The Highland Council	Agenda Item	12ii.
EDUCATION, CHILDREN'S AND ADULTS SERVICES COMMITTEE	Report No	ECAS/29/14
28 August 2014		

Assurance Report – Lead Agency Delivery of Children's Services

Report by Director of Care and Learning

Summary

The purpose of this paper is to provide assurance to the NHS Highland Child Health Commissioner in relation to services commissioned and delivered through Highland Council. It will be presented to the appropriate strategic committee of NHS Highland.

1. The Commission

1.1 The lead agency delivers a range of children's services on behalf of NHS Highland. A summary of the services provided is contained within the committee report (February 2014). There is an annual review of the service descriptors and revisions are agreed between the Child Health Commissioner and the Head of Health. To date there have been minimal revisions made to the service descriptors.

1.2 Looked After Children Health Service

The service descriptor has been reviewed and no alterations made.

Good progress continues to be made towards the full implementation of CEL 16 (2009). The statutory requirement for an initial health assessment is co-ordinated, monitored and quality assured by the Lead Nurse for LAC.

Progress is being made towards meeting the requirement to have an initial mental health assessment for all LAC.

Support for staff through supervision and governance of practice has been extended to all school nurses and health visitors and the frequency increased to quarterly. A rolling programme of learning and development continues.

The implementation of a settings based approach within residential child care has resulted in the development of local improvement plans specific to individual residential settings. These plans demonstrate the development of a settings based approach through the application of newly developed policies for diet and nutrition and admin of medicines - and through initiatives around smoking cessation and reducing pregnancy. Evaluation of the approach will

be ongoing and through the LAC improvement action plan. This addresses a recommendation in the Director of Public Health Annual Report 2013.

1.3 **Allied Health Professionals**

The National Delivery Plan for Allied Health Professions in Scotland 2012-2015 set out the target that by the end of 2014, 95% of all patients referred to AHP services will be seen within 18 weeks (from referral to first appointment). Within Highland Council AHP services for children and families a range of activities are being undertaken to meet this.

AHP's in Highland Council have continued to input caseload data into AWT (the NHSH activity and waiting times database used by AHP's). However the system does not reflect structures post integration and therefore is unable to run the reports required resulting in each individual member of staff's caseload and waiting times to be analysed manually. As part of the NHS AHP Demand, Capacity, Activity and Queue Project (DCAQ) we are working with NHSH service planning team to identify if AWT can be reconfigured to provide the reports we require or if not to develop a separate reporting tool and move away from the use of AWT.

An area of concern, and ongoing focus, is that initial attempts at self-reported waiting times data exposed the variation in application of "New Ways" access guidance. This is being address through the roll out of simple guidance and training provided to AHP service leads through the DCAQ project.

Highland Council AHP's are represented and actively engaged with the national AHP Children's forum in developing and testing principals regarding the identification of "urgent" and "routine" requests for assistance, based on wellbeing and impact, rather than more traditional criteria that has been commonly used up until now, and testing a potential model for triage.

Service leads for DCAQ are spending time over the summer understanding the demand of their services in order to identify the focus of activity in autumn in order to implement relevant queue theory to reduce waiting times.

Work is ongoing to improve the quality of the information on the database. E.g. ensuring the database is up to date and reflecting the true level of children waiting to be seen. A manual review of the waiting times (at July 2014) suggest that the longest waits for a very small number of children in each service are

- Occupational therapy – 66 weeks
- Speech and Language therapy – 35 weeks
- Physiotherapy – 10 weeks
- Dietetics – 12 weeks

Occupational therapy waiting times cause the most concern and the team are currently recruiting to the two remaining vacancies following redesign due to their inability to fill key posts. Further detailed work is taking place with this team to address their waiting times:

- Single point of access with all requests for assistance being reviewed and allocated by the team lead (all services)
- Team lead working with locally based occupational therapy staff to implement queue theory i.e. wherever possible to take the longest waits as a priority
- Integrated teams learning from each other to reduce the number of children requiring two occupational therapists leading on separate aspects of care.

