Children and Young People's Health Plan, Lanarkshire 2021-2023

Executive summary

The Children and Young People's Health Plan is a collaborative document that provides a central driving point to improve health and health services for children and young people across NHS Lanarkshire and both North and South Lanarkshire Health and Social Care Partnerships (HSCPs).

Our vision is to support and enable infants, children, young people and families to achieve the best health outcomes and realise their full potential.

Child poverty rates are high in Lanarkshire. The inequalities that existed prior to the COVID-19 pandemic will have been exacerbated by the pandemic, both by COVID-19 itself and by the measures put in place to control the virus' spread. NHS Lanarkshire and the North and South HSCPs have (and continue to) achieve great feats during this period, but resources are finite and so existing services have been impacted, and planned improvements delayed. However, the opportunity is being taken to learn from what has been achieved, to influence and improve services as they recover and/or are redesigned going forwards.

Therefore, within the Children and Young People's Health Plan we have set out 10 outcomes we want to focus on between 2021 and 2023 and an improvement plan setting out the actions we want to deliver on in relation to those outcomes.

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1.1	21/7/2021	After submission to Child Health Commissioner Group. A couple of data points updated including child poverty levels. Changing 'Looked after' terminology to 'care experienced' in light of 'the Promise' findings
1.2	27/08/2021	After submission to Lanarkshire NHS Board. Linked recommendations from the data (Page 27) to outcomes and actions contained within the Improvement Plan.

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Acronym list

ABI – Alcohol Brief Intervention
ACEs – Adverse Childhood Experiences
ADP – Alcohol and Drug Partnership
ADHD – Attention Deficit Hyperactivity Disorder
ASD – Autism Spectrum Disorder
ASQ-SE – Ages and Stages Questionnaire Social Emotional
BAAF – British Association for Adoption and Fostering
BMI – Body Mass Index
BPS – British Psychological Society
CAMHS – Child and Adolescent Mental Health Service
CECYP – Care Experienced Children and Young People
CEL – Chief Executives Letter
CHCSG – Child Health Commissioner Steering Group
CHS – Child Health Surveillance
CHW – Child Healthy Weight
CRWBIA – Children's Rights and Wellbeing Impact Assessment
CSP Board – Children's Services Partnership Board
CYP – Children and Young People
CYPIC – Children and Young People Improvement Collaborative
DNA/WNB – Did Not Attend/Was Not Brought
DPA – Data Protection Act
DWP – Department for Work and Pensions
FASD – Foetal Alcohol Spectrum Disorder
GIRFEC –Getting it Right for Every Child
GIRSLC – Getting it Right for South Lanarkshire's Children Strategy Group
GP – General Practitioner
HMRC – Her Majesty's Revenue and Customs
HNA – Health Needs Assessment
HPV – Human Papillomavirus
HSCP – Health and Social Care Partnership
IMH – Infant Mental Health
LGBTI – Lesbian, Gay, Bisexual, Transgender, Intersex
LHWSG – Lanarkshire Healthy Weight Strategy Group
LTV – Long Term Ventilated
MCHAT – Modified Checklist for Autism in Toddlers
MCN – Managed Clinical Network
MHWB – Mental Health and Well Being
MMR – Measles Mumps and Rubella
NHSL CMT – NHS Lanarkshire Corporate Management Team
NL – North Lanarkshire
NL ICSG – North Lanarkshire Improving Children's Services Group
PNIMH – Peri-natal Infant Mental Health
PR – Public Relations
RCS – Realigning Children's Services
SDQ – Strengths and Difficulties Questionnaire
SG – Scottish Government
SHANARRI – Safe, Healthy, Active, Nurtured, Achieving, Respected, Responsible, Included
SLT – Speech and Language Therapy
SIMD – Scottish Index of Multiple Deprivation
SL – South Lanarkshire
SRH – Sexual and Reproductive Health
UNCRC – United Nations Convention on the Rights of the Child
UNICEF – United Nations International Children's Emergency Fund

1. Introduction

Welcome to the Children and Young People's Health Plan. Within the document you can find: why the plan is needed; who it is for; our vision; the policy context; our governance structures; how children, young people and families have been engaged with; where we are now; how we will performance manage the action plan; and the improvement (action) plan. We have also provided a summary of evidence in relation to the impacts of COVID-19 on children and young people in the appendices.

2. Why do we need a children and young people's health plan?

The children and young people's health plan 2021-2023 is a collaborative document. It builds on the progress and achievements of previous plans 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 Lanarkshire HSCPs.

This time period, 2021 to 2023 is particularly important as we continue to combat the COVID-19 pandemic and how we recover from its impacts, and the impacts of the restrictions put in place to manage the pandemic.

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. 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 children and young people's health plan allows us to:

- Develop outcomes-focused plans based on needs assessment and evidenced-based practice.
- Set out where we are now and where we aspire to be, allow many aspects of children and young people's health and health services to be co-ordinated and performance managed from a single point.
- Present our contribution to and links with integrated children's services plans.
- Involve stakeholders in identifying priorities for action, improvement and service development.

3. Who is the plan for?

The children and young people's health plan 2021-2023 has been developed to benefit all Lanarkshire residents at any point from pre-conception, to infants, children young people and families, and the staff members who work with them.

The plan covers improvements related to.

This includes:

- Parents and prospective parents before, during and after pregnancy.
- Infants, children and young people from birth to 18 years (26 years for care leavers).
- Carers and families.
- NHS Lanarkshire and North and South Lanarkshire HSCP staff and independent contractors providing services to children, young people and families (including paediatric and adult services).
- Partner agencies providing services for children, young people and families.

4. Our vision

Our vision is to:
Support and enable infants, children, young people and families to achieve the best health outcomes and realise their full potential.

We will achieve our vision by:

- Improving health and wellbeing outcomes for all infants, children and young people by supporting them to adopt healthier lifestyles and by continually improving our service provision.
- Focusing on reducing health inequalities through prevention and targeted early intervention, ensuring infants, children and young people have access to the help they need when they need it.
- Recognise the impacts of the COVID-19 pandemic and work to reduce the inequalities that it has further exacerbated.
- Providing better outcomes and experiences for infants, children and young people with chronic conditions and complex additional support needs.
- Taking a trauma-informed approach to practice and services, ensuring we recognise, understand and are responsive to trauma and how it can impact on future outcomes.
- Building solutions with and around infants, children, young people and their families to ensure they are central to decisions that affect their health and wellbeing.

- Working closely with our partners in a collaborative way, ensuring infants, children, young people and families are at the centre of everything we do.
- Ensuring the rights of individual infants, children and young people are recognised, respected and promoted.
- Ensuring equality in all that we do, regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, or sexual orientation.
- Developing a capable and confident workforce through training, supervision and integrated working.

5. Principles that influence our work

Core principles that influence our work are reducing inequalities and ensuring the rights of children.

Tackling inequalities

Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups (NHS Health Scotland). Health inequalities are socially determined and fundamentally caused by the unequal distribution of income, wealth, and power. This subsequently influences the wider determinants of health, such as, poverty and low income, work, education, living conditions and access to services.

COVID-19 and in particular the infection control measures, including lockdown, have had a profound impact on infants, children, young people and families in Scotland. A summary of the wider impact of the COVID-19 pandemic on the health and wellbeing of children and young people across Scotland is included at Appendix 1-3. The content of these will inform our improvement plans.

Socioeconomically driven inequalities can increase the chances of children experiencing adversity in childhood, impacting negatively on health and wellbeing, attainment and life chances. A collaborative approach is required across community planning partners and communities to develop services which 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 to break the cycle of poor outcomes for children and families.

Innovative and creative responses were established to continue to support children and families throughout the pandemic and mitigate the negative impact the virus has caused. The children and young people's health plan will build on this work and so that all children, young people and families are supported, proportionate to their level

of need. In doing so, it will also ensure that where necessary, services are targeted towards those with the greatest level of need.

Children's rights

The United Nations Convention on the Rights of the Child (UNCRC) is an international human rights treaty that grants all children and young people a comprehensive set of rights. The Scottish Government's vision is a Scotland where children's human rights are embedded in all aspects of society – where policy, law and decision making takes account of children's rights and where all children have a voice and are empowered to be human rights defenders.

Whilst all articles in the convention have equal importance, four articles underpin the convention:

- Article 2 – Non-discrimination
- Article 3 – Best interest of the child
- Article 6 – Right to life, survival and development
- Article 12 – Right to be heard

NHS Lanarkshire and North and South Lanarkshire Health and Social Care Partnerships (HSCPs) will ensure that children's rights are recognised, respected and promoted through the design and delivery of policies, plans 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.

6. Policy context and planning landscape

The children and young people health plan has been developed in the context of legislation, national and local policy.

The Scottish Government National Performance Framework sets out the vision for Scotland and how everyone can work together to achieve the National Outcomes. '*We grow up loved, safe and respected so that we realise our full potential'* is the National Outcome for children and young people. This is inextricably linked to other National Outcomes on poverty, human rights, health, education and communities.

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

A range of legislation in Scotland safeguards and promotes the health, wellbeing and rights of children and young people. This includes the Children and Young People (Scotland) Act 2014 and the Child Poverty (Scotland) Act 2017.

Our work is supported by a range national strategies, plans and emerging programmes, including, the National Trauma Training Framework, *Transforming Psychological Trauma*, findings from the Independent Care Review and the Child Protection Improvement Programme.

Locally, the children and young people's health plan is developed in the context of a range of plans, including:

- *Achieving Excellence* Healthcare Strategy
- HSCP Strategic Commissioning Plans
- NHS Lanarkshire Annual Operating Plan
- Lanarkshire Mental Health and Wellbeing Strategy
- North and South Lanarkshire Integrated Children's Services Plans
- North and South Lanarkshire Corporate Parenting Plans
- North and South Lanarkshire Child Poverty Action Reports

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

In addition to the challenges posed by COVID-19, we also consider other recent drivers, including the Independent Care Review and the resulting Promise to keep children with their families where it is safe to do so and value the importance of relationships with families.

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.

North and South Lanarkshire Community Plans 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 and associated planning structures are in place. These plans set out the actions we will take *in partnership* to improve outcomes for children, young people and families. The children and young people's health plan makes a significant contribution to this agenda.

The Quality Framework for children and young people in need of care and protection (2019) is for community planning partnerships to support self-evaluation of services for these children and young people. A process of joint inspection of such services exists to look at the difference they are making to the lives of the children, young people and their families. It is designed to lead to improvement. Inspections continue to focus on prevention and early intervention, accurate assessment of risk and need, and effective planning and review.

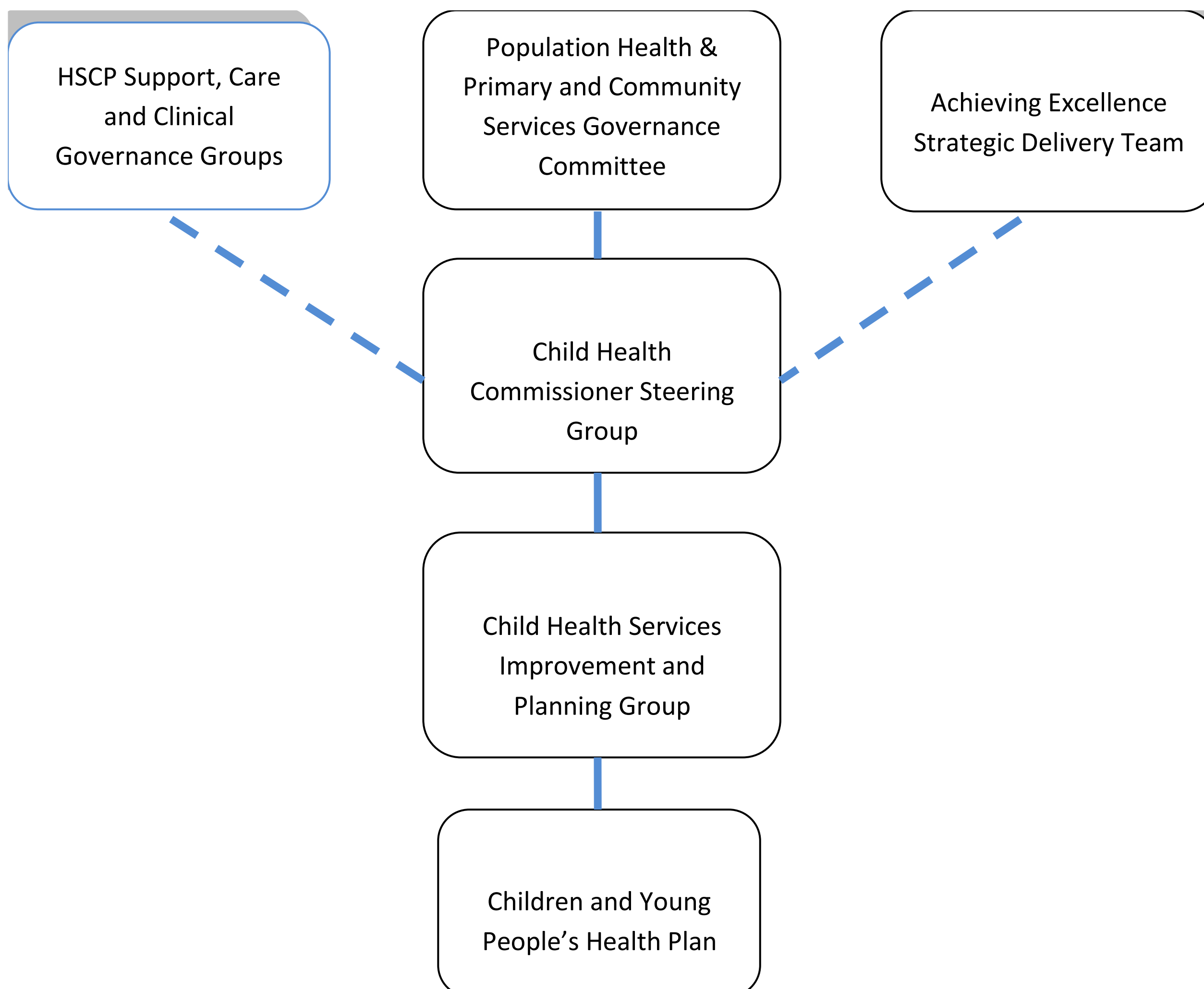
Findings from self-evaluation processes and inspections are used to inform improvement actions within the children and young people's health plan, specifically in relation to children in need of care and protection.

