

health for all children 4:

Guidance on Implementation in Scotland



GETTING IT RIGHT FOR SCOTLAND'S CHILDREN

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Ministerial Foreword

Children and young people deserve the best possible start in life, and we have a responsibility to give them that opportunity. That means providing effective support for parents and carers, early identification and intervention when there are problems, and action to help children and young people make healthy choices for a lifetime. And crucially, it means integrated working – working together and sharing expertise to meet the global needs of individual children and their families.



The fourth edition of *Health for All Children* provides a framework for connecting the range of different policies and spheres of activity that support children and young people's health and development in the early years and beyond. It sets out a clear core programme of child health contacts that every family can expect, wherever they live in Scotland. But it also recognises that individual families are different, and that we must be flexible and innovative if we want to ensure that all families are able to access and benefit from the advice, support and services that are available to them.

I warmly welcome implementation of *Health for All Children* in Scotland, which I believe offers a great opportunity to use the skills and expertise of a range of professionals to link effective child health promotion, prevention and care. I am enormously grateful to the Child Health Support Group Reference Group members for their valuable input to the development of this guidance.

A handwritten signature in black ink that reads "Rhona Brankin". The signature is written in a cursive, flowing style.

Rhona Brankin
Deputy Minister for Health and Community Care

Introduction

- 1.1 In 1988, the Royal College of Paediatrics and Child Health (RCPCH) established a multi-disciplinary working group to review routine health checks for young children. Its report, first published in 1989, was entitled *Health for All Children*. In later years, the remit of the review was extended beyond routine checks to detect abnormalities or disease, to include activity designed to prevent illness and efforts by health professionals to promote good health. The report of the most recent RCPCH review of child health screening and surveillance programmes in the UK was published in February 2003 as the fourth edition of *Health for All Children*¹, and is commonly referred to as *Hall 4*.
- 1.2 In February 2003, the Child Health Support Group, with the Scottish Executive Health Department, organised a national consensus conference to inform professionals and managers in NHSScotland and partner organisations about *Hall 4* and to provide an opportunity to consider whether and how to implement its recommendations in Scotland. Stakeholders welcomed the proposals in *Hall 4*, and asked the Scottish Executive to provide national guidance on how best to apply the recommended core programme of child health surveillance, screening and health promotion in Scotland, and how to identify and target support for vulnerable children and families. The Child Health Support Group established a multi-disciplinary reference group, chaired by Dr Zoë Dunhill MBE, to assist preparation of this guidance².
- 1.3 Draft guidance was published in December 2003 for a three-month consultation. Children 1st were commissioned to undertake some focus group consultation with parents on behalf of the Scottish Executive, and submitted a report of their findings for consideration with other consultation responses. Reid Howie Associates undertook an analysis of the 153 consultation responses received, and have prepared an overview report, published concurrently with this guidance³.
- 1.4 The majority of respondents welcomed implementation of *Hall 4* in Scotland, and the draft guidance. Many respondents provided helpful comments and suggestions to strengthen the draft guidance, and wherever possible, these have been taken on board in finalising this guidance. In particular, an action template is now included as an appendix, to assist NHS Boards and their partners in developing implementation plans.
- 1.5 Many of the concerns raised in the consultation related to the original *Hall 4* recommendations. The RCPCH *Hall 4* working group considered the best available evidence in arriving at their conclusions and recommendations, and this guidance does not, therefore, revisit these.

1 *Health for All Children*, edited by David M B Hall and David Elliman, Oxford University Press (2003).

2 See Annex 3 for membership.

3 *Health for All Children Draft Guidance on Implementation in Scotland: Analysis of Consultation Responses*, Reid Howie Associates for the Scottish Executive (2005) – www.scotland.gov.uk/publications.

Aims of the guidance

- 1.6 This guidance has been prepared to support consistent implementation across Scotland of the recommendations made by the RCPCH in the fourth edition of *Health for All Children (Hall 4)*. In doing so, it sets *Hall 4* in the context of other Scottish policies to promote effective and integrated provision of universal and targeted services for children and families, and describes the activity needed for implementation at national and local levels. It is not, and cannot be, a comprehensive guide to child health.
- 1.7 First and foremost, the rights and responsibilities to provide for their children's health and welfare rest with parents; this is enshrined in the Children (Scotland) Act 1995. But a range of services provided by the NHS, local authorities and voluntary and independent organisations, in health centres, nurseries, pre-schools and schools, family centres and community-based support services have a vital role in helping parents to ensure their child's healthy development and maximise their potential.
- 1.8 This guidance describes activities and initiatives already in place in Scotland; describes activities that are happening but not consistently around Scotland or to a sufficient level to meet the requirements of *Hall 4*; and makes recommendations, based on *Hall 4*, for changes to current practice. This guidance does not make an explicit distinction between these three aspects. Rather, it should be read as a holistic guide to child health surveillance and screening in Scotland, proposing that all aspects should be in place for effective child health promotion, screening and surveillance. This guidance also describes some initiatives that are currently in a developmental or pilot phase and will provide additional learning over the next few years to inform effective child health promotion and surveillance.
- 1.9 Throughout this guidance, the term "parent" includes all those with parental responsibility, including carers.

Who is the guidance for?

- 1.10 This guidance reflects the evidence-based framework set out in *Hall 4*, for intervention to assess, monitor and support children's health and development throughout childhood and adolescence, based on staged intervention and underpinned by strong health promotion activities. All those involved in planning, managing and delivering services for children and families have a role in ensuring its success.
- 1.11 The framework set out in *Hall 4* is firmly rooted in the need for an integrated approach to the delivery of services and support for children and families. This guidance is therefore for the range of professionals who work with children and families, including social workers, family support workers, community learning development workers, and practitioners in state and independent sector schools and early years settings, as well as staff in NHSScotland who plan, commission and provide care and treatment for children.
- 1.12 The Scottish Executive proposes to work with NHS Health Scotland to develop a leaflet for parents, setting out the core programme of screening, surveillance and health promotion and explaining the service that they will receive. NHS Boards will be responsible for disseminating this to parents, and advising how the programme is being rolled out in their area.

What does *Hall 4* say?

- 1.13 The fourth RCPCH review examined the evidence for existing child health surveillance and screening activity, including the purpose, content and timing of interventions. It takes account of the impact of social, economic and environmental factors on children's health. The recommendations in *Hall 4* also reflect the advice of the National Screening Committee (NSC), which considers all screening programmes on a national level.

Child health surveillance – used to describe routine child health checks and monitoring.

Child health screening – the use of formal tests or examination procedures on a population basis to identify those who are apparently well, but who may have a disease or defect, so that they can be referred for a definitive diagnostic test.

Health promotion – used to describe planned and informed interventions that are designed to improve physical or mental health or prevent disease, disability and premature death. Health in this sense is a positive holistic state.

- 1.14 The recommendations in *Hall 4* reflect a move away from a wholly medical model of screening for disorders, towards greater emphasis on health promotion, primary prevention and targeting effort on active intervention for children and families at risk. The philosophy and recommendations set out in *Hall 4* aim to:
- Establish an evidence-based core universal child health programme of screening, surveillance and health promotion, that effectively supports children's health and development.
 - Ensure that parents are supported and empowered to keep their children healthy and safe.
 - Ensure that the needs of vulnerable children and families are identified and met.
 - Promote the development of seamless support through integrated models of service delivery to make best use of available skills and resources across agency boundaries.
 - Promote a holistic model of family care, in which adult services recognise the impact of adult physical or mental ill health on children in the family.
 - Promote the need to monitor population health through systematic and effective data recording.
 - Highlight the need for efficient information sharing.
- 1.15 The guidance recognises that it is also important to empower and support children and adolescents themselves to take responsibility for their own health needs.
- 1.16 The RCPCH review found little or no evidence for the effectiveness of some of the health checks currently carried out by health professionals on children's health or wellbeing. Consequently, *Hall 4* recommends that certain checks be discontinued and that a reduced core programme of child health surveillance, with some enhanced screening activity, be offered to all children based on interventions proven to be effective in supporting children's health and development. *Hall 4* also recommends that this should incorporate enhanced health promotion work to inform and educate parents about their children's development and needs, so that they can seek the right advice and help when

they need it. These proposals recognise the regular contact that children and families have with other professionals in, for example, pre-school or family centres, and highlight a need to draw more effectively on these, by providing increased support and ensuring that there are clear routes for liaison, consultation and referral to health professionals when there are concerns about a child.

- 1.17 *Hall 4* recommends more effective targeting of support for those children and families who are most in need, whether by virtue of disability, disadvantage or other stresses. For the first time, the report includes recommendations for children's care from birth to adolescence.
- 1.18 *Hall 4* also stresses that screening and surveillance activity is of no value unless supported by high quality and accessible diagnostic, treatment and care services, planned and developed with service user involvement.
- 1.19 The Executive Summary from the fourth edition of *Health for All Children* is included in this guidance as Annex 2.

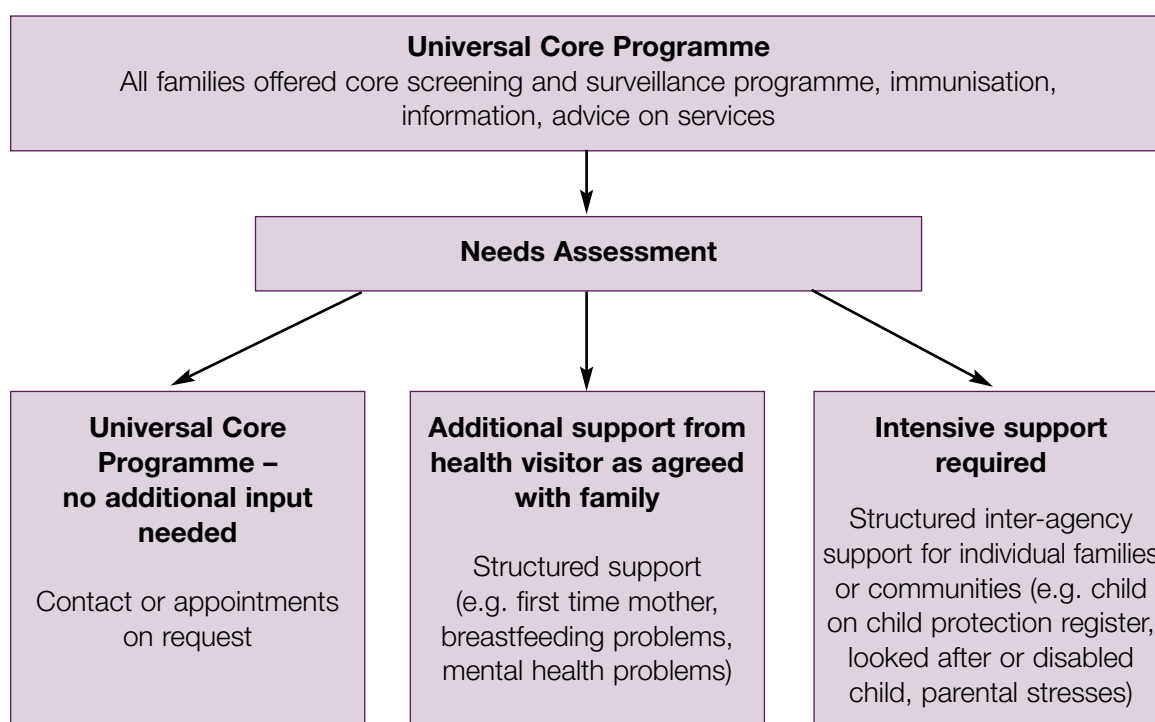
Key principles

- 1.20 The NHS provides a universal service to all families with young children. Current policy recognises the need to target that service more effectively in order to ensure that those families with greatest need receive the greatest level of support. This is reflected in the recommendations made in *Hall 4*.
- 1.21 Scottish data⁴ show that take up of health promotion advice and child health screening and surveillance contacts is much higher amongst parents from more affluent areas and circumstances, with children in need more likely to remain disadvantaged in health status and access to health care. When formal child health checks are made at 6-8 weeks, almost one in 10 children in deprivation⁵ categories 6 and 7 do not attend clinic appointments. By the time checks are made at 22-24 months, almost one in four children in deprivation categories 6 and 7 do not attend for clinic appointments, and this rises further to almost two in five children by the routine checks that currently take place at 39-42 months.
- 1.22 *Hall 4* is based on the principle of universal access to NHS services, but recommends that the way in which those services are delivered must be tied much more closely to identified need. In other words, universal access to NHS services does not necessarily have to mean uniform provision of those services.

4 Source: Child Health Surveillance Programme – Pre-school, ISD Scotland (August 2003).

5 Area deprivation scores are used for many purposes, particularly analysis for health services, and are commonly derived using the Carstairs Index. The scores are generally applied to the populations of postcode sectors, and are derived from selected Census data to quantify levels of relative deprivation or affluence in different localities. For more information about the Carstairs index, see "Deprivation and Health in Scotland" by Carstairs and Morris, *Health Bulletin*, Vol. 48 No. 4 (July, 1990) pp. 162-175.

1.23 There will always be a need to ensure universal provision of a health promotion and surveillance programme for all children and young people to enable families to take well informed decisions about their child's physical and mental health and development; to identify children with particular health or developmental problems; and to recognise and respond when a child may be in need. This guidance sets out a core programme of contacts that every parent can expect, wherever they live in Scotland. However, beyond this, contacts must be determined on the basis of each family's circumstances and needs, which will be different. Some parents need only information and ready access to professional advice when their child is injured or unwell or when they are worried about their child's development or welfare. Other parents may need considerable support, guidance and help at specific times, or over a continuous period, perhaps because of their child's serious ill health or disability, or because of their own personal circumstances. This approach is represented in the diagram below.



1.24 *Nursing for Health*⁶ advocated the development of Family Health Plans as an instrument to help families to think, with their health visitor, about their health and wellbeing. For families where a particular need had been identified, the plan would provide a means to record those needs, to set clear goals to address them, and actions that both professionals and the family would take in order to do so. NHS Health Scotland commissioned research on the potential development of Family Health Plans, followed by a consensus conference in September 2003. The Family Health Plan concept will be given further consideration within the context of the Integrated Assessment Framework (see *Policy Context* section).

6 *Nursing for Health – A Review of the Contribution of Nurses, Midwives and Health Visitors to Improving the Public's Health*, Scottish Executive (2001) – www.scotland.gov.uk/library3/health/ehpnr-00.asp.

- 1.25 In line with the recommendations made in *Hall 4*, this guidance promotes:
- A shift away from child health surveillance activity that concentrates on prevention and detection of specific developmental problems and disorders, to a more holistic approach which supports parents to ensure that they have the information, skills and resources they need to maximise their child's potential.
 - A refocused universal core programme of routine child health contacts that all families can expect, wherever they live in Scotland, with additional support and contacts for some families or communities on the basis of assessed need.
 - Enhanced neonatal and pre-school screening within the universal core programme to achieve optimum detection and treatment for specific conditions.
 - Improved team working so that parent support, health promotion and child assessment activities already being undertaken by a range of children's services – in, for example, family centres, nurseries and schools – support the early identification and referral of children with additional needs for support.
 - Development of community involvement and development approaches to public health promotion for child health, with priority for action in areas of disadvantage, in conjunction with Community Health Partnerships.
- 1.26 Allocation of NHS resources, such as input from health visitors and school nurses, should reflect the greater concentration of need.
- 1.27 *Hall 4* indicates that population-based child health screening and surveillance is only one way in which children's health problems are detected. Evidence has shown that parents notice and seek help for most significant health problems in the first instance, especially if they receive timely, appropriate and accessible information. Other family members, playgroup staff, childcare workers, nursery nurses, teachers and GPs may also detect problems in the course of their general contact with a child.
- 1.28 Individual children and families will require routine and targeted support from a range of professionals and agencies. Effective health promotion can also be universal and targeted and health promotion measures will require both a population focus, with information in a range of media provided to the public or sections of the public at large, and more focused and tailored information, targeted at vulnerable individuals and communities.
- 1.29 Central to the delivery of any new child health programme are integrated processes for assessment and planning services to meet the needs of families with identified needs. In order to ensure that a reduced universal core programme of contacts is augmented by targeted approaches to meeting the needs of families, the following will be needed:
- Reliable, effective and consistent assessment tools and approaches.
 - Universal and tailored packages of information to underpin the programme.
 - An effective needs assessment and planning process.
 - An efficient information system that supports professional activity.
 - Appropriate and efficient sharing of information between professionals about children with particular needs.
- 1.30 These issues are explored in more detail in this guidance.

