CHILD HEALTH SURVEILLANCE PROGRAMME PRE-SCHOOL

CLINICAL GUIDELINES

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Version History

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5	27/04/2018	Draft Issued to Surveillance National User Group	Rachael Wood, Ashley Goodfellow, Linda Kerr
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5.2	21/05/2018	Updated with comments from NHS Dumfries & Galloway, Lanarkshire and Lothian. Final version approved for publication.	Rachael Wood, Ashley Goodfellow
5.3	26/06/2018	Updated Childsmile response options.	Rachael Wood, Ashley Goodfellow

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1 Preface

Welcome to the 2018 revision of the Scottish Child Health Surveillance Programme Pre-School (CHSP-PS) Clinical Guidelines. These guidelines aim to support those who use the CHSP-PS system and undertake child health reviews, by providing information on CHSP-PS systems and processes, undertaking assessments and completion of child health review forms. This includes: health visitors, family nurses, GPs, paediatricians, public health specialists and child health administration staff.

The CHSP-PS is provided to all children in Scotland. It aims to ensure children have the best start in life through provision of health promotion and parenting support, early identification of physical and developmental problems, delivery of early and effective interventions and provision of support to children and families who need it most.

The CHSP-PS supports *Getting it Right for Every Child* – a holistic approach to assessing, planning and intervening for children across agencies – particularly health, education and social work. The data collected and reported from CHSP-PS allows for individual clinical assessment and recording, as well as population monitoring of child health and wellbeing. We are able to compare data from different geographical areas with different demographic characteristics and identify and respond to areas which require more focused intervention for improvement, for example, low breastfeeding rates or exposure to second hand smoke. National Services Scotland (NSS) Information Services Division is a key partner in the analysis and interpretation of this important health information.

Child health surveillance has undergone some significant change in recent times, particularly with the introduction of the Children and Young People (Scotland) Act 2014 and the revised universal health visiting pathway. This has included increased contact with children and families in the early years and the introduction of additional child health reviews at 13-15 months, 27-30 months and 4-5 years. In addition, the CHI and Child Health Transformation Programme will modernise our technology and ways of working to ensure child health surveillance is as efficient and effective as possible, and delivers good outcomes for children and their families. These developments provide real opportunities to improve the quality of the data which is collected and made available for use, in terms of its accuracy, timeliness and completeness.

We hope that you find these Clinical Guidelines of use and as always we welcome feedback on any aspect of the programme. We would like to thank all members of the Child Health Surveillance National User Group (NUG) and its subgroups for their continuing support and passion, particularly those who have been instrumental in the production of these guidelines.

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2 Introduction

2a The Child Health Programme and the national child health information systems

The Child Health Programme is the universal health promotion programme provided by NHS Scotland to all children and their families. The programme aims to enable each child to attain their highest possible standard of health, development and wellbeing by delivering health promotion services and detecting physical, developmental and/or social risks or problems at an early stage and facilitating effective intervention.

The Child Health Programme includes various elements such as formal screening for specific medical problems, screening of health and development, routine childhood immunisations, a structured programme of needs assessment, health promotion, and parenting support provided through regular child health reviews. Scottish Government policy on the Child Health Programme is found in the following documents:

- A New Look at Hall 4 – the Early Years – Good Health for Every Child
- The Scottish Child Health Programme: Guidance on the 27-30 month child health review
- Universal Health Visiting Pathway in Scotland - Pre Birth to Pre School

The Scottish Government's overarching approach to development of all children's services is reflected in the Getting It Right for Every Child (GIRFEC) programme. Elements of the GIRFEC approach have been embedded in statute through the Children and Young People (Scotland) Act 2014. The Act requires a shared understanding of child wellbeing, and single planning processes to meet the needs of children with significant wellbeing concerns. NHS Boards are responsible for delivery of the Child Health Programme. In the majority of cases, this will be the health visitor for pre-school children. If families are enrolled in the Family Nurse Partnership programme, the family nurse will deliver the Child Health Programme to children from birth to 2 years of age. Please note, the term health visitor is used throughout this document but can be interchanged with family nurse as appropriate.
The regular contact that Health Visitors have with preschool children through the universally offered child health reviews and the wider Health Visiting pathway contacts is essential to fulfilment of their role.

The CHSP-PS national information system supports delivery of child health reviews and some screening contacts for pre-school children. The system works by facilitating the invitation of children for reviews/contacts as they reach the appropriate age and recording and reporting the outcomes of reviews/contacts.

These clinical guidelines provide information on the CHSP-PS system. They are designed to support health professionals delivering reviews/contacts to pre-school children provide consistent care and collect consistent high quality information on children's health according to **nationally agreed definitions**. The CHSP-PS guidelines are produced and kept up to date by the system's National User Group.

Please send any comments on these guidelines to nss.childhealth@nhs.net.

2b CHSP-PS information flows

Generally speaking, when a child is due for a child health review, the CHSP-PS system sends an invitation to the family and sends the appropriate review form (in triplicate or duplicate) to the relevant health professional (e.g. Health Visitor). In some instances the health visiting team will arrange the appointment locally with the family. The different scheduling options are available in section 5. During the child's review, the health professional completes the form which then provides a summary record of their discussion with the family as well as findings and actions required. One copy of the completed form is given to the child's parent/carer, one is retained by the health professional in the child's clinical notes (if triplicate form used), and one is returned to the local child health department where the information contained is keyed into the system by administrative staff. Any issues listed on the form are also Read coded at this stage. This allows any problems to be followed up and further reviews scheduled if necessary.

As well as forming part of a child's clinical record, information entered into the CHSP-PS system is made available to the NHS Scotland Information Services Division (ISD) for statistical analysis purposes. A range of ISD child health publications based on CHSP-PS data can be found here. Detailed information on the CHSP-PS system and copies of all CHSP-PS forms are also available on the ISD website here.

The CHSP-PS system is linked to three other national child health information systems supporting provision of childhood immunisations (the Scottish Immunisation & Recall System (SIRS)), care for school aged children (Child Health Surveillance Programme – School (CHSP-S)), and complex care for children with disabilities (Support Needs System). All four of the linked child health information systems are satellite systems of the Community Health Index system (CHI), NHS Scotland's master patient index. **Users should be aware that changing a child's demographic details on CHSP-PS therefore changes their details on all the child health systems and the CHI, which is accessed by many other systems.**

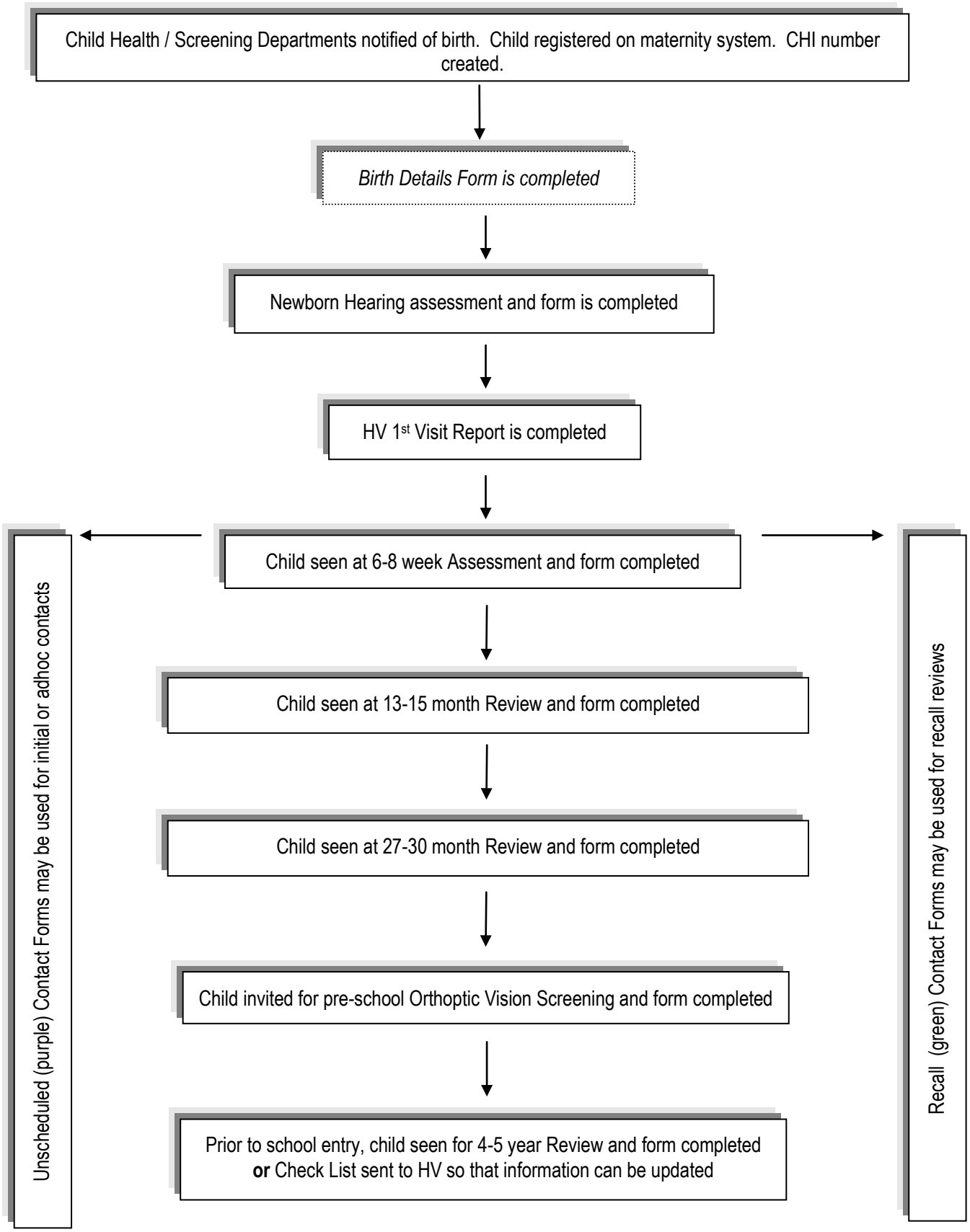
2c Reviews/contacts supported by the CHSP-PS system

