Agenda

Health & Wellbeing Board Buckinghamshire

Date: Thursday 27 September 2018

Time: 10.00 am

Venue: Mezzanine Room 1 - County Hall, Aylesbury

9.30 am Pre-meeting Discussion

This session is for members of the Committee only.

10.00 am Formal Meeting Begins

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Agenda Item		Time	Page No
1	**WELCOME & APOLOGIES**		
2	**ANNOUNCEMENTS FROM THE CHAIRMAN**		
3	**DECLARATIONS OF INTEREST**		
4	**MINUTES OF THE MEETING HELD ON 3 MAY 2018** The minutes of the meeting held on 3 May 2018 to be agreed as an accurate record and signed by the Chairman.		**5 - 12**

5 PUBLIC QUESTIONS

6 BUCKINGHAMSHIRE JOINT HEALTH AND WELLBEING BOARD PERFORMANCE DASHBOARD ANALYSIS REPORT - PRIORITY AREA 5 - SUPPORT COMMUNITIES **13 - 34**

Presenter: Dr J O'Grady, Director of Public Health, Buckinghamshire County Council.

7 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT - HEALTHY PLACES, HEALTHY FUTURE **35 - 72**

Presenter: Dr J O'Grady, Director of Public Health, Buckinghamshire County Council.

8 CHILDREN AND YOUNG PEOPLE UPDATE **73 - 76**

Presenter: Mr T Vouyioukas, Executive Director Children's Services.

- An update on OFSTED
- A high level update on the Children's Partnership Board

9 UPDATE ON HEALTH AND CARE SYSTEM PLANNING **77 - 86**

Presenters: Ms L Watson, Managing Director, Buckinghamshire Integrated Care System; Ms L Patten, Accountable Officer, Buckinghamshire Healthcare Trust; Mr N Macdonald, Chief Executive, Buckinghamshire Healthcare Trust and Ms D Richards, Head of Joint Care Commissioning, Buckinghamshire County Council.

- Integrated Care System Approach to Commissioning Intentions
- Update of the Better Care Fund

10 NHS HEALTHCHECK PRESENTATION **87 - 106**

Presenter: Dr S Habibula, Public Health Consultant, Buckinghamshire County Council.

11 PREVENTION AT SCALE **107 - 112**

Presenter: Mrs S Preston, Public Health Principal, Buckinghamshire County Council.

12 INTEGRATED LIFESTYLE SERVICES **113 - 114**

Presenter: Mrs S Preston, Public Health Principal, Buckinghamshire County Council.

13	**CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) TRANSFORMATION PLAN** Presenter: Ms C Hart, Specialist Commissioning Manager, Buckinghamshire County Council.	**115 - 204**
14	**HEALTH AND WELLBEING BOARD WORK PROGRAMME** Presenter: Mrs S Khan, Business Manager, Public Health, Buckinghamshire County Council.	**205 - 206**
15	**DATE OF NEXT MEETING** Thursday 6 December 2018 in Mezzanine Room 1, County Hall, Aylesbury.	

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Members

Dr R Bajwa (Clinical Chair, Buckinghamshire CCG), Ms J Baker OBE (Healthwatch Bucks), Mr S Bell (Chief Executive, Oxford Health NHS), Mrs I Darby (Chiltern District Council), Lin Hazell (Buckinghamshire County Council), Dr G Jackson (Clinical Lead, Buckinghamshire ICS), Mr N Macdonald (Chief Executive, Buckinghamshire Healthcare NHS Trust), Ms A Macpherson (District Council Representative), Mr R Majilton (Deputy Chief Officer, Buckinghamshire CCG), Mr N Naylor (South Bucks District Council), Dr J O'Grady (Director of Public Health), Ms L Patten (Chief Officer, Buckinghamshire CCG), Mr G Peart (Wycombe District Council), Ms G Quinton (Buckinghamshire County Council), Dr S Roberts (Clinical Director for Mental Health, Buckinghamshire CCG), Dr J Sutton (Clinical Director for Children's Services, Buckinghamshire CCG), Mr M Tett (Buckinghamshire County Council) (C), Mr T Vouyioukas (Buckinghamshire County Council), Dr K West (Clinical Director for Integrated Care, Buckinghamshire CCG) (VC), Mr W Whyte (Buckinghamshire County Council) and Ms K Wood (Wycombe District Council)

Minutes

Health & Wellbeing Board Buckinghamshire

MINUTES OF THE HEALTH AND WELLBEING BOARD HELD ON THURSDAY 3 MAY 2018, IN MEZZANINE ROOM 1, COUNTY HALL, AYLESBURY, COMMENCING AT 10:15 AM AND CONCLUDING AT12:05 PM.

MEMBERS PRESENT

Dr R Bajwa (Clinical Chair, Buckinghamshire CCG), Ms J Baker OBE (Healthwatch Bucks), Mrs I Darby (District Council Representative), Lin Hazell (Buckinghamshire County Council), Dr G Jackson (Clinical Lead, Buckinghamshire ICS), Mr N Macdonald (Chief Executive, Buckinghamshire Healthcare NHS Trust), Dr J O'Grady (Director of Public Health), Ms L Patten (Chief Officer ,Buckinghamshire CCG), Ms G Quinton (Buckinghamshire County Council), Dr S Roberts (Clinical Director for Mental Health, Buckinghamshire CCG), Mrs J Teesdale (Buckinghamshire County Council), Mr M Tett (Buckinghamshire County Council) (Chairman), Mr T Vouyioukas (Buckinghamshire County Council) and Dr K West (Clinical Director for Integrated Care, Buckinghamshire CCG)

OTHERS PRESENT

Miss S Callaghan (Buckinghamshire County Council), Mrs S Khan (Buckinghamshire County Council), Ms K McDonald (Buckinghamshire County Council), Ms P Scully (Oxford Health NHS Foundation Trust); Ms L Watson (Managing Director, ICS), Dr S Williamson (Interim Public Health Consultant) and Ms S Taylor (Committee Assistant)

1 WELCOME & APOLOGIES

Apologies had been received from:

- Mr W Whyte
- Mr G Peart
- Ms A Macpherson
- Mr N Naylor
- Dr J Sutton

Ms J Teesdale attended in place of Mr W Whyte. Ms S Khan would be attending in place of Ms McDonald for the remainder of 2018.

2 ANNOUNCEMENTS FROM THE CHAIRMAN

The Chairman reported that he had visited Bicester on 27 April 2018 along with other members of the Health and Wellbeing Board. Bicester had been nominated as a Healthy New Town and the visit highlighted how lessons had been learnt by time spent co-designing with the community e.g. town trails on the pavements to encourage activity and the social cohesion of engaging new estates on the outskirts with the older part of the town. The Chairman thanked Dr O'Grady for the input provided by the Public Health team.

The Chairman raised the recent issue reported in the media whereby women aged 68-71 had not been invited for breast cancer screening and asked what was happening in Buckinghamshire. Mr N Macdonald, Chief Executive, Buckinghamshire Healthcare Trust

(BHT), advised the breast screening programme was run nationally by Public Health England. There were women in Buckinghamshire who were affected and BHT had been asked to provide additional capacity in the breast screening unit. Once the data was received the people concerned would be invited as soon as possible.

3 DECLARATIONS OF INTEREST

There were no declarations of interest.

4 MINUTES OF THE MEETING HELD ON 29 MARCH 2018

Ms K McDonald, Health and Wellbeing Lead Officer, reviewed the following actions:

- A meeting had been arranged between the Chairman and Ms Fiona Wise, Executive Lead of the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Partnership (BOB STP).
- Mr Macdonald confirmed that Ms Baker from Healthwatch Bucks had been invited to the debrief meeting on winter planning.
- Dr Sutton had circulated the detailed data broken down by age relating to the emergency admissions for 0-19 year olds.
- Ms McDonald advised that the action to look into the data reported in other forums and the expectation for Health and Wellbeing Board's nationally would be included in the dashboard review report at the meeting in December 2018.
- Ms Baker had discussed the inclusion of a patient engagement metric with Public Health and reported that Dr S Williamson had agreed to join the project.

The Chairman asked for a target completion date to be added to the actions which were "work in progress".

RESOLVED: The minutes of the meeting held on 29 March 2018 were AGREED as an accurate record and signed by the Chairman.

5 PUBLIC QUESTIONS

There were no public questions.

6 BUCKINGHAMSHIRE HEALTH AND WELLBEING BOARD GOVERNANCE REVIEW 2018 AND DRAFT TERMS OF REFERENCE

The Chairman summarised that the Health and Wellbeing Board was a statutory board and that a small working group had reviewed the governance constitution and draft terms of reference.

Ms McDonald added that there were four recommendations listed in the paper contained in the agenda pack.

Key recommendations for the Board:

1. Terms of Reference (TOR)
2. Strengthen relationships with the boards delivering the priorities of the Joint Health and Wellbeing Strategy
3. Strengthening Communication and engagement:
4. Continue to work to provide clarity to the Boards interface with the Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS)

The recommendations in the Governance Review and Terms of Reference were agreed but there was debate on whether the Board needed to look at the interface between the STP and ICS and membership of the Board before the annual review was due in March 2019. There was agreement from members to retain the membership for the coming year but for dialogue to continue and for the board to receive updates at future meetings. The timeframe for a formal update of the Terms of Reference in March 2019 was therefore still realistic.

It was agreed that the number of Clinical Commissioning Group (CCG) representatives needed to be confirmed and would be agreed off line.

Action: Mrs Khan

RESOLVED: The Board AGREED the key recommendations and proposals for developing the Health and Wellbeing Board included in the report.

RESOLVED: The Board AGREED the draft terms of reference.

7 BUCKINGHAMSHIRE JOINT HEALTH AND WELLBEING BOARD PERFORMANCE DASHBOARD ANALYSIS REPORT

The Chairman welcomed Dr S Williamson, Acting Consultant, Public Health and Ms S Callaghan, Service Director, Education to the meeting.

The Chairman reminded the Board that a different item from the Health and Wellbeing Board Performance Dashboard Analysis report was discussed as a deep dive at each meeting.

Dr Williamson reported that the paper on Priority area 3 - Promote Good Mental Health and Wellbeing for Everyone was the third in the series and provided information and commentary on the 11 indicators. The Chairman advised that there had been a workshop on mental health last year and stressed it was a key item.

In response to questions from members the following key points were made:

Indicator 43 - Persistent absentees in Secondary school

- In 2016/17, the proportion of secondary school pupils classed as persistent absentees in Bucks was 14.8%. This was statistically significantly higher than the proportion across England at13.1%.
- The profile of the young people with long term absences was being reviewed to ascertain how to encourage children to have better attendance and avoid exclusions.
- It was reported that the data was from 2015-16 and that there had been a marked drop in absenteeism since 2016-17 due to the relevant services working closely together to provide better support, however, the data had not been benchmarked.
- Also, there had been changes in national policy as the actual rate where a child became defined as persistently absent changed. Currently, if a child's attendance rate dropped to below 95% they were perceived to be persistently absent. Previously, it was 90% which was why the data showed a decline.

Indicator 44 – Primary school fixed period exclusions

- The Education Service was working closely with schools to improve the outcomes.
- The number of fixed term exclusions was improving.
- There were 112 permanent exclusions two years ago; currently there were 59; however, the data in the pack was "lagged" and did not reflect the current position.

- There was a close correlation with the issues in the Special Education Needs (SEN) service. The extensive SEN improvement plan should start to impact on improved outcomes in terms of attendance and exclusion rates.

Indicator 47 – Adults (aged 18-69) in contact with secondary mental health services who live in stable and appropriate accommodation

- The commentary had been received from Oxford Health and Dr Scully emphasised the importance of stable accommodation for those with mental health issues in Buckinghamshire.
- There were significant pressures in Buckinghamshire which lead to people remaining in hospital for longer than needed.
- Ms Quinton mentioned that there was also an issue in Buckinghamshire regarding appropriate accommodation for older people and for those with learning difficulties and there was an opportunity with the growth agenda to plan ahead.

Indicator 48 - Excess under 75 mortality rate in adults with serious mental illness

Dr S Roberts, Clinical Director of Mental Health, CCGs, advised that, whilst benchmarked favourably with CIPFA peers, people were still dying unnecessarily and after discussion the Chairman recommended that this issue be re-visited at a future meeting to discuss what could be done in Buckinghamshire.

Action: Mrs Khan

Ms Baker advised that she would be working with Healthwatch England on a two year project focussed on mental health. There was also a Healthwatch Bucks "Feeling Happy Drawing Competition" open to schools and groups which Ms Baker asked the Board to promote.

RESOVED: The Board NOTED the analysis in the report.

8 UPDATE REPORT ON BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP (STP) AND THE BUCKINGHAMSHIRE INTEGRATED CARE SYSTEM (ICS)

The Chairman welcomed Ms L Patten, Accountable Officer, Clinical Commissioning Groups; Ms L Watson, Managing Director, Buckinghamshire Integrated Care System; Mr N Macdonald, Chief Executive, Buckinghamshire Healthcare Trust (BHT) and Ms G Quinton, Executive Director, Communities, Health and Adult Social Care (CHASC).

Ms Patten highlighted the following points from the presentation included in the agenda pack:

- Commissioning would be done at scale where it was possible to save money and share learning.
- The Accountable Care System had become the Integrated Care System and was working together to integrate services.
- Ms F Wise had started on 5 March 2018 as Executive Lead for the STP locally and would be in charge of the work streams to be done at scale.
- Ms Patten had joined Oxfordshire CCG as well as continuing her role with Buckinghamshire CCGs.
- The key programme areas were cancer alliance, prevention and population health management, capacity planning, digital and estates.
- Ms Patten suggested a more in depth look at the work of the cancer alliance at a later date.
- The areas where the STP shared best practice and provided assurance included urgent and emergency care, mental health, primary care and maternity.

In response to questions from Members the following key points were made:

- Ms Wise would be making links beyond the STP boundaries in order to maximise the benefit of shared national best practice.
- Ms Wise was aware that previously there had been work on patient engagement by Healthwatch Bucks and she would be looking into it.
- Ms Quinton commented that that she agreed with the concept of commissioning at scale and integrated health care. However, the funding regime and work force issues could cause problems and she felt there needed to be more equity across the whole system.
- The Chairman said Buckinghamshire was seeking to engage with MPs on the development of the Green Paper on Health and Social Care which was due out in the summer of 2018.

Ms Watson continued with the presentation and made the following key points:

- Ms Watson had been in post for three months as the Managing Director of the ICS.
- There were seven organisations that had made a commitment to work together through a formal memorandum of understanding for the delivery and planning of the strategy for health and care within Buckinghamshire. There was a collective vision: Everyone working together so that the people of Buckinghamshire have happy and healthy lives.
- The Objectives.
- The transformation so far.
- The need for engagement with communities which had been carried out by "Your Community, Your Care" roadshows; supplemented by comprehensive engagement with public and stakeholders; listening to professionals and ongoing participation in NHS/National Council for Voluntary Organisations development programme.
- The emerging care model consisted of four tiers; for those with minimal risk to those with extreme risk.
- The ICS Care Concept – to articulate to residents what it meant to them and what was available.
- Next steps – building on what already existed; a draft programme was still in discussion.
- Professional support services – investment in estates across Buckinghamshire, enhancement in A&E and patient experience at Stoke Mandeville hospital.
- Technology – improvement in the systems to support integrated team working and improve the efficiency and safety of booking appointments online.

In response to questions from members the following key points were made:

- The detail in the presentation highlighted the complexity of the system and that working together should make it easier for patients to move through the system more effectively due to shared records and shared working.
- The information on the CCG and BHT websites would be amalgamated in conjunction with public and stakeholder engagement and revisited at a later meeting.

Ms Quinton continued with the presentation and highlighted the following points:

- BCC had recently launched a new strategy called "Better Lives" which focussed on three key tiers; more people living independently ideally in their own homes; helping people in a crisis situation regain control of their lives; helping those who needed support on a long term basis.
- The strategy was underpinned by the "strengths approach" i.e. what people could do rather than what they could not do.

- Currently the Adult Social Care budget was £161m.
- There were 8,500 services users supported by 266 providers.
- 10,000 clients contacted BCC per annum; of which 7,500 lead to an assessment; with 2,200 resulting in the provision of a care package – a ratio of 5:1. The best practice ratio was 22:1; and indicated over-provision of services in Buckinghamshire which lead to dependency and worse outcomes for individuals.
- The average length of stay in residential care was 2.6 years; nationally the average was 1.8 years.
- There was a need to work closely with colleagues in health, reduced duplication in services, simpler pathways through the services and to provide a focus on prevention and reablement.
- Tier 1 - Living Independently - would be focussed on the provision of information and advice, building of strong local networks by working with communities to improve the health and wellbeing.
- Tier 2 – Regaining Independence – would look at reablement teams, discharge to assess pathways, rapid response and therapeutic teams in order to reduce duplication, provide earlier intervention and support to people to return home.
- Tier 3 – Living with Support - working with the care market e.g. housing with extra care for support. There would need to be changes to community support services rather than day care centres.

In response to questions from members the following key points were made:

- The quality metrics would need to be studied in order to move the appropriate provision and ensure funding was spent appropriately.
- There were improvements which could be made which would result in better outcomes for people.
- There was an opportunity through the integrated system to link the clinical cases with the provision and prevent people becoming dependent too early.
- The system needed to appear as one system.

RESOLVED: The Board RECEIVED the presentation and CONSIDERED its role in supporting the identified areas.

9 CHILDREN'S SERVICES UPDATE

Mr T Vouyioukas, Executive Director Children's Services, highlighted the following points:

- The Ofsted action plan update.
- The Children's Commissioner, John Coughlan, would be providing a report in late May 2018. Mr Vouyioukas would then provide an update to the Health and Wellbeing Board at the meeting on 27 September 2018.
- The SEND inspection was imminent. Mr Vouyioukas stressed the importance of management oversight and stronger service and staff management in relation to improving quality assurance in a similar way to Children's Social Care.
- The Conversions of all Statements to Education Health and Care Plans were triggered on time

In response to a member of the Board asking how they could help, Mr Vouyioukas made the following points:

- To bring examples of good and poor practice to his attention.

- Before making a referral to Children's Social Care it was important that all other options available to partner agencies had been exhausted.
- Approximately 70% of cases had a theme of domestic abuse, mental health and substance misuse and when cases were reviewed it was often evident that action should have taken place much earlier.
- The importance of working together with the Children's Safeguarding Board in improving outcomes for children

The Chairman acknowledged the improvement and transformation since 2014 due to partnership working.

RESOLVED: The Board NOTED the report.

10 UPDATE ON FEMALE GENITAL MUTILATION (FGM)

Ms McDonald reported that the Health and Wellbeing Board was established as the lead governance board with oversight of FGM and the FGM Strategy in Buckinghamshire in 2016. The action plan and operational issues were overseen by the Buckinghamshire Children's Safeguarding Board (BCSB). FGM was a shared priority of the four strategic boards through the joint protocol and the FGM strategy was signed off by all boards in 2017.

A coordinated approach with the right framework (strategy, robust guidance, and strategic oversight) was now in place and a virtual steering group were continuing to evaluate this.

It had been mandatory for acute trusts, mental health trusts and GP practices to submit data when a patient was identified with FGM since 2015 through the FGM enhanced data set. The data available was becoming increasingly more sophisticated but as a general rule, caution was advised in interpreting FGM Enhanced Dataset findings because data completeness was often low and varied by region, the submitter and data item. Many of these issues were covered in the quarterly data set quality statements.

The public health team continued to keep oversight of FGM data in Buckinghamshire. The difficulty was that any data below national average was suppressed to protect patient identity and all numbers between 0-4 were supressed with an asterisk in reporting tables. This had been the case for all reporting in the county to date.

Available evidence in the Buckinghamshire JSNA FGM chapter suggested that instances were very low in Buckinghamshire. While we would expect numbers to be lower than other areas for a number of reasons due to our demographics, it was also known that FGM was under reported and it was necessary to challenge this further to understand whether reporting was being impacted by other factors.

The Health and Wellbeing Board and BSCB jointly hosted a follow up workshop on FGM in November 2017 and the action plan had now been updated and would be taken forward by the BSCB and supported by the virtual FGM working group.

Ms McDonald said she would circulate a briefing note to the Board.

Action: Ms McDonald

11 HEALTH AND WELLBEING BOARD WORK PROGRAMME

Ms McDonald referred to the comprehensive work programme that had been planned for the meetings on 27 September and 6 December 2018. It was agreed that the Health Check

presentation would include an overview of the health equity audit and how primary care could maximise uptake in more at risk community groups at the meeting on 27 September 2018.

The Chairman thanked everyone for their attendance and participation.

12 DATE OF NEXT MEETING

Thursday 27 September 2018 in Mezzanine Room 1, County Hall, Aylesbury.

CHAIRMAN

Health & Wellbeing Board Buckinghamshire

Title	Health and Wellbeing Board Performance Dashboard Analysis Report: Priority Area 5 Indicators
Date	27 September 2018
Report of:	Dr Jane O'Grady, Director of Public Health

Purpose of this report:

Following agreement of the Buckinghamshire Health and Wellbeing Board Performance Dashboard reporting process in November 2017, this report provides information and commentary on indicators in *Priority 5. Supporting communities to enable people to achieve their potential and ensure Buckinghamshire is a great place to live*.

The analysis in Appendix 1 'Benchmarking of Health and Wellbeing Board Performance Dashboard Indicators 63-73' provides the most recent data published on the Public Health England website. More recent data was available for Indicator 67, and has been included. Figures for Buckinghamshire are presented with trends and comparison to statistical neighbours as well as national and regional values.

Summary of the issue:

Health outcomes are closely linked to measures of deprivation. Buckinghamshire is the 2nd least-deprived County Council and the 5th least-deprived Local Authority in the country. As a consequence, health and wellbeing outcomes within Buckinghamshire would be expected to be better than the national average. The majority of indicators reported here are better than the national average.

In order to identify opportunities to further improve health and wellbeing in Buckinghamshire, commentary on indicators that are similar to, or worse than, the national average are provided in Appendix 1. For Priority 5, these are:

- 63 Utilisation of outdoor space for exercise/health reasons
- 64 Adults who do any walking at least five times a week
- 65 Killed or seriously injured casualties on England's roads (per 100,000)
- 66 Mortality attributed to particulate air pollution
- 69 Social isolation: adult social care users who have as much social contact as they would like
- 70 Housing affordability ratio
- 73 Excess Winter Deaths Index (all ages),

Recommendation for the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to:

- note the analysis for the indicators provided, and indicator performance; and
- propose any further action required based on the data presented and consider how it can contribute to improving system performance.

Health & Wellbeing Board Buckinghamshire

Appendix 1. Benchmarking of Health and Wellbeing Board Performance Dashboard Indicators 63-73

How to interpret the indicators:

For each indicator local data are compared to national figures.

- Where Bucks data are statistically significantly better than the national average, the indicator is highlighted green.
- Where Bucks data are not statistically different to the national average, the indicator is highlighted amber.
- Where Bucks data are statistically significantly worse than the national average, the indicator is highlighted red.
- Where Bucks data are statistically significantly higher than the national average but there is no judgement as to whether this constitutes being better or worse, the indicator is highlighted light blue. These indicators require interpretation and local context.
- Where Bucks data are statistically significantly lower than the national average but there is no judgement as to whether this constitutes being better or worse, the indicator is highlighted dark blue. These indicators require interpretation and local context.

The time series in Bucks is provided for each indicator and compared with time series for England and the South East.

Comparison of the most recent data for Bucks that can be benchmarked is made with a set of 15 similar local authorities, identified by the Chartered Institute of Public Finance and Accountability (CIPFA). Bucks CIPFA peers are:

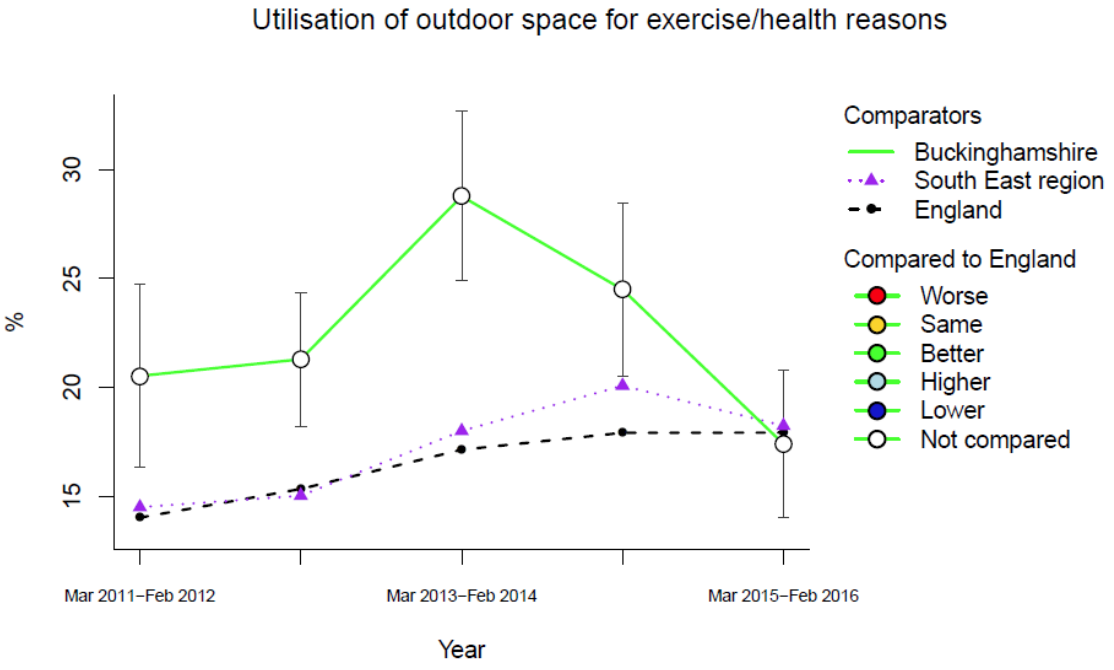
- Cambridgeshire
- Essex
- Gloucestershire
- Hampshire
- Hertfordshire
- Northamptonshire
- North Yorkshire
- Leicestershire
- Oxfordshire
- Somerset
- Suffolk
- Surrey
- Warwickshire
- West Sussex
- Worcestershire

Note that differences in an indicator value from one year to the next can appear large because the vertical axis does not start at zero.

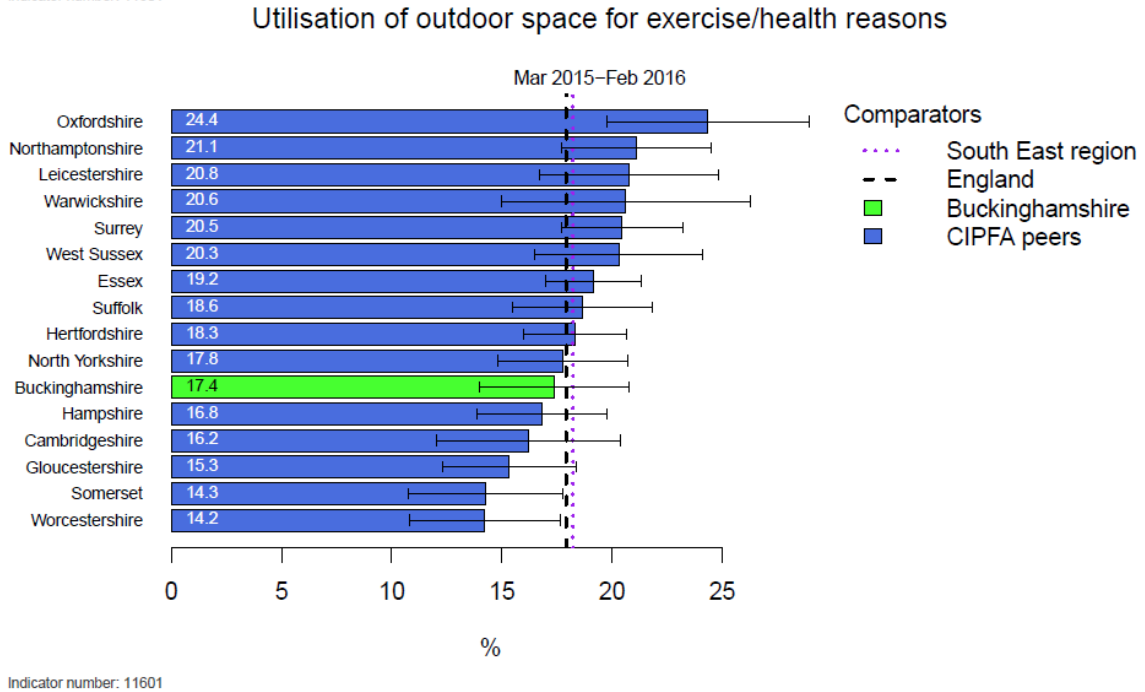
Priority 5. Support communities to enable people to achieve their potential and ensure Buckinghamshire is a great place to live

Indicator 63. Utilisation of outdoor space for exercise/health reasons (%) – NOT RAG RATED
The proportion of residents estimated to be making a visit to the natural environment for health or exercise purposes in the preceding 7 days, adjusted for demographic differences at the upper tier local authority level.

In 2015/16, the proportion of people using outdoor space for exercise/heath in Bucks (17.4%) was lower than in England (17.9%) and the South East (18.2%). Bucks had the 6th lowest rate among its CIPFA peers.



Indicator number: 11601

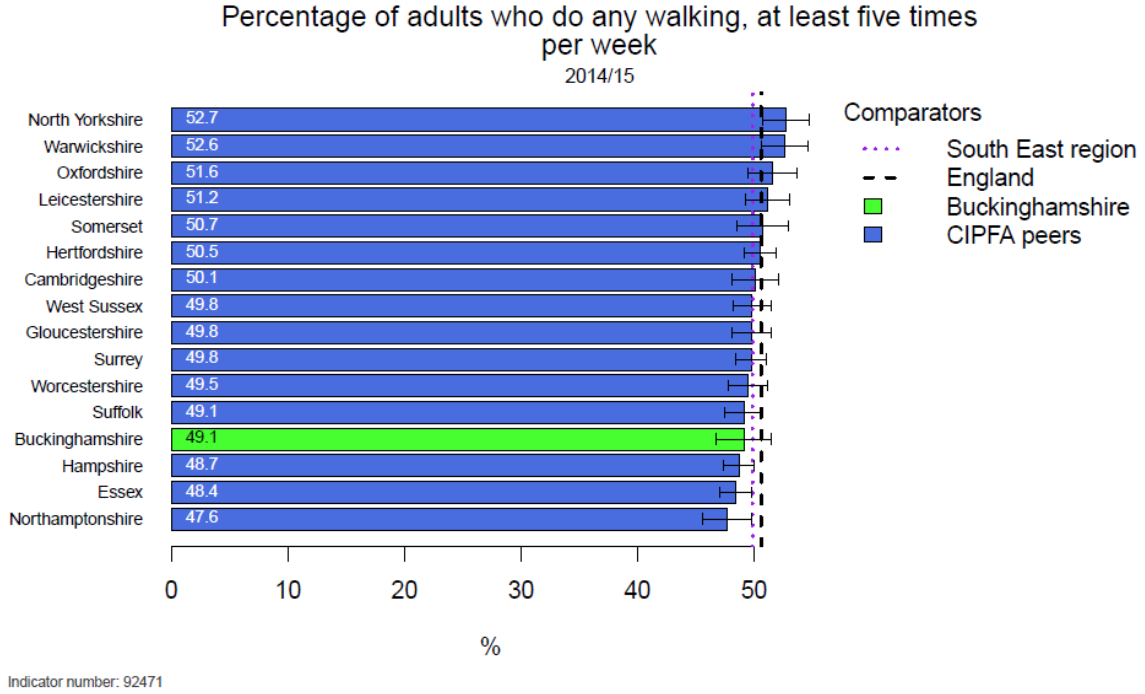


Indicator number: 11601

Indicator 64. Adults who do any walking (for at least 10 minutes) at least five times a week (%) – AMBER (similar)

Number of adults who did at least 10 minutes of walking on 20 days or more in the 28 day survey period as a proportion of all adults surveyed.

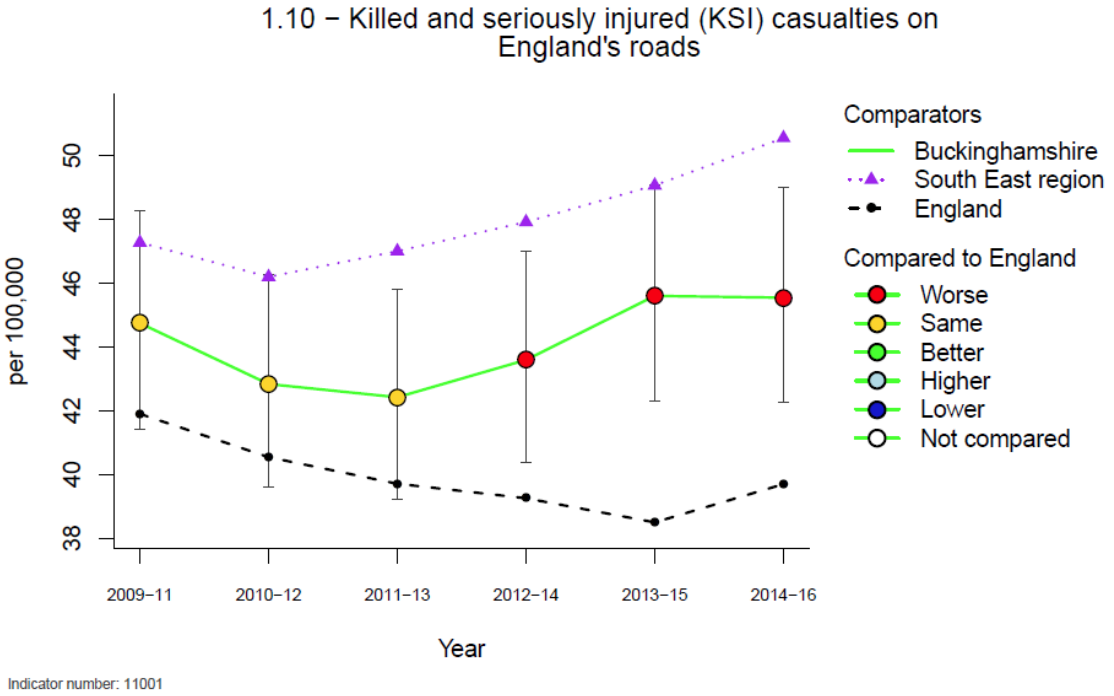
In 2014/15, 49.1% of adults reported walking for at least 10 minutes on at least five days per week. This is not statistically different to England (50.6%). The proportion in the South East was 49.4%. Bucks is ranked 13th among its CIPFA peers. No previous data are available for comparison.



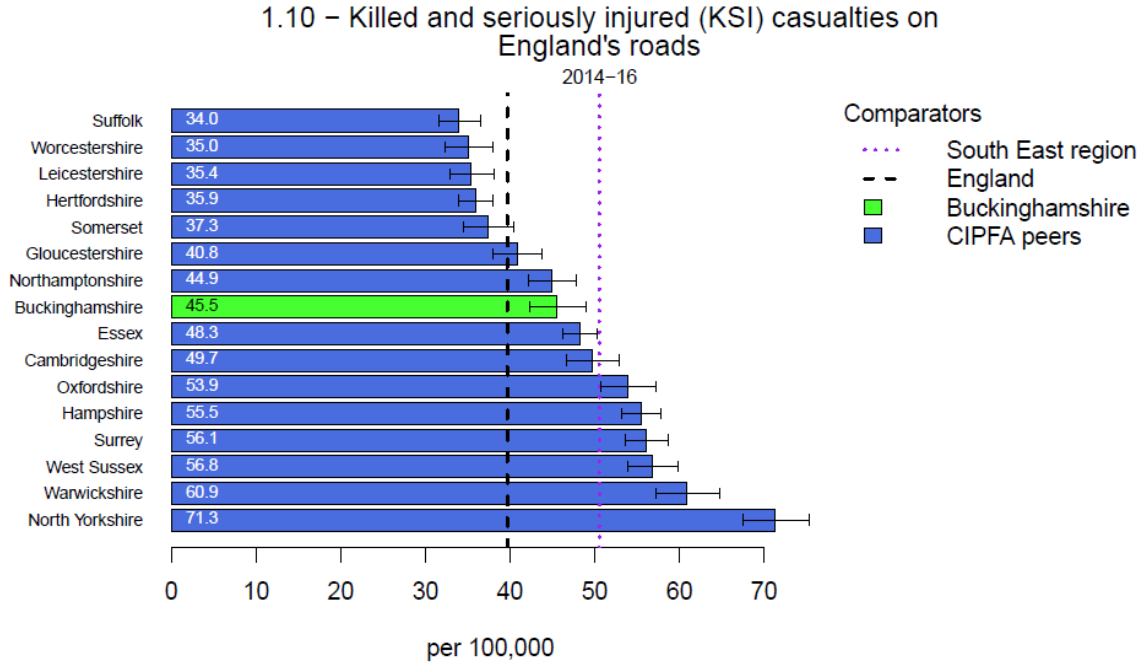
Indicator 65. Killed or seriously injured casualties on England's roads (per 100,000) – RED (worse)

Average number of people (all ages) reported killed or seriously injured on the roads each year per 100,000 resident population.

