CHILDREN AND YOUNG PEOPLE'S HEALTH PLAN LANARKSHIRE

2018-2020

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Governance Committee	Population Health & Primary and Community Services Governance Committee
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1. OUR VISION

Our vision is for all children and young people to have the best start in life and reach their full potential, regardless of their starting point.

The principles of *Getting it right for every child* (GIRFEC) will underpin our approach to promoting the health, safety and wellbeing of our children and young people, based on the SHANARRI wellbeing indicators – Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included.

In Scotland's Year of Young People 2018, we are committed more than ever to a joined-up approach to the planning and delivery of high quality services for children and young people across all partner agencies and communities.

2. CHILDREN'S RIGHTS

The United Nations Convention on the Rights of the Child (UNCRC) 1989 is an international human rights treaty that grants all children and young people a comprehensive set of rights.

Through implementation of the Children and Young People (Scotland) Act 2014 (Part 1), NHS Lanarkshire and partners will ensure that children's rights are realised and that they properly influence the design and delivery of policies and services. This means that children and young people will be meaningfully involved, at an early stage, in policy and service development, taking account of diverse views, experiences and circumstances.

3. TACKLING INEQUALITIES

Many families in Lanarkshire are thriving, providing opportunities for their children to lead fulfilling lives. Other families need support to thrive. The impact of factors such as deprivation, care experience, disability and other protected characteristics on their daily lives can be considerable. The effects of poverty in childhood, including living in a low income family and in poor quality housing, can be felt into adulthood and can affect every part of a child's life – from economic and material disadvantages to impacting negatively on health and attainment.

Some parents need support to fulfil their responsibilities to their children. A collaborative approach is required across community planning partners and communities to develop services and effectively tackle the range of circumstances which contribute to poor health and health inequalities. This requires a long term,

multi-faceted approach which focuses on prevention and early intervention where need is identified, to break the cycle of poor outcomes for all children and families.

An Equality and Diversity Impact Assessment has been undertaken and is available on request.

4. WHY DO WE NEED A CHILDREN AND YOUNG PEOPLE'S HEALTH PLAN?

This second Children and Young People's Health Plan for Lanarkshire builds on the progress and achievements of 2015-2018 and provides a central driving point to improve health and health services for children and young people across NHS Lanarkshire and both North and South Health and Social Care Partnerships. It remains essential that the services we provide to children, young people and their families are timely, of high quality, efficient and continually improving. We need to demonstrate, through the services we provide, that we understand the health needs of Lanarkshire's children and young people and that we are responsive to them. We need to make sure that we ask children and young people about their experiences of using our services and use this knowledge to improve the ways in which we work; ensuring services are appropriate and proportionate. We need to provide feedback to service users about what we are doing so that they can trust us to do what we say we will.

The Plan will help us to achieve our vision by;

- Improving outcomes for children and young people and reducing health inequalities by developing outcomes focused plans based on needs assessment and evidenced based practice.
- Setting out where we are now in terms of our planning and delivery framework and where we aspire to be, allowing many aspects of children and young people's health and health services to be co-ordinated and performance managed from a single point, whilst maintaining links with multiagency children's services plans.
- Involving children and young people in identifying priorities for action, improvement and informing service development.

The Plan has been developed in the context of a range of legislation and national and local policy, which includes:

- The Children and Young People (Scotland) Act 2014
- *Getting it right for every child*
- The Carers (Scotland) Act 2016
- The Child Poverty (Scotland) Act 2017
- Mental Health Strategy 2017-2027
- National Guidance for Child Protection in Scotland 2014

- Child and Adolescent Health and Wellbeing Action Plan (forthcoming)
- *Achieving Excellence* Healthcare Strategy
- CPP Local Outcome Improvement Plans (LOIPs)
- HSCP Commissioning Plans
- NHS Lanarkshire Local Delivery Plan
- North/South Lanarkshire Children's Services Plans
- North/South Lanarkshire Corporate Parenting Strategies
- Lanarkshire Parenting Support Strategy
- Universal health visiting pathway

This list is not exhaustive. These are supported by improvement programmes such as the Children and Young People Improvement Collaborative (CYPIC) and Realigning Children's Services (RCS).

5. WHO IS THIS PLAN FOR?

The Children and Young People's Health Plan has been produced for the following;

- Children and young people from birth to 18 years (25 years for care leavers).
- Parents (including parents to be), carers and families.
- All NHS Lanarkshire and North and South Lanarkshire Health and Social Care staff and independent contractors.
- All partner agencies providing services for children, young people and families.

6. PARTNERSHIP PLANNING FRAMEWORK

Health services alone cannot tackle the significant inequalities that exist in our society. Central to this Plan is the recognition that all agencies working with children and young people – in the statutory, voluntary and independent sectors - can deliver more by working together with children, young people and their families and in partnership with each other than by working alone, and that they share common goals.

In doing this both North and South Lanarkshire LOIPs reemphasise the importance of prevention and early intervention, improving outcomes for children, young people and families, and ensuring the wider determinants of health are tackled in a collaborative way.

Multiagency Children's Services Plans 2017-20 and associated planning structures are in place with similar priorities evident across the partnership areas.

North Lanarkshire Children's Services Plan priorities:

- Prevention
- Neglect, domestic abuse and substance misuse
- Mental health, wellbeing and resilience
- Looked after children and young people.

South Lanarkshire Children's Services Plan priorities:

- Prevention and early support
- Health and wellbeing
- Supporting vulnerable groups and keeping children safe

These plans set out the actions we will take *in partnership* to improve outcomes for children, young people and families.

Much of the operational delivery of the Children and Young People's Health Plan is the responsibility of Health and Social Care Partnerships and the actions within support the achievement of health and social care commissioning intentions and complement actions within multiagency children's services plans.

7. GOVERNANCE

The NHS Lanarkshire ***Child Health Services Improvement and Planning Group*** is responsible for overseeing the delivery of actions set out within the Children and Young People's Health Plan. The Child Health Services Improvement and Planning Group is a subgroup of the NHS Lanarkshire ***Child Health Commissioner's Steering Group***, which is subsequently accountable to the Population Health and Primary and Community Services Governance Committee. Please see Figure 1 below.

The Child Health Commissioner's Steering Group will receive reports from the Child Health Services Improvement and Planning Group on progress with implementation of the Plan, retaining a strategic overview of child health and health services, as well as providing a quality assurance role and solution-focused approach to emerging threats or challenges.

