
- Gathering more detailed information about a child's intrinsic characteristics and their immediate and wider environment using the My World assessment triangle
- Analysing the information to establish the strengths and pressures in a child's life, using the resilience matrix.
- Using the information gathered as the basis for planning, implementing, and reviewing the actions necessary to secure and promote the child's wellbeing, again using the wellbeing indicators.
4. INFANT FEEDING

Information on infant feeding is currently collected at the following points of contact:

- **Birth Details:** Feeding at birth, on hospital discharge, on discharge from community midwife
- **HV First Visit:** Feeding at birth, on hospital discharge, on discharge from community midwife, at HV First Visit
- **6-8 Week Review:** Current at 6-8 week review

Date, if stopped breast milk is also collected at HV First Visit and 6-8 weeks review.
Response options: breast milk only, formula milk only, both
The method of infant feeding is based on the previous 24 hour period.

5. APPROACHES TO ASSESSING GROWTH WITHIN CHILD HEALTH REVIEWS

Assessing children's growth is an important part of all child health reviews. Weighing and measuring children, and correctly recording and interpreting the results, is not straightforward, but accuracy is important. Appropriate equipment and good technique are required. Comprehensive good practice guidance is provided on the A4 UK-WHO growth charts and associated training materials provided by the Royal College of Paediatrics and Child Health (http://www.rcpch.ac.uk/child-health/research-projects/uk-who-growth-charts/uk-who-growth-charts). Important points to note include that gestational correction is required for babies born preterm (<37 weeks gestation) and that supine length is measured for children aged less than 2 years whereas standing height is measured for children aged 2 years or over.

All weight, length/height, and head circumference measurements taken during child health reviews should be recorded in metric units (kg, cm) to one decimal place on the relevant CHSP-PS form and plotted on the appropriate UK-WHO growth chart.

BMI centile is the appropriate measure of child (un)healthy weight for children aged 2 years or over. BMI is not appropriate/valid for younger children. The BMI centile for children should be calculated for children aged two to four years during the course of a child health review using the conversion chart provided on the A4 UK-WHO growth charts.

Weighing and measuring of children is part of wider promotion of good nutrition, adequate physical activity, and child healthy weight. Weighing and measuring should clearly link to subsequent action, for example enhanced HV support or helping families to access further assessment or specialist interventions as appropriate.
6. APPROACHES TO ASSESSING DEVELOPMENT WITHIN CHILD HEALTH REVIEWS

Assessing children’s development is a core part of all child health reviews. Staff undertaking reviews should have a good understanding of normal child development. Comprehensive information on healthy developmental trajectories/milestones is provided in Sheridan’s book *From Birth to Five Years*. The Personal Child Health Record (Red Book) also contains useful summary information on developmental milestones that most (at least 90%) children have reached by specified ages.

Assessing children’s development involves:

- A structured discussion with parents to assess the extent to which children are attaining expected milestones and to elicit any concerns that parents have about their child’s development
- Careful observation and/or examination of children to assess the presence of key skills
- Use of a relevant validated developmental assessment tool if required.

There is good evidence that in most instances, parental reporting of children’s developmental status, for example attainment of specific milestones, is highly accurate. If parents express significant concerns about an aspect of their child’s development, these should always be taken seriously and investigated appropriately. It is recognised that some parents will have difficulties in accurately reporting their children’s development, for example due to learning difficulties or mental illness.

There is a general trend towards greater reliance on parental reporting of children’s developmental status rather than practitioners always having to seek ‘proof’ through direct testing of children. Nevertheless, careful observation and/or examination of children during the course of child health reviews provides HVs with useful additional information on their developmental status. Direct examination, for example to assess muscle tone, response to being spoken to, and visual fixation, is likely to be appropriate for younger children, such as those attending a 6-8 week review. More ‘hands off’ observation, for example assessment of motor control by observing playing with small objects or of receptive and expressive language by observing interaction with carers whilst playing, is likely to be appropriate for older children, such as those attending a 27-30 month review.

If, after initial structured discussion and observation/examination, there are any uncertainties or concerns regarding a child’s developmental progress, a more in depth assessment should be undertaken using a relevant validated developmental assessment tool/questionnaire. A wide range of tools are available: details of those recommended for use in Scotland are provided in the national guidance on the 27 month review. The recommended tools vary in their purpose/scope: some support a general assessment of all developmental domains (ASQ3, SOGS II) whereas others focus on particular domains (e.g. ASQ SE, SDQ, SSLM) or the risk of particular conditions (e.g. M-CHAT). Other tools that support elicitation of parents’ views on their children’s development are also available (PEDS, PEDS:DM).