The reviews/contacts supported by the CHSP-PS system are as follows:

REVIEW/CONTACT	RECOMMENDED AGE RANGE FOR DELIVERY OF REVIEW	GESTATIONAL CORRECTION REQUIRED*	MAXIMUM AGE AT WHICH THE CHSP-PS SYSTEM CAN SCHEDULE REVIEW	COMMENTS
Birth Details	Not a scheduled review			Birth Details forms are used by a minority of Boards to transfer information from maternity to child health services
Newborn Hearing Screening	Not a scheduled review			Newborn hearing screening should be completed by 4 weeks after a child's due date
Health Visitor (HV) First Visit Report	11-14 days	No	None specified	By 14 days is preferable to allow for scheduling of subsequent reviews, however a first visit should always be undertaken even if child is >14 days old.
6 – 8 week Assessment	6-8 weeks	Yes	12 weeks	
13-15 month Review	13-15 months	Yes	18 months	
27-30 month Review	27-30 months	No	32 months	
4-5 year Review	After 4th birthday and prior to starting school	No	5½ years	
Pre-school Orthoptist Vision Screening (POVS)	After 4th birthday and prior to starting school	No	5½ years	
Recall Review	Any prior to starting school	n/a	5½ years	
Unscheduled Contact	Any prior to starting school	n/a	5½ years	

* In general, gestational correction is required when scheduling reviews for children aged up to 24 months. This means that children born prematurely (at <37 completed weeks gestation) are scheduled for the specified review by their due date rather than their actual date of birth (e.g. at 6-8 weeks past their due date for a 6-8 week assessment).

The programme of reviews/contacts is shown diagrammatically below:



3 Common themes across Child Health Reviews

3a Assessing children's wellbeing and needs within Child Health Reviews

Assessing children's wellbeing and 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 Health Visitor (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.

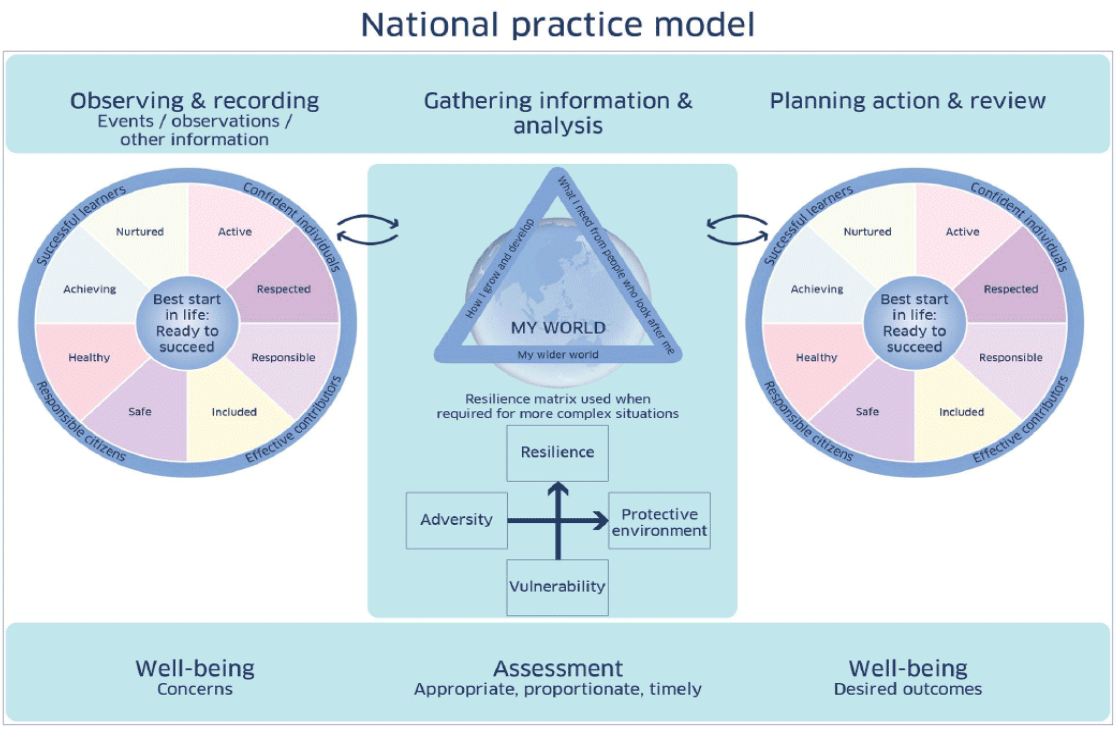
The *Getting it right for every child* (GIRFEC) approach provides a framework for assessing children's wellbeing and needs, analysing the information obtained, and using it to plan how to address any issues that have been identified.

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 'SHANARRI' indicators: safe, healthy, achieving, nurtured, active, respected, responsible, and included. Whenever practitioners come into contact with children, they should 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 gathered to establish the strengths and pressures in a child's life, using the resilience matrix.
- Using all this as the basis for planning, implementing, and reviewing the actions necessary to secure and promote the child's wellbeing, again using the wellbeing indicators.



3b The Health Plan Indicator

The Child Health Programme is a universal service offered to all children. It is acknowledged however that some children (and/or their families) may require additional support to enable the child to attain their highest possible standard of health, development and wellbeing. Health Visitors are asked to identify children requiring additional support using the Health Plan Indicator (HPI) variable.

An updated HPI is requested after every child health review. An HPI can initially be assigned anytime from the antenatal period up to the child reaching 6 months of age, reflecting the fact that for some children it takes time for the HV to get a comprehensive picture of need. An 'unknown' HPI should be assigned in these cases until assessment is complete. An 'unknown' HPI can also be assigned to children transferring in to a HVs care until assessment is complete.

Aside from 'unknown', the available HPI categories are 'core' and 'additional'. An additional HPI has been defined as follows:

An additional HPI indicates that the child (and/or their carer) requires sustained (>3 months) additional input from professional services to help the child 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.

HV pathway, p5

On subsequent contacts with the child or the family the HPI can be updated, if the child's needs have changed. Note that the HPI should reflect the needs of the child within the family and not the professional capacity to meet those needs (i.e. where professional resources are limited).

All professionals involved with the pre-school child have a responsibility to share information with the Health Visitor regarding the child or family but should not change the HPI. The Health Visitor is responsible for his/her caseload and keeping the HPI up to date. It is mandatory that the current HPI is recorded in the Updated HPI box on every form and check list once a review has been completed, even when the HPI is unchanged. If the updated HPI is recorded as 'Additional' there **must be an associated issue recorded** – see section on recording of issues below.

3c Infant feeding

Breast milk is the best source of nutrition for babies and promotion of breastfeeding is an important component of CHSP-PS. Information on infant feeding is routinely recorded at the Health Visitor First Visit (FV), 6-8 week and 13-15 month reviews (and on the birth details form if used) and this provides valuable data for monitoring breastfeeding rates at local and national level.