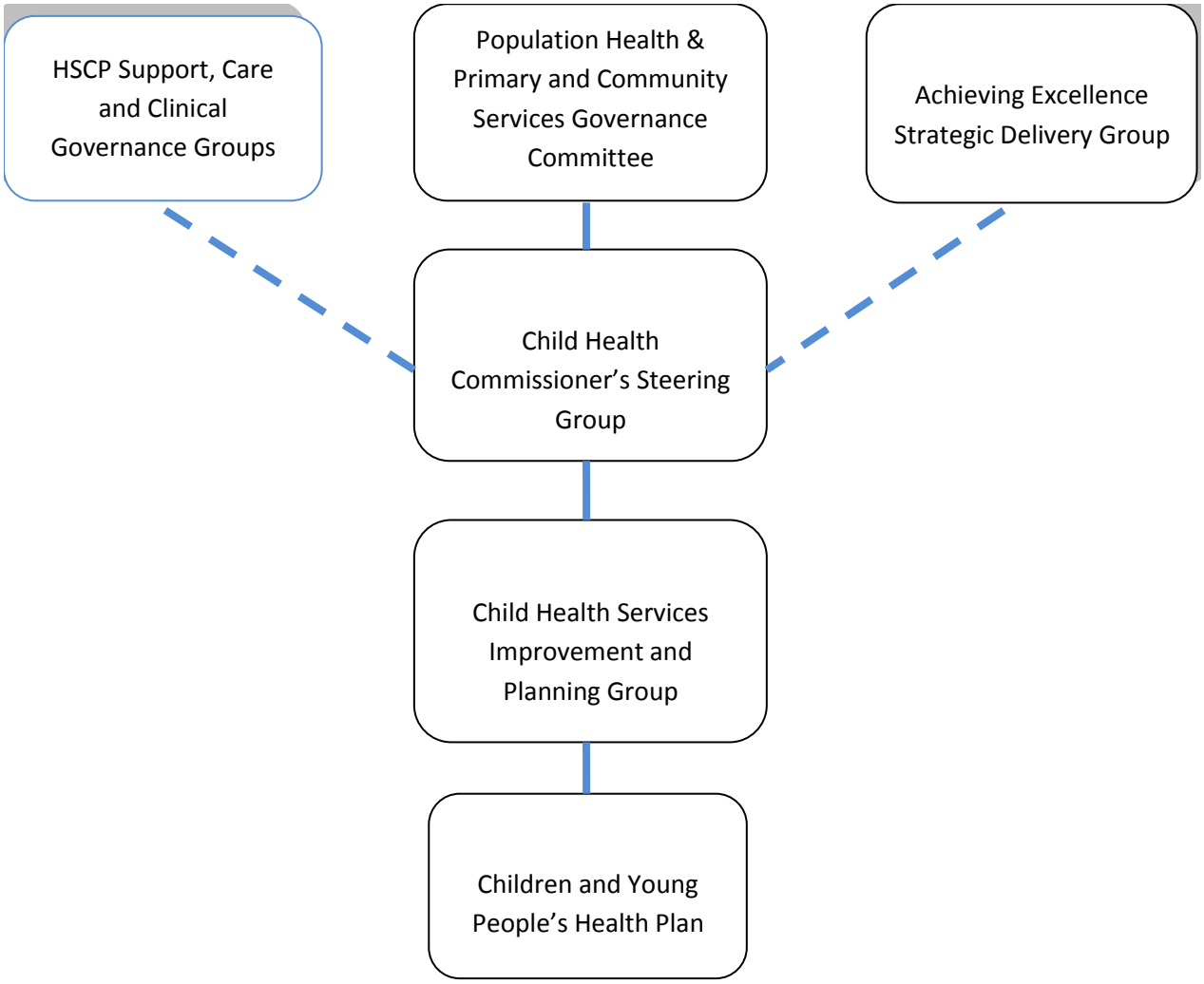


Figure 1: Governance Structure

8. CONTINUOUS IMPROVEMENT

A process of joint inspection of services for children and young people exists to look at the difference services are making to the lives of children, young people and families across community planning partners, including health and social work services. Services are benchmarked against:

- *How well are we improving the lives of children and young people* (Care Inspectorate, 2014)
- *How good are we now? How well do we protect children and meet their needs?* (HMIe, 2009)

A revised model of joint inspection of services for children and young people has been agreed which will focus on the most vulnerable children and young people. From April 2018, this new model will focus on the experiences of and outcomes for

children in need of protection and those who are looked after. Inspections will continue to focus on prevention and early intervention, accurate assessment of risk and need, and effective planning. Inspections will report on:

- How good is the partnership at recognising and responding when children and young people need protection?
- How good is the partnership at helping children and young people who have experienced abuse and neglect stay safe, healthy and recover from their experiences?
- How good is the partnership at maximising the wellbeing of children and young people who are looked after?
- How good is the partnership at enabling care experienced young people to succeed in their transition to adulthood?
- How good is collaborative leadership?

The process will involve self-evaluation and inspection. Findings from both will be used to inform and develop the Children and Young People's Health Plan and areas for improvement.

9. INVOLVING CHILDREN AND YOUNG PEOPLE

We are committed to enabling the involvement of children, young people and families in the development of activities and services aimed at improving health and wellbeing.

Article 12 of the UNCRC states that children and young people should have their say when adults are making decisions that affect them and their opinions are taken seriously. The Children and Young People (Scotland) Act 2014 will ensure that children's rights are realised and that they properly influence the design and delivery of policies and services.

We will continue to engage with children and young people to find out more about:

- What health and wellbeing issues are important
- How health information is accessed
- Experiences of using health services, and
- The best ways of involving children and young people in health service planning and improvement

Currently, the structures in place to support the above-mentioned work are:

- The national youth and children's parliaments
- Local youth participation structures across North and South Lanarkshire

The Children and Young People's Health Plan includes a range of programmes and services to improve health and wellbeing. Each service or programme lead has been asked to ensure that children and young people are involved in development and improvement activities as far as is practicable. All participation and engagement is recorded.

Health and social care staff also participate in activities to further support this engagement, for example, involvement in the Scottish Government Realigning Children's Services Programme which has allowed children, young people and parents to share their views about health and wellbeing, their living environment and access to services. In North Lanarkshire, staff are also involved in working with young people to co-produce a methodology which supports continued participation.

10. WHERE ARE WE NOW?

10.1 Population statistics

In 2016, the Lanarkshire population was 656,490 (339,390 in North Lanarkshire and 317,100 in South Lanarkshire). Children under five years formed 5.5% of the population whilst 5-14 year olds and 15-24 year olds made up 11.4% and 11.8% of the population respectively. In 2016, there were 6,855 total births.[1]

In the period 2014-16, stillbirth, neonatal death and infant death rates were as follows:

	North Lanarkshire	South Lanarkshire	NHS Lanarkshire	Scotland
Stillbirth (per 1000 births)	5.5 (n=20)	3.0 (n=10)	4.3	4.0
Neonatal death (per 1000 live births)	2.6 (n=10)	1.8 (n=6)	2.3	2.2
Infant death (per 1000 live births)	3.6 (n=13)	2.5 (n=8)	3.1	3.4

Table 1: Still birth, neonatal and infant death rates 2014-16[1]

[1] NHS Lanarkshire. Public Health 2016/17. The Annual Report of the Director of Public Health. http://www.nhslanarkshire.org.uk/Services/PublicHealth/Pages/Directors-Annual-Report-2016-2017.aspx

In the period 2012-2016, the rate of child deaths (in 1-15 year olds) was 9.3/100,000 in North Lanarkshire (n=6) and 8.9/100,000 in South Lanarkshire (n=5). The Scotland rate was 10.8/100,000.[2]

10.2 Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are described as adverse events or traumas that occur in a child's life which result in a chronic stress response. These include abuse (emotional, physical and sexual), neglect (emotional and physical) and household adversity such as domestic abuse, substance misuse, criminality or living in care. Experiencing ACEs affects both morbidity and mortality and as the total count of ACEs increases, so does the risk of experiencing a range of health harming behaviours and illnesses. For example, individuals who have experienced four or more ACEs are:

- Four times more likely to smoke and drink heavily
- Nine times more likely to experience incarceration
- Three times more likely to be morbidly obese.

Those with a higher 'ACE score' are also at higher risk of poor education and employment outcomes, low mental wellbeing, chronic health conditions, involvement in violence and teenage pregnancy.

