Agenda

Health & Wellbeing Board Buckinghamshire

Date: Thursday 14 September 2017

Time: 1.30 pm

Venue: Mezzanine Room 1, County Hall, Aylesbury

1.00 pm Pre-meeting Discussion

This session is for members of the Committee only.

1.30 pm Formal Meeting Begins

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6	**CHILDREN AND YOUNG PEOPLE UPDATE** **Presenter:** Ms Carol Douch, Service Director Children's Social Care	**13:40**	**15 - 18**
7	**DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT** **Presenter:** Dr Jane O'Grady, Director of Public Health	**14:00**	**19 - 62**
8	**BUCKINGHAMSHIRE JOINT HEALTH AND WELLBEING STRATEGY THEMED AGENDA ITEM ON PERINATAL MENTAL HEALTH** **Presenters:** Dr Nicola Widgington, General Practitioner Ms Ruth House, Health Visitor, Perinatal Mental Health Project Manager	**14:45**	**63 - 64**
9	**UPDATE ON HEALTH AND CARE SYSTEM** To provide an update to the Board with progress on: • Accountable Care System • Better Care Fund **Presenters:** Mr Neil Dardis, Chief Executive, Buckinghamshire Healthcare Trust Ms Lou Patten, Chief Officer, Aylesbury Vale and Chiltern Clinical Commissioning Groups Ms Sheila Norris, Executive Director, Communities, Health and Adult Social Care, Buckinghamshire County Council Ms Jane Bowie, Director of Joint Commissioning, Buckinghamshire County Council	**15:30**	**65 - 68**
10	**FORWARD PLAN** **Presenter:** Ms Katie McDonald, Health and Wellbeing Lead Officer	**16:25**	**69 - 72**
11	**DATE OF NEXT MEETING** The next meeting will be held on 7 November 2017 at 2.30pm in Mezzanine Room 1, County Hall, Aylesbury.		

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: Kristi Bhania on 01296 531024, email: kbhania@buckscc.gov.uk

Members

Mr R Bagge (District Council Representative), Dr R Bajwa (Clinical Chair), Ms J Baker OBE (Healthwatch Bucks), Mr S Bell (Chief Executive, Oxford Health NHS), Mrs I Darby (District Council Representative), Mr N Dardis (Buckinghamshire Healthcare Trust), Lin Hazell, Dr G Jackson (Clinical Chair), Ms A Macpherson (District Council Representative), Mr R Majilton (Director of Sustainability and Transformation), Ms S Norris (Managing Director, Communities, Health and Adult Social Care), Dr J O'Grady (Director of Public Health), Ms L Patten (Accountable Officer (Clinical Commissioning Group)), Ms G Rhodes White, Dr S Roberts (Clinical Director of Mental Health), Dr J Sutton (Clinical Director of Children's Services), Mr M Tett (Buckinghamshire County Council) (C), Dr K West (Clinical Director of Integrated Care), Mr W Whyte and Ms K Wood (District Council Representative)

Health & Wellbeing Board
Buckinghamshire

Status on Health and Wellbeing Board meeting actions:

14.9.17

Date	Action	Lead officer	Update	Status
9.3.17	Health and Wellbeing Board members agreed to submit the strategy through their own governing boards.	All members	Members to update at the September meeting https://www.buckscc.gov.uk/media/4509402/jhws2017april.pdf	In progress
9.3.17	Ms McDonald to follow-up with Jenny Baker and Sian Roberts, who agreed to take forward the proposal to work with Bucks Mind in producing the county-wide mental health directory.	KM	The Bucks Mind online database of mental health services was launched in July 2017 https://www.bucksmind.org.uk/bucks-mind-launches-online-database-of-mental-health-services/ https://www.bucksmind.org.uk/guide/	Complete
9.3.17	It was agreed to add an update on the Mental Health and Wellbeing to the forward plan for the October 2017 meeting. Ms McDonald would follow-up with organisational leads on progress before this date.	KM	This has now been moved to the December meeting	In progress
9.3.17	Board Members agreed to continue to support promotion of the Active Bucks website using all available communication channels to staff and residents. Members also agreed to continue to share any physical activity good practice, or project ideas, with Mr T Burton to ensure sharing across wider networks.	All members	In progress. Members to update at the September meeting http://activebucks.co.uk/	In progress

Health & Wellbeing Board
Buckinghamshire

Minutes

Health & Wellbeing Board Buckinghamshire

MINUTES OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY 9 MARCH 2017, IN LARGE DINING ROOM, JUDGES LODGINGS, AYLESBURY, COMMENCING AT 2.00 PM AND CONCLUDING AT 4.25 PM.

MEMBERS PRESENT

Mr M Appleyard (Buckinghamshire County Council), Ms J Baker OBE (Healthwatch Bucks), Lin Hazell (Cabinet Member for Children's Services), Dr G Jackson (Clinical Chair) (Chairman), Mr D Johnston (Managing Director, Children's Social Care, Children and Young People), Mr H Mordue (District Council representative), Ms S Norris (Managing Director, Communities, Health and Adult Social Care), Dr J O'Grady (Director of Public Health), Ms L Patten (Accountable Officer (Clinical Commissioning Group)), Dr S Roberts (Clinical Director of Mental Health), Ms S Robinson (Oxford Health Foundation Trust), Dr J Sutton (Clinical Director of Children's Services), Dr K West (Clinical Director of Integrated Care) and Mr D Williams (Buckinghamshire Healthcare NHS Trust)

OTHERS PRESENT

Ms J Bowie, Mr T Burton, Ms K McDonald, Ms D Richards and Mrs E Wheaton

1 WELCOME & APOLOGIES

Apologies were received from Mr M Tett, Mrs A Macpherson, Mr S Bell, Mrs K Wood, Mrs I Darby, Mr R Bagge, Mr N Dardis, Ms J Adey and Ms R Shimmin.

Mr H Mordue attended in place of Mrs A Macpherson and Ms S Robinson attended in place of Mr S Bell.

Dr G Jackson chaired the meeting.

2 ANNOUNCEMENTS FROM THE CHAIRMAN

The Chairman welcomed everyone to the meeting.

3 DECLARATIONS OF INTEREST

There were no declarations of interest.

4 MINUTES

The minutes of the meeting held on Thursday 15 December 2016 were confirmed as a correct record, subject to one minor amendment as follows:

Item 6, page 11, fifth bullet should read “Higher numbers of EHC (Education, Health and Care) Plans and increasing EHC assessments.”

The notes of the themed meeting held on Thursday 12 January 2017 were confirmed as a correct record.

5 PUBLIC QUESTIONS

The Chairman welcomed Ms L Whitney to the meeting. She submitted the following question in advance of the meeting which she read out.

“"I wish to ask what arrangements and timetable has the Health and Wellbeing Board put in place to ensure that the Sustainability and Transformation Plan (STP) covering Buckinghamshire receive proper scrutiny from Buckinghamshire County Council.

As I am sure you are aware, STPs are the plans that every part of England has to produce to show how care will be transformed and money saved over the next five years.

As a local resident I am concerned that these plans are being attempted at a pace and with a lack of money that will render them at best unachievable, and at worst deeply damaging to local services.

There has so far been insufficient public and staff involvement in the development of the plans, and the STPs have no formal place in law, so there are further concerns about how those responsible for implementing the plans will be held to account.

At the very least, these plans should be subject to proper scrutiny by the council’s Health and Wellbeing Board.

Government minister David Mowat has stated that if STPs “are failing to address the needs of stakeholders, including councils, they won’t go ahead.”

Councillors should therefore be able to play an important role in ensuring that local people and health and care staff are properly consulted on STPs, and that damaging elements of the plans are reconsidered.

And most recently STP areas have been instructed to produce “credible implementation plans” to turn proposals into action while reconciling contracts and financial targets.

I hope you will ensure that the STP covering residents in Buckinghamshire County receive the level of scrutiny and challenge that such an important plan deserves."

The Chairman explained that the STP would be discussed at this meeting and a response to the question would be provided during the item.

6 JOINT HEALTH AND WELLBEING STRATEGY REFRESH 2016 – 2021

Ms K McDonald, Health and Wellbeing Lead Officer, took Board Members through her presentation. The following main points were made:-

- Local authorities and clinical commissioning groups had equal and joint duties to prepare and publish Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies, through the Health and Wellbeing Board.

- They were required to set out the shared vision for Health and Wellbeing across the whole county and present the high level priorities and outcomes to be used as a basis to shape commissioning and coordinate action to work towards better health and wellbeing for the whole population.
- The strategy built on the priorities set out in the Joint Health and Wellbeing Strategy 2013-16 to ensure it would be fit for purpose for the next five years and would be aligned with future plans across health and wellbeing partnerships in the county.
- The key priorities of the Health & Wellbeing Strategy were detailed as follows:
    - Give every child the best start in life;
    - Keep people healthier for longer and reduce the impact of long term conditions;
    - Promote good mental health and wellbeing for everyone;
    - Protect residents from harm;
    - Support communities to enable people to achieve their potential and ensure Buckinghamshire was a great place to live.
- It was highlighted that the document is a high level strategy only and delivery of the strategy will be aligned with the wider Bucks health and social plans. The Health and Wellbeing Board will be able to measure success of the strategy through planned themed meetings and an annual report alongside the proposed development of a dashboard, including selected health and care indicators to accompany the strategy.

RESOLVED:

The Health and Wellbeing Board confirmed the Joint Health and Wellbeing Strategy as the final version.

Health and Wellbeing Board members agreed to submit the strategy through their own governing boards.

Action: Board Members

(i) FOLLOW UP FROM HWB MENTAL HEALTH THEMED MEETING ON 12 JANUARY

Ms K McDonald, Health & Wellbeing Lead Officer, reported on the actions coming out of the themed meeting on mental health and referred Board Members to the list of actions which had been assigned to individual organisations.

Ms McDonald to follow-up with Jenny Baker and Sian Roberts, who agreed to take forward the proposal to work with Bucks Mind in producing a county-wide mental health directory.

Action: Ms K McDonald

It was agreed to add an update the Mental Health and Wellbeing to the forward plan for the October 2017 meeting. Ms McDonald would follow-up with organisational leads on progress before this date.

Action: Ms K McDonald

7 BUCKINGHAMSHIRE HEALTH AND CARE SYSTEM PLANS

(i) HEALTH AND SOCIAL CARE INTEGRATION - ROAD MAP TO 2020

The Chairman welcomed Ms S Norris, Managing Director of Communities, Health and Adult Social Care (CHASC). Ms Norris took Board Members through the report and

made the following main points:-

- As a system-wide forum, the Health & Wellbeing Board was pivotal to the development of local integration plans.
- The Sustainability and Transformation Plan guidance stipulates that STPs should be aligned with local integration.
- The Health & Wellbeing Board had a key role to play in oversight of progress to drive forward transformation of services in Bucks.
- Given the rising demand on services and financial pressures all agencies were facing, there was a growing need to work together to improve performance and transform care.
- The Buckinghamshire system was developing, taking a strategic view with a set of agreed and shared outcomes and clear action plans to drive forward to reach a fully integrated health and care system by 2020/21.
- To support the next phase of development, four closely interlinked areas of work had been identified – each underpinned by an action plan which was currently being reviewed by the Transformation Delivery Group:-
    - Joint Commissioning
    - Integrated Provision
    - Back office (One Public Estate, Communications and Business Intelligence)
    - Governance.

RESOLVED:

Board Members noted the report and agreed the approach for the Health & Wellbeing Board's role in the on-going oversight of achieving integration by 2020.

(ii) PRESENTATION ON BUCKINGHAMSHIRE HEALTH AND CARE SYSTEM PLANS

Ms L Patten, Chief Officer for Aylesbury Vale and Chiltern Clinical Commissioning Groups, and Mr D Williams, Director of Strategy at Buckinghamshire Healthcare NHS Trust took Board Members through the presentation. The following main points were made:-

- 44 STP footprints across England of a scale which should enable transformative change and the implementation of the Five Year Forward View vision of:
    - Better health and wellbeing;
    - Improved quality of care; and
    - Stronger NHS finance and efficiency.
- Buckinghamshire, Oxfordshire, Berkshire West (BOB) 'footprint' 1.8m population, £2.5bn place based allocation, 7 Clinical Commissioning Groups, 6 Foundation Trust & NHS Trust providers, 14 local authorities.
- Resources allocated to BOB CCG commissioners for purchasing health services total £2.55bn in 2016/17 and will increase to £2.87bn by 2020/21, an increase of 12%.
- Programme management structure and process were reviewed in January 2017 and continues to be refined.
- The Sustainability and Transformation Plan (STP) Executive Board continues to drive this work.
- STP Operational Group oversees and aligns delivery of the three health and care system plans and BOB wide programmes.
- About 30% of efficiencies would come from working at scale at STP level and about 70% would come from local health and care plans.

RESOLVED:

Board Members discussed the presentation on Buckinghamshire Health and Care System Plans.

(iii) BETTER CARE FUND 17-19 UPDATE

The Chairman welcomed Jane Bowie, Director of Joint Commissioning (BCC) and Debbie Richards, Director of Commissioning and Delivery (CCGs). The following main points were made during the discussion:-

- The Better Care Fund (BCF) was a local single pooled budget to incentivise the NHS and local government to work in partnership to integrate health and social care services.
- The BCF was governed through a S75 agreement.
- The BCF in Buckinghamshire had followed the nationally-set financial contributions, made up of:
    - CCG minimum contributions;
    - Disabled Facilities Grant;
    - Care Act 2014 monies;
    - Former Carers' Breaks funding.
- There was a joint recognition that more could be done with the BCF to further the system integration.
- NHS England (NHSE) was due to issue a planning template and guidance at the end of 2016 but this had not yet happened. The latest timings for the guidance were mid-March.
- Once the guidance had been published, Buckinghamshire would submit a BCF Plan to NHSE which would consolidate many of the initiatives that were in the 2016/17 BCF.
- The final plan would go to the Council's Cabinet, the Integrated Commissioning Executive Team (ICET) and the CCG Executives for sign-off before being submitted to NHSE by mid-May (date to be confirmed).
- There would be a BCF workshop in June to consider the BCF Plan involving a wider range of stakeholders, including Health and Wellbeing Board Members.
- Members discussed how they could improve reporting of data to the Health and Wellbeing Board, including more detail on the exact numbers involved within the reported indicators.

RESOLVED:

Board Members agreed the approach outlined in the report and noted that the final submission would not be taken to the Health & Wellbeing Board (no planned meeting prior to the national submission deadline).

Board Members agreed that the Integrated Commissioning Executive Team would secure approval of the submission through its governance channels and would keep the Chairman and Vice-Chairman of the Health & Wellbeing Board informed throughout the process.

8 CYP IMPROVEMENT PLAN UPDATE

Mr D Johnston, Managing Director for Children's Social Care and Learning provided Board Members with a verbal update on the CYP Improvement Plan. The following main points were made:-

- Following an Inspection in 2014, Buckinghamshire County Council's Children and Young People Services had been subject to an improvement notice, resulting in an Improvement Board and Improvement Plan being put in place.
- Ofsted letters were published on Ofsted's website. Ofsted visits had taken place every three months.
- The Council was due a follow-up visit at the end of Feb but had been delayed until 11th and 12th April. The resulting letter would be published on Ofsted's website within approximately 3 weeks.
- Ofsted had not confirmed the date of their next full inspection.
- There had been an improvement in the recruitment and retention of social worker staff and the Council's agency staff level was around 20% which reflected favourably with the Council's peers.
- The Children in Need service had been restructured and there were now dedicated specialist teams in place.
- A transformation plan was being developed which focussed on children and families most in need and sought to support families and children at an earlier stage.

The Chairman thanked Mr Johnston for his update.

9 BUCKINGHAMSHIRE PHYSICAL ACTIVITY STRATEGY AND ACTIVE BUCKS

The Chairman welcomed Mr T Burton, Public Health Practitioner. The following main points were made during the presentation:-

- The Active Bucks programme had been designed to provide Bucks residents with the opportunity to increase their levels of regular physical activity, with a focus on engaging residents that do not achieve recommended activity guidelines.
- Between May 2016-September 2017, a minimum 142 activity programmes would be commissioned.
- 3,500 residents had provided feedback to help shape activities.
- 2,202 unique participants had taken part so far – 74.9% of these participants did not meet the activity guidelines at the point they registered with 35% classifying themselves as inactive.
- There had been over 10,300 attendances.
- 26 active Community Champions had been recruited to promote and support activity.
- There had been over 29,000 visits to the website with over 1,850 'first session free' activity vouchers downloaded.
- The current Buckinghamshire Physical Activity Strategy was developed in 2013/14 to last until March 2017. A multi-agency group agreed that the Strategy should be extended for an additional year to March 2018 to ensure the new Strategy incorporated the implications of the new national Sport England Strategy.
- Buckinghamshire County Council had been shortlilsted for an LGC award (Public Health category) for its whole system approach to physical activity.
- The Public Health team was currently working with 20 Bucks primary schools to introduce the Daily Mile initiative. Active travel was also being encouraged in schools by encouraging them to adopt School Travel Plans and improve cycling skills through the Bikeability programme.
- Adolescent girls remained more inactive than their male counterparts. A 'Girls Active' project was working with 11 Bucks secondary schools.

- Physical activity had been embedded into the Live Well, Stay Well single point of access for lifestyles and long term conditions. Physical activity was also highlighted in the Sustainability and Transformation Plan (STP) as a key means to prevent and treat various long-term conditions.
- Health walks through Simply Walks continued to expand with 80 individual weekly walks taking place across Bucks.
- An Expression of Interest had been submitted to Sports England as part of their Active Ageing Fund.

RESOLVED:

Board Members agreed to continue to support promotion of the Active Bucks website using all available communication channels to staff and residents. Members also agreed to continue to share any physical activity good practice, or project ideas, with Mr T Burton to ensure sharing across wider networks.

Action: Board Members

Board Members agreed to support and approve the development of the new Physical Activity Strategy to be ready by 2018.

10 REFRESH OF THE PHARMACEUTICAL NEEDS ASSESSMENT

The Chairman welcomed Dr E Youngman, Consultant in Public Health Medicine. The following main points were made during the presentation:-

- The Health and Social Care Act 2012 gave Health and Wellbeing Boards the statutory duty to develop and publish Pharmaceutical Needs Assessments (PNAs) for their areas by 1 April 2015.
- The Buckinghamshire Health & Wellbeing Board published their PNA in March 2015. Health & Wellbeing Boards were required to publish a revised assessment within three years of publication of their first assessment – by the end of March 2018.
- It was proposed that a steering group be established to complete the 2018 PNA.
- Ms L Patten, Chief Officer for Aylesbury Vale and Chiltern CCGs, offered her professional support and advice to the steering group.

RESOLVED:

Board Members noted and approved the process for carrying out a fit for purpose pharmaceutical needs assessment for Buckinghamshire as set out in the paper.

The PNA Steering Group to summit a progress report in September 2017.

Action: Dr Youngman on behalf of the PNA Steering Group

11 DATE OF NEXT MEETING

The next meeting is due to take place on Thursday 15 June 2017 at 10.30am.

CHAIRMAN

Health & Wellbeing Board
Buckinghamshire

Title	Children and Young People Update
Date	14 September 2017
Report of:	Gladys Rhodes-White - Interim Executive Director Children's Services Cllr Warren Whyte - Cabinet Lead for Children's Services
Lead contacts:	Carol Douch – Service Director, Children's Services

Purpose of this report:

1. To provide the Health and Wellbeing Board with an update on the Children and Young People's 'Change for Children' Programme, including the Early Help Review and Ofsted Improvement journey. A verbal update from Cllr Warren Whyte and Carol Douch will be provided at the meeting.

2. To update the Board on the refreshed Children's Strategic Partnership Board and plans for the future work programme and priorities. Further information on the Children's Partnership Board is included in this report.

Recommendation for the Health and Wellbeing Board:

1. To note the report and accompanying updates from the Cabinet Lead for Children and Young People Warren Whyte and Carol Douch
2. To discuss the role of the Health and Wellbeing Board in oversight of the Children's Partnership Board priorities and ensuring strong links with the Joint Strategic Needs Assessment and the Health and Wellbeing Board

Background documents:

Early Help Review Cabinet Paper 10 July 2017
https://democracy.buckscc.gov.uk/documents/s98409/Report%20for%20Early%20Help%20Review.pdf

Early Help review consultation (concludes 22 September) and information documents

https://www.buckscc.gov.uk/services/care-for-children-and-families/improving-early-help-services-for-children-young-people-and-families/

https://www.buckscc.gov.uk/services/care-for-children-and-families/improving-early-help-services-for-children-young-people-and-families/questions-about-changes-to-early-help-services/

1. Buckinghamshire Children and Young People's Strategic Partnership Board

Overview
The Children and Young People's Strategic Partnership Board held its first meeting in August 2017. The Board is an important strand of the Buckinghamshire Children and Young People's Partnership arrangements and will have an important role in bringing together key senior partners in a decision making forum.

The Board is currently agreeing a revised Terms of Reference, covered in this document and is working with public health colleagues to plan how it will identify local priorities and issues linked to the Children and Young People's Plan (CYPP), Joint Strategic Needs Assessment (JSNA), Local Community Plans and Partners' Plans; to co-ordinate and monitor agreed actions and priority areas.

The partnership will be informed by a variety of sources including the three Local Children's Partnership Boards, the Youth Voice Steering Group, the County Council's Residents' and Children and Young People's Surveys and other mechanisms that involve the views of children, young people, parents and carers. The Local Partnership Boards will identify gaps in service provision and provide two-way communication with the Strategic Partnership Board.