Current international (World Health Organisation) and UK (Scientific Advisory Committee on Nutrition and NICE) advice on infant feeding states the following:

- Breast milk is the best form of nutrition for infants
- Exclusive breastfeeding is recommended for around the first six months (26 weeks) of an infant's life.
- Infant formula is the only recommended alternative to breastfeeding for babies who are under 12 months old
- Babies should only drink first milks (whey based formula milk) until they are 12 months old
- Around six months is the recommended age for the introduction of solid foods for infants, whether breast or formula fed
- Breastfeeding (and/or formula feeding) should continue beyond the first six months, along with appropriate types and amounts of solid foods. The WHO recommends continued breastfeeding along with appropriate complementary foods up to two years of age or beyond whereas NICE recommends that, following the introduction of solids at around six months, breastfeeding continues for as long as the mother and baby wish
- Mothers who are unable to, or choose not to, follow these recommendations should be supported to optimise their infants' nutrition

The WHO defines exclusive breastfeeding as an infant having received only breast milk consistently from birth; and no other liquids or solids (even water) apart from required medicines (including vitamins). Once an infant receives any other liquids or complementary solid food, even temporarily, they can no longer be considered exclusively breastfed. The CHSP-PS system collects information on whether children were ever breastfed, whether they have always been exclusively breastfed up to the date of the review, and the 'current' mode of feeding (in the 24 hours prior to the review). Codes and definitions used for recording can be found in the Appendix.

3d Assessing growth

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. 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 healthy weight for children aged 2 years or over. BMI is not appropriate/valid for younger children. If required, the BMI centile can 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. Children identified as outwith a healthy weight range should have a Future Action identified, for example, enhanced HV support, helping families to access further assessment or specialist child healthy weight intervention as appropriate.

3e Assessing child development

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 questionnaire/tool if required. The Universal Health Visiting Pathway in Scotland, published in 2015, recommends that the Ages and Stages Questionnaire (ASQ-3) should be used for **all** children undergoing 13-15 month, 27-30 month, and 4-5 year universal child health reviews.

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 may 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 provide HVs and GPs 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.

3f Ages and Stages Questionnaire (ASQ-3)

As noted above, the Universal Health Visiting Pathway in Scotland recommends that the Ages and Stages Questionnaire (ASQ-3) should be used for **all** children undergoing 13-15 month, 27-30 month, and 4-5 year universal child health reviews. This provides additional evidence to inform HVs' overall judgement of children's developmental progress. Use of the ASQ-3 may be supplemented by use of the Ages and Stages Questionnaire: Social & Emotional (ASQ:SE-2), or other more specialist tools such as the Modified Checklist for Autism in Toddlers (M-CHAT), as necessary.

A wide range of developmental assessment questionnaires are available: details of those recommended for use in Scotland are provided in the national guidance on the 27 month review and in the Universal Health Visiting Pathway. The recommended questionnaires/tools vary in their purpose/scope: some support a general assessment of all developmental domains (e.g. ASQ-3) whereas others focus on particular domains (e.g. ASQ:SE-2, 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 (e.g. PEDS). Not all tools are relevant for children across the pre-school age range. It should be emphasised that use of validated tools should support rather than erode or replace HV professional judgement and decision making.

The Scottish Government letter issued to NHS Boards in October 2015 stated:

"As part of the Health Visiting Pathway **we are recommending that health visitors use a consistent tool to assess a child's development namely "Ages and Stages Questionnaire" (ASQ 3).** ASQ 3 is the mandated tool within the Family Nurse Partnership programme. If, in their professional judgement, health visitors require to use additional assessment tools other examples are provided in the pathway document."

At the end of a child health review, HVs use the relevant CHSP-PS review form to record their overall assessment of a child's development by recording No concerns (N); Concern newly suspected (C); or Concern/disorder previously identified (P) for each developmental domain relevant to the age of the child. Following 13-15 month, 27-30 month, and 4-5 year reviews HVs are also asked to record the ASQ-3 score obtained for each developmental domain. Finally, HVs are also asked to record which, if any, additional developmental assessment tools they have used as part of the review.

If Concern newly suspected; or Concern/disorder previously identified, is recorded against any developmental domain, there MUST be an associated issue recorded – see section on recording of issues below. In addition, the 'future action' section of the CHSP-PS forms allows recording of more detail about the additional support children will be offered to support their ongoing development.

Extensive information about the Ages and Stages Questionnaires is available on the ASQ website. Multiple versions of the ASQ-3 and ASQ:SE-2, suitable for children of specific ages, are available. It is important that the correct version appropriate for the age of the child is used in all child health reviews. The company that provides the ASQ recommends that gestational correction (i.e. using the child's age past their due date rather than their actual date of birth) should be applied when determining the correct version to use for children who were born preterm (i.e. at <37 completed weeks gestation) up until two years past their date of birth. This is slightly at odds with NICE guidance on assessing the development of children born preterm, which recommends that gestational correction should be applied up until two years past a child's due date. Either way, gestational correction will be required when determining the correct version of the ASQ to use for ex-preterm children attending their 13-15 month review. Note that ex-preterm children should be called for their 6-8 week and 13-15 month reviews based on gestationally corrected, rather than chronological, age.

Versions of the ASQ-3 and ASQ:SE-2 that are available, and the age ranges that they are suitable for are shown in the table below.

Child's age *Use gestationally corrected age for children born preterm until 2 years past their date of birth*	**Use this version of the ASQ-3**	**Use this version of the ASQ:SE-2**
1 month 0 days *through* 2 months 30 days	2 month	2 month
3 months 0 days *through* 4 months 30 days	4 month	6 month
5 months 0 days *through* 6 months 30 days	6 month	6 month
7 months 0 days *through* 8 months 30 days	8 month	6 month
9 months 0 days *through* 9 months 30 days	9 or 10 month	12 month
10 months 0 days *through* 10 months 30 days	10 month	12 month
11 months 0 days *through* 12 months 30 days	12 month	12 month
13 months 0 days *through* 14 months 30 days	14 month	12 month
15 months 0 days *through* 16 months 30 days	16 month	18 month
17 months 0 days *through* 18 months 30 days	18 month	18 month
19 months 0 days *through* 20 months 30 days	20 month	18 month
21 months 0 days *through* 22 months 30 days	22 month	24 month
23 months 0 days *through* 25 months 15 days	24 month	24 month
25 months 16 days *through* 26 months 30 days	27 month	24 month
27 months 0 days *through* 28 months 15 days	27 month	30 month
28 months 16 days *through* 31 months 15 days	30 month	30 month
31 months 16 days *through* 32 months 30 days	33 month	30 month
33 months 0 days *through* 34 months 15 days	33 month	36 month
34 months 16 days *through* 38 months 30 days	36 month	36 month
39 months 0 days *through* 41 months 30 days	42 month	36 month
42 months 0 days *through* 44 months 30 days	42 month	48 month
45 months 0 days *through* 50 months 30 days	48 month	48 month
51 months 0 days *through* 53 months 30 days	54 month	48 month
54 months 0 days *through* 56 months 30 days	54 month	60 month
57 months 0 days *through* 66 months 0 days	60 month	60 month
66 months 1 day *through* 72 months 0 days	N/A	60 month

The table above is available on the ASQ website, alongside a wide range of other free resources. An online calculator is also provided which identifies the correct version of the ASQ-3 and ASQ:SE-2 to use in any specific review based on a child's date of birth, date of review, and the number of weeks premature the child was at delivery.

In terms of scoring the ASQ-3, the following should be borne in mind. Each age specific version of the ASQ-3 contains a total of 30 questions enquiring about the child's ability to perform specific developmental activities, 6 for each of 5 developmental domains (communication; gross motor; fine motor; problem solving; and personal-social). Parents (with HV help if required) score each question as yes (i.e. the child can perform the relevant activity, 10 points); sometimes (5 points); or not yet (0 points). The total score for each domain is summed and plotted on the grid provided within the questionnaire's information summary sheet. The grid then indicates whether the child's score for that domain is above the cut off; close to the cut off (between 1 and 2 standard deviations below the mean for a child of that age, suggests a need for additional support and monitoring); or below the cut off (2 or more standard deviations below the mean, suggests a need for more in depth assessment).

Note that when summing the scores for any particular domain, two issues should be considered. Firstly, sometimes parents may score a child as not regularly doing an activity because they have progressed to a higher developmental level, and hence no longer display the lower level activity (eg they score the child as 'sometimes' walking holding on to furniture as the child can now walk unaided). In such cases it is legitimate for the HV, in discussion with the parents, to amend the score to yes/10 points.

