# Agenda

Health & Wellbeing Board Buckinghamshire

**Date:** Thursday 20 November 2014

**Time:** 2.30 pm

**Venue:** The Oculus, Aylesbury Vale District Council, The Gateway, Gatehouse Road, Aylesbury, HP19 8FF

| Agenda Item | | Time | Page No |
|---|---|---|---|
| 1 | **WELCOME AND APOLOGIES** | **2:30pm** | |
| 2 | **ANY ANNOUNCEMENTS FROM THE CHAIRMAN** | | |
| 3 | **DECLARATIONS OF INTEREST** | | |
| 4 | **MINUTES OF THE MEETING HELD ON 18 SEPTEMBER 2014** | | **3 - 8** |
| 5 | **PUBLIC QUESTIONS** | **2:40pm** | |
| 6 | **OFSTED IMPROVEMENT PLAN UPDATE**<br>Trevor Boyd, Interim Strategic Director for Children and Young People | **2:45pm** | **9 - 10** |
| 7 | **MENTAL HEALTH CONCORDAT**<br>Susie Yapp, Interim Service Director, Commissioning and Service Improvement, Buckinghamshire County Council<br><br>Dr Stephen Murphy, Clinical Commissioning Director - Mental Health and Staying Healthy, Chiltern Clinical Commissioning Group<br><br>Kurt Moxley, Senior Joint Commissioner (Mental Health) | **3pm** | **11 - 18** |
| 8 | **UPDATE ON THE BETTER CARE FUND SUBMISSION.**<br>Lesley Perkin, Programme Director for Integrated Care | **3:15pm** | **19 - 20** |
| 9 | **DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT**<br>Dr Jane O'Grady, Director of Public Health | **3:30pm** | **21 - 120** |
| 10 | **DRAFT HEALTH AND WELLBEING BOARD GOVERNANCE AND ANNUAL REPORT AND WORK PROGRAMME**<br>Patricia Birchley, Cabinet Member for Health and Wellbeing<br><br>Rachael Rothero, Interim Strategic Director, Adults and Family Wellbeing | **3:55pm** | |
| 11 | **AOB** | **4:25pm** | |

**12 DATE OF NEXT MEETING** **4:30pm**

29 January 2015, 10:30am, Mezzanine Rooms 1 and 2, County Hall, Aylesbury (meeting details tbc)

5 March 2015, 2:30pm, Council Chamber, Chiltern District Council, Amersham

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If you would like to attend a meeting, but need extra help to do so, for example because of a disability, please contact us as early as possible, so that we can try to put the right support in place.

*For further information please contact: Helen Waillling on 01296 383614*
*Fax No 01296 382421, email: hwailling@buckscc.gov.uk*

# Minutes

Health & Wellbeing Board Buckinghamshire

**MINUTES OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY 18 SEPTEMBER 2014, IN JUBILEE ROOM, AYLESBURY VALE DISTRICT COUNCIL, THE GATEWAY, GATEHOUSE ROAD, AYLESBURY, HP19 8FF, COMMENCING AT 1.35 PM AND CONCLUDING AT 5.27 PM.**

## MEMBERS PRESENT

Ms J Adey (District Council Representative), Ms J Baker OBE (Healthwatch Bucks), Mrs P Birchley (Cabinet Member for Health and Wellbeing), Mr T Boyd (Strategic Director for Children's Services), Ms I Darby (District Council Representative), Mr C Etholen (Deputy Cabinet Member for Health and Wellbeing), Dr A Gamell (Chiltern Clinical Commissioning Group), Ms N Lester (Chiltern Clinical Commissioning Group), Ms A Macpherson (Cabinet Member for Children's Services), Dr J O'Grady (Director of Public Health), Ms L Patten (Aylesbury Vale Clinical Commissioning Group), Dr G Payne (Medical Director, NHS England Thames Valley Area Team), Ms R Rothero (Interim Strategic Director for Adults and Family Wellbeing), Dr J Sutton (Aylesbury Vale Clinical Commissioning Group) and Dr K West (Aylesbury Vale Clinical Commissioning Group)

## OTHERS PRESENT

Mr D Johnston (Service Director, Child and Family Service), Ms K McDonald (Health and Wellbeing Lead Officer), Ms L Perkin (Programme Director for Integrated Care) and Ms H Wailling (Democratic Services Officer)

## 1 WELCOME AND APOLOGIES

Apologies for absence were received from Graham Jackson and Dr Stephen Murphy.

The Chairman welcomed David Johnston, Interim Service Director for Safeguarding for Children.

The Chairman welcomed Trevor Boyd as the Interim Strategic Director for Children's Services.

The Chairman welcomed Rachael Rothero as the Interim Strategic Director for Adults and Family Wellbeing.

## 2 DECLARATIONS OF INTEREST

There were no declarations of interest.

## 3 MINUTES OF THE MEETING HELD ON 24 JULY 2014

The Minutes of the meeting held on 24 July 2014 were agreed and signed as a correct record.

## 4 PUBLIC QUESTIONS

There were no public questions.

## 5 DISCUSSION RE: OFSTED REPORT

Angela Macpherson, Cabinet Member for Children's Services, introduced this item and said that the Ofsted Inspection Report had been received on 8 August 2014. It had been a very sobering and disappointing report, although the outcome had not been entirely surprising. In 2013-14 there had been an unprecedented rise in demand for Children's Services. There had been a 70% increase in referrals to the First Response Team. There had also been a 12% increase in the number of looked after children, which was an all-time high figure for Buckinghamshire. They also experienced significant difficulties in attracting experienced social workers to BCC. All these factors had created a 'perfect storm,' and due to these pressures there had been a backlog of cases.

David Johnston, Interim Service Director for Safeguarding for Children, then gave a presentation on the Ofsted Inspection Report and Improvement Plan. David Johnston had been in post since two days prior to the Ofsted inspection.

David Johnston said the following:

- Children's Services employed a significant number of agency staff, and there were upwards of 80% agency staff in the First Response Team. There was also a high turnover of staff.
- BCC had made 28 adoptions in the previous year. Some local authorities made over 100 adoptions a year (although these were larger authorities).
- Initial health assessments for children in care were crucial but the Council had very little control over these out of County. Some children had not been seen for up to 62 days since they began their placement. Following through a case for neglect was much more difficult if no health assessment had been carried out.
- The Children in Care Council had been functioning very well 18 months previously but there had not been any succession to replace Council members as they left to go to further education.
- Corporate parenting training was being held on 19 October 2014. All elected members and senior staff were corporate parents. There was also an extended corporate parenting responsibility to other partners too, who collectively were looking after the most vulnerable people. Corporate parenting responsibilities were not well understood, which was why the training was being held.
- Case records and how they were kept was very important. Looked after children needed to be able to access their records as adults and gain a clear picture of what they had been like as children. Murray Ryburn (Birmingham University) had written about records and how they conveyed information. They needed to turn from identifying problems to helping with solutions.
- When the Ofsted inspection had been carried out, 25% of foster carer reviews had been out of time. They were now all held on time, and a new manager was in place.
- 11% of looked after children in Buckinghamshire went to University. In some authorities this figure was as low as 4%.
- In the previous year, a number of Independent Reviewing Officers posts had been cut at the same time as the number of looked after children had increased. This was being addressed.
- There were 19-20 independent fostering agencies working in Buckinghamshire.
- 52% of looked after children were placed outside Buckinghamshire.
- Work was underway to review all unallocated cases.
- A 'Staying Put' Policy had been created, which allowed young people to remain with their foster families when they reached 18.
- A multi-agency thresholds document had been agreed and was being implemented. It would be reviewed.

- They were raising awareness of private fostering, when a child stayed with other people with their parents' agreement for more than 27 days. There had been an increase in privately fostered children, which required an increased number of visits.
- Looked after children in Buckinghamshire were different to cohorts in other authorities. There were a large number of looked after children under the age of 2 and also aged 13-14. Pastoral care was needed in primary schools to identify other issues which could arise as children reached their teens.
- Teenagers going into care had poor outcomes. Every time they moved placement they lost approximately six months of education. Teenagers in care might reach a point where they felt they had nothing left to lose, and people would change their view of them from 'troubled' to 'troublesome.' Even if they were troublesome, they were also troubled, and this needed to be conveyed.

**Member comments**

A member asked about the budget for the Children's Safeguarding Board. Angela Macpherson said that it was approximately £200k. Children's Services had dramatically reduced the Board's budget. Angela Macpherson had made it clear that there should be better proportionality, as BCC provided 75% of the budget. The Board's challenge was to focus on its key priorities.

A member said that they had not been aware of the decision to reduce the funding until it had been made. Angela Macpherson said that this came as a surprise to her as she had presented the budget proposals to the Safeguarding Board. However it had been a poorly attended meeting and there had not been much challenge.

Trevor Boyd said that finance officers were looking at budgets for the Safeguarding Board with partners.
A member asked who else provided funding for the Safeguarding Board. Dr Juliet Sutton said that the Police, Health, CAFCASS and Probation services all put in funding. David Johnston said that the Safeguarding Board first needed to decide what it was going to do and then set its budgets.

Trevor Boyd said that the MASH should help with bringing organisations together. David Johnston said that it should help, but noted that the MASH did not include the voluntary sector.

A member noted that there were a large number of referrals to social care from the Police. Mothers would be less likely to report domestic violence if they knew that a referral would be made to social care services. David Johnston said that this was partly down to statutory organisations needing to change the way they worked with families. One way was to provide support to families. Another way was through intervention. Social care would normally see a mother reporting domestic violence as acting as a protective parent.
Domestic violence referrals to social care services had increased. DCI Richard North and David Johnston were working on the figures. They would try and triage domestic violence through the MASH.

Dr Juliet Sutton said that GPs were informed of any domestic violence where a child was involved, and that they tried to act in a supportive way towards the family. David Johnston said that their initial approach was to minimise risks and for children to remain with their families where possible.

A member asked if academies had made a difference. David Johnston said that the relationship between BCC staff and the people running the schools made the difference. It was partly the responsibility of BCC to build up that relationship.

Dr Jane O'Grady said that she was a member of the Thames Valley Quality Surveillance Group, which liaised with people outside the Thames Valley and neighbouring quality surveillance groups.

**Agreed Actions**

- Small group of HWB to meet to discuss governance between HWB and Safeguarding Board and CYP Board to ensure improvements as part of the OFSTED Plan and provide assurances around lines of accountability.
- Governance paper and updated Terms of Reference to clarify role of HWB to come to next HWB meeting on 16 October **(KM)**
- Electronic copy of Protocol with Children's Safeguarding Board to be sent out
- Draft Ofsted Improvement Plan to be brought to next meeting, and to be a standing item at every future meeting.
- Letter from Tricia as Chair of HWB to Safeguarding Boards requiring protocols for escalation to HWB and invitation to future meeting for the HWB forward plan (annual reports).

## 6 HEALTHWATCH ANNUAL REPORT

Jenny Baker OBE, Chairman of Healthwatch Bucks, gave a presentation (attached) and told members that although currently it received some funding from BCC, the aim was that Healthwatch would become financially sustainable.

The first year of operation had been a start-up year, in which four projects had started. Healthwatch was offering a partnership opportunity to provide evidence.

The four projects were:

- Looked After Children with Action4Youth - 38 looked-after-children had been interviewed
- Bereaved Young People with Child Bereavement UK
- People with Learning Disabilities with Talkback – 30 voices through three focus groups. This had raised the idea of health passports.
- People who have been discharged from hospital

Some projects underway were legacies from the Local Involvement Network (LINk).

An Urgent Care Survey was being carried out, led by a volunteer panel.
Angela Macpherson asked if Healthwatch could expand their Urgent Care Survey wider than Chesham and Wycombe. Jenny Baker said that it was being more widely dispersed.

The project with the Service User and Carer Organisation (SUCO), to look at challenging behaviours in care homes, was an example of a project coming up from voluntary organisations.

Rachael Rothero asked about the 'Enter and View' powers which Healthwatch held, and noted that this was a unique and statutory responsibility.
Jenny Baker referred to the Dignity in Care project, which Healthwatch Bucks had commissioned Bucks New University to carry out. 24 care homes and domiciliary care services would be visited and reviewed via the 'Enter and View' process, carried out by eight volunteers. The 'Enter and View' Team had now received training for this, including Steve Baker MP.

Rachael Rothero said that the Dignity in Care project was a very important and exciting project. How would they receive regular updates over the three year period, and how would alerts be woven back in? Jenny Baker said that the Communications Strategy was currently being looked at. Also, CQC had now announced a care home programme, and they would need to look at any overlaps.
Rachael Rothero said that Healthwatch should have a direct line to the Adults Safeguarding Team and the Contracts Team.

Jenny Baker said that there was a lot of information available through NHS sources, and that they had received a presentation from Dr Reg Race. Some Healthwatch areas were providing a service for local authorities in pulling data together.

The Chairman thanked Jenny Baker for her report and said that any questions on the presentation would be answered at the next meeting, due to timing.

## 7 BETTER CARE FUND

Lesley Perkin said that the Health and Wellbeing Board was expected to set a target for acute admission reductions of at least 3.5% (c. £1.7m).

The profit and loss work had shown that Buckinghamshire was well above average in admissions but that there were some issues regarding length of stay. In Buckinghamshire a reduction in acute admissions would be made, but not necessarily of 3.5%. It was not about shifting the problem somewhere else, and there was a need to support people across the board.

Many questions remained about how the money would flow and how the performance would be monitored. The binding agreements would come back to the Health and Wellbeing Board and to the relevant governing bodies. At the same time a full business case was being created from the outline business case.

Following requests from members at previous meetings to have oversight of the key risks related to the BCF, a risk table was circulated. Most of the risks had also been in the original document. New risks were around the impact of the Care Act, and the risk that sufficient funding had not been identified.

**Member comments**

Rachael Rothero said that £1.4m of national funding had been allocated. The model required £4-5m, so there was a funding gap, which was a risk.

Lesley Perkin said that another risk was where demand flows might not match. They had made a fantastic start with the profit and loss work to understand this.

Rachael Rothero said that a current challenge was a performance target around acute bed-based care. If this created demand in another part of the system, they would need the flow of money, as collective systems.

Nicola Lester said that in the risk table there was no reference to the Primary Care Strategy. Lesley Perkin said that a risk would be created for that and for primary care preparedness.

Rachael Rothero said that there also needed to be a risk around ACHT, where they were supporting people. Rachael Rothero asked what the 3.5% per annum looked like in terms of demand flows in other areas. Lesley Perkin said that they had changed and created a new model of care.

Dr Geoff Payne said that they needed a corporate approach to risk sharing. Louise Patten said that there was a lack of trust in the new services being described, in them being successful enough. Had they tested them?
Lesley Perkin said that there was evidence internationally and nationally that was increasing all the time. They must not be insular in this.

Louise Patten said that it was about making sure that innovative work was fed back.

Patricia Birchley said that there was a role for District Councils too, not just for the County Council.

Rachael Rothero said that the profit and loss work had shown that a 3.5% reduction would destabilise the system. Would the local area team accept the Buckinghamshire approach?
Dr Geoff Payne said that the guidance did not require a 3.5% target. They would be supportive provided that they were allowed to be. The profit and loss work was quite compelling. The question was of having credible arguments and a challenging target.

Dr Annet Gamell said that it needed to be realistic and credible and what would lead to better out of hospital care. Shortening the length of stay would increase admissions.

Dr Geoff Payne said that it was easier to argue a 3.5% cost reduction.

Rachael Rothero said that this would cause there to be instability, unless there was realignment and reinvestment in another part of the system.

Dr Jane O'Grady said that it needed to be a reduction of all ages – not all of these would require social care.

**8 HEALTH AND WELLBEING BOARD WORK PROGRAMME**

**9 DATE OF NEXT MEETING**

16 October 2014, 2:30pm, Mezzanine Rooms 1 and 2, County Hall, Aylesbury

**AOB**
Isobel Darby asked that handouts in future be sent out before the meeting, and not tabled.

**CHAIRMAN**

**Children's Services Ofsted Improvement Plan – Progress Report November 2014**

On 10th November, Cabinet agreed the Draft Children Services Improvement Plan which will be submitted to Ofsted on 14th November. Cabinet also agreed to recommend to Full Council the release of £1.6m from the General Fund Reserve required to fund the additional 2014/15 measures in the Improvement Plan.

Work is already well underway on making the improvements needed. Since the inspection concluded we have responded quickly, and with a sustained pace, to focus on addressing immediate opportunities for change while at the same time laying the foundations to build pervasive and longer term changes in practice.

Actions taken in relation to Children's Social Care since September 2014:

- Appointment of David Johnston as the new Director of Children's Services who has a strong social care background (our local title is Managing Director of Children's Social Care [0-25] and Learning).
- Appointment of a new Chairman of the Buckinghamshire Local Safeguarding Board, Frances Gosling-Thomas. She is a high performing and experienced strategic leader operating at senior management and Director level for over 15 years in both local authorities and national improvement agencies.
- Detailed discussion with colleagues in our health economy involving the Hospital Trust, two CCGs and the Mental Health Trust to both identify the reasons for the increase in referrals between 2012/13 and 2013/14 and to agree an action plan for better controlling these referrals. Similar discussions have been had with Thames Valley Police.
- A meeting between the Leader of the Council and the Cabinet Member with responsibility for Children's Safeguarding and the Regional Crime Commissioner to discuss these issues.
- Funding arrangements of the Safeguarding Board are being reviewed in conjunction with all contributing parties.
- Reviewed and re-launched the Thresholds document, and related guidance, and developed a Multi-Agency Referral Form for social care and early help.
- The establishment of a multi-agency safeguarding hub (MASH) which went live six weeks ago.
- An initial seminar for Members and Senior Officers on their Corporate Parenting responsibilities was attended by over 50 Members and Officers. Further training sessions are planned.
- Reviewed Children's Services budgets following recommendations from the Member Led Task & Finish Group leading to an increase of £4.8m funding in the base budget as well as additional in year one off funding of £2.67m to address the Improvement Plan. Future year Improvement Plan funding, one-off and ongoing, will be considered within the Medium Term Planning process of the Council.
- Engaged an Improvement Adviser, Ann Goldsmith, with a significant children's social work senior management background, to support the implementation of service improvement initiatives that will assist with embedding robust good quality social work practice.

- Introduced five Practice Improvement Manager roles to the structure to support improvements to frontline practice and reduce the burden on more senior managers to free them up to make longer term strategic plans.
- Introduced retention and recruitment payments to social worker and manager roles in the First Response and Children in Need teams to create a stable and sustainable workforce.
- Reviewed and agreed changes to the First Response Service which are being implemented. This has included increasing the size of the team, and related budget, from 12 to 27 social workers and introducing the role of Contact and Referral Coordinator.
- Established a Resource Panel to scrutinise all requests for services where a child may need a high-level support package to prevent accommodation, or is otherwise at risk of being accommodated, and to review all cases of Looked After Children where the child may be supported to exit accommodation, or to receive a more appropriate package of care.
- Transferred the responsibility for completing Child Permanence Reports to the Children in Care units.
- Reviewed internal processes to ensure that all foster carers are reviewed annually and visited in line with National Minimum Standards.
- Completed a Health Check of our ICS system with the provider to develop a clear work plan to improve the efficiency and effectiveness of the system.
- Implemented a new performance management framework. New service and team performance information reports have been created to provide a platform for focused performance conversations to take place. The DCS reviews progress on performance targets and quality standards across the service every month with service managers. This new approach is driving a culture change using casework data to measure practice standards and performance targets.

There are strong governance arrangements in place to drive the delivery of the improvement programme in Buckinghamshire. A dedicated Improvement Board, chaired by the Chief Executive, is in place to review progress on the improvement plan. This Board will be held monthly and includes attendees from across the Council as well as representation from partner organisations and other Local Authorities. The first meeting of the Improvement Board is scheduled for 25th November.

The Improvement Plan is split into 6 workstreams which will be run as projects within an overall Improvement Programme. We hope to appoint a Programme Manager and team of Project Managers to support the Workstream Sponsors and Leads to drive through the changes shortly. The Risk and Insurance Manager is supporting the Workstream Leads to develop project and programme risk registers which will be monitored by the Improvement Board as well as by the Regulatory and Audit Committee. Cabinet and the Health & WellBeing Board will receive a quarterly report detailing progress against key milestones, success measures and risks.

**Trevor Boyd**
**Interim Strategic Director – Children's Services**
**13/11/14**

Health & Wellbeing Board
Buckinghamshire

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|---|---|
| **Title** | Mental Health Crisis Care Concordat |
| **Date** | November 2014 |
| **Report of:** | **Stephen Murphy**, Clinical Commissioning Director for Mental Health and Staying Healthy, Chiltern Clinical Commissioning Group<br><br>**Susie Yapp**, Interim Service Director, Commissioning and Service Improvement, AFW, Buckinghamshire County Council |
| **Lead contacts:** | **Kurt Moxley**, Senior Joint Commissioner (Aylesbury Vale Clinical Commissioning Group, Buckinghamshire County Council, Chiltern Clinical Commissioning Group |

1. **Purpose of this report:**

- This report explains the requirements of the national Mental Health Crisis Care Concordat and details the progress made on the implementation of the Buckinghamshire Crisis Care Concordat Declaration and Action Plan

2. **Summary of main issues:**

- The National Crisis Care Concordat was published in February 2014 which sets out principles and actions which would improve the outcomes for people experiencing mental health crises.

- It identified four strategic areas where public services should work together to deliver a high quality response when people of all ages with mental health problems urgently need help. The strategic areas are:
    - Access to support before the crisis point
    - Urgent and emergency access to crisis care
    - The right quality of treatment and care when in crisis
    - Recovery and staying well and preventing future crisis

- In the Thames Valley area, a number of organisations developed organisational action plans. Representatives of these organisations came together at a regional event in mid-September 2014.

- Commissioners in Chiltern Clinical Commissioning Group took on the coordination of the Buckinghamshire Declaration and Action Plan.

- An amalgamation of the Buckinghamshire Action Plans was carried out, the result of which was the compiling of the draft Buckinghamshire Action Plan.

- In October 2014, Chiltern Clinical Commissioning Group circulated the Buckinghamshire Declaration and Action Plan with a covering letter to all of the local relevant statutory organisations outlining the next steps.

- A number of comments on the content of the draft Action Plan have already been received from partner organisations. These will be incorporated in the final Action Plan before it is published on the national crisis care concordat website in December 2014.

- Monitoring progress against the final Action Plan will be through the mental health joint commissioning team and the Adult Joint Executive Team to the Buckinghamshire Health and Wellbeing Board.

**Recommendation for the Health and Wellbeing Board:**

- To receive this report
- To support the process for organisational sign-off
- To support the governance plan for the monitoring of progress against the Action Plan

**Background documents:**

a. National Mental Health Crisis Care Concordat (http://www.crisiscareconcordat.org.uk)
b. Local Buckinghamshire Declaration (attached)

**Mental Health Crisis Care Concordat ("the Concordat")**

## 1 Background

1.1 The Mental Health Crisis Concordat ("the Concordat") is a national multi-agency commitment to improve the experience and outcomes for people facing mental health crises. The Concordat is a joint statement, written and agreed by a number of national organisations as its signatories, that describes what people experiencing a mental health crisis should be able to expect of the public services that respond to their needs.

1.2 It is about how these different services can best work together, and it establishes key principles of good practice that local services and partnerships should use to raise standards and strengthen working arrangements. All the national bodies and national organisations that have signed up to the Concordat agree that improvements need to be made and sustained.

1.3 The Concordat has also been informed by engagement with people who have needed these services in the past and who were willing to share their experiences. This engagement has been led by voluntary organisations, principally Mind and Black Mental Health UK. With these contributions, the Concordat outlines an approach to improving services that reflects what people say they need - whether they are existing service users, carers, or other people seeking access to help, care or treatment.

1.4 The Concordat also contains a national action plan. This brings together the initial commitments made by the signatories to undertake work that supports the Concordat and helps to bring about its success. Much of this work is already underway. An annual Concordat Summit will be held by signatories to review progress and hold each other to account on the delivery of this action plan.

## 2 What this means in Buckinghamshire

2.1 There is growing evidence that it makes sense, both for the health of the population and in terms of economics, to intervene early when people may have an issue with their mental health, in order to reduce the chances of them going on to develop more serious and enduring mental health problems which are worse for the individual and harder and more expensive to treat.

2.1 The national Concordat is arranged around the key elements of a good mental health crisis care service and the local Buckinghamshire Action Plan will adopt this approach, covering:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

2.3 The Concordat sets out the elements of an effective system which would support organisations in Buckinghamshire to plan the changes needed to strengthen and improve responses in order to best address local circumstances.

2.4 Essentially what we are developing for people in a crisis is:

- An effective local system that anticipates, and where possible prevents, crisis, and which ensures timely and supportive crisis care.

2.5 In Buckinghamshire we are fortunate to have recently seen the restructuring of mental health services in the county.

2.6 There has been investment in a state-of-the-art psychiatric facility in Aylesbury which now provides a good level of psychiatric in-patient and crisis facilities. In addition the community system of mental health care, since April 2014, has been provided by a single integrated health and social care service for each of the two Clinical Commissioning Group areas; bringing together the previous variety of teams covering assertive outreach, crisis intervention and home treatment under one coordinated structure.

2.7 From the start of the year, we have seen psychiatric liaison services provided into the acute hospital at Stoke Mandeville in the Emergency Department, and more recently across the whole of the Stoke Mandeville and Wycombe Hospital sites.

2.8 Mental health services are now provided around the clock on every day of the week instead of the mainly office hours provision.

2.9 There remains more to be done. These actions will form the basis of the local Action Plan

**3 What work has been undertaken in Bucks to date including action plan and sign up?**

3.1 The national Concordat has been agreed by a partnership of national organisations and representative bodies. But real change can only be delivered locally. The most important ambition of the Concordat is that localities all over England adopt its principles.

3.2 The signatories of the national Concordat therefore expect that local partnerships between the NHS, local authorities, and criminal justice system work to embed these principles into service planning and delivery.

3.3 Just as the Concordat establishes a national agreement of principles, the ambition is for every local area to commit to agreeing and delivering their own Mental Health Crisis Declaration

3.4 The Concordat requires local statutory organisations to formally sign the local Declaration stating their commitment to working together to deliver on this for the people of Buckinghamshire

3.5 Locally, within Buckinghamshire, a number of organisations have been working together to look at the issues facing local people in a mental health crisis; commissioners from Chiltern Clinical Commissioning Group have led this work.

3.6 Representatives of the Buckinghamshire organisations came together at a regional Thames Valley Day on 17 September 2014 to draft our joint plans of action. The result of this early work is a local Declaration about what we commit to and an Action Plan about how this will be achieved. The actions in large part reflect work that is already underway across the system.

**4 Next steps including proposed governance and ownership after sign off**

4.1 The next step is for the local statutory organisations to formally sign the Declaration stating their commitment to working together to deliver on this for the people of Buckinghamshire. It is a requirement that the statutory organisations sign together as partners in commitment to this work.

4.2 The organisations being asked to formally sign are:

- Aylesbury Vale Clinical Commissioning Group
- Buckinghamshire County Council
- Buckinghamshire Healthcare NHS Trust
- Chiltern Clinical Commissioning Group
- NHS England Local Area Team
- Oxford Health NHS Foundation Trust
- Police and Crime Commissioner for Thames Valley
- South Central Ambulance Service NHS Foundation Trust
- Southern Health NHS Foundation Trust
- Thames Valley Police

4.3 A formal request has been sent from the lead organisation, Chiltern Clinical Commissioning Group, to the above organisations asking for sign-up, along with the 2014 Buckinghamshire Declaration and the draft Action Plan.

4.4 Regarding governance and future management of the progress of this work, this is planned to be though the mental health joint commissioning team via the Buckinghamshire Adult Joint Executive Team in the first instance and reporting to the Buckinghamshire Health and Wellbeing Board. It is to be anticipated that the Health and Wellbeing Board will have oversight of the action plan and ongoing commitment of partners to fulfil the tenet of the concordat through monitoring and exception reporting to ensure that progress is made.

# MENTAL HEALTH CRISIS CARE CONCORDAT 2014

## The 2014 Buckinghamshire Declaration on improving outcomes for people experiencing mental health crisis.

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We, as partner organisations in Buckinghamshire, will work together to put in place the principles of the National Mental Health Crisis Care Concordat to improve the system of care and support so that people in crisis because of a mental health condition are kept safe. We will help them to find the help they need – whatever the circumstances – from whichever of our services they turn to first.

We will work together to prevent crises happening whenever possible, through intervening at an early stage.

We will make sure we meet the needs of vulnerable people in urgent situations, getting the right care at the right time from the right people to make sure of the best outcomes.

We will do our very best to make sure that all relevant public services, contractors and independent sector partners support people with a mental health problem to help them recover. Everybody who signs this declaration will work towards developing ways of sharing information to help front line staff provide better responses to people in crisis.

We are responsible for delivering this commitment in Buckinghamshire by putting in place, reviewing and regularly updating the attached action plan.

**This declaration supports 'parity of esteem' between physical and mental health care in the following ways:**

- Through everyone agreeing a shared 'care pathway' to safely support, assess and manage anyone who asks any of our services in Buckinghamshire for help in a crisis. This will result in the best outcomes for people with suspected serious mental illness, provide advice and support to their carers, and make sure that services work together safely and effectively.
- Through agencies working together to improve individuals' experience (professionals, people who use crisis care services, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.

- By making sure there is a safe and effective service with clear and agreed policies and procedures in place for people in crisis, and that organisations can access the service and refer people to it in the same way as they would for physical health and social care services.
- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to staff, carers, patients and service users or the wider community and to support people's recovery and wellbeing

**We, the organisations listed below, support this Buckinghamshire Declaration. We are committed to working together to continue to improve crisis care for people with mental health needs in Buckinghamshire.**

| **Organisation** | **Signatory** |
|---|---|
| Aylesbury Vale Clinical Commissioning Group | |
| Buckinghamshire County Council | |
| Buckinghamshire Healthcare NHS Trust | |
| Chiltern Clinical Commissioning Group | |
| NHS England Local Area Team | |
| Oxford Health NHS Foundation Trust | |
| Police and Crime Commissioner for Thames Valley | |
| South Central Ambulance Service NHS Foundation Trust | |
| Southern Health NHS Foundation Trust | |
| Thames Valley Police | |

Health & Wellbeing Board
Buckinghamshire

| | |
|---|---|
| **Title** | Update on the Better Care Fund Submission |
| **Date** | October 2014 |
| **Update to be provided at the meeting:** | Lesley Perkin<br>Programme Director, Integrated Care |

**Purpose of this report:**
To update the Health and Wellbeing Board on the progress following submission of the Better Care Fund Plan in September.

**Summary of main issues:**
All HWBs and corresponding councils and CCGs have now received a letter confirming the outcome of their Better Care Fund (BCF) plan. Ninety-seven per cent of areas are approved (about 30 per cent with some conditionality) and only five are not approved. The process and level of resubmission required for final approval is still being finalised by the national team.

**The Buckinghamshire Plan has been 'approved with support' by the national process. The features of this level of approval are:**

- Risks were identified but are deemed non material (related mainly to template 2 analytics)
- Expected to take corrective action and resubmit the relevant elements of the plan by 28th November
- Likely to be 'approved' before Christmas
- Expected to move to focus on implementation

**Next steps on our journey in Buckinghamshire:**

- Developing the model further
  - Proposed future state will be described by January
  - Finalise s75 arrangements
  - Management
  - Governance
- Develop commercial strategy i.e. how to get the new service implemented

**Recommendation for the Health and Wellbeing Board:**

- The Board will receive an update at the meeting.

**Background documents:**

N/A

Health & Wellbeing Board
Buckinghamshire

| | |
|---|---|
| **Title** | • The Health of Children and Young People Director of Public Health Annual Report 2014<br>• DPHAR CYP Data Supplement |
| **Date** | 20 November 2014 |
| **Report of:** | Dr Jane O'Grady<br>Director Public of Health |
| **Lead contacts:** | Katie McDonald<br>Health and Wellbeing and Lead |

**Purpose of this report:**
The Director of Public Health has a statutory duty to write an annual report reviewing the health of the local population and the county council has a duty to publish it.[1] The content, focus and structure of Director of Public Health Annual Reports are decided locally.

**Summary of main issues:**
This report combines the views and ideas of young people in Buckinghamshire with what local and national evidence tells us about some of the key health issues and what works to address them. The health areas focused on in this report were determined by the schools that helped to shape it, as being relevant issues that are faced by young people today, resulting in the recommendations in the report that aim to help keep our children and young people as happy and healthy as they can be, and to achieve their full potential. The report is designed to be read on line and features content developed by young people including videos and infographics. The full report is supported by a data supplement that provides more detail on the health of the population.

The work carried out with the children and young people for the report is not a stand-alone project but part of a wider collaboration to encourage health promotion in schools. The report is underpinned by the results from a social norms project 'RUDifferent' commissioned by public health to raise awareness and reduce the pressure young people feel to get involved in risky behaviours.

**The report includes 8 overarching recommendations:**

1. Partners should continue to work together to ensure that more women are in good physical and mental health during and after pregnancy.
2. Continue to invest in evidence based interventions in the early years that support families and support children to develop well and reach their full potential
3. Continue to invest in evidence based interventions that promote emotional wellbeing and resilience in children and young people. This is vital as it supports them to achieve what they want from life and cope with adversity. It

[1] As outlined in section 73B(5) & (6) of the 2006 Act, and inserted by section 31 of the 2012 Health and Social Care Act)

reduces the adoption of health damaging behaviours and supports the adoption of health promoting behaviours.

