Agenda Item 3.5

NHS Highland

Meeting:	**Highland Health and Social Care Committee**
Meeting date:	**2nd March 2022**
Title:	**Children and Young People Performance Reporting**
Responsible Executive/Non-Executive: Chief Officer HHSCP	**Louise Bussell**
Report Author:	**Sally Amor Child Health Commissioner/Public Health Specialist**

1 Purpose

This is presented to the Board for:

Discussion
Assurance

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

This report relates to the following Corporate Objective(s)

Clinical and Care Excellence • Improving health		**Partners in Care** • Working in partnership	
A Great Place to Work • Learning from experience • Improving wellbeing		**Safe and Sustainable** • In control • Well run	

Other (please explain below) Whole system working for children and young people across Acute Services, HHSCP and commissioned services children and young people (Highland Council).			

2 Report summary

2.1 Situation

There is interest in understanding the performance of children and young people's health services provided by Acute Services, HHSCP and Highland Council. This informs a whole system approach to understanding and responding to health and health care need through preventive approaches that maximise health potential across life while providing assurance over service delivery and associated risks and pressures.

A refreshed reporting approach is proposed that brings the performance measures in the current Balanced Score Card (children and young people: health) into the one report. This was developed to support the Lead Agency performance arrangements, in 2012. It is recognised that there is a need to review and refresh the measures and this will take place alongside the Digital Road Map exercise that is being developed. (see all measures in Appendix One)

The propose reporting format reflects the role of the Child Health Commissioner to bring professional leadership and strategic oversight across the system of care for infants, children and young people's health and health services across of all NHS Highland.

By being clear of the risks and pressures across the HHSCP, Acute Services and Highland Council service managers can work together to improve access, flow, and avoid waste and variation. In addition, when there is clarity over the strengths and vulnerabilities across the children's health system this informs wider discussion with integrated services partners in the education and social care services, and the police and justice and third/independent sectors. This maximises collective endeavour to improve outcomes and wellbeing for children and young people.

In this first report in this new format, performance data is considered in relation to primary immunisation (Primary Care, HHSCP), infant feeding (Acute Services, HHSCP, Highland Council), the 27-30 month health visitor contact

(health visitors, Highland Council), and child and adolescent mental health waiting times to treatment (primary mental health workers, Highland council Phoenix Team, Acute Services). The commentary includes performance to national or Highland performance targets with consideration of associated risks with regard to the workforce and financial pressures.

The HHSCP Committee are invited to:

1. Discuss the format of the refreshed approach to reporting on children and young people's health services in north Highland. .
2. Discuss the performance measures and commentary as detailed in the report.
3. Make a decision on the format and approach as detailed going ahead on a quarterly basis and to advise if this will cover all measures in the Balanced Score Card over a twelve month period, or that the full suite of measures being reported on a quarterly cycle.

2.2 Background

With the development of the Lead Agency model in north Highland, Highland Council assumed responsibility and accountability for the delivery of health visiting, school nursing, specialist nurses (care experienced children and young people, addictions and learning disability), child protection advisor roles, primary mental health workers, and allied health professionals(speech and language, occupational therapy, dietetics and physiotherapy). Acute Services have responsibility and accountable for acute and community paediatrics and nursing, surgery, acute physiotherapy, and Tier 3/4 child and adolescent mental health services and the HHSCP has responsibility and accountability for elements of health care through GP and primary care settings.

Children and young people with a range of physical and mental health needs will move between the HHSCP, Acute Services and Highland Council health services as their health needs indicate. Teams and services are tasked with ensuring coordinated and seamless care to ensure that individuals needs are assessed are seen in a timely manner, by the most appropriate clinician with onward referral to regional or national services as indicated. Often this involves shared decision making across services and teams.

While parents and children/young people might not know the differing service responsibilities they are impacted when there are challenges in waiting times, recruitment/retention and managing clinical demand, financial risks and pressures. In a mature system of care, collective decision making will ensure that systems of care are not disproportionally impacted by decisions taken in isolation by one part of the system of care.

There are a wider range of measures in the health balanced score card (Appendix One). The Committee is asked to consider these are to be covered in full over a calendar year, or reporting in full, on a quarterly cycle.

The Balanced Score Card is due to be reviewed and refreshed as part of a wider exercise to develop a Digital Road Map and Balanced Score Card for maternity, neonates and children/young people's health services across Argyll and Bute and north Highland services.

2.3 Assessment

The health of infant's children and young people can be understood as an investment in health as a resource for life. The increased risk of adult illness, disease, disability and health harming behaviours, are now understood to be laid in the pre-conceptual period to three years of age, the first 1001 days. During this time this time, a complex interaction of genes, early relationships and early environments shape and inform subsequent health and health related behaviours. Children who grow up experiencing relational safety with their parents/primary care givers can do well even if they are experiencing insecurity of income, housing and food even as these pressures often exacerbate family distress, increase the risk of abuse and neglect and have an independent impact on learning and wellbeing.

Timely access to preventive health and treatment services, early identification of need and risk with ease of access to the right clinician, assessment and treatment intervention, limits the time a child experiences symptoms that can be debilitating and mean they miss out on peer interactions and schooling. Where there are concerns over growth and development, timely identification, assessment and intervention can ensure children can be supported to achieve their developmental potential while vaccinations reduce the risk of harmful consequences of infectious diseases.

Moving out of a COVID-19 orientated health and social care pattern of service delivery presents opportunities to consider and refresh the way the performance of health services for children and young people are understood by the HHSCP Committee. This is the more important and opportune given that infants, children and young people are recognised to have been significantly impacted by the public health population measures to mitigate and manage the risks of COVID-19 over a two year period (lockdown, self-isolation, school closures). This has led to disruptions to family life/wellbeing, school life/education and learning, friendship/peer interactions and limited opportunities to participate in wider society while access to health care may have been delayed or deferred. Some children, young people and families will have faced particular challenges in not accessing services and support. These effects will have played out despite the

best efforts across all services to support children, young people and families, to keep schools open where possible and to mitigate and manage risk while adjusting to changes in guidance and advice as the pandemic evolved.

Childhood immunisation

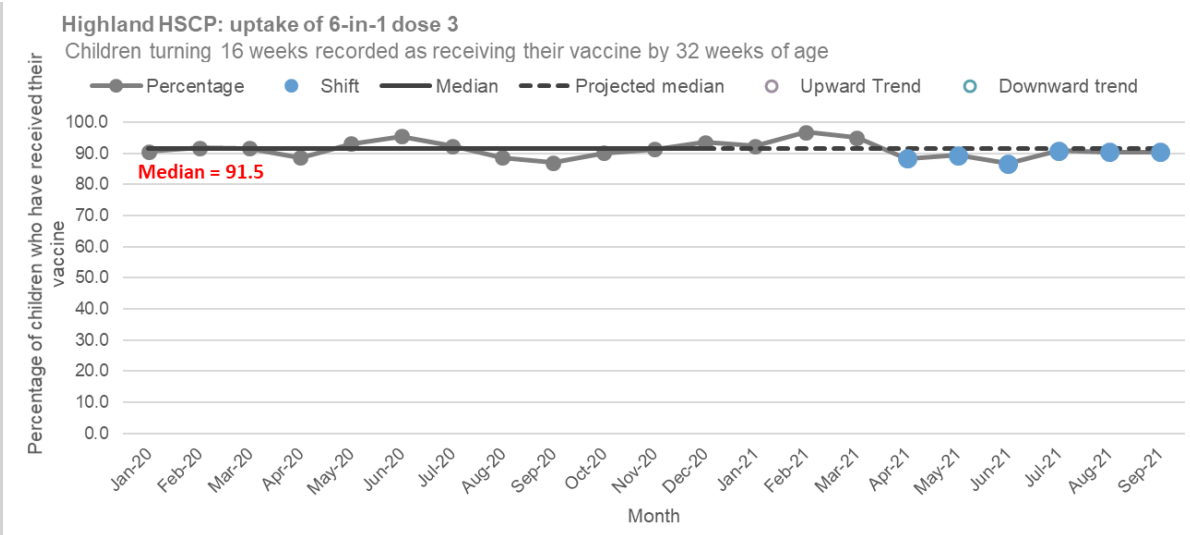
Context

Childhood immunisations seek to protect infants and children from infectious diseases that can have serious health implications and reduce the spread of infection across the wider population. In the HHSCP, primary immunisations are undertaken within primary care. Good uptake of immunisation, with a target proposed by the World Health Organisation (WHO) of 95%, provides reassurance that children are protected and that the risk if wider community spread of infectious diseases is reduced. There are no mandatory requirements for children to be immunised in the UK.

