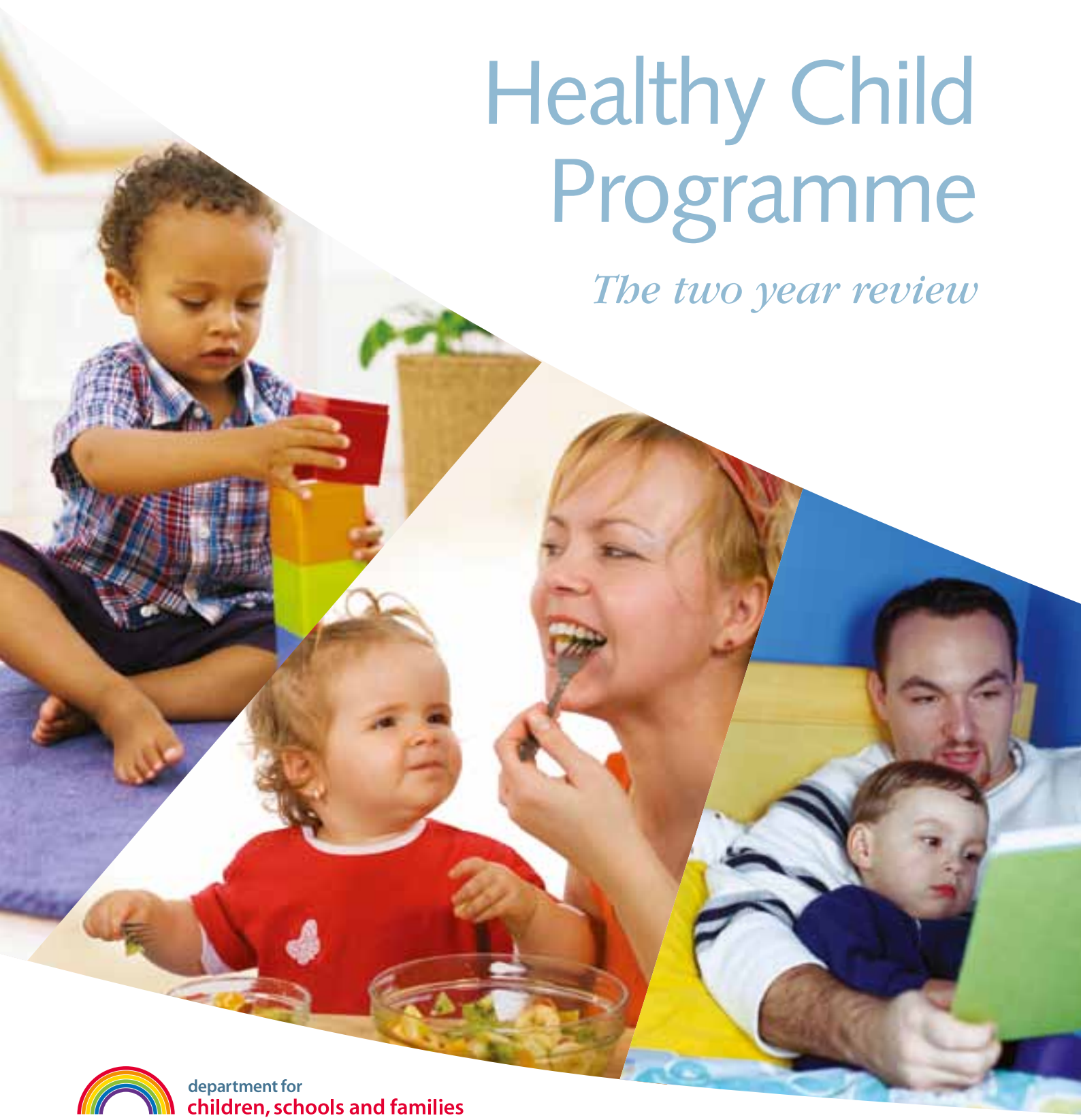
Department of Health

Healthy Child Programme

The two year review



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Healthy Child Programme

The two year review

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Foreword by Dr Sheila Shribman

When we published the Child Health Promotion Programme, now known as the Healthy Child Programme (HCP), in 2008 it was clear that this was only the beginning and that more needed to be done to support the service in order to ensure that all children benefit from the updated programme. The two year review was singled out as a priority for further work because it is an important time for children and parents. In addition, practitioners told us that they were unclear about what should be included in the review and some places were finding it hard to offer the review to all children within limited resources.

The world has changed since 2008. Faced with an increasing population and an economic recession, we still need to find ways of delivering a quality service to all children that makes the most of the expansion we have seen in children's early years services in recent years and that reflects the valuable support provided by new social networking sites for parents. Responsibility for the HCP remains with health services, albeit jointly commissioned and delivered through increasingly integrated services. The HCP depends on health visitors and general practice teams working closely together with Sure Start Children's Centres and other early years settings, including childminders, preschools and day nurseries. This is especially true at two years of age when children are gaining independence and often moving into early years provision.

This guide on the two year review is primarily aimed at HCP leads including health visitors and community paediatricians but contains relevant information for general practice, children's centres, commissioners and managers. We have assumed a core professional knowledge of the HCP as a whole and that the two year review has been commissioned as part of the HCP.

I would like to thank the many individuals who have contributed to this guide and are supporting the ongoing development of the HCP in England. The health of our children must remain at the heart of the NHS of the future.

Dr Sheila Shribman
National Clinical Director for Children, Young People and Maternity Services
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Introduction

The Healthy Child Programme[1] (formerly known as the Child Health Promotion Programme) is the universal public health programme for all children and families. It consists of a schedule of reviews, immunisations, health promotion, parenting support and screening tests that promote and protect the health and wellbeing of children from pregnancy through to adulthood. The review at two years of age[2] is one of the key reviews recommended in the Healthy Child Programme (HCP) and this guide provides additional information on the content and process of the two year review. It is designed to be read as a supplement to the updated guidance on the whole programme which was published in 2008.

There is strong evidence for the whole of the HCP which is based on *Health for All Children*,[3] the recommendations of the National Screening Committee, guidance from the National Institute for Health and Clinical Excellence (NICE) and a review of health-led parenting programmes by the University of Warwick.[4] The success of the whole programme depends on attaining equity of outcomes for all groups in our community.

This publication draws together the latest evidence on the health and development of two year olds and the views of parents and practitioners, and reflects wider developments in services for children and families such as Sure Start Children's Centres and the Family Nurse Partnership programme. The purpose is to update practitioners, recommend tools to support the review and suggest ways of delivering a progressive universal review that maximises quality, productivity and cost-effectiveness. Key to achieving the latter is the effective use of the knowledge and contact that all services have with a child of this age whether it be with the health visiting team (HVT), general practice, Sure Start Children's Centres and other early years settings. While it's for the health visitor to co-ordinate and lead the review this is a time of transition for children and families and HVTs have much to gain from working closely with these colleagues.

1 Department of Health (2009) *Healthy Child Programme: Pregnancy and the first five years of life*. London: DH

2 The review is best carried out between two years and two years six months but for ease of reference is referred to as the 'two year review' throughout this document

3 Hall D and Elliman D (2006), *Health for All Children*, Oxford University Press

4 Barlow J, Schrader McMillan A, Kirkpatrick S, Ghate D, Smith M and Barnes J (2008), *Health-led Parenting Interventions in Pregnancy and Early Years*, Research Report DCSF-RWO70, London: DCSF

Key messages for the two year review

- **Priorities at this age are the promotion of emotional development and communication skills, support of positive relationships in families and obesity prevention.**
- **Work effectively with mothers and fathers to develop self-efficacy and support change.**
- **Universal coverage is the goal. Achieving this can be challenging and needs integrated working across all children's services and general practice and outreach for disadvantaged groups.**
- **Reduce unequal outcomes for children.**
- **Promote the health of two year olds through community and public health actions.**
- **Integrated working with Sure Start Children's Centres and general practice and use of new media tools is the key to effective delivery and productivity.**
- **We need to get the infrastructure right to support delivery at two years.**
- **The two year review will need to be delivered in innovative and efficient ways that result in improved outcomes for all children and their families.**

Outcomes of the two year review

The two year review aims to optimise child development and emotional wellbeing and reduce inequalities in outcome.

Specific outcomes include:

- improved emotional and social wellbeing through strong parent–child attachment, positive parenting and supportive family relationships;
- improved learning and speech and language development through the home learning environment and access to early years learning;
- the early detection of and action to address developmental delay or abnormalities, ill health and growth impairments;
- maximised protection against communicable disease through high immunisation rate and reduced cases of vaccine-preventable diseases;
- prevention of obesity and the promotion of health-enhancing behaviours for every child such as eating a well balanced diet, playing actively, and having an appropriate weight and height for their age and general health; and

- the early detection of and action to reduce the adverse impact on the child of psychosocial issues such as poor parenting, disruptive family relationships, domestic violence, mental health issues and substance misuse through effective safeguarding.[5]

Guiding principles for the two year review

For the review to be effective in achieving these outcomes it needs to:

- be seen as useful by mothers, fathers[6] and other carers;[7]
- be a relevant, positive and supportive experience in which parents feel listened to and their concerns are acted upon;
- offer fathers and mothers information about the expected developments at this age and opportunities to learn through practical activities and reflection;
- focus on issues that are known to be relevant and common at this age;
- be informed by the best evidence available in terms of preventive and treatment interventions, and use evidence-based tools and not locally developed checklists or schedules;
- recognise the many and various influences on a child's health and development;
- offer continuity with previous and future reviews in its approach;
- focus on neurodevelopmental and emotional health as well as early detection of impairments;
- take a strengths-based approach using guiding skills that support and effect change in parent and child outcomes; and
- be adapted according to the needs of the local population, individual child and family.

The world is changing – 57% of mothers of under-fives are at work (40% of two year olds are in early years settings), fathers want to be involved, many use the internet to communicate and obtain information, mobiles are used to keep in touch and families lead increasingly busy lives.

