‘READY TO LEARN’ (30 month) ASSESSMENT

FIRST FULL YEAR DATA REPORT: JULY 2013-JUNE 2014

Public Health Directorate
NHS Greater Glasgow & Clyde
April 2015

FOREWORD

This report has been produced by NHSGGC Public Health/Health Improvement Directorate at the request of Linda De Caestecker (Director of Public Health) and Mark Feinmann (Director: North East Sector). The report presents the key findings from the 1st year of Ready to Learn (27-30 month) assessments conducted in NHS Greater Glasgow and Clyde.

An interim review of the 27-30 month assessment indicated inconsistencies in the use of 'Future Action' codes. This should be borne in mind when reading the related sections of this report.

The report is intended to update sector level data obtained from the 27-30 month assessment form. Any queries about this report should be made to:

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ACKNOWLEDGEMENTS

We would like to thank Paul Burton and Joyce Stoakes, Information Services (NHSGGC) for providing the original dataset and prompt and friendly responses to our queries.

CONTENTS

The Scottish Child Health Programme was set out in 2005 to provide care and support to help all children attain their health and development potential. Universal child health assessments or reviews are a core element of the Programme. The terms of the 27-30 month assessment were agreed in 2012 with the overall priorities described in national guidance as 'the promotion of strong early child development (particularly social/emotional and language/cognitive development) within a context of helpful parenting and wider family wellbeing, and the promotion of child healthy weight' (Scottish Government, 2012). The assessment was to be delivered by public health nurses (health visitors).

Uptake

The national 27-30 month review is known as *Ready To Learn* within NHSGGC and invitations are issued to children when they are approximately 27 months old. The total number of children eligible and invited for assessment during the first year of implementation (2013-2014) was 14,554. The average uptake of the assessment (calculated over a ten month period to allow for return delays) was 88%. The highest numbers of assessments were carried out in the three Glasgow City sectors (Glasgow South (2,519); Glasgow North East (1,919) and Glasgow North West (1,822)) and the lowest in Inverclyde (743). Glasgow North East had the highest number and proportion (1,386: 72.2%) of assessed children who were resident in an SIMD 1 area (i.e. an area in the highest deprivation category).

Place of Assessment

NHSGGC guidance recommended that assessments be undertaken in a clinic setting but the standard practice in each area was ultimately decided at local level. The place of assessment may have some relevance to findings. For example, figures suggest that heights and weights were more likely to be taken if the assessment was done in a GP surgery or a clinic than if carried out at home. Within

Glasgow City, almost half of all assessments were carried out in the home whereas in the Clyde area, they were mostly conducted in a clinic setting. Exceptions to this were in East Renfrewshire, where the highest proportion of assessments took place in a GP practice and West Dunbartonshire, where more than two thirds of assessments were done in the home.

Height, Weight, BMI

The national assessment form allows for the recording of children's height and weight and calculation of BMI. Completion of this will allow the ongoing monitoring of growth and any weight trends over time in our 30 month old population. Across NHSGGC, approximately 60% of children had either height or weight measured, 50% had both height and weight measured and 49% (5,677) had a BMI recorded. BMI calculations allow for plotting across appropriate centiles for this age group but the low numbers of BMI recording resulted in high levels of unknown weight classifications for children across NHSGGC. In West Dunbartonshire, most assessments were carried out in the child's home (68.7%) and the lowest height-weight measurements were recorded compared with all other sectors. This sector also had the highest proportion of unknown weight classifications recorded (73.6%), more than double that of the lowest unknown classifications (Inverclyde, 27.7%). Before implementation of the assessment, a decision was taken in NHSGGC that the taking of heights and weights would not be mandatory and this may account for poor recording of BMI. The policy is under revision.

Smoking

The household environment is a contributing factor in the health of young children and is something that health visitors routinely assess. In particular, the 27-30 month assessment asks health visitors to record whether parents/carers smoke and whether children are exposed to second hand smoke. Figures varied across the sectors but within NHSGGC as a whole approximately one fifth to one quarter of all children were recorded as living in households where a parent or carer smoked. However, the proportion of those who were said to be exposed to second hand

smoke was considerably lower in every sector. The exception to this was East Dunbartonshire where proportions of parent/carer smokers and children exposed to second hand smoke were both relatively low at 9.9% and 7.4% respectively. These findings suggest that parents/carers who smoke take some preventive measures to protect their children from second hand smoke.

Out-of-Home Care

National policy on the provision of nursery places is predicated on evidence of long term benefit to the language and cognitive skills of children who attend pre-school group care (e.g. nursery or playgroup) although any lasting impact on social and emotional development is more contentious. Recent research identified that the quality of pre-school provision, as opposed to provision *per se*, is the key factor in its effectiveness, notably for children under 3 years of age (NatCen Social Research, 2013). Attendance at out-of-home care is recorded at the 27-30 month assessment. Patterns of childcare at this age vary between the Glasgow and Clyde sectors. Nursery school was the most common form of pre-school care with levels between 41% and 48% in most areas. In the Clyde sectors considerably more children attended a playgroup (18-25%) compared to those in Glasgow City (7-12%) meaning that a higher proportion of children in Clyde sectors attended formal, group pre-school care. Children in Clyde sectors were also 2-3 times more likely to attend a registered childminder compared to those in Glasgow City. Considerably higher proportions of children were reported as attending no out-of-home care at all in Glasgow City.

Health Plan Indicator (HPI)

The Health Plan Indicator (HPI) was developed in 2005 as a tool for health professionals (primarily the health visitor) 'to reflect the child's needs in their family, community or wider context'. Currently, it has three categories: core, additional and intensive. The child's home environment, family circumstances, health and wellbeing should be taken into consideration when allocating to an HPI category. Children allocated as 'core' are recommended to remain on the universal child health

pathway; those allocated as ‘additional’ should receive additional input from the health visiting team and those allocated as ‘intensive’ are thought to require multiagency input. The HPI reflects a child’s needs at one point in time and so it is flexible and subject to change. The first HPI allocation should be made by the time the child reaches 6 months old: in practice, it is often allocated at the 6-8 week child health surveillance assessment. The 27-30 month assessment provides an opportunity to revise the allocation of all children’s HPI prior to the start of formal nursery education. Health visitors undertaking the assessments are provided with the current HPI of each child before the assessment including an option for ‘not known’. They are required to review this and update it on the assessment form even if the allocation remains in the same category.

In all sectors of NHSGGC at the 27-30 month assessment there were more children allocated as ‘core’ after the assessment than before it and fewer who had no HPI allocation. With the exception of Renfrewshire, the proportion of children recorded as ‘additional’ reduced after the assessment. With the exception of East Renfrewshire and Glasgow North West, the proportion of children recorded as ‘intensive’ reduced after the assessment.

The decrease in numbers of ‘unknown’ HPI suggests that health visitors often felt more able to allocate an HPI at 30 months than when the child was younger. The shift in numbers from ‘additional’ and ‘intensive’ to ‘core’ suggests that they were a little less risk averse in their decision making at this age.

Meeting Developmental Milestones

The developmental outcomes target at 30 months is defined as the percentage of children who have the code for ‘no new concern’ noted on each of the nine developmental domains listed on the national assessment form.

The current national target for 2013-14 is 85% of children to meet their developmental outcomes at 30 months. National figures show that only two health boards met this target in the first year of the 27-30 month assessment and the figure for NHSGGC was comparatively very low at 55%. The explanation for this is unclear but variation in assessment completion (in particular the use of the X code for

'assessment incomplete') is a likely explanation in the case of NHSGGC. The use of the incomplete assessment code in any one developmental outcome immediately disqualifies that assessment from contributing to the target figure and thereby impacts negatively on the percentage of children deemed to have reached their developmental milestones. The incidence of incomplete assessments of this type was high in NHSGGC. This indicates poor completion but also considerable potential for improvement through better form completion. More detail on the level of incomplete assessment figures by locality is given in the body of this report.

Tools and Concerns

A primary purpose of this assessment has been the early identification of any developmental delay that could impact on the child's readiness to learn at school age (age 5 yrs). Of particular interest was concern over behavior or language and communication. In NHSGGC two assessment tools were introduced to help health visitors assess development in these areas: Goodman's Strengths and Difficulties Questionnaire (SDQ) and Sure Start Language Measure-Revised (SSLM-R). Guidance suggested that these should be used in combination with health visitors' professional judgement. This judgement in relation to any arising concern was noted on the national 27-30 month form using prescribed codes.

Based on elevated SDQ scores, the proportion of newly suspected concerns noted in relation to behaviour was highest in Glasgow North East (12.7%) and Glasgow South (12.4%) and lowest in East Dunbartonshire (5.2%). In relation to attention it was highest in Glasgow North East (6.5%) and lowest in East Dunbartonshire (2%). In relation to speech, language & communication concerns were highest in Glasgow North East (12.1%) and lowest in East Dunbartonshire (6.5%).

Future Actions

The notation of future actions on the 27-30 month assessment form represents the suggested or recommended initial action by the health visitor. Logically, these should relate to any concerns identified and to the recommended pathways

developed for this assessment. In reporting, it is difficult to attribute 'future actions' to the noted 'concerns' and to assess whether these were appropriate at individual level. However, the findings reported at population/CHP level should provide useful information for planning of service resources. Glasgow South had the highest number and proportion of children with a noted future action to Speech & Language Therapy (SLT) (n=325: 12.9%) and to parenting (n=555: 22.1%). The lowest number and proportion with a future action to SLT was in East Dunbartonshire (n=58: 5.9%) and the lowest to parenting was in East Renfrewshire (n=88: 10.1%).

References

NatCen Social Research (March 2013), *The Early Education Pilot for Two Year Old Children: Age Five Follow-up. Research report*.

Scottish Government (2012) *The Scottish Child Health Programme: Guidance on the 27-30 month child health review* URL: http://www.gov.scot/Publications/2012/12/1478 Accessed April 2015].

‘READY TO LEARN’ ASSESSMENT AT 30 MONTHS

FIRST FULL YEAR DATA REPORT: JULY 2013-JUNE 2014

INTRODUCTION

This report is based on data collected from the 27-30 month reviews undertaken across NHSGGC in 2013-14. It represents the first full year of ‘Ready to Learn’ assessments.

All data used here is taken from RTL forms issued to HVs in the 27 fortnightly issue periods starting from 1 July 2013 to 30 June 2014. An additional two weeks was allowed for the return of forms. Any forms received by CHS to that point were included in this dataset.

Please note that the findings reported here are based on data from the first full year of implementation across NHSGGC. This is not the same time period as reported by ISD.

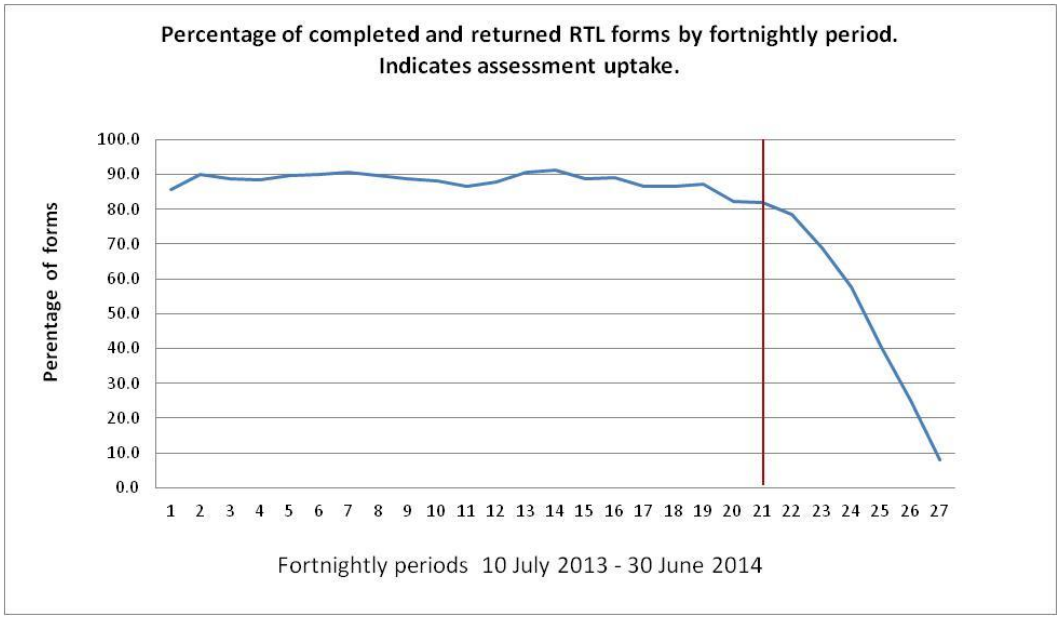
The total number of children eligible for and invited to a 27-30 month review in 2013-14 was 14,554. At 18th July 2014 a total of 11,589 forms had been returned and matched to Community Health Index (CHI) numbers on the screening department Child Health Universe system. This included 40 (<0.4%) returns from the last, additional fortnightly invitation period, taking the dataset coverage to just over 1 full year.

This data included a small number of children from North Lanarkshire (n=19) and South Lanarkshire (n=88). They are included in calculations relating to NHSGGC but not where figures are broken down by CHP.

UPTAKE

Based on the numbers above, the overall uptake figure across NHSGGC is 59% over the full 54 week period. A more accurate uptake figure is achieved by excluding the last twelve weeks when many invitations to assessment had not yet been returned completed or been processed by CHS. Using this revised cut-off (to the left of the red line in Figure 1) uptake is shown to be consistently high at an average of 88% over 10 months. See Figure 1.

Figure 1

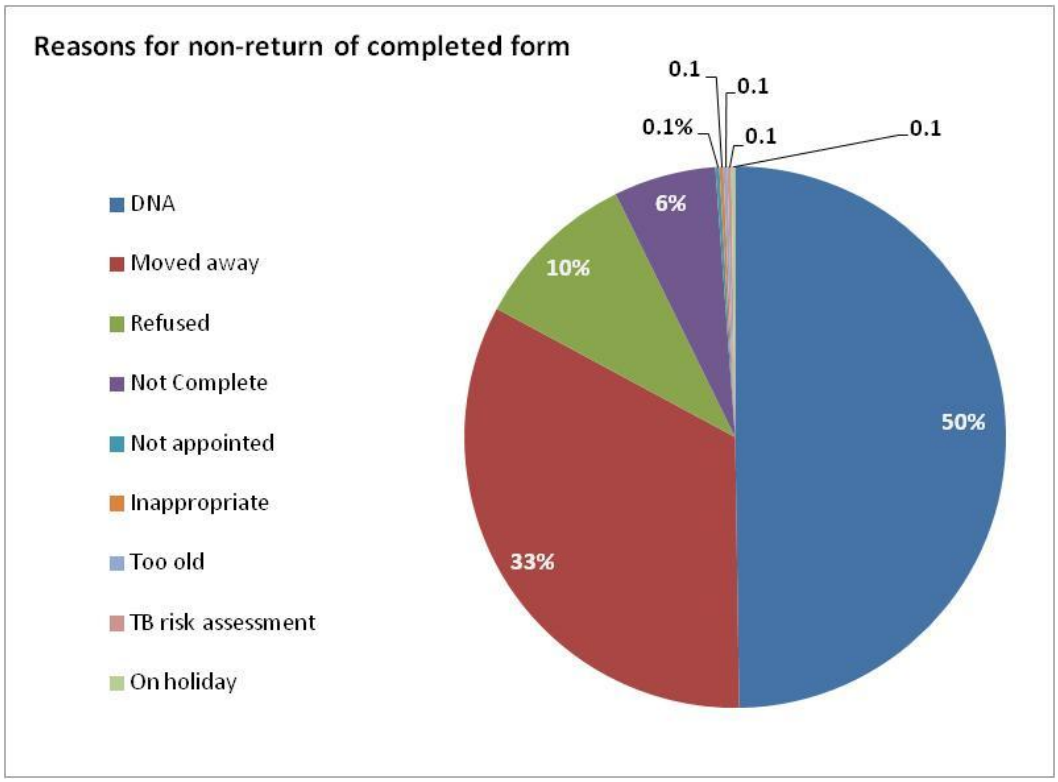


NON-RETURN OF COMPLETED ASSESSMENTS

As mentioned above there could be some delay in the return of completed assessment forms and/or entry into the CHS system. Throughout this report, forms that were returned but showed no completed assessment or that were not returned at all are referred to as 'non-returned' forms. A sample of 'non-returns' taken from the first 9 months of the assessment period was reviewed: while the largest proportion represented families who had refused or not turned up for the assessment, in at least one third of cases, the health visitor was able to note that the

child had moved away from the area. This emphasises the point that the proportion of non-returned completed assessment forms does not necessarily signify that an assessment was not carried out or that families did not engage with the assessment.