Primary Immunisation: Uptake of third dose 6-in-1 vaccine (offered at 16 weeks of age)

- Pre-school children are offered a total of five immunisation appointments as they reach 8,12 and 16 weeks; 12-13 months, and 3 years and 4 months. Multiple immunisations are offered at each appointment.
- The 6-in-1 vaccination at 16 weeks of age is used to illustrate the end of the first tranche of immunisation given to babies.
- Vaccination uptake at this age has been sustained throughout the course of the pandemic.
- By the time children reach 12 months of age around 95% of children in the Highland HSCP have received 3 doses of 6-in-1 vaccine. (Figure 1)

Figure 1

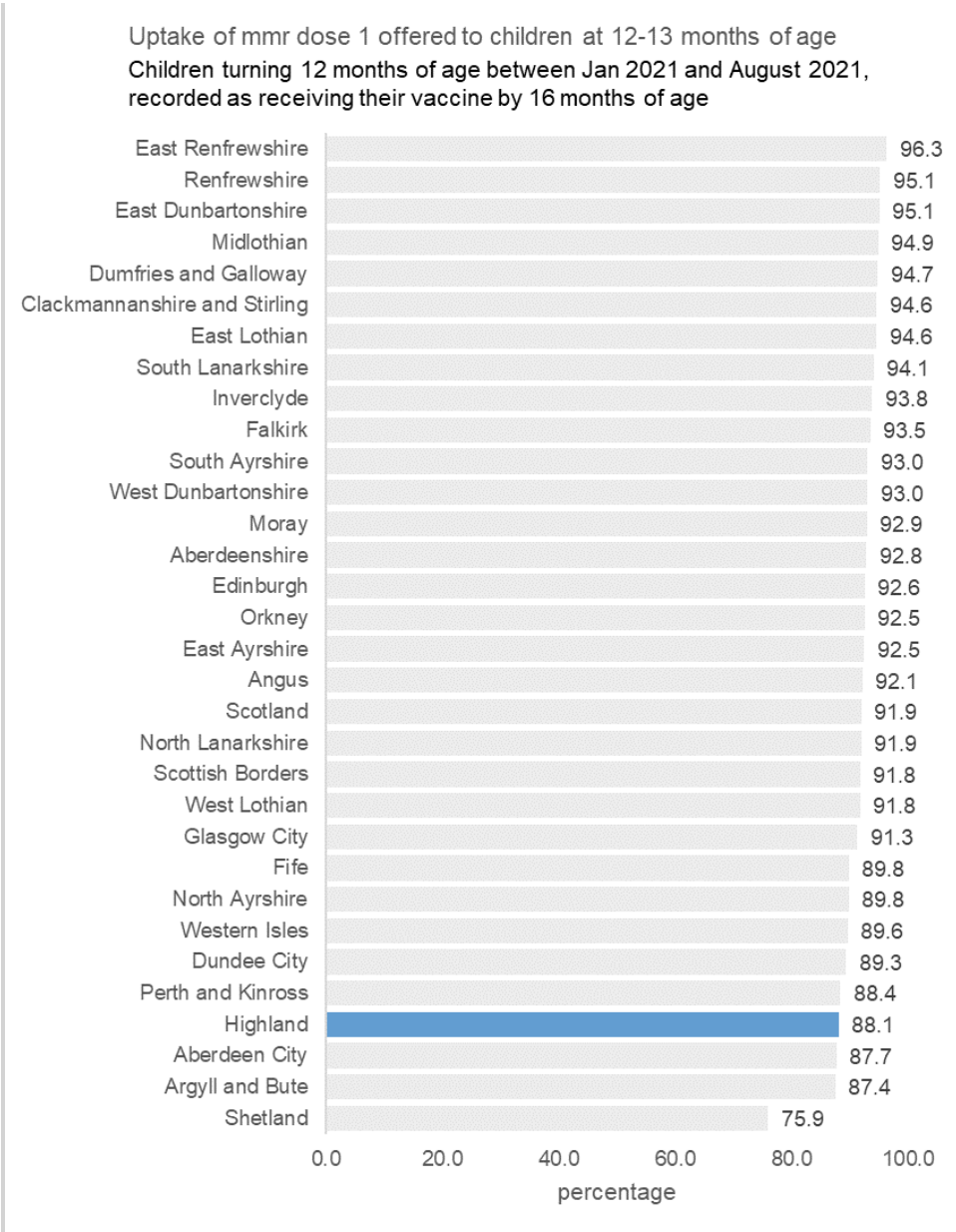


Data source: Pubic Health Scotland, [COVID-19 Wider Impacts on Health Dashboard]

Uptake of MMR1 (normally given at 12-13 months of age)

- The first dose of MMR vaccine is offered between 12-13 months old and the second dose at 3 years and 4 months. Although normally given at these times, it can be given at any age if missed.
- Uptake of MMR 1 by 16 months of age is currently at 88% in the Highland HSCP area.
- Vaccine hesitancy for the MMR immunisation can be understood in part as a legacy of the debates over autism risk that have long been systematically refuted while the legacy of mistrust remains,
- MMR vaccination coverage in the Highland HSCP at this age is amongst the lowest in Scotland (Figure 2)