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 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 risks or challenges.

Figure 1: Governance Structure



8. Involving children, young people and families

We are committed to working with children, young people and families to develop policies, programmes and services which improve 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 that their opinions are taken seriously. The Children and Young People (Scotland) Act 2014 aims to ensure that children's rights are realised and that children, young people and families properly influence the design and delivery of policies and services.

Through our collaborative work with partners to jointly develop Children's Services Plans, we consult and engage with children, young people and families to shape

service provision and improvement. The findings of engagement work across health services and partners have been used to inform the actions within the children and young people's health plan.

Recent examples of engagement activity include:

- NHS Lanarkshire breastfeeding summit involving parents/carers and infants.
- Online engagement with care experienced young people during national Care Day on 19th March 2021.
- The Infant Feeding Development Midwife and the Infant Feeding Team have consulted with service users on a range of topics using the NHS Lanarkshire breastfeeding support closed Facebook page.
- UNICEF Baby Friendly audits are routinely carried out by the Infant Feeding Team where service users' experiences, knowledge and understanding is assessed.
- NHS Lanarkshire Healthy Lifestyles in Pregnancy Service carried out a service user evaluation on the adaptation of the service during COVID-19.
- Gathering the views and experiences of parents and carers who have children with neurodevelopmental difficulties to inform the development of a neurodevelopmental service which includes post-diagnostic support.
- Focus group discussions with young people on the new University Hospital Monklands.
- Locality-specific consultation with young people on their priorities for their local neighbourhood.
- Consulting with young people on the use of library services for health information and advice, particularly in relation to mental health and wellbeing.
- Involvement of young people in the development of national and local relationships, sexual health and parenthood resources. Consultation with young people on access to and use of sexual health services and contraception.
- Development and commitment to the North Lanarkshire Children's Services Partnership Agreement (#NLCAskMe) which sets out how the Children's Services Partnership and children and young people in North Lanarkshire will work together.
- Establishment of and participation in Champions Boards to enable collaborative working with care experienced children and young people.

In addition, through various partnership youth events and consultations, we know that mental health and wellbeing remains a priority for young people with more support in areas such as LGBTI+ and mental wellbeing, suicide prevention, and exam stress. Young people want to have enough money and have things to do in their local area. They identified risk of homelessness as an important issue also.

In developing the Children's Services plan in South Lanarkshire children, young people and families were consulted on a range of topics included the impact of the COVID-19 pandemic. Participants felt that COVID-19 was unfair and worried them, including missed school/learning, the impact on future choices and missing contact with their friends.

The involvement of children, young people and families is an on-going process and we recognise that we need to strengthen our approach and move from consultation to genuine collaboration. Health services will ensure children, young people and families have the opportunity to shape service development and improvement activities by working collaboratively with practitioners in a way that allows children and young people's voices to be heard and acted upon. Implementation of Children's Rights and Wellbeing Impact Assessments will support this process.

NHS Lanarkshire has funded two Development posts, which will be allocated to local care experienced young people. These posts will influence change and support our commitment to keeping The Promise and are part of a Team of development posts funded by both NLC and SLC. The post holders will link with NHS Lanarkshire in relation to access to health services and service improvement, and are/or will become members of the Children and Young People's Service Improvement and Planning Group.

9. Where are we now?

This section provides data in relation to the Lanarkshire population. It takes time to generate and publish data, therefore in this report we are not able to quantify the impacts of the pandemic. However, we will summarise the child health services that were affected by the COVID-19 pandemic. National data on the impacts of the pandemic are summarised within the appendices.

Population statistics

In 2019 the Lanarkshire population was estimated to be 661,900 (341,370 in North Lanarkshire and 320,530 in South Lanarkshire). Children under five years formed 5.3% of the population (n= 34,844) whilst 5-14 year olds and 15-24 year olds made up 11.5% (n= 76,186) and 11.5% (n= 74,171) of the population respectively. Table 1 provides information on live births, etc.

Table 1: Stillbirths, perinatal, neonatal and infant death rates (2017-19, n = average of 3 year period)

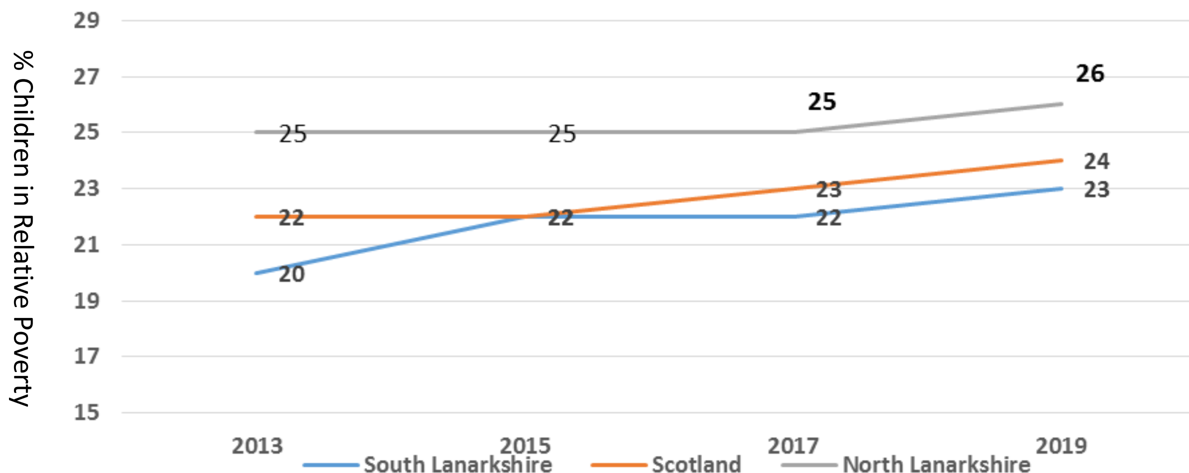
	North Lanarkshire	South Lanarkshire	NHS Lanarkshire	Scotland
Live births (per 1000 women 15-44)	54.1 (n=3461)	56.0 (n=3156)	55.0 (n=6617)	49.8 (n=51284)
Stillbirth (per 1000 births)	3.3 (n=11)	3.8 (n=12)	3.5 (n=23)	3.8 (n=196)
Perinatal deaths (per 1000 births)	4.6 (n=16)	4.9 (n=15)	4.7 (n=31)	5.4 (n=275)
Neonatal deaths (per 1000 live births)	2.0 (n=7)	1.5 (n=5)	1.8 (n=12)	2.2 (n=111)
Infant deaths (per 1000 live births)	3.2 (n=11)	2.2 (n=7)	2.7 (n=18)	3.3 (n=168)

Source: National Records of Scotland

Child poverty

Figure 2 shows the percentage of children in low income families in North and South Lanarkshire. 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, after housing costs). In 2019/20, 26.5% of children in North Lanarkshire lived in low income families and 23.1% in South Lanarkshire.

Figure 2: Percentage of Children in Relative poverty (percentage after housing costs are accounted for)



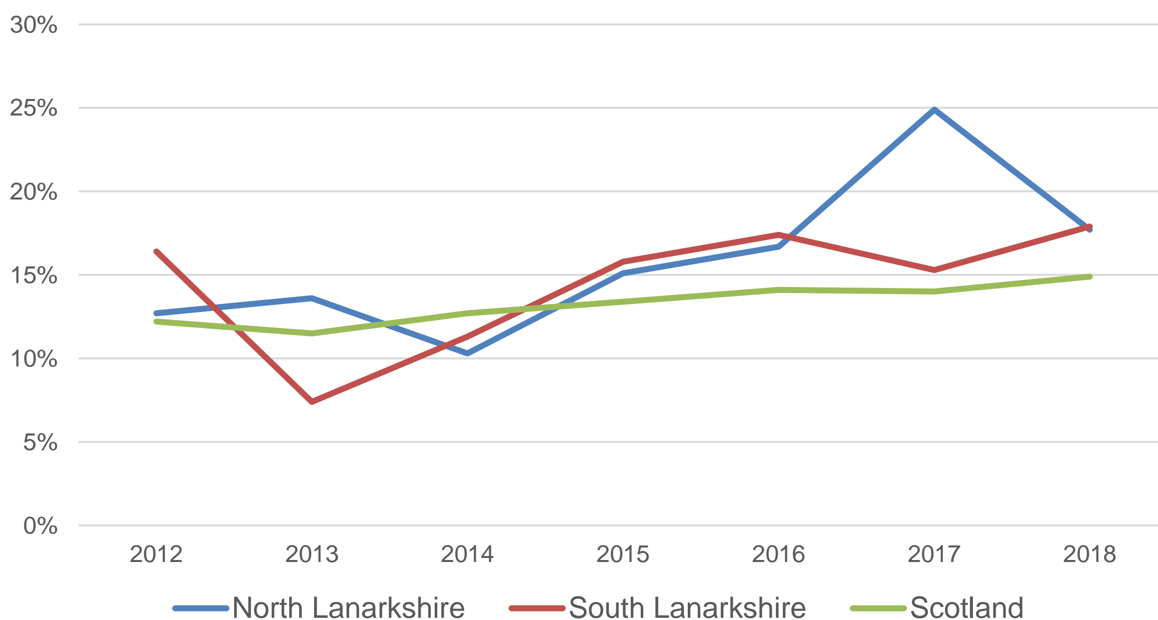
The Child Poverty (Scotland) Act 2017 places a duty on local authorities and NHS Boards to take action to address child poverty locally in relation to the three key

drivers of poverty – income from employment, income from social security benefits, and costs of living. A number of priority groups are identified as at higher risk of poverty. These include:

- Lone parent families
- Families which include a disabled adult or child
- Larger families (≥3 children)
- Minority ethnic families
- Families with a child under one year old
- Families where the mother is under 25 years of age

Figure 3 presents data on households with children where adults report a limiting long-term physical or mental health problem. In 2018, 17.7% of households with children in North Lanarkshire were reported to have an adult with a limiting long-term physical or mental health problem, 17.9% in South Lanarkshire and 14.9% in Scotland.