NHS Boards should ensure that their HVs have access to, and are trained in delivering, at least one all-domain tool and a reasonable range of more focused tools. Not all tools are relevant for children across the pre-school age range. Full details of age ranges are provided in the national guidance on the 27 month review, and the back of the 6-8 week and 27-30 month review forms list tools that are appropriate at those ages. It should be emphasised that use of validated tools should support rather than erode or replace HV professional decision making.

HV’s record the outcome of a child’s developmental assessment by recording no concerns; concern newly suspected; or concern/disorder previously identified for each developmental domain relevant to the age of the child. They are also asked to record which, if any, developmental assessment tools they have used to inform their judgement. The ‘issues list’ and ‘future action’ sections of the CHSP-PS forms also allow recording of more detail about the nature of any developmental concerns/conditions and what additional support children will be offered.

The 27 month form is most in line with this outline and the other forms will be amended in due course.
7. **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 HV who will return the computer copy with the HV First Visit Report to the local administration base.

At this point of contact, the method of infant feeding should be based on feeding up to 24 hours after birth.

8. **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 HV. 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.

9. **HEALTH VISITOR FIRST VISIT REPORT - HVFVR - (A4 Yellow)**

This visit is a universal assessment and the responsibility of care is transferred from the midwife to the HV. Completion of this form confirms the child's details on CHSP and ensures that future reviews are generated.

10. **6-8 WEEK ASSESSMENT (A4 White)**

The 6-8 week assessment is a universal screening contact. Children born more than 21 days premature (with EDD recorded) will be scheduled for the 6-8 week assessment by gestational age.

**10.1 Development:**

**10.1.1 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 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.

**10.1.2 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.
10.1.3 Vision and social awareness – The baby will regard the parent's face directly, follow a dangling object past midline and demonstrate a social smile.

10.2 Physical Examination:

10.2.1 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.

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

10.2.3 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.

10.2.4 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.

10.2.5 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.

10.2.6 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 relates to testicular position (incompletely descended or impalpable). Testicular position in all boys should be recorded in the appropriate box (on the form recording findings of the review). If scrotal position of either testicle is not confirmed at 6 weeks, further descent may occur post-natally until 6 months of age so boys should be recalled and reviewed at this stage. If complete testicular descent has not occurred by 6 months, refer to an appropriate specialist (following local pathways) as surgical correction (orchidopexy) may be indicated. Other abnormalities of male genitalia should also be recorded and managed appropriately (e.g. hypospadias, hydrocoele).

10.2.7 Eyes: The carer should be asked whether they think the baby sees. Eyes are examined by checking for the red reflex. The ophthalmoscope is set at +3 and at a distance of 30cm from the baby to look for a cataract seen as a silhouette against the red reflex. Look for nystagmus, squint, structural abnormalities and abnormal visual behaviour. The baby 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, in line with the Recording of Issues guidance – see section 15. This will then be Read Coded at the administration base and pre-printed on subsequent forms.
11. 27-30 MONTH REVIEW

The 27-30 Month review is a universal assessment.

11.1 Development outcome of assessment: To record your findings;

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

- N – no concerns
- C – concern newly suspected
- P – concern/disorder previously identified
- X – assessment incomplete.

If development is C or P an issue MUST be recorded, in line with the Recording of Issues guidance – see section 15. This will then be Read Coded at the administration base and pre-printed on subsequent forms.

Structured professional judgment supported by the informed use of validated assessment tools offers the best general approach to needs assessment. Tools will be agreed locally by NHS Boards.

11.2 Future Actions to be undertaken by HV following this review. If applicable, enter one of the following:

- P – provide
- S – signposted to
- D – discuss with
- R – request assistance from
- W – refused

11.3 Health Plan Indicator

If the updated HPI is recorded as ‘A’ there MUST be a diagnosis/concern or Issue recorded, in line with the Recording of Issues guidance – see section 15. This will then be Read Coded at the administration base and pre-printed on subsequent forms.

12. PRE-SCHOOL ORTHOPTIC VISION SCREENING (A4 Pink)

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. Optional for boards to use the pre school vision Recall form (A4 Grey).

13. 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
14. 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 HV 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

15. 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 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).