1.4 **CEL (2012) 4 Insulin Pump Therapy for People with Type 1 Diabetes**

Dieticians review patients as part of the Multi-disciplinary Team clinics where it is decided which patients are suitable for insulin pumps. It is their role to advise on initial doses of the fast acting insulin. They provide teaching sessions on carbohydrate counting. Once families are comfortable with this they review insulin doses, blood glucose carbohydrate amounts and physical activity. This allows them to calculate the insulin:carbohydrate ration (ICR) and review insulin sensitivity factor (ISR) and check patients are using this to correct any high blood glucose readings.

Once they are confident that the ICR and ISF are accurate they support families switching to an “Expert” meter, which calculates the insulin doses. They programme the meter for patients and show them how to use it. They attend insulin pump clinics twice a month and review pump downloads along with the rest of the team. They review ICR on a regular basis and provide advice on adjusting insulin for activity and ongoing support.

1.5 **Health Visiting Posts**

In June 2014 the Cabinet Secretary for Health and Wellbeing, Mr Neil, announced additional investment in the education of Health Visitors and the creation of new posts over the next four years, ensuring the delivery of 500 new health visitor posts by 2017-18 across Scotland.

Initially the funding will be invested in changing Health Visitor education and the creation of 50 new posts (2014-15). Further funding will be released in annually until 2017-18.

At the time of this report, the detail on how this will affect Highland is not available. The Principal Officer (Nursing) has been invited to be part of the implementation group tasked with taking forward the Health Visitor review recommendations.

1.6 **School Based Flu Vaccine Programme**

The school based flu vaccine programme is being rolled out to all primary school pupils during winter 2014. For Highland that involves offering around 17000 pupils the vaccination. The programme is required to be undertaken

during a nine week window from 06 October to 19 December (including two week school holiday) and will represent a considerable challenge for our Family Team members working in schools.

Planning has been undertaken with NHS Highland through the HICOG group. Highland Council has a School based flu vaccination subgroup with representatives from across Care & Learning. The Immunisation Project Lead nurse continues in post

School nurses have been liaising with primary school head teachers regarding suitable dates for vaccinating. It is essential that schools recognise the logistics surrounding the organisation of these sessions and ensure that pupils are available on the agreed day.

It was expected that there will be 'mop-up' vaccines for any pupils not available on the day of the session and the small number of at risk children under 9 years requiring 2 doses.

Discussions have been undertaken with NHS Highland pharmacy and transport departments to ensure that vaccine is available at the school on the correct day and maintained at the required temperature i.e. ensuring cold chain requirements are met. This has only been possible in a few schools close to pharmacies i.e. Wick and Inverness. For other areas NHS Highland has agreed to purchase, accommodate and maintain additional drug fridges where vaccine can be stored and collected by the school nurse on the day of vaccination

Consent forms will be sent directly to the schools from the national centre for distribution to each pupil via school bag mail. The consent forms will have a return envelope to the Child Health Department at Raigmore for the initial screen. They will be then sent on to the school nurse base for follow-up of any medical issues.

Through the Highland Council sub-group and using the Heads Up electronic communication system all primary school head teachers are being kept up to date about the roles and responsibilities that the schools are being asked to undertake.

It is expected that administrative staff will assist in the distribution of the consent forms to each class. Admin support will be required on the day of vaccination to record children receiving the vaccine, collate the completed consent forms and complete the vaccination schedules. It is hoped that support will be sourced from Shared Business Support staff and discussions are ongoing. Finally school nurses will require admin support to file all of the consent forms into the school nursing records after the vaccination session. These records are held at the nurse's base.

A teaching pack, covering infection and vaccination has been developed by Health Scotland for use in the classroom. Teachers may wish to use this to undertake some preparation with their classes.