Secondly, sometimes parents will omit an answer for one or more questions. If one or two answers are omitted for any one developmental domain, HVs should compute an imputed/estimated total score for that domain as follows. An average score for the questions in that domain that have been answered should be calculated by dividing the incomplete total score by the number of questions answered (4 or 5). This score should then be added to the incomplete total score (once if 5 questions were answered or twice if 4 questions were answered) to give an estimated total score for that domain. The estimated total score is then plotted on the information summary sheet as usual. If three or more questions are omitted for any developmental domain, no total score should be calculated or plotted for that domain.

Finally, in addition to the 30 questions about specific developmental activities, each ASQ-3 also asks parents a series of more open ended questions about any concerns they have about their child's development, e.g. their hearing, vision, communication, movement, behaviour. The responses to these questions should always be reviewed with parents and any concerns addressed, even if the domain specific scores are within the 'above the cut off' range.

Note that perfect correlation between ASQ scores and HVs' recording of development concerns is not to be expected. It may be legitimate for HVs to record a developmental concern despite 'above cut off' ASQ scores and vice versa.

3g Future Actions

The CHSP-PS child health review forms allow Future Actions to be recorded where a specific need has been identified which requires additional input from a health or other professional. Please see Appendix for codes and definitions to be used when recording future actions.

3h Childsmile

In 2011 Childsmile became part of the 6-8 week child health review. At that review, HVs are asked to consider whether a child should be referred for Childsmile oral health support based on assessment of risk. HVs record their referral decision in the Future Actions section of the form. Codes and definitions for recording Future Actions can be found in the Appendix. Please note, only codes R (request assistance from) and W (refused) should be used for future action related to Childsmile. The Childsmile future action recorded at 6-8 weeks or any subsequent review is printed for the HVs information on subsequent review forms.

In addition, linked data from other national health systems is also printed onto the 13-15 month, 27-30 month and 4-5 year review forms to show whether

- The child was known to be registered with a dentist
- The child is known to have attended a dentist over the 12 months prior to the review

The information provided is designed to support discussions between Health Visitors and parents about children's dental health. Further information on the Childsmile programme is available in the Childsmile manual.

3i Recording issues likely to be relevant to the child's ongoing health, development or wellbeing

All CHSP-PS child health review forms allow the recording of issues likely to be relevant to the child's ongoing health, development or wellbeing. Accurate recording of such issues supports both direct clinical care and facilitates population health monitoring and service planning at local and national level.

Issues are recorded by the health professional conducting the child health review in free text on the CHSP-PS form. When the form is keyed into the CHSP-PS database by child health department administrative staff, appropriate Read codes rather than the free text are entered. These Read codes (and their associated Read name/description) are then pre-printed on subsequent forms provided for the same child.

The following documents provide additional guidance on recording of issues:

- Recording of Issues on CHSP Pre-school and School: Guidance
- Recording of Issues on CHSP Pre-school & School: list of common issues and associated Read codes
- Recording of Issues on CHSP Pre-school & School: Health Visitor/School Nurse quick reference list
- Recording of Issues on CHSP Pre-School & School: Admin quick reference list

All of these documents are available through the ISD CHSP-PS web pages.

Validation rules that operate when information from a child health review is being keyed into CHSP-PS mean that a corresponding issue **must** be recorded in the following circumstances:

- When A (additional) is entered as the updated Health Plan Indicator (see above)
- When A (abnormal) is entered against any physical examination variable
- When C (concern newly suspected) or P (concern/disorder previously identified) is entered against any developmental domain (see above)

4 Specific points about individual reviews

Following all reviews, the relevant CHSP-PS form should be completed fully and accurately then promptly returned to the local child health department for timely data entry into the CHSP-PS system. A range of validation processes are built into the system to ensure accurate data entry. It is therefore important that review forms are completed as accurately and completely as possible or child health administrators will be unable to fully input review data into the national system and forms may be returned to the relevant health professional for follow up. Some variables on the forms are marked with an asterisk (*). These denote variables that, where possible, are pre-printed onto forms generated for specific children/reviews. For example, information on parental and grandparental country of birth (and hence TB risk/requirement for BCG vaccination) that is captured at the HV First Visit is pre-printed onto relevant subsequent forms generated for that child to avoid the need for repeated data collection. Further information on all the variables included on each form, including codes/response options and definitions, is provided in the Appendix.

4a 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. On this form, the method of infant feeding 'at birth' should be based on feeding up to 24 hours after birth.

4b Newborn hearing screening (A5 White)

This form has been designed to be completed by a Newborn Hearing Screener. Once a result has been recorded on CHSP-PS, 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.

4c Health Visitor First Visit report (A4 Yellow)

This visit is a universal assessment and marks the point at which responsibility of care is transferred from the midwife to the HV. Completion of this form confirms the child's details on CHSP-PS and ensures that future review invitations are generated.

4d 6-8 week assessment (A4 White)

The 6-8 week assessment is a universal screening contact. Children born prematurely (at <37 completed weeks gestation) are scheduled for their 6-8 week assessment 6-8 weeks after their EDD, not their actual date of birth. The 6-8 week assessment is undertaken jointly by the child's HV and GP.

Developmental assessment at 6-8 weeks usually involves direct examination of the baby, taking account of the following.

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 (lying face up) 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 (lying face down) 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.

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 hearing loss is suspected at any point, immediate referral should be made to appropriate local services.

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

Growth assessment is also undertaken as part of the 6-8 week assessment. Guidance on measuring the growth of infants during the 6-8 week review is as follows.

Length: Ideally, two examiners are needed but most parents are able to offer the required assistance. Babies should lie supine (face up) 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.

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

Head Circumference: A 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.

Physical examination is undertaken as part of the 6-8 week assessment. This provides a safety net following the newborn physical examination and a second opportunity to detect important congenital anomalies.

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.

Hips: All babies with risk factors for Developmental Dysplasia of the Hip (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 of babies aged <3 months should also 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.

Genitalia: Examination of the external genitalia of male and female children is an essential part of the physical examination 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 postnatally 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).

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.

The health professional conducting the physical examination (often the GP) is asked to record on the CHSP-PS form whether each aspect of the examination was normal (N), abnormal (A), doubtful or uncertain (D), or not done/incomplete (I). If abnormal is recorded against any aspect of the examination, there **must be an associated issue recorded** – see section on recording of issues above.

4e 13-15 month review (A4 grey)

The 13-15 month review is a universal assessment. The purpose of the review is as follows:

- Review *Getting it Right for Every Child* (GIRFEC) assessment and identification of child/family health/mental health and wellbeing needs and update Health Plan Indicator if required.
- Assessment should include: quality of parent – child relationship and mental health of the principal carer.
- Engage and share public health information and guidance to promote positive attachment and health and wellbeing.
- Undertake developmental and wellbeing review and CHSP-PS review.
- Advise on local services for children and families.
- Review immunisation status and prompt attendance where required.
- Routine enquiry about family finances/money worries and raise awareness of the advice available and offer families a direct referral to advice services.
- Agree future plan of care.

4f 27-30 month review (A4 Blue)

The 27-30 month review is a universal assessment. The purpose of the review is as follows:

- Review *Getting it Right for Every Child* (GIRFEC) assessment and identification of child/family health/mental health and wellbeing needs and update Health Plan Indicator if required.
- Assessment should include: quality of parent – child relationship and mental health of the principal carer.
- Engage and share public health information and guidance to promote positive attachment and health and wellbeing.
- Undertake developmental and wellbeing review and CHSP-PS review.
- Advise on local services for children and families.
- Review immunisation status and prompt attendance where required.
- Routine enquiry about family finances/money worries and raise awareness of the advice available and offer families a direct referral to advice services.
- Agree future plan of care.

4g 4-5 year review (A4 peach)

The 4-5 year review is a universal assessment. The purpose of the review is as follows:

- Undertake pre-school review and CHSP-PS review.
- Update Getting it Right for Every Child (GIRFEC) assessment and Health Plan Indicator.
- Engage and share public health information and guidance to promote positive attachment and health and wellbeing.
- Routine enquiry about family finances/money worries and raise awareness of the advice available and offer families a direct referral to advice services.
- Arrange discussion/meeting with School Nurse for children with a Health Plan Indicator of additional.
- Arrangements for transition to Education.

