NHS Lanarkshire

Public Health 2021/22

The Annual Report of the Director of Public Health

Acknowledgements

I am grateful to the staff within the Directorate of Public Health for all their work over the year. I am also grateful for their continued commitment, and the commitment of NHS Lanarkshire and staff in other organisations, to public health in Lanarkshire.

I would like to thank all the contributors to this report within the Directorate of Public Health and the NHS Lanarkshire Health Improvement Department.

Finally, I would like to extend my thanks to all organisations who work with NHS Lanarkshire to protect, maintain and improve the health of the public**.** This includes North Lanarkshire Council, South Lanarkshire Council, North Lanarkshire Health and Social Care Partnership and South Lanarkshire Health and Social Care Partnership.

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Cover photo: Green Health Partnership collage of photographs.
With thanks to *Clydesdale Community Initiatives* for their permission to reproduce the photographs. CCI offer outstanding opportunities for people experiencing long term physical or mental health issues, and social disadvantage to participate in a range of social and vocational activities that positively impact on health and wellbeing.

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Foreword

It is an honour and privilege to produce my first Director of Public Health Annual Report of 2021/22 after the first year of my tenure as Director of Public Health & Health Policy for NHS Lanarkshire.

Subsequent reports post 2017/18 have been delayed due to the pandemic and we hope now to get back into step with a regular DPH Annual Report going forward.

The main messages in this report are similar to that of previous years prior to the pandemic but include some even clearer themes and Public Health priorities which we need to focus on. The COVID-19 pandemic has taken a significant toll on the people of Lanarkshire from a number of perspectives. NHS Lanarkshire services met the challenges of the pandemic face on and staff have worked tirelessly to support the people and health of the population of Lanarkshire, however the impact on health services cannot be underestimated as detailed in the following chapters.

The impact that COVID-19 has had on inequalities is well documented, particularly for those living with existing health conditions and these have been profound. Those living in the most deprived areas of our community have been unequally affected, as have some minority ethnic groups and those with disabilities. The direct impact of the virus itself and also the indirect impact through reduced access to care have been significant.

The report focusses on several key areas in addition to the impact of COVID-19, a very pertinent issue which has come to the fore since 2021 are the increased pressures affecting all parts of our community due to the increased cost of living.

A number of excellent initiatives have been put in place to ensure the population of Lanarkshire are informed of all supports available to them from multiple agencies including the NHS. Community led programmes such as *Warm Hubs* have significant potential to promote health and wellbeing and help prevent the need for requiring clinical services.

We have also provided a health improvement focus on a number of the Public Health Priorities for Scotland including Smoking Cessation Services and restoring these to pre-pandemic service levels; Maternal Nutrition – a vital element in promoting the health and wellbeing of our mothers and babies. Mental health has been identified as one of six national Public Health priorities, this is extremely welcome and the impact of the pandemic on those key services is another area of high focus for the NHSL Board and our partners.

The work of the Health Promoting Health Service is growing pace, this is a settings-based population health approach, aligned to the Realistic Medicine Programme. Shared decision making and a personalised approach are key elements of practising Realistic Medicine. Again a key goal for NHS Lanarkshire is to restore to pre-pandemic levels and improve on the success of the programme as we move into a new healthcare world post-pandemic and to provide improved services for the people of Lanarkshire.

The impact of the pandemic on cancer and other screening programmes has been significant, however, I am pleased to advise that the cancer screening programmes are well

on their way to reaching pre-pandemic uptake levels and endeavouring to improve on those. However, we are not complacent, the impact of inequalities on cancer and other screening programmes is substantial and we are committed to improving on that.

The impact of the pandemic on access to dental services is well documented in the press and the media, NHS Lanarkshire is committed to remobilise; recover and encourage more training within domiciliary care dental specialisms to help address the challenges faced by those services and in turn promote the oral health and wellbeing of the population of Lanarkshire.

In next year's annual report, the intention is to review the recommendations from the 2021/22 report to ascertain what progress has been made, in particular in relation to Child Poverty.

Vision

Healthy people and communities thriving in inclusive, equitable and sustainable environments

Mission

*To **Build Back** from COVID-19 and **promote, protect and improve** the **health of individuals and communities** in Lanarkshire through the effective use of data, evidence based prevention strategies, leadership, advocacy, partnerships **and contribute to reducing health inequalities**.*

I have included a copy of our mission statement which sets out the vision and aspirations we have for the future of public health and how we can better serve the population of Lanarkshire.

Finally, I would like to thank the editorial team for all their work and participation in helping to produce this report.

Prof Josephine Pravinkumar – Director of Public Health & Health Policy

1. Health of the People of Lanarkshire

1.1 Population Profile

This section describes the population of NHS Lanarkshire, and how it is projected to change over the next 20 years. The number of births and deaths registered in 2021, and data on life expectancy are reported. Mortality information for specific diseases that cause the most deaths is presented. Detailed information on each area is included in the relevant section of the Statistical Appendix which readers are referred to.

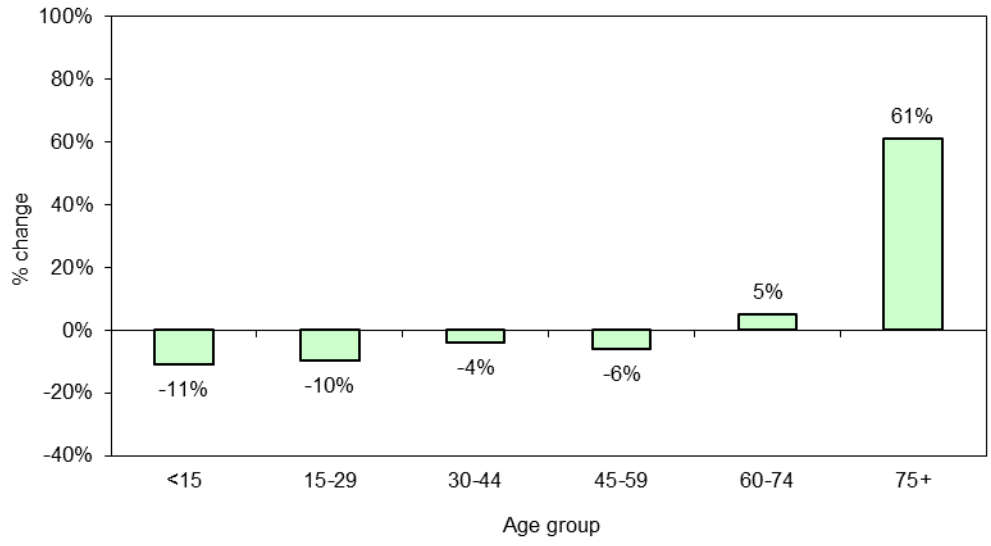
Population estimates and projections

The estimated population of the NHS Lanarkshire area on 30 June 2021 was 664,030. This is an increase of 0.3% (2,070) from the previous year's estimates by National Records of Scotland.

The median age of the population was 43, for Scotland as a whole it was 42. Eighteen percent of Lanarkshire residents were aged less than 16, 65% were of working age, and 18% were of pensionable age. This was close to the Scotland average of 17%, 65% and 18%. There were 20,648 (6.4%) more women than men.

The latest projections of Lanarkshire's future population are based on estimates for 2018, and show that the population is expected to rise about 0.5% in the next 10 years. The population is expected to fall slightly between 2031 and 2041, making the expected overall change in the 20 years from 2021 an increase of 0.3%. The projected change in the age structure of Lanarkshire's population between 2021 and 2041 is shown in Figure 1.1.1.

Figure 1.1.1 Projected percentage change in the age structure of Lanarkshire's population, 2021-2041



Key components in the changing Lanarkshire population are as follows:

- An increase of 25.7% in the population aged 75 and over is projected by 2031 from 2021, and a further increase of 28.1% by 2041. Overall this means a projected increase of 61.0% over the next 20 years, resulting in 32,757 more people aged 75 and over.
- The largest fall in population will be in the under 15 age group, with a projected decrease of 10.8% by 2041. There is estimated to be 11,903 less people aged under 15 in the next 20 years.

More details on population estimates and projections for Lanarkshire are provided in tables A2 and A3 in the Statistical Appendix.

Births

There were 6,405 live births registered among NHS Lanarkshire residents in 2021, an increase of 7.3% from 2020. The number of stillbirths decreased slightly from 32 in 2020 to 24 in 2021. The overall live birth rate per 1,000 women aged 15-44 was 53.0 for Lanarkshire, higher than the Scottish rate of 46.3.

Over the three-year period 2019-2021, 99.7% of all babies born alive in Lanarkshire survived their first year. There was an average of 22 deaths per year, excluding stillborn babies. These deaths were similar to the level in Lanarkshire for the period 2018-2020. The infant death rate (deaths during the first year of life) in Lanarkshire was 3.5 per 1,000 live births – slightly higher than the Scottish rate of 3.4 per 1,000 live births. Due to the small numbers involved, death figures among children aged one year or younger fluctuate from year to year.

Further information on births is shown in tables A4 and A5 in the Statistical Appendix.

Life expectancy

There is a decrease in life expectancy at birth in Lanarkshire between the time period 2009-2011 and 2019-2021. This decrease is 1.8 years for males (from 76.8 to 75.0 years) and 1.3 years for females (from 80.9 to 79.6 years). In the UK, life expectancy had been slowly increasing till a slight decrease in the most recent period. Scotland life expectancy had stabilised, but has started to decrease. For Lanarkshire, life expectancy gradually decreased from 2010-2012.

Women in Lanarkshire live on average 4.6 years longer than men. This gap between male and female life expectancy is similar to that for Scotland (4.2 years) and the UK as a whole (3.8 years).

Life expectancy is still below national levels; people in Lanarkshire live on average 1.4 years less than others in Scotland (men 1.6 years and women 1.2 years less). Compared to the UK as a whole, men in Lanarkshire die 3.6 years earlier and women 3.0 years earlier (2018-2020 data). Within Lanarkshire, life expectancy in South Lanarkshire is higher than in North Lanarkshire; in the South men live 1.7 years longer and women 1.6 years longer on average than those in the North.

Further information on life expectancy is shown in table A12 of the Statistical Appendix.

Deaths

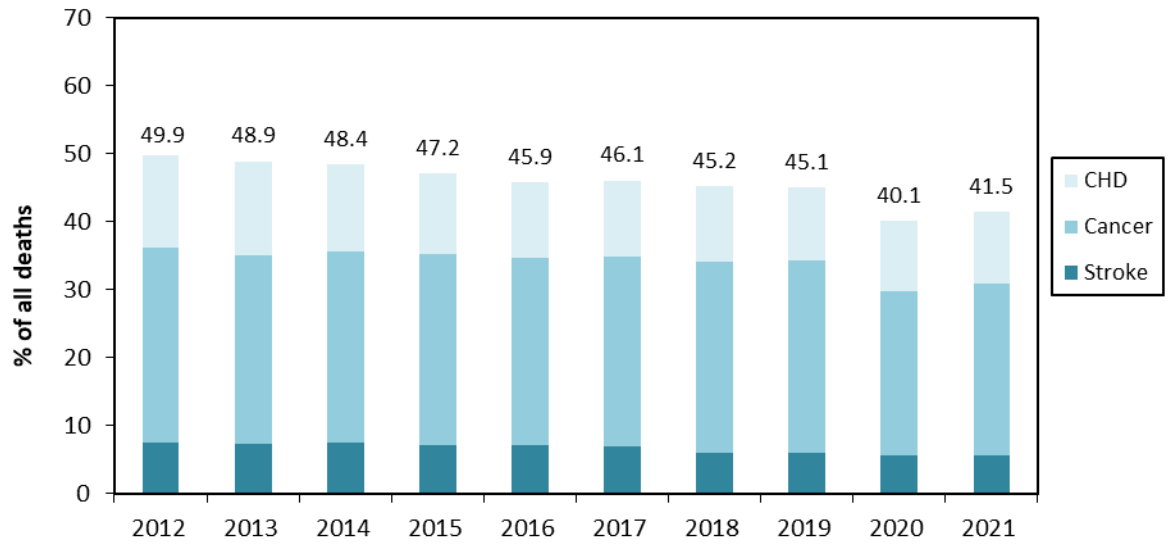
There were 8,132 deaths in Lanarkshire in 2021, a decrease of 226 (2.7%) from 2020.

Overall standardised mortality ratios (SMRs) in Lanarkshire remain above the Scottish average for both sexes, and for those under and over 75 years of age. Over the last 10 years, Lanarkshire' s SMR has ranged from 8.6% (in 2018) to 14.4% (in 2020) above the Scottish rate, and in 2021 was 12.2% above. The relative difference between Lanarkshire and Scotland continues.

There is wide variation in SMRs between the different localities in Lanarkshire, which reflects differences in deprivation levels. From one locality with an SMR 20.3% below the Scottish rate for males aged less than 75 years, to another locality with an SMR 47.4% above the Scottish rate for females aged less than 75 years.

There is a continuing reduction in the combined proportion of all deaths due to cancer, coronary heart disease (CHD) and stroke as shown in Figure 1.1.2. Since 2012, they have accounted for less than 50% of all deaths and in 2021, the proportion was 41.5%. This is mostly due to a decrease in deaths from CHD and stroke. There has not been any significant change in the proportion of cancer deaths over the last 10 years. In 2021, the 'big killer' diseases accounted for 3,375 deaths: individually cancer, CHD and stroke were responsible for 25.4%, 10.5% and 5.6% of all deaths in Lanarkshire, respectively. Respiratory disease, although it has been decreasing over the last 10 years, was also a significant cause of mortality in 2021, accounting for 8.8% of all deaths.

Figure 1.1.2 Proportion of deaths caused by the 'big killer' diseases in Lanarkshire, 2012-2021



More detailed information on mortality is provided in the tables and charts in A6–A11 of the Statistical Appendix.

Key Points

- Lanarkshire' s population increased between 2020 and 2021 and is expected to continue to increase over the next decade, before a slight decline. Overall, over the next 20 years, there will be an increase in Lanarkshire' s population.
- The proportion of the population older than 75 is expected to have a substantial increase over the next 20 years, while the proportion under 15 will have the greatest reduction. The proportion of working age adults will also decline in this time period.
- There were 8,132 deaths in Lanarkshire in 2021, a decrease of 2.7% from 2020.
- In 2021, the 'big killer' diseases accounted for 41.5% of all deaths – cancer (25.4% of all deaths), coronary heart disease (10.5%), and stroke (5.6%).
- Death rates in Lanarkshire are above the Scottish average, with significant variation within Lanarkshire reflecting differences in deprivation levels.
- Life expectancy in Lanarkshire has decreased and continues to be below Scottish and UK expectancies.

Priorities for Action

- Investment and service development/reorientation is required to address the needs of the predicted increased population of those aged 75 years and over in the next 20 years.
- The impact of inequities within Lanarkshire and between Scotland continue to result in preventable differences in mortality rates. Multidisciplinary, interagency and collaborative approaches are required to address this problem.
- Continued work is essential to ensure that the declining trends associated with the 'big killer' diseases are supported to continue and that hard won progress is not lost.

The statistics in this section were obtained from local analysis of data supplied by National Records of Scotland (NRS) or directly from NRS published online at National Records of Scotland. Statistics and Data [Internet]. Available from: http://www.nrscotland.gov.uk/statistics-and-data. And SIMD2020 version 2 published online at Scottish Government. Scottish Index of Multiple Deprivation 2020 [Internet]. 2020. Available from: http://www.gov.scot/collections/scottish-index-of-multiple-deprivation-2020.

