Agenda Item 4

The Annual Report of the Director of Public Health 2013

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Introduction

This year's Public Health Annual Report focuses on children and young people. Supporting and nurturing the youngest members of our population to grow, develop and reach their full potential is an essential part of our society and is the best approach to improving population health.

In April 2012, Highland Council became the employers for community-based child health staff as part of the integration of health and social care between the NHS and the Highland Council. NHS Highland now commissions integrated child health services from Highland Council and is developing an approach to the design and delivery of services for children, young people and families that is based on need and focussed on outcomes for children and young people. Acute services for children and those community child health services still provided by the NHS are included in this approach along with children's services in Argyll and Bute, presently provided by Argyll and Bute Community Health Partnership. Within this report we have adopted a life course approach to describing the mental and physical health and well-being of children and young people.

The early years (0- 5 years) are where we can have the greatest impact on the future health and well-being of children. Maintaining healthy development for older children and adolescents ensures that they are able to achieve their full potential through learning, education and later employment. There are specific groups of vulnerable children for whom it is particularly important that we support their development, provide appropriate care and ensure there is a smooth transition to adult services: these groups include looked after children and young people, children with exceptional health care needs and those with long term conditions.

Last year's report focused on the health and well-being of older people. I am pleased to report good progress with implementing the recommendations from that report, as integrated working on adult health and social care has developed over the last year.

M Somerville

Dr Margaret Somerville, Director of Public Health and Health Policy

Summary

Those aged under 18 years comprise 19% of the population in NHS Highland; this proportion has been reducing over time. While fewer children live in poverty in NHS Highland compared to Scotland as a whole, 39% live in areas classified as remote or very remote, presenting significant challenges around access to and provision of services. Immunisation rates are generally high.

The early years, from 0-5 years old, represent the critical time to give children the best start in life and prevent health and social problems later on. Encouraging breast-feeding and supporting parents to develop their parenting skills are two key interventions that improve children's health and well-being across the life course. A range of services provide these interventions across the NHS Highland area, supported by the Early Years Collaborative groups in both Council areas.

Nearly a quarter of children in NHS Highland are overweight or obese. Schools-based programmes in both Council areas encourage healthy diet and promote physical activity for all children.

Over 90% of school-leavers across NHS Highland have a positive destination on leaving school, and both Councils provide options to support young people into work and further education and training to help them achieve their potential.

There are fewer looked after children and young people in NHS Highland than elsewhere in Scotland. It is recognised that this group have poorer educational and health outcomes than their peers. Other vulnerable groups for whom specific support is available include young carers and gypsy and traveller children.

There are higher than expected numbers of children with exceptional needs in NHS Highland, although the reasons for this increase are not clear. Outcomes of care for diabetic children are improving, giving these individuals better health and independence. Significant work is in progress across the North of Scotland to improve unscheduled care for children and the Child and Adolescent Mental Health Services (CAMHS) in the Highland Council area have been redesigned and improved.

Recommendations

Children's services commissioning

- Operational units should ensure service provision reflects children and young people's needs and views through use of the children's health status profiles and regular engagement with service users and children's and young people's groups.
- The performance framework that follows from the new Highland Council Integrated Children's Services Plan should include more measurable and evidence-based outcome indicators.
- Information gaps should be addressed to ensure that services are targeted accurately at those who most need and can benefit from them:
  - Information on children from Argyll and Bute using services in Greater Glasgow and Clyde should be available for planning purposes to Argyll and Bute Community Health Partnership (CHP).
  - The new national Child Health Surveillance System should be implemented and the information routinely made available to service providers and commissioners for service planning purposes.
  - A more detailed and comprehensive needs assessment for children should be completed, including addressing the needs of children affected by parental substance misuse.

Life course

- Community Planning Partners (CPP) in the Highland area should agree a consistent set of assessment tools to evaluate child development across the early years to support the goals of the Early Years Collaborative.
- CPPs should develop their role as corporate parents with a focus on employability using the Family Firm approach.

Vulnerable groups

- A settings-based health improvement approach to residential care units should be implemented across Highland and Argyll and Bute CPPs, to include promoting mental health and well-being.

- The health needs of looked after children who are placed outwith the NHS Highland area should be identified and addressed.
- Improvements should continue to be made for medical examinations of children who report sexual abuse.

Long term conditions

- The *Getting it right for every child* (GIRFEC) process should be applied across all health services to ensure early coordinated support for the child and family.
- Preparation for transition into adult services should start at least two years before the child's 16th birthday.
- The approach to diabetes across the life course should be replicated for other long term conditions through the Medicines Management Improvement Group.
- Coordination of services, including funding arrangements, should be improved for children with complex care needs.

getting it right for every child

GIRFEC: Getting it Right for Every Child is the Scottish Government approach to ensuring all children get the support and services they need, through a responsible named person.

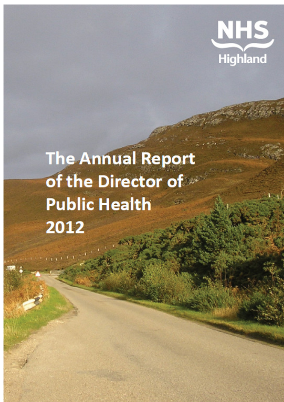
Improvement

- The focus on improving access to CAMHS should continue in both CPP areas along with the development of parent support services.
- Improvement activity for all services in both CPPs should focus on children and young people with exceptional needs, using the GIRFEC practice model.
- A case management community information system should be used for all staff working in child health, enabling them to share data with other professionals.

Consultation with young people

- NHS Highland should report back to Highland Youth Voice on progress with the issues discussed.
- Issues identified at the Highland Youth Voice conference in June 2013 should be reflected in For Highland's Children 4 Integrated Children's Service Plan and the Highland Social Care Partnership Children and Young People's Commissioning Group.
- Highland Youth Voice members should attend and work with District Partnerships and Ward Forums in Highland to implement actions identified at a district level.
- In Argyll and Bute, the work of the Youth Summit should be continued and used to inform service development.

Update on recommendations from 2012 annual report



The DPH report 2012 was about the health and well-being of older people.

Preventing falls

Prevention activities that promote exercise, strength and balance continue and include:

- 'You Time' programme organised by High Life Highland (HLH) Highland Council delivered in several places.
- 'Still Game' initiative, for people aged 60 or over to improve their lifestyles, is provided jointly with the Scottish Premier League.
- The evidence-based Otago exercise programme designed to prevent falls has now been developed for delivery outside High Life Highland facilities and is being piloted in two care homes.
- An inter-generational approach to falls prevention has been adopted in Argyll and Bute. Both young and older people have mapped out environmental risks for falls and developed action plans to reduce them.

The elderly and smoking cessation

Stopping smoking slows the rate of decline of lung function and increases average survival whatever the age of quitting. Of the successful one month quits recorded by the smoking cessation services in Highland in 2012, 19% of those were 60+ years old and 32% were in the 45-59 age bracket.

The Butterfly Scheme

The Butterfly Scheme is a national opt-in programme for patients and their families aimed at improving the safety and well-being of patients with dementia or confusion during their stay in hospital. It uses a discreet butterfly symbol to highlight the patient's needs. The pilot work in Raigmore Hospital is now being extended to other wards and feedback from patients and their carers is very positive.

Post Diagnostic Support

Argyll and Bute participated as one of four pathfinder sites in the development of the one year post diagnostic support

programme for people diagnosed with dementia. The partnership between the CHP, Argyll and Bute Council and Alzheimer Scotland has led to Award winning Community Based Dementia teams who will deliver the required standards of post diagnostic support.

Anticipatory Care Plans

The use of anticipatory care planning alongside poly-pharmacy assessments continues to be used throughout Highland, with a special focus on care home patients. The approach enables holistic care to be provided for those with multiple long term conditions. Research by York University will help develop this work further by being able to target the groups who will benefit the most.

Community and voluntary sector

The 2012 report makes the point that older people contribute to society as volunteers, informal care providers, leaders and opinions makers. The 'Let's Get On With It Together' partnership has secured funding from the 'Health and Social Care Alliance Scotland' to develop a Highland wide approach to self help and self management. A co-ordinator was appointed in May 2013 to continue the work.

Work with Argyll Voluntary Action is promoting the concept of co-production of services with older people; the growth of the Argyll and Bute Timebanks and Grey Matters Groups are seeing increasing involvement of older people supporting, and being supported by, new community initiatives across the area.

Developing indicators and monitoring performance

Performance indicators and outcomes for older adults were developed as part of the partnership agreement[1] between NHS Highland and Highland Council specifically to ensure that both the changes in service processes and their impact on older people are monitored. High Life Highland is piloting a score to measure well-being which will inform future service planning and delivery.

Argyll and Bute continue to monitor performance against a range of outcome measures using the Argyll and Bute Council based Pyramid system, to which all partners in the Reshaping Care for Older People programme now have access.

Section 1

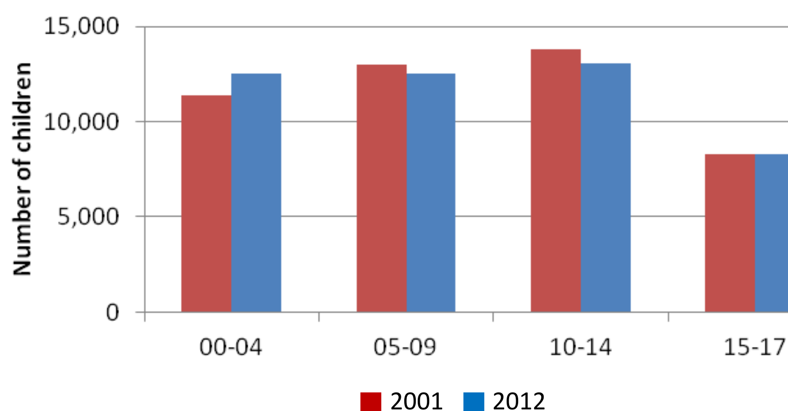
Children and young people in Highland

Population

The child population (those aged 0-17 years) of NHS Highland has been falling as a proportion of the whole population since 2001 (Figure 1), although overall numbers have not changed greatly. Children represented 22% of the population in 2001 and 19% in 2011. This trend is seen in Argyll and Bute, where children now comprise 18% of the population, and the North and West Operational Unit. In South and Mid Operational Unit, the numbers of children have stayed constant at just under 30,000 while the proportion they contribute to the population has declined from 22% to 19% (data available on-line). The Highland Council area is one of the few places in Scotland where the child population is stable or increasing, while it has been falling in Argyll and Bute.

Compared to the overall national situation, there are smaller proportions of children in NHS Highland living in the most socio-economically deprived areas based on the Scottish Indices of Multiple Deprivation (SIMD) measure. Also, based on income and benefits data, 12.3% of children in Argyll and Bute and 13.4% in Highland live in poverty, compared to 16.8% across Scotland as a whole. However, 39% of children in the NHS Highland area in 2011 lived in remote or very remote rural areas compared to 26% living in urban areas. In Argyll and Bute in particular, this figure includes many children (just over 16%) who live on islands, which presents specific issues of access to services and education. In comparison, the average national distribution of children is 6% living in remote and rural areas and 69% in urban areas.