Achieving change

- 1.31 Implementation of this guidance, along with the NHS modernisation programme already underway, provides an opportunity for coherent planning to shape the future of child health services. Effective implementation of the recommendations made in *Hall 4* and in this supporting guidance will require:
- Genuine joint working between services and agencies.
 - Effective information exchange and transfer protocols and systems.
 - Effective cross-referral mechanisms.
 - Multi-agency staff training and development.
 - Clear referral protocols and pathways which are familiar and accessible to non-health professionals.
- 1.32 Planning for implementation, including decisions about prioritisation, should therefore be considered on an inter-agency basis, and within the integrated children's services planning context. NHS Boards should agree with local authority planning partners an organisational development plan for implementation of this guidance over a three year period, aiming for full implementation by 2008.
- 1.33 Workforce planning and development will obviously be a key element in planning for implementation of *Hall 4*. This will require local planning partners to identify the contribution of staff across agencies and services to health improvement and support for children and families, and action to ensure that mechanisms are in place to support these contributions. The opportunity to develop the individual roles of primary care, health promotion, nursery, childcare and school staff will be key to implementing *Hall 4*. To support this, NHS Boards should consider:
- Allocation of a named health visitor or school nurse for every pre-school establishment.
 - More and regular health visitor or school nurse time in pre-school setting and family centres, to ensure effective liaison, support and training for non-health professionals.
- 1.34 Pre-qualifying training may also need to take this into account and the Scottish Executive will consider this issue with training providers. NHS Education for Scotland is currently reviewing the child health workforce in the context of a range of national policy developments, with a view to developing an associated educational framework.
- 1.35 Scottish Ministers have established a Cabinet Delivery Group on Children and Young People to drive forward work across the Scottish Executive to secure an integrated approach to the delivery of services focussed on children. The Delivery Group, which includes the First Minister and Ministers with responsibilities for health, education, justice, communities and finance, has identified workforce development issues as one of its five priorities for action. A National Review of the Early Years and Childcare Workforce is currently underway, examining roles and responsibilities, qualifications and training, recruitment and retention, career pathways and workforce planning. The Review is expected to be complete by the Summer of 2005, and will provide the longer-term direction for qualifications and training for early years and childcare staff.
- 1.36 To support local planning, an action template is attached at Annex 1, summarising the key areas of activity that NHS Boards are expected to take forward with their local partners.

Resources

- 1.37 The reduction in the number of universal routine contacts and developmental checks by health visitors and school nurses is expected to release some capacity to provide additional or intensive support for those children and families most in need.
- 1.38 The best way of delivering against a common set of outcomes, shared across all agencies, may be to pool or align resources with partners to deliver key inputs. For example, local authorities and NHS Boards might consider pooling resources to expand child and family support services.

Accountability and monitoring

- 1.39 This guidance is intended to be used to support local planning through integrated children's services planning arrangements. The Scottish Executive will be monitoring integrated children's services plans for each area, and these, together with annual updates, will inform the accountability process for NHS Boards. The Scottish Executive is working to rationalise existing quality improvement and accountability arrangements across services for children and young people. This will include new arrangements for an integrated system of inspection of services for children.
- 1.40 The Integrated Children's Services Planning Guidance lists the current performance indicators that the Scottish Executive and NHSScotland use to monitor progress in improving the health of children and young people. Revised and more focused national indicators will be published in 2005, as part of a quality improvement framework for services for children, young people and their families.
- 1.41 Responsibility for ensuring delivery of the universal core child health programme and of targeted support will continue to rest with the Chief Executive of the NHS Board, and for those aspects of the programme commissioned or delivered by local authority staff, with the Chief Executive of the local authority. In most cases, responsibility for delivery is likely to lie with Community Health Partnerships.
- 1.42 In terms of monitoring trends more generally, the Scottish Executive has commissioned *Growing Up in Scotland*, a longitudinal social survey to monitor the impact of Scottish Executive early years policies on longer term outcomes for children and young people. The survey will track a number of representative cohorts of children from birth until the age of 5. The first cross-sectional times series data are expected to be available for 2-3 year olds in 2007, 3-4 year olds in 2008 and 4-5 year olds in 2009. This will be published by the Scottish Executive.



2

policy context

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- 2.1 The Scottish Executive is committed to ensuring that every child has the best possible start in life and is able to reach their full potential. Scottish Ministers have identified their expectations and aspirations for all children and young people in Scotland:

Children and Young People in Scotland should be valued by ensuring that they are:

- **Safe:** Children and young people should be protected from abuse, neglect and harm by others at home, at school and in the community.
- **Nurtured:** Children and young people should live within a supportive family setting, with additional assistance if required, or, where this is not possible, within another caring setting, ensuring a positive and rewarding childhood experience.
- **Healthy:** Children and young people should enjoy the highest attainable standards of physical and mental health, with access to suitable healthcare and support for safe and healthy lifestyle choices.
- **Achieving:** Children and young people should have access to positive learning environments and opportunities to develop their skills, confidence and self esteem to the fullest potential.
- **Active:** Children and young people should be active with opportunities and encouragement to participate in play and recreation, including sport.
- **Respected & Responsible:** Children, young people and their carers should be involved in decisions that affect them, should have their voices heard and should be encouraged to play an active and responsible role in their communities.
- **Included:** Children, young people and their carers should have access to high quality services, when required, and should be assisted to overcome the social, educational, physical, environmental and economic barriers that create inequality.

- 2.2 These principles apply across agency, service and professional boundaries and are consistent with the principles enshrined in the United Nations Convention on the Rights of the Child⁷.
- 2.3 Experiences and influences in childhood will have far-reaching and profound effects in adulthood and later life. Efforts to tackle key health and social problems common in the Scottish population must begin in the early years and continue throughout the primary school years and adolescence. Improving child health, welfare and opportunity, particularly for our most disadvantaged children and young people, is a priority across all Executive portfolios and departments.
- 2.4 The philosophy of *Hall 4* is consistent with the Scottish Executive's emphasis on social justice and closing the opportunity gap between the most disadvantaged and the rest of society. This means that families should receive the help and support they need from our public services when they need it, unhindered by organisational boundaries and their care should be based on the best available evidence about what works. It also means that services should inform and involve children and their families in planning their care, and consult them about the kinds of services and support they want.

7 United Nations Convention on the Rights of the Child (1989) – www.unicef.org/crc/crc.htm

2.5 *Hall 4*, and this guidance on implementation, sits alongside other important initiatives to support children's development and welfare, all of which seek to:

- Promote a step-change in Scotland's public health through implementation of an action plan for health improvement, *Improving Health in Scotland – The Challenge*⁸, which includes a focus on intervention in the early years and at vulnerable points of teenage transition.
- Achieve seamless and more effective support for children and their families through implementation of *For Scotland's Children*⁹.
- Support delivery of integrated children's services through national roll-out of Integrated Community Schools, with every school becoming a Health Promoting School by 2007, supported by implementation of *A Scottish Framework for Nursing in Schools*¹⁰.
- Redesign assessment and support for children to help them achieve their full potential through the implementation of the Education (Additional Support for Learning) (Scotland) Act 2004¹¹.
- Improve protection and help for children at risk of abuse and neglect through a programme of national child protection reform¹², informed by *It's Everyone's Job to Make Sure I'm Alright*¹³ and supported by the *Protecting Children and Young People Charter*¹⁴ and *Framework for Standards*¹⁵.

2.6 Early evidence from initiatives such as Starting Well¹⁶ and Sure Start Scotland¹⁷, tells us that a joint approach, combining active health promotion and other targeted input for vulnerable communities, can make an important difference to families. The second phase of the Starting Well demonstration project will pilot some elements of *Hall 4* implementation.

8 *Improving Health in Scotland – The Challenge*, Scottish Executive (2003) – www.scotland.gov.uk/library5/health/ihis-00.asp

9 *For Scotland's Children – Better Integrated Children's Services*, Scottish Executive (2001) – www.scotland.gov.uk/library3/education/fcsr-00.asp

10 *A Scottish Framework for Nursing in Schools*, Scottish Executive (2003) – www.scotland.gov.uk/library5/education/sfns-00.asp

11 Education (Additional Support for Learning) (Scotland) Act 2004 – www.scotland.gov.uk/Topics/Education/School-Education/19094/17176

12 www.scotland.gov.uk/about/ED/CnF/00017834/childprotection.aspx

13 *It's Everyone's Job to Make Sure I'm Alright: Report of the Child Protection Audit and Review*, Scottish Executive (2002) – www.scotland.gov.uk/library5/education/iaar-03.asp

14 *Protecting Children and Young People: The Charter*, Scottish Executive (2004) – www.scotland.gov.uk/library5/education/ccel.pdf

15 *Protecting Children and Young People: A Framework for Standards*, Scottish Executive (2004) – www.scotland.gov.uk/about/ED/CnF/00017834/page1423929284.pdf

16 Starting Well National Health Demonstration Project – www.scotland.gov.uk/Topics/Health/health/17360/8261

17 Sure Start Scotland is the Government's programme to deliver the best start in life for every child by bringing together a range of services, e.g. early education, childcare, health and family support – www.scotland.gov.uk/surestartscotland/

Public health nursing

- 2.7 Following a national review of nurses' contribution to public health¹⁸, new models of community based nursing are emerging which provide a good platform on which to base review and development of child health surveillance and promotion. The development of public health nursing brings together health visiting and school nursing into a single discipline with a renewed focus on health improvement. The introduction of public health practitioners in Local Health Care Co-operatives, now Community Health Partnerships, has also created a key public health focus for the development of inter-agency partnership working, acting as a catalyst for service change and development.

Integrated children's services planning

- 2.8 The Scottish Executive has published new guidance for the preparation of integrated children's services plans¹⁹. This is intended to support rationalisation of local planning activity and encourage agencies to agree consistent improvement objectives and delivery strategies across universal and targeted services for children and young people. Planning for implementation of *Hall 4* should be part of the new integrated children's services planning arrangements.

Integrated Assessment Framework

- 2.9 The Scottish Executive will shortly be consulting on a draft *Integrated Assessment Framework for Scotland's Children*²⁰. As children grow and develop they routinely have contact with numerous professionals in health and education. Some children and young people have particular health, learning or other needs which require assessment and support from a range of different services and agencies. The Integrated Assessment Framework is intended to ensure the consistency and quality of assessments by introducing a common structure for assessing the needs of children and young people.
- 2.10 The aim of the Integrated Assessment Framework is to provide a means by which all services for children – universal and specialist – will be able to gather and share appropriate information, assess needs, plan and co-ordinate services for individual children. Core information collected for all children will connect with specialist assessments necessary to meet the needs of those children and families requiring additional support. The Integrated Assessment Framework will ensure that the child's experience is maintained at its centre and that account is taken of strengths, achievements, and the personal resources of the child and family as well as needs and risk of harm. This is considered further in the *Identifying and Targeting Support* section of this guidance.
- 2.11 As part of the Integrated Assessment Framework development work, the Scottish Executive is working with a number of professional groups, including health visitors, to establish common methods for recording information to ensure consistency and promote quick transfer of information within organisations and to other appropriate agencies when it is required.

18 *Nursing for Health – A Review of the Contribution of Nurses, Midwives and Health Visitors to Improving the Public's Health*, Scottish Executive (2001) – www.scotland.gov.uk/library3/health/ehpnr-00.asp

19 www.scotland.gov.uk/about/ED/CnF/00017842/Planning.aspx

20 Proposals to be published for consultation.

Improving support systems for children in need

- 2.12 The Scottish Executive Review of the Children's Hearings system²¹ has identified that although there are measures that can be taken to improve the Hearings system, the impact on the lives of children would be significantly greater if the wider network of support services was improved. There are concerns that at present, children are not receiving support when they need it, and that many are referred to the Children's Reporter when more effective local action would have been more appropriate.
- 2.13 As *For Scotland's Children*²² notes, "we do need a much more robust approach to putting children and families at the centre of the service network. That will be facilitated by treating all services for children as part of a Children's Services System and by all staff perceiving themselves as operating within that single system". The Scottish Executive will shortly be consulting on phase 2 of the Hearings Review, including options to strengthen individual agency and collective responsibility for identifying and addressing children's needs.
- 2.14 This will link with, and build on, the work to develop an Integrated Assessment Framework, outlined above, and with the developments underway within the child protection reform programme.

Community Health Partnerships

- 2.15 This guidance is published as Community Health Partnerships (CHPs) are beginning to take shape across Scotland. CHPs will have a significant influence on the organisation and delivery of person-centred locally integrated services. They will be a focus for integrating primary and specialist health services at a local level, will help advance and deliver the health improvement agenda, and will influence the deployment of resources. They will also have a lead role in the delivery of services for children and young people at a local level.
- 2.16 Statutory guidance²³ has been published to support the establishment of CHPs. Supplementary advice²⁴ has also been issued on how CHPs should inform local approaches to the integration of children's services. The guidance and supplementary advice recognise that one model does not fit all, and that approaches will develop to fit local circumstances.

21 *Getting It Right For Every Child: Summary Report on the Responses to the Phase One Consultation on the Review of the Children's Hearings System*, Scottish Executive (2004) – www.scotland.gov.uk/library5/education/girsum.pdf

22 *For Scotland's Children – Better Integrated Children's Services*, Scottish Executive (2001) – www.scotland.gov.uk/library3/education/fcsr-00.asp

23 *Community Health Partnerships: Statutory Guidance*, Scottish Executive (2004) – www.show.scot.nhs.uk/sehd/chp/Pages/CHPfinal%20guidanceOCT2.pdf

24 *Community Health Partnerships and Integrated Children's Services*, Scottish Executive (2004) – www.show.scot.nhs.uk/sehd/chp/Pages/advicenotes.htm

Participation and involvement

- 2.17 In 2001, the Scottish Executive published a framework for Patient Focus and Public Involvement (PFPI)²⁵, charging NHS Boards with the development of a local framework for sustainable patient and public involvement, identifying how the NHS Board would involve patients, carers, staff and the public in decision making at every level of the health service. The aim is to achieve a service where people are treated with respect, treated as an individual, and involved in decision making at all levels of planning and delivery of health services in NHSScotland. The principles of the approach are that patients and the public are treated as equal partners in decision making.
- 2.18 The involvement of children and young people is also seen as being a key element in providing and developing services to meet their needs. The United Nations Convention on the Rights of the Child (UNCRC) underpins the legislative and cultural progress in involving children and young people in making decisions. In particular, Article 12 of the UNCRC gives children the right to express their views freely in all matters affecting them and states that these views will be given due regard. The UNCRC was ratified by Great Britain in 1991 and in Scotland, the Children (Scotland) Act 1995 incorporated its principles by giving children and young people a right to express their views on a range of decisions which affect them.
- 2.19 Parents, carers, and where appropriate, children and young people, should be involved in local *Hall 4* implementation planning.

25 *Patient Focus and Public Involvement*, Scottish Executive (2001) – www.scotland.gov.uk/library3/health/pfpi.pdf



3

health promotion

health for all children 4: Guidance on Implementation in Scotland

- 3.1 *Improving Health in Scotland – The Challenge*²⁶ provides a strategic framework to support the processes needed to deliver a more rapid rate of health improvement for Scotland and to effect a step change in the health of Scotland's people. It focuses on four key themes: early years; teenage transition; workplace; and community. *The Challenge* also emphasises the importance of cross-cutting and partnership working – and there was considerable agreement in the consultation on this guidance, about the role that staff across sectors and agencies can play.
- 3.2 There is clear evidence that health throughout life is powerfully influenced by experiences in early childhood and even from conception. Promoting the health and wellbeing of mothers and children is key to preserving and promoting the health of current and future generations. As *The Challenge* states, “it is only by showing individuals that realistic, achievable changes in their own actions can bring both immediate and long-term benefit to them, their families and Scotland that we will succeed in improving health”.
- 3.3 Health promotion is the process of enabling people to increase control over and improve their health through the overlapping spheres of health education, prevention and health protection. As well as actions aimed at strengthening people's skills and capabilities, it includes actions directed towards changing social, environmental conditions to prevent or to improve their impact on individual and public health²⁷. Health education is communication activity aimed at enhancing positive health or preventing diminishing health in individuals and groups, through influencing beliefs, attitudes, and behaviour of those with power and of the community at large²⁸. In this guidance, health promotion, includes activity to promote both physical and mental health and wellbeing.
- 3.4 *Hall 4* is rooted in evidence-based effective practice, and health promotion activity is no exception. Initiatives such as the Starting Well national health demonstration project²⁹ and Sure Start Scotland, are already providing programmes of activity to promote children's healthy development through intensive home-based support for families and ensuring access to enhanced community-based resources. The Early Years National Learning Network³⁰, based at NHS Health Scotland, was established in 2003 to facilitate the sharing of learning across Scotland by disseminating the lessons learned from Starting Well and enhancing evidence-based policy and practice in early years activity.
- 3.5 Implementation of *Hall 4* will require NHS Boards and local authorities to work together to foster integrated approaches to health improvement through delivery of health promotion in primary care settings and in pre-school centres and schools. NHS Health Scotland produces a range of existing materials, and is planning a number of further initiatives that will support practitioners in developing and delivering these approaches.