Although data exists on various elements of adversity, there are no published studies on the prevalence of ACEs in Scotland. Key areas for action include:

- Raising awareness of ACEs across the workforce and communities to enable trauma-informed policy and practice. Considerations should be given to Routine Enquiry for ACEs and the need to implement the trauma training framework to support staff in this role.
- Prevention and mitigation of ACEs requires co-ordinated action and includes, tackling wider economic and social risk factors (such as poverty and isolation), tackling household adversity (such as substance use and domestic abuse) and continuing to provide evidence-based parenting support, targeted to those most in need.
- Building resilience and the development of trusted and stable relationships.[3]

The Solihull Approach supports staff to understand the importance of the quality of the parent-child relationship and its effect on the developing infant brain. To date,

[2] Scottish Public Health Observatory. Children and Young People Profiles. http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool

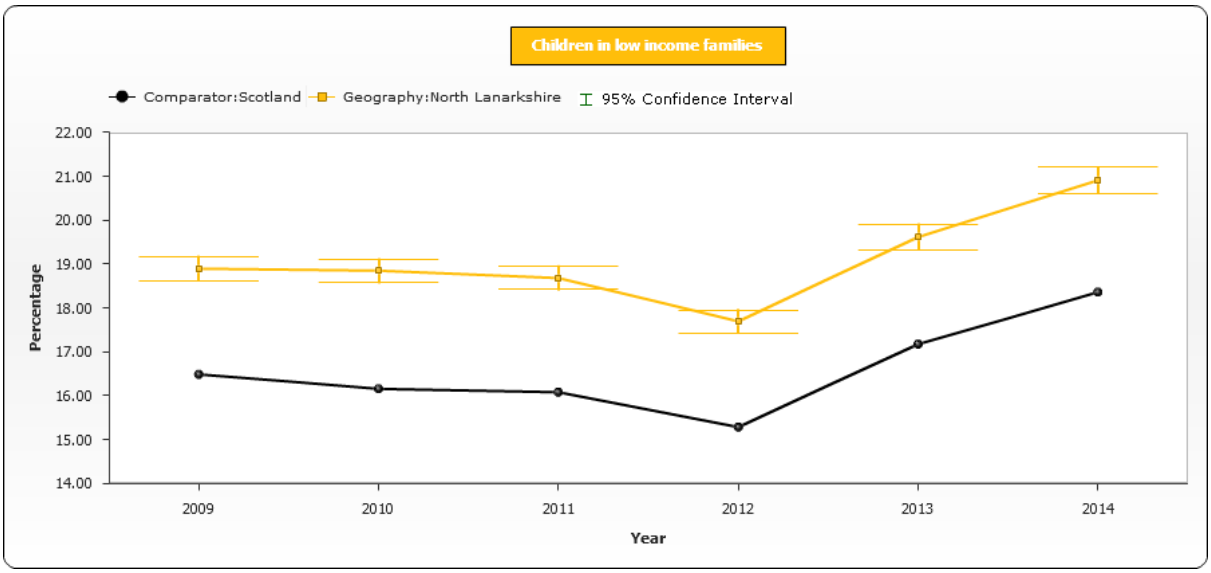
[3] Couper S and Mackie P. *Polishing the Diamonds: Addressing Adverse Childhood Experiences in Scotland*. Scottish Public Health Network, 2016.

2,643 multiagency staff have been trained in the Solihull Approach, including 232 health professionals.

10.3 Child poverty

Since 2012 there has been an increase in the number of children in low income families. This is defined as dependent children under 20 years old in families in receipt of out-of-work benefits or child tax credits (reported income less than 60% of the UK median). Figure 2 below shows children in low income families in North Lanarkshire. In 2009, 18.9% of children were in low income families, falling to 17.7% in 2012. Data for 2014 shows that **20.9%** of children in North Lanarkshire were in low income families (n=15,060 children). This is statistically significantly worse than the Scotland average of 18.4%.

Figure 2: Percentage of children in low income families in North Lanarkshire, by year

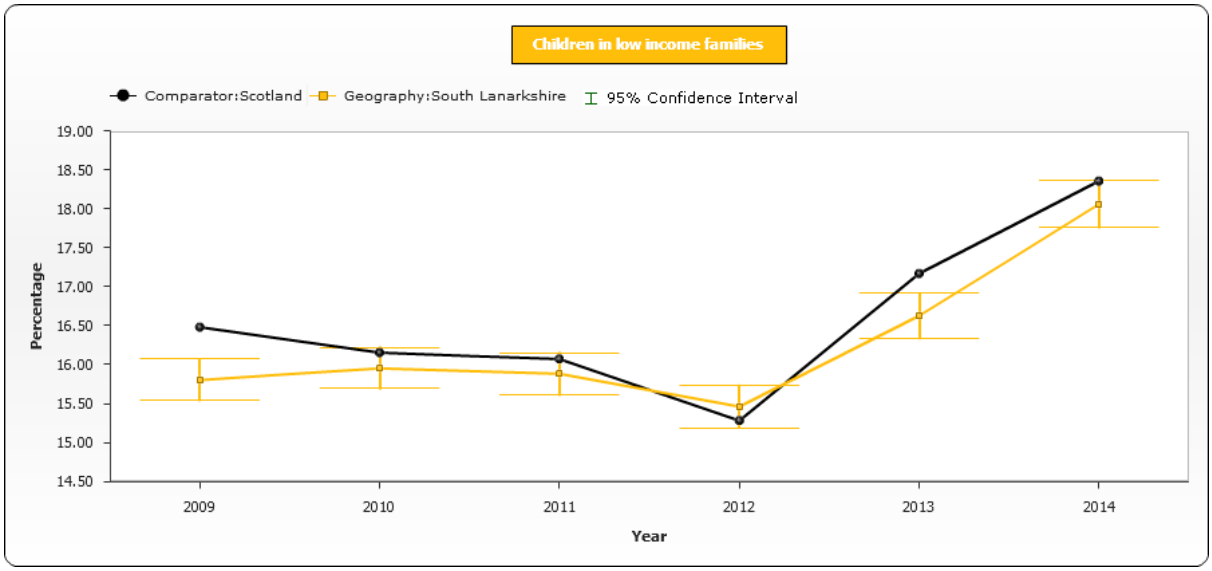


Source: HM Revenue & Customs

Data accessed from Children and Young People Profile, Scottish Public Health Observatory

Figure 3 shows children in low income families in South Lanarkshire. Following a similar trend to North Lanarkshire and Scotland, children in low income families decreased from 15.8% in 2009 to 15.5% in 2012. By 2014, children in low income families had risen to **18.1%** in South Lanarkshire (n=11,435 children). This is statistically not significantly different to the Scotland average of 18.4%.

Figure 3: Percentage of children in low income families in South Lanarkshire, by year



Source: HM Revenue & Customs

Data accessed from Children and Young People Profile, Scottish Public Health Observatory

In 2016, 30.7% of young people in North Lanarkshire were living in the most deprived income quintile, this is statistically significantly worse than the Scotland average of 21.5%. In South Lanarkshire, 21.4% of young people were living in the most deprived income quintile.

In 2017, 15.9% of children in both North and South Lanarkshire were registered for free school meals (15.6% in Scotland), demonstrating that at least this proportion are entitled to this financial and nutritional support.[4]

At December 2017, 69% of those eligible were registered and receiving monetary vouchers for fruit, vegetables and milk. Women's Healthy Start vitamins are provided universally during pregnancy. At November 2017, 16% of eligible children were receiving Healthy Start vitamins.