4. Continue to use the views, ideas and enthusiasm of young people to shape strategies and projects to improve their health and wellbeing and the services they receive.

5. Increase young people's awareness of the services and support available to them and use their advice to inform how best to communicate this information.

6. All partners should work closely together to improve outcomes and services for children and young people at risk of poorer health and wellbeing such as young carers, looked after children, those living in more disadvantaged areas and those with chronic illness or disability.

7. Ensure the health promoting potential of schools is as fully realised as possible.

8. Improve the data and information available on the health of mothers, babies, children and young people to guide our strategies and monitor progress.

The report and data supplement along with further information on the work carried out by public health can be found on the public health webpages http://www.buckscc.gov.uk/public-health.

**Recommendation for the Health and Wellbeing Board:**

The Health and Wellbeing Board is asked to note the Annual Report of the Director of Public Health and supporting Data Supplement, review the recommendations and discuss any actions required.

**Background documents:**

N/A

# THE HEALTH

# *of Children*

# AND YOUNG PEOPLE

# *Director of Public Health's*

## Annual Report 2014

Click on the coloured squares next to each subject to take you through to each of the sections.

# Director of Public Health Introduction

This is my first annual report following the successful transfer of Public Health responsibilities from the NHS to Buckinghamshire County Council.

The first 20 years of life is a time of rapid development and shapes a person for the rest of their life. If we get it right during this period we can have a profound positive impact on the health and wellbeing of young people now, but also on their future prospects, their health and happiness as adults and the social and economic prosperity of Buckinghamshire – hence the focus of this report.



We wanted to understand young people's views about their health and what they thought would help protect or improve it so we worked with two Buckinghamshire schools to select topics of interest and relevance to their pupils. This report combines young people's ideas for helping them stay healthy, local data and national and international evidence of what works to make recommendations to help keep our children and young people as happy and healthy as they can be and achieve their full potential.

I would like to thank the students and staff of Chiltern Hills Academy and Little Spring Primary School who helped us to develop this report for some lively classroom discussions, some fabulous posters and campaign ideas to help promote health among their peers. I would also like to thank the six Buckinghamshire schools who are participating in our work on social norms – the early results of which are also highlighted throughout the report.

This report is for the wide range of people and organisations who care about children and young people in Buckinghamshire and helping them achieve their full potential. I hope it will be of interest to a wide audience including parents, schools, local authorities, health services, colleges and local businesses and hopefully to young people themselves as we all need to work together to give everyone in Buckinghamshire the best start in life.

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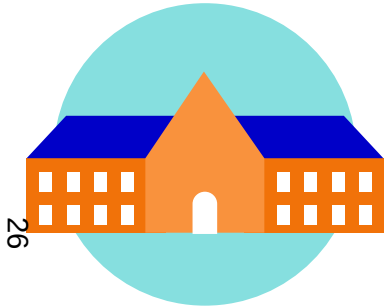
**Dr Jane O'Grady**
Director of Public Health

Buckinghamshire County Council
September 2014

# A collaborative approach to developing the Director of Public Health Annual Report

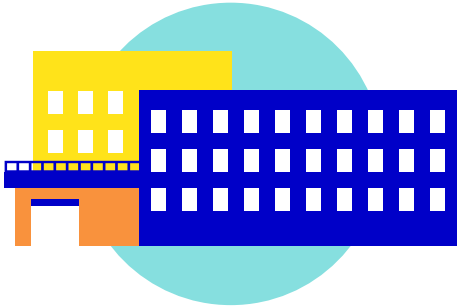




## WORK WITH LITTLE SPRING PRIMARY

Public Health organised for pupils to attend a healthy eating workshop delivered by a dietician, and a physical activity session based on cheerleading as a fun and inclusive activity. Based on what they had learned from these sessions, the pupils then created posters and poems to communicate what they felt the key health messages were. We also interviewed pupils about what they believe influences their health (see page 11).

Making exercise fun with a group cheerleading session.



## WORK WITH CHILTERN HILLS ACADEMY



The Public Health team with support from relevant partner agencies, delivered Personal, Social, Health and Economic Education (PSHE) lessons on healthy eating, smoking, emotional wellbeing, sexual health and alcohol to year 10 students.

Students were then invited to share their thoughts and ideas in relation to these health areas. These views can be found in the Classroom Sessions pages throughout this report. Staff from Chiltern Hills Academy then continued to work with students in Personal, Social, Health and Economic Education (PSHE) lessons to enable the students to develop their own health campaigns.

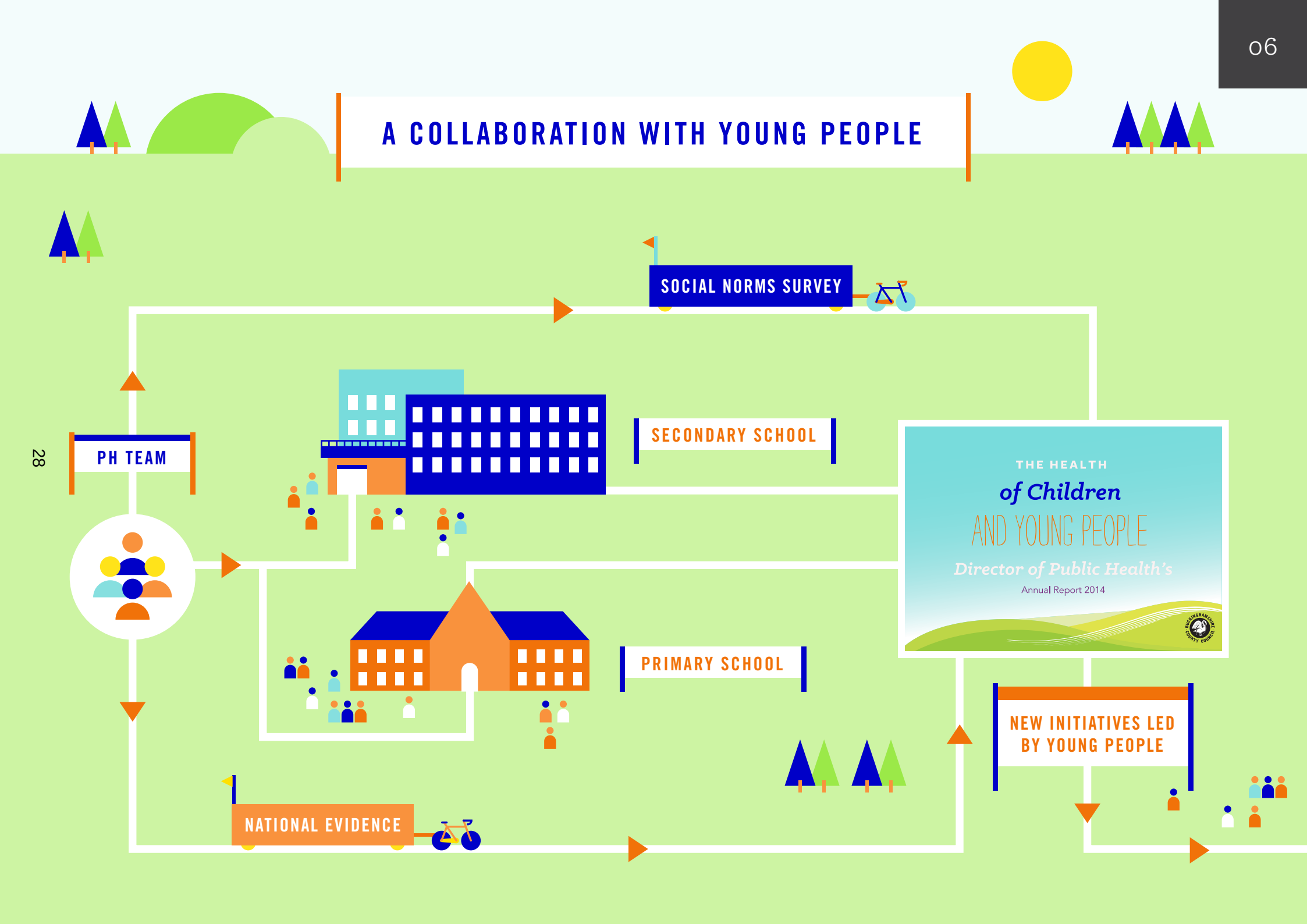
Students then faced their peers to determine the two best campaigns from each class. The winning nine groups 'pitched' their ideas to a professional judging panel with representatives from Public Health, Raw Design and Pinewood Studios.

The three winning pitches were an innovative smoking campaign called 'Cut it out', a thought-provoking film to challenge mental health stigma and discrimination, and a sexual health app to raise awareness and understanding of sexual health issues.

The Chiltern Hills Academy Health Campaign Competition

This report combines the views and ideas of young people in Buckinghamshire with what the local and national evidence tells us about some of the key health issues and what works to address them. The health areas focused on in this report were determined by the schools that helped to shape it, as being relevant issues that are faced by young people today.

# A COLLABORATION WITH YOUNG PEOPLE



# WHAT *Influences* THE HEALTH OF YOUNG PEOPLE?

# WHAT *Influences* THE HEALTH OF YOUNG PEOPLE?


Adapted from Dahlgren and Whitehead's Determinants of Health, 1991, and the WHO's Determinants of Adolescent Health and Development: An Ecological Model, 2014

# BEFORE THEY ARE BORN

The influences on a child's health start before they are born. The health and health behaviours of the mother will influence the baby's development before birth and whether they will have good health, not only in early childhood, but throughout their adult life.



# AFTER THEY ARE BORN

After they are born, the conditions in which children live, grow, learn and play have a profound effect on physical and mental wellbeing. The early pre-school years are a crucial time of rapid development. The family environment including parenting behaviour and parental mental wellbeing at this age will affect healthy brain development of the child, as well as social, emotional and thinking abilities. Habits that will protect children's health like healthy eating and being physically active can become established at this time.

# AS PRIMARY SCHOOL AGED CHILDREN

As children enter school, the school environment and peers become an increasingly important influence. Schools can have a significant positive effect on young people's health. As highlighted throughout the report, whole school approaches can foster physical health and emotional wellbeing. There are benefits to the school too as these approaches support better educational attainment and behaviour. Good educational attainment brings better health and employment prospects throughout life.

# ADOLESCENCE

Adolescence (between 10—19 years) is another very important time of profound development, second only to early childhood in the rate and breadth of developmental change. The brain develops rapidly during early adolescence particularly those areas that deal with social relationships, taking risks and controlling feelings and emotions. At this time adolescents are susceptible to peer influence and risk taking. Some of these behaviours may have immediate and harmful consequences.

Research shows that teenage choices around risky behaviours such as smoking, drinking or having underage sex are significantly influenced by the perception of how many of their friends and peers participate in such activities.

Young people tend to overestimate how much their peers are engaging in risky behaviours. The social norms project 'RUDifferent' was commissioned to raise awareness and in turn reduce the pressure young people feel to get involved in risky behaviours. The results from the survey that underpinned this work are detailed throughout the report.



Five of the 10 key risk factors for adult disease burden (tobacco, physical activity, overweight, unsafe sex and alcohol use) are either started or heavily influenced in adolescence.

**NEARLY 90% OF LIFETIME SMOKING IS INITIATED BETWEEN THE AGES OF 10 AND 20 YEARS IN THE UK.**

Smoking prevalence in the UK leaps from a population prevalence of less than 0.5% at age 11, to around 8% by 15 years.

Approximately 80% of lifetime alcohol or cannabis use is initiated under 20 years. Physical activity rates also fall at this time, particularly for girls. The good news is that potentially harmful behaviours such as smoking and alcohol use among young people have fallen. Unfortunately health promoting behaviours such as participation in physical activity or eating sufficient fruit and vegetables have also fallen.

# So what do young people in Buckinghamshire think influences their health?

Some of the key themes that secondary school pupils identified as influencing health behaviours were:


Primary school pupils also shared their thoughts with us on what they believe influences health.

# OVERVIEW OF *Health* OF CHILDREN & YOUNG PEOPLE *in Buckinghamshire*

# National data suggest that the health of young people in Buckinghamshire is generally better than the England average reflecting the lower levels of deprivation and generally better living conditions among Buckinghamshire families.

However, this is not a cause for complacency as the Chief Medical Officer for England has highlighted that when compared with the health of children in other European countries *"children and young people in England are not doing as well as they could".*

The proportion of children under 16 living in poverty in Buckinghamshire was 11% in 2011, approximately half the national average. However the proportion of babies born with low birth weight and dying in the first year of life is similar to the national average.

At the end of the first year of primary school 55% of children show a good level of development compared to the national average of 52% (2012-13).

A higher proportion of Buckinghamshire young people achieve good GCSE results and a lower proportion are not in education, employment or training at age 16-18 years.

Buckinghamshire children and young people also have lower admission rates to hospital for injuries, asthma, alcohol specific conditions, substance misuse, self-harm and mental health conditions than nationally.

Some children in Buckinghamshire experience poorer health than others. Children living in the most deprived areas of Buckinghamshire (on the index of multiple deprivation) are more likely to be underweight at birth and die in the first year of life than those living in the least disadvantaged areas.

At the end of the first year at primary school only 41% have a good level of overall development compared to 69% of children from the least disadvantaged areas.

Children and young people from the more disadvantaged areas also have higher levels of overweight and obesity, higher admission rates to hospital for a range of conditions including chest infections and asthma, injuries, self-harm and substance misuse. They are also more likely to be taken into the care of the local authority. Other young people experiencing poorer health include those with caring responsibilities, disabilities, or children in care.

For more information, graphs and data click here for the DPHAR data supplement on our webpage.

# *Emotional*
# WELLBEING

## Emotional wellbeing is about feeling good about yourself and your life, or "A positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment".

Emotional wellbeing is important in its own right but also supports children and young people to reach their full potential. Positive emotional wellbeing helps young people achieve well at school, supports the adoption of healthy behaviours such as regular physical activity and reduces the likelihood of engaging in more risky health behaviours like smoking.

The foundations of emotional wellbeing are laid in the early years from birth through to adolescence so this is a crucial time to act as the impact will be felt for the rest of their lives. As well as promoting emotional wellbeing, it is also important to support those who experience mental illness. One in ten young people have a diagnosed mental disorder such as conduct disorders, anxiety or depression, but early help can improve outcomes.



### Bucks Social Norms Survey

A survey of 13-14 year olds in six Buckinghamshire schools

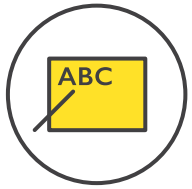
38% said they never felt anxious or depressed

26% Felt anxious or depressed once a year or less

12% said they felt anxious or depressed most days, and a further 13% felt this way about once a month.

When asked who they would talk to if they felt anxious or depressed, 39% said that they would talk to parents. 29% said they would talk to friends. 3% said they would go to the in-school counsellor and 1% said they would see an out of school counsellor. 18% said they would not talk to anyone. On this basis online support is now offered locally with the aim of engaging those who are not yet comfortable to talk to someone in person www.timetotalkbucks.org.uk

Visit www.RUDifferent.co.uk for more details on the project.




# CLASSROOM SESSIONS

14-15 year old pupils were asked to share their views on emotional wellbeing. Their thoughts and ideas are summarised below.



**What is emotional wellbeing?**

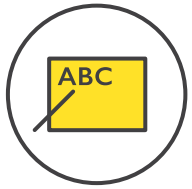
Being emotionally stable, being happy.

**What can you do to improve your emotional wellbeing?**

Being active / Eating healthily / Having fun / Hobbies / Thinking about others / Volunteering Listening to music / Making others happy / Sleep / Take advice / Speak to others who are going through the same thing / Keep off social websites which negatively affect you.

**What would help raise the profile of emotional wellbeing?**

Opportunities to talk in a class / group setting about the issues / Challenge judgments and increase understanding / Real life stories and stories from celebrities we look up to / Popular magazines and TV shows (features and adverts, real life stories) — shocking and scary stories to make people take notice.




# CLASSROOM SESSIONS

**What issues might prevent a person from seeking support?**

Judgmental people and fear of being judged / Family and friends may have different views on mental health / Lack of trust / Low self-esteem, social anxiety and awkwardness / Fear of information getting back to parents.

**What would encourage a person to seek support?**

Teachers / School / Adverts / Understanding counselling and what it involves / Concerned family and friends / A friend you can relate to / Reaching crisis point / Doing it for loved ones.

## FOLLOW UP WORK

Following the initial session, a group of students from Chiltern Hills Academy have been working on the development of a short film to raise awareness of how other people's reactions to mental illness can impact on a person.

They have also helped to design an infographic to complement their film (see page 18).

# START THE CONVERSATION. END THE SILENCE.

## NEGATIVE INFLUENCES ON EMOTIONAL WELLBEING

ATTENTION SEEKER!

40

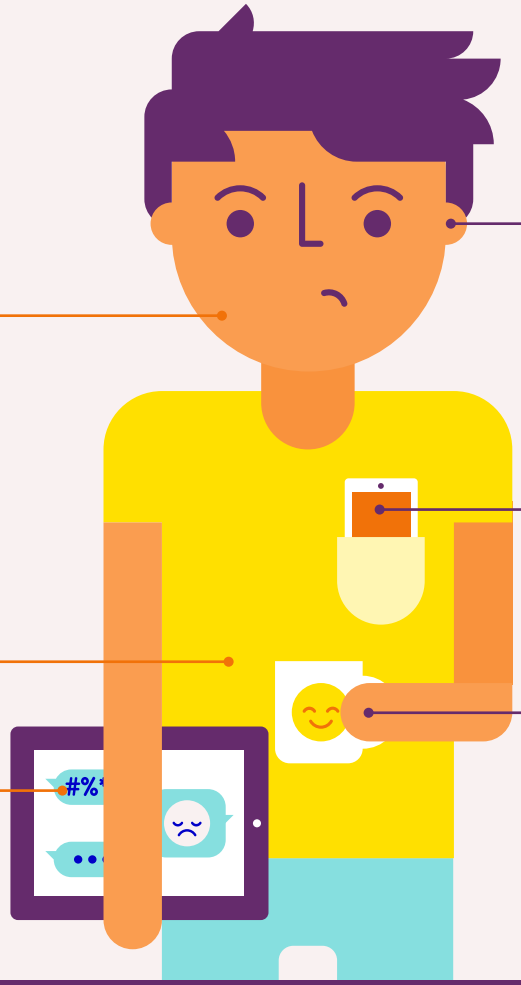
WEIRDO

Pull Yourself Together.

Judgemental, name-calling

Ignoring people who need a friend

Bullying or negative comments made on social media




Someone with a listening ear

Social media can help you to reach out and talk to someone

Friends with hugs & cups of tea

## POSITIVE INFLUENCES ON EMOTIONAL WELLBEING

I'M ALWAYS HERE FOR YOU.

IS THERE ANYTHING I CAN DO?

Would you like a hug?

**1 IN 10** young people have a mental illness

Around 50% of lifetime mental illness starts by **14 YEARS**

Who would young people speak to if they felt anxious or depressed?

**18% NOBODY**
**29% FRIENDS**
**39% PARENTS**
**14% OTHER**

**9 IN 10** YOUNG PEOPLE DIAGNOSED WITH A MENTAL ILLNESS HAVE EXPERIENCED STIGMA, PARTICULARLY FROM FRIENDS AND TEACHERS

If you need support or someone to talk to, please contact Time To Talk Bucks www.timetotalkbucks.co.uk

# What Works? — The Evidence

Parenting behaviour has a profound effect on a child's emotional wellbeing, and evidence based parenting programmes have been shown to promote wellbeing.

School based programmes including peer education approaches, building resilience, and whole school approaches which foster an ethos that promotes the emotional wellbeing of staff and students.

A universal approach to promoting emotional wellbeing such as working with a whole year group can help to avoid stigmatisation which our Buckinghamshire young people and national research have highlighted as a barrier to people seeking help at the right time.

The Five Ways to Wellbeing are five key things that people can do in order to improve their wellbeing. They are simple things that individuals can do in their everyday lives.



**CONNECT** with the people around you.

**BE ACTIVE** doing anything such as walking, dancing, or sport, boosts mood

**TAKE NOTICE,** be curious, be aware of the world around you

**KEEP LEARNING,** try something new. Set a challenge you will enjoy achieving.

**GIVE.** Do something nice for someone. Smile. Volunteer your time.

The five ways link very closely with the activities identified by young people in Bucks as promoting wellbeing.

five ways to wellbeing

# 2013/14 ACHIEVEMENTS

- Continued the Penn Resilience Programme in schools for 12-13 year olds.
- Social norms pilot project initiated in schools to reduce peer pressure to get involved in exploratory/risky health behaviours.
- 'Emotional Wellbeing and Mental Health of Children and Young People Group' formed to promote the emotional wellbeing of school aged young people, and support those experiencing mental illness.
- Emotional Wellbeing in Schools conference established.



# Recommendations

- Build support for development of emotional wellbeing at all stages by continuing to commission evidence based parenting support, healthy child programme, family nurse partnerships and emotional resilience training in schools.
- Promote the five ways to wellbeing to young people, and identify young champions for peer support.
- Ensure services are available to support parental mental wellbeing.
- Take a multi-agency approach to challenging misperceptions and stigma related to mental illness.
- Raise awareness of local support agencies amongst professionals, parents, and young people and ensure timely, appropriate, high quality services are available for all young people.

# *Alcohol*

Approximately 80% of lifetime alcohol use is initiated before 20 years of age. Alcohol consumption can be linked to a range of problems in young people including sleep disturbance, mental health problems and weight gain.

Alcohol tends to impair judgement and result in more risk taking behaviour and potentially putting young people in situations where they are vulnerable to a range of harms including accidents and injury, unsafe sex, becoming involved in violence either as a victim or perpetrator. It is also linked to truancy, antisocial behaviour and crime.

Over a longer period drinking alcohol above safe limits results in a wide range of chronic diseases in adulthood. It is also strongly associated with domestic violence. The Chief Medical Officer for England recommends an alcohol free childhood up to and including the age of 14. If children do drink alcohol between the ages of 15-17 years, it should be infrequently and in a supervised environment and never exceed recommended adult limits. Fortunately the number of young people drinking regularly has fallen dramatically. In 2002, national data showed that 52% of 15-year-old boys and 48% of 15-year-old girls reported drinking weekly; by 2010 this was down to 32% of boys and 23% of girls.



## Bucks Social Norms Survey

A survey of 13-14 year olds in six Buckinghamshire schools

93% of students drink once a month or less.
62% say they never drink alcohol.
31% say they only drink once a month

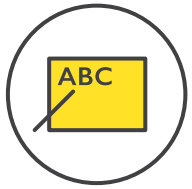
Students believed that 16% of boys and 15% of girls had been drunk in the past week. The reality was just 3% — significantly less.

Students thought that 1 in 3 of their year group were drinking once a week or more — actually it was less than 1 in 10.

22% felt that drinking was never a good thing to do.

39% thought it was ok occasionally.

Visit www.RUDifferent.co.uk for more details on the project




# CLASSROOM SESSIONS

14-15 year old pupils were asked to share their views on alcohol. Their thoughts and ideas are summarised below.

**What are the main risks of drinking too much alcohol?**

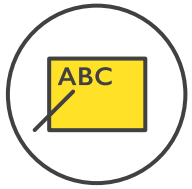
Cancer / Becoming violent / Personality changes / Effect on your liver, kidneys and brain / Having your stomach pumped / alcohol poisoning / Depression and anxiety / Sleep problems / Links to Sexually transmitted Diseases / Accidents.

**What influences young people's behaviours/views on alcohol?**

Parents / Taste of alcohol / Friends and peer pressure / Media, advertising / Special occasions / Awareness of health and social risks/ Social background.

**Where would young people go to find out more/ get support about alcohol?**

Way In (Counselling and information service based in Chesham) / People you trust / Teacher / Childline / Addiction / You Tube / Internet / Parents / GPs / Counsellors.




# CLASSROOM SESSIONS

**What issues might prevent a person from seeking support?**

Embarrassment.
Fear of being judged.
Don't want family to find out.
Worried about being seen visiting clinic.

**What would encourage young people to drink less?**

Inform young people more about how emotional wellbeing is linked to behaviours around alcohol.
Utilise the shock factor.

## What works? — The Evidence

- Enhancing family bonds and relationships
- Reduce peer pressure by challenging social norms i.e. raise awareness about actual drinking behaviours as young people tend to overestimate the extent to which their peers drink.

# 2013/14 ACHIEVEMENTS

- 100+ people who work with young people received training on helping young people avoid risky drinking including health visitors, school nurses, social workers and youth services.
- Alcohol and drug misuse services have been re-commissioned to include education work in schools through online learning and school visits.
- A successful Buckinghamshire wide campaign was run as part of alcohol awareness week in 2013 to encourage adult residents to consider whether they were inadvertently harming their health. The nationally recognised campaign, involving partners and 26 coffee shops led to a three fold increase in people seeking information from the Buckinghamshire County Council Alcohol Webpages.



# Recommendations

- Work with young people to develop appropriate communication messages around alcohol.
- Work with Alcohol Concern to ensure young people in Buckinghamshire are included in local campaign work and are able to contribute to national policy discussions at the Alcohol Concern national youth summit.

For more information please see
www.buckscc.gov.uk/healthy-living/alcohol

# HEALTHY EATING

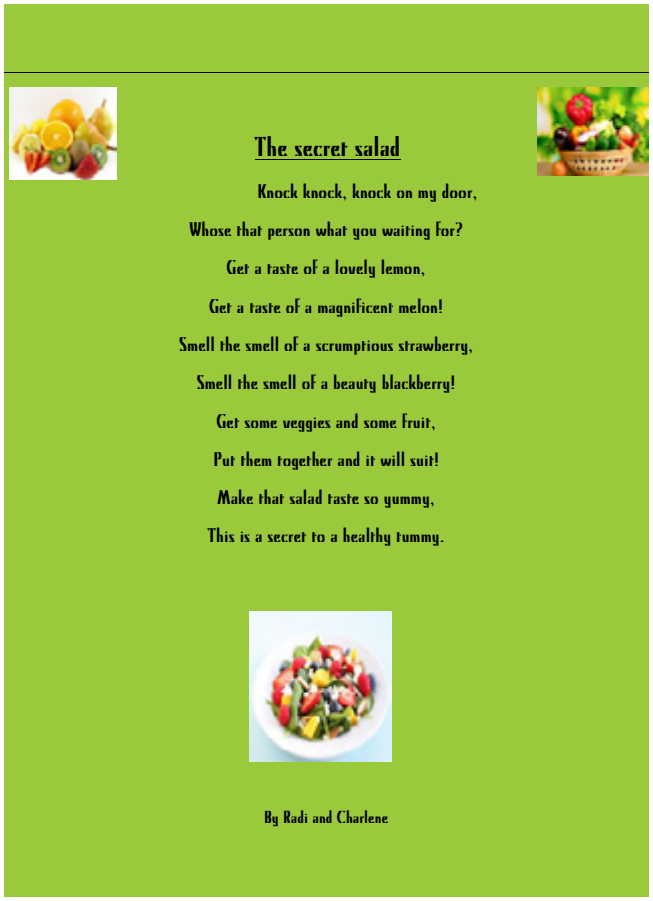
A healthy diet is vital at all ages but particularly while young people are growing and developing. Childhood and adolescence are important times for establishing healthy eating patterns. A healthy diet ensures good mental and physical development, helps improve concentration, learning and behaviour and helps maintain a healthy weight. A healthy diet also reduces the risk of many adult diseases.

# CLASSROOM SESSIONS



Little Spring Primary School pupils shared their creative ideas and thoughts with us on how to promote healthy eating. Pupils created poems and posters, the winner and runner up are shown here:


Healthy heroes poster (winner)




The Secret Salad (runner up)

# HEALTHY EATING: THE FACTS



CHILDHOOD OBESITY IS ASSOCIATED WITH A WIDE RANGE OF PROBLEMS INCLUDING PSYCHOLOGICAL PROBLEMS AND REDUCED SCHOOL PERFORMANCE AND SOCIAL FUNCTIONING.

THE MOST IMPORTANT MEAL OF THE DAY

## BREAKFAST

- IMPROVING CONCENTRATION
- IMPROVING LEARNING AT SCHOOL
- HELPING TO REDUCE OBESITY
- REDUCES SNACKING

62%

ACCORDING TO THE SOCIAL NORMS DATA 62% OF BUCKS PUPILS EAT BREAKFAST EVERY DAY.

CHILDREN'S DIETS TEND TO CONTAIN HIGH LEVELS OF ENERGY DENSE FOODS AND SUGAR. ENGLAND NOW HAS THE HIGHEST RATE OF SUGARY DRINK CONSUMPTION IN EUROPE.

## SNACKS

MORE THAN 1 IN 4 ARE OVERWEIGHT OR OBESE BY THE TIME THEY LEAVE PRIMARY SCHOOL.

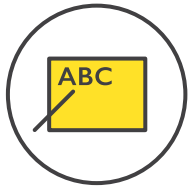
A GROWING PROPORTION OF CHILDREN AND YOUNG PEOPLE ARE OVERWEIGHT AND OBESE.

1/4

ONLY ABOUT A QUARTER OF CHILDREN EAT THE RECOMMENDED FIVE PORTIONS OF FRUIT AND VEGETABLES PER DAY.

NATIONAL DATA SHOWS THAT OVER THE LAST DECADE, THE PROPORTION OF CHILDREN EATING FRUIT DAILY AND EATING BREAKFAST HAS FALLEN.

UP TO 75% OF THOSE WHO ARE OBESE AS CHILDREN OR ADOLESCENTS ARE LIKELY TO GROW INTO OBESE ADULTS WITH LONG TERM CONSEQUENCES FOR THEIR HEALTH.




# CLASSROOM SESSIONS

14-15 year old pupils were asked to share their views on healthy eating. Their thoughts and ideas are summarised here.



## What is healthy eating?

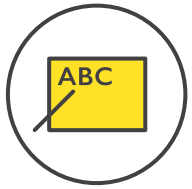
Good nutrition is eating healthy food e.g. fruit and veg, rice/pasta. It is having a balanced diet.

## What can you do to eat more healthily and encourage those around you to eat more healthily?

Have a team/all in it together approach / Increase willpower and self-discipline / Look at images of long-term health problems from unhealthy eating.

## What would influence young people's behaviours and views in relation to healthy eating?

Being body conscious or into sport / Whether food tastes nice / Friends and family / Advertising e.g. fast food restaurants / TV programmes – e.g. dieting and extreme eating programmes.




# CLASSROOM SESSIONS

**Where would young people go to find out more information about healthy eating?**

Online e.g. NHS websites / Ask personal trainer at the gym / Nutritionist/Dietician

**What might prevent a person from seeking support?**

Denial of problem.

**What would encourage a person to seek support?**

Family / Bad health / To control weight.

**What would help people to realise how important healthy eating is?**

Inform people of its importance but sensitively (especially weight) / Make it fun e.g. involve people and be interactive / Increase understanding of how healthy eating can help improve sporting performance / Demonstrations using real food / Improve the taste of healthy food / Cover the subject as part of other subjects e.g. science and media.

## What Works? - The Evidence

- Developing a healthy food environment in early years and schools
- Whole school approaches to healthy eating
- Promoting self-esteem and a positive body image
- Addressing lifestyle within the family and social settings
- Supporting the provision and promotion of health eating choices in communities.

# 2013/14 ACHIEVEMENTS

- Continued to commission MEND (Mind, Exercise, Nutrition, Do it!) programme. Fun family based active education programme designed for overweight children and a parent or carer.
- Drop in sessions run at selected children's centres to answer parents questions about healthy eating for under 5's.
- Completed the annual National Child Measurement programme (NCMP), which measures whether children are a healthy weight and advises parents/guardians of support available.
- Funded Chefs clubs at 18 schools teaching cookery skills to parents and pupils.



# Recommendations

- Continue to develop a multi-agency healthy eating strategy for Buckinghamshire that reflects the needs of different age groups.
- Improve access to informal and low cost/free cooking skills lessons for families or children.