The reasons for a review at 2–2.5 years

The time points for the Healthy Child Programme (HCP) were selected as 'best buys' from the existing evidence. Two years is a key time for:

- the development of speech and language, social, emotional and cognitive development;
- supporting parents as children gain independence and learn new skills and behaviours;
- transition as increasing numbers of children are gaining from early years learning with the Early Years Foundation Stage assessment offering continuity with the HCP; and
- taking stock of current health status and plan future health promotion matching services to need.

5 Department of Health (2008), *Community NHS Contract Integrated Guidance*, Appendix 1, p87–99

6 Throughout this document the word 'father' refers to biological fathers, and to other men who play a significant fatherly role in the life of a child

7 'Carers' in the context of this document refers to any family or non-family members who look after the child at this age

What parents say they want at the two year review

Feedback from parents suggests that:

- they want to know how well their child is progressing;
- they want to be able to seek advice from a wide variety of sources;
- fathers wish to be more involved;
- Sure Start Children's Centres are seen as a friendly and supportive environment where the HCP could be offered;
- GPs are seen as an important and accessible point of contact for children's health issues;
- many mothers and fathers welcome a face-to-face contact for this review with both parents present if possible;
- services need to be flexible to accommodate parental working patterns and wider family member involvement, especially for fathers; and
- group sessions are popular with parents.

The value of the two year review will be judged against competing priorities for time within a family and local services will need to design a system to reflect this, thinking about communication methods, timing and location for each family.

Disabled children

Research with parents of disabled children has highlighted that this group needs to be offered tailored preventive services, in particular the HCP. Disabled children are at greater risk of incomplete immunisation, poor dental care and higher obesity rates. It is essential that disabled children are not excluded from the two year review and that invitations are tailored to take into account existing service involvement. It is important that their fathers and other carers are fully involved.

The content and process of the two year review

Summary of HCP at this age

Universal

- **Review** with parents the child's social, emotional, behavioural and language development and uptake of immunisations to date.
- **Respond** to parental concerns about physical development, growth, hearing and vision.
- **Offer guidance** on behavioural management. Highlight that this is an opportunity to share concerns and information to address worries. Provide advice on nutrition and physical exercise and the promotion of language development.
- **Provide** information (including useful telephone numbers and websites) and signposting to relevant services.
- **Raise awareness** around dental care, accident prevention, sleep management, toilet training and sources of parenting advice and family information.

Progressive

- In addition, for those with increased risk factors (development, obesity, smoking, safety), use interviewing skills to support, help or refer on to those who can help most.
- Use local, high-risk, evidence-based prevention and early intervention programmes.
- The Family Nurse Partnership programme continues until age two.

Refer to page 54 of the HCP guidance document (October 2009).

1. Engaging and preparing mothers and fathers

Parental engagement is key to the success of the two year review, especially those who may be ambivalent about preventive services or for children who experience psychological, social or economic disadvantage. It can be harder to connect with parents at this age as they may have had little contact with services since their child was a baby and may not know the health visitor and their team. The following suggestions may help to engage effectively with mothers and fathers of children at this age:

- building a high level of community awareness of the HCP as a whole so all parents know what to expect and when;
- linking with facilities used by parents of children of this age such as Sure Start Children's Centres and other early years settings, general practice, websites, community groups and childcare facilities;

Example of invitation birthday card or letter

Dear (personal letter to mum and dad)

Now […] (insert child's name) is two years old it is time for their 'two year review'. This is a check-up that is offered to every family when their child gets to two. It gives you a chance to ask about anything you want to know more about, find out how your child is doing, catch up with other mums and dads of two year olds and think about […] (insert child's name) next stage.

I would like to invite you to come to […] (insert name of local health or children's centre) at one of the times below. Please come to whichever you prefer.

I look forward to seeing you and finding out how […] is getting on. At this review I will also give you your Bookstart pack which I hope that […] will enjoy. There are lots of websites and places to find out more about two year olds. You may like to explore these, and prepare for the review before we meet (insert links and attach information sheets etc).

Please let me know if these times aren't suitable and I will try to find a better time for you.

Best wishes

(from the person who will be doing the review)

PS: Dads, grandparents and others welcome!

- using communication methods preferred by local parents to invite them for their review such as texting, email and birthday cards. The invitation needs to be sensitive to the literacy levels and languages in the community;
- inviting both fathers and mothers and encouraging their participation, and linking the invitation with other opportunities such as Bookstart or Every Child a Talker;
- communicating in a way that is culturally sensitive and connects with mothers and fathers' motivations and interests at this age and celebrating achievements; and
- having a clear local policy for dealing with non-response which needs to reduce inequalities in access and ensure adequate safeguarding.

Making the two year review accessible

Local teams will decide with parents and other children's services where, when and how the review will take place – which could be at a child health clinic, in a Sure Start Children's Centre, general practice, other premises or at home. Timing of the review needs to be flexible to allow for parents' working routines.

Sure Start Children's Centres provide a good setting with opportunities to link the review with play-based learning, parenting and social support. Group sessions for the two year review work well and are popular. In groups, mothers and fathers can learn from each other, observe their own and other's children's development and carry out their own child's review. Child observation can be arranged in groups of similar aged children with careful observation being made of movement, hand function, visual behaviour, language and communication skills and behavioural and social skills. Some parents may have issues they wish to discuss on an individual basis and provision should be made for this.

Preparation for parents

Mothers and fathers may want to prepare for the review, which can be done by the following:

- They can be signposted to materials and online sources of information such as *Birth to five*, the Personal Child Health Record (PCHR) and other materials such as Early Years Foundation Stage (Ages and Stages) for children of this age.
- There are a number of high-quality websites on child development for parents that are increasingly used by a wide range of social groups. Many mothers use Netmums (www.netmums.com), Mumsnet (www.mumsnet.com) and other social networking sites (fathers may use www.dad.info) and these sources of support need to be encouraged.
- There is good research evidence that parental concerns can be elicited accurately with the use of a brief validated questionnaire, the Parental Evaluation of Developmental Status (PEDS)[8] or Ages and Stages questionnaire (ASQ) – see Appendices.

Preparation for practitioners

The content and detail of each review will vary according to how well the family is known to the HVT, early years staff and GPs.

If little is known about the family the HVT will need to review the case records and other information sources available (including child health and GP information systems and Contactpoint or equivalent) for important health events such as accident and emergency attendances, screening and immunisation uptake and whether the family is known to other statutory services.

8 Glascoe FP (2002), *Collaborating with Parents: Using Parents' Evaluation of Developmental Status (PEDS) to Detect and Address Developmental and Behavioral Problems*, Nashville, TN: Ellsworth & Vandermeer Press (www.pedstest.com)

Every child who attends an early years setting has an identified key person whose role is to establish close links with the child and family, building a consistent trusting relationship and facilitating sharing information with parents and carers.

A number of families will be receiving services such as Portage and sensory support and these are a good source of information on the children's needs.

This will bring the team up to date with the current status of the child and family in terms of recent health or social care contacts.

2. Relationship building and joint agenda setting between parent and practitioner

For any review to be effective it needs to meet the agenda of both the practitioner and the parent and will depend on a positive relationship being established where the parent feels listened to and valued as the expert in their child's life. The practitioner will use their communication skills to demonstrate a respectful, authoritative (not authoritarian), empathic and strengths-based approach that is directed to optimising health and wellbeing. A challenge for both parents and practitioners at the two year review is that they may not know each other and have to build a relationship based on one encounter. Ideas that can help include:

- a parent-led opening and joint appraisal of issues most relevant to themselves guided by the PCHR or other records;
- agreeing on the agenda together and reflecting on what has happened since the last review; and
- using open-ended questions such as:
  - What do you enjoy doing with your child?
  - What are your pre-school plans?

– Are there any issues in the family that you are concerned are affecting your child? If so, would you like some help with that?[9]

Promotional interviewing techniques will help to identify issues and guide parents in promoting their child's health and wellbeing through appropriate goal setting and linking with suitable resources for the family.

Many parents will be happy with their child's progress and require little further assistance other than contact information so that if needs arise, the family can make contact with the team at the appropriate time.

Those families with higher needs will require a more comprehensive assessment involving a wider range of statutory and non-statutory services. Practitioners will use the Common Assessment Framework (CAF) according to local protocols.

Where the professional has concerns about a child's progress or environment which are not understood by the parents they will need careful negotiation skills and support from other services in contact with the family. Safeguarding the interests of the child is always paramount and team members should be given supervision so that concerns are acted on.

3. Assessment of the child's development

Children's developmental progress varies considerably depending on a range of biological and psychosocial factors. Mothers and fathers are keen to know if their child's growth and development are normal and how they can optimise their child's progress. In making an assessment practitioners will draw on their direct observations, parents' and carers' accounts and information from other services and usually held by parents. Mothers and fathers should be encouraged to share the child's developmental journal or equivalent from early years settings at this review as it contains useful observations made as well as suggestions for promoting abilities.

Areas of developmental assessment

- Speech and language
- Emotional development, attachment and wider family relationships
- Learning
- Social skills
- Locomotor and fine movement
- Physical health
- Growth
- Hearing
- Vision
- Dental

Early years practitioners are encouraged to monitor children's progress linked to the developmental bands in the Early Years Foundation Stage (EYFS) as outlined in *Progress Matters*.[10] Early years practitioners will go on to complete the statutory EYFS profile at the end of the academic year in which a child turns five. This regular monitoring and assessment of children's progress across the six areas of learning and development listed below offers the health visitor and parents an important information source on which to base the two year HCP review as it provides a holistic picture of the child's early learning and abilities.

9 A study to examine the feasibility of developing a national tool to check child health and development during the childhood period 18 months to 3 years of age: final report submission by the Centre for Community Child Health and Murdoch Childrens Research Institute for the Victorian Department of Education and Early Childhood Development, Australia, March 2009

10 http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=productdetails&PageMode=publications&ProductId=DCSF-00217-2009&

The EYFS covers six areas of learning encompassing children's physical, intellectual, emotional and social development:

- personal, social and emotional development;
- communication, language and literacy;
- problem solving, reasoning and numeracy;
- knowledge and understanding of the world;
- physical development; and
- creative development.

For those children with a disability, there will also be useful information held in early support, Down's syndrome, visual impairment and hearing impairment developmental journals.

One of the key objectives of the HCP is the early detection of significant impairments. If a parent/carer or practitioner is concerned about a child's progress, a more formal assessment will need to be carried out using validated tools (see Appendix A for the list of recommended tools).