Figure 2



A total of 1,130 non-returns (i.e. returned by HV without complete assessment) were reviewed. 629 (55.7%) had no comment noted. 501 (44.3%) had comments noted by the health visitor as indicated in Figure 2.

Non-returns within sectors

Figures 3-10 below indicate the proportions within SIMD quintiles and CHPs where invitations to assessments were made but completed assessment forms were not returned to CHS or processed by CHS within the data collection period.

The graphs should be read with a degree of caution. For example, the 2.6% non-return rate in SIMD 5 in Glasgow North East represents only 1 child; the 13.8% non-return rate in SIMD 2 in East Renfrewshire represents only 9 children.

No consistent social gradient was evident in the non-returns.

Figure 3

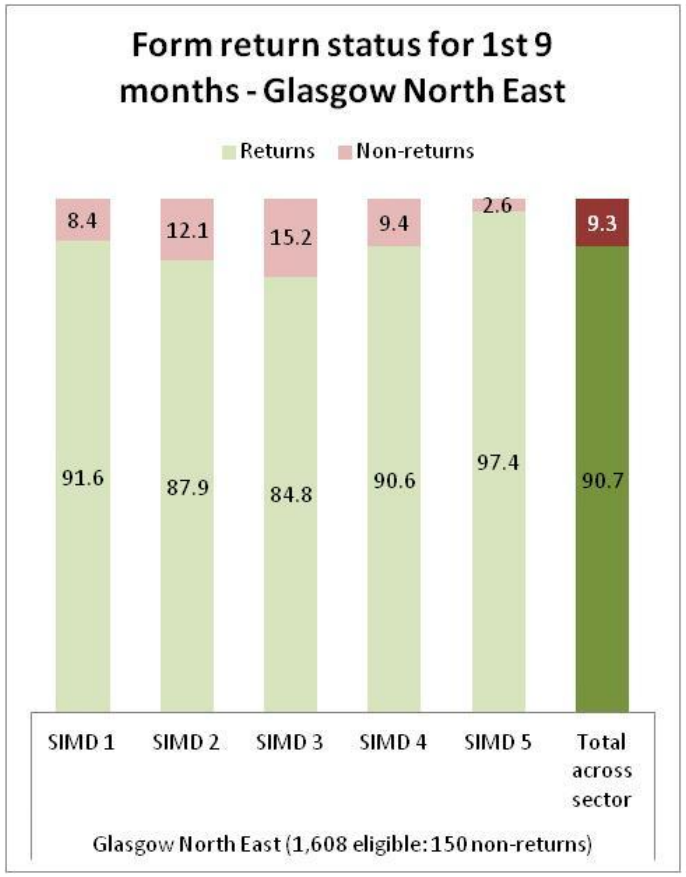


Figure 4

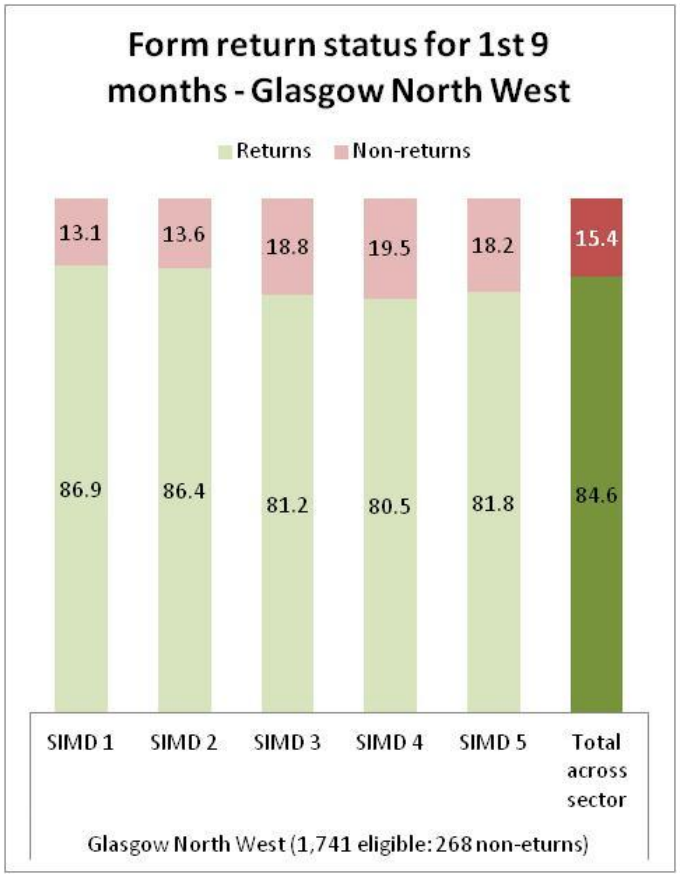


Figure 5

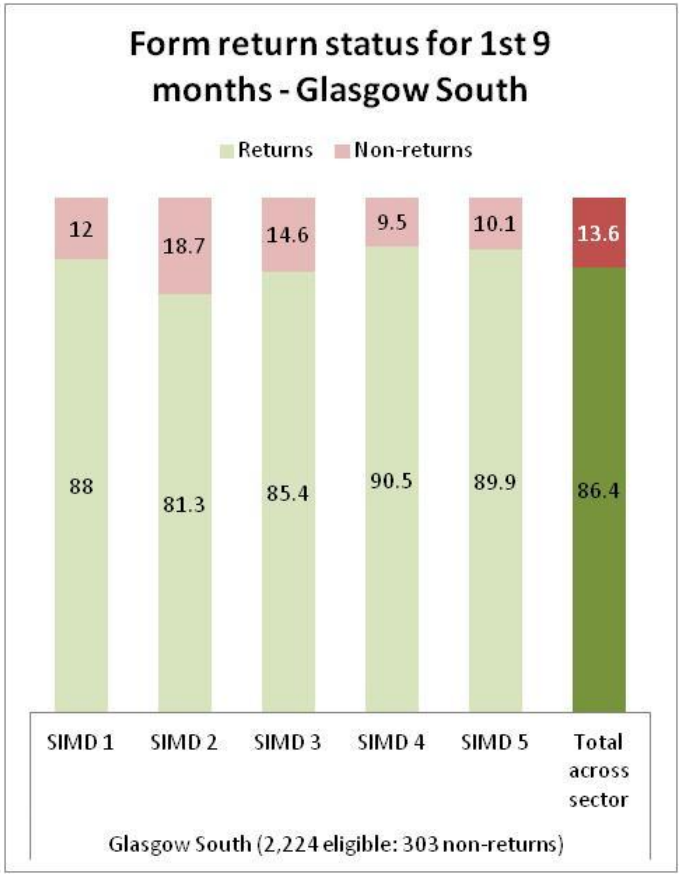


Figure 6

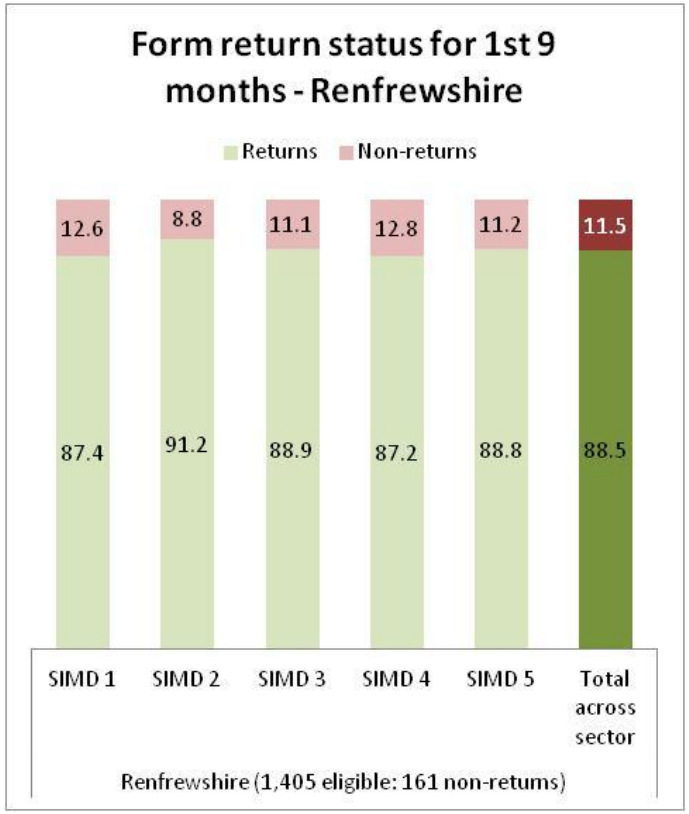


Figure 7

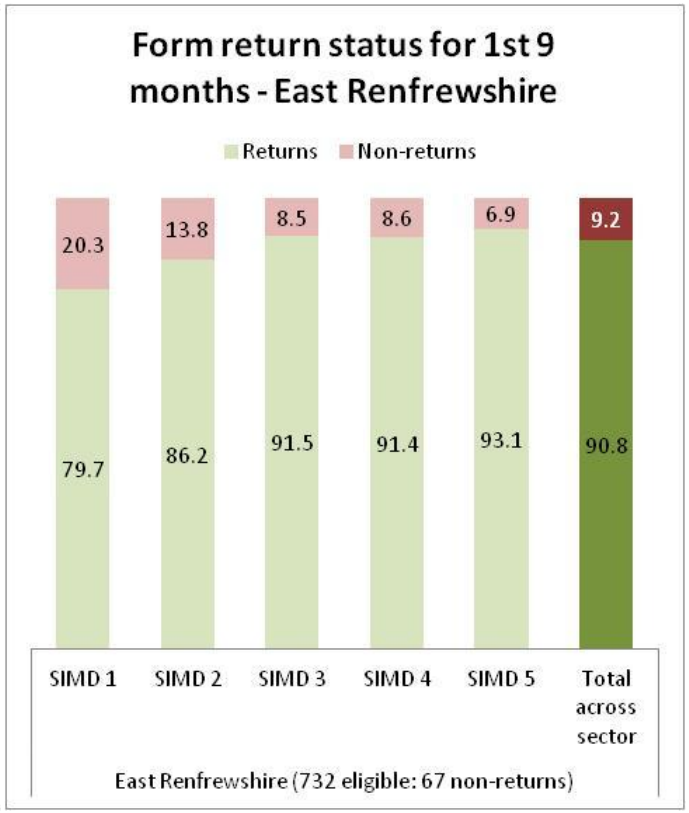


Figure 8

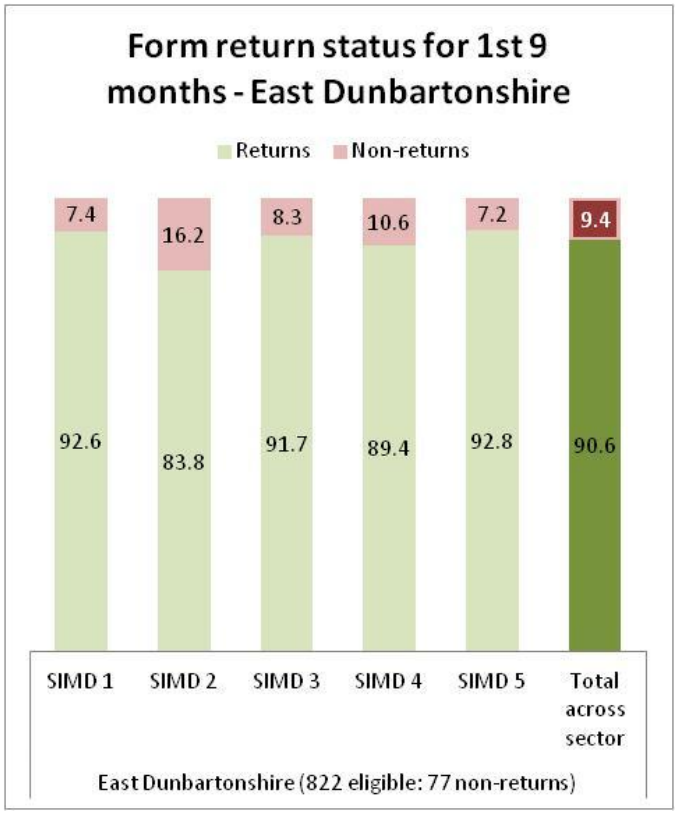


Figure 9

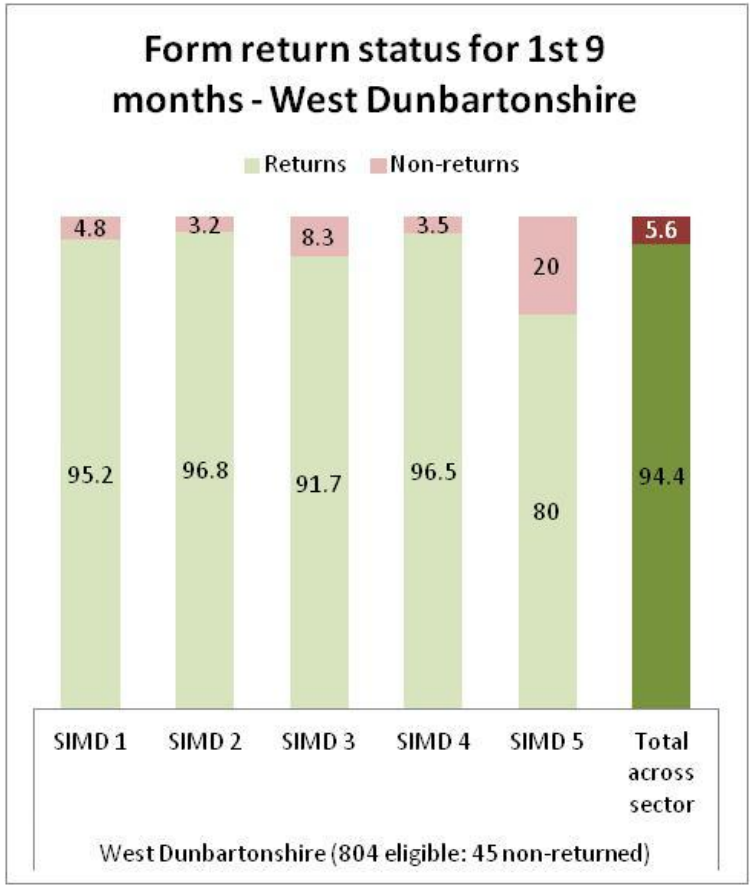
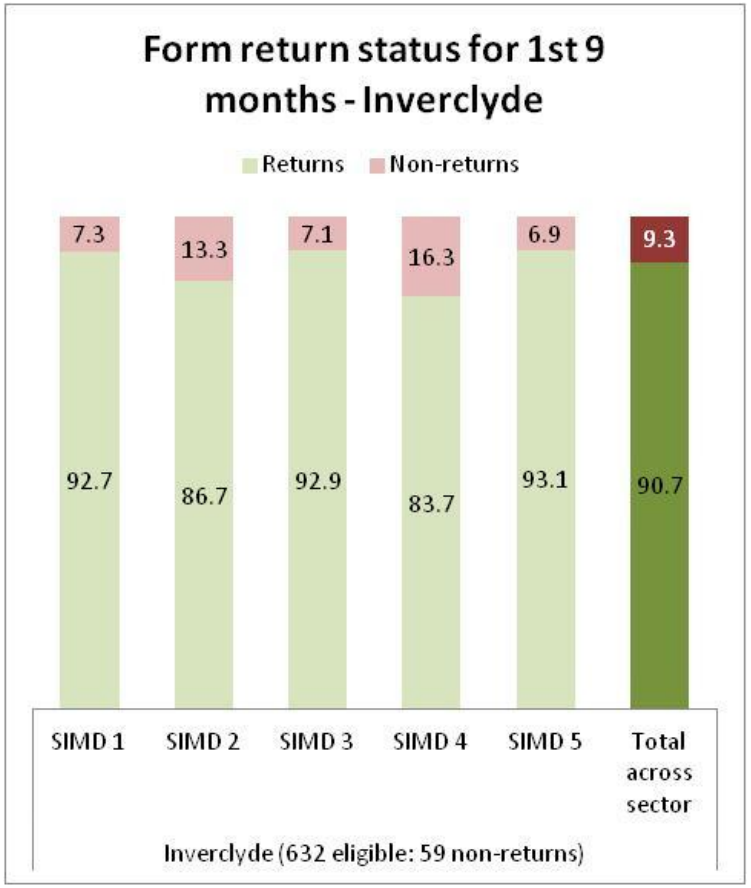


Figure 10



DISTRIBUTION OF ASSESSMENTS WITHIN SIMD AND BY CHP

The remainder of this report is based on the first full year of assessment and excludes all non-return figures. All subsequent graphs and tables are based only on cases where assessments were completed.