For more information see:
buckscc.gov.uk/healthy-living/healthy-eating-healthy-weight

# PHYSICAL ACTIVITY

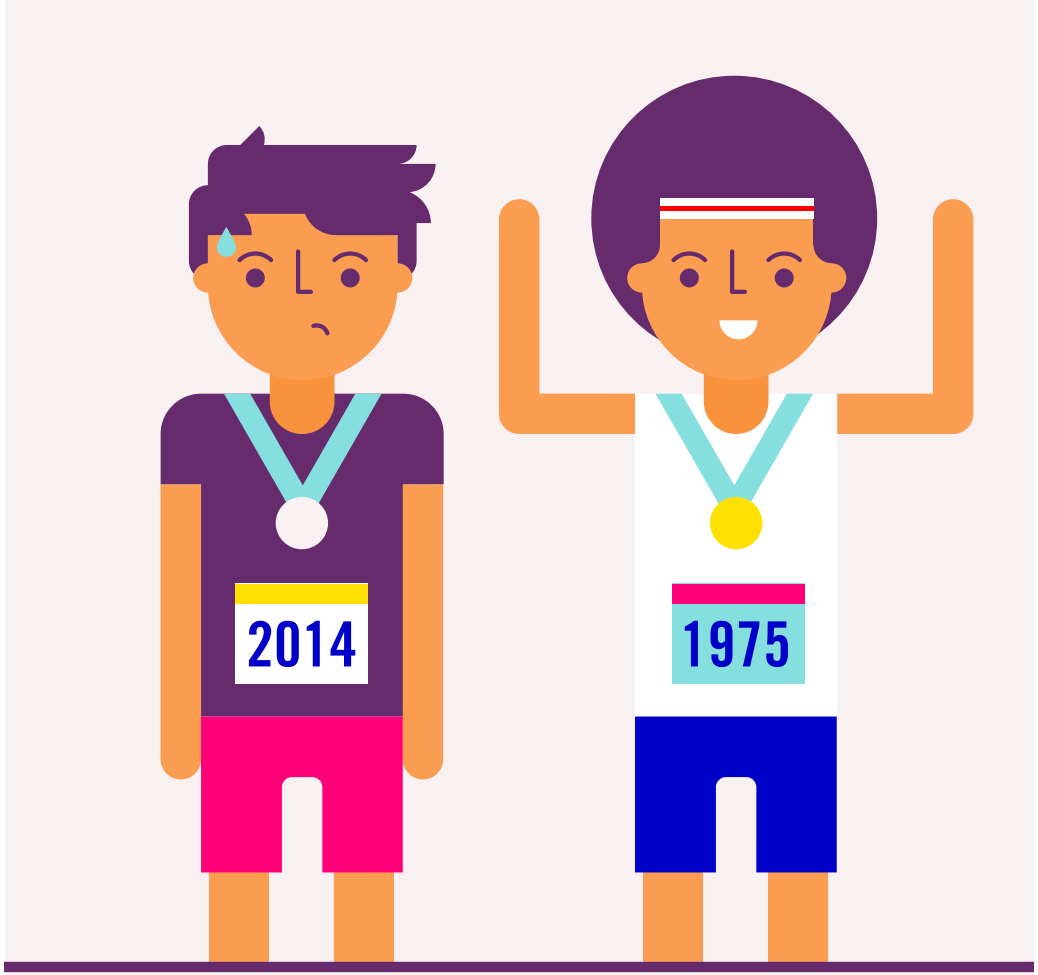
## Regular physical activity is vital for healthy growth and development and reduces the risk of developing many serious illnesses. It is also associated with better educational attainment.

The UK's Chief Medical Officer recommends that children and young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes every day and minimise the amount of time spent sitting.

55

There is a crucial window of opportunity between 4 and 7 years when children need to pick up the skills necessary to develop their physical abilities to their full potential. Teaching physical literacy can lead to sustained participation in sport and activity in life – but also helps a child develop their motor co-ordination and cognitive development. This is explained well in the following you tube clip: Start Young

We know today's children are the least active in history. They are 20% less active than in 1961 and data from 2010 shows that only 28% of boys and 15% of girls aged 11-15 years were meeting the Chief Medical Officers guidelines on activity. This has consequences for fitness – an important indicator of future health.




Today's children are about 15% less fit than their parents were. In a race over 1 mile, on average a child from 1975 would beat a child from today by 90 seconds!

## What works? — The Evidence

- A multi-faceted approach ensuring access to safe places to play, green spaces and environments that support active travel.
- Teaching physical literacy between the age of 4-7 years.
- Physical activity programmes in schools.

Being physically active isn't just about sport and competitive games. It is important to ensure that children and young people try lots of different things so that they can find something that suits them and they enjoy. At Little Spring Primary School, children were invited to participate in a cheerleading session.



# 2013/14 ACHIEVEMENTS

- Working with partners, developed a physical activity strategy and action plan for people of all ages in Buckinghamshire, to encourage more people to be more active more of the time!
- Commissioned a new approach to help teachers teach physical literacy in primary schools.

## Recommendations

- Roll out the physical literacy model of 'train and mentor' to 25 schools and evaluate outcomes
- Explore the use of technology in encouraging young people to be more physically active
- Continue to promote school active travel plans
- Work with communities to promote physical activity.

For more information see:
buckscc.gov.uk/healthy-living/physical-activity

# SMOKING

Nearly 90% of lifetime smoking is started between the ages of 10-20 years and about 40% before the age of 16. The earlier someone starts smoking the greater the likelihood that they will smoke more heavily in adult life, have higher levels of dependence and also be less likely to quit.

Smokers who start at a younger age are also more likely to develop illnesses such as lung cancer and heart disease. The decision to start smoking is most heavily influenced by parental smoking. Children who grow up in a household where one parent smokes are 70% more likely to start smoking than those who grow up in a smoke-free household.



According to national data, approximately 4% of children between the ages of 11 and 15 years are regular smokers. National data suggests that the proportion of young people who smoke has fallen for both girls and boys.

It is worth nothing that Shisha smoking - also called hookah, narghile, waterpipe or hubble bubble smoking, can be just as harmful as cigarette smoking, and is becoming increasingly popular among young people and adults across the UK. It is a way of smoking tobacco, sometimes mixed with molasses sugar or fruit, through a bowl and tube.

## Bucks Social Norms Survey

A survey of 13-14 year olds in six Buckinghamshire schools

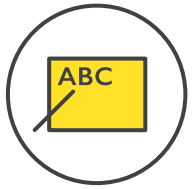
Students believe that only half of the students in their year never smoke. In fact the vast majority (93%) of the students questioned in the anonymous survey say they never smoke. This is better than the national average (86%).

The average number of days in a month respondents said they smoked cigarettes and shisha was 2 and 4 respectively.

**3/4**

Three quarters of students felt that smoking was never a good thing to do, whilst one quarter thought it was ok occasionally.

Visit www.RUDifferent.co.uk for more details on the project




# CLASSROOM SESSIONS

14-15 year old pupils were asked to share their views on smoking. Their thoughts and ideas are summarised below.

**What do students know about smoking?**

Young people correctly identified that smoking caused lung cancer, heart disease and oral cancer. Students did not identify the other health risks. The students were all instantly able to identify shisha and were well aware of this form of tobacco use. Young people felt that not smoking was 'common sense'

**What would help people to realise how important smoking prevention/cessation is?**

More frightening imagery of the harm caused

**What would encourage a person to seek support?**

Those who smoked were happy to talk about how they had tried to give up but did not identify any recognised form of support e.g. local stop smoking service or nicotine replacement therapy / Students knew and were enthusiastic about the CutFilms project (where students make short films to persuade their peers not to smoke).

## What works? — The Evidence

- Reducing the uptake of smoking is best achieved by influencing the adult world in which young people grow up so that young people do not see smoking as the norm
- Mass media interventions which use a range of methods to communicate key messages
- Point of sale interventions to deter illegal/underage tobacco sales.

# 2013/14 ACHIEVEMENTS

- Commissioned a Cut Films youth prevention project for a third year, which resulted in 52 short films being made by local young people on the harm caused by tobacco. A total of 46 participative workshops were held involving 537 young people as part of this project.
- A Smokefree Family Life project has been delivered across schools in Buckinghamshire that encourages young people not to start smoking and to support family members who smoke to quit.
- Enhanced our smoking cessation support in pregnancy to help mothers quit smoking during pregnancy and after the baby is born.
- A pilot smokefree parks project is being rolled out across five parks in Aylesbury in partnership with Aylesbury Vale District Council and incorporates a voluntary ban on smoking in play parks.
- Buckinghamshire County Council and all District Councils have signed up to the Local Government Declaration on Tobacco Control with support from both local CCGS. Buckinghamshire is the first county in the country to achieve sign up by all local authority organisations to this Local Government Association led commitment to tackle tobacco use.



**Cut Films Links**

Bucks Judges' Choice Winner
Maddies Choice (Chalfont's Community College)

Bucks Public Choice Winner
Every Puff Kills You (Holmer Green School)

Shortlisted: Aylesbury Youth Action – Ditch Smoking

# Recommendations

- Ensure youth prevention projects such as Cut Films and Smokefree Family Life continue to be commissioned as part of a broader tobacco control programme in Bucks. All youth prevention projects should include shisha use as well as cigarette smoking.
- Continue to support smokers to quit through a free smoking cessation service in order to reduce the number of children exposed to second-hand smoke and smoking imagery/role models.

*Smoke free park*

# SEXUAL *Health*

According to the World Health Organisation sexual health requires a positive and respectful approach to sexuality and sexual relationships, so that people can have safe sexual experiences, free of coercion, discrimination and violence.

The teenage years are particularly important for sexual health as this is when many young people start to explore their sexuality with the average age of first intercourse being 16 years (amongst people aged 16 to 24 at interview). Overall, the rate of all sexually transmitted infections in Buckinghamshire is 30% lower than the national average.

England has the highest teenage conception rate in Western Europe. Available evidence shows that teenage pregnancy adversely affects the mother's health and the children born to teenage mothers are more likely to experience a range of poorer outcomes later in life.

In Buckinghamshire, teenage pregnancy rates have been consistently low compared with most other areas in England. The teenage conception rate in Buckinghamshire is lower than the England average. Under 18 conception rates fell by 30% in 2012 and Buckinghamshire has the 8th lowest under 18 conception rate nationally. It is also important that we protect our children from sexual exploitation, as this is a major child protection issue across the UK.



## Bucks Social Norms Survey

A survey of 13-14 year olds in six Buckinghamshire schools

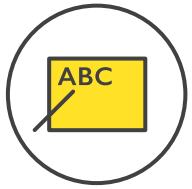
8% reported that they have had sex.

**67%** of the year 9 pupils surveyed did not know where their nearest sexual health clinic was.

The perception is that 12% of boys and 11% of girls had sex whilst under the influence of alcohol; the actual reported figure in this survey was just 2%

**32%** thought that parents and carers should be the main source of information on sex and relationships closely followed by nurses/health professionals **(30%).**

Visit www.RUDifferent.co.uk for more details on the project




# CLASSROOM SESSIONS

14-15 year old pupils were asked to share their views on sexual health. Their thoughts and ideas are summarised below.



## What is sexual health?

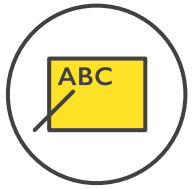
Sexually transmitted infections / sexual health check- ups / pregnancy / contraception (such as condoms, pills, the implant, injections and coils) / abortion.

## What influences young people's behaviours and views on sexual health?

Media – negatively through pressure to conform, positively through condom adverts in magazines for example / Alcohol – may affect decision making / Friends – positive and negative influence / Access to porn / Education – positive influence particularly in relation to the sex and relationship sessions delivered by school nurses in schools.

## What can young people do to keep themselves safe?

Use protection (e.g. condoms) / Make sure that young people are well informed and have all the information they need / Ensure that young people get to know their partners first and feel comfortable with them before having a sexual relationship.




# CLASSROOM SESSIONS

What might encourage a person to seek support?

Parents / Friends / Television / The Internet / Magazines.

Where would young people go to find out more information/get support about sexual health?

Sexual health clinic
Doctors
NHS Direct
Bucks Sexual health website
Pharmacies (for contraception)
Parents.

What might prevent a person from seeking support?

Embarrassment can get in the way of seeking support.

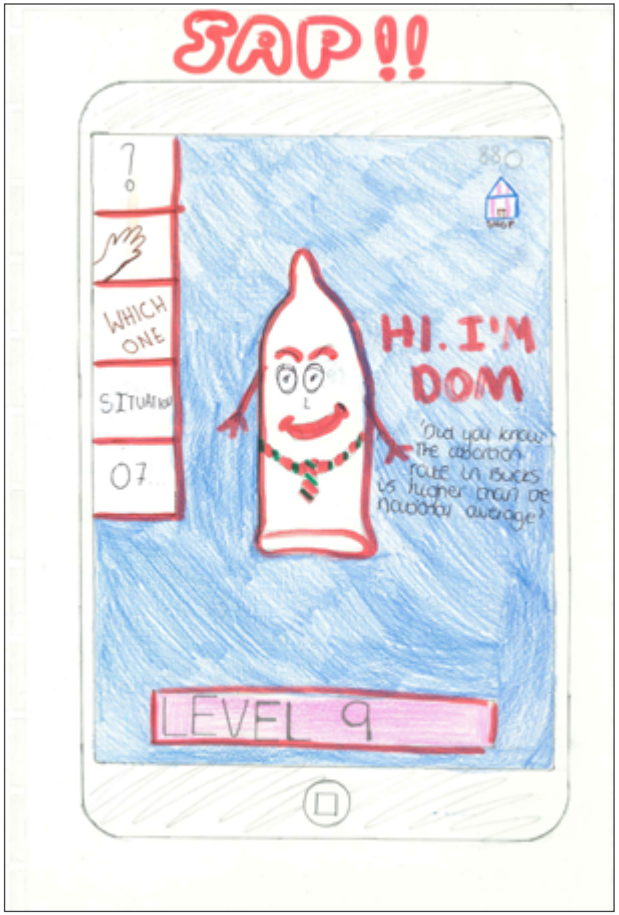
How can we encourage people to look after their sexual health?

Give young people information so that they can make informed decisions. The Internet may be the best place to access such information.

# What works? — The Evidence

- Accurate, high-quality and timely information that helps people to make informed decisions about relationships, sex and sexual health
- Preventative interventions that build personal resilience and self-esteem and promote healthy choices;
- Easy and rapid access to confidential, high quality sexual health services.






An initial sketch for "Dom the Condom", a central character for an educational Sexual Health App designed by students at Chiltern Hills Academy. This app is now in the process of being worked up by a design company with the aim of engaging young people in important sexual health messages through fun online games and quizzes.

# 2013/14 ACHIEVEMENTS

- Pilot project offering one to one support for young people at risk of poor sexual health which is already showing positive results.
- Basic and specialist sexual health training offered to a wide range of professionals including school staff, children's home staff and youth offending service staff.
- Work tackling child sexual exploitation has included a theatre in education production in secondary schools, Spotting the Signs training for sexual health staff and review of safeguarding policies.
- The Bucks Sexual Health website has been further developed and a magazine-style Facebook quiz launched to engage young people whilst delivering key sexual health messages (see links 1 & 2 below).
- Continued to implement and improve the Chlamydia screening programme, C-card programme (offering free condoms to under 25s), Emergency Hormonal Contraception in pharmacies (free to under 19s) and specialist young people's sexual health clinics.
- A project providing young people the opportunity to prioritise what they wanted and needed from sexual health services in Bucks based on the principles of the board game monopoly (see link 3 below).

# Recommendations

- Develop sex and relationship education resources for young people's settings as part of a wider Personal Social Health and Economic (PSHE) education programme, including information about consent and healthy relationships
- Work with young people to increase awareness of how to find local sexual health information and services and continue to promote the Bucks Sexual Health website (see link 1 below) and to explore the use of social media to communicate with young people.
- Roll out specialist training to professionals, especially those working with vulnerable young people (with an initial focus on professionals working with young people with learning difficulties and/or disabilities) to enable them to work effectively with young people around relationships and sexual health.
- Work with pupils at Chiltern Hills Academy to develop their sexual health app, the Sex App.

1. For more info: www.sexualhealthbucks.nhs.uk/
2. Pulling play list: pullingplaylist.com
3. Young People of Bucks: www.youtube.com/watch?v=qiPfyItRpKU&feature=youtu.be://

# Summary and Overarching Recommendations

This report demonstrates that the health and wellbeing of children and young people in Buckinghamshire is generally better than the national average. However it is equally clear that more needs to be done in Buckinghamshire to ensure that every child has the best possible start in life and achieves their full potential.



The wide range of influences on young people's health highlights the need to work with young people and their families, schools, communities, the NHS and local government to ensure the best outcomes for young people.

Each chapter in the report makes specific recommendations related to that topic. Taking into account the health profile, the evidence and these specific recommendations I have highlighted some overarching recommendations for all partners in Buckinghamshire who have an influence on the health and wellbeing of young people.

Buckinghamshire health profiles:
http://www.buckscc.gov.uk/public-health

1. Partners should continue to work together to ensure that more women are in good physical and mental health during and after pregnancy.
2. Continue to invest in evidence based interventions in the early years that support families and support children to develop well and reach their full potential.
3. Continue to invest in evidence based interventions that promote emotional wellbeing and resilience in children and young people. This is vital as it supports them to achieve what they want from life and cope with adversity. It reduces the adoption of health damaging behaviours and supports the adoption of health promoting behaviours.
4. Continue to use the views, ideas and enthusiasm of young people to shape strategies and projects to improve their health and wellbeing and the services they receive.
5. Increase young people's awareness of the services and support available to them and use their advice to inform how best to communicate this information.
6. All partners should work closely together to improve outcomes and services for children and young people at risk of poorer health and wellbeing such as young carers, looked after children, those living in more disadvantaged areas and those with chronic illness or disability.
7. Ensure the health promoting potential of schools is as fully realised as possible.
8. Improve the data and information available on the health of mothers, babies, children and young people to guide our strategies and monitor progress.

# Acknowledgements:


- Students and staff at Chiltern Hills Academy.
- Special thanks to teachers Anthony Griffiths and Heather Wood at Chiltern Hills Academy.
- Pupils and staff at Little Spring Primary School.
- Pinewood Studios, with special thanks to Ann Runeckles, for sitting on judging panel and supporting students in the development of their awareness raising mental health film.
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- Raw Design Studio – for the design of the report but also Rob Watson for sitting on the judging panel.
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- Andrea Young (Dietician) for helping with the initial healthy eating PSHE session at Chiltern Hills Academy, and delivering a healthy eating workshop at Little Spring Primary School.





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BUCKINGHAMSHIRE · COUNTY COUNCIL

# THE HEALTH OF CHILDREN AND YOUNG PEOPLE

## DATA SUPPLEMENT AND OVERVIEW

## DIRECTOR OF PUBLIC HEALTH'S ANNUAL REPORT

## 2014

**Buckinghamshire Public Health©**

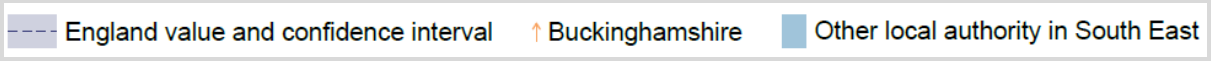
## PREFACE

This section is a supplement to the Director of Public Health's Annual Report 2014 on the health of children and young people, and should be read in conjunction with the main report. It provides a brief overview and additional analysis of outcomes related to maternal, children and young people's health.

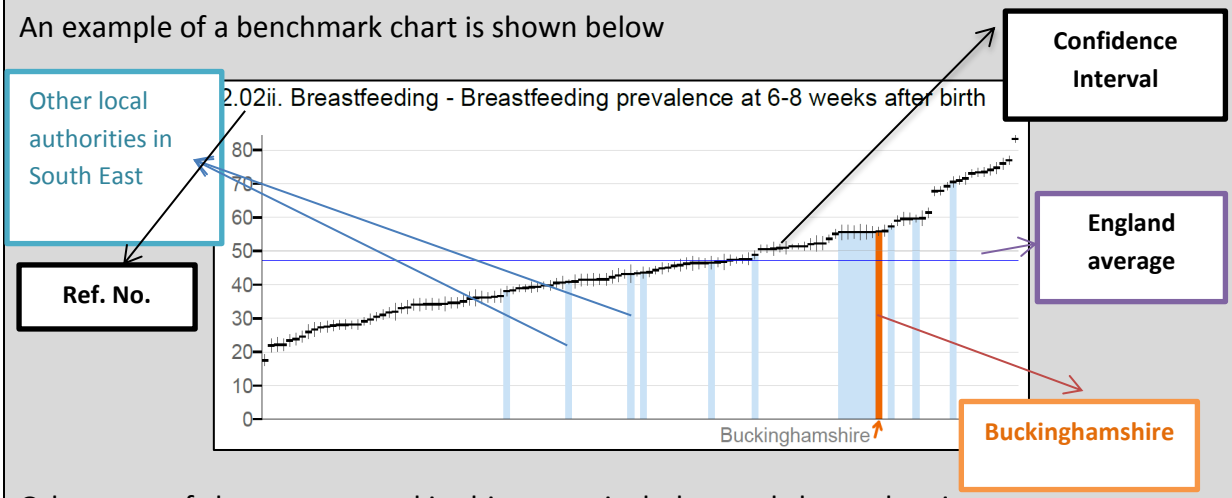
### Notes

Each indicator in this report is presented using different types of chart to show performance on the intended outcome. Definitions of public health outcome indicators are available at www.phoutcomes.info

The comparison charts for many indicators are obtained from the Public Health Outcomes Framework (PHOF) and benchmark Buckinghamshire's performance against local authorities and highlights other Local Authorities in the South East of England. Charts obtained from the PHOF summary profile for Buckinghamshire, display the reference number of the PHOF indicator which can used for reference only when accessing www.phoutcomes.info. The key used in these charts is shown below.




An example of a benchmark chart is shown below




Other type of charts presented in this report include trend charts showing rates or percentages for past few years by deprivation quintile (where possible) to understand the outcome over the years in context of deprivation levels in the population and compared with Buckinghamshire and England average. DQ1 means Deprivation Quintile 1 which is the least deprived. DQ5 means Deprivation Quintile 5, which is most deprived. Some benchmark charts compare CCG performance for certain indicators like flu vaccination uptake. Information in the report is also drawn from locally published reports as well as sources such as health needs assessments, literature review and profiles.

# Key Statistics on the Health of Children and Young People in Buckinghamshire

## DEMOGRAPHY

There are 126,500 children and young people aged 0-19 years living in Buckinghamshire (Census 2011), which is approximately a quarter of the total resident population. Around 1 in 4 (25.9%) school children aged 5-16 years are from Black and Minority Ethnic (BME) groups.

## WIDER DETERMINANTS OF HEALTH

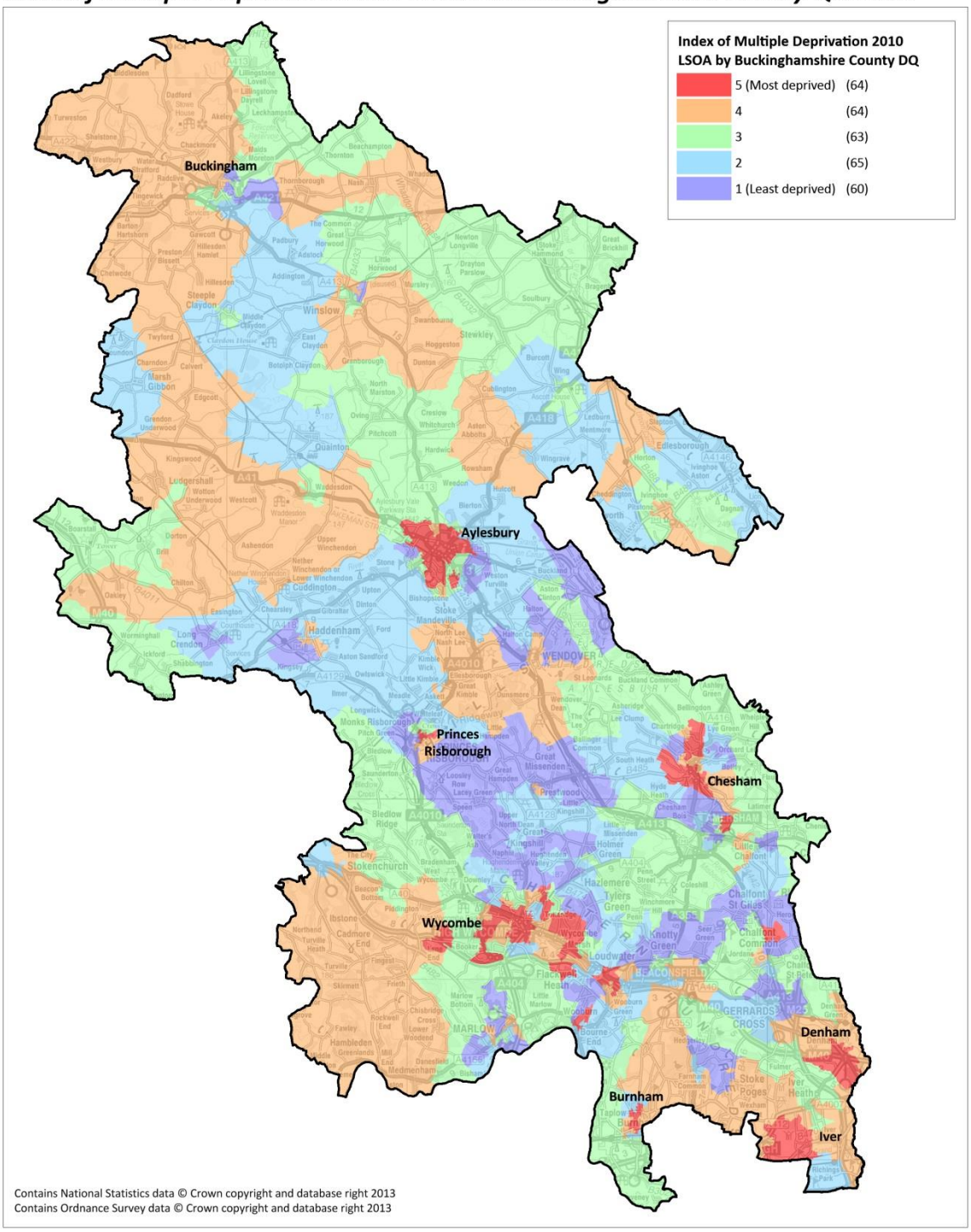
One in ten (10.5%) children under 16 years of age are living in poverty (2011), which is almost half the England average of 20.6% (2011) [Fig 7]. Buckinghamshire ranks the 6$^{th}$ best (i.e. lowest proportion of children living in poverty) local authority out of 150 upper tier local authorities on this indicator. Growing up in poverty increases the risks of poor health and educational outcomes in childhood and later life.

5.3% (2011) of households in Buckinghamshire are households of lone parents with dependent children, which was lower than the England average of 7.1% and the South East average of 6.1% during the same period. Although many children growing up in lone parent families can thrive they are at increased risk of developing social and emotional problems.

Throughout this report we analyse the health status of children and young people in geographical areas in Buckinghamshire. The population is divided into fifths known as quintiles based on the deprivation score of the area in which they live according to a nationally derived measure called the Index of Multiple Deprivation. The most deprived areas make up Quintile 5 and the least deprived Quintile 1. The location of these areas and populations is shown in the map (page 4).

# Deprivation Map of Buckinghamshire

***Index of Multiple Deprivation 2010 based on Buckinghamshire County Quintiles***




The map highlights areas of deprivation as classified by Index of Multiple deprivation (IMD) 2010. Further information is available via this link: https://www.gov.uk/government/publications/english-indices-of-deprivation-2010

## MATERNAL AND CHILD HEALTH

### Maternal Health

There were 6,197 live births in Buckinghamshire in 2012 compared to 6,133 in 2011 and 6,103 in 2010 (HSCIC, 2014). The health and health behaviours of the mother have a vital role on the child's development before birth and its health in childhood and as an adult. Good quality care throughout pregnancy and childbirth has a direct impact on the health and life chances of the child. All factors affecting a mother's health such as stress, diet, drug use, alcohol use and smoking have a significant impact on the development of the baby both before and after birth.

Almost two-thirds (63.4%) of Buckinghamshire mothers who gave birth in the last three years (2010/11-2012/13) were white British, followed by 12.8% were Asian (8% Pakistani; 2.7% Indian); 8.1% any other white including Irish; 2.1% Black and 5.7% were other & mixed ethnic groups (10% unknown). Thirty percent of all Buckinghamshire births were to mothers who live in the most deprived quintile (DQ5). In 2012/13, 27.3% of births were to mothers aged 35 years and over in Buckinghamshire which was higher than the England average of 19.4% (SUS, HSCIC, 2014). In Chiltern and South Bucks District Council, around one in three mothers were aged 35 or over, compared to one in four in Wycombe and Vale of Aylesbury districts (2012). Almost 1 in 7 pregnant women were obese (BMI>30) in 2012/13, which has implications for the health of the mother and baby.

In 2013/14 approximately 0.3% of pregnant women had pre-existing diabetes and 3.1% developed diabetes during pregnancy in Buckinghamshire. Type 2 diabetes is up to six times more common in people of South Asian descent and the prevalence of self-reported, doctor-diagnosed diabetes in England is 5.9% and 8.6% among Indian and Pakistani women respectively. Diabetes is also three times more common among women in the most deprived quintile (DQ5) compared to the least. Mothers with diabetes (type 1 and type 2) may have a higher risk of having a large baby, which increases the risk of a difficult birth, induced labour or a caesarean section or a miscarriage. Babies born to mothers with diabetes are at increased risk of serious health problems around the time of birth and poorer health in later life. The best way to reduce the risk to mother and the baby is good

control of diabetes and all other associated risk factors such as excess weight, before and during pregnancy.

Immunisation against flu is very important for pregnant women because they have a higher chance of developing complications if they get flu, particularly in the later stages of pregnancy. Flu in pregnant women could lead to premature birth (born before 37 weeks of gestation), low birth weight (birth weight less than 2500gms), and may even lead to stillbirth or death in the first week of life. Only 39.5% of pregnant women in Chiltern CCG and 43.1% of pregnant women in Aylesbury CCG in Buckinghamshire received the seasonal flu vaccine in 2013/14.

**Teenage Conceptions**

Despite falling rates England still has the highest teenage conception rate in Western Europe. Teenage pregnancy can adversely affect both the physical and mental health of mother and the health of the baby. Children born to teenage mothers are also more likely to experience a range of poorer outcomes later in life.

In Buckinghamshire, teenage pregnancy rates have been consistently lower than most other areas in England and have continued to fall [Fig 30]. In 2012, the teenage conception rate in Buckinghamshire was 17.3 per 1000 girls aged 15-17 years which was 38% lower than the England average of 27.7. The under 16 conception rate in Buckinghamshire was 3.5 per 1000 girls aged 13-15 years which was also 38% lower than the England average (5.6) during the same period [Fig 32]. In 2012, Buckinghamshire had the 8$^{th}$ and the 17$^{th}$ lowest rate nationally out of 150 local authorities for under 18 and under 16 conception respectively. In Buckinghamshire, under 18 conception rates fell by 30% between 1998 and 2012 in line with national trends. The under 16 conception fell by 13% between 2009 and 2012.

**Perinatal Mental Health**

Mental health problems are common following childbirth and can affect the woman, the baby, and family relationships without appropriate early intervention. Around one in 10 mothers may suffer from postnatal depression (mild or minor depressive illness), 1 in 20 (3-5%) from moderate-to-severe depressive illness and 2 in 1000 from more severe mental

health problems. Women with obsessive compulsive disorders, social anxiety and panic disorder are at risk of relapse in the postnatal period. Local estimates are that approximately 620 mothers may suffer from postnatal depression, 250 suffer from moderate-to-severe depressive illness and 12 will suffer from severe mental health problem known as puerperal psychosis every year.

**Smoking in Pregnancy**

Smoking during pregnancy is one of the preventable causes of ill health for the mother and the baby. Babies of mothers who smoked during pregnancy are more likely to be born prematurely; twice as likely to have a low birth weight, up to three times as likely to die from sudden unexpected death in infancy and have around 40% increased chance of dying before their 1st birthday. In Buckinghamshire, approximately 1 in 10 pregnant women smoked at the time of booking and 7.9% smoked at the time of delivery (2012/13). This was lower than the national average of 12.7% still smoking at the time of delivery in 2012/13. However, self-reported smoking in pregnancy is often under-reported and poorly recorded. Recent initiatives in Buckinghamshire to improve data collection should help our understanding of smoking in pregnancy locally, and to develop any specific targeted interventions.

**Breast Feeding**

Breastfeeding has a number of health benefits for both mother and the baby such as the reduction of the risk of infections in babies and the risk of breast cancer in the mother. In 2012/13, 55.9% of babies in Buckinghamshire continued to be breastfed at 6-8 weeks of age, which was higher than the England average of 47.2% [Fig 6]. Local data quality issues have made it difficult to get accurate breast feeding initiation figures for the last few years. However, preliminary quarterly data for 2013/14 indicates that the breast feeding initiation rate is around 80%.

**Low Birth Weight and Prematurity**

Poor maternal health may result in babies born at term (after 37 weeks of pregnancy) with low birth weight (less than 2.5kg), which in turn may increase the risk of death to the baby in the first year of life. Low birth weight is also associated with poorer intellectual

development, poorer educational achievement across all social classes, and is linked to an increased risk of health problems in middle age.

The percentage of term (after 37 weeks of pregnancy) babies born with low birth weight in Buckinghamshire was 2.7% in 2011 [Fig 4]. This was similar to the national average of 2.8% (2011), but 69% higher than the nationally best performing local authority (1.6%).

The percentage of low birth weight (LBW) among all babies (including preterm-babies born less than 37 weeks of pregnancy) was 7.3% in 2013, and has not changed significantly since 2001 (7.1%) [Fig 5]. Since 2001 the national figure has fallen from 7.9% to 7.3% (2012). The national data for 2013 is not available for comparison at time of publication. In 2013, the percentage of LBW babies was 44% higher among babies in the most deprived quintile (i.e. 9.1% of live births) compared to least deprived (i.e. 6.3% of live births) in Buckinghamshire. [Fig 5]

In 2012/13, the live born non multiple deliveries born prematurely (24-36 weeks) was 6.3% (24-32wks: 1%; 32-36weeks: 5.3%) in Buckinghamshire, which was similar to the England average of 6.1%. However, this percentage of premature babies was higher among teenage mothers (8.9%), Asian mothers (10.5%); women living in the most deprived areas (DQ5: 7.1%) and among current smokers (9.9%) compared to Buckinghamshire as whole.