Membership

The membership includes County Council and District Colleagues, NHS, include Acute Services, Mental Health Services and Clinical Commissioning Groups and Community and Hospital Services Provider, Police, Community Voluntary and Faith Sector representative.

Governance and accountability

The Board will report to the respective organisational corporate management teams, the Health and Wellbeing Board and have a dotted line to the Buckinghamshire Safeguarding Children Board (BSCB) and Buckinghamshire Safeguarding Adult Board (BSAB).

Functions

The Strategic Partnership Board will work at a strategic level to:

- Identify local priorities based on need and linked to the Children and Young People Plan, the Joint Health and Wellbeing Strategy, and the Joint Strategic Needs Assessment.
- Ensure that local representatives and their colleagues within their organisations are aware of and up-to-date with the CYP's Partnership's strategic direction.
- Give direction and specific actions to the Local Partnership boards and other task and finish groups
- Report on outcomes, achievements and issues to the Health and Wellbeing Board
- Monitor the delivery of outcomes for each priority identified.

- Identify, challenge and support areas that are not working well or that could be improved and develop community-focussed solutions using partnership support to tackle the issues. For example, where a provision is underperforming or missing; supporting voluntary, community and faith contributions, etc.

- Link closely with the Local Area Forums (LAFs) and Local Community Groups.

- Identify resource and funding opportunities

- Helping the Bucks Association of Secondary Heads, the Primary Executive Board and the Governors' Consultative Board to form their priorities.

- Promote community focussed solutions and the use of the Voluntary and Community Sector.

- Work together with the Clinical Commissioning Groups.

Agreeing the forward plan

The Board is at the stage of coordinating a forward plan and a set of performance metrics to guide prioritisation.

The aim is that the Strategic Board will focus on some of the 'Give Every Child the Best Start in Life' Joint Health and Wellbeing Strategy priority areas and the accompanying performance metrics which are due to be agreed by the Health and Wellbeing Board in November 2017.

Initial discussions with partners at the first meeting suggested deep dives into the following areas:

Childhood Obesity
Children's Mental Health
Eating disorders
Sexual Health
Transitions and
Disabilities
Repeat referrals at Accident and Emergency.

Information from Public Health and the Joint Strategic Needs Assessment flag the following indicators as areas for further analysis:

Where Buckinghamshire is worse compared to England average

- Emergency Admissions in Children aged 0-4 years (per 1000)
- Chlamydia detection in young people 15-24 years (per 100,000)[1]
- Hospital admissions caused by unintentional and deliberate injuries in young people 15 - 24 years (per 10,000)

Where Buckinghamshire is similar to national average where we would expect to see better results:

- Low birth weight of term babies

- School readiness: children with free school meal status achieving good level of development at the end of reception (%)
- Proportion of 5 year old children free from dental decay (%)
- Child mortality rate (1-17) (per 1000)
- Hospital admissions as a result of self-harm in children and young people aged 10-24 years (per 100,000)
- Children aged 0-15 years providing 20+ hours week of unpaid care (%)
- Hospital admissions caused by unintentional and deliberate injuries in children 0 - 14 years (per 10,000)

It is the intention of the Strategic Board to select a number of priority areas for focus in the first year and report back to the Health and Wellbeing Board with recommendations for action on a regular basis.

The Board will also have a role in assessing Early Help to provide evidence on the impact of new service areas and how well Buckinghamshire is performing.

As well as reporting into the Health and Wellbeing Board, the Strategic Partnership Board will work closely with the Buckinghamshire Safeguarding Children and Safeguarding Adult Boards Board and the Safer and Stronger Bucks Partnership Board (SSBPB) to ensure aligned approaches on common themes of interest. Action is currently being taken on a number of complex issues with a cross over between boards, including; Child Sexual Exploitation, the Prevent Agenda, Female Genital Mutilation, Domestic Abuse, Modern Slavery and Gangs and Youth Violence. The Children's Strategic Partnership Board will be kept informed of progress and also support in highlighting any gaps and escalating these to the appropriate forums. As reporting systems evolve, the Strategic Partnership Board may make recommendations to the Health and Wellbeing Board to co-ordinate 'Task and Finish' groups to focus on specific areas linked to the delivery of the overarching Joint Health and Wellbeing Strategy.

Health & Wellbeing Board
Buckinghamshire

Title	Director of Public Health Annual Report 2016/17 *From the very beginning: Pregnancy and Beyond*
Date	14 September 2017
Report of:	Dr Jane O'Grady, Director of Public Health

Purpose of this report:

It is a statutory duty for the Director of Public Health to produce an annual report on the health of their population. The theme of the 2016/17 report is the importance of a healthy pregnancy and the first months of life for the health, happiness and success of Buckinghamshire residents.

Summary of main issues:

The report highlights the vital importance of factors such as being a healthy weight, eating well and having good mental health during pregnancy and the particular risks to mother and baby of maternal smoking or alcohol or drug use at this time. The health of mothers and babies in Buckinghamshire is generally good, but 7.6% of babies are born prematurely, i.e. before 37 weeks, and 2% of babies born after 37 weeks are low birthweight, which can have lifelong consequences on their health. Births before 34 weeks account for half of all long term neurological disabilities in children and three quarters of neonatal deaths.

A range of factors contribute to prematurity and low birthweight, some of which are known and modifiable or avoidable. Known modifiable risk factors include maternal smoking, drug or alcohol misuse, domestic violence and maternal stress. What happens before birth and the early years affects a baby's health and life chances over the whole of their life into adulthood.

The report underlines the importance of maternal mental health for mother and baby and warm and sensitive parenting to help babies and children to develop well, be happy and ready to learn. It also highlights the devastating impact that domestic violence can have on the mother's and baby's health. Nationally 1 in 4 women will experience domestic abuse and it often starts or escalates during pregnancy. The ability of parents to give children the best start in life also depends on their social context. Many of the factors that impact on the chance of a healthy pregnancy and early childhood cluster together.

In Buckinghamshire, we need to ensure that people are provided with the right information, skills and support to make the best choices and look after their health and that of their baby. Success depends on the contribution of all partners and we need to work together with individuals and communities to improve outcomes for babies, their mothers and families.

The report recommends:-

- That key factors that could impact on the mother's, baby's and family's health are identified and addressed by frontline staff
- Buckinghamshire County Council and partners consider developing a comprehensive strategy to support parents in Buckinghamshire

- All parents should be encouraged to access universal parenting advice
- Data collection is enhanced so we can evaluate the impact of our services
- Schools consider how they can help prepare the next generation to be successful parents
- That all partners consider how they can contribute to improving outcomes for babies, mothers and families in Buckinghamshire.

The public health team are coordinating a workshop in October to explore how outcomes can be further improved for mothers and babies, and to develop an action plan to support the implementation of the report's recommendations.

Recommendation for the Health and Wellbeing Board:

- For members of the Health and Wellbeing Board to consider and endorse the Director of Public Health's Annual Report.
- For members of the Health and Wellbeing Board to discuss how their constituent organisations are able to support the recommendations set out in the report to improve outcomes for babies, mothers and families in Buckinghamshire.
- For members of the Health and Wellbeing Board to disseminate the Director of Public Health Annual Report through their organisations
- For members of the Health and Wellbeing Board to endorse the partnership workshop planned for October to improve outcomes for families, mothers and babies in Buckinghamshire.

Background documents:

1. From the very beginning: pregnancy and beyond - Full Report available as the first link on the Public Health DPHAR webpage: **http://www.healthandwellbeingbucks.org/jsna-dphar**
2. From the very beginning: pregnancy and beyond – express version (attached)
3. Data Supplement – Maternity (attached)
4. Data Supplement – Public health outcomes grid (attached)

EXPRESS

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2016/17

FROM THE VERY BEGINNING

Pregnancy and Beyond

1 Introduction

What happens during pregnancy and the earliest months after a child is born has a dramatic impact on a child's life and the adult they become. Getting it right at this critical time offers the best chance we have of raising happy and healthy children who reach their full potential, live satisfying lives and contribute positively to their community. Investing in the early years is good for society, promotes economic growth and reduces demand on health and social care services.

For these reasons this year's Director of Public Health Annual Report highlights the importance of pregnancy and the early years in Buckinghamshire.

2 The picture in Buckinghamshire

There are 6,000 babies born every year in Buckinghamshire and about three-quarters of these babies are delivered by Buckinghamshire Healthcare Trust. In Buckinghamshire Healthcare Trust, approximately one in four babies were identified by their mothers as being of non-white ethnicity. For all mothers giving birth in Buckinghamshire, one quarter of mothers were born outside the UK. The most common countries of origin of the mothers were Pakistan, Poland, India and South Africa.

The most common age of mothers in Buckinghamshire in 2015 was 30 to 34 years and the average number of babies born to a woman in Buckinghamshire over her lifetime is just under two per woman.

Teenage conceptions have almost halved over the last 19 years and in 2015 there were 153 deliveries to women estimated to be under 20 years old at the time of conception.

In 2015, 540 babies or 9% of all babies were born to lone mothers in Buckinghamshire. 10.8% of all children under 16 in Buckinghamshire are living in poverty, which is half the national average.

The health of mothers and babies in Buckinghamshire is generally good although the prevalence of low birthweight and prematurity are similar to the national average.

3 Low birth weight & prematurity

In Buckinghamshire, 7.5% of all babies (live and stillborn) are low birthweight, which is similar to the national average and has remained unchanged for several years. 7.6% of all live births are preterm.

A premature or preterm birth is when a baby is born alive before the 37th week of pregnancy and a low birthweight is below 2.5kg. There is a link between low birthweight and prematurity as premature babies are often low birthweight. Approximately 2% of babies born at term (after 37 weeks of pregnancy) are also low birthweight.

Low birthweight and preterm birth are important indicators of mother and baby's health. Preterm birth before 34 weeks accounts for three quarters of neonatal deaths and half of all long term neurological disability in children. 9.7% of all babies born in the most deprived fifth of the population in Buckinghamshire are low birthweight, compared with 5.8% in the least deprived fifth.

As the main report highlights, a range of factors contribute to premature delivery or low birthweight babies. Some factors are unknown, but others are known and modifiable or potentially avoidable including maternal smoking or alcohol consumption in pregnancy, drug misuse, domestic violence and maternal stress. Reducing modifiable risk factors, such as smoking in pregnancy, can help to reduce the prevalence of preterm birth and low birth weight.

In other cases there are clinical reasons for premature birth. Mothers at-risk of their babies being born prematurely for clinical reasons can be referred to a specialist prematurity clinic at Buckinghamshire Healthcare Trust.

4 The impact of the physical & mental health of the mother

The physical and mental health of the mother before and during pregnancy and after the baby is born is critical to the healthy development of the baby. The health of the father or other primary care giver is important too, but the mother's health has the most direct impact. The social circumstances in which the mother, baby and family live also have a very important influence on the health of the baby and family, both directly and indirectly.

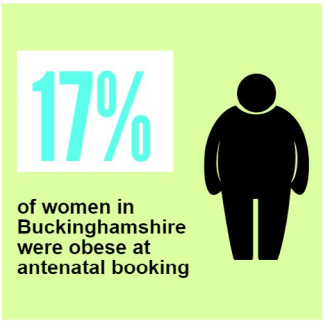
Factors in pregnancy, such as the mother's diet, weight, whether they or other family members smoke, and whether they drink alcohol or use drugs can affect the development of the baby before birth. For these reasons it is important mothers are as healthy as they can be before they become pregnant to give the baby the best chance of a successful start in life. As many pregnancies are unplanned (estimates range between one in six to one in three) and women may not realise they are pregnant for some months, the ideal is to encourage all women to live as healthy lives as possible, whether or not they are intending to become pregnant.

4.1 Healthy eating & health weight in pregnancy

Excess weight in pregnancy can result in serious complications during and after pregnancy, including gestational diabetes, miscarriage and stillbirth, pre-eclampsia (a serious condition that threatens the health of mother and baby), blood clots and death. The baby also has an increased risk of overweight or obesity and long-term health conditions as an adult.

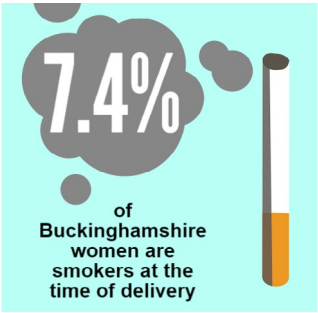
To give their baby the best start in life women who are overweight or obese should lose weight before becoming pregnant to ensure they're a healthy weight in pregnancy. Pregnant women should eat a balanced, healthy diet (including vitamin supplements) and remain physically active during pregnancy.

In Buckinghamshire, approximately 55% of women were a healthy weight at antenatal booking, 27% were overweight, and 17% were obese. There are about 1,630 pregnant women who are overweight and 1,110 obese per year. In Buckinghamshire there is an approved weight management programme for pregnant women who are obese and there were 68 referrals to this programme in 2015/16.



4.2 Smoking in pregnancy

Smoking in pregnancy has numerous harmful effects including an increased risk of miscarriage, stillbirth and preterm birth. Babies are twice as likely to be low birthweight and are 40% more likely to die before their first birthday if their mothers smoke. Household smoking increases the risk of meningitis, lung infections, asthma and children growing up to be smokers, thus passing the risk on to the next generation.



Women should have a smoke-free pregnancy by stopping smoking before they become pregnant and making sure their partner and other household members stop smoking too. Reducing adolescent smoking is the most effective way of reducing smoking amongst the next generation of parents.

In Buckinghamshire, 7.4% of women (432 women) smoke at time of delivery compared to 11% nationally. Of the 252 pregnant women referred to the smoking cessation service in 2015/16, 95 set a quit date and 42% quit. 32% of pregnant women under 20 years old supported by the Family Nurse partnership smoked at the start of pregnancy. By 36 weeks, 42% had quit and of the remaining women still smoking, two in three had reduced their smoking. There is scope to increase the proportion of women referred to smoking cessation services and setting a quit date.

4.3 Alcohol or drugs in pregnancy

Drinking more than one or two units of alcohol per day while pregnant increases the risk of babies being born at a low birthweight or prematurely. Higher levels of drinking, especially 'binge drinking', risk fetal alcohol spectrum disorder (FASD), which is associated with birth defects, poor development, learning difficulties, and poorer educational outcomes, mental health problems and substance misuse later in childhood. Drug misuse in pregnancy is often associated with a chaotic family life and has a direct toxic effect on the unborn baby causing low birthweight, prematurity and in some cases drug dependency in the baby.

The safest approach is not to drink alcohol at all in pregnancy. For people with problematic alcohol use or drug use in pregnancy a well-co-ordinated multi-agency response is required to help reduce risk to the unborn child and mother. Mothers with alcohol or substance misuse problems may also have mental health problems, be victims of domestic abuse or have other social problems. It is essential that frontline staff enquire about alcohol and drug use and identify co-existing problems to enable effective support and referral.

In Buckinghamshire, an estimated 3,420 women drink more than two units per week in the first three months (trimester) of pregnancy, with about 120 continuing to do so in the second trimester. Less than 2% of women entering drug treatment (less than five women) were pregnant which is similar to the 1% seen nationally. Between 22-25% of people accessing drug treatment services were parents (fathers or mothers) living with their children. A further 30% were parents no longer living with their children.

4.4 Maternal and Infant mental health and wellbeing

Although for most women becoming pregnant and having a baby is one of the happiest times of their lives, it can be a really challenging time too due to the psychological, social and physical demands of pregnancy and a new baby. Women are at greater risk of experiencing poor mental health soon after their baby has been born than at any other time in their lives, with a quarter of women experiencing a mental health problem during pregnancy or within the first year after having a baby.

Poor maternal mental health has consequences for mother and baby. Maternal stress in pregnancy can be transmitted to the baby resulting in low birth weight and prematurity. Feeling low in the first weeks after their baby is born, known as 'baby blues', is very common occurring in up to 8 in 10 women. Although it can be distressing, 'baby blues' is usually mild and short-lived. However if these feelings persist, or the mother feels like she is not coping or feeling distant from her baby or worried about any thoughts or feelings then they should always talk to a health professional for further advice and support.

If perinatal mental health problems go untreated they can have a serious impact on women and their families. Poor perinatal mental health can affect the bond between mother and baby, impacting on baby's development and mental health, and the mother's ability to parent their baby. By four years old, children of mothers with prolonged mental health problems are less likely to have good emotional, behavioural and social development leaving them poorly prepared for school. Maternal deaths are very rare, but suicide is the leading cause of maternal death. Postnatal depression also affects 10% of new fathers.

Anyone can experience perinatal mental health problems, but they are more common in women with a personal or family history of mental illness, women with relationship problems, a lone mother or a mother lacking social support, recent stressful life events, socio-economic disadvantage and teenage mothers.

Early detection and management of mental health problems are effective in reducing symptoms, and good referral pathways can improve identification of problems and access to care.

In Buckinghamshire, 8% of women score above the threshold for moderate depression at the six to eight week post-natal visit. National estimates suggest there would be 600 to 900 women per year experiencing mild to moderate depression or anxiety around the time of pregnancy and 200 women with severe mental illness. There were 600 admissions to hospital for 550 women around the time of pregnancy where there was also a co-occurring mental health problem.

All health and social care professionals should continue to help prevent and identify mental health problems at the earliest stages in pregnancy and after the child is born so that early and effective support can be offered to all families. In recognition of the importance of maternal mental health, Buckinghamshire launched a comprehensive pathway for maternal mental health in 2016.

5 Parenting

Sensitive, attuned parenting is one of the most important factors affecting a child's development and wellbeing. Good parenting promotes secure bonds (attachment) between parent and baby. Securely attached children have better physical, mental and emotional health and school achievement.

If children are exposed to stress but don't get the reassurance from parents they need due to unresponsive or inconsistent parenting this can lead to changes in their brain affecting the way they deal with stress in the future. This in turn can lead to lower educational attainment, adoption of risky behaviours, social, emotional and mental health problems.

Parenting can be challenging and may be influenced by parents own adverse childhood experiences, lack of social support, mental health problems, substance misuse or domestic violence. Economic or social issues such as poverty, parental education and knowledge about parenting can also adversely impact on parenting ability.

There are evidence based interventions that have been shown to improve parenting ability and improve attachment, behaviour and cognitive development. Parenting programmes are most effective when they start during pregnancy and the first two years of a baby's life. NICE recommends that all parents should be able to access parenting programmes and that the nature of the mother-baby relationship should be assessed by trained staff after birth and during the early years.

In Buckinghamshire, antenatal classes are offered to all parents by midwives, with health visitor involvement, across the county to help prepare parents for their new role. After the baby has been born health visitors offer parenting advice and support to all new parents and can refer for additional help if necessary. There are also a range of parenting interventions on offer for parents who need more support in Buckinghamshire.

6 The impact of social factors on pregnancy and children's health and development

Social factors increasing the risk of poorer outcomes include living in poverty and living in poorer quality housing. Children born to poorer mothers have poorer pregnancy outcomes and are more likely to be born low birthweight, have poorer development and educational attainment and more likely to be in contact with social care. Children living in poorer quality housing are also more likely to have poorer development and health problems.

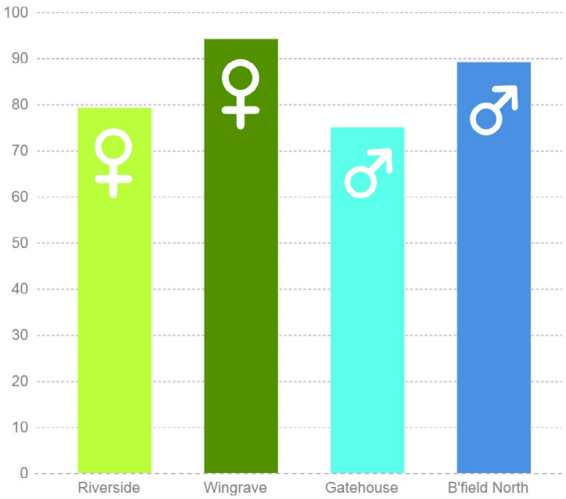
Due to the challenges of balancing the responsibility of caring for their children with a job, lone parents are more likely to be unemployed, employed part-time or have unstable employment and be in relative poverty compared to two parent families with consequent impact on the mental wellbeing of children.

Teenage mothers and their babies can also face a range of challenges. Teenage mothers can be less likely to finish their education and find a good job and have sufficient income to live on. The babies of teenage mothers can be at risk of poorer health and development. However, in recognition of this, extra support is available for teenage mothers and their babies.

Women from certain ethnic groups tend to be at greater risk of having low birthweight babies, which can impact on the baby's chance of good health. This may be partly due to their social circumstances if they live in less advantaged areas. Recent migrants to the UK who may not understand how the health and social care systems work, and mothers who have difficulty reading and speaking English, are at increased risk of complications during their pregnancy and the birth of their children.

Adverse childhood experiences (ACEs), for example dysfunctional homes, domestic violence, substance abuse or losing a parent increase the risks of poor outcomes throughout life including poor school achievement, substance misuse, mental health problems, unintentional teenage pregnancy, obesity, heart disease, cancer, unemployment, violence and imprisonment. The greater the number of ACEs experienced by a child, the higher the likelihood of poor outcomes.

In Buckinghamshire, about 10,500 children under 16 (10.8%) live in low income families (20% nationally). Health and educational outcomes are worse for children living in the more deprived areas in Buckinghamshire. Babies born in the most deprived fifth of the population are more likely to be born low birthweight and die in the first year of life and have poorer development by reception year at school than the Buckinghamshire average.