Figure 3: Adults reporting a limiting long-term physical or mental health problem - household with children



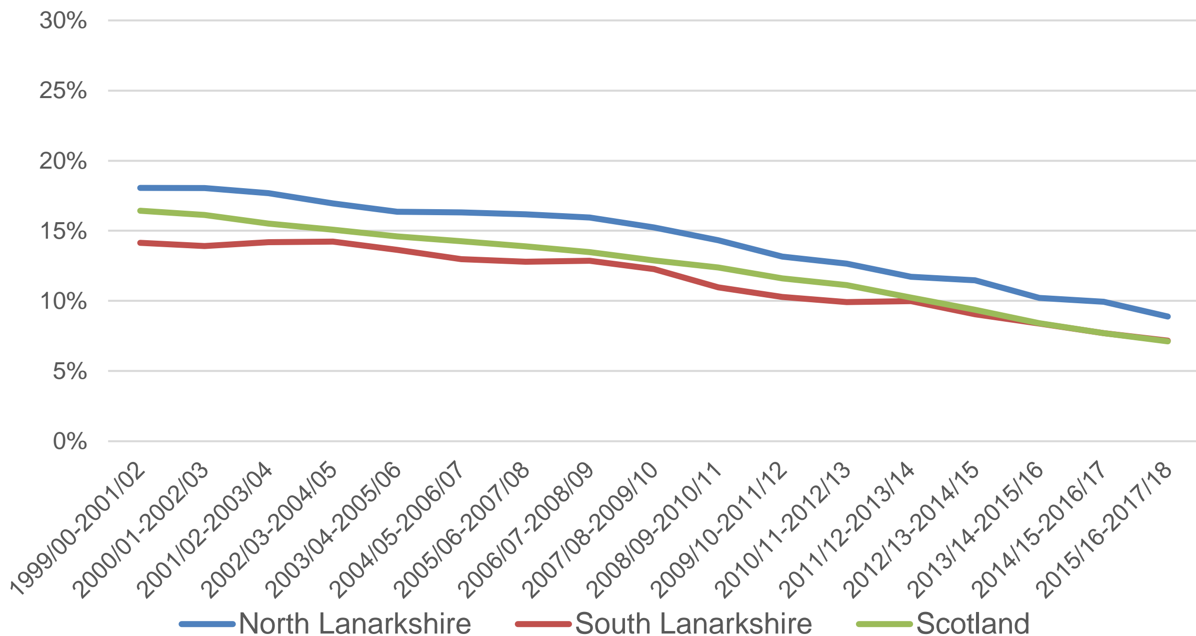
Source: Scottish Government, Scottish Surveys Core Questions

Families where the mother is under 25 years of age increases the risk of child poverty. Figure 4 below shows the percentage of first time mothers under the age of 19 years by local authority area, which shows a decreasing trend[1]. The latest data

[1] Data was not available for women under 25 years.

available (2016/17 – 2018/19) shows that 8.9% of first time mothers in North Lanarkshire were 19 years and under, this was 6.4% in South Lanarkshire, and 6.6% in Scotland. More information on teenage pregnancy rates can be found under the Maternal Health section below.

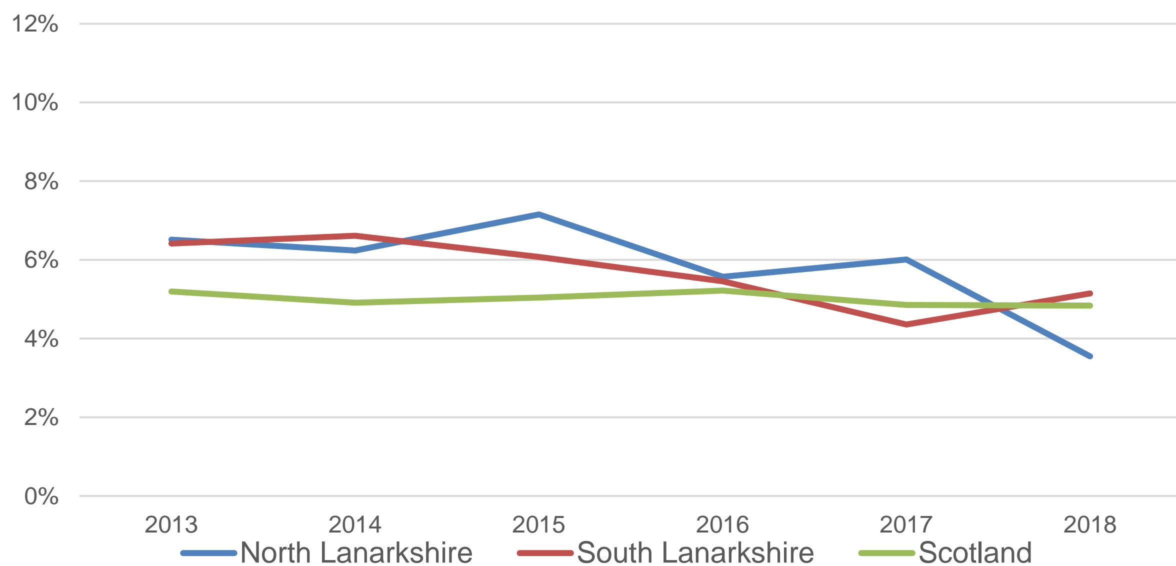
Figure 4: First time mothers who are 19 and under



Source: NHS Information Services Division, Age of First Time Mothers

Figure 5 show the percentage of single parent households in North and South Lanarkshire in from 2013 to 2018 (currently 4% in North Lanarkshire and 5% in South Lanarkshire).

Figure 5: Percentage of single parent households



Source: Scottish Government, Scottish Household Survey

Figure 6 sets out the proportion of large family households[2] in North and South Lanarkshire. In 2018, around 8.3% of families in North and 7.5% in South Lanarkshire were classed as large family households (compared to 5% nationally).

Figure 6: Large family households

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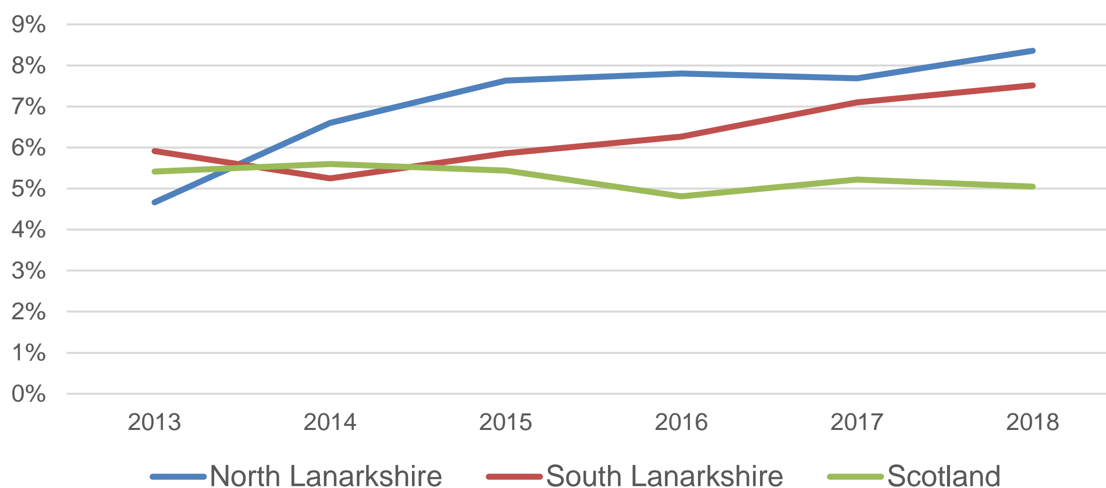
[2] A large family household is defined as 2 adults of any age and 3 or more children.



Source: Scottish Government, Scottish Household Survey

Both midwifery and health visiting teams have been delivering routine enquiry in relation to financial wellbeing. The BadgerNet electronic maternity system now allows for the recording of routine enquiry and referrals for financial advice. In the first nine months of 2020/21, 78.3% of women were asked about financial difficulties. Across North and South Lanarkshire health visiting services, routine enquiry was employed before or at the 6-8-week child health review in over 95% of cases, and referrals made where necessary.

In 2019, only 56% of those eligible were registered for the Healthy Start welfare benefit. The reduction in uptake of Healthy Start from previous years was due to the Healthy Start Issuing Unit receiving a bulk Universal Credit Full Service data migration from the Department of Work and Pensions (DWP) for eligible beneficiaries who had not yet applied for the benefit. In August 2019, the Scottish Government launched Best Start Foods, which will replace Healthy Start. Eligible families are being invited to apply for the new scheme during a period of migration. Healthy Start vouchers were discontinued in March 2020.

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) are described as adverse events or trauma which occurs 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 violence, 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 number of ACEs are also at higher risk of poor education and employment outcomes, low mental wellbeing, chronic health conditions, involvement in violence and unintended teenage pregnancy.

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. A range of multiagency staff have been trained, including midwives, health visitors, allied health professionals and community children's nurses. The Solihull on-line course is available for parents and carers to complete. During the COVID-19 pandemic the Solihull course was available to parents across Lanarkshire, without need for referral. Also during this period, Lanarkshire secured the licence for three Solihull online professional courses for staff – Understanding Trauma/Understanding Brain Development/Understanding Attachment. Targeted provision of the Incredible Years programme was paused in March 2020 however, alternative formats online are being explored. Whilst the programme has evidenced improvement in the SDQ (Strengths and Difficulties Questionnaire[3]) scores of participants, uptake and completion rates were often low.

Care experienced infants, children and young people

In South Lanarkshire from the period April 2019 – September 2020, 343 notifications were received from Social Work that an infant, child or young person had become care experienced. The majority of notifications were for school aged children (64%); 55% of notifications were made within 5 days of the infant, child or young person becoming care experienced. A child's plan was attached to the notification in 74% of cases. CEL 16 Health Needs Assessments were completed within 4 weeks in 69% of notifications (national standard 100%).

In North Lanarkshire from the period April 2019 – September 2020, 257 notifications were received from Social Work that an infant, child or young person had become care experienced. The majority of notifications were for school aged children (60%); 53% of notifications were made within 5 days of the infant, child or young person becoming care experienced. A child's plan was attached to the notification in 83% of cases. 97% of CEL 16 Health Needs Assessments were completed within 4 weeks.

A data collection form has been introduced to support the recording of outcomes following health assessments. This will allow for population monitoring of outcomes in this group of infants, children and young people to help ensure services meet identified needs. In the period June-December 2019 only 33% of data forms in South Lanarkshire and 32% in North Lanarkshire were completed and returned.

[3] The SDQ is a brief emotional and behavioural screening questionnaire for children and young people. The tool can capture the perspective of children and young people, their parents and teachers.

Maternal health

The numbers and rates of teenage pregnancies has reduced over time. For the period 2016-18, the pregnancy rate in women under 20 in North Lanarkshire was 34.9/1000 women and 30.8/1000 women in South Lanarkshire. The Scotland average was 30.5/1000 women. The teenage pregnancy rate for those under 16 years was 3.4/1000 in North Lanarkshire and 3.2/1000 in South Lanarkshire (3.0/1000 in Scotland). There remains a strong correlation between deprivation and teenage pregnancy, with rates higher in more deprived areas (although the absolute gap has narrowed over time nationally). Deprivation is also a factor in outcome of pregnancy with women in the more deprived areas more likely to deliver than terminate their pregnancy.

In 2019/20, 56% of pregnant women were overweight (including obese) at antenatal booking; 25% of women were in the obese category (BMI of 30 or more). In Lanarkshire, in the same timeframe, this figure was 27.4% of pregnant women with a BMI of 30 and above. Maternal obesity rates have increased over time and are associated with increasing deprivation. In the same period, 15.4% of women were smoking at antenatal booking (14.6% in Scotland). Smoking rates in pregnancy are significantly higher in the most deprived areas and is more common in younger women.

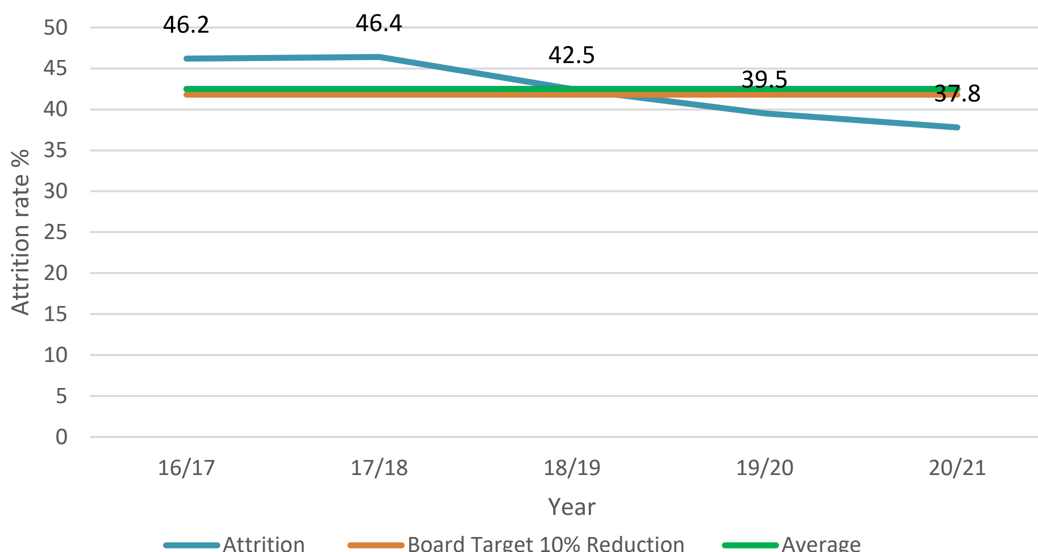
Children under five years

From April – September 2020, 50.5% (a slight increase from 49.8% in 2018/19) of babies were ever breastfed in Lanarkshire compared to 66.3% in Scotland. From April – September 2020, at the Health Visitor First Visit (10 – 14 days) 39.3% were breastfed (includes mixed breast and formula) and 55.5% in Scotland. At the health visitor First Visit (10-14 days), 35.9% of babies were breastfed (includes mixed breast and formula) and 52.7% in Scotland. By 6 – 8 weeks from April – September 2020, 31.7% of babies in Lanarkshire were overall breastfed (45.2% in Scotland). By 6-8 weeks, 28.8% of babies in Lanarkshire were exclusively breastfed (43.2% in Scotland). For each of these measures Lanarkshire was lower than Scotland. Furthermore, low breastfeeding rates are associated with lower maternal age and increasing deprivation.