Figure 2

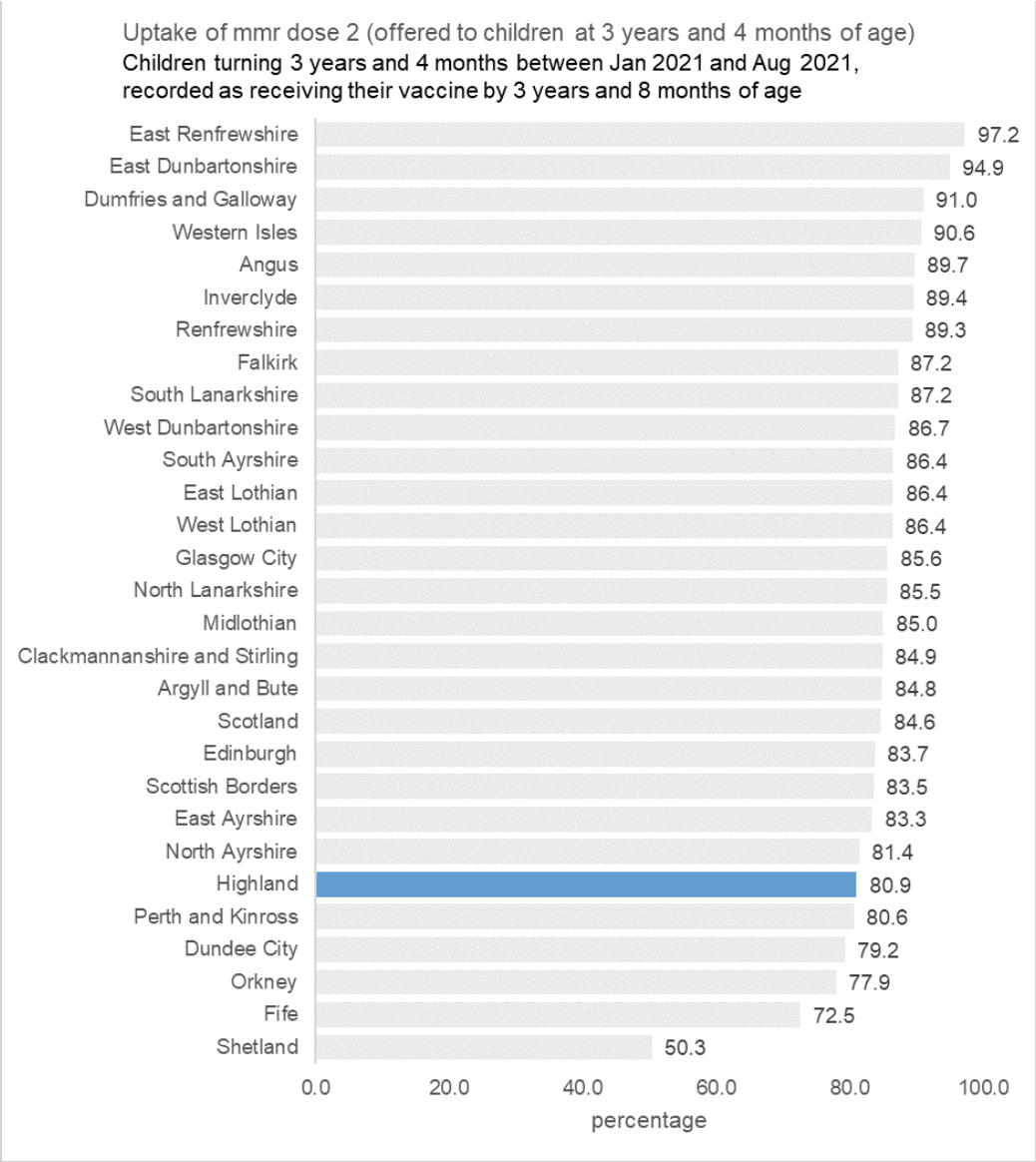


1.Children in NHS Grampian are offered the second dose of MMR vaccine at 4 years of age rather than 3 years 4 months and therefore the three Local Authority areas are not shown.

Uptake of MMR2 (normally given at 3 years and 4 months of age)

- Uptake of MMR 2 by 3 years and 8 months of age is around 81% in the Highland HSCP area (Figure 3).
- Vaccination coverage at this age in the Highland HSCP is amongst the lowest of any area in Scotland (Figure 3).
- The current level of MMR2 vaccination at three years and eight months, mean that 1 in 5 children in the Highland HSCP are not fully protected by this life stage.

Figure 3



1 .Children in NHS Grampian are offered the second dose of MMR vaccine at 4 years of age rather than 3 years 4 months and therefore the three Local Authority areas are not shown.

MMR1 and MMR2

- In the Highland HSCP, the percentage uptake of MMR1 by 16 months of age and MMR2 by 3 years and 8 months of age shows little deviation over time (Figures 4 and 5).
- While the vaccination can be given at any time, a slow start to population uptake will impact on MMR 2 coverage.

Figure 4

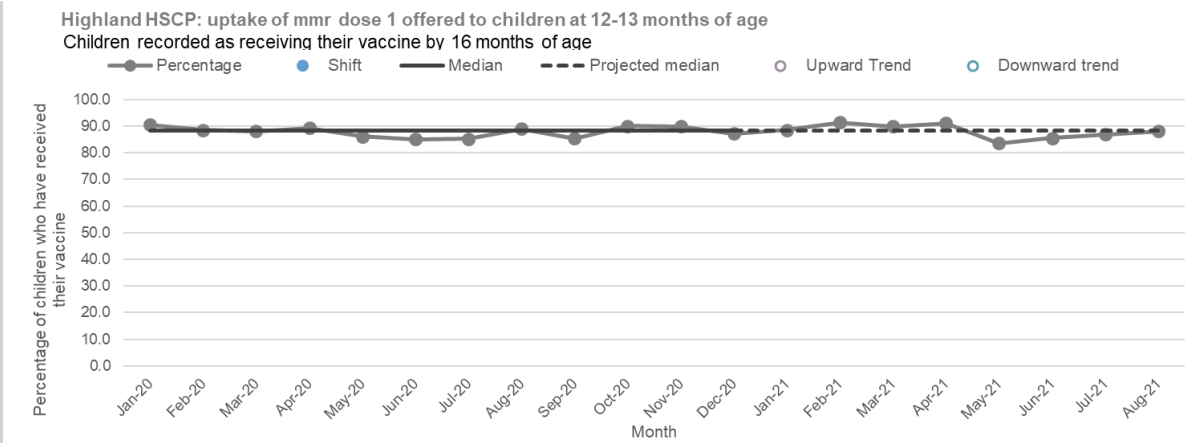
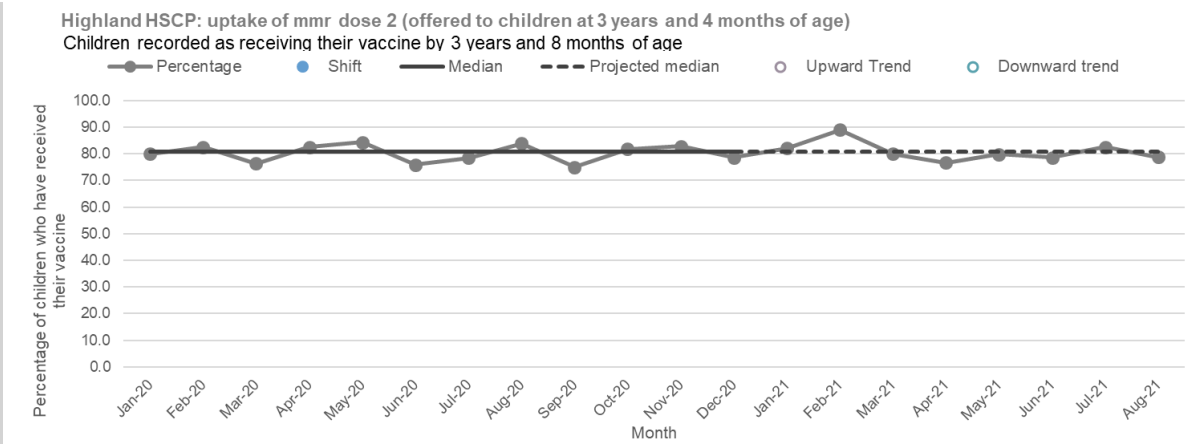


Figure 5



Management of risk

- Good uptake of immunisation reflects confidence in the benefits of immunisations by parents, along with availability of, and access to the vaccination.
- GPs, immunisation teams, paediatricians, midwives and health visitors are tasked with providing timely and reliable information on the benefits of immunisation, in the presence of increasing vaccine hesitancy.
- Conflicting advice from medical professionals is understood to be particularly damaging in reducing vaccine coverage.

- There are a range of training materials and resources to support health professionals in advising parents and encouraging participation in vaccination programmes.
- As more capacity becomes available in the Health Protection Team moving on from the demands of COVID-19 a programme of work to look at improving MMR coverage is planned alongside the work of the Vaccination Transformation Programme.