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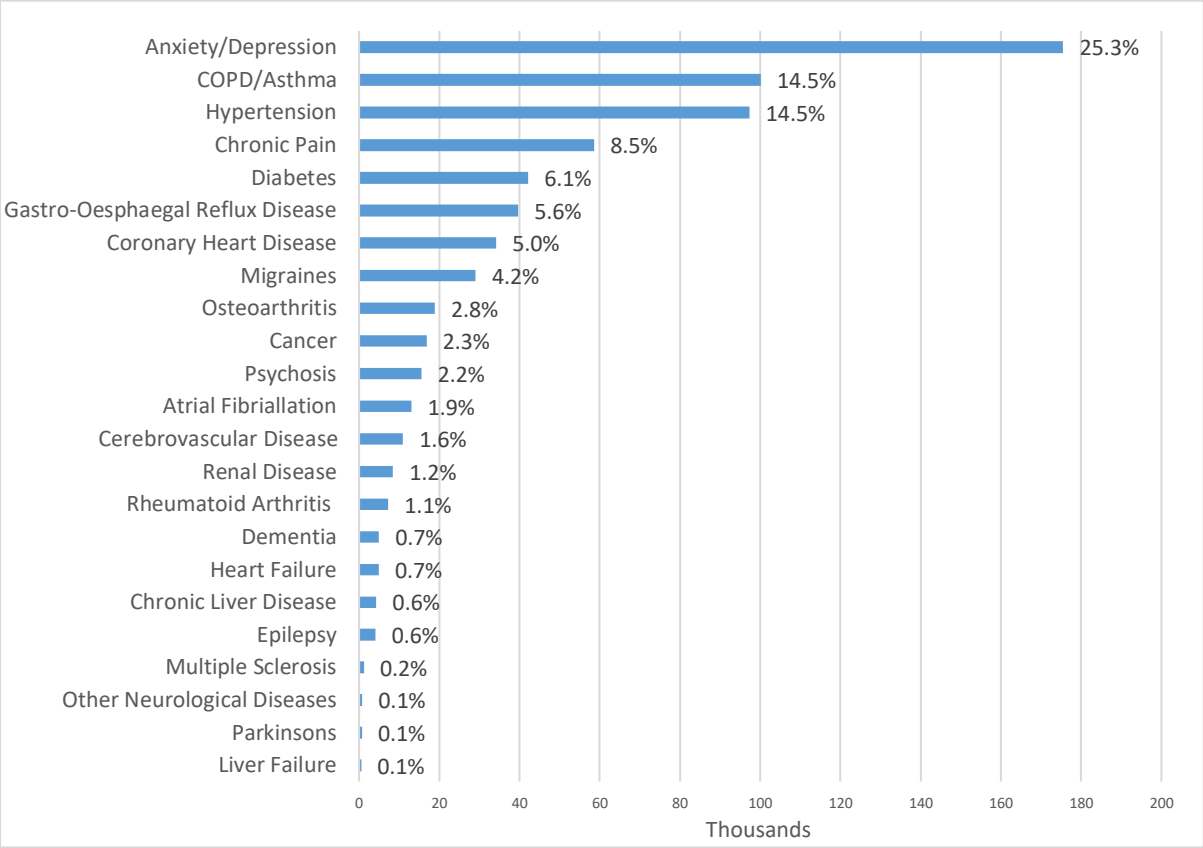
1.2 Long Term Conditions in Lanarkshire

Approximately 50% of the population of Lanarkshire report having one or more long term health conditions (LTCs). Anxiety/depression, chronic obstructive pulmonary disease (COPD)/asthma, hypertension, chronic pain, and diabetes were the top five most prevalent LTCs among residents in Lanarkshire (Figure 1.2.1).[1,2,3,4]

Figure 1.2.1 Prevalence of LTCs for all age groups in Lanarkshire, 2020/21



Mental Health

Indicators for mental health[5] showed that in Lanarkshire during the period 2017-21, males had a mean Warwick-Edinburgh Mental Wellbeing Scale score of 47.9 and females, 48.9 (the scores range from 14-70) which are low-mid range. The deaths from suicide rates during the period 2016-20 were 23.0 per 100,000 for males and 6.4 for females which are consistent with the Scotland average.

Although the indicators above for Lanarkshire's mental health were similar to others in Scotland, there has been a steady increase in prescription of antidepressants between 2010/11 and 2019/20[6] and NHS Lanarkshire accounted for 42,178,203 Defined Daily Doses (DDD) which equates to a rate of 209.77 DDD per 1,000 of population per day. This was the highest daily dose rate in Scotland, which had an average of 187 DDDs dispensed per 1,000 of population per day during the same period.

Cancer

Cancers causes significant ill-health and early death in Lanarkshire and Scotland as a nation. There has been a decrease in all cancer cases since 2016[7] with a sharp fall in 2020, which

may be due to a lack of detection during the pandemic. Analysis of Scottish Index of Multiple Deprivation (SIMD) showed that there were higher cancer rates in the more deprived areas.

During 2016-2020 there were 19,849 cancer registrations in NHS Lanarkshire, a crude rate of 601.9 per 100,000. There were 3,997 cancers in 2019 and 3,619 in 2020 for Lanarkshire which equates to a crude rate of 622.9 and 564.8 per 100,000 respectively.

Tracheal, bronchial, and lung cancer incidence for 2016-2020 showed that 3,402 cases were identified in NHS Lanarkshire, the crude rate was 103.2 per 100,000 of population.

Breast cancer incidence for 2016-2020 showed that 3,060 cases were identified in NHS Lanarkshire, the crude rate was 92.8 per 100,000 of population.

Colorectal Cancer Incidence

Year	Number of cases	Crude Rate per 100,000
2016-2020	2,124	64.4
2019	453	68.4
2020	371	56.0

In 2021/22 there were 6,895 hospital attendances at NHS Lanarkshire hospitals, both in- and out-patients under medical oncology[8] for patients living with cancer.

Health Surveys

In 2021 Lanarkshire residents gave their opinions to questions on their health and care.[3] The response to 'Are your day-to-day activities limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months?' was 'Yes, limited a lot' by 16%, 'Yes, limited a little' by 24% and 'No' by 60%. Some LTCs were reported to be chronic pain, a mental health condition, a physical disability and deafness or severe hearing impairment.

Key indicators were summarised from the Scottish Health Survey 2017-2021[4] and Lanarkshire residents reported increased rates compared to Scotland for;

'Limiting long-term illness'	37% (34% Scotland average)
'Food insecurity'	12% (9% Scotland average)
'Very low physical activity levels'	22% (20% Scotland average)
'Current smoker'	19% (16% Scotland average)
'Unpaid caring'	18% (15% Scotland average)

Some of these factors are complex and intertwined and as socio-economic factors affect health, so does health affect socio-economic factors.

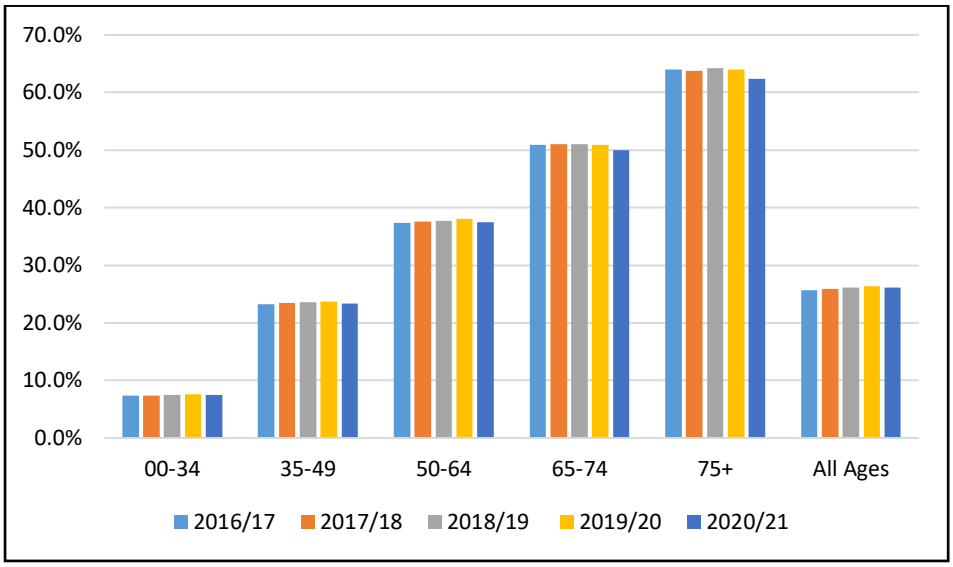
Multiple Long Term Conditions

There were 172,613 Lanarkshire residents recorded as having multiple long term conditions (MLTCs) (i.e. two or more LTCs) in 2020/21. This is about a quarter of the Lanarkshire

population, and is consistent with findings at the UK level that approximately 1 in 4 people have MLTCs.

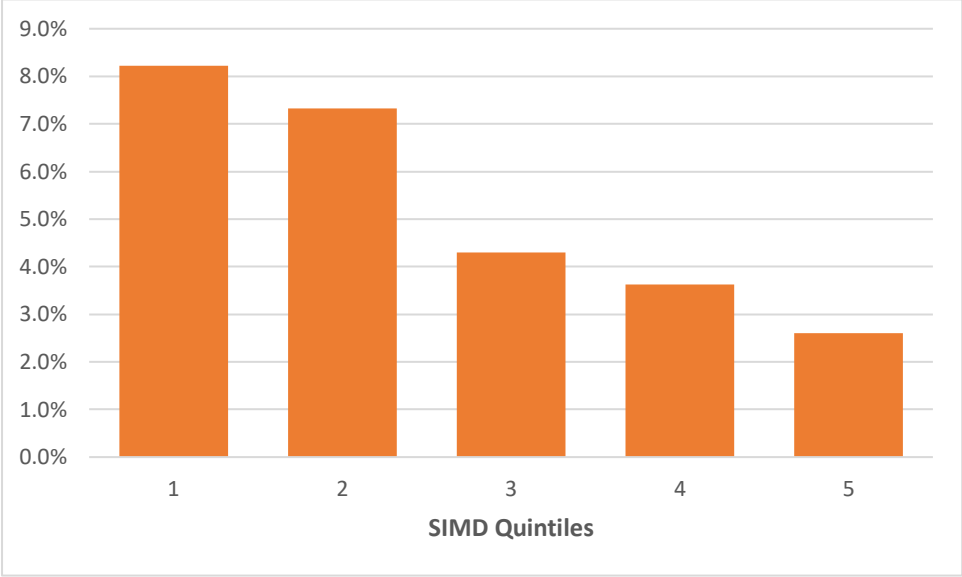
The percentage of people with MLTCs increases as people get older, with those aged 75 and over more likely to have a higher number of LTCs compared to other age groups (Figure 1.2.2).

Figure 1.2.2 Population in Lanarkshire with MLTCs, all ages, 2020/21



Prevalence of MLTCs in Lanarkshire increased with higher levels of deprivation. Whilst a gradient effect was apparent, the most notable difference was between the opposite ends of the spectrum, the most deprived (SIMD 1) having over three times higher percentage of MLTCs than the least deprived (SIMD 5) (Figure 1.2.3).

Figure 1.2.3 Population in Lanarkshire with MLTCs by deprivation quintile, all ages



Data also showed that healthcare activity is correlated with the number of LTCs people have. The average number of hospital outpatient appointments, emergency inpatient

admissions, elective inpatient admissions, emergency department attendances, and prescribed medications increased with higher number of LTCs. This is particularly evident in the average prescribed drugs count where those who had 5 or more LTCs had a 7-fold prescribed count compared to those with 0-1 LTCs.

Burden of ill-health in Lanarkshire

The three leading groups of causes of ill-health and early death in Lanarkshire are cancers, cardiovascular diseases and neurological disorders (Figures 1.2.4, 1.2.5).[1,2] The largest differences in burden for North Lanarkshire compared to Scotland – occur due to substance use disorders, other non-communicable diseases, and digestive diseases (Figure 1.2.4),[1] while the largest differences in burden for South Lanarkshire compared to Scotland – occur due to neurological disorders, diabetes and kidney diseases, and cardiovascular diseases (Figure 1.2.5).[2]

The leading cause of ill health in North Lanarkshire is depression, the rate of which is 11.7% higher than in Scotland.[1] The leading cause of ill health in South Lanarkshire is low back and neck pain, the rate of which is 1.5% higher than in Scotland.[2] The leading cause of early death in North Lanarkshire is ischaemic heart disease, the rate of which is 9.4% higher than in Scotland.[1] The leading cause of early death in South Lanarkshire is ischaemic heart disease, the rate of which is 10.4% higher than in Scotland.[2]

Figure 1.2.4 Leading grouped causes of ill health and early death in North Lanarkshire

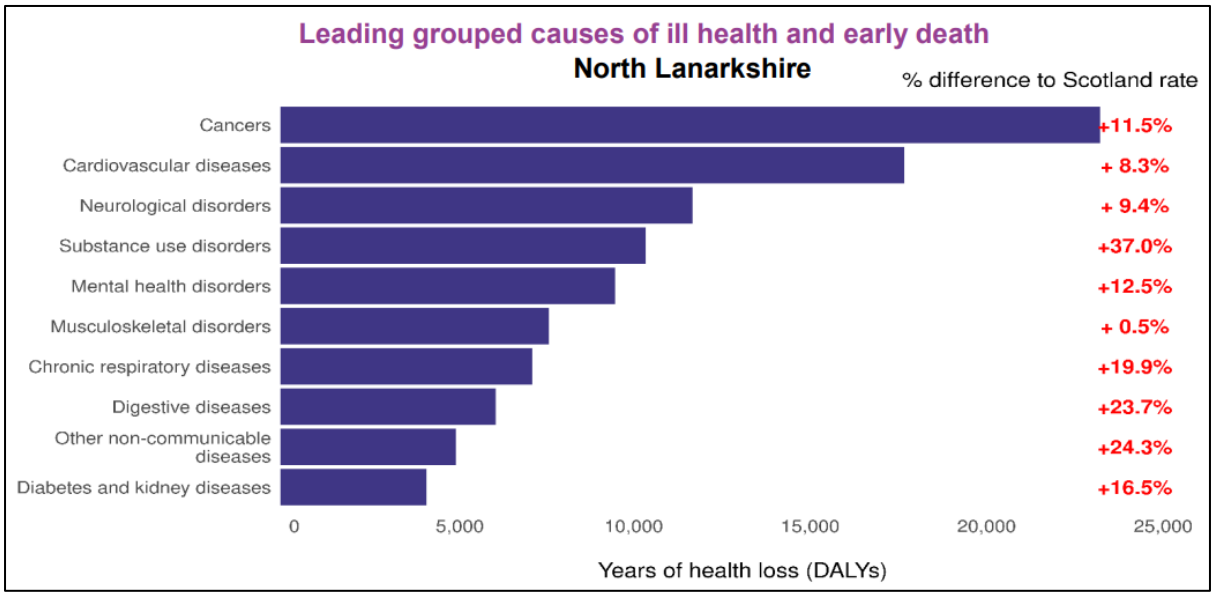
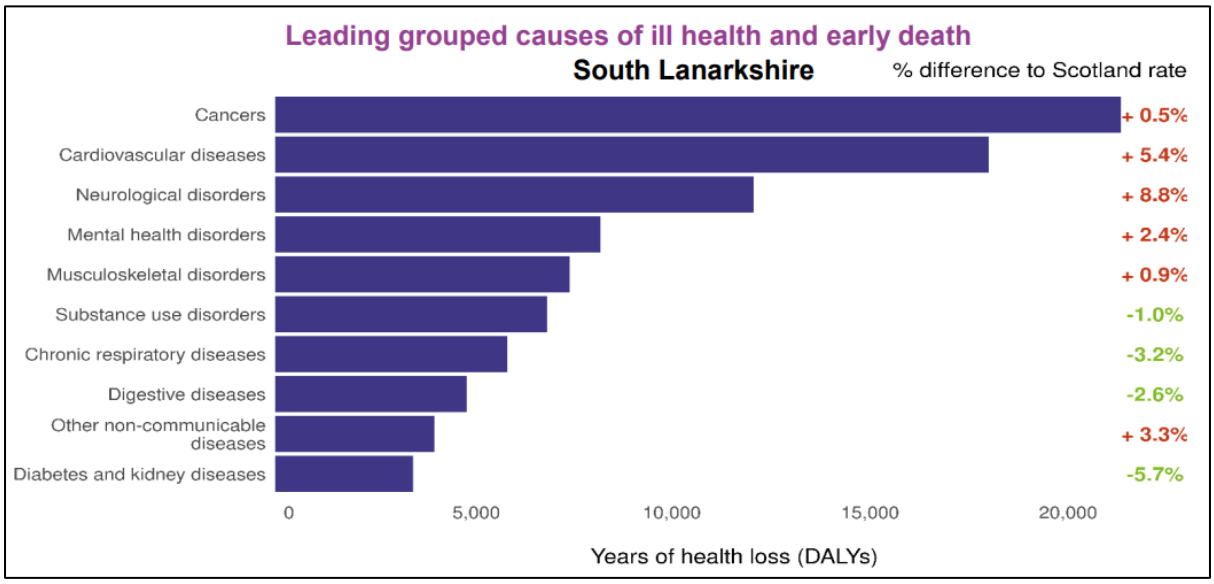