The Scottish Government has established a national stretch aim to reduce the drop off in breastfeeding between birth and 6-8 weeks. In 2017/18, the drop off in breastfeeding in Lanarkshire between birth and 6-8 weeks was 46.4%. The national stretch aim requires a 10% reduction in breastfeeding drop off (to 42.1%) by 2024/2025.

Figure 7 shows a 39.3% drop off in breastfeeding (between birth and 6-8 weeks) from January – June 2020 (April 2020 – June 2020 rate is 37.8% - this could have been influenced by COVID-19 but is following trend). For women who start breastfeeding, more are continuing to breastfeed until 6-8 weeks.

Figure 7: NHS Lanarkshire breastfeeding Attrition Rate between birth and 6-8 weeks



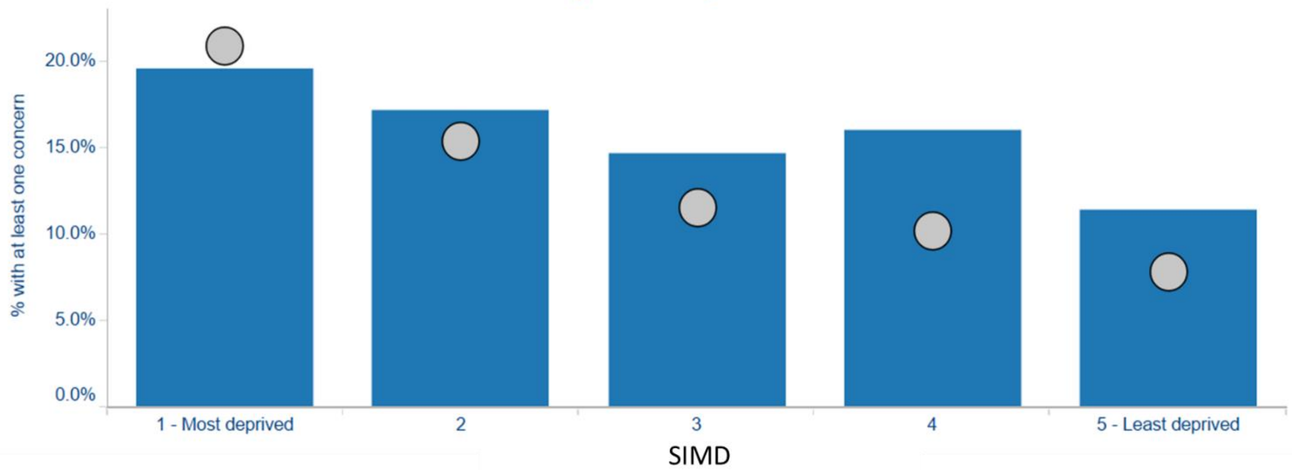
The Child Health Surveillance Programme sets out a schedule of universal child health reviews at specific points in a child's early years. Coverage of these reviews in Lanarkshire is high. In the period April-June 2019, 95.6% of children had a completed 6-8 week review (against a target of 95%). Coverage of reviews at 13-15 months and 27-30 months compare favourably to the national average, as can be seen in Table 2 below. The COVID-19 pandemic has influenced how reviews are carried out, with some health visitor reviews being conducted over the phone/online. Furthermore, the General Practice component of the 6-8 week review was stopped during the first lockdown and work is currently underway to catch up on remaining reviews.

Table 2: Child health surveillance – review coverage (Jan-Jun 2020)

CHS review	North Lan	South Lan	NHSL	Scotland
13-15 months	86.9%	90.2%	88.5%	83.0%
27-30 months	85.8%	88.9%	87.3%	76.0%

Child development is assessed during child health reviews, with anticipatory guidance and early intervention delivered as need is identified. In Lanarkshire in the period July 2019 to June 2020, 16.5% of children at 27-30 months were identified as having one or more developmental concern (13.5% in Scotland). Developmental concern was higher in children from the most deprived areas compared to the least deprived (19.6% and 11.4% respectively) as is shown in Figure 8 below.

Figure 8: Children with 1+ developmental concern at the 27-30 month review, by SIMD (July 2019 - June 2020)



The most common developmental concerns identified related to speech, language and communication.

Children's exposure to second hand smoke has declined in Lanarkshire over time. The most recent data from the Child Health Surveillance Forms at April 2019 shows that 5.4% of children are exposed to second hand smoke at 27-30 months (against a target of 7%). Exposure to second hand smoke is associated with deprivation, with a higher proportion of children in the most deprived areas being exposed when compared to the least deprived.

Children and young people's health and wellbeing

Table 3 shows child healthy weight data for P1 children in the school year 2018/19. The risk of overweight and obesity in Lanarkshire children has increased over time and the proportion of children who are a healthy weight has declined. Children from more deprived areas are less likely to be a healthy weight. Eleven percent of children in Lanarkshire are at risk of obesity (12.1% in North Lanarkshire and 9.9% in South Lanarkshire). This is slightly above the national average of 10.2%. P1 BMI measurement was paused in March 2020 due to COVID-19 pandemic.

Table 3: BMI distribution of children in Primary 1 2018/19

	% healthy weight	% at risk of overweight (inc. obese)	% at risk of obesity
North Lanarkshire	74.2	24.3	12.1
South Lanarkshire	76.4	22.1	9.9
NHS Lanarkshire	75.2	23.3	11.1
Scotland	76.6	22.4	10.2

Information Services Division – NSS/Public Health Scotland

In 2018/19 school year, 68.2% of P1 children in North Lanarkshire and 73.1% of P1 children in South Lanarkshire had no obvious dental decay experience (71.5% in

Scotland). In P7, 69.3% of children in North Lanarkshire and 73.5% in South Lanarkshire had no obvious decay experience (72.9% in Scotland).

Previous survey data from the 2015/16 Realigning Children's Services programme showed that 5% of South Lanarkshire pupils (S1-4) reported 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 second hand smoke 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 second hand smoke 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[4] (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.

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.

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.
In the period 2014-2018, the rate of death from suicide (in 11-25 year olds) was 7.9/100,000 in North Lanarkshire and 7.6/100,000 in South Lanarkshire. The Scotland rate was 8.9/100,000.

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[4] A proper alcoholic drink was consuming a whole alcoholic drink that was not labelled low alcohol.

Healthcare services

Routine childhood vaccination rates in Lanarkshire are high and compare favourably to the Scotland average. Uptake of the MMR vaccine (Jan-Dec 2020) at 24 months was 95.7% in North Lanarkshire and 96.7% in South Lanarkshire (94.9% in Scotland). In the same period, uptake of the 6 in 1 vaccine at 24 months was 97.2% in North Lanarkshire and 98.0% in South Lanarkshire (97.2% in Scotland).

Uptake of the 2nd dose of the HPV vaccine in S3 girls in 2018/19 was 86.7% in North Lanarkshire and 87.1% in South Lanarkshire (82.5% in Scotland). The HPV vaccination programme was paused in January 2021 and is due to restart in April 2021 due to the COVID-19 pandemic response.

At December 2019, 63.8% of referrals to CAMHS were seen within 18 weeks against a standard of 90% (see Figure 9 below). Performance has seen a declining trend until July 2019 where there is a gradual increasing trend in the proportion of patients treated within 18 weeks of referral. Demand for CAMHS services continues to rise both locally and nationally.

Figure 10 illustrates the rise in urgent referrals to CAMHS up until September 2019 where it reached a peak of 39%. Urgent referrals have since seen a recent reduction to 28% at November 2019.

Figure 9:Treatment within 18 weeks

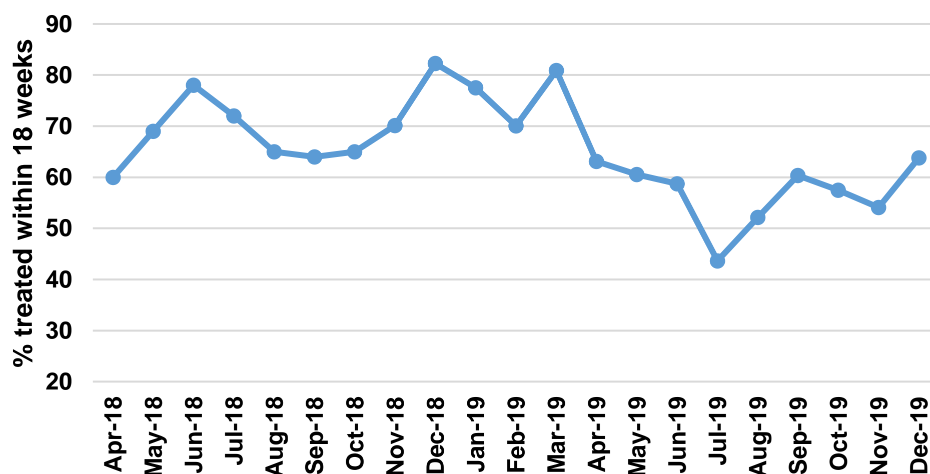
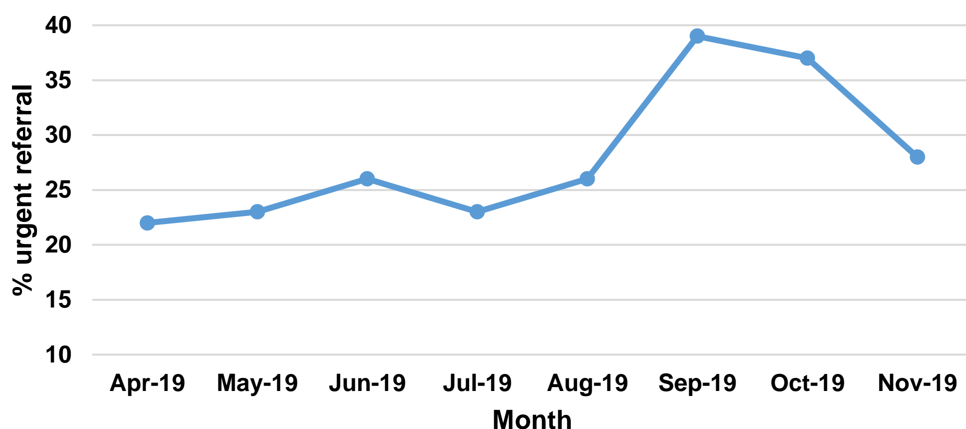


Figure 10: Urgent referrals



Recommendations from the data

- Continue work to reduce the proportion of children living in low income families in both North and South Lanarkshire, with strengthened support for those most at risk of poverty. This includes scaling up efforts on routine enquiry in relation to financial wellbeing and ensuring a high level of take up of Best Start Foods (Improvement Plan Outcome 2: Actions 2.1, 2.2 & 2.3).
- Continue to develop competence and confidence across staff groups in relation to recognising and responding to trauma and adversity and deliver accessible and evidence-based parenting support programmes, targeted to level of need (Improvement Plan Outcome 3: Actions 3.1, 3.2, 3.3 & 3.4).
- Increase the timeliness of social work notifications when infants, children and young people become care experienced, in relation to both in and out of area placements. Ensure high quality and comprehensive health assessments are undertaken. A stepping up of efforts is required in the recording of outcomes following health assessments (Improvement Plan Outcome 4: Actions 4.1 & 4.2).
- Continue to address unintended teenage pregnancies, particularly in the most deprived groups (Improvement Plan Outcome 9: Action 9.6).
- Effective interventions are required to tackle maternal obesity and maternal smoking, predominantly in the most deprived areas. Consideration should be given to actions that can be taken prior to conception to maximise health gain. This should include the use of alcohol before and during pregnancy (Improvement Plan Outcome 5: Actions 5.1, 5.4 & 5.5).
- Continue efforts to increase breastfeeding rates in Lanarkshire and reduce the drop off in breastfeeding between birth and 6-8 weeks (Improvement Plan Outcome 6: Action 6.1).
- Maintain high levels of coverage of child health reviews and reduce the proportion of children with developmental concerns, particularly in the most deprived areas (Improvement Plan Outcome 6: Actions 6.5, 6.6 & 6.8).
- Continue to reduce children's exposure to second hand smoke, in particular children living in the most deprived areas (Improvement Plan Outcome 6: Action 6.6).