Planning is on target with the only areas of concern currently being:

- Plans to be put in place for children absent on the day or requiring a second dose. It is anticipated that the numbers per school will rane from zero to around 10 pupils.
- Cold chain storage still being reviewed
- Administrative support from SBS to be finalised

2 Service Delivery - Performance Framework for Commissioned Service

The achievement of better outcomes for Highland's children, their families and the communities they live in is the overarching objective for children's services. The outcomes relate to the impact of services on the well-being of children and young people using the SHANARRI indicators (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included).

Each of the outcomes has a range of measures associated with them and the table below is an extract from the proposed revised performance management framework and relates specifically to the commissioned service (see *For Highland's Children 4* report at this meeting of the Committee).

It is worth noting that many of the performance measures are aspirational and mechanisms are not yet in place to capture or report on all of the required data

2.1

Performance Measure	Status	Comment
Hospital admissions for drug related issues will reduce		SMR01 – Awaiting data from NHS Health Intelligence (twice yearly)
Hospital admissions for Alcohol related reasons will reduce		SMR01 – Awaiting data from NHS Health Intelligence (twice yearly)
Improve the uptake of 27-30 month surveillance contact from the baseline of 52% to 95% by march 2016.		CHSP – only 1 data point available which gives the baseline of 52%. BOXI script to be set up
The percentage of children who reach their developmental milestones at their 27 – 30 month health review will increase year on year		Baseline measure to be established in December 2014. BOXI script to be set up
There will be a reduction in the percentage gap between the most and least affluence parts of Highland for low birth weight babies		SMR02 – Awaiting data from NHS Health Intelligence. (twice yearly)

95% uptake of 6-8 week Child Health Surveillance contact	Amber	CHSP
6-8 week Child Health Surveillance contact showing now difference in uptake between the general population and the least affluent parts of Highland.		CHSP – Awaiting data from NHS Child Health, BOXI script to be set up (twice yearly)
6-8 week Child Health Surveillance contact showing now difference in uptake between the general population and Looked After Children. .		CHSS – Awaiting data from NHS Child Health. BOXI script to be set up (twice yearly)
36% of new born babies exclusively breastfed at 6-8 week review by March 2017	Red	CHSS – exception report attached
A reduction in the percentage gap between the most and least affluent parts of Highland in the number of children exclusively breastfed at the 6-8 week review		CHSS – Awaiting data from NHS Child Health. BOXI script to be set up (twice yearly)
Maintain the 95% Allocation of Health Plan indicator at 6-8 week from birth	Green	CHSS – Awaiting data from NHS Child Health
Maintain the 95% uptake of primary immunisations by 12 months		CHSS – Awaiting data from NHS Child Health
Maintain the 95% uptake rate of MMR1 (% of 5 year olds)	Green	CHSS
Sustain the completion rate of P1 Child Health assessments at 95%		CHSS – Awaiting data from NHS Child Health (annual report)
90% of children and young people referred for specialist CAMHS (primary mental health workers) to be seen within 18 weeks by December 2014	Green	HC – PMHW data
95% of statutory health assessments to be done within 4 weeks of becoming looked after	Amber	LAC – variable performance with large monthly fluctuations (small numbers)
95% of initial Lac health assessments to be included in Child's Plans within 6 weeks	Amber	LAC – variable performance with large monthly fluctuations (small numbers)
Waiting times for AHP services to be within 18 weeks from referral to	Amber	AHP manual returns co-ordinated by team lead - child