In 2014-16, the rate of road casualties in Bucks was 45.5 per 100,000 population, which was statistically higher than in England (39.7 per 100,000). Bucks had the 8th lowest rate among its CIPFA peers.



Indicator number: 11001

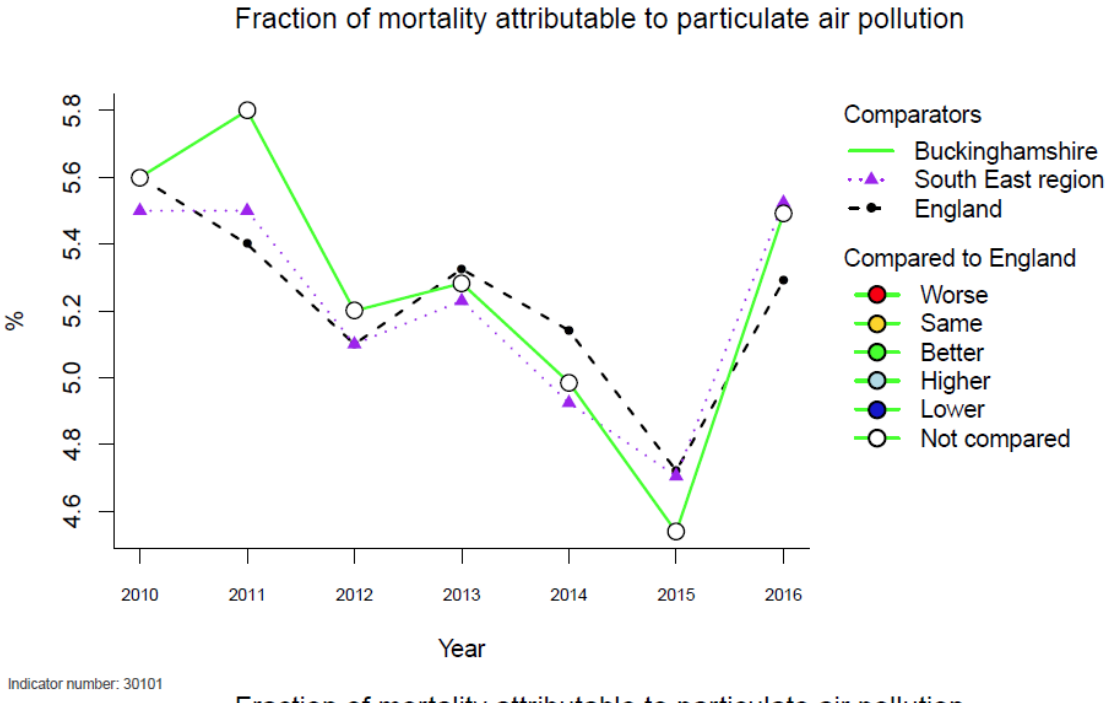


Indicator number: 11001

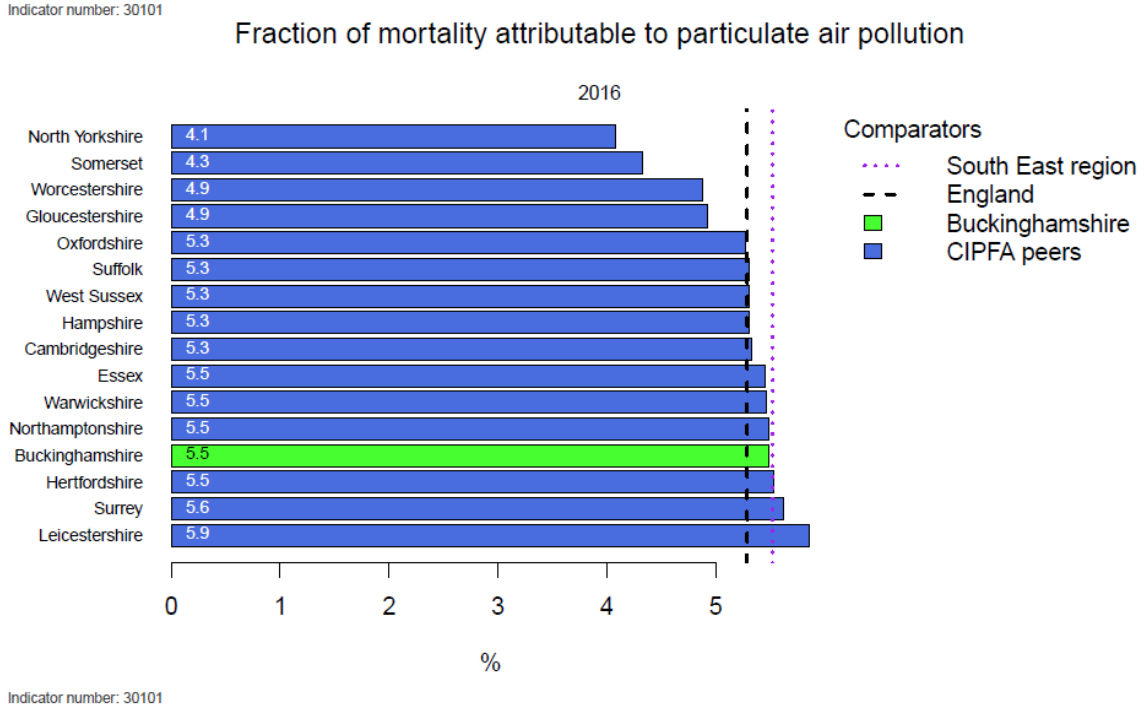
Indicator 66. Mortality attributed to particulate air pollution (%) – NOT RAG RATED

Mortality burden associated with long-term exposure to particulate air pollution at current levels, expressed as the percentage of annual deaths from all causes in those aged 30+ years.

In 2016, 5.5% of all deaths in Bucks among adults aged 30 years and over was attributed to particulate air pollution. This proportion was higher than that in England (5.3%) and the same as in the South East. Bucks had the 4th highest rate among its CIPFA peers.



Indicator number: 30101

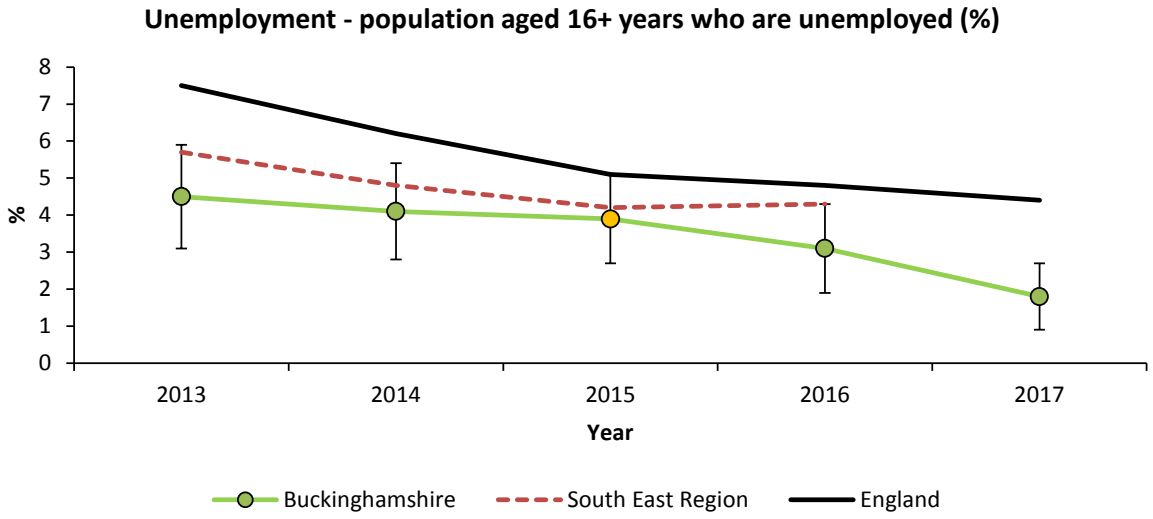


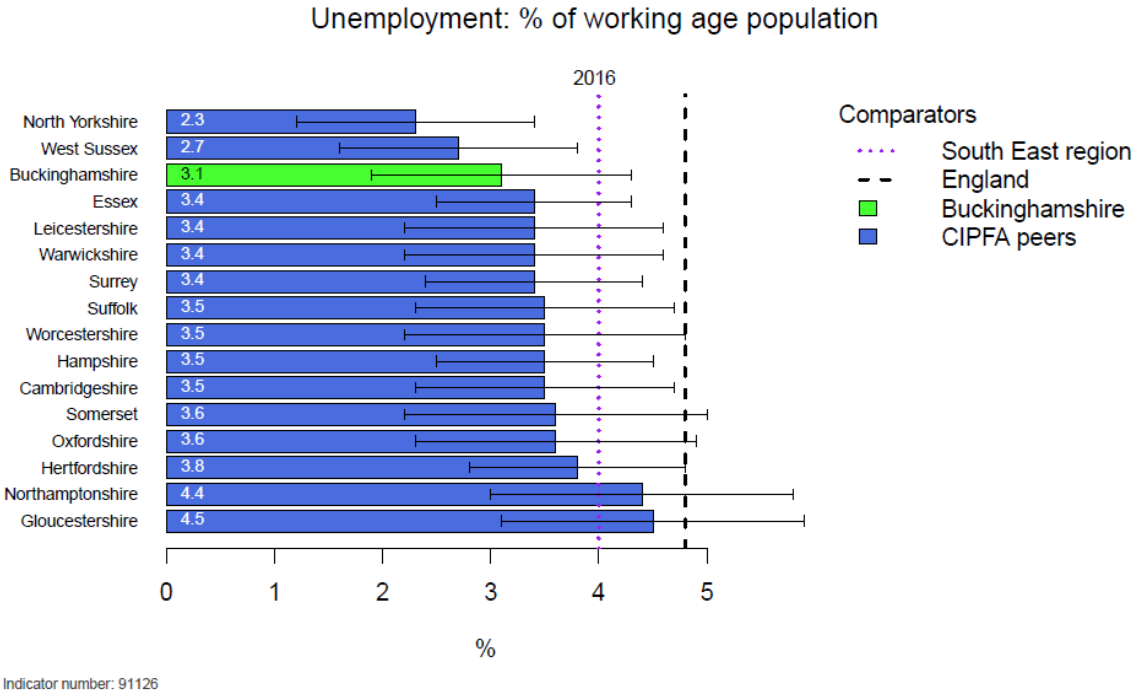
Indicator number: 30101

Indicator 67. Unemployment – population aged 16+ years who are unemployed (%) – GREEN (better)

Model-based estimated percentage of the adult population aged 16 years or more who were without a job and available to start work within two weeks of an interview and who had looked for work in the last four weeks.

In 2016, 3.1% of those aged 16+ years in Bucks were unemployed, which corresponds to 8,800 individuals. This proportion is statistically lower than in England (4.8%). Bucks had the 3rd lowest proportion among its CIPFA peers. The most recent data in 2017 shows that 5,100 individuals, or 1.8%, were unemployed in Bucks compared to 4.4% in England.



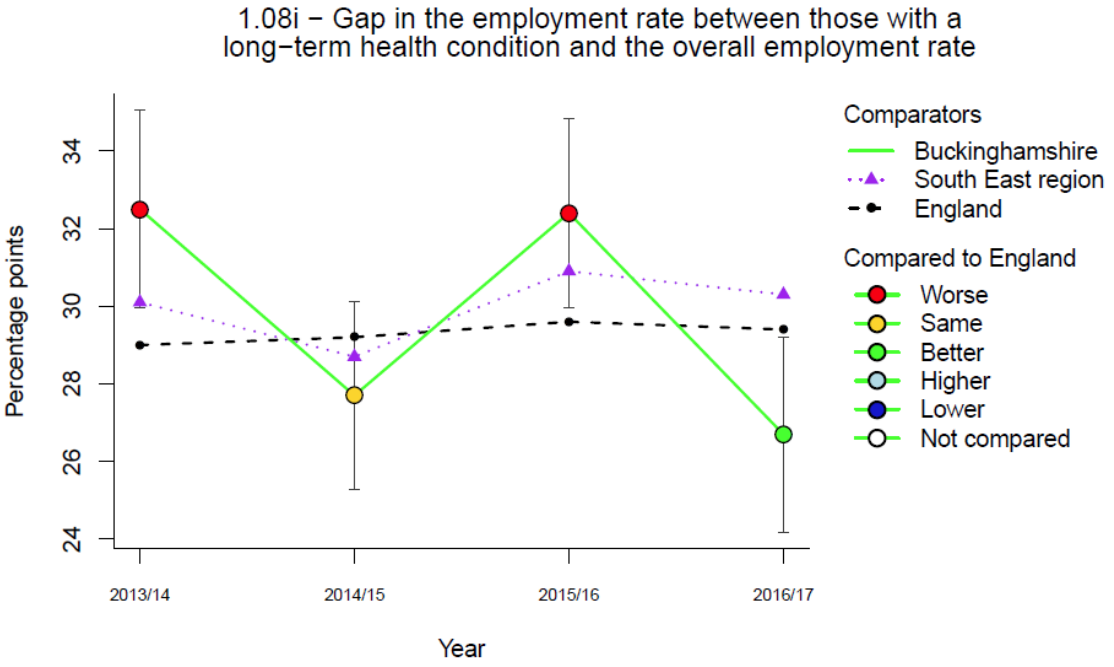


Indicator number: 91126

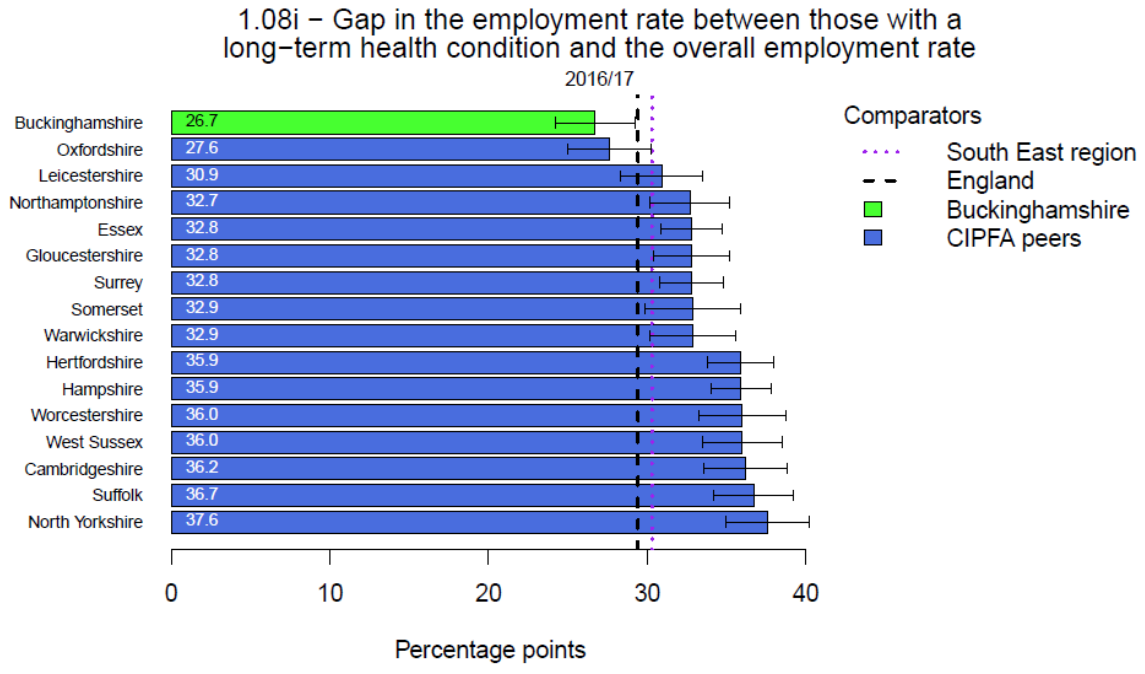
Indicator 68. Gap in employment rate between those with a long term health condition and the overall employment rate (%) – GREEN (better)

The differences in percentages between the percentage of respondents to the Labour Force Survey who have a long-term condition classified as employed and the percentage of all respondents in the Labour Force Survey classed as employed (aged 16-64 years).

In 2016/17, the gap in employment in Bucks was 26.7%. This is statistically lower than in England (29.2%). Bucks had the lowest employment gap among its CIPFA peers.



Indicator number: 90282

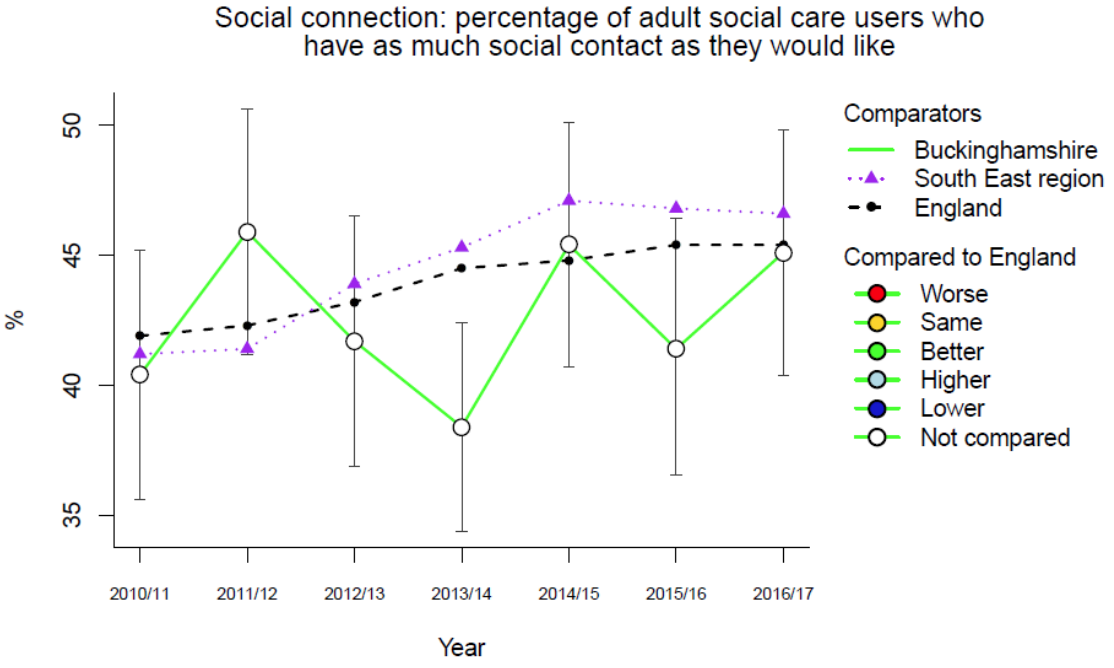


Indicator number: 90282

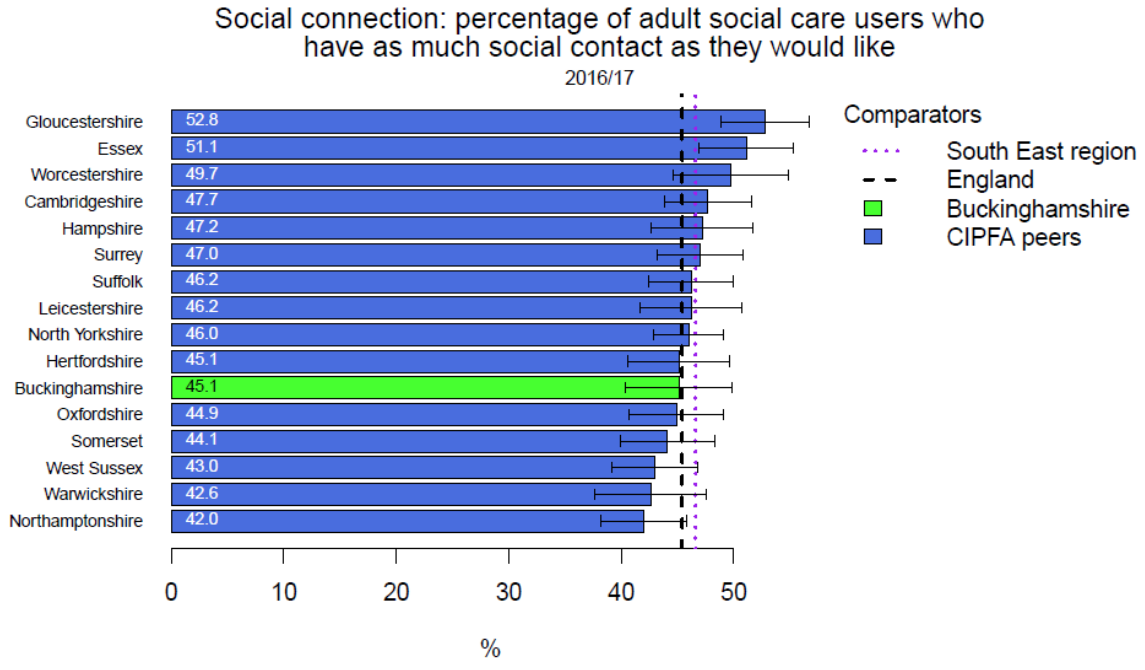
Indicator 69. Social isolation – adult social care users who have as much social contact as they would like (%) – NOT RAG RATED

The percentage of respondents to the Adult Social Care Users Survey who responded to the question "Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?" with the answer "I have as much social contact I want with people I like".

In 2016/17, 45.1% of respondents in Bucks stated that they had as much social contact as they would like. This proportion is lower than in England (45.4%) and the South East (46.6%). Bucks had the 6th equal lowest proportion among its CIPFA peers.



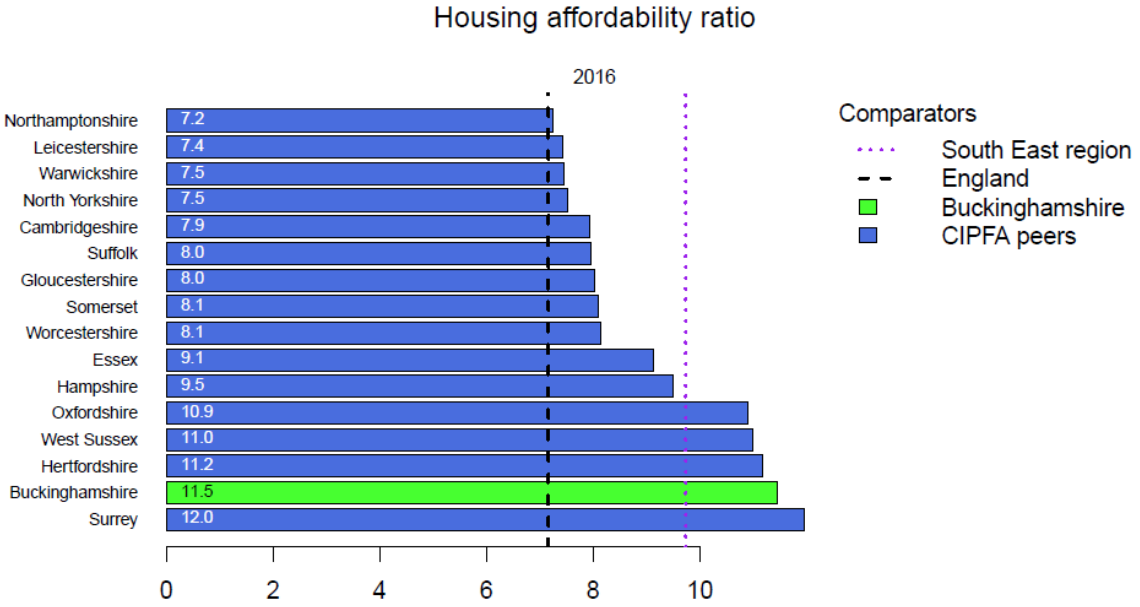
Indicator number: 90280



Indicator number: 90280

Indicator 70. Housing affordability ratio – NOT RAG RATED
The ratio of lower quartile house price to lower quartile earnings among residents.

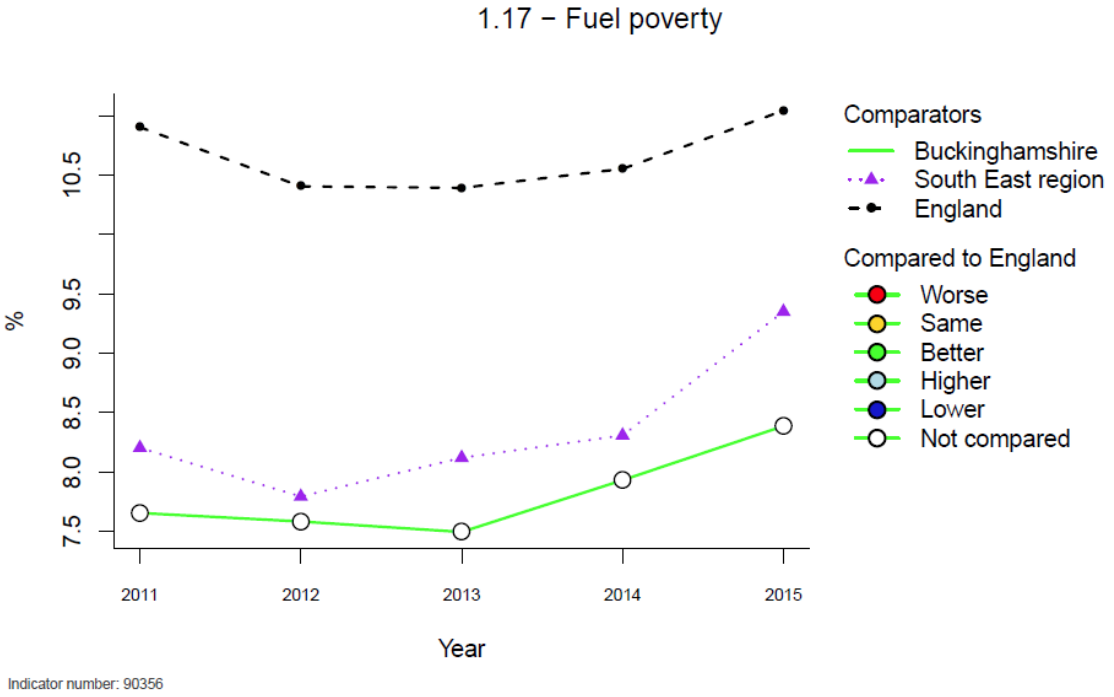
In 2016, the ratio of lower quartile house prices to lower quartile earnings in Bucks was 11.5. This compares to a ratio of 7.2 for England and 9.7 for the South East. Bucks is ranked 15th among its CIPFA peers. No previous data are available for comparison. This indicator is not RAG rated and confidence intervals are not provided.



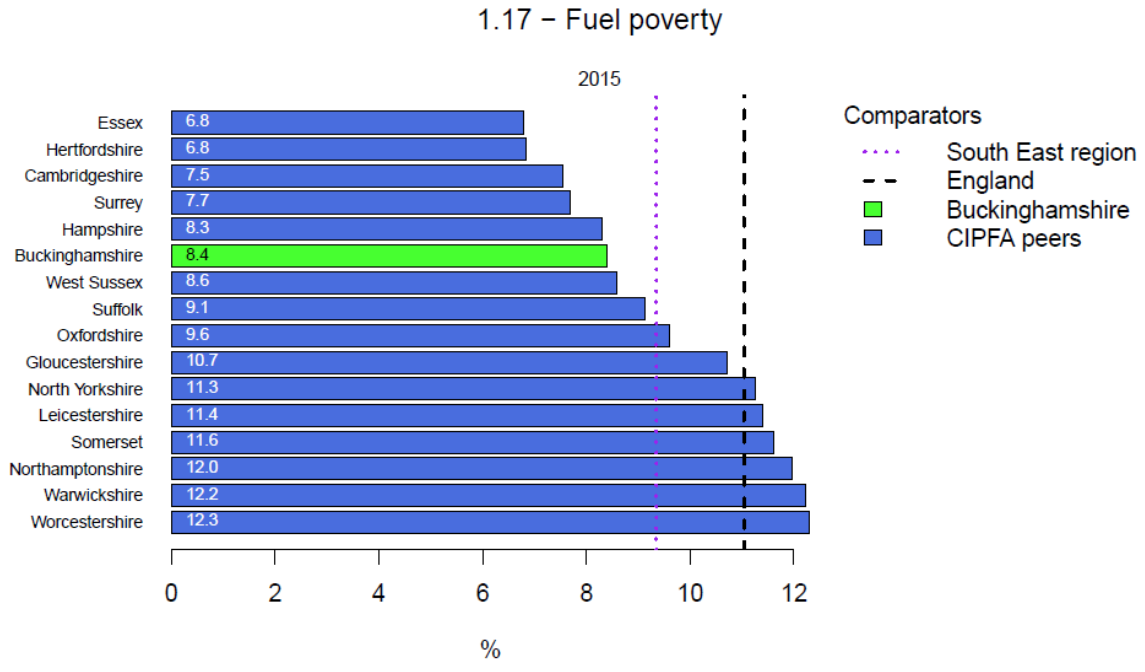
Indicator number: 92793

Indicator 72. Households experiencing fuel poverty (%) – NOT RAG RATED
The percentage of households in an area that experience fuel poverty based on the "Low income, high cost" methodology.

In 2015, the proportion of households in Bucks experiencing fuel poverty (8.4%) was lower than in England (11.0%) and the South East (9.4%). Bucks had the 6th lowest proportion among its CIPFA peers.



Indicator number: 90356

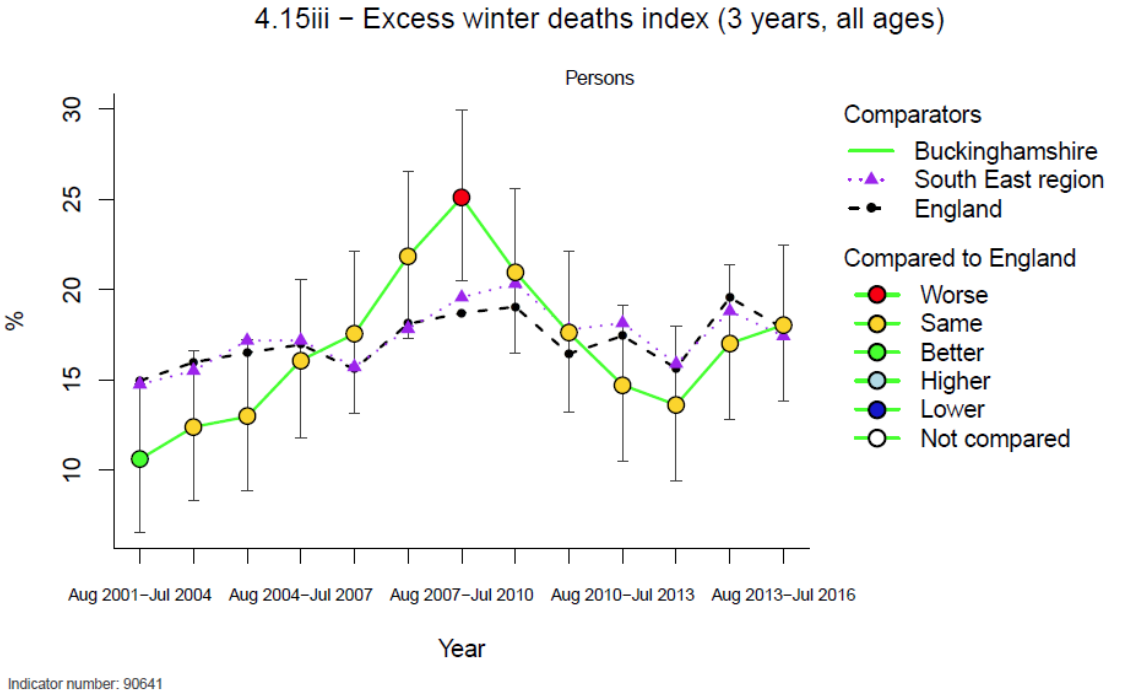


Indicator number: 90356

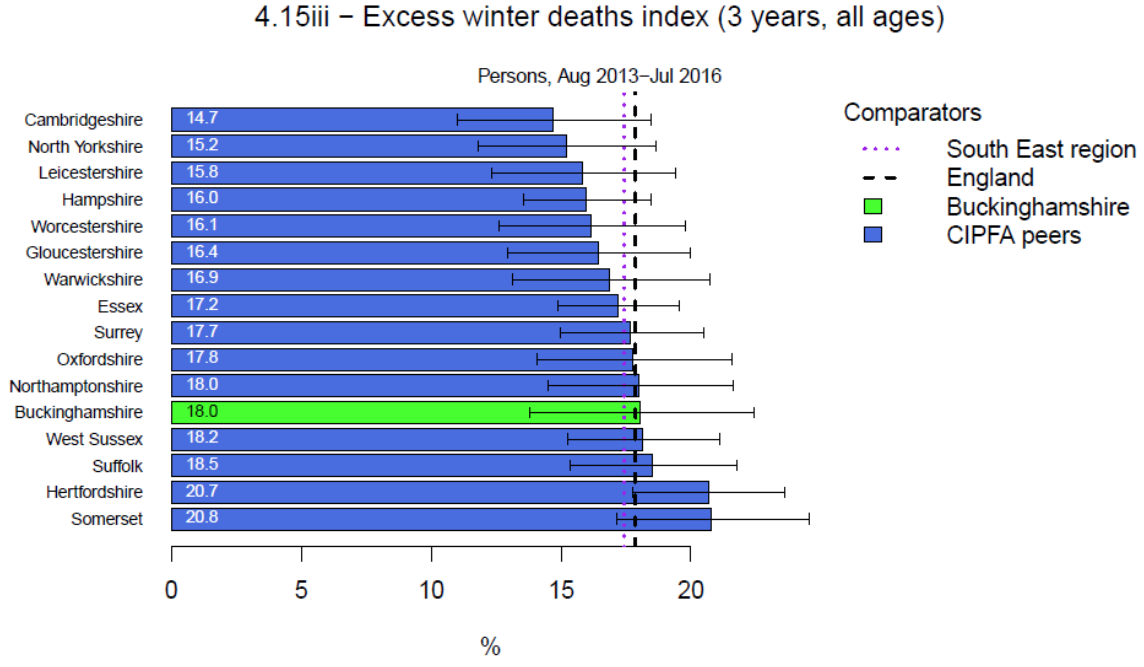
Indicator 73. Excess winter deaths index (all ages) (%) – AMBER (similar)

Excess Winter Deaths Index (EWD Index) is the excess winter deaths measured as the ratio of extra deaths from all causes that occur in the winter months (Dec-Mar) compared with the expected number of deaths, based on the average of the number of non-winter deaths (preceding year Aug to Nov and following year April to July).

In the 3-year period Aug 2013-Jul 2016, the EWD Index in Bucks (18.0%) was not statistically different to England (17.9%). Bucks had the 5th highest proportion among its CIPFA peers.