- Effective interventions are required at 27-30 months, 4-5 years and primary 1 to halt the increasing trend in childhood obesity (Improvement Plan Outcome 7: Action 7.1).
- Easily accessible community support should be available to protect and promote mental health and wellbeing in children, young people and families. Interventions should be in place for young people who report risk-taking behaviours, including excessive alcohol use (Improvement Plan Outcome 7: Action 7.4).
- Work should continue to improve referral to treatment times for those who require specialist CAMHS support (Improvement Plan Outcome 9: Action 9.4).

Impact to health services of response to COVID-19 pandemic

The NHS Lanarkshire response to the COVID-19 pandemic included creating and staffing COVID-19 wards, COVID-19 Assessment Centres, the COVID-19 vaccination programme, and the NHS Lanarkshire Test & Protect service. This required a proportion of staff to be redeployed, other staff needed to shield, and there were changes to how services were delivered to minimise the risk of infection transmission. This response to the pandemic was needed, but as resources are finite, there were impacts across NHS Lanarkshire and the Health and Social Care Partnerships. The impacts related to services related to children and young people are reported. Positively, the changes in working practices, and seeing what can be achieved, provides an opportunity to look afresh at our systems and services and consider how we can best deliver them going forwards.

The following services were stood down (at least temporarily) during the pandemic: the 6-8 week baby medical (GP) reviews; Primary 1 health reviews which aim to identify health concerns and risk of overweight and obesity; the HPV vaccination programme; oral health improvement programmes in nurseries, schools, communities and dental practices; pre-school Orthoptic Vision Screening (POVS). Various training programmes and service improvement plans were put on hold or delayed also including: development of Infant Mental Health service, Sensitive Conversations Training, introduction of the Child Death Review system.

The following services had reduced capacity: paediatrics to respond to demand for unscheduled paediatric care; CAMHS to deliver specialist mental health services; sexual health services for young people and reduced access to contraception and advice; Perinatal Mental Health Service to deliver specialist mental health support and treatment to pregnant and postnatal women; Speech Language & Communication to offer specialist interventions or assessment to low and medium risk patients. There were delays in completion of health assessments for care experienced children by health visitors and school nurses.

Other services needed to change how they operated, particularly moving away from face to face appointments and increasing telephone or online appointments, this included: Health Visitors and access to free Health Start Vitamins, breastfeeding support, Healthy Lifestyle in Pregnancy Service, physiotherapy for children with long term conditions, and smoking cessation for pregnant women and their families. Hospital visiting was limited, which impacted on patients' experience of being in hospital. Closure of or disruption to registration offices resulted in no birth certificates being supplied which impacted on healthcare of newborns and income insecurity for families.

Appendix 1-3 will go into more detail about the wider impacts of the pandemic, as health is not isolated in this, and impacts to families' financial security, children's education, leisure, and ability to socialise will impact their wider wellbeing and potential need for health services. Furthermore, some children will have been impacted by either they or a household member needing to shield.

10. Where do we want to be?

Linked to the Scottish Government National Outcomes and SHANARRI wellbeing indicators, we have set out the outcomes we want to achieve and an improvement plan setting out how we will achieve them. We are mindful of the impacts of COVID-19, the known and as yet unknown, and that these will influence our outcomes. Outcome development has 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, young people and families through individual services and partnership activities.
- Feedback in relation to impacts on Lanarkshire services and the Scottish population of the COVID-19 pandemic.

In the period 2021-2023 our expected outcomes are:

1. The rights of infants, children and young people are recognised, respected and promoted.
2. Financial insecurity is identified and supported through universal service provision and the consequences of child poverty are mitigated through targeted intervention.
3. The impact of adversity in childhood is understood, the workforce is appropriately trained, and effective interventions are in place to support parents, carers and families.

4. Health and wellbeing needs are identified and supported to ensure improved outcomes for care experienced infants, children and young people
5. Maternal health and wellbeing is improved before, during and after pregnancy.
6. Health and developmental outcomes for infants and children in their early years are improved and the difference in outcomes between socioeconomic groups is reduced.
7. The physical and mental health of children and young people is supported and improved by delivery of community support services which focus on prevention and early intervention.
8. Young people experience an effective transition between paediatric and adult health services.
9. Healthcare services are continuously improved to ensure accessible, high quality care is delivered in the right place, at the right time and by the right person.
10. Data systems and processes support the safe and effective management of information in relation to children and young people.

11. 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 achievement of our overarching vision for children, young people and families. These pieces of work are being progressed and governed through various boards and steering groups and include the childhood routine vaccination programme, pregnancy and newborn screening and pre-school vision screening programmes, the Oral Health Improvement Plan, Lanarkshire Additional Midwifery Service, Family Nurse Partnership and work to reduce teenage pregnancy rates.

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 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 work to safeguard children and the children and young people’s health plan as required.

12. 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 so that adjustments can be made as circumstances change throughout the life of the document.

To that end, the publication of this document was delayed by a year due to the COVID-19 pandemic, many changes have happened to staffing and services during that period. We have revisited this document and updated the action plan in line with where services improvements are now. We recognise that we are still in a phase of transition and that the plan remains fluid.

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 bi-annual reporting mechanism will be in place to monitor progress of the actions required. The Maternal and Child Health Dashboard will be used to track the performance, over time, of a range of key maternal and child health outcomes as implementation of the plan progresses, which will support identification of our strengths and areas for improvement. The Dashboard is currently being updated in line with the health plan and where possible we are considering outcomes by SIMD.

13. Communication

The Children and Young People's Health Plan 2021-2023 will be promoted widely to NHS and HSCP staff, independent contractors, relevant staff in partner agencies and children, young people and families, via existing partnership structures and the NHS Lanarkshire website and social media.

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.

14. Improvement Plan

	What will we do?	Timeframe	A: accountable; R: responsible; C: consulted; I: informed (ARCI)	Key performance indicator
Outcome 1: The rights of infants, children and young people are recognised, respected and promoted. ***UNCRC Articles 3, 12, 24, 42***				
1.1	Raise awareness and promote understanding of children's rights across all directorates within NHS Lanarkshire.	March 2022	A: Director of Public Health R: Child Health Commissioner C: CHCSG I: NHSL CMT	• Number of contributions on children's rights in NHS Lanarkshire staff briefings • produce twice yearly articles on UNCRC in the Pulse • Work across the Children's Services Partnerships North and South Lanarkshire collaboratively to promote children's rights • baseline staff survey results
1.2	Promote the use of Children's Rights and Wellbeing Impact Assessments (CRWIA).	March 2022	A: Child Health Commissioner R: Head of Evidence/Corporate Risk Manager (CAROL MCGHEE)/Equality and Diversity Manager C: CHCSG I: NHSL CMT	• % of policies/guidelines which support CRWIA
1.3	Support the development of a participation and engagement framework in NHS Lanarkshire	Sept 2022	A: Director of Public Health R: Child Health Commissioner C: CHCSG/ Director of Communications I: NHSL CMT	• Number of participation sessions • Number of children and young people engaged • Evidence of impact

Outcome 2: Financial insecurity is identified and supported through universal service provision and the consequences of child poverty are mitigated through targeted intervention *UNCRC Article 24, Article 3, Article 26, Article 27*				
	What will we do?	**Timeframe**	**A: accountable; R: responsible; C: consulted; I: informed (ARCI)**	**Key performance indicator**
2.1	Routine Enquiry of financial wellbeing is delivered across all midwifery teams.	March 2022	A: Head of Midwifery R: Senior Midwife C: SL Money Matters/NL Financial Inclusion Team I: SL Child Poverty Action Group/NL Tackling Poverty Officers Action Group	• Clevermed (Badgernet) Routine Enquiry report available • 95% of women are asked about money worries by their midwife at booking • 70% of women referred to money advice services engage with the service • Value of additional benefits gained (£)
2.2	Routine Enquiry of financial wellbeing is undertaken during child health surveillance (CHS) reviews within the Universal Health Visiting Pathway.	March 2023	A: NL/SL Associate Directors of Nursing R: NL/SL Senior Nurses C: SL Money Matters/NL Financial Inclusion Team I: SL Child Poverty Action Group/NL Tackling Poverty Officers Action Group	• 95% of Routine Enquiry is raised first visit to 6 week child health review • 95% of Routine Enquiry is raised at 13-15 month child health review • 95% of Routine Enquiry is raised at 27-30 month child health review • 95% of Routine Enquiry is raised at 4-5 year child health review • 80% of women referred to money advice services engage with the service • Value of additional benefits gained (£)
2.3	Maximise Best Start Foods registration and universal Vitamin D provision for children 0-3 years.	March 2022	A: Health Improvement Leads for both North and South Lanarkshire HSCPs R: Public Health Nutritionist C: Maternal and Infant Nutrition Steering Group I: CHCSG	• % registered with Best Start Foods (baseline when data become available) • Number of vitamins distributed (until Scottish Government measure confirmed)

2.4	Develop and test a robust homelessness notification process from local authority housing services to health visiting and education. Staff in education and health visiting services support children affected by homelessness through assessment of wellbeing.	March 2022	A: Head of Health Improvement R: Senior Health Improvement Officer Homelessness C: Health and Homelessness Steering Group I: NL/SL CSP Board	• % notifications – target 100% • % completed wellbeing assessments (source to be determined) • Delivery of updated materials to support education and health visiting services
Outcome 3: The impact of adversity in childhood is understood, the workforce is appropriately trained, and effective interventions are in place to support parents, carers and families ***UNCRC Article 6, Article 24, Article 18, Article 39***				
	What will we do?	**Timeframe**	**A: accountable; R: responsible; C: consulted; I: informed (ARCI)**	**Key performance indicator**
3.1	Implementation of Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce and the Scottish Psychological Trauma Training Plan.	March 2023	A: Director of Public Health/Director of Psychological Services R: Transforming Psychological Trauma Implementation Co-ordinators C: Trauma Training Implementation Group I: NHSL CMT	• Trauma Training delivery plan finalised • Increased proportion of cross sector staff trained to the appropriate level • Staff have improved access to regular supervision and support structures • Trauma-informed practice is embedded at a strategic policy level
3.2	Review and refresh the evidence based NL Parenting Pathway	March 2023	A: Associate Director of Nursing NL	• Mapping of current provision complete and recommended actions agreed

			R: North Health Improvement Manager Children and Young People (when appointed) C: CHCSG I: NL CSP Board	• Implementation of actions to address partnership delivery of parenting programmes is reflected in the North Lanarkshire Children's Services Plan
3.3	To increase workforce training and development that focusses on prevention and early intervention parenting support through the Solihull Approach.	March 2023	A: NL Health Improvement Lead R: Senior Health Promotion Officer Early Years C: NL Prevention Task Group/SL Prevention and Early Intervention Group I: NL/SL CSP Board	• Continue to increase number of Solihull trainers in Lanarkshire (3 new trainers in 2020) • Continue to increase number of staff participating in Solihull multiagency training utilising on line training whist face to face training is unable to take place. (6 staff trained with new on line foundation course) • Encourage uptake and increase number of parents/carers accessing online parenting support courses, over 4410 individuals across Lanarkshire have signed up. (March 2021) • Encourage professional on line course uptake, 1292 staff signed up. (March 2021) • Sustainable funding to support the Solihull Approach is secured
3.4	Deliver the Psychology of Parenting Programme in South Lanarkshire (Incredible Years for 3-6 year olds and 6-12 year olds).	March 2023	A: Health Improvement Lead for SL HSCP R: Health Improvement Manager Children and Young People C: SL CSP Board I: CHCSG	• Number of families enrolled in groups and % of target figure • % of children with an improved SDQ score on programme completion
Outcome 4: Health and wellbeing needs are identified and supported to ensure improved outcomes for care experienced infants, children and young people ***UNCRC Article 3, Article 6, Article 12, Article 19, Article 20, Article 21, Article 24, Article 25***				