**Deaths Under 1 Year of Age**

Infant mortality rates have fluctuated over the last decade in Buckinghamshire. The three year average infant mortality rate (IMR) in Buckinghamshire was 3.9 infant deaths per 1,000 live births (2010-12), [Fig 8] which was slightly lower than the national average of 4.1 per 1000 live births. This rate has fallen slightly from 4.2 per 1000 live births in 2001-03. Nationally, the local authority with the lowest infant mortality has a rate of 1.09 deaths per 1000 live births in 2010-12. Across the district councils within Buckinghamshire, the infant mortality rate ranges from 4.7 per 1000 live births in Aylesbury Vale, 3.9 in Wycombe, 3.5 in Chiltern to 1.8 South Bucks. Infant mortality rates were 3.7 times higher among infants in the most deprived quintile (6.3 / 1000) compared to the least deprived quintiles (1.7 / 1000) within Buckinghamshire (2010-12) [Fig 9].

**Childhood Immunisation**

In 2012/13, 96.6% of eligible children received all three doses of five-in-one vaccine (DTAP/IPV/HiB) by their first birthday [Fig 14]. This is a single vaccine that protects children against five separate diseases (diphtheria, tetanus, whooping cough, polio and Haemophilus Influenza type b). During the same period, 95.2% of eligible children received one dose of Measles, Mumps, and Rubella (MMR) vaccine before their 2nd birthday and 91.9% of eligible children received two doses of MMR vaccine before their 5th birthday. All the above figures in Buckinghamshire were much better than the England average (94.7% DTAP/IPV/HiB vaccine; 92.3% MMR one dose and 87.7% MMR 2 doses) during the same period. The small number of children, who were born to Hepatitis B positive mothers, should receive a full course of hepatitis B vaccine. In 2012/13, 90.1% of eligible one year old children received all doses of hepatitis B vaccine [Fig 11], but only 51.2 % of eligible two year old children received all doses of hepatitis B vaccine [Fig 12]. There is no comparable national data for hepatitis B vaccine uptake at this moment.

## THE SCHOOL YEARS

**School Readiness**

The percentage of children reaching a good level of development at the end of reception year was 54.9%, which was better than the national average of 51.7% (2012/13) [Fig 15]. Nationally, Buckinghamshire ranked 45th best performer (out of 150). However, this was much lower than the nationally best performing local authority, which has 69% of their children reaching a good level of development.

Among children eligible for free school meals, only 31.8% achieve a good level of development at the end of reception year in Buckinghamshire [Fig 17]. This was lower than the national average of 36.2% and much lower than the rate in the best performing Local Authority of 60% during the same period. Buckinghamshire ranks 101st nationally out of 150 local authorities for this measure, where 1 is the best performing area.

Within Buckinghamshire, only 41% of children from the most deprived Q5 areas reach a good level of development at the end of reception compared to 68.5% in the least deprived quintile [Fig 16].

**Childhood Obesity**

Obese children are at an increased risk of developing various health problems, and are also more likely to become obese adults. Obesity has been rising among children in England over the past 20 years. In Buckinghamshire, almost one in five (19.1%) children aged 4-5 years [Fig 24] and more than a quarter (28.2%) of 10-11 year olds children were recorded as either overweight or obese in 2012/13 [Fig 26]. This was lower than the England average of 22.2% in 4-5 year olds and 33.3% in 10-11 year olds during the same period. A higher proportion of children from the most deprived areas are overweight or obese (Reception: 20.7%; Year6: 32.9 %) compared to the above Buckinghamshire average figures. Childhood Obesity (including overweight) levels appear to have increased by 18% (from 16.2% to 19.1%) in Reception year and by 3% (from 27.3% to 28.2%) in Year 6 in Buckinghamshire between 2006/07 and 2012/13.

**Children and Young People's Mental Health**

The British Child and Adolescent Mental Health Survey found that 1 in 10 of children under the age of 16 had a diagnosable mental disorder. Among the 5 to 10 year olds, 5-10% (10% of boys; 5% of girls) had a mental health problem while among the 11 to 16 year olds the prevalence was 10-13% (13% for boys; 10% for girls). The most common problems are conduct disorders, attention deficit hyperactivity disorder (ADHD), emotional disorders (anxiety and depression) and autism spectrum disorders. Mental health problems in children and young people cause distress and have wide-ranging ill effects such as impacts on educational attainment, social relationships, life chances and health. Half of mental illness in adult life (excluding dementia) is known to have started before age 15 years and three quarters by age 18.

There are strong links between mental health problems in children and social disadvantage. Children and young people living in the poorest households are three times more likely to have a mental health problem than those growing up in better-off homes. Parental mental

illness is associated with increased rates of mental health problems in children and young people. It was estimated that one-third to two-thirds of children and young people whose parents have a mental health problem experience difficulties themselves.

**Educational Attainment**

In 2012/13, 71% of children in Buckinghamshire achieved at least 5(A*-C) GCSEs compared to 60.8% nationally [Fig 18]. Buckinghamshire ranks 7$^{th}$ best nationally out of 151 local authorities for this measure. The best local authority achieved 80% during the same period. The proportion of children achieving 5 (A*-C) GCSEs in Buckinghamshire was 83.0% among the children in least deprived quintile (DQ1) compared to 51.7% for the children in the most deprived quintile (DQ5) [Fig 19].

Among pupils with known eligibility for free school meals, 34.3% achieved at least 5(A*-C) grades compared to 38.1% for similar pupils in England. Achievement of at least 5(A*-C) grades was highest among Chinese students in Buckinghamshire (92.7%) followed by White (72.2%); Mixed ethnic background (64.2%), Asians (68.2%) and Black (62.3%) background.

In 2012, there were fewer (4.1%) 16-18 year olds not in education, employment or training (NEET) in Buckinghamshire than the national average of 5.8%. The proportion of NEET in the best performing local authority in England was 2% during the same period.

**Looked After Children (LAC)**

In March 2013, there were 400 children and young people in care in Buckinghamshire. The proportion of Looked After Children in Buckinghamshire was 34 per 10,000 under 18, which was 43% lower than the national average of 60 per 10,000 under 18 years in 2013. The rate for the authority in England with lowest proportion of Looked After Children was 20 / 10,000 children under 18 (2013). The proportion of children taken in to care increased steeply in Buckinghamshire by 30.8% (from 26 to 34/10,000) between 2008-13 compared to 11.1% rise (54 to 60 /10,000) in England [Fig 23]. Buckinghamshire has a higher proportion of children and young people placed in care outside the county (over 50%). This is mainly due to the lack of in-county foster placements. This was higher than the England average of 35% and the South East region of 28%.

Children and young people are taken into care for a range of reasons. In 2011-12, 44% of children were taken in to care because of 'abuse or neglect', which was lower than the England average of 56%. This was followed by 'family dysfunction' (38%), which was higher than England's average of 18% during the same period. The other reasons for children and young people taken into care were absent parenting (5%), child disability (4%) socially unacceptable behaviour (4%) and others (5% due to family illness / disability, family in acute stress, low income etc.). These factors were similar to England average (2011/12).

Of the Looked After Children in Buckinghamshire who were eligible to sit GCSE examinations, only 4% achieved at least 5 A*-C grades (including English and Maths) in 2013. The comparable figure for looked after children in England was 15.3% during the same period.[1]

Looked after children tend to have poorer health outcomes than their peers, in particular, they have four-five times higher rates of mental health disorders than those in private households[2]. The Strengths and Difficulties Questionnaire (SDQ) was completed for all children aged between 4 – 16 years, who have been in care for more than a year. In Buckinghamshire, the average score for all eligible looked after children were within the normal limits (12.93) compared to England average of 14.8 in 2012/13 (Normal score range: 0-13). Even though majority of looked after children in Buckinghamshire scored in the "normal" range, one in four (26%) had a score of 18 or above (SDQ), which is considered to indicate significant behavioural problems. National research identified that children and young people in care are also at increased risk of sexual abuse and exploitation compared to their peers.[3],[4]

In 2012, 76.9% of looked after children in Buckinghamshire had a Special Education Needs statement, which was higher than the England average of 71.5%. In Buckinghamshire,

[1] http://www.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/buckinghamshire/051_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf
[2] Meltzer, H., 2003. *The mental health of young people looked after by local authorities in England,* London: Office for National Statistics.
[3] Dillane, J. Hill, M. and Munro, C. (2005) *A Study of Sexual Exploitation of Looked After and Accommodated Young People* Barnardo's www.barnardos.org.*uk/se1-3.pdf*
*4 Jago, S. and Pearce, J. (2008) Gathering Evidence of the Sexual Exploitation of Children and Young People: A Scoping Exercise University of Bedfordshire. www.beds.ac.uk/__data/assets/pdf_file/0018/40824/Gathering_evidence_final_report_June_08.pdf*

15.7% of all school children had Special Education Needs statement, which was lower than the England average of 19.8% during the same period.

Every looked after child should have an initial medical assessment by a doctor within 4 weeks of receiving a request from a social worker. Our local health needs assessment identified that these were often delayed. Children under 5 years should have 6 monthly health assessments and over 5 years should have annual health assessments up to the age of 18. In Buckinghamshire, 90% of looked after children (who had been in care for 12 months continuously) had received a health assessment, which was higher than the England average of 83% (2012/13). The percentage of looked after children receiving Health assessments who are placed out of the county was lower for both initial health assessments (88%) and repeat health checks (80%) than the Buckinghamshire average of 90% during the same period.

Overall, 91% of looked after children, at the end of 2012-13 (who had been in care for 12 months continuously) were up to date with their immunisation which is below the national target of 95%. In Buckinghamshire, 80% of all looked after children have seen a dentist in the last 12 months, which was less than the national average of 82% (2013).

Children and young people from all backgrounds are taken in to care. However, evidence shows that certain risk factors are associated an increased risk of entering in to care. These include children from families living in more deprived circumstances, single parents or young parents, parents with mental illness or alcohol misuse[5].

**Sexually Transmitted Infections (STI)**

Sexually Transmitted Infections are infections that are spread primarily through sexual contact and are among the most important causes of illness due to infectious disease across all age groups, but in particular among young people. If not identified and treated early, STIs can lead to serious consequences such as infertility, ectopic pregnancy, cervical cancer and early death.

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[5] Simkiss DE, Stallard N, Thorogood. A systematic literature review of the risk factors associated with children entering public care. Child: Care, Health and Development. Vol 39, Iss 5, 628–642, Sep 2013

The rate of all acute sexually transmitted infections (including chlamydia) in Buckinghamshire was 23.9 per 1000 population aged 15 -24 (2012) compared to 34.4 in England [Fig 33]. This was 30% lower than the national average (34.4/1000) but 70% higher than the authority with the lowest rate (14.1 / 1000) nationally.

In the last decade, the number of people known to be living with HIV in Buckinghamshire has tripled from 119 (2002) to 361 (2012). The highest numbers are in Wycombe district (146 in 2011), followed by the Aylesbury district (136) South Bucks (40) and Chiltern (39). Almost half (49.2%) of them were diagnosed at the late stage of HIV infection (CD4 cell count <350mm$^3$) in Buckinghamshire (2010-12), which was similar to the England average of 48.3%. Among the people with HIV diagnosis, 66% were men, 39% were 45 years and older, 38% were aged 35-44 years, 18% were 25-34 years and 5% were less than 25 years old.

In 2012/13, 88.4% of girls aged 12-13 attending any school in Buckinghamshire received all three doses of HPV vaccine to help protect them from developing cervical cancer. This was slightly higher than the national average (86.1%) during the same period.

## HOSPITAL ADMISSIONS

### Accident & Emergency Attendances

The rate of accident and emergency attendances in children under five years of age in Buckinghamshire was 383.5 per 1000 children aged 0-4 years in 2011/12 [Fig 36], which was significantly lower than the England average of 510.8 per 1000 children aged 0-4 years. However, this was comparable to the South East average rate of 388.4 per 1000 children aged 0-4 years during the same period.

### Emergency Hospital Admissions

The emergency admission rate for children aged under 5 years increased significantly by 37% from 6164.6 per 100,000 population in 2003/04 to 8416.4 per 100,000 in 2012/13 [Fig 38]. Emergency admission rates among those under 19 years of age have also increased by 21% from 3314.9 (2003/04) to 4024.7 (2012/13) during the same period [Fig 54]. In

2012/13, the emergency admission rate, under 5 years among children in the most deprived areas (DQ5) was significantly higher by 23.4% than in children living in the least deprived areas (DQ1) [Fig 37,38]. Emergency admission rates were 36% higher among under 19 year olds living in most deprived quintile compared to the least deprived quintile during the same period [Fig 53, 54].

**Injuries**

In 2012/13, there were 870 hospital admissions due to unintentional/deliberate injuries among 0-14 years with a rate of 90 /10,000 resident population (Fig: 41). During the same period, there were 529 hospital admissions due to unintentional/deliberate injuries among 15-24 years with a rate of 98.6 /10,000 [Fig 42, Fig 43]. This was lower than the national average during the same period for both age groups (0-14 years: 103.8; 15-24 years: 130.7). In 2012/13, the rate of hospital admissions due to unintentional /deliberate injuries was higher in the most deprived (DQ5) areas among both age groups ( 0-14 years: 103, 15-24 years: 91) compared to the least deprived (DQ1) areas ( 0-14 years: 86.6, 15-24 years: 86.9) in Buckinghamshire [Fig 41, Fig 43].

**Alcohol**

There were 80 hospital admissions due to alcohol specific conditions among young people aged under 18 with a rate of 22.5/100,000 in 2010-13 [Fig 44]. This was significantly lower by 47% than the national average of 42.7/100,000 and has dropped in the last 10 years by 35%. Admission rates were similar among young people living in the most deprived areas (DQ5) (26.1 /100,000 population) and in the least deprived areas (DQ1: 24.4/100,000 population) [Fig 45].

**Substance Misuse**

There were 50 admissions over a 3 year period (2010/11 to 12/13) for substance misuse, with a rate of 30.8 per 100,000 population aged 15-24 [Fig 47]. This was 59% lower than the national average of 75.2 per 100,000 population aged 15-24. This admission rate was higher in the most deprived areas (40.3 per 100,000) compared to the least deprived areas (5.2 per 100,000) during the same period [Fig 48].

**Self-harm**

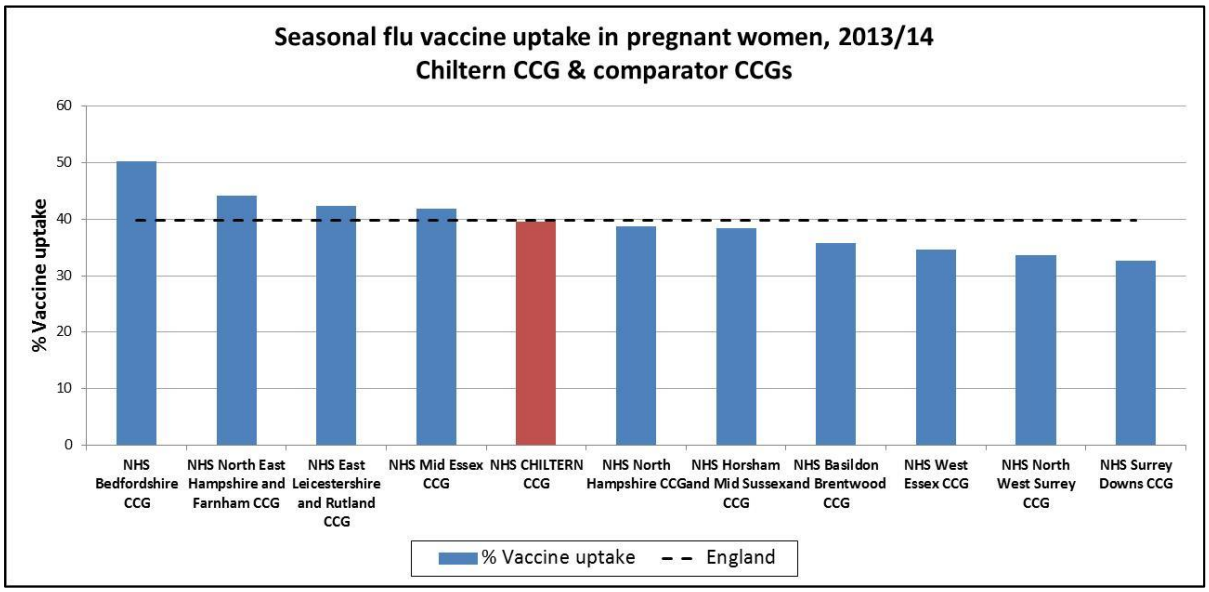
In the last 3 years (2010/11 – 12/13), there were 477 hospital admissions among young people aged 10-24 related to self-harm with a rate of 179.8 per 100,000 population [Fig 49]. This was 49% lower than the national average (352.3/100,000) which is statistically significant. This has fallen slightly over the last 3 years (from 193.2 in 2007/08- 2009/10) in Buckinghamshire, while the trend was increasing nationally (from 329.5 in 2007/08- 09/10). The rate of hospital admissions as a result of self-harm among 10-24 years was 41% higher in the most deprived areas (DQ5: 232/100,000) compared to the least deprived (DQ1: 137/100,000) over the last three year period (2010/11 – 12/13) [Fig 50], which was statistically significant.

**Asthma**

There were 170 asthma related admissions in 2012/13 with a rate of 137.8 per 100,000 population aged under 19 [Fig 51]. This was 38% lower than the national rate of 221.4, which was statistically significant and has fallen by 24% in the last 10 years. The rate of asthma related hospital admissions among children and young people in the most deprived areas (241/100,000) was more than twice as high than that in the least deprived areas(102/100,000) in 2012/13 [Fig 52].

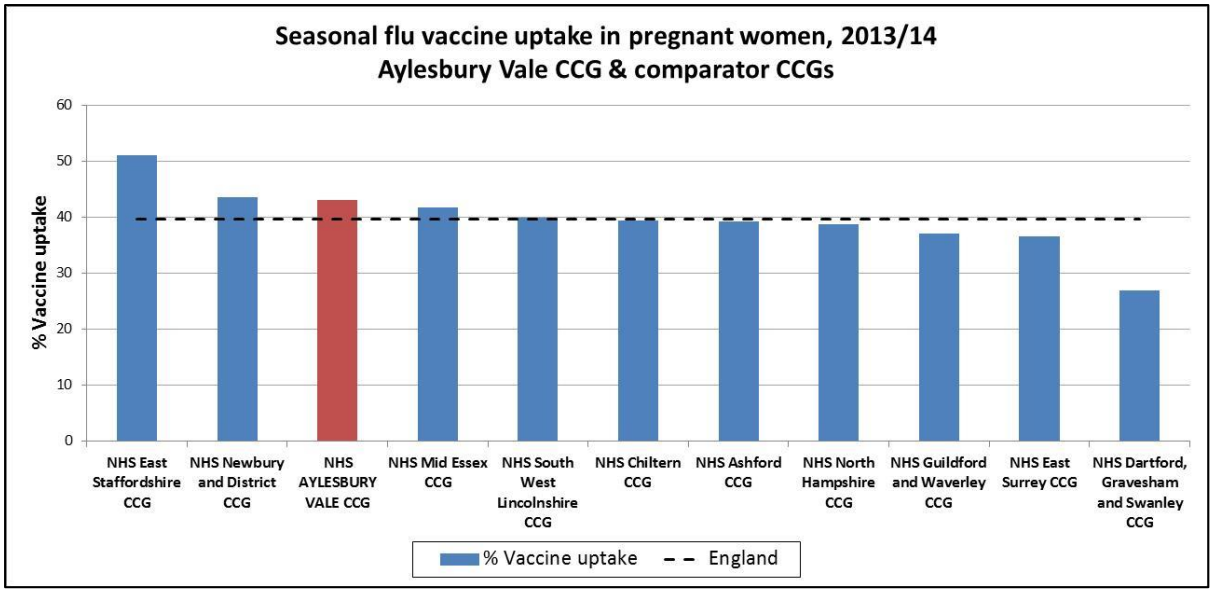
# MATERNAL AND CHILD HEALTH

**Figure 1: Seasonal influenza vaccine uptake (%) in pregnant women - 1 September 2013 to 31 January 2014. NHS Chiltern CCG and comparator CCGs.**



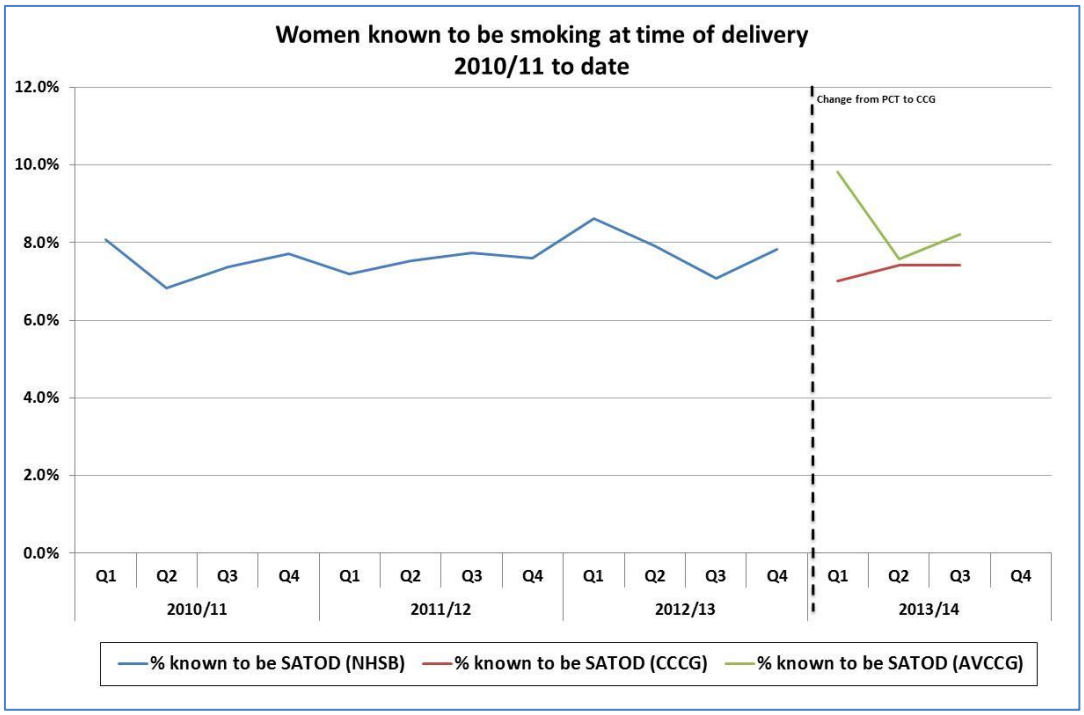

*Source: ImmForm website: Registered patient GP practice data*

**Figure 2: Seasonal influenza vaccine uptake (%) in pregnant women - 1 September 2013 to 31 January 2014. NHS Aylesbury Vale CCG and comparator CCGs.**




*Source: ImmForm website: Registered patient GP practice data*

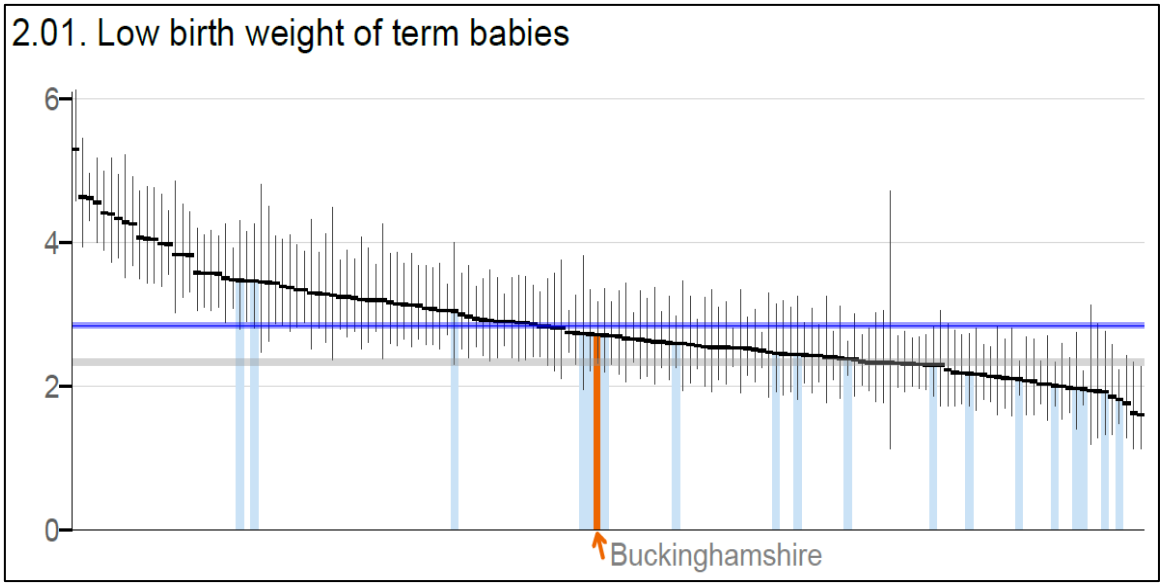
**Figure 3: Percentage of women who smoke at the time of delivery (SATOD) – Quarterly trend data for Buckinghamshire, 2010/11 – 2013/14.**




*Source: Health & Social Care Information Centre returns on smoking status at time of delivery.*

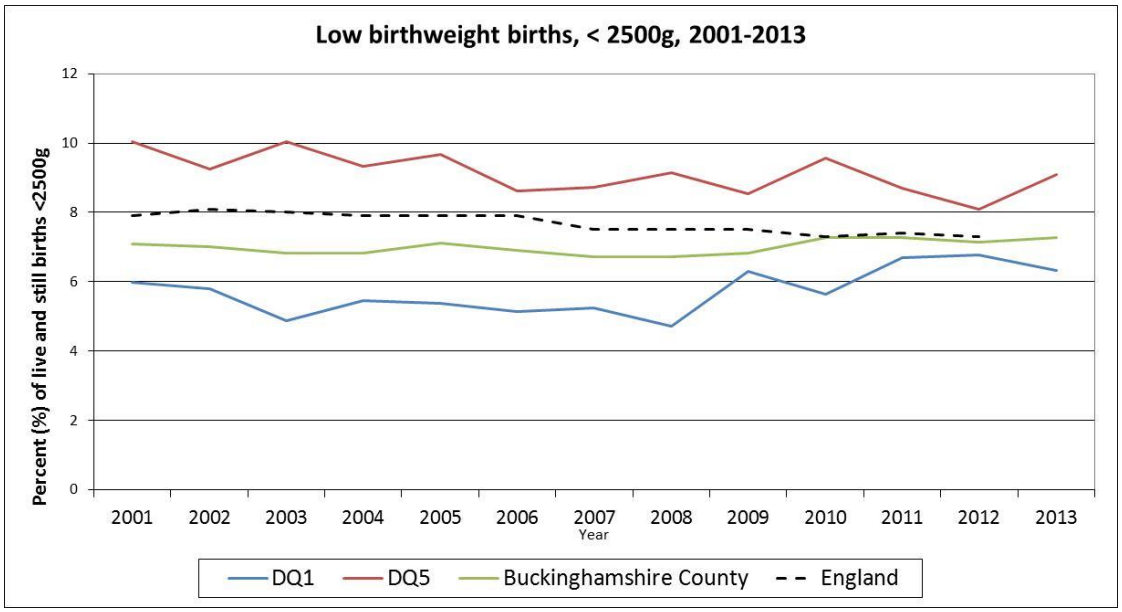
**Figure 4: Percentage of all live births at term (37 complete weeks) with low birth weight (<2500grams) in Buckinghamshire benchmarked against other local authorities in South East - 2011.**

**Key:** England value and confidence interval ↑ Buckinghamshire Other local authority in South East



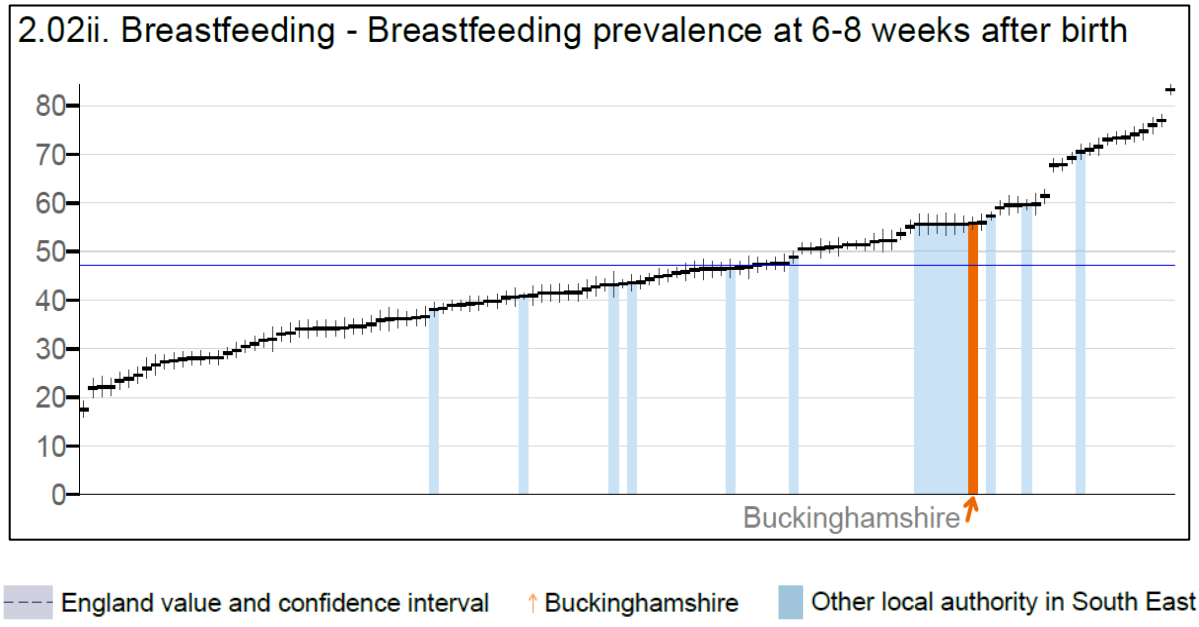

*Data stated as percentage (%). Source: Public Health Outcomes Framework (PHOF)*

**Figure 5: Percentage of all births with low birth weight (<2500 grams) in Buckinghamshire by deprivation quintile, Trend chart. 2001 – 2013.**




*Source: ONS birth files. Note that 2013 data for England is not published.*

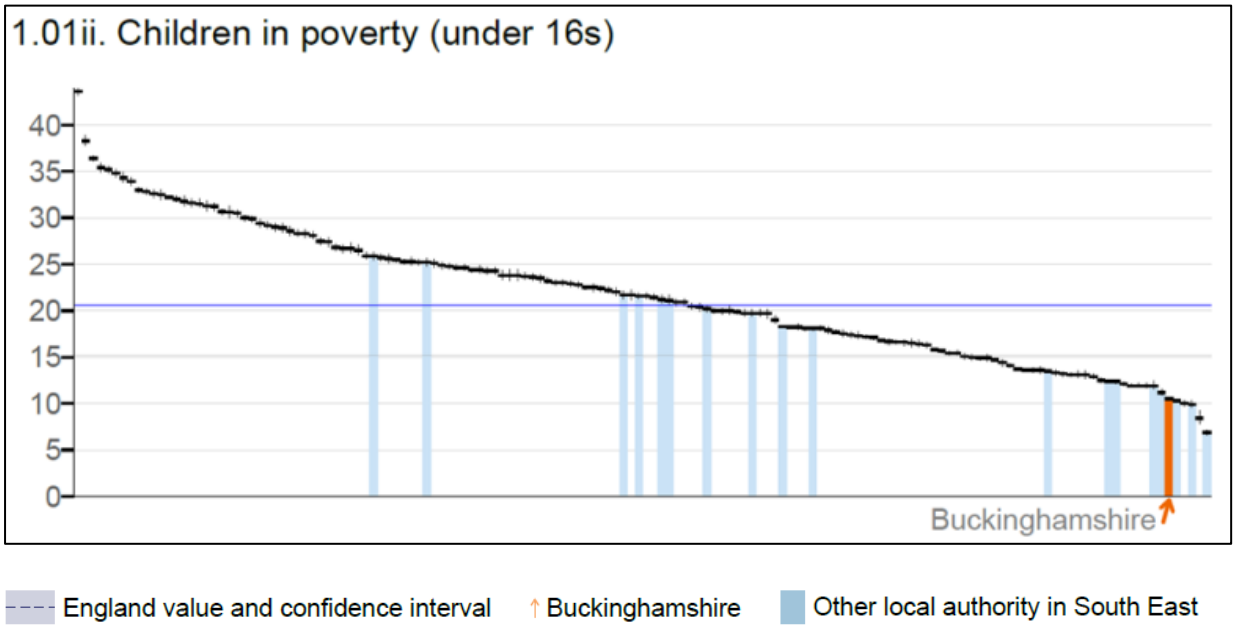
**Figure 6: Percentage of all infants due a 6-8 week check that are totally or partially breastfed in Buckinghamshire in Buckinghamshire benchmarked against other local authorities in South East, 2012/13.**