treatment by December 2014		with longest wait recorded.
95% of children in P1 will have their body mass index measured		CHSS – Awaiting data from NHS Child Health (annual report)
90% of young women in S2 to receive HPV immunisation by march 2017		CHSS – Awaiting data from NHS Child Health (annual report)
The percentage of young women who receive PHV immunisation will be no different between the most and least affluence areas		CHSS – Awaiting data from NHS Child Health. BOXI script to be set up. (annual report)
The percentage of young women who receive PHV immunisation will be no different between the general population and the Looked After Children Population		CHSS – Awaiting data from NHS Child Health. BOXI script to be set up (annual report
An increase in uptake of Healthy Start Scheme to 85% of eligible beneficiaries by 2014		NHS intelligence – Awaiting data (quarterly reporting)
Increase the number of parents participating in a validated parenting course who have 3-4 year olds with severely disruptive behaviour		Framework being put in place. Highland has applied to be in the 4th wave of Psychology of Parenting Project. If successful training will commence in spring 2015 involving 43 staff across council, prison services and third sector. (estimated that 10% of 3-4 year olds have severely disruptive behaviour – circa 500). Data definition required and reporting systems to be established.

3 Monetary Value of the Commission

The budget transferred at the beginning of the commission was £7.257m, which included a savings target of £0.399. There have been a number of in-year adjustments to budgets to reflect changing circumstances. Currently the budget transferred from the NHS to support the commissioned service stands at £8,675,252

A Resource and Commissioning Group has been established, which will meet every two months. The main remit of the group is to

- monitor and understand the children's services budget

- to be a forum for escalation of unresolved issues
- discuss and agree commissioning intentions before forwarding to Strategic Commissioning Group
- to scrutinise the performance framework and review exception reports where targets are not being met.

4 Preventative Spend Allocation

Proposals around the use of preventative spend money have been agreed and are being implemented. The detail around health posts include:

- health visitors, trainee health visitors and staff nurses x 12 posts
- primary mental health workers x 2 posts

These posts have been added to the funded establishments of the family teams and recruitment is ongoing. It will be increasingly difficult to disaggregate the NHS funded posts from post funded through the preventative spend allocation.

In addition preventative spend money has been made available to the NHS to support breastfeeding. The NHS wishes to ensure that any support provided is evidence based and is currently undertaking a literature review to ensure decisions are based on best practice.

Preventative spend money has also been identified to continue the provision of the Family Nurse Partnership Programme beyond cohort 1.

5 Exception Reports

Breast Feeding report (attached)

6. Implications

6.1 Risk Implications
It is intended that this reporting framework will better manage risk in the Partnership Agreement

6.2 Equalities Implications
Many of the services detailed in this report, make a significant impact on health and social inequalities

6.3 There are no resource, legal or carbon clever implications from this report.

Recommendation

Members are asked to consider and comment on the issues raised in this report.

Bill Alexander
Designation: Director of Care and Learning
Date: 28 August 2014
Author: Sheena MacLeod, Head of Health