Throughout the full first year of assessments the highest numbers were carried out in Glasgow South, Glasgow North East and Glasgow North West (2,519; 1,919 and 1,822 respectively) and the lowest in Inverclyde (743). Figures 4 –11 show the percentage spread and number of children who received a 27-30 month assessment across the CHP areas and by SIMD quintile. As an example, Figure 4 reads: of the 1,919 children who received an assessment in Glasgow North East, 72.2% (1,386) were resident in an SIMD 1 area.

Glasgow North East had the highest number and proportion of deprived families and the lowest number and proportion of affluent families with children who received the assessment. A converse balance between affluence and deprivation was found in East Renfrewshire and East Dunbartonshire.

DISTRIBUTION OF ASSESSMENTS WITHIN SIMD BY CHP

Figure 4 – Glasgow North East

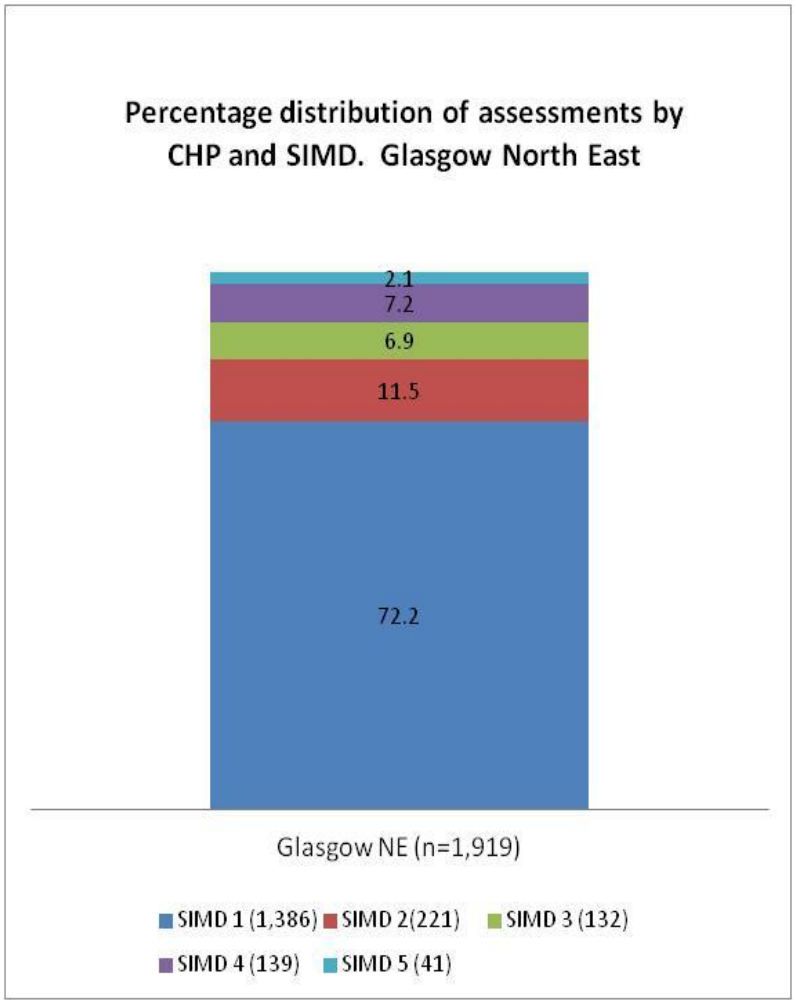


Figure 5 – Glasgow North West

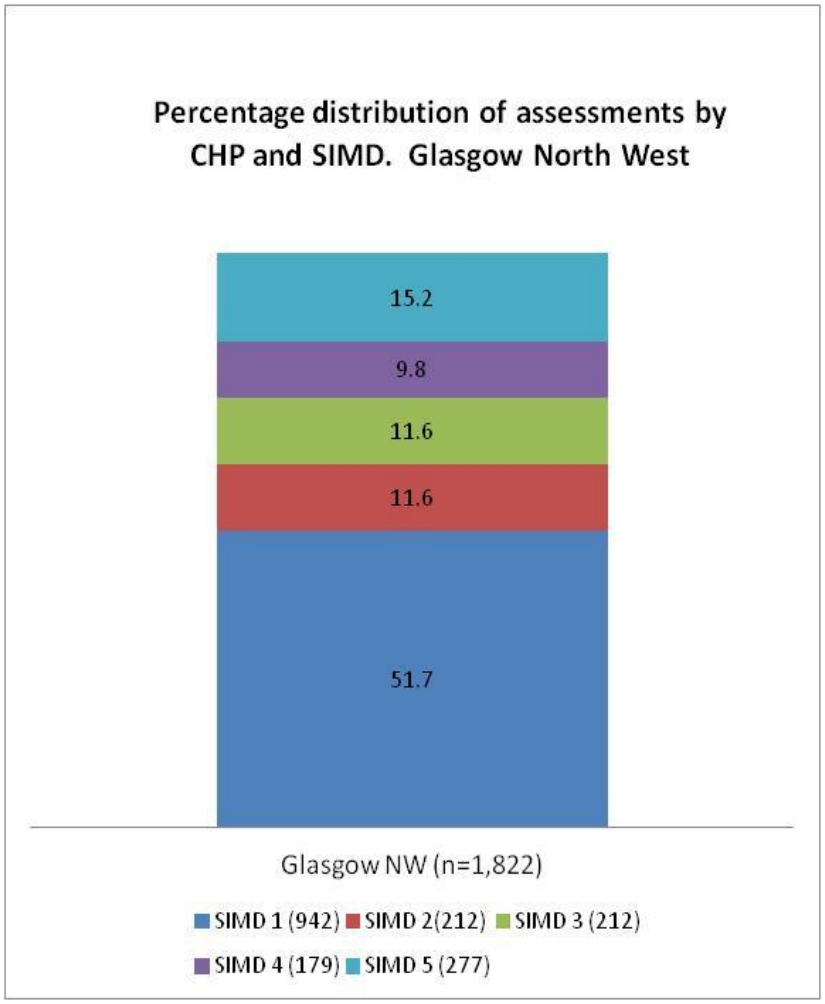


Figure 6 – Glasgow South

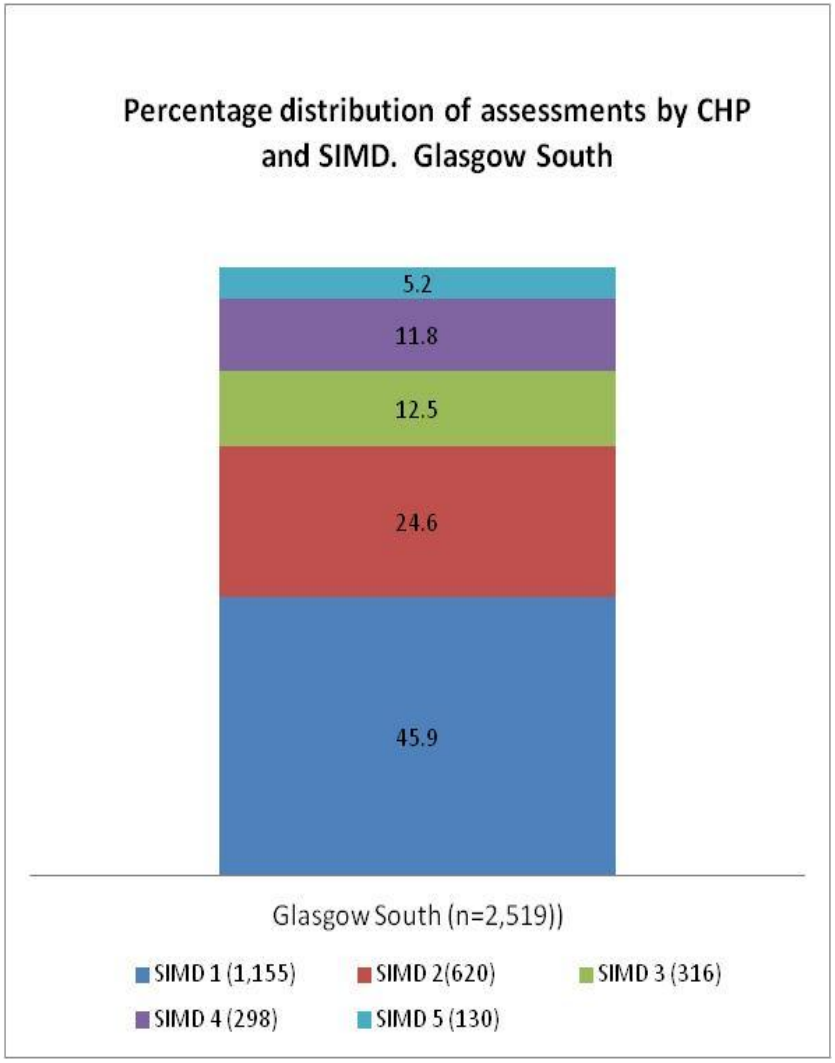


Figure 7 – Renfrewshire

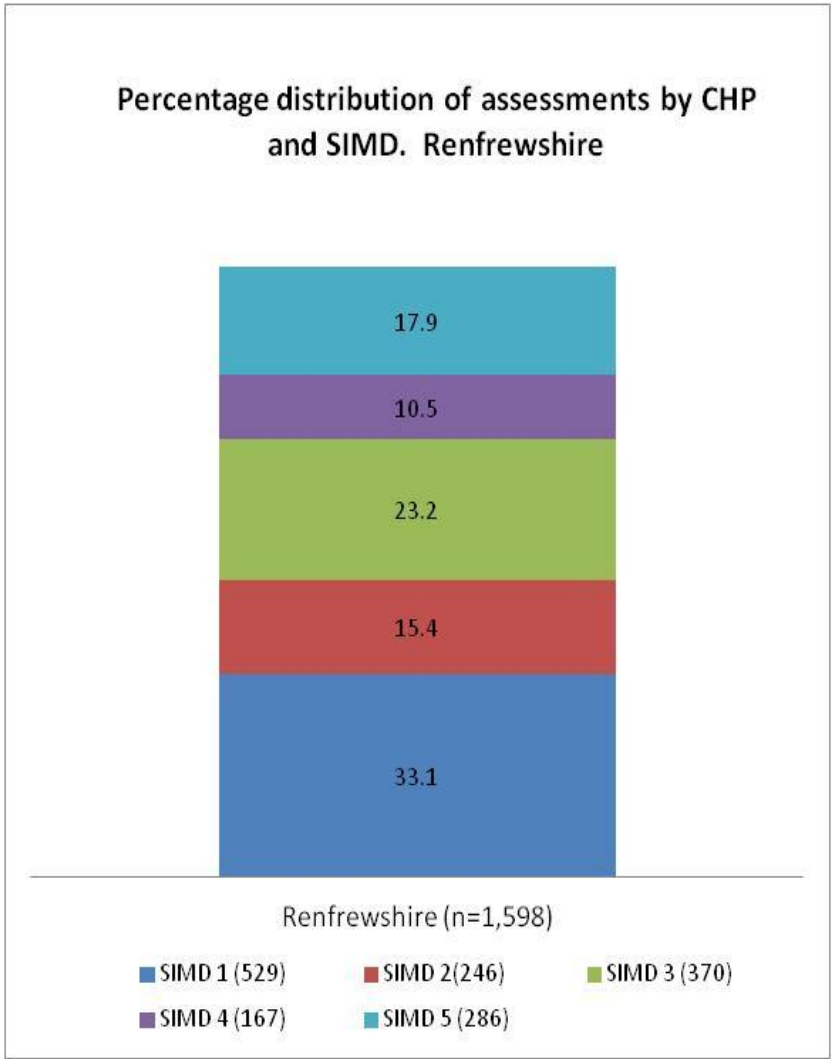


Figure 8 – East Renfrewshire

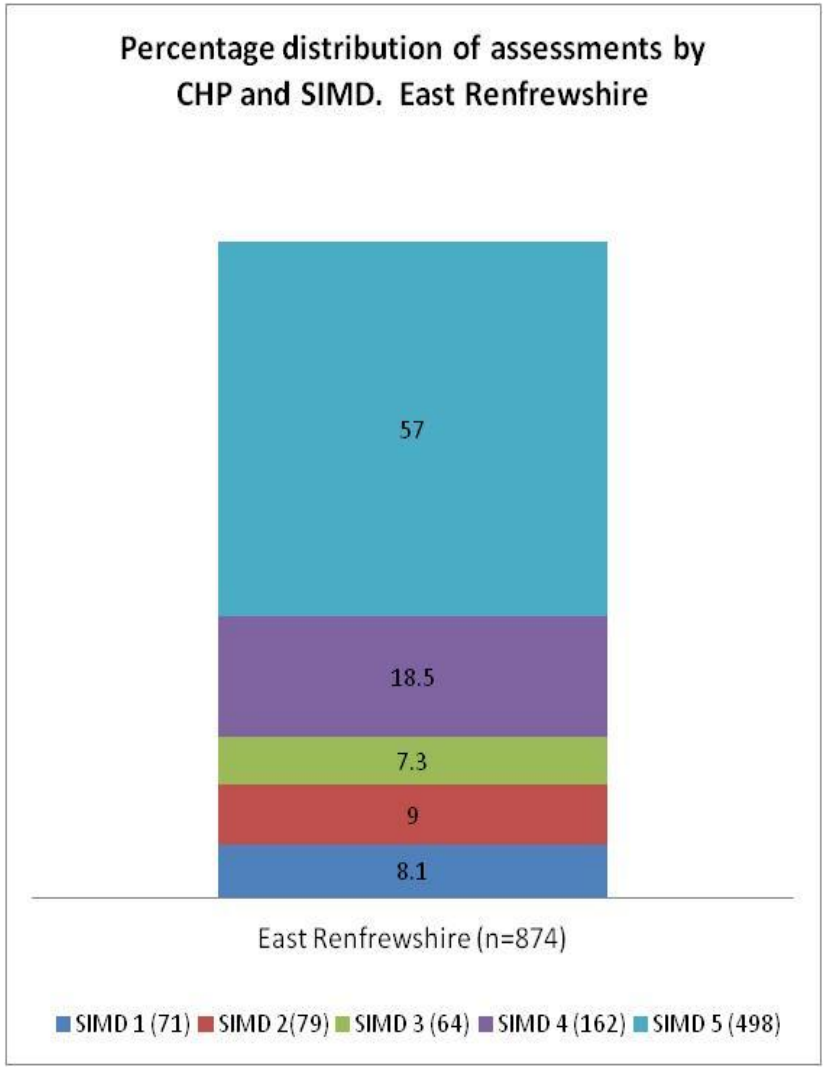


Figure 9 – East Dunbartonshire

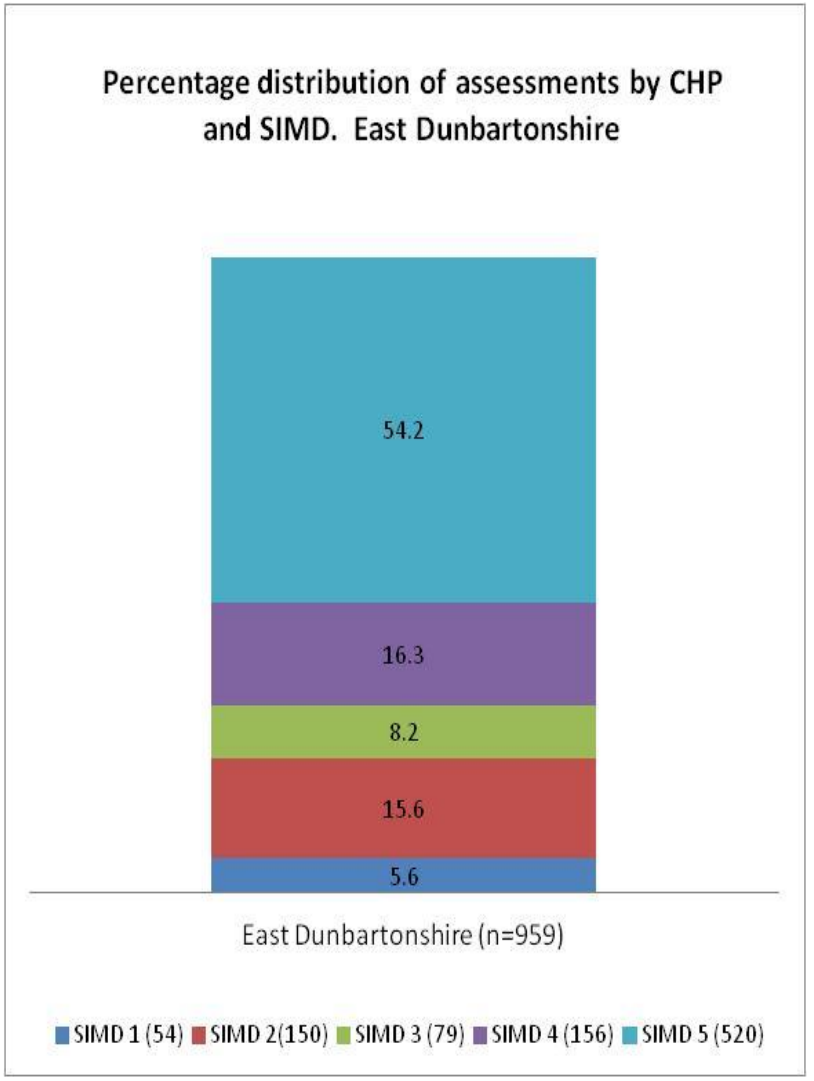


Figure 10 – West Dunbartonshire

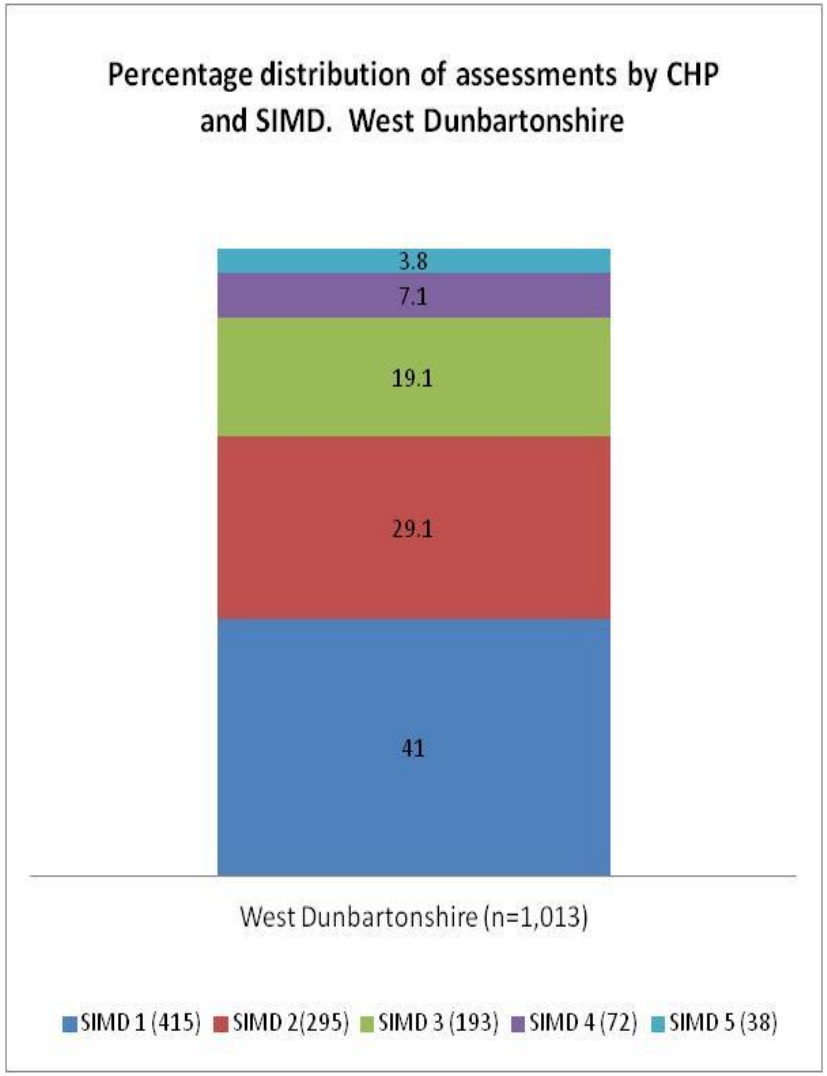
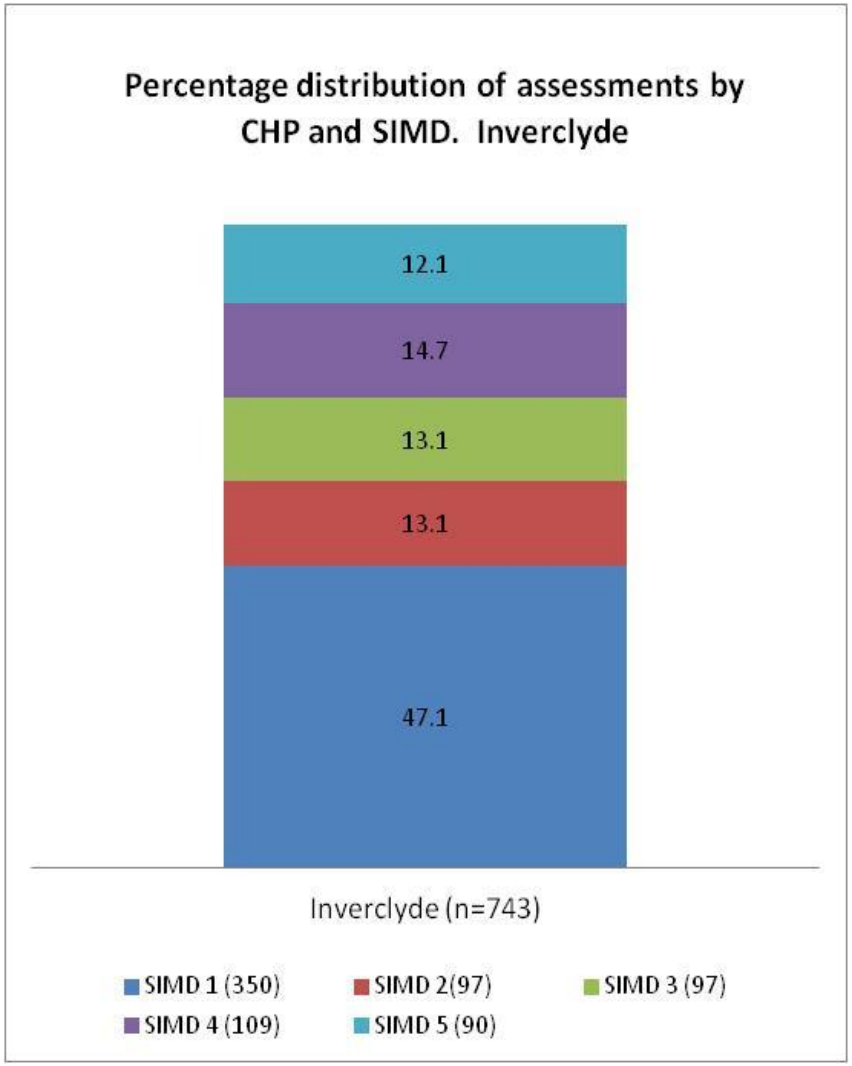


Figure 11 – Inverclyde



PRE-SCHOOL CARE

Exposure to opportunities for learning and communication is an influential factor in the development of young children. NHSGGC 27-30 month guidance reflects this by including early nursery places as a service pathway in response to complex need.