The gap in life expectancy for people living in the most deprived fifth of Buckinghamshire compared to the least deprived fifth is 5.4 years. This difference is even more marked at ward level. A baby girl born in Riverside has a life expectancy of 79.2 years, while a baby girl born in Wingrave has a life expectancy of 94.2 years. A baby boy born in Gatehouse has a life expectancy of 75.0 years, while a baby boy born in Beaconsfield North has a life expectancy of 89.2 years.

6.1 Domestic abuse

Domestic abuse can happen to anyone and anyone can commit abuse. It can happen to women and men, in same-sex and heterosexual couples, and among all occupational groups. Domestic abuse involves any incident of controlling, coercive or threatening behaviour, not just violence or abuse between partners. Domestic abuse often starts or escalates during pregnancy. Nationally, one in every four women will experience domestic abuse in their lifetime. In Buckinghamshire from October 2015 to 2016, there were 8,923 reported incidents of domestic abuse.

The impact of domestic abuse in pregnancy is far reaching. It can result in a wide range of impacts on mother and baby including miscarriage, preterm labour, low birthweight, and long lasting physical disability. The impact on the mother includes physical harm, depression, anxiety and post-traumatic stress disorder. Women who have experienced domestic abuse are 15 times more likely to misuse alcohol, nine times more likely to misuse drugs, and five times more likely to attempt suicide. As well as the physical and psychological effects, a woman experiencing domestic abuse may find it difficult to attend her antenatal care appointments, making it even harder to identify the abuse and offer help.

The stress experienced by a woman experiencing domestic abuse may have harmful effects on the unborn child and children experiencing domestic abuse grow up with a range of problems from difficulty sleeping and temper tantrums in younger children to behavioural problems, substance misuse, eating disorders or self-harm in older children. Early identification of women at risk by asking all pregnant women in a safe, confidential environment about domestic abuse, and intervening early can help protect mother and baby, support the mother child relationship, and improve their health and wellbeing.

6.2 Access to services

A range of services have a vital role to play in helping women have a healthy pregnancy and healthy baby, ranging from services that help women stay healthy before they become pregnant to sexual health and contraception services that support good sexual health and the ability to plan pregnancies and avoid unintended pregnancy. A short inter-pregnancy interval of less than 12 months increases the risk of complications including preterm birth, low birthweight, stillbirth and death highlighting the importance of good contraception.

Unplanned conceptions can be reduced through better relationship and sex education in schools before children are sexually active, the promotion of emotional resilience in children and adults and the provision of long acting contraception and good family planning.

Women book into antenatal care at the start of their pregnancy and first see the midwife between nine to 12 weeks into pregnancy. This enables early identification and appropriate response to any factors that may impact on pregnancy and wellbeing and opportunity to screen for a variety of conditions before 21 weeks of pregnancy.

In Buckinghamshire, 14% of women book into antenatal care after 13 weeks at Buckinghamshire Healthcare Trust thus reducing the opportunities for early advice and support at this critical time.

The Healthy Child Programme is the core universal public health service for children and families. The programme comprises health promotion, child health surveillance and screening including immunisations, health and development reviews and advice and support to parents. It is led by health visitors in collaboration with other professionals.

The health visiting service in Buckinghamshire offers a series of mandated visits to babies and their families within two weeks of birth, at six to eight weeks post-birth, at one year and two and a half years for the 32,000 children under five years old living in the county. Health visitors ensure that babies, young children and their families receive early help and support to stop problems developing and to build firm foundations that maximise the chances of experiencing good health and wellbeing throughout life.

7 Summary and recommendations

Buckinghamshire County Council, the District Councils and NHS organisations in Buckinghamshire are all members of the Buckinghamshire Health and Wellbeing Board and are committed to giving every child in Buckinghamshire the best start in life, as set out in Buckinghamshire Joint Health and Wellbeing Strategy. In order to do this we need to work together with individuals, communities and partners to improve outcomes for babies, their mothers and families. The role of health services is clear in this report, but success depends on the contribution of all partners beyond the NHS. Whether we have a role in ensuring that people are living in good quality housing, or that the environments we live in support healthy lifestyles, or children's education helps them make the right choices or making sure all our frontline staff are trained to recognise signs of mental health problems and respond appropriately, we can all make a vital contribution.

There is a role of course for individuals and we need to ensure that people are provided with the right information, skills and support to make the best choices and look after their health and that of their baby. The choices people make and their ability to give children the best start in life also depend on their social context. We need to be aware of this and ensure that in improving outcomes for our babies and the future generation of Buckinghamshire residents that no babies and families get left behind.

Recommendations

1. **Healthcare professionals in contact with pregnant women or new mothers should assess all the factors that could impact on the mother's, baby's and family's health and offer advice, support and referral to appropriate services. This includes lifestyle factors such as smoking, alcohol consumption, drug use, weight and healthy eating as well as mental health, exposure to domestic violence and other social factors. There is significant scope to increase referrals to support services to improve outcomes for babies, mothers and families.**

2. **Buckinghamshire County Council and partners should consider whether there is a need to develop and implement a new comprehensive strategy to support parents in Buckinghamshire.**

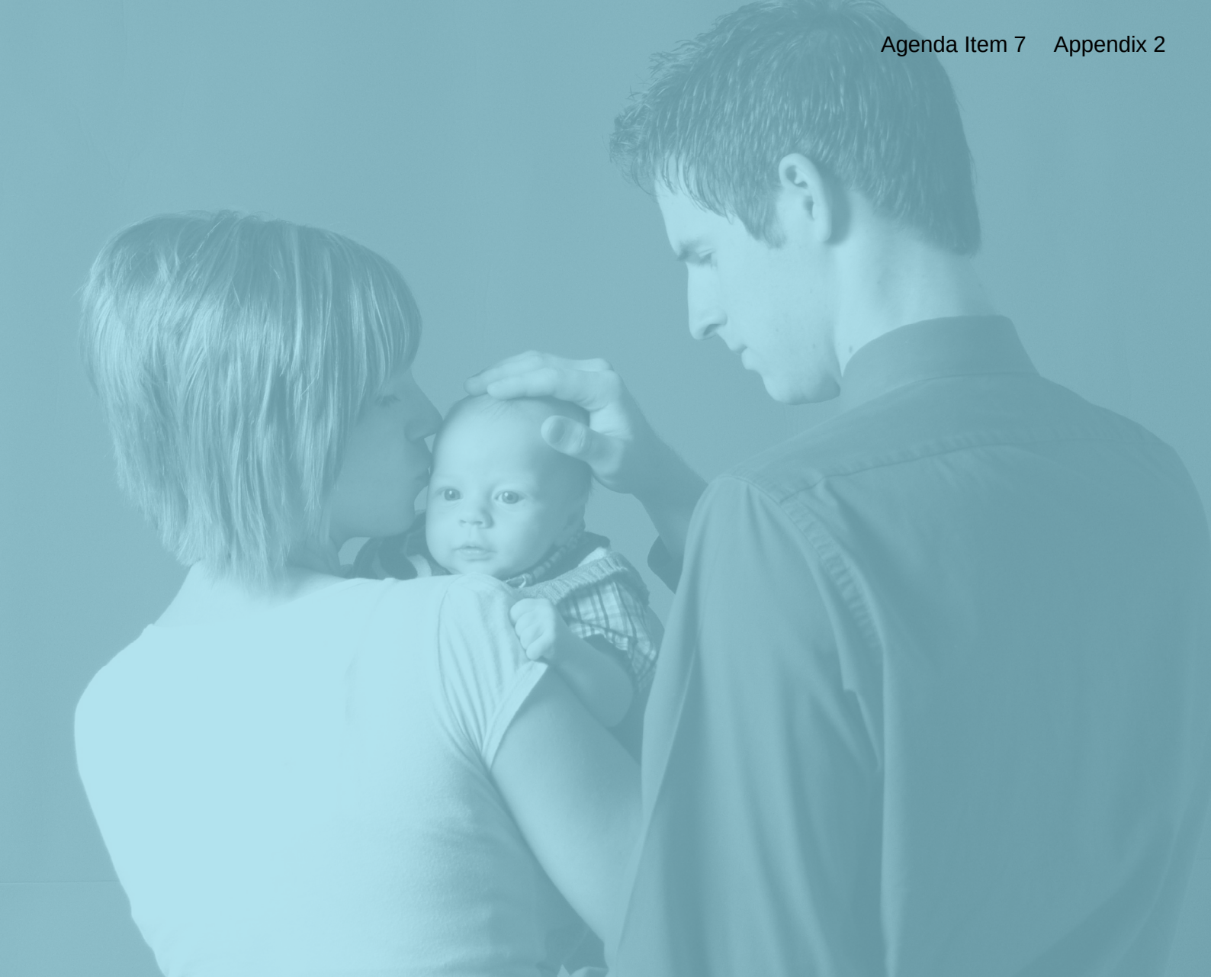
3. **All professionals in contact with pregnant women and families with young children should encourage parents to access universal parenting advice via the red book, national start4life website, baby buddy app and the Buckinghamshire Family Information Service.**

4. **Commissioners and providers of maternity, early years, mental health and substance misuse services should enhance the data collected on the physical and mental health of mothers and babies, the prevalence of risk factors and referral to and outcomes of services. This should enable us to monitor progress and evaluate the impact of our services. Key data should be reported annually to the Health and Wellbeing Board.**

5. **Buckinghamshire County Council should work closely with schools to explore how the new compulsory PSHE can prepare young people for a healthy and happy life and addresses emotional resilience, healthy relationships, sexual health and healthy lifestyles. One of the future benefits of this should be healthier parents and babies and healthy, planned pregnancies.**

6. **Partners should consider how they can contribute to improving outcomes for babies, mothers and families in Buckinghamshire.**

For the contact details of all services included in this report please visit the public health webpages at http://www.healthandwellbeingbucks.org/public-health.



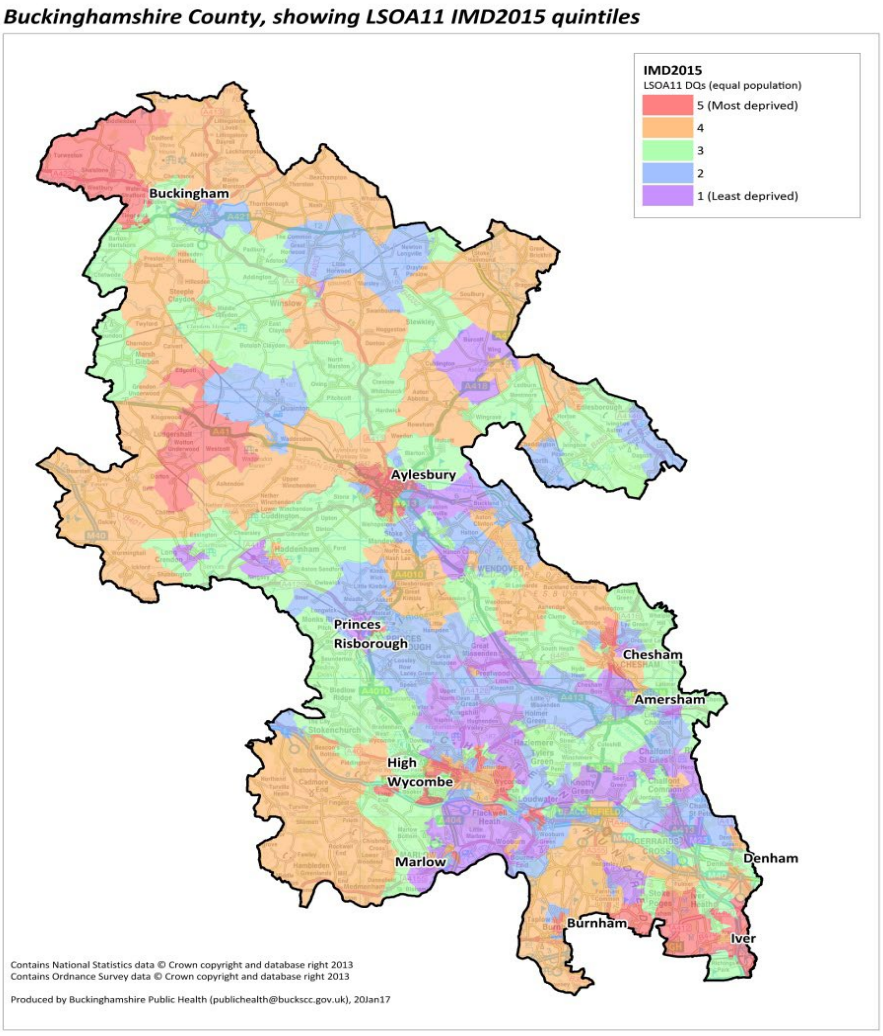
Maternity Data Supplement

Maternity Data Supplement

1. Deprivation and deprivation quintiles in Buckinghamshire

Figure 1 shows the Index of Multiple Deprivation in Buckinghamshire. Areas around Aylesbury, Chesham and High Wycombe have higher values of deprivation than the Buckingham average. Five quintiles each containing approximately 20% of the population are used to discuss health inequalities. Deprivation Quintile 1, or DQ1, contains the fifth of the population who live in the least-deprived areas; DQ5 contain the fifth of the population living in the most-deprived areas.

Figure 1. Deprivation quintiles in Buckinghamshire, 2015.



Source: Department for Communities and Local Government (DCLG) English indices of deprivation 2015.

2. Live births

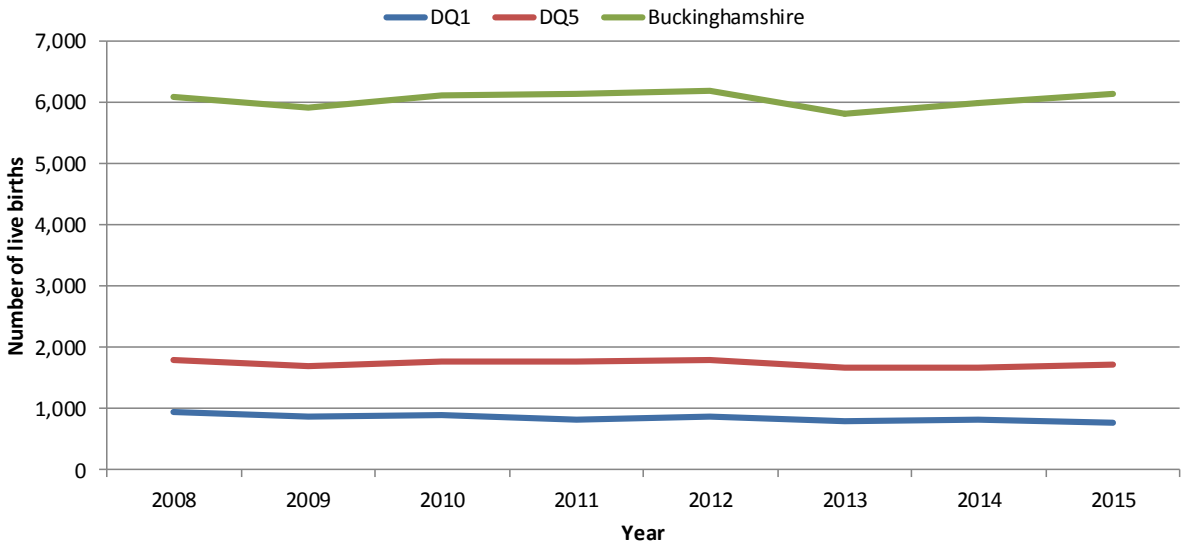
There were 6,140 live births in Buckinghamshire in 2015, see Table 1. Figure 2 shows the number of live births per year from 2008 to 2015. Numbers of live births are approximately constant, with approximately twice as many births in DQ5 (most deprived 20% of the population) compared to DQ1 (least deprived 20% of the population). The ratio of the number of live births in DQ5 to DQ1 ranges from 1.9 in 2008 to 2.2 in 2015.

Table 1. Number of live births by mother's usual place of residence (deprivation quintile) in Buckinghamshire, 2008-15.

Deprivation quintile	Year							
	2008	2009	2010	2011	2012	2013	2014	2015
DQ1	951	862	894	825	856	793	812	774
DQ2	1,043	1,052	1,092	1,123	1,115	996	998	1,161
DQ3	1,185	1,120	1,145	1,136	1,113	1,117	1,167	1,100
DQ4	1,109	1,175	1,208	1,292	1,319	1,249	1,340	1,387
DQ5	1,789	1,698	1,764	1,757	1,792	1,667	1,672	1,718
Bucking-hamshire	6,077	5,907	6,103	6,133	6,195	5,822	5,989	6,140

Source: Office for National Statistics Annual Public Health Birth Files.

Figure 2. Number of live births by mother's usual place of residence (DQ1 and DQ5) in Buckinghamshire, 2008-15.



Source: Office for National Statistics Annual Public Health Birth Files.

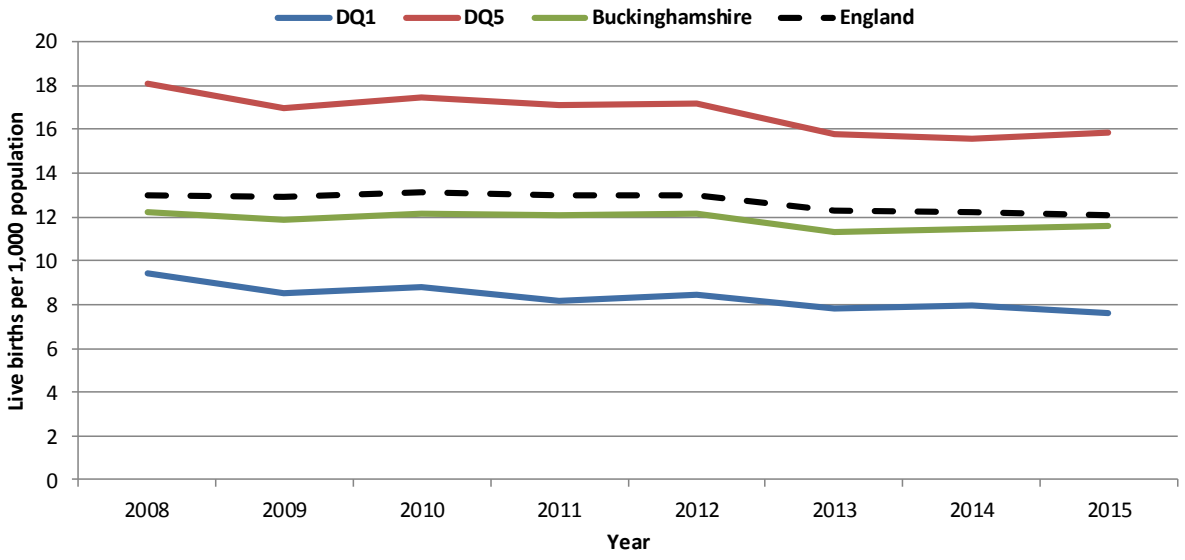
The **crude birth rate** is the annual number of live births per 1,000 population, and is lower in Buckinghamshire than in England, see Table 2. Figure 3 shows the crude birth rate from 2008 to 2015. Crude birth rates in DQ1, DQ5 and Buckinghamshire are decreasing significantly each year.

Table 2. Crude birth rate by mother's usual place of residence (deprivation quintile) in Buckinghamshire, 2008-15.

Deprivation quintile	Year							
	2008	2009	2010	2011	2012	2013	2014	2015
DQ1	9.4	8.5	8.8	8.1	8.4	7.8	8.0	7.6
DQ2	10.5	10.5	10.9	11.1	11.0	9.8	9.7	11.1
DQ3	11.9	11.2	11.4	11.3	10.9	10.9	11.3	10.6
DQ4	11.5	12.0	12.2	12.8	12.9	12.0	12.6	12.6
DQ5	18.1	17.0	17.4	17.1	17.2	15.8	15.6	15.8
Buckingham-shire	12.2	11.8	12.1	12.1	12.1	11.3	11.5	11.6
England	13.0	12.9	13.1	13.0	13.0	12.3	12.2	12.1

Source: Office for National Statistics Annual Public Health Birth Files.

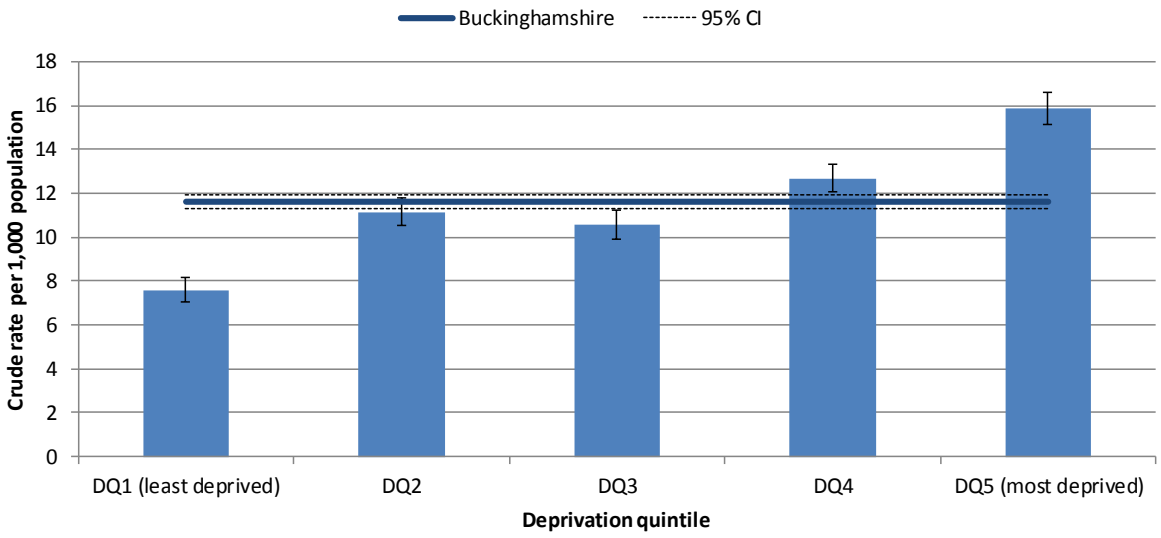
Figure 3. Crude birth rate by mother's usual place of residence (DQ1 and DQ5) in Buckinghamshire, 2008-15.



