Guidance on specific sections (headings)

The guidance below is supplementary to the implementation guidance for Healthy Child Record standard and provides guidance for completing specific sections of the record. It should be used by providers, suppliers and health care professionals to support implementation of the standard.

It is not expected that at each episode of care (an interaction with a healthcare professional such as one on the Healthy Child Programme or a visit to a GP), that each section (heading) will be completed. Only sections (headings) considered relevant by a healthcare professional will be completed.

Patient demographics

- NHS number with the option to record not known or not available. Existing national guidance should be followed, including how to handle patients without an NHS number, e.g. overseas visitors, services personnel, prisoners.
- PDS (Patient Demographic Service) will be used as the source of information to ensure this section can be completed correctly.
- To obtain demographic information about a patient, the system needs to be able to communicate with national systems and databases, known as the spine. Where an organisation does not have a system linked to PDS, other demographics fields will need to be used, with local person identity matching software.
- Hospital numbers are not unique so should either be avoided or reference the organisation where the number was generated.
- A history of local patient identifiers should be kept, so it is important to understand the organisation which assigned the local patient identifier.

Demographic history

- The information in this section (heading) will be populated from PDS using the history flag, which is used to indicate whether or not the information is historic data.

GP practice

- If a child is not registered with a GP practice, then the GP practice record entry should appear in the Healthy Child Record with the text "no known GP practice".
- Normally children are registered with one GP practice. However, sometimes a GP serves a patient on a temporary basis and so may also need to access the Healthy Child Record. In this instance, both permanent and temporary GP practices should be recorded.

Individual requirements

- This section (heading) will be used to record both the individual requirements for the parent/carer/legal representative and, when older, the child themselves. This is not to record any disabilities.
- The data options in this section (heading) comply with the NHS England Accessible Information Standard which sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. Further information on the Accessible Information Standard can be found here.

- A parent, carer or child may choose to opt out of registering with a GP practice. System design should enable this to be recorded.
- The code and any hierarchy below it can be used to indicate whether the child and/or their parent/carer requires wheelchair access.

Birth details

- The information under this section (heading) is taken from the birth notification via PDS or the birth discharge summary.
- Type of delivery (attempted) will allow any failed delivery attempts to be recorded against the child's record.
- The APGAR score recorded as part of the birth details at 10 minutes is optional and should be recorded where considered necessary by a healthcare professional.
- Maternal problems in pregnancy are problems encountered by the mother but considered relevant in the ongoing care of the child. Care should be taken to ensure that if it is coded it relates to the child and not the mother.

- It is envisaged that fetal problems diagnosed before birth will be taken from the mother's maternity record. This will be a manual process to transfer the information to ensure the context is correct.
- Problems during delivery is aligned with maternity services data set (MSDS) v2.0. To support implementation a section of SNOMED CT, the digital clinical language used between systems, can be applied if applicable.

89700002 | Shoulder girdle dystocia (disorder) |
270500004 | Prolapsed cord (disorder) |
1091821000000108 | Acute fetal compromise (finding) |
13866000 | Fetal acidemia affecting management of mother (disorder) |
206390008 | Fetal blood loss (disorder) |
13866000 | Fetal acidemia affecting management of mother (disorder) |
206292002 | Meconium aspiration syndrome (disorder) |
56110009 | Birth trauma of fetus (disorder) |

- Physical problems detected at birth will be recorded using SNOMED CT. To support implementation a section of SNOMED CT can be applied if applicable as a 'starter for 10'

83095000 | Fetal cephalhematoma (disorder) |
82729001 | Caput succedaneum (disorder) |
49000007 | Bruising in fetus OR newborn (disorder) |
297982009 | Skin problem (finding) |
397932003 | Talipes equinovarus (disorder) |
21850008 | Plagiocephaly (disorder) |
312608009 | Laceration - injury (disorder) |
78141002 | Erb-Duchenne paralysis (disorder) |
80281008 | Cleft lip (disorder) |
87979003 | Cleft palate (disorder) |
204712000 | Anal atresia (disorder) |
71358006 | Absent finger (disorder) |
249820005 | Absence of toe (finding) |
58150001 | Fracture of clavicle (disorder) |

- Type of delivery will be recorded using SNOMED CT however the options below are aligned to the MSDS v2.0 which uses delivery method from the NHS Data Dictionary.