Indicator number: 90641



Indicator number: 90641

Health and Wellbeing Board Dashboard Indicator Commentary – Review of Red and Amber Indicators and Indicators requiring interpretation

Indicator 63. People using outdoor space for exercise/health reasons (%)
Definition
The proportion of residents estimated to be making a visit to the natural environment for health or exercise purposes in the preceding 7 days, adjusted for demographic differences at the upper tier local authority level. The data source for this indicator is the Natural England, 'Monitor of Engagement with the Natural Environment' (MENE) survey. Visits to the natural environment are defined as time spent "out of doors," for example, in open spaces in and around towns and cities, including parks, canals and nature areas; the coast and beaches; and the countryside including farmland, woodland, hills and rivers.
Explanation
Adults are recommended to achieve a minimum of 150 minutes of physical activity per week to keep healthy.
Are more recent data available? (Please provide)
No.
What work has been done?
The Active Bucks programme 2015-17 engaged over 3,922 unique participants in a wide range of activities, many of which took place in urban and country parks and open spaces across the county and have been sustained beyond the programme funding. Park Runs take place in parks across the county, attracting hundreds of people who are able to take part in running at their own pace, and providing opportunities for people to volunteer to support these weekly events. The Simply Walks programme continues to deliver over 80 volunteer-led walks each week, attracting over 700 walkers. While some routes are in towns, many are in parks and open spaces taking advantage of the network of rights of way in country parks and across the countryside. The programme is part of the Walking for Health national scheme. An interactive map for leisure walks can be found on the BCC website. We are progressing with a number of new walking and cycling links throughout the county, which will provide local communities with greater opportunity to access schools, workplaces and services. The latest of these is the Waddesdon Greenway, due to open in September, which provides a safe and attractive active travel connection between Waddesdon and Aylesbury Vale Parkway station, a journey which could, otherwise, only be made via the A41. BCC was awarded funding by the Department for Transport for the period 2017-20 for Bikeability core cycle training (Levels 1, 2 and 3) and Bikeability Plus modules. Described as *cycling proficiency for the 21st Century*, these will be delivered through schools. The waterways in Bucks play a significant role in the attractiveness and prosperity of the county, and to the quality of life of our residents. BCC are working with the Canal and River Trust to make improvements to the towpaths, especially for cycle ways.
What work is planned?
There are a number of community cycling projects across Bucks to encourage a shift in behaviour and encourage sustainable travel to train stations, for example, the A413 Buckingham and Winslow Link.

The Bucks Physical Activity Strategy 2018-23, adopted by the H&WB Board in March 2018, aims to reduce the proportion of Bucks residents who are inactive and increase the proportion of residents who achieve the national guidelines for physical activity. This partnership strategy is based on four principles: Active Communities, Skilled Workforce, Working Collaboratively and Active Environments, which highlights areas for action such as improving the quality, access and usage of existing green spaces. Examples of the first year's action plan include:

- support local providers to establish weekly activities in identified parks and open spaces in Aylesbury for inactive communities;
- improvements to Stoke Poges Country Park;
- improvement of Gosford and Totteridge recreation grounds to increase year round usage;
- new park runs;
- develop a directory of conservation based projects and volunteering opportunities; and
- deliver Active Bucks activities which take place in urban and country parks and open spaces.

Can the Health and Wellbeing Board support work targeting this indicator?

The Health and Wellbeing Board can support work targeting this indicator identified in the Bucks Physical Activity Strategy and by the Natural Environment Partnership. In particular, partners responsible for the provision and promotion of natural environment assets can improve quality, accessibility and usage; and partners delivering front-line services can encourage their clients to make use of the local natural environment with the aim of improving their health outcomes.

Indicator 64. Adults who do any walking (for at least 10 minutes) at least five times a week (%)
Definition
Number of adults (16+ years) who did at least 10 minutes of walking on 20 days or more in the 28 day survey period as a proportion of all adults surveyed. The data sources for this indicator are: Department for Transport, Active People Survey and Sport England.
Explanation
Adults are recommended to achieve a minimum of 150 minutes of physical activity per week to keep healthy.
Are more recent data available? (Please provide)
Latest data in PHE Health profiles is 2014/15.
What work has been done?
See Indicator 63. In 2017/18 a Schools Walking Zones project was delivered which created 5-10 minute walking zones around schools to encourage walking as part of the school journey and reduce congestion around school gates. Ten schools participated in this project. Nordic Walking activities have been included as part of the 2018-19 Active Bucks programme to encourage regular participation in these activities. 'Be Active at Work Walking maps' have been created to encourage people to get out and about and be more active during their working day. Maps have been created for people working in: • Cressex Industrial Park, High Wycombe and the surrounding area; and • Globe Business Park, Marlow and the surrounding area.
What work is planned?
School Travel Plans to reduce car journeys, increase physical activity and improve road safety have been successfully implemented in some primary schools, and work is underway to promote their use in secondary schools. We are promoting a *HomeRun app* which enables car sharing for dropping off children at school. This app was trialled at Bierton school in 2017. Ongoing support for the Simply Walks Programme and promotion of walking for health.
Can the Health and Wellbeing Board support work targeting this indicator?
Partners can support the Simply Walks programme, and assist in the promotion of the benefits of walking for health to their clients.

Indicator 65. Killed or seriously injured casualties on England's roads (2014-16)
Definition
Number of people reported killed or seriously injured (KSI) on the roads (all ages), per 100,000 resident population.
Explanation
In the last three years (2014-2016) in Bucks, 722 people were reported as killed or seriously injured (KSI) on Bucks roads. Areas with low resident populations and high inflows of people or traffic may have artificially high rates because the resident population is not an accurate measure of exposure to transport. This is likely to affect results in Bucks because of the number of major highways (M40, M4, M25 and M1) and through traffic in and around Bucks. Bucks also has sparsely populated rural areas which have high numbers of visitors (e.g. Black park, Pinewood studios, etc.) or through traffic (e.g. Heathrow and London traffic). Data quality may vary as different police forces use different reporting systems for collecting data. Approximately half of police forces now use the CRASH or COPA reporting systems which are considered to be more accurate as it is the system, rather than the police officer, that determines the severity of the injury. Thames Valley Police have not currently transferred over to the CRASH reporting system which may affect the quality of data for the number of injuries deemed serious.
Are more recent data available? (Please provide)
No.
What work has been done?
The TEE Business Unit has implemented a number of measures in response to the high rate of KSI in Bucks. • The Network Safety Team carries out the BCC statutory obligation to maintain a safe highway and carry out analysis on collisions resulting in injuries. • TEE identifies sites annually for potential casualty reduction, carry out remedial engineering measures and conduct road safety education initiatives. • TEE reviews injury collisions which have occurred within the last 5-year period, in order to identify those sites and routes that have the highest collision rate and casualty severity. Routes are ranked by the rate of collisions per km that have resulted in a road user being killed or seriously injured. Sites where there is a history of five or more collisions within the last five years are identified. There are currently over 160 sites meeting this criterion across Bucks. • In 2017/18 the Network Safety Team implemented 4 safety schemes in Bucks costing approximately £206k. First year rate of return calculations show that safety schemes deliver a net cost saving to society of approximately £800k p.a. • In 2017, TEE successfully bid for Department for Transport (DfT) funding for the A40 between Stokenchurch and West Wycombe. This stretch of road was identified as an area qualifying for the DfT Road Safety fund and was awarded £999K for improvements specifically to address the high number of collisions. Work has started at selected sites and will continue this year. • Education initiatives are delivered primarily aimed at more vulnerable road users such as young drivers, potential new young drivers, older drivers, and motorcyclists. These include: o "Safe Drive Stay Alive" theatre production in partnership with Thames Valley Police and Bucks Fire and Rescue. o Older driver assessments, eyesight and general road safety. o Targeted campaigns: Mobile phones, Seat belts, Drink & Drug driving, and speeding. o Approved Driving Instructor (ADI) Training. o Virtual Reality Goggles to engage with young people using simulation.

- "Be A Better Biker" motorcycle courses – in partnership with Bucks Fire and Rescue service delivered by Thames Vale Advanced Motorcyclists.
- Business Driver assessments.

- Each new scheme on the highway (including new developments) and major changes to existing road layouts are subject to The Road Safety Auditing process in order to ensure potential safety issues are not introduced onto the BCC network.

What work is planned?

- TEE has identified 8 sites to be prioritised within this year's safety scheme budget of £250K. These sites will be subject to detailed design and costing before a final programme is known.
- The A40 DfT safety fund scheme is continuing to implement the measures following detailed design. These will be completed by mid-2019.
- The above educational initiatives are delivered annually.

Indicator 66. Mortality attributable to particulate air pollution (%)

Definition

Mortality burden associated with long-term exposure to particulate air pollution at current levels, expressed as the percentage of annual deaths from all causes in those aged 30+ years.

Explanation

In Bucks, 5.5% of the people who died during 2016 had air pollution as a contributory factor, which, for example, exacerbated long-term conditions such as respiratory or cardio-vascular conditions. The fraction of mortality attributable to particulate air pollution in Bucks was not statistically different to the level seen nationally. This rate is comparable to other Counties in the South East and those with a similar socio-economic profile to Bucks.

Are more recent data available? (Please provide)

No.

What work has been done?

The UK government is supporting 5 cities to become Clean Air Zones by 2020 with plans to develop several more in towns and cities across the country after then. We are able to locally declare the more polluted parts of Bucks as Air Quality Management Areas (AQMA). This ensures appropriate monitoring occurs and actions plans are put in place to reduce the levels of pollution. Within Bucks, AQMA exist in areas such as Aylesbury, Wycombe and Chesham.

A multi-agency Bucks air quality workshop was held in May 2018. This has galvanised action across the county with the following points being examples of areas of work happening locally to improve air quality.

- Encouraging active and sustainable travel for appropriate journeys in LTP4 e.g. Bucks Commute Smart, expansion of the cycle network.
- Encouraging use of Travel Plans at schools and workplaces to reduce emissions.
- Working with developers to increase take-up of cleaner vehicles, e.g. AVDC Local Plan - if more than 10 dwellings, then electric charging infrastructure has to be provided for private use.
- Adopted freight strategy, trying to divert heavy vehicles away from existing busy areas.
- Getting to school strategy – educating parents about air quality.
- Intelligent Traffic Systems strategy being developed by TfB – aiming to reduce traffic in densely populated areas.
- Passenger Transport – encourage bus operators to use cleaner vehicles through contract specification.

What work is planned?

Work to improve air quality in Bucks is coordinated by the multiagency Bucks Air Quality Group. Examples of planned work include

- District Councils hoping to apply for grants for on street charging points.
- Transport Strategy will be reviewing travel plan guidance within the next year.
- Further promotion of cycling and walking.
- Aim to require Home to School service fleet vehicles to meet emissions standards.
- DfT's new Road to Zero strategy includes the launch of a £400M Charging Infrastructure Investment Fund and a push for charge points to be installed in newly built homes and in new lamp posts

Can the Health and Wellbeing Board support work targeting this indicator?

- Support in the location of air quality monitoring stations in hotspot areas.
- Support for on street electric vehicle charging.

Indicator 69. Social Isolation - adult social care users who have as much social contact as they would like (%)
Definition
The percentage of respondents to the Adult Social Care Users Survey who responded to the question "Thinking about how much contact you've had with people you like, which of the following statements best describes your social situation?" with the answer "I have as much social contact I want with people I like".
Explanation
Are more recent data available? (Please provide)
No. Data for 2017/18 will be published in October.
What work has been done?
Following publication of the 2016/17 outturns, we conducted analysis of responses and conducted further research via a number of focus groups, to better understand the issues and challenges faced by our service users. The detailed analysis resulting from the focus groups and this survey informed our approach to delivering care and support services over the subsequent year and drive improvement where possible.
What work is planned?
Following completion of the 2017/18 user survey further analysis is underway to inform improvement actions required.
Can the Health and Wellbeing Board support work targeting this indicator?

Indicator 70. Housing affordability ratio

Definition

The ratio of lower quartile house price to lower quartile earnings among residents.

Explanation

In 2016 the average house price at the lower quartile (25th centile) was 11.5 times greater than the average earning at the lower quartile (25th centile). This is the first year that data have been published on the PHE website.

Are more recent data available?

There is a similarly defined statistics in Table 4c of the following link

https://www.ons.gov.uk/peoplepopulationandcommunity/housing/datasets/ratioofhousepricetoresidencebasedearningslowerquartileandmedian

which covers the period 2002-17. This indicator is different to Indicator 70. Using this alternative indicator provide more context below.

Data for 2017 show that the ratio of lower quartile house prices to lower quartile earnings in Bucks is currently 12.7. Breakdown by district shows that the highest ratio is in Chiltern (18.0) and lowest in Aylesbury Vale (12.0). The ratio in South Bucks is 14.7 and the ratio in Wycombe is 12.0.

What work has been done?

The Table below summarises the number of affordable houses delivered in Bucks by District Councils 2016/17. It also provides a breakdown of types of affordable houses.

Districts	Housing Price to Earnings Ratio (2017)	Net Additional Dwellings	Additional Affordable Dwellings	Social Housing Letting
AVDC	11.08	1,323	240	345
CDC	18.04	234	20	66
SBDC	15.69	569	0	102
WDC	11.48	788	100	171
Total		2,914	360	684

What work is planned?

- The main driver for this indicator will be from national policy. New national policy places an emphasis on greater housing development across the country.
- Bucks will experience significant growth in housing, which is accelerating, particularly in Aylesbury Vale.
- District Councils will be negotiating levels of affordable housing for all new developments in accordance with the local plan policy for affordable housing.
- The district council seek on site affordable housing, from all housing developments, however, the developer may provide financial contribution for affordable housing where the developer is unable to provide affordable housing on site.

Can the Health and Wellbeing Board support work targeting this indicator?

The Health and Wellbeing Board can advocate for the inclusion of affordable housing in new developments across the county.

Indicator 73. Excess winter deaths Index (all ages) (%)
Definition
Excess Winter Deaths Index (EWD Index) is the excess winter deaths measured as the ratio of extra deaths from all causes that occur in the winter months (Dec-Mar) compared with the expected number of deaths, based on the average of the number of non-winter deaths (preceding year Aug to Nov and following year April to July).
Explanation
The indicator demonstrates that Bucks EWD Index is not statistically different to the English average. Among counties of a similar socio-demographic profile, Bucks EWD Index is within the same range as its peers without any statistically different rates between counties noted. Over time, the rate of EWD naturally fluctuates depending on the severity of winter conditions across the country.
Are more recent data available? (Please provide)
No.
What work has been done?
The Bucks Multi-agency Urgent Care Board (UCB) oversee the development of a sustainable system-wide approach to address emergency hospital admission and A&E attendances and has taken a number of initiatives specifically to tackle winter pressure and associated hospital admissions and deaths. For example, the provision of an urgent treatment centre, minor injury unit and GP streaming within A&E. The annual flu vaccination is pro-actively offered to all at risk groups in Bucks. The UCB leads on the delivery of a multi-agency communications plan that links with the national NHS flu campaign to promote the vaccination to the local population. Bucks County Council offers an additional local vaccination scheme to ensure all is own staff and staff of its commissioned services are offered the vaccination. This includes supporting local pharmacy providers to run ad-hoc vaccination clinics in local care and nursing homes to offer the vaccination to care home staff.
What work is planned?
The initiatives described above will continue to run for the 2018-19 winter period. In addition, the group most vulnerable to flu infection (those aged 65+ years) are being offered an adjuvanted vaccination this year. This means it is strengthened to support their bodies to develop an adequate immune response to the vaccination and thus ensure they are as well protected as possible. Bucks County Council has a Strategic Winter Plan to ensure that essential services for the population can continue despite potentially prolonged periods of adverse weather.
Can the Health and Wellbeing Board support work targeting this indicator?
The Health and wellbeing Board can support this work by encouraging its constituent member organisations to continue to work in multi-agency and cross organisational boundary forums to ensure the delivery of the above work.

Healthy places, healthy futures growing great communities

Director of Public Health Annual Report 2018

Executive Summary

Executive Summary

1. The places and communities in which we live influence our health and wellbeing throughout life, the development and educational attainment of our children and young people, and the social and economic success of Buckinghamshire. This year's Director of Public Health Annual Report focuses on the importance of the physical and social environments in which we live to our health and wellbeing. The report covers the health of Buckinghamshire residents and some key factors affecting our current and future health. It highlights how positively shaping the places we live can help reduce the health and wellbeing challenges facing our residents throughout life. The report focuses on six areas of the physical and social environment that play an important role in health and wellbeing: community life; housing; healthy travel; pollution; healthy food; and the natural environment. It also identifies that certain groups are more likely to be exposed to adverse environmental conditions such as damp or cold housing, air and noise pollution and that children, older people and people with existing poor health are more vulnerable to the impacts of adverse conditions.

Health in Buckinghamshire

2.1 Buckinghamshire residents are some of the healthiest in the country but too many people are still living with potentially preventable ill health and disability and dying prematurely from preventable diseases. In addition not all residents enjoy the same levels of good health.

2.2 Life expectancy is increasing but not all those extra years are lived in good health. Healthy life expectancy is approximately 69.4 years for men and 70.3 years for women. Healthy life expectancy is 12 years shorter for men and 14 years shorter for women than life expectancy.

2.3 People living in our more deprived wards have poorer health and lower life expectancy and healthy life expectancy than the rest of Buckinghamshire. The life expectancy gap between wards is 12 years for men and 16 years for women and a similar pattern is seen for healthy life expectancy.

2.4 Many of the commonest causes of ill health and early death are long term conditions such as diabetes, heart disease, cancer, strokes and dementia and a significant proportion of these conditions are preventable. The chances of developing these conditions is influenced by the lives we lead, the places and communities in which we live, learn and work and the health related behaviours we adopt such as being physically active, eating healthily, not smoking or drinking too much alcohol. As people age they tend to develop more long term conditions but this is not inevitable as adopting healthy lifestyles can prevent or delay the onset of a wide range of long term conditions.

2.5 Over the next 20-25 years the number of people aged 65 years and over in Buckinghamshire is set to increase by 60,000 which will increase the numbers of people living with long term conditions and disability unless we age more healthily. Although some health related behaviours have improved other behaviours have not. More than 6 in 10 adults are overweight or obese in Buckinghamshire and "millennials" (people born between early 1980s and late 1990s typically) are set to be the most obese generation on record with more than 7 in 10 overweight or obese by the age of 35-44 years. Overweight and obesity are driven by poor diet and low levels of physical activity and are key risk factors for a wide range of long term conditions including diabetes, heart disease, stroke, some cancers and dementia.

2.6 Good mental health is a vital resource for life and also an important driver of physical

health. It is estimated that 1 in 8 men and 1 in 5 women in Buckinghamshire have a common mental health problem such as anxiety or depression. People with poorer mental health are also at increased risk of poorer physical health. Poor physical health can also adversely affect mental health.

2.7 Loneliness and social isolation are increasingly recognised as raising the risk of developing depression and anxiety but also heart disease, stroke, dementia and early death. National estimates suggest that 1 in 20 people feel lonely often or all the time and that loneliness affects all ages with some surveys reporting loneliness to be highest in 16-24 year olds.

2.8 Children and young people make up one quarter of the Buckinghamshire population. Although children and young people in Buckinghamshire tend to be healthier than the national average there is no room for complacency as UK children's outcomes are worse than in many other wealthy European countries.

2.9 Low levels of physical activity and unhealthy eating in young people in Buckinghamshire are leading to overweight and obesity that can lead to poorer physical and mental health in childhood and adulthood. There are also rising concerns around children's and young people's mental health and wellbeing. In Buckinghamshire it is estimated that 1 in 13 children and young people aged 5-16 years have a clinically diagnosable mental health disorder.

2.10 Children and young people are particularly vulnerable to threats to their health from adverse social and environmental conditions both from before birth and as they grow up.

Community life and wellbeing

3.1 The communities in which we grow up, live, work and play profoundly affect our happiness, physical and mental health and our chances of success in life.

3.2 Having supportive social networks, being able to participate in community life and having a voice in local decisions play a vital contribution to health and wellbeing.

3.3 People who have strong social networks tend to live longer and have better mental and physical health than those who don't. Conversely social isolation and loneliness is linked to a range of physical and mental health problems. People experiencing social isolation are more likely to visit their GP, attend accident and emergency departments and be admitted to hospital as an emergency and three and a half times more likely to enter local authority funded residential care. Social isolation and loneliness can affect anyone at any age but there are risk factors that help predict who may be more likely to become socially isolated or feel lonely e.g. children in care, people with ill health or disability, bereavement, living alone, caring responsibilities. Strong cohesive communities can reduce levels of social isolation and loneliness, help lower levels of crime, social disorder and depression.

3.4 Young people growing up in communities with positive role models and social norms are less likely to participate in health harming behaviours and more likely to engage in health promoting behaviours.

3.5 The strength and cohesiveness of communities is reliant on the people who live in them. However planning, policies and design can make it easier for people to meet, make friends and get involved in their communities. Good design can help by creating safe, attractive multi-use indoor and outdoor spaces that are accessible and welcoming for everyone to use to make it easy for people to meet informally and connect with friends and neighbours. Involving a wide range of users of all ages in the design of public spaces can improve wellbeing, foster a sense of

community and place and is more likely to result in spaces that people will use and care for. People who live in environments that encourage people to walk or cycle rather than using the car are more positive about the places they live and engage more in community life. Good design can also reduce the levels of crime in an area and make people feel safer. This helps encourage more people to get out into their community and reduces social isolation.

3.6 A strong programme of cultural and social activities co-designed with residents also helps develop cohesive communities and foster a sense of place and pride in an area and can benefit health and wellbeing at all ages.

Healthy Homes

4.1 The ability to stay healthy and independent, access and maintain education, training and employment and contribute to community life depends on having a safe, affordable and stable place to live.

4.2 The affordability of housing is a key issue for Buckinghamshire. House prices in Buckinghamshire are among the highest in the country and rents are also higher than the national average. A lack of affordable housing can lead to financial hardship and stress, overcrowding and in the most severe cases homelessness. Families living in overcrowded housing can experience a range of health problems and strained family relationships. Their children are also at risk of emotional problems, developmental delay and difficulty studying.

4.3 Poor housing conditions such as housing in poor repair, being cold or damp or having poor indoor air quality are linked to poorer physical and mental health, poorer educational attainment, accidents, higher hospital admissions and excess winter deaths. Children and older people and those with long term conditions or disability are particularly vulnerable to poor housing conditions. Poor quality homes cost the NHS at least £1.4bn and wider society over £18.6bn per year nationally.

4.4 Home improvements have been shown to improve health outcomes particularly for older people and those living with long term conditions on lower incomes.

4.5 Homes also need to be designed to be flexible and to be able to be adapted to peoples changing needs throughout life, enabling them to remain safe and independent in their own home as they age. A range of well-designed property types to meet a range of needs including the needs of people with specific disabilities is essential to keep people healthy and independent. The benefits include reducing the need for health and social care, enabling timely discharge from hospital and rapid recovery from ill health. This is important now and for the future with the predicted growth in our older population.

4.6 Ensuring neighbourhoods are also designed to meet the needs of all ages from the very young to the very old and people with disabilities is also important to maintaining good health and ensuring everyone can participate in community life and access the services and facilities they need.

Healthy Travel

5.1 We travel for work and play, to get to school, shops and other services, but how we travel and for how long and how far has significant implications for our health, the health of others and society as a whole.

5.2 Active travel such as walking and cycling improves our health through promoting physical activity but also by reducing air and noise pollution, increasing community connections and making communities safer. Active travel improves our mood, reduces stress and reduces the risk of developing many long term conditions including diabetes, heart disease, cancer, high blood pressure and obesity. Active travel also reduces congestion, absenteeism and boosts economic productivity. Communities where more people walk and cycle are healthier, safer and have better social connections.

5.3 Motor vehicles have enabled people to travel further for work, school and leisure but the benefits need to be weighed against the harms. Long commutes have a detrimental effect on health and wellbeing. They are associated with higher levels of stress, anxiety, depression, higher blood pressure, higher weight, risk of diabetes and cardiovascular disease. They also reduce the amount of time people have for recreational activities, cooking, sleeping and participating in community life. Effects are seen even with commutes of 10 miles one way. In Buckinghamshire the average commuter travels nearly 11 miles each way to work which is longer than the England and South East average.

5.4 Motor vehicles are a major contributor to noise and air pollution which is detrimental to health and children's development.

5.5 Road accidents are also a significant source of early death and disability, especially among younger age groups, claiming 21 lives and over 200 serious injuries each year in Buckinghamshire.

5.6 Good public transport links benefit people who cannot drive due to age or disability and reduces travel costs for all. People using public transport increase their levels of physical activity and have lower stress and exposure to air pollution compared to car travel.

5.7 Designing places to support active travel and good public transport will improve the health and wellbeing of communities. A key facilitator of healthy travel is designing places where houses, employment opportunities, shops, leisure and amenities are close together, reducing the need to travel long distances and ensuring places are connected by safe and attractive walking and cycling routes and public transport so that people have a range of travel options.

Air and Noise Pollution

6.1 Air pollution is the most significant environmental hazard to health. Exposure to air pollutants increases the risk of lung cancer and other lung diseases, cardiovascular disease and increases the risk of death. There is also emerging evidence that long term exposure to air pollution is linked to low birthweight and poorer development in children and the progression of Alzheimer's and Parkinson's diseases.

6.2 Short term episodes of high air pollution are linked to a rise in heart attacks, strokes and exacerbations of lung problems and increased emergency admissions to hospital.

6.3 Many of the air pollutants impacting on health result from road traffic and in urban areas where pollution is a problem, 80% of pollution arises from road traffic. The eight air quality management areas in Buckinghamshire all relate to the road network.

6.4 Children, older people and those with existing cardiovascular or lung disease are more vulnerable to the effects of air pollution.

6.5 Excessive noise impacts on health through sleep disturbance and increased stress and is linked to increased blood pressure and increased risk of conditions such as heart disease and stroke as well as poorer educational attainment in children.

Green spaces and the natural environment

7.1 Being in contact with the natural environment is vital for our physical and mental health and wellbeing at all ages.

7.2 People with access to green spaces have better self-reported health and are more likely to be physically active and be a healthy weight.

7.3 Exposure to green spaces reduces stress levels and depression and caring for natural landscapes has been shown to improve health and depressive symptoms.

7.4 Patients in hospital recovering from surgery who have views of green and open spaces have a shorter recovery time and lower levels of pain and anxiety.

7.5 Every 10% increase in green space is associated with a reduction in disease equivalent to a gain of 5 years of life

7.6 Green spaces are beneficial for children's play and physical activity and exposure to green spaces within and around schools improves children's attention, learning and educational attainment. Children living in deprived areas with more green spaces were less likely to be overweight and obese than children living in comparable areas with less green space.

7.7 People walk more and socialise more in areas where there are more green spaces and trees which helps to build community ties and reduce social isolation. In addition there is less graffiti vandalism and littering in outdoor spaces with natural landscapes than in comparable plant-less spaces and residents report fewer acts of aggression and violence in these areas.

7.8 Urban greening incorporates green infrastructure such as trees, green walls and roofs and natural drainage measures. This can protect human health by reducing the heat island effect of towns and reducing the impact of heatwaves which can harm the health of the very young and older people particularly. Urban greening can also reduce air pollution by absorbing pollutants and create natural sound barriers reducing noise pollution too. Trees and green roofs also reduce flood risk by absorbing water.

Healthy Food

8.1 The quality and quantity of the food and drink that we consume are important contributors to our health. A poor diet increases the risk of becoming overweight or obese, developing diabetes, heart disease, stroke, some types of cancer and dementia and contributes to 30% of years lived in disability and early deaths. For every additional sugar sweetened drink consumed per day the risk of developing high blood pressure increases by 8% and the risk of developing heart disease increases by 17%.

8.2 Trends in food consumption show that we are eating more meals out of the home and these are often in larger portions and less healthy when compared to food cooked in the home. Research suggests that access to unhealthier food retail outlets is associated with increased weight in the general population and increased obesity and unhealthy eating in children living in low income areas. In addition there is often a higher density of takeaway food outlets in areas of higher deprivation and these communities can often

have limited access to alternative options.

8.3 Increased access to outlets selling healthier food is associated with improvements in diet and adult weight. Providing healthy affordable food in schools is associated with better dietary behaviours and nutrition.

8.4 Growing your own food, in a private or community garden or allotment has many benefits. It has been shown to improve people's diet, reduce overweight and obesity in children, lower levels of stress and depression and increase physical activity through gardening. Community allotments and gardens are an important asset and have also been shown to increase social networks and can support the wellbeing of people with long term physical and mental health conditions and socially excluded groups.

Summary and Recommendations

9.1 Good health helps people live rewarding lives and achieve their goals. It supports children's educational attainment, adult's ability to work and everyone's ability to participate in and contribute to community life. The health and wellbeing of our population is vital for the social and economic success of Buckinghamshire. Planning for and investing in the health of our population should be regarded as vital as investing in the infrastructure of our county and take the same long term view.

9.2 This report has shown the myriad ways in which the places where we grow up, live, work, play and age impact on our mental and physical health and wellbeing. It has also highlighted that key groups are more vulnerable to the impact of less healthy environments particularly children, older people and people with existing health problems. In addition some groups are more often exposed to poorer environmental conditions such as people on low incomes, people living in more deprived areas, older people and those with long term conditions. Communities and neighbourhoods need to be designed with this in mind to ensure they meet the needs of all residents and ensure that everyone has a chance to live as healthy a life as possible.

9.3 The impacts of our living environments are wide ranging and are felt throughout life. Where we live can influence how happy we are, whether we know our neighbours and how strong the community ties are and our opportunities to live healthy lives. It can also influence how well children develop and how they do at school, crime levels, fear of crime and economic productivity. All these factors interact and influence our risk of developing a wide range of long term conditions such as high blood pressure, obesity, diabetes, heart disease, stroke, cancer and dementia.

9.4 Improving the health of our residents also makes sound economic sense and reduces demand on health and social care and other public sector services. As our population grows and ages it is more crucial than ever that all our residents start well, live well and age well and delay or prevent the onset of ill health, disability and frailty.

9.5 Improving health through improvements to the environment and community life has additional benefits as it helps Buckinghamshire remain a thriving and attractive place to live and work, can contribute to reducing congestion, air and noise pollution, mitigate the impact of climate change and attract inward investment.

9.6 A wide range of stakeholders have a role in influencing whether our environment is healthy. This includes residents and communities, community, voluntary and faith groups, local authorities, developers, schools, businesses and the public and private sector. Much good work is already underway across Buckinghamshire to protect and improve the places we live and to strengthen communities. However there are significant opportunities for us all to work

together to further improve the health and wellbeing of the people who live and work in Buckinghamshire.

To continue and support this good work the following recommendations are for all stakeholders.

Recommendations

R.1 The promotion and protection of the health and wellbeing of everyone who lives and works in Buckinghamshire should be a major consideration when planning new developments or improving existing developments. This should be supported by health impact assessments where appropriate, to understand the impact on health and wellbeing of these changes, particularly for those most vulnerable and with the greatest risk of poor health.

R.2 Where possible, local authorities and developers should engage communities in co-designing new developments and making improvements to existing developments. They should ensure input from a wide range of current and future residents of all ages and abilities to ensure developments work for all. The WHO 'Age Friendly' Cities guidance and UNICEF Child Friendly Cities and Communities initiative offer useful principles to inform discussions.

R.3 Local authorities, communities, town and parish councils and local area forums should use this report to consider how they might work together to improve the health and wellbeing of their residents, drawing on the assets in their communities and their local knowledge of what might need to change. This could include strengthening the social ties in an area, increasing community engagement and reducing social isolation or making improvements to the built and natural environment. A useful set of questions to inform discussions is the Place Standard toolkit which uses 14 questions designed to cover the physical and social aspects of a place and help determine priorities for action.

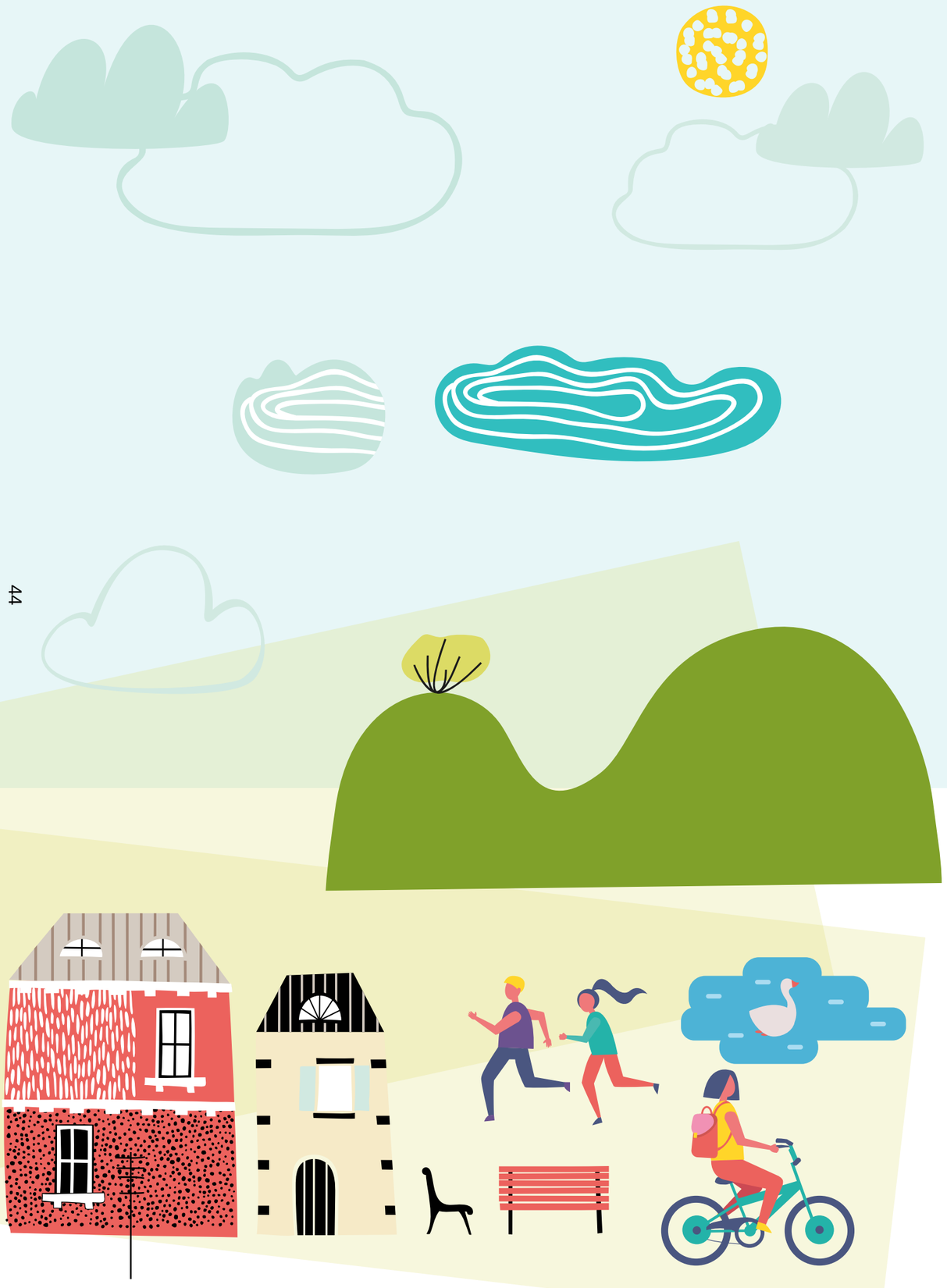
R.4 The public and private sector, voluntary, community and faith sector including local authorities, the NHS, schools, universities and businesses should use this report to consider how they can help improve health and wellbeing through their actions that impact on the environment or strengthen communities in Buckinghamshire. This can include the services they provide, their policies on community engagement and co-design of services with communities, travel, land use and corporate social responsibility.

R.5 We should, where possible, encourage planning for new and existing developments to:

- Be socially inclusive, welcoming and accessible to all sections of our community. Designed on a human scale for people and taking into account the needs of children and older people and those with disabilities.
- Provide safe, welcoming indoor and outdoor public places where people can meet.
- Encourage physical activity, active travel and access to good public transport.
- Incorporate natural landscaping and urban greening and good access to high quality green and blue public spaces e.g. parks and community gardens that people of all ages and backgrounds can enjoy.
- Improve access to healthy affordable food.
- Be designed to help reduce crime.
- Provide good quality homes using lifetime home principles and affordable housing.
- Provide good access to employment, retail and community facilities and health services which can ideally be accessed by walking or cycling through mixed land use policies.
- Minimise the impact of climate change and minimise air, water and noise pollution.
- Foster strong social connections and a sense of belonging and link new and existing communities effectively.