26 *Improving Health in Scotland – The Challenge*, Scottish Executive (2003) – www.scotland.gov.uk/library5/health/ihis-00.asp.

27 Public Health Electronic Library – www.phel.gov.uk/glossary/glossary.asp.

28 *Health Promotion: Models and Values*, Downie, Tannahill & Tannahill, 2nd Edition (1996), Oxford Medical Publications.

29 *Towards a Healthier Scotland*, published by the Scottish Executive in 1999, announced the establishment of four locally based health demonstration projects in priority areas of child health, the sexual health of young people, coronary heart disease and cancer, to act as testing grounds for action and a learning resource for the rest of Scotland.

30 See www.phis.org.uk/projects/default.asp?p=fa for further details.

Early years

- 3.6 The primary responsibility for children's health and development rests with parents. However, they need information and support to fulfil that responsibility most effectively and all pre-school children and their families should, therefore, have access to an effective health promotion programme, delivered by the network of health, social work and education professionals through their routine contacts with children and families.
- 3.7 Parents and prospective parents will continue to need different forms of information and advice about healthy living, and social support will be needed to help parents and prospective parents to understand their own and their children's social, emotional, psychological and physical needs. These include:
- **Written information about pregnancy and birth, and healthy infant and child development** – NHS Health Scotland produces extensive public information about child health and development in various publications and on the Internet³¹. All pregnant women receive comprehensive information in preparation for parenthood in a free NHS Health Scotland publication, *Ready Steady Baby*³², which includes advice on health and development from conception to infancy. NHS Health Scotland is currently reviewing the format and content of *Ready Steady Baby* to extend coverage of information beyond infancy to the pre-school period. New mothers also receive written information on breastfeeding and on prevention of cot death³³, to support the advice that they receive from their midwife. Patient information leaflets for use with the newborn screening programmes (hearing, cystic fibrosis, PKU and congenital hypothyroidism) are also published by NHS Health Scotland.
 - **Healthy living information and advice** – Health visitors, school nurses and other members of the primary care team should provide advice on a range of issues in the course of their regular contact with individual parents and children at clinics, GP practices, family centres and at home. Leaflets and posters can be used to highlight key issues about diet, exercise, and effective management of behaviour, and signpost children and their families to different sources and types of information and support.
 - **Access to information and professional advice about specific aspects of child development and behaviour through group activities and workshops** – Parenting education and support programmes should be provided in a wide range of health service and local authority settings, and many voluntary organisations offer direct access to support through helplines or self-referral.
 - **Support through local community networks** – For example, breastfeeding peer support, smoking cessation services and other addiction services and networks.

31 www.hebs.com.

32 *Ready Steady Baby – A Guide to Pregnancy, Birth and Parenthood*, Health Education Board for Scotland (Revised Second Edition 2002) – www.hebs.com/readysteadybaby/index.htm.

33 Leaflet currently under review.

- 3.8 Where written information is published, it must be clear and be available in a range of formats and languages.
- 3.9 The core child health programme provides valuable opportunities to assess needs and provide support and information for parents at key points in the early years, and to develop empathetic and trusting relationships, which provide the best basis for effective health promotion. Establishing such relationships requires skill, particularly for successful engagement with families who may be suspicious, unaware of or reluctant to engage with the public services that are available. NHS Boards and local authorities should collaborate to ensure that staff receive appropriate training and support to capitalise on opportunities for interaction with parents at key points in the early years. NHS Boards should also ensure that professional supervision is in place for all frontline staff, so that regular opportunities are available for them to discuss concerns.
- 3.10 Eighty five per cent of three year olds and 100 per cent of four year olds in Scotland are currently accessing a part-time place in a pre-school education centre³⁴. Staff in early years settings, such as family centres, nurseries and pre-schools, are usually in daily contact with children and parents, and are therefore in a strong position to reinforce health promotion messages. Indeed, many already do so routinely.
- 3.11 Although pre-school centres are not required to meet the Scottish Executive target to become a health promoting school, many are already applying the principles and introducing effective approaches to improving the health of children and their families.

School years

- 3.12 Integrated Community Schools are founded on the twin principles of improving educational attainment and enhancing social inclusion, by bringing together professionals and services – including health, education and social work – to take a holistic approach to education and support for children and their families. They are therefore ideally placed to support children and families in adopting healthy lifestyles, through activity embedded in the school curriculum and through wider community activity. The White Paper, *Towards a Healthier Scotland*³⁵, identified the concept of health promoting schools as a key component of future health improvements. Integrated Community Schools are leading the way, working towards becoming Health Promoting Schools by 2007.

A health promoting school is one in which all members of the school community work together to provide children and young people with integrated and positive experiences and structures, which promote and protect their health. This includes both the formal and the informal curriculum in health, the creation of a safe and healthy school environment, the provision of appropriate health services and the involvement of the family and wider community in efforts to promote health.

World Health Organisation (WHO), 1995

34 *Pre-school and Childcare Statistics 2004*, Scottish Executive (2004) – www.scotland.gov.uk/stats/bulletins/00346-00.asp

35 *Towards a Healthier Scotland*, Scottish Executive (1999) – www.scotland.gov.uk/library/documents-w7/tahs-00.htm

- 3.13 The Scottish Executive, in partnership with NHS Health Scotland, CoSLA and LT Scotland, has established the Scottish Health Promoting Schools Unit (SHPSU) to champion, facilitate and support the implementation of the health promoting school concept throughout Scotland through strategic and practical support to local authorities, schools, NHS Boards and other stakeholders. In conjunction with national and local partners, the SHPSU has developed *Being Well – Doing Well*³⁶, which provides a broad statement, based on a holistic view of education and health promotion, as a foundation for planning processes. It draws upon current thinking and practice, and aims to:
- Promote discussion of the health promoting schools concept within the context of other developments.
 - Identify the values, aims and key characteristics of health promoting schools.
 - Establish a broad national consensus on the nature of health promoting schools.
 - Inform the planning and development of health promoting schools at national and local levels.
 - Promote an integrated approach through partnership working to the development and maintenance of health promoting schools.
 - Provide a basis for the development of instruments and procedures for evaluating the progress made by schools towards becoming and improving as health promoting schools.
- 3.14 The work of the SHPSU has recently been strengthened by the appointment of three new health specialists for food, physical activity and mental wellbeing to help schools build all these strands into a single whole school approach to health.
- 3.15 In 2003, the Scottish Executive published *A Scottish Framework for Nursing in Schools*³⁷, which sets out the role of the school nursing team and standards for practice. NHS Health Scotland is currently undertaking development work on a school health profiling tool that will inform the development of school health plans and ultimately the school planning process. This will inform school-based approaches to health improvement, including the activities of the school nursing service within each school. The role of the school nursing service will move away from a focus on routine surveillance, towards a combination of school population-focused health improvement, and addressing the individual health needs of vulnerable children.
- 3.16 In accordance with the recommendations in both *Hall 4* and *A Scottish Framework for Nursing in Schools*, there should be a named nurse for each school, with access to a wider team of health support such as community children’s nurses, paediatricians and therapists.

36 *Being Well – Doing Well: A Framework for Health Promoting Schools in Scotland*, Scottish Health Promoting Schools Unit (2004) – www.ltscotland.org.uk/wholeschoolissues/files/beingwelldoingwell.pdf

37 *A Scottish Framework for Nursing In Schools*, Scottish Executive (2003) – www.scotland.gov.uk/library5/education/sfns.pdf

Nutrition and physical activity

- 3.17 In common with virtually all other developed industrialised countries, obesity is increasing in Scotland. Of particular concern is the increasing incidence of obesity in children. Efforts to tackle obesity through the promotion of healthy choices must therefore be a key component of any child health programme in Scotland. The question of body weight, obesity and body image is a complex question for children and young people, and they require sophisticated support that ensures the relationship they have with food and physical activity remains as positive as possible.
- 3.18 *Hall 4* stresses the need for a multi-agency approach to the promotion of healthy eating and physical activity. It also recommends a wide range of activity to promote healthy eating and exercise amongst all children, and not just those who are overweight or at risk of obesity. It notes that “a programme that addresses the issue of obesity in the population as a whole will also be likely to reduce the risks of cardiovascular disease, diabetes and cancer”.
- 3.19 Health promotion activity in the early years should encourage breastfeeding for infants exclusively for 4-6 months. However, it is important that women are supported in whatever feeding choice they make for their baby. Mothers who are unable to breastfeed may need particular emotional support. The Scottish Executive is supporting implementation of the Breastfeeding (Scotland) Act 2004³⁸. The Executive is also working on the development of national infant feeding strategy to promote infant nutrition and increase the update and duration of breastfeeding.
- 3.20 It is important that parents are aware of the link between first weaning foods and early oral health. NHS Health Scotland is producing a new weaning leaflet to help parents introduce their child to healthy foods and drinks and establish good oral hygiene practice from an early age.
- 3.21 Pre-school centres can play a significant role through health education, discouraging consumption of high sugar and high fat foods and drinks by providing healthy alternatives, encouraging consumption of fruit and vegetables, and providing varied opportunities for physical activity. Physical development and movement is one of the five key areas in the curriculum framework for children aged three to five years. The Scottish Executive is already working with the pre-school and childcare sector to support active play, and NHS Health Scotland has produced *Adventures in Foodland*³⁹, a resource for pre-school centres on healthy eating and play. The Executive is also investing in the further development and rollout of the Play@Home resource⁴⁰, a physical activity programme for children from birth to five years.

38 Breastfeeding etc (Scotland) Act 2004 –

www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2005/20050001.htm

39 *Adventures in Foodland: Ideas for making food fun from an early age*, NHS Health Scotland (2004) – www.ltscotland.org.uk/earlyyears/Foodland.asp

40 Play@Home – www.fife-hpd.demon.co.uk/playhome/

- 3.22 There is a great deal of activity already underway to encourage and support school age young people in making healthy choices, both in and outwith school. *Hungry for Success*⁴¹ introduced nutrient standards for school meals in both primary and secondary schools, and detailed guidance has been published to support implementation and the establishment of free fruit schemes. Good practice initiatives such as breakfast clubs, fruit and salad bars and healthy tuck shops, have also been established in schools across Scotland. The Scottish Executive is also developing support materials and advice for teachers about how they can best deliver nutrition education in schools, including practical food skills, shopping and making meals.
- 3.23 *Active Schools*⁴² also continues to be developed and rolled out, supported by the recruitment of more than 600 Active School Co-ordinators by 2007 to help get pupils more active. Local authorities are also working to promote physical activity outwith the pre-school and school environment by increasing the accessibility and affordability of sport and leisure facilities for children and young people. It is important that an active life for children and young people includes access to a range of options such as dance, outdoor activities, walking and cycling, so that they enjoy being active in their everyday lives.
- 3.24 A new education performance measure⁴³ has been introduced which focuses on how schools and authorities might encourage pupils to take part in health related physical activity for one hour each day.

Oral health

- 3.25 Dental disease in childhood is a significant marker for later poor health and is associated with deprivation and disadvantage. It is also a major reason for young children being hospitalised and for the administration of general anaesthesia to young children. And it is largely preventable.
- 3.26 Although there has been a decline in childhood dental caries over the last 30 years, there has been little improvement over the last 10 years in the youngest children. In Scotland, around 55% of children start school with evidence of dental decay⁴⁴.
- 3.27 The risk factors for early dental disease include absence of registration with, and regular attendance at a dentist (both child and parent), diet, whether the parent is enabling tooth brushing with fluoride toothpaste, socio-economic status, and underlying medical history. In preparation for teething, information and advice should be made available to parents in their child's first year about the risk factors for dental disease, and the action that they can take to reduce these, including advice about weaning. Children under seven years are usually not well-equipped to manage effective tooth brushing without adult supervision and parents should be advised to check regularly how thoroughly their child is brushing until they are confident that the child has acquired the necessary skill.

41 *Hungry for Success: A Whole School Approach to School Meals in Scotland*, Scottish Executive (2002) – www.scotland.gov.uk/library5/education/hfs.pdf

42 www.sportscotland.org.uk/ChannelNavigation/Our+activities/TopicNavigation/Active+Schools/

43 National Priorities: Performance Measure 5.1 E – www.nationalpriorities.org.uk/priorityDocs/priority5DocsPM5_1_E_1.html

44 Scottish Health Boards Dental Epidemiological Programme Report of the 1999 – 2000 survey of 5 year old children.

- 3.28 Information should be made available to parents within their child's first year in preparation for teething, including advice about risk factors for problems with milk teeth, such as sustained use of sugared and sweetened drinks in bottles. There is a need to build on existing oral health promotion work, roll this out to other staff groups, and to apply health promotion messages from infancy, in the early years and beyond.
- 3.29 The range of practitioners in touch with children and families are well placed to identify risk factors for dental disease and communicate messages about the importance of oral health. There are many opportunities for professionals to identify risk factors for dental disease and to promote key oral health messages, some in the course of their regular contact with children and parents, others on a more opportunistic basis. It is vital that all healthcare workers, including members of the dental team, give consistent advice.
- 3.30 The key oral health promotion messages are to:
- Encourage registration with a dentist from birth and regular attendance for dental check-ups.
 - Provide advice about the impact of sugary food and drink consumption, aimed at reducing the level, and especially the frequency, of such consumption.
 - Encourage twice daily supervised tooth brushing with a 1000 ppm fluoride toothpaste.
- 3.31 Oral health should be included in advice and support from health and other child care professionals about weaning, diet and nutrition. This should be prominent in health promotion advice linked to the core child health programme set out in Annex 1. Staff in family and pre-school centres should have access to health promotion material on oral health.
- 3.32 School health services are also in a strong position to offer oral health advice consistent with the dental and oral health statement outlined in *A Scottish Framework for Nursing in Schools*, contributing to positive oral health by:
- Working with schools to develop suitable policies on nutrition and health promotion.
 - Developing awareness of oral health with children, young people and parents.
 - Working with pre-school centres and schools to facilitate the development of regular tooth brushing programmes through structured interventions such as breakfast clubs and post-snack brushing.
- 3.33 In response to the consultation on *Towards Better Oral Health in Children*⁴⁵, the Scottish Executive is currently considering a range of new measures to support children and young people's oral health.

45 *Towards Better Oral Health in Children – A Consultation Document on Children's Oral Health in Scotland*, Scottish Executive (2004) – www.scotland.gov.uk/consultations/health/ccoh.pdf

Unintentional injury

- 3.34 Unintentional injuries (including poisonings) are the most common cause of death and a cause of considerable morbidity in children between the ages of 1 and 14 years. Reducing incidence, and the social class gradient, are highlighted by *Hall 4* as an important objective, requiring multi-agency collaboration and investment at national and local levels. Health and child care professionals are well-placed to promote positive messages about safety and to encourage a safe environment for children in the course of their regular contact with children and families.
- 3.35 As well as primary prevention, *Hall 4* suggests that a home visit by a health visitor or other community worker following an unintentional injury to a child, may help to prevent further incidents. At a community level, local accident and emergency admission data, as well as other sources of health and social data, should be used to inform the development of multi-agency strategies, linked to children's services and community planning, for a reduction in the number of unintentional injuries.