In South Lanarkshire, midwives and health visitors (as well as other agencies) refer families for Financial Inclusion support to the Telephone Advice Line (TAL). In 2016/17, 473 referrals were made to the TAL; 90.9% of referrals were made by midwives (n=430). Five percent of referrals (n=24) were made by health visitors. Data available for 2017/18 (to January 2018), shows that 471 referrals were made to the TAL; 55.2% (n=260) by midwives and 39.9% (n=185) by health visitor. Improvement work in Blantyre shows that of the total referrals made to the TAL by health visitors, 63% were engaging with the service at January 2018. In North Lanarkshire, midwives and health visitors refer families for Financial Inclusion support but have no dedicated TAL; therefore no comparable data is available. This will be reviewed in 2018/19.

[4] Scottish Public Health Observatory. Children and Young People Profiles. http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool

10.4 Looked After children and young people

In 2015, 764 children were Looked After in North Lanarkshire (10.7/1000) and 558 children were Looked After in South Lanarkshire (9.0/1000). The rate for Scotland was 14.8/1000.[4]

In South Lanarkshire in the period Jul-Dec 2017, 114 notifications were received from Social Work relating to children and young people who had become Looked After. The majority of notifications were for school-aged children (62%); the remainder were for pre-school children. Eighty-seven percent of notifications were made within 4 weeks of the child or young person becoming Looked After. A Child's Plan was attached to the notification in 66% of cases. Thirty-six percent of CEL16 health needs assessments were completed within four weeks (against a target of 100%); 65% of pre-school assessments were completed within four weeks and 19% of school-aged assessments.

In North Lanarkshire in the period Jan 2017-Jan 2018, 281 notifications were received from Social Work relating to children and young people who had become Looked After. The majority of notifications were for school-aged children (64%); the remainder were for pre-school children. Thirty-nine percent of notifications were made within 4 weeks of the child or young person becoming Looked After. A Child's Plan was attached to the notification in 41% of cases. Eighty-two percent of CEL16 health needs assessments were completed within four weeks (against a target of 100%); 86% of pre-school assessments were completed within four weeks and 80% of school-aged assessments.

10.5 Early years and development, including maternal health

Teenage pregnancies have reduced over time and continue to be closely linked to deprivation. For the period 2013-15, the pregnancy rate in women under 20 was 38.4/1000 in North Lanarkshire and 29.7/1000 in South Lanarkshire. The Scotland average was 32.4/1000. The teenage pregnancy rate for those under 16 years is similar to the national average; 4.1/1000 in both North and South Lanarkshire and 4.0/1000 in Scotland.[5]

In the calendar year 2017, women booking for pregnancy had 2,490 vulnerabilities identified and recorded in the electronic clinical record. The majority (69%) of these vulnerabilities related to mental health issues, 37% related to financial issues and 11% to drug or alcohol misuse. In those under 21 years, 400 vulnerabilities were

[5] ISD Scotland. Teenage Pregnancy Year of Conception Ending 31 December 2015. http://www.isdscotland.org/index.asp

identified. Forty-six percent related to financial issues and 45% to mental health issues. Thirteen percent of vulnerabilities were related to drug or alcohol misuse.[6]

In 2016/17, 55.8% of pregnant women were overweight (including obese) at antenatal booking; 27.1% of women were obese (BMI of 30 or more). Maternal obesity increases with increasing deprivation. In the same period, 15.4% of women were smoking at antenatal booking. Smoking in pregnancy increases with increasing deprivation and is more common in younger women.[7]

In year 2016/17, breastfeeding initiation (ever breastfed) in Lanarkshire was 47.7% (63.5% in Scotland). At the health visitor First Visit (10-14 days), 23.8% of babies were exclusively breastfed (36.5% in Scotland). By 6-8 weeks, 19.9% of babies in Lanarkshire were exclusively breastfed (30.3% in Scotland). Low breastfeeding rates are associated with lower maternal age and increasing deprivation.[8]

Of the 1,706 children born in the quarter Jul-Sep 2017, 1,612 (94.5%) received a 6-8 week child health review. Overall, 90.4% of reviews were completed by 10 weeks of age (against a target of 90%), although performance across GP practices is variable.

The table below shows coverage and outcomes from the 27-30 month child health review. Coverage has increased over time to over 93% for children born in 2014 (please note children born at the end of 2015 may not yet have been scheduled for their 27-30 month review). Around 70% of children have no developmental concerns at 27-30 months against the national stretch aim of 85%. The majority of concerns related to speech, language and communication. Exposure to second hand smoke has decreased over time and currently less than 10% of children are affected.

Year of birth	No. of children	% uptake 27-30 month review	% children with no developmental concerns	% children exposed to SHS
2011	7518	82.42%	71.08%	11.9%
2012	7337	86.81%	76.40%	10.8%
2013	7215	89.33%	78.40%	10.8%
2014	7363	93.26%	65.31%	8.8%
2015	7097	60.50%	63.39%	8.0%

Table 2: Child health review 27-30 months

The 13-15 month review was implemented in Lanarkshire from 1st October 2017. Coverage of the 13-15 month review in the period October–December 2017 was 62%.

[6] BadgerNet
[7] ISD Scotland. Births in Scottish Hospitals Year Ending 31 March 2017. http://www.isdscotland.org/index.asp
[8] ISD Scotland. Infant Feeding Statistics 2016/17. http://www.isdscotland.org/index.asp

10.6 Health and wellbeing

The table below shows child healthy weight data for P1 children in the school year 2016/17. Just over a fifth of children in Lanarkshire are at risk of overweight and obesity; 1 in 10 is at risk of obesity. The proportion of those at risk of overweight and obesity has slightly increased over time. Children from more deprived areas are less likely to be a healthy weight.[9]

	% healthy weight	% at risk of overweight (inc. obese)	% at risk of obesity
North Lanarkshire	75.9	22.8	10.2
South Lanarkshire	77.7	21.0	9.3
NHS Lanarkshire	76.8	21.9	9.8
Scotland	76.1	22.9	10.5

Table 3: Body Mass Index of Primary 1 Children 2016/17

In 2016/17 school year, 67.7% of P1 children in North Lanarkshire and 73.4% of P1 children in South Lanarkshire had no obvious decay experience (70.9% in Scotland). In P7, 65.3% of children in North Lanarkshire and 66.5% in South Lanarkshire had no obvious decay experience (69.4% in Scotland).[10]

Five percent of South Lanarkshire pupils (S1-4) report being current smokers. Smoking was more prevalent in older pupils, girls and those living in more deprived areas. Sixteen percent of pupils reported being exposed to SHS every day or most days (ranging from 26% in the most deprived quintile to 7% in the least deprived). In North Lanarkshire, 5% of S1-4 pupils reported current smoking. S4 girls were the group most likely to smoke (34%). Eighteen percent of pupils reported being exposed to SHS every day or most days (ranging from 26% in the most deprived quintile to 7% in the least deprived).

Around a third of S1-4 pupils in South Lanarkshire indicated that they had ever had a proper alcoholic drink (9% in S1 rising to 65% in S4). Twenty-three percent of S4 pupils said they drank alcohol at least once per week. In North Lanarkshire, 38% of S1-4 pupils indicated that they had ever had a proper alcoholic drink (12% in S1 rising to 66% in S4). Fifteen percent of S4 pupils said they drank alcohol at least once per week. There was a clear association in both areas between drinking and mental wellbeing.

Overall, 8% of South Lanarkshire pupils (S1-4) indicated that they had ever taken illegal drugs (9% in North Lanarkshire). This figure increased with age from 2% in

[9] ISD Scotland. Body Mass Index of Primary 1 Children in Scotland 2016/17. http://www.isdscotland.org/index.asp

[10] Scottish Public Health Observatory. Children and Young People Profiles. http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool

S1 to 16% in S4 in South Lanarkshire, and from 2% in S1 to 18% in S4 in North Lanarkshire.