Figure 1: Change in the child population of NHS Highland (aged 0-17 years) from 2001 to 2012 by age band



Data source: National Records of Scotland (NRS) Mid Year Population Estimates for 2001 and 2012: data available online at: http://www.gro-scotland.gov.uk/statistics/theme/population/estimates/mid-year/index.html

Births and deaths

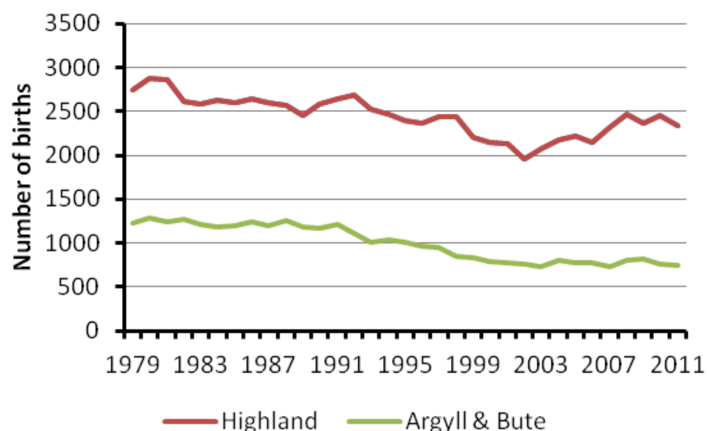
The number of births in NHS Highland has generally fallen over the last 30 years, although the more recent data shows a levelling off of this fall in Argyll and Bute and a slight increase in Highland (Figure 2). The birth rate across NHS Highland has been fluctuating since 2000, but generally shows a slight increase; it is currently lower in Argyll and Bute (8.3 per 1000 population) and North and West (8.9 per 1000 population) than in South and Mid (11.8 per 1000 population). The female population of child-bearing age (15-44 years) has also been falling, from 55,813 in 2001 to 51,498 in 2011; again, there is a smaller reduction in South and Mid compared to North and West and Argyll and Bute. As a consequence, the general fertility rate is higher in South and Mid (63.9 live births per 1000 women aged 15-44 years) compared to Argyll and Bute and North and West (with 53.8 and 58.3 live births per 1000 women aged 15-44 years respectively). There are 5-7% more boys born each year than girls.

Numbers of teenage pregnancies in girls aged under 16 years have been falling across Scotland as a whole since the mid 1990s, although the fall in the teenage pregnancy rate is less marked. In NHS Highland, numbers are small and do not show a clear trend over time, although the rate is consistently lower than the Scottish rate (5 vs 5.7 per 1000 girls aged 13-15 years for 2011). The same trend, although less marked, is seen across Scotland for those aged under 18 and under 20 years,

but in Highland numbers and rates have stayed constant at or above the Scottish average for these age groups.

Since 2001 there have been fewer than 15 infant deaths (deaths of children in the first year of life) each year in NHS Highland, resulting in low and very fluctuating infant mortality rates. Deaths in children aged 1-14 years are few, around 8-9 each year; mortality rates in this age group are slightly, but not significantly, higher than the Scottish rate. Deaths in young people aged 15-24 years old are also low, around 25-30 per year, and are consistently, but not significantly, higher than the Scottish average: 7.2 per 10,000 population in 2009-11 compared to 5.1 across Scotland. The commonest causes of death in this group are due to external causes, particularly road traffic and other accidents.

Figure 2: Births in Highland and Argyll and Bute from 1979-2011



Data source: Births to NHS Highland residents – data extracted from National Records of Scotland vital event files (birth series) held by NHS Highland

Birth rates calculated per 1000 population from National Records of Scotland Small Area Population Estimates

Health

Low birth weight, defined as a birth weight of less that 2,500g, has long been seen as a marker for poor health later on in life[2]. Excluding multiple births, around 4-5% of babies born in NHS Highland each year have a low birth weight. The proportion has been falling slightly in recent years and is comparable to the Scottish average. There is a clear association with socio-economic deprivation with the latest (2012) data showing that 5.7% of babies born into the least affluent fifth of the population are of low birth weight compared to only 2.8% of

those born into the most affluent fifth. Around 2-2.5% of NHS Highland babies are born with a high birth weight of over 4,500g.

Ensuring children are fully protected against common childhood infectious diseases through immunisation has long been a key aim of child health services. NHS Highland currently achieves high coverage for all childhood immunisation programmes (Table 1), except for MMR1, where the uptake is below the 95% target level at two years, although it is achieved by age five across Highland. Immunisation against human papilloma virus (HPV), to prevent cervical cancer is offered to girls in their second year at secondary school; uptake in NHS Highland for the 2011/12 school year was 83% compared to 82.8% in Scotland, although there was considerable variation across localities.

Table 1: Primary immunisation uptake in children aged 2 years as measured during 2012

Operational Units	Number in Cohort [1]	% completed primary course by 2 years of age			
		DTP/Pol/Hib [2]	MenC	PCV	MMR1
North & West Highland	760	97.0	94.6	95.3	93.0
South & Mid Highland	1,656	97.5	95.6	96.1	93.5
Highland HSCP/ Highland Council	2,416	97.4	95.3	95.9	93.4
Argyll & Bute CHP	807	97.1	95.4	95.9	93.2
NHS Highland	3,231	97.2	95.3	95.8	93.3
Scotland	58,971	98.2	96.2	96.9	95.0

Based on childs NHS Board of Residence, Time period - 1 January to 31 December 2012, Data Source - SIRS, ISD Scotland

[1] Children reaching 2 years of age during the evaluation period 1 January to 31 December 2012 (i.e. born 1 January to 31 December 2010)

[2] For this cohort of children the vaccination was recorded as one injection on the SIRS system. For children who received primary immunisations outwith Scotland it includes only those who have received 3 doses of each: Diptheria, Tetanus, Pertussis, Polio and Hib

Key:

DTP/Pol/Hib = Diptheria, Tetanus, Pertussis, Polio and Hib (3 doses)

MenC = Meningococcal serogroup C conjugate vaccine (2 doses under 12 months)

PCV = Pneumococcal conjugate vaccine (2 doses under 12 months)

MMR1 = Measles, mumps and rubella vaccine (1 does over 12 months)

To eliminate measles altogether, 95% of the population must be immune, so it is good that 95% of 5 year olds in Highland have had at least one dose of MMR.

But 15% of Highland teenagers remain susceptible to measles infection, due to reduced levels of MMR uptake in the late 1990s and early 2000s following unfounded concerns about the vaccine's safety, according to Health Protection Scotland.

For the past two years S3 pupils who are known to not have had two doses of MMR have been offered the vaccine along with their booster diphtheria, tetanus & polio vaccine in school. In June 2013 the Scottish Government initiated a national catch-up campaign targeting 10-17 year olds who have not received two doses of MMR. All those in this cohort have been invited to be immunised at their GP practice.

There are fewer hospitalisations for unintentional injuries in NHS Highland compared to Scotland, but there has been little change over time, while the Scottish rate has been falling (Table 2). Hospitalisations for alcohol-related diagnoses in those aged 0-19 years have been falling in NHS Highland, from 220 in 2007/8 to 126 in 2011/12 (provisional data only). While this trend is encouraging, the NHS Highland rate of 187.6 per 100,000 population is still 50% higher than the Scottish rate of 123.8 per 100,000.

Table 2: Rates of hospitalisations for unintentional injuries in children aged 0-14 years in NHS Highland[1,2,3,4]

Areas	Financial Year				
	2007-08	2008-09	2009-10	2010-11	2011-12
North & West Highland	786.7	931.4	856.2	956.9	663.0
South & Mid Highland	975.3	878.9	897.5	958.5	1,052.4
Highland HSCP / Highland Council	910.6	896.5	883.7	958.0	926.1
Argyll & Bute CHP / Argyll & Bute Council	787.7	806.0	862.6	739.8	775.0
NHS Highland	876.1	871.7	878.0	899.8	886.2
Scotland	1,044.4	982.4	982.2	935.7	926.2

[1] Derived from data collected on discharges from non-obstetric and non-psychiatric acute hospitals (SMR01) in Scotland with an emergency admission type code of 32-35 and ICD10 code of V01-X59 or Y85-Y86 in any of six diagnosis positions at 3 digit level

[2] A child could have had several emergency admissions in a financial year and therefore number of admissions will be greater than the number of individuals

[3] Data not analysed down to district level due to small numbers and therefore risk of disclosure

[4] Crude rates per 100,000 population aged 0-14 years using NRS mid-year estimate series as the population denominator

Table 3: Rates of hospitalisations for alcohol-related diagnosis in those aged 0-19 years in NHS Highland[1,2,3,4]

Areas	Financial Year				
	2007-08	2008-09	2009-10	2010-11	2011-12 [p]
North & West Highland	429.4	256.5	228.4	279.9	236.2
South & Mid Highland	219.8	272.9	189.3	173.9	134.4
Highland HSCP / Highland Council	292.0	267.3	202.5	209.3	167.9
Argyll & Bute CHP / Argyll & Bute Council	383.6	340.2	294.6	225.8	240.1
NHS Highland	318.3	287.9	228.1	213.8	187.6
Scotland	200.6	163.4	140.5	131.8	123.8

[1] General acute inpatient and daycase discharges with an alcohol-related diagnosis in any of six positions (see Appendix A1 of ISD's full report on Alcohol-related Hospital Statistics 2011/12 for a list of ICD10 codes included as an alcohol-related diagnosis) http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2013-05-28/2013-05-28-ARHS2011-12-Report.pdf?22008913756

[2] Data source: SMR01: discharges from non-obstetric and non-psychiatric hospitals. Discharge information is based upon on the patient's first episode within a continuous inpatient spell of treatment (CIS) and a patient may change consultant, significant facility, specialty and/or hospital during a CIS. The recording of alcohol misuse may vary between hospitals.

[3] Data not analysed down to district level due to small numbers and therefore risk of disclosure

[4] Crude rates per 100,000 population aged 0-19 years using NRS mid-year estimate series as the population denominator

[p] Provisional

While children's health is generally good in Highland, there are many long-term conditions (LTC) from which they may suffer and require support from health and social care services. Getting reliable data on the numbers of children suffering from LTCs is difficult, so the Epidemiology and Health Science Team has used a variety of data sources to calculate indicative numbers of children with LTC at different ages in each operational unit (Table 4). Such data are essential for planning appropriate services for children and young people at each stage of their lives; it is also important for the current services to review their activity in the light of these estimates.