Breast feeding

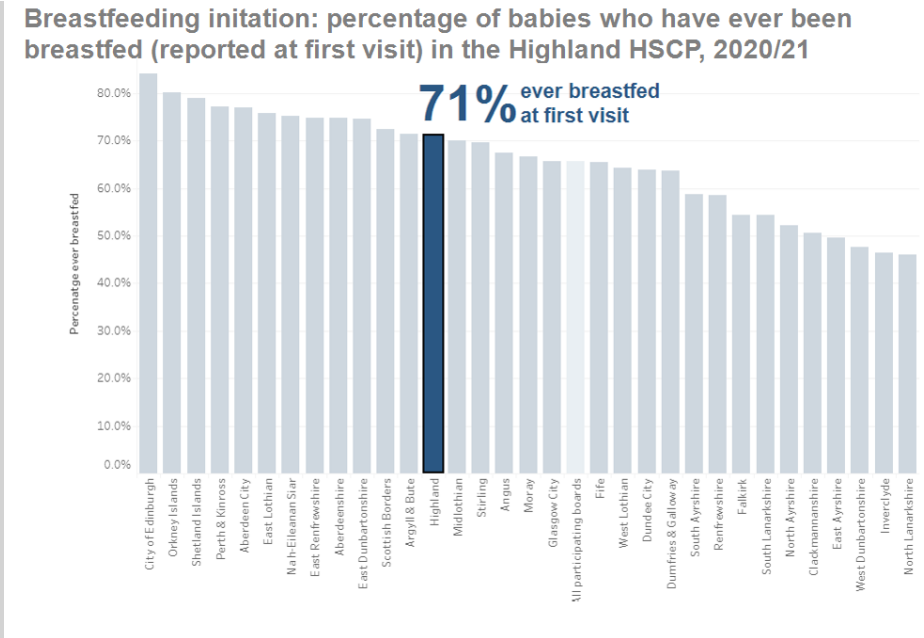
Context

Breast feeding confers many benefits for infants and mothers both short term and across life: healthy growth, reduction in disease, attachment and relationships, cognitive benefits and advantages and physical development. Some of these are effects are understood to be intergenerational. The WHO and Scottish Government recommend that children are exclusively breastfed for the first six months of life while the benefits of breast feeding alongside bottle feeding are now better understood and encouraged. There are many opportunities to promote and support breastfeeding from the school curriculum, to preconception clinics, antenatal and parenting advice and post delivery support in hospital and on the return home. Infant feeding advisors and peer support workers play a key role in supporting the maintenance of breast feeding through the first weeks and months to support the six month goal.

Breastfeeding rates

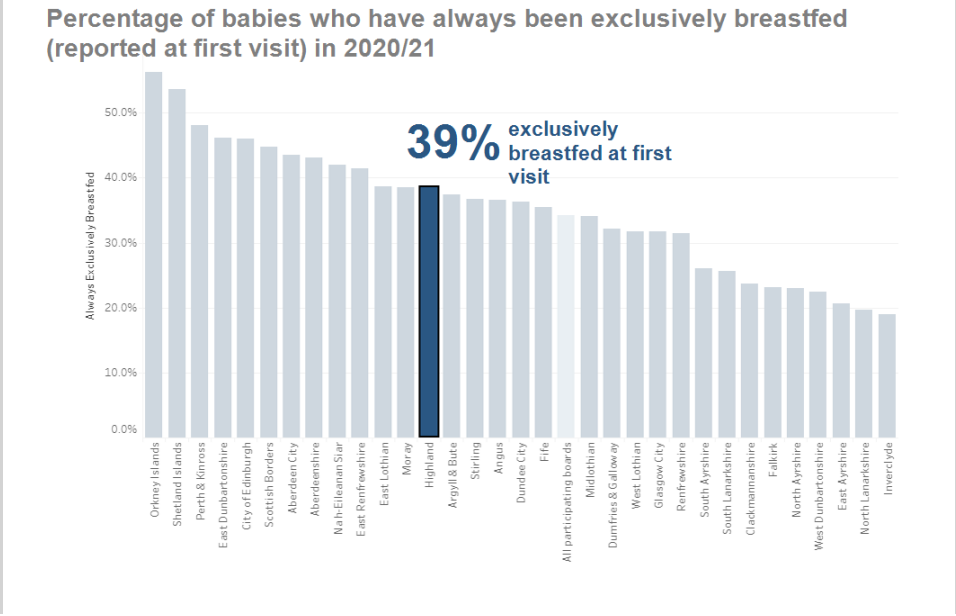
Initiating and supporting breastfeeding in the early weeks through supporting women with skills, advice and support contributes to sustained breast feeding rates.

Figure 6



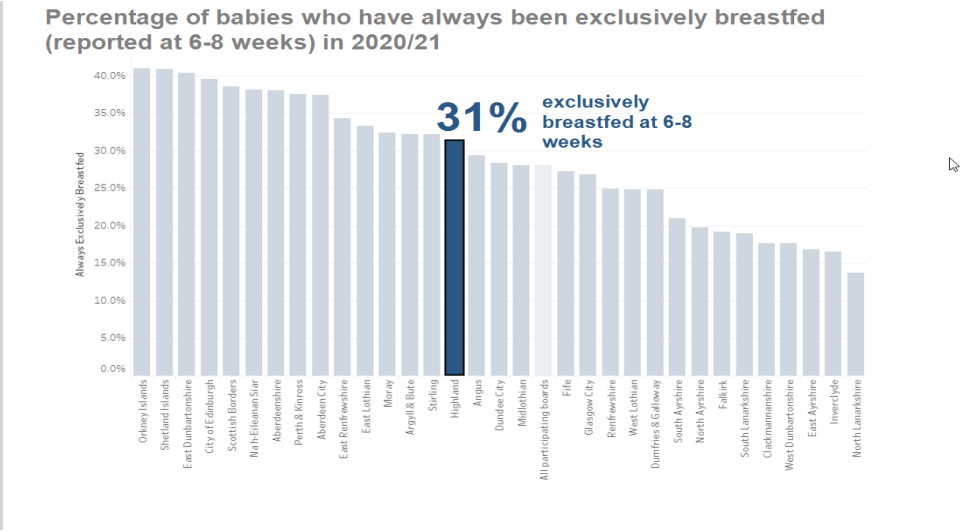
- 7 in 10 babies born in the Highland HSCP in 2020/21 were breastfed for at least some time after their birth (Figure 6).

Figure 7



- 4 in 10 babies were being still being exclusively breastfed at the Health Visitor First Visit (about 10-14 days of age) (Figure 7).

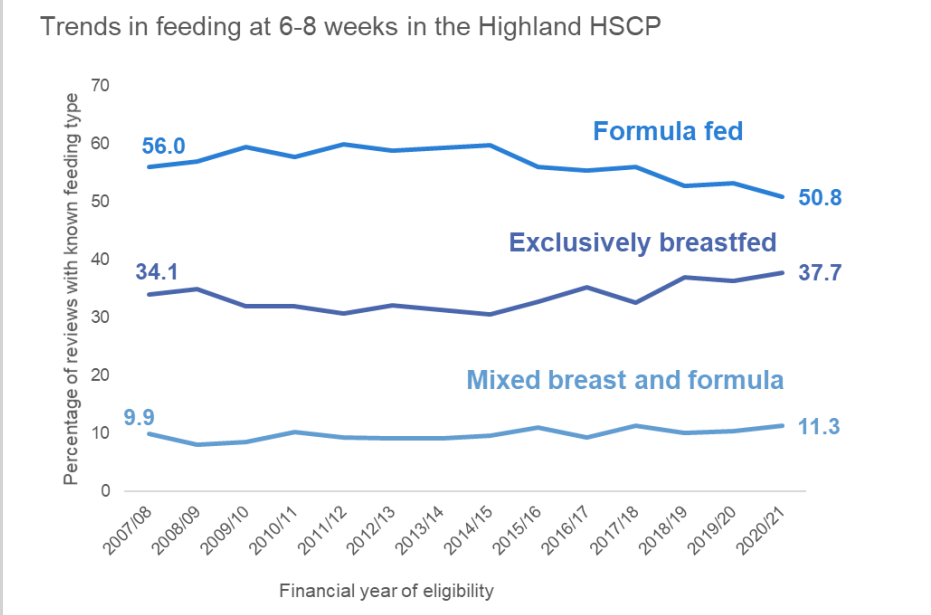
Figure 8



By 6-8 weeks, 31% of babies had always been exclusively breastfed. This figure is unchanged from 2016/17.