4h 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. Note it is optional for boards to use the pre-school vision Recall Form (A4 Grey).
The Pre School Orthoptic Visions Screening (POVS) Guidelines and Pathway are available from the ISD website.

4i 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. Main method of review should be indicated.

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.

4j Unscheduled contact (A4 Purple)

The unscheduled review form should be used for initial and adhoc contacts only. For example:

- a transfer into caseload
- a contact out with the routine surveillance programme (e.g. recognition of additional problem/concern, the closure of an episode of care)
- a change of HPI out with routine surveillance programme
- a referral out with routine surveillance programme

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 Health Visitor and Treatment Centre details.

The appropriate review form for routine surveillance contacts should be used, even when a child is out with the age range indicated on the form. For example, a 13-15 month review being undertaken when a child is older than 15 months should be recorded on a 13-15 month review form. This ensures that information from the review is included in reports for that specific review. However, it should be noted that all reviews should be completed within the recommended age parameters for the review, where possible, to ensure children are assessed in a timely way at the appropriate stage of development.

4k 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).

The checklist will cease when your Board implements the 4-5 year review.

5. Appointment scheduling

There are different scheduling options available to appoint children in discussion with your local administration base. The appointment method selected will be for all reviews scheduled to that HV/clinic, unfortunately the system does not allow a different appointment method to be selected for individual review types.

- Appointment Method 1 – timed appointments generated by CHSP, for specific date(s)/time
  eg Monday 1st October 2018 at 2.15pm
  Appointment letter posted direct from the print centre to parent/carer (two weeks in advance of appt). CHSP paperwork sent to HV/Clinic two weeks in advance of appointment. A clinic queue will be generated and sent to HV/Clinic if children are due to be scheduled but cannot be allocated an appointment as there are no appointment slots available.

- Appointment Method 2 – timed appointments generated by CHSP, for specific date(s), between specified times (for drop in clinics)
  eg Monday 1st October 2018 between 2pm and 4pm
  Appointment letter posted direct from the print centre to parent/carer (two weeks in advance of appt). CHSP paperwork sent to HV/Clinic two weeks in advance of appointment. A clinic queue will be generated and sent to HV/Clinic if children are due to be scheduled but cannot be allocated an appointment as there are no appointment slots available.

- Appointment Method 3 & 4 (no longer used)

- Appointment Method 5 – children are scheduled by CHSP, when review is due.
  Parent/carers are asked to telephone the clinic to make an appointment
  eg telephone the above number now, to arrange an appointment for week starting: 1/10/18
  Letter posted direct from the print centre to parent/carer (two weeks in advance of when review is due). CHSP paperwork sent to HV/Clinic two weeks in advance).

- Appointment Method 6 – children are scheduled by CHSP, when review is due. HV/Clinic organises own appointments. Appointment letters are sent to HV/Clinic who complete appointment details and post to parent/carer. CHSP paperwork and appointment letters sent to HV/Clinic two weeks in advance

- Appointment Method 7 – same as Appointment Method 6, except no appointment letter is generated by CHSP - HV/Clinic can use their own or telephone.

Note the you cannot select a different appointment method for different reviews, the same method must apply to all reviews.

6. 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.

6a Routine outputs

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

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 ① - child attended for review, form should be completed and returned to your admin base
- Circle ② - child could not attend (reason given), will be re-invited providing child does not reach max age for review offered
- Circle ③ - 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 and any missed two appointments are followed-up.

Assessment / Review Forms
This is sent with the Attendance Register in advance of the clinic date. These are coloured multi-part forms. Where applicable, data may be pre-printed where this has been recorded at previous reviews. The completed computer copy should be returned promptly to your local admin base.

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 ③ in attendance register twice). Child will not be re-invited unless you indicate in the comments column and return this sheet to the local admin base.

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 a new Clinic Queue list is received, the previous list should be disregarded.

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

Examination Result – Overdue Report
This is a list of children whom you indicated as having attended on the Attendance Register by circling ① but no Review Form has been submitted. Check if computer copy has been filed in error, if not please supply a photocopy to your local admin base.

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.

6b Standard ad hoc outputs

Standard ad hoc outputs/reports are available on request from your local administration base, e.g. a list of children allocated to HV caseload.

Other reports (Ad Hoc)
To maintain data quality other reports can be produced locally.

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

- HPI analysis
- Infant Feeding rates
- Attendance rates

7 Additional reading

Title	Author	Published
A New Look at Hall 4. The Early Years, Good Health for Every Child	Scottish Government	Scottish Government (Jan 2011) ISBN 978-0-7559-942-2 http://www.scotland.gov.uk/Resource/Doc/337318/0110676.pdf
The Scottish Child Health Programme: Guidance on the 27-30 month child health review	Scottish Government	Scottish Government (Dec 2012) ISBN 978-1-78256-268-9 http://www.scotland.gov.uk/Resource/0041/00410922.pdf
Universal Health Visiting Pathway in Scotland: pre-birth to pre-school	Scottish Government	Scottish Government (Oct 2015) ISBS *978-1-78544*-770-9 http://www.sehd.scot.nhs.uk/mels/CEL2013_13.pdf
Community Paediatrics (3rd Edition)	Leon Polnay	Churchill Livingstone (2002) ISBN 978-0-443-06348-0
Mary Sheridan From Birth To Five Years – Children's Developmental Progress (4th Edition)	Edited by A Sharma and H Cockerill	Routledge (Jan 2014) ISBN 978-0-415-83354-7

Appendix: Definition, response options, and validation rules for all variables recorded on CHSP-PS forms

The following table includes all variables contained within the universal child health review forms (Health Visitor First Visit, Newborn Hearing Screening; 6-8 Week Assessment, 13-15 Month Review, 27-30 Month Review, 4-5 Year Review and Pre-school Orthoptic Vision Screening) plus the birth details, recall review and unscheduled contact forms. Health Visitors are asked to ensure that all CHSP-PS forms are completed fully and accurately to ensure the highest possible data quality within the CHSP-PS system. This will result in both accurate clinical records for children and robust information for analysis purposes to support service planning and population health monitoring.
'Mandatory' variables are those that must have a value entered when a review record is being keyed into CHSP-PS, otherwise the system will reject the entire review record as incomplete. This is therefore a technical/system issue. Often 'unknown' response options can be keyed against mandatory variables hence the mandatory status does not necessarily guarantee good data quality. Health Visitors should complete all variables, whether 'mandatory' or not.
Some variables on the CHSP-PS forms are marked with an asterisk (*). These denote variables that, where possible, are pre-printed onto forms generated for specific children/reviews. For example, information on parental and grandparental country of birth (and hence TB risk/requirement for BCG vaccination) that is captured at the Health Visitor first visit is pre-printed onto relevant subsequent forms generated for that child to avoid the need for repeated data collection. Information on pre-printed status of variables is included in the comments column below.

***Key to review types**

F	Health Visitor First Visit
6	6-8 Week Review
13	13-15 Month Review
27	27-30 Month Review
4	4-5 Year Review
U	Unscheduled Review
R	Recall Review
H	Hearing / UNHS - Universal Newborn Hearing Screening
V	Vision / POVS - Pre-school Orthoptic Vision Screening

Demographic / Birth details

*Review variables included on**									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					
									Scheduled date of review	Start of scheduling period the child health review was scheduled to take place	ddmmyy	n/a	Generated by CHSP-PS system and pre-printed on form
									Date of visit / review / assessment	Date Health Visitor first visit was completed	ddmmyy	**Yes**	
									Name/address/ postcode	Child's demographic details		Pre-printed	These variables are provided by maternity services to local child health departments when a child is born and used to create a record within the CHSP-PS system for that child. The variables are then pre-printed onto the child's HV first visit and subsequent forms. Health Visitors have the opportunity to update/amend key demographic variables on all CHSP-PS forms (see 'change to…' variables below). The updated information would then be keyed into the CHSP-PS system and this would be pre-printed on any subsequent forms for the child. Discrepancy between the estimated date of delivery and the child's actual date of birth is used to schedule the 6-8 week review at 6-8 weeks post EDD for premature babies in some Boards. However note that some areas override this by entering the actual date of birth as a default value against the EDD hence the EDD cannot be assumed to be accurate in all areas.
									CHI no	Community Health Index number	10 digit number	Pre-printed	
									Gender	Child's gender	Male, female	Pre-printed	
									Birth Weight	Child's birth weight	Weight in grams	Pre-printed	
									Place of birth	Child's place of birth	Code from national (ISD) reference file	Pre-printed	
									Mothers DOB	Mother's date of birth	ddmmyy	Pre-printed	
									Health Visitor	Health Visitor identification number for Health Visitor responsible for the child's care	Code from local (NHS Board) reference file	Pre-printed	
									HB	NHS Board of child's residence	Code from national (ISD) reference file	Pre-printed	
									HD	Health district/locality of child's residence	Code from local (NHS Board) reference file	Pre-printed	
									Time	Time of birth	24 hour clock (NNNN)	Pre-printed	
									EDD	Estimated date of delivery	ddmmyy	**Yes** if not pre-printed	
									Treatment Centre	General Practice or community clinic where the child should be scheduled to receive child health reviews	Code from local (NHS Board) reference file	Pre-printed	Pre-printed from information previously keyed into CHSP-PS
									GP	Name of General Practitioner where the child is registered on CHI			