The local community paediatrician overseeing the HCP will need to work with the health visitors to decide which tools are suitable locally and to ensure consistency of approach across the district. Regular audit of processes and outcomes is important in order to ensure continuous improvement in quality and to refine existing pathways of care.

4. Guidance on health promotion, parenting and goal setting

At two years, around half of parents report no concerns about their child's health and development and the other half report concerns mainly about speech, language and communication or behavioural problems such as sleep, feeding or tantrums. An important part of this review is to offer guidance to parents and to help them to find the choices that are best for them and their child. This can be the most complex part of the review, requiring up-to-date and accurate information, skills in effective behaviour change methods and the ability to explore emotional issues when necessary. Mothers and fathers make decisions about their child's health and behaviour in the context of their lives, weighing up the economic, social and emotional benefits and drawbacks of choices. Health professionals share their knowledge, and guide parents to find the best way forward for their child and themselves and to set positive and realistic goals for the future. Sometimes they may also need to enable parents/carers to see that a child's progress, which they view as acceptable, is of concern.

Using validated tools

Validated instruments are a resource to support professional judgement and provide a more formal way to assess development and behaviour where there is a concern. On the advice of the National Screening Committee and the HCP Expert Group, they should not be used as part of routine population screening. The instruments need to be agreed locally depending on training and experience of staff. They should all be evidence based. 'Home-made' checklists or local materials adapted from copyrighted materials which have not been rigorously evaluated for UK use should not be used. If the health visitor is unable to make a clear clinical judgement about the health and development of a child then more expert opinion needs to be sought.

Information sharing, behaviour change and parenting support

Mothers' and fathers' preferred ways of obtaining information will vary. There is a multitude of media options available including text, telephone advice lines, web information, discussion forums, email prompts, and printed leaflets, brochures and guidebooks. Oral messages are more effective when standardised and accompanied by written information, e.g. pamphlets, single-page handouts or age-paced newsletters (see the *Toddler Express* example on this page), the PCHR and *Birth to five*. Consistency in health-promoting messages should be achieved across children's centres, nurseries, general practice and childcare providers.

The way in which information is shared in face-to-face contacts will depend on a number of factors:

- whether this is future oriented general information or information focused on a particular issue;
- the sensitivity of the information and the parent/carer's attitude to it; and
- the parent/carer's age, socio-economic status, ethnicity, literacy level and familiarity with the English language.

Practitioners often find it helpful to elicit the parent's own understanding of the topic in hand before providing information to complement or expand this understanding.

However, information and advice giving are often insufficient to bring about behaviour change, especially in areas which already have established patterns in family life, e.g. diet and eating behaviours and parenting approaches.

Learning from evidence-based programmes, such as the Family Nurse Partnership (FNP) programme, highlights some key methods that can be used in the two year review.

A number of clinical trials using motivational interviewing (MI) have shown improved rates of behaviour change in a wide range of complex clinical areas. MI works by eliciting and activating someone's innate desire to do things differently, through a combination of an empathic and collaborative style with a distinct set of skills. Most parents are profoundly motivated by the desire to do the best they can for their children and skilled practitioners can use MI to encourage and support health behaviour change.[11]

Parenting support within the review may take a number of forms, from affirming a parent's progress with their child to enabling a parent to access further support for presenting challenges. Practitioners undertaking the review should be knowledgeable about the range of parenting support services in their area and help families to access these as appropriate.


Toddler Express

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Children's Foundation www.thechildrensfoundation.co.uk

11 Rollnick S, Miller W and Butler C (2008), *Motivational Interviewing in Health Care: Helping Patients Change Behavior,* New York: Guilford Press

Priority topics at two years

Nutrition, active play and obesity prevention

Immunisation

Personal, social and emotional development

Speech, language and communication

Injury prevention

Nutrition, active play and obesity prevention

The increase in the number of children who are overweight or obese presents a major public health challenge and is a priority for the HCP. Two years is the key age for identifying children who are overweight and for establishing life-long healthy eating and physical activity habits and must be the focus of the two year review. This section provides the key messages for all children at this age and recommends specific actions to reduce the risk of obesity at this age.

Factors influencing a child's weight include:

- parental attitudes to food (e.g. a dependence on convenience food, portion size);
- family eating behaviours – children at this age model their eating on parental eating practices;
- poor sleeping patterns;
- food choices (e.g. frequent eating of food high in fat, sugar and salt and sugary drinks, rather than fresh food, vegetables and fruit and water);
- the cultural context of food (e.g. importance of food in celebrations and as treats/rewards);
- disincentives to physical activity (e.g. car use rather than walking);
- ease of home entertainment which leads to individuals being sedentary for long periods (e.g. TV watching, which is often also a snack opportunity, and computer games); and
- rarely, the presence of a medical condition (e.g. Prader–Willi syndrome) or a hereditary predisposition to overweight.

Key messages for all families with young children

Children aged two to four are more likely to thrive and have a healthy weight for their age if the following messages are clearly communicated:

- Like the rest of the family, a toddler needs a variety of foods from the four main food groups:
  - milk and dairy products (3 portions a day)
  - meat, eggs, fish, beans and pulses such as lentils (2–3 portions a day)
  - bread and other cereals and potatoes (3–5 portions a day)
  - fruit and vegetables (5 portions a day).
- Like adults, children should not eat many foods containing a lot of fat and added sugar, such as biscuits, cakes, puddings and ice cream.
- Foods to avoid are salty foods, sugary and acidic drinks, raw eggs, raw shellfish, some large fish (e.g. swordfish) and whole nuts. (See *Birth to five* pp 44–5.)
- Six to eight drinks per day are needed to ensure adequate hydration. Water and milk are the most appropriate drinks and any squashes or cordials must be well diluted.
- All children under five should be given vitamin drops containing vitamins A, C and D. It's especially important to give vitamin drops to children who are fussy about what they eat, children living in northern areas of the UK and those of Asian, African and Middle Eastern origin. (See *Birth to five* p 48.)
- Three meals of toddler-sized portions and two to three nutritious snacks per day should provide all the nutrients and energy toddlers need. (See *Birth to five* pp 49 and 55.)
- Toddlers benefit from a daily routine of meals and snacks based around their sleeping pattern.
- Meals should be in social groups with the child sharing enjoyment with the adults as a positive experience.
- There should be regular meals with their family as often as possible in a pleasant, sociable environment with no distractions (such as television).
- They should have only short periods of being sedentary unless they are asleep. Support the family to reduce the time they are sitting in front of a screen to less than two hours in total per day. Some experts say that there should be no screen time at all for children under two years old.
- Frequent, active, child-led play is fundamental to the healthy development of children in so many ways:
  - motor skills of jumping, hopping, climbing, skipping, balance, throwing, kicking
  - social interaction
  - happiness and wellbeing
  - creative learning and cognitive function
  - not playing may mean poor development.
- Parents are very important role models for encouraging healthy eating and active play at this age through the right emphases, attitudes, environment and opportunities.
- Support families with smoking cessation services at this age as food will often be used as a substitute.

Vegetarian diet in toddlers

It is possible for a child to get the energy and nutrients he or she needs from a vegetarian diet, but a little extra care is needed. Nutrient-rich foods, such as milk, cheese and eggs, can provide protein, vitamin A, calcium and zinc but obtaining enough iron from a meat-free diet may be more difficult. If the child eats fish, iron can be found in oily fish, such as sardines, pilchards and tuna. Iron is also found in pulses, such as beans and lentils, in dried fruit and in breakfast cereals. The iron is more easily absorbed if the child has foods or drinks that are high in vitamin C. (See *Birth to five* p 52.)

Parents of vegan children can get advice from the Vegan Society or the Vegetarian Society.
www.vegansociety.com
www.vegsoc.org

Healthy Weight, Healthy Lives: A Cross-Government Strategy for England (Department of Health, 2008) is the cross-government strategy to address overweight and obesity in the population as a whole with an initial emphasis on children. A key part of the strategy is the Change4Life social marketing campaign aimed at changing behaviour in relation to nutrition and physical activity. Change4Life is primarily aimed at families with children aged five to 11 years. A Change4Life Early Years Toolkit is available to local supporters of Change4Life, including health practitioners, which provides tips on helping to change the behaviour of children aged three to four. Alongside Change4Life the campaign Start4Life is aimed at pregnant women and families with children from birth to the age of two and has similar behaviour change messages to Change4Life geared at this specific age group.

Ethnic and cultural food preferences

There are differences in food choice in different faith and cultural groups. There may be individual differences in food choices within groups, and healthcare professionals should find out about each child from his or her parent or guardian.

The food diary in Appendix C can be used to support good nutritional practice at this age.

Children at risk of obesity

At two years, if not before, children at particular risk of obesity or causing concern should be identified and their growth measured. There are a number of risk factors including:

Family and social factors:

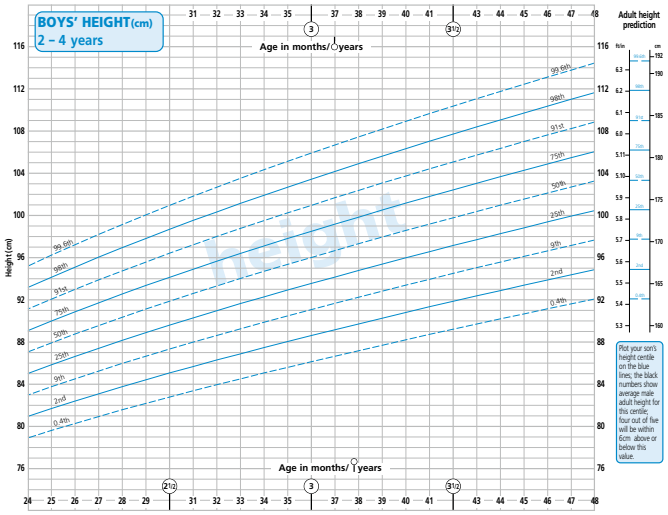
- Parental obesity
- Family history of heart disease or diabetes
- Poverty
- Race and ethnicity

Pregnancy:

- Maternal obesity
- Excess weight gain in pregnancy
- Gestational diabetes
- Smoking

Infancy:

- Birth weight
- Rapid weight gain
- Bottle feeding
- Early weaning



Measuring growth at two to two and a half years

- Accurate measurement and plotting on standard growth charts is the best method for judging healthy growth.
- Only professionals who are competent in weighing and height measurement in this age group should carry these out.
- Measurement values should be plotted on the UK World Health Organization growth charts and recorded in the PCHR.
- It is important to consider whether the child has had a recent measurement carried out in their GP's practice or at the hospital as this can be considered when assessing growth.
- The printed advice on the growth charts together with local procedures should be followed when considering referral for further assessment of growth.
- Body mass index charting should be used for overweight and obese children.