Healthy places, healthy futures growing great communities

Director of Public Health Annual Report 2018



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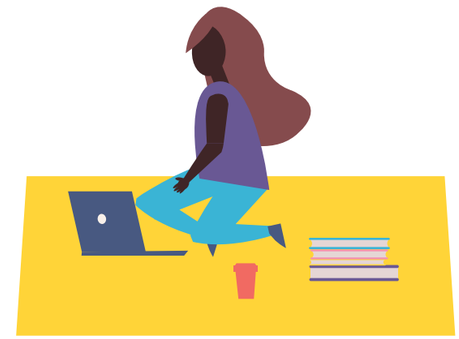

Foreword

It is a statutory requirement for the Director of Public Health to produce an annual report on the health of their local population. This year, my report focuses on the importance of the places we live, work and play and the communities we belong to for our health and wellbeing. It highlights how well designed places and socially connected communities offer solutions to our current and future health challenges.

This is particularly relevant as Buckinghamshire is changing, along with the world around us. Our population is growing and ageing and we will see significant new housing and infrastructure developments in the short and medium term. This can bring opportunities for Buckinghamshire residents but must be managed effectively to mitigate any potential adverse effects. These changes are a great opportunity to involve residents in designing healthy places for people to live, learning the lessons from the past and ensuring design supports health and wellbeing, and makes healthy choices the easy choices. We need to ensure that new developments reflect the needs of all sections of society and our growing older population. When we look around the places we live through the eyes of a three year old, or an older person, or someone with disabilities, what would we see? Would the places we live work for us then? We also need to future proof our developments as far as possible, anticipating and mitigating the impact of climate change for example.

Whilst we plan the physical environment we must recognise that the social environment and the social connections in our communities are equally important. Having supportive social networks, being able to participate in community life and having a voice in local decisions makes a vital contribution to our health and wellbeing. Policies that involve people in decisions that affects them whether in planning, local authority services or health care or other sectors strengthens independence and enables people to feel more in control. This is not only good for their health but also often results in better decisions. Planning neighbourhoods with welcoming places to meet and interact is a vital component but the heart and spirit of the community depends on the people who live there and participate in community life and make it a great place to live.

Certain groups in society are more vulnerable to the effects of adverse living conditions such as poor quality housing or exposure to air and noise pollution, including the very young, older people and people with long term health conditions. Key groups are also more likely to experience poorer living conditions such as those living on low incomes or in more deprived areas. It is important to take the particular needs of these groups into account to ensure that the health of the most vulnerable is protected.

There is much good work already underway in Buckinghamshire by the District Councils and County Council to keep Buckinghamshire thriving and attractive and many active communities making their neighbourhoods a great place to live. This report aims to highlight some of the most important environmental determinants of health in Buckinghamshire and the importance of strong communities. My report is for the public and private sector in Buckinghamshire – local authorities, developers, the NHS, schools, universities and businesses who can influence our physical and social environment in a wide variety of ways as well as the residents and communities. This report can be used to inform plans for new large-scale developments but also to prompt ideas from communities, community groups, town and parish councils, the voluntary and faith sector about the small social or environmental changes they might make to improve the places they live and the health of their community. Finally, I recognise that planning the places we live often involves managing conflicting demands and aspirations e.g. for transport, green space and affordable housing but I strongly believe that building health and wellbeing into the fabric of our communities will benefit everyone in Buckinghamshire.

Dr Jane O'Grady
Director of Public Health
June 2018

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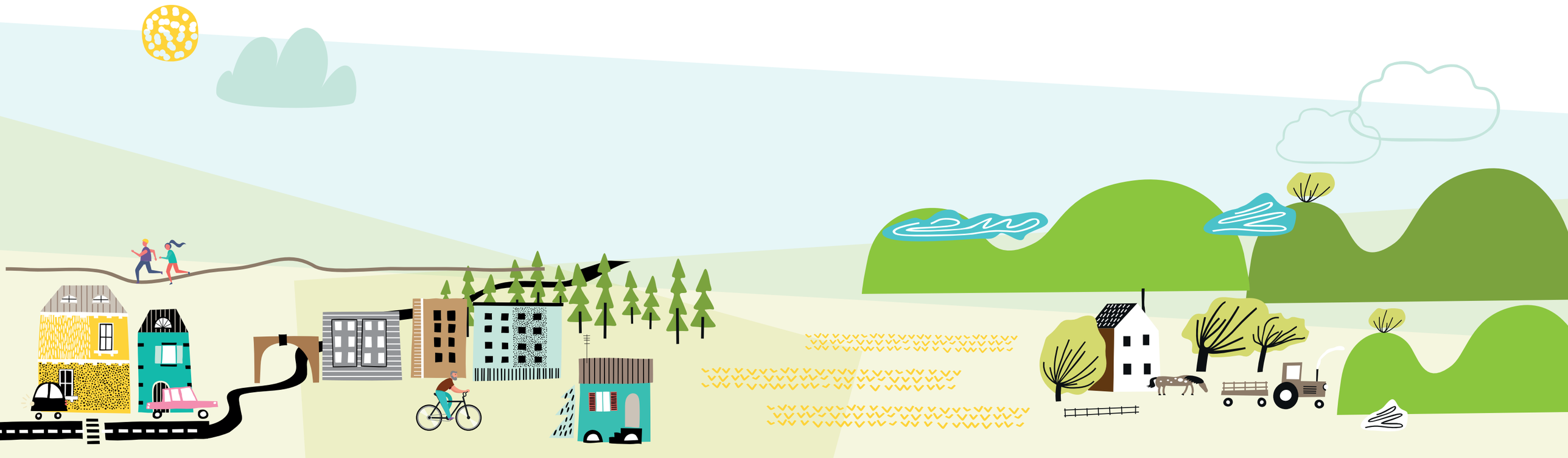


The State of Health in Buckinghamshire

How healthy are we and what are the challenges to our health?

Buckinghamshire residents are some of the healthiest in the country. Life expectancy has increased by 3.9 years and 3.0 years for men and women respectively between 2001-03 and 2014-16. Life expectancy now stands at 81.9 years for men and 84.9 years for women. However, not all these extra years are lived in good health. Too many of our residents are living with potentially avoidable ill health and disability and not all residents enjoy the same levels of good health. On average men in Buckinghamshire can expect to live in good health until 69.4 years of age and women until they are 70.3 years - a gap between life expectancy and healthy life expectancy of approximately 12.5 years for men and 14.6 years for women.

Certain groups in Buckinghamshire also have poorer health. The fifth of the population living in the most deprived areas of Buckinghamshire have worse health across a wide range of measures than the rest of Buckinghamshire. Men in the most deprived fifth die 5.2 years earlier and women die 4.7 years earlier than those in the least deprived fifth. The contrast is even greater when average life expectancy within each ward is compared. Life expectancy for men living in Gatehouse ward (74.5 years) is nearly 12 years shorter than men living in Cholesbury, The Lee and Bellingdon ward (86.4 years). Life expectancy for women living in Riverside ward (79.4 years) is 16 years shorter than women living in Greater Marlow ward (95.4yrs).

Early deaths from conditions that are considered preventable* are significantly lower in Buckinghamshire than the national average at 132.5 deaths per 100,000 in 2014-16. However, this still accounts for approximately 670 deaths per year and premature mortality from conditions considered preventable is almost 60% higher for men than for women.

Many of the commonest causes of death, illness and disability in Buckinghamshire are from long term conditions such as heart disease, diabetes, cancer, strokes and dementia. These account for 70% of spending on NHS and social care and affect large numbers of people. However, a significant proportion of these are preventable and are linked to how we live our lives. For example, a poor diet increases the risk of a wide range of conditions including obesity, diabetes, heart disease, stroke, some cancers and dementia. It is estimated in the South East of England poor diet accounts for nearly 70% of disability and early death from heart disease, contributes to nearly half of disability and early death due to diabetes and more than a third of early death and disability caused by stroke. Low levels of physical activity also contribute to rising levels of obesity and increase the risk of many long term conditions and musculoskeletal problems. Adopting healthy lifestyles reduces the risk of many of these conditions and it has been found that living a healthy life in middle age reduces the likelihood of developing dementia, disability and frailty. The environment and communities in which we live profoundly influence how easy it is to live healthily and the choices we make.

Good mental health is a vital resource for life as well as an important driver of physical health. It is estimated that one in eight men (12.5%) and nearly one in every five women (19.7%) in Buckinghamshire have a common mental health disorder such as anxiety or depression. Across the South East, nearly one in seven adults surveyed experienced symptoms of a common mental health disorder in the preceding week. People with poor mental health also have poorer physical health. Loneliness and social isolation are increasingly recognised as raising the risk of developing depression, anxiety and dementia, heart disease, stroke and early death. National estimates suggest that 1 in 20 people feel lonely often or all the time but the highest reported rate is found in 16-24 year olds. We do not have local data on loneliness and social isolation for the general population but nearly half of adult social care users in Bucks state that they have as much social contact as they would like (45.1%). This is slightly lower than the proportion across the South East (46.6%) and England (45.4%). The proportion of adult carers in Bucks who have as much social contact as they would like is lower at approximately one in three (30.8%). This is significantly lower than the proportion nationally (35.5%).

The health of children and young people

Children and young people (under 20 years of age) make up a quarter (25.0%) of the Buckinghamshire population, and 23.7% in England. Although children and young people in Bucks tend to be healthier

*These include but are not limited to infectious diseases (such as tuberculosis, measles, whooping cough, viral hepatitis and HIV), many cancers, type II diabetes mellitus, heart disease, stroke and diseases related to alcohol and substance misuse.

than the national average there is no room for complacency as UK children's health outcomes are worse than those in most other wealthy European countries [1]. Low levels of physical activity and unhealthy eating in our children and young people is resulting in overweight and obesity that can lead to poorer physical and mental health. Only 16% of girls and 23% of boys aged 5-15 years, in the South East of England are reported to achieve the recommended levels of physical activity. Levels of overweight and obesity among children in reception year and year six are 18% and 27% respectively. This is equivalent to nearly 1100 children in reception year and nearly 1400 children in year 6 who are overweight or obese. Approximately 1% (0.98%) of reception year and 1.4% children in year 6 are underweight.

There are also rising concerns around children's and young people's mental health and wellbeing. Recent national estimates suggest that one in ten children has a clinically diagnosable mental health disorder [2]. In Buckinghamshire, the estimate is slightly lower at 7.9% (or slightly more than one in 13 children aged 5-16 years). In 2016/17, there were 329 hospital admissions for self-harm per 100,000 children and young people aged 10-24 years. This is significantly lower than the rate nationally (405 per 100,000).

Children and young people are particularly vulnerable to threats to health from before they are born and as they grow up. Adverse environments can result in low birth weight and poorer development and poorer physical and mental health. Children are particularly vulnerable to poor housing conditions, air and noise pollution, extreme temperatures and lack of safe spaces to play and be active. The communities and surroundings in which they live influence whether they will adopt healthy or harmful behaviours and these behaviours will then tend to stay with them throughout life.

Investing in child health reaps impressive economic rewards with each pound spent returning more than £10 to society over a lifetime. Poor health in childhood leads to reduced workforce participation and productivity and lower national wealth.

What does the future hold?

1.1 Population changes

In 2016, the population of Bucks had a similar age profile to that in England except there was a smaller proportion aged 20-34 years in Bucks (16.2%) than in England (20.1%), and a larger proportion aged 40-59 years in Bucks (28.6%) than in England (26.5%).

For older people, Bucks and England have similar age profiles, with 18.3% (Bucks) and 17.9% (England) of the population aged at least 65 years, and 2.5% (Bucks) and 2.4% (England) for those aged at least 85 years.

Buckinghamshire is expecting to see significant growth over the coming years. Based on projections for births, deaths and migration as well as an estimated 45,000 new homes being built between 2015 and 2039, the population of Buckinghamshire is estimated to increase by 100,000 people between 2015 and 2039. This will mean that the population of Buckinghamshire will reach approximately 635,000 by 2039.

The age profile in Buckinghamshire is also set to change over the next 20-25 years. The number of children aged 0-4 years and 5-9 years is estimated to increase by 1368 (4%) and 1165 (3%) respectively between 2016 and 2039. Over the same time period, the number of people aged 65 years and over is estimated to increase by nearly 60,000 people (60%). The largest percentage increase will be seen among the over 85 year old age group, increasing from 13,578 to 33,700 (a 148% increase between 2016 and 2039). The working age population (aged 16-65 years) is estimated to remain relatively stable, increasing by less than 16,000 (6%) between 2016 and 2039.

1.2 Health related behavioural changes

Although some health related behaviours have improved (e.g. levels of smoking over the last decade), others behaviours have not. The UK has the highest prevalence of obesity in Western Europe and obesity levels have increased from 15% in 1993 to 27% in 2015, the fastest rise in any developed nation. More than 7 in 10 millennials (those born between early 80s and mid 90s) are set to be overweight or obese by the age of 35-44 on current trends and are on track to be the most obese generation since records began with consequent adverse impacts on their health and their risk of developing a range of long term conditions. This compares to 5 in 10 baby boomers (born 1945-55).

The rise in the older population will increase the numbers of people living with long term conditions and disability unless we age more healthily. The number of cases of dementia is expected to increase significantly across the county, doubling by 2050 [2]. However the good news is that living a healthy life in middle age (not smoking, a healthy diet, being physically active, maintaining a healthy weight and not drinking alcohol above recommended limits) can lead to healthier ageing reducing the risk of disability, dementia and frailty. We need to ensure that the environments in which we live make healthy choices the easy choices.

1.3 Other changes

Other factors that can adversely impact on our health could include weakening of social ties in our communities, increased pollution levels and increases in extreme weather.

The living environment

We know that the places and communities in which people grow up, learn, live, work, play and age can influence child development, educational attainment, mental and physical health and how well people age. It also influences the friendliness of neighbourhoods and how included people feel, crime and fear of crime and economic productivity. This in turn influences demand on health and social care services and other public sector services. This report focuses on the health and wellbeing benefits of living in a good place.

It has long been recognised that the places people live affect their health and wellbeing via the factors shown in the diagram below.

The World Health Organisation defines a 'Healthy City' as one that supports health, recreation and wellbeing, safety, social interaction, easy mobility, a sense of pride and cultural identity and is accessible to the needs of all citizens. The same aspiration could be applied to towns and villages throughout Buckinghamshire.

This report highlights key areas impacting on health and wellbeing:

- Community life
- Housing, land use and inclusive design
- Healthy travel
- Air and noise pollution
- Natural environment and green spaces
- Access to healthy food.

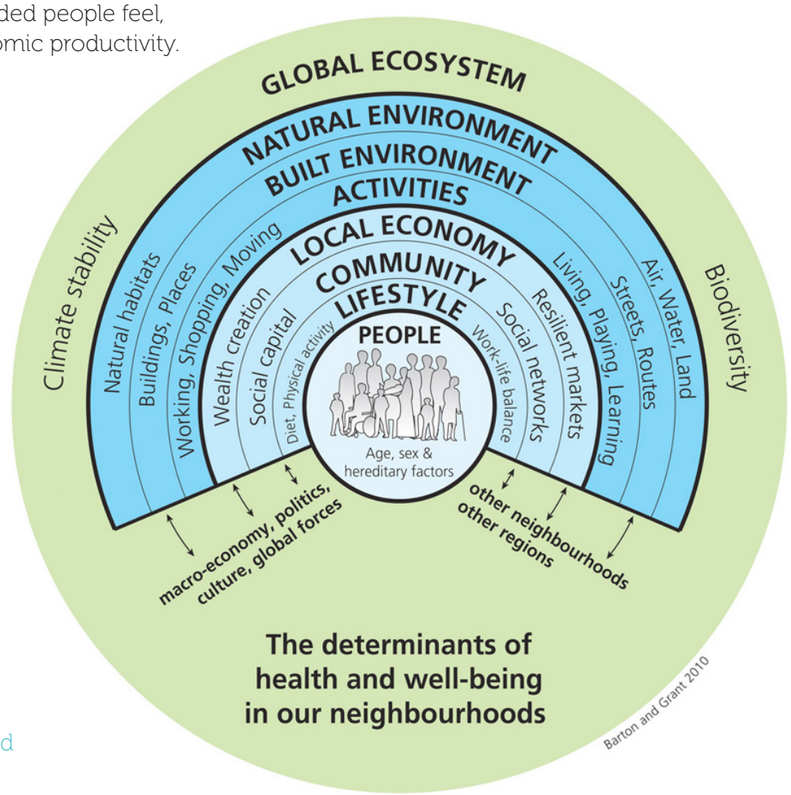


Figure 1 - The wider determinants of health and wellbeing in our neighbourhoods. A health map for the local human habitat. Barton and Grant, 2006. [3]

Community life

Introduction

The communities we grow up, play, work and live in profoundly affect our happiness, physical and mental health and our chances of success in life. People thrive in communities where there are strong social ties, a feeling of community and a sense of belonging and where everyone has the opportunity to participate fully in community life. Having a voice in local decisions also makes a vital contribution to health and wellbeing.

All communities have strengths and assets as well as needs that can contribute to the health and wellbeing of community members. This includes members of the community themselves, local groups and strong social networks, physical assets like buildings and parks and resources and assets brought by the public, private and voluntary sector. Involving and empowering communities is central to health and wellbeing particularly for disadvantaged groups.

Nationally, around two in every three people feel a sense of belonging to their neighbourhood with around a quarter of people (27%) feeling that they could personally influence decisions affecting their local area.

Key facts:

Nationally, more than half of people (51%) said they would like to be more involved in decisions made by their local council.

Around two thirds of people in the South East participated in voluntary work in the last year (67%), though this has fallen since 2013/14 and more than three quarters had given to charity in the last four weeks (77%). [4]

In Buckinghamshire there are over 2,500 registered charities and 175,000 volunteers. It is estimated that volunteers in Bucks contribute an estimated £225m a year to the UK economy.

The importance of social ties

People who have strong social networks tend to live longer and have better mental and physical health than those who don't. Strong well connected communities can benefit everyone throughout life. Children and young people growing up in communities with positive social norms are less likely to participate in health harming behaviours such as smoking and drug taking and more likely to engage in health promoting behaviours such as being more physically active.

The health benefits of social interaction include reduced risks of depression, high blood pressure and cardiovascular problems and faster recovery from episodes of ill health. Older people with strong social connections have better physical health, less fear of crime and lower rates of early death. Social participation has also been associated with a reduction in dementia and cognitive decline. At a community level cohesive communities also have lower levels of depression, loneliness and crime.

Social isolation and loneliness*

Social isolation and loneliness can affect people at any age through a range of circumstances related to the individual and the local community [4]. Some of the common factors causing social isolation and loneliness include living alone, bereavement, ill-health, reduced mobility, caring responsibilities, job loss, access to local services and amenities, fear of crime and transport issues. These factors affect different groups to different extents. For instance, poor transport can contribute significantly to isolation in rural areas.

Communities play a crucial role in supporting people. Having the right support network can have a large impact on the ability of an individual to cope with adverse events in life including promoting recovery from illness. Conversely, being lonely for long periods of time has also been shown to affect health related behaviours, resulting in higher chances of having unhealthy lifestyles such as smoking cigarettes and drinking in excess [5].

Key facts:

Among adult carers in Bucks, less than a third consider themselves to have as much social contact as they would like (30.8%). This is statistically significantly lower than the proportion nationally (35.5%) and lower than the proportion across the South East (33.2%).

In 2016/17, among Buckinghamshire residents using adult social care services, less than half consider themselves to have as much social contact as they would like (45.1%). This is similar to the proportion nationally (45.4%) and the proportion across the South East (46.6%).

As social isolation and loneliness fluctuate over time and because they are difficult to measure, understanding how many people are isolated or lonely is difficult. However, nationally about one in every six older adults are in contact with family and friends less than once per week and one in nine are in contact with family and friends less than once per month. Estimates of loneliness nationally, show that approximately one in 20 people feels lonely all of the time or often.

**Social isolation is when an individual is lacking in the quantity or quality of their social network and this can be in terms of family, friends or their local community. Loneliness is a personal, subjective feeling. Both are significant factors that influence health, but are distinct. An individual can be socially isolated whilst not being lonely and vice-versa. An individual's level of social isolation and loneliness can fluctuate over time.*

It is increasingly being recognised that loneliness and isolation can be experienced earlier in life and may even be more common among younger age groups [6]. The most recent survey of community life found that a higher proportion of 16 to 24 year olds expressed feeling lonely often or always (10%) compared to any other age group and that as age increased the proportion who felt lonely decreased, with the lowest levels among the over 75 year olds [4].

Key facts:

In Bucks the proportion of people living alone increases to 28.4% among people aged 65 years and over. This is statistically significantly lower than the proportion nationally (31.5%)

A higher proportion of homes in Buckinghamshire (5.44%) are lived in by a single adult over the age of 65 years compared to England (5.24%) and the South East (5.33%).

Across all ages, approximately one in 10 residents in Bucks lives alone (10.5%). This is statistically significantly lower than the average across the South East (12.1%) and nationally (12.8%).

Children and young people who are at increased risk of being isolated and lonely include those with a disability, learning difficulty or special educational need, children who are homeless, children who are in care and children who have suffered from abuse or neglect [7].

The health impacts of social isolation and loneliness affect both physical and mental health. Individuals who are socially isolated are more than three times as likely to suffer from depression and anxiety and nearly twice as likely to develop dementia. Social isolation and loneliness have also been shown to make an individual two to three times more likely to be physically inactive [8] and have been linked to higher blood pressure and an increased risk of heart disease and stroke [9].

People experiencing social isolation are more likely to visit their GP and Accident and Emergency Departments, more likely to be admitted to hospital as an emergency and three and a half times more likely to enter local authority funded residential care [8]. Loneliness increases the likelihood of death by a quarter and the likelihood of premature death among people without strong social ties is between 2 and 5 times higher compared to people with strong social ties [10].

Key facts:

Across the South East, nearly three quarters of people (72%) say that they chat to their neighbours regularly, with a higher proportion (84%) saying that people from different backgrounds in their neighbourhood get on well.

Nationally, two in every five people feel that they can trust the majority of their neighbours, with three quarters feeling that they could at least trust some of their neighbours.

Communities that promote connections and a community spirit can reduce levels of social isolation and loneliness and consequently improve the health and wellbeing of residents. Neighbourhoods lacking positive social connections have higher rates of social disorder, anxiety, depression and crime.

Planning for vibrant socially connected communities

Planning, policies and design alone cannot create strong, well-connected communities but they can make it easier for people to come together, make friends and get involved in their communities. Good design can help by creating safe, attractive multi-use indoor and outdoor public spaces that are accessible and welcoming for all and make it easy for people to interact with each other on a daily basis.

Well-designed public spaces should be incorporated into all new developments and there is much that can be done in existing towns and neighbourhoods too. In existing neighbourhoods this can range from significant redesign and regeneration to trialling temporary features to improve public spaces which if successful and popular could lead to more permanent changes of use. Interventions that improve public spaces have included pocket parks, reclaiming derelict land for community gardens and temporary street closures for play or events.

Involving a wide range of residents in the design of public spaces can improve wellbeing, helps foster a sense of community and place and is more likely to result in spaces that people will use and care for. Joint decision making and co-production, involving communities and stakeholders in the design, governance or delivery of local infrastructure in lower income communities, is associated with improvements in depression, sense of community, social capital, partnership working, adult skill development, learning and training, sense of empowerment and self-esteem. However in a minority of cases there were adverse impacts related to consultation fatigue, distress and frustration and stress from accessing and participating in the decision making processes.

Good design features

People who live in environments that encourage people to walk or cycle rather than use the car have a stronger sense of community, are more positive about the places they live and engage more in community life. People are more likely to walk or cycle where housing, shops, amenities and workplaces are all close together and there are safe and attractive routes between them. Conversely areas where there is high car use and busy roads reduce interaction between neighbours and people have fewer friends locally. A pedestrian environment enables the development of art and culture in the public realm, encouraging more visits and contributing to the vibrancy of the area.

Crime and the fear of crime impacts on people's mental health and can make people reluctant to leave their homes to socialise and access vital facilities. Good design can help reduce the level of crime in an area and make people feel safer. Crime can be reduced by making places more attractive, and by promoting a mix of land uses, dwelling sizes and types of dwelling. This makes it more likely that there are people around throughout the day and evening leading to reduced crime and increasing feelings of safety. Good design has been shown to reduce likelihood of graffiti, litter, vandalism and broken windows by up to 60%. 'Secured by Design' is a national police initiative to incorporate prevention of crime into the design and build of new homes.

Inclusive public places

The quality of the built environment is key to maintaining mobility and independence for older people and people with disabilities and also works for families with children and parents with pushchairs. Wide, clearly defined and obstacle free pedestrian routes, crossings with dropped kerbs, tactile paving and adequate signals and wayfinding aids may improve comfort and safety for a wide range of residents. Adequate road crossings, toilets, regular public seating, shade and shelter and the attractiveness of the environment are important factors in encouraging people to get out of their homes and to use a public space. People are also more likely to socialise in areas with interesting features and with natural landscaping and this is covered more in the section on green spaces. Children need safe child friendly environments that are easy to get around, free from pollution with green spaces and places to play.

Throughout this report we have highlighted that children and young people, older adults and people with long term conditions or poorer health are more susceptible to and often more likely to experience the adverse effects of poorer environments. There are helpful guides and initiatives such as the UNICEF child friendly cities and communities and the WHO guide to creating Age Friendly environments that can support communities, towns and local areas to help make communities that work for everyone.

Cultural and social life

A strong programme of cultural and social activities co-designed with residents also helps develop cohesive communities and foster a sense of place and pride in an area. Regular engagement with social, art and cultural activities can benefit health and wellbeing at all ages. Engagement in structured art and cultural opportunities improves the cognitive abilities of children and young people.

Older people attending art, music or other types of educational classes have better mood and life satisfaction than those who don't. Older people say art and culture is important in making them feel happy, helping them meet other people and encouraging them to get out and about. Specially-designed art activities have also been found to have a positive impact on health conditions like dementia, depression and Parkinson's disease.

Many people contribute to community life through volunteering which also benefits their health. Volunteering is associated with better health and life satisfaction and less depression. However sometimes volunteers may experience burnout and stress from responsibilities so a balanced approach helps to ensure that both volunteers and their community can benefit.

Healthy homes

Introduction

The ability to stay healthy, access and maintain education, training and employment and contribute to community life is reliant on having a safe and stable place to live. Living in an affordable good quality home is fundamental to people's physical and mental health, helps them maintain independence for as long as possible, recover from illness and reduces demand on the NHS and social care. A sufficient supply of good quality affordable housing is also vital to the economic and social success of an area.

The evidence

High quality, warm and energy efficient housing improves physical and mental health and reduces deaths. Conversely poor housing conditions are linked to poor health, accidents and excess winter deaths. A home is considered decent if it: meets the current statutory minimum standard for housing; is in a reasonable state of repair; has reasonably modern facilities and services; and provides a reasonable degree of thermal comfort [11]. Across England in 2016, one in five owner occupied homes (19.7%) is considered to be 'non-decent'. A higher proportion of privately rented homes (26.8%) are considered non-decent whilst a lower proportion of socially rented homes are considered non-decent (12.6%).

Poor quality homes cost the NHS in England at least £1.4bn per year and wider society over £18.6bn. Children and older people or those with long term conditions are particularly vulnerable to poor housing conditions.

Cold homes

Excess cold experienced in the winter months can exacerbate a range of health problems, including respiratory and circulatory conditions, mental health problems and accidental injury for all age groups. A major factor contributing to living in a cold home is fuel poverty, where the required fuel cost is above average and if a household were to spend that amount to heat the home, the amount of money they would be left with would put them below the poverty line [12]. Factors making households susceptible to living in fuel poverty are low household income, the energy efficiency of a home and the cost of heating.

Children and young people living in cold homes are more than twice as likely to have a respiratory condition and five times more likely to suffer from mental health problems [13]. Hospital admissions are also higher among children living in colder homes. The long term impact of living in cold homes includes poorer educational attainment and lower emotional resilience [14]. Adults living in cold homes have increased risk of respiratory disease, rheumatism and arthritis, mental health problems and increased risk of winter deaths from cardiovascular and respiratory disease [15].

It is estimated that 10% of excess winter deaths are due to fuel poverty. In addition, households living in fuel poverty are not only more likely to live in a cold home, but also more likely to have less disposable income, meaning household members may be less able to eat healthily, afford other essentials and take part in social activities.

Key facts:

In Buckinghamshire, it is estimated that there were 17,551 households living in fuel poverty (8.4%) in 2016. This is slightly lower than the proportion nationally (11.0%) and across the South East (9.4%).

Buckinghamshire experiences 18% more deaths during winter months compared to the non-winter period. This is comparable to England (17.9%) and the South East (17.4%). This equates to approximately 230 additional deaths during winter months

Indoor Air Quality

Poor indoor air quality from materials used in the home has been linked to a range of problems including cardiovascular and respiratory disease and some cancers. Damp and mould are more likely in colder homes and can trigger exacerbations of asthma and make people more prone to respiratory infections. Children living in damp homes with mould are between 1.5 and 3 times more likely to have coughing and wheezing symptoms compared to children living in damp-free housing [14]. Across England, it is estimated that more than one in 25 homes has a damp problem. Damp is more common in privately rented accommodation (8.2%) and lowest in owner occupied accommodation (2.7%) [16].

Injuries in the home

There are more injuries sustained in the home than anywhere else, resulting in approximately 6000 deaths per year nationally. Children under five and older people aged over 65 years are most likely to sustain an injury in their home. Injuries sustained in and around the home are the leading cause of avoidable death in children aged under 5 years [17]. Each year, the cost of injuries sustained in the home is estimated to cost society over £45bn [18].

Falls are the most common accident in the home in all ages [18]. The majority of these are due to trip hazards resulting from factors such as poor design or disrepair. Older people are most at risk of suffering a fall and within this age group, a fall is

more likely to result in a fracture and subsequent loss of independence. In England, it is estimated that there are 1.3m households with people aged 55 and over who live in a home with a serious hazard [19].

Key facts:

There were 2036 emergency admissions due to falls in people aged 65 years and over in Bucks in 2016/17. However, it is not possible to determine the proportion of these falls that arose in the home.

There were 580 hip fractures in older residents in Buckinghamshire during 2016/17. After adjusting for age, there are 573 hip fractures per 100,000 people aged 65 years and over, which is similar to the rate nationally (575 per 100,000).

Home Improvements

Home improvements have been shown to improve health outcomes particularly for older people and those living with long term conditions on lower incomes. Housing refurbishment including damp-proofing, reroofing and new window installation is associated with improvements in general health outcomes. Home improvements have also been shown to reduce risk of falls and improve social outcomes.

Affordable Housing

The affordability of housing is increasingly becoming a problem as house price increases are consistently higher than wage increases. Housing affordability has worsened in the last two decades, with working people now expecting to pay around 7.6 times their annual earnings on average to purchase a home in England and Wales in 2016. This is up from 3.6 times earnings in 1997.

A lack of affordable housing can lead to financial hardship and stress, overcrowding and in the most severe cases homelessness. Families living in overcrowded conditions experienced a range of health related problems such as poor and irregular sleep patterns, depression and anxiety, strained family relationships and break-ups [20]. Children and young people living in overcrowded conditions experience particular difficulties including health problems such as respiratory and infectious diseases, difficulties studying, emotional problems and developmental delays. More than 80% of families living in overcrowded homes identified lack of space as a major contribution to anxiety, stress and depression.

One impact caused by difficulty finding affordable housing is that people may turn to Houses in Multiple Occupation (HMO) in order to find somewhere to live. Poorly managed HMOs can pose a risk to physical and mental health with increased risks associated with sharing facilities with others (e.g. personal hygiene, food preparation, fire safety). Lack of affordable homes is also linked to increase levels of homelessness. Someone is homeless if they have no access to accommodation either through a legal agreement (such as a tenancy) or an implied agreement (such as living with family or friends). This can potentially include people who are facing eviction, living in temporary accommodation, squatters, rough sleepers, people at risk of violence, those housed in poor quality accommodation that is a risk to their health and those who cannot afford their current accommodation. However while all these groups will be entitled to advice and assistance, currently local authorities do not have a duty to house everyone. All persons who approach the local authority for assistance are assessed on a case by case basis.

Homelessness can cause ill health, but in addition ill health can also result in loss of income or challenging behaviour and put some households at greater risk of becoming homeless. Approximately three quarters of homeless people report a physical health problem, with 41% reporting a long term condition (compared to 25% in the general population) [21]. The longer a person experiences homelessness the more likely their health and wellbeing will be at risk. The average age of death of a single homeless person who is rough sleeping is 30 years lower than the general population [22].

Only households assessed as being a priority need for housing, under the Housing Act, will potentially be given accommodation on an emergency and longer term basis. Groups deemed to be priority for housing generally include households with dependent children and/or households with a vulnerable member (e.g. due to medical reasons). Eligible individuals or families may be housed in temporary accommodation while their application for housing is considered or until suitable and secure accommodation is available. Temporary accommodation can include bed and breakfast, hostel, private sector or local authority/housing association stock and can be outside of the local authority where the housing application has been made.

Providing affordable housing for vulnerable people such as adults with learning disability and adult with substance misuse problems can lead to better social, behavioural and health related outcomes. Provision of affordable housing for homeless people increases ability to engage with health care services, improves quality of life, mental health and employment.

Key facts:

Average house prices are highest in South Bucks (£616,000) and Chiltern (£552,000), followed by Wycombe (£401,000) and Aylesbury Vale (£334,000).

The ratio of average house prices to earnings in Buckinghamshire (10.7) is higher compared to the national average (7.6) as well as the South East (9.4).

In 2016, median house prices in South Bucks were more than 14 time average earnings of residents living in the district and in Chiltern the ratio was 13.9. Wycombe and Aylesbury Vale have slightly lower ratios at 10.9 and 9.4 respectively. However, these are all higher than the ratio for England.

Buckinghamshire also has higher rents than the England average with rents across the four Districts ranging from 9% to 24% higher than the national average.

House prices in Buckinghamshire in July 2017 were among the highest in the country with average house prices in all four districts significantly higher than the national average of £243,000.

Less than one in every 1000 households in Buckinghamshire (0.9 per 1000) is classified as being statutory homeless (living in temporary accommodation provided under the homelessness legislation). This is significantly lower than the rate nationally (3.3 per 1000 households) and across the South East (2.2 per 1000 households).

Homes for all ages and abilities

The right home environment for people with additional needs protects and improves health and wellbeing, and enables people to live safely and independently in their own home. It also helps delay and reduce the need for health and social care, prevents hospital admissions, enables timely discharge from hospital and enables rapid recovery from periods of ill health. Good design and building quality should ensure homes can be adapted to people's changing needs throughout life and enable people to stay in their own homes.

Older people spend a greater proportion of time in their homes and local neighbourhoods compared to other age groups. However, it is estimated that 2 million people aged 55 and over in England are not living in homes that meet their needs, and a high proportion of homes with older residents are not specifically designed for people as they get older (96%). This increases the risk of accidents and injuries as well as poorer physical and mental health. Developing age-friendly homes, neighbourhoods and towns is one of the most effective policy responses to our ageing population.

There is a shortage of well-designed, high-quality, appropriate and attractive housing in the right place for older people. More than three in every four adults aged 65 years and over in Bucks live in their own homes. However, nationally more than one in five older adults lives in a home that does not meet the decent standard [19]. Nearly half the cost of poor housing to the NHS arises from poor housing among older people and is estimated at £624 million per year nationally.

Eight out of 10 older people say they would like to downsize, but only three out of 10 do so. Many people who do downsize move only at a time of crisis, when they are not necessarily making good decisions. Housing for older people needs to be close to shops, services and cultural facilities, and connect well to the public realm with good public transport links. The quality of the surrounding environment is also important, including access to shared, open, green spaces with well-placed benches and public toilets.

The majority of people living with a disability live in housing that is not designed to meet their needs. Home modifications for people with disabilities can help sustain independence, prevent hospital admissions and support earlier discharge from hospital as well as reduce care costs [19]. Ensuring homes meet the needs of people with disabilities is also important for supporting people to remain safe and independent. It is estimated that 93% of homes lack access features for people with limited mobility.

Different people will have different needs necessitating a range of housing options from mainstream and accessible homes to supported and extra care housing. Extra care housing is accommodation that has been designed to meet the needs of older people who need additional support, often with varying levels of support available. Evidence shows that extra care housing can delay admission to a care home and provide a cost-effective alternative to residential care and can improve quality of life and social contact. There is also some evidence that extra care housing can reduce health costs.