16. RECORDING DIAGNOSES, CONCERNS OR ISSUES

Recording of issues supports both direct clinical care and facilitates population health monitoring and service planning at local (e.g. NHS board) and national level.

List any issues likely to be relevant to the child’s ongoing health, development or well-being.

Remember

- if A (abnormal) is entered, a diagnosis/concern MUST be recorded
- if development is C or P an issue MUST be recorded
- if updated HPI is recorded as ‘A’ there MUST be a diagnosis/concern or Issue recorded.

All diagnoses/concerns or issues will be Read Coded at the administration base and pre-printed on subsequent forms.

Refer to the following guidance documents:

- Guidance - Recording of Issues on CHSP Pre-school and School

- Quick reference list for Health Visitors/School Nurses - (short list, only free text description)

- Read code lists (full list – contains free text description, read code, read code text and comments)

Note: both the quick reference list and the Read Code lists, contain the same problems/issues – the Read Code list is the full version.
17. HEALTH PLAN INDICATOR (HPI)

NHS provides a robust core universal service to all families with young children, and acknowledges that some families may require additional support.

HPI should be assigned anytime from antenatal period up to 6 months of age. If not assigned by 6-8 week assessment good practice would be to recall child in 16 weeks to enable the HPI to be assigned.

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.

<table>
<thead>
<tr>
<th>Universal Programme</th>
<th>Well-being Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>All families offered core screening and surveillance programme, immunisation, information, advice on services.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Programme</th>
<th>Additional Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving universal Health Visiting service. Contact or appointments on request.</td>
<td>An additional HPI indicates that the child requires sustained (&gt;3 months) additional input from professional services to help them attain their health or development potential. Any services may be required such as additional HV support, parenting support, enhanced early learning and childcare, specialist medical input, etc</td>
</tr>
</tbody>
</table>

Refer to local guidance on models of assessment and allocation of the Health Plan Indicator (HPI)
For national guidance see Bibliography ref 3.
- C The core programme
- A The core programme + structured additional programme.
- U Unknown (until HPI assigned)

On subsequent contacts with the child or the family the HPI can be updated, if the child’s needs have changed, by 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 HV regarding the child or family but should not change the HPI. As the named person the HV is responsible for the caseload and keeping the HPI up to date. If the HV is not in attendance, the HPI must not be changed without discussion with the HV.

An HPI of ‘U’, Unknown indicates that a needs assessment has not been completed i.e. new births or transfer-ins (refer to local guidance).

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 the updated HPI is recorded as ‘A’ there MUST be a diagnosis/concern or Issue recorded, in line with the Recording of Issues guidance – see section 15. This will then be Read Coded at the administration base and pre-printed on subsequent forms.

Assessment is informed by GIRFEC principles and underpinned by the national practice model.
18. CHILDSMILE

In 2011 Childsmile became part of the 6-8 week assessment requiring Health Visitors to record their decision to refer a child for Childsmile oral health support based on assessment of risk. This is the trigger for dental health support worker intervention and also acts as an information point which can be longitudinally linked and fed back at subsequent assessments.

The new 27-30 month review has three oral health fields, which may be pre-populated. These fields are dental registrations at 12 months, participation status in 12 months since first birthday and the value entered in the decision field at the 6-8 weeks assessment. In this manner data from previous information points and systems can be made available at a later stage to inform decision making. This continuous assessment and review allows for longitudinal assessment and the establishment of feedback loops over a number of years. It also means information collected previously and available at subsequent review, can be used to direct discussion with a parent or current and future risk.


19. APPOINTMENT SCHEDULING

There are different scheduling options available to appoint children in discussion with your local administration base.

20. 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 all sample reports contain test data.

20.1 Routine Outputs

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

20.1.1 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 A - child attended for examination and the review form should be completed and returned to your admin base
- Circle C - 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

20.1.2 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.
20.1.3 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 È twice). Child will not be re-invited unless you indicate in the comments column and return sheet to the local admin base.

20.1.4 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. When new queue received disregard the previous queue.

20.1.5 Attendance Register – Outstanding Pages

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

20.1.6 Examination Result – Overdue Report

This is a list of children for whom you indicated as having attended on the Attendance Register by circling Â 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.

20.1.7 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 from your local administration base.

20.2 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 HV order.

20.2.1 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.

20.2.2 Other reports (Ad Hoc)

To maintain data quality other reports can be produced locally.