Mental health and wellbeing

- 3.36 Interventions in the early years are likely to be the most effective in preventing a child developing mental health problems. These include interventions to improve and enhance the wellbeing of the mother and the baby, which promote good early parent-child attachment and interaction, and which support parents' problem-solving skills and recognise and support the role of fathers.
- 3.37 Implementation of *Hall 4* also links strongly with implementation of the Framework⁴⁶ for children and young people's mental health, a draft of which has been published by the Scottish Executive for consultation. The Framework has been developed to support integrated approaches to children and young people's mental health, across mental health promotion, prevention of mental illness, and care and treatment for those with mental health problems. It highlights mental health promotion and stresses the importance of considering the child's global environment, recognising elements which support mental health and wellbeing as well as those factors which may increase the risk of mental health problems, including the potential impact of a parent's ill health on their child.
- 3.38 The Framework promotes a "mainstream" approach to mental health and wellbeing, which equips a range of health and other children's services professionals with the basic skills to be able to support parents in developing a basic understanding of risk and protective factors that may affect their child's mental health and wellbeing. To support this, NHS Education for Scotland has published a mental health competency framework⁴⁷ for all those involved in supporting children, young people and their families.

46 *Children and Young People's Mental Health: A Draft Framework for Promotion, Prevention and Care*, Scottish Executive (2004). Draft for consultation until end March 2005 – www.scotland.gov.uk/consultations/health/cypmh-00.asp

47 *Promoting the Wellbeing and Meeting the Mental Health needs of Children and Young People: A Development Framework for Communities, Agencies and Specialists Involved in Supporting Children, Young People and Their Families*, NHS Education for Scotland (2004) – www.qacpd.org.uk

- 3.39 Education policy and practice already has a strong focus on promoting and supporting emotional wellbeing, and the Health Promoting Schools concept broadens this focus beyond the curriculum to a “whole school approach”.
- 3.40 *Children and Young People’s Mental Health: A Framework for Promotion, Prevention and Care* sets out the range of activities and approaches that we would expect to see in place to support children and young people’s mental health and wellbeing.

Sexual health

- 3.41 Implementation of *Hall 4* can link with and contribute to action to implement the national sexual health strategy⁴⁸. This highlights the various influences that can determine sexual wellbeing, and the consequent need for an integrated approach.
- 3.42 The Strategy recognises the role of parents in influencing their children’s attitudes to sex and relationships, and recommends that NHS Boards, in conjunction with other statutory and voluntary sector interests, should provide programmes for parents and carers to enhance communication skills around relationships and sexual health. It also recognises that some vulnerable children and young people may not have access to comprehensive school-based sex and relationships education (SRE), and seeks to address this through ongoing implementation of the McCabe report⁴⁹. The Scottish Executive is working with NHS Health Scotland, Directors of Education and Social Work and other key stakeholders to ensure that vulnerable children and young people, including those who are disaffected or excluded from school, receive SRE that is consistent with national guidance on the provision of SRE in schools.
- 3.43 The Strategy recommends that an executive director within each NHS Board should be responsible for sexual health and wellbeing, and that a lead clinician should be appointed to drive forward the Strategy’s practical plan for action. A National Sexual Health Advisory Committee (NSHAC), with a wide ranging membership and chaired by the Minister for Health and Community Care, will be established to advise on policy, monitor and support implementation of the Strategy.

Smoking

- 3.44 Smoking is the greatest single, preventable cause of ill health and premature death in Scotland, and parental smoking, has serious effects on children’s health, both in the short and longer term. *Hall 4* highlights that smoking in pregnancy is associated with low birth-weight babies, and after birth, for the babies of mothers who smoke, the risks of sudden infant death, middle ear disease, meningitis and respiratory diseases are significantly increased. It also indicates that two thirds of women who succeed in stopping smoking whilst pregnant, restart after the baby is born.

48 Respect and Responsibility – Strategy and Action Plan for Improving Sexual Health, Scottish Executive (2005) – www.scotland.gov.uk/library5/health/shst.pdf

49 *Report of the Working Group on Sex Education in Scottish Schools*, Scottish Executive (2000) – www.scotland.gov.uk/library2/doc16/sexedwg.pdf

- 3.45 The universal core child health surveillance programme offers an opportunity to provide ongoing support to mothers who were successful in stopping smoking during pregnancy. It is also an opportunity to provide advice to parents about impact of their smoking on their child's health (both in the short and longer term), and to provide information about local smoking cessation services. However, as *Hall 4* emphasises, this must be done sensitively and within the context of providing wider support and health promotion advice, recognising that for many parents, smoking is a response to pressures and stresses of one sort or another.
- 3.46 Though trends have been moving in the right direction, the decline in smoking rates over the past 30 years have mainly been amongst more affluent groups. We know that some of the highest rates of smoking are to be found amongst our most disadvantaged communities. The approach advocated in *Hall 4* relates well to the need for targeted smoking cessation approaches. To assist professionals, NHS Health Scotland and ASH Scotland have developed *Smoking Cessation Guidelines for Scotland: 2004 Update*⁵⁰ and the companion desktop guide, *Encouraging Smokers to Stop: What You Can Do*. These provide up to date evidence on effective smoking cessation interventions and practical guidance on the delivery of smoking cessation services.
- 3.47 In January 2004, the Scottish Executive published the *Tobacco Control Action Plan*⁵¹ which sets out a programme for action spanning prevention and education, protection and controls, and the expansion of smoking cessation services. This recognises that achieving any reduction in smoking levels requires action to minimise the number of 'new recruits' to the smoking habit, and emphasises that in particular, "discouraging young people from starting to smoke needs to be given the utmost priority". 96 per cent of schools now provide education on tobacco. School nurses have a key role in this, as well as providing advice and support for young people who wish to stop smoking.

Drugs and alcohol

- 3.48 Implementation of *Hall 4* also links with, and can support action to, support children and young people in developing healthy attitudes to drugs and alcohol, and to support parents in talking to their children about these issues. Local Drug and Alcohol Action Teams (DAATs), the Scottish Executive and NHS Health Scotland have developed information and communications materials to support this. The core child health programme can also provide opportunities to identify parents and young people at risk of developing drug or alcohol problems, and to facilitate access to appropriate support services.

50 *Smoking Cessation Guidelines for Scotland: 2004 Update*, NHS Health Scotland and ASH Scotland – www.healthscotland.com/tobacco

51 *A Breath of Fresh Air for Scotland – Improving Health in Scotland: The Challenge – Tobacco Control Action Plan*, Scottish Executive (2004) – www.scotland.gov.uk/library5/health/abfa.pdf

- 3.49 Young people are one of the four pillars of the national *Tackling Drugs in Scotland* strategy, with a key aim “to help young people resist drug misuse in order to achieve their full potential in society”. To achieve this, 99% of schools are now providing drug education for school pupils, within a wider framework to encourage young people to make responsible and healthy lifestyle choices. The strategy also recognises the need for action to ensure that particularly vulnerable children and young people, including those who may not be attending school regularly, are able to access drugs and alcohol information and services. Local DAATs will be leading the development of prevention and treatment services for under 16s.
- 3.50 Children and young people are similarly highlighted as a key priority within the *Plan for Action on Alcohol*, which was published in 2002. An update is due to be published shortly.
- 3.51 *The Scottish Framework for Nursing in Schools*⁵² highlights the role of school nurses in supporting the multi-agency effort required to promote healthy attitudes to drugs and alcohol, through the provision of advice and support to teachers, children and young people, and their families. School nurses also provide an important link between NHS primary care services, schools, local DAATs and specialist addiction services.
- 3.52 Action to address drugs, alcohol and substance misuse is already an identified key priority for use of the Changing Children’s Services Fund.

52 *A Scottish Framework for Nursing In Schools*, Scottish Executive (2003) – www.scotland.gov.uk/library5/education/sfns.pdf



4

screening and detecting problems

health for all children 4: Guidance on Implementation in Scotland

Formal screening

- 4.1 Screening is the use of formal tests or examination procedures on a population basis to identify those who are apparently well, but who may have a disease or defect, so that they can be referred for a definitive diagnostic test. Some defects can only be detected by health professionals if a search is made or through the use of specific screening tests.
- 4.2 The UK National Screening Committee (NSC) was established in 1996 to advise the Department of Health and the devolved administrations in Scotland, Wales and Northern Ireland on all aspects of screening policy. In forming its proposals, the NSC draws on the latest research evidence and the skills of specially convened multi-disciplinary expert groups, which always include patient and service user involvement. The NSC assesses proposed new screening programmes against a set of internationally agreed criteria. In 1996, the NHS was instructed not to introduce any new screening programmes until they had been reviewed by the NSC. The NSC has endorsed the recommendations in *Hall 4*.
- 4.3 *Hall 4* found that much existing screening activity did not meet the criteria for screening tests, yet cogent arguments were often made for their continued usefulness in the evaluation and care of apparently healthy children.
- 4.4 Whilst screening has the potential to save lives or improve quality of life through early diagnosis of serious conditions, the process is not 100% accurate – in any screening programme, there are some false positive results (wrongly reported as having the condition) and false negative results (wrongly reported as not having the condition). Screening can reduce the risk of developing a condition or its complications, but it cannot guarantee protection. Parents should be made aware of the benefits and limitations of screening tests so that they can make informed decisions about whether to participate. Patient information leaflets on screening are already produced by and available from NHS Health Scotland. Parents should also be provided with information, including sources of support, following diagnosis.
- 4.5 Staff should always know when, where and how to refer a child whose screening test result gives cause for concern. The route of referral will depend on the particular condition and local protocols. Early detection has implications for other aspects of the child's care, including diagnostic and treatment facilities. Planning and monitoring of screening programmes must take into account the implications for these other services.
- 4.6 Children's services professionals across a range of settings should also be clear about sources of advice and referral protocols when they suspect that a child may have a problem which requires health assessment.

Hearing screening

- 4.7 In line with national guidance from the UK National Screening Committee and HDL(2001)51⁵³, all NHS Boards are expected to have introduced Universal Newborn Hearing Screening (UNHS) in 2005.
- 4.8 In line with the recommendations made in *Hall 4*, once UNHS is in place, universal distraction testing at 7-9 months should be abandoned. The National Newborn Hearing Screening Implementation Group has recommended that universal distraction testing should be discontinued once UNHS has been in place for one full year. The Group has already recommended increased vigilance amongst professionals in relation to risk groups such as children who have suffered from meningitis, received ototoxic drugs (i.e. those which may damage the hearing mechanism), children with middle ear disease and children with developmental disorders which may mimic hearing loss or be associated with hearing loss.
- 4.9 If the school entry hearing sweep test is currently in place, this should continue whilst further evidence about its effectiveness is collected and evaluated. No further routine hearing testing should be undertaken. Similarly, no new hearing screening programmes should be introduced until further evidence is available.
- 4.10 Audiology services must be able to respond to the concerns of referrers and parents promptly. NHS Boards should therefore review the local arrangements for access to paediatric audiology services and staff training to ensure efficient referral and testing for children with suspected hearing loss. Audiological assessment and follow up should be arranged automatically for any child who:
- Has had bacterial meningitis.
 - Has had prolonged treatment with ototoxic drugs.
 - Has had a severe head injury.
 - Is experiencing learning, behavioural or speech and language difficulties.
- 4.11 NHS Boards should ensure co-ordination of the local paediatric audiology programme, including screening, training, audit and monitoring.

Vision screening

- 4.12 All children should be screened by an orthoptist in their pre-school year, between the ages of four and five years, removing the need for vision testing on school entry. This reflects recommendations by the UK National Screening Committee and *Hall 4*, and is already being implemented in some areas using a database to manage orthoptist screening in pre-school centres, health centres and primary schools to maximise coverage and accessibility.

53 www.show.scot.nhs.uk/sehd/mels/HDL2001_51.htm

- 4.13 Until an orthoptist pre-school vision screening programme is in place, children's visual acuity should be tested on school entry by an orthoptist, or through a programme which is supervised by an orthoptist or an optometrist. The evidence for screening in secondary school remains inconclusive. On that basis, if screening on a single occasion is already in place, it should continue, but more frequent screening should cease, and no new vision screening should be introduced in secondary school.
- 4.14 There is little evidence of the benefits of screening for colour vision defects and no attempt should be made to screen for colour vision defects in primary school. If screening is already in place for adolescents, it should continue, but no new colour vision screening should be introduced. Adolescents whose career planning might be affected by a colour vision impairment should be advised to visit an optometrist for expert advice and assessment. Children and young people who are found to have a colour vision defect should be advised that this may be an important issue in relation to certain career choices.
- 4.15 Arrangements should be made for any child undergoing assessment for educational under achievement or other school problems to have a visual acuity check. Vision screening should also be undertaken in schools for children with hearing impairment.
- 4.16 One person in each NHS Board area should be designated to take overall responsibility for monitoring vision screening programmes.

Screening for postnatal depression

- 4.17 The universal child health surveillance programme offers a clear opportunity to detect those at high risk, and those who have developed symptoms and signs of a mental health problem.
- 4.18 Guidance on the identification and treatment of postnatal depression and perinatal mental illness has already been published in MEL(1999)27 and in the *Framework for Mental Health Services in Scotland*⁵⁴. This suggests that detection of postnatal depression may be done in the course of a routine assessment interview or by using the 10-item self-report Edinburgh Postnatal Depression Scale⁵⁵. Although *Hall 4* reiterates the advice of the National Screening Committee that screening for postnatal depression should not be routinely offered at present, the National Screening Committee has advised that, whilst the Edinburgh Postnatal Depression Scale (EPDS) should not be used as a screening tool, it may be used as a checklist as part of a mood assessment for postnatal mothers, alongside professional judgement and clinical interview. The SIGN guideline on postnatal depression⁵⁶ suggests that the EPDS should be used at approximately six weeks and three months following delivery and should be administered by trained health visitors or other health professionals.
- 4.19 Perinatal and Postnatal depression services are being expanded across Scotland.

54 *A Framework for Mental Health Services in Scotland, Scottish Executive (1999)* – www.show.scot.nhs.uk/publications/mental_health_services/mhs/Framework%20Document.pdf

55 www.rcpsych.ac.uk/publications/gaskell/81_1.htm

56 *Postnatal Depression and Puerperal Psychosis: A national clinical guideline*, No 60, Scottish Intercollegiate Guidelines Network (2002) – www.show.scot.nhs.uk/sign/pdf/sign60.pdf

Screening for obesity

- 4.20 *Hall 4* advises that where there is concern that a child may be overweight, his/her height and weight should be measured and the body mass index (BMI) calculated and recorded. It also recommends that health professionals should offer support to children and families who want to control their weight. However, *Hall 4* recommends against use of BMI for universal screening until there is consensus about the effectiveness of intervention programmes.
- 4.21 During the consultation on draft guidance, some argued that height and weight should be measured and BMI recorded more regularly than *Hall 4* advises. *Hall 4* advises against regular universal height and weight measurement as this takes up valuable practitioner time and there is little evidence of proven benefit in terms of outcome.
- 4.22 However, *Hall 4* does recognise that population trends in BMI might be useful for monitoring the impact of public health interventions and recommends that measurement of height and weight should be made at or around the time of school entry and measurements stored so that BMI can be calculated and used as a public health indicator. In Scotland, height and weight data have also been collected (though not consistently) for a number of years at P7 (age 10/11) and S3 (age 13/14). In order to ensure continued study of longitudinal trends, universal recording of height, weight and BMI should continue at P7, but only on a periodic basis, every three years. This will be triggered through the Child Health Surveillance School System and will commence in academic year 2007/08. Where it is in place, recording of height, weight and BMI at S3 should discontinue. This is reflected in Annex 1. Arrangements for identifying and monitoring obesity in children and young people will be kept under review.
- 4.23 Public health strategies to prevent obesity are reflected in the Health Promotion section of this guidance.