Source: Office for National Statistics Annual Public Health Birth Files.

The crude birth rate is higher in more deprived areas, see Figure 4. There is a significant trend. Table 3 shows the proportion of women who are of childbearing age (15-49 years) in each deprivation quintile. There is a significant trend.

Figure 4. Crude birth rate by mother's usual place of residence (deprivation quintile) in Buckinghamshire, 2015.



Source: Office for National Statistics Annual Public Health Birth Files.

Table 3. Proportion of women of childbearing age by deprivation quintile, 2015.

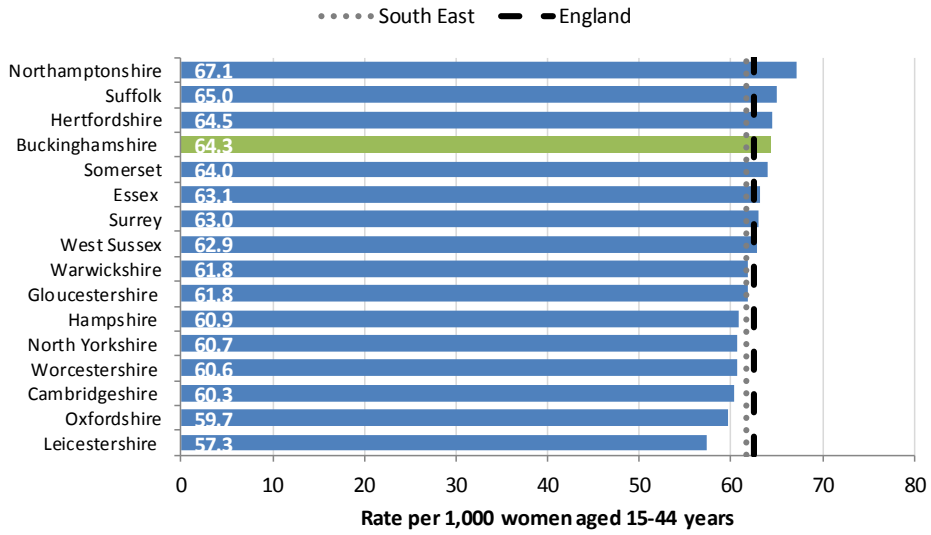
Deprivation quintile	Females 15-44 years	All females	%
DQ1	14,630	52,421	27.9%
DQ2	18,302	54,033	33.9%
DQ3	18,001	53,325	33.8%
DQ4	21,587	56,467	38.2%
DQ5	22,916	53,061	43.2%
Buckinghamshire	95,436	269,307	35.4%

Source: Office for National Statistics, Mid-2015 Population Estimates for Lower Layer Super Output Areas in England and Wales by Single Year of Age and Sex.

The **general fertility rate** is the annual number of live births per 1,000 women of childbearing age (ages 15 to 44 years).

Comparison is made against a set of similar local authorities identified by the Chartered Institute of Public Finance and Accountancy (CIPFA). These are referred to as CIPFA peers. Among Buckinghamshire's CIPFA peers, Buckinghamshire had the 4th highest general fertility rate in 2015, see Figure 5.

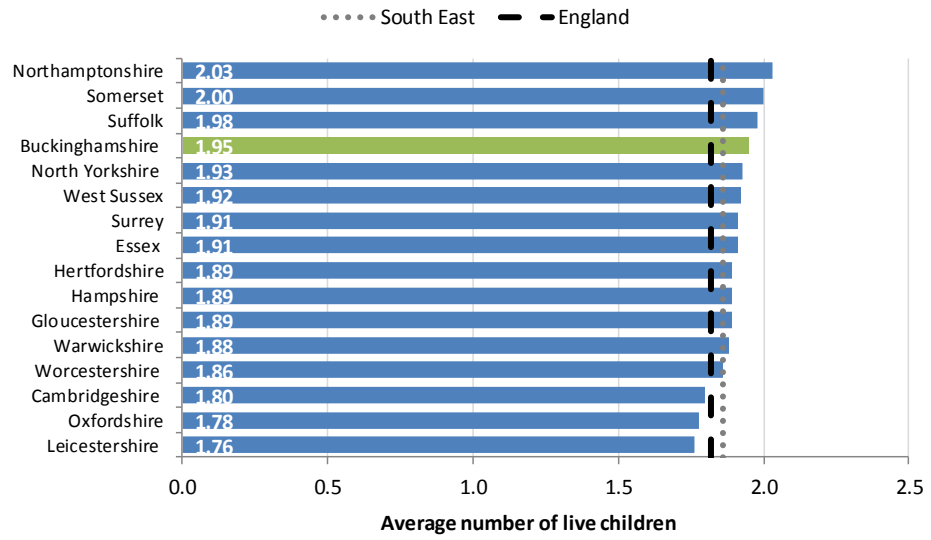
Figure 5. General fertility rate among Buckinghamshire's CIPFA peers, 2015.



Source: Office for National Statistics Birth Summary Tables, 2015.

The **total fertility rate** is the average number of children a woman would have in her lifetime In Buckinghamshire it is just under 2 children each at 1.95 (the technical definition is the average number of live children that a group of women would bear if they experienced the age-specific fertility rates of the calendar year in question throughout their childbearing lifespan). As with the general fertility rate, Buckinghamshire's total fertility rate in 2015 was high among its CIPFA peers, see Figure 6.

Figure 6. Total fertility rate among Buckinghamshire's CIPFA peers, 2015.

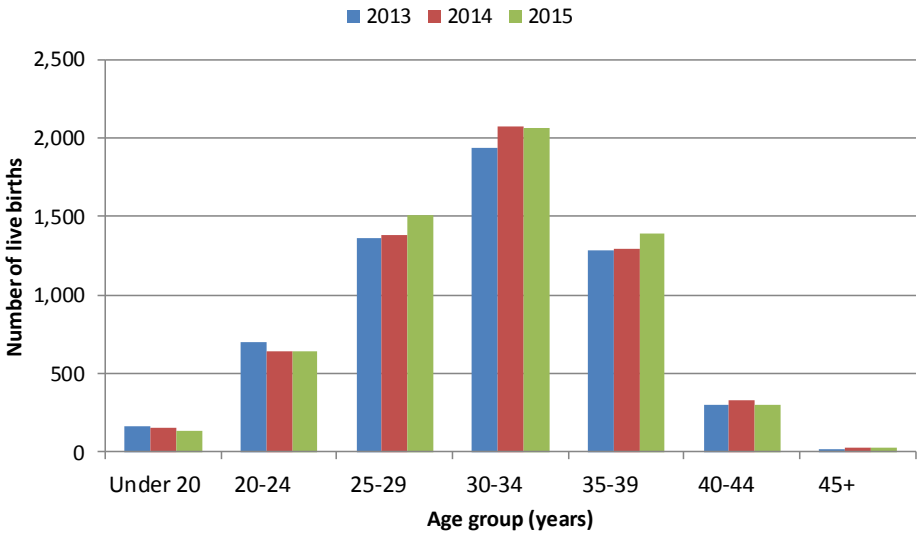


Source: Office for National Statistics Birth Summary Tables, 2015.

3. Mother's age at birth of child

Figure 7 shows that, for all maternities, the commonest age of women giving birth is between 30 and 34 years of age, and that there are more mothers aged 35+ years than under 25 years of age.

Figure 7. Age of mothers in Buckinghamshire, 2013-15.



Source: Office for National Statistics, Vital Statistics Table VS2.

4. Ethnicity

Table 4 shows the ethnicity of mothers admitted to maternity services in hospitals in 2015. Home births and births in NHS Foundation Trusts that do not submit data to the Birth Episode Commissioning Data Set are excluded. Nearly three quarters (73.9%) of hospital admissions to deliver a baby are to White mothers. Those who identify themselves as Asian/Asian British form the second largest proportion (17.1%).

Table 4. Ethnicity of mother in hospital admissions to deliver a baby, 2015.

Ethnic group	Num-ber	%
White	3,168	73.9%
Mixed/multiple ethnic groups	63	1.5%
Asia/Asian British	732	17.1%
Black/African/Caribbean/Black British	118	2.8%
Other	71	1.7%
Not known/Not stated	132	3.1%
Total	4,284	100%

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

5. Mother's place of birth

Table 5 shows the place of birth for mothers in Buckinghamshire in 2013-15. Approximately a quarter of mothers are born outside the UK.

Table 5. Mother's place of birth, 2013-15.

Year	Born outside UK	Born in UK	Total
2013	1,452 (24.9%)	4,370 (75.1%)	5,822 (100%)
2014	1,504 (25.1%)	4,485 (74.9%)	5,989 (100%)
2015	1,608 (26.2%)	4,532 (73.8%)	6,140 (100%)

Source: Office for National Statistics Annual Public Health Birth Files.

Most mothers not born in the UK are from (in order) Pakistan, Poland, India and South Africa, see Table 6.

Table 6. Live births for the 10 most-common countries of birth of mothers not born in the UK, 2013-15.

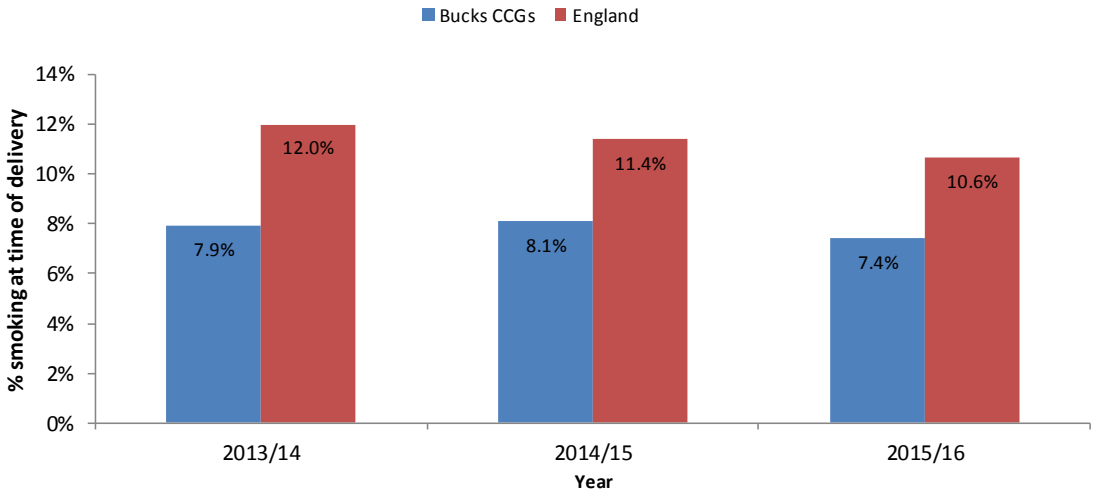
2013			2014			2015		
Country of birth	No.	% of all live births	Country of birth	No.	% of all live births	Country of birth	No.	% of all live births
1 Pakistan	324	5.6%	1 Pakistan	342	5.7%	1 Pakistan	345	5.6%
2 Poland	186	3.2%	2 Poland	182	3.0%	2 Poland	209	3.4%
3 India	83	1.4%	3 India	104	1.7%	3 India	95	1.5%
4 South Africa	67	1.2%	4 South Africa	54	0.9%	4 South Africa	65	1.1%
5 Germany	45	0.8%	5 Germany	50	0.8%	5 Romania	53	0.9%
6 Ireland	40	0.7%	6 Ireland	40	0.7%	6 Germany	46	0.7%
7 U.S.	35	0.6%	7 U.S.	40	0.7%	7 U.S.	41	0.7%
8 Romania	33	0.6%	8 Romania	38	0.6%	8 Ireland	38	0.6%
9 Zimbabwe	31	0.5%	9 Zimbabwe	33	0.6%	9 Zimbabwe	33	0.5%
10 Sri Lanka	26	0.4%	10 Sri Lanka	29	0.5%	10 Slovakia	32	0.5%
Total births outside UK	1,452	24.9%	Total births outside UK	1,504	25.1%	Total births outside UK	1,608	26.2%
Total births	5,822		Total births	5,989		Total births	6,140	

Source: Office for National Statistics Annual Public Health Birth Files.

6. Smoking status at time of delivery

7.4% of women registered at GP practices within the Clinical Commissioning Groups (CCGs) in Buckinghamshire (NHS Aylesbury Vale CCG and NHS Chiltern CCG) had not quit smoking at time of delivery in 2015/16. There has been no change over the last three years, see Figure 8. Nationally, the trend for women's smoking status at time of delivery is decreasing.

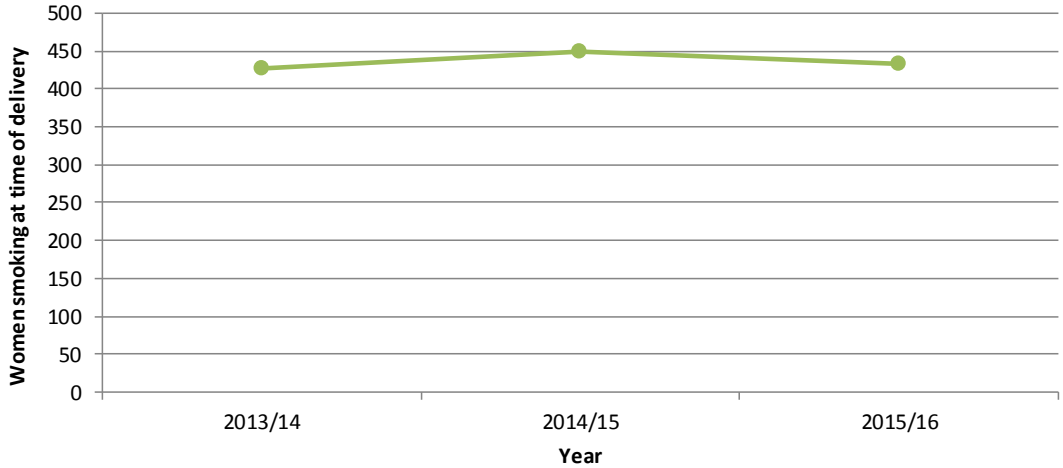
Figure 8. Percentage of women smoking at time of delivery, 2013/14-2015/16.



Source: NHS Digital, Lifestyle Statistics.

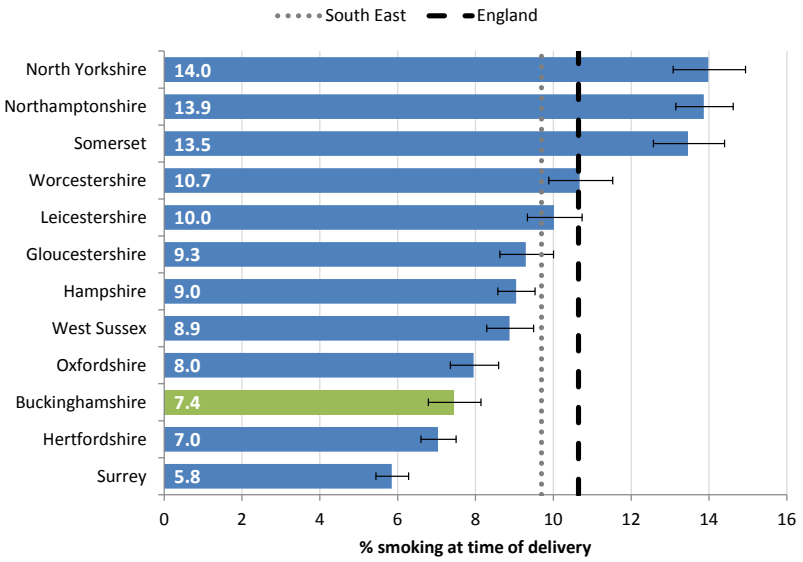
The number of women who had not quit smoking at time of delivery is shown in Figure 9. Numbers are approximately constant, and the rate is one of the lowest among Buckinghamshire's CIPFA peers, see Figure 10. Buckinghamshire's rate (7.4%) is significantly lower than the mean value of local authorities in both the South East region (9.7%) and England (10.7%). Values for CIPFA peers not included in Figure 10 are not published for data quality reasons.

Figure 9. Number of women smoking at time of delivery, 2013/14-2015/16.



Source: NHS Digital, Lifestyle Statistics.

Figure 10. Smoking status at time of delivery, 2015/16.

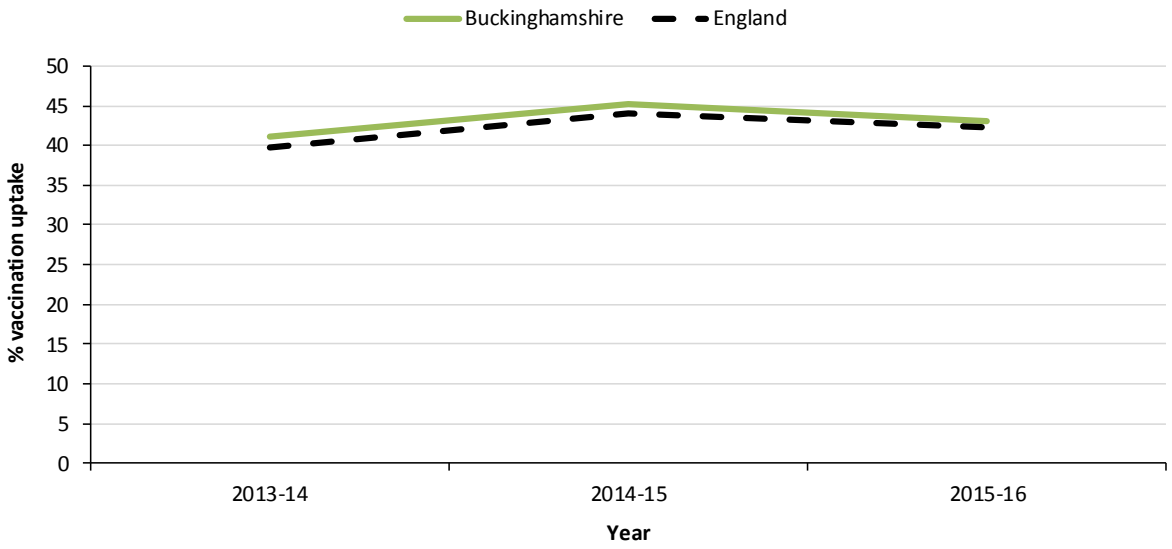


Source: Public Health England (PHE) Public Health Outcomes Framework, Indicator 2.03.

7. Flu immunisation among pregnant women

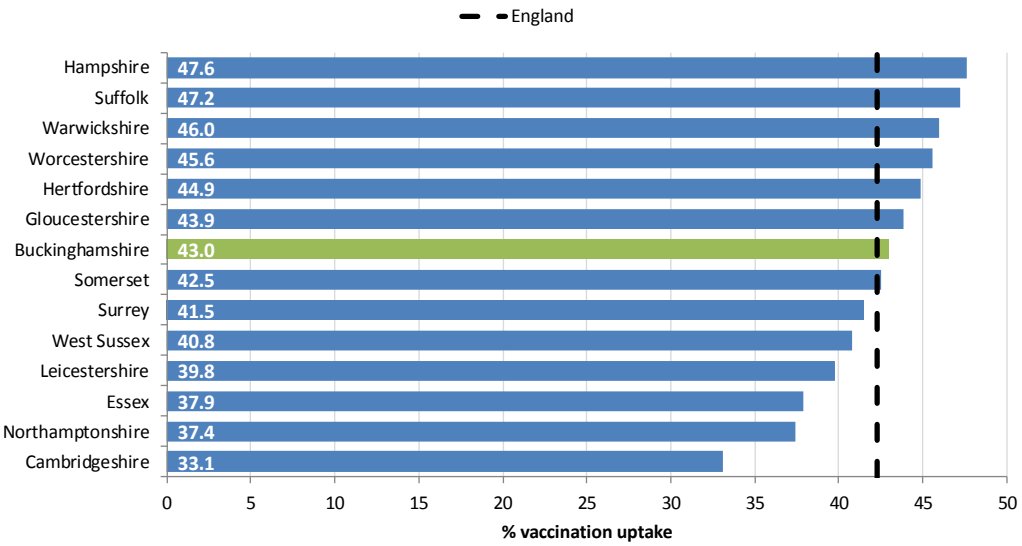
There is some evidence that seasonal influenza vaccination uptake has increased since 2013/14, see Figure 11. Buckinghamshire's influenza vaccination uptake (43.0% in 2015/16) is higher than the England average (42.3% in 2015/16), but is worse than many of its CIPFA peers, see Figure 12.

Figure 11. Flu vaccine uptake among pregnant women, 2013/14 to 2015/16.



Source: Public Health England (PHE) Seasonal flu vaccine uptake in GP patients in England.