395683001 | Born by normal vaginal delivery (situation) |
271368004 | Delivered by low forceps delivery (finding) |
395681004 | Born by forceps delivery (situation) |

407614003 | Born by ventouse delivery (situation) |
407613009 | Born by breech delivery (situation) |
395682006 | Born by elective caesarean section (situation) |
407615002 | Born by emergency caesarean section (situation) |

National screening programme

- The information under this section (heading) relates to the information recorded as part of the three uniform childhood population screening programmes listed below:
    - NHS newborn and infant physical examination (NIPE) screening programme
    - NHS newborn blood spot (NBS) screening programme
    - NHS newborn hearing screening programme (NHSP)

- The NHS newborn and infant physical examination (NIPE) screening programme is split into two sections (headings) based on NHS England service specification No.21 NHS Newborn and Infant Physical Examination Screening Programme which follows the two stage NIPE screening care pathway:

    1. **Newborn** examination within 72 hours of birth
    2. **Infant** examination between 6-8 weeks of age

- For the Healthy Child Record each of the current screening programmes must have its own section (heading). However, systems need to be capable of updating a generic model should the screening programmes change in the future.

Newborn blood spot screening

- A record should be provided of the end-to-end blood spot screening process from the date the blood spot card was completed, the date the card was received in the laboratory and the date of the outcome of each of the screening tests performed.
- The outcomes of the screening tests should be recorded for each of the individual tests performed and must conform to the nationally defined blood spot test outcome status codes. These codes are for screening laboratories and child health organisations to record the outcomes of newborn blood spot (NBS) screening.
- Further information on the newborn blood spot screening process and supporting publications/guidelines are produced by Public Health England (PHE)

Newborn hearing screening

- A record should be provided of each of the individual screenings tests performed including automated auditory brainstem response (AABR) and otoacoustic emission (OAE) with the associated outcomes.

- The overall outcome of the newborn hearing screening must be recorded in line with nationally agreed outcome screening SNOMED CT codes.
- Further information on the newborn hearing screening process and supporting publication/guidelines are produced by PHE.

Newborn and infant physical examination (72 hours)

- A record should be provided of each of the specific infant physical examination tests performed by a healthcare professional. This includes the four screening elements:
    - Eyes
    - Heart
    - Hips
    - Testes
- The outcome of each of the physical examination checks performed should be recorded using the national SNOMED CT standards as defined by PHE.
- Additional physical checks may be performed in addition to the four mandatory checks and these may vary by region by different providers. The Healthy Child Events Specification allows the capability for these additional checks to be captured as part of this encounter. These additional checks performed sit within the examination findings section (heading).
- For any problems identified at this stage this should be recorded under the problem list section (heading)
- Further information on the newborn and infant physical examination and supporting publications/guidelines are produced by PHE

Newborn and infant physical examination (6-8 Weeks)

- A record should be provided of each of the specific infant physical examination tests performed by a healthcare professional at 6-8 weeks. This includes the four screening elements:
    - Eyes
    - Heart
    - Hips
    - Testes
- The outcome of each of the physical examination checks performed should be recorded using the national SNOMED CT standards as defined by PHE.
- Additional physical checks may be performed in addition to the four mandatory checks and these may vary by region by different providers. The Healthy Child Events Specification allows the capability for these additional checks to be captured as part of this encounter. These additional checks performed sit within the Examination Findings section (heading).
- Further information on the newborn and infant physical examination and supporting publications/guidelines are produced by PHE.

Referral details

- This is to record that the referral has been made, not the process of completing the referral.

- Coded text ‘self-referral’ should be used where the patient is not referred or transferred from a health/care organisation. Where ‘self-referral’ is recorded the referrer elements should be left blank.

Admission details

- The record should allow for the display of all instances that a child is admitted to a healthcare setting with relevant ODS codes (including admissions to neonatal intensive care units).

Discharge details

- The record should allow for the display of all instances that a child is discharged from a healthcare setting with relevant ODS codes (including discharges from neonatal intensive care units).
- The information recorded here is complementary to the discharge summary. Any transfer of care or movement between services can be recorded using existing PRSB transfer of care sections (headings) (i.e. discharge summary, emergency care discharge summary etc).

Observations

- A record should be provided as part of the Healthy Child Record of all measurements recorded against the child. This includes weight, height/length and head circumference.
- Measurements of babies/children may occur at any clinical intervention. As well as being a requirement at some of the mandated Healthy Child Programme reviews, measurements may also occur at other ad hoc encounters.
- BMI centiles are required within the record. Systems should calculate using the height/weight/gender and age of the child using the UK90 and WHO data tables. The gender and age will be held within Patient Demographics section (heading).
- Any measurement taken as part of the National Child Measurement Programme (NCMP), that are recorded on a clinical system should also be held in this area of the clinical record.