	What will we do?	Timeframe	A: accountable; R: responsible; C: consulted; I: informed (ARCI)	Key performance indicator
4.1	Strategic commitment to and operational delivery of the NHS Lanarkshire Corporate Parenting Action Plan	March 2023	A: Executive Director NMAHPs R: Child Health Commissioner/NL/SL Director of Nursing C: CHCSG/NHSL CMT I: NL/SL CSP Board	• Bi-annual report on CEL16 • 100% of notifications from social work within 5 days • 100% of health assessments completed within 4 weeks • Baseline and bi-annual reports on health and wellbeing outcomes
4.2	Complete sub analysis of health outcome data available from the CHSP, Health Needs Assessment outcome forms, school annual review data. Devise audit tool for records to extract outcome evidence. Capture experience and views of children and young people.	March 2022	A: Executive Director of NMAHP's R: Associate Nurse Directors HSCP's C: CHCSG I: NL/SL Corporate Parenting Groups	• Produce report from Sub Analysis • Identify gaps • Agree priority actions to inform plans
Outcome 5: Maternal health and wellbeing is improved before, during and after pregnancy ***UNCRC Article 3. Article 24***				
	What will we do?	**Timeframe**	**A: accountable; R: responsible; C: consulted; I: informed (ARCI)**	**Key performance indicator**

5.1	Implementation of the National Preconception Health and Care Action Plan	March 2023 – depend ent on launch date, etc	A: Director of Public Health R: Consultant in Public Health C: NL/SL CSP Board I: CHCSG	• National Action Plan launched • Development of local response • Additional KPIs to be agreed based on the above
5.2	Review and implement the National Managed Clinical Network Needs Assessment Report to develop a Specialist Community **Perinatal** Mental Health Service for Lanarkshire. That ensures women and their partners and families receive the support they need to experience optimal health and wellbeing	March 2023	A: Associate Nurse Director, Mental Health R: Senior Charge Nurse, Perinatal Mental Health Service C: Adult Mental Health Clinical Quality Group I: CHCSG	• Royal College of Psychiatrists Quality Network for Perinatal Mental Health Services Community Standards accreditation [extending referral up to 6 months post-natal]
5.3	Implement the recommendations of the NHS Scotland MCN Perinatal Mental Health Needs Assessment (Delivering Effective Services) and the aims of the PNIMH Programme Board in relation to Perinatal Mental Health Services and Maternal and Neonatal Psychological	March 2023	A: Chief Officer NL HSCP R: Consultant Clinical Psychologist/ Chief Midwife C: Lanarkshire PIMH (Perinatal Infant Mental Health) Steering Group I: Lanarkshire MHWB (Maternal Health Well-being) Strategy Steering Group	• Establishment of MNPI service • National indicators currently in development, informed by the BPS, Division of Clinical Psychology perinatal clinical psychology service provision, will include target 6 weeks from referral to assessment.

	Interventions. Review and implement the national MCN Needs Assessment Report to develop a multi-disciplinary maternity and **neonatal** psychological intervention service for Lanarkshire which ensures that women and their partners and families receive access to psychological interventions supporting optimal mental health and wellbeing during the perinatal period.			
5.4	Implement recommendations from the evaluation of the Healthy Lifestyle in Pregnancy Service to increase referrals to and engagement with the service.	March 2022	A: Health Improvement Lead for NL HSCP R: Public Health Nutritionist C: Maternal and Infant Nutrition Steering Group I: CHCSG/LHWSG	• 40% of eligible women (BMI of 30 or more) are referred to the Healthy Lifestyle in Pregnancy Service by March 2022 • 30% of those referred engage with the service (opt-in) by March 2022
5.5	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	March 2023	A: Health Improvement Lead, SL HSCP R: Tobacco Control Programme Manager /Senior Midwife	• 48 pregnant women in the 40% most deprived data zones (at Health Board level) in Lanarkshire have set a quit date between April 2020 and March 2021 and are not smoking at 12 weeks by March 2021 • A target of 28% conversion rate for quit dates set versus 12 week quits for pregnant women in the

	quit date) and stop smoking (at 12 weeks).		C: Tobacco Control: Service Development and delivery thematic group I: Lanarkshire Tobacco Control Steering group	40% most deprived data zones (at Health Board level) in Lanarkshire where the quit date set is between April 2020 and March 2021 • 52 pregnant women in the 40% most deprived data zones (at Health Board level) in Lanarkshire have set a quit date between April 2021 and March 2022 and are not smoking at 12 weeks by March 2022 • A target of 30% conversion rate for quit dates set versus 12 week quits for pregnant women in the 40% most deprived data zones (at Health Board level) in Lanarkshire where the quit date set is between April 2021 and March 2022 • Increase the % of pregnant women not smoking at 34-38 weeks gestation by 2023 (baseline data to be established)
Outcome 6: Health and developmental outcomes for infants and children in their early years are improved and the difference in outcomes between socioeconomic groups is reduced ***UNCRC Article 3, Article 6, Article 24,***				
	What will we do?	**Timeframe**	**A: accountable; R: responsible; C: consulted; I: informed (ARCI)**	**Key performance indicator**
6.1	Delivery of two funded projects: • Sensitive Conversations training[5]	March 2022	A: Head of Midwifery/ NL/SL Director of Nursing R: Infant Feeding Lead/Public Health Nutritionist	• Reduce the breastfeeding drop off rate by 10% from 46.4% (2017/18) to 41.8% by 2025

[5] This training provides staff with the key skills to approach and manage difficult conversations around infant feeding.

	• Improving practice within the Neonatal Unit		C: Lanarkshire Breastfeeding Group I: CHCSG	
6.2	Implementation of Scottish Government Mental Health Strategy and Perinatal and Infant Mental Health Programme in relation to **Infant** Mental Health (IMH) and specialist IMH Services.	March 2023	A: Chief Officer NL HSCP R: NHSL Infant Mental Health Service Lead C: NHSL Perinatal and Infant Mental Health Forum I: NL/SL CSP Board/CHCSG	• Establish Infant Mental Health Easy Access Telephone Advice Line and Consultation System for Health Visitors • Improve access for Infants (0-3rd birthday) to CAMHS, CAYP and Reach Out Teams: number of referrals seen per year and fast tracking of referrals • Increase Infant Mental Health Training to wider workforce • Develop 'Infant Mental Health: When to be Concerned' LearnPro module • Produce pan-Lanarkshire multi-agency Infant Mental Health Indicator Set
6.3	Roll out of effective early language interventions at 27-30 months in North Lanarkshire.	March 2022	A: NL Associate Director of Nursing/AHP Lead R: NL Speech and Language Therapy Manager/NL Senior Nurse C: Universal Health Visiting Pathway Implementation Group I: CHCSG	• 90% of children with an identified speech and language concern at 27-30 months has an agreed action • Reduced number of children requiring access to specialist level SLT services • 85% of all children within each SIMD quintile reach all of their expected developmental milestones in relation to speech and language at 4-5 years (when data become available)
6.4	Develop, test and implement a speech and language pathway and early intervention resource which is delivered by Health Visitors at 13-15 months.	March 2022	A: NL/SL Associate Director of Nursing/AHP Lead R: Speech and Language Therapist/NL/SL Senior Nurse	• 90% of children with an identified speech and language concern at 13-15 months has an agreed action • 85% of all children within each SIMD quintile reach all of their expected developmental milestones in relation to speech and language at 27-30 months

			C: Universal Health Visiting Pathway Implementation Group I: CHCSG	
6.5	Undertake pre-five emotional and behavioural pathway service improvement work in two health visiting teams North and South HSCPs (links to 6.2/10.2).	March 2022	A: NL/SL Associate Director of Nursing R: Early Years Improvement Co-ordinator/NL/SL Senior Nurse C: Universal Health Visiting Pathway Implementation Group I: CHCSG	• 95% EB developmental outcome recording compliance in all completed 13 – 15 month and 27 month CHS Reviews Application of additional assessment toolkits based on risk stratification process (SDQ/ASQ-SE/MCHAT) • Menu of service interventions utilised to effect improved developmental outcome (aligned to HV intervention and formal parenting pathway provision) • Formal RfA's • Child pathway outcome likely to be based on intervention programme engagement and EB developmental outcome review
6.6	Undertake pre-five child healthy weight (CHW) pathway service improvement work South Lanarkshire HSCP (links to 7.1/10.2).	March 2022	A: NL/SL Associate Director of Nursing R: Early Years Improvement Co-ordinator/ NL/SL Senior Nurses C: Universal Health Visiting Pathway Implementation Group I: CHCSG	• % of CHW fields completed at 27-30 months and 4-5 years • 95% recording outcome compliance in all completed 27month/4 years CHS reviews (Laser Stadiometer evaluation link this outcome measure) • 95% BMI recording/Z Score recording on IGROW for children in Amber (BMI > 91st C/Red pathway (BMI > 99.6C) • % children in amber pathway signposted to community based CHW programme (Full of Beans Programme) • % children RfA GOALS Programme (Red Pathway only)

				• % children RfA GP (Red Pathway only) • % of children RfA Dietician (Red Pathway only)
6.7	Reduce the percentage of children exposed to second hand smoke at First Visit, 6-8 weeks, 13-15 months and 27-30 months.	March 2023	A: Health Improvement Lead, HSCP SL /Tobacco Control Programme Manager R: NL/SL Health Visitor/ Tobacco Control Team Leader/Health Improvement Senior C: Tobacco Control: Workforce Development & Monitoring, Improvement and Evaluation Thematic Groups I: Lanarkshire Tobacco Control Steering Group	• Reduce the % of children exposed to second hand smoke at 27-30 months to 6% by March 2021 and 5% by March 2022 • Baseline data and targets to be established for First Visit, 6-8 weeks and 13-15 months (by March 2022). • Analysis of exposure data by SIMD and targeted action agreed at 27-30 months (by March 2022) and First Visit, 6-8 weeks and 13-15 months (by March 2023)
6.8	Implement the universal 4-5 year child health review.	March 2023	A: NL/SL Associate Directors of Nursing R: NL/SL Senior Nurses C: Universal Health Visiting Pathway Implementation Group (earlier stages) I: CHCSG	• 95% of children have a completed 4-5 year review for school entry by March 2023
Outcome 7: The physical and mental health of children and young people is supported and improved by delivery of community support services which focus on prevention and early intervention ***UNCRC Article 6, Article 24, Article 27, Article 31***				
	What will we do?	**Timeframe**	**A: accountable; R: responsible; C: consulted; I: informed (ARCI)**	**Key performance indicator**
7.1	Deliver child healthy weight interventions.	March 2023	A: Service Manager LWMS R: Healthy Lifestyle Programme Manager C: LHWS Interventions Group	• % schools utilising the Healthy Schools Framework

			I: NL/SL CSP Board	• % children/young people referred into LWMS who are offered a package of support (BMI higher than 98th centile) • % of children and families who complete the CHW programmes • Number of CHW training sessions delivered to internal and external staff (i.e. Health Visitors, Teachers)
7.2	Deliver South Lanarkshire Alcohol and Drug Partnership (ADP) Strategy actions which support children and young people.	March 2022	A: SL ADP Strategic Lead R: SL ADP Development Officer C: GIRSLC Strategy Group I: SL CSP Board	• Number of ABI training activities delivered to staff working directly with young people • Number of ABIs delivered to young people • Number of teachers accessing the Healthy Schools website • Increased % of young people accessing supports on discharge from hospital
7.3	Deliver substance misuse education and awareness raising across school, further education and community youth settings.	March 2022	A: NL ADP Strategic Lead (when in post) R: NL ADP Development Officer C: NL ICSG I: NL CSP Board	• Number of staff trained in Alcohol and Brief Intervention (ABI) in a variety of young people settings with the approach to alcohol harm reduction • Number of alcohol education briefing sessions in a variety of youth settings in North Lanarkshire
7.4	Implement the Children and Young People Mental Health and Wellbeing Community Support and Services Framework	March 2023	A: NL/SL CSP Board/NHSL Board R: Health Improvement Lead NL HSCP/ NL ICSG/GIRSLC C: Lanarkshire MHWB Strategy Steering Group I: CHCSG	• Scoping of existing prevention and community based support complete (June 2021) • Implementation of national Community Support Framework (March 2023) • Development of a community support element of the Healthy schools Framework (March 2022)
Outcome 8: Young people experience an effective transition between paediatric and adult health services ***UNCRC Article 3, Article 12, Article 24***				