However, overall breastfeeding rates have been increasing in the Highland, mainly as a result of an increase in mixed breast and formula feeding (Figure 9).

Figure 9



Related factors for uptake and sustaining breastfeeding include deprivation (Figure 10) and the age of the mother (Figure 11).

Figure 10

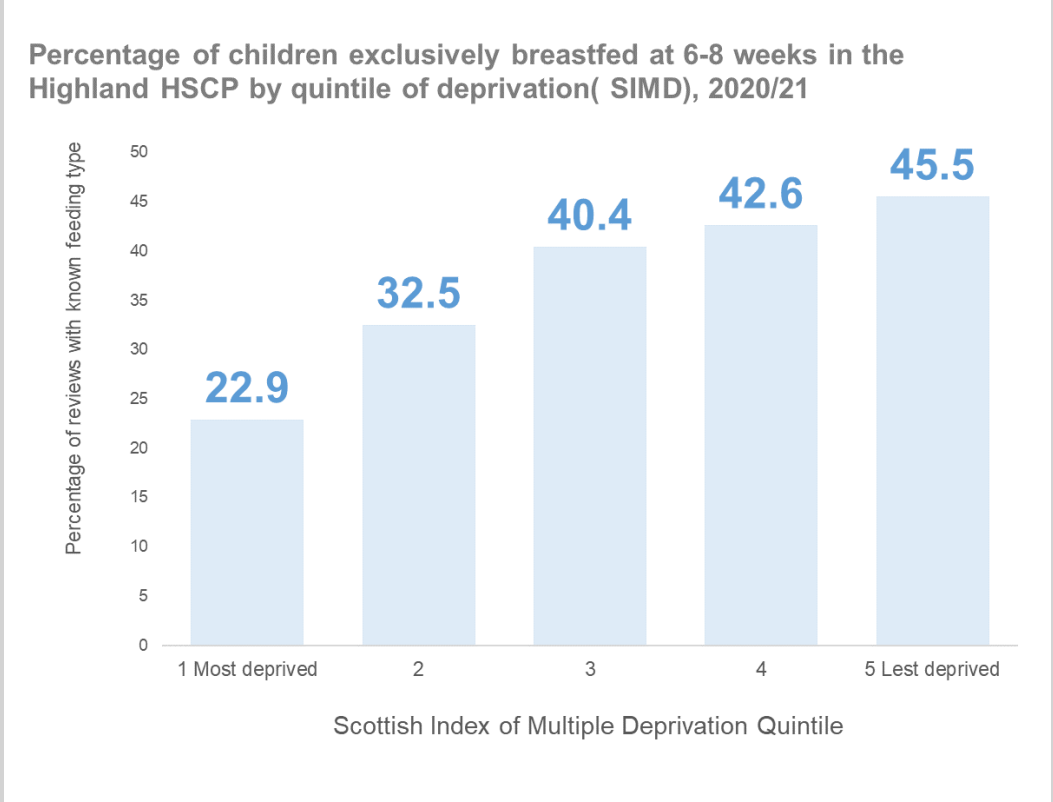
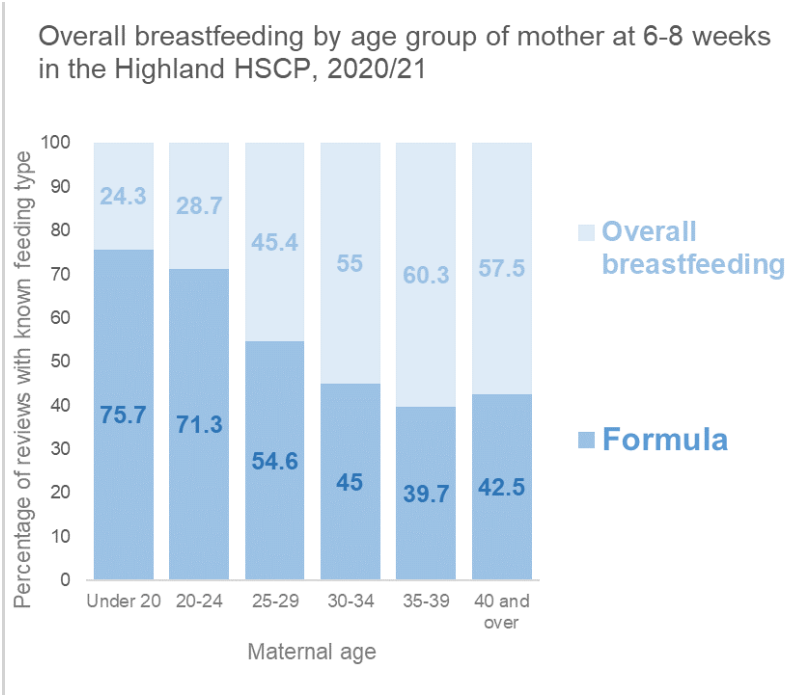


Figure 11



Managing risk

- The cultures, attitudes and practice that support high levels of breastfeeding and the related benefits for infants and mothers require ongoing support and investment across services (maternity, neonatal, paediatric, health visiting, GPs/Primary Care) and teams along with women, families and communities and integrated children and young people's integrated service partners.
- Current investment in staffing and training needs to be sustained or enhanced if Highland wishes to further improve uptake to be a high performer across Scottish local authorities.
- The UNICEF Baby Friendly Initiative is the framework that supports training and practice in maternity, health visiting and early years settings. The necessary resources from health improvement teams to maternity and health visiting need to be available to support ongoing participation in the accreditation process with associated commitment from operational units to provide leadership commitment and to ensure staff have the opportunity to attend training and development and undertake audits.

Child health reviews (surveillance)

Context

Child health reviews incorporate assessment of an infant/child's health, development, and wider wellbeing alongside provision of health promotion advice and parenting support.

Early child development is influenced by both biological factors (such as prematurity) and environmental factors (such as the parent child interactions and parenting capabilities and opportunities for play/fun as well as the impact of household insecurity: income, housing, food). The most impactful time is in the 1001 days from conception to 27 months: laying the foundations for health and wellbeing across the life course with regard to both mental and physical health and wellbeing. Identifying problems with parent infant/child interaction and early child development is important as they are strongly associated with long-term health, educational, and wider social difficulties. Identifying relationship and, or developmental problems early provides the best opportunity to support children and families to improve outcomes.

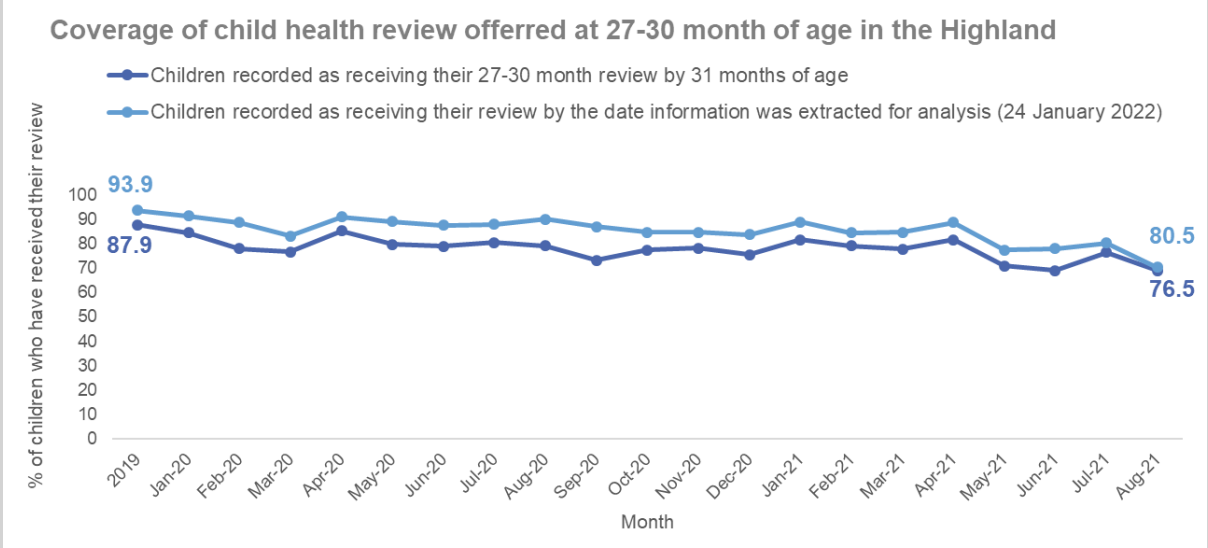
Child development reviews are part of the Universal Health Visiting Pathway (Scottish Government 2015) which details the home visiting contacts that health visitors are required to undertake with parents of preschool children. The pathway creates opportunities to review child development and provide reassurance, advice and to focus on family strengths with onward referral as indicated as needs are identified. Information collected at Child Health Reviews includes: development (social, behavioural, communication, gross motor, vision, hearing), physical measurements (height and weight) and diagnoses / issues (Read coded) through the ASQ assessment tool.