The Highland Council

Education, Children & Adult Services Committee – 28 August 2014

Agenda Item	
Report No	

Support for Breastfeeding
Report by Director of Care and Learning

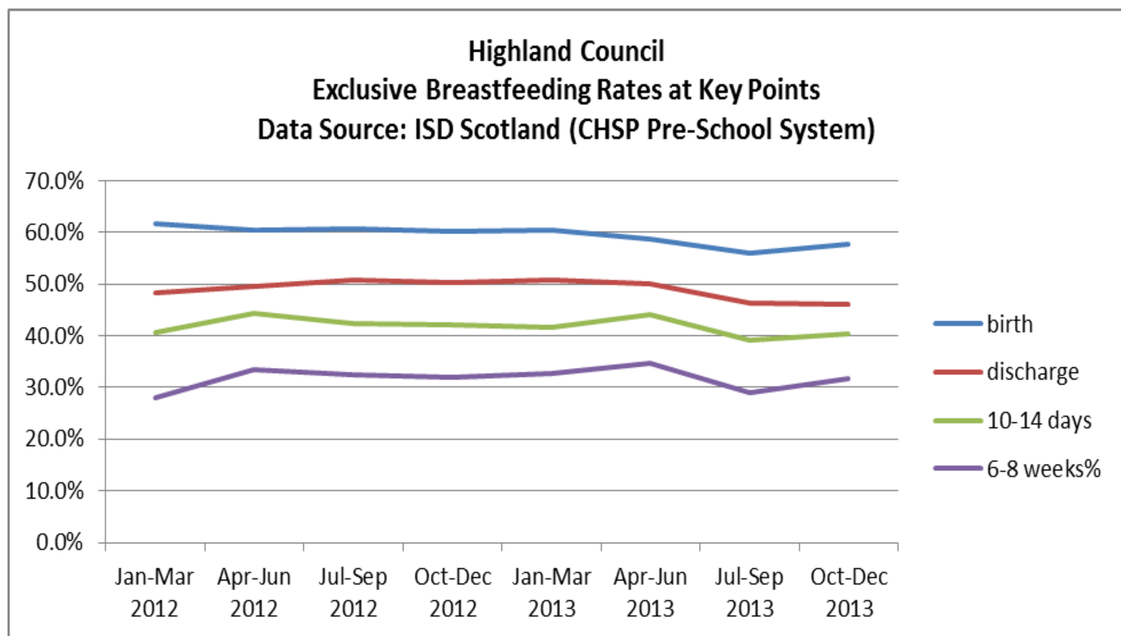
Summary
The purpose of this paper is to report on current breastfeeding rates and the return rate of the 6-8 week surveillance forms within the Highland Council area, both of which are shared performance measures within the For Highland Children's Framework

1. Background

1.1 Breastfeeding rates for the past 10 years have remained relatively static throughout Scotland. Nationally the rate for babies exclusively breastfed at 6-8 weeks is about 26.2%. Highland has consistently performed within the upper quartile.

1.2 The Information Services Division (ISD) publishes National statistics every 3 months, which are 6 months in arrears. The latest data available is up to quarter ending December 2013. Each data period only relates to children born in that quarter.

1.3



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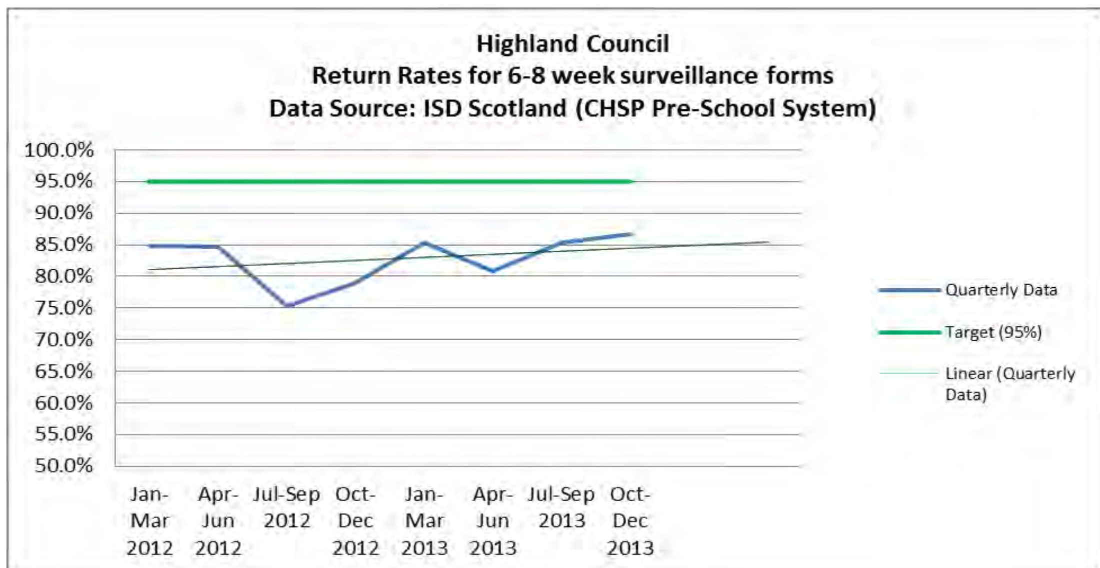

Highland Context

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2.1 For the Care and Learning Service breastfeeding statistics are derived from data collected from the Health Visitors contacts, normally around 10-14 days post birth and again at 6-8 weeks. During these contact visits, the Health Visitor records the method of feeding on the Child Health Surveillance Programme Pre-school form. (CHSP-PS).