Figure 1.2.5 Leading grouped causes of ill health and early death in South Lanarkshire



Key Points

- At least one in four people in Lanarkshire report having a minimum of two or more long term medical conditions.
- Mental health conditions, cardiovascular disease, and cancers represent significant long term problems for Lanarkshire residents.
- Compared to the rest of Scotland, these conditions are more prevalent in Lanarkshire.

Priorities for Action

- Long term conditions are common in Lanarkshire and provision for these needs should be planned.
- Cancers, cardiovascular disease, and neurological conditions are more prevalent in Lanarkshire, compared to Scotland in general. A collaborative approach can help to reduce preventable conditions.
- Due to the substantially higher prevalence, substance use disorders are a particularly important issue to be addressed in North Lanarkshire.

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2 Cost of Living Crisis

Background

The UK is experiencing a cost of living crisis due to a rapid increase in prices over the last year with rates of inflation almost at a 40-year high. This comes after a period of stalled improvements in mortality trends, four decades of widening health inequalities and the COVID-19 pandemic. It is not clear how long this situation will continue due to wider uncertainties including the impact of war in Ukraine and supplier issues as a result of the pandemic and Brexit.

In response to this crisis, the UK and Scottish Governments have taken a range of mitigating measures designed to target the most vulnerable households. This includes benefits up-rating, cost of living payments to those on means tested benefits, pensioners and disabled, an increase in the Scottish Child Payment, national living and minimum wage increases and ongoing support to households through the Energy Price Guarantee as well as other supports.

A Health Impact Assessment (HIA) report[1] by Public Health Scotland suggests that, despite these national mitigating measures, the crisis is likely to have a range of adverse health impacts on individuals and households and that some key groups will be differentially affected. Those with the least will suffer most as those households with the lowest incomes spend proportionately more of their income on essentials that are seeing the largest rises (food and utilities) and they are less likely to have savings to provide a buffer. This will lead to widening health inequalities and increasing demand on public services.

The HIA report recommends mitigating actions including increasing/protecting incomes, improving energy efficiency, reducing transport barriers, prioritising education and support for children and young people, reducing other health harms, and avoid stigmatising approaches and communications.

NHS Lanarkshire response to the cost of living crisis

NHS Lanarkshire has a long history of taking action to support those in poverty and have contributed to the implementation of Child Poverty plans[2,3] with Community Planning Partners.

The cost of living crisis has led NHS Lanarkshire to urgently consider what further actions can be taken to mitigate the impact of this crisis on patients and carers and to support NHS staff who may also be affected by the crisis both personally and through the anticipated increased demand on services.

A cost of living short life working group was formed in autumn 2022 and has developed an outcome focused action plan, informed by national and local evidence of need.

Achievements to date include:

- Development of a communications plan to promote the financial support services available.
- Establishing a cost of living webpage[4] which links to financial and mental health supports.
- Distribution of 10,000 money worries leaflets across NHS and social care sites.
- Development of a staff health and wellbeing strategy and staff support guide.
- Supporting NHS services to routinely ask patients about financial wellbeing and refer them on to financial support services.
- Promoting health improvement programmes such as free infant vitamin distribution and Quit Your Way (stop smoking) services.
- Expanding opportunities for digital appointments to reduce the need to travel to appointment.
- Maintaining accreditation as a living wage employer.
- Targeting NHS employment opportunities to key vulnerable groups.
- Promotion of free access to period products across NHS sites.

A range of monitoring measures have been agreed to record progress against the actions in the plan. These include: referrals to financial services; evidence of reach of communications messaging; uptake of health improvement programmes; and patient and staff case studies.

Key Points

- The cost of living crisis is likely to lead to adverse health impacts, widen existing health inequalities and increase demand on health and social care services.
- A NHS Lanarkshire cost of living action plan has been developed to mitigate the impact of the crisis on patients, carers and staff.
- This plan builds on the collaborative work already established through the Child Poverty action plans.

Priorities for Action

- Review health and social care services to ensure they are delivered in ways which minimise unnecessary costs for patients.
- Services to routinely ask patients about their financial wellbeing and refer on to support services where required.
- Ensure cost of living concerns are addressed in the NHS staff health and wellbeing strategy with a focus on the needs of lower paid staff.
- Collaborative whole system working with local authorities, third sector and other partners to direct resources and interventions towards those most vulnerable.

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3 Health Protection

3.1 COVID-19 and Health Inequalities

Introduction

Evidence has shown that both the direct and indirect impacts of the COVID-19 pandemic are unequally distributed across society. This is not unique to COVID-19, historically pandemics have disproportionately affected specific groups within the population. The 2009 H1N1 influenza pandemic was associated with a higher mortality among those living in deprived areas and those in non-White ethnic groups compared to White populations in the UK.[1]

This chapter provides a brief overview of the epidemiology of COVID-19 infection in NHS Lanarkshire and how the trends compare with those at a national level and within Lanarkshire across different sectors of the population.

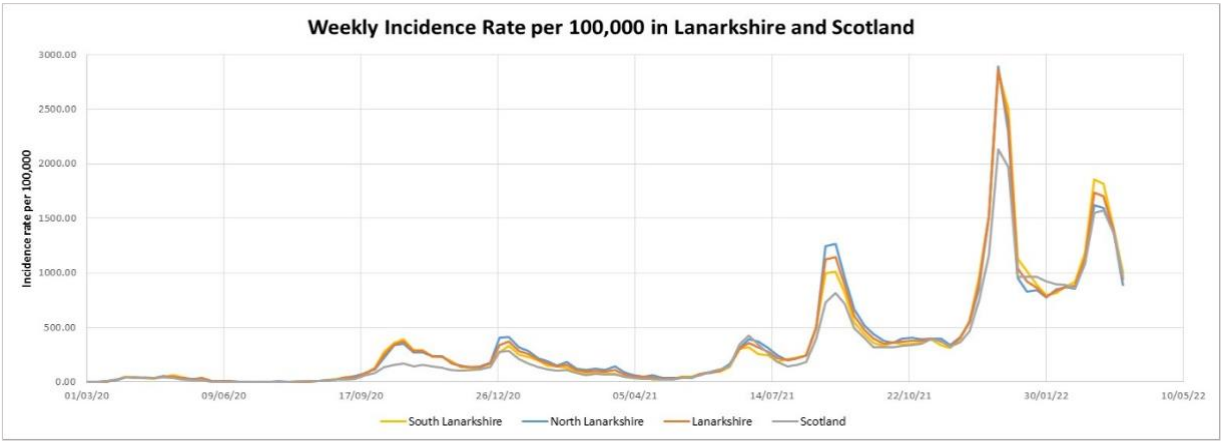
NHS Lanarkshire in comparison with the national trends

The data from Public Health Scotland (PHS)[2] was used to compare the incidence in Lanarkshire with the rest of Scotland. The cumulative incidence of COVID-19 across the period of the pandemic has been 44,454 per 100,000 in Lanarkshire compared to a Scotland cumulative incidence of 39,281 per 100,000. The cumulative incidence rate in NHS Lanarkshire was the highest NHS Board in Scotland.

Data extracts from the PHS Open Data[2] source were used to calculate the weekly 7-day incidence rate in NHS Lanarkshire and in the two local authority areas of North and South Lanarkshire and compared to the Scotland incidence in the corresponding weeks. Rates were compared for weeks commencing 01/03/2020 to 27/03/2022 when community testing was stood down.

Over these 109 weeks, the weekly incidence rate in NHS Lanarkshire was above the Scotland rate for 84 weeks (77%), for 72 weeks (66%) the incidence was 10% or more higher in Lanarkshire than Scotland (Figure 3.1.1).

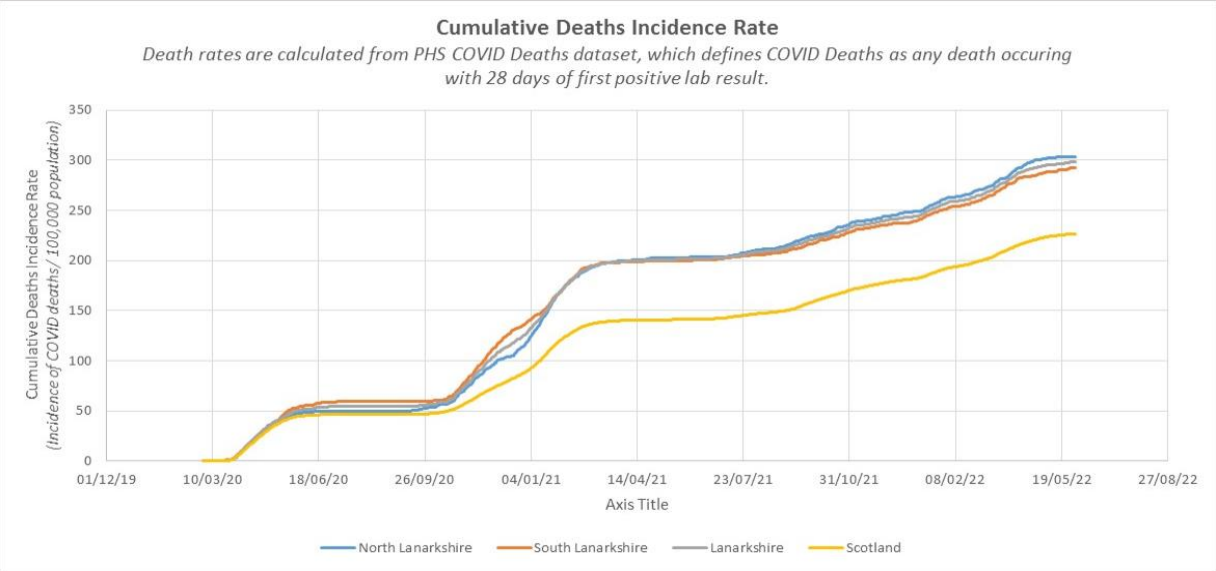
Figure 3.1.1 Weekly incidence rate per 100,000 in Lanarkshire and Scotland



During the pandemic there were two main sources of data on COVID-19 deaths. Data from National Records of Scotland which used all deaths where COVID-19 was recorded on the death certificate regardless of a positive test result for COVID-19, the second was from PHS based on deaths within 28 days of a COVID-19 positive test result. Based on the PHS data up to 01/06/2022 when PHS stopped reporting this death statistic, the cumulative crude

death rate in Scotland for COVID-19 was 226 per 100,000 while in NHS Lanarkshire it was 298 per 100,000. The rate in Lanarkshire was the second highest in Scotland. Although the cumulative death incidence rate was slightly higher in North compared to South Lanarkshire, the difference was relatively small compared to the difference with the overall Scotland rate (Figure 3.1.2). There is evidence at a Scotland level that higher deprivation and certain comorbidities including chronic kidney disease, diabetes, chronic obstructive pulmonary disease, neurological disease and cancer significantly increased with risk of COVID-19 death as did older age and male sex.[3] This impact of deprivation is likely to be an important factor for the cumulative death incidence being higher in Lanarkshire than the overall Scotland rate.

Figure 3.1.2 Cumulative deaths incidence rate for Lanarkshire and Scotland



Impressive vaccine effectiveness has been reported in preventing severe outcomes from COVID-19, however the vaccines do not prevent 100% of infections and a small proportion of those infected will progress to have severe outcome. Analysis at a Scotland level of individuals vaccinated in the first wave of the vaccination programme showed that older age, increasing number of underlying comorbidities, recent admission to hospital, being in a high risk occupation, being a care home resident, being male, being socioeconomically deprived, and being an ex-smoker were all associated with an increased risk of hospitalisation or death in people who received at least one vaccine dose.[4] Similarly, a study into patients admitted to intensive care units in the first wave of the pandemic, demonstrated that those living in the most socioeconomically deprived areas were more likely to be admitted to, and have poorer outcomes after, critical care.[5]

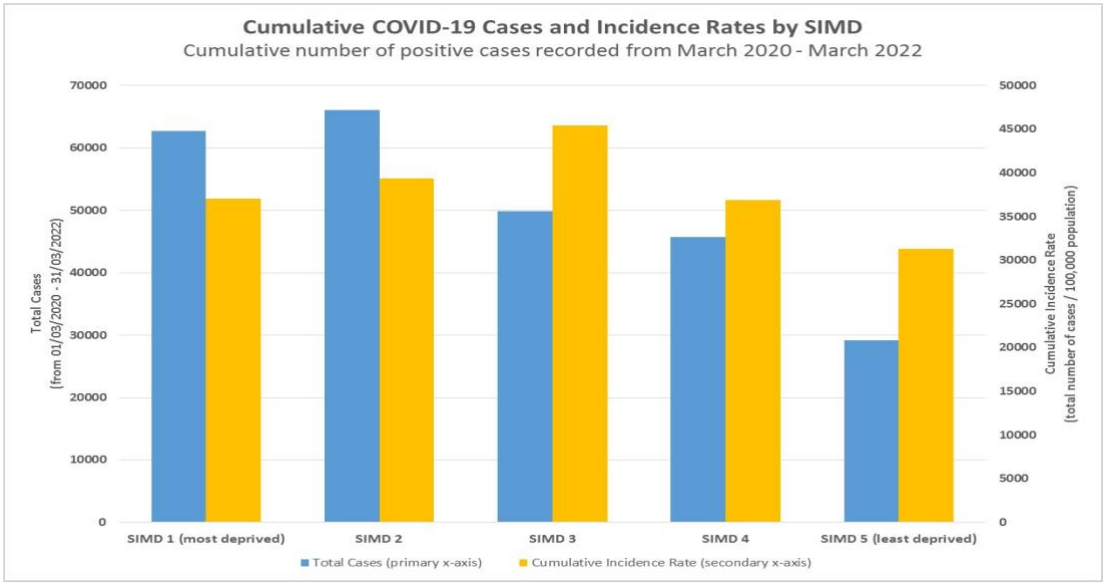
The data above suggest that the burden of COVID-19 in NHS Lanarkshire was greater than the overall Scotland burden. There is no single explanation for this, some of this may be due to differences in testing rates across Scotland and case ascertainment, some may reflect the greater burden of infection among more deprived communities, the impact of population density, and incidence of underlying comorbidities.