In South Lanarkshire in 2015/16, 67% of secondary school pupils (S1-4) were categorised as being close to average in relation to total difficulties on the Strengths and Difficulties Questionnaire (SDQ). Twenty-one percent of pupils had a raised (high or very high) total difficulties score; emotional symptoms being the most commonly reported difficulty. Sixty-four percent of pupils were categorised as being close to average in relation to prosocial behaviour; 22% had low or very low scores.

In North Lanarkshire in 2017, 69% of secondary school pupils (S1-4) were categorised as being close to average in relation to total difficulties on the Strengths and Difficulties Questionnaire (SDQ). Eighteen percent of pupils had a raised (high or very high) total difficulties score; emotional symptoms being the most commonly reported difficulty. Sixty-one percent of pupils were categorised as being close to average in relation to prosocial behaviour; 24% had low or very low scores.

In both areas, older pupils were more likely to have a raised total difficulties score. Girls were more likely than boys to have raised scores, particularly for emotional symptoms. Boys were more likely to have raised scores for conduct problems.[11]

In the period 2012-2016, the rate of death from suicide (in 11-25 year olds) was 8.4/100,000 in North Lanarkshire (n=5) and 7.5/100,000 in South Lanarkshire (n=4). The Scotland rate was 8.3/100,000.[12]

10.7 Transitions

No specific data is available in relation to transition from paediatric to adult services. Work has been initiated in Rheumatology services to assess the benefits of using the Ready Steady Go programme for transition. The development of a transition pathway for young people who are invasively ventilated at home is also underway.

10.8 Health services

In 2016, 91.8% of children (<18 years) were registered with the NHS General Dental Service (94.1% in Scotland). Of those registered, 86.2% of Lanarkshire children participated in the NHS General Dental Service over a 2-year period (84.9% in Scotland)

Uptake of the MMR vaccine (in 2017) at 24 months and 5 years was 96.0% and 94.6% respectively in North Lanarkshire and 96.3% and 96.0% respectively in South

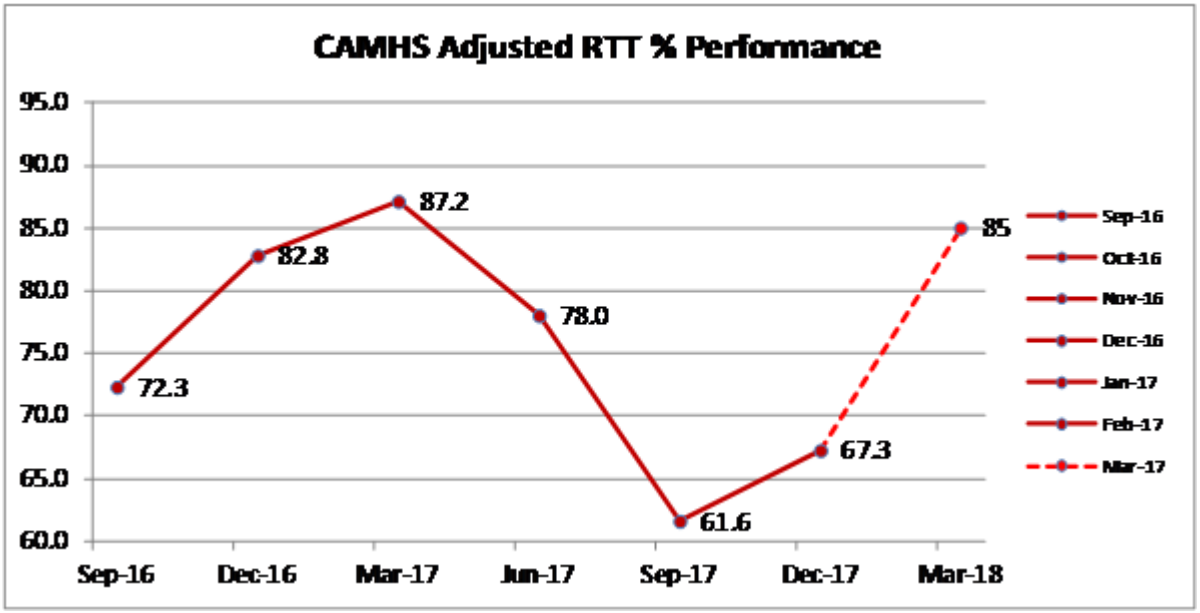
[11] Scottish Government. Realigning Children's Services programme data.
[12] Scottish Public Health Observatory. Children and Young People Profiles. http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool

Lanarkshire. Uptake of the HPV vaccine in S3 girls in 2015 was 88.6% in North Lanarkshire and 91.9% in South Lanarkshire (88.1% in Scotland).

In the three-year period 2014/15-2016/17, the rate of children (aged 0-15 years) admitted to hospital due to asthma in North Lanarkshire was 233.0/100,000 (n=150). This is statistically significantly worse than the Scotland average of 160.3/100,000. In South Lanarkshire, 177.0/100,000 (n=99) children were admitted to hospital due to asthma.[12]

At March 2018, 85% of referrals to CAMHS were seen within 18 weeks (against a standard of 90%). Performance has varied over time as can be seen in the Figure 4 below. CAMHS in Lanarkshire has 6% lower performance than the national average (with a 20% less staffing investment). Referral to CAMHS has doubled in the last six years.

Figure 4: CAMHS Referral to Treatment Performance September 2016-March 2018



10.9 Data and quality

In the period 2016/17, there were 6,784 live births. First Visit reviews were undertaken for 6,778 children (99.9% of live births). Of the First Visit reviews undertaken, 98.4% had valid infant feeding data recorded. At 6-8 weeks, 6,460 reviews were undertaken (95.2% of live births). Of these reviews, 90.4% had valid infant feeding data recorded.

A health 'surveillance form' was introduced for completion during CEL16 health needs assessments for Looked After children and young people, to establish baseline data on the health status of those who are Looked After. The health

surveillance forms have been completed for 29% of CEL16 health needs assessments in South Lanarkshire and 9% in North Lanarkshire.

11. WHERE DO WE WANT TO BE?

11.1 Overarching aims

We aim to:

- Improve health and wellbeing outcomes for all children and young people by supporting them to adopt healthier lifestyles and by continually improving our service provision.
- Provide better outcomes and experiences for children and young people with chronic conditions and complex additional support needs.
- Build solutions with and around children, young people and their families to ensure children and young people are central to decisions that affect their health and wellbeing.
- Ensure the rights of individual children and young people are respected and promoted across the protected characteristics, including, disability, race, religion and sexual orientation.
- Focus on reducing health inequalities through prevention and targeted early intervention, ensuring children have access to the help they need when they need it.
- Improve health outcomes and reduce health inequalities by working closely with our partners in a collaborative way, ensuring children and families are at the centre of everything we do.

11.2 Expected outcomes

Linked to National Outcomes and SHANARRI indicators, we have set out the outcomes we want to achieve and an improvement plan setting out how we will achieve them. These have been informed by:

- Collating and analysing data on the health and wellbeing of our children and young people
- Reporting on progress with previous improvement plans, including risks and challenges
- Engagement with children and young people through individual services and partnership activities.