*Data stated as percentage (%). Source: Public Health England.*

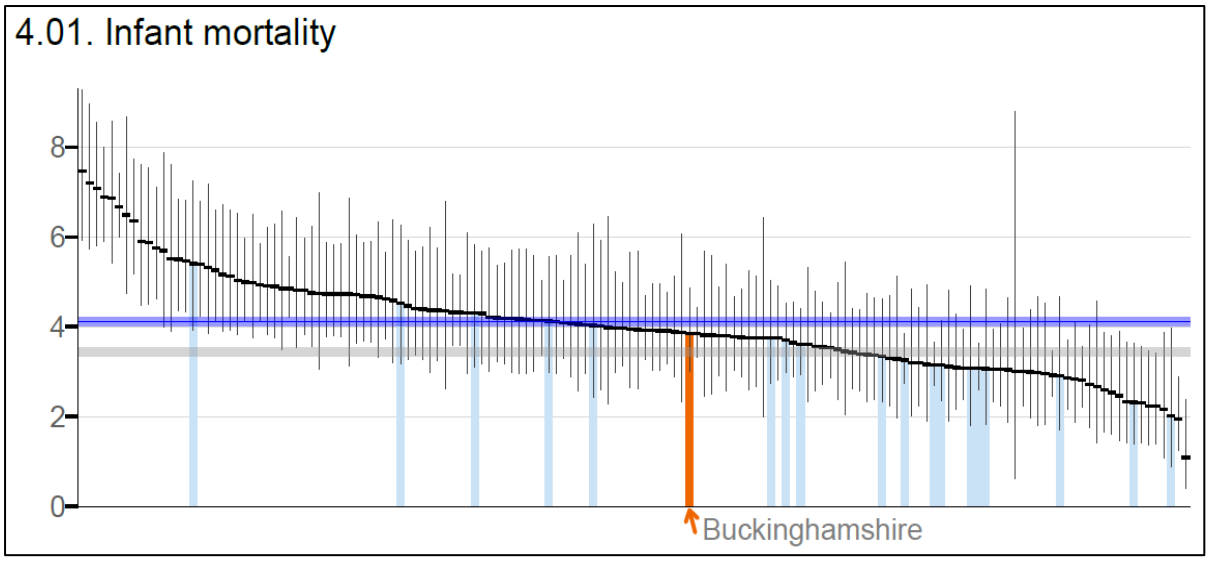
# CHILDREN AND YOUNG PEOPLE'S HEALTH

**Figure 7: Percentage children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is < 60% median income) for under 16s only in Buckinghamshire benchmarked against other local authorities in South East, 2011.**



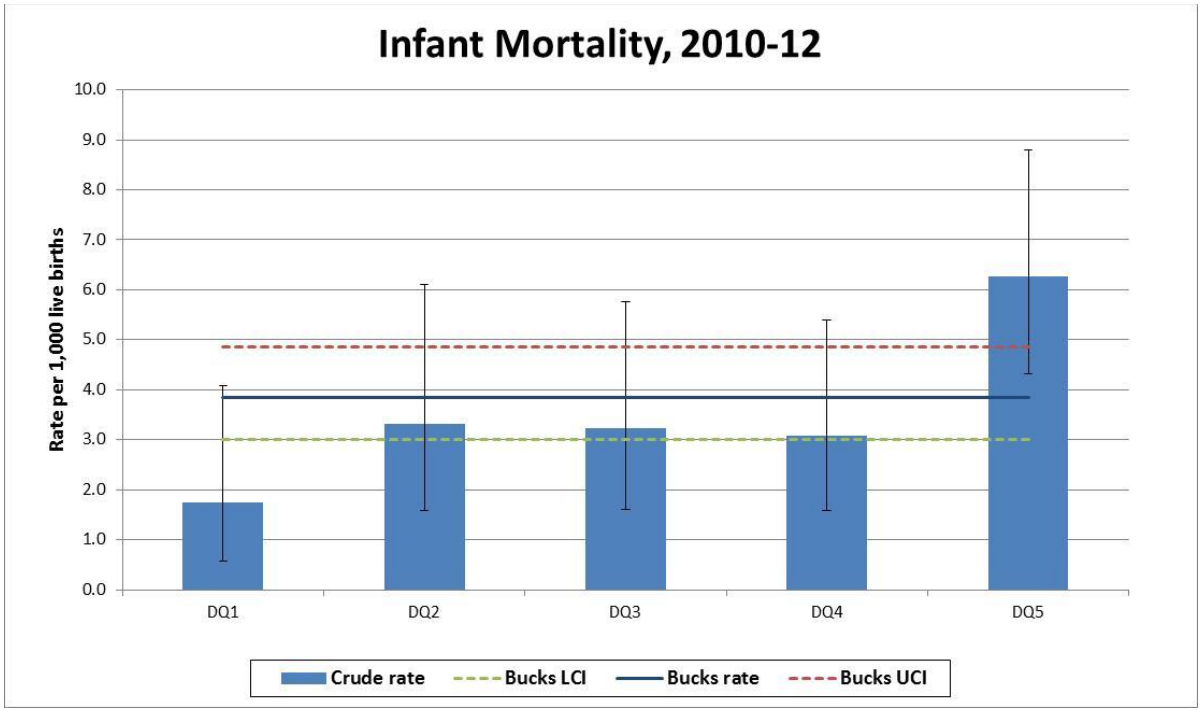

*Data stated as percentage (%). Source: Public Health England.*

**Figure 8: Infant mortality rate - Number of deaths in infants aged under 1 year per 1,000 live births in Buckinghamshire benchmarked against other local authorities in South East, 2010-2012.**



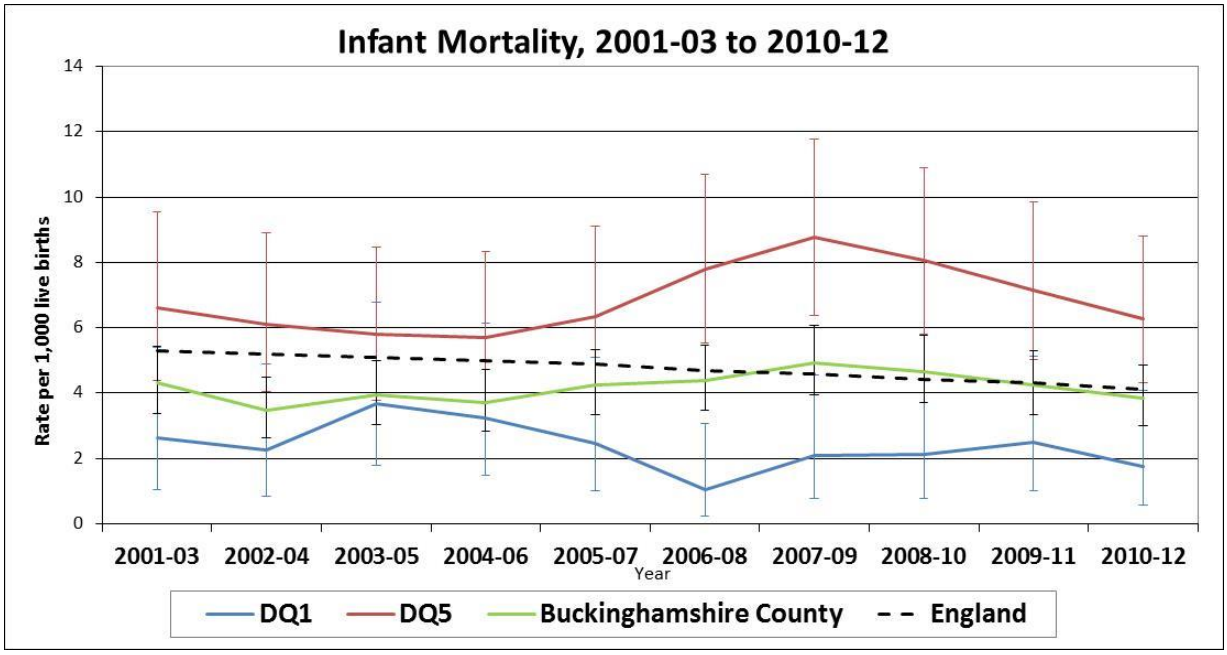

*Data stated as rate per 1000 live births. Source: Public Health England.*

**Figure 9: Infant mortality rate – Number of deaths in infants aged under 1 year per 1,000 live births in Buckinghamshire by deprivation quintile 2010-12.**
[DQ1 – Least deprived. DQ5 – Most deprived]



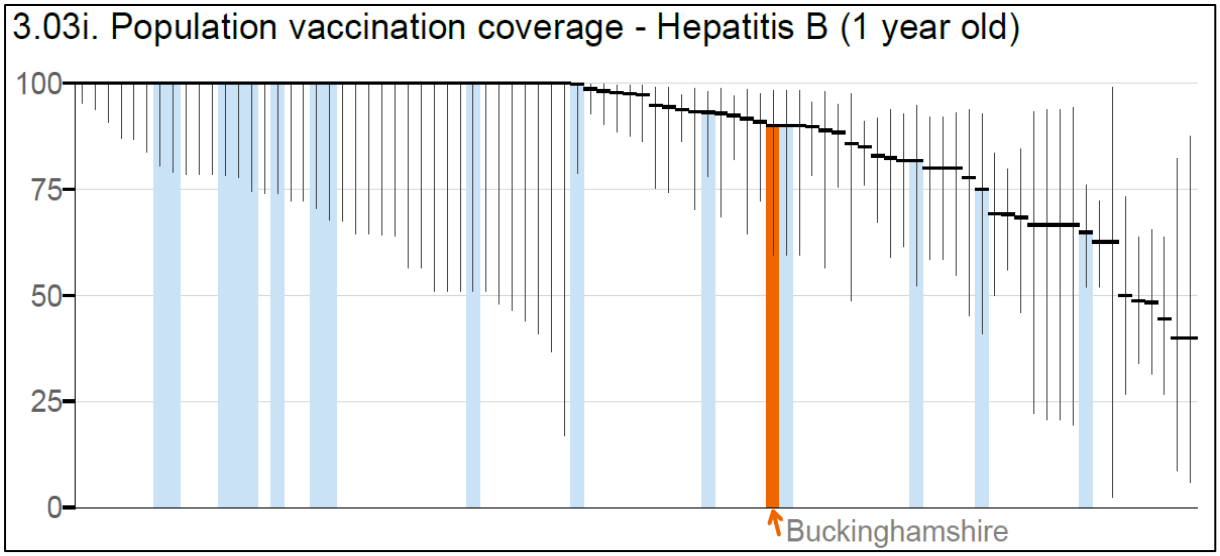

*Source: ONS Annual District Birth and Death Extracts*

**Figure 10: Infant mortality rate in Buckinghamshire by deprivation quintile. Trend chart. 2001/03 – 2010/12.**



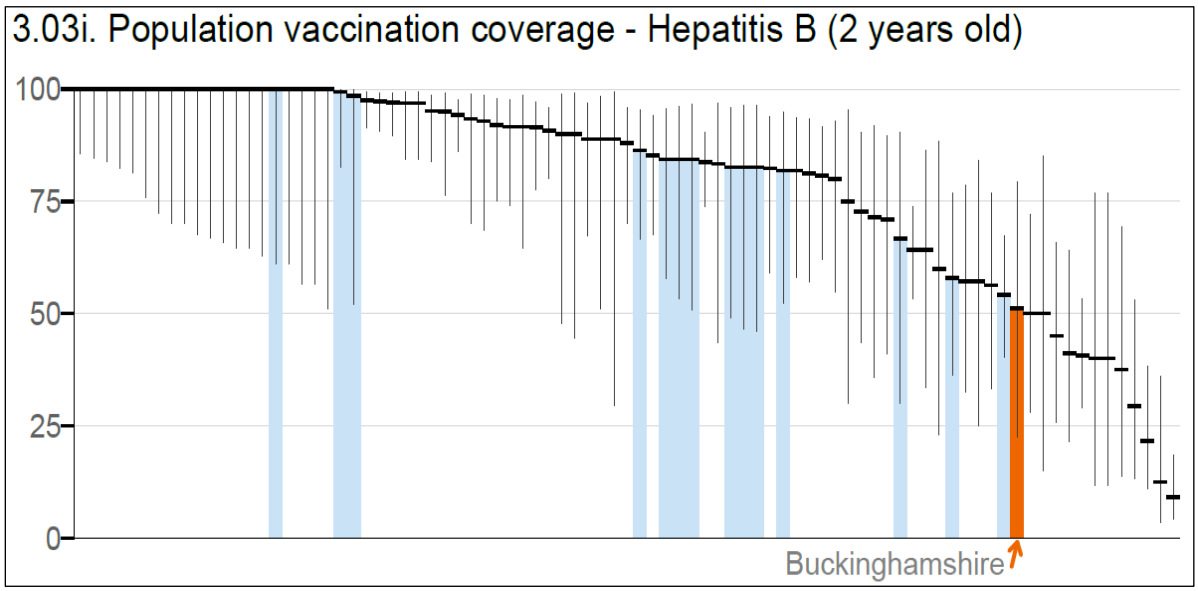

*Source: ONS Annual District Death Extracts*

**Figure 11: Percentage of eligible children who received 4 doses of Hepatitis B vaccine at any time by their 1ST birthday in Buckinghamshire benchmarked against other local authorities in South East, 2012/13.**



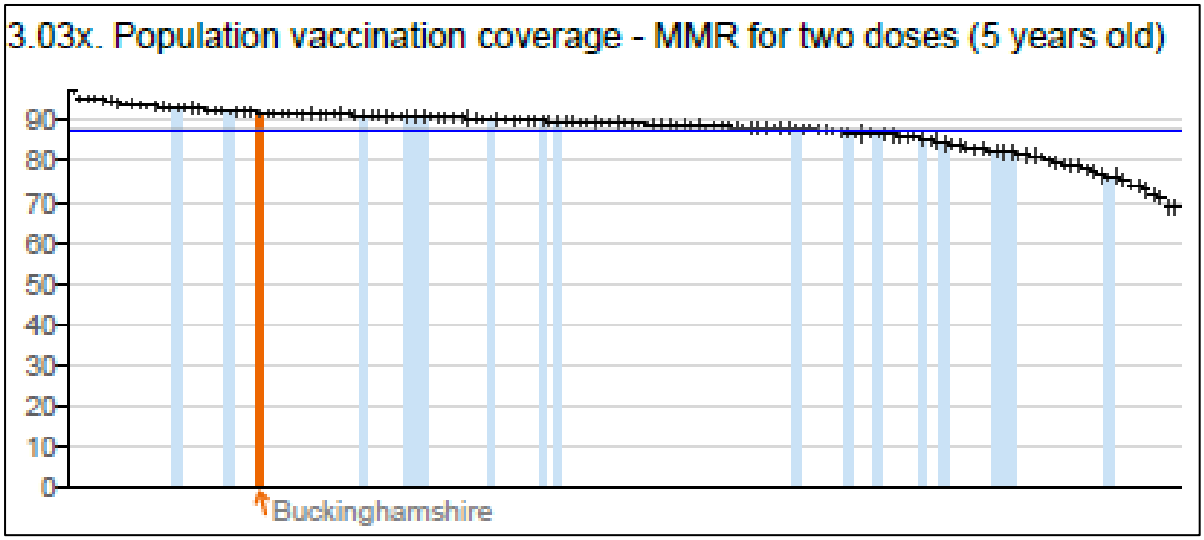

*Data stated as percentage (%)*

**Figure 12: Percentage of eligible children who received 4 doses of Hepatitis B vaccine at any time by their 2nd birthday in Buckinghamshire benchmarked against other local authorities in South East, 2012/13.**



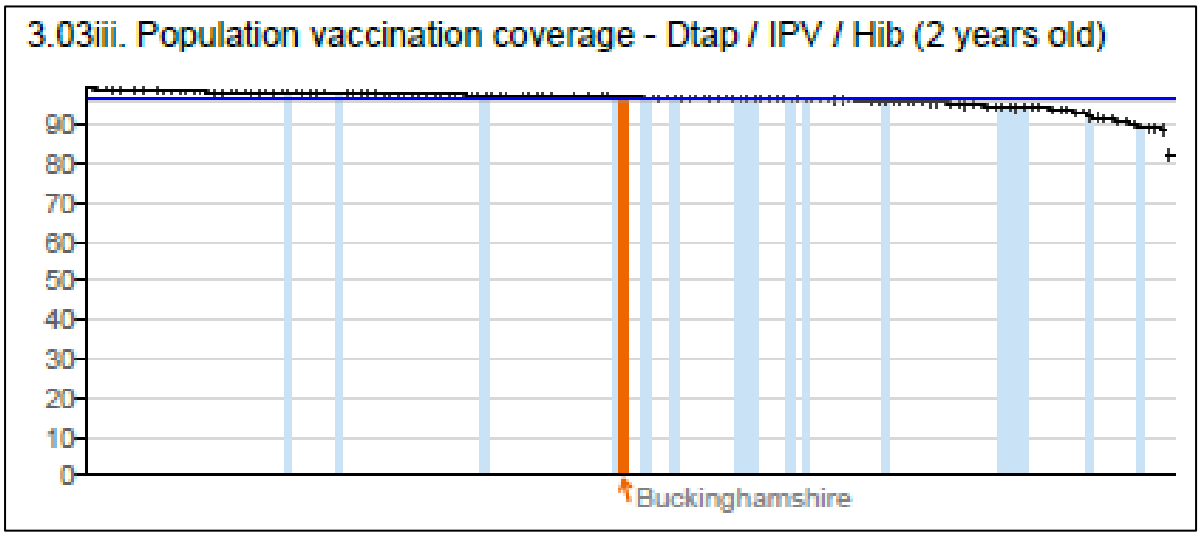

*Data stated as percentage (%)*

**Figure 13: Percentage of eligible children who have received two doses of MMR vaccine on or after their 1st birthday and at any time up to their 5th birthday in Buckinghamshire benchmarked against other local authorities in South East, 2012/13.**



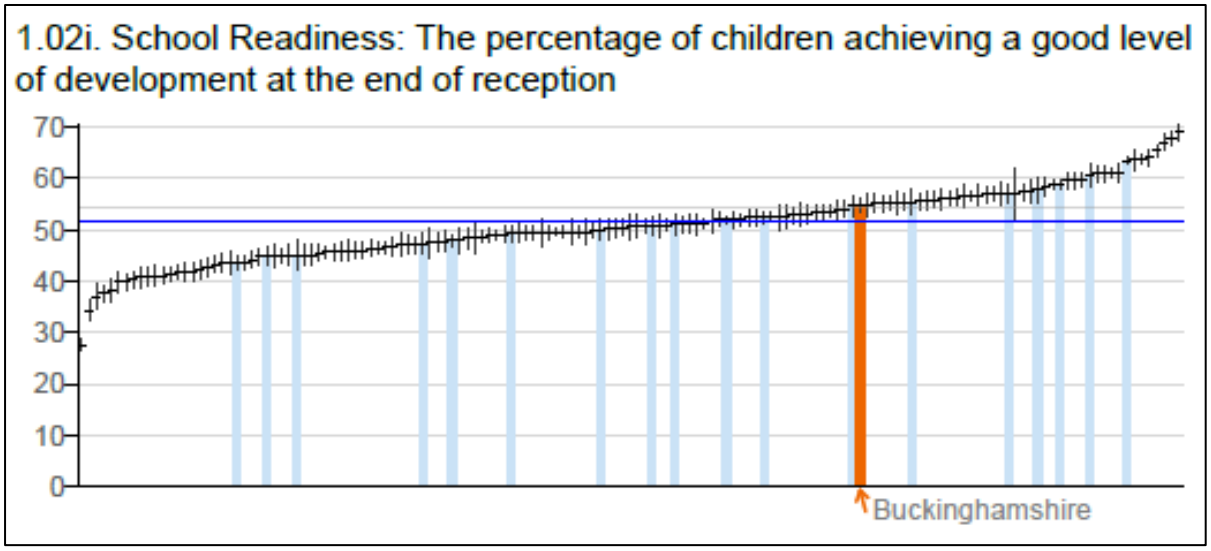

*Data stated as percentage (%). Source: Public Health England.*

**Figure 14: Percentage of eligible children who have received two doses of Dtap / IPV / Hib vaccine at 2 years old in Buckinghamshire benchmarked against other local authorities in South East, 2012/13.**



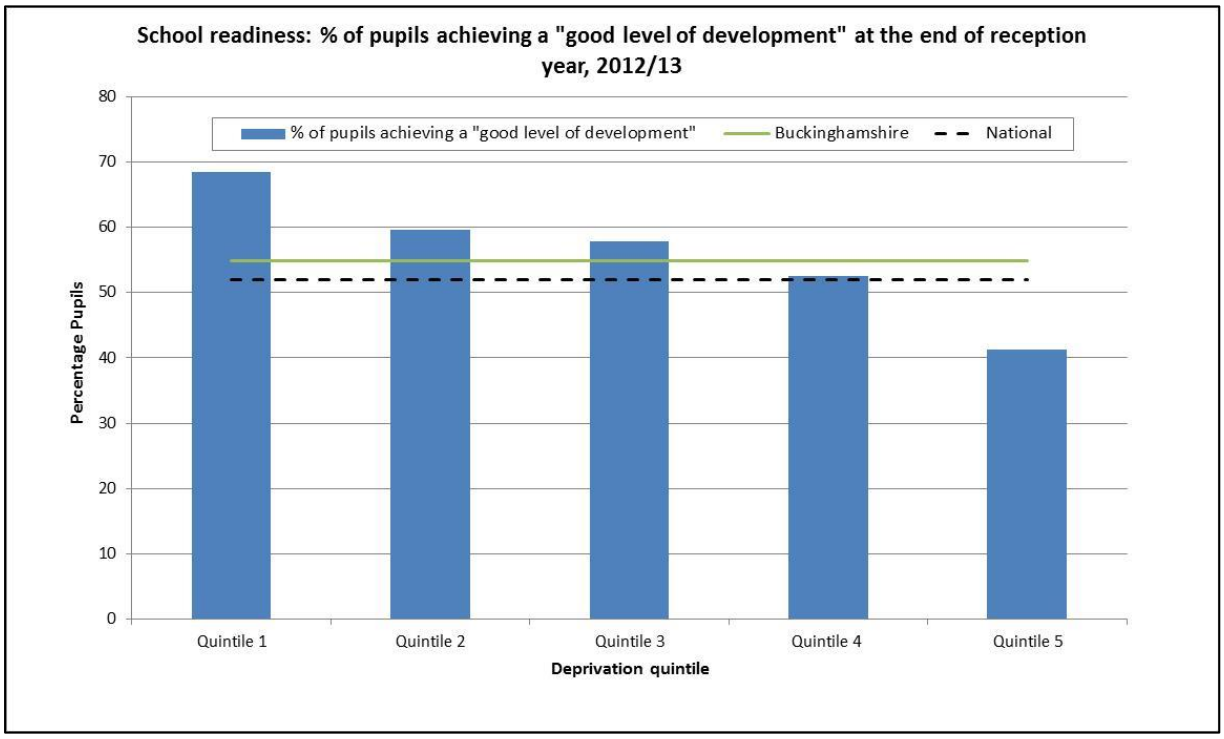

*Data stated as percentage (%). Source: Public Health England.*

**Figure 15: School readiness: All children achieving a good level of development at the end of reception as a percentage of all eligible children in Buckinghamshire benchmarked against other local authorities in South East, 2012/13.**



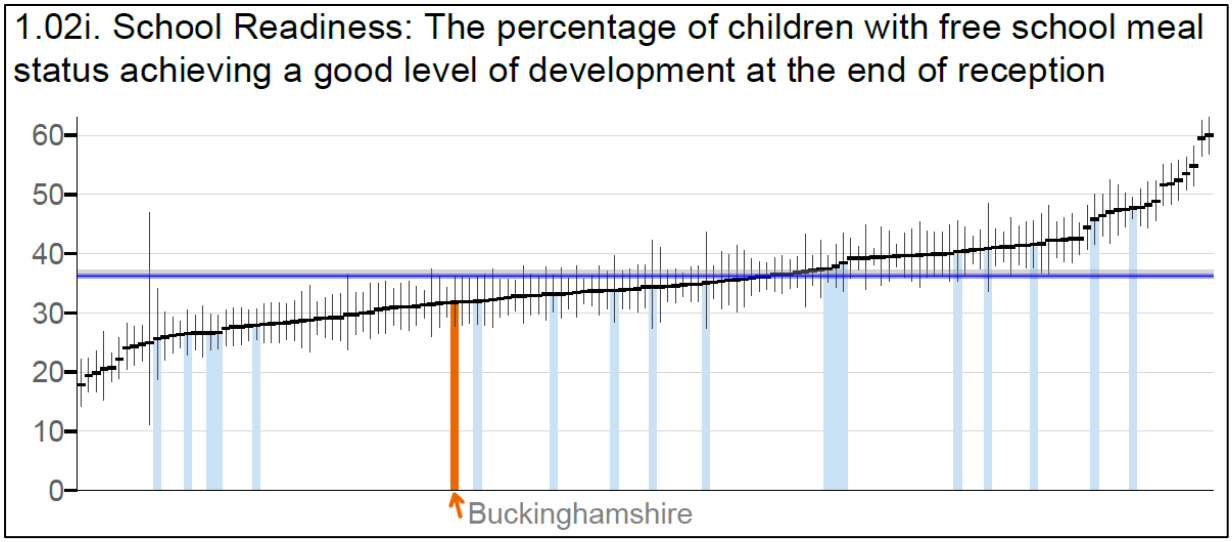

*Data stated as percentage (%). Source: Public Health England.*

**Figure 16. School readiness - Percentage of pupils achieving good level of development at end of reception year by deprivation quintile, 2012/13.**



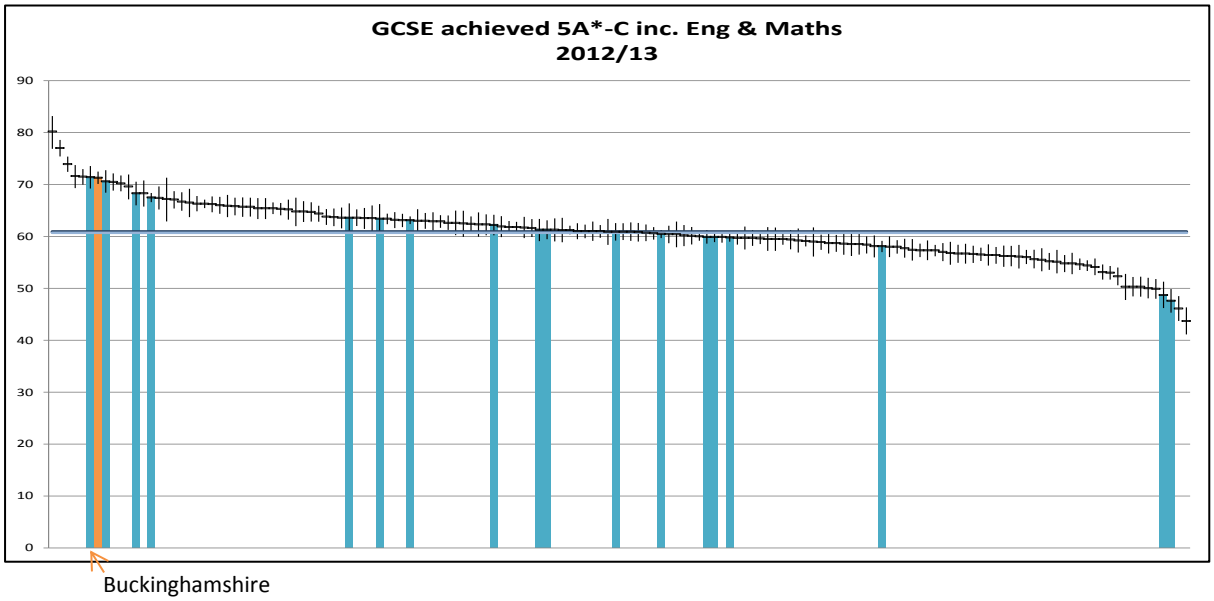

*Source: School Management Support Team, Performance and Information, Buckinghamshire County Council*

**Figure 17: School readiness: All children achieving a good level of development at the end of reception as a percentage of all eligible children by free school meal status in Buckinghamshire benchmarked against other local authorities in South East, 2012/13.**



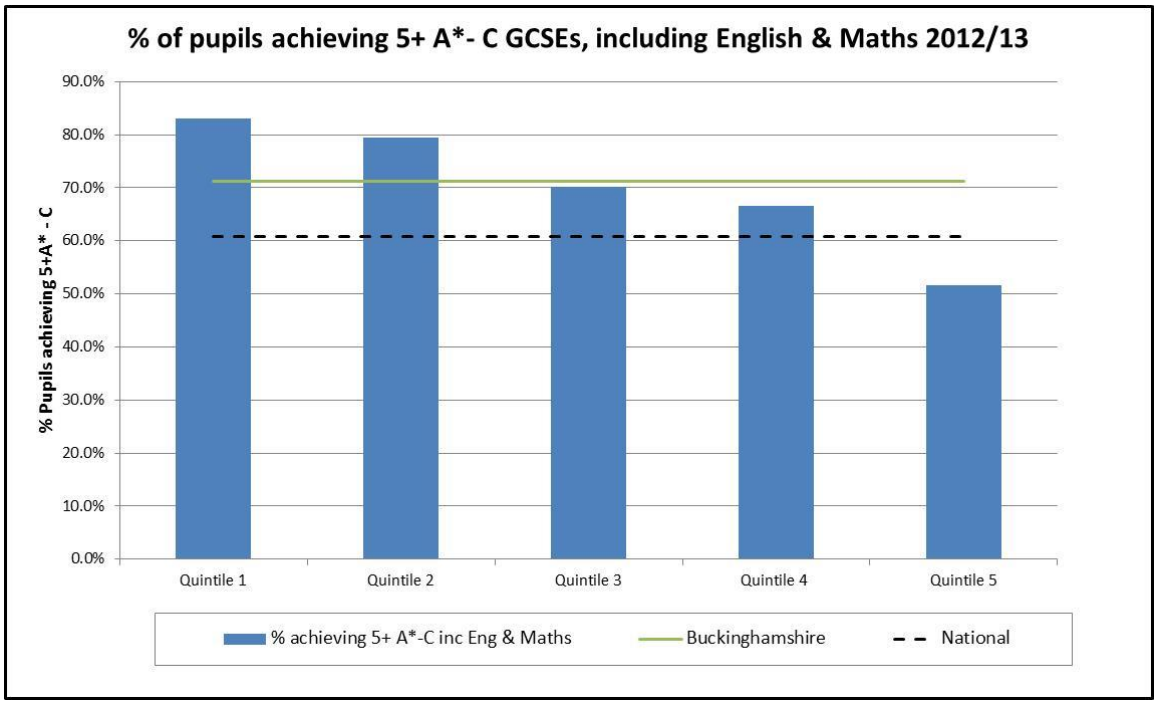

*Data stated as percentage (%). Source: Public Health England.*

**Figure 18: GCSE achievement by pupils in Buckinghamshire – The percentage of pupils achieving 5A*-C GCSE's including English and Maths in Buckinghamshire benchmarked against Other local authorities in South East, 2012/13.**



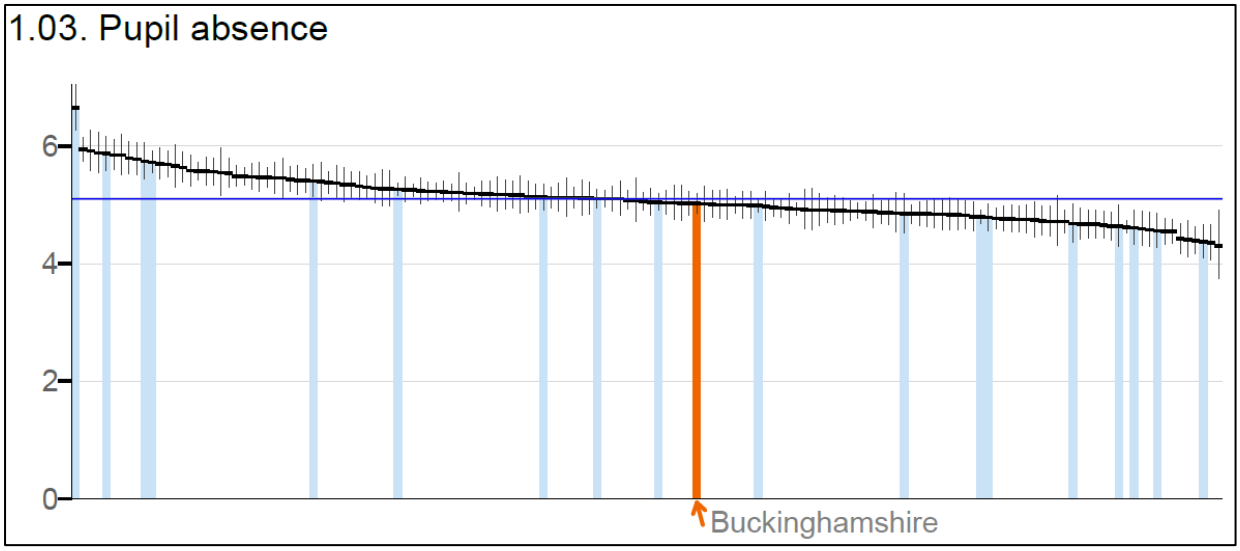

*Data stated as percentage (%) Source: Children and Young People's Benchmarking Tool, Public Health England.*

**Figure 19: GCSE achievement: Percentage of pupils achieving 5+A* -C at GCSE in Buckinghamshire, by deprivation quintiles, 2012/13.**