The current performance target is for 95% coverage of the contact. This target is ambitious and assumes universal coverage with a margin of error for moves in and out of the area and between addresses.

27-30 month health visitor child health surveillance contact

Coverage

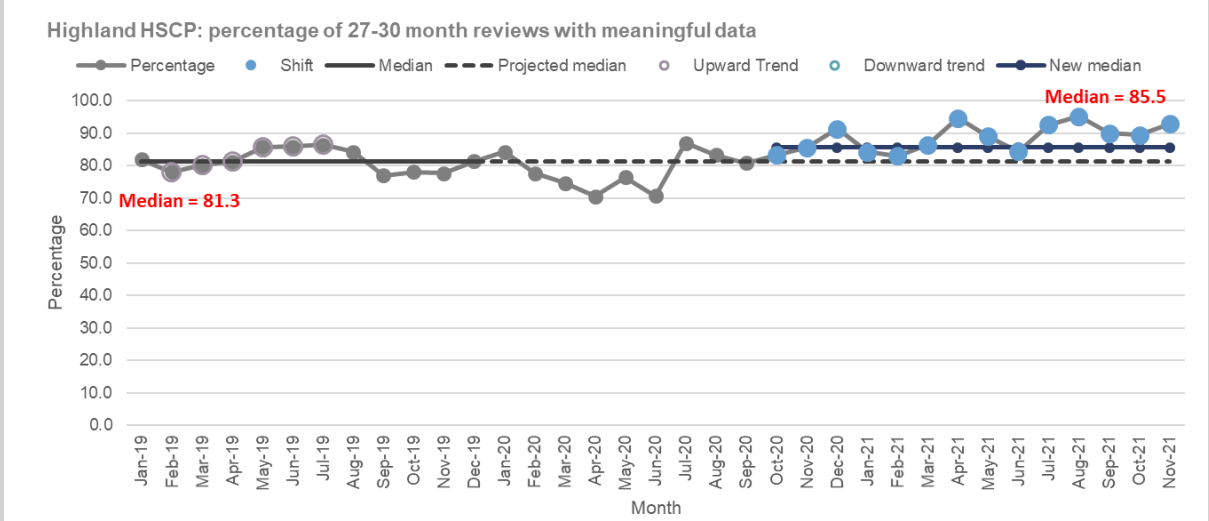
Figure 12



Review coverage continues to increase as children age, but the proportion of children recorded as receiving their review by 31 months of age has declined in the Highland health visitor service since the pandemic in spring 2019.

There are also challenges in the quality of the data recorded for the reviews (Figure 13) with improvements over time that inform understanding of the developmental domains where there may be concerns.

Figure 13



The quality of data collected is of interest to ensure a clear understanding of the developmental needs for children and related opportunities to respond in a timeous way. The impact of the COVID-19 pandemic on child development has yet to be understood in full and needs to inform recovery and remediation of any unintended consequences on infant/child development.

The proportion of children in the Highland HSCP reported as having more than one developmental concern is now above the pre-pandemic levels of 2019. (Figure 14) Changes in the data may reflect changes in the way reviews are being undertaken and reported (Figure 15). However, the increase in children with one or more developmental delay concern can also be observed across Scotland.

A similar increase in reporting concerns about developmental delay can also be observed at the 13-15 year review stage both locally and nationally. The increases noted are highly unlikely to be occurring because of chance

Figure 14

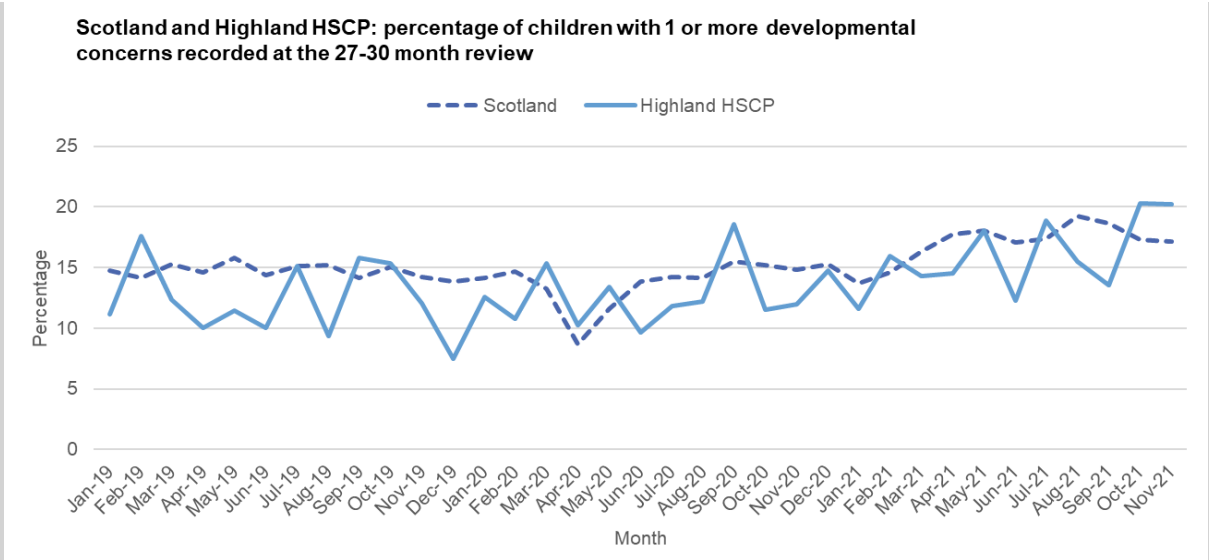
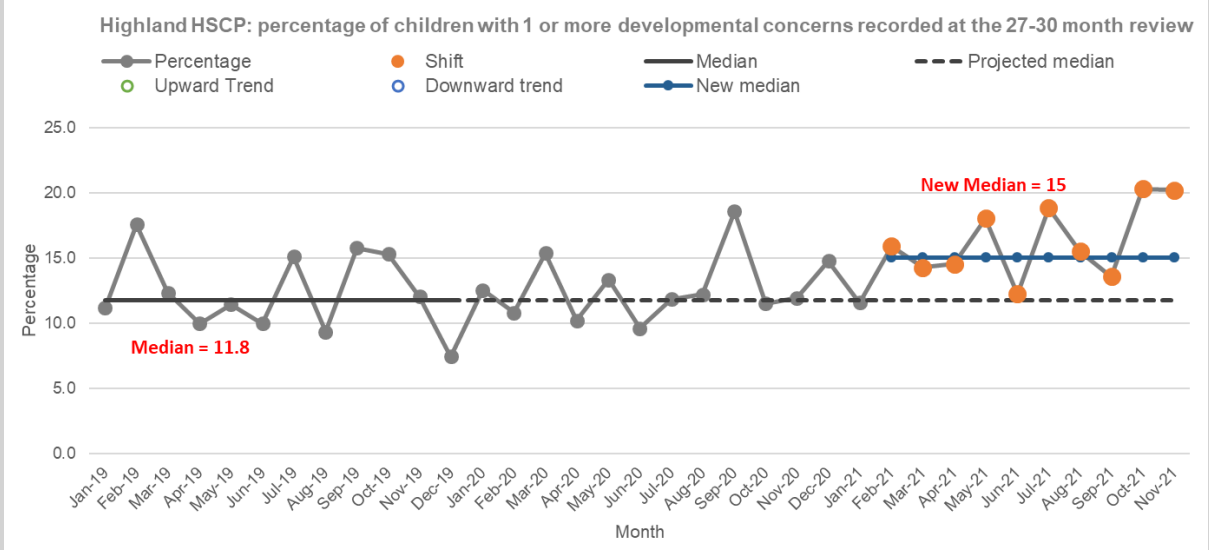