Inequalities of COVID-19 within the NHS Lanarkshire population

As described above the burden of COVID-19 was greater in Lanarkshire than overall in Scotland and within Lanarkshire, the burden was not equally distributed.

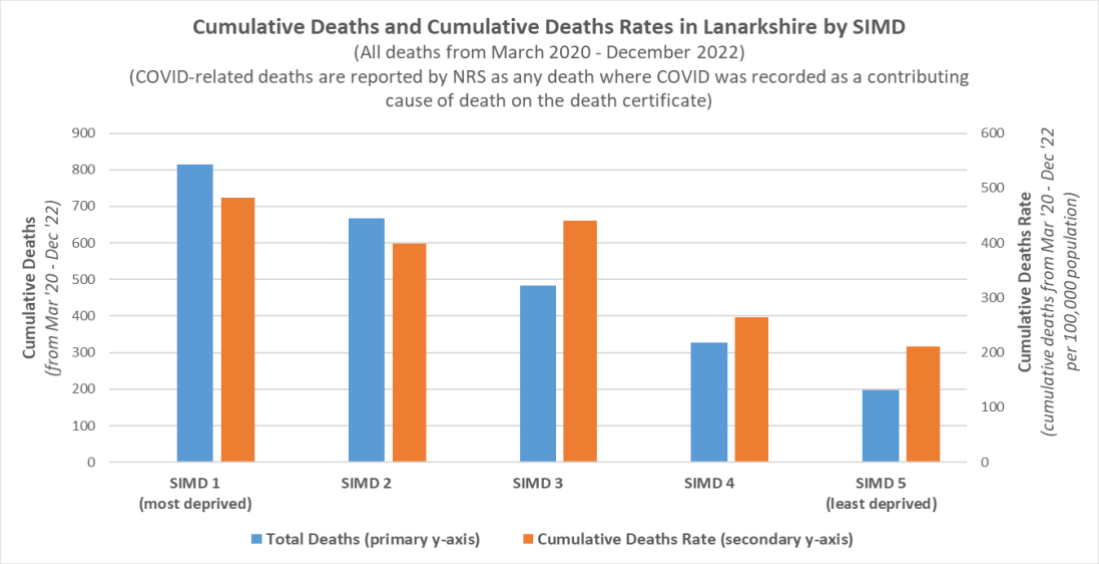
The cumulative incidence of COVID-19 (March 2020 to March 2022) in Lanarkshire was lower in the least deprived quantile (SIMD 5) compared to other areas (Figure 3.1.3). There is no single factor that influenced incidence by deprivation. Some of the difference may be differences in engagement with testing and case ascertainment especially for asymptomatic (those with no symptoms) cases. Some will be due to the risk of infection, this may have been influenced by the ability to work from home, working with the public, population density, number of daily contacts and use of personal protective equipment. As described above, deprivation was an important risk factor for hospitalisation and death among those who became infected. Overall about 50% of the population of Lanarkshire is resident in SIMD 1 or 2 areas, which is 10% higher than the Scotland value.

Figure 3.1.3 Cumulative COVID-19 cases and incidence rates per 100,000 by SIMD



The overall rate of dying with COVID-19 recorded on the death certificate was twice as high in the most deprived compared to least deprived areas of Lanarkshire (Figure 3.1.4). Whist the death rate was similar in SIMDs 1-3, it was lower in SIMD 4 and 5.

Figure 3.1.4 Cumulative deaths and cumulative death rates per 100,000 in Lanarkshire by SIMD



COVID-19 Community testing

In Lanarkshire, the expansion of community testing was accompanied by work to ensure equitable access to testing across all groups of the population. This work was operationalised at the population level by considering both incidence and testing rates in different areas and using this to target some of the mobile community testing sites and Lateral Flow Device (LFD) collection pop-up sites to these areas. A small team was also established who worked directly with community groups, religious centres and other groups to explain the importance of testing and to provide tests for those who may otherwise find it harder to access LFD testing.

Care Homes

Residents of care homes were one sector of the population severely impacted by the pandemic at a number of levels. In the first wave between March and May 2020, two fifths of care homes of older people had an outbreak of COVID-19.[6] As the pandemic evolved the impact on care home residents was not only the direct impact of COVID-19 infection, but also the wider impact of long periods of isolation, restrictions on visiting, outings and communal activities within the home.

Isolation and loneliness were not confined to residents of care homes, more loneliness and less social contact and support was also reported by older adults living in the community.[7] A larger social network, more social contact, and better perceived social support seemed to be protective against loneliness and poor wellbeing.

Long COVID

There is an increasing body of evidence on the long term effects of COVID-19 infection and a condition called post-COVID-19 syndrome, which has become known as 'long COVID'. Symptoms can persist for 12 weeks or more after the original infection and are wide ranging including respiratory, digestive system, muscular, cardiovascular and neurological symptoms.

A study from England found the prevalence of persistent symptoms was higher in females than males and increased with age. Obesity, smoking or vaping, hospitalisation, and deprivation were also associated with higher probability of persistent symptoms, while Asian ethnicity was associated with a lower probability.[8] A separate study also identified a similar range of factors associated with an increased risk of long COVID in particular age, being female, poor pre-pandemic mental health, and poor general health. Individuals with asthma also had a higher risk, as did those categorised as overweight or obese, through association for symptoms lasting 12+ weeks were less pronounced. Non-white ethnic minority groups had a lower risk of long COVID.[9]

Whilst there are no good estimates on the total number of long COVID cases in different areas, as the overall incidence of COVID-19 was higher in Lanarkshire than the overall Scotland incidence and some of the risk factors such as deprivation are greater in Lanarkshire than at the overall Scotland level, it can be predicted that the burden of long COVID may be greater in Lanarkshire than the Scotland average.

Key Points

- The incidence and mortality from COVID-19 in Lanarkshire was greater than the overall Scotland average.
- In Lanarkshire the greatest burden of COVID-19 was among the most deprived communities.

- The Health Protection Team worked with partners to make COVID-19 testing as accessible as possible to all groups of the population.

Priorities for Action

- Ensuring the lessons learnt from COVID-19 are captured and used to inform future public health responses.
- Further in-depth analysis is being undertaken to achieve a deeper understanding of the wider impact of COVID-19 on the population of Lanarkshire. This understanding will help inform future work including that of the role of NHS Lanarkshire as an anchor institution.

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3.2 Health Protection General Update

The work of the Health Protection Team covers a wide range of infectious diseases and environmental issues from norovirus to meningitis to contaminated water and preparedness for major incidents. The Health Protection Team will respond both to local issues and work with Public Health Scotland and other agencies as part of a co-ordinated response to wider health protection issues. Below provides a brief overview of some of the areas of work undertaken by the Health Protection over the past year.

Mpox (previously known as Monkeypox) Incident and Immunisation Programme

Since May 2022, public health agencies in the UK and many other countries across the world have been responding to an outbreak of Mpox. Most cases in the UK have been in England. In Scotland there have been 97 laboratory confirmed cases (data to 19 December 2022).[1]

Anyone can get Mpox, however the majority of cases are men who are gay, bisexual, or other men who have sex with men (GBMSM).

In response to this national increase in Mpox, the Health Protection Team in NHS Lanarkshire worked with colleagues in Infectious Diseases, Sexual Health and Microbiology to establish pathways that ensured individuals with possible Mpox received the appropriate clinical care and laboratory testing. As part of the public health response, the close contacts of confirmed cases were identified and contacted by the team to provide advice and to offer vaccination where appropriate and in accordance with the national guidance.

Mpox is caused by a virus similar to the one that causes smallpox. Therefore, vaccines designed for smallpox were used to prevent or reduce the severity of mpox. An immunisation programme was established in Lanarkshire to offer the vaccine to GBMSM individuals, as they were at highest risk of coming into contact with mpox and to help reduce how much it is passed on.

Increase in Group A Streptococcal infections

Streptococcus pyogenes, also known as Group A Streptococus (GAS) are bacteria that can cause a range of presentations including sore throats, impetigo, scarlet fever and in a small number of cases severe invasive infection (iGAS). Most cases of scarlet fever occur in children under 10 years of age, however people of any age can become infected.

Peaks in GAS infections are typically observed during the winter and spring months. Pre-pandemic cyclical increases were observed every 3 to 4 seasons with the last peak activity in 2017/2018. In the winter of 2022/23 there was an earlier increase in GAS and iGAS cases than in previous seasons and the peak for laboratory confirmed cases of GAS was substantially higher than seen in the previous peak. Some of this increase in laboratory reports may be due to improved case ascertainment and more testing as well as a true increase in the incidence of GAS infection in the community.

The Health Protection Team worked with colleagues in Education to provide a package of materials to support Head teachers in managing the increased number of GAS infections amongst pupils and outbreaks of scarlet fever in schools.

A number of cases of iGAS occurred in Lanarkshire. The Health Protection Team worked to identify the close contacts of these cases to provide information on the signs and symptoms to be alert to and to arrange prophylactic antibiotic treatment as appropriate.

TB cases and incidents

Tuberculosis (TB) is an infectious disease caused by a bacterium called Mycobacterium tuberculosis or other bacterium in the Mycobacterium tuberculosis complex. It is spread by droplets containing the bacteria being coughed out by someone with infectious TB, and then being inhaled by other people.

The initial infection clears in over 80% of people but, in a few cases, a defensive barrier is built round the infection and the TB bacteria lie dormant. This is called latent TB; the person is not ill and is not infectious. If the immune system fails to build the defensive barrier, or the barrier fails later, TB can spread to the lungs or develop in the other parts of the body it has spread to.[3]

The number of case of TB has been generally declining since 2000. About 60% of TB cases identified in Scotland were born outside of the UK.[4] Refugees and other populations in humanitarian settings face substantial threats to health and survival, such as poverty, crowded living conditions, undernutrition and poor access to health services – all conditions in which TB transmission thrives. The Public Health Team has been working with the Lanarkshire resettlement team to explore active and latent TB in the refugee and asylum seekers community as well as the wider Lanarkshire population.

A key component of the work of the TB Team is supporting individuals diagnosed with TB in the community, including helping them to adhere to their treatment which lasts for a number of months. The team work with TB patients to identify their close contacts and screen them if required to identify if they have become infected with TB, either latent or active infection to enable them to receive the appropriate treatment and prevent any ongoing spread of the infection.

Immunisation programmes

As a public health measure, immunisations are very effective in reducing the burden of disease. The European Region of the World Health Organization recommends that on a national basis at least 95% of children are immunised against diseases preventable by immunisation and targeted for elimination or control. These include diphtheria, tetanus, pertussis, polio, Haemophilus influenza type b, measles, mumps and rubella.

The national Vaccination Transformation programme commenced in April 2018 and since April 2022 has seen NHS Boards and Health and Social Care Partnerships take on responsibility for the delivery of all vaccinations, previously a number of vaccines were delivered in General Practice.

The uptake rates for the childhood immunisations are high in Lanarkshire and are often above the Scotland average.[5]

The autumn flu and COVID-19 booster immunisation programmes started across Lanarkshire on 5 September 2022. For the autumn COVID-19 booster, among the eligible cohorts (aged 50 years and over, frontline health and social care workers, older care home residents and clinically vulnerable individuals) 224,169 individuals resident in Lanarkshire have been vaccinated, equating to 69.7% of the overall eligible cohort, the overall uptake at a Scotland level is 72.4%. Among the eligible cohort 219,544 individuals have been vaccinated against flu in Lanarkshire, equating to 61.5%, the overall uptake at a Scotland level is 63.6% (data to week 05, 2023).[6]

HIV outbreak among Lanarkshire residents who inject drugs

In February 2020 there was a reported significant increase in cases of HIV in Lanarkshire residents who inject drugs. An NHS Lanarkshire Incident Management Team (IMT) was immediately established to further assess and manage this situation. This was connected to

the Greater Glasgow and Clyde (GGC) HIV outbreak.[7,8] From 2015 to February 2023, as part of this outbreak, the NHS GGC HIV IMT has identified 190 individuals who are HIV positive.

In Scotland, rates of cocaine injecting have significantly increased and in Glasgow city centre cocaine injecting has more than doubled. The rise in HIV infections in the centre of Glasgow has been linked to homelessness and people moving to injecting cocaine. Injecting cocaine increases the frequency of injecting episodes and so increases the risks of sharing injecting equipment and unprotected sex. Other key factors identified in the HIV outbreak were poorer opiate substitution therapy (OST) retention, incarceration and wider socioeconomic factors.

The NHS Lanarkshire HIV IMT continues to meet and has membership from across NHS Lanarkshire including Public Health, specialist BBV clinical services, Labs, Communications, Primary Care, Paediatrics, Maternity Services and BBV Third Sector Services and also includes representatives from NHS GGC HIV IMT, Public Health Scotland and the Scottish Government.

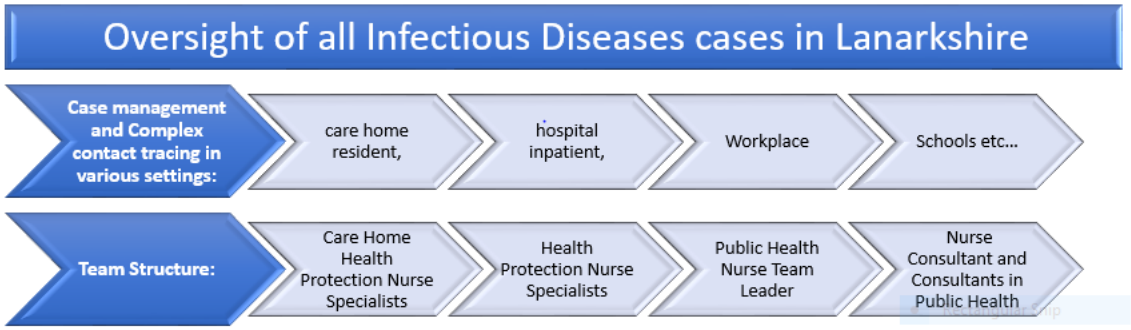
In response to the Lanarkshire outbreak a Lanarkshire HIV Prevention and Control Plan was developed and continues to be delivered by the Lanarkshire BBV Prevention and Care Network. The response to the outbreak includes an increase in targeted testing, development of new testing interventions including postal testing schemes, ongoing provision of injecting equipment provision, condom provision, awareness raising with service users, and education and training for staff.

Care Home Oversight Management and Support

Across the three Acute Hospital Sites of University Hospital Wishaw, University Hospital Hairmyres and University Hospital Monklands there are 1,653 inpatient beds to serve the population of Lanarkshire.

Due to the ageing population, there has seen a rise in the number of people requiring accommodation within residential Care Homes. Health Protection Scotland report that there are 1,616 Scottish care homes offering 44,887 places by 580 different service providers. Within Lanarkshire, there are 92 Care Homes with 4,360 resident places.