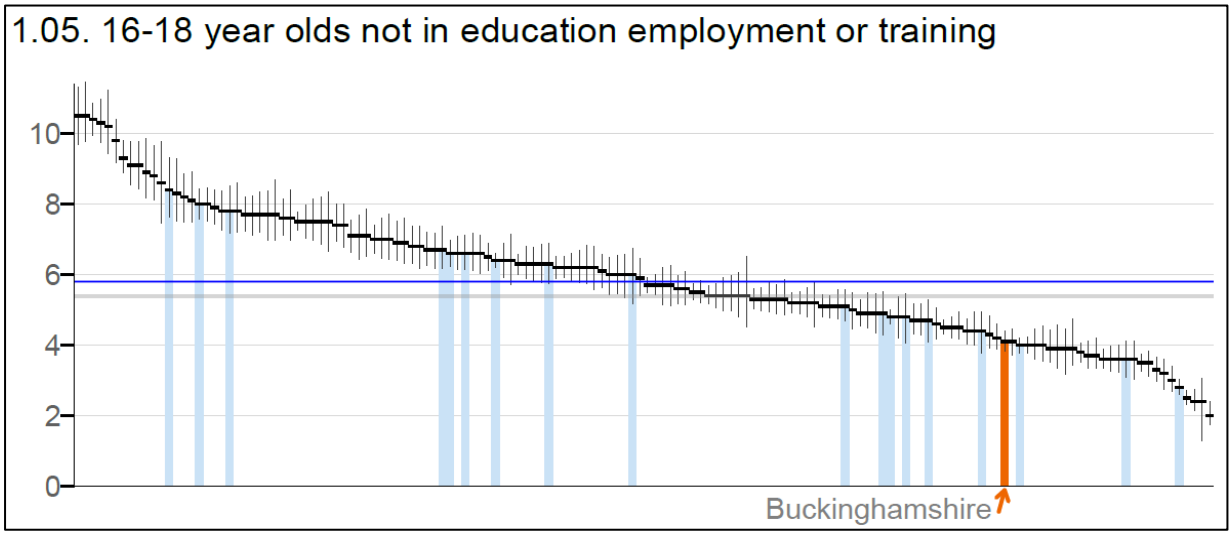

*Source: School Management Support Team, Performance and Information. Buckinghamshire County Council*

**Figure 20: Pupil absence – Percentage of half days missed by pupils due to overall absence (incl. authorised and unauthorised absence) in Buckinghamshire benchmarked against other local authorities in South East, 2011/12.**



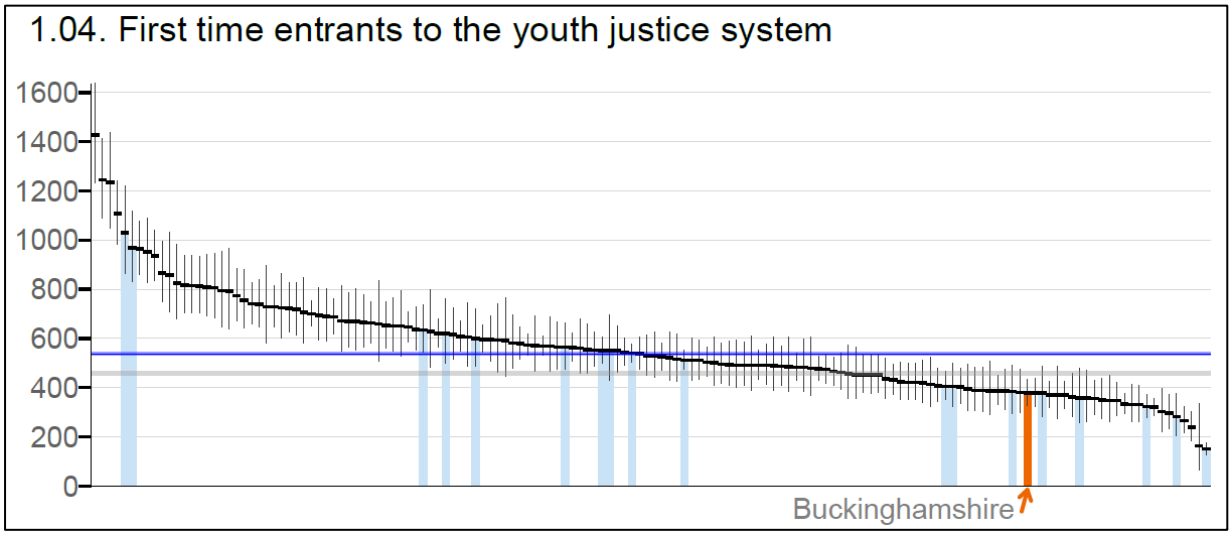

*Data stated as percentage (%). Source: Public Health England.*

**Figure 21: Percentage 16-18 year olds Not in Education, Employment or Training (NEET) in Buckinghamshire benchmarked against other local authorities in South East, 2012.**



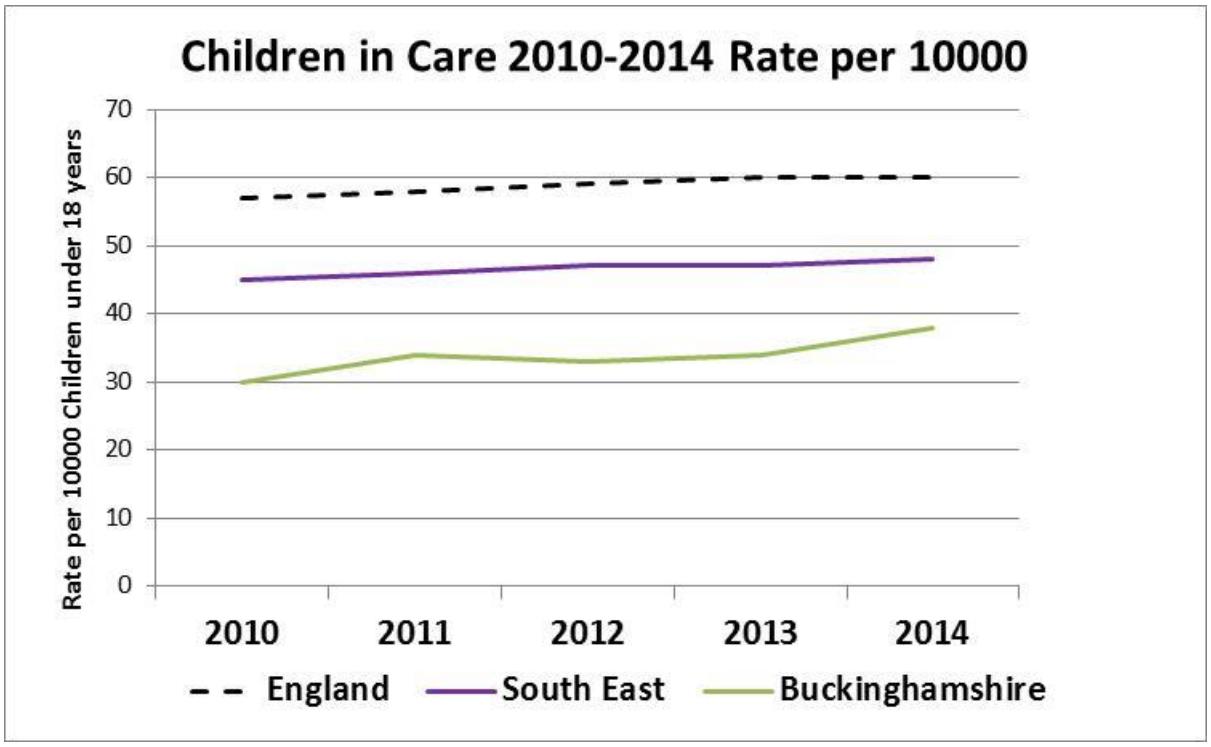

*Data stated as percentage (%). Source: Public Health England.*

**Figure 22: Rate of 10-17 year olds receiving their first reprimand, warning or conviction per 100,000 population in Buckinghamshire benchmarked against other local authorities in South East, 2012.**



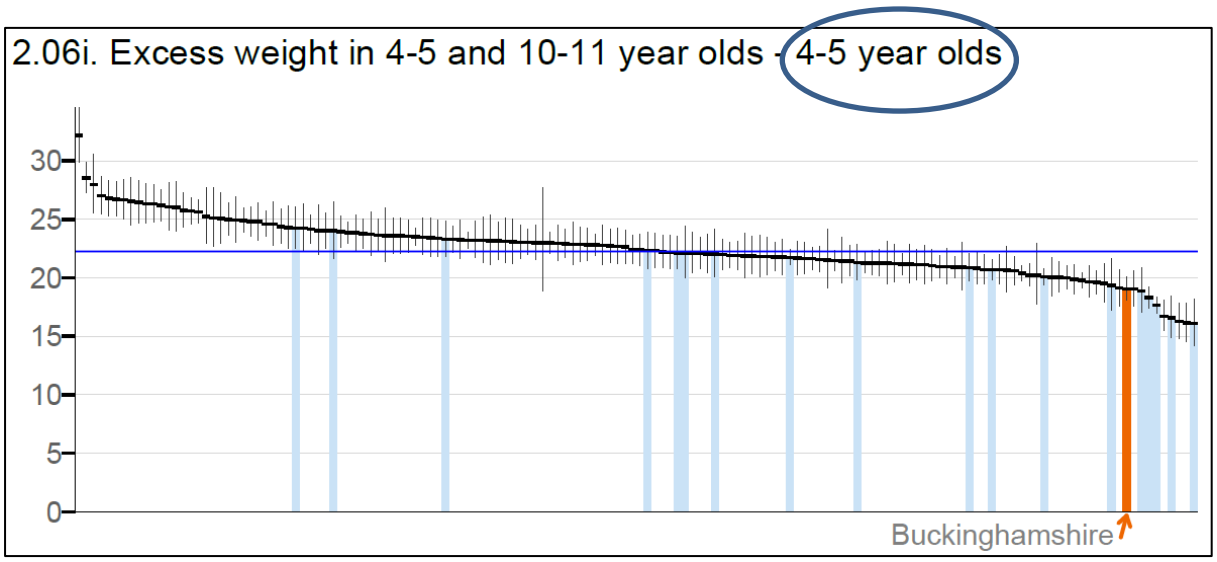

*Data stated as rate per 100000 10-17 year olds. Source: Public Health England.*

**Figure 23: Rate of children in Buckinghamshire under 18 years of age in care. Trend chart, 2010 - 2014.**



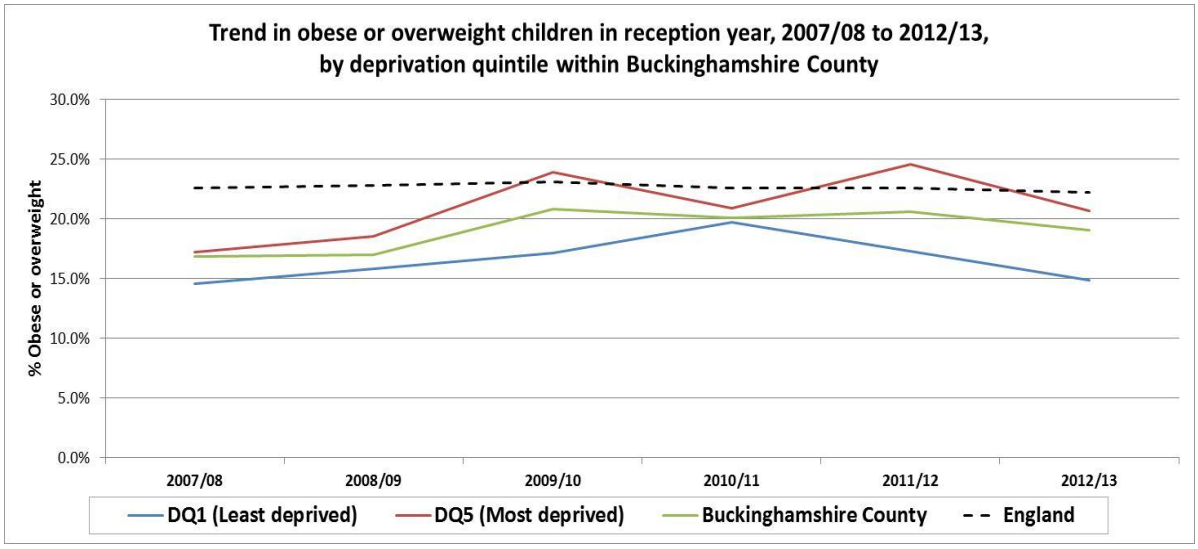

*Source: Department for Education, 2014*

**Figure 24: Excess weight in children in reception year – Percentage children aged 4-5 classified as overweight or obese in Buckinghamshire benchmarked against other local authorities in South East 2012/13.**



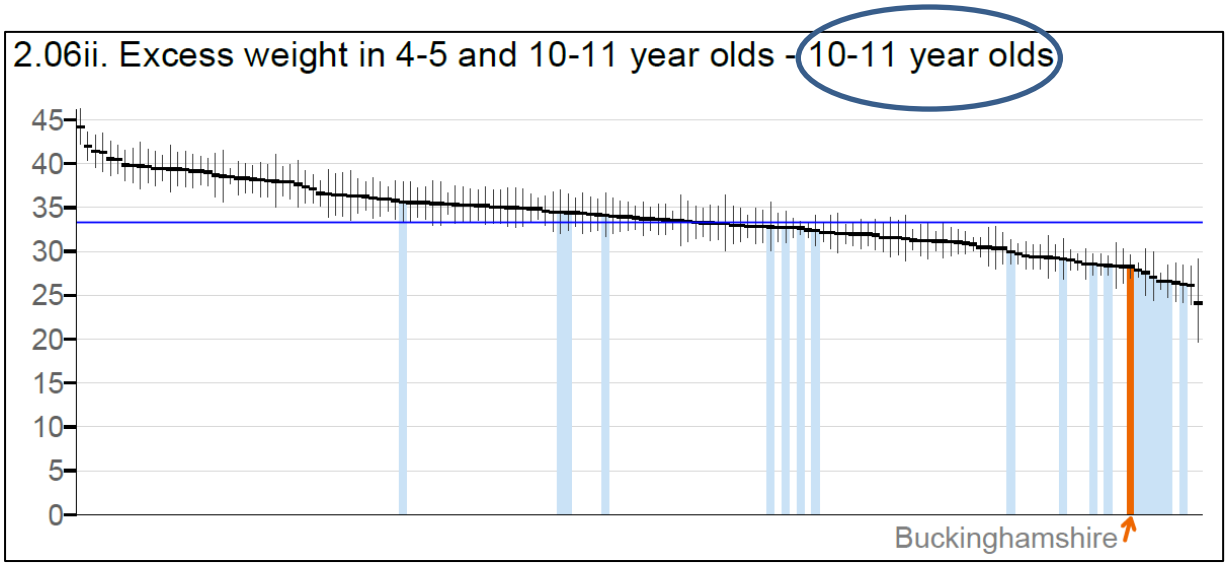

*Data stated as percentage (%). Source: Public Health England.*

**Figure 25: Excess weight in children in reception year – Percentage children aged 4-5 classified as overweight or obese in Buckinghamshire by deprivation quintile. Trend chart 2007/08 – 2012/13.**



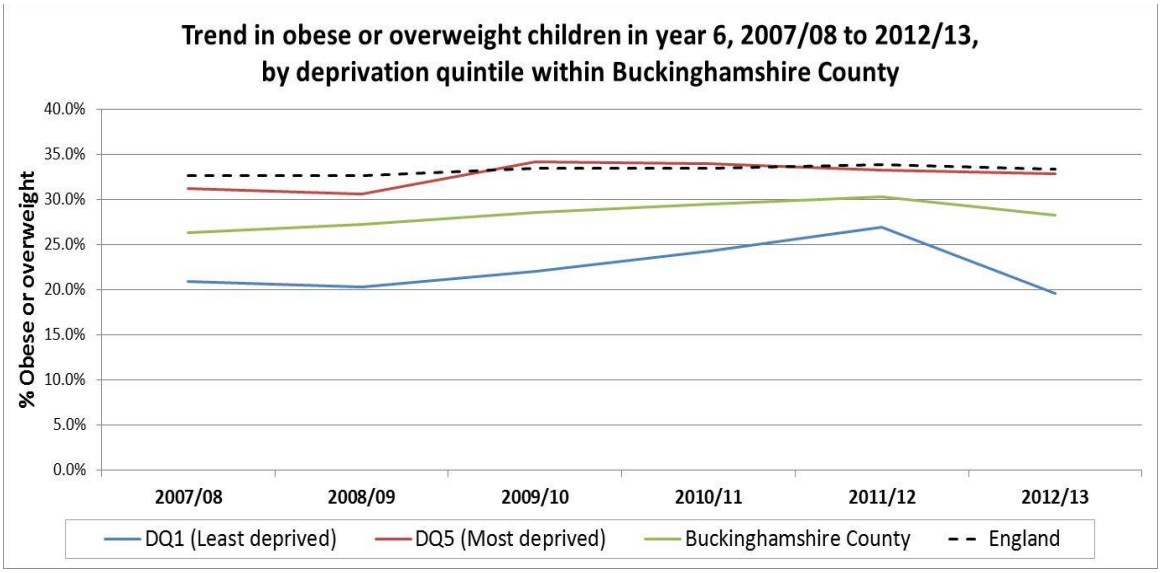

*Source: Health and Social Care Information Centre, National Child Measurement Programme*

**Figure 26: Excess weight in children in year 6 - Percentage of children aged 10-11 classified as overweight or obese in Buckinghamshire benchmarked against other local authorities in South East, 2012/13.**



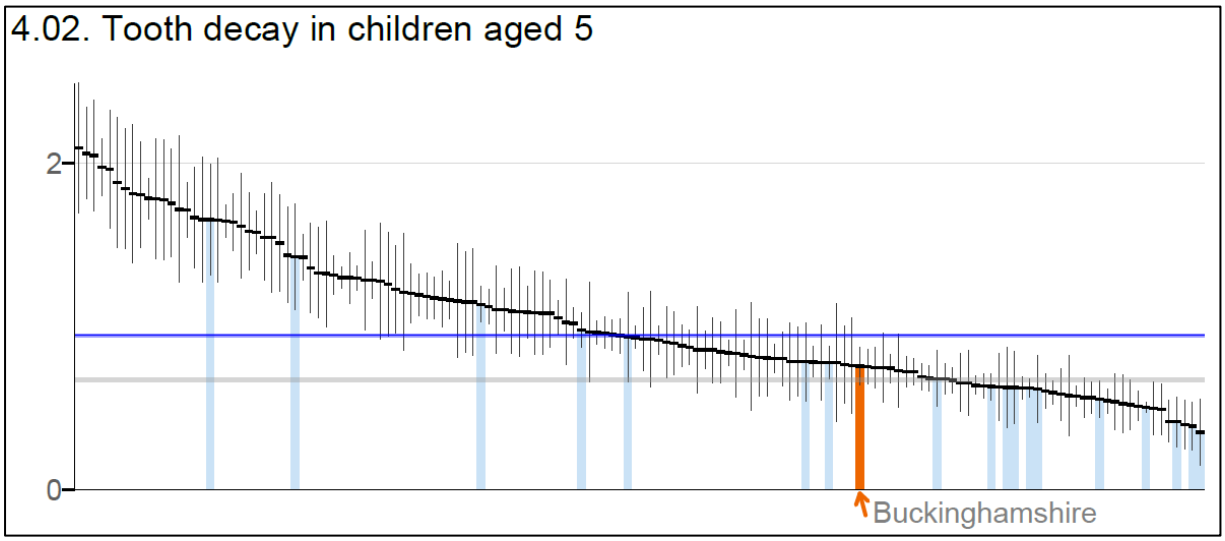

*Data stated as percentage (%). Source: Public Health England.*

**Figure 27: Excess weight in children in year 6 - Percentage children aged 10-11 classified as overweight or obese in Buckinghamshire by deprivation quintile. Trend chart. 2007/08 – 2012/13.**



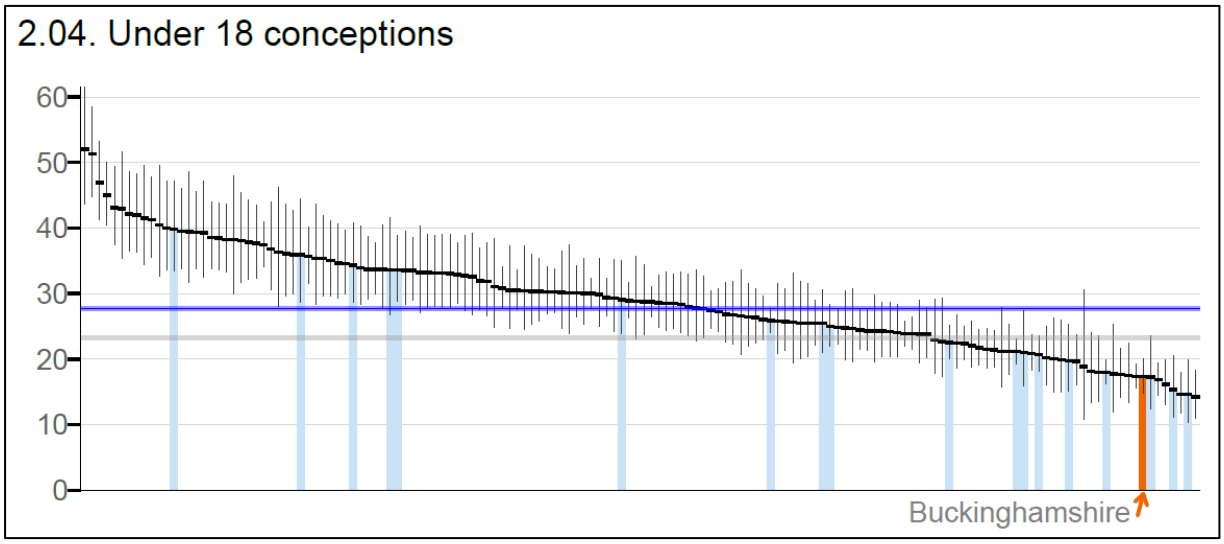

*Source: Health and Social Care Information Centre, National Child Measurement Programme*

**Figure 28: Percentage children aged 5 with tooth decay in Buckinghamshire benchmarked against other local authorities in South East, 2011/12.**



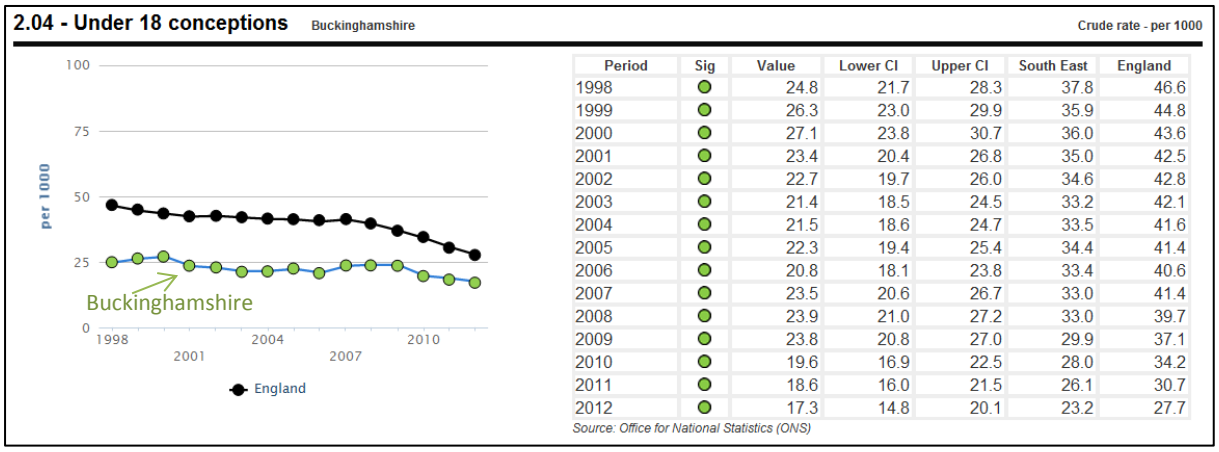

*Data stated as percentage (%). Source: Public Health England.*

**Figure 29: Teenage conception rate in girls aged 15-17 years in Buckinghamshire benchmarked against other local authorities in South East, 2012.**




*Data stated as rate per 1000 girls aged 15-17 years. Source: Public Health England.*

**Figure 30: Teenage conception rate in girls aged under 18 years in Buckinghamshire. Trend chart. 1998-2012.**

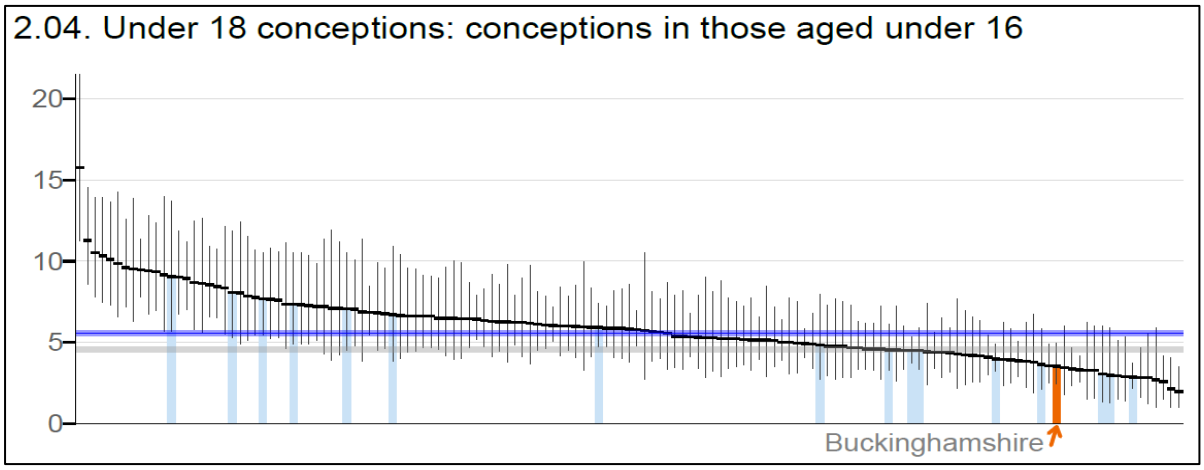



| Period | Sig | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|
| 1998 | | 24.8 | 21.7 | 28.3 | 37.8 | 46.6 |
| 1999 | | 26.3 | 23.0 | 29.9 | 35.9 | 44.8 |
| 2000 | | 27.1 | 23.8 | 30.7 | 36.0 | 43.6 |
| 2001 | | 23.4 | 20.4 | 26.8 | 35.0 | 42.5 |
| 2002 | | 22.7 | 19.7 | 26.0 | 34.6 | 42.8 |
| 2003 | | 21.4 | 18.5 | 24.5 | 33.2 | 42.1 |
| 2004 | | 21.5 | 18.6 | 24.7 | 33.5 | 41.6 |
| 2005 | | 22.3 | 19.4 | 25.4 | 34.4 | 41.4 |
| 2006 | | 20.8 | 18.1 | 23.8 | 33.4 | 40.6 |
| 2007 | | 23.5 | 20.6 | 26.7 | 33.0 | 41.4 |
| 2008 | | 23.9 | 21.0 | 27.2 | 33.0 | 39.7 |
| 2009 | | 23.8 | 20.8 | 27.0 | 29.9 | 37.1 |
| 2010 | | 19.6 | 16.9 | 22.5 | 28.0 | 34.2 |
| 2011 | | 18.6 | 16.0 | 21.5 | 26.1 | 30.7 |
| 2012 | | 17.3 | 14.8 | 20.1 | 23.2 | 27.7 |

Source: Office for National Statistics (ONS)

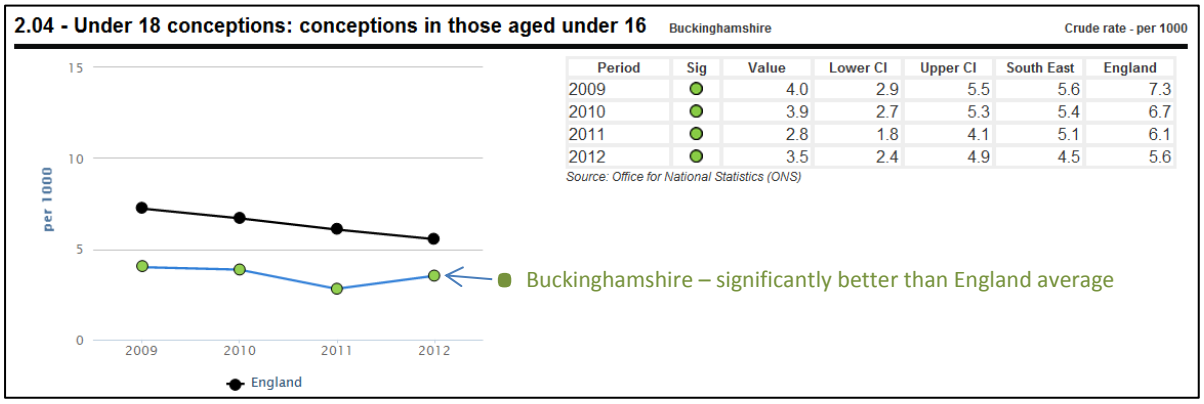
*Data stated as rate per 1000 girls aged 15-17 years. Source: Public Health England.*

**Figure 31: Teenage conception rate: Number of conceptions per 1000 girls aged under 16 in Buckinghamshire benchmarked against other local authorities in South East, 2012.**



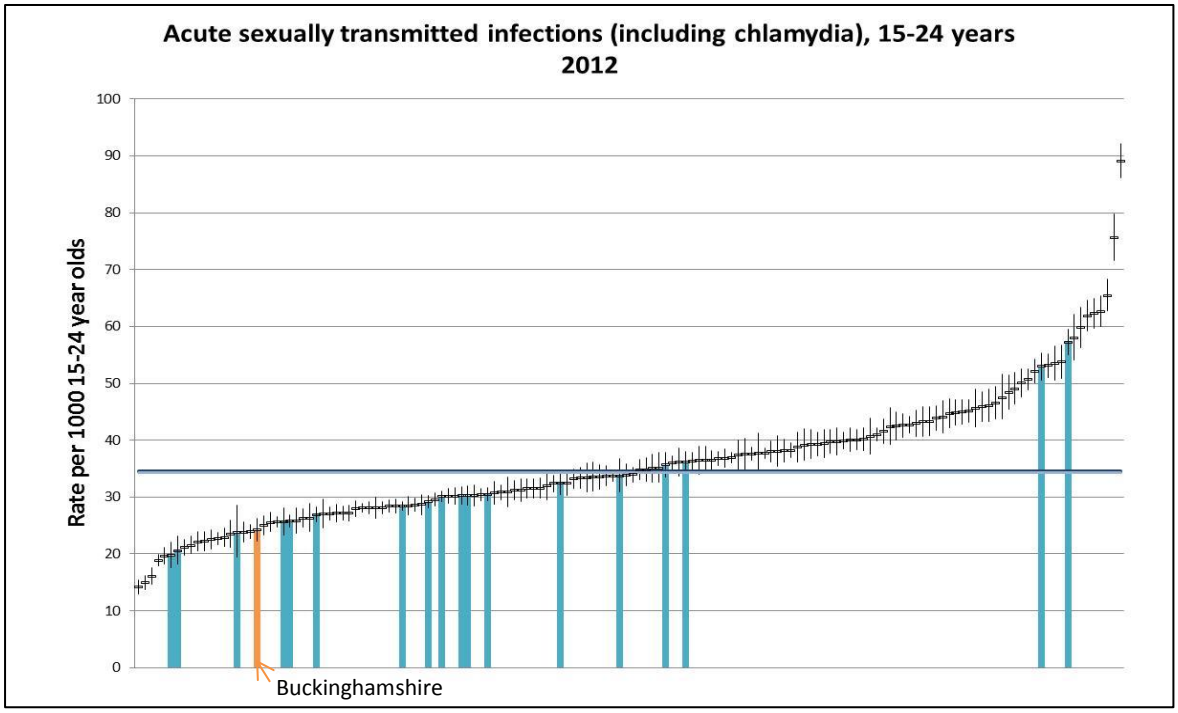

*Data stated as rate per 1000 girls aged 15-17 years. Source: Public Health England.*

**Figure 32: Teenage conception rate in girls aged under 16 years in Buckinghamshire. Trend chart 2009-2012.**



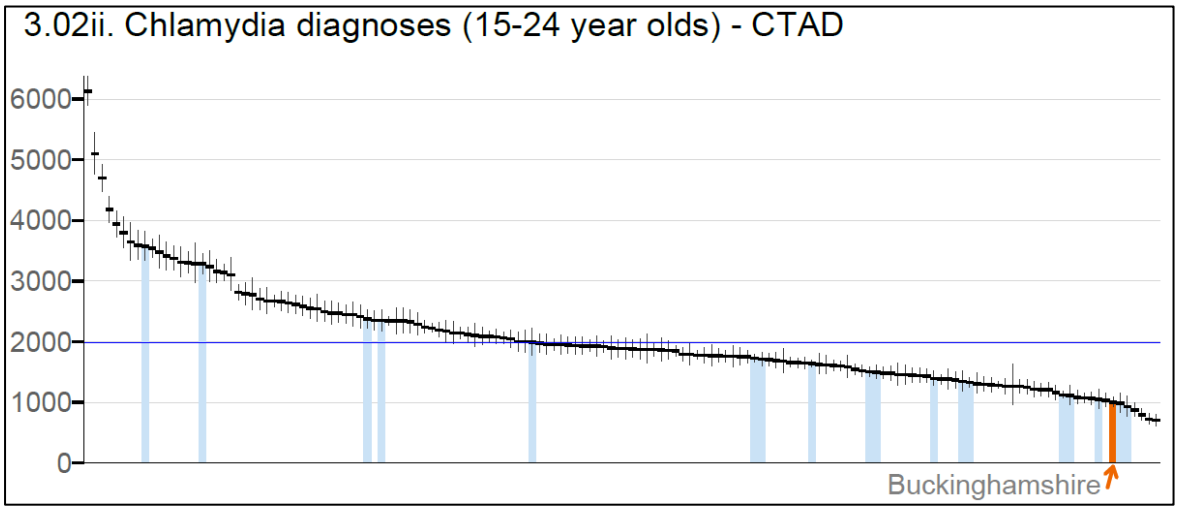

*Data stated as rate per 1000 girls aged 15-17 years. Source: Public Health England.*