Figure 15



Managing risks

- Uptake of the contact reduced and has yet to recover from the impact of COVID-19 that created barriers to health visitors having face to face contact with parents and some administrative challenges to accessing, completing and returning the assessment paperwork.
- The health visiting service are currently working with a high number of trainees, recruited to address wider workforce challenges. The risks are captured within the Highland Council Risk Register and have been discussed at the Infant Children and Young People's Clinical Planning Group.
- Ongoing performance review at the HHSCP will provide a forum to support dialogue over the risks with related consideration of when the uptake might improve and the related development of an improvement trajectory.

Access to child and adolescent mental health services

Context

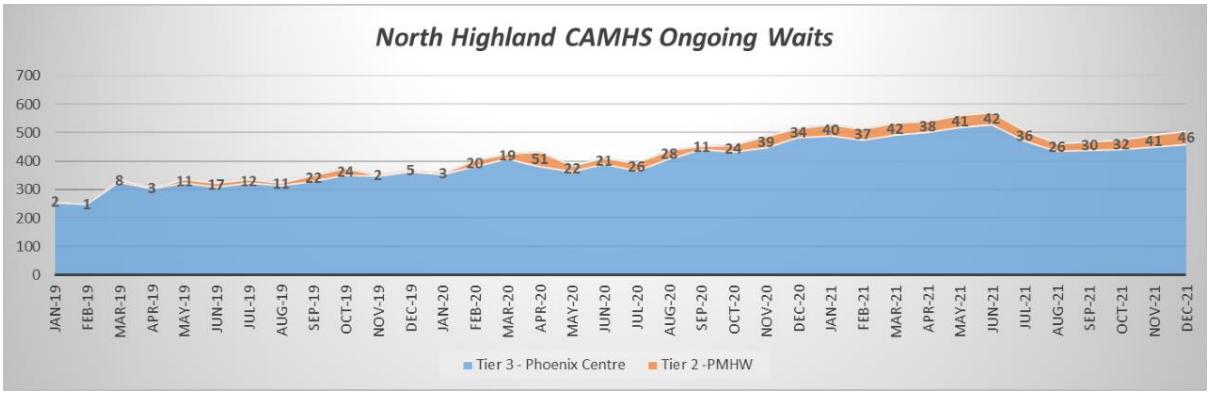
The mental health of babies, children and young people can be understood as a resource for life. The feelings, behaviours and responses of infants, children and young people to the day to day of their lives are informed by their primary experiences of relationships and wider environments, as evidenced in the way they respond to others and different situations. They do better when the adults in their lives, parents, wider family, school and community are able to buffer the stressors in their life and provide relational safety and security.

Such awareness creates many opportunities to reduce the risk of developing mental health difficulties by supporting parents in their relationships with their infants, children and adolescents and responding to distress in non-shaming and supportive ways and thereby supporting resilience as the ability to 'make sense of' feelings and their lives.

Timely access to mental health support as needs present and before they become more complex is the task of the Primary Mental Health Worker Service (Highland Council) working in preschool, primary and secondary school settings with the role of building awareness and capacity within the workforce, (training, consultation and supervision) as well as direct clinical work. When needs are more complex with greater levels of risk, this is the function of the Phoenix Tier 3 CAMHS Service (Raigmore).

The Scottish Government performance indicator requires that children and young people are seen within 18 weeks of referral. Waiting list pressures in the Phoenix Service were evidence in the service prior to spring 2019, COVID-19 (Figure 16), though less so in the primary Mental Health Worker Service.

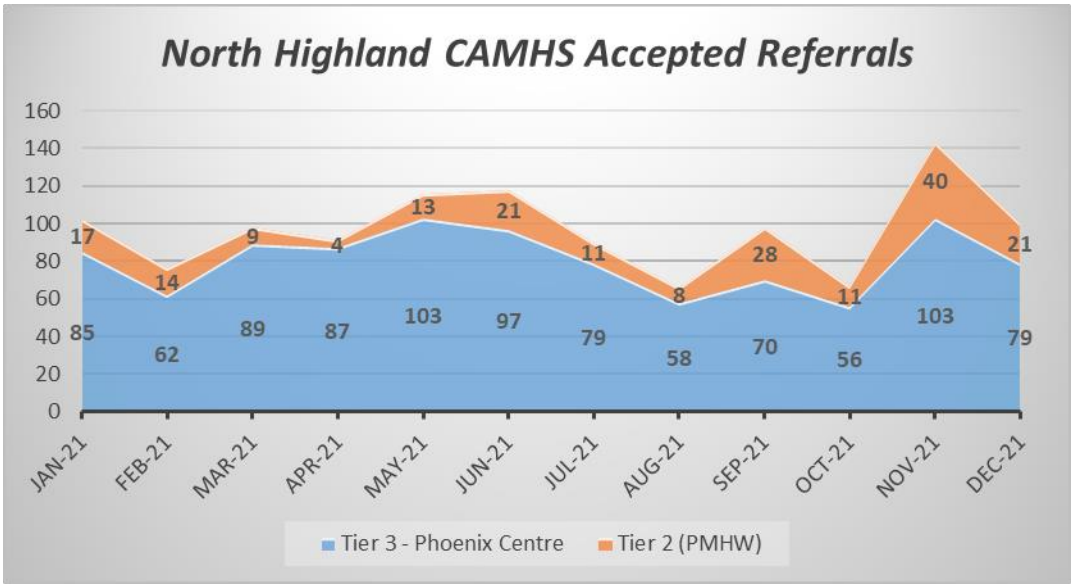
Figure 16



Responding to the risks associated with COVID-19 disrupted access to care and also created a perfect storm for additional mental health need as explored elsewhere in this report. It is interesting to observe that demand in both the primary mental health worker team and the Phoenix Service reflects similar patterns of referral over the last twelve months (Figure 17). These patterns may have been disrupted by Lockdowns and episodes of self isolation for individual children. Prior to COVID-19 it is generally understood that referrals increased after school holidays when children returned to

education settings where needs may be more visible.