	What will we do?	Timeframe	A: accountable; R: responsible; C: consulted; I: informed (ARCI)	Key performance indicator
8.1	Improve transition planning for children and young people between services	March 2022	A: Chief Officer HSCNL/ Chief Officer HSCSL/Director of Acute Services R: Associate Medical Director/ Children's Services representative /Adult Services representative C: CHCSG I: Getting it right for South Lanarkshire's children/ Integrated Children's Services Group (North Lanarkshire)	• Set up a multidisciplinary group to progress transition planning, workstreams should include: transitions between paediatric and adult services; transition between hospital sites and wider community services. • Plans for transition accepted by relevant management teams
8.2	Establish governance for invasive long term ventilated (LTV) patients and implement transition protocol and associated guidance on emergency admissions and discharge planning.	March 2022	A: Chief Officer HSCNL / Chief Officer HSCSL R: Nurse Director NL HSCP /Associate Medical Director C: Head of Health, HSCNL I: CHCSG	• A system of liaison meetings is established linked to HSCNL clinical governance structures • 100% of young people preparing to transition have a specific care plan encompassing physical care, LTV care and a plan to meet social and educational needs where this is appropriate
Outcome 9: Healthcare services are continuously improved to ensure accessible, high quality care is delivered in the right place, at the right time and by the right person ***UNCRC Article 3, Article 24,***				
	What will we do?	**Timeframe**	**A: accountable; R: responsible; C: consulted; I: informed (ARCI)**	**Key performance indicator**

9.1	Deliver the GIRFEC Implementation Plan to provide a programme of multi-agency learning and development on key areas identified by frontline staff.	March 2022	A: NL/SL Directors of Nursing R: Nurse Consultant Children and Families/SL Associate Director of Nursing C: CHCSG I: NL/SL CSP Board	• Design phase, development of trainers and testing of learning modules complete by August 2022 • Training programme delivered in partnership by December 2022 • Roll out of GIRFEC Training Calendar for multi-agency staff across North Lanarkshire
9.2	Implementation of the Neurodevelopmental Pathway, including support for children and young people with FASD, ASD and ADHD.	March 2022	A: Chief Officer HSCNL R: Clinical Director CAMHS/(FASD Lead if one in post) C: Clinical Director Paediatrics I: CHCSG	• Number of children appointed to the service • Number of children attending for assessment/formulation and diagnosis • Number of children requiring a treatment plan and on-going support • Waiting time monitoring and improvement
9.3	Implement a comprehensive system for the review of and learning from the deaths of children and young people.	March 2022	A: Chief Officer HSCNL/Director of Public Health R: Associate Medical Director / Lead Clinician for Child Death Reviews /Consultant in Public Health C: NHSL Child Death Review Group I: CHCSG	• Implementation of the National Death Review Hub (October 2021) • Number of child deaths • % of completed child death reviews • Annual report on causes of death, shared learning and identified improvement actions
9.4	Develop and implement a Did Not Attend/Was Not Brought (DNA/WNB) policy for children and young people.	March 2022	A: Chief Officer HSCNL R: Associate Medical Director C: CHCSG I: NHSL CMT	• To ensure transferability of policy between services a working group is going to be established • DNA/WNB policy complete and takes into account the Rights of the Child • Policy approved by senior management and shared with relevant staff

				• Number of children who DNA/WNB and follow up actions • Waiting times
9.5	Implementation of the national Tier 3 CAMHS specification and local CAMHS Strategic Review recommendations.	June 2022	A: Chief Officer HSCNL R: CAMHS Clinical Director/CAMHS Service Manager C: Director of Planning/ Director of Information and Digital Technology I: NL/SL CSP Board/CHCSG	• CAMHS referrals up to 18 years • 100% of accepted referrals assessed within 4 weeks • 90% referrals treated within 18 weeks • Centralised accommodation requirements for North and South teams delivered • IT enablement across the service delivered • Neurodevelopmental model rolled out in two clinics (one north and one south) (see 9.2)
9.6	Provide accessible young people Sexual and Reproductive Health Services in all localities.	March 2023	A: General Manager Adult Health Services (HSCNL)/ Chief Officer HSCNL R: Consultant in SRH (YP) C: Lanarkshire Young People's Sexual Health Services Steering Group I: Lanarkshire Sexual Health Strategy Steering Group	• Provision of at least one clinic per week per locality • Increased attendance from YP living in SIMD 1 and 2 areas • Consultation completed with young people to identify barriers to attendance • Actions identified from the above are implemented
Outcome 10: Data systems and processes support the safe and effective management of information in relation to children and young people ***UNCRC Article 16, Article 24***				
10.1	Ensure all data collected and reported on children and young people are of high quality.	June 2022	A: Associate Nurse Directors for North and South Lanarkshire HSCPs R: Specific Senior Nurses in North and South Lanarkshire HSCP	• 95% completeness and return of CHS forms by June 2022 • 95% completeness of Care Experienced status on CHS forms by June 2022

			C: Universal Health Visiting Pathway Implementation Group/School Nursing Implementation Group I: CHCSG	• 95% completeness of height and weight measurement at 27-30 month reviews and 4-5 year reviews by June 2022 • 95% completeness of CECYP health data form by June 2022 • Baseline to be established for completeness of smoking status & exposure to second hand smoke on CHS forms by June 2022
10.2	Deliver a programme of IT enablement across children's services.	March 2023	A: Director of Information and Digital Technology R: NL/SL Director of Nursing/Health and Social Work Manager Children's Services/ Records Information, Management and Technology Manager C: Primary and Mental Health eHealth Group I: CHCSG	• Implement Morse community healthcare system, including mobile solutions, across health visiting, school nursing and CAMHS (see 9.5) • Implement the national Scottish Child Public Health and Wellbeing System for child health surveillance and immunisation by August 2022. • IT requirements, including mobile solutions, for community paediatrics scoped and agreed

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

CHCSG: Child Health Commissioner Steering Group
NHSL CMT: NHS Lanarkshire Corporate Management Team
CSP Board: Children's Services Partnership Board
LHWSG: Lanarkshire Healthy Weight Strategy Group
GIRSLC: Getting it Right for South Lanarkshire's Children Strategy Group
NL ICSG: North Lanarkshire Integrated Children's Services Group
Lanarkshire MHWB Strategy Steering Group: Lanarkshire Mental Health and Wellbeing Strategy Steering Group

UNCRC: https://www.unicef.org.uk/what-we-do/un-convention-child-rights/

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Appendix 1: Impact of the COVID-19 pandemic and school closures on children and young people

1. Mental wellbeing

Key issues for young people include:

- Concerns about COVID-19 transmission
- Adapting to COVID-19 measures in schools (physical distancing)
- Worries about future aspirations and longer term financial and job security.
- Anxiety and fear associated with returning to 'the outside world' (YMCA survey).

Some surveys show little or only modest differences in mental wellbeing over lockdown compared to pre-lockdown baselines. However, this appears to mask differences in sub-groups including:

- girls continuing to report lower mental wellbeing.
- wellbeing scores were lower in pupils from lower income households
- those with special educational needs and disability.
- those with English as an additional language.

A Scottish poll reports family COVID bereavement as 8% which suggests that nearly one in ten children may have experienced bereavement due to COVID-19.

2. Poverty

A number of Scottish studies indicate increasing concern about the impact of rising poverty on the wellbeing of children and families and evidence suggests that worsening financial situations continues to have a detrimental effect on families' mental health, particularly those reliant on social security.

Services report an increase in new families in crisis, many of whom may not have been previously identified as vulnerable and therefore not known to services.

Many 'vulnerable' families who were eligible for a place in the school hubs had not taken up the offer, in part due to a sense of stigma.

Food poverty is highlighted with one survey reporting that nearly half of low income families surveyed struggle to put food on the table on a regular basis.

Some deprived rural communities particularly highlighted food poverty as an issue with poor access to cheaper foods.

3. **Digital Exclusion:**

Whilst Education has strived to provide IT enablement to known vulnerable families, many more families have become more disadvantaged during the pandemic.

Without intensive support and addressing the digital divide, the long term negative impact of school closures on earnings is estimated to be much higher for young people from less well-off backgrounds.
Some families lack the space to support children’s learning due to overcrowding and/ or poor-quality housing and lack of outdoor space – all of which have impacted negatively on the wellbeing of families.

4. **Play deprivation**

Emerging evidence suggests that some children may have experienced a sustained loss of play and regular peer interaction during the pandemic.

Younger (primary) age groups appear to be at greatest risk of loss of peer interaction (both online and in-person). This did not recover in the summer when many restrictions were lifted. Scottish evidence previously reported (Public Health Scotland CEYRIS survey 2) suggests that even after the lifting of restrictions children may still miss out on regular peer interactions, particularly those directly impacted by COVID-19.

5. **Shielding:**

It is becoming apparent that children who are/were isolating or shielding (or living with a family member who is) may be an under-recognised group at risk of adverse impacts from COVID-19.
Data estimates one in three children in Scotland may be at risk of potential adverse impacts due to increased risk of isolation.
The most recent Family Fund survey in Scotland reports that despite the lifting of shielding requirements, many disabled and seriously ill children are still living with restrictions on their day-to-day activities, including a loss of play, social and recreational activities.
The most significant drop in informal support (since pre-lockdown) is reported in recreational and play activities (79% reduction).

The Royal College of Paediatrics & Child Health reports that some children who were shielding (in particular) felt forgotten during lockdown, and felt that the messaging and support services were inappropriate and aimed at the over 70s. Key priorities for young people who have been shielding were to provide mental health support as they reintegrate into society and better communication and messaging.

6. **Children and families impacted by disability**

For some children with special education needs and disabilities, school closures had a beneficial effect on their anxiety levels, with some parents considering home education as a long-term option.
Key factors which helped were:

- a more flexible approach to learning
- less social pressure
- more child-led learning.

However, this is not consistent across all groups with evidence of increased levels of anxiety in autistic children due to loss of routine, with some reports of problems in return to school arrangements
The impact on the wellbeing of disabled and seriously ill children appears greater and concerns include:

- Lack of essential support, particularly in educational psychology, speech and language therapy and occupational therapy.
- Many families struggling financially.
- Parental concern about the negative impact of COVID-19 on children's physical health has doubled from 27% at the start of lockdown to 58% in August 2020.
- Deteriorations are also seen in mental health and children's behaviour and emotions.

7. Black and Minority Ethnic (BME) Children and Young People

Research by Intercultural Youth Scotland reports BME young people's feelings of disadvantage (compared to their white peers) in relation to their education and future opportunities as a result of COVID-19.

Other key issues raised were:

- worries about the disproportionate impact of COVID-19 on BME people
- the impact of police presence during lockdown which it is reported limited opportunities for BME young people to exercise and socialise during lockdown.

8. Increased exposure to domestic abuse

Scottish evidence reports that throughout lockdown, services received reports of children being exposed to increased levels of abuse. There were some reports of children who had fled domestic abuse experiencing severe isolation and digital exclusion, with remote engagement with younger children being reported as very difficult.

9. Adverse childhood experiences

Some children have not been visible during lockdown and school closures.

The pandemic is impacting on children's experiences of trauma in terms of increasing the risk of ACEs (e.g. domestic abuse, bereavement, family mental illness, extreme poverty etc.) and limiting the ability of adults and services to identify children and mitigate the impact of trauma.

10. Child exploitation/modern slavery

For the first time, ONS modern slavery statistics report that more National Referral Mechanism referrals were received for child potential victims than adults (over the period Apr-Jun). This research is particularly relevant to care experienced children in England and Wales and it is not clear what the Scottish position is, but we cannot assume there is no increased risk.

11. Online safety and bullying

There is some emerging UK evidence of an increase in online bullying during lockdown (YMCA survey). There are also indications of increases in online sexual abuse during the pandemic (based on data on UK-wide Childline and NSPCC helpline data). A NSPCC briefing suggests that this may be aggravated by children and young people using online platforms to counter loneliness without sufficient understanding of online risks.

For most children and young people schools provide a strong learning environment, significant safety, nurturing relationships and a safe space to hang out with friends. The importance of re-establishing friendships, as well as the critical importance of positive and supportive relationships schools provide should not be underestimated.

Summarised by Geraldine Queen

Appendix 2: The impact of COVID-19 on 2-4 year olds in Scotland

Summary of PHS report (full report found here)

Extract of key messages:

1. COVID-19 and in particular the infection control measures, including lockdown, have had a profound impact on 2–4 year old children in Scotland.
2. This age group sees rapid development and it is important that children are able to develop fully at each stage if they are to reach their full potential later.
3. Family environment – parents felt that lockdown had enabled them to maintain good relationships with their children except for a small minority who felt their relationship with their child had worsened.
4. Physical development – children had largely remained active in lockdown although quality of sleep for many children had deteriorated.
5. Social development – many families saw a reduction in their income and parents often exhibited a high level of stress which would have affected the children.
6. Learning experiences – at this age it is important children have the opportunity to mix with other children. This was severely restricted during lockdown. In addition, not all children were able to access good quality outside space easily, and this was associated with household income, so active play was also restricted for some children. However, parents saw an increase in their children's imaginative play.
7. Children's play began to reflect their experience of COVID-19 factors such as isolation, curtailment of access to services and even death being apparent in their imaginative play.
8. Development and wellbeing – Strengths and Difficulties Questionnaire (SDQ) scores for this age group showed a large decrease in those children scoring 'close to average' compared to a similar cohort of children assessed in 2019, showing that a substantial proportion of children were suffering from mental health and wellbeing difficulties during lockdown.
9. Access to services – an important minority of parents found it difficult to access children's services during the pandemic. However, 70% of parents had indicated that they would have liked help with their children's response to COVID-19 during lockdown.
10. While some services were maintained, especially immunisation, other services were more limited, in particular child health reviews by health visitors, access to dental services and

11. lower use of emergency services. As need was unlikely to have dropped this suggests children were not always receiving the care they needed.