Table 4: Indicative numbers of children living with particular conditions in NHS Highland

Condition	Expected / indicative number of Children School Populations [6]			
	N	P	S	Total
Long term conditions (LTC)				
Hearing impairment [1]	11	52-59	51-58	114-127
Visual impairment [1]	6-13	23-45	22-45	51-102
Speech & Language	95	2093	1627	3814
Stuttering (wide C.I.s)	89	324	118	531
Disabilities [2]	234	1845	2050	4129
Additional support needs [3]	51	540	490	1081
Children with exceptional needs	2	6	6	14
DCD [4]	126	450	446	1022
Muscular Dystrophy	0	1	1	3
Specialist conditions (not always long-term)				
Diabetes	2	41	111	154
Asthma	493	1755	1672	3920
Cancers [5]	2	2	3	7
Palliative	10	36	36	82
Epilepsy	12	97	114	222
Cystic Fibrosis	1	7	7	16
IBD	1	5	4	10
Endoscopy & Colonoscopy	10	36	36	82
Enteral / Parenteral nutrition	6	20	20	46
Rheumatoid Conditions [1]	6-13	23-45	22-45	51-102

[1] Lower and upper estimates
[2] Disabilities moderate and severe defined according to the Discrimination Disability Act and have a wide range in values
[3] Those recorded on the Special Needs System (SNS)
[4] Developmental Co-ordination Disorder
[5] Incidence (new cases per year), total of haematological & non-haematological cancers
[6] School populations: N = Nursery; P = Primary; S = Secondary
C.I.s = confidence intervals
Data sources: For these and notes regarding the conditions themselves, read the prevalence guide (intranet site) or request from Epidemiology & Health Science Team sara.huc@nhs.net

Section 2

A life course approach

Considering influences on health in a life course approach demonstrates their cumulative effect in later life and how health inequalities become entrenched across generations. This approach is now informing the development of appropriate services for children and young people at each stage of their lives: in early years, during school-age years and in adolescence. As parents are the primary carers and educators of children and young people, new ways to meet their needs also need consideration. We need to provide consistent high quality universal services to all children and their families and also pay specific attention to addressing the needs of vulnerable groups.

Prof Phil Wilson, Director of the Centre for Rural Health, University of Aberdeen writes
Poor long-term physical and mental health is most strongly predicted by factors present in childhood[3]. These factors may be:

- Genetic.
- Antenatal (e.g. maternal stress hormones, smoking and alcohol consumption).
- Located in the family/upbringing (e.g. harsh parenting, parental discord, poor diet).
- Located in the wider environment (e.g. relative poverty, neighbourhood problems).

Sometimes the risks may simply add up to increase the risk of ill health, sometimes they amplify each other and sometimes they interact in more complex ways.

Adverse childhood experiences such as bereavement, exposure to violence, abuse and neglect are strongly associated with increased risks for serious physical and mental health problems in adulthood[4]. Some, but not all, of these increased risks are mediated through later behaviours: smoking, problem drug and alcohol use, violence or other forms of risk-taking. Other mechanisms include the 'programming' of brain circuits linked to stress responses[5].

Roots of Empathy is an anti-bullying programme run by the charity Action for Children. It has been piloted in 6 primary schools in the Highland Council area as "Tiny Teachers". A baby and parent visit the class nine times throughout the school year; a trained Roots of Empathy instructor guides pupils in labelling the baby's emotions and raising levels of empathy amongst classmates. In the pilot intervention in North Lanarkshire, 55.5% of primary school pupils receiving the programme increased their pro-social behaviour, a third more than pupils in the control group

The evidence now clearly supports early intervention with children at risk of poor outcomes, showing it can be more effective than just waiting until obvious problems declare themselves – though gathering this sort of evidence can be very difficult. Highly effective early interventions include intensive home visiting programmes (e.g. the Family Nurse Partnership), enhanced nursery provision[6] and therapeutic interventions with foster carers[7]. The Family Nurse Partnership, for example, which provides support to young vulnerable mothers with children under two years, can halve the level of problem substance use and high risk sexual behaviour in the teenage years[8]: no intervention offered during adolescence has ever been shown to be anywhere near as effective. These interventions are costly, and not every child needs them, so we need to find ways to identify which children would benefit most.

We know a lot about which social, emotional and behavioural factors predict long term ill health. For example:

- Early conduct problems predict psychopathic personality traits, mental-health problems, substance dependence, numbers of children, financial problems, work problems, and drug-related and violent crime at age 26[9].
- Attention-deficit/hyperactivity disorder (ADHD) predicts problem substance use[10] and smoking[11].
- Language delay predicts mental health problems at age seven[12] and at age 34[13].
- The children who took part in the 1958 British birth cohort who were rated by their teachers as being in the highest quarter of the cohort for emotional and behavioural problems had double the mortality by age 46 years compared with the quarter of children with the lowest scores[14].

Early years

In pregnancy, women with high levels of stress have higher cortisol levels that influence the developing baby's brain and its ability to deal with pressures and stressors once born. Alcohol and drugs can also adversely influence early weight, uterine development and impact negatively on an infant's mental as well as physical health (Box A). Babies born to women who smoke are at greater risk of miscarriage, prematurity and a low birth weight.

Box A

Alcohol is toxic to the developing foetus and can result in structural abnormalities and impaired brain development that are likely to have implications for health, well-being and achievement throughout life.

Fetal Alcohol Syndrome (FAS) has a prevalence of 1-2 in 1000 live births; there are probably 3-5 babies born with FAS in NHS Highland each year. Affected infants have a range of congenital anomalies that may require corrective surgery and life-long engagement with specialist services, as well as support from health and social care throughout their education.

Fetal Alcohol Spectrum Disorders (FASDs) have a prevalence of 1 in 100 live births; around 25 affected infants are born each year in NHS Highland. Less is understood about this condition and how to best identify and support children who may be affected. These children are likely to experience difficulties in behaviour, learning, relationships and educational achievement during childhood and into adult life[15].

Parents in Argyll and Bute are given part of the Bookbug Baby Pack at 28 weeks pregnant to facilitate bonding with the baby and promote the importance of interacting with the baby in pregnancy. The remainder is given at 6-8 weeks. The Bookbug early years programme has been developed by local partners in health, library services, the Creative Arts in Schools Team, Community Learning and Development and the third sector.

Women of reproductive age generally have poor dietary intakes of some key nutrients including iron, calcium, folate, vitamin D and have low iron and vitamin D status.

The Healthy Start scheme helps families on a low income by providing vouchers for fruit, vegetables and milk to pregnant and breastfeeding women and young children, as well as free vitamin supplements. The scheme also encourages earlier and closer contact with health professionals who can give advice on pregnancy, breastfeeding and healthy lifestyle choices.

HEALTHY START

NHS Highland distributes Healthy Start maternal and children's vitamins free to beneficiaries through the Midwifery and Public Health Nurse workforce and encourages non-beneficiaries to access these from Community Pharmacies (Box B).

Box B

Our local programme of work to increase uptake of Healthy Start has included:

Work with Community Pharmacies and Dispensing GPs - to increase access to Healthy Start vitamins and support a one-year pilot of Healthy Start maternal vitamins and children's vitamin drops through local Community Pharmacies.

Work with the media – to communicate consistent messages about Healthy Start through local community newsletters, publications and local radio programmes.

Work with Retailers – to engage with retailers and wholesalers through the Scottish Grocers Federation network, and encourage more retailers to sign up to Healthy Start with a view to improving local access to healthy food, particularly in remote and rural Highland communities.

Once born, parenting styles and behaviours are a significant mediator of mental health and well-being for the infant. Most brain development takes place in the child's first three years. A parent or care giver who provides consistent and reliable affection and care will enable the infant to develop positive attachment styles which helps to develop the necessary emotional, social and cognitive skills that are required throughout life.

While having a baby is for most women a joyous experience, a significant minority of new mothers experience mood disorders and depression that will benefit from being identified and managed. Low mood can influence the relationship between a mother and her newborn baby.

When there have been adverse experiences in the pre-natal months and early years of life it is important that additional needs, risks and vulnerabilities are identified early and assessed to ensure the most appropriate intervention. This approach is supported by the development of the GIRFEC

process in both the Highland and the Argyll and Bute Community Planning Partnerships (CPPs) where the midwife is given the responsibility of being the named person.

Health Visitors and other public health nurses also support children in the early years as part of the universal programme and as named persons for children with additional needs. However, while assessment and intervention processes have been updated as part of the GIRFEC Practice Model, child health staff do not have computer-based casework systems. This limits innovation, and also constrains necessary information sharing with professional colleagues.

Box C

There is international evidence that 20-30% of children do not currently meet their developmental goals at 27-30 months.

The new 27-30 month check will include enquiry about language development, behaviour, hyperactivity, attention problems, emotional difficulties and peer relationship problems as well as assessing coordination, muscle control and physical growth. Provided every child receives this check, it should provide a good opportunity to reduce social inequalities in health[16]. At the moment the only services in contact with every child aged 0-2 years are general practice and health visiting/public health nursing. If GPs and health visitors work closely with families, any developmental risks or concerns can be identified early and an action plan (Child's Plan) can be agreed detailing any support or interventions needed to ensure the child is able to meet his/her full potential.

"It therefore makes good sense to find ways to identify these early signs of vulnerability so that our resources can be used to benefit the children who most need them. For this reason, Scottish Government has asked each health board to reinstate a universal health check for every child at 27-30 months, with a particular focus on language, behaviour and parenting."

Professor Phil Wilson, Centre for Rural Health

The Early Years Collaborative requires assessment that children are meeting their developmental milestones at key stages in the early years. Presently, different assessment tools are used by different professional groups to evaluate how far these milestones are achieved. Practitioners recognise the need to develop a consistent set of assessment tools.

School years

Although the first few years of life are now increasingly recognised as the crucial time for child development, when interventions to provide good support, parenting skills and care can make the most impact, it is still important to ensure that children can make the most of their school years to maximise their learning and development potential.

One of the key public health challenges for children and young people of school age is achieving and maintaining a healthy weight. In Highland there are higher rates of obese and overweight children at P1 than across Scotland as a whole and rates have remained constant over the last 4 years: approximately 24% of P1 children in NHS Highland in 2011/12 had a Body Mass Index (BMI) above the 85th centile[17].

Some examples of schemes promoting physical activity:

Play@home; Rain Starts Play; Care And Learning Alliance; after school clubs; High Life Highland provides Active Schools Programmes, Community Sports Hubs, Youth Services and outdoor education; safer routes to schools; cycling proficiency; junior sports clubs and junior sections of adult sports clubs; 'Coaching Champions' in Argyll and Bute has created multiple sporting opportunities for young people; uniformed organisations; forest schools (e.g. Abriachan); local activities (e.g. Cool Moves in NW Sutherland).

The causes of overweight and obesity are complex, resulting from a combination of biology, behaviour and environment. It is therefore difficult to provide a single explanation of the higher trends in BMI in Highland children compared to the rest of Scotland. Actions to encourage healthy weight are clear, but not easy to implement: environmental and cultural changes are needed along with education to support behavioural change to improve diet and physical activity levels. Reducing the stigmatisation associated with being overweight is also important.

Physical activity has a role to play in supporting a healthy weight. It also contributes to mental health, social and emotional development, learning and concentration, community capital, independence, problem solving and self esteem. There is a growing body of evidence linking sedentary behaviour with chronic disease morbidity and mortality in adults and preliminary evidence suggests sedentary behaviour may also be a health risk in children and young people.

Family activity and/or strong family support for children's activity is key.

The main motivation for doing physical activity and movement is having fun. Therefore children and families need to experience a variety of activities (including games, sport, active travel) in order to find something they enjoy, and can build into daily routines.