Figure 17

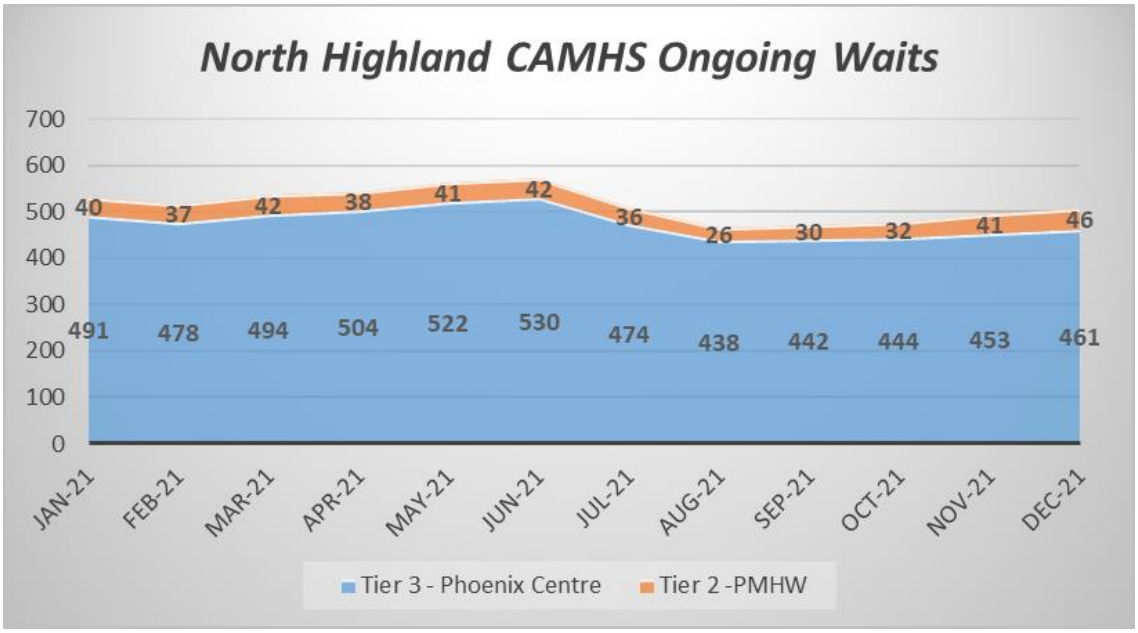


Referrals can be understood as an indication of expressed mental health need. It is well understood that the time it can take for children and young people and their families to have their needs understood and responded and to access mental health care and support can result in greater and more complex presentations of need. The need for cooperation between the Phoenix CAMHS service and the Primary Mental Health Worker service in Highland Council as part of the commissioned service cannot be overstated.

There is interest in understanding the referral into the primary mental health worker service as it might be expected that there would be greater referral numbers given their referral base, across all schools. Linked to this would be understanding of referrals to school counselling services that have been implemented by education services Highland Council over the last eighteen months and how the three services complement and align to meet need. Waiting lists pressures have continued to rise over the past twelve months across both services (Figure 17).

There have also been increased demands on the Phoenix Team by complex higher risk presentations of need requiring Tier 4 community support and/or admission to the impatient unit/Raigmore children's unit. Eating disorder presentations are notably higher across the UK, attributed to the unintended consequences of COVID-19 measures on children and young people’s mental health.

Figure 17



Managing risks

- The Scottish Government is taking an active interest in the waiting times for the Phoenix Service with associated Ministerial scrutiny.
- The CAMHS Programme Board has oversight of the risks and is aware and acting on the following areas.
- An active programme of recruitment to address the shortfall of 14.8 WTE CAMHS clinicians with additional Scottish Government resource.
- On a positive note, 1.6 WTE CAMHS Psychiatrists have been recruited and will take up post into March and two GPs with a special interest in CAMHS have been identified, one in post and also to start in March.
- Work is ongoing to improving the functionality of Trak care to support business intelligence for the Team.
- Work is being undertaken to support the Primary Mental Health Worker team with skills development and supervision.
- Further understanding the flow between services and aligning mental health interventions and support between the PMHW team and the Phoenix service is to be a priority over the coming months with the oversight of the CAMHS Programme Board.
- There are many opportunities to prevent poor mental health and offset deterioration of mental wellbeing in the way parents are supported to understand and develop their capabilities and capacities, as for the skill set and attention to settings, cultures and practice in universal midwifery, health visiting school nursing and primary/secondary schooling settings.

2.4 Proposed level of Assurance

This report proposes the following level of assurance:

Substantial		Moderate	x
Limited		None	

3 Impact Analysis

3.1 Quality/ Patient Care

As detailed above

3.2 Workforce

As detailed above

3.3 Financial

The report assumes resource as is and the potential to maximise health for individuals and families by working to ensure the services work together and understand the flow between services and teams.

3.4 Risk Assessment/Management

As detailed above

3.5 Data Protection

No issues of note

3.6 Equality and Diversity, including health inequalities

An impact assessment has not been completed as this is an assurance report on performance.

3.7 Other impacts

The report details the value of all services, clinicians and teams working collectively to improve the health outcomes for children, young people and their families. No one service works in isolation.

3.8 Communication, involvement, engagement and consultation

See below.

3.9 Route to the Meeting

This report has been written by the Child Health Commissioner to provide a system view across all services. Stakeholder communication with the operational units has been constrained by the time scales for identifying and reporting on the data to create the one report as a proposed model for moving ahead. Where time and capacity allowed, there were informal discussions with

colleagues. For future reports, it is proposed that the report be led by the Child Health Commissioner and developed through the Children and Young People's Health Strategy Group.

4 Recommendation

The HHSCP Committee are invited to:

4. Discuss the format of the refreshed approach to reporting on children and young people's health services in north Highland. .
5. Discuss the performance measures and commentary as detailed in the report.
6. Make a decision on the format and approach as detailed going ahead on a quarterly basis and to advise if this will cover all measures in the Balanced Score Card over a twelve month period, or that the full suite of measures being reported on a quarterly cycle.

4.1 List of appendices

The following appendices are included with this report:

- **Appendix One**: Children and Young People Balanced Score Card Performance Measures

Appendix One

Children and Young People Balanced Score Card Performance Measures

- Percentage uptake of 6-8 week Child Health Surveillance contact
- Percentage of new born babies exclusively breastfed at 6-8 week review
- Percentage Allocation of Health Plan indicator at 6-8 week from birth
- Percentage uptake of primary immunisations by 12 months
- Percentage of dental registrations of 0-2 year olds
- The number of 2 years olds who have seen a dentist in the preceding 12 months
- Percentage increase in the coverage of the 27-30 month contact
- Percentage of children who reach their developmental milestones at their 27 – 30 month health review
- Percentage uptake rate of MMR1 (% of 5 year olds)
- Percentage of children in P1 with their body mass index measured
- Percentage of children in P1 within the healthy weight (epidemiological) category.
- Percentage of young women in S2 who have received HPV immunisation
- Percentage of statutory health assessments done within 4 weeks of becoming looked after
- Percentage of initial LAC health assessments included in Child's Plans within 6 weeks
- Percentage of children and young people referred to CAMHS waiting less than 18 weeks for treatment, at month end *(Interim Measure)*
- Percentage of children and young people referred to AHP services, waiting less than 18 weeks from date referral received to census date
- Percentage of children and young people waiting less than 12 weeks for treatment, on the Acute Medical Paediatric waiting list, at month end
- Percentage of children and young people waiting less than 12 weeks, on the Acute Medical Paediatrics outpatient waiting list, at month end
- Percentage of children and young people waiting less than 12 weeks for treatment, on the Acute Surgical Paediatric waiting list , at month end
- Percentage of children and young people waiting less than 12 weeks, on the Acute Surgical Paediatric outpatient waiting list, at month end
- Percentage of children and young people waiting less than 12 weeks for treatment on the Community Paediatrics waiting list , at month end
- Percentage of children and young people waiting less than 12 weeks, on the Community Paediatric outpatient waiting list, at month end
- Percentage of children and young people attending Emergency Departments who were seen within 4 hours

Population/Inequality Measures

- The rate of LBW babies born to the most deprived compared to those born in the least deprived parts of Highland will reduce.
- Percentage uptake of the 6-8 week Child Health Surveillance contact across deprivation quintiles
- Percentage uptake of the 6-8 week Child Health Surveillance contact uptake between the general population and Looked After Children

- Percentage uptake between the most and least deprived parts of Highland in the number of children exclusively breastfed at the 6-8 week review
- Percentage increase in uptake of Healthy Start Scheme of eligible beneficiaries