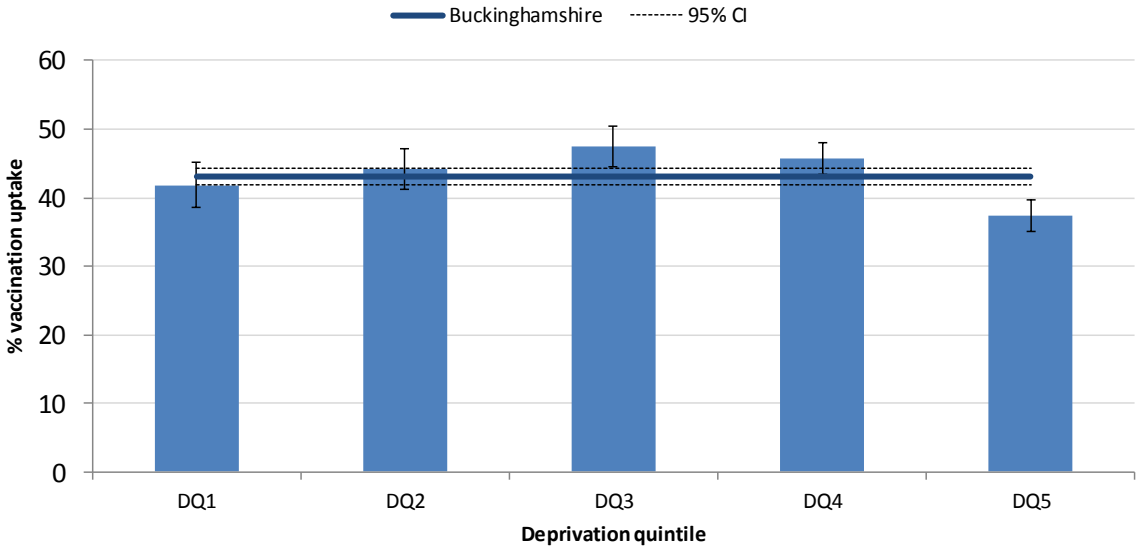
Figure 12. Seasonal flu vaccine uptake among pregnant women, 2015-16.



Source: Public Health England (PHE) Seasonal flu vaccine uptake in GP patients in England: winter season 2015 to 2016.

Figure 13 shows the percentage uptake of seasonal influenza vaccination by pregnant women in 2015-16. Those who are living in the most deprived areas (DQ5) have a significantly lower uptake (37.3%) than the Buckinghamshire average (43.0%).

Figure 13. Seasonal flu vaccine uptake among pregnant women by deprivation quintile, 2015/16.

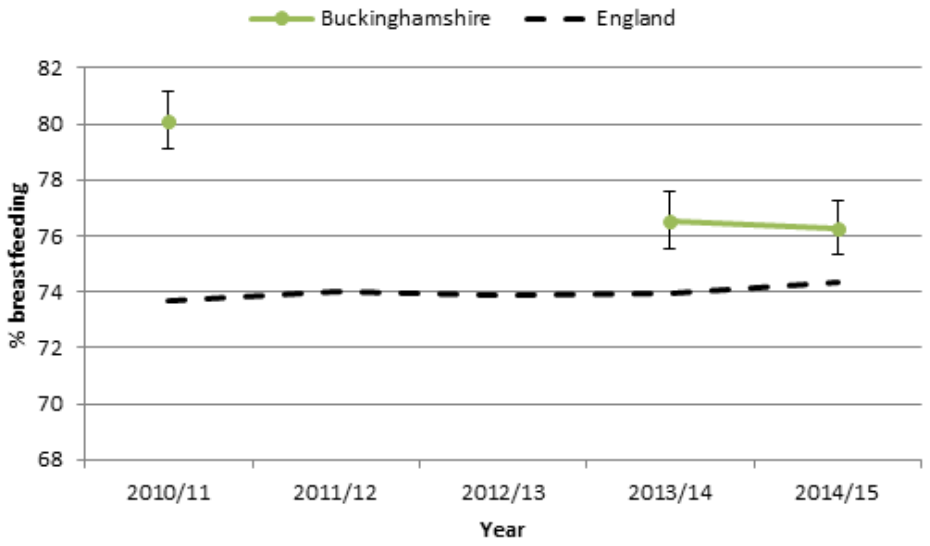


Source: Public Health England (PHE) Seasonal flu vaccine uptake in GP patients in England: winter season 2015 to 2016.

8. Breastfeeding

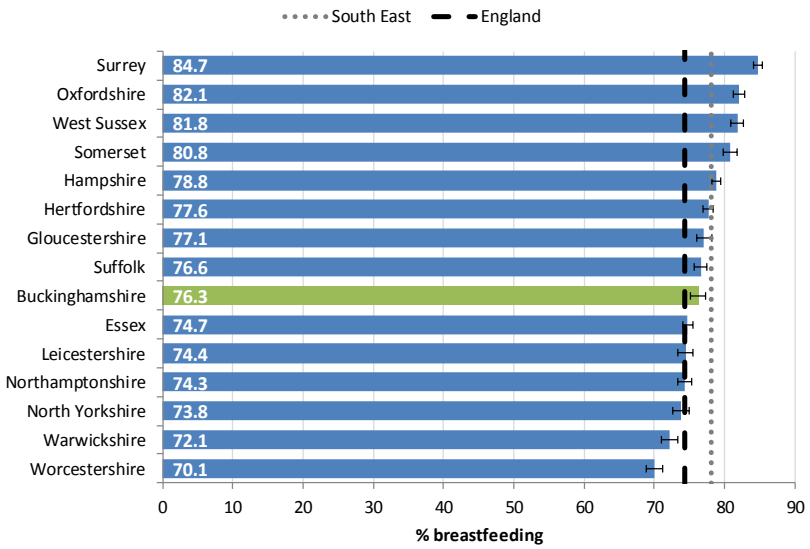
Figure 14 shows that breastfeeding initiation in Buckinghamshire is significantly higher than the England average, but is worse than many of its CIPFA peers, see Figure 15. The proportion of women initiating breastfeeding in Buckinghamshire in 2014/15 (76.3%) is significantly lower than in the South East region (78.0%). Values for missing CIPFA peers are not published for data quality reasons.

Figure 14. Breastfeeding initiation in Buckinghamshire, 2010/11-2014/15.



Source: Public Health England (PHE) Child Health Pregnancy.

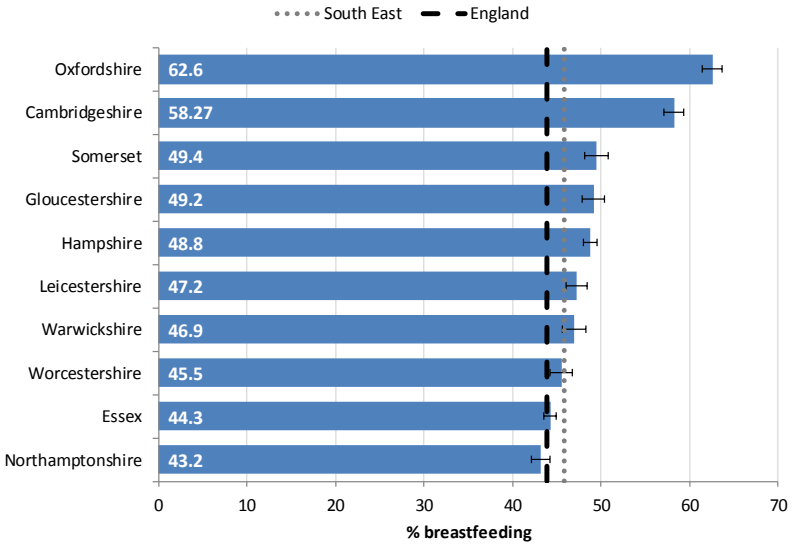
Figure 15. Breastfeeding initiation among Buckinghamshire's CIPFA peers, 2014/15.



Source: Public Health England (PHE) Public Health Outcomes Framework, Indicator 2.02i.

In common with several of its CIPFA peers, Buckinghamshire's return for breastfeeding prevalence at 6-8 weeks was not published in 2014/15 owing to concerns with data quality, see Figure 16.

Figure 16. Breastfeeding at 6-8 weeks (historical method) among Buckinghamshire's CIPFA peers, 2014/15.

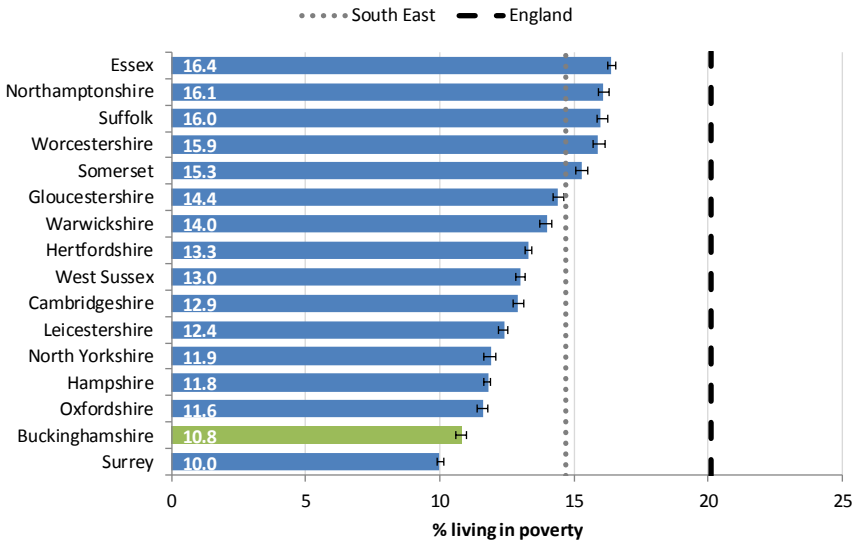


Source: Public Health England (PHE) Public Health Outcomes Framework, Indicator 2.02ii.

9. Children living in poverty

In 2014, the proportion of children (aged under 16 years) in Buckinghamshire living in poverty[1] (10.8%) was significantly lower than in the South East region (14.7%) and England (20.1%), see Figure 17. Only Surrey had a lower proportion of children living in poverty.

Figure 17. Percentage of children in low income families among Buckinghamshire's CIPFA peers, 2014.

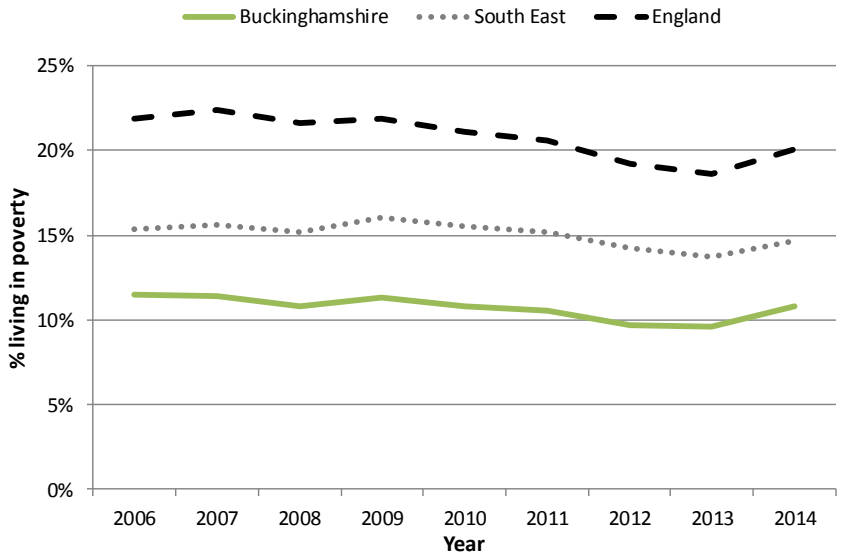


Source: Public Health England (PHE) Public Health Outcomes Framework, Indicator 1.01ii.

There is strong evidence that the proportion of children in Buckinghamshire that are living in poverty decreased between 2006 and 2014, see Figure 18.

1 Children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% of the median income.

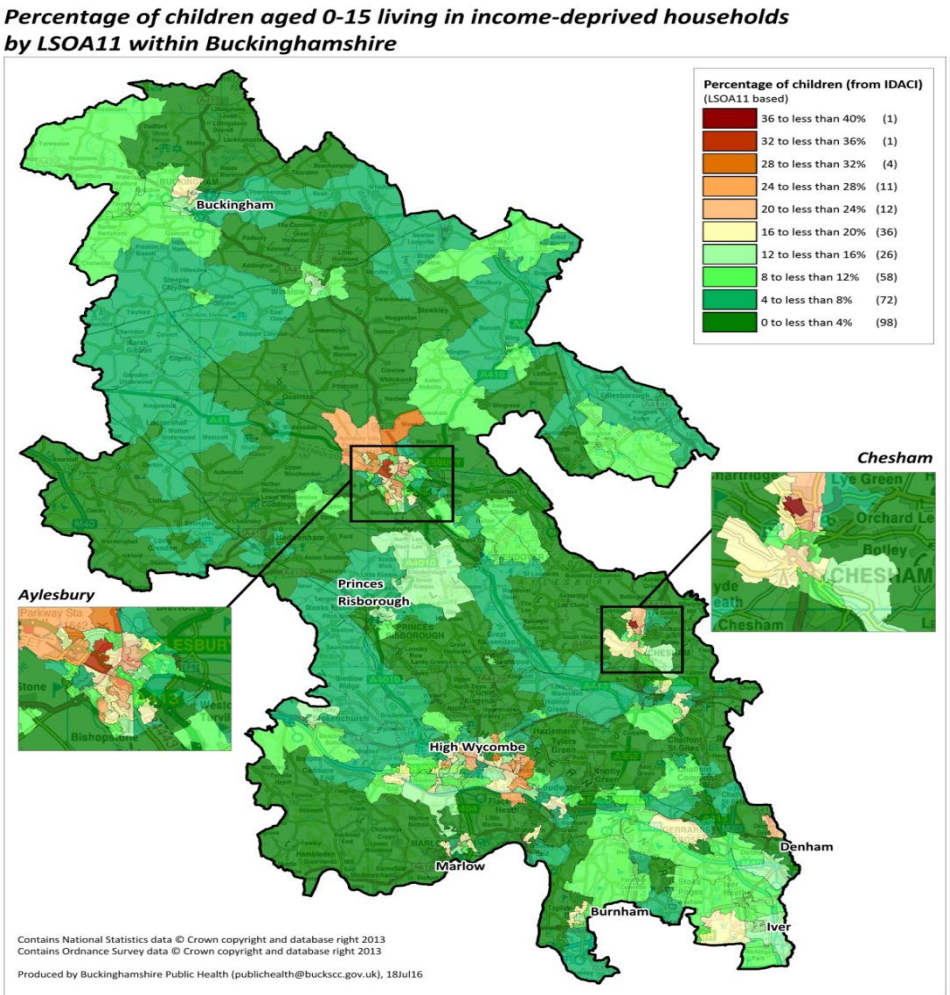
Figure 18. Percentage of children in low income families in Buckinghamshire, 2006-14.



Source: Public Health England (PHE) Public Health Outcomes Framework, Indicator 1.01ii.

The percentage of children who are living in income-deprived households is shown in Figure 19. Areas near Chesham have the highest percentage of children living in income-deprived households in Buckinghamshire. Other areas of high income deprivation include Aylesbury and High Wycombe.

Figure 19. Income Deprivation Affecting Children Index, 2015.

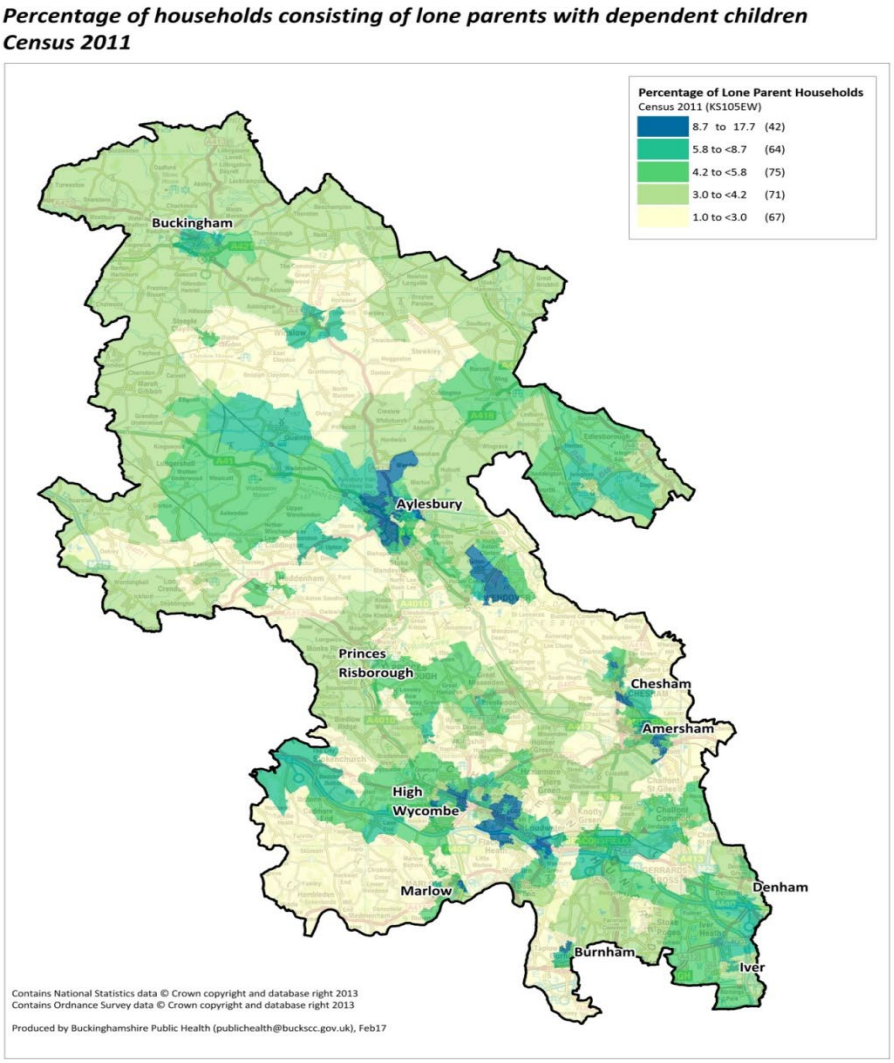


Source: Department for Communities and Local Government (DCLG) English indices of deprivation 2015.

10. Lone parents

The highest proportions of lone parent families tend to occur in places of highest deprivation, particularly Aylesbury and High Wycombe, see Figure 20 and Table 7.

Figure 20. Percentage of households consisting of lone parents with dependent children, 2011.



Source: Census 2011.

Table 7. Number and proportion of lone-parent households, 2011.

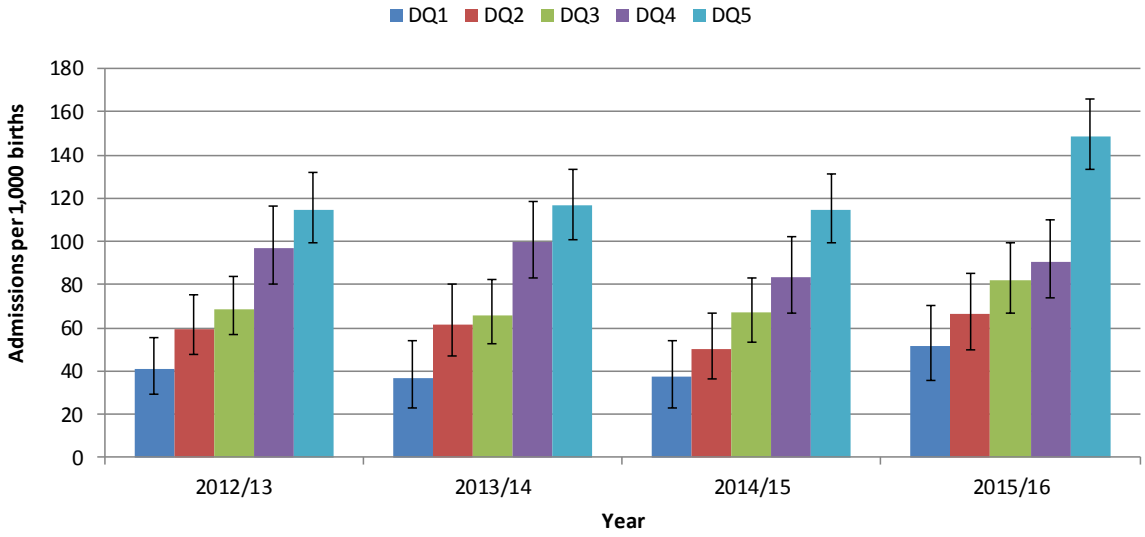
Deprivation quin-tile	Lone households	All households
DQ1	1,339 (3.4%)	39,852
DQ2	1,691 (4.2%)	39,985
DQ3	1,806 (4.5%)	40,410
DQ4	2,262 (5.5%)	40,928
DQ5	3,452 (8.7%)	39,552
Buckinghamshire	10,550 (5.3%)	200,727

Source: Census 2011.