In 2018-20 our expected outcomes are:

1. Unmet need is identified and addressed to ensure improved outcomes for looked after children and young people
2. The stretch aims of the CYP Improvement Collaborative are achieved through early intervention and targeting of services
3. The health and wellbeing of children and young people is improved
4. CYP experience smooth and efficient transition between paediatric and adult services
5. Health services are person-centred, safe and effective
6. Data systems support the identification of need and risks in vulnerable populations and allow monitoring of improvement
7. CYP and families are actively involved in the planning and provision of health services
8. Health services have an active role in preventing and mitigating the effects of child poverty
9. The wider workforce understands the impact of Adverse Childhood Experiences (ACEs) on child and adult wellbeing

12. ALIGNED WORKSTREAMS

There are a number of services and workstreams which relate to the health and wellbeing of children and young people which are not specifically mentioned in the improvement plan. These important areas of work are key contributors to expected outcomes and support the achievement of our overarching aims. These pieces of work thread through the Children and Young People's Health Plan to the Integrated Children's Services Plans and Local Outcome Improvement Plans, and are being progressed and governed through various boards and steering groups e.g. childhood immunisations, pregnancy and newborn screening and pre-school vision screening programmes, the Dental Action Plan, Lanarkshire Additional Midwifery Service and work to prevent teenage pregnancy.

NHS Lanarkshire child protection services work in partnership across agencies to safeguard children and young people. The child protection team provide advice, supervision and training to staff working with children and families, participate in the Initial Referral Discussion (IRD) process, and support organisational policy and practice. The child protection work plan has an established governance process via Child Protection Committees and the NHS Lanarkshire Public Protection Group. Links will be made between the children protection work plan and the Children and Young People's Health Plan as required.

13. PERFORMANCE MONITORING

In order to ensure that the Children and Young People's Health Plan is being implemented and that outcomes are being achieved, it is imperative that we monitor progress and operational delivery. We also need to ensure that there is an amount of flexibility within our strategic planning and that adjustments can be made as circumstances change throughout the life of the document.

The key performance indicators detailed in the improvement plan will be used to report progress on implementation of the Plan. These will be reviewed by the Child Health Services Improvement and Planning Group with exception reporting to the Child Health Commissioner's Steering Group. A reporting template is in place to monitor progress of the actions required. A Maternal and Child Health Dashboard is under development to track the performance, over time, of a range of key maternal and child health outcomes as implementation of the Plan progresses.

14. COMMUNICATION

The Children and Young People's Health Plan 2018-2020 will be disseminated widely to NHS and Health and Social Care staff, independent contractors, relevant staff in partner agencies and children, young people and families (via existing partnership structures).

This will be supported by focused discussion about key outcomes at local forums and professional meetings by members of the Child Health Services Improvement and Planning Group.

15. IMPROVEMENT PLAN

Outcome 1: Unmet need is identified and addressed to ensure improved outcomes for looked after children and young people				
	What will we do?	**Timeframe**	**ARCI**	**Key performance indicator**
1.1	Ensure timely notification to NHSL of children and young people (CYP) becoming Looked After and ensure health assessments are completed within 4 weeks of notification.	March 2020	A: Executive Director NMAHPs R: Associate Nurse Directors/Chief Social Workers NL/SL C: CHCSG I: Children's Services Partnerships NL/SL	• 100% of Social Work notifications are received by NHSL within 5 days of a child or young person becoming Looked After by March 2019. • 100% of CEL16 health assessments are completed within 4 weeks of notification by March 2019. • The above targets are maintained by 2020.
1.2	Analyse data on Looked After CYP receiving a health assessment and report on the key health issues.	March 2020	A: Executive Director NMAHPs R: Child Health Commissioner/Head of Assurance C: CHCSG I: Children's Services Partnerships NL/SL	• Baseline data is reported by September 2018 (pre-five and school-age). • Action plan on two areas for improvement developed by March 2019. • Delivery of action plan and further two areas for improvement developed by March

				2020.
1.3	North Lanarkshire Looked After CYP health needs assessment report used to inform action plans above (1.2).	March 2020	A: Interim Director of Public Health R: Assistant Health Promotion Manager C: CHCSG I: NL Corporate Parenting Group	• As above.

Outcome 2: The stretch aims of the CYP Improvement Collaborative are achieved through early intervention and targeting of services				
	What will we do?	**Timeframe**	**ARCI**	**Key performance indicator**
2.1	Based on the outcome of national work, develop and implement local actions to improve preconception health and care.	March 2020	A: Interim Director of Public Health R: Public Health Specialist C: Preconception Health and Care working group I: CHCSG	• Local action plan in place by September 2018.
2.2	Implement improvement actions relating to the prevention, identification, diagnosis and on-going support for foetal alcohol spectrum disorder (FASD).	March 2019	A: Interim Director of Public Health R: Public Health Specialist (FASD) C: FASD Steering Group/ADP I: CHCSG	• Agree a set of indicators to measure success by June 2018. • Delivery of action plan by March 2019. • Ensure links to neurodevelopmental pathway (5.4).
2.3	Ensure the development of the Perinatal Mental Health Service to enable the early identification of symptomatic women or those at high risk of mental health problems in the preconception, antenatal and postnatal periods.	March 2020	A: Senior Nurse, Mental Health R: Senior Charge Nurse, Perinatal Mental Health Service C: Adult Mental Health Clinical Quality Group I: CHCSG	• 95% of the Quality Network for Perinatal Mental Health Services Community Standards is achieved by March 2020.
2.4	Implement recommendations from the evaluation of the Healthy Lifestyle in Pregnancy Service to increase referrals to and engagement with the service.	March 2020	A: Health Promotion Manager R: Public Health Nutritionist C: Maternal and Infant	• 40% of eligible women (BMI of 30 or more) are referred to the Healthy Lifestyle in Pregnancy Service by March 2019.

			Nutrition Steering Group I: CHCSG	• 30% of those referred engage with the service (opt-in) by March 2019, increasing to 35% by March 2020.
2.5	Implement the breastfeeding improvement programme.	March 2020	A: Executive Director NMAHPs R: Infant Feeding Lead/Public Health Nutritionist C: Maternal and Infant Nutrition Steering Group I: CHCSG	• Maintain breastfeeding initiation rate of 48% by March 2019. • Reduce attrition rate between first visit and 6-8 weeks to 18% by March 2019.
2.6	Undertake improvement work to identify effective early language interventions for children identified at risk following 27-30 month review to support the achievement of expected developmental milestones by 4-5 year review.	March 2020	A: Director of AHPs R: Speech and Language Therapy Manager/Associate Nurse Directors NL/SL C: CYPIC I: CHCSG/Children's Services Partnerships NL/SL	• Universal and targeted early language interventions will have been tested and effective approaches identified for local use. • SLT pathway linked to universal pathway will be agreed and completed. • Reduced number of children requiring access to specialist level SLT services.
2.7	Improve uptake, timing and quality of child health reviews at First Visit, 6-8 weeks, 13-15 months and 27-30 months.	March 2019	A: Nurse Directors NL/SL R: Public Health Specialist/Associate Nurse Directors NL/SL	• 98% of children have a completed First Visit review by March 2019. • 95% of children have a completed 6-8 week