*Review variables included on**									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					

									Change of -Forename/Surname -GP -CHSP PS TC -SIRS TC -Caseload HV -Address/Postcode	If any pre-printed demographic data is incorrect it should be updated in the Change of Details box Updated Health Visitor identification number for Health Visitor responsible for the child's care	Free text TC/HV codes available from local (NHS Board) reference file	If applicable	The child's name/address [as recorded on CHI (Community Health Index)] is pre-printed on all CHSP-PS forms. The Health Visitor can update/amend the name/address on any form but note that when this is input into CHSP-PS it will also update all linked child health systems and the CHI database. The GP details are not entered into CHSP-PS system to avoid conflict with data held on CHI. The HV No is the code number for the Health Visitor responsible for the child's care (the 'caseload HV') as recorded on the CHSP-PS system and is pre-printed on all forms. If responsibility is passed to another HV, the new HV can update/amend the HV number accordingly. Note when this is input into CHSP-PS it will also update all linked child health systems.
									GP/TC name	Name of General Practice or community clinic where the child is registered	Free text	No	
									CHSP TC no	General Practice or community clinic where child should be scheduled for child health reviews	Code from local (NHS Board) reference file	**Yes**	
									SIRS TC no	General Practice or community clinic where the child where the child should be scheduled to receive routine childhood immunisations	Code from local (NHS Board) reference file	**Yes**	
									Carer present with child (at review) - primary carer -additional carer -other	Carer(s) present with child at review. Primary carer refers to the adult living (at least most of the time) with the child who provides most day to day care. Additional carer refers to a second adult (living with the child or not) who contributes to their day to day care. In most but not all cases, the primary and additional carers will be the child's mother and father.	Must complete one box with Yes	**Yes**	

Review variables included on*									**Wording of variable on CHSP PS Form**	**Definition**	**Response options**	**Mandatory variable?**	**Specific validation rules/comments**
F	**6**	**13**	**27**	**4**	**R**	**U**	**H**	**V**					
									Current LAC status	Is the child currently (at the time of the	See list at foot of table	**Yes**	

										review) looked after by the Local Authority for any reason?			
									Ethnicity	Child's ethnicity as stated by their primary carer	See list at foot of table	**Yes**	Pre-printed from information previously keyed into CHSP-PS if available
									Is English 1st language at home?	Is English the main language spoken in the child's home?	Y (yes), N (no)	**Yes**	Pre-printed from information previously keyed into CHSP-PS if available
									Bilingual/multilingual	Is the child routinely exposed to more than one spoken language in their home and/or care environment?	Y (yes), N (no)	**Yes**	Pre-printed from information previously keyed into CHSP-PS if available
									Schedule for immunisation	Parental consent for child to be invited for childhood immunisations through the SIRS system OR HV indication of whether an appointment should be issued for the child's first primary immunisations – or not if these are to be done during the 6-8 week review	Y (yes), N (no) Plus free text comment	n/a	Not entered into CHSP-PS system, can be used to update SIRS scheduling. Note that use of this variable varies between areas as described
									At risk TB	Child eligible to receive BCG vaccination	Y (yes), N (no)	Pre-printed	Pre-printed from SIRS system, if available
									TB risk status - child - parents/carers (x2) - grandparents (x4)	Country of birth of child Country of birth of parents Country of birth of grandparents	Free text	**Yes**	'Child' variable not on HV first visit form (as born in UK) Pre-printed from SIRS system if available Write UNKNOWN if unable to obtain countries of birth
									Has BCG been given? BCG given If yes, date	Has child received BCG vaccination? If Yes date BCG given	Y (yes), N (no) ddmmyy	No	
									Vitamin K given -I/M -oral	Has child received Vitamin K by intramuscular injection or orally?	Y (yes), N (no)	No	Pre-printed on 6-8 week form from information previously keyed into CHSP-PS if available Must be blank if I/M is Y

Review variables included on*									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					
									Blood Spot Results for the child relating to the following conditions:		Blank (no result)	Pre-printed	Bloodspot screening results are provided to Board child

Review variables included on*									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					
									PKU Phenylketonuria TSH Congenital hypothyroidism CF Cystic fibrosis MCD Medium chain acyl-CoA dehydrogenase deficiency HBO Haemoglobinopathy HCU Homocystinuria MSU Maple Syrup Urine Disease GA1 Glutaric Aciduria type 1 IVA Isovaleric Aciduria		NORM (Condition not suspected REF (condition suspected (child referred to specialist for diagnostic assessment) VER (awaiting verification) UNKN (unknown/unavailable) RFD (test refused/declined LATE (test done late – CF only) NONE (test not done)		health/screening departments from the national screening laboratory. Results are input into SIRS by administrative staff then printed onto 6-8 week CHSP-PS forms generated for children.
									Newborn Hearing Screening Results (R & L)	Results of the child's newborn hearing screening relating to right and left ears	P (Pass) R (Refer) W (Withdrawn) indicates parents refused screening I (not done/incomplete)	Pre-printed	Newborn hearing screening results are provided to Board Child Health/Screening Depts from Audiology services. Results are input into CHSP-PS by administrative staff then printed onto 6-8 week CHSP-PS forms printed for children.
									Sleeping -Prone -Supine -Side	Does the child routinely sleep on their front (prone)? on their back (supine)? on their side?	Y (yes), N (no) or blank	**Yes**	
									Primary carer current smoker	Is the child's primary carer a current smoker? Primary carer refers to the adult living (at least most of the time) with the child who provides most day to day care. If a carer uses e cigarettes only, they should not be classed as a current smoker.	Y (yes), N (no)	**Yes**	
									Child exposed to 2nd hand smoke	Is child regularly exposed to second hand smoke within their home, car, and/or care environment from any source? Exposure in the home means anyone smoking anywhere inside the house or on the doorstep with the door open. Regularly means once a week or more frequently. If the child is exposed to vapour from e cigarettes only, they should not be classes as exposed to second hand smoke.	Y (yes), N (no)	**Yes**	
									Concerns raised by carer -Feeding/diet	During the child health review, has the child's carer raised specific	R (raised) or blank	No	

Review variables included on*									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					
									-Growth -Sleep -Development -Physical health -Other	concerns about any of the areas listed?	If R Other – space for free text comment		

Feeding details

*Review variables included on**									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					
									Ever breast fed	Since birth has the child ever been put to the breast to feed or been given expressed breast milk?	Y (yes), N (no)	**Yes**	Pre-printed on 6-8 week form from information previously keyed into CHSP-PS if available
									Always exclusively breast fed	From birth has the baby only ever been fed breast milk and no other liquids or solids apart from medicines or vitamins?	Y (yes), N (no)	**Yes**	Pre-printed on 6-8 week form from information previously keyed into CHSP-PS if available
									Current feeding (previous 24 hours)	Method of feeding that the child has received over the 24 hours prior to their child health review. 'Breast milk only' includes either feeding at the breast or being fed expressed breast milk 'Other' would include babies with special nutritional needs receiving non milk feeding	B (breast milk only) F (formula milk only) M (mixed breast & formula milk) O (other) U (unknown)	**Yes**	
									Child's age when breastfeeding stopped: weeks, days	Age of the baby when they were last breastfed (either put to the breast to feed or given expressed breast milk)	Age in completed weeks (up to 2 digits) and days (1 digit with values 0 to 6 permissible)	**Yes if Ever breastfed=Y and Current feeding=O**	Pre-printed on 6-8 week form from information previously keyed into CHSP-PS if available
									Child's age when breastfeeding stopped: completed months		Age in completed months (up to 2 digits)		Pre-printed on 13-15 month form from information previously keyed into CHSP-PS if available
									Child's age when weaning foods introduced: months	Age of the child when they were first weaned on solid foods	Age in months (up to 2 digits)		