Figures 12 and 13 indicate the level of attendance at out-of-home, pre-school care that children who had a 27-30 month assessment receive across CHPs. Recording does not allow any comment on the amount of time any one child spends in pre-school care or the quality of care provided.

Attendance at nursery school was the most common form of pre-school care with levels between 41% and 48% in most areas, although this dipped below 40% in East Renfrewshire, West Dunbartonshire and Inverclyde. Locality differences also existed with regard to attendance at playgroup with those in Clyde sectors considerably more likely to attend playgroup (18-25% attendance) compared to children in Glasgow City sectors (7-12% attendance).

Children in Clyde sectors were 2-3 times more likely to attend a registered childminder compared to those in Glasgow City.

Glasgow City sectors had the highest proportion of children who did not attend any pre-school care (35-40%) compared to approximately 25% in Clyde sectors (with the exception of West Dunbartonshire where 37% received no pre-school care). Sector differences in patterns of pre-school care usage may have relevance for CHP differences in SDQ peer problems subscale scores (see Figure 20, page 22) i.e. Clyde sectors have lower levels of elevated peer problem scores compared with Glasgow City sectors.

Figure 12 – Glasgow City Sectors

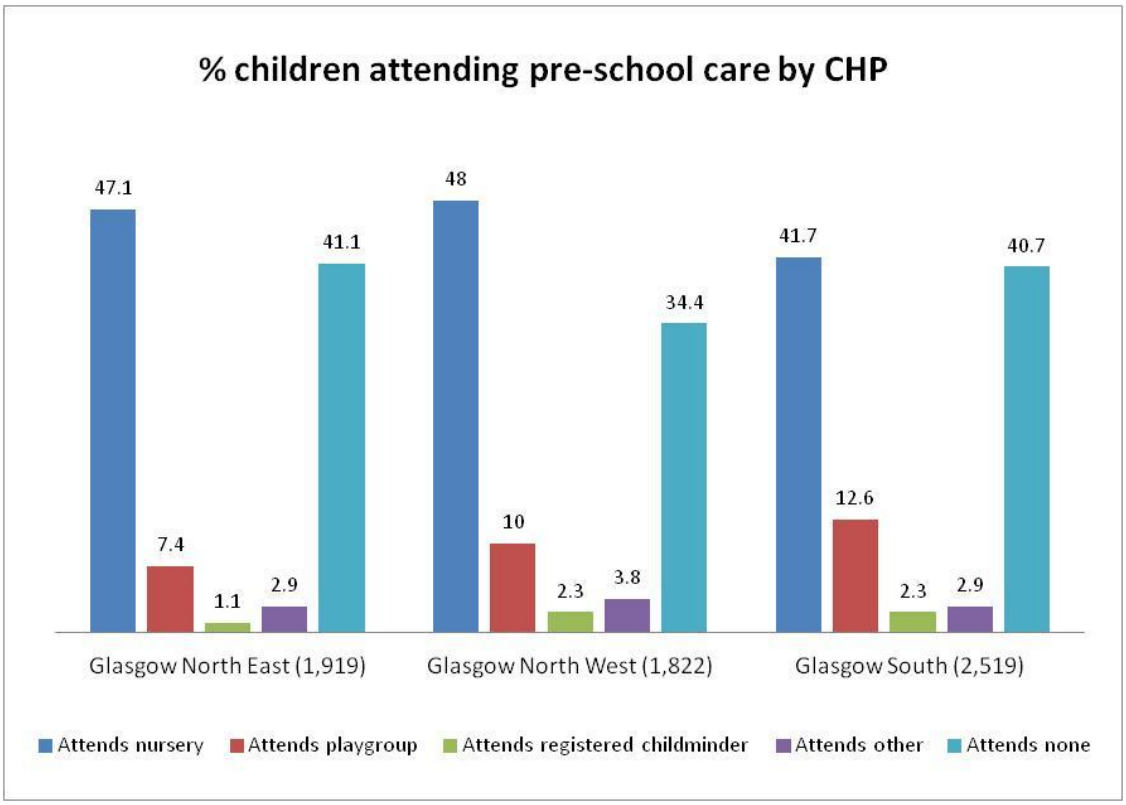
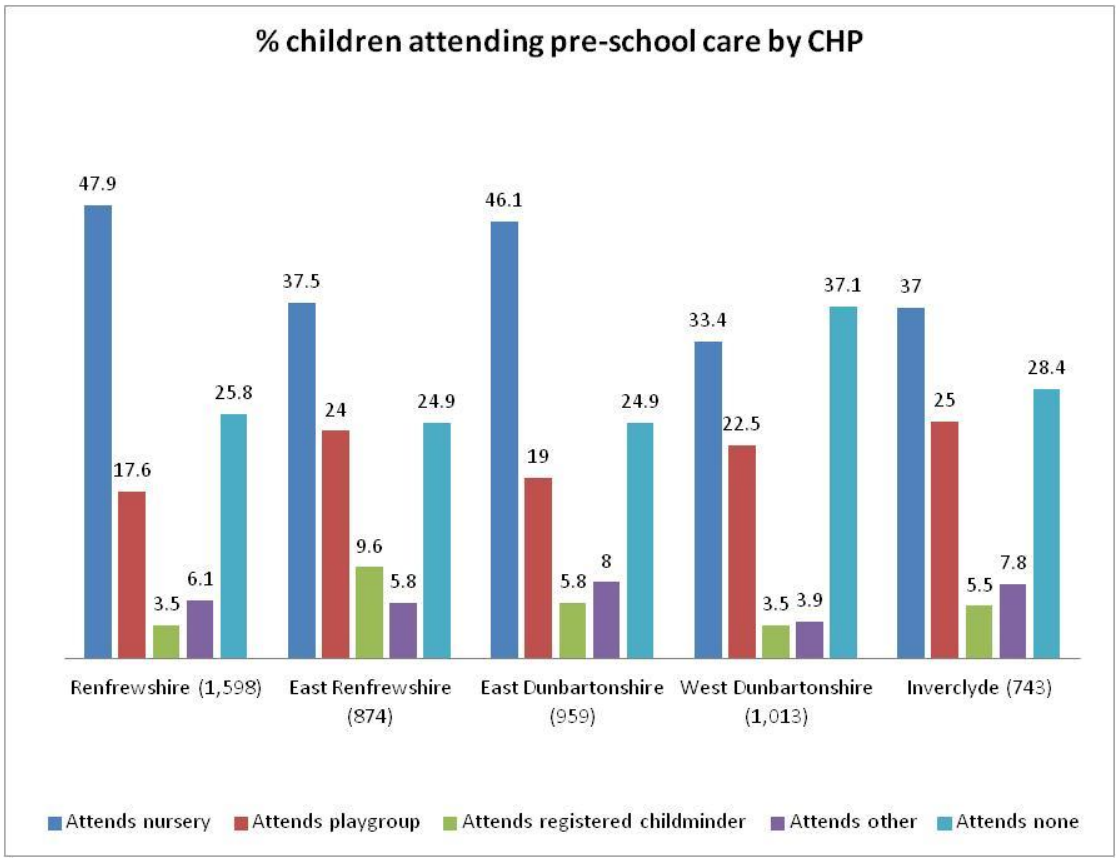


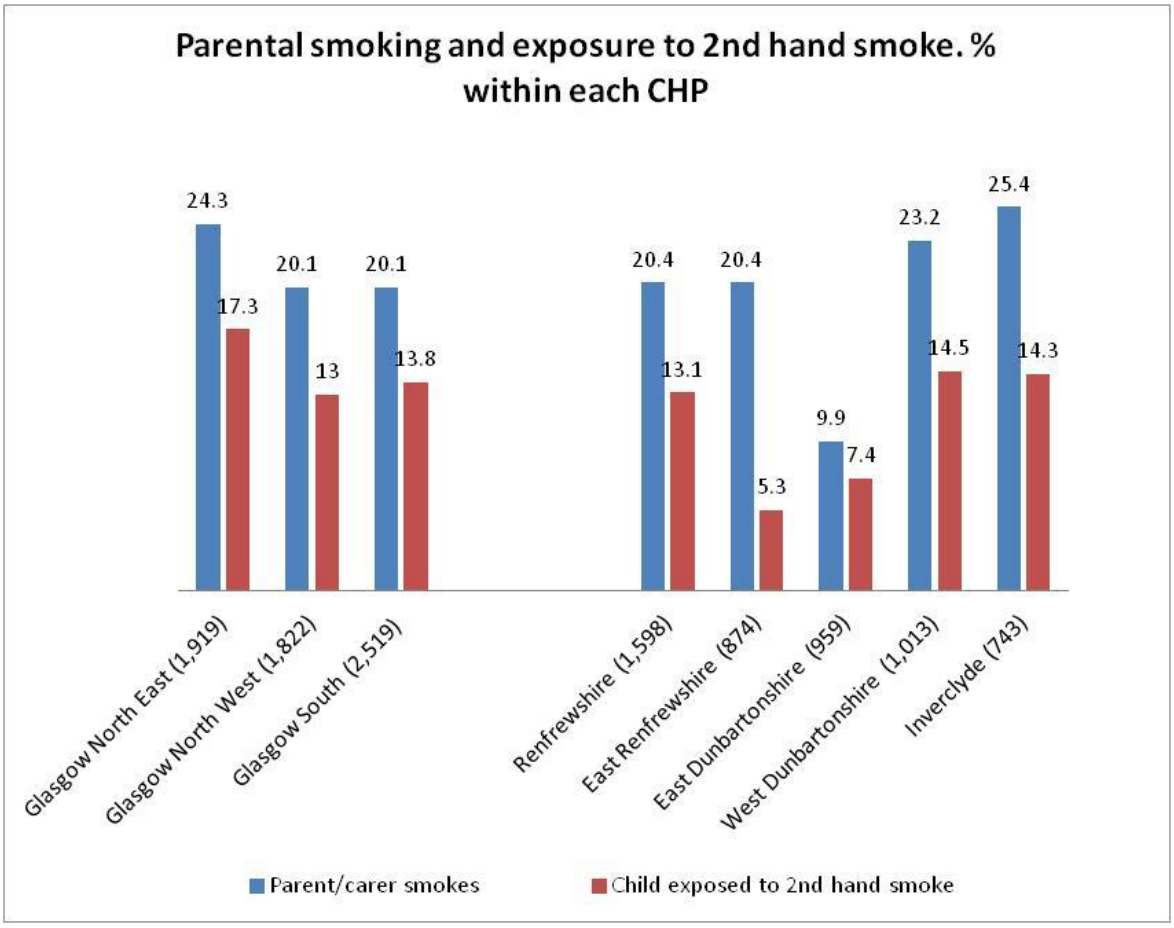
Figure 13 – Clyde Sectors



Approximately one fifth to one quarter of all children were recorded as living in households where a parent or carer smoked. However, the proportion of those who were said to be exposed to second hand smoke was considerably lower within each sector. The exception to this was East Dunbartonshire where proportions of parent/carer smokers and children exposed to second hand smoke were both relatively low.