2.2 At the 6-8 week check, the GP carries out a medical examination of the baby, and following this, the form is returned to NHS Highland so that the data can be entered onto the national CHSP-PS system. Performance is variable across GP practices and work continues through the Early Years Collaborative to improve this.

3 Ongoing Actions

3.1 The Community Planning Partnership has committed to supporting Highland to being breastfeeding friendly, and the Council has agreed to commit funding from the preventative spend allocation to support breastfeeding.

3.2 Work has begun to review the approach across Highland to support breastfeeding. This is focussing activity at key data collection points (birth, discharge from hospital, 10-14 days and 6-8 weeks). These key points are where it is considered that a range of interventions across the NHS, council and partners will make the biggest difference. If breastfeeding can be successfully supported at each point it is more likely that women will continue to breastfeed for longer.

3.3 The review process involves: A literature review is about to determine what the most effective support is in the early weeks. This will inform the best use of the funding made available from the Maternal Infant Nutrition Framework funding (MINF) and the preventative spend allocation from Highland Council. The use of the additional funding and the impact of the support provided will be part of a formal evaluation.

3.4 In addition education in schools is being undertaken for the next generation of parents, utilising the curriculum for excellence's health and wellbeing outcomes to raise breastfeeding awareness in 3-18 year olds.

3.5 Discussions will take place with other mainland boards who are achieving better performance rates, primarily Lothian.

3.6 Mapping the experience of women who are breastfeeding their babies at the key points to better understand what helps and what hinders successful breastfeeding. This will be done from a mother's perspective and there is some evidence from facebook feedback about mothers views. Midiwfery and Health Visitors practice at the key points has been mapped, including what they do well and what they want to improve. This work will be reported back through MINF improvement group.

3.7 Setting new performance measures to improve activity from birth to 6-8 weeks. By increasing initiation rates and sustaining feeding rates from birth to 10-14 days will help support the achievement of the 6-8 week performance measure of 36% mothers exclusively breastfeeding.

3.8 The return rate of the 6-8 week surveillance forms is improving, but it is recognised that more work is required to increase the return rate to achieve the target of 95% by December 2014. Whilst improving the return rate of the forms does not in itself increase breastfeeding rates it does increase the accuracy of information and supports targeted action where required.

3.9 Other actions being undertaken include: staff training in new standards to maintain accreditation in the UNICEF Baby Friendly Initiative, leaftets to support information and guidance to staff and clients, support for breastfeeding peers, telephone contacts, groups, facebook pages, sticker scheme, key workers in each area / family team to support UNICEF and triage, formula marketing and maintenance of full WHO code compliance, tongue tie service (appendix – Driver Diagram)

4 Expected Impact of Actions

4.1 It is expected that these actions will help to improve breastfeeding rates and the accuracy of data about breastfeeding rates over time.

Recommendations

Members are asked to acknowledge the actions in place to improve breastfeeding rates and improved data collection.

Designation: Director of Care and Learning
Date:

Authors: Sheena MacLeod, Head of Health, Sally Amor, Child Health Commissioner

Aim | Primary | Secondary | Theory of actions that impact

Aim: To increase the numbers of babies exclusively breastfeeding at birth, discharge, 10-14 days and 6-8 weeks (33.3% National Standard, 36% NHSH Standard)

Primary

- Highland will have a supportive environment to breastfeed.
- Women are prepared and encouraged to breastfeed at every point of their breastfeeding journey.
- Breastfeeding will become the normal feeding method for Highland women.
- Knowledge and skills of breastfeeding for all staff will enable women to breastfeed for as long as they wish.
- Voluntary peer support will become part of all existing teams and utilised appropriately.
- Acute breastfeeding problems will be managed quickly and effectively.
- Breastfeeding will raise its profile within NHSH, HC, A&B Council and its partners.