Developmental disorders and disabilities

- 4.24 Although routine developmental screening examinations may detect extreme variations from normal development, most disabilities and disorders are found by other means. They are often identified by examination in the period immediately after birth. They are often also detected by a child's parents or family, or professionals who are in regular contact with the child, by close observation and follow up of children at risk, or noted opportunistically when a child presents to health services for other reasons. Development is a continuum and it is sometimes difficult to separate 'normal' from 'abnormal' presentation at any precise age.
- 4.25 Evidence suggests that formal universal screening for developmental delay and disorder, speech and language delay, autism and co-ordination disorder makes little contribution to the detection of serious impairments, and it is not, therefore, recommended. *Hall 4* found that developmental screening programmes also performed poorly when tested against the National Screening Committee criteria.
- 4.26 The detection of problems is discussed further in the following two sections on surveillance in the early years and in school-age children and young people.



surveillance – early years

health for all children 4: Guidance on Implementation in Scotland

- 5.1 *Hall 4* sets out a core programme of health checks, screening activity and health promotion for all children from birth to five years. This would be supplemented by additional support for children and families identified as being in need and/or at risk. The reasons for that need of additional support may be wide-ranging and may not necessarily be linked to geographic area or economic status. This issue is considered in more detail in the “Targeting Support” section of this guidance.

The core universal programme of contacts

- 5.2 The content of the core programme of contacts for all children is set out in Annex 1 and is intended to ensure that every child and family receives a consistent minimum core programme of contacts, wherever they live in Scotland. The core programme in the early years provides opportunities to establish a comprehensive overview of the child’s state of health and family circumstances on the basis of routine checks and screening completed by health professionals such as midwives, GPs and paediatricians within the first 10 days following birth, and thereafter by the primary care team. Most examination and assessment is concentrated within the first six to eight weeks of life, with periodic contact and review thereafter.
- 5.3 Information gathered in this very early period should provide the basis for establishing the nature and frequency of contacts, on the basis of assessed need, co-ordinated by the health visitor and agreed with the family and, where necessary, with other agencies. This should assign the family to one of the models of continuing contact and support described previously in the diagram on page 5, and should also be recorded in the child’s own record:
- The core programme.
 - The core programme + structured additional support.
 - The core programme + intensive inter-agency support.
- 5.4 All families should receive the core programme of routine contacts for screening, checks, immunisations and health promotion advice and support as set out in Annex 1. Within this programme, some visits to the home are important to ensure a full assessment of the family’s needs.

5.5 There are contacts for immunisations at⁵⁷:

Age	Vaccine	Method
2 months	Diphtheria, tetanus, pertussis (whooping cough), polio and Hib (DTaP/IPV/Hib)	One injection
	Men C	One injection
3 months	Diphtheria, tetanus, pertussis (whooping cough), polio and Hib (DTaP/IPV/Hib)	One injection
	Men C	One injection
4 months	Diphtheria, tetanus, pertussis (whooping cough), polio and Hib (DTaP/IPV/Hib)	One injection
	Men C	One injection
Around 13 months	Measles, mumps and rubella (MMR)	One injection
3 years 4 months – 5 years	Diphtheria, tetanus, pertussis (whooping cough) and polio (dTaP, IPV or DTaP/ IPV)	One injection
	Measles, mumps and rubella (MMR)	One injection

- 5.6 These contacts should provide opportunities to review with the parent how they are coping and how their child is progressing, and to consider any concerns that the parent may have. By use of service redesign and skill mix in the primary care team, child health and immunisation clinics in primary care settings should be organised to facilitate effective health promotion and enable parents and carers to seek and receive advice by appropriately trained practitioners. This can be supported through integration of immunisation mail shots with the provision of age and stage appropriate health promotion and child development information, together with details of where parents can access advice and support if they have queries or concerns.
- 5.7 NHS Health Scotland is planning to extend its range of materials on child health and development to include a booklet and DVD on toddler parenting.

Surveillance contact at 7-9 months and 39-42 months

- 5.8 Analysis of Scottish information systems indicates that children in the most disadvantaged circumstances (post code areas in Deprivation Categories 6 and 7) are far less likely to take up these routine health checks. The most vulnerable children have therefore been least likely to benefit from advice and support from health professionals.
- 5.9 Health visitors and school nurses are currently involved in providing a range and level of routine child health contacts which some children and families do not need. With the redesign of services outlined in *Hall 4* and reflected in this guidance, and with the advent of a range of new services such as NHS 24, the support and advice networks available to parents are improving. Taking these changes into account, we propose that the present contacts at 7-9 months and 39-42 months for routine developmental checks should not be universally provided. This is intended to increase the capacity of health visitors and school nurses to focus on those children and families who are most in need of additional and intensive support.

57 NHS Health Scotland Immunisation Website – www.healthscotland.com/immunisation/

- 5.10 Beyond the core programme of contacts outlined in Annex 1, the health visitor should use their professional judgement, as they do currently, to consider the nature and frequency of further contacts with the family for review of child development, according to their needs. This should be negotiated and agreed with each family, and recorded. In addition to the agreed programme of contacts, opportunistic reviews should be undertaken as and when the family makes contact with the primary care team. The need for support may also be identified through other professionals in contact with the child and/or family such as early years settings or adult health services.

Contact at 24 months

- 5.11 For the reasons outlined above, the present routine developmental contact at 22-24 months should not be universally provided. The primary care team should ensure a universal health promotion and development contact for all families at 24 months, but this should not be provided in the same way for all families – the framework outlined in the diagram on page 5 should be used to determine the nature of the health promotion contact as follows:

Core programme – Written information circulated to all families about child development at this age, with an invitation to contact a designated person in the primary care team if the parent has any worries about their child. Information should be based on a parental checklist regarding the main areas of development in the Parent Held Child Health Record.

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

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

- 5.12 NHS Health Scotland is planning to develop a "checklist", linked to the proposed new toddler parenting booklet, to support the universal health promotion "contact" at 24 months.

Detecting developmental problems

- 5.13 Some concern was expressed in the consultation exercise, that developmental problems may be missed in children who receive only the core universal programme outlined in Annex 1. *Hall 4* suggests that parents, relatives, early years and other health staff detect most problems in the course of their routine contact with the child. However, they need accurate information about the normal range of development and where to seek advice if they have concerns (see *Responding to Concerns* on page 37).

- 5.14 Delayed language development may occur in isolation, but may also occur in association with other problems such as conductive deafness, cognitive impairment, behaviour and conduct disorders and attention deficits. It may also be a presenting feature of other serious disorders. Health and early years professionals should therefore be vigilant in looking out for speech and language disorders and other communication and developmental conditions, such as autism, which may become more obvious in the second year of life. Children with neurosensory or conductive deafness may present with delayed speech at this time.
- 5.15 *Hall 4* advises that delay in walking is also common and usually nothing for parents to worry about before the age of 18 months. Children whose delay in walking has an underlying neurological reason are usually identified early on, and normally by 18 months. But there are risk factors to look out for. Boys who appear to be slow in walking, who do not have a family history of bottom shuffling, or who also have evidence of developmental delay, who show evidence of clumsiness or weakness, or have difficulty with running or stairs, should have a creatine phosphokinase estimation to exclude muscular dystrophy.
- 5.16 Where there is a concern about an individual child's presentation or development, formal assessment to confirm or refute these initial suspicions is desirable. This should be undertaken as part of a more comprehensive clinical assessment involving the network of child development services and should include consideration of referral to a community paediatrician.
- 5.17 *Hall 4* identifies the following services and systems that are required to ensure early identification of disabilities and disorders:

Universal core programme

- Competent, thorough neonatal examination.
- Assessment of family circumstances and need for support within 8 weeks.
- Developmental review and health promotion contacts at agreed ages, with inclusion of both open and structured questions to parents or carers about the child's progress.
- Accurate information to parents and carers about milestones in healthy child development in an accessible format.

Structured additional or intensive support

- Planned follow-up of newborns judged to be at high risk.
- Follow-up of infants and children suffering any form of neurological insult.
- Recognition that parents are often right when concerned about their child's development, coupled with easy access to specialised assessment when needed.
- A holistic approach to assessment that recognises how the impact of several minor problems can be cumulative and cause significant disability.
- Training and support of child care staff to identify possible problems and act appropriately when concerned. NHS Boards should ensure that appropriate training is available.
- Network of health, social and educational services that can provide a prompt, co-ordinated response to referrals within clear care pathways.

- 5.18 NHS Boards should bring the attention of education authorities to children who are under three years of age and who have a disability. The education authority may make an assessment of the child's needs and provide appropriate additional support to meet these.

Responding to concerns

- 5.19 Parents are often the first to suspect that something is amiss with their child. Practitioners in contact with children, such as nursery and playgroup staff, also become skilled at identifying the child whose health or development requires further assessment. The universal core programme has an important role in early detection of problems, but identification of new problems cannot rely wholly on universal screening and surveillance. Parents and formal and informal carers in touch with children need accurate information about child development to help them understand the significance of their observations, and about appropriate sources of advice or referral for diagnostic assessment. This should be addressed through joint work between local authorities and NHS Boards, via Community Health Partnerships.
- 5.20 It is essential that parents know where to go for advice when they have a concern about a child. Health visitors, school nurses and GPs are likely to be the first point of contact when parents have concerns. Health professionals should be equipped to advise and support parents to clarify their worries. They can help parents to decide whether, when, and how to obtain assessment or advice on child development.
- 5.21 When they seek help, anxious parents must receive an alert and sympathetic response to their concerns. They should not be given reassurance without careful exploration of the basis for their concerns. Professionals who reassure parents inappropriately can contribute to avoidable delay in the diagnosis of disabilities.
- 5.22 Parents may raise their concerns with staff in their child's nursery, pre-school or school. Education and childcare staff already have some valuable expertise in child development, and this should be enhanced by training so that they too, are able to help parents seek appropriate advice.
- 5.23 Early years staff should also already be observing, assessing and recording children's progress against the five key curriculum areas on a regular basis, and are well-placed to support review of a child's development. Non-health professionals may require additional training and support to assist them in providing this extremely valuable input. However, there is no assumption that nursery nurses or other pre-school practitioners are to become experts in child health and development. Rather, the proposal is to build on and use more effectively the work that these practitioners are already doing, and to ensure that readily accessible advice is available for staff when they are concerned about a child. Whilst early years staff are in a prime position to encourage children to adopt healthy lifestyles and to identify potential causes for concern, they should raise any concerns with a health or social services professional for follow-up.

- 5.24 Every NHS Board area has access to multi-disciplinary teams for diagnosis of illness and disability in children. In some cases, these are based in multi-agency child development centres, whilst in others, they are part of community child health services or hospital based paediatric teams. As part of the integrated assessment framework⁵⁸, NHS Boards will need to work with their partners in local authority children's services to ensure that there are explicit care pathways for parents with concerns about their child's development. These care pathways should be recorded and disseminated to all health, education and social services professionals working in children's services. The care pathway should include local arrangements for referral and access to multi-disciplinary assessment of child development either in a child development centre or in NHS secondary care services. Wherever possible, the pathway should indicate where parents can access sources of general information and support directly, for example through helplines, voluntary organisations and parent support groups.
- 5.25 Local care pathways should describe referral and access arrangements for assessment and treatment of:
- Problems with movement or walking.
 - Problems with vision and/or hearing.
 - Communication.
 - Developmental delay.
 - Emotional and behavioural difficulties.
 - Problems with growth, including failure to thrive.
- 5.26 Local care pathways and protocols should be monitored and evaluated on an ongoing basis to ensure their effectiveness.

⁵⁸ See *Identifying Need and Targeting Support* section, page 44.



surveillance – school-age children and young people

health for all children 4: Guidance on Implementation in Scotland

- 6.1 Although each child will receive a health check on entry to primary school, there is little formal child health surveillance beyond this point. For school-age children, both health promotion and the detection of problems should be a part of mainstream school life. (Health promotion is discussed in an earlier section of this guidance.)
- 6.2 The new GMS (General Medical Services) contract and the emerging Community Health Partnerships are essential building blocks in delivering health care for school-age children and young people. *Hall 4* highlights that on average, school-age children are in contact with their GP twice per year between the ages of 5 and 14, rising to three times per year between the ages of 15 and 17. Each contact between a primary health professional and a child should be seen as an opportunity for ongoing child health surveillance, used to detect any health issues or concerns and to provide health promotion advice. Innovative approaches should also be developed to incorporate this within other key contacts such as immunisation points, interaction with the school nursing service, and in the context of the health promoting school concept.

The core programme of contacts

- 6.3 The core programme of child health contacts with school-age children and young people is outlined in Annex 1. Children and young people will continue to be immunised as follows⁵⁹:

Age	Vaccine	Method
10-14 years	BCG (against tuberculosis)	Skin test then, if needed, one injection
13-18 years	Tetanus, diphtheria and polio (Td/IPV)	One injection

- 6.4 These immunisation contacts provide an opportunity for health professionals to check a child's immunisation status and to provide health promotion material and information about where children, young people and their parents can access support and advice if required.

Identifying problems and providing support

- 6.5 The majority of children with a serious disability or disorder will be identified in the course of their early and pre-school years. However, some needs will only become evident in a classroom context. Teachers get to know their pupils well in the first year of primary school and are already required to review each child as part of a baseline assessment process.
- 6.6 The Education (Additional Support for Learning) (Scotland) Act⁶⁰ was passed in 2004 and comes into force from Autumn 2005. The Act will replace the current Record of Needs system and marks a move from the term "special educational needs" to a much wider and more encompassing concept, "additional support needs". The new term incorporates any factor which causes a barrier to learning and could relate to social, emotional,

⁵⁹ NHS Health Scotland Immunisation Website – www.healthscotland.com/immunisation/

⁶⁰ Information about the Additional Support for Learning Act is available on the Scottish Executive website – www.scotland.gov.uk/library5/education/aslbsh-00.asp.

cognitive, linguistic, disability, or family and care circumstances. For instance, additional support may be required for a child or young person who is being bullied; has behavioural difficulties; has learning difficulties; is a parent; has a sensory or mobility impairment; is at risk; or is bereaved. Some additional support needs will be long term while others will be short term and the effect they have will vary from child to child. However, in all cases, it is how these factors impact on the individual child's learning that is important, and this will determine the level of support required.

- 6.7 Under the new legislation, education authorities are required to identify, address and keep under review provision for the needs of all children and young persons with additional support needs for whose education they are responsible. They are also required to publish their policy and arrangements for identifying and addressing additional support needs, what the role and rights of parents and children and young people are, and who they should contact to obtain information and advice.
- 6.8 In identifying and addressing children's additional support needs, local authorities must seek and take account of information (including formal assessments) from other agencies such as health and social work services. When requested, health, social work and other agencies will be expected to provide advice and information, including reports and formal assessments, to assist the local authority in identifying a child's or young person's additional support needs and, where necessary, establishing a Co-ordinated Support Plan. This will be a statutory, strategic, long-term planning document for children and young people with the most complex needs, who require support from services outwith education to support their learning. Parents have new rights including the right to ask the education authority to assess their child for additional support needs, and to ask for a particular type of assessment, such as a medical assessment.
- 6.9 The Scottish Executive is preparing a Code of Practice to set out how the new system will operate, and on proposals for the timescale in which agencies must respond to an education authority request for assistance for an individual child. Primary care staff will need to be familiar with the provisions of the Act and the guidance provided in the Code, and clear and efficient referral pathways for expert assessment must be in place and familiar to teaching staff.

School nursing

- 6.10 In the context of the school nursing framework⁶¹, school nurses have a key role in delivering the aims of *Hall 4* for school age children and young people. This is particularly relevant in relation to delivering the core programme but also in relation to identifying, assessing and delivering support to children with particular needs. The framework refocuses the nursing service in schools to ensure that best use is made of school nurses' skills and expertise. Nurses working in schools should focus less on routine surveillance of children and young people and take a more proactive approach to assessing and meeting the health needs of each school, promoting healthy lifestyles and healthy schools, supporting children with chronic and complex health needs, and supporting vulnerable children and young people.

61 *A Scottish Framework for Nursing in Schools*, Scottish Executive (2003) – www.scotland.gov.uk/library5/education/sfns.pdf

- 6.11 NHS Boards are developing action plans for implementing the school nursing framework, which signalled that additional investment would be required to increase the number of staff to meet the new demands.