East Renfrewshire (15.1%) and Inverclyde (11.1%) had the greatest discrepancy between levels of parental smoking and child exposure to second hand smoke (see Figure 14 below).

Figure 14



Local guidance states that assessments should be undertaken by a health visitor in a clinic setting. This allows staffing to be planned on a sessional basis rather than having each health visitor make an additional home visit to all eligible families on their caseload. In practice, different areas delivered the assessments in different settings including the child's home or the GP surgery.

Figures 15 and 16 indicate that, within Glasgow City, assessments were most commonly carried out in the home whereas in the Clyde area, assessments were most commonly conducted in a clinic setting, with the exception of East Renfrewshire (where most assessments were done in a GP practice) and West Dunbartonshire (where more than two thirds of assessments were done in the home).

Figure 15

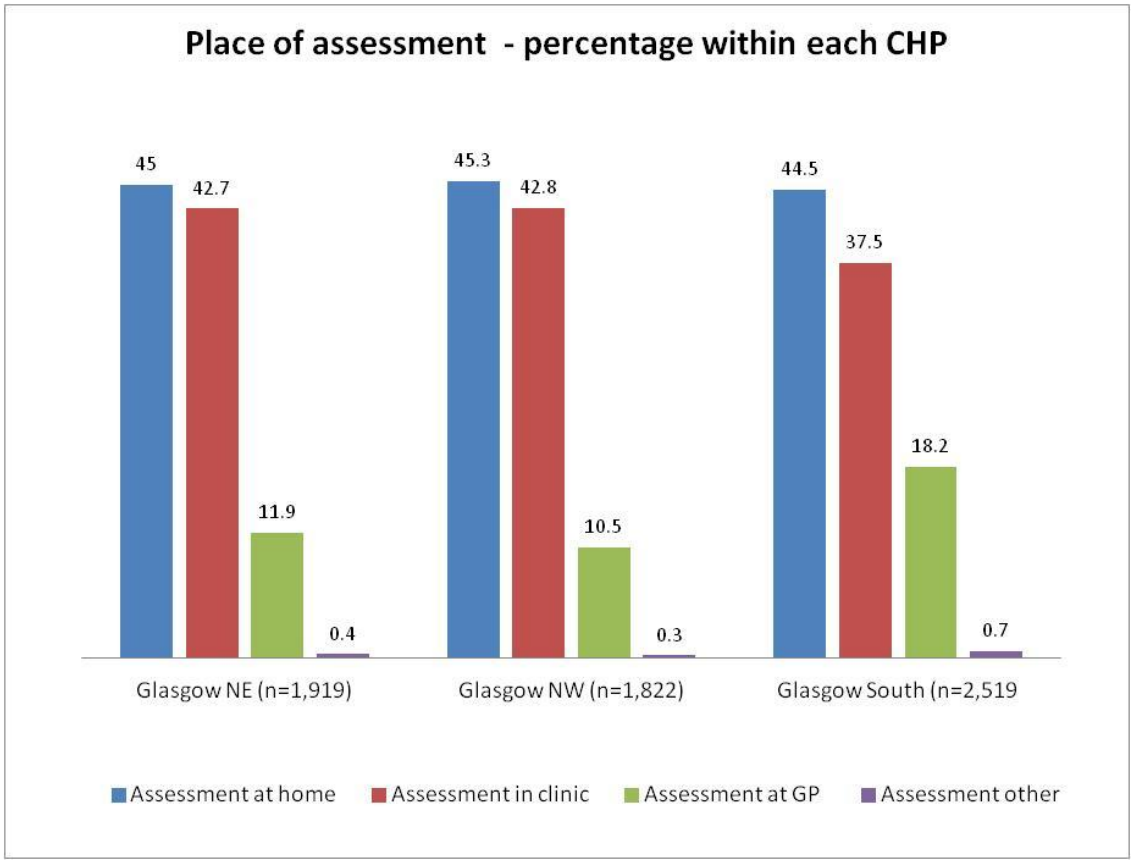
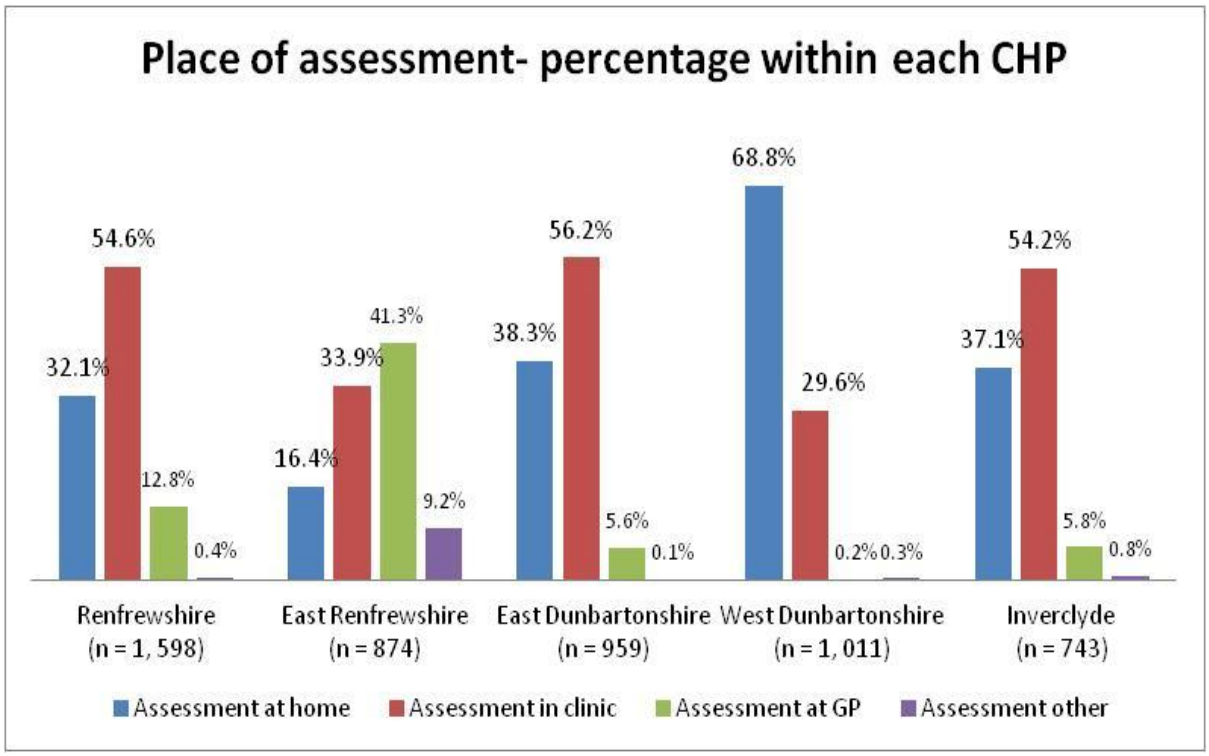


Figure 16



HEIGHTS, WEIGHTS & BMI

National guidance on the delivery of the 27-30 month assessment states that the taking of heights and weights is mandatory. In NHSGGC this was not considered mandatory although all health visiting teams were supplied with equipment to facilitate the taking of heights and weights.

Across NHSGGC:

51.9% (6,012) children had their height measured at the assessment;

57.9% (6,714) children had their weight measured at the assessment;

50.1% (5,807) children had both height and weight measured at the assessment.

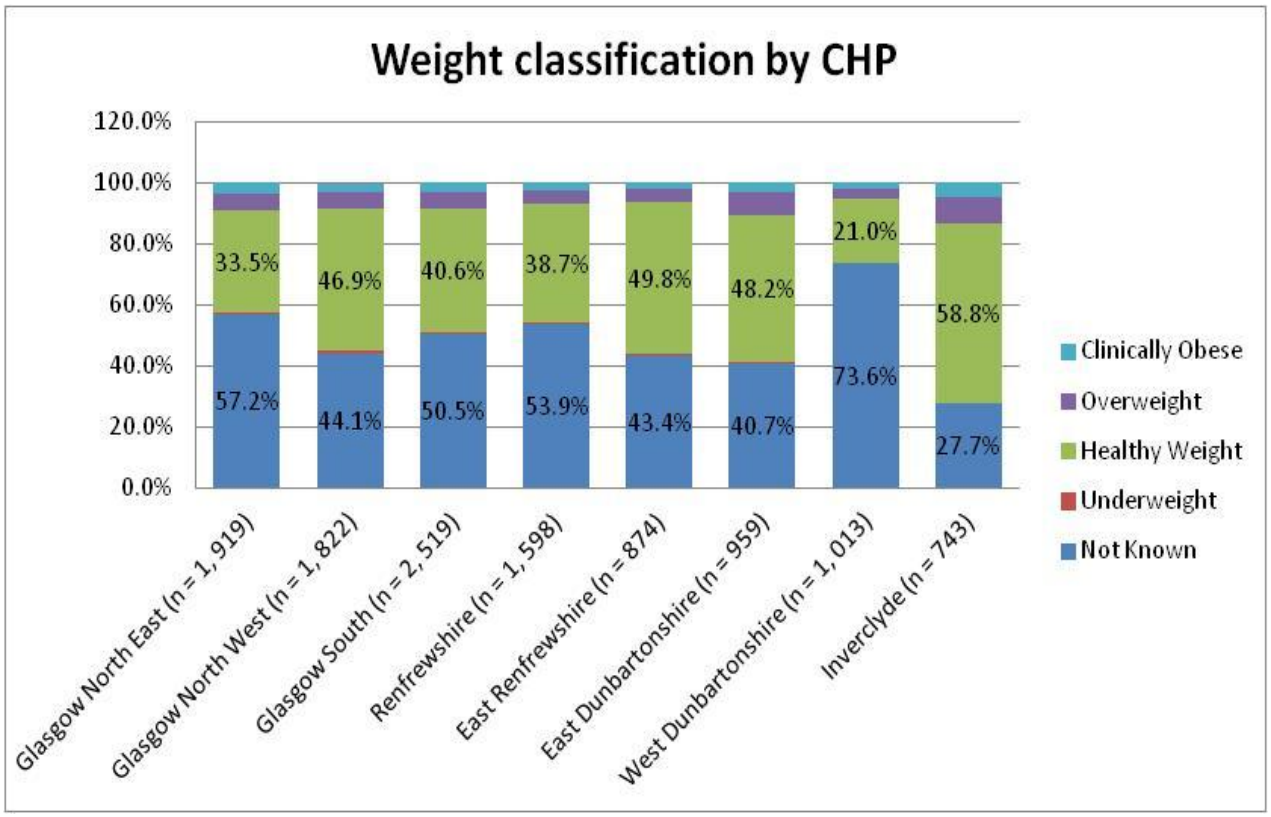
Where height and weight was taken a BMI could be calculated. Across NHSGGC:

49% (5,677) children had a BMI noted and 51% (5,912) had no BMI noted.

BMI calculations allowed for plotting across appropriate centiles for this age group. The distribution of weight classification within CHPs is shown in Figure 17 below. This graph includes proportions where weight categories were unknown (i.e. heights & weights were not taken and/or recorded to allow the BMI calculation). West Dunbartonshire had the highest proportion of unknown weight classification (73.6%): almost treble that seen in the CHP with the lowest unknown classification (Inverclyde, 27.7%).

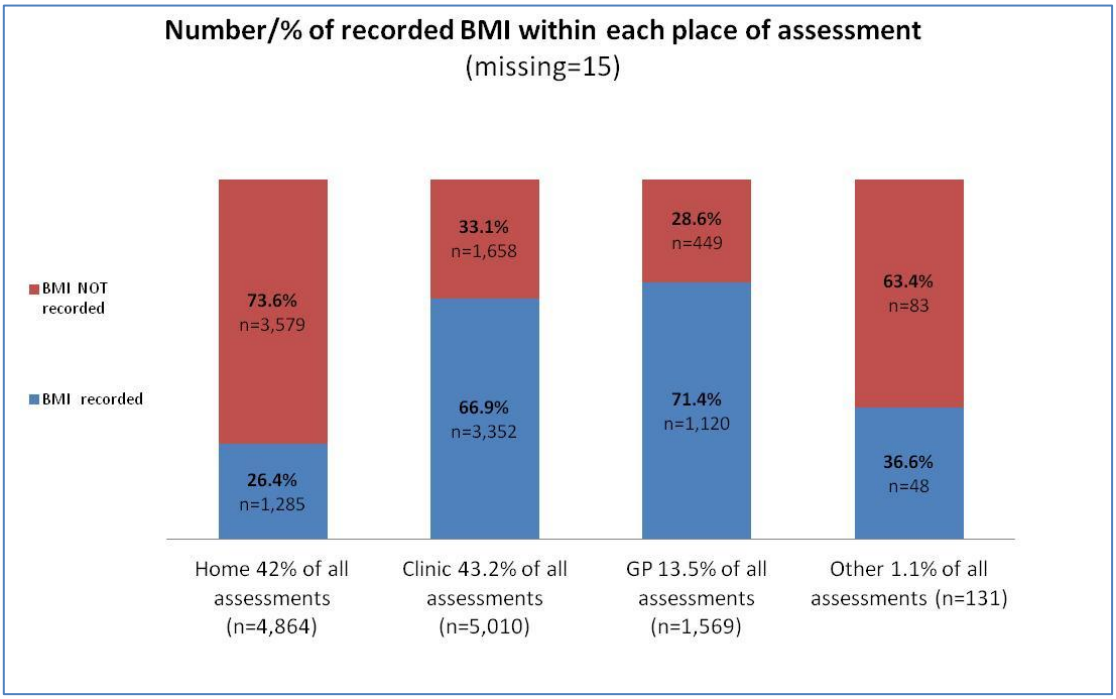
The high proportion of unknown weight classifications makes sector comparisons of the prevalence of overweight/obese children inappropriate.

Figure 17



The place of review may have been an influential factor in whether heights and weights were taken thereby allowing calculation of BMI and weight classification. The largest proportion of assessments (43.2%) were carried out in a clinic setting where 66.9% of children had both heights and weights measured. However, the smaller number of children assessed in a GP practice (13.5%) were more likely to have measurements taken (71.4%) and a BMI noted. See Figure 18 below.