Key facts:

In Bucks, around one in thirty older people live in care homes (residential or nursing homes). The proportion of older people in care homes rises from less than 1% of those aged 65 to 74, to more than 15% of those aged 85 and over.

Lifetime neighbourhoods and age friendly environments

The environments in which people live need to be designed to support their health throughout life. The World Health Organisation (WHO) describes a lifetime neighbourhood as:

"...a place where a person's age doesn't affect their chances of having a good quality of life. The people living there are happy to bring up children and to grow older – because the services, infrastructure, housing, and public spaces are designed to meet everyone's needs, regardless of how old they are." [23]

Lifetime neighbourhoods are those which offer everyone the best possible chance of health, wellbeing, and social, economic and civic engagement regardless of age. They provide the built environment, infrastructure, housing, services and shared social space for all people whether they are old or young, disabled or frail. Most features of lifetime neighbourhoods will benefit all generations.

The WHO has promoted the concepts of age-friendly cities and lifetime neighbourhoods. WHO describes an age-friendly city as one that:

"...is an inclusive and accessible urban environment that promotes active ageing ... adapts its structures and services to be accessible to and inclusive of older people with varying needs and capacities."

Urban and rural areas will present different challenges. For example, urban areas may more frequently suffer poor access to space or low social cohesion. Rural areas may have difficulty in providing access to services over more dispersed residential areas, for example, public transport and shops.

It is clear that designing neighbourhoods that work for all and particularly our growing child and older adult population is vital for the continued success of Buckinghamshire.

Healthy travel

Introduction

We travel for work and play, to get to school, shops and other services, but how we travel, and how far and for how long, has significant implications for our health, the health of others and society as a whole.

The mode of travel we choose matters. Active travel such as walking and cycling improves our health through promoting physical activity but also by reducing air and noise pollution, increasing social connections and making communities safer. It improves our mood, reduces stress and the risk of developing long term conditions or dying early. It is also the lowest carbon, cheapest and most reliable and sustainable form of transport. It reduces congestion, absenteeism and boosts economic productivity.

The evidence

Active Travel

Adults who do regular physical activity are at lower risk of many chronic diseases such as heart disease, diabetes, stroke, some cancers, depression and dementia. Children and young people who are physically active have better cardio-respiratory health, better bone health and muscle strength, improved attention and better educational attainment, lower anxiety and stress and higher self-esteem [24]. However, levels of physical activity are gradually declining and it is conservatively estimated that physical inactivity costs the NHS £1bn per year, with wider societal costs of more than £8bn per year [25].

Active travel can contribute significantly to helping people achieve the recommended levels of physical activity per week and areas that encourage people to walk or cycle to work, school or shops have healthier residents than those that don't.

Walking improves our mood and reduces the risk of anxiety and depression as well as improving our physical health. Walkable neighbourhoods and towns are better for everyone. Areas where more people walk are more sociable, are safer and feel safer. Places that are designed to be more walkable increase the accessibility of public space for people of all ages, different mobility levels and backgrounds and reduces social isolation.

There are an increasing number of studies demonstrating the benefits of cycling. A recent British study found that people who commuted by bike had almost half the risk of developing and dying from heart disease and cancer. In addition, on average, cyclists take 15% fewer sick days compared to non-cyclists. Commuters who shift from private vehicle to public transport or active forms of travel have been shown to have a significant reduction in weight [26].

Key facts:

Compared to commuters travelling by car, cyclists have a 46% lower risk of developing heart disease and 52% lower risk of dying from heart disease and a 45% lower risk of developing cancer and a 40% lower risk of death from cancer [27].

One of the main barriers for people switching to cycling is perceived safety with more people choosing to cycle if routes are physically separated from other traffic. 64% of people say they would cycle more if they had access to separated cycle routes [28]. Areas where separated cycle routes have been introduced have seen an increase of up to 171% in bike lane usage. Increases are particularly seen among less experienced cyclists and those with lower levels of confidence including children, women and less active people. Separated cycle routes are also linked to real benefits to cyclist safety with reduced levels of collisions with motor vehicles. The health benefits of cycling outweigh the risk from injuries by about 20 to 1 and it has been estimated that for an average commute, the health benefits to society and the individual of each person shifting from car to bicycle is more than £1100 per year [29].

There are many opportunities for children to be active as part of their travel, often to and from school. Children who walk or cycle to school on average get about 20 extra minutes of physical activity per day compared to children that are driven and, switching from driving to school to walking has been estimated to save families £642 per year [30]. It is estimated that approximately one in five cars on the road during peak hours in the morning are involved in school travel. For schools in residential areas, this can concentrate traffic in these areas, increasing pollution and the risk of road traffic injuries.

Active travel increases physical activity levels and reduces the number of cars on the road which reduces air pollution from road traffic all of which benefit health. Active travel is also good for the economy and people who walk or cycle to work tend to be more productive and take fewer sick days. The health and economic benefits of active travel have been found to outweigh the cost by up to 11 times with an average of £5.62 in benefits for every £1 spent on active travel in the UK [25].

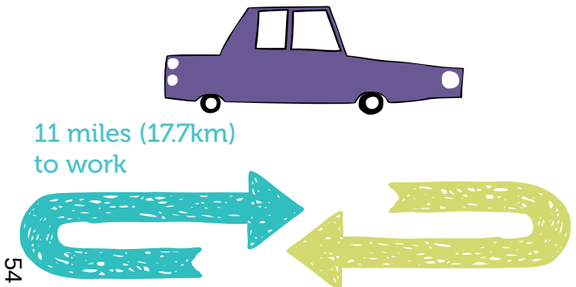
People who live in environments that encourage people to walk or cycle rather than use the car have a stronger sense of community, better social connections and are more positive about the places they live than those who live in areas of heavy car use. They are more likely to know their neighbours, trust others and engage in community life.

Motorised transport and health

Motorised transport has seen the distances people can travel for work, school and leisure increase and can bring many benefits. These include improved access to employment, reduced social isolation and better access to health care. These need to be balanced against the adverse consequences of this mode of travel for health and communities.

Neighbourhoods where housing and amenities are far apart, characterised by "urban sprawl", have higher car use and higher levels of obesity and other health problems which taken together are equivalent to the population ageing 4 years.

Commuting



In Bucks, the average commuter travels nearly 11 miles (17.7km) each way to work, longer than the average for England (9.3 miles, 15.0km) and the South East (10.3 miles, 16.6km).

Key facts:

Between 2001 and 2011 the average commuting distance increased by more than 11% in Buckinghamshire, similar to the increase nationally. This equates to an increase of around 340,000 additional miles (550,000 kilometres) travelled each day by commuters in Bucks.

The average journey time to work in Buckinghamshire is around 34 minutes each way (68 minutes per day in total).

A higher proportion of commuters travel to and from work by car (43%) compared to the England average (35%).

Long commutes are increasingly being recognised as having a detrimental effect on our health and wellbeing. They have been linked with higher levels of stress and anxiety and higher blood pressure. In addition, long commute times reduce the amount of free time people have for recreational activities, cooking and sleeping and participating in community life with consequent adverse impact on their health.

As the distance commuted increases, people's health suffers, with lower levels of physical activity and fitness, higher body weight and cholesterol, waist circumference and risk of diabetes and cardiovascular disease [31]. Studies have shown that driving more than 10 miles one way to and from work five days a week was associated with an increased risk of developing high blood sugar and cholesterol and commuting more than 30 miles a day was associated with high blood pressure, stress and heart disease. Statistics show the longer we drive the less happy we are and that happiness decreases with every mile of commute. Workers with longer commutes are 33% more likely to suffer from depression and 12% more likely to report stress at work. They are also 46% less likely to get the recommended minimum of seven hours of sleep each night [32]. Studies have shown that, to have the same level of satisfaction as someone who walks, a commuter travelling for more than one hour per day has to earn 40% more money. Changing from a long commute to a short walk to work has the same impact on happiness as a single person finding a new partner [33] [34].

A recent report looking at congestion in towns and cities shows that commuters in Aylesbury spend on average 32 hours stuck in congestion each year. Out of 111 towns and cities in the UK that were assessed, commuters in Aylesbury spent the 6th highest amount of time in congestion [35].

Key facts:

The average commuter in Aylesbury spends 32 hours each year stuck in congestion

Commuters in Aylesbury have one of the highest average time spent in congestion in the UK (6/111).

Road traffic accidents can also contribute to harm. Speed is the main cause of premature deaths and injuries in road accidents, 9 in every 10 pedestrians survive if hit by vehicle travelling at 20mph, 5 out of

Key facts:

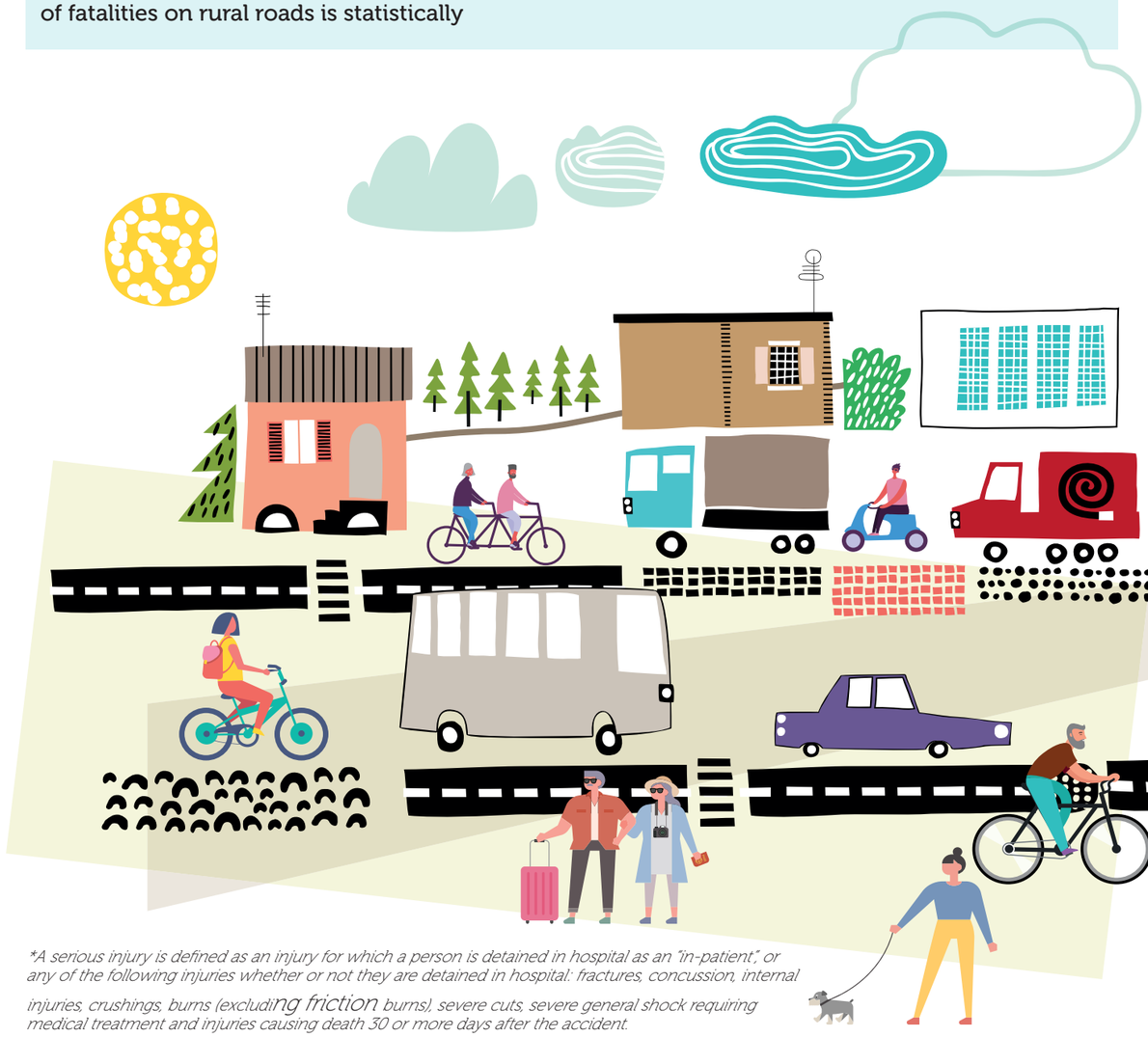
Between 2014 and 2016, there were 241 people killed or seriously injured* (KSI) on average each year on the roads in Buckinghamshire.

On average, slightly more than half (53.2%) of deaths or serious injuries on the road in Bucks occurred on rural roads (128), and approximately one in ten (26) occurred on motorways (10.8%). Urban roads in Bucks accounted for an average of 87 deaths and serious injuries per year (36.0%).

Between 2014 and 2016, there were 21 deaths per year on the roads in Bucks. Two thirds of deaths (an average of 14 deaths) occurred on rural A roads and minor rural roads (67%). Around one in six deaths (17.5%) occurred on urban roads. Similarly, around one in six deaths (15.9%) occurred on motorways, equivalent to an average of 3 deaths per year. The proportion of fatalities on rural roads is statistically significantly higher to the proportion of deaths on urban roads and motorways.

In the three years 2014-16 there were 14 pedestrian or cyclist deaths, 14 motorcyclist deaths, 33 deaths of car occupants and 2 deaths of other road users. Over the same time period, there were 209 pedestrians and cyclists who were killed or seriously injured (28.9%), 160 motor cyclists (22.2%), 322 car occupants (44.6%) and 23 other road users (3.2%) who were killed or seriously injured.

There is wide variation in the rate of KSI between the districts, with the highest rate in South Bucks (79.6 per 100,000), followed by Aylesbury Vale (41.7), Wycombe (39.8) and Chiltern (39.1). However, the difference is only statistically significant for South Bucks, which is also significantly higher to the national average.



**A serious injury is defined as an injury for which a person is detained in hospital as an "in-patient", or any of the following injuries whether or not they are detained in hospital: fractures, concussion, internal injuries, crushings, burns (excluding friction burns), severe cuts, severe general shock requiring medical treatment and injuries causing death 30 or more days after the accident.*

10 die if hit by vehicle travelling at 30 mph and 9 in 10 die if hit by vehicle at 40 mph. Nationally, whilst the majority of road traffic injuries (all casualties) arise on 30mph built up roads (58%), less than one in three deaths on the roads occur on 30mph built-up roads. In comparison, 60mph roads account for less than one in every six casualties, but more than one in every three deaths nationally (36%).

Traffic calming measures have been found to reduce the number of accidents by 40% whilst also reducing the severity of the accidents [36]. Speed bumps and chicanes in the road are the most effective ways of reducing vehicle speed [37]. However, speed bumps need to be effectively designed to minimise the potential impact on air quality due to extra braking and fuel consumption [38].

Motorised vehicles are a major contributor to air and noise pollution, accounting for approximately a third of air pollution from particulate matter [39]. However, the impact of air pollution from road traffic is greater in built up areas where concentrations of vehicles are higher [40]. As a result, road traffic is responsible for a large proportion of air quality management areas due to Nitrogen Dioxide (96%) and particulate matter (76%) in the UK [41]. The cost of ill health due to air pollution from road traffic is estimated to be between £4.5-10bn to the UK economy each year [40].

Transport networks and health

The design of our transport network and roads influence how we choose to travel from place to place but also about how we interact with each other. Roads, especially large or busy roads can act as a significant barrier and can have a negative impact on health. 'Community severance', where busy roads reduce access to goods, services or people can isolate communities and neighbourhoods increasing the difficulty in accessing important facilities such as schools, doctors' surgeries and shopping centres. This is especially important for children and older people. Community severance creates a self-perpetuating cycle, whereby the presence of a busy road causes individuals to rely more on cars to move around, thus causing higher congestion on the roads and greater severance. Living on a road with heavy traffic can reduce the opportunity for social interaction with neighbours. Residents living on streets with light car traffic volumes have three times more friends and twice as many acquaintances than those living on streets with high car traffic.

Public transport

Travelling by public transport compared with driving a car has a number of benefits for both mental and physical health and wellbeing. Using public transport increases amount of time being physically active by between 8-33 minutes on average. On average, residents living in areas served by a good public transport network or where there is "mixed land use" (where houses, jobs and amenities are close to each other) own significantly fewer cars, drive significantly less and use active and public modes of transport for a higher proportion of their travel [42].

In addition to boosting levels of physical activity, using good quality public transport is associated with lower levels of stress compared to driving and can reduce exposure to air pollution as car users have higher exposure to air pollutants that people on buses and trains [43] [44].

Air and Noise Pollution

The evidence

Air Pollution

Air pollution is a mixture of particles and gases that damage health, the environment and the economy. The most important pollutants with respect to health are particulate matter (PM) and nitrogen dioxide. Particulate matter is classified by size and includes *PM10* and *PM2.5* which comprise all particles smaller than 10 microns and 2.5 microns respectively. *PM2.5* is most strongly linked to health outcomes as at this size the particles can be inhaled deep into the lungs. The very small particles *PM0.1* once inhaled can pass directly into the bloodstream. The particles can be composed of combustion products, abrasion of engine components, brakes and tyres on road surfaces or generated during construction and agricultural processes. In urban pollution hotspots, particularly those close to roads, the source is mainly from traffic and the particles include soot, part burnt petrol and diesel and compounds that form benzene based carcinogens and waste matter from road surfaces. There are considerable differences in emissions between vehicles but on average diesel exhaust contains up to 30 times more PM than petrol. In the countryside agriculture and upwind industries make a larger contribution to air pollution. Nationally, 38% of *PM2.5* is produced by households burning wood, coal and other solids fuels in open fires and stoves.

Nitrogen dioxide and related oxides of nitrogen are gases produced by combustion. In areas where the UK is exceeding recommended limits 80% of the emissions are due to transport, the largest source of which is diesel cars and vans.

Air pollution is the largest environmental risk to the public's health contributing to cardiovascular disease, lung cancer and respiratory disease. More than one in every 20 deaths in the UK is attributed to long term exposure to *PM2.5* air pollutants. That is the equivalent of approximately 25,000 deaths per year [45].

Long term exposure to PM contributes to the development of cardiovascular disease, lung cancer and respiratory disease and increases the risk of death. Exposure to elevated levels of *PM2.5* increases the risk of death and shortens life expectancy by several months to a few years. Short term exposure to elevated PM2.5 levels can trigger wheezing and exacerbations of asthma and bronchitis, heart attacks and heart rhythm disturbances and strokes [46] and has been linked to an increase in hospital admissions as well as deaths [47]. There is also emerging evidence linking long term exposure to *PM2.5* to the progression of Alzheimer's and Parkinson's disease, diabetes, low birthweight and developmental outcomes.

Nitrogen dioxide (NO2) at high concentrations is a respiratory irritant that can cause inflammation of the airways and shortness of breath. Studies have shown links between high concentrations of NO2 and impaired lung development and respiratory infections in children and adverse effects on adult lung function.

Older people, children and those with cardiovascular or respiratory disease are particularly vulnerable to the effects of air pollution. Exposure to air pollution is also unevenly distributed across the population with deprived communities more likely to be living near busy polluting roads. Air pollution varies substantially over small distances being typically highest near the source and can decline rapidly further away. Air pollution levels are typically as high within vehicles as outside so higher levels of air pollution are experienced not only by those who live or work on busy roads but also those who drive for a living.

Key facts:

Buckinghamshire has eight Air Quality Management Areas, where levels of pollutants do not meet the national air quality objectives. All eight AQMAs relate to excess levels of Nitrogen Dioxide and are associated with areas surrounding roads

Aylesbury Vale and Wycombe Districts each have three AQMAs, whilst South Bucks and Chiltern each have one AQMA. [48]

In Bucks, one in every 18 deaths (5.5%) is attributed to poor air quality.

In Buckinghamshire mean fine particulate matter levels (PM2.5) arising from human activity is 9.9micrograms/m3. This is comparable to England (9.9) and the South East (9.7).

The costs to society of air pollution are similar to those caused by obesity and smoking, with health related costs estimated between £22bn and £67bn and costs due to lost economic productivity estimated at almost £0.8bn.

Noise pollution

Noise is an often underestimated threat that can cause a number of short- and long-term health problems. Excessive noise seriously harms human health and interferes with people's daily activities at school, at work, at home and during leisure time. It impacts on both physical and mental health through sleep disturbance and increased stress. It is estimated that the direct health impact of noise pollution costs the UK economy over one billion pounds per year.

Noise pollution is associated with poor sleep and stress, increased blood pressure and increased risk of conditions such as heart attack, stroke and dementia. In children, exposure to noise pollution can have a negative effect on development and education with evidence showing poorer educational attainment and worse health in children exposed to higher levels of noise pollution. Children exposed to noise have poorer concentration and for every 5 decibel increase in average noise that children are exposed to, reading age decreases by two months.

In the UK, about half of the UK population live in areas where daytime sound levels exceed the recommended limit, causing adverse impacts on health. About two-thirds of the population live in areas where the night-time guidelines recommenced by the WHO are exceeded [49].

Outside night noise levels of 55 decibels (dB) plus exposure is considered increasingly dangerous for public health. About 40% of the population in EU countries are exposed to road traffic noise at levels exceeding 55 (dB) and 20% are exposed to levels exceeding 65 (dB) during the daytime; and more than 30% is exposed to levels exceeding 55 (dB) at night [46].

Noise pollution disproportionately affects the most vulnerable in society, with homes in more deprived communities exposed to higher levels of noise pollution from busy roads. In addition, the impacts of noise pollution are greater among children and older people.

People value quiet areas, with 91% identifying the importance of protecting quiet areas from an increase in noise. In Buckinghamshire, there were over 1500 noise complaints in 2014/15. The rate of noise complaints per 1000 residents is highest in Wycombe District (4.0) followed by Chiltern (3.5), Aylesbury Vale (2.0) and South Bucks (1.6).

Green spaces and the natural environment

Introduction

There is a strong body of evidence that shows that being in contact with the natural environment is vital for our mental wellbeing and physical health at all ages. People with access to good quality green space have better mental and physical health and every 10% increase in green space is associated with a reduction in disease equivalent to a gain of 5 years of life.

The natural environment also helps mitigate some of the threats to our health from air pollution, noise pollution and extreme weather events including heat waves and flooding and provides a host of social and economic benefits. Green space and views of green space encourage social connections in communities, helps children concentrate at school and helps people recover more quickly in hospital. Many studies have shown the importance of incorporating green spaces into the design of towns, cities and housing developments.

The evidence

Green spaces and health

People with access to good quality green space have better self-rated health and are less likely to be overweight and obese. Natural landscaping and surroundings have been shown to positively influence people's attitudes and motivations to be physically active and as a result people living near green spaces are more likely to be physically active with all the benefits that being active provides. Living within 500m of green spaces increases the likelihood of doing at least 30 minutes of physical activity per day. The creation or improvement of a park or open space leads to an increase in local peoples' activity levels by up to 48%.

People also make more walking trips to local amenities such as shops and cafes when they perceive there are many natural features along the route including roadside trees. In less green neighbourhoods people judge distances to be further than they are which may discourage walking.

Undertaking physical activity in green spaces appears to offer additional health benefits compared to physical activity in indoor settings, with a greater positive effect on mental health. Experiments have shown walking in natural environments results in an increase in positive emotions and a fall in blood pressure. For people with depression, exercising in the natural environment has been associated with greater feelings of positivity, increased energy and decreases in tension, confusion, anger and depression compared to exercising indoors.

The strong positive impact that exposure to green spaces has on people's mental wellbeing and mental health extends beyond just doing exercise outdoors. Clinical studies have shown that within 5 minutes of viewing a nature setting, positive changes occur in blood pressure, heart rate, muscle tension and brain activity.

Caring for natural landscapes has been shown to improve self-reported health and depressive symptoms. Exposure to green spaces reduces stress levels and depression, especially in more deprived communities.

Studies have also shown that areas with higher amounts of green space have lower levels of hospital admissions for mental health conditions, even after adjusting for other factors such as how urbanised an area is and the level of deprivation. Furthermore, when people do become unwell, being close to or having a view of greenery can help with recovery. Patients in hospital recovering from surgery have a shorter recovery time, reduced need for pain medication and lower anxiety if they can look out over green and open spaces.

Key facts:

Nearly one in every five (18%) Buckinghamshire households lives within 300m of a natural green space of at least 2 hectares, and only 58% of households live within 2km of a natural green space of at least 20 hectares.

Less than one in every five residents in Bucks (17.4%) spend time in outdoor green and open space (excluding shops and own garden) in a usual week.

Between 2013/14 and 2015/16 the proportion of adults using outdoor space for exercise or health reasons has fallen from 28.8% to 17.4%.

Buckinghamshire has over 43 hectares of open access land and a Right of Way network that spans over 3300km.

There are 1270km of promoted recreational routes across Bucks.

Green spaces throughout life

Green spaces for children and young people

The ability to participate in safe outdoor play is one of the most important benefits of green spaces for young people. It helps their physical and social development and keeps them healthy. Open spaces enable children to play freely and develop their imagination and creativity and interact with the natural environment. Play enables children to socialise and meet others from different backgrounds, contributing to a strong sense of community and helping to foster community cohesion.

Green spaces encourage children to be more physically active with benefits for their health. Parks with shaded areas have been shown to increase teenage girls' activity levels and girls' activity levels more than doubled in areas conducive to walking. Studies show that children living in deprived areas with more green spaces were less likely to be overweight and obese than children living in comparable areas with less green space.

Exposure to green spaces within and around schools is also good for children's learning, improving their levels of attention and educational attainment [51]. Travelling to school via green routes has also been linked to better memory and attention.

Green spaces also might be important at the very start of life. Pregnant women who live closer to green spaces have lower risk of low birthweight babies. For every 10% increase in green space within 100m of the home, there is an increase of up to 436g in average baby weight [52]. The effect is greater among women with lower levels of education. The effect also extends to green space that is further from the home. Having more green space within 500m of the home still has an important positive impact on birth weight.

Key facts:

In Buckinghamshire, levels of overweight and obesity among children in reception year and year six are 18% and 27% respectively.

Approximately one in every six girls (16%) and one in every four boys (23%) aged 5-15 years, in the South East of England are reported to achieve the recommended levels of physical activity.

During the week, three in every five (60.8%) children aged 15 years in Bucks spends at least 7 hours a day doing sedentary activities outside of school (e.g. playing computer games, on the internet, watching TV, etc.).

Green spaces for older people

Living close to green and open spaces is particularly important for older people, reflecting the fact that they spend a larger proportion of their time in their local neighbourhood compared to other age groups.

Research has shown that older people who lived near parks, tree-lined streets and spaces for taking walks showed greater longevity over a 5 year period and that walking in natural surroundings can boost immunity, lower stress indicators and reduced depression.

Studies have also shown the benefits of gardening for healthy ageing. Physical health was better and perceived stress levels decreased significantly among those aged 50-88 years who maintained a community garden plot compared to those who exercised indoors.

The benefits of green space are also seen for people with dementia where access to gardens improves socialisation and sleep, reduced agitation and aggression and the risk of experiencing injuries. Quality of life measures for people with dementia, their families and staff appear to improve at long term care facilities with therapeutic gardens.

Benefits to communities

Well-designed environments can encourage social interaction and facilitate the building of well-connected communities. Good natural landscaping encourages greater use of outdoor areas by residents and well managed green common spaces are very important in promoting the development of social ties in housing developments. Studies have shown that more social activities occurred in green common spaces than treeless spaces of the same size. Older adults who have more exposure to green common spaces report a stronger sense of unity among residents and a stronger sense of belonging to the neighbourhood. There is less graffiti, vandalism and littering in outdoor spaces with natural landscapes than in comparable plant-less spaces and residents in these areas also report fewer acts of domestic aggression, property crime and violence.

Protecting us from extreme weather events, air and noise pollution

Natural landscaping can help mitigate the threats to our health from air and noise pollution, flooding and heat waves. Urban greening is the process of landscaping developed areas to incorporate green infrastructure such as trees, green walls, green roofs and drainage measures.

Climate change is bringing more extreme weather events such as the heat wave that resulted in an extra 35,000 deaths across Europe in 2003 [53]. The risk to health of heat waves is particularly marked in urban areas which are prone to the 'urban heat island' effect - a phenomenon where built up areas absorb and trap heat meaning temperatures can be as much as 5° Celsius higher than rural surroundings.

The urban heat island effect can be mitigated by urban greening, using green roofs, green walls, living architecture and tree lined streets. Trees can help reduce the urban heat island effect and reduce air temperatures by 1-2° Celsius. The lower temperatures can reduce the risk of heat exhaustion, which is especially a risk in vulnerable populations such as the very young and older people. The shading effect of trees around buildings has also been estimated to reduce heating and cooling costs by 20% and use of air conditioning by up to 30% thus helping save costs, energy and reducing greenhouse gases. Green roofs also improve the energy efficiency of homes by offering additional insulation. Installing a green roof can reduce the need for cooling in the summer as temperatures under a green roof are up to 15°C cooler in summer. In winter temperatures under a green roof are 4.5°C warmer, reducing the need for heating. For older people, this can help with winter warmth and avoid fuel poverty.

Urban environments are also more at risk of flooding, due to surface run-off from paved over areas. Street trees are able to absorb up to 60% of rain water, with mature trees soaking up between 50 and 100 gallons of rainwater during a storm [54]. This reduces surface run-off and acts as a flood prevention measure. Green roofs offer similar flood protection as they can absorb up to 90% of rainwater. Rainwater absorbed by trees and green roofs is then released gradually, reducing the risk of flooding.

Urban greening is an effective strategy to improve health by improving air quality and reducing levels of noise pollution. Whilst all trees and greenery absorb air pollutants, the effect is greatest in built up areas where pollution is highest. The traffic on our streets and roads contributes to approximately 50% of air pollutants, with the highest levels in built up areas. Urban trees and greenery are able to improve air quality by absorbing airborne particulates and can cut pollution from fine particulate matter by as much as 25% [55].

It is not only air pollution that urban greening can improve. The insulation properties of green roofs extend to noise insulation, with some green roofs able to reduce noise in the home from external sounds by up to half. Living on a street with trees can also help to reduce the level noise pollution by creating a natural sound barrier.

It is estimated that the direct health impact of noise pollution costs the UK economy over £1 billion per year. Noise pollution is associated with poor sleep and stress, increased blood pressure and increased risk of conditions such as heart attack, stroke and dementia. Children exposed to noise have poorer concentration and for every 5 decibel increase in average noise that children are exposed to, reading age decreases by two months.

Using urban greening to improve health and wellbeing

In addition to the benefits described above in relation to reducing impacts of heat events, flooding and noise, residents living in areas with trees have a stronger sense of community and experience less crime and have a greater life expectancy. Living on a street with 10 extra trees improves happiness to the same extent as being seven years younger.

Residents living in housing with nearby trees and greenery have been shown to be more able to cope with major life events compared to those living in homes with more barren surroundings e.g. surrounded by concrete. Green walls also offer the opportunity to provide greenery in very small spaces, using vertical surfaces to grow plants. Green walls can also be effective ways of bringing the natural environment into indoor spaces, offering the benefits to people whilst they are inside. Having greenery indoors in hospitals and schools can improve recovery times for patients and reduce symptoms from conditions such as attention deficit and hyperactivity disorder among children.

The visual impact of green walls in public places can lower blood pressure, reduce stress and promote physical activity through creating an alluring and inviting environment. Green walls and greenery in workplaces has been linked to increased productivity, reduce common symptoms such as cough and tiredness and has been linked to improving health and food literacy.

Urban greening can also offer benefits to employees, employers and the economy. Studies have shown that having views of nearby nature can improve worker productivity and reduce stress and potentially reduce sickness absence.

Healthy Food

Introduction

Both the quality and the quantity of food and drink that we consume are important factors in determining our health. Poor diet contributes to 30% of all early death and disability in the UK [56]. A poor diet increases the risk of becoming overweight and obese, developing diabetes, suffering from heart disease or stroke and increases the risk of a range of cancers, fractures in later life and complications during pregnancy that may result in poorer outcomes for the baby.

In the South East of England, poor diet contributes to nearly 70% of disability and early death associated with heart disease, nearly half of disability and early death for diabetes, and more than a third of early death and disability due to stroke [57].

Poor diet accounts for nearly 70% of heart diseases in the South East of England

Key facts:

For diabetes, poor diet contributes to nearly half of disability and early death

More than a third of early death and disability caused by stroke is due to poor diet in the South East. [57]

Obesity is one of the main results of eating an unhealthy diet. Since the early 1990s, across England, there has been an increase in the proportion of adults considered overweight or obese, rising from 47% in 1991 to 61.3% in 2015/16. Obesity results from an energy imbalance between the amount we take in and the amount we expend. Our bodies are excellent at efficiently capturing energy from the food we eat and conserving it. As a result, weight management programmes focus primarily on the amount of food we eat compared to the amount of exercise we take. However, evidence suggests that people underestimate the amount of calories that they eat by as much as 1000 calories per day [59].

Key facts:

In Bucks nearly one in every four (23.4%) children aged 5 years has at least one decayed, missing or filled tooth (dmft).

Buckinghamshire Children aged five with any signs of dental disease have on average three teeth that are decayed, missing or filled.

Obesity is becoming an issue at earlier ages. Being overweight or obese in childhood greatly increases the risk of being an unhealthy weight in adulthood. Furthermore, by affecting people at an earlier age there is an increase in the length of time that the individual is overweight or obese and therefore at greater risk of developing complications.

Key facts:

More than one in every 15 children in reception year in Bucks is obese (6.5%), equivalent to 391 children.

Excess weight (overweight or obese) affects more than 1000 children in reception year in Bucks, equivalent to nearly one in every six children (18%).

At year 6 (10-11 years) in Bucks nearly one out of every seven children is obese (14.6%) and more than a quarter are either overweight or obese (27.2%). This is equivalent to 744 obese children and 1384 overweight or obese children.

Consuming too much sugar can cause weight gain and increases the risk of conditions like diabetes, heart disease, high blood pressure and dementia and is also one of the main causes of dental decay. Soft drinks (excluding fruit juices) are the largest single source of sugar for both adults and children providing 29% of the total sugar intake in children aged 11-18 years. For every additional sugar sweetened drink consumed per day, the risk of developing high blood pressure increases by 8%, whilst the risk of developing heart disease increases by 17% [58]. Drinking sugary drinks is also one of the main causes of dental decay in children. One in four children aged five and 12 years have dental decay and this is associated with a range of negative impacts. If everyone in England achieved the recommendation of only 5% of energy intake from sugars, the estimated savings to the NHS would be between £396-576m per year [61].

Eating a diet high in saturated fats is a major contributor to higher levels of cholesterol. Reducing saturated fat intake can help reduce cholesterol and it is estimated that if cholesterol levels were 10% lower across the whole of the UK, there would be approximately 25,000 fewer deaths every year [57].

Eating a diet high in fruit and vegetables reduces the risk of heart disease and stroke by as much as 30% [61]. Switching to a diet high in fruit and vegetables, replacing fatty foods, has also been shown to reduce blood pressure by as much as medication.

The environment and communities in which people live affects their access to healthy affordable food and influences their eating patterns.

The evidence

Eating foods from out of the home food outlets

Food bought from out of home food outlets is generally considered to be less healthy than food prepared in the home, with higher levels of sugar, fat and salt. In addition to this, portion sizes bought from out of the home food outlets tend to be larger [62].

Currently, over a quarter of adults (27%) have at least one meal per week that is bought from an out of home food outlet, either from a takeaway or restaurant. Research suggests that increased access to unhealthier food retail outlets is associated with increased weight in the general population and increased obesity and unhealthy eating behaviours in children living in low income areas. There is an association between the density of takeaway food outlets and areas of deprivation with higher densities of takeaway food outlets in more deprived areas. This issue is exacerbated by the trend towards purchasing fresh food from out of town or edge of town super markets rather than local providers. This has resulted in the phenomenon known as food deserts, which are more common in deprived communities [63].