			C: Child Health Surveillance Task and Finish Group I: CHCSG	review and 90% are completed by 10 weeks of age by March 2019. • 95% of children have a completed 13-15 month review by 18 months of age by March 2019. • 95% of children have a completed 27-30 month review by 32 months by March 2019. • Data to assess completeness of reviews is collated by September 2018 and a plan for improvement is developed by March 2019.
2.8	Implement the universal 4-5 year child health review.	March 2020	A: Nurse Directors NL/SL R: Associate Nurse Directors NL/SL C: Health Visiting Pathway Implementation Group I: CHCSG	• Progress report on implementation by March 2019. • Full implementation by August 2019. • 95% of children have a completed 4-5 year review by 5.5 years by March 2020.
2.9	Ensure anticipatory measures and interventions are in place to support children to achieve their expected developmental milestones.	March 2020	A: Nurse Directors NL/SL R: Associate Nurse Directors NL/SL C: Health Visiting	• 85% of all children within each SIMD quintile reach all of their developmental milestones at 27-30

			Pathway Implementation Group/CYPIC I: CHCSG	months by March 2019. • 85% of all children within each SIMD quintile reach all of their developmental milestones at 13-15 months by March 2020
2.10	Increase the proportion of pregnant smokers referred to the Specialist Stop Smoking Service and Pharmacy from the most deprived areas who uptake cessation support (set a quit date) and stop smoking (at 12 weeks).	March 2020	A: Assistant Health Promotion Manager R: Stop Smoking Service Manager C: MQIC Cessation Advisory Group/ Pregnancy Working Group I: Tobacco Control Strategy Group	• 58 pregnant women in SIMD 1 and 2 who have set a quit date between April 2018 and March 2019 and are not smoking at 12 weeks by March 2019. • 59 pregnant women in SIMD 1 and 2 who have set a quit date between April 2019 and March 2020 and are not smoking at 12 weeks by March 2020. • A target of 28% conversion rate for quit dates set versus 12 week quits for pregnant women in SIMD 1 and 2 where the quit date set is between April 2018 and March 2019. • A target of 30% conversion rate for quit dates set versus 12

				week quits for pregnant women in SIMD 1 and 2 where the quit date set is between April 2019 and March 2020. • Increase the % of pregnant women not smoking at 34-38 weeks gestation.
2.11	Reduce the number of children exposed to second hand smoke at 27-30 months.	March 2020	A: Assistant Health Promotion Manager R: Smoking Prevention and Education Manager C: Children's Services Partnerships NL/SL I:	• % of children exposed to second hand smoke at 27-30 months is reduced to 8% by March 2019 and 7% by March 2020.

Outcome 3: The health and wellbeing of children and young people is improved				
	What will we do?	**Timeframe**	**ARCI**	**Key performance indicator**
3.1	Provide training and CPD opportunities to 80 additional nursery and primary school teachers each academic year to support implementation of the Healthy Schools approach.	March 2020	A: Health Promotion Manager R: Child and Adult Healthy Weight Manager C: LHWSG I: Children's Services Partnerships NL/SL	• The Healthy Schools approach is used within 60% of nursery and primary schools in North Lanarkshire and 30% of nurseries and primary schools in South Lanarkshire.
3.2	Provide targeted 'Healthy Children' or 'Mini Movers' health and wellbeing groups for nursery aged children in each locality in North and South Lanarkshire. Provide open access universal 'Healthy Families' health and wellbeing groups for lower primary school aged children and a parent/carer in each locality in North and South Lanarkshire.	March 2020	A: Health Promotion Manager R: Child and Adult Healthy Weight Manager C: LHWSG I: Children's Services Partnerships NL/SL	• An average of 16 CHW groups (combination of Healthy Children or Mini Movers & Healthy Families groups) will be available across Lanarkshire throughout the academic year. • A minimum of 1 group will be available throughout the academic year in every locality in North and South Lanarkshire.
3.3	Ensure that Health Visitors are aware that Healthy Families flyers should be given out to every family (regardless of child weight status) following a completed 27-30 month health review or P1 health surveillance appointment.	March 2020	A: Health Promotion Manager R: Child and Adult Healthy Weight Manager C: LHWSG I: Children's Services Partnerships NL/SL	• Every Health Visiting team receives an annual briefing on the CHW RFA Care Pathway and associated community-based CHW services.

3.4	Support people working in education and youth settings to have a wide range of skills, knowledge and confidence regarding tobacco prevention and protection education.	March 2020	A: Assistant Health Promotion Manager R: Smoking Prevention and Education Manager C: Tobacco Control Implementation Group I: Children's Services Partnerships NL/SL	• Baseline data established by March 2019. • Action areas for improvement by March 2020.
3.5	Identify further preventive action in relation to alcohol use in young people, including responsibilities for delivery and performance monitoring.	March 2020	A: R: C: I:	• To be agreed.
3.6	Deliver on local Incredible Years implementation plans.	March 2019	A: Chief Social Workers NL/SL R: Health Improvement Manager for CYP/ CAMHS Clinical Team Manager Early Intervention C: Children's Services Partnerships NL/SL I: CHCSG	• % completion of Incredible Years programmes. • Establish baseline % of children with an improvement in their behavioural difficulties (SDQ scores) by August 2018.
3.7	Scope the range of mental health and wellbeing resources for young people in Lanarkshire with a view to bringing together under one "umbrella/brand" for ease of access and referral. The intention is to develop a similar resource to Well Connected.	March 2019	A: Service Manager Paediatrics and CAMHS R: Assistant Health Promotion Manager/CAMHS Clinical Team Manager Early Intervention C: Good Mental Health for All Steering Group	• Establishment of multi-agency group to lead the work. • Scoping of existing mental health and wellbeing resources and areas for development. • Establishment of a

			I: Children's Services Partnerships	single "brand" and promotion of available support.

Outcome 4: CYP experience smooth and efficient transition between paediatric and adults services				
	What will we do?	**Timeframe**	**ARCI**	**Key performance indicator**
4.1	In line with Principles of Good Transition 3, ensure service specific pathways are in place to allow smooth and effective transition between paediatric and adult services in the following specialty areas: • Diabetes • Asthma • Neurodisability (inc. Epilepsy) • Rheumatology • Gastroenterology	March 2020	A: Chief Accountable Officers NL/SL R: Associate Medical Director Primary Care C: Transition Subgroup I: CHCSG	• Agree a set of pathways in each of the specified areas of the plan and operationalize by March 2019. • Ensure maintenance by March 2020.
4.2	Develop work to manage the transition of children with complex healthcare needs and life limiting conditions.	March 2020	A: Chief Accountable Officers NL/SL R: Associate Medical Director Primary Care C: Transition Subgroup I: CHCSG	• Transition pathway in place for long term invasively ventilated young people by March 2019. • Learning from long term ventilation work developed into other areas by March 2020.

Outcome 5: Health services are person-centred, safe and effective				
	What will we do?	**Timeframe**	**ARCI**	**Key performance indicator**
5.1	Ensure delivery of the operative parts of the Children and Young People (Scotland) Act 2014, focussing on practice change across services. Implement Parts 4 and 5 of the Act following approval of revised legislation and guidance.	March 2019	A:Executive Director NMAHPs R: General Manager Paediatrics and CAMHS /Senior Nurse C: CYP Act Implementation Group/Child Health Commissioner/Information Governance Committee I:CHCSG	• CYP Act action plan delivered by March 2019. • Develop action plan for Parts 4 and 5 of the CYP Act (to include Information Governance) by March 2020 (or when available).
5.2	Improve local systems for reviewing and sharing learning from childhood deaths by implementing recommendations from the national Child Death Steering Group and agreeing a WoS approach.	March 2019	A: Executive Director NMAHPs R: General Manager Paediatrics and CAMHS /Public Health Specialist C: Clinical Leads Paediatrics and EDs I: CHCSG	• All child deaths in Lanarkshire are reviewed as per local policy.
5.3	Develop and implement a DNA policy for services working with children and young people.	March 2019	A: Executive Director NMAHPs R: Director of AHPs/General Manager Paediatrics and CAMHS C: Relevant service leads/staff groups I: CHCSG	• DNA policy implemented by March 2019. • DNA rates monitored by the Capacity Planning and Waiting Times Group (baseline data required).
5.4	Develop a neurodevelopmental pathway to support the assessment and diagnosis	March 2020	A: R: Clinical Director	• Pathway developed. • New models of working

	of a range of neurodevelopmental disorders, including, ASD, ADHD and FASD.		CAMHS C: Clinical Director Paediatrics/Director of AHPs I:CHCSG	tested. • Change management programme in place.