Figure 18



DEVELOPMENTAL OUTCOMES – MEETING ALL MILESTONES

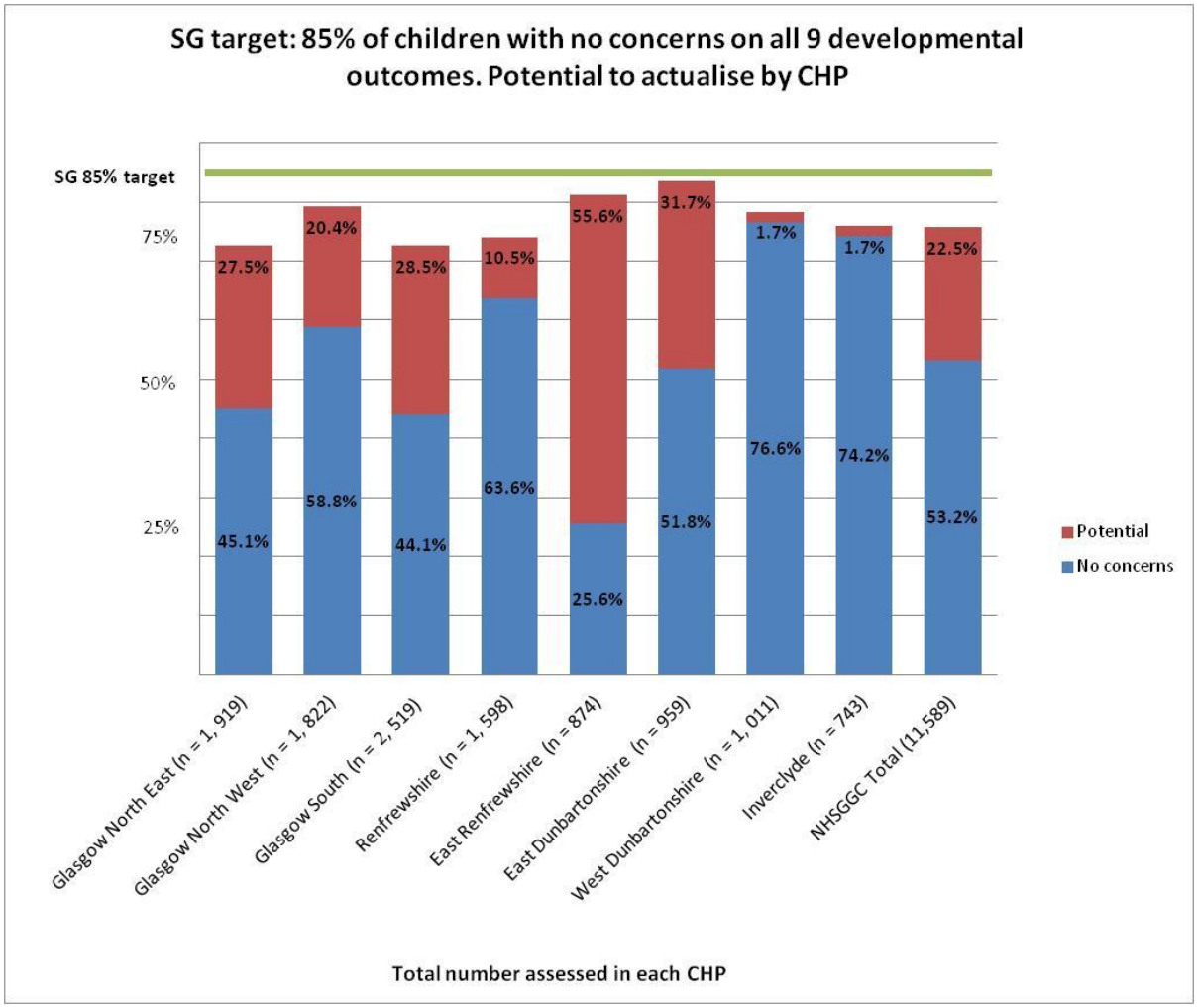
All health boards are now asked to report to the Scottish Government on the developmental outcomes of children at 30 months. The Government defines the level of children who meet their expected developmental outcomes at 30 months as the percentage of those who have no concerns noted on any of the nine developmental outcomes listed on the assessment form.

The current national target for 2013-14 is 85% of children to meet their development outcomes at 30 months.

The blue bars in Figure 19 show the percentage of children in each CHP who met their development milestones by having no concerns noted on all 9 developmental outcomes (55% across NHSGGC). The red bars show the percentage of children that had missing data/incomplete assessments on at least 1 developmental outcome but no concerns on the remaining outcomes. It is possible that, had the children represented in the red bars been assessed for all 9 developmental outcomes and

had these showed no concerns, there would have been an increase in the proportion of children meeting the SG target. The red bars indicate the level of this potential increase. It is unlikely that all those represented in the red bars would, in reality, have no concerns for all un-assessed outcomes: correct completion could also indicate new or previously known concerns. Nevertheless, the potential to increase the blue bar towards the target remains.

Figure 19



The potential increase is most evident for East Renfrewshire where only 25.6% of children had no concerns on all 9 developmental outcomes. However more than half the children assessed in this sector (55.6%) had incomplete assessments on at least 1 developmental outcome: approximately a third were not assessed for attention, social and emotional development and more than half did not have sensory motor development assessed. Although unlikely, had all of those with incomplete assessments turned out to have no concerns, this would have brought the level

‘meeting their milestones’ in East Renfrewshire to 81.2%, much closer to the government target.

These findings demonstrate that CHP/health visitor variation in the process of conducting the assessment impacts positively or negatively in the proportion of children deemed to have reached their `developmental milestones’.

As we have seen above, the overall figure for those meeting their developmental milestones in NHSGGC is somewhat distorted by the high number of incomplete assessments, notably in East Renfrewshire. Table 1 indicates considerable locality variation in the comprehensiveness and holistic nature of the assessment. Across all CHPs, incomplete areas of assessment related primarily to physical/sensory motor development. West Dunbartonshire and Inverclyde appear to have conducted a more detailed and comprehensive assessment of children’s development when compared with other CHPs. East Renfrewshire had the least comprehensive/holistic assessment of child development and appears to have largely concentrated on behavioural and language development.

Specifically in East Renfrewshire:

- 35% of children had an incomplete assessment in relation to their social development;
- 34.9% had an incomplete assessment in relation to their emotional development;
- 34.7% had an incomplete assessment in relation to attention;
- 63.6% had an incomplete assessment of their vision;
- 62% had an incomplete assessment of their hearing;
- 50% had an incomplete assessment of their fine motor skills;
- 49.4% had an incomplete assessment of their gross motor skills.

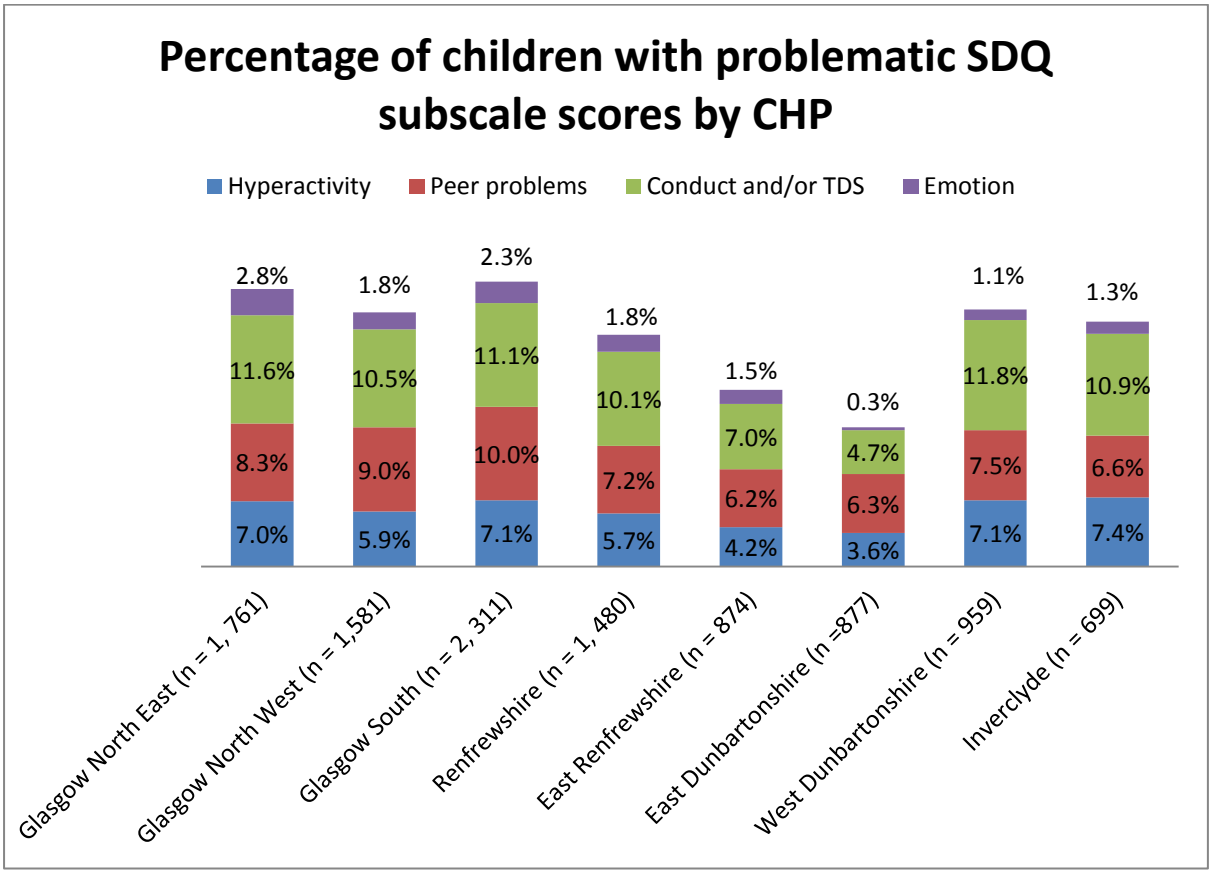
The figures above suggest that the overall figure for children reaching their developmental milestones in NHSGGC (55%) should be read with caution. The number of incomplete assessments impacts negatively on the number & percentage children deemed to have reached their `developmental milestones’.

Table 1

CHP	**Developmental Outcomes: Percentage and Number (in Brackets) of Children with Incomplete Assessments**								
	Behaviour	**Attention**	**Speech, L &C**	**Social**	**Emotional**	**Gross Motor**	**Fine Motor**	**Vision**	**Hearing**
Glasgow NE (n =1, 919)	0.6% (11)	0.6% (12)	0.8% (16)	0.6% (11)	0.7% (13)	9.1% (175)	11.8% (227)	35.3% (667)	33.8% (649)
Glasgow NW (n = 1, 822)	0.3% (5)	0.3% (6)	0.4% (7)	0.3% (5)	0.3% (5)	7.1% (130)	7.5% (136)	23.4% (427)	22.6% (411)
Glasgow South (n = 2, 519)	0.7% (17)	3% (79)	0.6% (14)	2.8% (70)	2.8% (70)	23.9% (603)	24.3% (612)	38.1% (959)	35.9% (904)
Renfrewshire (n = 1, 598)	0.3% (5)	0.4% (7)	0.4% (7)	0.3% (5)	0.3% (5)	0.6% (9)	0.8% (12)	13.1% (209)	10.4% (166)
East Ren. (n = 874)	0.8% (7)	**34.7%** (303)	0.6% (5)	**35%** (306)	**34.9%** (305)	**49.4%** (432)	**50%** (437)	**63.6%** (556)	**62%** (542)
East Dun. (n = 959)	0.2% (2)	0.2% (2)	0.4% (4)	1% (10)	0.6% (6)	5.8% (56)	6.2% (59)	34.1% (327)	29.1% (279)
West Dun. (n = 1, 013)	0.2% (2)	0.2% (2)	0.1% (1)	0.2% (2)	0.3% (3)	0.1% (1)	0.1% (1)	1.6% (16)	1.2% (12)
Inverclyde (n = 743)	0.7% (5)	0.7% (5)	0.7% (5)	0.7% (5)	0.7% (5)	0.4% (3)	0.4% (3)	0.7% (5)	0.5% (4)

New concerns were identified by health visitors using a combination of their professional judgement and the prescribed assessment tools (Goodman's Strengths and Difficulties Questionnaire (SDQ) to support assessment of psycho-social development and the Sure Start Language Measure-Revised (SSLM-R) to support assessment of language development). Elevated SDQ scores indicate concerns over development. Figure 20 shows the level of elevated scores, indicating a likely problem, within each CHP.

Figure 20



Figures 21, 22, 23 and Table 2 show the proportion within each CHP where 'concerns newly suspected' were identified in relation to the three areas of prime interest: behaviour (conduct); attention (hyperactivity) and speech, language & communication.

Please note: Previous (unpublished) research conducted by the Public Health/Health Improvement Directorate highlighted discrepancies between assessment tool scores and notations of developmental concerns.