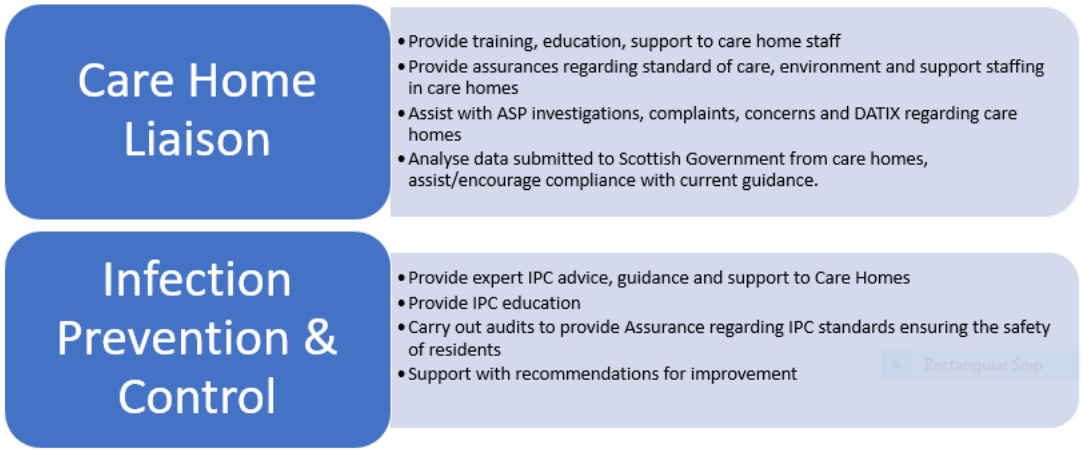
The Health Protection Team role includes supporting and advising Care Home staff on Infection Control Policy, this is heightened during periods of infection outbreaks.



Regardless of the size, if a Care Home population has a situation whereby two or more residents develop symptoms which could be from a source of infection they must report this to their Public Health Dept/Health Protection Team and the Care Commission. On receiving

this information from the Care Home, the Health Protection Team will commence a risk assessment of the situation in line with outbreak management policy and standard infection control guidance.

At the outset of the COVID-19 pandemic each Health Board was tasked by the Scottish Government in setting up a Care Home Assurance Team to facilitate additional support to Care Home staff. Care Homes required this due to the impact on them from COVID-19 on this higher at risk, vulnerable population. The focus was on ensuring appropriate Infection Prevention and Control as well as support and training around Personal Protective Equipment (PPE). This Team continues to work in close partnership with the NHSL Health Protection Team.



Multi agency co-ordination and communication, particularly during winter pressures, between the Health Protection Team, Acute services, Primary Care, Social Care and Council staff is paramount in ensuring efficient management, containment and conclusion of outbreak situations.

The Health Protection Team facilitate daily communications on restrictions or open outbreak situations with Care Homes to ensure more effective and efficient planning of admissions and discharges between Acute Hospital sites and Care Home facilities. This was especially important when the system was under significant pressure.

NHS Lanarkshire Health Protection Team had designated Care Home Health Protection Nursing within the team. In addition, there is a Nurse Consultant Lead. With this specialist aligned support, the Health Protection Team can ensure one to one or locality input including visits to the Care Homes to provide advice pertinent to their individual, person centred needs. There is provision of ongoing outbreak oversight and professional clinical advice and support to Care Home staff in line with current Guidance or Policy, and adherence to the National Infection Prevention and Control Manual for older people and adult care homes.[9]

The Health Protection Team provide continued multi agency co-ordination of Care Home and community health care services during winter pressures such as flu and Norovirus season for optimum management and support at peak times. Previously Care Home staff have been invited to attend Table Top Exercise Workshops to support them in Winter preparedness and Outbreak management and Guidance awareness. The next planned Workshop is scheduled in the Autumn of 2023.

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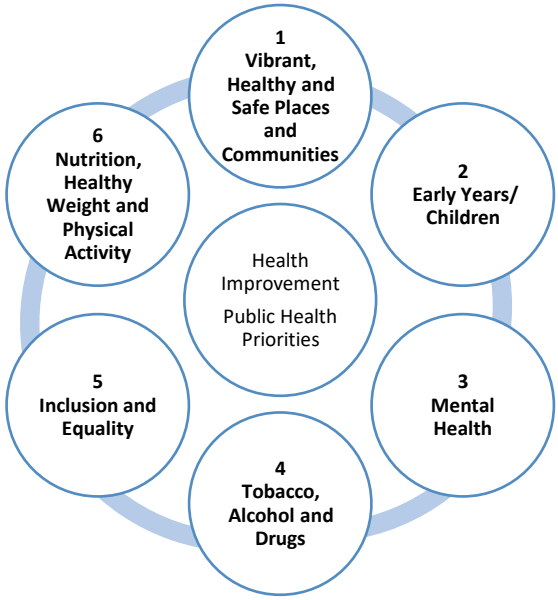
4 Health Improvement

4.1 Introduction to Health Improvement and the Public Health Priorities

The Health Improvement Department strives to address health inequalities and improve the health and wellbeing of individuals and communities. The right to health includes the right to access health services but also the wide range of things that help us live in good health, for example, access to education, good housing, financial security and affordable healthy food.



The COVID-19 pandemic and the continuing cost of living crisis has had a major negative impact on health inequalities, in particular, social isolation, mental health, poverty and financial insecurity. To help mitigate the impact and assist in the recovery of our communities, health improvement revised many of their programmes to ensure there was a clear focus on the most vulnerable and ensured an inequalities focussed approach was embedded into all work streams.

Inequalities focussed population health and community led activities continue to be a priority now more than ever and health improvement work continues to be flexible and responsive to the health and wellbeing needs of our communities. Programmes of work are person centred, inequalities focussed and developed with the communities that we serve.

The six Public Health Priorities (PHP)[1] are intertwined throughout all health improvement areas of work and have had a major impact on addressing health inequalities prior to and throughout the pandemic and now into the cost of living crisis. Below are some key areas of work undertaken by health improvement that directly contribute to the outcomes of the six PHPs.

Health improvement work in partnership with communities and partner agencies to create **Vibrant, Healthy and Safe Places and Communities (PHP 1)** by identifying joint resources and assets at a community level. Underpinned by empowerment and community resilience, health improvement programmes deliver a holistic approach to addressing health and social inequalities. Contained within this report is an example of the Health Promoting Health Service (HPHS) which is a settings-based health promotion approach that aims to support the development of a health promoting culture and embed effective health improvement practice within a variety of health settings.

Early Years and Children (PHP 2) recognises the impact that early childhood poverty, disability and adverse childhood experiences can have on health outcomes throughout a person's life. COVID-19 and the cost of living crisis both have had a major impact on children and young people. Disruption in education, increased food and fuel poverty and the

negative impacts of the pandemic on children and young people's mental health are key priorities for health improvement.

COVID-19 and the current cost of living crisis has exacerbated poor **Mental Health (PHP 3)** across Lanarkshire. Due to the spread of COVID 19 and subsequent lockdown measures, many face to face mental health and wellbeing training or support programmes were converted to online platforms. These were welcomed by individuals and communities as they allowed people to stay connected to others and seek mental health and wellbeing advice and support during this very stressful time. In recovering programmes and supports, consideration is given to what works well online and what benefits from being face to face. Our approach and collective actions/programmes of work are distilled in our Good Mental Health for All North and South Lanarkshire Delivery Plans.

Tobacco, Alcohol and Drugs (PHP 4) are intertwined with all public health priorities, as the impact of COVID-19 and the cost of living crisis has had an impact on many health harming behaviours. Health improvement have adapted by creating online platforms for many of their programmes to support people who were either considering starting a health harming substance or were already using health harming substances. Included in this report is an example from NHS Lanarkshire Health Improvement Tobacco Control Team which evidences positive outcomes during this period of time.

COVID-19 and the cost of living crisis has highlighted the stark differences in life expectancy between our most affluent and least affluent areas across Lanarkshire. **Inclusion and Equality (PHP 5)** are fundamental to the work of health improvement. Equality and values based approaches are used to identify and support vulnerable groups within communities. By addressing health inequalities, health improvement champion anti-stigma, fairness and equality across communities. Some examples of our work are; Keep Well, Poverty & Financial Security, Health and Homelessness, and Gender-Based Violence.

Being physically active and eating a healthy balanced diet are important for not only our physical health, but also our emotional and mental health. It is well documented that the pandemic and the current cost of living crisis has had a negative impact on many people's ability to access fresh healthy food, maintain a level of exercise (due to lockdown restrictions) and their ability to cook for themselves or their family due to experiencing food and fuel poverty. Health improvement have responded to the needs of individuals and communities to improve their **Nutrition,** maintain a **Healthy Weight** and be **Physically Active (PHP 6)** by offering free access to physical activity programmes, green health and healthy weight services across Lanarkshire. We have included in this report an example from the NHS Lanarkshire Maternal and Infant Nutrition programme which evidences positive outcomes during this period of time.

Reference

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4.2 Health Promoting Health Service (HPHS)

Background

HPHS is a settings-based population health approach, aligned to Realistic Medicine.[1,2] It is a framework rooted in prevention and health improvement aimed at acute and community hospital settings. The overall aim is to help reduce health inequalities by looking at the wider determinants of health that are often underpinning ill-health. There are four key outcomes set by the Chief Medical Officer in the HPHS letter,[3] summarised these are:

1. Embedding a health promoting culture amongst staff and patients.
2. Embedding pathways to referral of services.
3. Supporting staff health and wellbeing by offering safe spaces to talk.
4. Transforming the hospital environment.

Aim of HPHS

Lanarkshire's health demonstrates growing inequalities between the most and least deprived groups, this gap being exacerbated due to the impact of COVID-19.[4] People at increased risk of health inequalities make proportionately greater use of acute and community hospital services, putting staff and services under greater pressure.[5] The aim of HPHS in acute hospital settings, is to embed a **holistic needs assessment (HNA)** that identifies the wider social determinants of health impacting on the health of an individual resulting in a need for acute services.

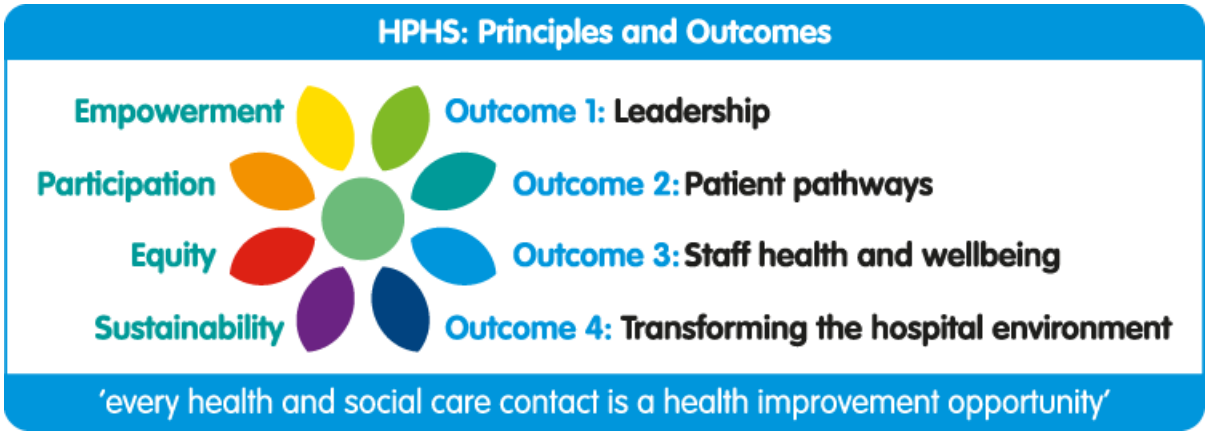
HNA in hospitals

Supporting the recovery of services from the initial phase of the pandemic; funding was made available to HPHS to recruit three Health Improvement Seniors to implement and embed a HNA approach in each of the three acute hospital settings over an 18-month period from March 2022. The HPHS team are also working with allied health professionals and discharge teams in the hospitals to implement this approach; as well as third sector partners such as the Carers Network, Voluntary Action North Lanarkshire and Voluntary Action South Lanarkshire. This early intervention HNA approach, supports the Discharge without Delay programme and helps to support individuals return to their communities where social issues can then be addressed.

Working with the acute hospital senior management teams to identify the areas where the HNA should be embedded; resulted in a different approach being taken at each of the three acute sites. University Hospital Hairmyres is focusing on the Cardiology and Vascular wards since evidence suggests that many of the in-patients of these wards, reside in SIMD 1 and 2 areas and live with multiple comorbidities. The focus for University Hospital Monklands is on those attending Renal Outpatients in receipt of dialysis since the need for frequent dialysis impacts on employment leading to financial insecurity. University Hospital Wishaw is focusing on staff health and wellbeing due to the impact of the pandemic on the workforce. A separate HNA was created for staff to facilitate this support. They also prioritised supporting patients with complex needs in the surgical and critical care department.

Other engagements

Looking at how we get support to those who need it at as early a stage as possible, led to engagement with the Scottish Ambulance Service (SAS) Clinical Effectiveness Team and the Pathways Hub. SAS has identified populations who are high intense users of their service and NHS services and felt they could benefit from using a HNA approach.[6] The premise being that SAS would identify and alert the HPHS team when they were conveying a patient to hospital who needed a HNA and for those not conveyed to hospital, support would be provided from our third sector partners and the Community Liaison Hospital Discharge Support Team. This is to be a short test of change in the areas covered by the University Hospital Monklands to ascertain the feasibility of this going forward.



HNA benefits

- As a longitudinal approach, an aspirational outcome is there will be a reduction in repeat hospital visits where wider social determinants of health have been met, that will reduce clinician workload and costs/bed days. Case studies and cost avoidance/cost-benefit analysis are being prepared to highlight this. One case study demonstrated cost avoidance of at least £62,564 when a HNA and person-centred conversation was carried out with an individual.
- Understanding which social determinants impact the lives of an individual by using a HNA approach can assist in finding out 'What Matters to You', and to understand where help and support is needed to ensure swift facilitation of discharge to home surroundings with support.

Key Points

- Identifying the needs of each hospital site required a collaborative approach looking at the available evidence of need.
- HNA identifies the wider determinants of health and signposts to the support needed to help alleviate/ameliorate issues allowing individuals to support themselves.
- A partnership approach to undertaking an HNA as early as possible in the patient journey helps facilitate Discharge without Delay.

Priorities for Action

- Establishing the use of the HNA within teams to support person-centred care, shared decision making and safe and effective discharge home following evaluation of the outcomes met and identifying any gaps.

- Embedding the programme further by recruiting more staff to support the learning needs of the workforce and establish sustainability of adopting a holistic needs approach to care.
- Establishing early intervention by working with the SAS Pathways Hub to utilise the HNA.

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4.3 Good Mental Health for All

Background

Never has there been a bigger challenge to our mental health and wellbeing than COVID-19.[1,2,3] We have prioritised actions which drive good mental wellbeing across Lanarkshire, including:
1. Challenging the stigma around mental health; 2. Promoting good mental health; and 3. Addressing the barriers (social, environmental, financial or cultural) that make it more difficult for some people to take up opportunities to improve their mental wellbeing.[4]

Our approach to promoting good mental health and the collective actions/programmes of work undertaken by all community planning partners is distilled in our Good Mental Health for All North and South Lanarkshire Delivery Plans. This is one of four key work streams driven under Lanarkshire's Mental Health and Wellbeing Strategy (2019 – 2024), *Getting It Right For Every Person (GIRFEP)*.[4]

Challenging Mental Health Stigma and Discrimination

Stigma Free Lanarkshire (SFL) are a small team who have had a big impact.