Some suggestions for community and population activities

- Support and promote retail and catering schemes that promote healthy choices.
- Support and promote schemes and facilities that encourage physical activity, such as safe outdoor space for free play.

Overweight and obese toddlers

If the child is confirmed as overweight or obese the HVT should:

- offer individual counselling and ongoing support of positive lifestyle changes; and
- consider family-based as well as individual evidence-based interventions, depending on the age and maturity of the child. HENRY (www.henry.org.uk), MEND 2–4 (www.mendprogramme.org/mendservices/minimend) and Trimtots are projects aiming to optimise eating behaviours and physical activity at this age and are currently being evaluated.

- Support and promote behavioural change programmes and tailored advice to help motivate people to be more physically active:
  - Diet: offer interactive cookery demonstrations, videos/DVDs and discussions on meal planning and shopping for food and drink to fathers as well as mothers (e.g. the Department for Children, Schools and Families Let's Get Cooking programme).
  - Active play: offer interactive demonstrations, videos/DVDs and group discussions on physical activities, opportunities for active play, safety and local facilities to both parents. Encourage parents to walk with their toddlers and young children as often as possible rather than using buggies.
  - Family programmes to prevent obesity: provide ongoing tailored support to each parent or family member as necessary and incorporate behaviour change techniques.

Immunisation

At the two year review all children's immunisation status should be checked and action taken to ensure outstanding immunisations are given at the earliest opportunity. Information should also be provided to parents and carers on future routine immunisations based on recommended guidance.[12]

Reducing inequalities in immunisation coverage (NICE)

- There should be dedicated local co-ordination of immunisation services for the routine programme, for at-risk groups and during catch-up campaigns.
- Clear advice should be distributed to patients, parents and carers about the nature and purpose of the immunisation programme, including special catch-up campaigns.
- Practitioners who offer advice about immunisation as well as those who give immunisations should be appropriately trained and provide consistent and authoritative advice.
- Local immunisation data should be available for analysis, both for care of the individual child and for analysis on a population level.
- Health visitors and other community nurses should follow up with parents, families and patients who do not attend or complete an immunisation course.

www.nice.org.uk/guidance/index.jsp?action=byID&o=11831

Some children with chronic conditions will require targeted immunisations. The review should be used to check on this and ensure that, if any are needed, appropriate arrangements are in place to see that they are given.

Health visitors and other nurses should be trained to give immunisations and transfer the data to child health information systems so that coverage is maximised among groups where uptake may be low. This can include giving immunisations in non-traditional settings, e.g. for homeless families, travellers and care leavers.

Personal, social and emotional development

As all experienced practitioners will be aware, this age can be challenging for mothers and fathers. This can be a time for tantrums and oppositional behaviour, sleep disturbance along with the development of toileting skills.

The key issues to cover at the two year review are:

- the provision of experiences to help children develop a positive sense of themselves and others, social skills and a positive disposition to learn now and in the future;
- the presence of close relationships leading to the growth of self-assurance, promoting a sense of belonging which allows children to explore the world from a secure base;
- evidence of authoritative parenting which is characterised by high levels of maturity expectation, supervision, disciplinary efforts, sensitivity to and support for a child's needs;
- the involvement of fathers;
- the development of a secure and positive attachment between each parent and the child;

12 Department of Health (2006), *Immunisation against infectious disease*, 'The Green Book', www.dh.gov.uk/en/Publichealth/Healthprotection/Immunisation/Greenbook/DH_4097254

- developing a child's social and cognitive skills through appropriate structuring of the environment and interaction with them; and
- toilet training. Although many children will still be wet at night, toilet training should have been established by 24 months. Constipation and stool holding need to be recognised as they can considerably reduce a child's confidence and competence. Good supportive seating (toilet inset seat with feet supported on a foot stool or appropriate potty or potty chair) can help promote healthy toileting.

Children whose fathers are highly involved in their upbringing from their earliest years are more likely to succeed academically, be more stable emotionally, and are less likely to become involved in crime and other anti-social behaviours. Fathers should be supported and encouraged to develop speech, language and communication skills. The National Literacy Trust in association with the Fatherhood Institute has produced some high-quality materials targeted at fathers (see www.fatherhoodinstitute.org/index.php?id=12&cID=961).

Further actions

With appropriate training, use of Ages and Stages social and emotional scales and the Home Observation and Measurement of the Environment (HOME) Inventory can be useful for assessment and supporting parents (see Appendix A).

Early years settings and Sure Start Children's Centres run a range of effective parenting groups and courses, e.g. Webster-Stratton, Mellow Parenting and Triple P.[13] For families with high levels of vulnerability and who need more intensive programmes, those such as the Family Intervention Projects can be helpful.

Building and sustaining quality of family relationships (parent to parent and parent to child)

There is compelling evidence that how parents get on greatly influences children's lives and child outcomes. The founding phase of family life, i.e. when partners adjust to becoming parents in the early years, is a particularly vulnerable time for couples when relationship satisfaction declines and levels of conflict rise. It is also a time when practitioners routinely come into contact with couples.

In its work with families, One Plus One (www.oneplusone.org.uk/PUBS/Publication.php?Ref=3) identified the 'turned to moment' – a moment when a parent turns to a practitioner with a relationship issue, often under the guise of a problem with their child. Within the context of the two year review practitioners need to be aware of this and respond supportively, offering advice tailored to the family's needs.

Speech, language and communication

Verbal communication skills are essential for children if they are to form successful social relationships, achieve in their educational endeavours and go on to secure employment and contribute to society as adults. Failure to develop communication skills has a high cost for the individual, their family and society in general.[14] Speech, language and communication needs (SLCN) can occur as a specific impairment, in association with or as

13 Barlow J, Schrader McMillan A, Kirkpatrick S, Ghate D, Smith M and Barnes J (2008), *Health-led Parenting Interventions in Pregnancy and Early Years*, Research Report DCSF-RWO70, London: DCSF

14 Bercow J (2008), *The Bercow Report: A Review of Services for Children and Young People (0–19) with Speech, Language and Communication Needs*, Nottingham: Department for Children, Schools and Families (www.dcsf.gov.uk/bercowreview)

a symptom of a wider pattern of impairments. SLCN may be caused by biological, genetic, psychosocial and environmental factors, such as disadvantage and ethnicity.

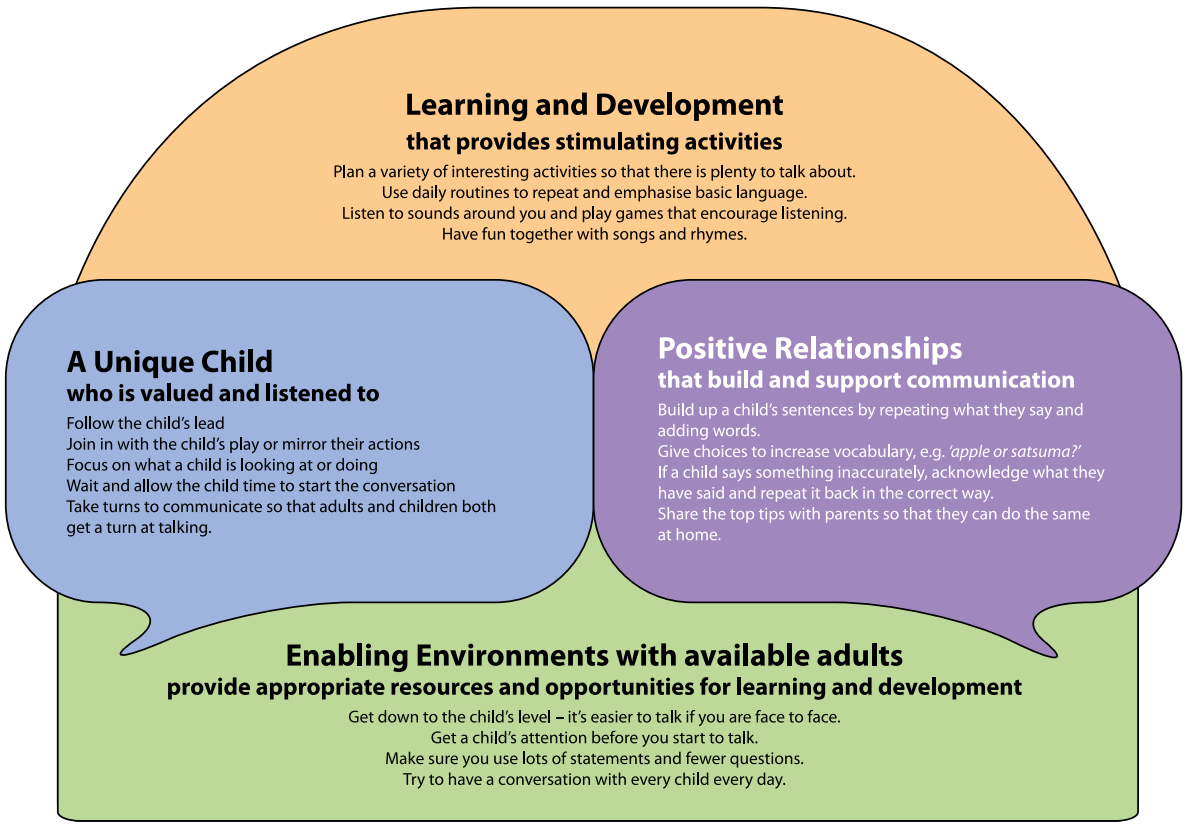
At two to two and a half years a child should be demonstrating the following speech and language skills:

- understanding more complex instructions;
- using a wide range of words (200 or more) and using these in two or three word combinations; and
- being intelligible to a familiar listener (although strangers may still have difficulty understanding).