Box D

Findings from the Scottish Health Survey 2011[18]

In 2011, 65% of children aged 2-15 years met the 2011 UK physical activity recommendations of at least 60 minutes physical activity a day (data based on self-report):

• boys were more likely than girls to be meeting the recommendations (69% of boys vs. 62% of girls), as in all previous years.

• the proportion of children who met the recommendations remained stable up to the 8-10 age group (70-72%), before declining to 50% of those aged 13-15 years.

• fewer girls aged 13-15 years met the recommendations than boys (59% of boys vs. 41% girls).

The Highland Council Lifestyle Survey of young people 2013 indicates a general downturn in P7, S2 and S4 pupils taking part in activities such as walking and playing sport outside school.

Active Schools offer a wide range of extra-curricular and community sports programmes for children and young people. A partnership between Early Years, Active Schools and Football Development in the Dunoon area supports nurseries with mini kickers coach education, equipment, resources and support. Additional physical activity programmes are now offered within the curriculum.

Best practice is demonstrated in the High 5 programme in the Highland Council area and nutrition based work in early years settings across both CPP areas.

"High 5" Healthy weight intervention

High 5 is a school based health & well-being programme, focussing on food, health, physical activity and emotional literacy. It forms part of NHS Highland's response to a national Health Improvement Target, so pupils currently have their weight and height measured at the start of the programme.

- Around 20 lesson plans now cover each key learning stage. Teachers use these plans to construct an 8-lesson programme appropriate to age, class-composition, and what else is happening within wider curriculum plans.
- 144 primary schools are now involved in the programme. Of these: 45 have already completed delivery; 33 have programmes in progress or committed to a start date; 54 have development sessions booked for teachers in preparation of delivery and another 12 schools have committed to running the programme. Approximately

The Smoke-Free Home and Smoke-Free Car Project is run by NHS Highland in partnership with The Highland Council, Argyll and Bute Council and Scottish Fire & Rescue Service. The project involves smokers and non-smokers promising to make part or their entire home smoke-free. It aims to reduce children's direct exposure to second hand smoke at home and in cars. To date 734 families have signed up to the smoke-free pledge, 577 of the pledges are diamond which gives an additional commitment for parents to try to stop smoking.

Susan Birse, NHS Highland

3,900 pupils have participated in the programme so far, and that number will continue to rise.

- Participating schools have reported excellent engagement with the lesson plans and the whole school approach that is encouraged. Involvement of parents and carers is an important element of the programme.

Tobacco Control

Around 15,000 young people between the ages of 13 to 24 in Scotland start to smoke each year[19]. Evidence shows that the younger an individual starts to smoke, the more likely they are to be an adult smoker, the heavier they are likely to smoke during adulthood and the more likely they are to fall ill and die early as a result of smoking[20]. Around two-thirds of smokers in the UK started smoking under the age of 18 and over a third (39%) started under the age of 16[21]. We also know that young people from the most deprived areas progress to regular smoking more rapidly than those in the least deprived areas[22]. Smoking rates are also disproportionately high amongst certain groups of young people, such as looked after children and young offenders[23]. Supporting young people in not smoking will therefore have both health and inequality benefits.

We also know that health behaviours do not exist in isolation. Action to support young people to negotiate decisions about tobacco must also take account of the potential interactions between smoking and other health damaging behaviours.

Smoking rates for 13 and 15 year olds in Scotland are at their lowest since reporting began in 1982[22]. NHS Highland is on track to achieve our 2014 targets for smoking rates in this age range:

- 3% of 13 year old girls smoke (target 3%)
- 3% of 13 year old boys (target 2%);
- 14% of 15 year old girls (target 14%)
- 11% of 15 year old boys (target 9%)[22].

While there has been good progress in reducing smoking rates in young people, there is still more to be done. The uptake of smoking over the age of 16 remains a concern with smoking rates rising from 13% among 15 year olds[22] to around 24% among 16-24 year olds[24].

In 2010 around half of Scottish 13 and 15 year olds who said they regularly smoke had successfully bought cigarettes from a shop[22]. Furthermore, despite the introduction of legislation to address proxy sales, 54% of 13 year olds and 55% of 15 year olds report getting someone else to buy them cigarettes from a shop[22]. In the Highland Council area there has been a marked decrease in the proportion of 15 year old regular smokers who obtain cigarettes from shops (from 78% in 2006 to 27% in 2010). However, this change is likely to be attributable, in part, to the legal age for smoking being increased from 16 to 18 in October 2007.

Box E

A Smoking Prevention & Education Road Show was offered to all secondary schools in the Highland Council area; 22 schools took up the offer. The programme was designed to support young people not to start smoking and to equip teachers and agencies working with young people to increase their knowledge, confidence and understanding of tobacco issues.

The Tobacco-Free Youth Newsletter supports teachers to deliver effective tobacco prevention and education to children and young people.

Children's Residential Units: NHS Highland is working with Local Authority and Private Units to develop a rigorous policy on tobacco and a strong anti-smoking ethos.

Trading Standards: NHS Highland is working with Trading Standards to reduce the availability of tobacco products to under 18's, including supporting more young people to take part in the Test Purchasing Volunteer Scheme and developing pathways to ensure intelligence about underage sales or illicit tobacco trade is passed on appropriately.

Adolescence

During adolescence:

- Young people experience key biological, cognitive, emotional, and social changes, building on the experiences of childhood and creating the foundational skills for adult life.
- Further change is taking place with remodelling of the basic structures of the brain affecting impulse control, intuition and logic.
- Young people are particularly prone to risk-taking and experimentation as they learn to manage new capabilities and greater freedom.

These behaviours are a normal part of establishing independence, but can also lead to negative and sometimes serious outcomes for a young person. Substance misuse and sexual health are particular areas where young people may experiment and come to harm. Hospital admissions for alcohol-related diagnoses and unintentional injuries in young people have already been reported in Section 1.

Services for adolescents need to be particularly sensitive to their needs, engaging and communicating with young people in ways that support their development, provide appropriate information and recognise their differences from older adults. It is particularly important to engage young people in the design and planning of services they may use. The last section of this report describes the consultation exercise that has taken place with Highland Youth Voice.

The (normal) onset of puberty in girls can be as early as eight or as late as sixteen and is a little later in boys. Physical and hormonal changes during puberty prompt the development of sexual interest and awareness, sexual identity and orientation and, eventually, sexual behaviours.

There has been a long-term reduction in teenage pregnancy rates in Scotland and Highland since the mid 1990s[25] and the proportion of young Scots who report being sexually active at a mean age of 15.5 declined a little between 1998 and 2006[26].

NHS Highland, The Highland Council and Argyll and Bute Council support a programme of comprehensive sex and relationships education in schools.

NHS Highland, The Highland Council, Police Scotland and the voluntary sector, have developed mechanisms to improve young people's confidentiality in sexual health services, while protecting them from sexual abuse.

A partnership between NHS Highland and the voluntary sector provides a dedicated young person's drop in sexual health service in Inverness.

Following consultation with young people, a sexual health website has been developed for Argyll & Bute. The website contains information for young people and adults on well-being in sexual health, local services and support.

Self-reported lifestyle data from national and local surveys of young people report an encouraging downward trend in alcohol use with a less clear-cut reduction in drug use (Box F).

Box F

Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)[27] demonstrated comparable findings across both the Highland and Argyll and Bute CPPs:

Alcohol

- In 2010 a greater proportion of 15 year olds (86%) than 13 year olds (59%) thought it was OK for someone their age to try alcohol to see what it was like.
- There was a considerable decrease, from 12% in 2006 to 3% in 2010, in the proportion of 13 year olds reporting that they usually drank at least once a week.

Drugs

- 11% and 9% of 13 year olds and 41% and 43% of 15 year olds from Highland and Argyll and Bute CPPs respectively reported having ever been offered drugs. Across Scotland 42% of 15 year olds and 16% of 13 year olds reported having ever been offered drugs.
- 3% of 13 year olds and 23% of 15 year olds in the Highland CPP confirmed that they had ever used or taken drugs in 2010 compared with 4% of 13 year olds and 24% of 15 year olds in Argyll and Bute.

In the Highland Council area, lifestyle surveys have been carried out every 2 years since 2009. The 2013 results are not yet fully available but preliminary results show

- P7, S1 and S4 pupils indicate a steady downward trend in self-reported alcohol use, with P7 pupils going from 10.4% in 2009 to 2.8% in 2013, S2 pupils 29.7% in 2009 to 12.6% in 2013 and S4 pupils going from 52.9% in 2009 to 30.9% in 2013.
- There has also been a downward trend in self-reported drug use of S2 and S4 pupils with S2 pupils going from 4.5% in 2009 to 4.2% in 2013 and S4 pupils 11.6% in 2009 to 7.5% in 2013. P7 pupils 2013 response indicated the same level as 2009 at 1.8%.

Following a training needs assessment in 2011, a range of sexual health training courses have been offered to staff working with looked after young people. The courses delivered include; BBV Awareness, LGBT Diversity and Inclusion, Talking to Young People about Sex and Relationships. Staff at the care homes are informed of future training courses and information updates around sexual health.

Transition to adulthood

The transition from school and adolescence to adulthood is a critical time for young people to test the skills and knowledge they have developed to cope with independent living. The majority of young people will progress with relative ease into adulthood and live happy and fulfilling lives. For some who have had more challenging experiences during childhood and adolescence, there may be additional challenges and the outcomes may be less certain and sometimes poor.

The NHS Highland and Highland Chief Executives have established a strategic stakeholder group to improve processes and outcomes for young people making the transition to adulthood. It includes representatives of families and practitioners from both children and adult services. The group has prioritised the development of improved joint processes across agencies, respite, inclusion in school and further education, information for families and employability – as well as the implementation of self-directed support.

Across the CPPs in both Highland and Argyll and Bute, there is a focus on supporting young people to achieve a "positive destination" on leaving school (Higher Education, Further Education, training, employment, voluntary work and Activity Agreements) through 16+ initiatives. Skills Development Scotland produces data to help local partnerships support positive destinations for school leavers[28,29].

Table 5: Summary of School Leaver Destinations

		Highland	Argyll and Bute
Proportion in a positive destination	September 2012	90.7%	90.1%
	March 2013	91.8%	90.7%
Women in a positive destination		88.3%	89.8%
Men in a positive destination		86.4%	82.8%
Proportion moving from a positive to a negative destination between September 2012 and March 2013	Women	3.2%	2.8%
	Men	3.6%	5%
	Most deprived	9.1%	13%
	Least deprived	3.2%	No change
Proportion unemployed and seeking work	September 2012	5.9%	7.6%
	March 2013	5.5%	7.1%

A higher number of young people achieve a positive destination in both CPPs than across Scotland as a whole in March 2013. (Highland, 91.8%; Argyll and Bute, 90.7%; Scotland, 89.5%). While encouraging, the data does not tell the whole story, as a positive destination on leaving school

may not be permanent or sustainable for the young person. Inequalities are apparent in achieving and sustaining a positive destination between young men and women and between those from the most and least socio-economically deprived areas, with differences more marked in Argyll and Bute (Table 5).