Developmental / ASQ Scores / Tools

Review variables included on*									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					
									Development -Speech, Language & Communication -Problem Solving -Emotional/Behavioural -Gross Motor -Personal/Social -Vision -Fine Motor -Hearing	Results of the developmental assessment undertaken as part of the child health review relating to the specific developmental domains **C** - Concern newly suspected means that the concern has been identified for the first time as a result of the assessment undertaken within the child health review. **P** - Concern/ disorder previously identified means that the child was known to have developmental delay or a specific developmental disorder prior to the child health review being undertaken.	N (no concerns) C (concern newly suspected) P (concern/disorder previously identified) X (assessment incomplete)	**Yes**	The exact domains vary between reviews/forms. These results relate to the Health Visitor's overall assessment of the child's development, taking into account any parental concerns, a developmental history, observation and/or examination of the child, and the results of any developmental assessment questionnaires/ tools that have been completed.
									ASQ Score	Scoring of the developmental assessment undertaken as part of the child health review relating to the specific development domains	Score between 0 and 60	**Yes**	It is extremely important that the correct version of the ASQ form is used for the child's age, as there are different scoring cut-offs depending on the form used. (see page 15 of the Clinical Guidelines)
									Tools	Record of any validated developmental assessment questionnaires/ tools completed as part of the child health review	01 PEDS (Parents' evaluation of developmental status) 02 PEDS:DM (Parents' evaluation of developmental status: developmental milestones) 03 ASQ 3 (Ages and stages questionnaire version 3) 05 SDQ (Strengths and difficulties questionnaire) 06 ASQ:SE (Ages and stages questionnaire: social and emotional version 2) 07 SSLM (Sure start language measure) 08 M-CHAT (Modified checklist for autism in toddlers) 10 Other (indicates a different validated developmental assessment questionnaire was administered as part of the child health review) 11 None	**Yes** (must complete at least 1 box)	Use of up to 4 questionnaires/ tools can be recorded

Growth / Physical Examination

Review variables included on*									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					
									Length / Height	Child's length or height (depending on child's age/form) in centimeters to one decimal place	NNN.N (or 0 to indicate not done)	**Yes**	Length (measured with child lying supine) should be measured for children aged up to 2 years. Standing height should be measured for children aged 2 years or more.
									Weight	Child's weight in kilograms to two decimal places	NNN.NN (or 0 to indicate not done)	**Yes**	
									OFC	Occipito-frontal circumference in centimeters to one decimal place	NN.N (or 0 to indicate not done)	**Yes**	OFC is not on 13-15 months, 27-30 month or 4-5 year forms
									Date measured	Date on which growth measurements were taken	ddmmyy	**Yes** if any growth measurement > 0 recorded	This variable is only completed by HVs if date of measurement is different to date of review/assessment. If no date measured is recorded on the form, administrative staff key in the date of review as a default value for this variable

Review variables included on*									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					
									Physical examination -Heart -Hips (R and L) -Testes (R and L) -Genitalia -Femoral pulses (R & L) -Eyes (red reflux) (R & L)	Results of the physical examination undertaken as part of the child health review relating to the organs specified (right and left where applicable)	N (normal) A (abnormal) D (doubtful or uncertain) I (not done/incomplete)	**Yes**	

Childsmile / Dental

Review variables included on*									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					
									Childsmile outcome at last review	What was recorded in the 'Childsmile' box in the Future Action section of the child's last review	R (request assistance from) W (refused)	Pre-printed	This information is taken from the results of a child's last health review that were previously entered into the CHSP-PS system.

Review variables included on*									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					
										See Future action variable below			
									Registered with dentist	Was the child registered with an NHS dentist	Y (yes), N (no)	Pre-printed	Information on registration with and attendance at NHS dental care is obtained from the national Management Information and Dental Accounting System (MIDAS) (used to manage payment of high street dentists for provision of NHS care) and provided by the Information Services Division. The MIDAS information is linked into the CHSP-PS system on a monthly basis and information for specific children is then printed on certain CHSP-PS forms.
									Ever attended dentist Attended dentist in last 12months	Has the child ever attended an NHS dentist for any reason or attended over the 12 months prior to their child health review?			
									Toothbrushing twice daily	Does the child currently brush teeth twice daily	Y (yes), N (no)	No	

Future Action

Review variables included on*									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					
									Future Action - GP (General Practitioner) -Parenting support -Audiology -Speech & Language -Community Paediatrics -CAMHS (Child & Adolescent Mental Health Services) -Childsmile -Smoking cessation -Child Healthy Weight -Early education -Financial advice services -Social work -Physio/OT (Occupational Therapy) -Other Services	Record of specific actions the Health Visitor intends to take to support the child/family following the child health review. '**P**rovide' indicates that the Health Visitor and/or associated skill mix team will directly provide the specified additional support (only relevant for some options). '**S**ignposted to' indicates that parents have been given details of specified local services and how to access them. '**D**iscuss with' indicates that the Health Visitor will formally discuss the child/family with the specified service to inform future management plans. '**R**equest assistance from' indicates that the Health Visitor will formally refer the child/family to the specified service, whilst retaining responsibility for oversight of the child's wellbeing and outcomes as their GIRFEC named person. **W** 'Refused' indicates that the carer has been offered provision/ signposting/ discussion/ referral to the specified service but has refused this.	P (provide) S (signposted to) D (discuss with) R (request assistance from) W (refused)	No	Only codes R (request assistance from) and W (refused) should be used for future actions related to Childsmile.

Nursery / School details

Review variables included on*	Wording of variable on	Definition	Response options	Mandatory	Specific validation rules/comments

F	6	13	27	4	R	U	H	V	CHSP PS Form			variable?	
									Attends -Nursery -Playgroup -Registered childminder -Other childcare -None	Does the child currently regularly (at least once a week) attend the specified form of childcare for any period?	Must complete at least one box with Y	**Yes**	
									School Code	5 digit school code			Used by Administrative staff to record child' school on CHSP-PS and subsequently on CHSP-School
									Deferred entry	Is the child to be deferred to the following year for school entry	Y (yes), N (no)	No	

Issues / Issues Status / Read Coding. Recall & Unscheduled reviews

Review variables included on*									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					
									Summary List of issues	List of any issues likely to be relevant to the child's ongoing health, development, or wellbeing. Up to 4 issues can be recorded on any one form. Extra forms can be used to record additional issues if required. There is no upper limit to the number issues that can be recorded on the system.	Free text	**Yes** if HP=A **or** any developmental domain=C or P **or** any physical examination=A (6 week review only)	Medical, social and wider environmental issues affecting the child and/or their family (and hence the child indirectly) should be recorded. Detailed guidance on recording of issues is available here. The free text recorded by HVs is not entered into the CHSP-PS system – see below.
									Issue status	Indicates the status of each listed issue	0 (referred/assistance requested) 1 (issue ongoing) 2 (no longer has issue) 3 (amend issue) 4 (no information available) 5 (issue/code incorrectly recorded) 6 (discharged due to DNA – did not attend)	**Yes** If there is an 'open' issue'	Recording code 2, 3, or 5 will cause that issue to be marked as closed within the CHSP-PS system. Once an issue is closed within the system, the associated Read Code/Issue will no longer be pre-printed out on subsequent forms for the child.
									Read code	Read code relevant to each issue listed by the Health Visitor responsible for the child health review (see above)	5 character alphanumeric code	No	Read codes relating to the free text recorded by HVs are assigned by administrative staff in child health departments when completed forms are input into the CHSP-PS system. The Read codes and their associated Issue status codes are then pre-printed onto subsequent forms generated for the child. The Read code term is also printed in the free text space on subsequent forms for ease of interpretation of the Read codes.
									Recall to HV/GP in		3 digit code	No	Recall/ follow up appointments are in addition to the national schedule of universally offered child health reviews and are only requested by Health Visitors when clinically necessary. The interval specified must be greater than 4 weeks to ensure adequate time is available for the results of the current review to be input into CHSP-PS and the recall appointment invitation issued. Note Recall to GP is only on the 6-8 Week & Recall Forms
									Appt	Duration of recall/ follow up appointment to be scheduled	S (short) M (medium) L (long)	No	Local rules determine how S, M, and L appointments are scheduled in different Boards
									Reason for recall	Reason for recall/ follow up appointment	Free text	No	If information is entered against this variable, it is pre-printed on subsequent recall review forms for the child.