Outcome 6: Data systems support the identification of need and risks in vulnerable populations and allow monitoring of improvement				
	What will we do?	**Timeframe**	**ARCI**	**Key performance indicator**
6.1	Utilise information on the health and wellbeing of CYP to deliver effective joint strategic commissioning through the Realigning Children's Services (RCS) programme.	March 2019	A: NL/SL Children's Services Partnerships R: Public Health Specialist C: NL/SL RCS Task and Finish Groups I: CHCSG	• Action plans developed on key priorities in NL by March 2019. • Action plans developed in SL on CYP Looked After at home and young women's mental health by March 2019.
6.2	Develop a maternal and child health dashboard to monitor performance and outcomes.	June 2018	A: Associate Medical Director R: Public Health Specialist/Head of Assurance C: CHSIPG members I: CHCSG	• Dashboard in place and refreshed quarterly. • Link to Integrated Children's Services Plans NL/SL.
6.3	Ensure all data collected and reported on children and young people are of high quality.	March 2020	A: Nurse Directors NL/SL R: Associate Nurse Directors NL/SL C: Public Health Specialist/Associate Medical Director I: CHCSG	• Completeness and return of CHS forms (baseline data required). • Completeness and return of LAC health forms (baseline data required). • Ensure application of General Data Protection Regulations.
6.4	Ensure accurate completion and return of	March 2020	A: Assistant Health	• Establish baseline data

	the Mandatory Data Set (MDS) for tobacco control onto the ISD database.		Promotion Manager R: Stop Smoking Service Manager C: Tobacco Control Monitoring, Improvement and Evaluation Group I: Tobacco Control Strategy Group	by March 2019. • Action areas for improvement by March 2020.

Outcome 7: CYP and families are actively involved in the planning and provision of health services				
	What will we do?	**Timeframe**	**ARCI**	**Key performance indicator**
7.1	Evidence the involvement of children and young people in service planning and development, using appropriate methods of engagement.	March 2019	A: Child Health Commissioner R: CHSIPG members C: Service users, children and families, professional groups. I: CHCSG	• Collation and reporting of all engagement activity by March 2019. • Link to Community/Public Engagement Mapping.
7.2	Explore the involvement of young people in the NHS Lanarkshire Public Reference Forum.	March 2019	A: Executive Director NMAHPs R: Public Health Specialist/Programme Manager for Person-Centred Care C: Child Health Commissioner I: CHCSG	• Young people participating in quarterly forum meetings.

Outcome 8: Health services have an active role in preventing and mitigating the effects of child poverty				
	What will we do?	**Timeframe**	**ARCI**	**Key performance indicator**
8.1	Increase Healthy Start Scheme registration and uptake of Healthy Start vitamins across Lanarkshire.	March 2019	A: Health Promotion Manager R: Public Health Nutritionist C: Maternal and Infant Nutrition Steering Group I: CHCSG	• Healthy Start Scheme registration is increased from 70% to 75%. • 30% of eligible children in Lanarkshire receive Healthy Start vitamins.
8.2	Ensure that financial inclusion is discussed with all women who book for pregnancy and referral made when appropriate.	March 2020	A: Head of Midwifery R: Senior Midwife Community and Outpatients C: Financial Inclusion Groups I: Children's Services Partnerships NL/SL	• 80% of women are asked about money worries by their midwife at the booking appointment by March 2019, increasing to 95% by March 2020. • 70% (median) of women referred to the South Lanarkshire Telephone Advice Line (TAL) engage with the service by March 2020. • Pilot TAL established in North Lanarkshire by March 2019.
8.3	Routine Enquiry on financial wellbeing is undertaken from health visitor First Visit to 6-8 week child health review.	March 2019	A: Associate Nurse Director SL/NL R: Senior Nurses SL/NL C: Improvement Co-ordinator CYPIC/Financial	• 80% of Routine Enquiry is raised before or at the 6 week assessment by March 2019, increasing to 95% by March 2020.

			Inclusion Groups I: Children's Services Partnerships NL/SL	• 70% of families referred to the South Lanarkshire TAL engage with the service by March 2020. • Baseline established for engagement with money advice services in North Lanarkshire by March 2019.
8.4	Develop systems and processes to ensure that financial inclusion is discussed with, and information given by, stop smoking service staff, to all pregnant clients and clients with whom a child lives in their home.	March 2020	A: Assistant Health Promotion Manager R: Stop Smoking Service Manager C: North Financial Inclusion Group, Tobacco and Pregnancy Steering Group I: Children's Services Partnerships NL/SL	• Systems and processes established by March 2019. • Baseline data and tests of change established by March 2020 for: • % of pregnant clients and clients with whom a child lives in their home referred to the financial inclusion service by stop smoking service staff. • % of pregnant clients and clients with whom a child lives in their home referred to the service who then engages with it.

Outcome 9: The wider workforce understands the impact of Adverse Childhood Experiences (ACEs) on child and adult wellbeing				
	What will we do?	**Timeframe**	**ARCI**	**Key performance indicator**
9.1	Continue to deliver Solihull training as an approach to understanding the importance of high quality parent/child relationship.	March 2019	A: Health Promotion Manager R: Senior Health Promotion Officer Early Years C: Parenting Strategy Group I: Children's Services Partnerships NL/SL	• Development of trainers/advanced trainers to deliver programme by March 2019. • Maintenance of staff groups previously trained by March 2019. • Deliver, in partnership, training courses for identified staff in North and South Lanarkshire by March 2019.
9.2	Implement actions to mitigate the impact of ACEs.	March 2020	A: Interim Director of Public Health R: Senior Health Promotion Officer Early Years/Strategic Lead SL ADP C: Locality Health Improvement Leads/Public Health Specialist I: Children's Services Partnerships NL/SL	• Number of Resilience documentary viewings. • Locality action plans in place. • Trauma training framework requirements considered. • Actions to address ACEs in respective Children's Services Plans and LOIPs.
9.3	Identify and meet the health needs of children and young people experiencing or at risk of homelessness.	March 2020	A: Health Promotion Manager/Assistant Health Promotion	• Complete Health Needs Assessment for CYP experiencing

			Manager R: Senior Health Promotion Officer C: Health and Homelessness Steering Groups for North and South HSCP I: Children's Services Partnerships NL/SL	homelessness, outline recommendations and develop action plan to meet those needs. • Number and percentage of children affected by homelessness that have a wellbeing assessment completed with key housing/homelessness indicators included. • Agreement that homelessness is a 'significant event' between Housing/Homelessness services, Education and Health and other relevant agencies. • Midwives, health visitors and education staff understand the impact of homelessness on CYP.

A: accountable; R: responsible; C: consulted; I: informed.

Key
CHSIPG: Child Health Services Improvement and Planning Group
CHCSG: Child Health Commissioner's Steering Group
CYPIC: Children and Young People Improvement Collaborative

LHWSG: Lanarkshire Healthy Weight Strategy Group