**Figure 33: Acute sexually transmitted infections (including chlamydia) rate per 1000 15-24 year olds in Buckinghamshire benchmarked against other local authorities in South East. 2012.**



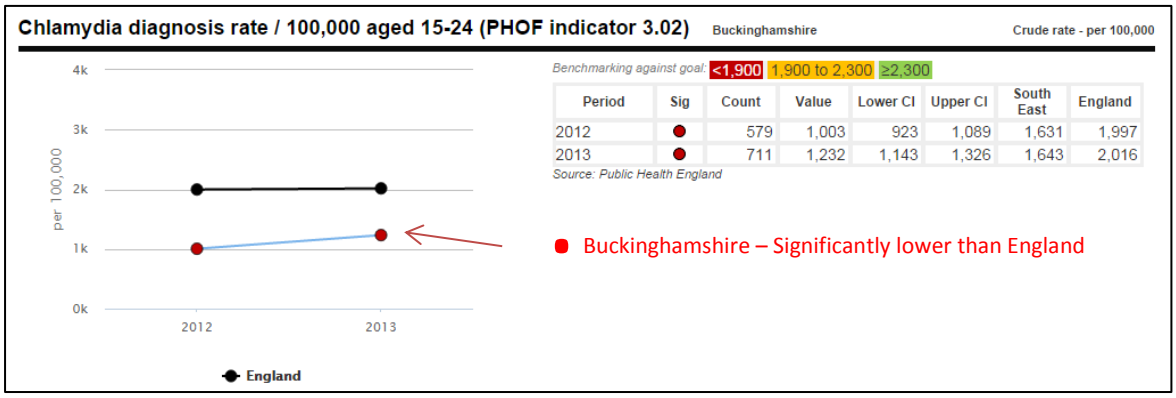

*Source: Children and Young People's Benchmarking Tool, Public Health England*

**Figure 34: Chlamydia diagnosis rate per 100,000 young people aged 15-24 year old in Buckinghamshire benchmarked against other local authorities in South East. 2012.**




*Data is crude rate of chlamydia diagnoses per 100,000 young adults aged 15-24 Source: CTAD data*

**Figure 35: Chlamydia diagnosis rate per 100000 young people aged 15-24 year olds in Buckinghamshire. 2012, 2013.**

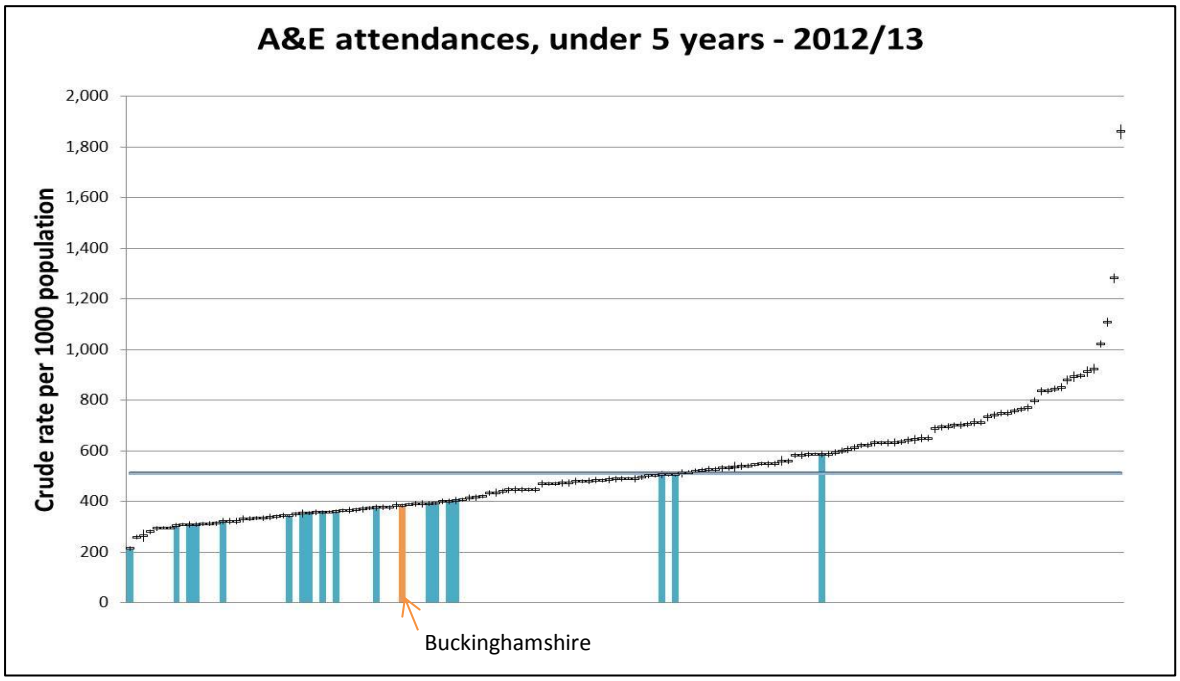



| Period | Sig | Count | Value | Lower CI | Upper CI | South East | England |
|---|---|---|---|---|---|---|---|
| 2012 | | 579 | 1,003 | 923 | 1,089 | 1,631 | 1,997 |
| 2013 | | 711 | 1,232 | 1,143 | 1,326 | 1,643 | 2,016 |

*Source: Sexual health profiles, Public Health England, 2014.*

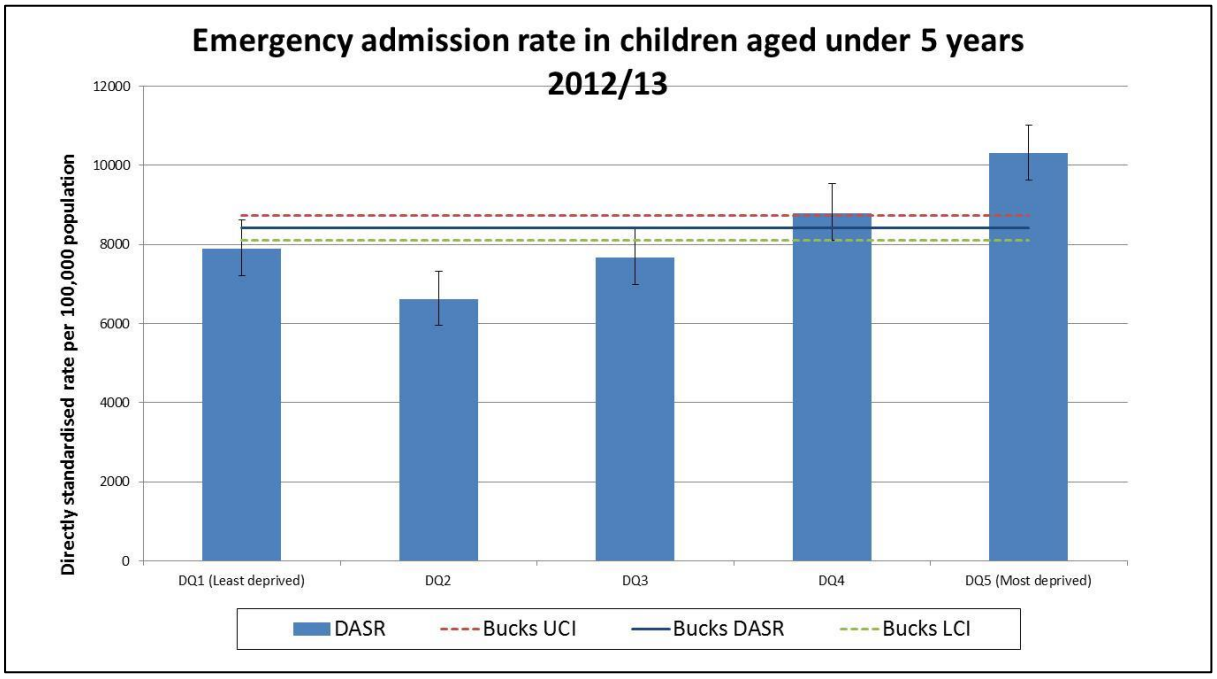
# HEALTH CARE SERVICES

**Figure 36: A&E attendance rate per 1000 population aged 0-4 in Buckinghamshire benchmarked against other local authorities in South East, 2012/13.**



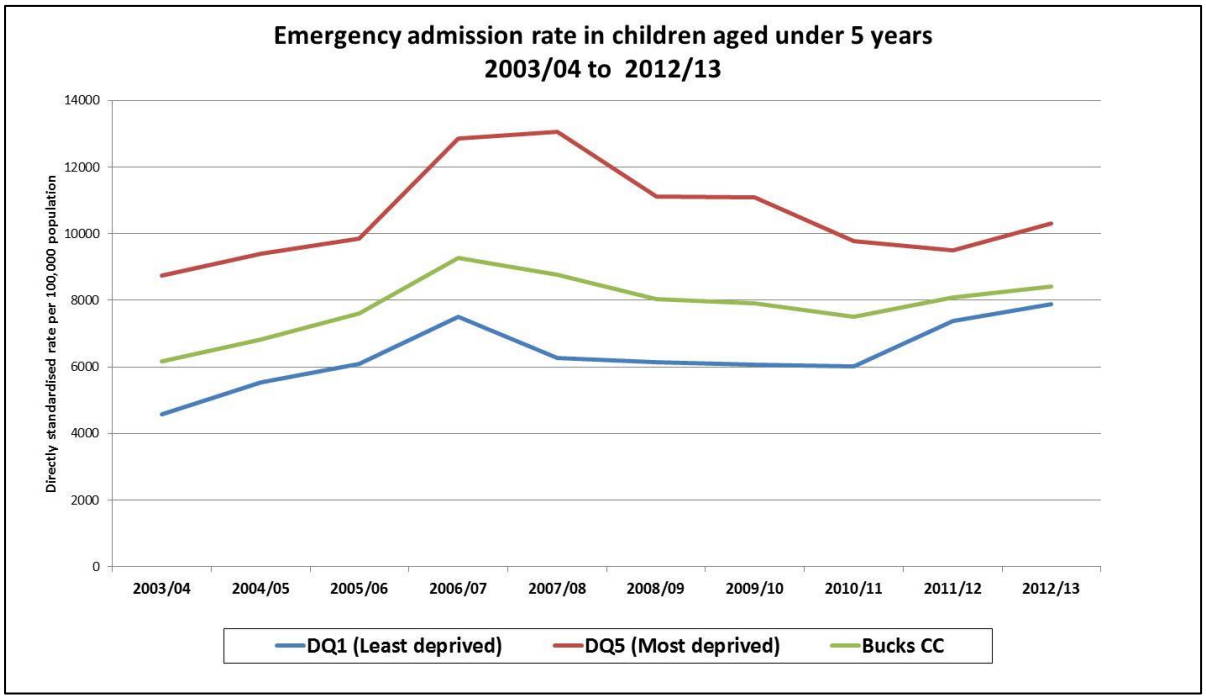

*Source: Children and Young People's Benchmarking Tool, Public Health England.*

**Figure 37: Emergency admissions rate per 100,000 population in children aged under 5 years in Buckinghamshire by deprivation quintile, 2012/13.**



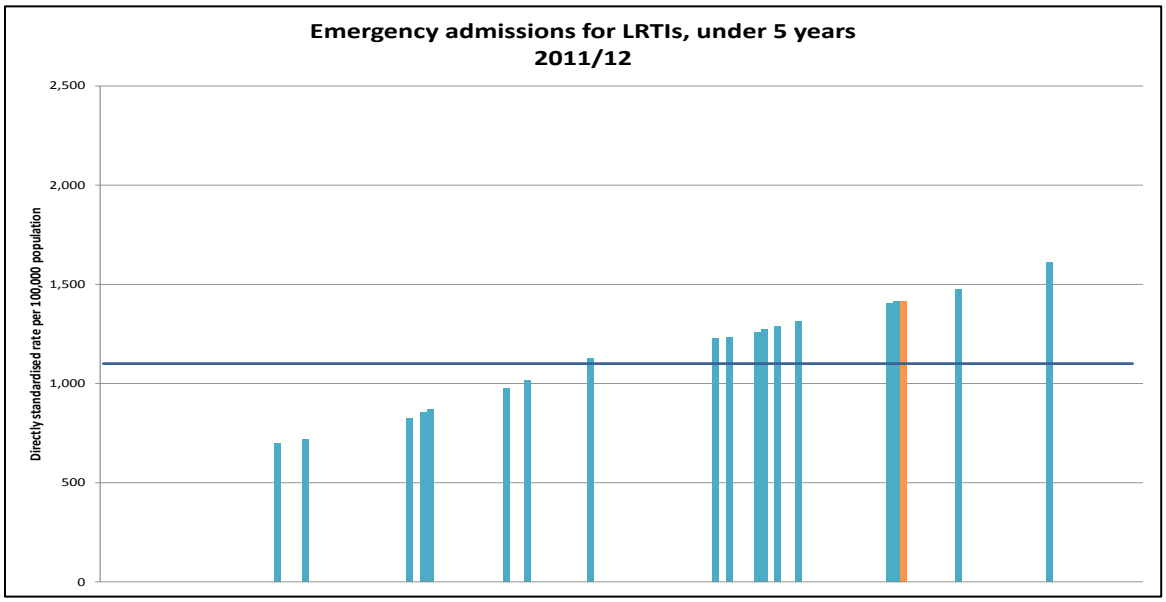

*Source: SUS Admitted Patient Care (APC) Minimum Data Set (MDS)*

**Figure 38: Emergency admissions per 100,000 population aged, under 5 years in Buckinghamshire by deprivation quintiles. Trend chart 2003/04 – 2012/13.**



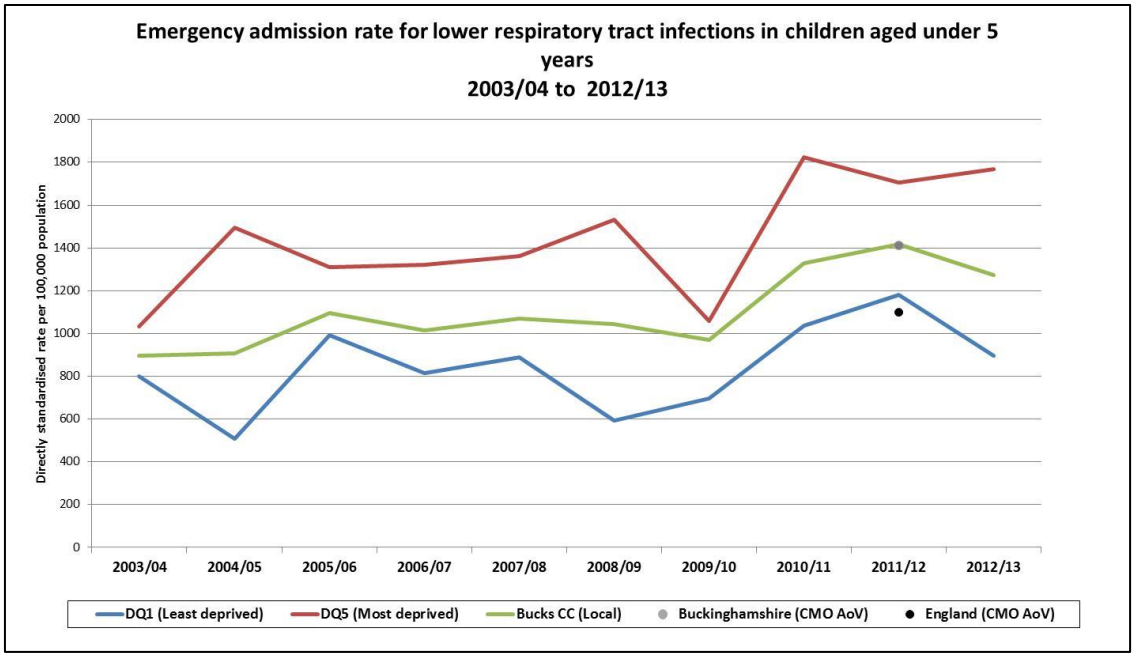

*Source: SUS Admitted Patient Care (APC) Minimum Data Set (MDS)*

**Figure 39: Emergency Hospital admissions rate per 100000 population aged under 5 years for lower respiratory tract infections (LRTI) in Buckinghamshire benchmarked against other local authorities in South East, 2011/12.**



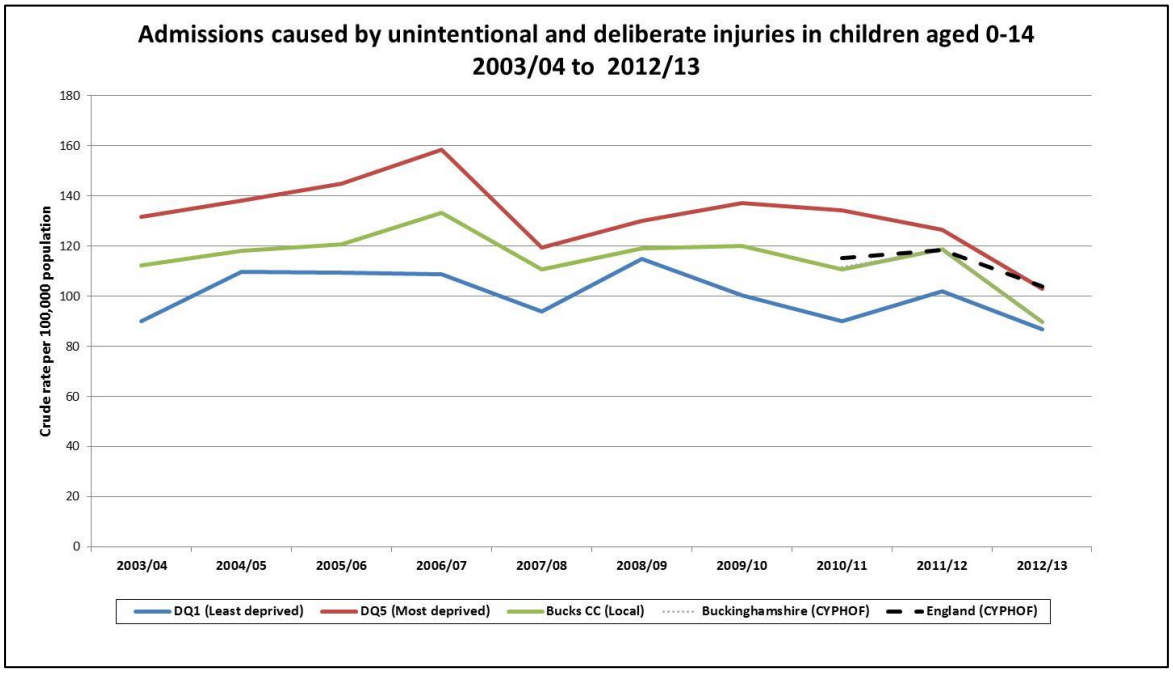

*Source: CMO Report 2012, Atlas of Variation*

**Figure 40: Emergency Hospital admissions rate per 100000 aged under 5 years for lower respiratory tract infections in Buckinghamshire by deprivation quintile. Trend chart – 2003/04 – 2012/13.**



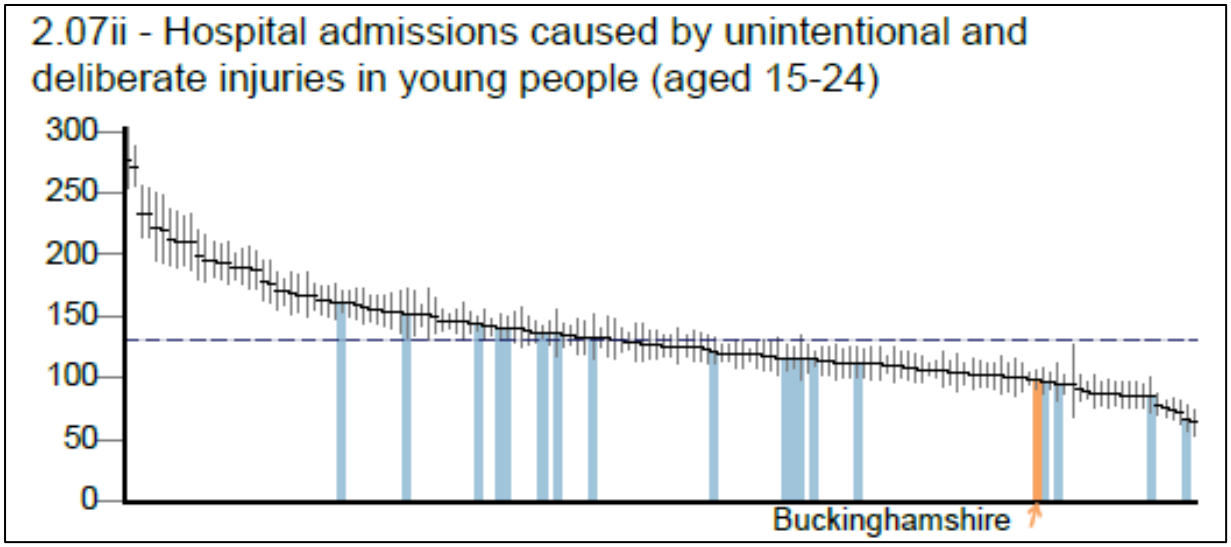

*CMO AoV denotes Chief Medical Officer's Atlas of Variation Report findings.*
*More info at http://www.rightcare.nhs.uk/index.php/nhs-atlas/*
*Link to CMO's report - http://www.chimat.org.uk/CMO2012*
*Source: SUS Admitted Patient Care (APC) Minimum Data Set (MDS)*

**Figure 41: Hospital Admission rate per 100000 population aged 0-14 years caused by unintentional and deliberate injuries in Buckinghamshire by deprivation quintile. Trend chart 2003/04 – 2012/13.**



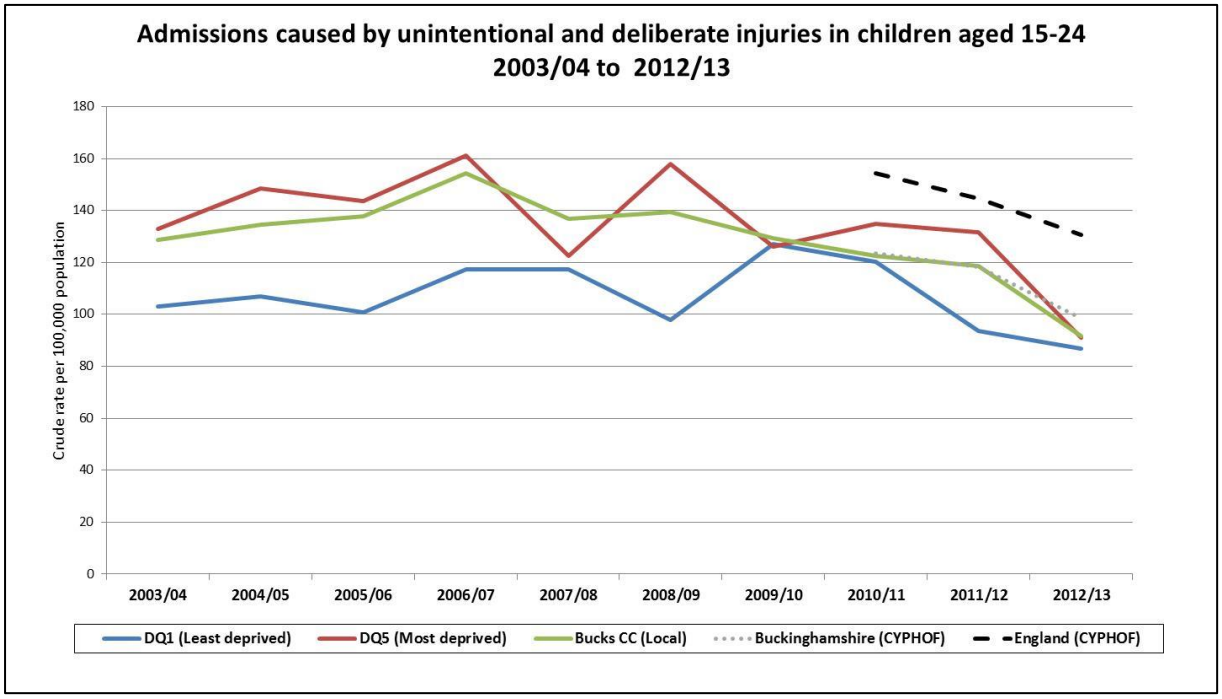

*Source: SUS Admitted Patient Care (APC) Minimum Data Set (MDS)*

**Figure 42: Hospital admission rate per 10,000 young people aged 15-24 caused by unintentional and deliberate injuries in Buckinghamshire benchmarked against other local authorities in South East, 2012/13.**



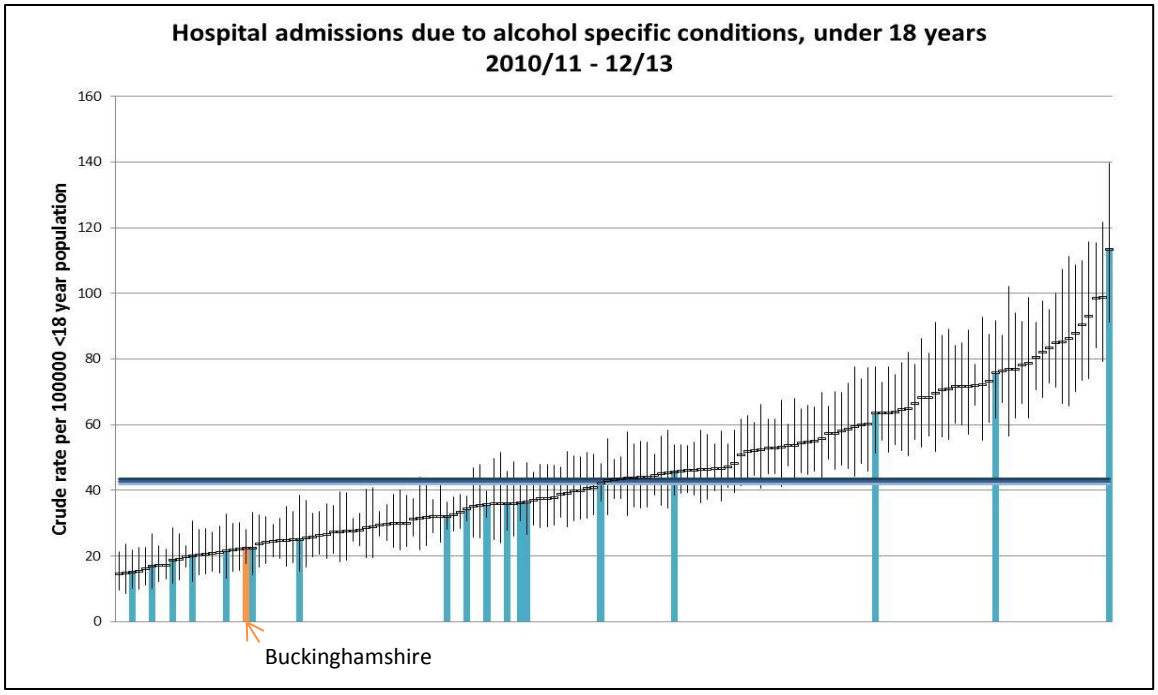

*Source: Public Health outcomes framework, Public Health England*

**Figure 43: Hospital admission rate per 10,000 young people aged 15-24 caused by unintentional and deliberate injuries in Buckinghamshire by deprivation quintiles. Trend chart, 2003/04 – 2012/13.**



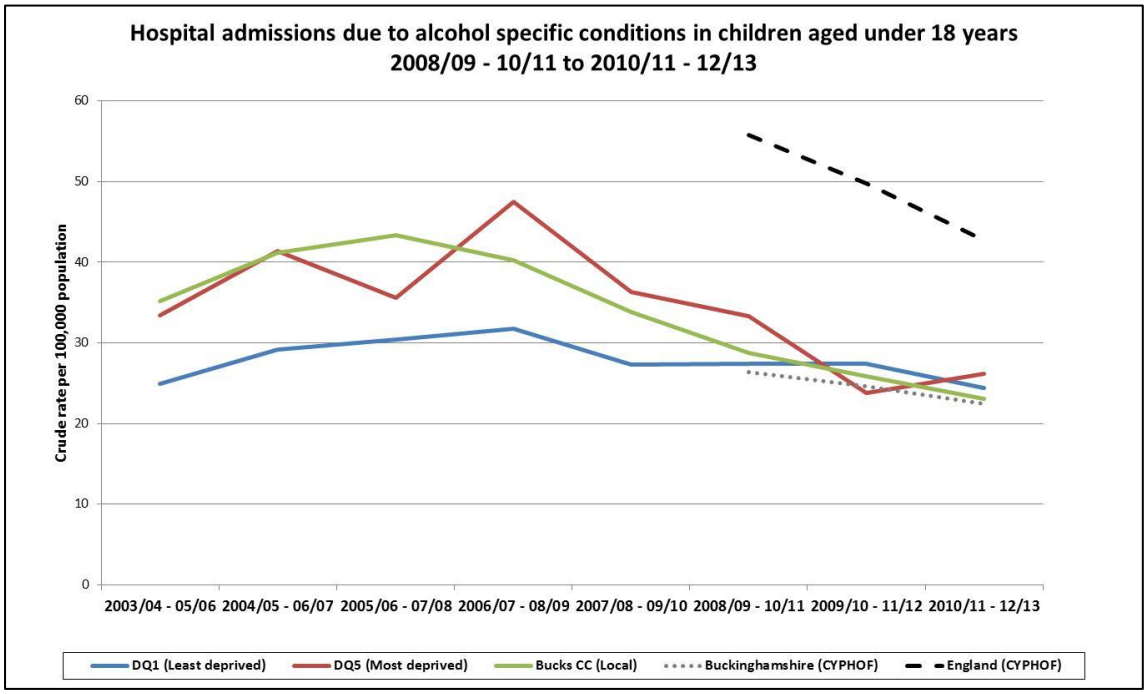

*Source: SUS Admitted Patient Care (APC) Minimum Data Set (MDS)*

**Figure 44: Hospital admission rate per 100,000 population aged under 18 years, due to alcohol specific conditions in Buckinghamshire benchmarked against other local authorities in South East, 2010/11 – 2012/13**



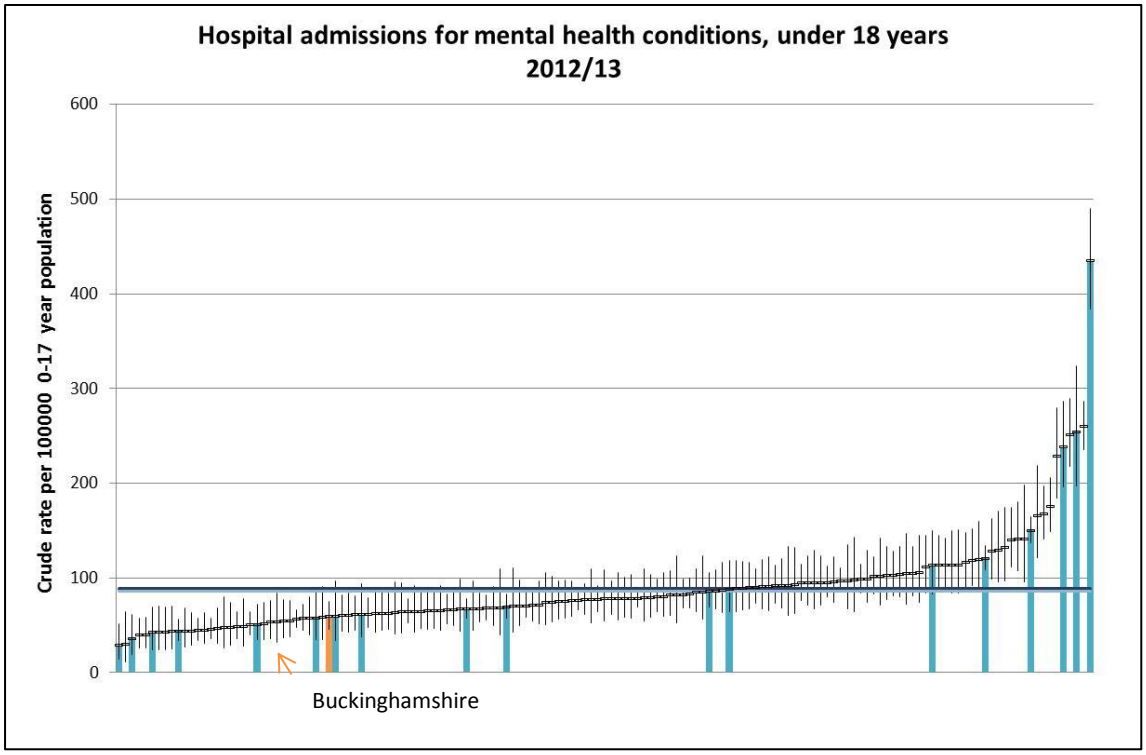

*Source: Children and Young People's Benchmarking Tool, Public Health England.*

**Figure 45: Hospital admission rate per 100,000 population aged under 18 years, due to alcohol specific conditions in Buckinghamshire by deprivation quintiles. Trend chart, 2003/04 – 2012/13**