So as to not limit how the observations are measured and recorded, the model shows the high level (parent) SNOMED term and allows use of any terms in the hierarchy underneath it. For example, the model allows all SNOMED CT under the parent Blood pressure (observable entity) | 75367002 to be used.

National child measurement programme

- This section (heading) includes measurements taken as part of the National Child Measurement Programme (NCMP) which is a nationally mandated public health programme. Further information on the NCMP Programme can be found here.

- For measurements recorded as part of the National Child Measurement Programme, the School Year is taken from the date of the measurement and the child's date of birth.

Feeding status

- A record should be provided of all instances of feeding status recorded. This includes reviews where this is a mandated public health indicator (i.e. New Baby Review and 6-8 week health visitor review) and other ad hoc encounters.
- Feeding method and feeding concerns should be recorded each time the child is seen.
- Duration of breastfeeding is calculated by asking mothers if they are breastfeeding their child. If no, they should be asked when the last date of breast milk feeding was (to the nearest month and year).
- Feeding method is aligned to the current Data Dictionary Enteral Feeding Method and SNOMED CT has been created to support implementation. However the heading must be referred to as feeding method.

1104211000000107 | Breast feeding (regime/therapy)
40043006 | Bottle feeding of patient (regime/therapy)
1104231000000104 | Feeder cup feeding (regime/therapy)
229914003 | Nasogastric feeding (regime/therapy) |
229913009 | Orogastric feeding (regime/therapy) |
229917005 | Gastrostomy feeding (regime/therapy) |
310244003 | Nasojejunal feeding (regime/therapy) |

Allergies and adverse reactions

- A record should be provided of new and existing allergic and adverse reactions relevant to the child. Coded information on causative agents is important to healthcare professionals to enable safe operation of prescribing decision support.
- When a child is diagnosed with an allergy related condition (e.g. anaphylactic shock or urticarial skin rash) this will be recorded in the supplier system in addition to the recording of the causative agent under the allergies and adverse reactions section (heading).
- Where there is a diagnostic code for an allergy recorded in the supplier system, the system should trigger an allergy entry (see– allergies and adverse reactions section (heading). There is a significant risk to patient safety if allergies are not explicitly notified as allergies.
- Guidance on good practice recording of allergies and adverse reactions is provided by NICE

Family history

- The record should allow for all conditions in the child's parents or family members, deemed to be significant to the care or health of the child, to be stored
- 'Family' in this context refers to blood relations only.

Vaccinations

- The record should allow for the capturing of all vaccinations including routine vaccinations of children in accordance with the Public Health England Green Book, as well as any vaccines outside the schedule and those administered abroad.
- The system must record vaccines in line with nationally agreed naming and utilisation conventions.
- The system must be able to record as discrete data elements data associated with any vaccination administered (including travel vaccinations)
- The vaccine manufacturer should be derived from DM+D code
- SNOMED CT will be used for recording the pre-coordinated vaccination to show sequence number and the vaccination administered if it's part of the Public Health England Green Book. Therefore, dose sequence is not a mandatory field
- If applicable, when recording Indication for vaccinations given as part of the Green Book either free text or SNOMED CT can be used. Example SNOMED CT is

171279008| Immunisation due (finding)|

- Example list for SNOMED CT for site of vaccine

91775009 | Structure of left shoulder region (body structure)/left shoulder
762211005 | Structure of part of left upper limb (body structure)
61396006 | Structure of left thigh (body structure)/left thigh
762084003 | Structure of left quadriceps femoris muscle (body structure)
91774008 | Structure of right shoulder region (body structure)/right shoulder
762212003 | Structure of part of right upper limb (body structure)
11207009 | Structure of right thigh (body structure)/right thigh
264252008 | Upper thigh (surface region) (body structure)/upper thigh

- Example list for SNOMED CT for route of vaccine

26643006 | Oral route (qualifier value) |
37839007 | Sublingual route (qualifier value) |
34206005 | Subcutaneous route (qualifier value)
78421000 | Intramuscular route (qualifier value) |
372464004 | Intradermal route (qualifier value) |
46713006 | Nasal route (qualifier value) |

Medications and medical devices

- This section (heading) has been designed for the recording of two pieces of information
    - Any new medication issued by a clinician as well as medication changes and medications discontinued (**medication statement model**)
    - Any medication physically administered by a healthcare professional such as the giving of vitamin K in a maternity environment **(medication administration model)**
- Each element of the medication (e.g. name, route, dose, frequency etc.) should be presented in a clear and logical format (e.g. in tabular form). See National Patient Safety Agency (NPSA) guidance
- For dose direction duration this can be derived from the start and end dates if no other information is available.
- Example list for route of administration.