11. Perinatal mental health admissions

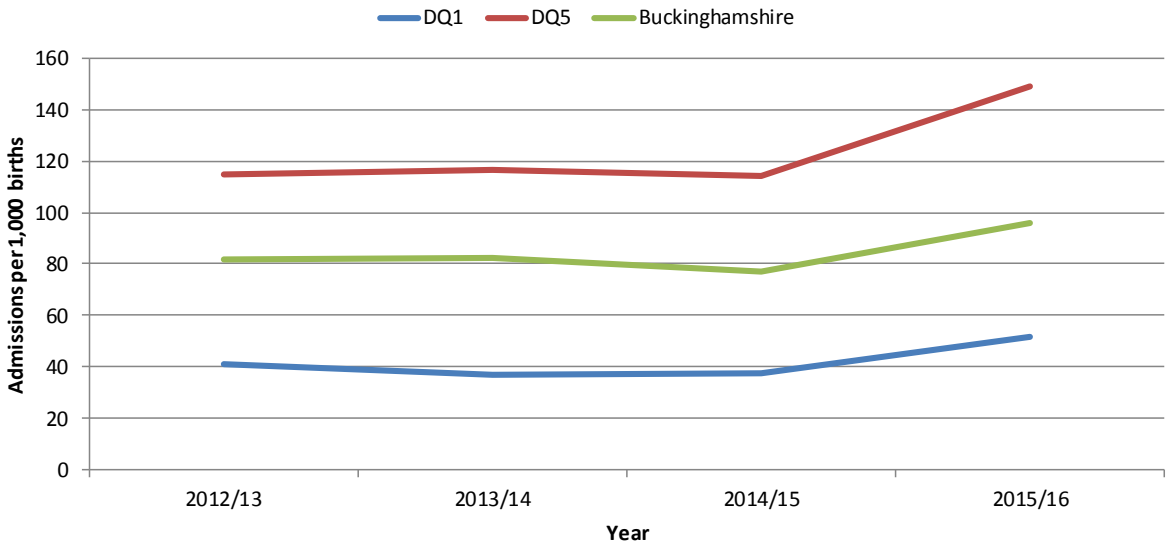
Those living in more deprived areas have a higher proportion of maternity admissions where there was also a mental health diagnosis, see Figure 21. Figure 22 shows that there has been a recent increase in the rate of admissions per 1,000 births.

Figure 21. Maternity admissions where there is also a mental health diagnosis in Buckinghamshire by deprivation quintile, 2012/13-2015/16.



Source: SUS Admitted Patient Care (APC) Minimum Data Set (MDS) and Office for National Statistics Annual Public Health Birth Files.

Figure 22. Maternity admissions where there is also a mental health diagnosis per 1,000 births, 2012/13-2015/16.

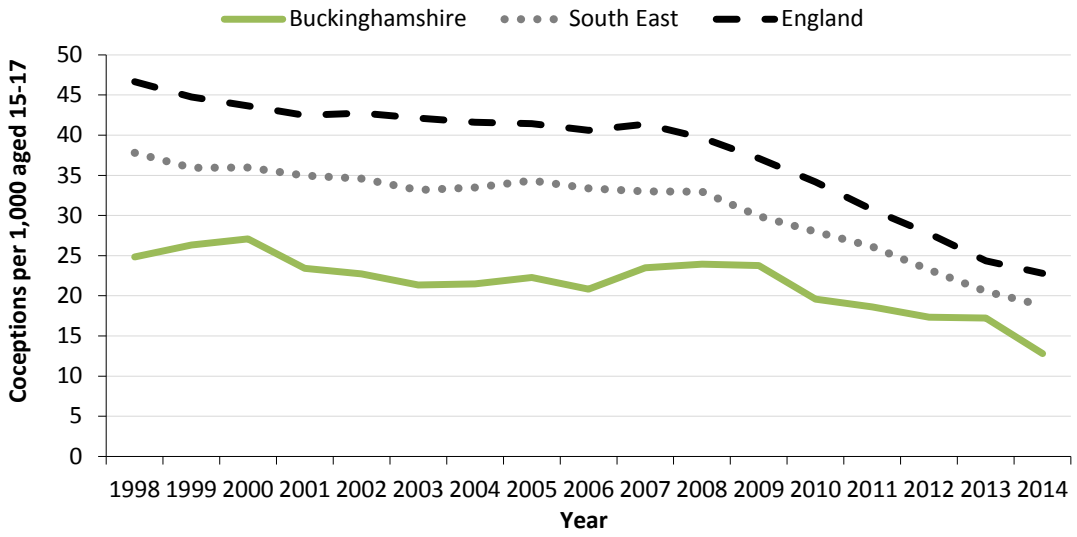


Source: SUS Admitted Patient Care (APC) Minimum Data Set (MDS).

12. Teenage conceptions

Figure 23 shows that conceptions among those aged 15-17 years has been decreasing since 1998.

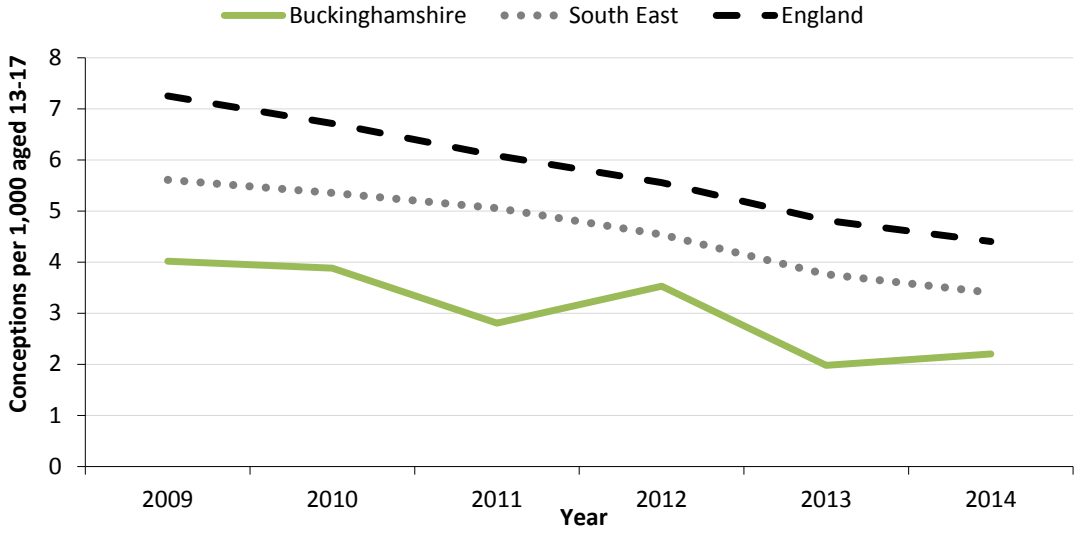
Figure 23. Teenage conceptions per 1,000 females aged 15-17 years, 1998-2014.



Source: Public Health England (PHE) Public Health Outcomes Framework, Indicator 2.04.

In Buckinghamshire, conceptions in those aged 13-15 years has halved from 4.0 per 1,000 in 2009 to 2.2 per 1,000 in 2014, see Figure 24. This trend is significant and reflects the regional and national trends.

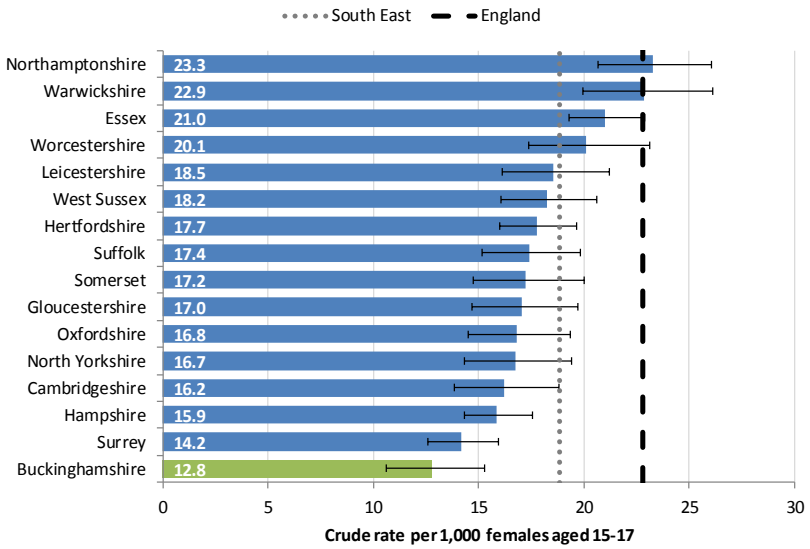
Figure 24. Teenage conceptions per 1,000 females aged 13-15 years, 2009-14.



Source: Public Health England (PHE) Public Health Outcomes Framework, Indicator 2.04.

In 2014, Buckinghamshire had the lowest rate of teenage conceptions per 1,000 females aged 15-17 years among its CIPFA peers, see Figure 25. This value (12.8) was significantly less than in the South East region (18.8) and England (22.8).

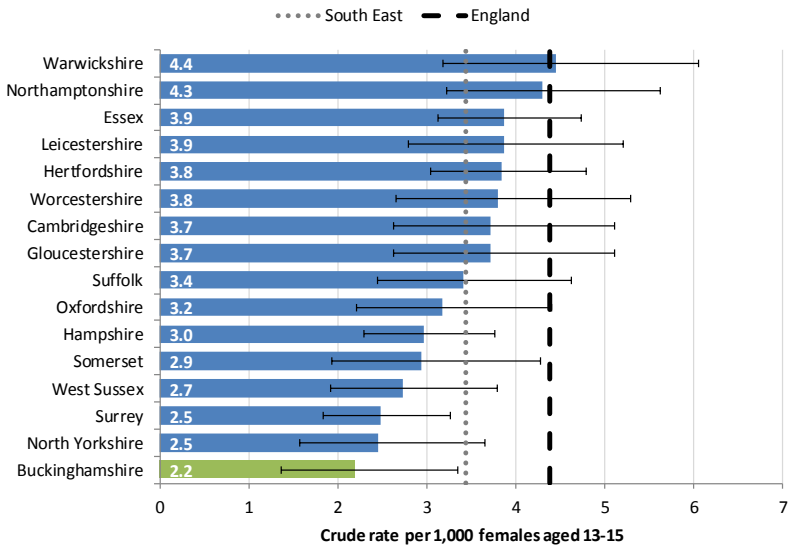
Figure 25. Teenage conceptions per 1,000 females aged 15-17 years among Buckinghamshire's CIPFA peers, 2014.



Source: Public Health England (PHE) Public Health Outcomes Framework, Indicator 2.04.

In 2014, Buckinghamshire had the lowest rate of teenage conceptions per 1,000 females aged 13-15 years among its CIPFA peers, see Figure 26. This value (2.2) was significantly less than in the South East region (3.4) and England (4.4).

Figure 26. Teenage conceptions per 1,000 females aged 13-15 years among Buckinghamshire's CIPFA peers, 2014.

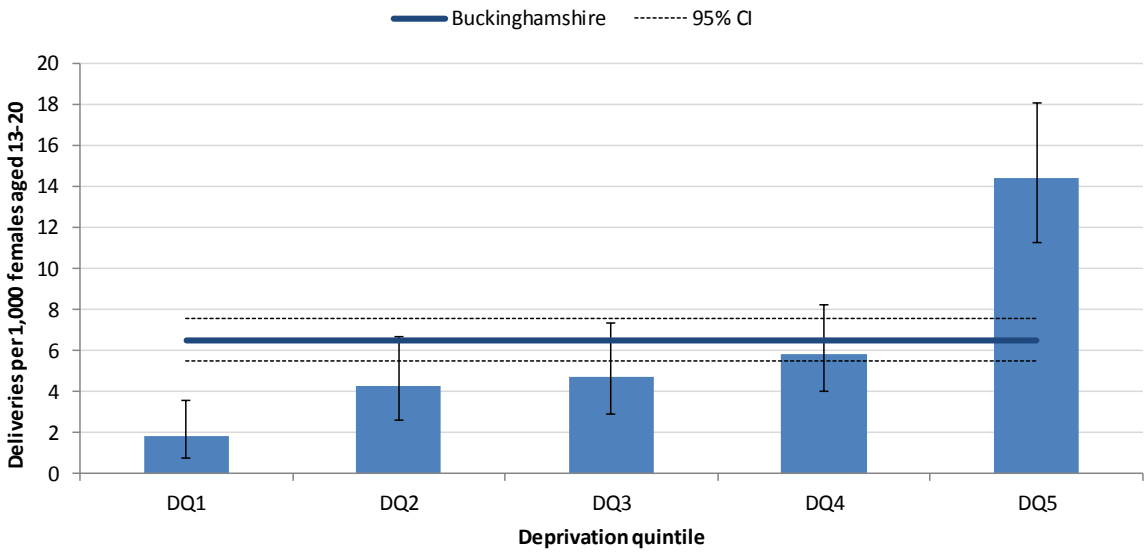


Source: Public Health England (PHE) Public Health Outcomes Framework, Indicator 2.04.

13. Teenage deliveries

Figure 27 shows that the number of deliveries per 1,000 females under 20 years of age at time of conception is highest in the most deprived quintile (DQ5). This value (14.4) is significantly higher than the Buckinghamshire average (6.5).

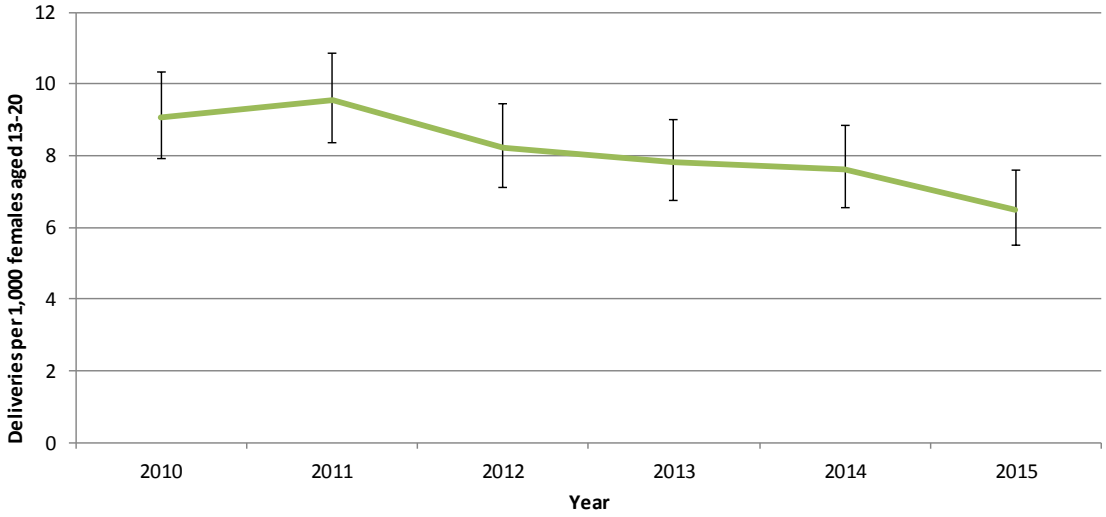
Figure 27. Number of deliveries per 1,000 females under 20 years of age at time of conception by deprivation quintile, 2015.



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

Figure 28 shows that the number of deliveries to mothers aged under 20 years at conception per 1,000 females has been decreasing since 2010.

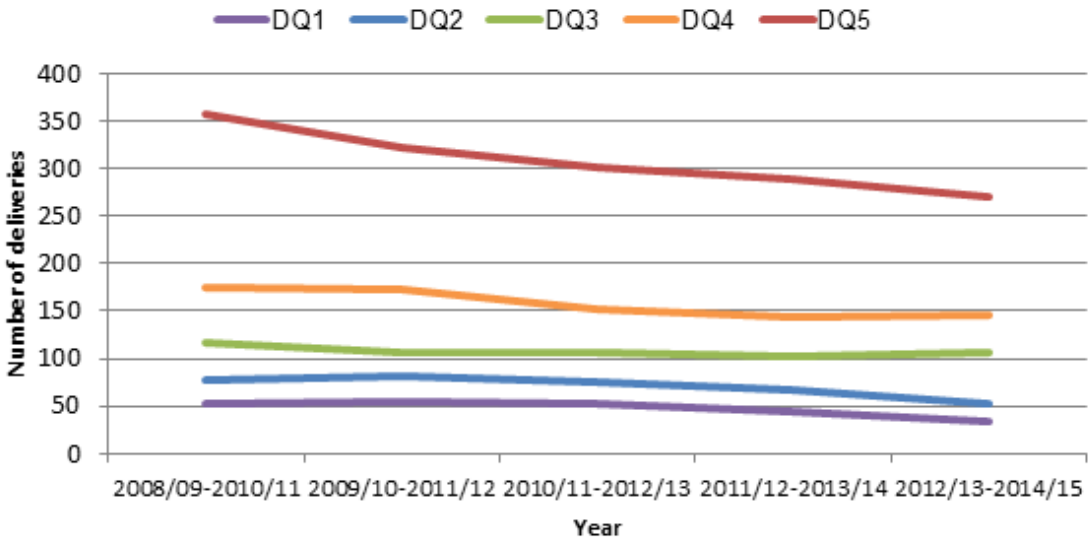
Figure 28. Number of deliveries per 1,000 females under 20 years of age at time of conception in Buckinghamshire, 2010-15.



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

The number of deliveries to mothers under 20 years of age at time of conception in each deprivation quintile is shown in Figure 29. There are more deliveries in the most deprived areas (DQ5), and a clear deprivation gradient.

Figure 29. Deliveries to mothers resident in Buckinghamshire who conceived aged under 20 years by deprivation quintile, 2008/09-2010/11 to 2012/13-2014/15.

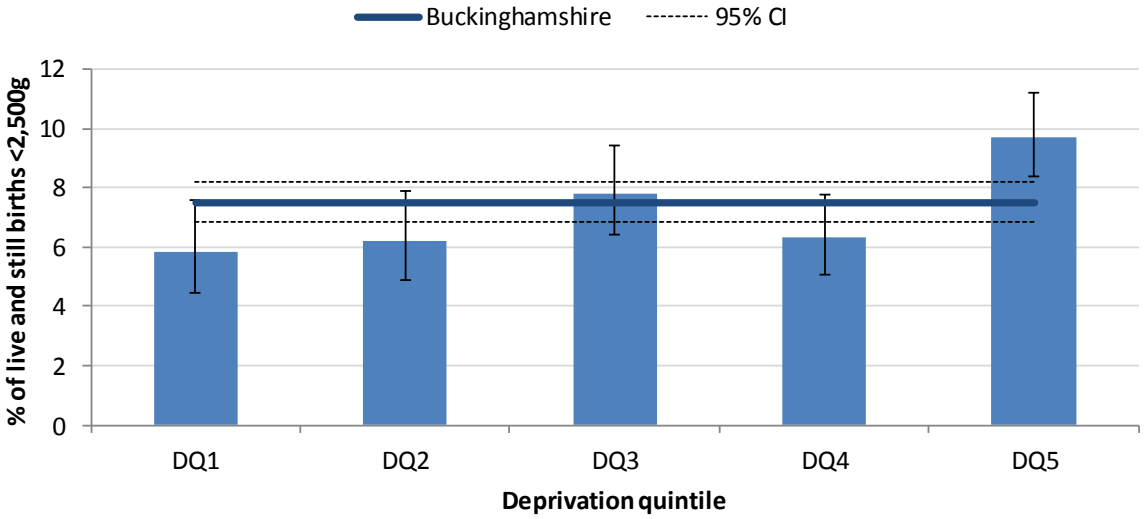


Source: SUS Admitted Patient Care (APC) Minimum Data Set (MDS).

14. Low birth weight

Mothers living in the most deprived areas (DQ5) had a significantly higher proportion of babies with low birth weight (less than 2,500g) in 2015 than the Buckinghamshire average, see Figure 30.

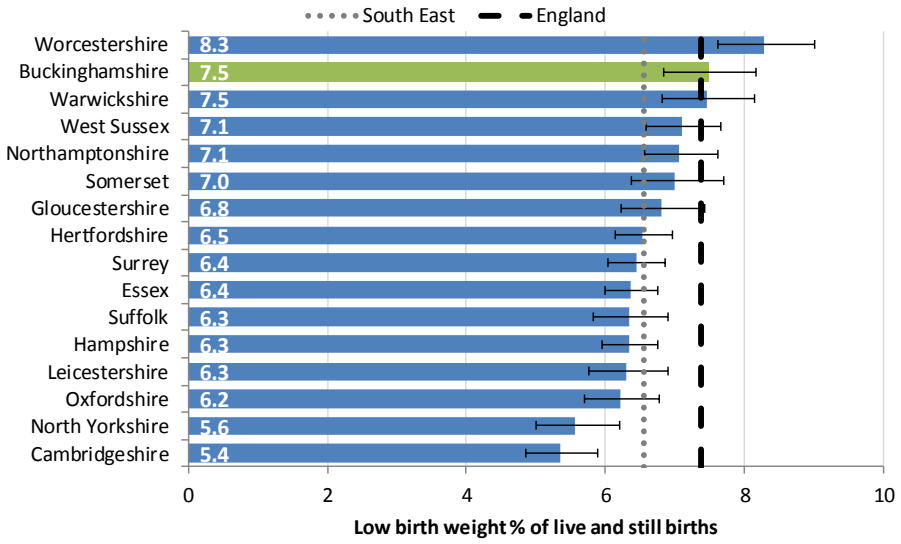
Figure 30. Low birth weight of all births in Buckinghamshire by deprivation quintile, 2015.



Source: Office for National Statistics Annual Public Health Birth Files.

Among its CIPFA peers, Buckinghamshire had the second highest rate of low birth weight babies in 2015, see Figure 31.

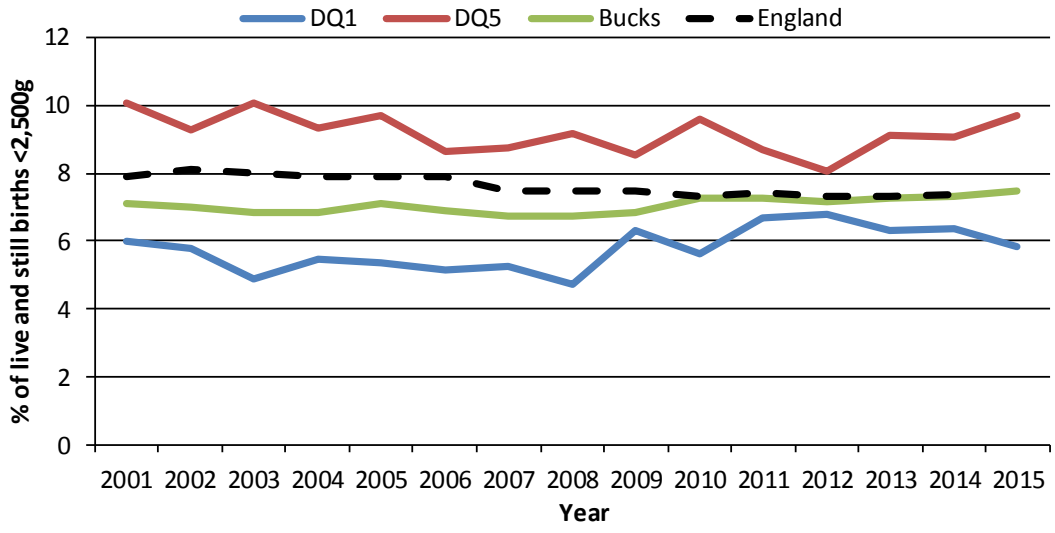
Figure 31. Low birth weight for all births among Buckinghamshire's CIPFA peers, 2015.