Typically developing children display a relatively wide range of ability, especially in the pre-school years which can often make it difficult for the practitioner to know what is 'normal'. The charity I CAN has produced materials for parents and practitioners including a chart of milestones for speech and language and a DVD for parents.[15]

Early identification of SLCN can be facilitated by good staff training and the use of standardised assessment methods (see Appendix A). Glossary sheets explaining various communication impairments aimed at professionals are available from the charity Afasic (www.afasic.org.uk).

Face-to-face discussion of speech and language milestones with a member of the health visiting team, as well as discussion with other parents, will help parents to recognise whether their child is experiencing SLCN.



Source: Department for Children, Schools and Families (2008), *Every Child a Talker – Guidance for Early Language Needs Practitioners*, London: DCSF

15 www.ican.org.uk/

Health visitors, their team and early years practitioners have a key role in signposting parents to a range of services and information resources, e.g. support groups which aim to facilitate parents learn the skills necessary to prevent communication impairments developing. Families where a child is experiencing more specific SLCN should be signposted to specialist services such as speech and language therapy. It may also be appropriate to refer to a paediatrician or audiologist to identify possible associated conditions such as global developmental disorder or sensory impairment. The Area Special Educational Needs Co-ordinator (SENCO) will be able to support the early years setting in delivering a supportive environment around the child with SLCN.

Promotion of language and communication skills starts as early as possible with early exposure to books and reading,[16] turn taking and games, and universal programmes such as Every Child A Talker (ECAT) in early years settings.[17] The diagram on page 23 illustrates the contribution made by positive relationships and techniques to support speech and language development in an enabling environment.

Bilingual homes

Language and culture are inextricably linked. There are a significant number of families from different cultures and traditions in the UK. Many of these families speak their own language (mother tongue) at home and only hear or speak English outside the home. Language skills in bilingual homes will range from those individuals who can speak two or more languages with a high proficiency, through to those who are only able to understand and speak their mother tongue.

Bilingualism does not cause SLCN and parents should never be encouraged to stop speaking their mother tongue in order to learn the majority language. Parents are central to their child's language development and will give the best language models in their own mother tongue.

Learning a mother tongue at home does not prevent a child learning an additional language: laying down a firm foundation in a mother tongue supports the acquisition of an additional language.

At the two year review, practitioners should ask parents what their expectations are for a child of this age. This discussion should include what type of parent–child interaction the parents view as appropriate. This information may be particularly important when working with bilingual families: not all cultures view young children as appropriate conversation partners and some may discourage children from initiating conversation with adults.

The majority of language milestones, assessment tools and questionnaires have been developed for monolingual English-speaking families.

If a child from a bilingual family is assessed or compared with these resources, there is a high risk that false and unreliable results will be generated. This is still true if assessments are translated into the family's mother tongue. As a result, it is not recommended that assessments or parent questionnaires are informally translated into other languages at a local level. Assessments and questionnaires which are appropriate for use with bilingual families will be available on the Royal College of Speech and Language Therapists website (www.rcslt.org) in the near future.

16 www.booktrust.org.uk/
17 http://nationalstrategies.standards.dcsf.gov.uk/node/158181

The practitioner will then need to discuss their own expectations and explore any gap which has been revealed. This conversation should be facilitated by an interpreter where the family do not share the practitioner's mother tongue. Professional interpreters should be utilised and it is poor practice to use family members.

Injury prevention

Injury prevention is an essential part of universal and targeted safeguarding of children. The commonest injuries at this age are home based due to falls, burns and scalds and accidental poisoning with household products or medicines. Those families where safety is not a priority or where low income is an issue are particularly vulnerable.

Issues to cover at the two year review include:

- promotion of hazard awareness in the home (e.g. stairs, electric plugs, cupboard safety);
- parents knowing what equipment to buy and where in their area it is available; and
- free installation of smoke alarms and safety equipment, which is an important means to address health inequalities for disadvantaged families.

Include injury prevention as part of intensive home visiting programmes for families at higher risk. This is likely to have a range of other beneficial effects for maternal and child health.[18]

High-need families and the two year review

Families with high levels of need may already be well known to the HVT and other agencies. Families transferring into an area or who are highly mobile will require full assessment of their needs. Many are likely to be known to early years providers who may be able to usefully contribute to needs assessment and joint intervention. A clear understanding of information sharing protocols in the area will be essential to ensure facilitation of information exchange between agencies.[19] It is likely that many of these families will have their review in a home setting. The health visitor is most likely to be carrying this out and will ensure that the appropriate stages of the review are performed according to the needs of the child and family. The HOME Inventory has been extensively trialled as a means of standardising the assessment of the home environment and can be used as a method of monitoring the impact of the HVT interventions.[20] Professionals need to be aware of the importance of engaging with fathers and father figures, and recording their details.

For those families taking part in the FNP programme, there will be a formal transfer of service from the FNP team to the health visitor at two years.

18 Kendrick D, Barlow J, Hampshire A et al. (2007), Parenting interventions for the prevention of unintentional injuries in childhood, *Cochrane Database of Systematic Reviews*, **4**, CD006020

19 www.everychildmatters.gov.uk/informationsharing

20 Kendrick D, Elkan R, Hewitt M et al. (2000), Does home visiting improve parenting and the quality of the home environment? A systematic review and meta-analysis, *Archives of Disease in Childhood*, **82**(6): 443–51

Recording the review and setting goals

It is recommended that the review findings are recorded in a standardised way to enable an appropriate record to be kept for each individual child and allow data to be aggregated to support service delivery audit. The record should be in a format which can be kept in the PCHR.

Suggested record of the two year review

Parent and health visiting team record for two year review

Date of review .....

Age of my child .....

Notes – I am/we are happy with .....

..... development and behaviour and have no concerns

I/we have some worries about .....

.....

.....

If measured:

Height .....

Weight .....

Development .....

Immunisations are up to date/need updating (delete as necessary)

Discussion areas

.....

.....

We have agreed the following goals .....

Pre-CAF/CAF .....

Arrangements for review .....

The review summary should be shared appropriately with the general practitioner and early years setting (nursery or childminder) or children's centre

Child public health review at two years

Part of the review at aged two includes not only an individual child level process but also planning the HCP and reporting on outcomes for the population.

A key activity for HVTs will be to report on outcomes for their population. This may be at several different levels:

- caseload;
- GP practice; or
- children's centre catchment.

Further work needs to be done to develop quality measures, outcomes and data systems (including the PCHR) for the HCP and the two year review in particular. Examples could include:

- percentage coverage of the two year review;
- percentage of fathers present;
- percentage of coverage by postcode or population group;
- percentage of immunisation completeness by two years;
- a measure of social and emotional wellbeing;
- percentage of disadvantaged families with home safety equipment;
- percentage with healthy weight/growth or conversely overweight/obesity (periodic survey);
- number and percentage of parents identifying speech, language and communication concerns/language measure (EYFS profile);
- number and percentage of children aged two years six months with known special educational needs; and

- percentage who have had significant accident and emergency attendances/ hospital admissions.

(See also examples in Department of Health (2008) *Community NHS Contract Integrated Guidance*, Appendix 1, pp 87–99.)

HVTs need to work closely with community paediatricians and public health departments to select and collate appropriate data to support these and link them to the Every Child Matters Outcomes Framework and the local Children and Young Persons Strategic Plans and outcome measures.

System and infrastructure requirements

A number of system and organisational level prerequisites are necessary to support universal delivery of the two year review. Many of these are needed for the HCP as a whole but are included here to reflect developments since the updated guidance was published in 2008.

Commissioning the two year review

While the focus of this guide has been on the review itself commissioners have the responsibility for deciding what outcomes they wish to see for young children and families, what funding is available and who will provide the HCP. The following commissioning requirements for the HCP and the two year review reflect national competencies for commissioning:

- The two year review is to be commissioned in collaboration with local providers as part of the overall HCP.
- The HCP needs to be jointly commissioned by the Children's Trust and highlighted within Local Area Agreements with active NHS and Practice-Based Commissioning involvement.
- The contribution of the HCP to joint outcomes and its place in integrated provision and care pathways needs to be specified.
- To have in place methods of gathering user feedback on the HCP, especially from disadvantaged groups and changing local contracts accordingly.
- The HCP is to be commissioned on a progressive universal basis which requires a systematic method of child health data collection and stratification of the population and matching HCP resources to need and future expected outcomes for children.
- For the commissioning of the HCP to be clinically led i.e. public health with the involvement of front-line staff responsible for the implementation of the HCP.
- Currency and pricing options that are realistic in what can be achieved within the funding provided.
- To base local contracts on the national service specification for the HCP (www.dh.gov.uk/en/publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_091451) using robust, meaningful and accessible metrics for the HCP quality and outcomes.

Ensuring quality

- Including quality indicators as part of commissioning the programme.
- Ensuring supervision is in place for front-line staff – working with families with very young and vulnerable infants is difficult work and staff need clinical and reflective supervision.
- Matching staff competencies to HCP responsibilities and complexity of communities and families.
- Clarifying the lead role of the health visitor for the HCP and making sure that sufficient numbers of health visitors are in place to lead local teams and deliver a high-quality comprehensive HCP.
- Improving the current level and quality of user feedback for the HCP.
- Introducing clear responsibilities at a public health level for monitoring the programme at a population level, i.e. coverage, screening, immunisations, short- and longer-term impacts.
- Linking the currencies to the outcomes through an understanding of key outcome indicators that are recorded, managed and evidenced in service delivery by commissioners and providers.

Maximising productivity

- Using information, professional judgement and parent's views to match services to need and future outcomes at population and individual level.
- Aligning resources and skills with progressive universal provision with evidence-based intensive preventive programmes for high-need families and a light-touch approach for low-need families.
- Deciding locally the most efficient and effective way of providing the HCP, making the most of children's services, in particular Sure Start Children's Centres and other early years settings and general practice.
- Matching competencies to programme responsibilities and ensuring adequate training, information technology, data systems and administrative support to free up professionals' time for families.
- Integrating the HCP within Sure Start Children's Centres and early years services through the named health visitor.
- Using the EYFS profile as a base for the two year review when available.
- Offering group sessions for reviews.
- Using new media and social networking sites to promote the role of mothers and fathers in their child's reviews and sharing information.
- Discontinuing unproven practices and materials, avoiding duplication, non-productive clinics and contacts not in the recommended HCP schedule.