Review variables included on*									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					
									Recall requested on	Date of the previous review where the recall/follow-up was requested		Pre-printed	
									Reason for Recall	Reason for recall as noted n the previous review form		Pre-printed	
									Review carried out -on examination -by telephone -by review of notes	How was the recall review carried out?	Y (yes)	**Yes**	
									Reason for using this form	Reason why an unscheduled review form has been completed for the child	1 (transfer into caseload) 2 (outwith age range for routine contact) 3 (change of HPI – Health Plan Indicator – outwith routine contact) 4 (referral outwith routine contact)	**Yes**	

Health Plan Indicator / Support Needs Status / Parental Consent

Review variables included on*	Wording of variable on	Definition	Response options	Mandatory	Specific validation rules/comments

F	6	13	27	4	R	U	H	V	CHSP PS Form			variable?	
									Health plan indicator	Summary indicator of the child's overall need for ongoing support. An additional HPI indicates that the child (and/or their carer) requires sustained (>3 months) additional input from professional services to help the child attain their health or development potential. Any services may be required such as additional Health Visitor support, parenting support, enhanced early learning and childcare, specialist medical input, etc.	C (core) A (additional) U (unknown)	**Yes**	After the HV first visit, the latest HPI recorded in the CHSP-PS system for the child is pre-printed onto subsequent forms if available
									Updated HPI	Updated Health Plan Indicator recorded at the end of the child health review. See Health Plan Indicator variable above for full definition.	C (core) A (additional) U (unknown)	**Yes**	
									Support Needs Status	Child's status on the Support Needs System	0 (Not active on SNS) 1 (Active – not yet notified to doctor) 2 (Active – not yet assessed) 3 (Active – being assessed) 4 (Previously on SNS) 8 (No planned assessment)	Pre-printed	Information on SNS status is provided from the linked SNS system and printed onto the specified CHSP-PS forms generated for children
									Summary comment	Any additional information the Health Visitor wishes to record	Free text	n/a	Not entered into the CHSP-PS system

Practitioners involved / Place of Review

Review variables included on*									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					
									Practitioners involved in review: -HV (Health Visitor) -Staff Nurse (Nursery nurse/FSW (Family Support Worker) -GP (General Practitioner) -Other	Health professional(s) directly involved in delivering the child health review	Must complete one box with Y (yes)	**Yes**	Multiple practitioners can be marked as Y if applicable
									Place of review: -Home -Clinic -GP Practice -Other	Location(s) where the child health review was delivered	Must complete one box with Y (yes)	**Yes**	Multiple locations can be marked as Y if applicable
									Signature Print name	Signature and name of the health professional(s) completing the CHSP-PS form	Free text	n/a	Not entered into CHSP-PS system
									ID No:	Professional identification number of the health professional(s) completing the CHSP-PS form	Codes from local (NHS Board) reference file	**Yes**	

Universal Newborn Hearing Screening – UNHS

The Universal Newborn Hearing Screening Form is completed by the Hearing Screening Services and is not pre-printed by CHSP.

Review variables included on*									Wording of variable on CHSP PS Form	Definition	Response options	Mandatory variable?	Specific validation rules/comments
F	6	13	27	4	R	U	H	V					
									Mother's surname, if different	Mother's surname if baby's surname is different	Free text	**Yes**	
									In NICU / SCBU (Y/N)	Has baby been in Neonatal/Special Care Unit	Y (yes), N (no)		
									First screening / overall outcome -R L	Result for Right / Left ear	Result: P – Pass R – Refer W – Withdrawn consent I – Not done/incomplete	**Yes**	
									- Date	Date of screening	ddmmyy	**Yes**	
									- Test Used	Type of test used to screen	Q – screening OAE Z – screening ABR B – Diagnostic O – Other	**Yes**	
									- Comment	Additional information the screener wishes to record	Free text		
									Second follow-up/overall outcome Third follow-up/overall outcome	Result, Date and Test Used if a second/third test is required			
									Examiner (Y/N)	Health professional who carried out the hearing screen/test	Y (yes), N (no)	**Yes**	
									Signature Print Name	Signature and name of health professional completing CHSP Form	Free text	n/a	
									Clinic Code	Identification number of the clinic where the screen was carried out	Code from local (NHS Board) reference file	**Yes**	

Pre-school Orthoptic Vision Screening - POVS

Review variables included on*	Wording of variable on	Definition	Response options	Mandatory	Specific validation rules/comments

F	6	13	27	4	R	U	H	V	CHSP PS Form			variable?	
									HV Name HV Tel No	Name of child's Health Visitor and HV telephone number		Pre-printed	
									Location	Location where the vision screen was delivered		**Yes**	
									Change of nursery	Updated/corrected nursery details			
									HPI*	Health Plan Indicator	Latest HPI is printed for information only	n/a	
									Proposed School (if known)	Proposed school should be entered if parent/carer has indicated child's proposed school on the Vision Screening Consent Form	Free text		Information of the proposed school helps populate CHSP-School
									Child under review by HES	If the child is already being seen by the Hospital Eye Service	Y (yes), N (no)		
									Consent Withdrawn	Yes indicates parents have declined vision, by returning the Vision Screening Consent Form	Y (yes)		
									DNA Letter Required	Yes indicates child has failed to attend vision screening. A letter will be sent to parents asking them to take child to High Street optician if they have any concerns	Y (yes)		
									Visual acuity (with glasses) Y/N	Was the child wearing glasses to undertake the test	Y (yes) or N (no)		
									R L	Result – right eye Result – left eye	N – normal A – abnormal D – doubtful I – incomplete	**Yes**	
									logMAR result	logMAR result – right eye logMAR result – left eye	n.nnn	**Yes**	
									Test Used	Test used to carry out the vision screen	L – Keeler Crowded Test K – Kay's Picture Crowded Test P – Kay's Picture Single Test S – Sonksen Crowded logMAR Test	**Yes**	

Review variables included on*	Wording of variable on	Definition	Response options	Mandatory	Specific validation rules/comments

F	6	13	27	4	R	U	H	V	CHSP PS Form			variable?	
									Cover Test		Various tests indicated on the back of the CHSP Form		
									Ocular Movements		N – normal A – abnormal D – doubtful I – incomplete		
									Convergence		N – normal A – abnormal D – doubtful I - incomplete		
									Prism Reflex		N – normal A – abnormal D – doubtful I - incomplete		
									Stereo Acuity		N – normal A – abnormal D – doubtful I - incomplete		
									Other Results	Additional information the screener wishes to record	Free text		
									Outcome of Screening	Overall outcome of the vision screening test	P – Pass R – Refer C – Recall F – Ongoing follow-up	**Yes**	
									Proposed recall location	Location code, if a Vision Screening recall is required. A Vision Recall Form will be generated	Code from local (NHS Board) reference file		Not all NHS Boards choose to print a Vision Recall Screening form - some NHS Boards have their own system in place for recalling children
									Comments	Additional information the screener wishes to record	Free text		
									Signature Print Name	Signature and name of health professional completing CHSP Form	Free text	n/a	
									Exam No	Identification number of the health professional who carried out the screen	Code from local (NHS Board) reference file	**Yes**	
									Tear off slip to parent/carer	The screener should complete the tear-off slip so parent/carer knows the outcome of the screen & if further follow-up required			

Response options for current LAC status

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 or 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 (e.g. supported accommodation, hospital)

6 Yes, looked after in residential care (any form of residential care e.g. local authority or voluntary children's home or crisis care refuge)

Response options for ethnicity

Group A - White

1A Scottish
1B Other British
1C Irish
1K Gypsy/ Traveller
1L Polish
1Z Other white ethnic group

Group B - Mixed or multiple ethnic groups

2A Any mixed or multiple ethnic groups

Group C - Asian, Asian Scottish or Asian British

3F Pakistani, Pakistani Scottish or Pakistani British
3G Indian, Indian Scottish or Indian British
3H Bangladeshi, Bangladeshi Scottish or Bangladeshi British
3J Chinese, Chinese Scottish or Chinese British
3Z Other Asian, Asian Scottish or Asian British

Group D - African

4D African, African Scottish or African British
4Y Other African

Group E - Caribbean or Black

5C Caribbean, Caribbean Scottish or Caribbean British
5D Black, Black Scottish or Black British
5Y Other Caribbean or Black

Group F - Other ethnic group

6A Arab, Arab Scottish or Arab British
6Z Other ethnic group

Group G - Refused/Not provided by patient

98 Refused/Not provided by patient (indicates that the individual was asked for their ethnicity but declined to respond)

Group H - Not Known

99 Not Known (indicates that the individual was not asked to give their ethnicity)