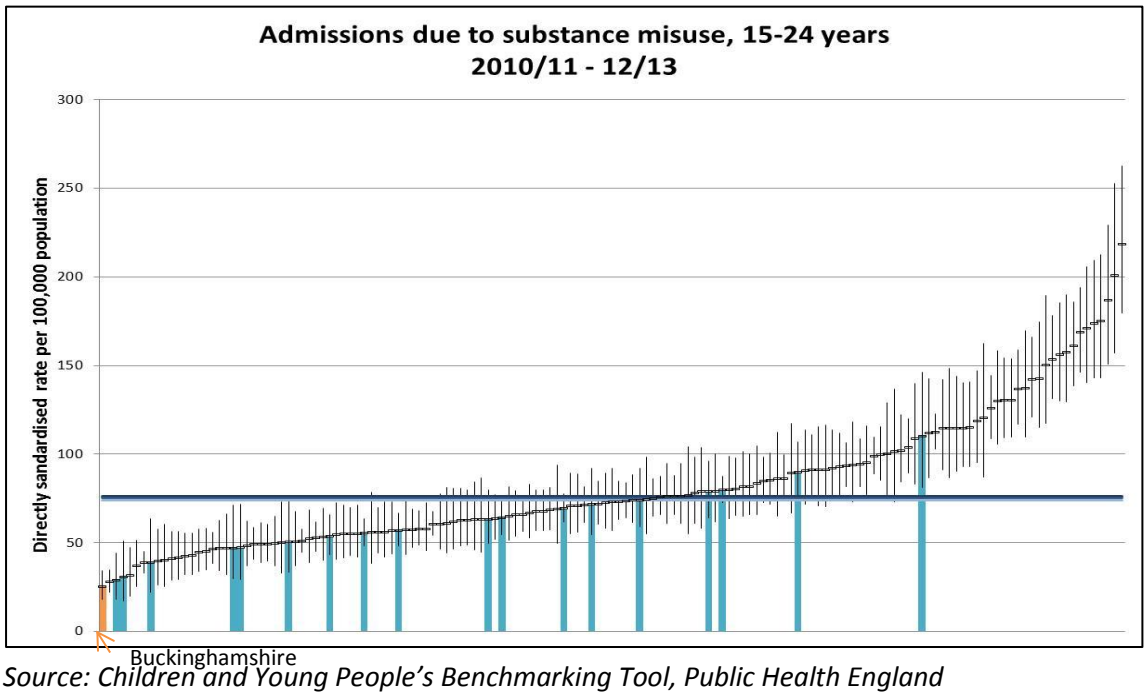

*Source: SUS Admitted Patient Care (APC) Minimum Data Set (MDS)*

**Figure 46: Hospital admission rate per 100,000 population aged 0-17 years for mental health conditions in Buckinghamshire benchmarked against other local authorities in South East, 2012/13.**



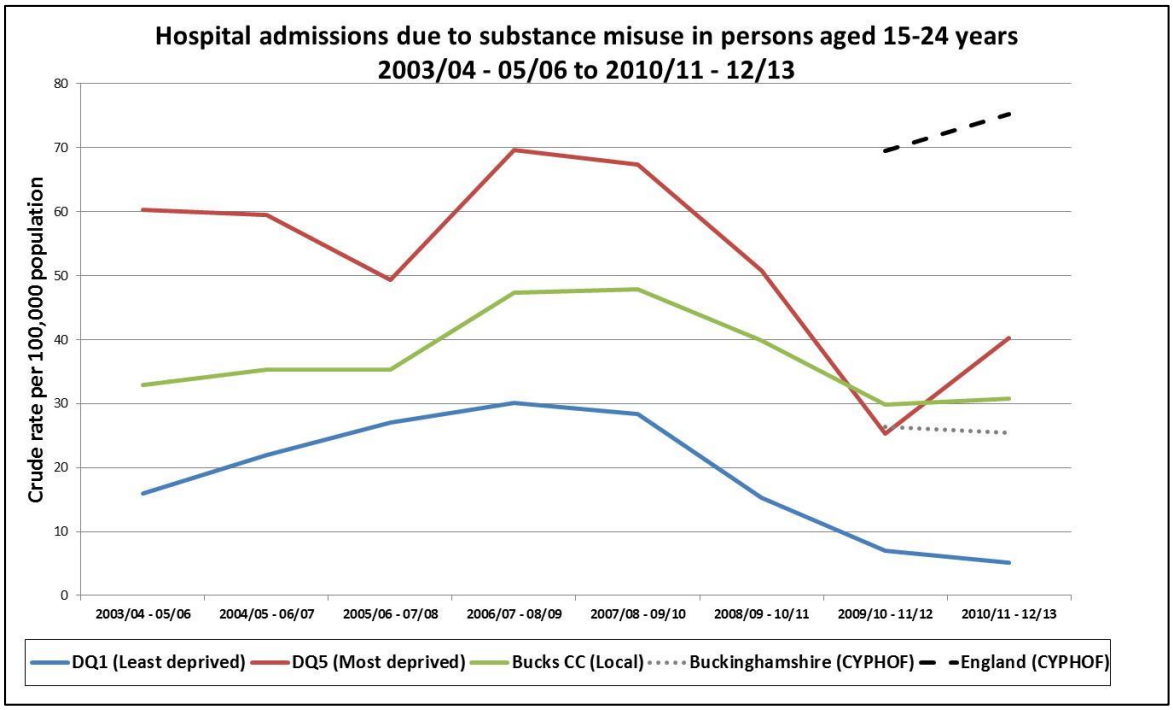

*Source: Children and Young People's Benchmarking Tool, Public Health England*

**Figure 47: Hospital admission rate per 100000 population aged 15-24 years due to substance misuse in Buckinghamshire benchmarked against other local authorities in South East 2010/11 – 2012/13.**



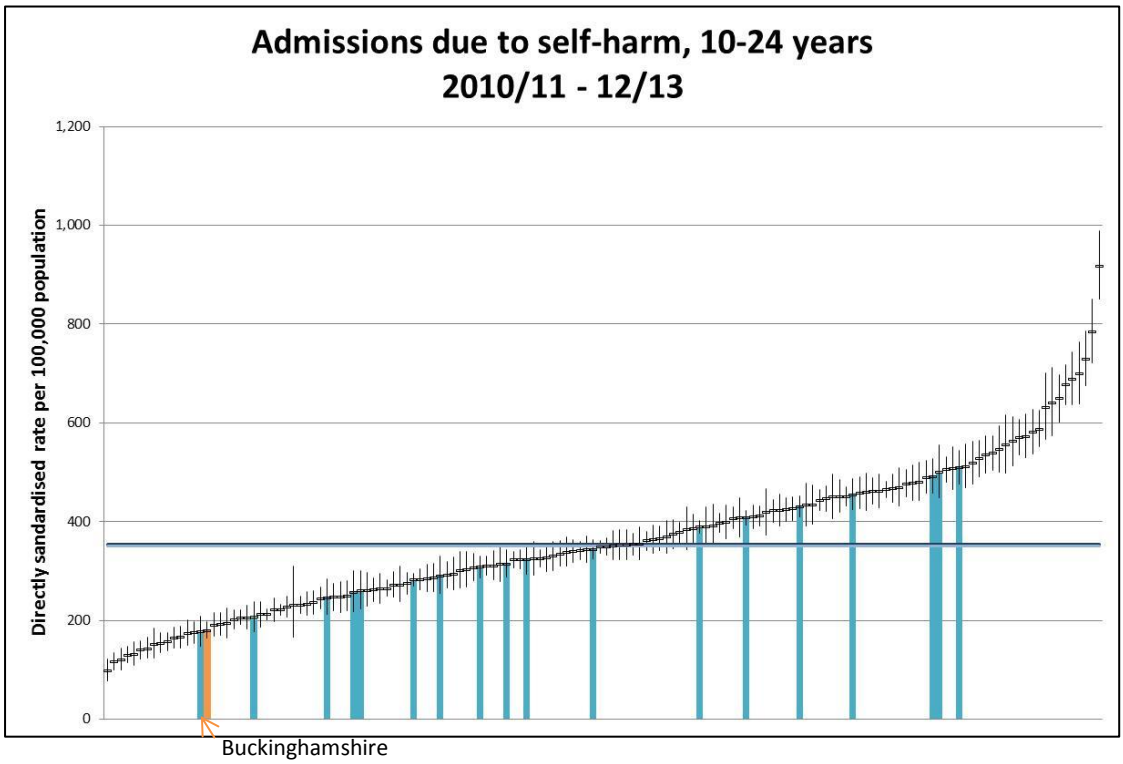

*Source: Children and Young People's Benchmarking Tool, Public Health England*

**Figure 48: Hospital admission rate per 100,000 population aged 15-24 years due to substance misuse in Buckinghamshire by deprivation quintiles. Trend, 2003/04 – 2012/13.**



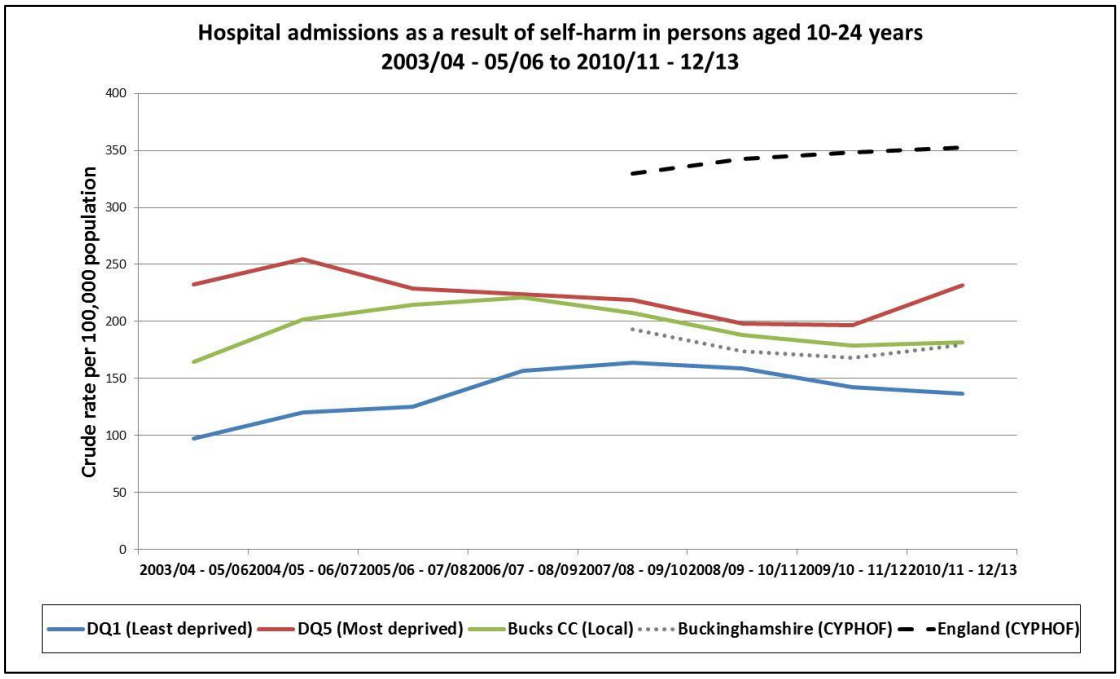

*Source: SUS Admitted Patient Care (APC) Minimum Data Set (MDS)*

**Figure 49: Hospital admission rate per 100,000 population aged 10-24 years due to self-harm in Buckinghamshire benchmarked against other local authorities in South East, 2010/11 – 2012/13.**



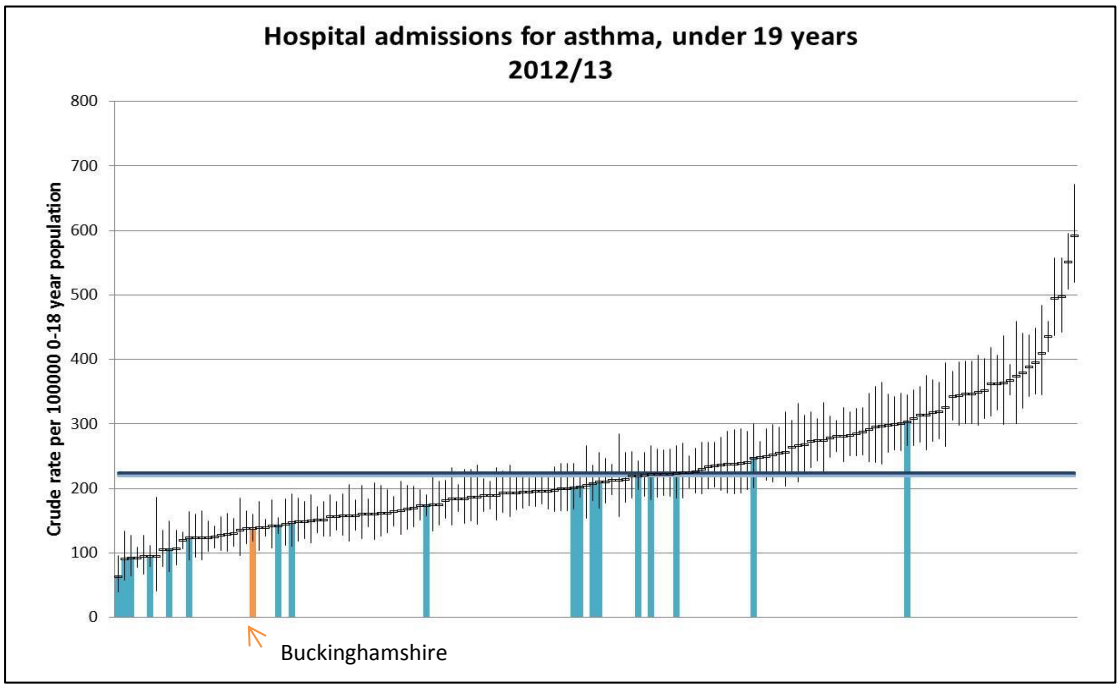

*Source: Children and Young People's Benchmarking Tool, Public Health England*

**Figure 50: Hospital admission rate per 100000 population aged 10-24 years due to self-harm in Buckinghamshire by deprivation quintiles. Trend chart 2003/04 – 2012/13.**



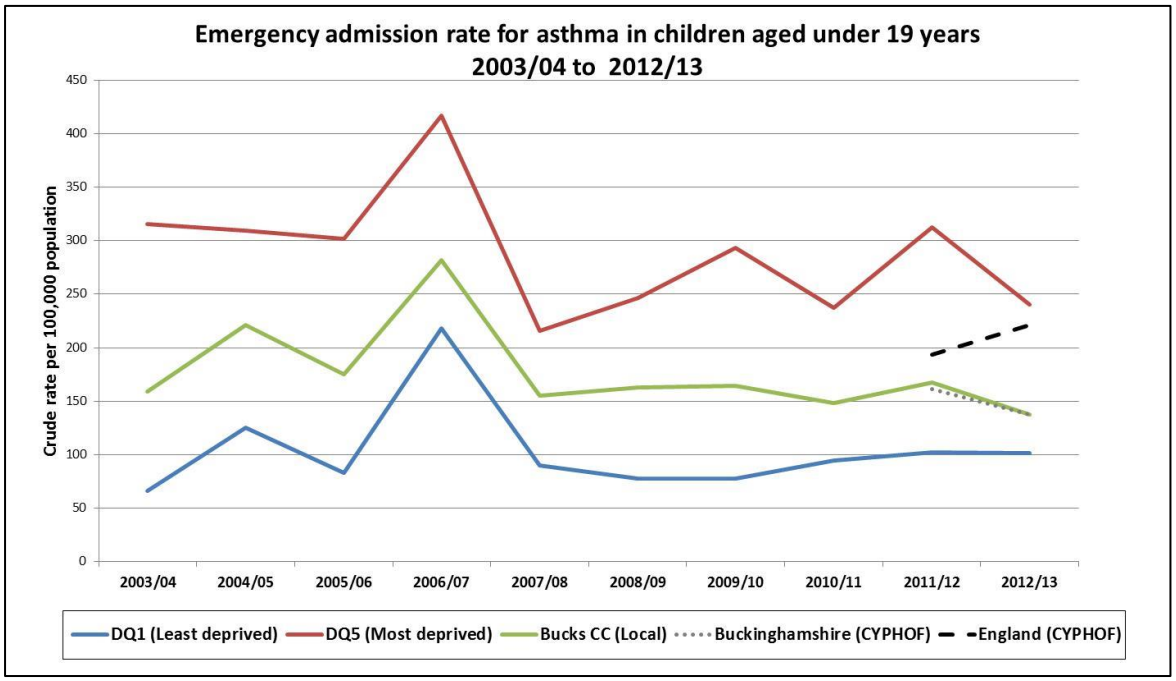

*Source: SUS Admitted Patient Care (APC) Minimum Data Set (MDS)*

**Figure 51: Emergency hospital admission rate per 100,000 population aged 0-18 years due to asthma in Buckinghamshire benchmarked against other local authorities in South East, 2012/13.**



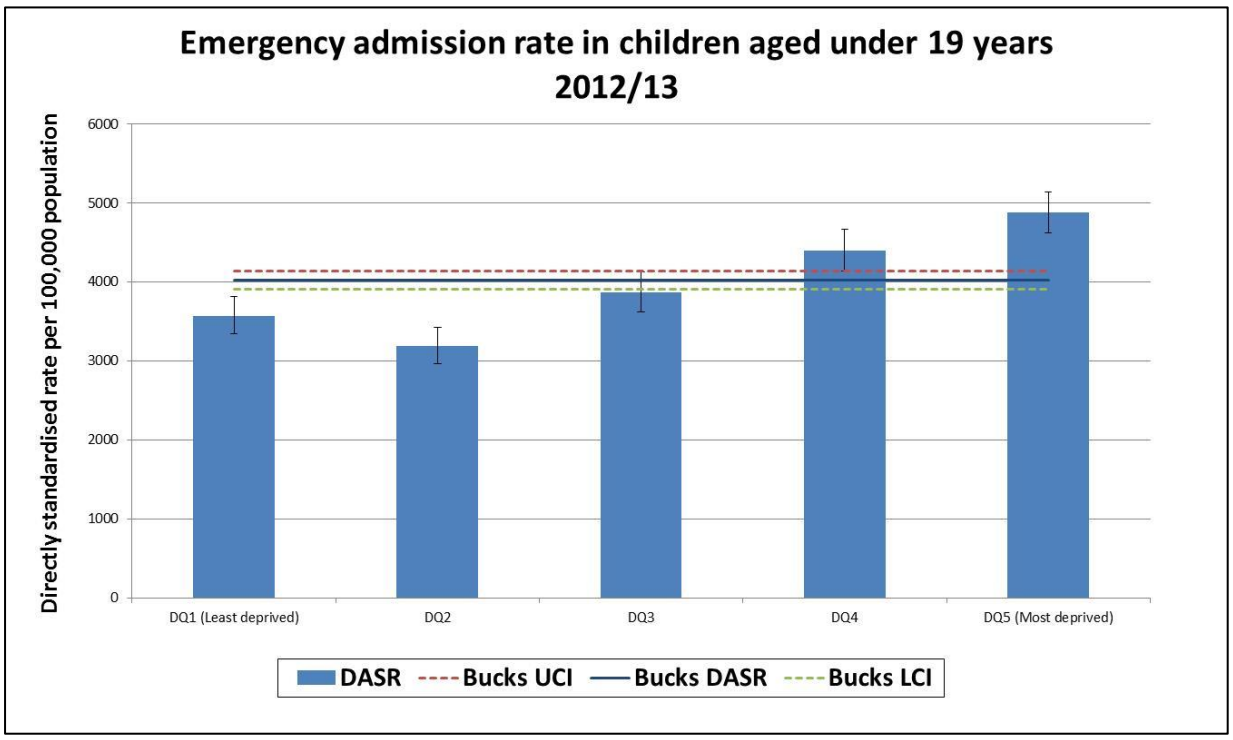

*Source: Children and Young People's Benchmarking Tool, Public Health England.*

**Figure 52: Emergency hospital admission rate per 100000 population aged 0-18 years due to asthma in Buckinghamshire by deprivation quintiles. Trend chart 2003/04 – 2012/13.**



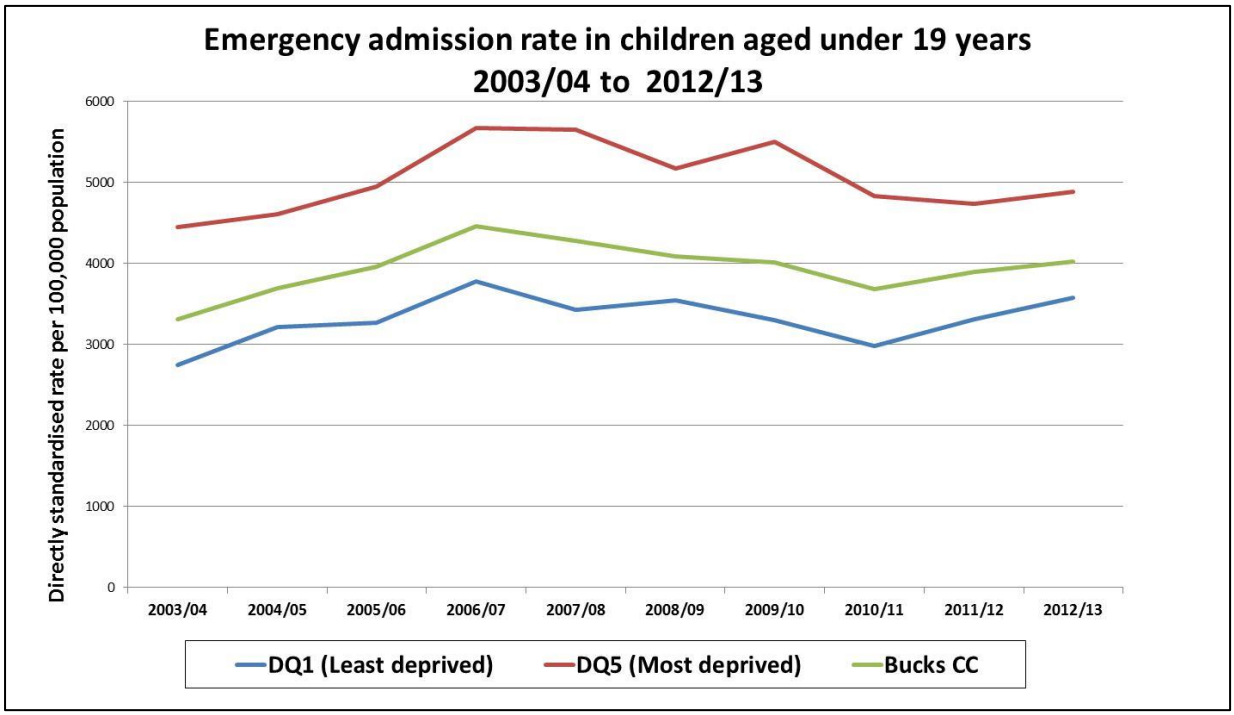

*Source: SUS Admitted Patient Care (APC) Minimum Data Set (MDS)*

**Figure 53: Emergency admission rate per 100000 population aged under 19 years for all causes in Buckinghamshire by deprivation quintiles. 2012/13.**



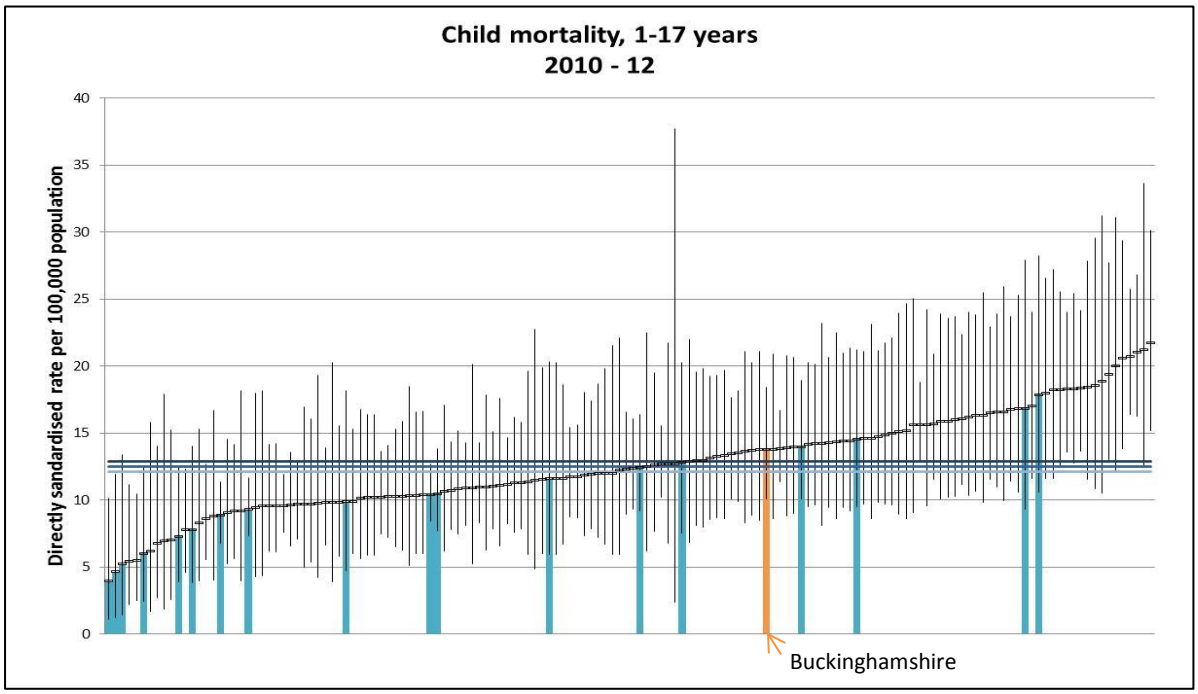

*Source: SUS Admitted Patient Care (APC) Minimum Data Set (MDS)*

**Figure 54: Emergency admission rate per 100000 population aged under 19 years for all causes in Buckinghamshire by deprivation quintile. Trend chart 2003/04 – 2012/13.**



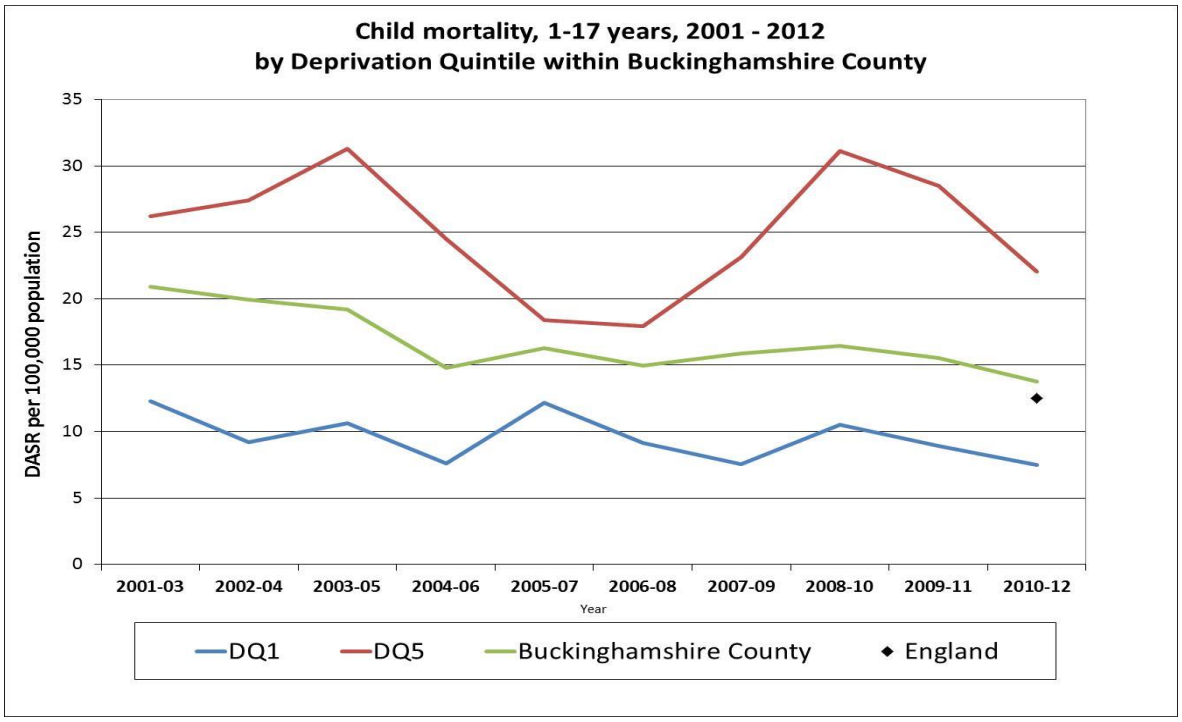

*Source: Secondary Uses Services, Admitted Patient Care (APC) Minimum Data Set (MDS)*

**Figure 55: Child mortality rate – Deaths in children aged 1-17 years per 100000 Population aged 1-17 years in Buckinghamshire benchmarked against other local authorities in South East, 2010-12.**




*Source: Children and Young People's Benchmarking Tool, Public Health England.*

**Figure 56: Child mortality rate – Deaths in children aged 1-17 years per 100000 Population aged 1-17 years in Buckinghamshire by deprivation quintiles. Trend chart. 2001-12.**




*Source: ONS Annual District Death Extracts.*

# DATA SOURCES

| No. | Data/Information Source | Governing Organisation |
|---|---|---|
| 1. | Children and Young People's Benchmarking Tool | ChiMat, (Child and Maternal) PHE |
| 2. | CMO Report 2012, Atlas of Variation | NHS Right Care |
| 3. | Education and skills statistics | Department for Education |
| 4. | HSCIC | Health and Social Care Information Centre |
| 5. | ImmForm | NHS England |
| 6. | Integrated Performance Measure Return | Department of Health |
| 7. | National Child Measurement Programme | Health and Social Care Information Centre |
| 8. | ONS Annual District Death Extracts | Office for National Statistics |
| 9. | Public Health Outcomes Framework | Public Health England |
| 10. | Secondary Uses Services | South Central Commissioning Support Unit |
| 11. | School performance data | County Council |
| 12. | The British Child and Adolescent Mental Health Surveys 2004 | Office for National Statistics, Health & Social Care Information Centre |
| 13. | Child maltreatment review | http://www.eviper.org.uk/downloads/child_mal.pdf |
| 14. | Maternal health outcomes | http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1313012/pdf/9219414.pdf |

# TABLE OF FIGURES

# GLOSSARY

| | |
|---|---|
| **Confidence interval** | Confidence Interval gives an indication of the level of uncertainty of the calculation. It is simply a range within which the true value is likely to fall, based on the data used in the analysis. A 95% confidence interval tells us that we can be 95% certain that the true rate lies somewhere between the lower and upper limits of the confidence interval. |
| **Statistical Significance** | Statistical significance (also mentioned just as significant) means that a difference that is observed is unlikely to be due to chance alone. |
| **Crude rate** | These are calculated by dividing the total number of events (e.g. cases, deaths etc.) in a given time period by the total number of persons in the population. |
| **DASR** | Directly Age-Standardised Rate (DASR) rate. DASR for an area is the number of events, usually expressed per 100,000, that would occur in that area if it had the same age structure as the standard population (e.g. European population) and the local age-specific rates of the area applied. This is useful for comparing populations with different age structures. |
| **Diagnosis rate** | The proportion of the people diagnosed to have the condition among all tested for this condition during a certain period. This is calculated by dividing the number of cases diagnosed (numerator) by the number of people tested or screened (denominator). |
| **Term births** | Childbirth at the end of a normal duration of pregnancy, between 37 to 40 weeks of gestation or about 280 days from the first day of the mother's last menstrual period. |

# ABBREVIATIONS

| | |
|---|---|
| AoV | Atlas of Variation |
| APC | Admitted Patient Care |
| A&E | Accident and Emergency |
| APC | Admitted Patient Care |
| BCC | Buckinghamshire County Council |
| BME | Black and Minority Ethnic |
| BMI | Body Mass Index |
| CCG | Clinical Commissioning Group |
| ChiMat | Child and Maternal Health observatory, PHE |
| CMO | Chief Medical Officer |
| CTAD | Chlamydia Testing Activity Dataset |
| CYP | Children and Young People |
| DH | Department of Health |
| DQ | Deprivation Quintile (DQ1 = Least deprived. DQ5 = Most deprived) |
| DtaP / HiB | Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type b vaccine. |
| FSM | Free School Meal |
| GCSE | General Certificate of Secondary Education |
| HSCIC | Health and Social Care Information Centre |
| ImmForm | Immunisation Form. A web-based tool managing immunisation data |
| IMR | Infant Mortality Rate |
| LRTI | Lower Respiratory Tract Infections |
| MDS | Minimum Dataset |
| MenC | Meningococcal C vaccine |
| MMR | Measles Mumps Rubella |
| NCMP | National Child Measurement Programme |
| NEET | Not in Education Employment Training |
| NHS | National Health Services |

| | |
|---|---|
| ONS | Office for National Statistics |
| PCV | Pneumococcal conjugate vaccine |
| PHE | Public Health England |
| PHOF | Public Health Outcomes Framework |
| SATOD | Smoking at the time of delivery |
| SDQ | Strength and Difficulties questionnaire *(Scoring - 0-13 Normal, 14-16 Borderline, 17+ Significant behaviour problem)* |
| STI | Sexually Transmitted Infections |
| SUS | Secondary Uses Services |