Areas for innovation

- Closer working with Sure Start Children's Centres and early years providers at service and system levels.
- Raising public awareness of the HCP and developing the role of mothers and fathers in the HCP for low-need families.
- Population stratification systems based on future outcomes.
- New ways of engaging the most disadvantaged families using learning from FNP and children's centre outreach work.
- Preparing and supporting staff to use more effective models of change.
- Encouraging and supporting the exercise of professional judgement and self-management reducing the need for a 'tick list' approach and overly bureaucratic systems.

Accountability and responsibilities

As joint commissioning develops and services work together more closely it becomes more important for families, practitioners and providers to be clear about who is accountable for what in the HCP. This will be agreed locally and the following may help inform those discussions:

- Leadership at commissioning level from public health and community paediatrician to monitor the programme at population level and provide clinical leadership for the HCP.
- Leadership from the children's commissioner across health and local authority for overall commissioning of the programme including user feedback.
- Provider manager – to deliver the contract and create the conditions necessary for safe delivery of a quality HCP and support the health visitor as lead for the HCP. Inform commissioners if universal coverage is not achievable.
- In their lead role, the health visitor, with managerial and PCT support, is accountable for the delivery of the HCP to a defined population (general practice, community or children's centres) – this could include:
  - ensuring that a system is in place to offer a review to all children at this age and informing the manager if they are unable to deliver the HCP contract;
  - working closely with children's centre staff, early years professionals, general practice, child care providers and other practitioners as nearly 40% of children under the age of two are enrolled in formal childcare (rising to 86% by age three to four years);[21]
  - ensuring that all staff delivering the two year review are appropriately trained and supervised and managers are informed of training needs;
  - judging the level of need based on knowledge of the child and family, and the balance of risk and protective factors;
  - monitoring coverage, outcomes and quality of the HCP for their defined population; and
  - sharing information with children's service partners.
- Appropriate safeguarding infrastructure and supervision will need to be in place.
- Sure Start Children's Centres and early years services will have an increasingly important role in the two year review. Their contribution needs to be agreed locally.
- General practice sees young children more often than any other service and their role must not be underestimated. While the two year review does not require hands-on GP involvement, the information a practice has on a child and their family needs to be readily accessible to the health visitor. There needs to be a reliable and effective system in place for discussing children about whom the health visitor and/or GP have concerns.

Workforce issues

The HCP needs a competent workforce who have the knowledge, skills and attributes to ensure that the programme is delivered to a high standard. Practitioners need to be:

- skilled in assessing parental preferences;
- able to signpost fathers and mothers to appropriate resources;
- competent in using evidence-based approaches to listening, eliciting concerns and assessing the child at this age by

21 Department for Children, Schools and Families (2008), *Childcare and Early Years Survey of Parents 2008*, Research Report DCSF-RR136, London: DCSF

obtaining information from fathers, mothers and carers; and

- able to conduct direct observation of the child's physical, emotional and neuro-developmental abilities as necessary.

The forthcoming Healthy Child e-Learning resource will enhance competence. The Children's Workforce competencies framework (Skills for Health) is helpful for assessing and developing staff.

How many staff and what competencies are needed to deliver the HCP will be decided locally. National learning on workforce issues suggests that the following need to be thought about locally:

- There needs to be an increase in the number of health visitors, and Strategic Health Authorities (SHAs) and local commissioners and providers will be expected to have plans in place to address the current shortfall taking forward the Action on Health Visiting programme that has been developed with Unite/the Community Practitioners' and Health Visitors' Association.[22]
- While skill mix has brought a number of advantages we know little about what the best balance of registered to non-registered professionals is for different communities. Research from the FNP programme suggests that qualified nurses have significantly better outcomes for this intensive programme than 'para-professionals'. This supports other evidence that qualified professionals can have better outcomes where there are complex needs requiring a therapeutic intervention.
- Community peer support systems have been shown to be effective in improving certain outcomes e.g. breastfeeding.
- Up-to-date learning on emotional wellbeing and speech, communication and language, obesity prevention and immunisations are key for the two year review.

Working together

Experience of successful working together between health and children's centres suggests that the following are needed:

- **Communication:** Engagement to share ideas and enable people to do things together from planning through to implementation.
- **Adequate planning:** A comprehensive plan of what needs delivering and how essential it is for success, sign up at board level in terms of commitment and resources, careful project and logistics management from the outset.
- **Co-location:** Co-location of staff from different agencies in the same office wherever possible facilitates communication and encourages shared learning to take place.
- **Forging links with the multi-agency team:** This requires development of good relationships and trust and the recognition of the different professional cultures with a readiness to understand partner priorities and barriers and to overcome them jointly.
- **Maintaining the momentum:** Regular meetings to clarify each other's roles are a key factor in maintaining the momentum. Joint working allows individuals to share their specialist skills and knowledge to meet the needs of children and young people and families.[23]

22 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107005

23 Tope R, Thomas E and Jones E (2009), *Identification of Working Examples of Integrated Practice between Children's Services and Health*, HERC Associates

Delivering the two year review through children's centres

The Government is on track to achieve its target of 3,500 Sure Start Children's Centres by 2010 (one for every community). Over 3,000 centres are now operational, providing access to services for almost 2.4 million children and their families. Sure Start Children's Centres offer significant opportunities for improving children's health and are a key vehicle, along with general practice, for delivering the HCP, particularly through the named health visitor role. Delivery of child and family health services is part of Sure Start Children's Centres 'Full Core Offer'.

The recently published *Healthy lives, brighter futures: The strategy for children and young people's health* heralds a strengthened role for health in children's centres, with a named health visitor for every centre.

Delivering the two year review with general practice

GPs and the wider primary healthcare team see young children more than other health services and they are key players in the HCP as a whole. The health visitor lead will ensure that general practice is kept informed of individual children and families as well as how the programme is being delivered to their children.

Those leading and providing the HCP also need to increase the involvement of GPs by:

- regular planned meetings to discuss individual children, especially where safeguarding and health concerns exist;
- using and sharing child public health profiles to further highlight priorities of health need and monitoring of the HCP as a whole;
- implementing service level agreements for the HVT with the practice;
- regular meetings with practice managers;
- where possible, use of integrated information systems;
- focusing on specific clinical issues, e.g. asthma or injury attendances to the local hospital, breastfeeding and disability services;
- ensuring that information is shared about children who have fallen behind with their routine immunisations and that arrangements are made to follow up those children and their families;
- active contribution to the Joint Strategic Needs Assessment process to develop the local Children and Young Persons Plan; and
- supporting the training of nursing and medical students and GP trainees. (SHA Service Increments for Teaching funding can support this for medical students.)

Appendices

Appendix A: Tools used to support the two year review

It is not necessary or appropriate to use these tools for every child. They are to be used to support professional judgement. The following list has been chosen as 'best buy' and reflects in the current state of knowledge which may change. Several of these have not been extensively used in the UK and will need to be piloted and evaluated locally and through further research. For example, further evidence will need to be gathered in the UK when using the Communicative Development Inventory (CDI) and the Home Observation and Measurement of the Environment (HOME) Inventory tools where there are no clear cut-off points. It is not acceptable to use unevaluated 'home-grown' surveys and questionnaires and their use is discouraged.

Domain	Tools/instruments	Notes	Availability and costs where known (as of September 2009)
Physical health	*Height and weight* Measurement of child's weight and height	Use approved height measure and weighing scales Use UK-World Health Organization growth charts[1] No member of the health visiting team (HVT) should be expected to measure weight or height without appropriate training and supervision. Research has indicated that observation by parents and professionals is a poor guide to whether a child is overweight or obese	Low-resolution charts are available as downloads from: www.rcpch.ac.uk/Research/UK-WHO-Growth-Charts Email growthcharts@rcpch.ac.uk to request electronic high-resolution images of the 0–4 years charts; please note that the Royal College of Paediatrics and Child Health does not distribute hard copies Charts are copyright © 2009 Department of Health; this copyright notice should be reproduced on all copies Hard copies also available from Harlow Printing Ltd (email sales@harlowprinting.co.uk, Tel: 01914 554286)

1 UK-World Health Organization growth charts 0–4 years (copyright © Department of Health)

Domain	Tools/instruments	Notes	Availability and costs where known (as of September 2009)
	General health question 'In general would you say that your child's health is excellent, very good, good, fair or poor?' *Sleep* 'Is your child's sleep a problem for you?' None, mild, moderate or large problem	Standardised method of ascertaining general health status[2]	
General development	Schedule of Growing Skills 2[3]	20 minutes for complete assessment, less for individual domains	http://shop.gl-assessment.co.uk/home.php?cat=360 £180 Training DVD £99
	Ages and Stages Questionnaire (ASQ)	Parents indicate child's developmental skills on 25–35 items (4–5 pages) using a different form for each well visit. Reading level varies across items from 3rd to 12th grade. Takes around 15 minutes	www.brookespublishing.com/asq US$249.95 (starter kit with English questionnaires) www.pbrookes.com/ Training options: live training, training video

2 A study to examine the feasibility of developing a national tool to check child health and development during the childhood period 18 months to 3 years of age: final report submission by the Centre for Community Child Health and Murdoch Childrens Research Institute for the Victorian Department of Education and Early Childhood Development, March 2009

3 Bellman M, Lingam S and Aukett A (1997), *Schedule of Growing Skills,* Windsor: NFER–Nelson

Domain	Tools/instruments	Notes	Availability and costs where known (as of September 2009)
	Parents' Evaluation of Developmental Status (PEDS)	Birth to eight years. Ten questions eliciting parents' concerns in English, and many other languages Written at the 10–11 year literacy level. Determines when to refer, provide further testing, provide patient education, or monitor development, behaviour/emotional, and academic progress. Provides longitudinal surveillance and triage	www.pedstest.com/ Training options: downloadable slide shows with notes, case examples, and handouts, website discussion list (covering all screens), short videos PEDS starter kit £32
	Denver Developmental Screening Test[4]	NOT to be used as screening test but can support professional judgement	
Speech, language and communication	Sure Start Speech and Language Measure. The Third Implementation of the Sure Start Language Measure Harris F, Law J and Roy P City University, London 2005 Communicative Development Inventory (CDI) Corkum V and Durham P (1996) Journal of Child Language, 23, 515–528	See Pickstone et al. (2002) for an extensive review, full references for tests and their properties[5]	www.surestart.gov.uk