Figure 21

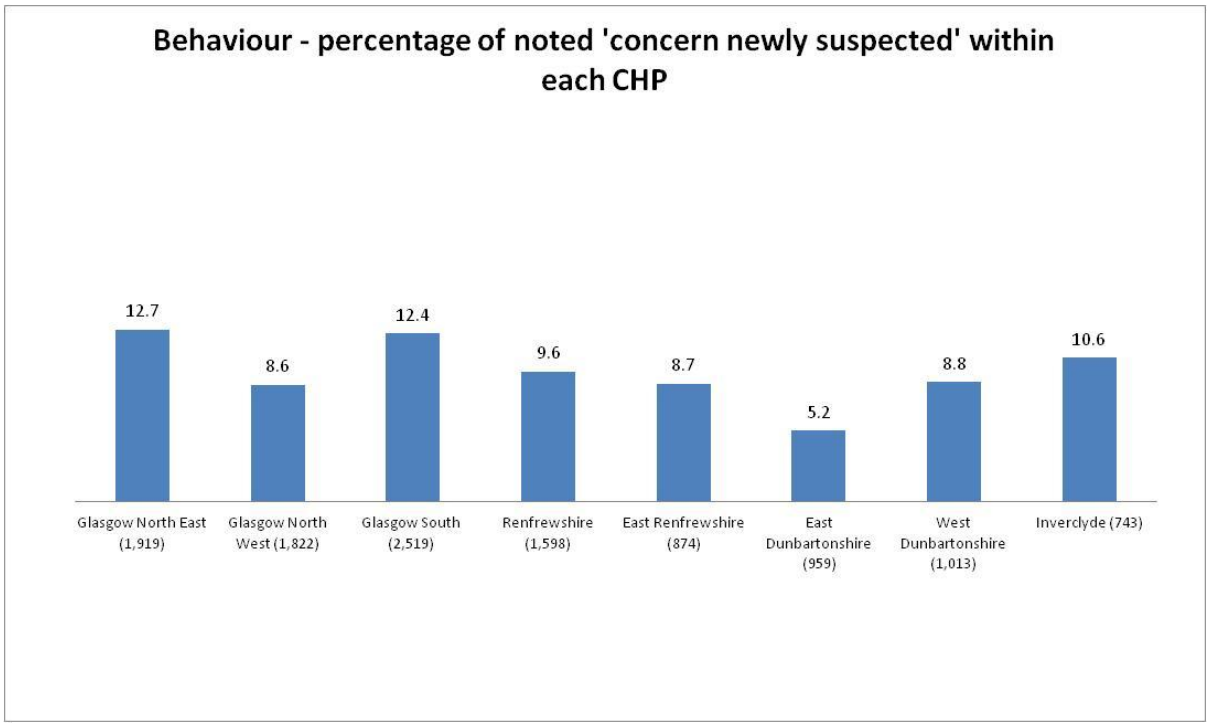


Figure 22

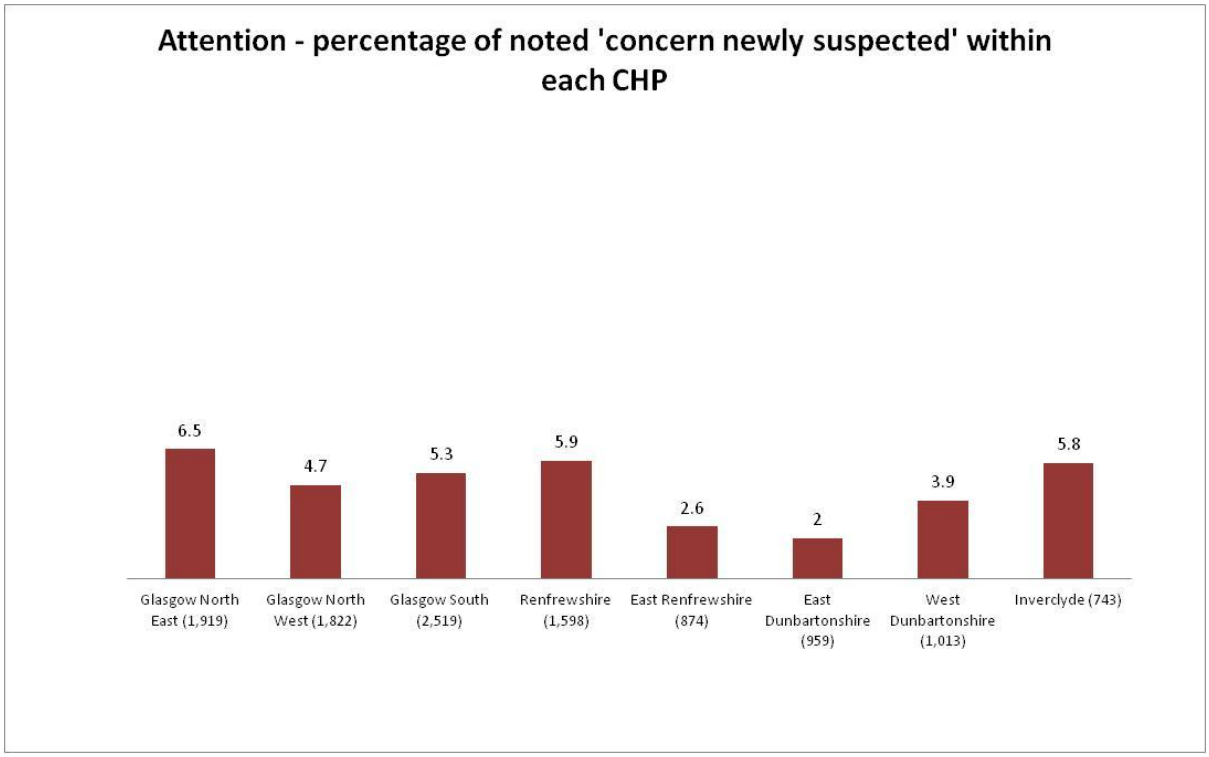


Figure 23

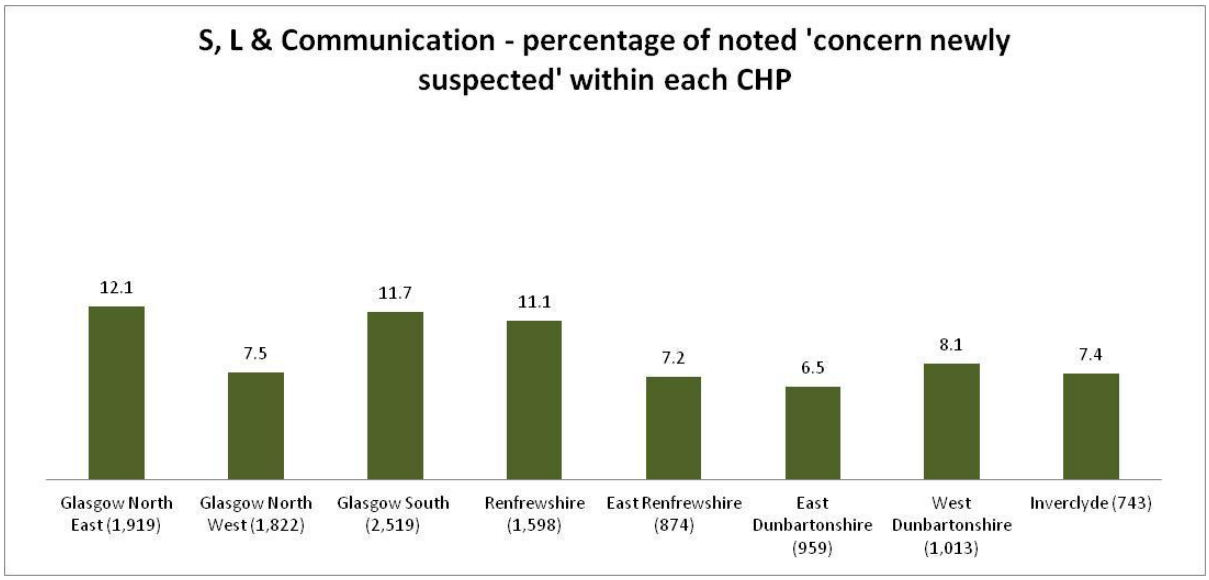


Table 2 supplements Figures 21-23 by including the number of children with a 'concern newly suspected' in relation to behaviour, attention and speech, language and communication for each CHP/sector.

Table 2

CHP (Total No. of Assessments)	Behaviour (No. of Children)	Attention (No. of Children)	S&L Communication (No. of Children)
Glasgow North East (1,919)	12.7% (243)	6.5% (124)	12.1% (232)
Glasgow North West (1,822)	8.6% (157)	4.7% (86)	7.5% (137)
Glasgow South (2,519)	12.4% (312)	5.3% (133)	11.7% (294)
Renfrewshire (1,598)	9.6% (154)	5.9% (94)	11.1% (178)
East Renfrewshire (874)	8.7% (76)	2.6% (23)	7.2% (63)
East Dunbartonshire (959)	5.2% (50)	2% (19)	6.5% (62)
West Dunbartonshire (1,013)	8.8% (89)	3.9% (40)	8.1% (82)
Inverclyde (743)	10.6% (79)	5.8% (43)	7.4% (55)

Table 3 shows ‘concerns newly suspected’ for the remaining six areas of assessment. No formal assessment tool is used for gross motor, fine motor, vision or hearing. Social and emotional development is included in the SDQ assessment and this may influence HV level of concern in these areas.

Table 3

Developmental Outcomes – Percentage of 'Concerns Newly Suspected' (Number of Children in Brackets)						
CHP (Total No. of Assessments)	Social	Emotional	Gross Motor	Fine Motor	Vision	Hearing
Glasgow North East (1,919)	5.4 (104)	3.6 (70)	0.2 (4)	0.3 (6)	0.6 (12)	1 (19)
Glasgow North West (1,822)	3.7 (67)	2.3 (42)	0.4 (8)	0.3 (6)	1.1 (20)	0.8 (14)
Glasgow South (2,519)	5.7 (143)	3 (76)	0.4 (9)	0.2 (6)	0.7 (18)	0.6 (16)
Renfrewshire (1,598)	4.5 (72)	2.3 (37)	0.4 (7)	0.3 (4)	1.1 (18)	1.2 (19)
East Renfrewshire (874)	1.9 (17)	1.6 (14)	0.5 (4)	0.1 (1)	0.3 (3)	0.2 (2)
East Dunbartonshire (959)	2.4 (23)	0.8 (8)	0.1 (1)	0.2 (2)	0.4 (4)	0.2 (2)
West Dunbartonshire (1,013)	3.4 (34)	2.7 (27)	0.9 (9)	0 (0)	0.9 (9)	0.9 (9)
Inverclyde (743)	3.2 (24)	1.9 (14)	0.7 (5)	0.5 (4)	1.1 (8)	1.7 (13)

HEALTH PLAN INDICATOR (HPI)

The 27-30 month assessment provides an opportunity to revise the allocation of a child’s HPI prior to the start of formal nursery education. For those previously allocated as ‘core’ this opportunity was unlikely to have arisen unless the health

visitor had been notified of concern or changing circumstances by the family or another professional.

The HPI indicates the level of contact a child will have with their health visitor or HV team staff. In this sense a higher number of children allocated as 'additional' or 'intensive' is likely to impact on the HV workload. Historically, the allocation of HPI has been influenced by local variation in caseloads and perceptions of vulnerability and risk.

Figure 24

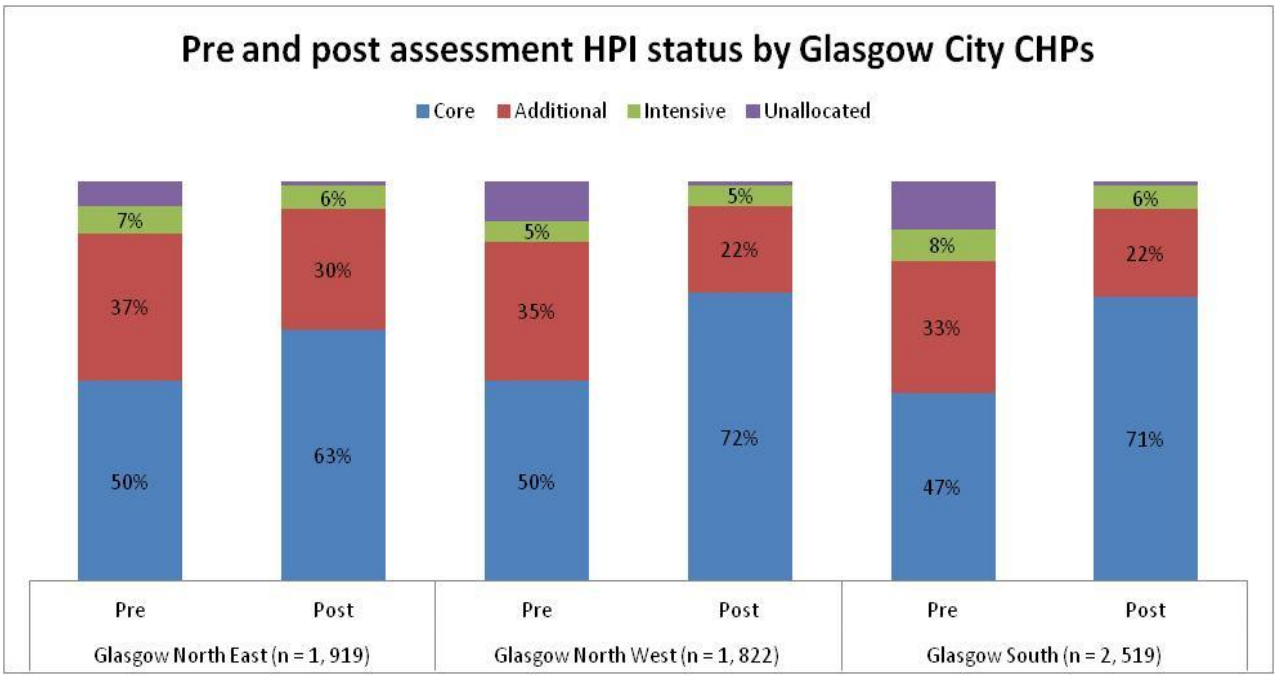
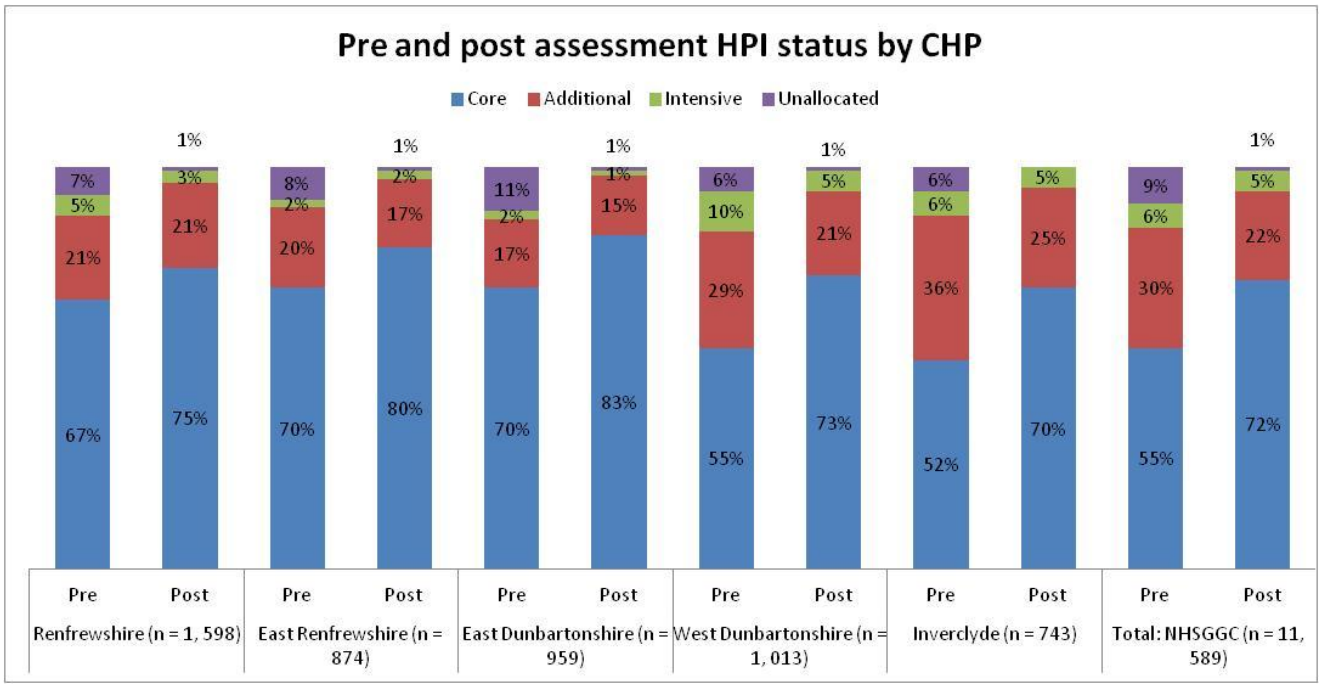


Figure 25



Figures 24 and 25 show the proportion of children within each CHP by their HPI allocation before and after the 27-30 month assessment.

In all sectors there were more children allocated as 'core' after the assessment than before it and fewer who had no HPI allocation. With the exclusion of East Renfrewshire and Glasgow North West the proportion of children recorded as 'intensive' reduced after the assessment.

FUTURE ACTIONS

The notation of 'future actions' on the 27-30 month assessment form represents the suggested or recommended initial action by the health visitor.

Table 4 shows all 'future actions' noted in relation to recommended service pathways excluding SLT and parenting. Future actions to SLT and parenting programmes are shown separately (Table 5) because they were the service pathways for the primary items of interest (speech, language & communication and behaviour).

For children with complex needs (i.e. both language and behavior difficulties) the suggested pathway included an early nursery place. Approximately 1 in 10 children in West Dunbartonshire (11.1%) and 9.3% in Glasgow North East had a future action to early education.

There were very few future actions to Social Work in all localities.

A further breakdown of specific types of future actions in relation to parenting is shown in Figures 26 and 27.

Table 4 – 'Future Action' to services as percent within each CHP (includes any 'future action' (D, P, R, S and, where applicable, W).

For example: 16 children (0.9%) within Glasgow North East had a 'future action' to social work noted.