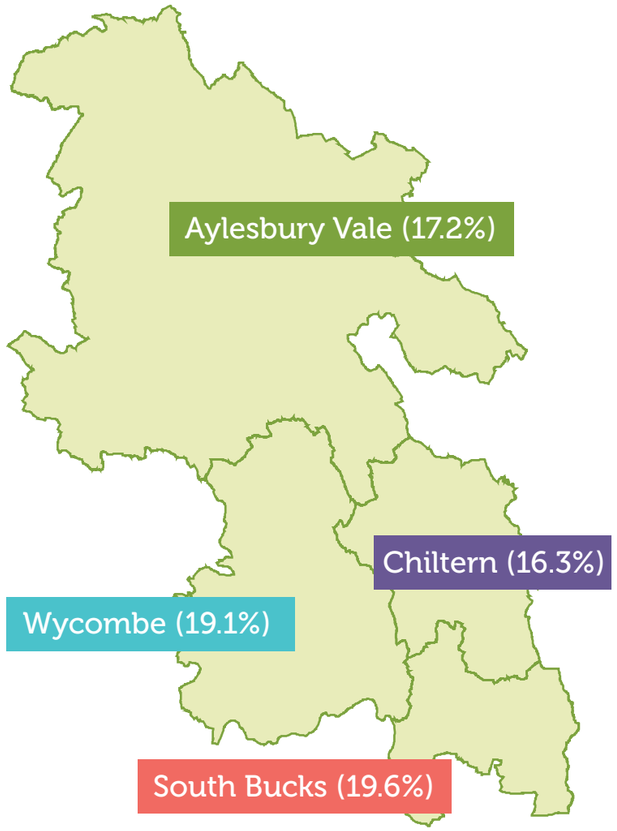
Evidence suggests that increased access to outlets selling healthier food is associated with improvements in diet and adult weight [64]. There is also evidence that providing healthy affordable food in schools is associated with improved healthier food sales, dietary behaviours and better nutrition.

There are nearly 200 fast food outlets in Buckinghamshire. However, this is likely to be a conservative estimate with some shops and restaurants also selling fast food. The highest density of fast food outlets (number of outlets per 100,000 people) is in Wycombe (64) followed by Chiltern (50) and Aylesbury Vale (49.8). South Bucks has the lowest density of fast food outlets (39.4). This compares to an average density across England of 88 fast food outlets per 100,000 people [65].

Key facts:

Among children in year 6 (10-11 years) the highest levels of excess weight are in Aylesbury Vale (28.8%), followed by South Bucks (28.5%), Wycombe (26.8%), Chiltern (23.7%)

Among adults the highest levels of overweight and obesity are in Aylesbury Vale (64.0%) followed by Wycombe (60.7%), South Bucks (54.7%) and Chiltern (52.1%)



Levels of excess weight vary by area. Among children in reception year (4-5 years) the highest levels of excess weight are in South Bucks (19.6%), followed by Wycombe (19.1%), Aylesbury Vale (17.2%), Chiltern (16.3%)

Home and locally grown foods

Community gardens and allotments offer a range of health benefits. Locally grown foods on personal and community allotments and gardens are predominantly fruits and vegetables. Growing food locally has been shown to support people to have a more balanced diet and achieve the recommended five portions of fruit and vegetables per day.

Gardening also offers opportunities to take exercise and is a great way to get outdoors and be active. Depending on the level of exertion, gardening and working on an allotment count as moderate or vigorous intensity physical activity as well as strengthening exercises. This means that gardening and working on an allotmen can help adults achieve the recommendation of 150 minutes of moderate intensity physical activity and lower the risks from conditions such as heart disease and stroke.

A common reason for people not to have a healthy diet is that they are unsure what food to eat as well as lacking confidence in preparing healthier meals. Growing your own food has also been shown to increase food and health literacy, overcoming these barriers and enabling people to improve their diets. This is particularly important in childhood and schemes teaching children to grow food in a community garden or allotments have shown improvements in food literacy [66] and reductions in overweight and obesity [67].

The mental health benefits of allotment gardening include lower levels of stress and depression through being immersed in nature, engaging with the natural environment and viewing green space. Community allotments can be used as 'horticultural therapy', and have been shown to support people with chronic pain, dementia and long term mental health conditions.

There are a number of wider benefits from allotments and community gardens including the opportunities to socialise. Allotments have long been an important aspect of British culture as a community asset, providing a different type of meeting point than other amenities such as leisure centres, shops, food outlets and town centres. Use of community allotments has been linked to lower levels of social isolation and more community networking. Community allotments have been shown to increase social networks within communities, especially in groups at high risk such as socially excluded groups, substance misusers and people with long-term physical and mental health conditions.

Summary and Recommendations

The health and wellbeing of our population is vital for the social and economic success of Buckinghamshire. Good health helps people live a satisfying life and achieve their goals. It supports children's educational attainment, adult's ability to work and everyone's ability to participate in and contribute to community life.

This report has shown the myriad ways in which the places where we grow up, live, work, play and age impact on our mental and physical health and wellbeing. It has also highlighted that key groups are more vulnerable to the impact of poor environments particularly children, older people and people with existing health problems. In addition some groups are more often exposed to poorer environmental conditions such as people on low incomes, people living in more deprived areas, older people and those with long term conditions. Communities and neighbourhoods need to be designed with this in mind to ensure they meet the needs of all residents and ensure that everyone has a chance to live as healthy a life as possible.

The impacts of our living environments on our health are wide ranging and are felt throughout life. Where we live can influence how happy we are, whether we know our neighbours and how strong the community ties are. They can also influence how well children develop and how they do at school, crime levels, fear of crime and economic productivity.

When it comes to health the impacts are far reaching. The places and communities in which we live affect our ability to live healthy lives which has a profound impact on our risk of developing a wide range of long term conditions such as high blood pressure, obesity, diabetes, heart disease, stroke, cancer and dementia. As our population ages it is more crucial than ever that our residents age well and delay or prevent the onset of long term conditions, disability and frailty. The opportunities to be active and have access to healthy affordable food also affect the health of our children and young people. Moreover, young people growing up in strong communities are more likely to adopt positive health behaviours and resist harmful patterns of behaviour.

The places and communities in which we live influence our mental wellbeing which affects all other aspects of our health and lives. The presence of strong social connections and community spirit can help protect mental wellbeing and reduce loneliness and social isolation. Well-designed neighbourhoods with welcoming places to meet that are accessible to all help improve social connections. Green spaces and places to be physically active also produce a wide range of mental wellbeing and physical benefits.

The places we live and work determine the quality of the air we breathe and the levels of noise we experience. There is good evidence that poor air quality increases the risk of a wide range of long term conditions and has a harmful impact on child health and development. Noise pollution also has a significant impact on physical and mental health. Significant sources of air pollution include road and rail traffic and construction so it is important that with housing growth and the significant infrastructure developments in Buckinghamshire that action is taken to mitigate the impact of air and noise pollution. Good spatial design can also help mitigate the health effects of extreme weather due to climate change e.g. heat waves and flooding. Good design and policies can also help reduce energy use and contribute to a more sustainable future.

Finally the provision of a wide range of quality affordable and adaptable housing is vital to our residents, helping them stay physically and mentally healthy throughout life and live in suitable accommodation as their needs change.

Improving the health of our residents makes good economic sense and reduces demand on health and social care and other public sector services. Improving health through improvements to the environment and community life has additional benefits as it helps Buckinghamshire remain a thriving and attractive place where people want to live and work, can contribute to reducing congestion, air and noise pollution, mitigating the impact of climate change and attract inward investment.

A wide range of stakeholders have a role in determining whether our environment is healthy. Communities have a key role to play in making places successful and attractive to live in. Other key partners include local authorities, developers, businesses and the public and private sector working with communities, voluntary and faith groups. Much good work is already underway across Buckinghamshire to protect and improve the places we live and to strengthen communities. There are very significant opportunities for us all to work together. This includes the recent awarding of Garden Town status to Aylesbury which offers a unique chance to ensure that as the town grows we can create well planned sustainable environments and desirable communities in which to live. There are other place shaping initiatives taking place across Buckinghamshire and opportunities to share good practice across the county and beyond.

To continue and support this good work the following recommendations are for all stakeholders including communities themselves.

Recommendations

1. The promotion and protection of the health and wellbeing of everyone who lives and works in Buckinghamshire should be a major consideration when planning new developments or improving existing developments. This should be supported by health impact assessments where appropriate, to understand the impact of these changes on health and wellbeing particularly for those most vulnerable and with the greatest risk of poor health.

2. Where possible, local authorities and developers should engage communities in co-designing new developments and making improvements to existing developments. They should ensure input from a wide range of current and future residents of all ages and abilities to ensure developments work for all. The WHO 'Age Friendly' Cities guidance and UNICEF Child Friendly Cities and Communities initiative offer useful principles to inform discussions.

3. Local authorities, communities, town and parish councils and local area forums should use this report to consider how they might work together to improve the health and wellbeing of their residents, drawing on the assets in their communities and their local knowledge of what might need to change. This could include strengthening the social ties in an area, increasing community engagement and reducing social isolation or making improvements to the built and natural environment. A useful set of questions to inform discussions is the Place Standard toolkit, using 14 questions designed to cover the physical and social aspects of a place and help determine priorities for action.

4. The public and private sector, voluntary, community and faith sector including local authorities, the NHS, schools, universities and businesses should use this report to consider how they can help improve health and wellbeing through their actions that impact on the environment and strengthen communities in Buckinghamshire. This can include the services they provide, their policies on community engagement and co-design of services with communities, travel, land use, and corporate social responsibility.

5. We should, where possible, encourage planning for new and existing developments to:

- Be socially inclusive, welcoming and accessible to all sections of our community. Designed on a human scale for people and taking into account the needs of children and older people and those with disabilities.
- Provide safe, welcoming indoor and outdoor public places where people can meet.
- Encourage physical activity, active travel and access to good public transport.
- Incorporate natural landscaping and urban greening and good access to high quality green and blue public spaces e.g. parks and community gardens that people of all ages and backgrounds can enjoy.
- Improve access to healthy affordable food.
- Be designed to help reduce crime.
- Provide healthy good quality homes using lifetime home principles and affordable housing.
- Provide good access to employment, retail and community facilities and health services which can ideally be accessed by walking or cycling through mixed land use policies.
- Minimise the impact of climate change and minimise air, water and noise pollution.
- Foster strong social connections and a sense of belonging and link new and existing communities effectively.

Appendix

Community Appraisal Tool

The Place Standard – How Good is Our Place?

The Place Standard is a way of assessing places. Whether the place is well-established, undergoing change, or is still being planned. The Place Standard tool provides a simple framework and allows you to think about the physical elements of a place as well as the social aspects.

The Place Standard is a tool that is used to assess the quality of a place. The tool pinpoints the assets of a place, as well as areas where a place could improve, helping to identify priorities for a particular place.

The tool is simple and free to use. It consists of 14 questions which cover both the physical and social elements of a place:

1. Can I easily walk and cycle around using good-quality routes?
2. Does public transport meet my needs?
3. Do traffic and parking arrangements allow people to move around safely and meet the community's needs?
4. Do buildings, streets and public spaces create an attractive place that is easy to get around?
5. Can I regularly experience good-quality natural space?
6. Can I access a range of spaces with opportunities for play and recreation?
7. Do facilities and amenities meet my needs?
8. Is there an active local economy and the opportunity to access good-quality work?
9. Do the homes in my area support the needs of the community?
10. Is there a range of spaces and opportunities to meet people?
11. Does this place have a positive identity and do I feel I belong?
12. Do I feel safe here?
13. Are buildings and spaces well cared for?
14. Do I feel able to take part in decisions and help change things for the better?

The local Place Standard Tool is available at www.placestandard.scot/start/buckinghamshire

All responses are anonymous and will be combined with other responses to develop a spider diagram (see Figure 2) to help inform local services.

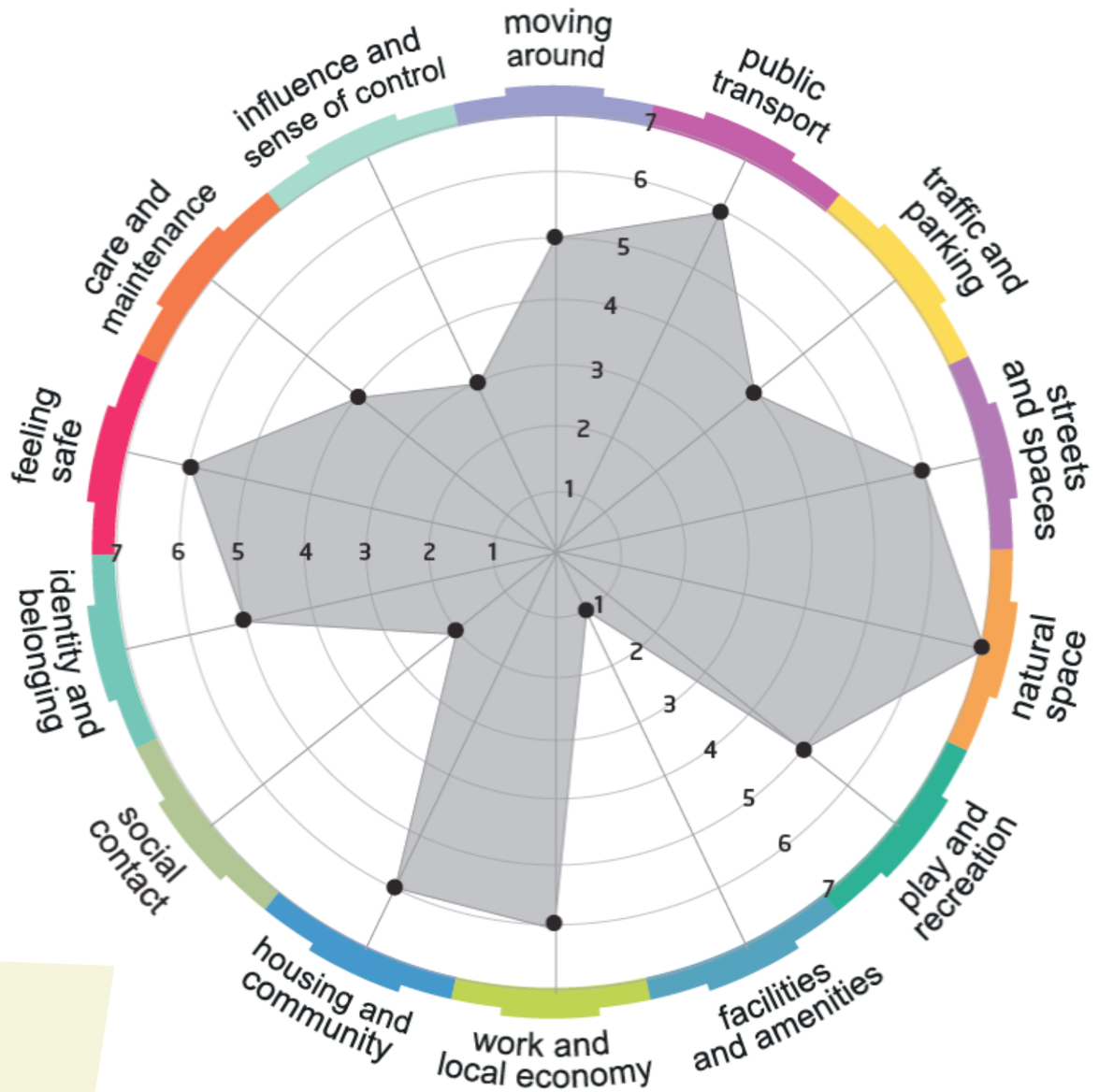


Figure 2 - Example of an assessment of a community using the Place Standard.

Appendix – Public Health Outcomes Grid

Public Health Outcomes Grid - Director of Public Health's Annual Report - Buckinghamshire 2018

Indicator		Unit	Year	Bucks		South East	England	Time series	CIPFA Peers	
Number	Name			Count	Value	Value	Value		Mean excluding Bucks	Rank 1-5 are best 12-16 are worst
Overarching										
1	Healthy life expectancy at birth (Male)	Years	2014-16	-	69.4	66.1	63.3		65.9	1
2	Healthy life expectancy at birth (Female)	Years	2014-16	-	70.3	66.3	63.9		66.4	1
3	Life expectancy at birth (Male)	Years	2014-16	-	81.9	80.6	79.5		80.6	1
4	Life expectancy at birth (Female)	Years	2014-16	-	84.9	84.0	83.1		84.0	1
Wider Determinants										
5	School readiness: % children achieving good level of development at the end of reception	%	2016/17	4,791	73.5	74.0	70.7		71.8	3
6	Sickness absence - % of employees who had at least one day off in the previous week	%	2014-16	-	2.5	2.2	2.1		2.0	14
7	Killed or seriously injured casualties on England's roads	Rate per 100,000	2014-16	722	45.5	50.6	39.7		47.7	8
8	Violent crime including sexual violence - violence offences per 1,000 population	Rate per 1,000	2016/17	5,788	11.0	19.4	20.0		16.6	1
9	Domestic Abuse related incidents and crimes	Rate per 1,000	2016/17	-	16.0	18.9	22.5		19.7	4
10	Social Isolation - % of adult social care users who have as much social contact as they would like	%	2016/17	-	45.1	46.6	45.4		46.4	6
11	Fuel poverty	%	2015	17,551	8.4	9.4	11.0		9.7	6
12	Children in care	Rate per 10,000	2017	455	37.0	51.0	62.0		46.5	5
Health Improvement										
13	Low birth weight of term babies	%	2016	157	2.8	2.3	2.8		2.3	16
14	Excess weight in 4-5 year olds (NCMP)	%	2016/17	1,088	18.0	21.4	22.6		21.3	2
15	Excess weight in 10-11 year olds (NCMP)	%	2016/17	1,384	27.2	30.6	34.2		30.3	3
16	Smoking Prevalence in adults - current smokers (APS)	%	2016	-	11.2	14.6	15.5		13.8	1
17	Excess weight in adults	%	2016-17	-	57.8	59.7	61.3		60.6	3
18	Adults reporting as physically inactive (<30 mins of moderate to high intensity physical activity/week 19+)	%	2016/17	-	17.5	19.3	22.2		20.1	1
19	Diabetes Prevalence (QOF)	%	2016/17	-	5.9	6.0	6.7		6.2	5
20	Admission episodes for alcohol-related conditions - narrow definition	Rate per 100,000	2016/17	2,594	502.6	525.1	636.4		584.9	4
21	Cancer screening coverage - Breast	%	2017	46,832	79.4	76.9	75.4		77.7	3
22	Cancer screening coverage - Cervical	%	2017	47783	74.7	73.2	72.1		74.4	7
23	Cancer screening coverage - Bowel	%	2017	47,783	60.9	61.0	58.8		61.9	10
24	Cumulative % of the eligible population offered an NHS Health Check who received an NHS Health Check	%	2013/14-16/17	57,762	44.3	45.5	48.9	N/A	48.4	10
25	Self-reported wellbeing - People with a low happiness score	%	2016/17	-	6.2	7.8	8.5		7.7	4
26	Self harm in children: Hospital admissions as a result of self-harm 10-24yrs	Rate per 100,000	2016/17	294	329.2	449.3	404.6		476.5	3
27	Average difficulties score for all looked after children aged 5-16 who have been in care for at least 12 months	Score	2016/17	-	14.3	14.6	14.1		14.7	7
28	Emergency hospital admissions for intentional self-harm	Rate per 100,000	2016/17	657	126.3	197.3	185.3		194.9	2
29	Women 6-8 weeks post-natal with an Edinburgh Post Natal Depression Score indicative of post-natal depression	%			7.3	N/A	N/A	N/A	N/A	-
30	Recorded dementia prevalence (65+)	%	Sep-17	4,333	4.3	4.2	4.3		4.2	11
31	Under 18 conceptions	Rate per 1,000	2015	101	10.4	15.0	18.8		14.8	1

Figure 3 - Buckinghamshire Public Health Outcomes Grid

Public Health Outcomes Grid - Director of Public Health's Annual Report - Buckinghamshire 2018

Indicator		Unit	Year	Bucks		South East	England	Time series	CIPFA Peers	
Number	Name			Count	Value	Value	Value		Mean excluding Bucks	Rank 1-5 are best 12-16 are worst
Health Protection										
32	Chlamydia detection rate (15-24)[1]	Rate per 100,000	2016	685	1,181.8	1,500.5	1,882.3		1588.9	14
33	Children in care with up to date immunisations	%	2017	285	95.3	80.9	84.6		75.4	1
34	Population vaccination coverage - Flu (aged 65+)[2]	%	2016/17	70,984	71.3	70.2	70.5		71.4	10
35	Population vaccination coverage - Flu (at-risk individuals)[3]	%	2016/17	27,421	48.1	48.3	48.6		48.8	10
36	HIV late diagnosis[4]	%	2014-16	36	43.4	43.4	40.1		44.7	-
37	Incidence of TB[5]	Rate per 100,000	2014-16	133	8.4	7.1	10.9		4.8	16
Healthcare and Premature Mortality										
38	Infant mortality	Rate per 1,000	2014-16	64	3.5	3.2	3.9		3.4	11
39	Under 75 mortality rate from all CVD	Rate per 100,000	2014-16	707	52.3	61.5	73.5		62.2	2
40	Under 75 mortality rate from all Cancers	Rate per 100,000	2014-16	1,529	112.8	126.9	136.8		124.5	1
41	Under 75 liver disease mortality considered preventable	Rate per 100,000	2014-16	123	8.8	13.2	16.1		12.3	1
42	Mortality attributable to particulate air pollution	%	2016	-	5.5	5.5	5.3		5.2	13
43	Directly Age Standardised Rate of Mortality in persons (aged 65+) with a recorded mention of dementia	Rate per 100,000	2016	731	710.7	840.7	867.6		820.3	1
44	Excess under 75 mortality rate in adults with serious mental illness (Indirectly standardised ratio)	%	2014/15	-	351.1	347.5	370.0		353.3	9
45	Suicide rate	Rate per 100,000	2014-16	97	7.2	9.8	9.9		9.6	2
46	Hip fractures in people aged 65 and over	Rate per 100,000	2016/17	580	572.6	560.4	575.0		568.2	8
47	Excess winter deaths Index - 3 years	Ratio	Aug 2013-Jul 2016	698	18.0	17.4	17.9		17.3	12
48	Mortality rate from causes considered preventable	Rate per 100,000	2014-2016	1,988.0	132.5	159.6	182.8		156.7	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

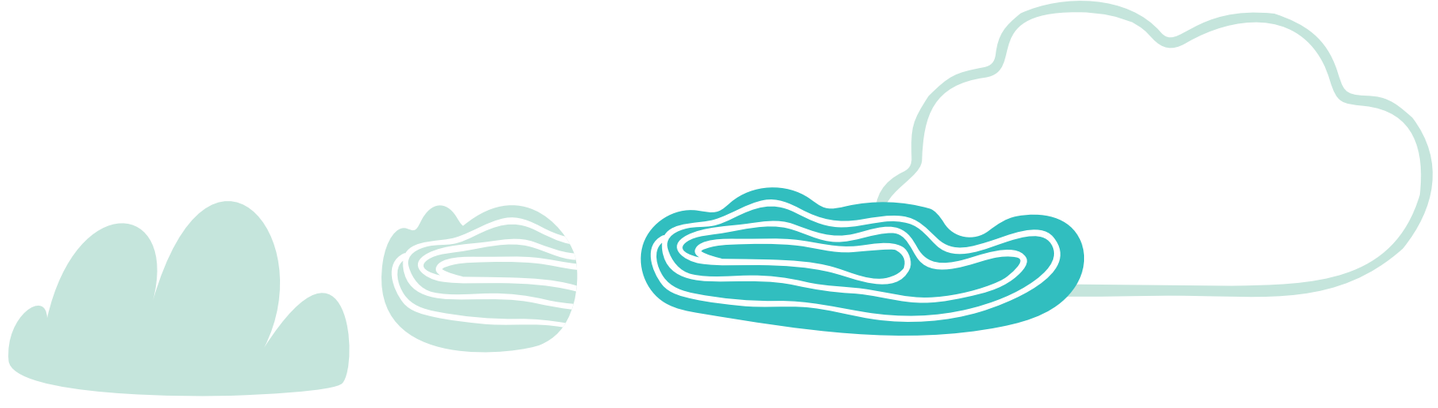


Figure 3 - Buckinghamshire Public Health Outcomes Grid

Update on recommendations from 2016 Director of Public Health Annual Report

Recommendation	Progress
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.	• Buckinghamshire CCG has commissioned a specialist Perinatal Mental Health service. This service has developed a perinatal mental health pathway in Buckinghamshire which is being promoted and embedded into everyday practice. • The health visiting service has an infant feeding specialist now in post and the service is working towards UNICEF baby friendly status accreditation. Stage 1 of the process has been achieved and the service is currently being assessed for stage 2 accreditation. • Buckinghamshire Healthcare Trust (BHT) have implemented a set of actions to improve the identification, recording and referral of pregnant women with high risk lifestyle behaviours, including: • Midwives are being supported by the CCG and healthcare providers to develop skills in delivering holistic care, including identifying high risk women and referring to appropriate services. • Pathways are being developed with new providers of lifestyle services to improve referral and care.
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.	• A 'Transition to Parenthood' pathway (from ante-natal to post-natal care) has been developed and is being implemented. The pathway for vulnerable women is in development.
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.	• The Baby Buddy app has been commissioned in Bucks with the additional ability to adapt the platform to be more specific to Buckinghamshire. • The app is promoted by maternity service and other stakeholders. Uptake and usage of the Baby Buddy app is regularly monitored and information is used to target its promotion in areas with higher need and poor uptake. • Buckinghamshire Family Information Services provides national and local information and sources of support during maternity and parenthood is included. • A local tool to support signposting to relevant information sources and services is being developed for non-healthcare staff and volunteers in contact with pregnant women and families with young children. This includes signposting for services relating to lifestyle factors, social issues, mental health concerns and domestic violence.

Recommendation	Progress
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.	• BHT has reviewed the process of identifying and recording relevant information on pregnant women and has implemented a process to improve data accuracy and completeness. • BHT is working with the new lifestyle service provider to improve data collection. • The maternity and health visiting services have implemented a number of actions to improve the completeness and accuracy of data related to breastfeeding. • Key indicators related to physical and mental health of mothers and babies are included in the Health and Wellbeing Board Performance Dashboard. These include indicators assessing: • Maternal mood • Smoking status at the time of delivery • Low birth weight of term babies • Infant mortality.
5. Buckinghamshire County Council should work closely with schools to explore how the new RSE/ 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.	• A PSHE lead has been in post since December 2017. PSHE training sessions have been organised and delivered for primary and secondary PSHE school leads, and primary and secondary school PSHE forums (12 secondary and 20 primary leads plus other PSHE teachers have attended). These sessions have been facilitated by the PSHE lead and have resulted in increasing engagement from schools and improved sharing of practice and models. This will inform the report to be produced by the PSHE lead. • A PSHE webpage has been set up which is available to all PSHE staff in schools. A termly newsletter is sent to schools to update them on the latest local and national updates. • An increasing number of schools have joined the PSHE association which provides resources, tools and expert advice. • A response to the Relationship and sex education consultation was made and the consultation was circulated to schools. The PSHE lead has encouraged schools and pupils to respond to the consultation.
6. Partners should consider how they can contribute to improving outcomes for babies, mothers and families in Buckinghamshire.	• The Health and Wellbeing Board hosted a workshop in October 2017 with over 50 delegates attending from a range of key organisations across Bucks including the councils, healthcare providers, healthcare commissioners and the voluntary and charitable sector. The workshop focussed on identifying activities that would improve outcomes for mothers, babies and families in Buckinghamshire with a particular focus on those with poorer outcomes. • Individuals and organisations attending the workshop who were able to contribute to further developing and implementing activities and projects were identified and, where appropriate, engaged in the activities above.

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Health & Wellbeing Board
Buckinghamshire

Title	Director of Public Health Annual Report Healthy Places, Healthy Futures – Growing Great Communities
Date	27 September 2018
Report of:	Director of Public Health Dr. Jane O'Grady
Lead contacts:	Dr. Jane O'Grady 01296 387423

Purpose of this report:
This report presents the Director of Public Health Annual Report and asks the Health and Wellbeing Board and its member organisations to identify the actions they will take in response to the recommendations in the report.

Summary of main issues:
It is a statutory duty for the Director of Public Health to produce an annual report on the health of their population. While it is the duty of Buckinghamshire County Council to publish the report, the report is an independent report for all partners in Buckinghamshire.

The theme of this year's annual report is the vital importance of the places and communities in which people live to their health and wellbeing. This is particularly relevant at a time when the population of Buckinghamshire is growing, changing and ageing and there are plans for significant housing growth and infrastructure developments in Buckinghamshire over the next 20 years. It is estimated that health care accounts for only 10 to 25% of our health and that the social, economic and physical environment accounts for at least 60%. The focus of this report is closely aligned to Priority 5 in the Buckinghamshire Health and Wellbeing Strategy "S*upport communities to enable people to achieve their potential and ensure Buckinghamshire is a great place to live*"

Where we live can influence how happy we are, whether we know our neighbours, how strong community ties are and our opportunities to live healthy lives. It can also influence how well children develop and how they do at school, crime levels, fear of crime and economic productivity. All these factors interact and can influence our health and risk of developing a wide range of long term conditions such as high blood pressure, obesity, diabetes, heart disease, stroke, cancer and mental health problems.

The report sets out a brief overview of the health and wellbeing of Buckinghamshire residents, and focuses on six areas of the physical and social environment that play an important role in health and wellbeing: community life; housing; healthy travel; air and noise pollution; healthy food; and the natural environment.

The report also identifies that children, older people and people with existing poor health are more vulnerable to the impacts of adverse living conditions such as damp or cold housing, air and noise pollution and certain groups are also more likely to be exposed to adverse environmental conditions such as people on low incomes.

The report also includes an update on the recommendations from last year's annual report and an executive summary.

On average Buckinghamshire residents are some of the healthiest in the country but too many people are still living with potentially avoidable disability and long term conditions such as diabetes, heart disease and stroke. It is possible to prevent or delay the onset of a wide range of long term conditions by altering the way we live our lives and the places we live.

Improving the health of our residents makes sound economic sense and reduces demand on health and social care and other public sector services. As our population grows and ages it is more crucial than ever that all our residents start well, live well and age well to help everyone achieve their potential and get the most out of life and delay or prevent the onset of ill health. Planning for and investing in the health of our population should be regarded as a key infrastructure investment in our Buckinghamshire and take the same long term view as planning for other county infrastructure.

A wide range of people and organisations can influence whether the places we live promote or harm our health including residents and communities, community, voluntary and faith groups, local authorities, developers, schools, businesses and the NHS. The report highlights the importance of involving residents of all ages and abilities in designing and shaping the places they live and identifies several useful resources which can be used by communities to help identify and prioritise improvements they might want to make.

This report aims to stimulate conversations and action across partners and communities in Buckinghamshire to promote health and wellbeing through influencing the environments in which we live and makes several recommendations for all partners.

The recommendations in the Director of Public Health Annual report are:

1. The promotion and protection of the health and wellbeing of everyone who lives and works in Buckinghamshire should be a major consideration when planning new developments or improving existing developments. This should be supported by health impact assessments where appropriate, to understand the impact on health and wellbeing of these changes, particularly for those most vulnerable and with the greatest risk of poor health.

2. Where possible, local authorities and developers should engage communities in co-designing new developments and making improvements to existing developments. They should ensure input from a wide range of current and future residents of all ages and abilities to ensure developments work for all.

3. Local authorities, communities, town and parish councils and local area forums should use this report to consider how they might work together to improve the health and wellbeing of their residents, drawing on the assets in their communities and their local knowledge of what might need to change.

4. The public and private sector, voluntary, community and faith sector including local authorities, the NHS, schools, universities and businesses should use this report to consider how they can help improve health and wellbeing through their actions that impact on the environment or strengthen communities in Buckinghamshire. This can include the services they provide, their policies on community engagement and co-design of services with communities, travel, land use and corporate social responsibility.

5. We should, where possible, encourage planning for new and existing developments to:

    - Be socially inclusive- welcoming and accessible to all sections of our community. Designed on a human scale for people and taking into account the needs of children and older people and those with disabilities.
    - Provide safe, welcoming indoor and outdoor public places where people can meet.
    - Encourage physical activity, active travel and access to good public transport.
    - Incorporate natural landscaping and urban greening and good access to high quality green and blue public spaces e.g. parks and community gardens that people of all ages and backgrounds can enjoy.
    - Improve access to healthy affordable food.
    - Be designed to help reduce crime.
    - Provide good quality homes using lifetime home principles and affordable housing.
    - Provide good access to employment, retail and community facilities and health services which can ideally be accessed by walking or cycling through mixed land use policies.
    - Minimise the impact of climate change and minimise air, water and noise pollution.
    - Foster strong social connections and a sense of belonging and link new and existing communities effectively.

Recommendation for the Health and Wellbeing Board:

- The Health and Wellbeing Board is requested to note the Director of Public Health Annual Report and endorse the recommendations
- Members of the Health and wellbeing Board are requested to identify how their organisation can contribute to improving the health of our population through their actions on the key areas identified in the report and responses to the recommendations

- The health and wellbeing board is requested to agree its role in taking forward and monitoring the recommendations of the DPH annual report

Background documents:

http://www.healthandwellbeingbucks.org/resources/Councils/Buckinghamshire/public-health/DPHAR/Healthy%20places,%20healthy%20futures%20DPHAR.pdf

http://www.healthandwellbeingbucks.org/resources/Councils/Buckinghamshire/public-health/DPHAR/Executive%20Summary.pdf

Title	Children's Services Update
Date	Thursday 27th September
Report of:	Tolis Vouyioukas - Executive Director Children's Services Cllr Warren Whyte - Cabinet Lead for Children's Services Cllr Mike Appleyard – Cabinet Member for Education and Skills
Lead contacts:	Richard Nash – Service Director, Children's Social Care Sarah Callaghan – Service Director, Education

Purpose of this report

1. To provide the Health and Wellbeing Board with an update on the Children and Young People's Strategic Partnership and the key headlines within Children's Services.

Recommendation for the Health and Wellbeing Board

2. To note the key developments within the service and the specific issues identified in relation to children's health and wellbeing.

Children's commissioner

3. Following his appointment in March 2018, the DfE appointed commissioner, John Coughlan has completed his 3 month review of Children's Services. His main findings included:

    a. A significant amount of work is required to establish and normalise good social work and child care practice across the organisation.
    b. Good early progress is being made but unquestionably this engagement needs to be made more systematically and then sustained relentlessly.
    c. Previous officer leadership had driven a hard and data based approach to performance management which did not take sufficient account of the quality of practice.
    d. Changes to practice are already being implemented, supported by changes in performance and quality assurance.
    e. Changes are being driven at pace but nobody should be under any illusions that there are quick fixes as the scale of the necessary improvement is significant.

4. The commissioner's recommendation to the Department for Education is that there should be no alternative delivery model in Buckinghamshire and that the Council should retain its Children's Services. The current direction of travel should be endorsed in terms of the internal leadership's improvement planning. That said, he recommends that some external support should be commissioned. A primacy should be placed on the support and development of front line managers and staff, balancing a firm application of consistent high standards with a systematic range of mechanisms to ensure those managers and staff are closely involved in and own the improvement process.

Ofsted Action Plan Update

5. Following the Ofsted inspection, a significant amount of immediate remedial action has been taken to establish a firm base for improvement within the service. 97% (35 of 36) of immediate actions set out within this high level action plan have been progressed, with many ongoing as a continuous, integral part of the delivery of our services.

6. The most recent review of progress against the identified improvement actions show that

the majority have been progressed satisfactorily. On the whole, there is more to do to improve compliance across the service. On their own, however, these do not necessarily demonstrate to what extent children, young people and their families are experiencing improved outcomes.

Ofsted monitoring visit

7. Following the November 2017 inspection of Children's Social Care, Ofsted have recently conducted a two-day monitoring visit in July. During this visit, inspectors reviewed the progress made in the following areas:

    a. Thresholds for working with children in need.
    b. The recognition, understanding and response to risk for children in need.
    c. The quality of direct work with children and parents, and the links between this work and children's plans.
    d. The quality of plans, the quality and timeliness of arrangements for the review of children's progress, and the understanding that children and their families have of these plans, and of what needs to improve.
    e. The quality of management oversight and supervision, particularly in the following areas: assessing the impact and progress of work; support for social workers to address any difficulties in working effectively with families; and the guidance and support provided to social workers in their direct work with children.
    f. The speed and decisiveness of the response to escalating risks.
    g. The effectiveness of the quality assurance of social work with children in need.