Young people are eligible for Activity Agreements if they have left school, are aged between 16 and 19 and are unable to access other options for various reasons. They may have additional support needs, have been in care or supported by social workers, look after someone else at home, have disabilities or learning difficulties or other problems that make life difficult.

"My Activity Agreement was great! Good experience - I'd like to do it again if I could."

Children and young people who are looked after may be at particular risk of not achieving a positive destination at the age of 16. They tend to move to independent living at a younger age than the general population. Health outcomes for this group have been found to be worse than that of the general population at the same age: including drug and alcohol abuse, mental health problems and emotional and behaviour difficulties. They are also more likely to face homelessness and unemployment.

Local Authorities are required to undertake a "pathway assessment" for such young people. The numbers entitled to a pathway plan assessment and the proportion receiving it for 2011/12 for the two local authorities show a very different profile with Highland recording 100% for 48 young people leaving care and Argyll & Bute recording 48% for 27 young people, against a Scottish average of 73%[30].

A proportion of those leaving care are eligible for aftercare services in recognition of the likely additional vulnerabilities they may have experienced during childhood and adolescence.

One third of care leavers in the Highland Council area are in employment, education or training, and 23% in Argyll and Bute compared to the Scottish average of 24% (Table 6, Box G).

Box G

Highland Council has a protocol to help this group of Looked After young people find housing and develop the skills to live independently and successfully. Housing services are part of the core group of professionals around the young person and once assessments clearly state that the young person is ready to live independently they are housed quickly through the protocol. A specialist health professional is required to work directly with these young people.

The Argyll and Bute Employability Pipeline *identifies national and local services, charting them against provision locally available and creating the Strategic Skills Pipeline. Activities in the pipeline aim to support the transition from broad general education to senior phase of curriculum for excellence and on to post-16 learning choices for pupils in secondary school S3 – S6.*

Table 6: Young people eligible for aftercare services (1), percentage receiving aftercare and percentage in employment, education or training as at 31st July 2012

Local authority area	Young people eligible for aftercare services	Percentage receiving aftercare services	Percentage of those receiving aftercare services with unknown economic activity	In employment, education or training	
				As percentage of those receiving aftercare with known economic activity	As percentage of all eligible for aftercare services
Argyll & Bute	44	100	30	32	23
Highland	104	100	9	36	33
Scotland	**3,870**	**66**	**12**	**42**	**24**

(1) Table excludes children who are on a planned series of short term placements.

Data source: Children's Social Work statistics 2011-12 additional tables, Scottish Governments statistics

Highland Youth Voice Consultation on Opportunities for All

This consultation in February 2013 covered work experience, careers advice and guidance and skills for learning, life and work amongst other topics.

Feedback included:

- Need for a council-wide work experience policy including flexibility of scheme and closer working with businesses.
- Good support for matching learner to placement to ensure relevance and focus on young person's needs.
- Better preparation for and awareness of what work experience is about, for learners and employers.
- Greater prioritisation for provision of opportunities, as there is often uncertainty as to what these are.

- More focused support given by key career experts when the young person needs it.
- Increased availability of information about opportunities ranging from extra-curricular to international.

Increase life skills provision and make it available to all (examples range from money management to kitchen/cooking skills, from transition skills to learning how to learn, from independent living to basic technology).

The Argyll and Bute Employability Partnership, led by the Opportunities for All team and in partnership with the Scottish Government, hosted a Youth Employment Summit in November 2012. The event attracted over 150 delegates from a range of organisations and businesses, and included strong representation from local young people.

The points raised at the event are now reflected in the Argyll and Bute Youth Employment Activity Plan for 2013/14 which will focus on the following key outcomes:

1. Career Management Skills.

2. Corporate Parenting Responsibility.

3. Education and Training to allow some young people to gain their first critical experience of the world of work.

4. Job Creation.

5. Procurement – Community Benefit: suppliers and contractors required to provide training, work experience and jobs for young people through its purchase of goods and services.

During the course of academic session 2012/13 Argyll and Bute Education Service introduced a Risk Matrix for use by all secondary school guidance staff to identify young people at risk of becoming disengaged and moving into a negative post school destination. The Risk Matrix scores each individual using 24 separate measures. Due to the success of this initial work with secondary schools the local authority has agreed to roll out the process for use with early years and primary school establishments.

Section 3

A focus on vulnerability

Looked after children and young people

Under the provisions of the Children (Scotland) Act 1995, 'looked after children' are defined as those in the care of their local authority. The majority will come into one of the following two categories: *Looked After away from home* or *Looked After at home* where the child or young person has been through the Children's Hearing system and is subject to a Supervision Requirement (regular contact with social services) with *no condition of residence*. The child then continues to live in their regular place of residence (i.e. the family home).

Across the United Kingdom the principal reason for a child or young person entering care is as a result of abuse or neglect. In the Highland CPP an audit of child protection information from August 2011 to July 2012 found that parental alcohol misuse was a concern identified at the time of the case conference for 37 children. An audit of cases on the Child Protection Register (April 2011 – March 2012) showed that 60% had substance misusing parents.

Looked After Children and Young People (LACYP) experience poorer health across the life course than their peers and are at greater risk of not achieving their potential in life through education and employment opportunities. This disadvantage can then perpetuate inter-generational health inequalities.

NHS Highland has a shared responsibility and duty as a corporate parent with public agencies in both Highland and Argyll and Bute CPPs, in promoting the welfare and well-being of LACYP as if they were our own children. Scottish Government policy requires that this be reflected in organisational policy and in the way staff are supported to deliver their roles when involved in the lives of these children and young people.

Scottish Government publishes LACYP figures annually. The national profile shows that most LACYP are aged under 12 years (60%) with just over a fifth under the age of five years; a similar age profile is seen for the cohort of looked after children in Highland. From the most recent data there are just under 700 LACYP for the NHS Health Board area (507 by

Highland Council and 190 for Argyll and Bute Council), in general, LACYP in Highland and Argyll and Bute are younger than elsewhere in Scotland, contain a similar proportion from minority ethnic groups and are less likely to be in community care. The most striking differences are

- The proportion of LACYP with additional support needs was over double the national average for the Highland Council at 24% compared to 11% nationally.

- The proportion of LACYP in residential care for Highland Council was almost double the national average, 16% versus 9% respectively with the rate in Argyll and Bute intermediate at 13%[30].

Table 7: Main characteristics of children & young people being looked after as at 31st July 2012 by age-band: Scotland and LAs in NHS Highland

	Local Authority		
	Argyll & Bute	Highland	Scotland
Number(1)	190	507	16,248
Rate(2)	1.0%	1.1%	1.5%
% aged under 5y(3)	19%	23%	21%
% aged 16y or over(3)	5%	9%	10%
% from MEGs(4)	3%	2%	3%
% with ASN(5)	12%	24%	11%
% in Community care	87%	84%	91%
% in residential care	13%	16%	9%

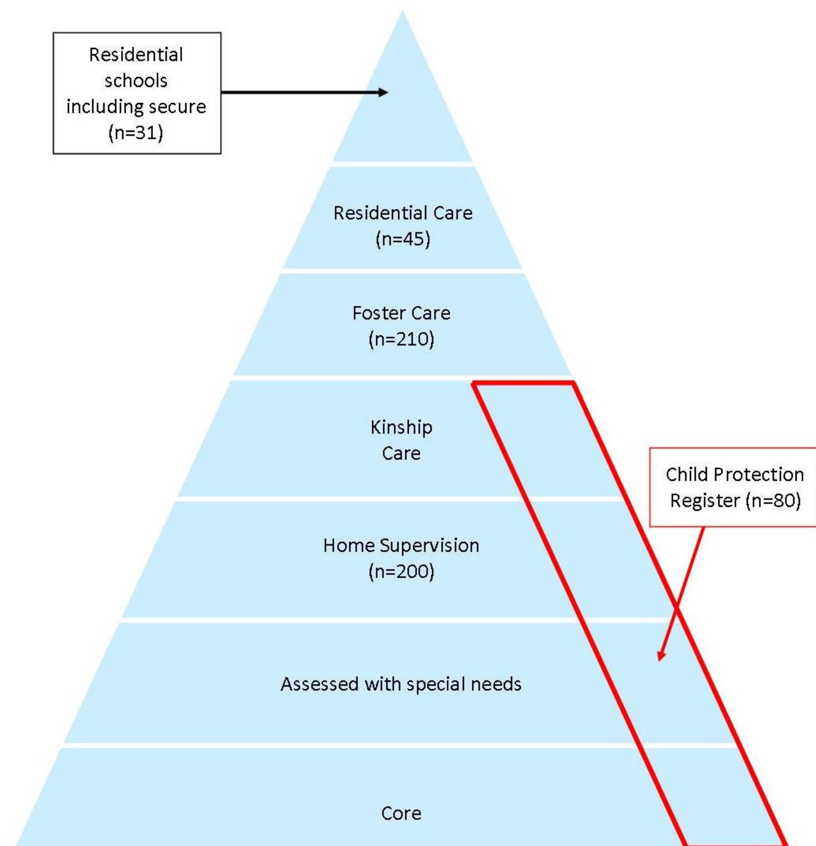
(1)Figures are provisional and may be revised in 2012/2013
(2)Calculated as the number per population aged 0-18 years of the mid 2011 population estimate (NRS)
(3)proportion aged 0-4y or 16 y & over of the total number of LACYP number as at July 2012
(4)'Minority Ethnic Group' includes the ethnic groups Mixed Ethnicity, Black, Asian, and Other Ethnic Background.
(5)Until 2012 the additional support needs category w as presented as 'disability'. This has been amended because the information collected does not meet the definiton of 'disability' outlined in the Equality Act 2010
Source: Childrens Social Work statistics 2011-2012; Scottish Government

The majority of LACYP are placed in the community (80-90%) most of whom are with foster carers or with friends and relatives (Figure 3). The remainder are in residential care which includes local authority or voluntary sector provided residential facilities and in residential schools, crisis care or secure accommodation within or outwith the Local Authority area.

Highland Council have set up a Family Firm Scheme as part of their corporate parenting responsibilities. Work placements are offered to all Looked After young people who may or may not have a positive destination on leaving school. These placements can be part of an activity agreement or as a standalone placement to gain experience in the work place. Young people on placement over 16 years of age have full access to internal vacancies.

Linda MacLennan-Shareef, Highland Council

Figure 3: Looked After Children and Young People in Highland Council May 2012 by type of care



Note: children on the child protection register are not necessarily looked after

National trends show that over the last 10 years, there has been a reduction in the proportion of those being looked after at home (43% to 32%) and in those in residential care (14% to 9%) but a greater proportion placed in community settings away from home i.e. foster carers, prospective adopters and kinship care and other community settings.

The health needs of LACYP across a life course

Early years

In the early years, entry into the care system for infants over seven months appears to be predictive for poorer outcomes in health and achievement in later life, at school and work.