26643006 | Oral route (qualifier value) |
37839007 | Sublingual route (qualifier value) |
34206005 | Subcutaneous route (qualifier value)
78421000 | Intramuscular route (qualifier value) |
46713006 | Nasal route (qualifier value) |

Emergency care attendance

- The record should allow for the display of a list of all instances of an emergency care attendance such as Accident and Emergency attendance, or Out Of Hours GP

Personal contacts

- The record should allow for the display of a list of personal contacts (e.g. family, friends, relatives etc.)

Professional contacts

- The record should allow for the display of a list of health/care contacts that are currently or previously involved in the care of the child

Social context

- This section (heading) is split into two parts; one section (heading) details any family and household factors and the other personal factors about the child's social context.

- Social factors within the household including the household composition and environmental factors should be detailed within the 'household' section (heading). Factual concerns about the environment which are not specifically safeguarding but may impinge upon it can be recorded here. For example, serious lack of hygiene in the home, no suitable baby food in the house, no heating in the babies' room and inadequate clothing, dog appears very vicious etc.
- Current drug and substance use should be recorded under this section (heading). This should include all substances that are considered harmful to the patient and misused including illegal drugs and prescription drugs such as methadone, tobacco, caffeine.

Educational history

- This part of the record is designed to record the outcome of an education assessment and the type of special educational need a child may have, as recorded in the Community Services Data Set

Problem list

- This section (heading) allows for the recording of all relevant diagnoses and problems and issues.
- The format of the onset date of the diagnosis recorded should allow for partial dates, as the exact date may not be known.
- This is a summary of problems that require investigation or treatment. This would include significant examination findings, symptoms and signs, which are likely to have relevance and are not a diagnosis.
- It is recommended that coded items are included in the values for problem and issues.
- The naming of this section (heading) may be displayed differently in a system if it is felt that the current wording of 'problem list' has negative connotations.
- Any dietary habits considered a problem or issue should be recorded under this heading.
- It is vital that for each entry into this section (heading) has a condition end date entered once the condition, problem or issue was resolved.

Investigation results

- This section (heading) is used to record the results of investigations. Investigations undertaken where results are not available are recorded under plan and requested actions. The action is the request to the lab to undertake analysis. Therefore, this section does not record investigations undertaken where results are not available.
- Important or relevant results should be included in the 'clinical narrative' as text, together with the reason that the test was carried out

Information and advice given

- This section (heading) is designed to record advice given by a healthcare professional regarding the child which was given to the child or whoever accompanied the child. It is important that this is concise and is only information which is pertinent is recorded. This section (heading) can be used to record advice about dental hygiene and other health promotion provided by healthcare professionals at the mandated healthy child programme touchpoints.
- Where children, parents or carers are provided with literature (e.g. pamphlets) there is no need to provide details of the information contained in the literature e.g. simply state that the patient was provided with a pamphlet.

Safety alerts

- The safety alerts section (heading) could potentially contain sensitive information. Therefore, sufficient role-based access controls should be in place to ensure this information is only shared with those care professionals where there is a need to do so.
- There may be situations where it not advisable to share information in this section (heading) with the person to whom it relates. Appropriate policies and technical solutions need to be in place for these situations.
- All information needs to be reviewed on a regular basis, but it is particularly important for this type of information, given its sensitive nature. There must be mechanisms in place to validate the information in this section (heading) and for it to be reviewed regularly and if applicable put an end date within the model.
- At this stage, it is recommended the safety alerts are recorded as free text **only**

Legal information

- This section (heading) is intended to record whether the child is a 'looked after child' and/or is on a Child Protection Plan
- If no end date plan should be considered active and once end dates have been included information should stay on system for 24 hours
- Access must be controlled to this information as per SCCI1609: Child Protection - Information Sharing

Clinical risk factors

- Relevant clinical risk factors associated with the development of a medical condition should be recorded under this section (heading).
- This section (heading) can be used to record the fact that a child was at a higher risk of TB and/or hepatitis B.
- Specific assessments and actions taken to reduce the clinical risk should be recorded under this section (heading).