4 Frankenburg WK, Dodds J, Archer P et al. (1992), The Denver II: a major revision and restandardization of the Denver Developmental Screening Test, *Pediatrics*, **89**: 91–7

5 Pickstone C, Hannon P and Fox L (2002), Surveying and screening preschool language development in community-focused intervention programmes: a review of instruments, *Child: Care, Health and Development,* **28**: 251–64

Domain	Tools/instruments	Notes	Availability and costs where known (as of September 2009)
	Law J and Roy P (2008) Parental Report of Infant Language Skills: a review of the development and application of the Communicative Developmental Inventories. Child and Adolescent Mental Health, 13 (4), 198–206 Gillham B, Boyle J and Smith N (1997) First Words and First Sentence Tests Hodder Arnold H and S Publishers London		Not currently in print
	Social and Communication Questionnaire (SCQ) (autism/ autistic spectrum disorders) Rutter M, Bailey A and Lord C (2003) Los Angeles, CA: Western Psychological Services	Helps evaluate communication skills and social functioning in children who may have autism or autistic spectrum disorder (ASD). In less than 10 minutes the parent or primary caregivers identify individuals who may have autism and should be referred for a complete diagnostic evaluation UK-based tool developed by Rutter et al. and validated in the UK Valid for toddlers between 16 months and 30 months	http://shop.gl-assessment.co.uk/home.php?cat=363 £99 full set

Domain	Tools/instruments	Notes	Availability and costs where known (as of September 2009)
	The Modified Checklist for Autism in Toddlers (M-CHAT) (plus interview follow-up)	A validated screening for toddlers between 16 and 30 months of age, to assess for risk for ASD. Twenty-three yes/no questions. Translations in multiple languages available. Not all children who score at risk for ASD will be diagnosed with the disorder. For this purpose a structured follow-up interview exists for use in conjunction with the M-CHAT Checklist takes 5–15 minutes	Available at no cost www2.gsu.edu/~psydlr/Diana_L._Robins,_Ph.D..html The follow-up interview refines assessment accuracy
Social/ emotional/ behaviour	Ages and Stages Social-Emotional 24–30 months[6]	Ages and Stages Questionnaire is used in the UK in the Family Nurse Partnership	Details as above
	Achenbach Child Behaviour Checklist[7]	99-item measure of children's internalising (anxiety, depression) and externalising (inattention, oppositional defiance, aggression) behaviours. All tools US based and normed	www.aseba.org/index.html
	Brief Infant Toddler Social Emotional Assessment (BITSEA)[8]		US$105.00 http://pearsonassess.com/ Training options: none 5–7 minutes Materials US$2 per test

6 Bricker D and Squires J (1999), Ages & Stages Questionnaires ® (ASQ): *A Parent-Completed, Child-Monitoring System*, 2nd edition, Baltimore: Brookes Publishing, www.brookespublishing.com/asq

7 Achenbach TM (1966), The classification of children's psychiatric symptoms: A factor-analytic study, *Psychological Monographs*, **80**: 1–37

8 Briggs-Gowan MJ, Carter AS, Irwin JR et al. (2004), The Brief Infant-Toddler Social and Emotional Assessment: screening for social-emotional problems and delays in competence, *Journal of Pediatric Psychology*, **29**: 143–55

Domain	Tools/instruments	Notes	Availability and costs where known (as of September 2009)
	Strengths and Difficulties Questionnaire[9]	There is limited but encouraging use of the 3–4 year SDQ questionnaire in two year olds. Further data is being gathered as part of the formal evaluation of FNP sites which will help to inform further development	www.sdqinfo.com/b7.html No charge
Parenting style observation	HOME Inventory[10]	Well-validated tool which has shown good correlations with child outcome The HOME Inventory (infant–toddler version) consists of six subscales measuring aspects of stimulation in the home: 1. emotional and verbal responsivity of the mother 2. avoidance of restriction and punishment 3. organisation of the environment 4. provision of appropriate play materials 5. maternal involvement with the child 6. opportunities for variety in daily routine The inventory is designed to be administered by an interviewer within the child's home, and is based on observations of the interviewer	To obtain materials for administering and scoring the HOME Inventories, contact Lorraine Coulson, HOME Inventory LLC, Distribution Center, 2627 Winsor Drive, Eau Claire, WI 54703, USA. Email: lrcoulson@ualr.edu. Tel: 715-835-4393 US$40 for manual http://ualr.edu/case/index.php/home/home-inventory/

9 Strengths and Difficulties Questionnaire, www.sdqinfo.com/b1.html

10 Bradley R and Caldwell B (1979), Home observation for the measurement of the environment: a revision of the pre-school scale, *American Journal of Mental Deficiency*, **84**: 235–44

Domain	Tools/instruments	Notes	Availability and costs where known (as of September 2009)
Family environment	What do you enjoy doing with your child? What are your pre-school plans? Are there any issues in the family that you are concerned are affecting your child? If so, would you like some help with that?[11]		These questions have been tested and recommended for use in Australia in triggering discussions with parents around the family environment

11 Council of Australian Governments. See reference 2 on page 35

Appendix B: PEDS response form

PEDS Response Form

Acme Pediatrics
Provider

Child's Name Roger J. Parent's Name Malinda J.

Child's Birthday 8/8/05 Child's Age 2 Today's Date 8/10/07

Please list any concerns about your child's learning, development, and behavior.

I'm worried about how my child talks and relates to us. He says things that don't have anything to do with what's going on. He's oblivious to anything but what he is doing. He's not doing as well as other kids in many ways.

Do you have any concerns about how your child talks and makes speech sounds?

Circle one: No (Yes) A little COMMENTS:

He repeats odd things like "Wheel of Fortune"

Do you have any concerns about how your child understands what you say?

Circle one: No (Yes) A little COMMENTS:

I can't tell if he doesn't understand, doesn't hear well or just ignores us

Do you have any concerns about how your child uses his or her hands and fingers to do things?

Circle one: (No) Yes A little COMMENTS:

He's good with manipulatives but does a lot of the same things over and over: spinning wheels on cars, flicking light switches, flipping pages

Do you have any concerns about how your child uses his or her arms and legs?

Circle one: (No) Yes A little COMMENTS:

He's very coordinated and very fast!

Do you have any concerns about how your child behaves?

Circle one: No Yes (A little) COMMENTS:

still lots of tantrums but headbanging is almost gone. Behavior therapy has been helpful and his tantrums are less severe and shorter

Do you have any concerns about how your child gets along with others?

Circle one: No Yes (A little) COMMENTS:

He doesn't seem interested in watching other kids, let alone playing with them

Do you have any concerns about how your child is learning to do things for himself/herself?

Circle one: (No) Yes A little COMMENTS:

He's very independent

Do you have any concerns about how your child is learning preschool or school skills?

Circle one: (No) Yes A little COMMENTS:

He's too young for any of that!

Please list any other concerns.

We spend lots of time playing with Roger and talking to him. This seems to be helping him be more engaged. I still wonder about his hearing.

Appendix C: Food diary

Children's food diary **Week commencing ……..**

	Breakfast	Midmorning	Lunch	Midafternoon	Evening meal	Night
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						
SUNDAY						

Include everything your child eats and drinks with approximate amounts

Appendix D: References and resources

Evidence base for the Healthy Child Programme

Hall D and Elliman D (2006), *Health for all Children* (revised 4th edition), Oxford: Oxford University Press.

Barlow J, Schrader McMillan A, Kirkpatrick S, Ghate D, Smith M and Barnes J (2008), *Health-led Parenting Interventions in Pregnancy and Early Years*, Research Report DCSF-RWO70, London: DCSF.

Kendrick D, Elkan R, Hewitt M et al. (2000) Does home visiting improve parenting and the quality of the home environment? A systematic review and meta-analysis, *Archives of Disease in Childhood*, **82**: 443–51.

Policy documents

Department of Health (2009), *Healthy lives, brighter futures: The strategy for children and young people's health*, London: DH/DCSF.

Department of Health (2009), *Healthy Child Programme: Pregnancy and the first five years of life,* London: DH.

Department of Health (2008), *Community NHS Contract Integrated Guidance*, Appendix 1, pp87–99.

Every Child Matters, www.dcsf.gov.uk/everychildmatters

Family Nurse Partnership (FNP)

Olds D (2006) The Nurse Family Partnership: An evidence based preventive intervention, *Infant Mental Health Journal*, **27(1)**: 5–25.

familynursepartnership@dh.gsi.gov.uk

Child public health

Blair M, Stewart-Brown S, Waterston AJ and Crowther R (2003), *Child Public Health*, Oxford: Oxford University Press.

Blair M and Hall DMB (2006), From child health surveillance to child health promotion, *Archives of Disease in Childhood*, **91**: 730–35.

Early years

Department for Children, Schools and Families (2008), *Childcare and Early Years Survey of Parents 2008*, Research Report DCSF-RR136, London: DCSF.
http://nationalstrategies.standards.dcsf.gov.uk/node/83902

Child development resources and assessment instruments

Williams N, Mughal S and Blair M (2008), 'Is my child developing normally?' – a critical review of web based resources for parents, *Developmental Medicine & Child Neurology*, **50**: 893–97.

Glascoe FP (2002), *Collaborating with Parents: Using Parents' Evaluation of Developmental Status (PEDS) to Detect and Address Developmental and Behavioral Problems*, Nashville, TN: Ellsworth & Vandermeer Press LLC, www.pedstest.com

Davies S and Feeney H (2009), A pilot of the Parents' Evaluation of Developmental Status tool, *Community Practitioner*, **82(7)**: 29–31.

Bellman M, Lingam S and Aukett A (1997), *Schedule of Growing Skills*. Windsor: NFER–Nelson.