School years

We know a little more about the health needs of older children (5 to 17 years) from two surveys across the UK undertaken ten years ago with key pointers as follows[31]:

- The general health status of LACYP, as rated by carers, was slightly worse in Scotland than England with 13% rated as fair, bad or very bad compared to 8% in England.
- Those in foster care were rated as having better health than those in other care settings.
- With the exception of asthma, hay fever and eczema, the prevalence of all conditions asked about were higher in LACYP than those in private households; eye problems, bed wetting and speech & language difficulties were the three most common problems.
- The prevalence of mental health disorders was 45% overall, with conduct disorders the most common condition. Over one-fifth of LACYP, mainly older children in residential care, suffered from self-harm in Scotland.
- The prevalence of smoking, alcohol use and recent drug taking were all higher in LACYP and higher in Scotland than England for smoking and drug use. Obesity was also identified as an issue.
- One-fifth had experienced rape or sexual abuse and another two-fifths had experience of sexual intercourse.

Limited and inflexible access to dedicated services for these children creates further inequity and results in poorer health outcomes. The challenges in providing services are compounded by the number of times these children move between NHS boundaries.

Children who move placements frequently even within their own locality may also experience poorer access to healthcare.

Jane Park, Highland Council

Transitions into adulthood

There is some evidence that care leavers have worse health and social outcomes relative to those not being in care. When seen alongside poorer educational achievement it is perhaps not surprising that those who have been in the care system continue to experience disadvantage and inequality across a life course.

Access to health services

Chaotic family life and multiple placement moves have meant that historically, children and young people in the care system have missed routine check-ups and immunisations. A national directive (CEL 16 (2009)) now requires a health assessment to be undertaken within 4 weeks of a child or young person becoming looked after[32]. Alongside the GIRFEC processes in each CPP, the health assessment presents a key opportunity to ensure that each child's or young person's health needs are identified and responded to in a timely manner.

We are also aware that LACYP are vulnerable to early risk-taking behaviour as reflected in a greater proportion starting smoking at an earlier age than their peers and drinking alcohol

Mood affects food preferences and food choices affect mood. Staff in residential units are working with LACYP to balance pre-existing food preferences, with nutrition, and the development of food related independent living skills. Staff receive training and support on the inter relationship between diet and mood, and how they can understand and influence food culture in residential units.

Dave Rex,
Specialist Dietitian for Health Promoting Schools and ASD

earlier and to excess. A higher proportion of this group are also more likely to become pregnant and go on to become teenage parents.

One way that has been identified to address these challenges is a settings based approach to health improvement for residential units[33]. There has been developmental work in some residential units in the Highland CPP regarding diet and nutrition through this approach. This settings approach could equally be applied to mental health and well-being, parenting, behaviour management and physical activity.

Related improvement activity resulted in an improvement in the number of LACYP whose status is reflected in the allocation of the Health Plan Indicator, more timely assessment and better quality plans.

Argyll and Bute CPP

Argyll and Bute Council are establishing a Corporate Parenting Board to listen to and consult with LACYP in Argyll and Bute to ensure that their needs are taken into account when developing and improving council services. The board will include young people themselves, children and families, officers and representatives from other local and national agencies who are involved with the care of children. In addition, Argyll and Bute Council's Children's Champions will contribute their knowledge of the issues for looked after children in their own communities.

Child Protection

Self evaluation and audit confirm continuing improvements in processes and outcomes for children at risk of significant harm. Previous and current inspection processes also inform developments in practice.

Universal health services perform a critical role in identifying and contributing to the assessment of children at risk of harm, and staff work with other professionals and families to reduce risk. The use of the GIRFEC Practice Model ensures a holistic and co-ordinated approach to the management of risk.

Specialist advice from paediatricians and mental health staff assists with understanding whether abuse has occurred, the impact of it, and the actions that should be taken to promote recovery. There are challenges in a rural area like Highland to

ensure that a 24/7 response is always available, and this has proved particularly challenging with regard to medical examinations of children who report sexual abuse. Improvements have been achieved, but ensuring safe and effective service provision continues to be a priority.

Young Carers

Young Carers are defined as young people under the age of 18 who provide care, assistance or support to a parent, sibling, grandparent or other person who is affected by a range of conditions (e.g. physical or mental illness, disability, substance misuse).

The impact of young carers taking on a caring role can significantly reduce their life chances and have an adverse effect on their development, physically, emotionally, educationally and socially.

- They are more likely to miss school and leave with no qualifications.
- They are less likely to achieve positive employment outcomes.
- They are more likely to suffer bullying due to their circumstances.
- They have an increased risk of self-harm due to the stress of their caring role.

Identification of young carers can be problematic and they often go unrecognised. Many of them do not recognise that they are in a caring role, whilst others are wary of the consequences of being identified and the impact on their families. Universal support will be required to ensure young carers have the same opportunities as their peers to be safe, healthy, active, nurtured and achieving.

Gypsy travellers

There are between 62 and 92 gypsy and traveller children in the Highland Council area at any one time. During school session 2012-13, 108 traveller children were on a mainstream school roll in Highland – 17 children in nursery; 85 children in primary; and 6 children in secondary.

Gypsy and traveller children who enrol and attend mainstream school are included in health programmes within this setting.

Access to dental services is often through the school setting but some families do access this service independently. Many families also access and register with GP practices in the Highland area.

38 children were not on a mainstream school roll while in Highland. 12 children were provided with alternative provision when in the area. 26 children either did not engage, or were only in the area for a short period of time and arrangements were not able to be made to support the children.

Gypsy and traveller children and young people who do not access mainstream education are provided with information regarding access to health services and specific programmes either directly by the health service or through links with housing and education.

A key aim of the Development Officer Interrupted Learners, working with the gypsy traveller community, is to support attendance at school as a means of enhancing the social and emotional well-being and academic progress of the children and young people and enhancing their access to universal services within the NHS. Attendance over session 2012-13 ranged from 55% - 83% and generally, the number in school in any week has risen, with only a very few weeks having less than session 2011/12, and highlighting a year on year increase in the number of children on a school roll.

Section 4

A focus on long term conditions

Children with exceptional needs

There are a small number of children and young people who experience what have been determined as exceptional needs (CEN) **(**Box H). This cohort have extensive and wide ranging needs and use many services across health at a local, national and UK-wide level, education, social care and the voluntary sector.

Box H

A child or young person (up to the age of 19) is defined as having exceptional needs if they have severe impairment recorded in at least four of the following categories together with enteral or parenteral feeding

- learning and mental functions
- communication
- motor skills
- self care
- hearing
- vision

OR

have severe impairment recorded in at least two categories and require ventilation/Continuous Positive Airways Pressure

AND

the impairments are sustained and ongoing or expected to last for more than six months.

At the current time there are 46 children who meet this definition across NHS Highland. There is an equal gender split. Of the group five require some kind of ventilation support and 39 are fed through an enteral feeding tube. The majority, (38 children) live in areas covered by the Highland Health and Social Care Partnership, with eight living in Argyll and Bute. The predicted number of 14 children with exceptional health

The quotes below are from parents of children with exceptional needs:

"I use a condition specific forum to post questions, vent my feelings and get feedback. I feel I get understanding and support here"

"Going to the group (Birnie Play Group) got me out. It helps me to feel positive and that I have something to offer other parents from my experience"

"The school have been supportive recognising the impact of being a sibling. He can have 'time out' and has additional support to catch up with work following his brother's operation"

care needs for the NHS Highland population is much lower than this figure (see Section 1). The explanation for this discrepancy is unclear; problems with data collection and collation may account for some of it, as the current Child Health Surveillance System is due for replacement. It may also represent a number of families moving into Highland with a child or young person with this level of need. Currently, there are separate planning and funding processes in the agencies managing these children's complex care packages, which require better coordination.

Early years

A baby may be identified as having exceptional needs in the first weeks or months of life, often after a period in neonatal intensive care. The effect on parents and families can be life changing and devastating. Providing appropriate care and treatment often means the child being cared for outwith Highland and parents may have less accessible support from family and friends. We know that prompt and timely communication and coordination of care is really important in supporting parents at this time. A case note review of pre-school children with exceptional healthcare needs in 2012 recommended improvements to the delivery of services in the early months and years to better support families (Box I)[34].

School years

The impact on family life for parents of a child with exceptional healthcare needs cannot be underestimated: what are the implications for family life if your child cannot feed by itself and is fed by a tube? What are the impacts on siblings of multiple appointments, continuing personal care needs and hospital admissions? For families this may also come about as the consequences of a degenerative or life limiting condition becoming more apparent adding further complexity to their experience of being a parent.

A consultation exercise in 2012 sought the views of parents with children who met the CEN criteria, on their experience of being a parent. It covered the following areas:

- The challenges and opportunities of parenting a child with exceptional needs.
- Support required for the family and siblings.

- Opportunities for support in existing parenting strategies within both CPPs.
- Identification of particular needs for this cohort.

Transitions

The move out of children's services into adult services is a significant event for the young person and their families. Opportunities for independent living may be limited and constrained and it may involve a move to different clinicians and care staff.

Box I

Early Years Case Note Audit for children with exceptional needs (CEN) 2012:

Eight children were identified within the Highland CPP who met the criteria for CEN and were of pre-school age at the time that the audit was undertaken. The findings were analysed by focusing on the GIRFEC framework.

Coordinated care was evident in local practice, with the GIRFEC approach well established in some of the areas of care. However gaps in service provision which could influence the delivery of coordinated care were also highlighted. Specific findings included:

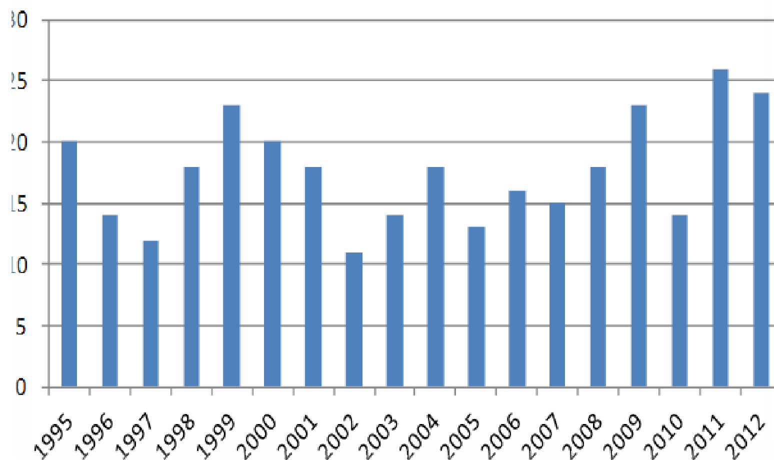
- The Lead Professional was identified for some children but not all.
- Variation in the identification of who undertook the Lead Professional role.
- Limited evidence regarding initial and anticipatory care meetings taking place.
- Variation in the child planning process.

Diabetes

Type 1 diabetes in childhood is a lifelong condition, needing a multi disciplinary team and good engagement with and support from families to ensure a diabetic child can grow and develop as normally as possible.

The incidence of diabetes in those aged under 16 years in Highland Health and Social Care Partnership (HSCP) area fluctuates with no clear trend in recent years, although it is above the national average (Figure 4). The reason for this higher incidence is not fully understood.