Transition

- 6.12 The transition from early years to primary school, primary school to secondary school, and from secondary school to employment or further education or training have been identified as vulnerable stages of development for children and young people. Transitions between geographical and agency areas can also be vulnerable points. The exchange of information within and between agencies at these points has been identified as a major weakness in the way that services are delivered to meet the identified needs of individuals and families. This is particularly relevant in relation to the needs of vulnerable children and the exchange of information that allows agencies to carry out integrated assessment of need and to track these individuals. It is particularly important that information is passed on where there are concerns about a child's welfare.
- 6.13 A transition record is already completed at the end of pre-school and passed on to primary schools, though practice currently varies across Scotland. NHS Boards and local authorities should work together to develop mechanisms for the transfer and use of this record by both school health and education staff, and ensure that these arrangements extend to partner providers of pre-school education. It is important that robust mechanisms are in place to ensure that any information about a child's health needs is transferred efficiently when a child transfers between institutions.
- 6.14 The years from the early stages of secondary school education and adolescence to adulthood are times of great change for young people. It is vital that in this period, young people feel supported, maintain self-esteem, and avoid a wide range of health-damaging behaviours and other hazards. Schools, working in partnerships with families and communities, can make a vital difference in this period.
- 6.15 The Additional Support for Learning Act includes provisions to strengthen future needs planning arrangements for those young people with additional support needs, who need extra help, to ensure a successful transition to post-school life. The Act requires that transition planning should begin at least 12 months before a young person will leave school. The Code of Practice, when finalised, will recommend that joint planning and preparation should be carried out by the education authority and identified future agencies well before this date. Education authorities will be required to provide information to other agencies at least 6 months before the young person leaves school to allow them adequate time to prepare.

Independent schools

- 6.16 Independent schools should ensure that arrangements are in place for pupils to receive health promotion advice and activities, including immunisation, consistent with this guidance.

Children outwith school

- 6.17 In planning and delivering the universal core programme of contacts, NHS Boards should make particular arrangements to identify those children who are not in school, and to ensure that they receive care and support consistent with this guidance. This will require close liaison between NHS and education authority services. These children and young people may include those who:
- Are home educated.
 - Are in secure or special residential care with associated education provision.
 - Are in hospital or residential respite care.
 - Have been excluded from school.
 - Are truanting.
- 6.18 The *Framework for Nursing in Schools*⁶² recommends that community, practice and school profiling should identify vulnerable groups of children and young people who may require extra or different support and help, and that school nurses should be supported to work in a range of settings in order to meet these needs. The *Framework* also recognises that the needs and problems of school age children and young people are not restricted to term time and can often be more exaggerated during the school holiday periods. It advises that this should be reflected in appropriate service provision.
- 6.19 These issues link with the following section on Identifying Need and Targeting Support.

62 *A Scottish Framework for Nursing in Schools*, Scottish Executive (2003) – www.scotland.gov.uk/library5/education/sfns.pdf



7

identifying need and targeting support

health for all children 4: Guidance on Implementation in Scotland

- 7.1 All children in an area will require primary health surveillance and health care, whatever their circumstances. This does not, however, imply that all families must receive the same service in the same way. *Hall 4* highlights that some families may need substantially more input than others to achieve greater equity of outcome, and this approach is demonstrated in the diagram on page 5. But *Hall 4* also suggests that at present:
- The distribution of health visitors across the UK shows little correlation with deprivation levels.
 - Most health visitors target their time according to the perceived needs of their clients but the extent of this, measured by the ratio of time devoted to the most versus the least needy clients, varies widely.
 - Taking into account caseload size and deprivation levels of each caseload, there are substantial differences between the workload of individual health visitors.
 - Allocation of health visitors (and other similar resources) should be based on a formula using these parameters.

Assessing need for additional or intensive support

- 7.2 Almost all families will, at some point, experience difficulties and may, for a period of time, need some extra support. However, some children and families will face particular challenges in their lives and need different, additional or intensive support to overcome them. No one method has proved superior in identifying all children and families who may be in need and require something different or additional to the universal core programme.
- 7.3 The universal core programme provides opportunities for health professionals to identify children and their needs, and to ensure appropriate planning for additional or intensive support when necessary, in line with the model on page 5. There is a range of tools and checklists which can be used to assist this process, but these should not be used in isolation. The reasons for decisions about assessed levels of need and appropriate responses should be recorded.
- 7.4 When there are serious and complex needs, support is likely to be required from colleagues in other services and sectors to undertake a comprehensive assessment which considers:
- **What a child needs to grow and develop**, including health and education, social skills, confidence and independence, and the ability to form appropriate relationships.
 - **What a child needs from those who look after them**, including good basic care, stimulation and emotional warmth, guidance and boundaries, safety and stability. It is important to establish a picture of the ability of parents and caregivers to understand and meet the needs of their child. Family circumstances can have a significant impact on the ability and confidence of parents and caregivers to look after their child and encourage their progress and development.
 - **The child's wider world**, including their wider family, their financial and housing circumstances, their neighbourhood and the social networks in which they live. An account of the family's community and wider world assists in understanding how a child or young person is developing and the opportunities that their carers have to respond to their needs.

- 7.5 The assessment should also consider factors which may enhance a family's capacity to cope with stresses or problems, such as the availability of extended family support, good relationships with friends or neighbours or factors promoting personal resilience. The objective is to plan the right course of action to achieve positive outcomes for the child.
- 7.6 As indicated in the Policy Context section of this guidance, the Scottish Executive will shortly be consulting on proposals to strengthen the way in which children's needs are identified and met, and to clarify individual agency and collective responsibilities. All Scottish Executive consultations are published on the Scottish Executive website at – www.scotland.gov.uk/Consultations/Current.

Integrated Assessment Framework

- 7.7 The Scottish Executive is also developing a model for an Integrated Assessment Framework, which will be subject to full consultation. The aim is to facilitate efficient and effective information sharing and assessment and lead to integrated support for children across all agencies. The Framework will establish a common set of core data that can be shared across organisations when there is either consent, or cause for concern. The core record will include a chronology of key achievements, events, developments and changes in a child's life so that the pattern and any impact on the child can be observed, and if necessary, responded to.
- 7.8 The Framework will support the integration of a range of information and assessments from different professionals and agencies into a coherent view of a child's strengths and needs. Children are already assessed in a variety of ways within universal and specialist services. The difference will be that all professionals will be working to the same frame of reference – the Integrated Assessment Framework – and will be required in their assessments to take account of the child's life in the context of the families and communities within which they live. The proposal will mean that a child will not have to be subjected to repeated assessments if he/she moves from one geographical area to another, as the assessment information will transfer with the child and be able to be built on and updated in the new area. When children and young people move at key transition stages in their lives, for example from primary school to secondary, or at school leaving age, important information can go with them.

The Framework will:

- Set out common standards and processes for recording and decision-making.
- Set out what assessment involves.
- Define the information to be taken into account when assessing the “whole” child or young person.
- Provide guidance on when multi-agency assessments should be undertaken.
- Provide guidance on using information to establish an assessment and action plan.
- Set out requirements for the electronic sharing of information.
- Set out clear guidance for information sharing and in what circumstances information should not be shared.
- Ensure that parents, children and young people have clear information about safeguards for information, about giving consent to share and identifying circumstances in which some information which they might prefer to keep private might need to be shared.

Protecting children and young people

- 7.9 All agencies and professionals in contact with children and families have an individual and shared responsibility to contribute to the welfare and protection of vulnerable children and young people. This applies equally to services for adults, working with parents to tackle problems which may have a negative impact on the care or wellbeing of their child. Every professional in contact with children or their families must be aware of their duty to recognise and act on concerns about child abuse or neglect.
- 7.10 Implementation of *Hall 4* does not change or impact on the services in place across Scotland, which local agencies have reviewed in the context of *It's Everyone's Job to make Sure I'm Alright*⁶³ and the child protection reform programme, to improve both individual agencies' practice and effective integrated working. As part of this process, NHS Boards have been asked to implement a plan for immediate action⁶⁴.
- 7.11 As part of the national child protection reform programme⁶⁵, the Scottish Executive has published a Charter⁶⁶, setting out what children and young people need and expect to help protect them when they are in danger of being, or have already been, harmed by another person. There are key messages for all those who provide services for children and families about the importance of maintaining a child-focus, rather than a process or single-agency focus, and the need to reflect this in practice. *A Framework for Standards*⁶⁷ has also been developed to translate the commitments made to children in the Charter into practice. It sets out what each child in Scotland can expect from professionals and agencies to ensure that they are adequately protected and their needs are met. It also sets out what parents or other adults who may report abuse and neglect can expect.

Domestic abuse

- 7.12 Domestic abuse is a serious social problem in its own right and is also profoundly damaging to children's emotional and social development. Domestic abuse may begin, or become more serious during pregnancy and research into incidence in primary care populations has identified that domestic abuse may occur more often than physical conditions for which we routinely offer screening. The Scottish Executive published guidelines for health care workers on responding to domestic abuse⁶⁸ in March 2003, which provide information about the nature of the problem and how to equip services to facilitate disclosure and provide appropriate support for women experiencing abuse, and their children. This includes advice for community based health professionals including midwives, health visitors and GPs on how to ask questions and explore the area of violence within family relationships.

63 *It's Everyone's Job to Make Sure I'm Alright: Report of the Child Protection Audit and Review*, Scottish Executive (2002) – www.scotland.gov.uk/library5/education/iaar.pdf

64 Child Protection: Plan for Immediate Action, Letter to NHS Boards, December 2003 - www.show.scot.nhs.uk/sehd/publications/DC2003120ChildProt.pdf

65 www.scotland.gov.uk/about/ED/CnF/00017834/childprotection.aspx

66 *Protecting Children and Young People: The Charter*, Scottish Executive (2004) – www.scotland.gov.uk/library5/education/ccel.pdf

67 *Protecting Children and Young People: A Framework for Standards*, Scottish Executive (2004) – www.scotland.gov.uk/about/ED/CnF/00017834/page1423929284.pdf

68 *Responding to Domestic Abuse: Guidelines for Health Care Workers in NHSScotland*, Scottish Executive (2003) – www.scotland.gov.uk/library5/health/rdag-00.asp

- 7.13 Where there is a history of domestic abuse within a family, or any indication of injury or assault upon an adult, professionals providing or contributing to programmes of additional or intensive support should be alert to and ask parents about the possibility of domestic abuse, and consider the potential for harm to any children involved.

Substance misuse

- 7.14 *Hidden Harm*⁶⁹ estimated that between 41,000 and 59,000 children in Scotland have a drug-misusing parent, and between 80,000 and 100,000 are affected by a parents' alcohol misuse. There needs to be a concerted effort from all services and professionals to ensure that the needs of these children are met and that they are protected from harm. The Scottish Executive's response⁷⁰ to *Hidden Harm* was published in 2004.
- 7.15 Guidance⁷¹ for professionals working with children and families affected by substance misuse was published in 2003. This sets out the minimum expectations on service providers, planners and commissioners to protect the welfare of these children and to ensure that their needs are being met. It stresses the importance of cross-cutting work between social work, health, adult and children services and other agencies in education and criminal justice, and highlights good practice. All Drug Action Teams and Child Protection Committees are required to have in place local policies to support substance misusing parents and their children in line with this guidance. NHS staff working with children and families should be familiar with the guidance and with their local policy for supporting substance misusing parents and their children.

Support for children, young people and their families

- 7.16 *Growing Support*⁷², a Scottish review of multi-agency support provided for vulnerable families with very young children, found a broad consensus across professions and support agencies about the factors that make children and families more likely to be vulnerable. There was less agreement about the respective agencies' responsibilities to intervene. Although the review found examples of excellent support for children and families by health services, much health care was reactive, and preventative work took little account of the difficulties that vulnerable families may have in following the comprehensive and sensible advice offered. Health visitors' contact with parents and children needs more careful focus to avoid duplication, superfluous surveillance, and to achieve maximum impact. A greater focus on health promotion and direct work with parents rather than routine health surveillance would better meet the needs of vulnerable families.

69 *Hidden Harm – Responding to the needs of children of problem drug users*, the report of an inquiry by the Advisory Council on the Misuse of Drugs, Home Office (2003) – www.homeoffice.gov.uk/docs2/hiddenham.html

70 *Hidden Harm: Scottish Executive Response to the Report of the Inquiry by the Advisory Council on the Misuse of Drugs*, Scottish Executive (2004) – www.scotland.gov.uk/library5/health/hhser.pdf

71 *Getting our Priorities Right – Good Practice Guidance for Working with Children and Families Affected by Substance Misuse*, Scottish Executive (2003) – www.scotland.gov.uk/library5/education/gopr.pdf

72 *Growing Support: A Review of Services for Vulnerable Families with Very Young Children*, Scottish Executive (2002) – www.scotland.gov.uk/library5/social/gsr.pdf

- 7.17 A review of local provision of parent education and support programmes⁷³ found an extensive range of services offering practical help, information, parenting education and advice, and emotional support to parents in difficulty in each local authority area, delivered by health and social work professionals in organisations in the public, voluntary and independent sectors. NHS Boards and local authorities should continue to work with voluntary and private sector partners to provide programmes and models to suit local needs.
- 7.18 In addition to practical support programmes, there is a wide range of local and national support networks for families experiencing particular problems, as well as more general help lines such as ChildLine and ParentLine. NHS professionals should ensure that children, young people and their families are aware of the range of support mechanisms available to them, and help them to access these.

Service design and planning

- 7.19 Redesigning universal health services to provide more effective support for vulnerable children requires NHS Boards and primary care teams to work closely with local authorities. As well as identifying individual children and families, NHS Boards should work with their local authority partners within the integrated children's services planning context, to assess levels of need within particular communities and allocate resources, such as input from health visitors, school nurses, public health practitioners and health promotion services, to reflect any concentration of need in particular areas or communities. Relevant voluntary agencies and projects should also be involved, given the specific expertise that many have in supporting families.
- 7.20 In some cases, a family's need for support will be apparent in the pre-birth or neonatal period, and the child and parents will already be receiving additional or intensive support from a midwife, health visitor and/or other agencies. If this is the case, efforts should be made to maintain continuity in care as far as possible, and to build on the relationships already established with the family.

⁷³ *Supporting Parenting in Scotland*, Sheila Henderson, Social Work Research Findings No 33, Scottish Office (1999)



8

information collection and sharing

health for all children 4: Guidance on Implementation in Scotland

- 8.1 All agencies gather information from children and families to enable them to decide how best to help, and to keep records of their contact with children and families including details of their assessments, plans for intervention, treatment and support. Systematic data recording and efficient information sharing is vital for effective teamwork within and across agencies to implement *Hall 4* effectively.

Child health information systems

- 8.2 The current child health information systems are well established, though with the exception of the Scottish Immunisation and Recall System (SIRS), they are not currently used in all NHS Board areas. They are primarily clinical systems (as opposed to being merely data collection systems) and provide useful support to clinicians dealing with children. The paper forms, computer input screens and output reports, upon which these systems are based, require review and revision to support implementation of *Hall 4*. The systems will also need improved communication with each other and with other systems. Interim amendments are being made to the existing systems to ensure compatibility with *Hall 4*, and these will be in place by July 2005.
- 8.3 The Scottish Executive has established a Maternal and Child Health Information Strategy Group (MCHISG) to develop a strategic approach to the development and implementation of integrated information systems for children. This will involve redesigning the child health systems, working towards a single integrated record using modern technology. This work will provide a clear direction for the development of child health information systems, both in the light of *Hall 4*, and also in recognition of clinical and public health need for better information and communication in child health. The MCHISG has identified some key priorities to be addressed including support for *Hall 4*, information sharing within the NHS and with other agencies, development of an integrated child health record, support for patient access to their information, and support for patient transitions.
- 8.4 The MCHISG has recently completed its first report, with recommendations for the future of child health systems over the next 5 years. The proposals include:
- A nationally agreed set of child health information data standards.
 - A single electronic integrated child health record.
 - National CHI registration at birth.
 - A national Child Health Surveillance Programme clinical screening and surveillance system.
 - Systems for clinical specialities and specialised information requirements.
 - A national maternity system.
- 8.5 The report will be presented to the e-Health Board to inform national development of IT and clinical information systems.

Effective monitoring

- 8.6 Current child health information systems provide invaluable information about the uptake of screening programmes, referrals of children with development problems or disabilities, false negatives, and time lapses between referral and diagnosis and between diagnosis and treatment. It is important to keep under review age at diagnosis, false positive rates, waiting times at each point in the network of services and differences between age of diagnosis for high risk and low risk cases. The development of a single electronic integrated child health record discussed above will support this monitoring.