8. Inspectors considered a range of evidence, including case files, meetings with social workers and managers, discussions with senior managers and analysis of other documentations and data. The key findings are shown below:

    a. From a very low base, the local authority is making some early progress in improving services for children and young people who are the subject of a child in need plan.
    b. Senior leaders have a clear and well-informed understanding of the significant weaknesses in the quality of work with children in need. Plans to improve practice are credible and well devised. Senior managers are strongly committed to moving forward at a realistic pace, and are determined to achieve rapid and sustainable improvements in children's circumstances and outcomes.
    c. While the impact of most social work remains too weak, there are encouraging signs of early improvement, underpinned by realistic plans to build on this foundation.
    d. The majority of social workers who spoke with inspectors said that they have opportunities to express their views, and that recently appointed permanent senior managers are more visible, responsive, approachable and practice orientated. Staff expressed cautious optimism that practice is slowly improving, and that the culture is increasingly transparent.
    e. Caseloads are too high, and this limits the time that social workers have available to spend working directly with children and their families.
    f. The quality and impact of management oversight and supervision are too variable: managers do not consistently support and assist social workers to evaluate and build an improved understanding of the needs of children.
    g. Not all risks are fully recognised or understood, and this leads to failures and delays in the safeguarding of a minority of children. Some children's cases continue to be stepped down too quickly before children's circumstances and outcomes sustainably improve.
    h. Most child in need plans lack focus and specificity and do not achieve purposeful, timely and measureable outcomes for children. Most contingency plans are too vague and generic and are not tailored to individual children's circumstances.

Children and Young People's Strategic Partnership

9. The Children and Young People's Strategic Partnership brings together partners from children's services, health, the police and the voluntary sector to work together to improve outcomes for children and young people across the county. This is achieved by delivering the key priorities of the children and young people's plan as well as reducing duplication and improving coordination of services across the partnership.

10. The Children and Young People's Plan identifies the vision and priorities of the Partnership and sets out how all those working with families in Buckinghamshire aim to help them improve their lives. The vision and priorities inform and be reflected in the plans of all those working with children, young people and families in the county and steer the commissioning intentions and the resource allocations of appropriate partner organisations.

11. The Plan covers children and young people aged 0 to 19 years and up to 25 years for those with special educational needs and disabilities or using after care services. The Plan does not include everything we will be doing, but concentrates on the outcomes and priorities which will make the biggest difference to children, young people and families in Buckinghamshire.

12. The Plan aims to support the delivery of the following outcomes for children, young people and families:

    a. Children and young people are safe.
    b. Children and young people live fulfilling lives.
    c. Children and young people are healthy.
    d. Children and young people reach their potential in education and in other aspects of their lives.
    e. Children, young people and families are resilient and build their own solutions – this connects with all four of the below priorities.

    The priorities which will drive these outcomes are:

    a. Keep children and young people safe and in their families wherever possible.
    b. Enable and support children, young people, parents and carers to overcome the challenges they may face.
    c. Improve children and young people's health and well-being.
    d. Provide opportunities for children and young people to realise their full potential.

13. The Plan is due to be updated and revised before the end of the calendar year.

Special Educational Needs and Disabilities (SEND)

14. Work continues to improve support provided to children and young people with SEND. Compliance with the 20 week Education, Health and Care Plan (EHCP) statutory timescale continues to rise with 60% of Education Health and Care Plans being issued on time in June 2018. This is an increase from 6.5% in January 2018.

15. A training programme has been delivered to SEN officers to equip them with the skills to work effectively with families. This training programme included input from Buckinghamshire parents who were able to provide feedback on their experiences to increase understanding.

16. Quality Assurance work continues and plans are being developed to join up with the Beyond Auditing initiative currently being implemented by Social Care colleagues. This

will ensure the child's journey is looked at holistically through many different lenses and provide consistency of approach.

17. We continue to await the SEND inspection conducted by the Care Quality Commission and Ofsted. The next potential date for inspection is 10th September and then every Monday thereafter, excluding school holidays.

Schools

18. The Side by Side initiative continues to grow with opportunities now for schools to learn from each other as part of a peer led school improvement model. These opportunities include supporting secondary schools who are not yet graded "good" by Ofsted to identify areas for improvement and work with colleagues from across the school community to raise standards.

Buckinghamshire Integrated Care System

Better Care Fund, Improved Better Care Fund and Delayed Transfers of Care

Jane Bowie, Service Director, CHASC (Communities, Health and Adult Social Care) , Buckinghamshire County Council
Debbie Richards, Chair Buckinghamshire Accident & Emergency Delivery Board

September 2018

Better Care Fund Plan – Update

Refreshing our Plan for 2018/19

The national current Better Care Fund framework (BCF) is a 2 year plan from 1 April 2017 to 31 March 2019.

We have had the opportunity to refresh our plan at the mid point. The guidance on the refresh made it mandatory to refresh the Delayed Transfers of Care (DToC) target in line with the “national expectation”.

We retained the other BCF National Metrics in line with our original BCF Plan.

We took the opportunity to make minor amendments the 18/19 budget to reflect the efficiencies delivered through recommissioning and contract renegotiation achieved in 17/18. Our revised plan was agreed through Integrated Commissioning Executive Team (ICET) partners and submitted following discussion with Natalie Jones, (regional Better Care Manager) to NHSE.

Changes to the DToC Metric

The national expectation for DToC in 2018-19 is that the number of hospital beds occupied by people whose transfer has been delayed, should not average more than 4,000 by end September. This national expectation reflects the Government's Mandate to NHS England for 2018-19 setting an ambition for reducing DToC, to be met through partnership working between the NHS and local government.

The contribution that each system needs to make to achieve the national ambition has been established at the Health and Wellbeing Board level.

Health and care partners were set a target based on their 17/18 performance and the level of challenge was related to the distance they were from achieving their 17/18 target.

The target is to be achieved by Sept 2018 and performance sustained for the remainder of 18/19.

Buckinghamshire DToC Targets

	NHS average days delayed	Adult social care average days delayed	Joint average days delayed
Target from Sept 2018	24.9	6.8	0.1
Reported June 2018	41.5	10.9	0.6
Current distance from target	> 16.6	>4.1	>0.5
For comparison performance in June 2017	41.7	5.5	1.03

Buckinghamshire DToC Targets

DToCs don't exist in isolation and we are also focusing on individuals who have an extended length of stay. These are identified as those patients who are in hospital longer than 7 days and those in hospital longer than 21 days

A programme of work is underway with the Red Cross and NHS Improvement which is designed to target patients who remain in hospital for longer than expected. It is anticipated that this will:-

- Improve patient flow and reduce the numbers of stranded and super stranded
- Reduce DToCS
- Improve process

We are aligning this extra capacity with our existing Red Cross Home to Hospital service

Challenges

- On a monthly basis the most days delayed are caused by the wait for non acute NHS interventions
- The next most significant contributing factor is waiting for both health and social care packages of care
- Frimley NHS Foundation Trust has more DToCs amongst its Buckinghamshire residents than our residents in Buckinghamshire NHS Trust (BHT).
- The wait for Care Package In Home remains the most usual reason for delays attributable to Adult Social Care.
- Some lengthy delays have been as a result of individual patients with complex needs in mental health settings requiring specific follow on support

Some delays are system driven and a range of activities are in place to address these. Some delays result from the ways we are working with service users and their families. Examples of this include:-

- Clients who self fund their ongoing care needs, staying in a hospital bed whilst they identify their ongoing placement
- Wait for practical problems to be addressed, e.g. waiting for major adaptations

System wide activities

High Impact Change activities – a set of activities which have an evidence base and are being implemented across the NHS, including:-

- Early discharge planning - Established
- Systems to monitor patient flow - Established
- Multi-disciplinary discharge teams - Plans in place with a view to establishing by Q3
- Home first/discharge to assess – Plans in place
- Seven day service – Plans in place
- Focus on choice - Established
- Enhancing health in care homes – Established
- Trusted Assessor - Plans in Place

Progress and performance is reported to the Accident and Emergency Delivery Board.

System wide activities

- NHS Improvement is currently supporting BHT as a critical friend to identify opportunities for system improvements in relation to discharges and process
- Improving digital connectivity and partnership working with health and care partners in Frimley Hospitals Trust to improve our efficiency
- QIPP – Quality, Innovation, Productivity and Prevention targeted programmes of work to improve performance
- Daily 09:00 medically fit call with SMH (which includes Clinical Commissioning Group (CCG) presence) to discuss all patients on the medically fit list.
- Review of Community Care Co-ordination Team triage process for Rapid Response and Intermediate Care (RRIC) and reablement due to take place in next 2/3 weeks.
- A system-wide Discharge to Assess (D2A) business as usual model proposal to ensure opportunities within existing resources are maximised.
- DToC escalation framework has been presented to ICET and to be routed through the system wide Accident & Emergency delivery group and board. This process will support timely discharge and escalation as appropriate.
- Urgent and Emergency Care (UEC) STP (Sustainability and Transformation Plans) funding to support projects to help reduce long stayer patients in the acute has been secured for the Bucks system. The three high impact changes agreed:
  - Introduction of Action Squad, supported by BHT, Community Services and ASC reviewing patients over 21 days on a daily basis
  - Weekly Escalation Call with Chief Nursing Officer, Chief Operating Officer BHT, Director ASC, CCG – a review of the top10 longest stay patients across the Trust
  - A review of the Choice Policy and it's comprehensive implement of this and introduction of electronic record to monitor use, followed by refresher training for all staff

Health and Wellbeing Board is asked to:-

- Confirm reporting to continue quarterly from Integrated Commissioning Executive Team to the HWB

- Confirm that ICET will continue to oversee the preparation and submission of Quarterly BCF returns


Just 10 days in hospital leads to the equivalent of 10 years' ageing in the muscles for people over 80.*
NHS
We've pledged to do everything we can to keep our elderly people safer, and out of hospital, where appropriate.
What will you do?
NHS Aylesbury Vale and NHS Chiltern Clinical Commissioning Groups
*Functional impact of 10 days of bed rest in healthy older adults. J Gerontal A Biol Sci Med Sci.2008

Health & Wellbeing Board Buckinghamshire

NHS Health Checks in Buckinghamshire

27th September 2018

www.buckscc.gov.uk/healthandwellbeingboard

To cover:

1. Summary of the NHS Health Check programme
2. How are NHS Health Checks delivered in Buckinghamshire?
3. Who is taking up NHS Health Checks?
4. Outcomes from NHS Health Checks
5. Emerging evidence on NHS Health Checks
6. Challenges
7. Recommendations

1. Summary of the NHS Health Check Programme

- The NHS Health Check is a mandatory health check-up for adults in England
- People who are in the 40-74 age group without a pre-existing condition, are invited for a free Health Check every five years
- The aim is to invite 20% of eligible people every year over a five year period.
- It's designed to identify modifiable risk factors for major causes of early death and disability such as stroke, kidney disease, heart disease, type 2 diabetes, dementia and offers opportunities to prevent them.
- Cardiovascular disease is one of the conditions most strongly associated with health inequalities as the risk factors such as smoking, physical inactivity and obesity are greater in lower socio-economic groups.

2. How are NHS Health Checks delivered in Bucks?

Public Health England determine the total eligible population at the start of each year

The Bucks Public Health team notifies practices of the number of people to invite each year

Practices use their IT systems to identify who to invite from their lists

Practices send out invitations

The majority of NHS Health Checks are delivered by primary care by practice nurse or health care assistants

www.buckscc.gov.uk/healthandwellbeingboard

Health & Wellbeing Board Buckinghamshire

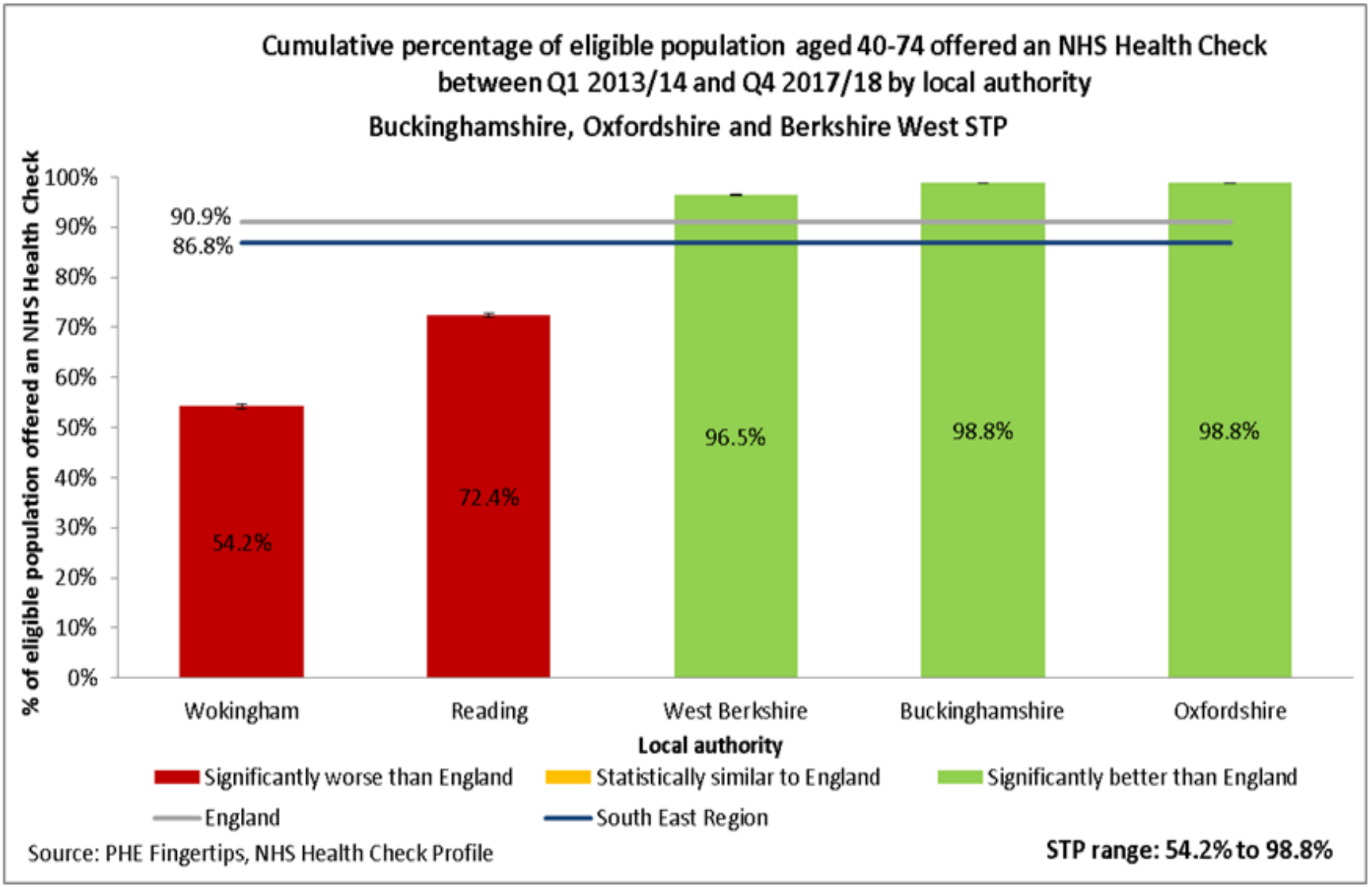
2.1 How are NHS Health Checks delivered in Bucks – Cont.

- There were 161,700 people eligible for an NHS Health Check over the 5 year period (2013/18) – on average 31,000 people each year.
- 98.8% of eligible people in Bucks were invited for an NHS Health Check over a 5 year period (one fifth invited every year).
- Of those that were invited, 45.8% of people took up the offer and received an NHS Health Check (48.7 % England average).
- In addition to NHS Health Checks in primary care, the new 'Integrated Lifestyle Service' delivers outreach NHS Health Checks, targeting hard to reach and higher risk groups.
- Each year, a Public Health campaign is run to raise awareness of the programme.

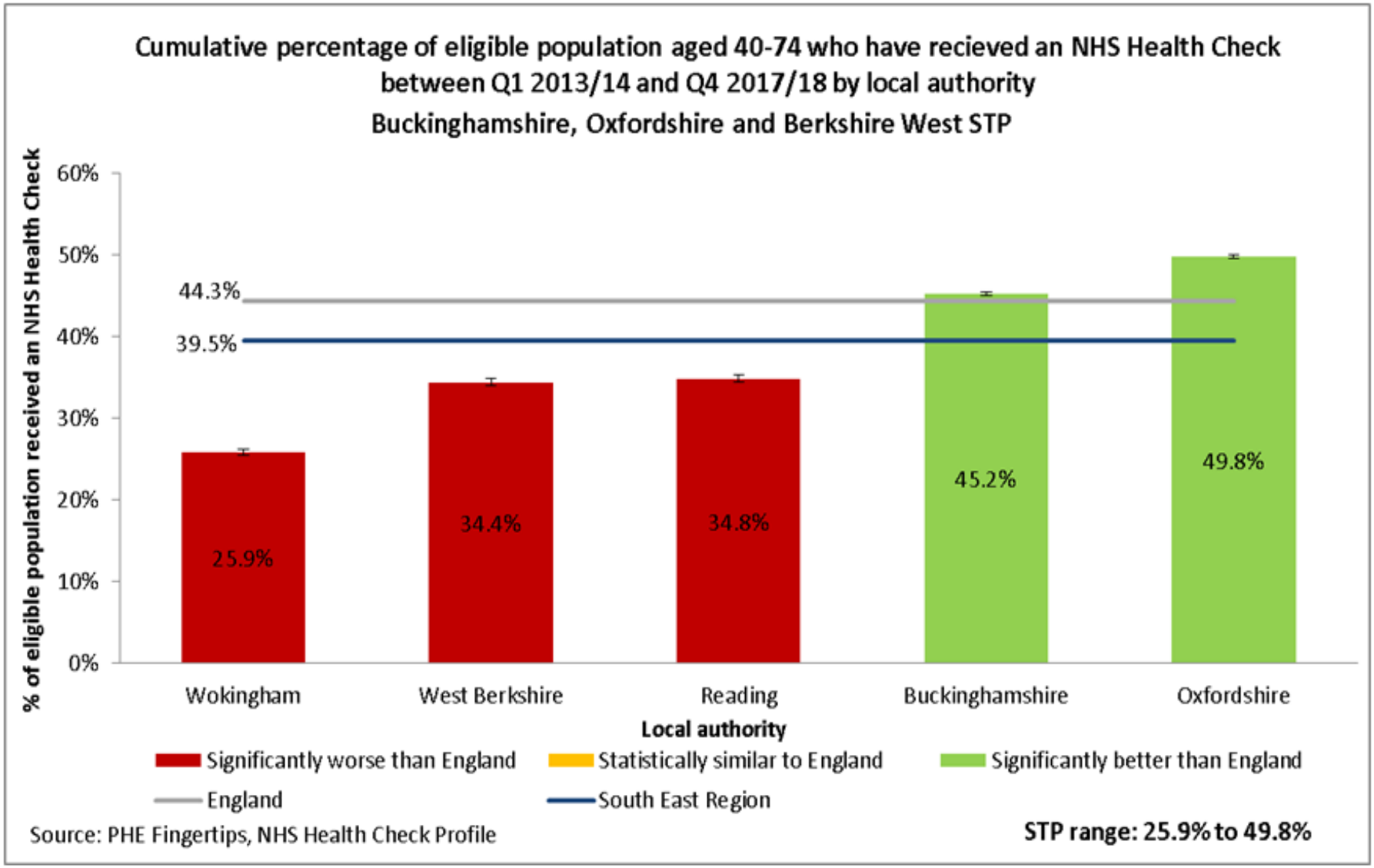
Year	No of People Invited	No of Health checks delivered	% Uptake
2013/14	31,625	14,037	44.4
2014/15	35,167	15,214	43.3
2015/16	32,616	14,400	44.2
2016/17	31,083	14,111	45.4
2017/18	27,965	14,820	53.0
Total	158,456	72,582	45.8

Health & Wellbeing Board Buckinghamshire

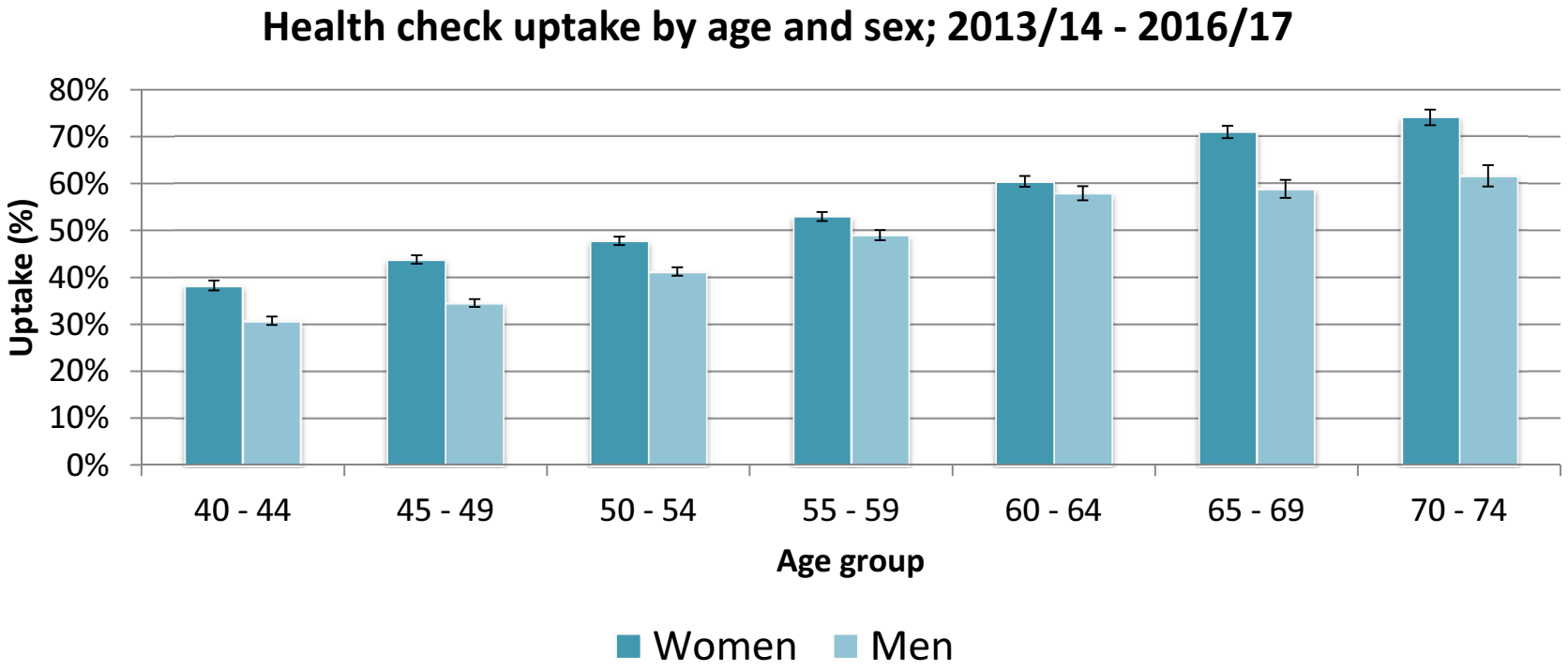
NHS Health Checks Offered



NHS Health Checks Received



3. Who is taking up NHS Health Checks?

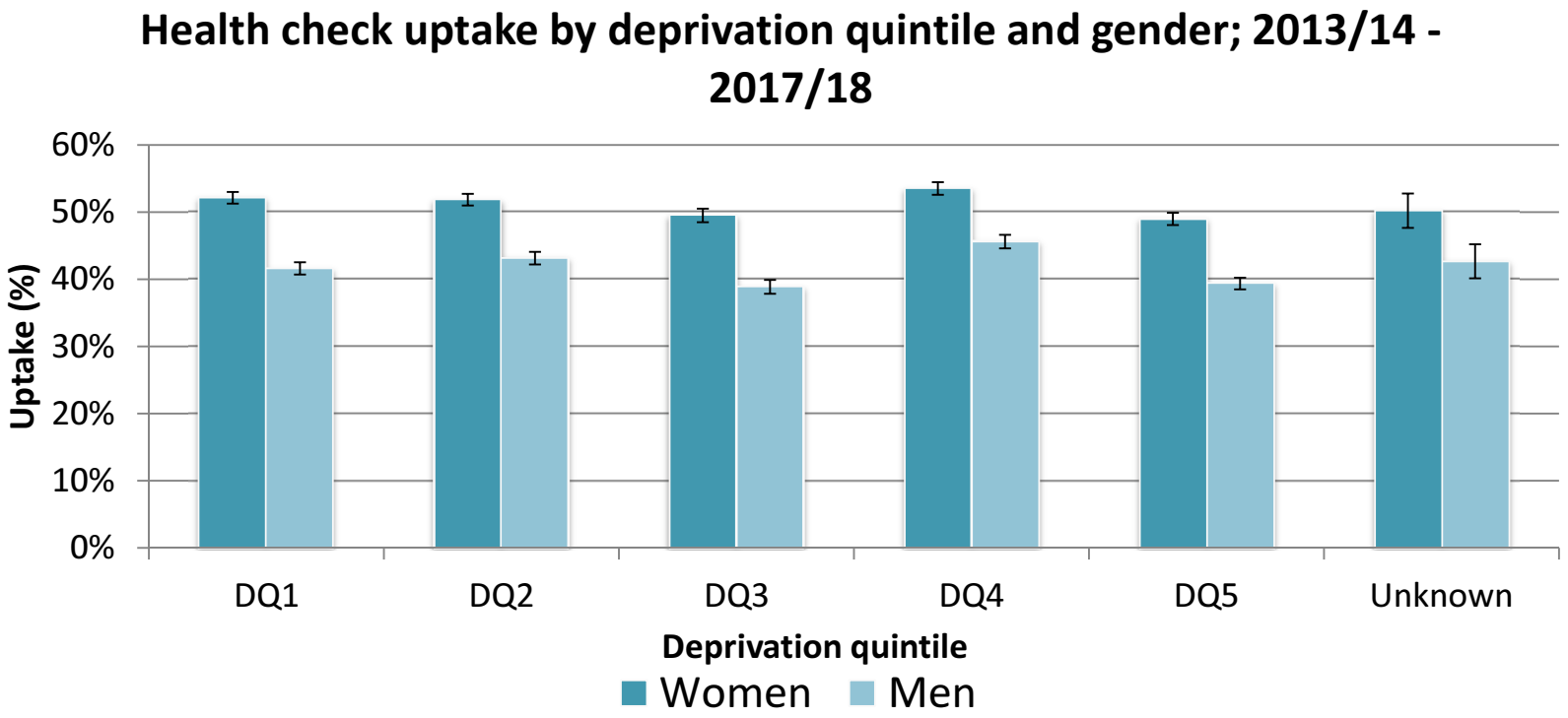


- Uptake is higher among women across all age groups
- Highest uptake is among older age groups.

www.buckscc.gov.uk/healthandwellbeingboard

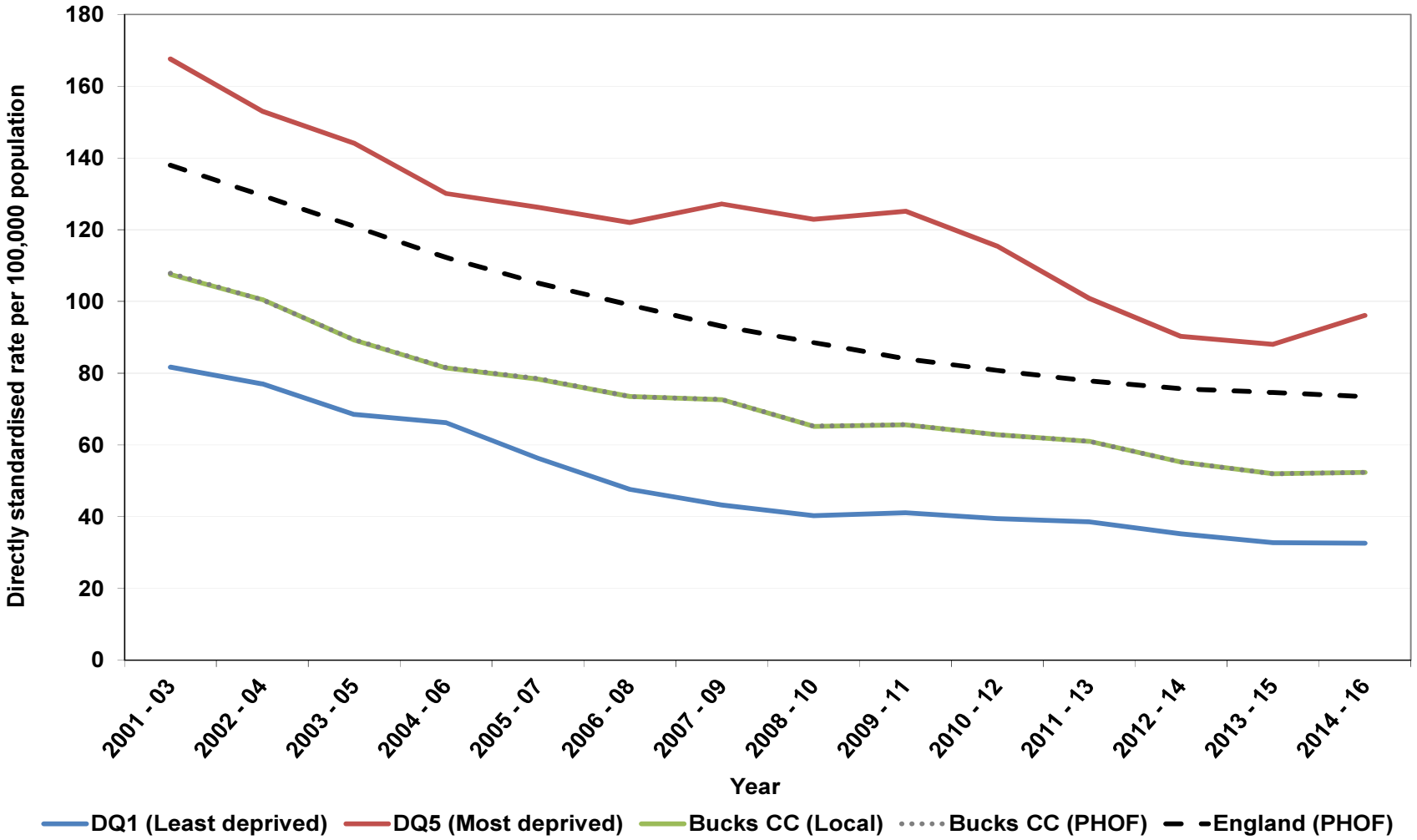
Health & Wellbeing Board Buckinghamshire

3.1 Who is taking up NHS Health Checks? – Cont.



- Uptake is similar across deprivation quintiles

Under-75 mortality rate from all CVD by Bucks deprivation quintiles, 2001-03 to 2014-16.



Source: ONS Annual District Death Extract and Primary Care Mortality Database.

3.2 Who is offered NHS Health Checks?

29,829 people were invited for NHS HC by Primary Care (2016/17)

- Of those, 22,812 people had their ethnicity recorded (77%)

Of those with recorded ethnicity:

- 17,052 people were White British (75%)
- 3,072 people were from Other White background (13%)
- 2,688 people were from BME communities (12%), of those, 1,598 (60%) were Asian

Of those invited for health checks, the uptake was:

- 60% among White British (10,256)
- 36% among other White background (1,103)
- 56% among the BME groups (1,598), of those 914 (61%) were Asian

Ethnicity	NHS HC Offered		NHS HC Uptake	
	Number	%	Number	%
White British	17,052	75%	10,256	60%
Other White	3,072	13%	1,103	36%
BME	2,688	12%	1,506	56%

4. Outcomes of the NHS HC Programme In Bucks (2013/18)

- **2,975** individuals were identified as being at high risk of developing cardiovascular disease in the next 10 years
- **14,556** individuals had a raised BP >140/90 at the check
- **2,951** individuals were identified as having elevated blood glucose levels
- **6,634** people with elevated blood cholesterol

- **38,679** individuals were identified as overweight or obese individuals
  - 6% were referred to services.

- **12,050** inactive individuals
  - 43% received brief intervention
  - 14% received signposting to services
  - 4% were referred to services

- **7,380** people were identified as smokers
  - 65% of these received cessation advice
  - 10% were referred to smoking cessation services

4.1 Outcomes of NHS Health Checks 2013/18

Identified Risk Factors	
High Risk Individuals	1 in 21
Raised Blood Glucose	1 in 21
Raised Cholesterol	1 in 9
Smokers	1 in 8
Raised BP	1 in 4
Physically inactive	1 in 5
Obese or Overweight	1 in 2

5. Emerging evidence (The National Programme)

Each year NHS Health Check can on average:

- Result in approximately **1,000** people at age 80 years being free of cardiovascular diseases, dementia, and lung cancer
- **Prevent 1,600 heart attacks** and save 650 lives
- **Prevent 4,000 people** from developing **diabetes**
- **Detect** at least **20,000 cases** of **diabetes** or **kidney** disease earlier

- The detection of chronic kidney disease, familial hypercholesterolemia, hypertension and type 2 diabetes is significantly more frequent among people who have had an NHS HC.

- There is good evidence that statin prescribing rates are significantly higher – by around 3-4% among people having an NHS HC compared to non-attendees. Similar trends have been reported for anti-hypertensives

https://www.healthcheck.nhs.uk/commissioners_and_providers/evidence/

5.1 Emerging evidence/The National Programme -Cont.

- Optimal anti-hypertensive treatment of diagnosed hypertensives averts within 3 years:
  - 9,710 heart attacks, saving up to **£72.5 million**
  - 14,500 strokes, saving up to **£201.7 million**

- Optimally treating high risk AF patents averts within 3 years:
  - 14,220 strokes, saving up to **£241.6 million**.

- The NHS HC programme successfully engages people with the greatest health needs, actively reducing health inequalities. Premature death rates from CVD in the most deprived 10% of the population are almost twice as high as rates in the least deprived 10%.

Summary:

- The NHS Health Checks benefit people who are at high risk of developing CVD
- Nationally, people having an NHS Health Check have better management of cardiovascular risk factors.
- Nationally, there is emerging evidence of lower rates of stroke among people who had a health check compared to people who didn't
- NHS HC actively reduces health inequalities

6. Challenges:

- **Resilience in primary care** is a major challenge –NHS HC often offered through 1 or 2 members of staff any staff absence has a significant effect on programme delivery
- **Engaging practices** -Finding the most appropriate ways to engage and support GP practices given the pressures on primary care and the priority placed on this programme
- **Getting buy in** to increase the priority placed on NHS Health Checks
- **Engaging the harder to reach groups-** ethnic minorities or those in very rural areas, people not registered with GP, younger age groups
- **Variation in quality of data** is a major challenge as it makes it difficult to assess quality of care and patients' follow-up
- **Investment in IT systems and data quality** has presented some challenges - this takes time and commitment from practices and the CCG IT team.

7. Recommendations

- Practices explore cross-working within ICS clusters or through extended access services to offer greater access to NHS Health Checks and increase resilience
- Everyone having an NHS Health Check should benefit from tailored lifestyle advice and access to local services, such as stop smoking services, and/or clinical management to help them reduce their CVD risk.
- Practices to ensure appropriate follow-up for individuals with identified risk factors
- The NHS RightCare CVD Prevention Pathway should be used to optimise clinical management of conditions such as raised cholesterol and hypertension.
- Tackling health inequalities by adopting recruitment and delivery approaches that encourage those with the greatest health need to attend a NHS Health Check must remain at the heart of the programme.
- Invitations for an NHS Health Check should be prioritised to people with the greatest health need.
- Explore further opportunities for increasing uptake of the NHS Health Check programme among higher risk groups
- Make sure there is a strong link with the local diabetes prevention programme.

Thank you

Information Sources

- Buckinghamshire NHS Health Checks, Health Equity Audit 2017
  - Data from 2013/14-2016/17
- Buckinghamshire NHS Health Checks, 3 year evaluation
  - Data from 2013/14-2015/16
- Public Health Outcomes Framework
  - Available here
- Buckinghamshire NHS Health Checks local data system (QUEST)
- Emerging evidence on the NHS Health Check: findings and recommendations. A report from the Expert Scientific and Clinical Advisory Panel. Feb 2017.
  - Available here

Health & Wellbeing Board
Buckinghamshire

Title	Prevention at Scale pilot update
Date	27 September 2018
Report of:	Jane O'Grady, Director of Public Health
Lead contacts:	Sarah Preston, Public Health Principal, spreston@buckscc.gov.uk, 01296 382 539

Purpose of this report:

The purpose of this report is to update Health and Wellbeing Board members on the progress of the Prevention at Scale pilot in Buckinghamshire, and request continued support from member organisations to identify opportunities and engage with and deliver the actions identified to enable this work to be taken forwards.