20.2.3 Statistical

Various statistical outputs are available on request from your local admin base for example:

1. HPI Analysis;
2. Breast Feeding;
3. Attendance rates;
## 21. BIBLIOGRAPHY - ADDITIONAL READING AND REFERENCES

<table>
<thead>
<tr>
<th>Title</th>
<th>Author</th>
<th>Published</th>
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22. DOCUMENTATION REVIEW AND UPDATE

We would welcome any comments, please send to: NSS.NISGServiceManagement@nhs.net

All comments will be discussed by the CHSP-PS Clinical Development Group and the CHSP-PS National Users Group and this document will be reviewed every 6 months and updated as required.

The Child Health Programme, all CHSP-PS PS Assessment and Review forms and relevant documentation and guidance is available on the ISD Scotland website.

FIELD DEFINITIONS ON CHSP FORMS

1. ALL FORMS
   - Forms come with pre-printed information, please review and update if required
   - All boxes should be completed
   - Demographic information should be checked and updated as appropriate
   - Caseload HV and Treatment Centre details should be checked and updated as appropriate
   - Record concerns raised by carer. Do not use this section as a checklist of issues discussed
   - Diagnoses, social issues or other concerns to be recorded – see section 15
   - 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 (NB not applicable to HVFVR)
   - Health Plan Indicator (HPI) – see section 16
   - 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
   - All professionals involved in the review must sign, print name and date the form
   - HV numbers determined locally

Remember
   - if A (abnormal) is entered, a diagnosis/concern MUST be recorded
   - if development is C or P an issue MUST be recorded
   - if updated HPI is recorded as ‘A’ there MUST be a diagnosis/concern or Issue recorded.

2. HV FIRST VISIT REPORT
   - Ensure EDD is completed as this is used to calculate gestational age
   - Indicate Caseload HV 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
   - Method of infant feeding should be based on the previous 24 hour period
   - The HV must sign, print name and date the form

3. 6-8 WEEK ASSESSMENT
   - Method of infant feeding should be based on the previous 24 hour period
   - Childsmile - enter Y to indicate a referral has been made. See local pathway.
   - All professionals involved in this assessment must sign, print name and date the form

4. 27-30 MONTH REVIEW
   - Current LAC Status – refers to whether the child is a Looked After Child at the time the review is carried out
   - TB Risk Status - if not already identified insert information required. Where information is unavailable indicate ‘unknown’. Children at risk should be offered BCG immunisation, Practitioners should adhere to local policy
   - Issues status should be updated and any new concerns recorded – see section 15
   - After discussion with parents sharing of the findings of 27-30 month review with early education and childcare should be viewed as routine and recorded as Y. Active refusal should be recorded as N. Where no discussion has taken place this should be recorded as X
   - Sign, print name and date the form

5. RECALL REVIEW
   - Complete the sections relevant to the review
   - Information Report - to request a printout of all surveillance and immunisation data for a child enter “Y”
   - Sign, print name and date the form.
6. UNSCHEDULED CONTACT
   - Complete the sections relevant to the contact
   - 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
   - Information Report - to request a printout of all surveillance and immunisation data for a child enter "Y"
   - Sign, print name and date the form.

7. PRE-SCHOOL CHECK LIST – LIST OF CHILDREN ELIGIBLE FOR SCHOOL ENTRY
   - Enter ‘Y’ in ‘Monitor in school’ box and ‘reason’ in order for a summary list to be produced (if requested) for the School Nurse
   - School may be pre-printed if information already recorded. Update as appropriate
   - If deferred entrant please indicate and recall to the HV for contact prior to school entry
   - Sign, print name and date the form

Current LAC Status – Looked After Children are defined in law (Children (Scotland) Act 1995) as those in the care of their local authority. Looked After Children can either remain in their family home (under the supervision of the local authority) or be placed in an alternative residential setting (for example with approved kinship carers, foster carers, prospective adopters, or in residential care homes).
   The codes available for current LAC Status are:
   0  No, not currently looked after by local authority
   1  Yes, looked after at home
   2  Yes, looked after with friends/relatives (placed with friends/relatives who are not approved foster carers)
   3  Yes, looked after with foster carers (placed with approved foster carers provided by or purchased by the local authority)
   4  Yes, looked after with prospective adopters
   5  Yes, looked after in other community placement (eg supported accommodation, hospital)
   6  Yes, looked after in residential care (any form of residential care eg local authority or voluntary children’s home or crisis care refuge)

Code 0 should be used if the child is not a Looked After Child at the time their review is carried out.
   The appropriate code (1-6) should be used if the child is Looked After at the time of their review