Information collection

- 8.7 Systems for recording, storing and retrieving information gathered from children and families or generated in the course of professionals' work provide:

- A record for the clinician or practitioner of the work undertaken and the outcomes to assist their ongoing work with the family, and to ensure they are accountable to their patient or client, to their profession, and to their employing organisation or equivalent.
- Aggregate information about presenting conditions and problems, what was done and the outcome to assist managers and planners to assess needs and plan services.
- Information for families about their child's health status and treatment or care.

- 8.8 As indicated in the previous section of this guidance, the Scottish Executive will be consulting on an Integrated Assessment Framework, intended to secure more consistency in the type and format of information gathered about individual children, and to support more effective information sharing. This links with and will build on current eCare pilots, funded through the Modernising Government Fund (MGF), which are developing IT systems for exchanging and making effective use of information to ensure more integrated support for children and young people. They are also developing change programmes around ways of working across agency boundaries. The Scottish Executive is working with local authority and health partners in Aberdeen, Glasgow, Dumfries and Galloway and Lanarkshire to pilot the following:

- **An integrated children's service record** to define and develop the structures and standards for an integrated care record for children, integrating health, social work and education.
- **An integrated assessment framework** that will allow the sharing of assessment information between the partner agencies.
- **A personal care record** to provide a secure store for the records of a child from health, education, and social services and the Scottish Children's Reporters Administration.
- **A framework for sharing information about children at risk** to extend the technologies and processes currently used to share information on older people in Lanarkshire, to children with child protection issues.

- 8.9 The eCare pilots are due to be completed in 2005. The products and learning from these development projects will be made available on the eCare web site in due course – www.ecare-scotland.gov.uk.

Information sharing

- 8.10 In order to identify and address children's holistic needs, information sharing within and across agencies is vital.
- 8.11 One of the aims of eCare is to develop systems and procedures that will ensure that as many barriers to information-sharing as possible are removed. eCare is much more than an IT solution. It is about ensuring that organisation and cultural change also occurs to enable practitioners to feel comfortable in using the tools and in sharing information across agencies.
- 8.12 Health professionals should inform and advise parents and, where appropriate, children, that to provide proper care, information is recorded in written records and on computer. Each organisation involved in a child's care should be able to give parents, carers and children information about how data is collected, how it is stored and shared, and the safeguards in place to ensure that only those who need it will have access to patient or client information. Sharing information between professionals and agencies should be based on parental consent unless there are concerns about a child's welfare or safety which would override patient confidentiality.
- 8.13 The Scottish Executive is developing guidance for health professionals on consent and confidentiality issues, which will be published for consultation. This will include advice on the capacity of children and young people to make decisions for themselves and circumstances in which there is a difference of opinion between a child or young person and their parent.
- 8.14 In the meantime, the Executive has already published good practice guidance⁷⁴ on sharing information about children at risk for health professionals and other agencies working with families. A one-page summary⁷⁵ has also been published. This stresses that if there is concern that a child may be at risk of harm, this will always override a professional or agency requirement to keep information confidential. It also advises professionals responsible for adults with serious illness, including adults with severe mental illness, drug or alcohol dependence or brain injury, that they should always consider the impact on any dependent children. NHS Boards should ensure that staff across Divisions are familiar with the advice set out in the summary good practice guide.

74 *Sharing Information About Children At Risk: A Guide to Good Practice*, Scottish Executive (2003) – www.scotland.gov.uk/library5/health/sicr-00.asp

75 *Sharing Information About Children At Risk: A Brief Guide to Good Practice*, Scottish Executive (2004) – [www.show.scot.nhs.uk/sehd/cmo/CMO\(2004\)19.pdf](http://www.show.scot.nhs.uk/sehd/cmo/CMO(2004)19.pdf)

Information for families

8.15 National guidance⁷⁶ sets out the requirements for effective working in partnership with parents. This depends on good information for parents from professionals. Achieving partnerships with parents and children in the planning and delivery of services to children requires that:

- They have sufficient information at an early stage both verbally and in writing to make informed choices.
- They are aware of the various consequences of the decisions they may take.
- They are actively involved wherever appropriate in assessments, decision-making, care reviews and conferences.
- They are given help to express their views and wishes and to prepare written reports and statements for meetings where necessary.
- Professionals and other workers listen to and take account of parents' and carers' views.
- Families are able to challenge decisions taken by professionals and make a complaint if necessary.
- Families have access to independent advocacy when appropriate.

The Parent Held Child Health Record

8.16 *Hall 4* reviewed the use and content of the Parent Held Child Health Record (PHCHR), introduced a decade ago to facilitate partnership with parents and empower them in overseeing their child's development and health care. Parents and health professionals make varied use of the PHCHR. Whether professionals make entries in the book or ask for it at health appointments or at contact with services such as attendance at Accident and Emergency Departments, is important to parents and influences how they view the book. NHS Boards should adopt the PHCHR as a basis for recording information on child health.

8.17 Each local health care system has tended to develop its own version of the PHCHR, which has undermined its usefulness when families move from one area to another. A UK working group has reviewed and revised the PHCHR in the context of the recommendations made in *Hall 4*.

⁷⁶ Scotland's Children: The Children (Scotland) Act 1995 Regulations and Guidance – Volume 1: Support and Protection for Children and their Families, Scottish Office (1997).



annex 1

the universal core programme
for child health screening and
surveillance

health for all children 4: Guidance on Implementation in Scotland

Universal Core Programme of Contacts

Neonate – first 24 hours

- Full clinical examination, including:
 - Examination of the palate
 - Hip test for dislocation (Ortolandi and Barlow manoeuvres)
 - Inspection of eyes and examination of red reflex
 - Thorough check of cardiovascular system for congenital heart disease
 - Check genitalia (undescended testes, hypospadias, other anomalies) and record testicular descent
 - Check femoral pulses
- Plot and record birth weight
- Record head circumference
- Record length (only if abnormality suspected)
- Record length of pregnancy in weeks
- Record problems during pregnancy/birth
- Record feeding method at discharge
- Vitamin K administration, following discussion with parents
- Review any problems arising or suspected from antenatal screening, family history or labour
- Neonatal hearing screening (being phased in)
- Health promotion – discuss:
 - Baby care
 - Reducing SIDS risks
 - Feeding
 - Jaundice, Hepatitis B and BCG Vaccines
 - Smoking cessation
- Discuss any parental concerns
- Identify parents who might have major problems with their infant (e.g. domestic violence, substance abuse, learning difficulties, mental health problems)
- Provide information about local support networks and contacts for additional advice or support when needed

Early discharge

Where a mother and baby are discharged within 24 hours, arrangements should be made to ensure that the full neonatal examination is completed.

Neonatal hearing screen

HDL(2001)51, which issued in June 2001, advised the service about the introduction of universal newborn hearing screening. NHS Boards are expected to implement the screening programme in 2005.

Vitamin K

Each NHS Board area should have a single protocol for the administration of Vitamin K, with which every member of staff involved with maternity and newborn is familiar.

Screening

Advise that no screening test is perfect. Details of signs and potential emerging problems in PHCHR and who to contact if concerned.

Within first 10 days of life

<ul style="list-style-type: none"> • Plot and record weight (where appropriate on clinical suspicion) • Blood spot test for – phenylketonuria, hypothyroidism & cystic fibrosis • Record feeding method • Record whether there are smokers in the household • Record diagnoses or concerns (coded): <ul style="list-style-type: none"> > Feeding > Illness > Crying > Appearance > Weight > Sleeping > Child protection issues > Other • Impairment/abnormalities in infant • Parents' health and wellbeing • Discussion of birth registration • Health promotion – discuss: <ul style="list-style-type: none"> > Reducing SIDS risks > Immunisation schedule > Feeding > Safety > Parenting skills > Smoking cessation • Discuss any parental concerns • Identify parents who might have major problems with their infant (e.g. domestic violence, substance abuse, learning difficulties, mental health problems) • Provide information about local support networks and contacts for additional advice or support when needed 	<p><u>Cystic fibrosis screening</u> HDL(2001)73, which issued in October 2001, advised about the introduction of a newborn screening programme for cystic fibrosis using the existing blood spot test. The programme was introduced across Scotland in February 2003.</p> <p><u>PKU and congenital hypothyroidism</u> HDL (2001)34, which issued in April 2001, provided guidance on the organisation of newborn screening for phenylketonuria and congenital hypothyroidism.</p> <p><u>Haemoglobinopathies</u> Assessment work in relation to screening for haemoglobinopathies is currently underway. No decision has yet been taken in relation to a screening programme in Scotland.</p> <p><u>Screening advice</u> Advise that no screening test is perfect. Details of signs and potential emerging problems in PHCHR and who to contact if concerned.</p> <p><u>Frequency of visits</u> Visits to the family home are usual on several occasions within the first 10 days of life. Some new parents may need to be seen more frequently than others. In particular, additional support should be provided for babies who have special needs or who needed treatment in the neonatal intensive care unit.</p> <p><u>Weight</u> Whoever is responsible for weight measurement must be able to deal with questions about the interpretation of the weight chart.</p>
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6-8 weeks – must be completed by 8 weeks

- 2 months – DTaP/IPV/Hib & MenC immunisation
- Repeat hip test for dislocation (Ortolandi & Barlow manoeuvres)
- Repeat inspection of eyes and examination of red reflex
- Repeat thorough check of cardiovascular system for congenital heart disease
- Repeat check of genitalia (undescended testes, hypospadias, other anomalies) & record testicular descent
- Check femoral pulses
- Check blood spot result
- Plot and record head circumference
- Plot and record weight (and note state of dress)
- Length (only in infant who had a low birth weight, where disorder is suspected or present, or where health, growth or feeding pattern causing concern)
- BCG considered/been done? (For targeted population)
- Record smokers in household (Pre-school)
- Record feeding method
- Diagnoses/concerns (coded):
 - > Feeding
 - > Illness
 - > Crying
 - > Appearance
 - > Behaviour
 - > Weight gain
 - > Growth
 - > Hearing
 - > Eyes
 - > Movement
 - > Sleeping
 - > Child protection issues
 - > Other
- Gross motor:
 - > Pull to sit
 - > Ventral suspension
 - > Handling
- Hearing and communication:
 - > Response to sudden sound
 - > Response to unseen mothers voice
- Vision and social awareness:
 - > Intent regard mothers face
 - > Follow angling object past midline
 - > Social smile
- Where used, enter national special needs system when clinical diagnosis recorded
- Health promotion – discuss:
 - > Nutrition
 - > Development
 - > Safety
 - > Smoking
 - > Immunisation schedule
 - > Parenting skills
 - > Sleeping position
- Parents' health and wellbeing
- Discuss any parental concerns
- Provide information about local support networks and contacts for additional advice or support when needed
- Review family's circumstances and needs to make an initial plan with them for support and contact over the short to medium term. Identify high risk situations and carry out a risk assessment

Immunisation

Whoever is responsible for immunisation must be able to deal with questions about vaccines.

Weight

Whoever is responsible for weight measurement must be able to deal with questions about the interpretation of the weight chart.

Head circumference

If no concern at this stage, no further routine measurement required.

3 months

- Immunisation – DTaP/IPV/Hib & MenC
- Plot and record weight (and note state of dress)
- Health promotion – discuss:
 - > Weaning
 - > Nutrition
 - > Development
 - > Safety
 - > Smoking
 - > Oral health
 - > Immunisation schedule
 - > Parenting skills
- Discuss any parental concerns
- Provide information about local support networks and contacts for additional advice or support when needed
- Review family's circumstances and needs

Immunisation

Whoever is responsible for immunisation must be able to deal with questions about vaccines.

Weight

Whoever is responsible for weight measurement must be able to deal with questions about the interpretation of the weight chart.

4 months

- Immunisation – DTaP/IPV/Hib & MenC
- Plot and record weight (and note state of dress)
- Health promotion – discuss:
 - > Weaning
 - > Nutrition
 - > Development
 - > Safety
 - > Smoking
 - > Oral health
 - > Immunisation schedule
 - > Parenting skills
- Discuss any parental concerns
- Provide information about local support networks and contacts for additional advice or support when needed
- Review family's circumstances and needs

Immunisation

Whoever is responsible for immunisation must be able to deal with questions about vaccines.

Weight

Whoever is responsible for weight measurement must be able to deal with questions about the interpretation of the weight chart.

13 months

- Immunisation – MMR
- Plot and record weight (and note state of dress)
- Health promotion – discuss:
 - > Nutrition
 - > Development
 - > Safety
 - > Smoking
 - > Oral health
 - > Physical activity
 - > Immunisation schedule
 - > Parenting skills
- Discuss any parental concerns
- Provide information about local support networks and contacts for additional advice or support when needed
- Review family's circumstances and needs

Immunisation

Whoever is responsible for immunisation must be able to deal with questions about vaccines.

Weight

Whoever is responsible for weight measurement must be able to deal with questions about the interpretation of the weight chart.

Gait

Whenever a child is seen for the first time after s/he begins to walk, s/he should be observed walking to check that the gait is normal.

3-5 years	
<ul style="list-style-type: none"> • Immunisation – dTaP, IPV or DTaP/ IPV & MMR • Plot and record weight • Health promotion – discuss: <ul style="list-style-type: none"> > Development > Safety > Nutrition > Smoking > Oral health > Physical activity > Parenting skills • Discuss any parental concerns • Provide information about local support networks and contacts for additional advice or support when needed • Review family's circumstances and needs • Vision screen performed by an orthoptist at 4-5 years 	<p><u>Immunisation</u> Whoever is responsible for immunisation must be able to deal with questions about vaccines.</p> <p><u>Weight</u> Whoever is responsible for weight measurement must be able to deal with questions about the interpretation of the weight chart.</p> <p><u>Vision screening</u> Where pre-school orthoptist vision screening cannot be implemented immediately, children should instead be screened on school entry. As a minimum, training and monitoring should be provided by an orthoptist or optometrist.</p>

Entry to primary school	
<ul style="list-style-type: none"> • Record height • Plot and record weight • Record Body Mass Index (BMI) for public health monitoring purposes only • Sweep test of hearing (continue pending further review) • Identify children who may not have received pre-school health care programme for any reason • Identify any physical, developmental or emotional problems that have been missed and initiate intervention • Check that pre-school vision screening undertaken and make appropriate arrangements where not • Ensure all children have access to primary health and dental care • Dental check at P1 through the National Dental Inspection Programme • Oral health promotion: <ul style="list-style-type: none"> > Dentist registration and attendance. > Twice daily supervised brushing > Reducing sugary food and drink consumption 	<p><u>Height</u> The 1990 nine-centile charts have been agreed as the standard measurement of height by the Royal College of Paediatrics and Child Health.</p> <p><u>Physical examination</u> There is no evidence to justify a full physical examination or health review based on questionnaires or interviews on school entry.</p> <p><u>Vision testing</u> Vision testing on school entry should only be undertaken where a universal pre-school orthoptic vision screening programme is not in place.</p> <p><u>Dental checks</u> The National Dental Inspection Programme identifies children at greatest risk of oral disease and is used to inform the school health plan.</p>

Primary 7

- Dental check through the National Dental Inspection Programme
- Oral health promotion:
 - > Dentist registration and attendance
 - > Twice daily supervised brushing
 - > Reducing sugary food and drink consumption
- Other health promotion activity should include:
 - > Smoking
 - > Nutrition
 - > Physical activity
 - > Substance use
 - > Sexual health
 - > Personal safety
 - > Mental health and wellbeing

Dental checks

The National Dental Inspection Programme identifies children at greatest risk of oral disease and is used to inform the school health plan.

Health promotion

Development of an effective core programme of health promotion in schools is premised on the roll out of Health Promoting Schools.

Body Mass Index

To be recorded for public health monitoring purposes every 3 years from 2007/08. This will be triggered by the Child Health Surveillance School System.

Secondary school

- Age 10-14 years – BCG immunisation
- In areas where vision is checked at 11 years old, this should continue pending further review by the National Screening Committee. If not being undertaken, it should not be introduced
- Age 13-18 years – Td/IPV immunisation
- Dental check at S3 through the National Dental Inspection Programme
- Oral health promotion:
 - > Dentist registration and attendance
 - > Twice daily supervised brushing
 - > Reducing sugary food and drink consumption
- Other health promotion activity should include:
 - > Smoking
 - > Nutrition
 - > Physical activity
 - > Substance use
 - > Sexual health
 - > Personal safety
 - > Mental health and wellbeing

Dental checks

The National Dental Inspection Programme identifies children at greatest risk of oral disease and is used to inform the school health plan.