Source: Office for National Statistics, Vital Statistics Table VS2.

Babies with low birth weight as a proportion of live and stillbirths is shown in Figure 32. The average value for Buckinghamshire is similar to the England average.

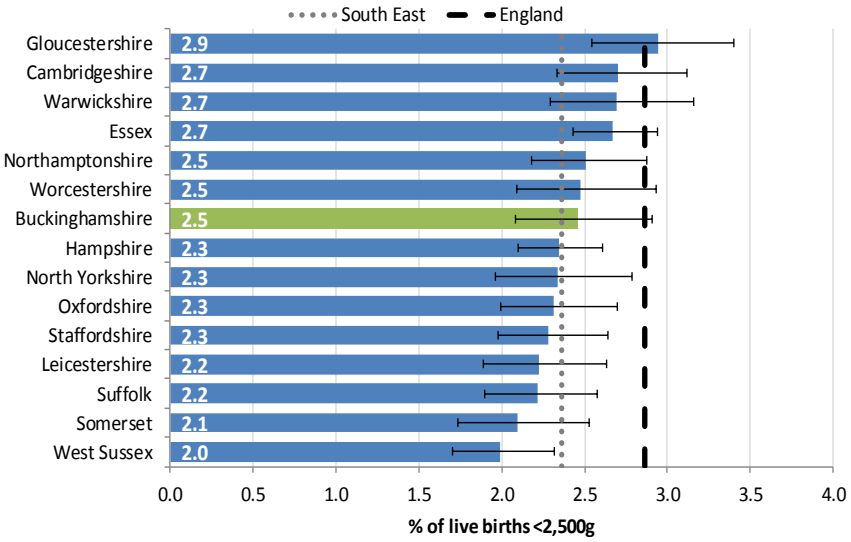
Figure 32. Low birth weight of all births in Buckinghamshire, 2001-15.



Source: Office for National Statistics Annual Public Health Birth Files.

For term babies, Buckinghamshire's proportion of low birth weight babies in 2014 was higher than many of its CIPFA peers, see Figure 33.

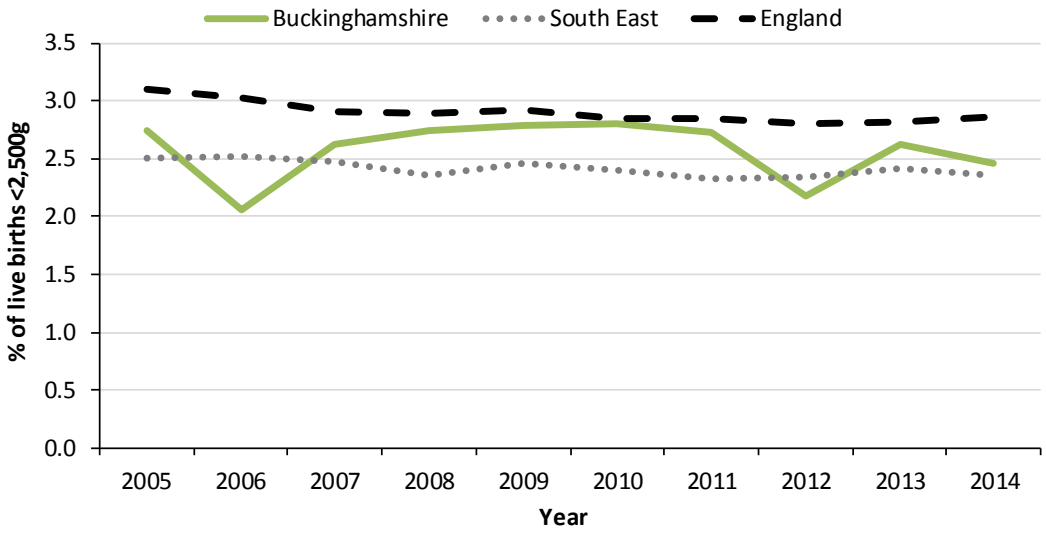
Figure 33. Low birth weight of term babies among Buckinghamshire's CIPFA peers, 2014.



Source: Public Health England (PHE) Public Health Outcomes Framework, Indicator 2.01.

Babies with low birth weight at term (at least 37 complete weeks) as a proportion of live births is shown in Figure 34. The average value for Buckinghamshire is similar to the England average.

Figure 34. Low birth weight of term babies in Buckinghamshire, 2005-14.

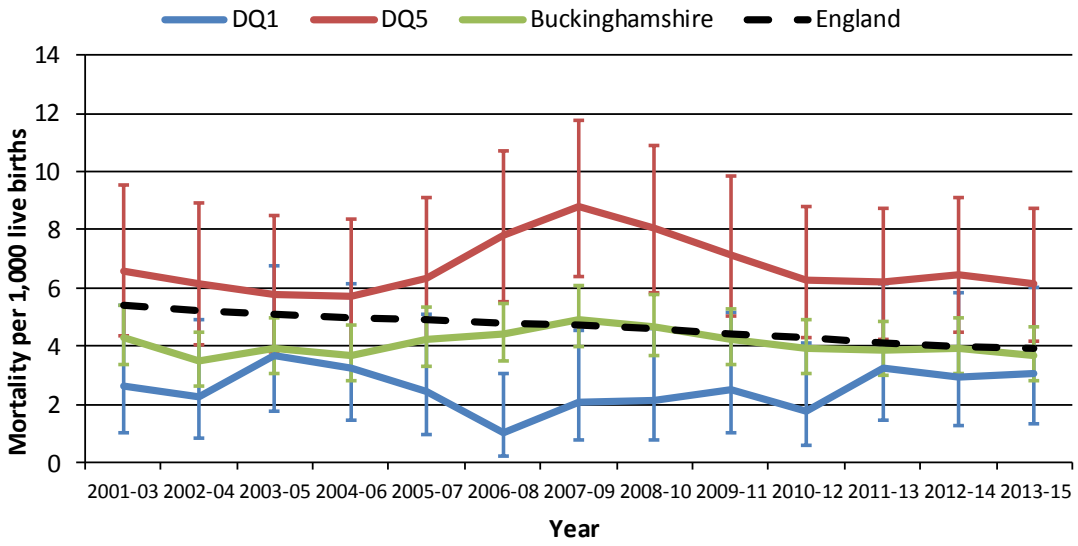


Source: Public Health England (PHE) Public Health Outcomes Framework, Indicator 2.01.

15. Infant mortality

Infant mortality in Buckinghamshire has been approximately 4 deaths per 1,000 live births since 2001-03, see Figure 35.

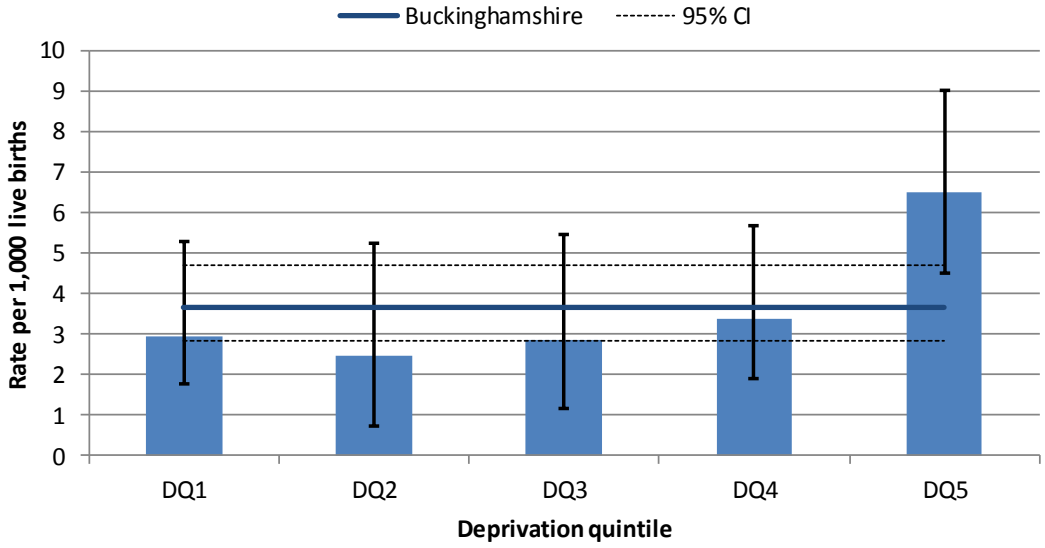
Figure 35. Infant mortality per 1,000 live births, 2001-03 to 2013-15.



Source: Office for National Statistics Primary Care Mortality Database (PCMD) and Annual Public Health Birth Files.

Those living in the most deprived areas (DQ5) have the highest rate of infant mortality, see Figure 36.

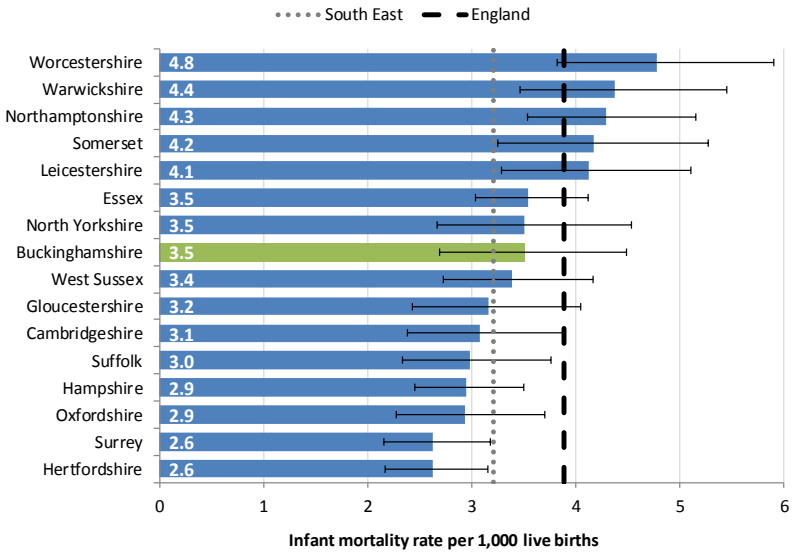
Figure 36. Infant mortality per 1,000 live births by deprivation quintile, 2013-15.



Source: Office for National Statistics Primary Care Mortality Database (PCMD) and Annual Public Health Birth Files.

Buckinghamshire's infant mortality rate for 2013-15 was worse than many of its CIPFA peers, see Figure 37.

Figure 37. Infant mortality rate among Buckinghamshire's CIPFA peers, 2013-15.



Source: Public Health England (PHE) Public Health Outcomes Framework, Indicator 4.01.

16. Infant hospital admissions

Table 8 shows the number of all and emergency hospital admissions for infants (under 1 year of age). Of the 1,709 infants admitted to hospital in 2015/16, 1,237 had one admission, 295 had 2 admissions, 92 had 3 admissions and 85 had 4 or more admissions.

Table 8. All and emergency hospital admissions for infants, 2011/12-2015/16.

Admissions		Year				
2011/12		2012/13	2013/14	2014/15	2015/16	
All	Infants	1,518	1,645	1,477	1,563	1,709
	Total admissions	2,256	2,371	2,162	2,370	2,583
Emergency	Infants	1,297	1,473	1,352	1,445	1,579
	Total admissions	1,744	1,985	1,885	2,071	2,197

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

17. Early Years Foundation Stage

The proportion of Buckinghamshire pupils achieving a Good level of development in the Early Years Foundation Stage is higher than England for White, Mixed and Chinese ethnic Groups, as shown in Table 9.

Table 9. Number of pupils achieving a Good level of development in the Early Years Foundation Stage by ethnicity, 2016.

	White		Mixed		Asian		Black		Chinese		All pupils	
	No. of pupils	%	No. of pupils	%	No. of pupils	%	No. of pupils	%	No. of pupils	%	No. of pupils	%
Bucks	4,724	73	526	75	935	59	158	67	29	76	6,577	71
England		70		71		68		68		69		69

Source: Department for Education (DfE) Early Years Foundation Stage profile results: 2015 to 2016 (Additional Tables).

Table 10 shows the percentage of pupils in each deprivation quintile who achieve a Good level of development in the Early Years Foundation Stage.

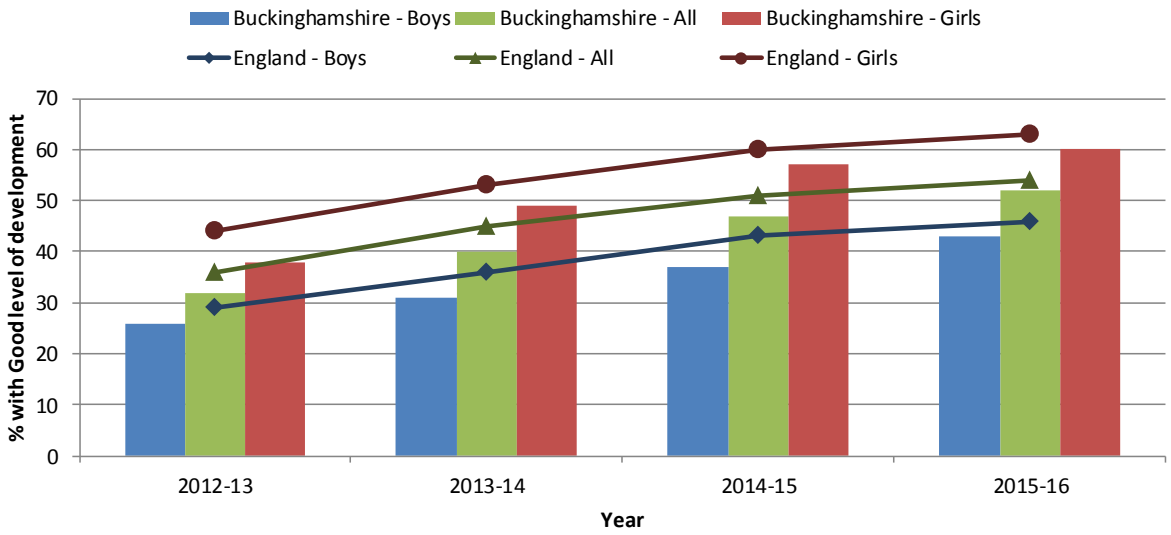
Table 10. Percentage of pupils achieving a Good level of development in the Early Years Foundation Stage by deprivation quintile, 2016.

Deprivation quintile	Number of pupils	% achieving a Good level of development
DQ1	1,125	78.8%
DQ2	1,093	75.3%
DQ3	1,268	73.1%
DQ4	1,197	70.1%
DQ5	1,637	61.0%
Other	262	64.1%
Total	6,582	70.5%

Source: Department for Education (DfE) Early Years Foundation Stage profile results: 2015 to 2016.

Compared to England, lower proportions of pupils who are eligible for free school meals achieve a Good level of development, see Figure 38. In 2015/16, 43% of boys and 60% of girls eligible for free school meals achieved a good level of development. On average, 52% of Buckinghamshire pupils eligible for free schools meals achieved a good level of development.

Figure 38. Percentage of pupils eligible for free school meals achieving a Good level of development in Early Years Foundation Stage, 2012-13 to 2015-16.

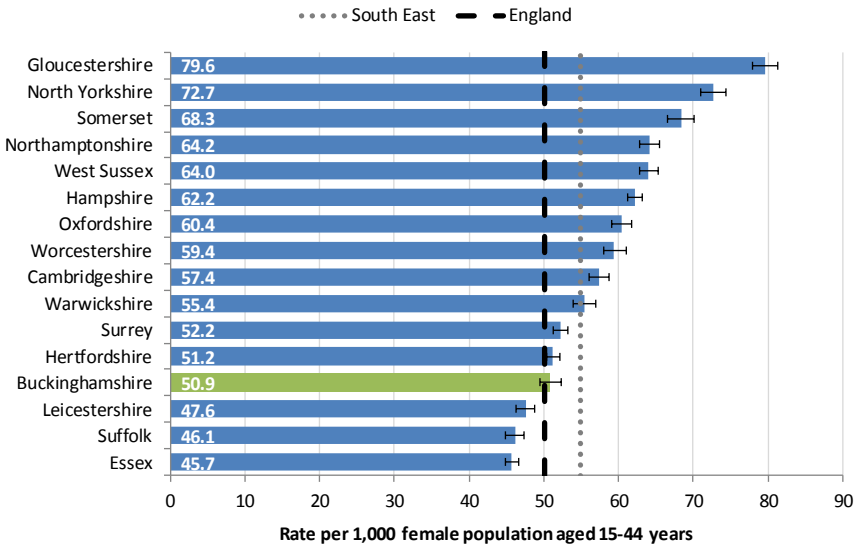


Source: Department for Education (DfE) Early Years Foundation Stage profile results: 2012-13 to 2015-16.

18. Long-acting reversible contraception

Figure 39 shows that Buckinghamshire's total prescriptions per 1,000 females aged 15-44 years in 2014 was similar to the England average, comparatively low among its CIPFA peers and statistically lower than local authorities in the South East region.

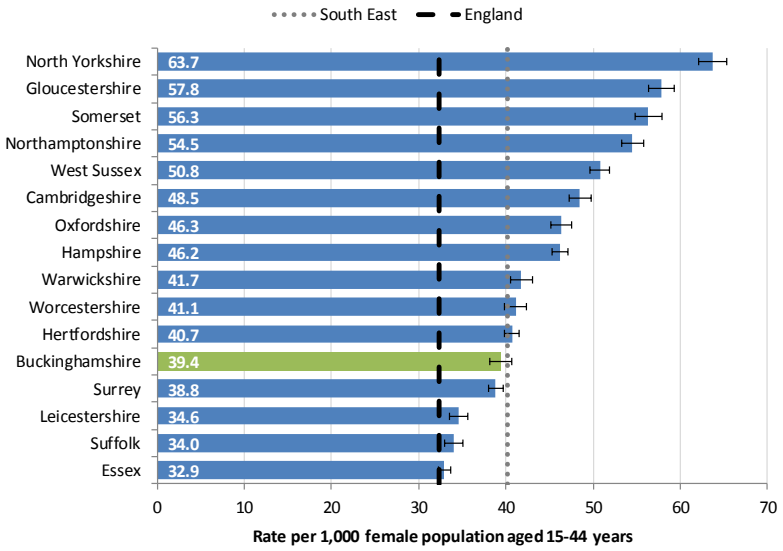
Figure 39. Total LARC prescriptions, excluding injections, per 1,000 females aged 15-44 years among Buckinghamshire's CIPFA peers, 2014.



Source: Public Health England (PHE) Sexual and Reproductive Health Fingertips Tool.

GP-prescribed LARC in Buckinghamshire in 2014 was comparatively low among its CIPFA peers, see Figure 40.
26

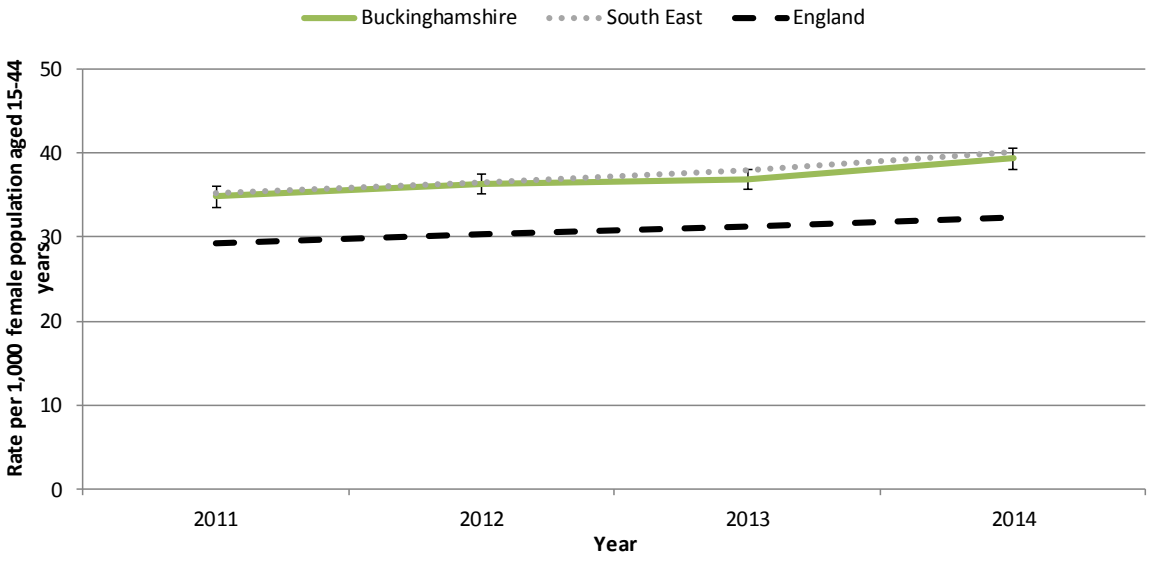
Figure 40. GP-prescribed LARC, excluding injections, per 1,000 females aged 15-44 years, 2014.