Figure 4:



Data from Raigmore Paediatric Diabetic Service.

The majority of children and young people with diabetes in the HSCP are seen at Raigmore with peripheral clinics in Fort William, Skye, Wick and Golspie. As of 1st January 2013, there were 138 children with type 1 diabetes in the Highland Council region, of whom 97 were reviewed at the specialist diabetes centre in Inverness, and between 6 and 12 at each of the peripheral locations. The number of consultations in peripheral clinics ranged from 12-47 per annum, with just over 400 consultations taking place in Inverness. Whereas there has been a modest increase in the number of patients in the last few years, there has also been a steady and disproportionate increase in the number of clinic visits. Children generally transfer to the adult service at the age of 16 years and planning for this transition should start around two years

earlier. Transition clinics are run jointly by the children's and adult's diabetes teams and are held as required in Inverness or at peripheral sites.

Children and young people with diabetes in Argyll and Bute CHP are managed within the NHS Greater Glasgow and Clyde service. Currently, there are 48 children under the care of this service.

Access to Specialist Nurses underpins good diabetic care with the role involving home visiting, telephone enquiries and support, involvement in schools and early years establishments and attendance at Child Plan meetings. Some children and young people with diabetes will have complex and challenging lives in addition to their long term condition, requiring extensive and intensive input from services.

A Medicines Management Improvement Group involving Highland and Argyll and Bute CPPs has produced a flow chart with embedded guidance for nursery, primary and secondary schools.

If diabetes is managed well by good blood sugar control (HbA1c) then the implications for health across a life course are good. If poorly managed the consequences are profound with risks to vision, circulation and renal function with potentially life limiting consequences. Figure 5 details the average individual's HbA1c for children and young people in the Highland HSCP area. The data reflects a striking reduction in HbA1c levels over time, with the overall average for Highland now 72.6 mmol/l (the first time on record it has been below 75 mmol/l), indicating much improved diabetic control. This trend is also evident in the peripheral clinics. The overall average for Golspie is particularly impressive, but with small clinic attendance, the figures should be treated with caution. Diabetes is particularly challenging at key points across the life course:

Early years

When diabetes occurs in a toddler, eating habits are often erratic and injections can prove particularly stressful.

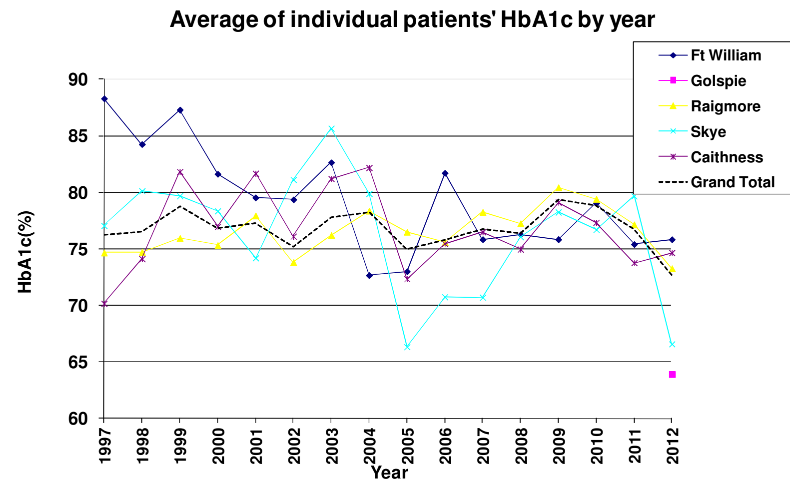
School years

Active support from school staff is required, particularly for younger children.

Transitions

During adolescence, when the young person seeks (or is given) more independence, they may not have the skills, knowledge, emotional maturity or inclination to manage their own diabetes. Parents may also find “letting go” difficult.

Figure 5:



Data from Raigmore Paediatric Diabetic Service.

Note: for the purpose of this analysis, an average HbA1c for the year has been calculated for each patient (figures for the first 6 months after diagnosis are discounted). These averages have then been aggregated by clinic. For young people who have been transitioned to adult services during the year, data up to the point of transition has been included.

The Scottish Government initiative on insulin pump availability for young people has provided young people in Highland with an alternative approach to diabetes management. Pump therapy can be liberating in terms of lifestyle, and has been shown to reduce the incidence of disabling hypoglycaemia. To be safe and effective, a high degree of commitment is required on the part of the family.

Section 5

A focus on service improvement

NHS Highland is committed to service improvement through the rigorous and systematic use of improvement methodologies throughout the organisation. This Highland Quality Approach aims to improve the person's experience and outcome of care, by ensuring services are patient-centred and delivered as appropriately, efficiently and effectively as possible.

Both CPPs are also subject to the Care Inspectorate's integrated children's service inspection process, which seeks to evaluate how well the lives of children and young people are improving through the joined up efforts of community planning partners. Argyll and Bute CPP underwent inspection in the spring of 2013 and the Highland CPP will be inspected in autumn 2013. The final reports will inform future service provision. Improvement activity is already being undertaken across children's services, examples of which are highlighted below.

Remote and rural health care

When children become seriously unwell, their clinical condition can often deteriorate very quickly unless they get expert help quickly. However, in the remote areas covered by NHS Highland, health professionals are unlikely to see such children very frequently, because of the small populations living in these areas. Seriously ill children may therefore need to be transferred, often over long distances, to specialist centres to get the care they need, posing challenges for all those involved. Good assessment, intervention and stabilisation prior to retrieval and transfer are central to managing risk and providing high quality care (Box J).

A national audit undertaken in 2007/08 identified around 300 children and young people across NHS Highland requiring high dependency care; 75% presented directly to Raigmore while the next most frequent location was Fort William, with less than ten presenting to locations in Argyll and Bute (Box K)[35].

Box J

The Emergency, Out of Hours and Critical Care Improvement Group has been working to provide good standardised systems of care across Highland:

- A summary of the investigative services, facilities and clinical staff available at each location providing out of hours care for children is now in place.
- A paediatric early warning signs chart has been developed for use in remote sites.
- A standardised communication tool for transfers from remote sites is now in use across Highland.
- Each Rural General Hospital is evaluating their own capacity for providing emergency and out of hours care for children.
- A consultant paediatrician is now linked to each Rural General Hospital and Broadford Hospital on Skye.
- Highland is currently participating in a paediatric unscheduled care pilot study involving all health boards in the north of Scotland.

Box K

An audit of transfers to Raigmore from peripheral sites was undertaken to develop a transfer document for use with all patients and identify potential high risk “flash points” during the transfer process. All completed incident forms following a transfer of high dependency children from August 2010 to December 2012 were reviewed. Of the 11 completed incident forms, half involved infants aged under one year. Incidents occurred in primary care, during ambulance transfer or at a peripheral hospital. Issues identified included:

- Opportunities to improve management before and during transfer.
- The need to improve communication with Raigmore.
- Timely access to air and road ambulance.
- Opportunities to improve documentation prior to transfer

Implementing the recommendations will be overseen by the Emergency Care Out of Hours and Critical Care Improvement Group

Child and Adolescent Mental Health Services

Specialist Child and Adolescent Mental Health Services (CAMHS) are required to meet the Scottish Government waiting list target of treatment starting within 26 weeks by March 2013 and 18 weeks by December 2014. This target applies to the CAMHS service at Raigmore and within Argyll and Bute CHP as well as the Primary Mental Health Worker (PMHW) service in the Highland Council.

Since 2012, activity to improve and redesign CAMHS services has been underway with a particular focus on the Raigmore service at the Phoenix Centre. The March 2013 target was achieved and NHS Highland moved from being one of the worst performing Boards to one of the best. The improvement has been maintained through the hard work of the whole CAMHS team supported by the Quality Improvement Team and is well on track to achieve the 2014 target (Figure 6)

In April 2012, as part of the process of Integrating Care between the Highland Council and NHS Highland, the Primary Mental Health Worker (PMHW) Team transferred from NHS Highland to the Highland Council. This service is part of the wider Child and Adolescent Mental Health Service (CAMHS), within the NHS and is required to meet the expected targets of other CAMHS services in providing intervention for all new referrals within 26 weeks of the referral being made.

Primary Mental Health Workers (PMHWs) are specialist Child and Adolescent Mental Health Service (CAMHS) workers who are qualified and registered with a professional body In Highland. PMHWs come from a variety of backgrounds e.g. mental health nursing, social work, paediatric nursing and allied health professionals.

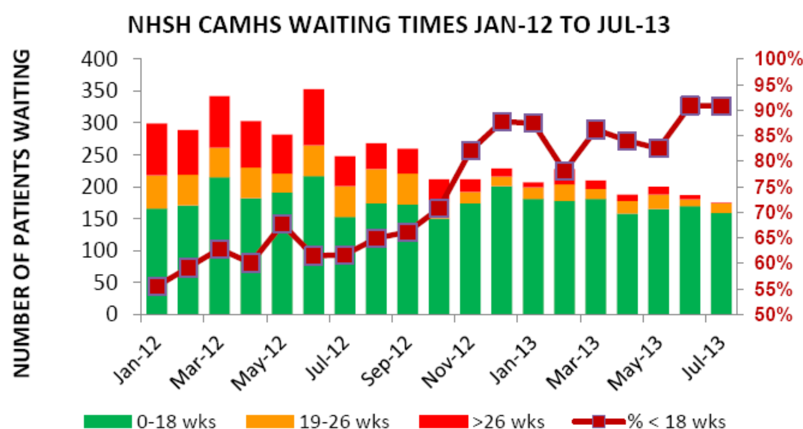
From March 2013, when the 26 week HEAT Target came into force, there have been a total of 65 children and young people who have received intervention for the first time from the PMHW service. Of these, 55 (85%) have waited less than the 26 Week HEAT target and 49 (75%) have been seen within 18 weeks. A significant number (46%) have been seen within 6 weeks of the request for service being made. The longest wait for any child/young person referred since March has been 36 weeks.

"... by improving outcomes and reducing inequalities for all babies, children, mothers, fathers and families across Scotland to ensure that all children have the best start in life and are ready to succeed."

Aileen Campbell, Minister for Children & Young People (24/01/13)

As part of helping pregnant women to stop smoking, the ante-natal department in Raigmore aims to offer carbon monoxide monitoring to all pregnant women. An audit noted that only 7/20 women were offered this test, as the others were not seen by the relevant staff member. The system has now been changed so that the test is offered to all women when they have their blood tests. Uptake is now 100%. Regular audit by the clinic staff checks that this improvement is maintained.

Figure 6



Review is about to be undertaken of the Abuse and Trauma recovery service, commissioned from Children 1st and supervised by the CAMHS team.

The Early Years Collaborative

The stretch aims of the Early Years Collaborative[16]

- *Reduce by 15% the rate of stillbirth and infant mortality by 2015 (workstream 1).*
- *85% of children to reach all of the expected developmental milestones by the time of the child's 27-30 month health review by December 2016 (workstream 2.)*
- *90% of children to reach all of the expected developmental milestones by the time the child starts primary school, by December 2017. (workstream 3).*

As discussed elsewhere in this report, the evidence for improving outcomes for children and young people in the early years is now clear and compelling. Across Scotland it is evident that there are gaps in practice where the evidence is not being used or where its use is patchy and unreliable. The Scottish Government have launched this collaborative to ensure that Scotland is the best place in the world to grow up. The idea of the "collaborative" is that all areas in Scotland will share good practice and experiences in achieving improvements and help accelerate the pace of change across the country.