Frankenburg WK, Dodds J, Archer P et al. (1992), The Denver II: a major revision and restandardization of the Denver Developmental Screening Test, *Pediatrics*, **89**: 91–7.

Pickstone C, Hannon P and Fox L (2002), Surveying and screening preschool language development in community-focused intervention programmes: a review of instruments, *Child: Care, Health and Development*, **28**: 251–64.

Achenbach TM (1966), The classification of children's psychiatric symptoms: A factor-analytic study, *Psychological Monographs*, **80**: 1–37. www.aseba.org/index.html

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Briggs-Gowan MJ, Carter AS, Irwin JR et al. (2004), The Brief Infant–Toddler Social and Emotional Assessment: screening for social-emotional problems and delays in competence, *Journal of Pediatric Psychology*, **29(2)**: 143–55.

Strengths and Difficulties Questionnaire, www.sdqinfo.com/b1.html

Bradley R and Caldwell B (1979), Home observation for the measurement of the environment: a revision of the pre-school scale, *American Journal of Mental Deficiency*, **84**: 235–44.

Practice issues

www.oneplusone.org.uk/PUBS/Publication.php?Ref=3

Osborne LM (1982), Group well-child care: an option for today's children, *Pediatric Nursing*, **8(5)**: 306–8.

Escobar GJ, Braveman PA, Ackerson L et al. (2001), A randomized comparison of home visits and hospital-based group follow-up visits after early postpartum discharge, *Pediatrics,* **108(3)**: 719–27.

Bidmead C and Cowley S (2008), Partnership working to engage the client and health visitor. In: Calder MC (ed.), *The Carrot or the Stick: Towards Effective Practice with Involuntary Clients in Safeguarding Children Work,* Lyme Regis: Russell House Publishing.

Waterston T, Welsh B, Keane B et al. (2009), Improving early relationships: a randomized, controlled trial of an age-paced parenting newsletter, *Pediatrics* **123**(1): 241–47.

Rollnick S, Miller W and Butler C (2008), *Motivational Interviewing in Health Care: Helping Patients Change Behaviour*, New York: The Guilford Press.

Unite/Community Practitioners' and Health Visitors' Association (2009), *Community nursery nurse handbook*, London: Unite/CPHVA.

www.everychildmatters.gov.uk/informationsharing

Nutrition and obesity prevention

www.nhs.uk/Change4life/Pages/Default.aspx

www.infantandtoddlerforum.org/

Foresight (2007), *Tackling Obesities: Future Choices*, London: Office for Science.

National Institute for Health and Clinical Excellence (2006), *Obesity: Recommendations for the NHS. Preventing Overweight and Obesity*, London: NICE.

Cross-Government Obesity Unit (2008), *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England,* London: DH/DCSF.

Immunisation

www.london.nhs.uk/publications/tools-and-resources/pct-performance--quick-guides

Department of Health (2005), *Vaccination Services – Reducing Inequalities in Uptake*, London: DH.

Toilet training

Vermandel A, Van Kampen M, Van Gorp C and Wyndaek JJ (2008), How to toilet train healthy children? A review of the literature, *Neurourology and Urodynamics*, **27**: 162–6.

Speech and language

Bercow J (2008), *The Bercow Report: A Review of Services for Children and Young People (0–19) with Speech, Language and Communication Needs*, Nottingham: DCSF. www.dcsf.gov.uk/bercowreview

www.ican.org.uk/

www.booktrust.org.uk/

Department for Children, Schools and Families (2008), *Every Child a Talker – Guidance for Early Language Needs Practitioners*. London: DCSF.

- The National Literacy Trust publishes a number of leaflets aimed at parents which are available in a range of languages. The leaflets include one which encourages parents to use their mother tongue with children: www.literacytrust.org.uk/talktoyourbaby/CommunicatingDads.pdf; www.literacytrust.org.uk/talktoyourbaby/quicktips.html
- CPLOL (the European umbrella organisation for speech and language therapists) publish a 'poster' outlining language development stages. See www.cplol.org/eng/posters.htm. The poster prints on to A4 and includes advice for parents and pointers which indicate when to seek help. It is available in a range of languages including Welsh and English. This can be a useful starting point to share with parents and initiate a discussion about their own child's skill level.

- Afasic publish a range of leaflets aimed at health and education professionals which explain speech language and communication difficulties. These leaflets include one on bilingualism which explains some of the terminology commonly used. See www.afasic.org.uk/pub.htm and www.afasic.org.uk/pdf/glossary%2028.pdf.

Injury

Department for Children, Schools and Families (2008), *Staying Safe Action Plan*. London: DCSF.

Department for Children, Schools and Families (2009), *Accident Prevention Amongst Children and Young People – A Priority Review*. London: DCSF/DH/DfT.

NHS Choices. Accidents to Children in the Home. www.nhs.uk/conditions/accidents-to-children-in-the-home/pages/introduction.aspx

Kendrick D, Barlow J, Hampshire A et al. (2007), Parenting interventions for the prevention of unintentional injuries in childhood, *Cochrane Database of Systematic Reviews*, **4**, CD006020.

Leeds Primary Care Trust has produced a useful guide on how you can decide which is the scheme best suited for your area. www.rospa.com/homesafety/info/equipment_schemes.pdf

Infrastructure

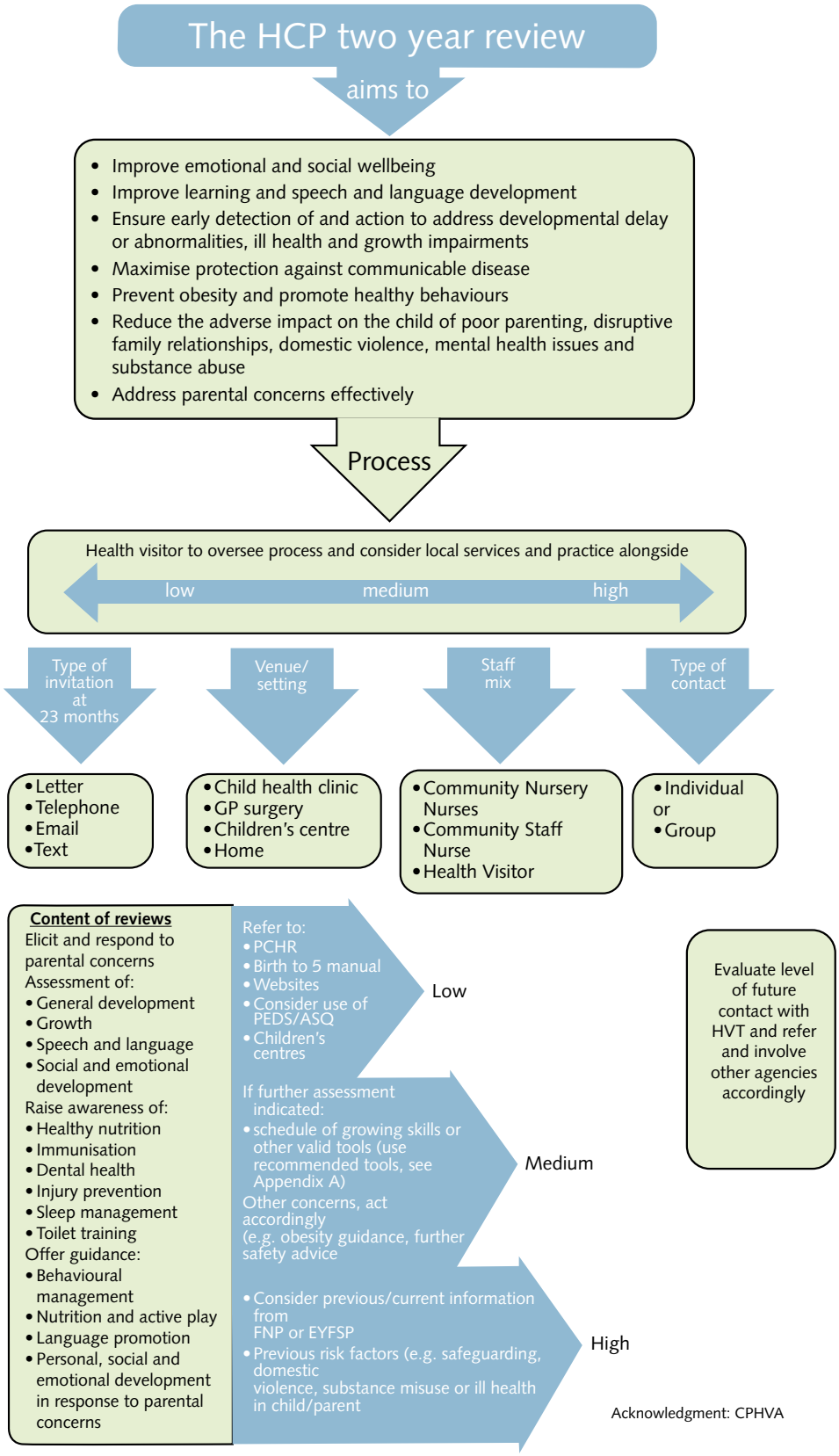
Department of Health (2008), *Community NHS Contract Integrated Guidance*, Appendix 1, pp 87–99.

Blair M (2001), The need for and role of a coordinator of child surveillance/promotion, *Archives of Disease in Childhood*, **84**: 1–5.

Tope R, Thomas E and Jones E (2009), *Identification of Working Examples of Integrated Practice between Children's Services and Health*, HERC Associates.

UK-World Health Organization growth charts 0–4 years (copyright © Department of Health).

Appendix E: Flow chart of two year review



Flow chart of two year review

Appendix F: Evaluation of guidance

Please rate guidance document for (0–10) 10 = Excellent 0 = Poor

Format .....

Content .....

Resource materials/references .....

Please let us know what you found most useful about this guidance document

.....

.....

Please let us know what you found least useful

.....

.....

How might you make the document more useful in a future edition

.....

.....

.....

How are you going to use this document in the next few months (describe what three (or more) actions you will take as a direct result of reading/referring to it)

1 .....

2 .....

3 .....

Other.....

What areas of the Healthy Child Programme would you welcome future guidance on?

.....

.....

Please return to

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