Source: Public Health England (PHE) Sexual and Reproductive Health Fingertips Tool.

GP-prescribed LARC in Buckinghamshire is significantly higher than the England average, see Figure 41.

Figure 41. GP-prescribed LARC in Buckinghamshire, 2011-14.

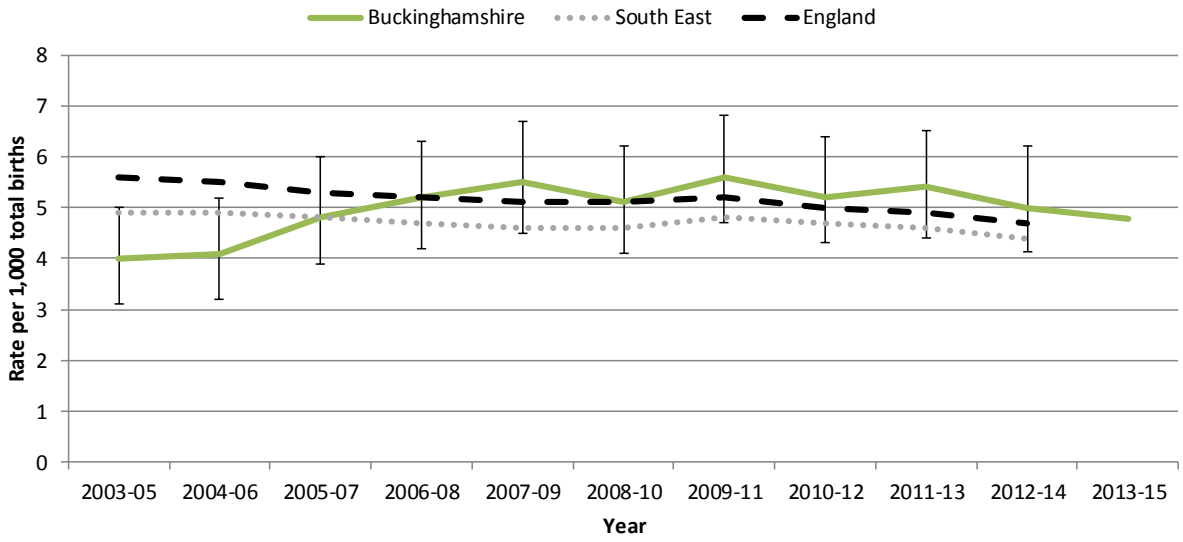


Source: Public Health England (PHE) Sexual and Reproductive Health Fingertips Tool.

19. Stillbirth

Figure 42 shows that the three-year average of stillbirths per 1,000 total births in Buckinghamshire has been approximately constant since 2006-08, compared to a decreasing national trend.

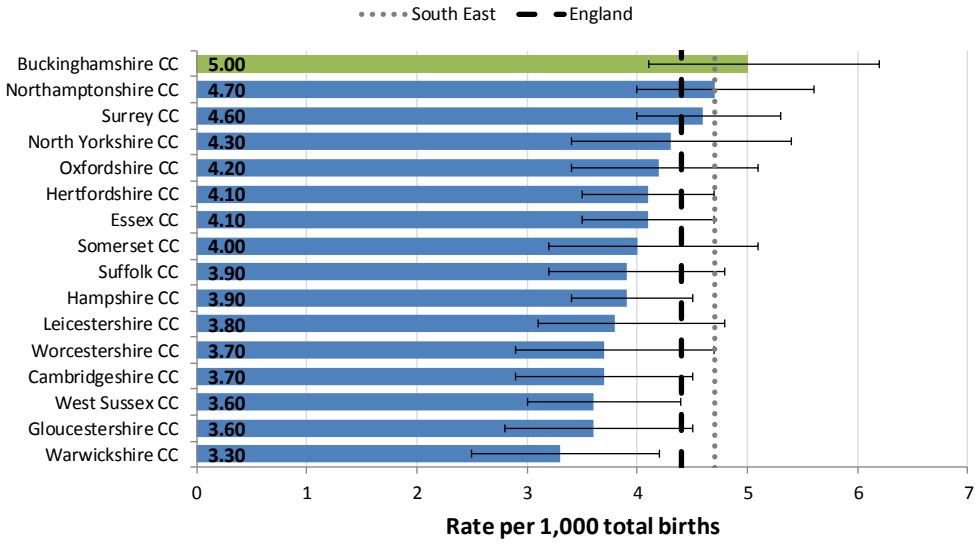
Figure 42. Stillbirths per 1,000 total births in Buckinghamshire, 2003-05 to 2013-15.



Source: NHS Digital Indicator Portal, Indicator P00468.

In 2012-14 there were 91 stillbirths. Buckinghamshire had the highest rate among its CIPFA peers for stillbirth in 2012-14, see Figure 43.

Figure 43. Stillbirths per 1,000 total births among Buckinghamshire's CIPFA peers, 2012-14



Source: NHS Digital Indicator Portal, Indicator P00468.

Public Health Outcomes Grid - Director of Public Health's Annual Report - Buckinghamshire 2016

Indicator		Unit	Year	Bucks		South East	England	Time series	CIPFA rank 1=Best 16= worst
Number	Name			Count	Value	Value	Value		
Overarching									
0.1i	Healthy life expectancy at birth (Male)	Years	2012-14	-	69.5	65.9	63.4		1
0.1i	Healthy life expectancy at birth (Female)	Years	2012-14	-	67.8	66.6	64.0		4
0.1ii	Life expectancy at birth (Male)	Years	2012-14	-	81.4	80.5	79.5		2
0.1ii	Life expectancy at birth (Female)	Years	2012-14	-	85.0	84.0	83.2		1
Wider Determinants									
1.02i	School readiness: % children achieving good level of development at the end of reception	%	2014/15	4,364	68.4	70.1	66.3		4
1.09i	Sickness absence - % of employees who had at least one day off in the previous week	%	2011-13	-	1.9	2.4	2.4		5
1.10	Killed or seriously injured casualties on England's roads	Rate per 100,000	2012-14	675	43.6	47.9	39.3		8
1.12ii	Violent crime including sexual violence - violence offences per 1,000 population	Rate per 1,000	2015/16	5,453	10.4	16.8	17.2		3
1.18i	Social Isolation - % of adult social care users who have as much social contact as they would like	%	2015/16	-	41.4	46.8	45.4		4
1.17	Fuel poverty	%	2014	16,462	7.9	8.3	10.6		6
CYPi	Children in care	Rate per 10,000	2015	435	37.0	49.0	60.0		5
Health Improvement									
2.01	Low birth weight of term babies	%	2014	134	2.5	2.4	2.9		9
2.06i	Excess weight in 4-5 year olds (NCMP)	%	2014/15	1,090	18.6	20.3	21.9		3
2.06ii	Excess weight in 10-11 year olds (NCMP)	%	2014/15	1,377	26.7	30.1	33.2		2
2.14	Smoking Prevalence in adults - current smokers (APS)	%	2015	-	11.0	15.9	16.9		1
2.12	Excess weight in adults	%	2013-2015	-	61.7	63.3	64.8		3
2.13ii	Adults reporting as physical inactive (<30 mins of moderate to high intensity physical activity/week)	%	2015	-	22.0	25.1	28.7		1
2.17	Recorded Diabetes	%	2014/15	25,116	5.9	5.7	6.4		6
2.18	Admission episodes for alcohol-related conditions - narrow definition	Rate per 100,000	2014/15	2,526	502.3	518.9	640.8		3
2.20i	Cancer screening coverage - Breast	%	2015	45,703	79.9	76.8	75.4		2
2.20ii	Cancer screening coverage - Cervical	%	2015	102,872	75.9	74.7	73.5		5
2.20iii	Cancer screening coverage - Bowel	%	2015	43,522	57.3	59.2	57.1	N/A	15
2.22iv	Cumulative % of the eligible population offered an NHS Health Check who received an NHS Health Check	%	2013/14-15/16	43,651	43.9	45.1	48.6	N/A	10
2.23iii	Self-reported wellbeing - People with a low happiness score	%	2014/15	-	7.7	8.0	9.0		8
CYPii	Self harm in children: Hospital admissions as a result of self-harm 10-24yrs	Rate per 100,000	2014/15	325	364.8	414.9	398.8		4
2.08i	Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months	Score	2014/15	-	13.9	14.6	13.9		N/A
2.10ii	Emergency hospital admissions for intentional self-harm	Rate per 100,000	2014/15	691	135.1	193.1	191.4		3
2.04	Under 18 conceptions	Rate per 1,000	2014	124	12.8	18.8	22.8		1
Health Protection									
3.02	Chlamydia detection rate (15-24)[1]	Rate per 100,000	2015	766	1,316.6	1,527.0	1,887.0		12
CYPiii	Children in care with up to date immunisations	%	2015	300	93.8	82.2	87.8		4
3.03xiv	Population vaccination coverage - Flu (aged 65+)[2]	%	2015/16	70,072	71.0	70.3	71.0		11
3.03xv	Population vaccination coverage - Flu (at-risk individuals)[3]	%	2015/16	27,554	45.0	44.9	45.1		9
3.04	HIV late diagnosis[4]	%	2013-15	36	45.6	43.6	40.3		5
3.05ii	Incidence of TB[5]	Rate per 100,000	2013-15	129	8.2	7.6	12.0		15
Healthcare and Premature Mortality									
4.01	Infant mortality	Rate per 1,000	2013-15	63	3.5	3.2	3.9		9
4.04i	Under 75 mortality rate from all CVD	Rate per 100,000	2013-15	689	52.0	62.3	74.6		1
4.05i	Under 75 mortality rate from all Cancers	Rate per 100,000	2013-15	1,504	113.1	129.4	138.8		1
4.09i	Excess under 75 mortality rate in adults with serious mental illness	Indirectly standardised ratio	2013/14	-	302.6	338.9	351.8		3
4.10	Suicide rate	Rate per 100,000	2013-15	113	8.5	10.2	10.1		2
4.14i	Hip fractures in people aged 65 and over	Rate per 100,000	2014/15	532	533.9	559.7	571.3		7
4.15iii	Excess winter deaths Index - 3 years	Ratio	Aug 2012-Jul 2015	653	17.0	18.8	19.6		3
4.03	Mortality rate from causes considered preventable	Rate per 100,000	2013-2015	1,976.3	134.1	161.2	184.5		1

Rag Rating: 1. Red: <1,900; Amber: 1,900-2,300; Green: ≥2,300. 2. Red: <75; Green: ≥75. 3. Red: <55; Green: ≥55. 4. Green: <25; Amber: 25-50; Red: ≥50. 5. Red: >50th-percentile of UTLAs; Amber: ≤50th to >10th; Green: ≤10th.

All other indicators compared to England: Better Similar Worse | Lower Similar Higher | Not Compared

Health & Wellbeing Board
Buckinghamshire

Title	Buckinghamshire Joint Health and Wellbeing Strategy themed agenda item on perinatal mental health
Date	14 September 2017
Presentation of:	Dr Nicola Widgington, General Practitioner Ruth House, Health Visitor, Perinatal Mental Health Project Manager

Purpose of the presentation:

For the Health and Wellbeing Board to consider in more detail the Joint Health and Wellbeing Strategy priority on perinatal mental health to identify potential gaps where a partnership approach from the Health and Wellbeing Board can add value.

Background:

The Health and Wellbeing Board is committed to giving every child the best start in life. A healthy pregnancy and early years are key to achieving these aims. In order to do this we need to work together with individuals, communities and partners to improve outcomes for babies, their mothers and families.

What happens during pregnancy and the earliest months after a child is born has a dramatic impact on a child's life and the adult they become. Getting it right at this critical time offers the best chance we have of raising happy and healthy children who reach their full potential, live satisfying lives and contribute positively to their community. Investing in the early years is good for society, promotes economic growth and reduces demand on health and social care services.

The refreshed Joint Health and Wellbeing Strategy states that:

During maternity, we will improve the health and wellbeing of mothers and their babies by:

- *Supporting the adoption of healthy lifestyles for the whole family.*
- *Ensuring good support for maternal and paternal mental health.*
- *Early detection and support for people experiencing domestic violence.*
- *Ensuring access to high quality parenting advice and support.*
- *Delivering targeted campaigns to raise awareness about the importance of antenatal care to all women and offer culturally sensitive information, advice and support to women from specific ethnic groups according to need.*

Under the **Promote good mental health for everyone** priority, the strategy states that we will:

- *Improve maternal mental health by building effective screening for mental health issues in pregnancy and maternity pathways and ensuring rapid access to effective intervention for all women who require it.*

At the meeting on 14 September, Dr Nicola Widgington and Ruth House will present to the Board on Perinatal Mental Health in Buckinghamshire.

The presentation will look at:

- Why perinatal mental health services are so important
- The consequences of perinatal mental illness
- Warning signs that someone maybe suffering from perinatal mental illness
- How we can improve detection (and why detection is sometimes poor)
- Service provision, programmes and future working in Buckinghamshire

The presentation will be followed by a roundtable discussion to:

- Reflect on the presentation
- Consider any gaps
- Look at what the Health and Wellbeing Board can do and
- Next steps

Recommendation for the Health and Wellbeing Board:

To consider the presentation on the day and contribute to the roundtable discussion, specifically to consider:

1. What can my organisation do to support this priority?
2. What action can the HWB take together to support and promote perinatal mental health and wellbeing?
3. What do I want others to do to support this priority?

Background documents:

Health & Wellbeing Board
Buckinghamshire

Title	Better Care Fund 17-19
Date	14th September 2017
Report of:	Jane Bowie, Director of Joint Commissioning
Lead contacts:	Jane Bowie; Susie Yapp

Purpose of this report:

To update the Health & Wellbeing Board on the Better Care Fund plan for 17-19, which was submitted to NHS England on the 11th September 2017. A draft plan was first presented to the Health and Wellbeing board on the 9th March and delegated authority for finalising and submitting this report was granted to the Integrated Commissioning Executive Team (ICET). The plan has since been informed by a stakeholder engagement event and a late draft approved by the CCG governing body, which also endorsed delegated authority for finalising and submitting the plan to ICET.

Summary of main issues:

The Better Care Fund (BCF) was first announced in the Government's Spending Review of 2013 and established in the Care Act 2014. The BCF brings together health and social care budgets into pooled budgets for each Health and Wellbeing Board area to support more person-centred, coordinated care. In the first two years of the BCF, the total amount pooled nationally was £5.3bn in 2015-16 and £5.8bn in 2016-17.

The Government has published a Better Care Fund policy framework for 2017-19 and announced funding of £5.128bn BCF in 2017-18 and £5.617bn. In addition in the 2017 budget an additional £2bn funding over the next three years was announced (£1bn in 2017/18, £674m in 2018/19 and £337m in 2019/20) to be pooled within the BCF. This is the 'improved BCF' (iBCF).

The BCF has four national conditions attached to the funding:

1. Plans to be jointly agreed
2. NHS contribution to adult social care is maintained in line with inflation
3. Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care
4. Managing Transfers of Care (a new condition to ensure people's care transfers smoothly between services and settings).

The iBCF may only be used for the purposes of meeting adult social care needs; reducing pressure on the NHS, including supporting more people to be discharged from hospital; and ensuring that the local social care market is supported

The iBCF must:

- Be pooled in the BCF
- Meet national condition 4 of the BCF (managing transfers of care)
- Provide quarterly reporting

The planned areas of spend for 17-19 align with the wider integration initiatives across the Buckinghamshire system, particularly the Sustainability and Transformation Plan (STP) for Buckinghamshire, Oxfordshire and Berkshire West, the Roadmap to Integration and the Health and Wellbeing Board Strategy. The planned areas of spend for the iBCF announced in the Budget will help to support adult social care and care providers and are in line with national conditions.

The main focus of spending in the existing BCF are largely unchanged from 2017-18. Agreement has also been reached locally on the areas of spend for the iBCF. It has been agreed with the CCGs that the BCF plan will include more details of health and social care activity and improvement metrics in relation to all areas of spend (this has not been sufficiently strong in the BCF plan previously) and that we will agree on some local improvement measures to support

- delivery of best practice models that have been identified nationally to support improved patient flow and discharge; i.e. the High Impact Change Model
- social work support for achieving the 28 day Continuing Health Care multi-disciplinary team assessment performance
- proactive support to community hospitals and Wexham Park hospital discharges
- maintaining improved access to reablement and reduced transfer of care waits

The Integrated Commissioning Executive Team (ICET) provides joint accountability and oversight of the strategic direction, budget and performance of the Better Care Fund. In addition a joint management sub group (ICET JMG) meets quarterly to review the financial arrangements, performance and value for money of the schemes that sit within the section 75 agreements that are in place for the Better Care Fund.

Performance of Better Care Fund schemes against national and local metrics are regularly reviewed by ICET and by the Health and Wellbeing Board to ensure schemes are delivering results. The ICET has recognised that there are many sources of health and social care data available that can facilitate our understanding of the impact of integration initiatives. A joint working group are currently reviewing the range of health and social care data sources available across the system with a view to developing a dashboard that will better measure the cost benefit realisation of the Better Care Fund Schemes.

In addition, it is a requirement of the fund that a quarterly return on the finances and performance of the BCF is submitted to NHS England and a quarterly return on the iBCF is submitted to DCLG.

The BCF narrative plan had previously been shared with NHS England for informal comment and whilst there were a few suggestions made and put in place, overall it was felt the plan was good. Areas have been addressed to help ensure it meets the standard expected in the national sign-off process.

The national sign off process will include:-

- Review by a panel including Margaret Wilcox on 20th September
- Regional moderation 25th September
- National moderation 27th and 28th September
- Final plan sign off 5th October

NHSE did advise on 1st September that Simon Stevens (Chief Executive NHSE) has further revised guidance on the BCF, specifically that there would be no negotiation for trajectories relating delayed transfers of care so there could yet be changes to the process.

Recommendation for the Health and Wellbeing Board:

To approve retrospectively the Better Care Fund Plan for 17-19.
To continue with governance and sign-off arrangements in place

Background documents:

2017-19 Integration and Better Care Fund Policy Framework :
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf

Buckinghamshire Roadmap to Integration:
https://democracy.buckscc.gov.uk/documents/s94866/Health%20and%20Social%20Care%20integration%20report%20for%209%20March%20HWB.pdf

Appendix 1: Final Buckinghamshire Better Care Fund Plan 17-19

N.B. Final BCF plan will be circulated as an additional agenda item on the 11th September following submission to NHS England

Health & Wellbeing Board Buckinghamshire

Draft Health and Wellbeing Board Forward Plan 2017/18:

Date	Item	Lead officer	Report Deadline	Further Information
14 September 2017	Director of Public Health Annual Report	*Dr J O'Grady*	Monday 4 September 12 noon	
	Buckinghamshire Joint Health and Wellbeing Strategy themed agenda item on Perinatal Mental Health	*N Widgington R House*		
	Update on Health and Care System - Accountable Care System - Better Care Fund Update	*Lou Patten/Neil Dardis, Sheila Norris* *Jane Bowie*		To provide an update to the Board on progress
	Children and Young People update	*Gladys Rhodes White*		
7 November 2017	Buckinghamshire Joint Health and Wellbeing Strategy themed agenda item (tbc)	*K.McDonald to co-ordinate*	Thursday 26 October	To be agreed
	Update on Health and Care System Planning	*Lou Patten/ Neil Dardis and Sheila Norris*		To provide an update to the Board on progress
	Pharmaceutical Needs Assessment	*Emily Youngman*		
	Better Care Fund Update	Jane Bowie		To include update on progress of BCF and Scorecard
	Children and Young People	Tolis Vouyioukas, Executive Director Children's Services		
	Healthwatch Annual Report	Jenny Baker		

Health & Wellbeing Board Buckinghamshire

	Female Genital Mutilation Update	K McDonald/Matilda Moss		
7 December 2017	Buckinghamshire Joint Health and Wellbeing Strategy themed agenda item	*K.McDonald to co-ordinate*	Monday 27 November 12 noon	To be agreed
	Joint Health and Wellbeing Strategy Priority Updates Mental Health and Suicide Prevention	*K.McDonald to co-ordinate*		Follow up from mental health and early years
	Update on Health and Care System Planning	*Lou Patten*		To provide an update to the Board on progress
	Better Care Fund Update	Jane Bowie		To include update on progress of BCF and Scorecard
	Children and Young People update	Tolis Vouyioukas, Executive Director Children's Services		
	Safeguarding Boards Annual Reports	Matilda Moss/Nikki Barry		
18 January 2018	Buckinghamshire Joint Health and Wellbeing Strategy themed agenda item	K McDonald to co-ordinate	Monday 8 January	To be agreed
	Update on Health and Care System Planning	Lou Patten/Neil Dardis and Sheila Norris		
	Better Care Fund	Jane Bowie		To include update on progress of BCF and Scorecard
	Children and Young People Update	Tolis Vouyioukas, Executive Director Children's Services		
29 March 2018	Buckinghamshire Joint Health and Wellbeing Strategy themed agenda item	K McDonald to co-ordinate	Monday 19 March	
	Update on Health and Care System Planning/ Sustainability and Transformation Partnership and	Lou Patten/ Neil Dardis and Sheila Norris		

Health & Wellbeing Board Buckinghamshire

	Accountable Care System			
	Better Care Fund Update	Jane Bowie		
	Pharmaceutical Needs Assessment	Emily Youngman		
	Children and Young People update - To include update on FGM	Tolis Vouyioukas, Executive Director Children's Services		