Plan and requested actions

- The plan should make clear who is expected to take responsibility for actions.
- Shared decision-making principles should apply to the development of the plan and where the child's or parents/carers opinions differ, this should be recorded under the section (heading) ''professional summary'.
- The plan could be presented in various ways in the source system to prompt complete information to be recorded e.g. table, best practice prompts, etc.
- This is not to record a **care plan.** This is just a snapshot and not around recording a lengthy care plan with success and failure factors

Parent/guardian/personal comment

- The record should allow for the storing of all free text comments made by the child or parent or guardian. Please note - this section (heading) is not designed to be completed by a healthcare professional, but the information will be made available in the future via exchange of information from a digital PCHR with the consent of the parent/carer or child.

Professional summary

- This is a summary of an encounter. This may include interpretation of findings and results, opinion and specific action(s). Planned actions will be recorded under 'plan and requested actions'.

Assessment scales

- This is for storing results of relevant assessments and outcome measures with dates performed.
- It will allow for recording of which specific assessment was undertaken as well as global and subscale scores where relevant.
- For children this is based around the mandated Ages and Stages (ASQ) assessment due at the 2-2 ½ Year Developmental Review, but can be used to record an ASQ done at any stage of the child's development
- For support around any copyright issues please contact NHS Digital via clin.licences@nhs.net or visit their website for more detail.
- This is an example list of assessment scales that may be used in the child and community setting and may be recorded under this heading. This is a starter for 10 list only.

716619000 | Ages and Stages Questionnaires Third Edition score (observable entity) | Parent & any children of….
e.g. 952621000000104 | Ages and Stages Questionnaires Third Edition 2 month questionnaire - fine motor score (observable entity) |
446366007 | Ages and stages questionnaire second edition score (observable entity) |Parent & any children of….
Griffiths being authored for April 2019 SNOMED release
718384003 | Bayley Scales of Infant Development score (observable entity) |

1053311000000103 | Personal Wellbeing Score rating (observable entity)
718426000 | Warwick Edinburgh Mental Well Being Scale score (observable entity) |
803351000000106 | Whooley depression screen score (observable entity) |

Examination findings

- This is a summary of any findings carried out as a result of a clinical examination by a healthcare professional.
- It is recommended that this section (heading) holds the additional checks that may be carried out at the newborn and infant physical examination that are in addition to the four mandated screening elements.
- Each record of an examination finding will include a named examination and associated findings, which may include both coded and narrative elements.
- This section (heading) allows recording of the hearing and screening vision checks that should be done as part of the school entry review
- School entry review procedure codes in SNOMED CT are shown below:

345401000000106 | School entrant hearing screening (procedure) |
345421000000102 | School entrant vision screening (procedure) |

Developmental skills

- This part of the record will allow a healthcare professional to record concerns about developmental skills that have not been achieved, but also record a date reported by a parent/carer when a developmental skill was achieved.
- A partial date may be recorded under ‘date first achieved’ if parents do not know the exact date.
- SNOMED CT has been created to record the ‘skill’ with a separate SNOMED CT created to indicate the time it was seen, whether a healthcare professional was unable to assess, or recorded as developmental skill achieved or not achieved.

Health and wellbeing assessment and reviews

- This is a summary of each of the health and wellbeing reviews that are carried out by a health visitor. The sections (headings) do not include the ante-natal visit as this is expected to be recorded on the mother’s record.
- As part of the specific health and wellbeing reviews listed below it is expected that information may be stored within more than one place within the child record. For example, a measurement recorded at a 1 Year review will be stored in both the measurements and 1 Year review sections (heading). This is the same across many elements.
- It is recommended for the Healthy Child Record that each of the current health and well being assessments has its own section (heading). However,

systems need to be capable of updating a generic model should the reviews change in the future.

Post birth review

- This is summary of information recorded as part of a post birth review and includes a list of examination and results carried out prior to discharge from maternity.

New baby review

- This is a summary of information recorded as part of a new baby review undertaken as part of the mandated health vsitor reviews and based on the information recorded in a PCHR.

6-8-week health visitor review

- This is a summary of information recorded as part of a 6-8 week health visitor review.

1 Year review

- This is a summary of information recorded as part of a 1 Year review.

2 - 2.5 Year health and development review

- This is a summary of information recorded as part of a 2 - 2.5 Year health and development review.

School entry review

- This is a summary of information recorded as part of a school entry review

Ad hoc health review

- This is a summary of information recorded as part of an ad hoc health review.

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