Secondary → Theory of actions that impact

- **Data collection is accurate and reliable from I.S.D. to enable monitoring.** → Improvement work through EYC to improve CHSP-PS form returns to 95% by June 2015 through collaborative working with GP's, HV, Practice Managers.
  3 monthly reporting on breastfeeding rates at each of the four monitoring stages: birth, discharge, 10-14 days, 6-8 weeks.
- **Use of UNICEF BFI audit tool for midwifery, health visiting and neonatal settings to evaluate best practice and target areas of concern.** → 3 audit tools: midwifery, HV and Neonatal to be used quarterly in various settings.
  Midwifery complete CQI's monthly
  Women's experiences from this can inform health professional practice.
- **Maintenance of UNICEF BFI award within whole NHSH.** → Deliver mandatory training to all staff who have contact with pregnant or breastfeeding women.
  Breastfeeding should be a core Personal Development Plan competency for all staff.
  Strict adherence to UNICEF BFI hospital and community standards.
  Practical skills reviews with various staff members will ensure safe and effective practice.
- **Ante-natal information.** → Ante-natal checklist and conversations in pregnancy to be used by all midwives and health visitors.
  Ante-natal breastfeeding booklet to be distributed to all women.
  Use of peers in ante-natal classes. Peer led ante-natal Facebook page. Peer ante-natal baby massage.
  High quality ante-natal education given by midwife (Lead midwife to audit use of parent education programme)
  Health visitor contact in ante-natal period re-enforcing breastfeeding.
- **Post-natal support.** → Completion of post-natal checklist and conversations. Completion of breastfeeding assessment twice in first 10 days and completion of breastfeeding assessment during HV first visit.
  Referral to breastfeeding peer supporter. Referral to breastfeeding support group. Peer led post-natal breastfeeding Facebook page. Baby wearing. Skin to skin contact.
  Provide support contact numbers: national and local (within breastfeeding post-natal booklet)
  Engage with local parents and ask what they would like.
  Optimal information and advice given to women. Prioritise breastfeeding to support women.
- **Baby Welcome Sticker Scheme.** → Provide information on public places for women to feel supported and encouraged to feed.
  Use of peers to buddy new mums to support breastfeeding in public.
  Engage with HC and CPP to participate in sticker scheme.
  Update NHS Highland participants on website.
- **Effective peer support network.** → Funding, Ongoing training, Up-date training, Further opportunities – baby massage, baby wearing
  Co-ordination
  Telephone support, Group support, Face to face on occasion.
- **Breastfeeding Awareness Sessions within schools 3-18 curriculum.** → Nursery resources to all PT teachers nursery in 2013. Nursery – PS, PS-P7, P7 train the trainer, S1-S6 and S6 train the trainer programmes: all HWB group ratified. Teachers encourage to use resources.
  Training available if required.
  Mandatory programme addition for Highland Schools.
- **Effective and efficient management of breastfeeding problems.** → Key workers in each operational unit for midwives and health visitors.
  Appropriate referral to Lactation Consultant at clinic. Appropriate referral of tongue ties to Lactation Consultants.
  Use of referral pathways in hospital and community areas.
- **Adherence to WHO Code of Marketing of Breastmilk Substitutes.** → NO advertising of formula milk or companies within NHSH, HC or CPP.
  Bi-annual formula feeding panel chaired by IFA – any information cascaded to staff.
  Guide to formula milks sent to staff.
- **Positive media marketing.** → Plan media releases monthly. Use of media: magazines, newspapers, radio, Facebook and Twitter.
  Planned programme on partner support. Mass picnics for CPP involvement with sticker scheme
  Media coverage on longer term breastfeeding.
  Aim to normalise breastfeeding images in public in Highland.