Sadly, we still live in a society where admitting psychological distress or difficulty coping are deemed a weakness. Many people feel shame about seeking help. Stigma leads to discrimination in accessing healthcare or opportunities to improve health and wellbeing as well as fundamental discrimination in human rights: housing; employment; education.

Unless challenging mental health and discrimination is at the core of our efforts to mitigate the impact of both COVID-19 and the current cost of living emergency, the people who need help and support most will be the ones least likely to access it.

The SFL team, comprising a co-ordinator, two development workers and an administrator provide specialist expertise. Working in collaboration with See Me, Scotland's national body for challenging mental stigma and discrimination, they have also provided key messages and an evidence base on how to reconfigure services in ways that ensure mental health needs are recognised, normalised and talked about. Stigma and discrimination cannot become barriers for people accessing vital supports.[1,4]

Digital Inclusion

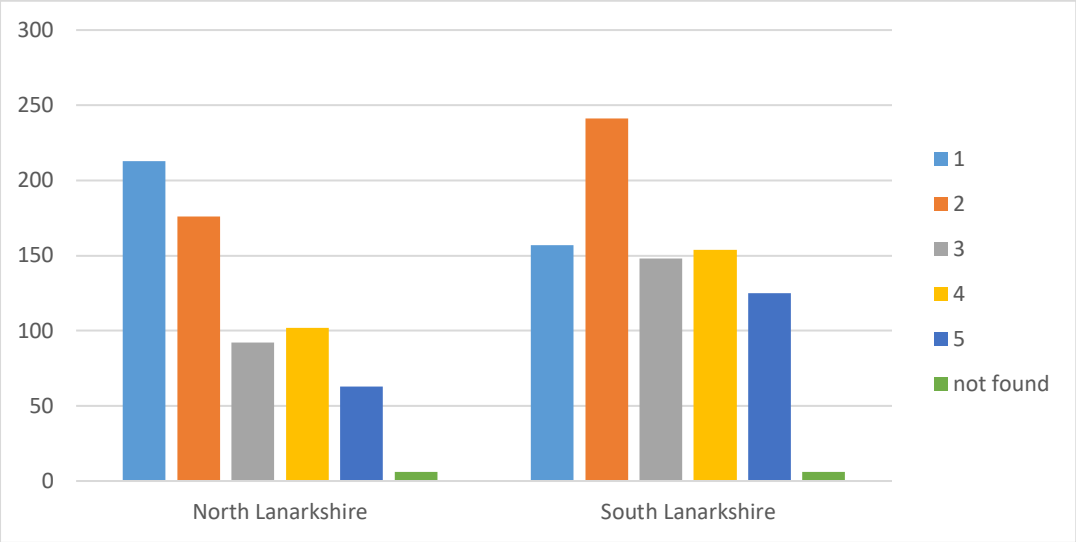
Using Digital Technology to promote mental health and wellbeing as well as improve accessibility to supports was a priority during COVID-19 and beyond.[2,3,4]

Well Connected, our social prescribing programme aimed at linking people with non-clinical sources of support in the community, went online with a bespoke downloadable app in May 2021. A Pan-Lanarkshire Suicide Prevention app was launched at the same time.

Psychological Services were unable to deliver their popular face-to-face Stress Control classes, so developed a range of free online courses, self-help videos and resources for Lanarkshire residents. This includes Calm Distress, a five-session programme of videos and workbooks to help people manage low mood, anxiety and stress. These have proved

popular across all socio-demographic groups (Figure 4.3.1), with almost half of those registering living in SIMD 1 and 2.

Figure 4.3.1 Total number of Calm Distress registrations per Council by SIMD



Recovery

When it comes to mental ill-health, recovery can mean different things. For some people, it will mean no longer having symptoms of their mental health condition. For others, it will mean managing their symptoms and regaining control of their life, and learning new ways to live the way they want. Recovery is a process that is not always straightforward.[1,2,4]

On a dark, windy, rainy day (2 November 2022), 150 people came together to share stories and celebrate recovery. For many it was the first opportunity to connect with others face-to-face since before the pandemic. 100% of people said they enjoyed the event. 95% said they had learned something about recovery. 89% said the event had helped with their own recovery.

"Inspiring and humbling to open up and release your feelings"
"It has sparked inspiration for helping others and making a positive difference in High Schools (Coatbridge High School)"
"Without a doubt, helped my recovery"

Distress Brief Interventions

Distress Brief Interventions (DBI) are an innovative way of supporting people in distress.[4,5] DBI consists of two parts, with Level 1 seeing trained front-line health, police, paramedic and primary care staff help ease any individual. They then ask the person if they would like further support and, if they agree, they are referred to the DBI service with a promise of contact within the next 24 hours to start providing further face-to-face support.

Level 2 is provided by commissioned and trained third sector staff who contact the person within 24-hours of referral and provide community-based problem solving support, wellness and distress management planning, supported connections and signposting.

Between October 2021 and September 2022, an average of 190 people per month received a DBI. The most common presenting problems included: depressed/low mood (65% of referrals), stress/anxiety (56% of referrals), suicidal thoughts (40% of referrals).

Key Points

- Stigma surrounding mental health and wellbeing remains a barrier to accessing support. The Stigma Free Lanarkshire team provide an important role in building capacity across partners to address this.
- Online tools to support mental health and wellbeing were launched during the pandemic and remain a key element of the current programmes.
- Between October 2021 and September 2022, an average of 190 people per month have received Distress Brief Interventions. The most common presenting problems included: depressed/low mood (65% of referrals), stress/anxiety (56% of referrals), suicidal thoughts (40% of referrals).

Priorities for Action

- Deliver an annual recovery event for Lanarkshire enabling people with lived experience to share stories of recovery and explore what recovery means to them.
- Focus on embedding a whole systems approach to creating the conditions for inclusive workplaces and communities.
- Promote a confident, competent and skilled workforce through delivering training and building capacity, focusing on Mental Health Awareness and Suicide Prevention at the Informed Level as per national guidance.

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4.4 Creating a Smoke-free Lanarkshire

Background

The Tobacco Control Programme in Lanarkshire is informed by national and local strategy; policy; legislation and evidence.

Vision: A society for children which is smoke-free and where all adults are positive smoke-free role models, whether they smoke or not.

Aim: Protect children's health, tackle inequalities and reduce the prevalence of smoking in Lanarkshire from 21.8% to 11% by 2022.

Tobacco Control Programme

The Tobacco Control Programme focuses on four key areas for action; Smoking Cessation, Prevention, Protection, and Support and Leadership. Smoking cessation services in Lanarkshire are provided via three main interventions, all of which are under the umbrella brand of Quit Your Way. There is a nurse-led specialist service, a community pharmacy service and a telephone helpline operated by NHS24. Throughout 2022, the Tobacco Control programme has had successes, e.g. improved quit rates, introduction of new legislation. The programme also has had challenges, e.g. recovery from COVID-19 pandemic in its strive to achieve a smoke-free generation by 2034.

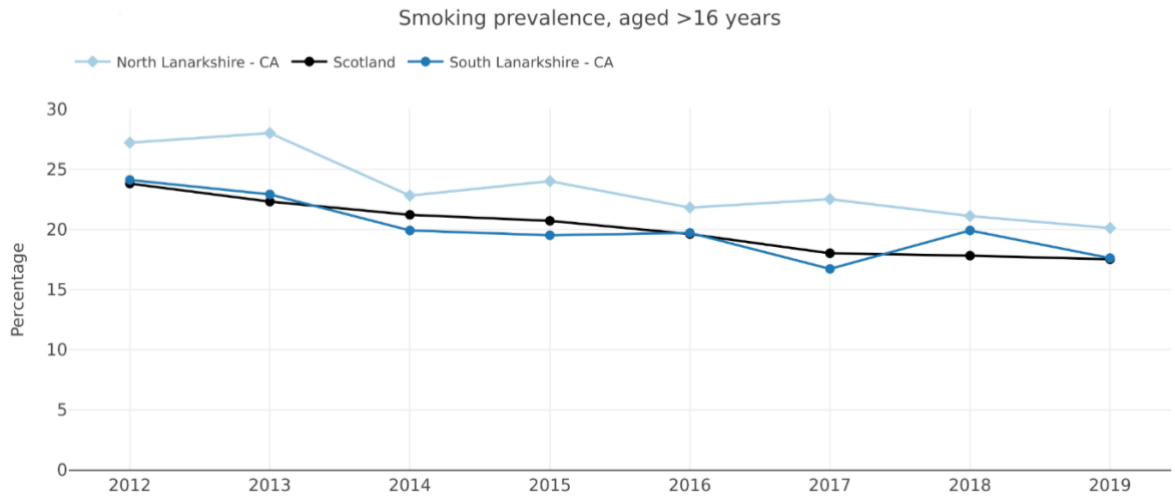
Key Points

- Overall, smoking prevalence (Figure 4.4.1) is continuing to reduce.[1] It has not however reached 11%, and still of major concern is the growing difference between the most and least deprived populations.
- The Prohibition of Smoking Outside Hospital Buildings (Scotland) Regulations 2022 came into force on 5 September 2022.
- Demand for Smoking Cessation Services (Figure 4.4.2) has reduced significantly, however quit rates (Figure 4.4.3) are increasing.
- Exposure to Second Hand Smoke (Figure 4.4.4) within households where children reside continues to be an area of concern.

Priorities for Action

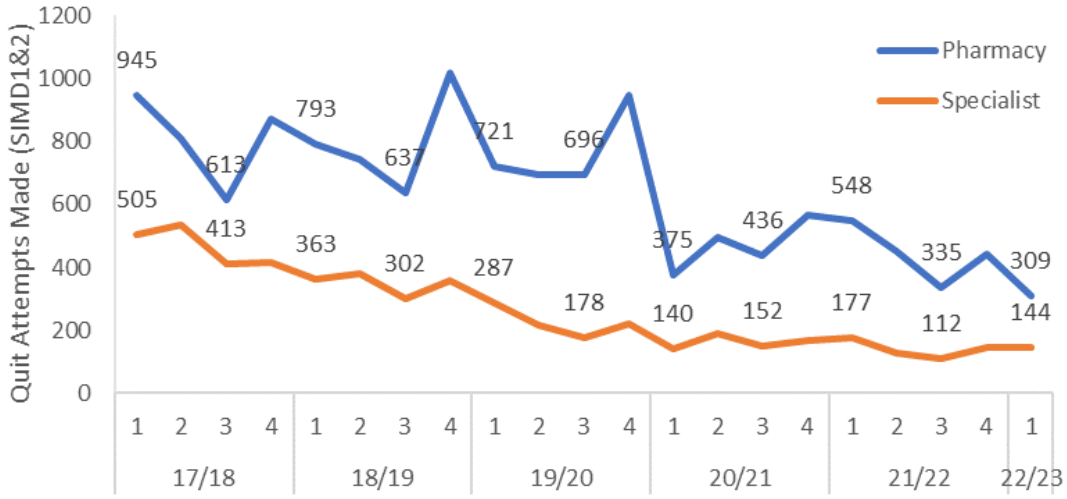
- Focus efforts on tackling inequality especially supporting people to stop smoking: including those living in most deprived areas; pregnant women and their families; those with mental health issues and people who are hospitalised.
- Support the national review of stop smoking services and development of National Tobacco Control Strategy.
- Develop interventions which enable the retention of clients who have set a quit date to remain engaged with the Quit Your Way service beyond the twelve-week stage of cessation attempt. For example, use of digital health technology such as Near Me, Smoke Free App, additional telephone support.
- Place Children at the centre of tobacco prevention and protection activity, e.g. Promoting the concept of Positive Smoke-free role models.

Figure 4.4.1 Smoking Prevalence



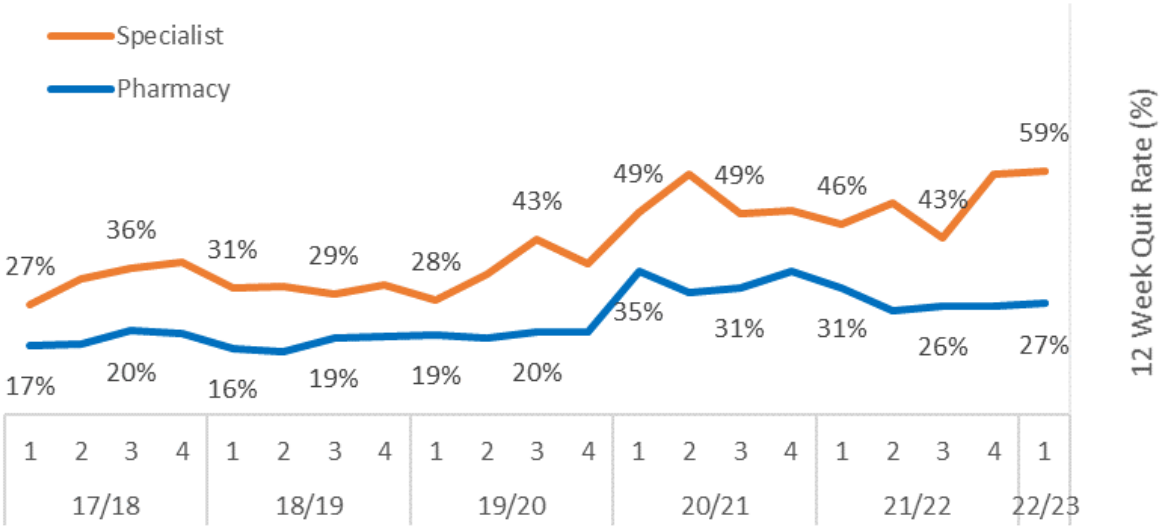
Source: Scottish Public Health Observatory profiles

Figure 4.4.2 Demand – Footfall (Quit Attempts Set) for SIMD 1 & 2



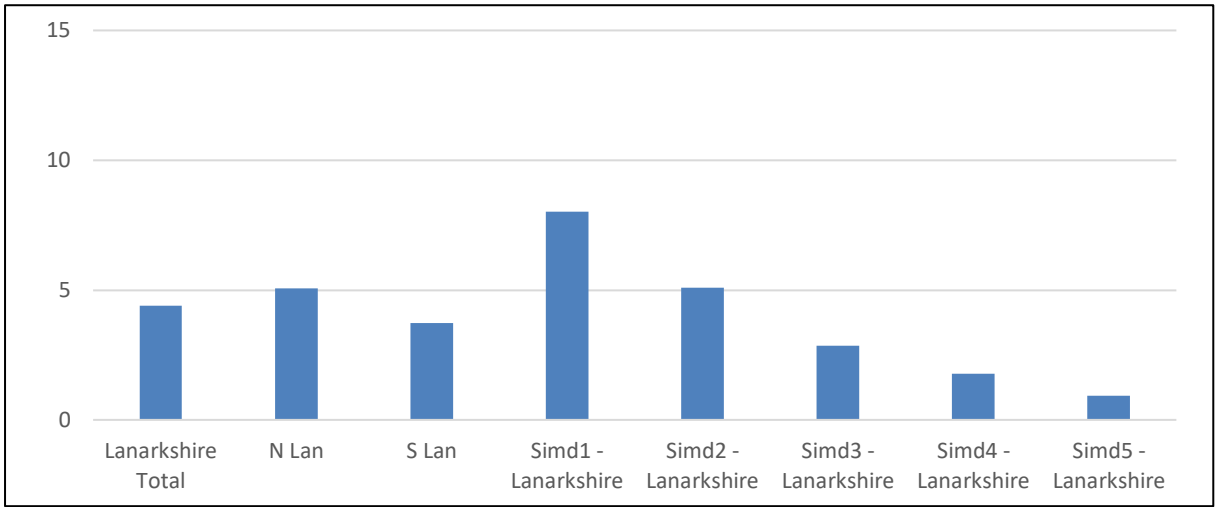
Source: Scottish Smoking Cessation Database

Figure 4.4.3 12 Week Quit Rate Trends SIMD 1 & 2



Source: Scottish Smoking Cessation Database

Figure 4.4.4 Percentage of Second Hand Smoke at 27-30 months (2020/21)



Source: Child Health Surveillance Programme, Public Health Scotland Information Request ref IR-2021-00632

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4.5 Maternal and Infant Nutrition

Background

The Maternal and Infant Nutrition (MIN) programme aims to develop, implement, monitor and review the programme of work to improve the nutritional status of women of child bearing age and children under five years, including improving the rate and duration of breastfeeding.