Access to children's services:

Most parents did not require the use of any of these services, but there was a mixed response in terms of whether they managed to access services or not:

- 30% of parents and carers who had wanted to access health visiting services during lockdown had not been able to
- 13% of parents and carers who had wanted to access GP services during lockdown had not been able to
- 44% of parents and carers who had wanted to access AHP services during lockdown had not been able to

- 59% of parents and carers who had wanted to access nursery staff during lockdown had not been able to
- 18% of parents and carers who had wanted to access school staff during lockdown had not been able to
- 57% of parents and carers who had wanted to access family support workers during lockdown had not been able to
- 29% of parents and carers who had wanted to access social workers during lockdown had not been able to
- 49% of parents and carers who had wanted to access voluntary organisations during lockdown had not been able to.

Child Development Reviews.

In 2019, 81% of children who were eligible for a 27–30 month review had been assessed by the time they were 31 months old. In January–April 2020 this proportion was 65–70%, with the highest coverage (70%) achieved in March. The lower levels of coverage seen in January and February suggest that this effect may not be due to COVID-19 service impacts alone.

The findings of child development reviews, as well as their delivery, have changed in the pandemic period. The proportion of children reviewed who have at least one developmental concern recorded at the 27–30 month review fell in March and April 2020 before returning to pre-pandemic levels by June 2020. In April 2020, 9% of children undergoing a 27–30 month review had a developmental concern identified compared to the pre-pandemic average of 16%. The recording of full, meaningful data for all areas of development was also lower in this period, with 73% of 27–30 month review records having full data recorded in April 2020, compared to 91% in the period June 2019 to February 2020.

These data suggest that service disruption due to COVID-19 affected the undertaking of reviews. This may be due to changes in whether and how services were delivered, and it may also be that some parents and carers deferred reviews due to reluctance to engage with health services during the pandemic. National guidance issued at the start of the pandemic recommended that 27–30 month reviews should be conducted remotely (by phone or video consultation) where

feasible. The lower data completeness on review records may therefore reflect difficulties in completing a full developmental assessment without face-to-face contact. In addition, some reviews were being undertaken when the child was older than 27–30 months and so it may have appeared they had less developmental concerns than would be expected for that age group.

In view of these factors, and the fact that changes in the actual occurrence of developmental concerns are unlikely to occur over such a short time period, the dip in March to May 2020 in the proportion of children identified as having a developmental concern is likely to reflect a fall in the detection, rather than the occurrence, of such issues – especially of age appropriate developmental concerns.

There is some evidence of 'catch-up' in coverage among children who became eligible for review in the early part of 2020. However, there remains a proportion of children who have not had a documented developmental assessment. The combined impact of fewer children having reviews, and a lower proportion of those reviewed having developmental concerns identified, means that across Scotland during the period March to July 2020, around 800 children fewer were identified as having a developmental concern at 27–30 months, than would be expected based on pre-pandemic levels.

MMR Uptake.

The data also show that increased early uptake has been achieved across all deprivation groups, indicating that the approaches taken may be beneficial in future efforts to reduce inequalities in immunisation. Uptake of the vaccine can be measured by early uptake (immunisation by 3 years and 5 months) and by immunisation by 3 years and 8 months. In 2019, early uptake was 52%, and was 50% in March 2020. Since then there has been a substantial and sustained rise in the proportion of children with early uptake, to around 70%. The proportion of children immunised by 3 years and 8 months was also higher in March (84%) and April (85%) 2020, than in 2019 (81%).

There was a substantial decrease in the number of children attending dental services in the period 1 March to 30 June 2020, compared with previous years, reflecting the restrictions that were introduced around dental care. Over the previous 4 years, an average of nearly 60,000 children aged 2–4 years had contact with NHS General Dental Services (GDS) over the equivalent 4 month period, reflecting over one-third of the population of this age group. In 2020 there were only 8,193 children who had contact with NHS GDS in this period (5% of the population). There was a gradient in participation by deprivation, with 6% of children in the least deprived areas having had contact with dental services, compared with 4% in the most deprived areas.

In March to June 2020 only 3.1% of 2–4 year olds received a Childsmile intervention in primary care dental practices, compared with an average of 22% over the previous 4 years. In addition to the interventions delivered in dental practices (toothbrushing instruction, diet advice and fluoride varnishing) there are nursery, school and

community components, such as supervised daily toothbrushing in nurseries. These are also likely to have been substantially affected by the service changes and restrictions during the pandemic.

Conclusions:

What is also clear from the routine data is that the closure, pausing and/or non-use of healthcare services and interventions disproportionately affects the most deprived families with young children.

The experience of children aged 2–4 years during the lockdown period March to July 2020, and possibly beyond, has not by and large been positive. Although certain aspects of children's lives stayed the same or even improved, many deteriorated and the relatively low percentage of children close to average on the SDQ measure demonstrate this.

Children's use of services also decreased during the lockdown period. In some cases this might be seen in a positive light if it meant children did not need them. However, apart, possibly, from use of A&E, there is no reason to think that children should have needed less input from services.

It is imperative that children's services remain operational, as much as is possible, during any return to lockdown. This includes prioritising face-to-face services such as health visiting and developmental reviews, and interventions such as dental health. There could be some learning for other services from the successes of the immunisation programmes during lockdown. It is also important to ensure that children who may already be at risk of disadvantage do not lose out further as a result of changes in service availability or means of delivery. Evidence from the CEYRIS survey, particularly in relation to access to child health services such as AHPs, suggests that some groups of children, such as those with additional support needs or with a disability, may be disproportionately negatively affected by the infection control measures. These children need additional support put in place.

•Play is important for children's development and consideration should be given to keeping open parks and playgrounds designed for young children.

•Staff in early learning and childcare settings should be appropriately trained to deal with the impact of COVID-19 on children, including mental health and wellbeing and issues related to financial or food insecurity.

•Learning opportunities for children, and supporting parents to help them realise those opportunities, have been consistent themes. Accessible ways for parents and carers to obtain information on how to support their child's learning should be considered. This should include making available printed materials to mitigate the impacts of digital exclusion.

•As indicated in the CEYRIS study, the mental wellbeing of parents and carers of children in this age group may also have been negatively affected by the pandemic. This may mean they have fewer emotional resources available to support their children's development and wellbeing. Specific support for parents of young children should be considered and where support was in place prior to lockdown this should continue. Due to the somewhat solitary nature of lockdown young children have had less opportunity to speak to or engage with trusted adults, such as nursery staff. This

is also true when children are self-isolating. This may have meant issues such as domestic violence and the impact on the child have not been picked up. Contactor children with adults out with the home, either through (for example) childcare, nursery school, other professionals, or with trusted members of their wider family, is therefore essential.

•Many AHP services have been paused in schools and nurseries, including speech and language therapy. This, together with a ban on singing, may mean young children are not developing the communication skills as rapidly as would be expected.

Going forward, the health and welfare of children in this age group needs to be monitored closely. The large decrease in SDQ scores, the lack of access to facilities at perhaps critical times and the stress felt by both parents and children during the pandemic are all factors which may have long-term implications for children's development.

Summarised by Geraldine Queen

Appendix 3: The impact of COVID-19 on 10-17 year's old

Summary of PHS report (full report found here)

Extract of key messages:

1. **Mental Health, Social Development and Relationships:**
   - For many young people loneliness has been an unintended consequence during lockdown. There has been a particular impact on young people who are more vulnerable e.g.
     Young people who have communication difficulties
     Care Leavers
     Young people who live alone
     Young carers
     Young people engaged in the justice system
     Young people who have had previous mental health difficulties
   - A survey carried out in April 2020 showed that 40% of 11 – 12 year olds had experienced moderate to extreme concern about their mental health. The impact on mental health increased with age with 49% of 13 – 15 year olds and 61% for 16 – 18 year olds.
   - Young people with existing mental health issues described barriers to seeking help, for example, not wanting to burden families or the NHS, the need for privacy, feeling ashamed or undeserving of help or feeling not sufficiently unwell to need such support.
   - Compared to the same period in 2019, referrals to CAMHS were 53% lower between April – June 2020 but referrals between October and December 2020 were similar to the same period in the previous year.
   - In June 2020 the number of young people waiting to be seen by CAMHS was at the lowest level.
   - On a more positive note, some young people reported that during lockdown they felt they enjoyed spending time at home with their family members.
   - Lock down measures have been especially difficult for families who were just about coping or who were beginning to struggle prior to the pandemic.
2. **Impact on the digital connectedness of young people:**
   - Social media has helped young people keep connected however it has also put additional pressure on young people to engage online.
   - Inequalities in relation to digital connectedness persist in particular access to computers, mobile devices and broadband or data packages.
   - Some school staff indicated that they were concerned that some young people may not have access to adequate resources to allow young people to complete online learning.
   - Increased social media use may expose young people to online cyberbullying, online predators and exposure to potentially harmful social media content.

- There is evidence shown from the wider impacts of the COVID-19 pandemic that excessive screen time may be associated with health risks such as poor sleep, frequent snacking or obesity due to a sedentary lifestyle.

3. **Impact of COVID-19 on the risks of abuse, neglect and exploitation of young people:**
    - Being confined to home by law may have exacerbated risks of abuse, neglect and exploitation, this being due in part to the stress of striving for greater independence and/or privacy.
    - Data from Police Scotland reported that there had been an 18% increase in all online child sexual abuse crimes.
    - One survey found that 5 – 8% of young people felt unsafe at home, although this is not known whether this is higher than pre pandemic.
4. **Impact of COVID-19 on young people's physical health:**
    - The likelihood of severe illness and hospitalisation from COVID-19 is very much lower in younger age groups compared to older people.
    - In a survey of young carers during lockdown, it was indicated that just over one third felt they were struggling to look after themselves in relation to eating, sleeping and exercising well.
    - Girls and older boys reported that their sleep quality had deteriorated during lockdown.
    - Some young people reported that they felt they were more engaged in physical activity during lockdown.
5. **Impact on access to and usage of health and other services for young people:**
    - Whilst some services for young people were delivered using virtual methods, disruptions to other services such as mental health support or support for those with additional needs were reported.
    - For young people involved with youth justice services some had experienced delays to hearings and in some cases halted progression from custody.
    - The delivery of school based immunisation programmes was inevitably disrupted during the pandemic.
    - Sexual health and orthodontic services have also been impacted.
    - Use of emergency healthcare by children aged 5 – 14 years fell substantially at the end of March 2020 compared with previous years.
    - Planned admissions fell dramatically in March 2020 reaching its lowest levels in April 2020, when they were 60% lower than the same weeks in previous years.
6. **Impact of COVID-19 on education:**
    - Two surveys of young people were carried out which showed that early in the pandemic (first lockdown) less than half of young people were not concerned about impact on their education. In the second survey, young people were more concerned, particularly older pupils which may indicate additional stress or pressures of the exam years.

- More vulnerable young people expressed concerns about school closures, school work and their future life chances.
- Parents/carers with degree level qualifications were more likely to undertaken the required support for their children with school work/activities compared to parents/carers with no formal qualifications.
- Whilst young people returning to the classroom had concerns about the need for social distancing, they were keen to return and see their friends and receive support from their teachers.

Points for consideration:

During the pandemic services and supports for young people have been paused, delayed or adapted as necessary to suppress and control the virus. Key actions for considering in future:

- Where possible young people should be given the choice of online or face-to-face consultations.
- Services for children and young people should adopt a trauma informed approach to delivery. This is in line with policy and is even more appropriate in light of COVID-19.
- Inequalities in access to digital communication has been exacerbated. Local/national government and private providers should consider the robust and equitable provision of technology and connectivity.
- Services should provide accessible information on the varying forms of social media, how they operate and risks involved in accessing online platforms so that young people can be protected from potential harms associated with their use.
- There is a need to raise awareness that for some children and young people, home is not always a safe place for them to be.
- Information on how best to protect young people should be readily available and accessible.
- Some young people have disengaged with some services during the pandemic. Efforts should be raised to reach out to those young people at risk of further disengagement in a more timely manner.
- In times of family conflict, services such as education or youth services may need to provide a trusted adult to offer support.

Summarised by Irene Campbell, Programme Manager Maternal and Child Health, 12th April 2021