CHP (Total No of Assessments) % (No)	GP	Audiology	Comm Paeds	CAMHS	Childsmile *	Smoking Cessation *	CHW	Early Education *	Financial Advice Services	Social Work	Physio/OT	Other Services*
Glasgow NE (1,919)	2.7 (51)	2.6 (50)	2.1 (40)	0.2 (4)	4.7 (91)	1.7 (31)	0.1 (1)	9.3 (178)	1 (16)	0.9 (16)	0.6 (10)	4.1 (78)
Glasgow NW (1,822)	1.9 (35)	1.3 (24)	1.1 (20)	0.1 (2)	4.1 (75)	2 (36)	0.2 (4)	7.3 (132)	0.9 (15)	0.6 (16)	0.5 (9)	4.2 (78)
Glasgow Sth (2,519)	3.6 (90)	1.7 (43)	1.8 (44)	0.2 (6)	4.9 (123)	1.9 (50)	0.2 (6)	7.9 (199)	1.5 (38)	0.9 (25)	0.5 (14)	2.8 (68)
Renfrewshire (1,598)	1.7 (26)	3.2 (50)	1.3 (20)	0.2 (2)	2.7 (44)	2.3 (35)	0.1 (1)	4.7 (76)	1 (15)	0.8 (14)	0.9 (14)	3.3 (52)
East Ren (874)	0.6 (6)	1.3 (11)	0.4 (4)	0.1 (1)	0.7 (7)	0.1 (1)	0 (0)	2.6 (23)	0.6 (6)	0.8 (7)	0.4 (4)	0.9 (9)
East Dun (959)	1 (10)	1 (10)	0.6 (6)	0 (0)	0.6 (6)	0.4 (4)	0 (0)	2.5 (25)	0.3 (3)	0.3 (3)	0 (0)	1.7 (17)
West Dun (1,013)	0.8 (8)	1.8 (18)	1.5 (15)	0.1 (1)	6.1 (61)	2.6 (26)	0.2 (2)	11.1 (112)	0.5 (5)	1.5 (15)	1.6 (16)	2.3 (23)
Inverclyde (743)	1.1 (9)	2.3 (17)	2 (15)	0 (0)	2.8 (21)	4 (30)	0 (0)	3.9 (29)	0.5 (4)	0.9 (7)	0.8 (6)	4.2 (32)

Table 5 – Any future actions to SLT and parenting by sector/CHP

CHP (Total no of assessments)	SLT % (No.) *	Parenting % (No.)
Glasgow North East (1,919)	10.7 (205)	19.9 (380)
Glasgow North West (1,822)	8.3 (151)	12.9% (235)
Glasgow South (2,519)	12.9 (325)	22.1% (555)
Renfrewshire (1,598)	11.2 (178)	11.8% (187)
East Renfrewshire (874)	8.1 (71)	10.1% (88)
East Dunbartonshire (959)	5.9 (58)	15.4% (149)
West Dunbartonshire (1,013)	10.7 (108)	14.1% (142)
Inverclyde (743)	9.1 (68)	11.8% (88)

Figure 26

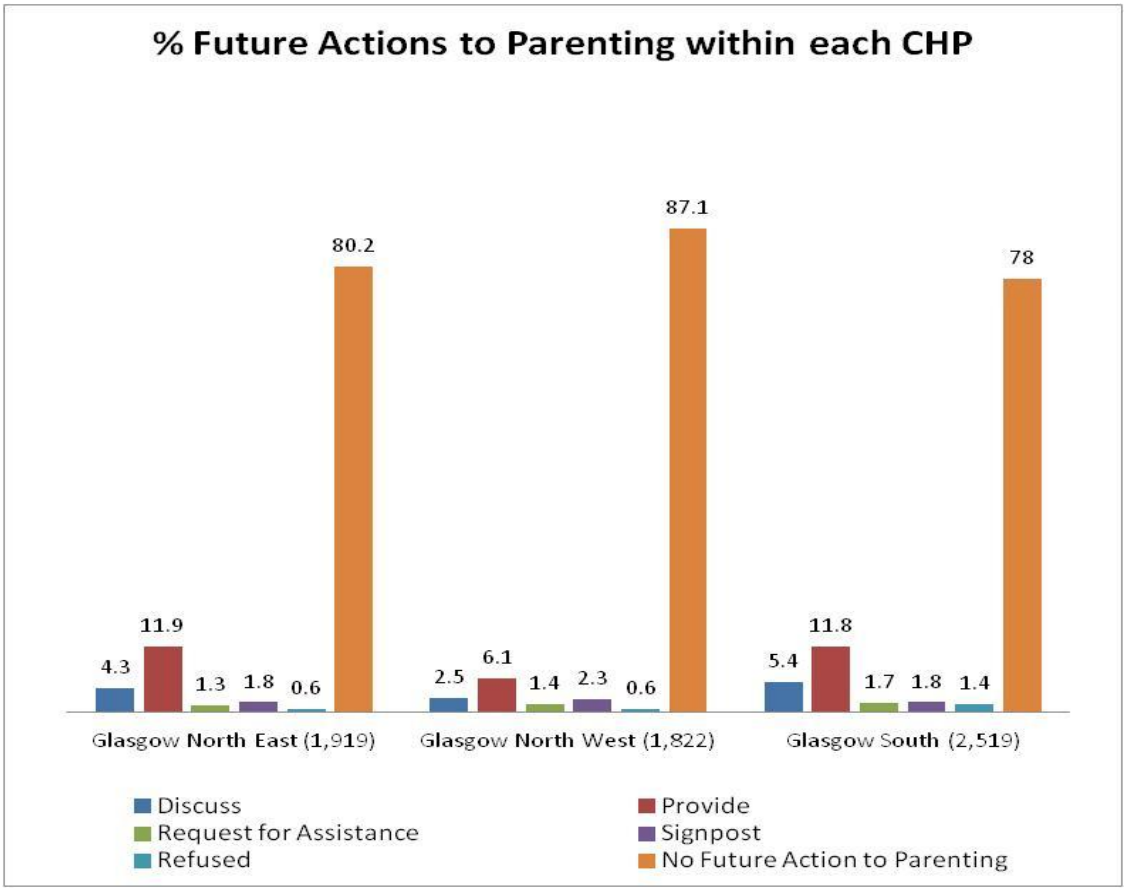
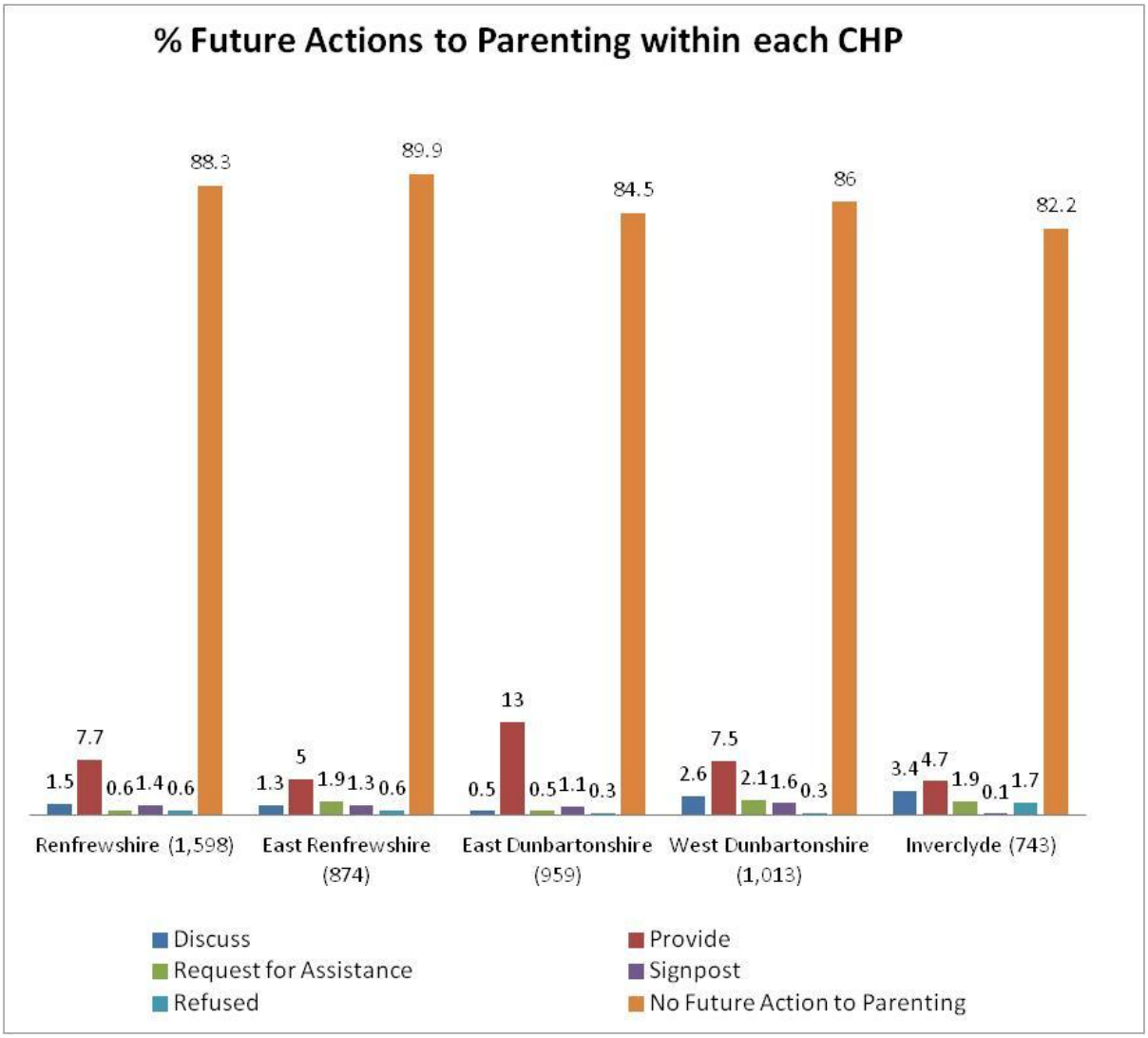


Figure 27



SPEECH, LANGUAGE AND COMMUNICATION

Initially, NHSGGC guidance for the 27-30 month assessment recommended that health visitors request assistance from SLT for children who could say only 20 words or less from the SSLM-R assessment (see Figure 28 for proportions in each word range within each CHP). However, ongoing discussion with SLT led to a change in recommendations to reflect their professional view that word count alone is not an appropriate criteria for a request for assistance. A more significant indicator of possible need for specialist SLT intervention is when a child has poor

comprehension or stutters or stumbles over words regardless of their SSLM-R word count.

SLT services have recently provided numbers of children for whom requests for assistance were made following the RTL/30 month assessment and those who were triaged and accepted for specialist SLT assessment (Figure 29 and Table 6). It is unclear whether these figures include children who had low word count alone (as per original guidance).

Figure 28

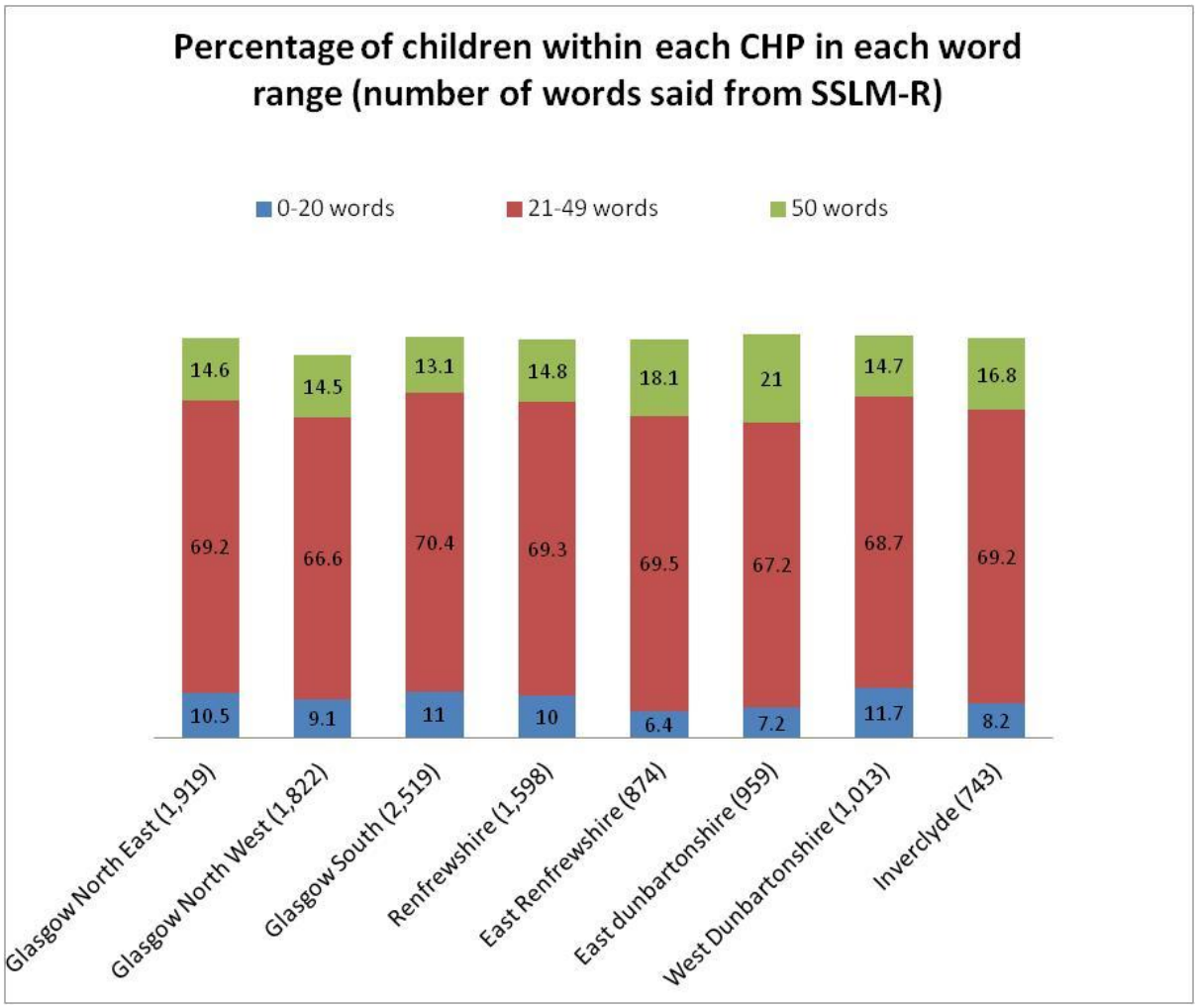


Figure 29 – Percentage of requests for assistance that were accepted for SLT triage/assessment

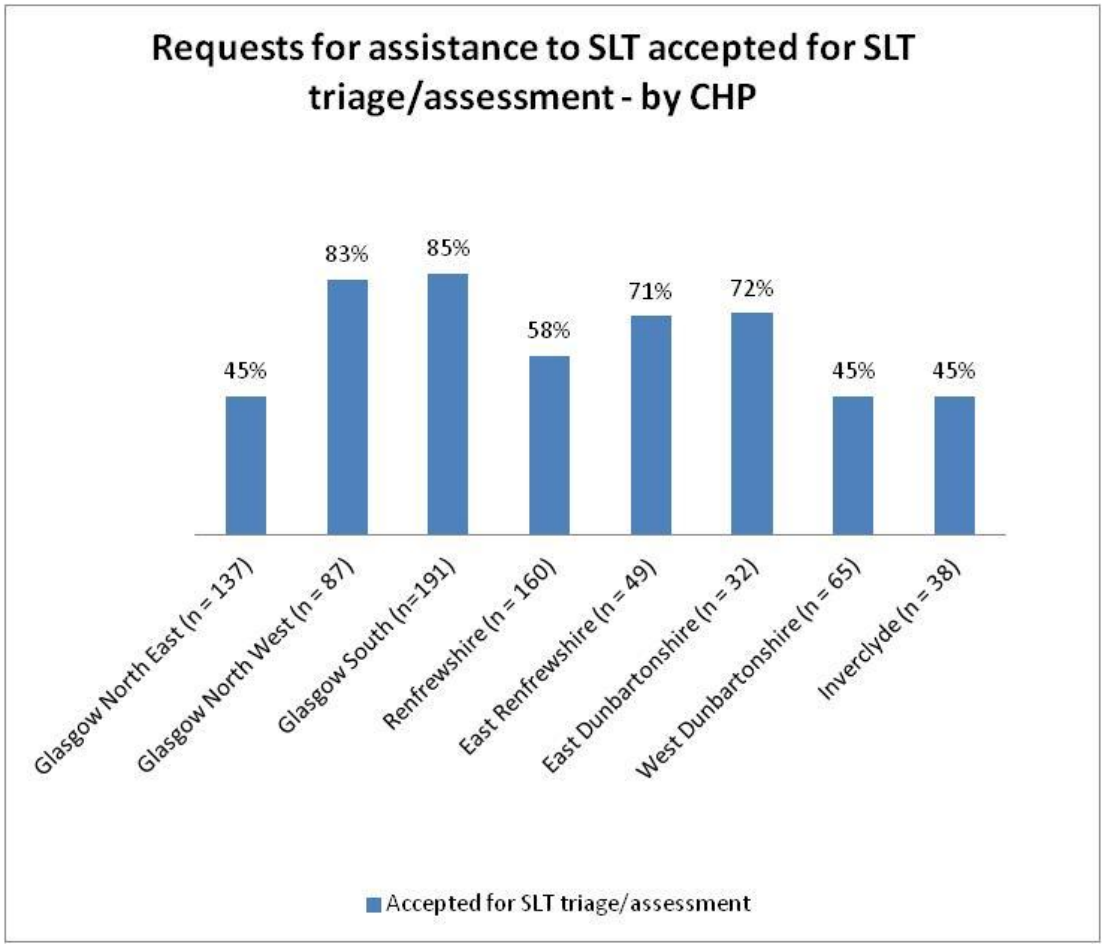


Table 6 supplements Figure 29 percentages of Request for Assistance who were accepted by SLT for triage/assessment. It shows the actual number of children accepted by SLT and the number who were already in the SLT system at the time the RfA was made. The number noted as 'already in system' suggests that health visitors are not always aware of children who are already engaged with specialist SLT services.

Table 6 – Number of requests for assistance to SLT and service response

CHP	Total number of RfAs	Already in system	Supported by HV	Accepted for SLT triage/assessment
Glasgow North East	137	26	No data	62
Glasgow North West	87	2	No data	72
Glasgow South	191	No data	No data	163
Renfrewshire	160	38	29	93
East Renfrewshire	49	10	No data	35
East Dunbartonshire	32	3	No data	23
West Dunbartonshire	65	8	28	29
Inverclyde	38	21	No data	17

Concluding remarks

Data from the 27-30 month assessment does not provide information on whether families engaged with the recommended pathways. This would require additional follow-up and a system of data collection that is not currently in place.

April 2015