Main Programme

MIN covers nutritional aspects in many stages of life; from preconception, pregnancy, the postnatal period, breastfeeding and the introduction of solids to toddler nutrition. Key work streams include:

Universal Maternal and Infant vitamin scheme: Vitamins free for all pregnant women, women in the postnatal period until their child's first birthday or for the duration of breastfeeding and vitamin D for all babies from birth until their third birthday. There are over 80 NHS and non-NHS venues which are distribution points across Lanarkshire: these venues include health service venues, community facilities such as leisure centres and libraries, and venues of community & voluntary sector organisations. In light of the current cost of living crisis where many families are struggling to buy food, it is even more vital that vitamins are accessed. More than 90% of pregnant women received Healthy Start vitamins throughout pregnancy and 6,128 children's ProHealth vitamin D drops were distributed in 2021/22.

Breastfeeding Friendly Scotland: A scheme to ensure breastfeeding mothers receive a warm welcoming environment within businesses, buildings and premises by supporting their staff with key messages, window displays and certificates of commitment. During and following the recovery period of the COVID-19 pandemic, the infant feeding team adapted a blended model of Near Me, telephone and face to face contact including a breastfeeding clinic with the frenotomy service, this has now fully returned in person. There are 28 active 'community mothers' volunteers now present in postnatal wards and local groups to support breastfeeding mums. During the COVID-19 pandemic, an online breastfeeding group enabled effective support at a time when mothers were feeling isolated and vulnerable. Face to face groups have started to recover throughout localities. Scottish Breastfeeding Week in 2022 saw the return of a successful in-person conference with more than 90 people attending from NHS Lanarkshire, both councils, parents & families. The team have delivered MIN and Baby Friendly training to a wide variety of internal and external staff and partners to ensure consistent evidence based messaging within our communities.[1] This year also saw both maternity and health visiting/family nurse services successfully achieve UNICEF Baby Friendly Reaccreditation for 2022.

Working in partnership with North Lanarkshire Council, a multi-agency group has been piloting the Breastfeeding Friendly Scotland Early Learning, Schools and Local Authority award. This sees all areas of the council; including education, human resources, communications and property services, as breastfeeding friendly. These pilots are a first for Scotland and will go a long way to change the culture and create supportive, nurturing communities for our babies of the future. Community champions from Community Learning

& Development and third sector are also in place. A multi-agency working group has also commenced in partnership with South Lanarkshire Council with commitment agreed through Corporate Management and work has commenced to work towards the same framework approach.

Healthy Lifestyle in Pregnancy Service: For those with a Body Mass Index ≥ 30, this service is run by a specialist midwife, dietician and physiotherapist who offer advice on food and drink, good nutrition for baby, exercise in pregnancy to reduce potential pregnancy/labour/postnatal risks for mum. In response to COVID-19 restrictions, the service moved to online Near Me and telephone appointments before returning face to face as restrictions allowed. The team have been part of a wider multidisciplinary Gestational Diabetes steering group to improve and synergise pathways of care. Public Health Scotland has released their Births in Scotland data report for 2021/22 which shows the rates of overweight and obesity in mothers are the highest since records began across all age groups and deprivation levels.[2] In Lanarkshire, rates of those living with obesity at their booking appointment have also increased to the highest at 30.9% (from 25.9% in 2020/21), and a breakdown of 33.2% in North Lanarkshire and 28.5% in South Lanarkshire. These figures remain higher than the Scottish figure of 27.3%.

Key Points

- More than 90% of pregnant women received Healthy Start Vitamins throughout pregnancy and 6,128 children's vitamin D drops were distributed in 2021/22.
- Development and pilot of a Breastfeeding Friendly Scotland Early Learning, Schools and Local Authority award by working in partnership with North Lanarkshire Council and education colleagues has been pioneering.
- Healthy Lifestyle in Pregnancy Service works with Gestational Diabetes Pathway of care to improve pathways of care and optimise health and wellbeing of mother and baby.

Priorities for Action

- Roll out of new registration/data collection system for MIN vitamin scheme and targeted promotion.
- Working towards completion of North Lanarkshire Local Authority award, a first for Scotland! Replication of the same Breastfeeding Friendly whole council approach with South Lanarkshire Council.
- Achieving Sustainability status for UNICEF Baby Friendly Gold Award.

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5 Healthcare Public Health

5.1 Cancer Inequalities

Nationally, lung cancer is the most common cause of death in Scotland from cancer with double the number of deaths per year compared to colorectal cancer. Cancer incidence is 34% higher in Scotland's most deprived areas in comparison to the least deprived, with the likelihood of developing lung cancer three times higher in deprived areas in Scotland.[1]

Cancer diagnoses of more advanced stages are more likely in areas of socio-economic deprivation. These more advanced stages are more likely to include metastatic disease, meaning poorer outcomes for the individuals.[2]

Cancer diagnosis across Scotland was affected by the global COVID-19 pandemic. Across Scotland, by the end of 2020, there had been 4,869 fewer cancers diagnosed in comparison to 2019, a decrease of 14.6%. By the end of 2021, cancer diagnosis had risen close to pre-pandemic numbers.[3]

Cancer incidence and mortality data is routinely published by Public Health Scotland (PHS) for health board areas. However, lower level data, such as locality level is not routinely made available. In 2022, both health and social care partnerships, NHS Lanarkshire, and MacMillan Cancer Support entered an exciting partnership to bring Macmillan's Improving Cancer Journey programme to Lanarkshire. As part of the scoping process, detailed data analysis has been compiled and shared across the health board area. Much of the data highlighted in this report has been provided by PHS as part of the planning for Improving Cancer Journey programme. Data presented is for 2016-2020.

Cancer Incidence by Locality

All malignant neoplasms (excluding C44*) 2016-2020 European age-sex standardised rate (EASR)

In North Lanarkshire, 646 people per 100,000 population were diagnosed with cancer, higher than the national rate of 637 people per 100,000 population diagnosed across the same time period.

Rutherglen & Cambuslang has the highest rate of cancer incidence in South Lanarkshire at 682 per 100,000 population. This compares to the highest in North Lanarkshire, Bellshill, at 667 per 100,000 population. The lowest rates of cancer incidence in each partnership are in Motherwell (627 per 100,000 population) and Clydesdale (605 per 100,000 population).

Cancer Incidence by Cancer Type and Area

The following table outlines the age-sex standardised cancer incidence rate across the partnerships, Lanarkshire, and Scotland for the six most common cancers.

* unspecified/other skin cancer

Table 5.1.1 European age-sex standardised cancer incidence rates (EASRs) per 100,000: 2016-2020

Cancer Type	North Lanarkshire	South Lanarkshire	Lanarkshire	Scotland
All malignant neoplasms excl C44	645.8	636.9	641.4	630.9
1 - Trachea, bronchus and lung	120.1	104.1	112.0	102.3
2 - Female Breast	165.5	180.0	172.9	164.0
3 - Prostate	145.7	153.9	149.9	158.0
4 - Colorectal	69.2	68.2	68.7	73.6
5 - Malignant melanoma of skin	25.1	29.1	27.2	25.8
6 - Head and Neck	27.4	24.3	25.8	24.4

Lanarkshire's incidence for four of the most common cancers is higher compared to Scotland. While incidence is lower in Lanarkshire for colorectal cancer, published data from PHS on mortality from colorectal cancer across 2019, 2020, and 2021 highlights that mortality is higher in Lanarkshire than Scotland.[4] This may be partly attributable to the lower uptake of bowel screening in Lanarkshire in comparison to Scotland. It is also difficult to conclude whether or not the COVID-19 pandemic and recovery process has had an impact on this data.

Table 5.1.2 outlines the EASR for all malignant neoplasms (excluding C44) by deprivation quintile across Lanarkshire and in comparison to Scotland. This shows that cancer incidence is lower in Lanarkshire across all SIMD quintiles in comparison to Scotland except in the least deprived quintile. This is reversed when North Lanarkshire EASRs are compared to Scotland rates. This is likely to be influenced by the higher level of deprivation across North Lanarkshire in comparison to South Lanarkshire.

Table 5.1.2 European age-sex standardised cancer incidence rates (EASRs) per 100,000 by deprivation quintile: 2016-2020

SIMD Quintile	North Lanarkshire	South Lanarkshire	Lanarkshire	Scotland
1 - most deprived	746.2	703.8	705.7	735.9
2	715.0	659.7	670.3	671.7
3	625.1	624.7	612.7	614.2
4	584.2	577.2	578.4	581.4
5 - least deprived	543.7	609.9	580.1	571.2

Cancer Staging

The stage attributed to a cancer reflects the extent to which a cancer has developed and spread. Stages are typically assigned as a number from 1-4, with 1 indicating the cancer is confined to the organ it originated in (has not spread) and 4 being a cancer which has spread beyond the original organ and local lymph glands (regional lymph nodes) to elsewhere in the body. Patients diagnosed with stage 1 disease tend to have better outcomes and longer survival compared with patients diagnosed with stage 4 disease; this is also known as metastatic disease.[5]

Analysis of staging data for 2016-2020 shows that cancer of the bronchus and lung is most often diagnosed at later stages than the rest of the cancer trends investigated. Approximately 44.7% of cases of cancer of the bronchus and lung in South Lanarkshire are diagnosed at stage 4, meaning metastatic disease is evident. This value is slightly higher in North Lanarkshire at 46.6%. Investigation by locality highlights the percentage remains similar across the ten localities in Lanarkshire and is similar to the national average at 45.3%. The proportion of later stage cancer diagnosis within lung cancers will result in the higher mortality reported.

Likely due to the impact of cancer screening programmes, a larger percentage of cancers of the female breast and colorectal cancer are diagnosed at earlier stages. Around 80% of female breast cancers are diagnosed at stages 1 and 2 in South Lanarkshire (78% in North Lanarkshire). Thirty-five per cent of colorectal cancers in South Lanarkshire are diagnosed at stages 1 and 2 in comparison to 32.5% in North Lanarkshire. Improving uptake within the bowel screening programme would help further improve the percentage diagnosed at these earlier stages.

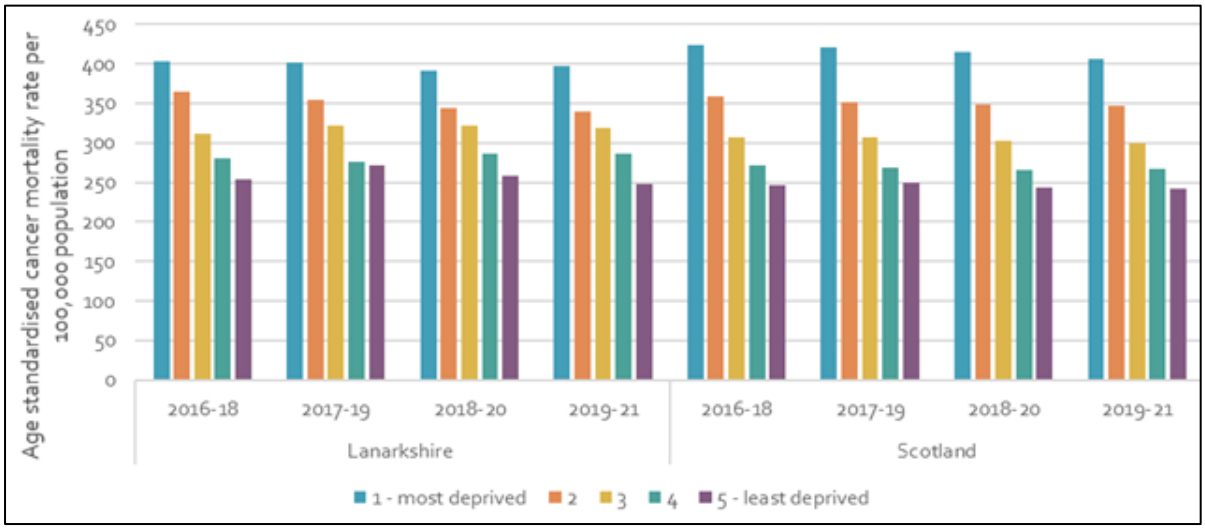
Most prostate cancers are also diagnosed at later stages with around 30% at stage 4 and 22% at stage 3 across South Lanarkshire. The percentage diagnosed at stage 4 is higher in North Lanarkshire with 28.9% diagnosed at stage 4 and 22.7% diagnosed at stage 3. Differences across the localities are evident with less people in Cambuslang/ Rutherglen being diagnosed in stages 1 and 2 (19.2%) in this area in comparison to South Lanarkshire (27.4%) and Scotland (31%).

Approximately 53% of people across Lanarkshire diagnosed with malignant melanoma of the skin are diagnosed at the earliest stage with a melanoma of less than 1.00mm.

Cancer Mortality by Deprivation Quintile

The age standardised cancer mortality rate per 100,000 population for malignant neoplasms (excluding C44) by SIMD quintile for Lanarkshire and Scotland is presented in Figure 5.1.1 below. This graph shows that for those malignant neoplasms combined a higher mortality in the more deprived quintiles is evident. Individual data by cancer type shows quite a mixed picture with no obvious relationship across the SIMD quintiles.

Figure 5.1.1 Cancer Mortality by Deprivation Quintile, 2016-2021



Lanarkshire cancer mortality has been decreasing in the most deprived quintiles from 2016 to 2021 but mortality has been decreasing across all quintiles Scotland-wide. The data above includes the first nine months of the global pandemic and therefore may be skewed as a result of the fewer cancers diagnosis across that period.

Key Points

- Inequality in cancer incidence and mortality is evident within Scotland and Lanarkshire.
- Use of local data will help target key messages on signs and symptoms of cancers in those areas and populations where later stage diagnosis is recorded.
- Regular participation of screening programmes in more of the population would increase the percentage of early stage cancer diagnosis, improving outcomes.

Priorities for Action

- Continue to promote the uptake of breast screening programme in areas of deprivation.
- Reinstate bowel screening promotional work.
- Recover NHS Lanarkshire activity around Detect Cancer Early promoting early signs and symptoms of lung cancer particularly.