Health promotion

Development of an effective core programme of health promotion in schools is premised on the roll out of Health Promoting Schools.



annex 2

health for all children,
fourth edition
executive summary

health for all children 4: Guidance on Implementation in Scotland

Executive Summary, Fourth Edition of *Health For All Children*
Edited by David M B Hall and David Elliman (2003)

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1. The 2002 programme sets out proposals for preventive health care, health promotion and an effective community-based response to the needs of families, children and young people. It takes account of, and is in line with, Government policies and initiatives. The report does not address issues of hospital or acute care but provides links to other sources of information on these topics.
2. Primary care organizations (PCOs) working in partnership with other agencies will need to ensure that the programme is available and accessible to all families within their boundaries, including socially excluded and hard-to-reach groups.
3. In the light of growing evidence that communities, relationships, and the environment are important determinants of health, investment in community development and social support networks is increasingly important; health professionals should contribute to and sometimes lead in these aspects of health care.
4. PCOs should ensure that allocation of resources between and within areas reflects the greater needs of neighbourhoods that are challenging by reason of deprivation, violence, language barriers, lack of facilities, hostility, etc. Staff recruitment and support should take account of the difficulties of working in such areas.
5. The holistic approach of family medicine is commended and the importance of considering the impact on children of parental mental and physical illness, domestic violence and substance misuse is stressed. Health professionals working with adult patients should enquire about their children and liaise closely with paediatric services where needed.
6. Every child and parent should have access to a universal or core programme of preventive pre-school care. The content of this is based on three considerations: the delivery of agreed screening procedures, the evidence in favour of some health promotion procedures, and the need to establish which families have more complex needs.
7. Formal screening should be confined to the evidence-based programmes agreed by the Child Health Sub-group of the National Screening Committee. The agreed screening programmes are given in the table on page 351. Screening activities outside this framework are important in order to ensure continuing refinement of the evidence base, but should be treated as research, reviewed by an ethics committee, time limited, and reported for peer review.
8. There is good evidence to support health promotion activity in a number of areas including prevention of infectious diseases (by immunization and other means), reducing the risk of sudden infant death, supporting breastfeeding, encouraging better dental care, and informing and advising parents about accidental injury.

9. There is as yet no single health promotion measure to reverse the emerging problem of obesity, but the importance of the problem and the need to address it as a public health issue are stressed.
10. There is growing evidence that language acquisition, pre-literacy skills, and behaviour patterns are all amenable to change by appropriate patterns of child management. These insights can be incorporated into programmes like Sure Start but can equally well be provided in non-Sure Start areas.
11. Many illnesses, disorders, and disabling conditions are identified by means other than routine preventive care programmes, but health professionals must respond promptly to parental concerns. Reluctance to carry out appropriate assessment or refer for more expert advice remains an important cause of delays in diagnosis in both primary and secondary care. Clear pathways of care are vital to facilitate prompt and appropriate referrals and need to be developed at local level.
12. Formal universal screening for speech and language delay, global developmental delay, autism, and postnatal depression is not recommended, but staff should elicit and respond to parental concerns. An efficient preliminary assessment or triage process to determine which children may need intervention is vital.
13. The core programme includes antenatal care, newborn examination, agreed screening procedures, support as needed in the first weeks with particular regard to breastfeeding, review at 6-8 weeks, provision of health promotion advice either in writing (where appropriate) or by face-to-face contact, the national immunization programme, weighing when the baby attends for immunization, and reviews at 8 or 12 months, 24 months, and between 3 and 4 years. However, it is expected that staff will take a flexible approach to the latter three reviews according to the family's needs and wishes, and face-to-face contact may not be necessary for all families.
14. The Personal Child Health Record is commended. There should be a basic standardised format for universal use, which should be used to gather a core public health dataset.
15. Children starting school should receive the agreed screening programmes and their pre-school care, immunization record, and access to primary health care schedule should be reviewed.
16. There is an evidence base for the health care of school-age children derived from a range of interview studies with teachers and children designed to establish what they perceive as their main needs. It should include the following: support for children with problems and special needs; participation in Health Schools programmes designed to improve the school environment and social ethos, promote emotional literacy, exercise opportunities and healthy eating, and reduce bullying; health care facilities for young people in line with their clearly stated and well-established requirements for privacy and confidentiality.

17. There is an urgent need to secure the provision and the quality of a range of more specialized services to back up those working in primary health care, education and social services.
18. Access to a child development centre or team and a network of services, including referral to tertiary units when needed, is essential for the assessment of children with possible or established disabilities. There is ample evidence as to what parents expect, in terms of quality, from those services. The care of children with disabilities involved all the statutory agencies and, in many cases, the voluntary sector as well.
19. Emotional and behavioural disorders are common, but service provision is often inadequate and fragmented. A substantial investment involving all statutory agencies is needed, both in preventive programmes at community level and in managing both straightforward and complex problems.
20. There are statutory duties in respect of child protection, looked after children, and adoption procedures. The requirements for staffing are set out in the body of the Report. Child abuse in all its forms is a major but often unrecognized problem, and there is an urgent need for better multi-agency training of all staff and for improved support for those working in this difficult area.
21. There are also statutory duties in respect of liaison work with education authorities with regard to children who have special educational needs. In addition, the development of health promoting policies and programmes for school age children, in collaboration with education professionals, parents, and young people, requires staff time and expertise.
22. The report stresses the importance of leadership and management of the whole programme. A coordinator is needed to develop and sustain an overview of the health of all children within the district for which the PCO is responsible.
23. It must be clear who is responsible for screening programmes, maintenance and reporting of immunization uptake, introduction of new immunization programmes, health promotion, care pathways for children with health or development problems, socially excluded groups, child protection, looked after children, links with education, staff training, and data management.
24. Since all these activities are interlinked, there is a need for a multi-agency steering group to ensure a focus on desired objectives and outcomes.
25. All staff in contact with children should be appropriately trained and take part in regular continuing professional development.

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annex 3

child health support group
reference group

health for all children 4: Guidance on Implementation in Scotland

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annex 4

hall 4 action template

health for all children 4: Guidance on Implementation in Scotland

AREA	ACTION	TIMESCALE
<p>Integrated children's services planning</p>	<ul style="list-style-type: none"> • Identification of a lead within the NHS Board to champion implementation of the national <i>Hall 4</i> guidance and work with local authority partners to consider and address the implications for local authority staff. 	2005/06
	<ul style="list-style-type: none"> • Universal and targeted programmes for child health surveillance, screening and health promotion, should be clearly defined and established in each NHS Board. They should be designed to ensure access and take-up by children and families who are vulnerable or at risk of social exclusion. This will require: <ul style="list-style-type: none"> – A review of existing arrangements for universal child health screening and surveillance, including the way in which resources are allocated. – Close alignment with local authority planning for services for children and families in need. • Community Health Partnerships (CHPs) have a key role in the implementation of the national <i>Hall 4</i> guidance. The additional advice for CHPs on integrated child health services states that CHPs should nominate a member of their senior management team to take the lead responsibility for the operational delivery of child health services. This responsibility will include delivery of child health promotion, screening and surveillance in accordance with this guidance. 	2005/06
	<ul style="list-style-type: none"> • NHS Boards should work with their local authority partners to develop and agree a development plan for local implementation of the national <i>Hall 4</i> guidance over a three year period, which: <ul style="list-style-type: none"> – Identifies key actions, milestones, timescales for implementation. – Identifies mechanisms to support, train and develop staff across agencies in delivering <i>Hall 4</i>, including inter-agency training and development opportunities. • NHS Boards should work with their local authority partners to identify appropriate link funding streams such as the Changing Children's Services Fund and those associated with the Additional Support for Learning Act, waiting times initiatives, and the Oral Health Strategy. 	2005/06

Achieving Change (continued)

AREA	ACTION	TIMESCALE
Workforce strategy	<ul style="list-style-type: none"> NHS Boards should work with their local authority partners to review the numbers, availability, distribution and skills base of staff required to deliver <i>Hall 4</i>, to inform strategic workforce planning and development. 	2005/06
	<ul style="list-style-type: none"> NHS Boards will need to work with their local authority partners to ensure that child care practitioners, teachers and other staff are equipped and supported to use opportunities for health promotion and early identification of problems effectively, and that they are aware of the appropriate response to concerns. This will require: <ul style="list-style-type: none"> – Allocation of a named health visitor or school nurse to each school and early years establishment, with access to a wider network of health support. – More and regular health visitor or school nurse time in family centres, early years and school settings, to enable effective liaison, support and training for non-health professionals as well as a source of advice and support for parents. – Clear referral protocols and pathways which are familiar and accessible to non-health professionals. – Provision of open access services in pre-school settings along the Integrated Community Schools model. – A programme of in-service training for non-health professionals. 	2005/06
	<ul style="list-style-type: none"> NHS Boards should ensure that measures are in place to provide professional support for health visitors and school nurses in their work with other agencies to deliver targeted programmes of additional and intensive support for families in need or at risk. 	2005/06
	<ul style="list-style-type: none"> In order to ensure allocation of NHS resources to areas of greatest need, NHS Boards and local authorities will need to consider any measures necessary to attract key professionals to work in areas of high concentration of need - for example, in remote and rural communities and in areas of deprivation. 	2005/06

Health Promotion

AREA	ACTION	TIMESCALE
<p>Early years and school age children</p>	<ul style="list-style-type: none"> NHS Boards and their partner agencies should ensure that all parents are provided with written information about pregnancy and birth, and healthy infant and child development (and that information is provided in an alternative format or language if needed). 	2005/06
	<ul style="list-style-type: none"> NHS Boards should provide health promotion advice for parents, children and young people through primary care settings, family centres, childcare and pre-school centres and schools. 	2005/06
	<ul style="list-style-type: none"> NHS Boards should provide access to information and professional advice about specific aspects of child development and behaviour through groups and workshops. 	2005/06
	<ul style="list-style-type: none"> NHS Boards should provide support for parents through local community networks for healthy living – for example breastfeeding networks. 	2005/06
	<ul style="list-style-type: none"> NHS Boards should incorporate health promotion and prevention activities and policies within the core child health programme, including: <ul style="list-style-type: none"> Nutrition and physical activity Oral health Unintentional injury Mental health and wellbeing 	2005/06
	<ul style="list-style-type: none"> NHS Boards should review the way in which health promotion information is provided to ensure maximum impact. This should include: <ul style="list-style-type: none"> Dissemination of specific health promotion materials at regular contacts (e.g. mail shots for immunisations.), coupled with – Provision of information for parents and young people about access to advice about health and any concerns they have (e.g. NHS 24, special clinics) Community support (e.g. work within existing community networks) 	2006/07
	<ul style="list-style-type: none"> NHS Boards should review and develop targeted health promotion and prevention activity to maximise impact with particularly vulnerable groups. 	2005/06

Formal Screening

AREA	ACTION	TIMESCALE
Hearing	<ul style="list-style-type: none"> NHS Boards should ensure co-ordination of the local paediatric audiology programme, including screening, training, audit and monitoring. 	2005/06
	<ul style="list-style-type: none"> NHS Boards should abandon universal distraction testing at 7-9 months once Universal Neonatal Hearing Screening has been in place for one year. 	2005/06
	<ul style="list-style-type: none"> NHS Boards should continue the school entry hearing sweep test, unless already abandoned. No further routine hearing testing should be undertaken. 	2005/06
	<ul style="list-style-type: none"> NHS Boards should review local arrangements for access to paediatric audiology services and staff training to ensure efficient referral and testing for children with suspected hearing loss. 	2005/06
	<ul style="list-style-type: none"> Each NHS Board should designate a Child Health Vision Screening Co-ordinator (similar to the Pregnancy & Newborn Screening Co-ordinator) to take overall responsibility for monitoring vision screening programmes and ensuring the <i>Hall 4</i> recommendations on vision screening are implemented. 	2005/06
Vision	<ul style="list-style-type: none"> All children should be screened by an orthoptist in their pre-school year, between the ages of four and five years. Once this is in place, vision screening on school entry should cease. 	2006/07
	<ul style="list-style-type: none"> Until an orthoptist pre-school vision screening programme is in place, children's visual acuity should be tested on school entry by an orthoptist, or through a programme which is supervised by an orthoptist or an optometrist. 	2005/06

Formal Screening (continued)

AREA	ACTION	TIMESCALE
	<ul style="list-style-type: none"> NHS Boards should continue vision screening in secondary school at a single point only, unless already abandoned. No further routine vision screening should be undertaken. 	2006/07
Vision (continued)	<ul style="list-style-type: none"> NHS Boards and local authorities should make arrangements for any child undergoing assessment for educational under achievement or other school problems to have a visual acuity check. 	2005/06
	<ul style="list-style-type: none"> NHS Boards should ensure that vision screening is undertaken in schools for children with hearing impairment. 	2005/06
Obesity monitoring	<ul style="list-style-type: none"> NHS Boards should make arrangements for routine recording of height, weight and BMI at school entry. No further routine recording, except on a 3-yearly basis at P7, to be triggered by the Child Health Surveillance Schools System. 	2006/07

Surveillance – Early Years

AREA	ACTION	TIMESCALE
The new programme of contacts	<ul style="list-style-type: none"> NHS Boards should work with their partner agencies to introduce the core programme for the early years as described in Annex 1 of the national <i>Hall 4</i> guidance, including arrangements to provide care in line with the diagram on page 5. NHS Boards should ensure that a universal health promotion contact is provided for all families with children at aged 2 years, in line with the approach described on page 35 of the national <i>Hall 4</i> guidance. 	2006/07
Disabilities & disorders	<ul style="list-style-type: none"> NHS Boards should work with their key partners to establish explicit care pathways for parents or early years professionals who have concerns about a child's health or development. These should be developed and disseminated in line with advice on page 38 of the national <i>Hall 4</i> guidance. NHS Boards should ensure that parents are provided with accurate information about the normal range of child development and where to seek advice if they have concerns. NHS Boards and local authorities should ensure that information is available about local services. Where there are concerns about a child's presentation or development, a formal assessment should be undertaken to confirm or refute initial suspicions. This should be undertaken as part of a more comprehensive clinical assessment involving the network of child development services and should include consideration of referral to a community paediatrician. 	2006/07

Surveillance – School Age Children and Young People

AREA	ACTION	TIMESCALE
The core programme	<ul style="list-style-type: none"> NHS Boards should work with their partner agencies to implement the core programme described in Annex 1 of the national <i>Hall 4</i> guidance, and ensure that services and systems are in place to meet any additional or intensive support that children and young people require. 	2006/07
Transition	<ul style="list-style-type: none"> NHS Boards should work with their local authority partners to ensure that robust mechanisms are in place for the efficient transfer of any information about a child's health needs when a child moves between educational establishments and between education and health settings. 	2006/07
Independent schools	<ul style="list-style-type: none"> Independent schools should ensure that arrangements are in place for pupils to receive health promotion advice and child health checks, consistent with this guidance and other health improvement policies. 	2006/07
Children outwith school	<ul style="list-style-type: none"> NHS Boards should work with their local authority partners to identify children and young people who are not in school, and to ensure that they receive care and support consistent with the core child health programme outlined in the national <i>Hall 4</i> guidance. 	2006/07

Identifying Need and Targeting Support

AREA	ACTION	TIMESCALE
	<ul style="list-style-type: none"> NHS Boards should work with their local authority partners to assess patterns of need within communities in their area. Allocation of NHS resources, such as input from health visitors, public health practitioners and health promotion professionals, should reflect concentration of need. 	2005/06
Assessing need	<ul style="list-style-type: none"> NHS Boards should redesign health visiting services to provide more effective support for those individual children and families most in need. 	2005/06
	<ul style="list-style-type: none"> NHS Boards will need to ensure that mechanisms are in place for recording decisions about individual families' assessed level of need and associated health visitor input. 	2005/06
Support for families	<ul style="list-style-type: none"> NHS Boards, local authorities and voluntary agencies should work together to provide universal and targeted parenting support. 	2005/07

Information Collection and Sharing

AREA	ACTION	TIMESCALE
Information sharing	<ul style="list-style-type: none"> NHS Boards should ensure that parents (and, where appropriate, young people) are provided with information about how data about their health is collected, stored and shared, and the safeguards in place to ensure that only those who need it will have access to patient or client information. 	2005/06

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