The Collaborative has set "stretch aims" for three areas of improvement covering pre-birth to primary school entrance, with associated workstreams (see margin). An improvement methodology, based on small tests of change, has been introduced to support transformational change in service delivery, and to achieve these stretch aims.

Breastfeeding is one of the most effective ways of ensuring babies get a good start in life and protects their health later on. The World Health Organisation (WHO) currently recommends that babies should be exclusively breastfed for six months and the Scottish Government has set health boards a target of 36% of babies to be exclusively breast-fed at 6-8 weeks. NHS Highland has achieved a rate of 31% (29.9% in

Argyll and Bute and 31.2% in Highland), compared to a Scottish average of 26.2%, but there is room for improvement. In both CPPs the early years teams are using small tests of change and Plan, Do, Study and Act cycles to improve services (Box L).

NHS Highland has been working with Highland Council to raise awareness of breastfeeding through the school curriculum. Teaching sessions have been developed that focus on nurturing and shifting the perception that formula feeding is "as good as breastfeeding".

Box L

Breastfeeding rates have been static across Scotland for the last 10 years at around 26.2% exclusively breast-fed at the time of the 6-8 week check. But in northern Highland, 25% of forms were not returned for the October-December 2012 cohort of babies, making the calculated rates very unreliable.

Small Test of change:
To improve to 95% the completion and return of the 6-8 week form by December 2014

By making small changes to the process and service, work is underway to improve the return rate and help target activity where it is needed to improve breast-feeding by new mothers

Integrated Children's Services Plans

For Highlands Children 4 (FHC4) is the Children's Service Plan for the Health & Social Care and Education, Culture & Sport Services in Highland Council and incorporates the contribution of children's services delivered by NHS Highland.

NHS Highland is fully accredited with UNICEF for Baby Friendly Initiative (BFI) both for hospital and community status; one of only 4 Health Boards who now have fully accredited status. Standards are audited quarterly to support the accreditation.

The plan identifies outcomes for children and their families and improvement priorities for the next five years, based on existing Council policy commitments, the partnership agreement with NHS Highland and the Youth Convenor's action plan. It provides a framework for monitoring outcomes and articulates the mechanism agreed for evaluating and measuring outcomes, responsibilities and timescales.

The leadership group includes lead officers from Highland Council and NHS Highland, SCRA and Northern Constabulary. In addition there are staff representatives from NHS Highland

and Highland Council, third sector partners, elected members and the Children's Champion. Sub-groups cover Curriculum for Excellence, Early Years, Child Protection, LAC, Youth Action, Mental Health, Additional Learning Needs and Disability, Young Carers, Play, Transitions, Public Health and Well-being, Supporting Parents and the Practice model.

Integrated Children's Service Plan
2014-2017

"Working together to achieve the best for children, young people and families"

The Argyll and Bute Community Planning Partnership has just published its Integrated Children's Services Plan setting out its priorities and actions to improve children's services over the next 3 years. Examples of good practice include:

- NHS Highland has delivered a number of initiatives around smoking prevention, dental hygiene, sexual health and alcohol and drugs awareness.
- Strathclyde Police provide information and advice to students on drugs awareness, personal safety and internet safety.
- Strathclyde Police also offer work experience placements to secondary school pupils to provide them with an insight into policing. Participants are given access to divisional departments including CID, community safety and community policing and the control rooms.
- Fire safety sessions are delivered in primary schools, with road and cycle safety continuing to be a priority throughout all schools in Argyll and Bute.

The 2013 Inspection of Services for Children and Young People in Argyll and Bute highlighted the following areas of good practice:

Getting it Right Antenatal identifies vulnerable pregnant women at an early stage and provides coordinated support to improve their parenting skills and the provision of suitable housing.

Nurse co-ordinators work with children and young people who are looked after away from home, families affected by homelessness, and the gypsy traveller community. They enable families to access the help they need quickly. Their work is highly effective in helping children, young people and families to stay healthy and be included within their communities.

Section 6

Consulting Young People

Highland Youth Voice Consultation

We now understand better than ever before that our health and well-being is important to each of us as individuals, in family life, with friends and the people who live alongside us in our communities. We also know that we can influence how much health we have in both positive and not so helpful ways by the way we choose to live our lives and also that the world around us has a big influence on our health and well-being: the decisions we make every day and the way we make the most of the world around us are all important.

Highland Youth Voice is the democratically elected youth parliament of the Highlands, made up of around 100 young people from across Highland.

Highland Youth Voice: Nothing About Us Without Us

Sabhal Mòr Ostaig Skye

As part of writing this report we consulted Highland Youth Voice (HYV), the Highland's Children Forum (HCF) and Barnardos to better understand what is important to young people with regard to their health and well-being. We wanted to capture the thoughts, experiences and needs of young people in relation to the services, communities and people that have an influence on their lives across the following areas:

- Universal services across all age groups
- Long term conditions
- Vulnerable groups
- Mental health and well-being
- Becoming an adult

The Highland Youth Convener is a full-time, consistent link for elected Highland Council members and senior officials to seek the views of young people.

We worked with locality-based Youth Development Officers from High Life Highland and involved the local HYV members, youth forum members and other local young people. Issues and ideas were captured visually on body maps (Figure 7). The local work was further developed through workshops at the annual summer HYV Conference 'Staying Alive' at Sabhal Mòr Ostaig on Skye, attended by approximately 80 representatives from Highland schools.

"Requirement to be more young people friendly."

"Lots of different contradictory advice from various professionals- linked up working is needed."

School nurse – "who are they – what do they do?"

"Young people feel that there is no one to turn to and no one to talk to. Also HUG should be involved in schools."

"Can doctors and nurses visit schools to say what they do and become familiar with them "make it less scary for young children"

"Ask NHS to look at what specialised services e.g. audiology, eye clinic can be delivered locally in rural areas so people don't have to travel so far for routine appointments."

In addition to the HYV event Highland Children's Forum undertook a series of consultation workshops with groups of young people with additional needs.

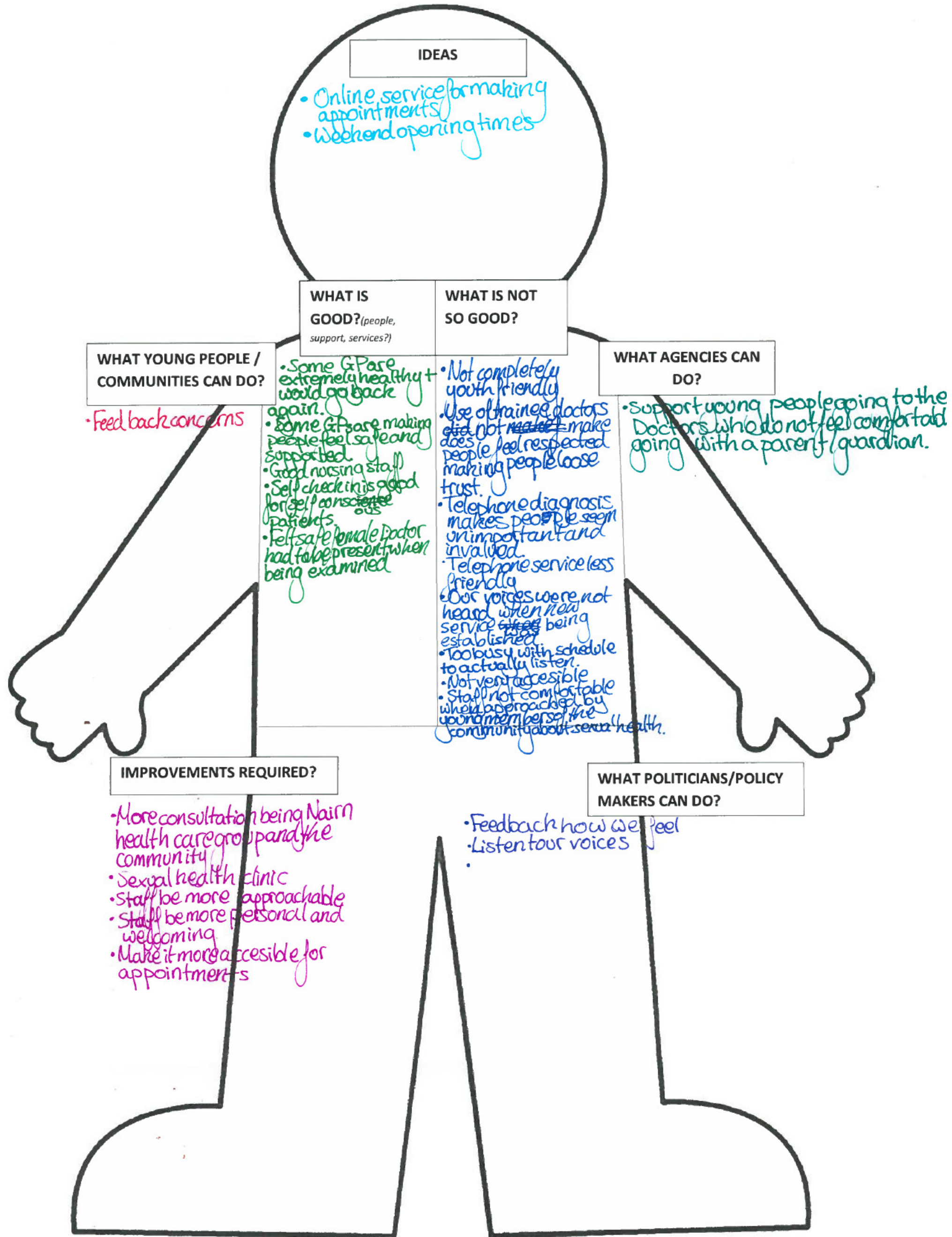
The issues identified through these consultations will be incorporated into For Highland's Children 4 as the Highland CPP integrated children's service plan. We will be reporting back to HYV later in 2013 (Box M).

Box M: Issues identified: *Nothing About Us Without Us Consultation*

- Mental health support: particularly around stigma, stress, exam pressure and access to advice and support.
- Youth health support (including sexual health drop in) - improvements required.
- Better awareness and understanding of NHS staff roles and responsibilities in young people's lives.
- Better access to and signposting to additional information on common long term conditions with local NHS contact details.
- Access to specialist health services out of Inverness.
- Increased disability awareness raising across CPPs.
- School meals remain poor in some areas particularly in secondary schools.
- Consider development of Health and Well-being peer educators in schools.
- Requirement for services to be more young people friendly.

Argyll and Bute CPP also undertake regular consultation children and young people. The development of the Integrated Children's Services Plan in Argyll and Bute has emanated from extensive consultation with children and young people from across the area. The final stage of consultation is currently underway and involves 8000 children and young people across the authority.

Figure 7



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