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5.2 Impact of the COVID-19 Pandemic on Dentistry

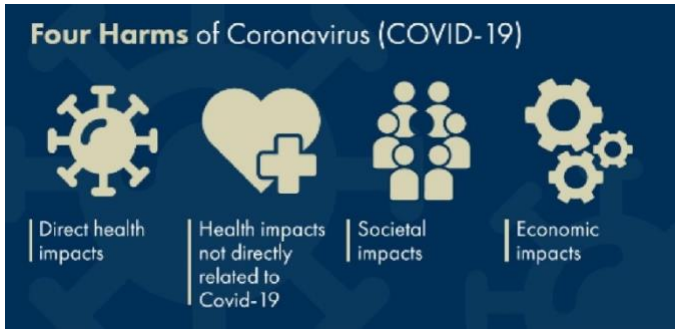
In December 2020, the Scottish Government published *COVID-19: Framework for Decision Making – Assessing the Four Harms of the Crisis*.[1] The impact of the COVID-19 pandemic on dentistry and oral health in Scotland through the lens of the 'Four Harms' is described below:

Harm 1. The virus causes direct and tragic harm to people's health.
A systematic review suggested dry mouth, taste dysfunction and oral mucosal lesions (e.g. ulcers) as common oral manifestations in patients with COVID-19.[2] The discussion paper addressing the impact of COVID-19 on children, young people, and their families confirmed that, relative to other age groups, the direct health impacts of COVID-19 on children have generally been limited.[3]

Harm 2. The virus has a wider impact on our health and social care services in Scotland.
Common to all services are the limitations that SARS-CoV-2 infection and COVID-19 precautions have placed on capacity – where capacity is not limited to physical space, but includes all elements that may influence a safe optimum number of individuals seen for care in a given period. A potential backlog (unmet need due to COVID-19) has built up over the course of the pandemic which is difficult to reduce.

The remobilisation of primary care NHS dental services was undertaken in five phases as follows:[4]
Phase 1 (from 20 May 2020): Capacity in urgent dental care centres was increased, and provision expanded to include patients with acute and essential oral health care needs.

Phase 2 (from 22 June 2020): All dental practices reopened for face-to-face consultation with patients requiring urgent dental care treatments that could be provided using non-aerosol generating procedures (AGPs).



Phase 3 (from 13 July 2020): Dentists were able to see patients for the full range of routine non-AGP dental care. From 17 August 2020, aerosol associated treatments were permitted for urgent dental care only.

Phase 4 (from 1 November 2020): Practices were able to provide the full range of NHS treatments to all patients in need of both urgent and non-urgent care. Dentists were also able to provide domiciliary care.

Phase 5 (from 1 April 2022): Dentists were allowed to de-escalate their infection prevention and control measures in line with national guidance to alleviate system pressures and allow an increase in patient throughput.

Harm 3. The restrictions which have been put in place affect our broader way of living and society.

Numerous lockdowns have had wide-reaching effects, including changes to individual and family behaviours which continue to have potential impacts on oral health. This is particularly true in the form of increased snacking and sugar intake. The alteration in diet would be expected to be compounded by reductions in effective, daily oral health behaviours, especially where oral health improvement (OHI) staff are not in place to encourage and reinforce these. Enhanced prevention is an essential focus to prevent children experiencing dental decay, particularly at a time when access to dental care may be challenging, and reduce the requirement for dental extractions under general anaesthetic.

There have also been impacts from lockdowns and the pandemic on mental health. This has affected staff as well as patients. Additionally, mental health issues have led to disruptions in daily routines, poor dietary choices, increased medication use, and potential increases in other risk behaviours – all in turn likely having impacts on oral health. A study of health compromising behaviours in England showed that with the exception of smoking, there has been an increase in oral health compromising behaviours (especially consumption of sugar containing food and alcohol).[5]

Harm 4. The impact on our economy, with a damaging effect on poverty and inequality.

Existing oral health inequalities are likely to have worsened as a result of the pandemic. A review of oral health inequalities in England found that people living in more deprived areas were less likely to have accessed dental services since resumption after the height of the pandemic. It also noted that the cessation of OHI programmes had primarily impacted on more socially disadvantaged groups, further widening health inequalities.[5] The OHI programmes in Scotland are also targeted at various priority groups, aimed at reducing oral health inequalities in children, older people and other vulnerable populations. The focus on reaching those who are experiencing poverty and inequalities is an essential feature of the recovery of the oral health programmes.

There can be economic impacts of poor oral health if acute dental problems result in absence from work, which will have a disproportionate effect on those who do not receive sick pay if absent. Poor child oral health is also associated with school absences, which may also mean time off work for parents. In addition, poor child oral health is associated with poorer educational outcomes, which could have life-long implications.[6]

Along with the financial impact of COVID-19, there is a cost of living crisis, as well as any economic implications from Brexit, all of which mean increased pressure on household incomes. In the short term, paying for dental treatment will inevitably be a lower priority for some families.

Key Points

- The four harms are related: harms to health impact on society and the economy, just as the societal and economic effects impact on physical and mental health and wellbeing.
- The COVID-19 pandemic has had a sustained impact on the delivery of dental services, which are only recovering gradually.
- The disruption of oral health improvement programmes had primarily impacted on more socially disadvantaged groups, further widening health inequalities.

Priorities for Action

- Remobilise oral health improvement programmes and the National Dental Inspection Programme.
- Recover NHS dental services to a position comparable with pre-pandemic service provision with focus on clearing the backlog in routine dental care and reducing oral health inequalities among children.
- Encourage local general dental practitioners to apply for training to become dentists with enhanced skills in domiciliary care.

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5.3 Population Screening

NHS Lanarkshire provides all of the national population screening programmes that are available in Scotland. Table 5.3.1 shows the number of people in the target population, as well as uptake for each programme and a brief summary of our achievements against Healthcare Improvement Scotland standards.

Uptake rates for some screening programmes have improved (e.g. breast and bowel screening) and others have fallen (e.g. cervical screening) during the years of the COVID-19 pandemic, and rates are still lowest in more disadvantaged areas as measured by Scottish Index of Multiple Deprivation (SIMD). Data for SIMD 1 (most deprived) and SIMD 5 (least deprived) quintiles are also included within Table 5.3.1 where available. There are also notable screening inequalities across age and gender, for example, fewer younger women (24-49) attend cervical screening in comparison to the older age group (50-64) and lower uptake is evident in males compared to females within the bowel screening programme.

Multiple factors will impact on the ability of the screening programmes to recover fully following the screening pause during the pandemic, and these differ by screening programme. As a result of staffing shortages, access to primary care remains challenging in some areas of Lanarkshire and this will impact on the ability of the eligible population to access cervical screening. Similar staffing challenges have been evident across radiology (where Abdominal Aortic Aneurysm (AAA) Screening is undertaken), vascular, and endoscopy services. In addition, pandemic related measures in health centres and community clinics have delayed recovery in the Diabetic Eye Screening (DES) Programme.

Uptake remains high in all pregnancy and newborn screening programmes.

Activity to raise awareness of the benefits of screening and address the barriers to screening participation has been restarted following the pause resulting from the COVID-19 pandemic and staff redeployment. Action within Lanarkshire to address screening inequalities is driven through the Health Inequalities Screening Action Plan (2021-23). This includes allocation of the Scottish Government Screening Inequalities Fund to support a number of new areas of work, the continuation of an outreach approach to engage with people experiencing homelessness, and community development work in areas of deprivation to encourage and support increased uptake of cervical screening.

A national equity in screening strategy is being developed and when available, the local plan will be updated to reflect any recommendations; including measures to improve access for non-cancer screening programmes.

Key Points

- Screening can help prevent conditions (including cancers) developing as well as detecting conditions and cancers at an early stage when treatment is more likely to be successful. Maximising uptake across the population and targeting areas where uptake is lowest will improve outcomes for those individuals and at a population level.
- Where members of the population make an informed choice not to participate in population screening programmes, awareness of the signs and symptoms of conditions, including cancer, is important to improve outcomes and detect conditions earlier.

- Barriers to accessing services, whether it is a screening test or any required diagnostics, exist. This will form part of the work within the health inequalities screening action plan from 2023.

Priorities for Action

- Continue work on the recovery of DES & AAA Screening Programmes
- Continue efforts to encourage engagement with, and participation in, population screening programmes in the most disadvantaged populations.
- Investigate barriers to accessing screening services from test to diagnostics to improve patient outcomes

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Table 5.3.1 Summary of Screening Programmes in Lanarkshire

	Target population	Denominator /time frame	Standard	Uptake	Outcomes[1]
Bowel screening	All males and females aged 50 to 74 years	181,560 men and women May 2019 – April 2021	Nationally agreed KPIs, including the target uptake of 60%.	61.5% All persons. Uptake varies across SIMD quintiles from 54.5% in SIMD 1 (most deprived) to 72.0 % in SIMD 5 (least deprived).	Inequalities across gender and deprivation are evident from the data. Standards for pre assessment and colonoscopy waiting times continue to be a challenge following the introduction of the qFIT test in 2017.
Breast Cancer Screening	Females 50-70 years	88,985 women Apr 2018 – Mar 2021	Nationally agreed standards including minimum uptake of 70%.	71.7% Uptake varies across SIMD quintiles from 63.3% in SIMD 1 (most deprived) to 80.5 % in SIMD 5 (least deprived).	Meets all standards except uptake, time to issue results and time to assessment from first adequate screen. Across Apr 2018- Mar 2021, 336 invasive cancers were detected in women following breast screening: 74 were detected at the first screen (women aged 50-52) and 262 were detected at subsequent screens in women 53-70 years old.
Cervical screening	All women aged 25-64 years	176,119 women Data from Apr 2020 – Mar 2021	Nationally agreed standards including the target uptake of 80% in each Scottish Index of Multiple Deprivation (SIMD) quintile.	25-49 year olds 70.4% 50-64 year olds 73.0%. Uptake varies across SIMD quintiles from 64.5% in SIMD 1 (most deprived) to 79.3% in SIMD 5 (least deprived).	Meets all standards apart from uptake and laboratory turnaround times for cytology.

Universal Newborn Hearing Screening (UNHS)	All newborn babies born to Lanarkshire residents or moving into Lanarkshire under the age of 12 weeks	6437 Apr 2021 – Mar 2022	98% of babies should have completed the hearing screen by 10 weeks.	98.1%	18 babies with moderate to severe permanent hearing loss were detected through screening.
Newborn Bloodspot Screening	All new-born babies born to Lanarkshire residents and babies with no bloodspot result moving into Lanarkshire before age 12 months	5903 Apr 2021 – Mar 2022	99.5% of infants who have undergone screening tests have a screening result available or are recalled for repeat testing by 20 days of age.	99.8%	6 babies were identified with one of the 9 conditions screened in the new-born blood spot programme.[2] A further 6 babies were identified as carriers for Cystic Fibrosis, 15 for Sickle Cell Disease, and 5 as carriers for other haemoglobinopathies.
Diabetic Eye Screening	Patients with diabetes aged 12 years and over	Currently unavailable	Nationally agreed Key Performance Indicators (KPIs), including minimum uptake of 80% uptake.	Local data suggests 78.9% uptake for those invited for screening; however, KPIs for the programme are currently unavailable.	Currently unavailable
AAA Screening	Men aged 65 years	3986 men aged 65 Apr 2021 – Mar 2022	Nationally agreed KPIs, including minimum uptake of 80% uptake.	81.5% for those invited for screening. Uptake varies across SIMD quintiles from 76.3% in SIMD 1 (most deprived) to 87.6 % in SIMD 5 (least deprived).	9 large aneurysms detected and referred for treatment. However, during 2021/2022, less screening tests were undertaken while the programme continues to fully recovery.

[1] Case numbers less than five have been suppressed.

[2]Full details of the new born bloodspot screening test and the conditions screened for can be found at https://www.nhsinform.scot/healthy-living/screening/newborn/blood-spot-tests

5.4 Children and Young People

The health of children and young people in Lanarkshire remains a public health priority. NHS Lanarkshire aims to work with children, young people and those that care for them to ensure they achieve the best health outcomes possible and realise their full potential.

Unfortunately, child poverty remains an issue in Lanarkshire and inequalities that existed for many children and young people before the COVID-19 pandemic have been exacerbated, both by the pandemic itself and also the measures put in place to mitigate the virus.

While health and social care services have been working to recover services, this is being done in a context of rising costs of living and other socioeconomic difficulties for our families.

A longstanding commitment within NHS Lanarkshire is the yearly production of Local Child Poverty Action Plans that are developed in collaboration with both Local Authority and wider partners. These plans cement our commitment to tackling child poverty in our communities using the levers available to us as an NHS. This includes work with our Integrated Community Children's Service nursing team to identify children within families who have exceptional support needs and ensuring they are linked with energy companies regarding prioritisation of supply and also ensuring they have access to additional funds to support rising energy costs.

Sadly, Scotland has a higher mortality rate for under 18s than any other Western European country, with over 300 children and young people dying each year.[1] Around a quarter of those deaths could be prevented.[2] Public health, alongside colleagues from Paediatrics and the Quality Directorate have been undertaking implementation of new Scottish Government guidance around Child Death Reviews.

The aim is to ensure that the death of every child in Scotland is subject to a quality review. New multi-disciplinary, multi-agency procedures have been put in place to ensure engagement with families and carers is consistent and that they are supported from a bereavement perspective and those deaths that are not subject to any other review are reviewed through a high quality consistent process.[3] The ultimate aim of this Child Death Review programme is to channel learning from reviews across Scotland that could direct action to help reduce preventable deaths.

Many children and young people in Lanarkshire are care experienced and data shows that while a care placement can have a positive impact on their lives and most attain good health, there are those who have poorer outcomes than their peers.[4] As Corporate Parents, NHS Lanarkshire is working collaboratively to ensure the national priorities within The Promise Plan 21-24[5] are aligned with our local Children's Services Plans. A recalibration of support so that what matters to care experienced children, young people and their families is the highest priority and the foundation of how we can use lived experience alongside available data to improve their life chances.

Key Points

- Inequalities across a number of areas, including health, have been exacerbated for children, young people and their families following the pandemic.
- Child poverty remains an issue for many in Lanarkshire.
- Child death review activity is an important tool to learn from and potentially prevent the unnecessary deaths of children and young people.
- Health outcomes for care experienced children and young people remain poorer and addressing gaps in access and support is a key priority.
- NHS Lanarkshire alongside key partners are working together to tackle these issues through The Children and Young People's Health Plan and The Local Child Poverty Action Plans among others.

Priorities for Action

- While the health and care system faces challenges on a number of fronts, it is important to recognise that the early years, early intervention and prevention are key to improving the life chances of our future populations.
- Collaborative approaches to support our children, young people and their families are critical to their success.
- Strengthen a rights-based approach to all aspects of support for children, young people and their families in preparation for implementation of the United Nations Convention on the Rights of the Child.

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6 Statistical Appendix

General notes:

- Lanarkshire has two Health and Social Care Partnerships (HSCPs) – North Lanarkshire and South Lanarkshire. The HSCPs cover the same geographical areas as North Lanarkshire Council and South Lanarkshire Council. There are ten localities within the HSCPs – six in North Lanarkshire (*Airdrie, Coatbridge, North, Bellshill, Motherwell and Wishaw*) and four in South Lanarkshire (*Cambuslang/Rutherglen, East Kilbride, Clydesdale and Hamilton*). On 1 April 2014, changes to NHS board boundaries resulted in NHS Lanarkshire becoming coterminous with the HSCPs and local authorities. The tables in the Statistical Appendix indicate whether information relates to the old or new NHS Lanarkshire boundary, the exception being where all data relate to April 2014 onwards.
- Populations shown and used in rates calculations are, for NHS Lanarkshire, the HSCPs and Scotland, mid-year estimates produced by National Records of Scotland (NRS). Locality populations are from NRS small area population estimates at data zone level.

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