Summary of main issues:

Prevention at Scale in Buckinghamshire

The LGA Prevention at Scale (PAS) pilot is identifying and developing opportunities across the whole system, including County and District Councils, the NHS, communities, the fire service, Department of Work and Pensions and the voluntary, faith and community sector, to address the prevention challenge to reach, engage and motivate residents to change their lifestyle behaviour.

Getting prevention at scale right means we can develop a greater reach for prevention which will make a significant improvement in the health and wellbeing of our communities and deliver our Joint Health and Wellbeing Strategy.

The support offered by the LGA is enabling a number of focused projects to be developed and tested and for the learning to then be applied on a larger scale to develop Prevention at Scale locally. In order to get maximum value from the LGA resource, it was decided that the project will be linked to the implementation of the new integrated lifestyle service, Live Well Stay Well.

Progress update on the focused projects being taken forwards

1. Digital innovation

The new integrated lifestyle service includes a website, which enables professional referrals and self-referrals. It also allows residents to complete a lifestyle assessment and access support online. Prevention at Scale has supported expert user testing (January 2018) and client user testing (March 2018) on the new website to ensure the best user experience is available. The user testing provided invaluable insight

and recommendations. Many changes have already been made, including refining the registration process and lifestyle assessment questions, with many more changes being incorporated into a development plan for the service. The learning from this will be shared with stakeholders and has already been shared with the digital workstream for Adult Social Care transformation so everyone can benefit from what has been learnt.

2. Behavioural insight

This project focuses on developing insight about how we can engage and motivate key groups (men, people from black and Asian ethnic groups, routine & manual workers, more deprived communities) to make lifestyle behaviour changes, specifically stopping smoking and losing weight (healthy eating & physical activity). Working with partners to engage the priority groups, the insight work (using interviews, observing individuals behaviours and a survey) is being completed between June – September 2018. A comprehensive report will be produced including a set of 'personas' for key priority groups to inform communications campaigns, service development and understanding of how to support communities to make changes themselves.

The insight work will be followed by a co-design stakeholder workshop at the end of September to begin the next stage of applying the insight developed. With support from the LGA, the personas will also be used to develop a micro targeting communications approach to enable the most effective communications possible with priority groups.

The learning from the insight, co-design and resulting developments will also be able to be applied more widely to other services and will be shared with stakeholders.

3. Community and stakeholder engagement in improving lifestyles

This involves engaging the whole system, including health and social care professionals, the fire service, Department of Work and Pensions and the voluntary, faith and community sector, in the identification of opportunities and the co-creation of routes and processes to support residents to make lifestyle behaviour changes. There are many strands to support the whole systems approach, which started with a successful stakeholder event in January 2018. This was attended by over 30 different organisations including the voluntary & community sector, faith groups, fire service, Department of Work and Pensions, NHS, District Councils, and BCC directorates.

As a result of this event a number of key actions were identified and are being developed with partners, including

Key Action	Progress update
Developing the approach to Making Every Contact Count (MECC) in Bucks – to provide the confidence to those working with residents to have an effective conversation about lifestyle behaviour change	• Bucks MECC steering group established • Adult social care have committed to embed MECC into new social worker strength based training and every day

	delivery as part of transformation programme • Developing an easily accessible 10 minute online training video for MECC to support stakeholders to have discussions with residents (Available from October) • Ensuring Bucks is fully engaged with the MECC offer being developed across the Sustainability and Transformation Partnership (STP)
Working to develop community capacity to promote healthy lifestyles through engaging and upskilling existing volunteers	• Scoped existing volunteer networks and opportunities with BCC communities team • Developing community engagement plan with Live Well Stay Well which builds community capacity • Offering MECC training to community groups and volunteers (from October)
Creating a multiagency communications plan for the new integrated lifestyle service based on PAS insight work	This will be developed as part of the insight co-design and campaign planning between October 2018 and January 2019
Exploring opportunities to engage with Bucks businesses by working with Bucks Business First staff and using links to promote healthy lifestyles messages to businesses	Agreement to take a phased approach to get businesses on board – starting with developing a range of fact sheets which raise awareness of the impact and benefits of having a 'healthy, happy and productive' workforce. This will be informed by the PaS insight work
Exploring opportunities with DWP staff to deliver MECC as part of their interaction with clients	Ensuring DWP are involved and engaged in the STP MECC offer when developed
Exploring opportunities to work with the Fire Service to integrate their service offer with prevention	Using fire stations for the children's weight management programme and NHS Health Checks
Engaging faith groups in supporting residents to make lifestyle behaviour changes	• Invited to present at the Aylesbury interfaith network • Offering NHS health checks at Chesham Mosque (September)

A second stakeholder event will be held on 31st October 2018. This will continue to engage stakeholders in the Prevention at Scale programme. This will include key note speakers from The Design Council and the LGA digital team. The event will also include key approaches to developing successful projects, a Bucks progress update with the key learning so far, and to share outcomes from the behavioural insight work. It will also be an opportunity to support stakeholders to develop their roles in engaging and motivating residents to make lifestyle behaviour changes. The

event will conclude by agreeing the next steps to continue to take the Prevention at Scale work forwards.

The Design Council
As part of Prevention at Scale the LGA is supporting a programme of workshops with The Design Council during September and October 2018. The Design Council use techniques to explore and reframe challenges using a people centred approach to develop solutions. This will be used to inform the further development of the whole system approach and the application of the insight produced.

How will Prevention at Scale be evaluated?
The LGA have commissioned an external organisation to evaluate Prevention at Scale to specifically understand if the Prevention at Scale intervention has helped the pilot sites scale up their prevention programmes.

Locally using the KPIs and monitoring reports from the integrated lifestyle service, we will be able to measure the number of referrals into the lifestyle services, the sources of these referrals and the healthy lifestyle outcomes achieved. Google analytics can provide data on the user journeys on the LWSW website, showing areas for improvement or areas to expand and enhance. This will be used along with user satisfaction surveys undertaken by the LWSW provider. The impact and reach within priority groups of communications campaigns developed as a result of the behavioural insight can also be measured. Understanding the improvement in the engagement of organisations across the whole system with supporting residents to make lifestyle behaviour changes, can be assessed by including the numbers engaging and accessing MECC training, and qualitative feedback of local changes being made within community organisations.

Next Steps.
The LGA Pilot officially finishes in November 2018. However for Buckinghamshire this is the start of the Prevention at Scale work. Prevention at Scale work will continue to develop, with many elements continuing to be developed and delivered past the end of the pilot. We will continue to use the learning gained from the pilot, including the behavioural insight work which will inform a co-designed communications campaign in January 2019, targeting priority groups. The second stakeholder event in October will enable the lessons to be shared and to identify further opportunities and actions moving forward to engage the whole system approach and co-design services to support our residents make lifestyle behavior changes.

Recommendation for the Health and Wellbeing Board:

1. To note the update for the Prevention at Scale pilot
2. Member organisations to commit to continuing to support and participate in the Prevention at Scale pilot and resulting work within their organisations. Particularly:
    a. Engagement to develop and deliver the multiagency communications plan
    b. Involvement in co-design work based on the insight developed

c. Leadership to ensure plans are in place for integrating MECC into frontline staff roles and monitoring the delivery and impact within the organization.
d. Encouraging partner community organisations to engage and access MECC training.

Health & Wellbeing Board
Buckinghamshire

Title	Live Well Stay Well (Integrated Lifestyles Service) Update
Date	27 September 2018
Report of:	Jane O'Grady, Director of Public Health
Lead contacts:	Sarah Preston, Public Health Principal, spreston@buckscc.gov.uk, 01296 382539

Purpose of this report:

This report is to update the Health & Wellbeing Board members on the new Live Well Stay Well Service. We would also like to request ongoing support from the members of the board to ensure their organisations are proactively promoting and referring to Live Well Stay Well to support the residents of Buckinghamshire to make healthy lifestyle changes.

Summary of main issues:

Service Overview

Live Well Stay Well, the new integrated lifestyle service for residents in Buckinghamshire, went live on the 1st April 2018. The service offers a single point of contact for residents to access a range of support to lose weight, quit smoking, get more active, drink less alcohol, feel happier or manage their diabetes.

The service also offers outreach NHS health checks, support to families to manage a child's weight and referral to support for residents with the emotional challenges of managing a long term condition

The new service individually tailors the help offered including online support for all residents, with more intensive phone or face to face support for stop smoking and losing weight being available for key groups. The service will also refer and signpost residents to a range of external services such as physical activity opportunities, diabetes management and alcohol reduction.

Just one professional referral or self-referral can give residents access to all this support. Referrals can be made through the website www.livewellstaywellbucks.co.uk. A professional referral can be made by any organisation who has consent from the person they are referring, including community and voluntary sector organisations.

The lifestyle service has been commissioned by Buckinghamshire County Council Public Health Team, with the single point of access element commissioned in partnership with the Buckinghamshire Clinical Commissioning Group.

Delivery in Quarter 1

Live Well Stay Well has received 2446 referrals into the service (both professional referrals and self-referrals) with 2131 clients completing an initial assessment (24% completed digitally).

Over half (1230 referrals, 50.3%) of all referrals received in quarter 1 have been from GP Practices. The second largest professional referrer was BHT (164 referrals, 6.7% of all referrals). Ongoing activity is planned to continue to engage a wide range of stakeholders through Live Well Stay Well and as part of the Prevention at Scale project, to continue to increase professional referrals into the service. In addition, Live Well Stay Well will be promoting the service directly to the general public to increase the number of self-referrals.

More information on the outcomes of the service will be available in future quarters; the length of interventions (usually 12 weeks) means that meaningful information on those residents undertaking interventions in the first quarter is not yet available.

Live Well Stay Well Stakeholder Launch

The official launch of the service was held on the 24th May which saw over 120 attendees from a range of organisations including local government, the NHS, voluntary sector and community groups.

Animations (Maggie's Story and Omer's Story) were developed to introduce stakeholders to what Live Well Stay Well can offer residents, and the different ways the service can be accessed (professional referral or self-referral).

There was lots of positive feedback from the event as attendees found the presentations, marketplace and networking opportunity useful. Many stakeholders have since been in touch with Live Well Stay Well to request more information and promotional materials.

All of the presentations from the event and animations are available at https://www.livewellstaywellbucks.co.uk/News/119/live-well-stay-well-launch-event

Recommendation for the Health and Wellbeing Board:

1. To note the update for the Live Well Stay Well service
2. Member organisations help to support this prevention initiative by proactively promoting and referring residents to Live Well Stay Well

Background documents:

None

Buckinghamshire County Council
Visit **democracy.buckscc.gov.uk** for councillor information and email alerts for local meetings

Report

Title:	**Children and Young People's Mental Health: Buckinghamshire Transformation plan**
Date:	27 September 2018
Author:	Caroline Hart – Joint Commissioner (All Ages Mental Health)
Contact officer:	Caroline Hart – Joint Commissioner (All Ages Mental Health)

1 Purpose of Paper

For Information and comment

To share a draft of the refreshed Buckinghamshire Transformation Plan for Children and Young People's Mental Health and Emotional Wellbeing ahead of its publication at the end of October 2018.

- Please note this is an **early draft** for comment and will be subject to design work once the final text is completed.

Transformation Plan for Children and Young People's Mental Health and Emotional Wellbeing

'Futures in Mind', published by government in 2015, proposed that local areas should produce and publish a Transformation Plan for Children and Young People's Mental Health and Wellbeing. Plans should articulate the local offer and cover the whole spectrum of services for children and young people's mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.

Futures in Mind anticipated that the lead commissioner would draw up local plans, working closely with Health and Wellbeing Board partners including local authorities. It also set out a number of other requirements, including that there should be an annual declaration of current investment and the needs of the local population with regards to the full range of provision for children and young people's mental health and wellbeing.

To support the ambition for transformation set out in 'Futures in Mind', NHS England committed to prioritising the further investment within mental health services, and since 2015 transformation funding has provided an additional £1,590,426 for investment into the Buckinghamshire CAMHS service.

The Buckinghamshire Transformation Plan was published in 2015. The plan reflected that children and young people's mental health services in Buckinghamshire had just been recommissioned (new service model started 1st October 2015 – 5 year contract awarded to Oxford Health Foundation Trust in partnership with Barnardo's and Beat), with the new model reflecting many of the themes identified through 'Futures in Mind'. The service is commissioned as an integrated service under section 75 arrangements (pooled budget) between Buckinghamshire Clinical Commissioning Group (CCG) and Buckinghamshire County Council (BCC).

Annual updates to the Transformation Plan were completed for 2016/17 and 2017/18, in line with the expectation of 'Futures in Mind' and the 2018/19 update is currently being finalised ahead of publication at the end of October. The update has been written in partnership with Oxford Health and other stakeholders and takes account of feedback from service users and their families.

There has been recent feedback from NHS England on the lack of detail in the plan published by Buckinghamshire last year. In addition, the NSPCC recently 'red flagged' the plan published by Buckinghamshire last year as they felt it did not make sufficient reference to the increased mental health needs of children who have experienced abuse and neglect. Feedback from both of these sources is being considered in the updated plan for this year.

Draft priorities set out in the refreshed plan are:

Develop resources and skills in universal services to enable improved early support and advice for children and young people with mental health concerns

- Ensure resource to promote good mental health and self-help resources are available through schools, youth services and voluntary partners.
- Deliver training sessions for parents and support parents in the establishment of a parent support group.
- Delivery of training on mental health to young people through schools.
- To work with the Local Authority in the early help review to consider how mental health can be integral to the early help strategy and pathways.

Increase access to NHS commissioned service

- Work with voluntary sector partners to explore maximising workforce to deliver mental health support into schools particularly to support younger children.
- Ensure sustainability of waiting time standard of 90% referral to assessment within 4 weeks.
- Develop and implement pathway for all age neurodevelopment presentations with aim to reduce waiting times in CAMHS to offer assessment in less than 6 weeks from receipt of full required pre-referral information.
- Develop engagement strategy to raise awareness and support under-represented groups to access mental health services.

Ensuring children and young people in crisis have access to timely support to prevent/minimise escalation to more complex needs

- Improve and extend the response to children and young people in crisis – particularly outside of core hours and to include those who may have complex presentations, including

young people who may have autism and mental health problems leading to severe behavioural difficulties.

- Co-location of CAMHS staff into social care teams (Looked After and adoption teams and court team).
- Work with social care in developing the in county provision and assessment unit to ensure environment and resources to best support young people presenting in crisis who are not detainable within a mental health setting but are unable to stay with their parents/carers.
- To review the clinical pathway for young people presenting with emotionally unstable personality disorders and develop an all age pathway to support young people through transition.

Continue to embed whole system working to ensure services work together to meet the mental health needs of this group of children and young people

- Improve positive behaviour support for children that exhibit challenging behaviour in the context of poor mental health for those with a learning disability.
- Develop work on Transitions to consider the mental health needs of care-leavers as they move out of care and into independent or supported living.
- Develop network to support the mental health needs of those not in education, employment or training (NEET) and for those not attending a school through home education or absentees.

Buckinghamshire Transformation Plan for Children and Young People's Mental Health and Emotional Wellbeing

2015- 2019

Caroline Hart, Commissioner for All Age Mental Health

Sian Roberts, Clinical Director, Mental Health and Learning Disabilities

August 2018

Buckinghamshire County Council

NHS Buckinghamshire Clinical Commissioning Group

Contents

1. EXECUTIVE SUMMARY

2018-2019 Transformation Plan Refresh

The 2018-2019 Refresh Local Transformation Plan (LTP) builds on the new CAMHS model set out in the original 2015 plan and is developed in accordance with feedback from service users, stakeholders and the changing needs of the local population within Buckinghamshire.

The experience of young people, parents and carers has been central in developing the LTP for 2018-2019. CAMHS have a young people's participation group, Article 12, that includes a full-time participation worker to support this work with children, young people, parents and carers. In addition, the Eating Disorders team have a Young People's Forum whereby a small group of young people are involved in improving information and communication within the eating disorder pathway. Young people have been involved in reviewing letters and information booklets distributed at the initial assessment stages. A Parent Advisory Group (PAG) has seen set up to represent the voice of parents and carers. The group meets quarterly and gives input in to the CAMHS annual review.

Key Messages from Young People and Families have highlighted the following;

"We would like a person in school to raise awareness, offer support for young people and training for teaching staff on understanding mental health and how to support students with mental health needs.

"More support and information for 16-18 years old's who will be moving to adult services is really important for their transition so they know what to expect. If there's an official process on how it should be done, then make sure it is followed".

"We need more resources like apps, websites, films, self-help online and a self-help podcast designed with young people and staff together.

"Review the service young people/parents/guardians/professionals are receiving over the phone.

Feedback from the PAG has highlighted that parents would like CAMHS to offer more mental health training and for there to be more information on our CAMHS website including “what to expect at CAMHS”.

Extensive consultation has also been carried out with stakeholders in the county and annual stakeholder events have been held. These have included;

- GPs
- Schools including primary, secondary and Pupil Referral Units
- Public Health
- CCG and Council commissioners for
    - Children’s health
    - Children’s disability services
    - Adult mental health
    - Adult learning disabilities
- Social Care
- Early Help
- Buckinghamshire Safeguarding Board
- Youth Service
- Third Sector organisations
- National Youth Advocacy Service

The Annual Stakeholder event held in July 2018 focused on three key themes; Accessibility, Communication and Collaboration and stakeholders were invited to share their views on how CAMHS could continue to develop its service based on each of these themes.

Accessibility

Generally, feedback was positive about greater accessibility to CAMHS compared to the old model. The Single Point of Access number was welcomed by all as significant change in knowing that there was one number to phone for the county and that this number was available from 8am-6pm. The move away from GP-only referrals to referrals by all professionals and self-referrals by parents of young people aged 14 years was welcomed. Suggestions for improvement for the year ahead included making CAMHS more accessible to where the young people are such as using social media, whatsapp groups. A suggestion was made that CAMHS could be available 24/7 on a dedicated phoneline and as part of the NHS 101 number. More training on understanding mental health issues in schools was identified as part of the curriculum to young people but also as a training need to schools staff. Finally, feedback on making our website more service-user friendly

was identified and how young people could find out information about mental health issues.

Communication

At the annual review, the level of communication between CAMHS and partner agencies was recognised as greatly improved compared to the old model. Stakeholders gave specific feedback as to how CAMHS could improve with their links with schools including knowing when a young person has been discharged from CAMHS. Better communication about the Single Point of Access was identified as a need to share with stakeholders, improving google searches and clearly identifying this on the Oxford Health website.

Collaboration

Stakeholders felt that there was good collaboration between CAMHS and partner agencies. Schools in particular valued the link worker role and the ability to access CAMHS training in various mental health topics. Early intervention was identified as an area that needed more CAMHS input and in particular, work with front-line social workers and health seen as an area that could benefit from closer collaboration. The stakeholder view was that if there could be closer collaboration with CAMHS that early help/intervention to a family could be more effective and reduce the need for more costly interventions.

The Needs of Young People in Bucks

In Buckinghamshire the estimated midyear population is 533,000 which is projected to increase to 551,000 by 2020. From this population, 90,824 children and young people are aged 5-17 years **with a significant proportion under the age of 13** (23%) compared to 21.3% in England. The proportion of people from an ethnic minority group in Buckinghamshire is 12.8% which is lower than the rest of England (13.6%). Applying national prevalence estimates of 1 in 10 young people presenting with a diagnosable mental health condition, there would be **approximately 9,082 young people who need mental health services in the county**. The Joint Strategic Needs Assessment (JSNA) and surveys carried out on the mental health needs of young people, e.g. WAY survey of 15 year olds and school nursing health assessments, have found that children and young people in Buckinghamshire generally have better mental health compared to the rest of England with lower rates of emotional disorders, conduct disorders and hyperkinetic disorders. Admissions to hospital for mental health conditions/substance misuse or self-harm were also found to be significantly lower than the rest of England. Overall child mental health compares well to national figures, analysis of the data shows evidence of a social gradient and that some young people are at greater risk of mental ill health.

Vulnerable Groups of Children & Young People in Bucks

Despite mental health for young people in Buckinghamshire being generally better than the rest of England, there are vulnerable groups of young people within the county that require targeted services.

In the past year, we have seen a significant increase in the number of children entering the care system from 458 to 512 with a predicted growth rate of 8%. The mental health of Looked After children in the UK is significantly poorer than that of their peers with almost half of children and young people in care meeting the criteria for a psychiatric disorder. In Buckinghamshire, Looked After Children have significantly higher scores (43.1%) that caused concern on the Strengths and Difficulties Questionnaire compared to statistical Local Authority neighbours with the exception of Cambridgeshire (44.6%) and is higher than England (38.1%). Although it is noted that 3 out of 10 looked after children did not have a SDQ assessment so it is possible that this figure is higher than current estimates.

School exclusions and persistent absentees is a problem in the county and needs to explored further. The proportion of fixed term exclusions for primary school pupils is much higher (11.4%) than the England value of 1.2%, but statistically lower for secondary school pupils compared to the England value. Persistent absentees is much worse (14.0%) than the national average (13.5%). The mental health needs of NEET (not in education, employment or training) remains an unknown and needs to be better understood.

Key Priorities for 2018-2019

- Work in Partnership with Social Care and Health in ensuring the mental health needs of Looked After children are being identified and responded to in a timely way by sharing data on the Strengths and Difficulties Questionnaire and ensuring that **every child in care** has this mental health screening assessment.
- Children and young People in crisis have access to timely support to prevent/minimise escalation to more complex needs
- To ensure that there is a whole system approach to children and young people with mental health needs that exhibit challenging behaviour
- To understand the mental health needs of NEET by working more closely with partner agencies
- To develop a pre-birth strategy so that vulnerable infants are identified at a much earlier stage and parents are given the right help at the right time thereby reducing the number of children being removed from a parent's care.
- To develop resources and skills in universal services to enable improved early support and advice for children and young people with mental health concerns.

- To increase access to NHS commissioned service

1. Introduction

The mental health needs of the children and young people in Buckinghamshire are met through a number of services and organisations some formally commissioned as mental health services such as the Child and Adolescent Mental Health Service (CAMHS) and some through statutory and non-statutory agencies such as youth services, schools and voluntary sector organisations.

The Child and Adolescent Mental Health Service in Buckinghamshire was recommissioned in 2014/15 with a new service model which started on 1st October 2015. The service is provided by Oxford Health Foundation Trust in partnership with Barnados and is jointly commissioned by NHS Buckinghamshire Clinical Commissioning Group (CCG) and Buckinghamshire County Council (BCC) under a pooled budget section 75 arrangement. The service model represents a significant transformation from the provision prior to 2015, and was based on assessment of the local needs, stakeholder feedback including Children and Young People (CYP), parent and carers and existing CAMHS staff. It embraces a whole system approach, promoting early intervention and prevention with the aim of reducing escalation of need and improving outcomes for children and young people.

The model, based on The Balanced System Model [1], was developed by the provider to utilise the Thrive model[2], the outcome reflects many of the themes identified through Future in Mind[3] with ongoing engagement with young people and stakeholders in developing the service. The service is now in year three of a five year contract. Monthly project meetings are held to track continued transformation in addition to monthly performance monitoring meetings.

Investment through Future in Mind has enabled a faster pace of change for the service and enabled increased access to a service across the children and young people population in line with the expectations of the Five Year Forward View for Mental Health.[4]

The 18/19 transformation plan has been developed to demonstrate the journey taken since 2015 and to show the direction of travel for the next 2 years. As previous years have demonstrated the full benefits of transformation are not always realised immediately but developed over time, with plans updated each year and amended as a result of changing demands, evidence and feedback.

[1] https://www.bettercommunication.org.uk/the-balanced-system/

[2] https://www.annafreud.org/media/3214/thrive-elaborated-2nd-edition29042016.pdf

[3] https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

[4] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

2. Ambitions for Children and Young People's Mental Health and Emotional Wellbeing in Buckinghamshire

Positive mental health for young people

This is the vision that has been agreed following consultation across CYP, parents and stakeholder on the vision for Buckinghamshire CAMHS.

This is underpinned by the following objectives:

a) All those living and working in Buckinghamshire will know where to find mental health and emotional wellbeing help and advice that they can trust.

b) All children and young people who need mental health services will receive the right help, in the right place when they need it.

c) All services working with children and young people will promote wellbeing across both physical and mental health.

d) All young people who are transitioning between services are supported throughout the process to ensure transfers are managed safely, timely and appropriately.

e) All young people who use the service will be involved in decisions affecting the care they receive through collaborative setting of their own targets and planning their discharge from the service.

f) Children, young people, parents, carers and other stakeholders will influence the development of the service through participation and feedback.

3. Promoting Resilience, Prevention And Early Intervention

Our priorities for 2018/2019

- *Develop resources and skills in universal services to enable improved early support and advice for CYP with mental health concerns*

- *Increase access to NHS commissioned service*

Our population

- *The population of 0-17 year olds registered with a GP in Buckinghamshire is 122,520 with 90,824 young people between 5 and 17 years.*
- *National prevalence data would suggest that Buckinghamshire has 9080 children and young people with a diagnosable mental health disorder.*
- *Overall child mental health in Buckinghamshire compares well to national figures, however analysis of the data shows evidence of a social gradient and that some young people are at greater risk of mental ill health.*
- *The birth rate for Buckinghamshire is approximately 6,000 per annum, between two maternity sites. Current prevalence rates would suggest that approximately 1600 infants are at risk of developing mental health difficulties.*

You said we need:

- *A single place to find mental health training and more mental health training for parents and carers, including foster and adoption parents, young people and stakeholder*
- *more information on the CAMHS website[5] about 'What to expect at CAMHS'*
- *a parent led support group*
- *more promotion of the work undertaken and ensuring that it is easily accessible to the population of Buckinghamshire*
- *More resources like apps, websites, films, self-help online and a self-help podcast designed with young people and staff together.*
- *To make CAMHS more accessible to where the young people are such as using social media, whatsapp groups*
- *More training on understanding mental health issues in schools was identified as part of the curriculum to young people but also as a training need to schools staff*

[5] https://www.oxfordhealth.nhs.uk/camhs/bucks/services/

Buckinghamshire offers:

Developing Resilience in Children & Young People

Buckinghamshire Public Health have commissioned two evidence based resilience programmes for universal delivery in schools as a means of promoting mental health and building individual resilience. They are the UK Penn Resilience Programme and the Friends Resilience Programme. The programmes teach cognitive-behavioural and social problem-solving skills to build resilience, promote realistic thinking, and provide adaptive coping skills and social problem-solving in children. Penn Resilience Programme Training continues to be available to schools through the Buckinghamshire Public Health offer.

Since 2015 48 primary schools and 19 secondary schools have had staff trained to deliver evidence based resilience programmes the “Friends” programme and Penn resilience.

Training in Recognising Mental Health Problems

Psychological Perspectives in Primary Care (PPEP care)

CAMHS deliver training in understanding and recognising various mental health problems across the county to professionals including foster-carers. We deliver Psychological Perspectives in Primary Care (PPEP care), an evidence-based programme designed by Reading University for the CYP-IAPT (Children and Young People’s Improving Access to Psychological Therapies). Topics include supporting young people with low mood, anxiety, self-harm, challenging behaviour, eating disorders and PTSD.

In addition, bespoke training is offered to schools in understanding and responding to children’s attachment needs in school. The CAHBS service (children and adolescents who engage in harmful behaviours) offers regular consultation and training to schools in managing sexualised behaviour in pupils.

Over 500 professionals have attended the training to date.

Emotional Wellbeing in Schools Annual Conference

The conference was held for the fifth year in November 2017 with the theme ‘Schools in Mind’. The conference was organized by Public Health in partnership with organisations such as BCC’s Educational Psychology Service, Young Carers Bucks, the third sector, Buckinghamshire Schools, Connexions and Time to Talk Bucks, the School Nursing Service and Child and Adolescent Mental Health Services (CAMHS).

94% of attendees who completed an evaluation form indicated they agreed or strongly agreed that they were satisfied the workshops had met the intended

outcomes, with 95% of respondents indicating at least one thing they would take away from workshops to implement in school.

Planning is underway for the sixth conference in November 2018.

The conference was highly attended by over 100 delegates from across mainly Buckinghamshire schools with others represented from the School Nursing Service, CAMHS, BCC colleagues and its partners as well as the third sector.

School Link Worker

CAMHS have a named clinician attached to every primary and secondary school in the county. The school link worker meets with school staff once a term to discuss any concerns the school may have about particular children and will give appropriate advice regarding how that child's needs can be met at school or recommend a further assessment to be carried out by CAMHS. This initiative has helped with earlier identification of children who may be at risk of mental health difficulties by ensuring that the right help is delivered at the earliest opportunity.

Promotion of mental health resources

The young people from Article 12 participation group have worked with Oxford Health to develop a one –stop place for resources, information and advice on mental health and emotional wellbeing. The website outlines mental health services in Buckinghamshire, provides information on services and conditions and promotes resources such as videos, apps, national guidance.

Perinatal Mental Health

The Field Report (2010) and the 1001 Critical Days Manifesto have highlighted the importance of early intervention to prevent children from adverse circumstances growing up and becoming poor adults who have higher risk of mental health difficulties and increased risk of repeating the cycle of neglect/abuse towards their own children. These reports have found that the first five years of a child's life are crucial in determining that child's later life chances and to have positive mental health. In particular, the first two years of a baby's life are critical to affect change as the brain develops and neural connections are formed with a "window of opportunity" for parents to deliver sensitive care during this period. Parents who are known to be high risk because of mental health problems, personality disorder, history of childhood trauma, domestic abuse or substance misuse need to be offered services to ensure positive outcomes for their children.

Estimated prevalence of Perinatal Mental Health Disorders in Buckinghamshire

Perinatal MH disorders based on 6100 live births	
Post-partum psychosis	15
Chronic serious mental illness	15
Severe Depression	190
Mild/moderate anxiety/depression	610 - 915
Post-Traumatic Stress Disorder	190
Adjustment Disorder/Distress	915 – 1,825

Source: Public Health England Fingertips Data

In Buckinghamshire we have developed a Perinatal Mental Health Network and Strategy to identify and offer early help to all parents who may have a mental health problem. The multiagency network includes midwifery, health visiting, social care, primary care, primary and specialist adult mental health services. The network have worked together to develop a multiagency pathway and work together on a day to day basis to ensure this group of parents are supported at the most appropriate level by the most appropriate service.

Buckinghamshire has a diverse population and the services are required to serve both a large rural and isolated population together with an urban and mixed ethnic minority population. In response to this need the network has developed a perinatal strategy to improve access to perinatal clinical input into shared maternity clinics to enable access to vulnerable and hidden women and signposting to the appropriate service for their needs.

Perinatal Mental Health Team

The Buckinghamshire Perinatal Mental Health Team is a specialist team that support women who are experiencing moderate to severe mental health difficulties within the perinatal period. In addition, the team provides pre-conception counselling for women considering starting a family who have existing mental health concerns as well as training for other professionals working with this client group. They accept referrals through the Single point of access, where they triage and undertake specialist assessments on-going support, sign posting and treatment as appropriate.

The team currently consists of Psychiatrist (0.2 WTE), Team Manager (1.0 WTE), Specialist Social worker (1.0 WTE), Specialist Community Psychiatric Nurse (CPN)

(0.6 WTE), Administrator (0.6 WTE), Cognitive Behavioural (CBT) Therapist 0.2 WTE.

During 2017/18 338 women accessed perinatal mental health support from the adult services.

Postnatal Depression Groups

Postnatal depression groups are run three times a year in the north and south of the county for women with mild-moderate mental health difficulties. CAMHS have developed a manualised group therapy programme that incorporates CBT for anxiety and depression as well as thinking about the infant's attachment needs. The groups are co-run by Adult IAPT CBT therapists and Health Visitors.

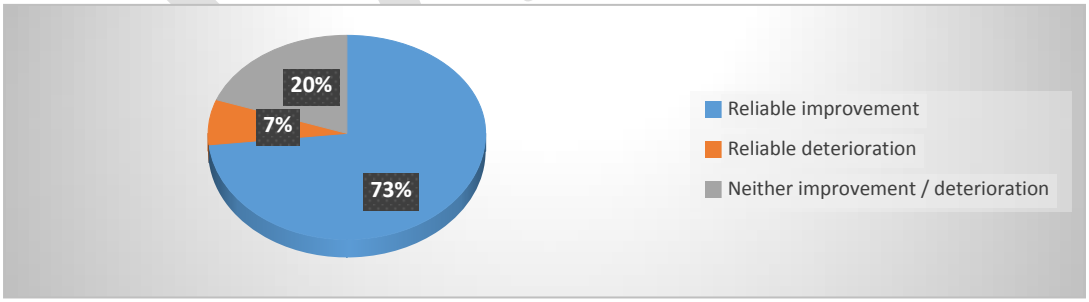
Since Jan 2015, 22 postnatal depression groups have been completed offering treatment to 156 women who have attended.

The following standardised measures are used to evaluate the groups:

- *The Patient Health Questionnaire (PHQ-9) is a self-administered 9 item scale measuring depression which incorporates DSM IV depression diagnostic criteria.*
- *The Generalised Anxiety Disorder Scale (GAD-7) is a self-reported 7 item questionnaire for screening and measuring severity of generalised anxiety disorder.*
- *The Edinburgh Postnatal Depression Scale (EPDS) is a 10 item questionnaire developed to identify women experiencing postnatal depression.*

The graphs below show that 73% of women who attended the groups showed improvement when comparing their pre-treatment and post-treatment scores.

Analysis of PHQ9 and GAD7 data for all 20 groups



For 2018/19 and onward we will…

Promote good mental health, self-help resources and self-referral.

Through consultation with young people a card to promote the CAMHS website has been developed and is in the process of being agreed and printed. The card will

promote the CAMHS website and resources available through this. It will be available through schools, colleges, youth services and voluntary partners.

Continue to explore ways to promote mental health and the services available to support children and young people.

Continue to develop the website using feedback from parents, carers, young people and stakeholders to include further resources on “what to expect at CAMHS”, training utilising digital methods such as podcasts, webinars

Provide training sessions to parents and support parents in establishment of parent support group

Dates have been agreed for the parent support group, to be supported by the CAMHS participation worker. It is anticipated that each of these sessions will have a training component. Additionally CAMHS have been in contact with local schools inviting schools to host training sessions for parents.

Delivery of training on mental health to young people through schools and colleges

As requested by young people, CAMHS have some training sessions planned for delivery to young people through school settings. Some of the Article 12 group have expressed an interest in sharing their own mental health experiences to enhance this training.

Increase service offer to Buckinghamshire colleges through training and establishment of link workers.

In recognition of the additional mental health needs that are reported in the colleges, it is proposed that link workers and a training programme are established, working with the college team to facilitate additional support in line with the greenpaper.

Transforming children and young people’s mental health provision: a green paper

Buckinghamshire was delighted to be invited to submit an expression of interest to be a trailblazer for the green paper.

The paper focuses on earlier intervention and prevention, especially in and linked to schools and colleges.

The proposals include:

- *creating a new mental health workforce of community-based mental health support teams*

- *every school and college will be encouraged to appoint a designated lead for mental health*
- *a new 4-week waiting time for NHS children and young people's mental health services to be piloted in some areas*

The first roll out of Community Based Mental Health Support Teams will commence later in 2018. There is a commitment to have a fifth to a quarter of the country having these new teams by 2022/23.

We are awaiting the outcome of whether we have been successful in our bid to further develop the support to schools and colleges through mental health support teams.

Further develop the perinatal mental health service

Following a successful bid process the service has secured funding from NHS England to expand the team to enable increased access for more women. The service is currently recruiting to the new posts. It is anticipated that the new service will increase access to 5% of women giving birth.

4. Improving Access to effective support – A system Without Tiers

Our priorities for 2018/2019

Continue to embed whole system working to ensure services delivering to CYP work together to meet the mental health needs of this group of children and young people

Ensuring CYP in crisis have access to timely support to prevent/minimise escalation to more complex needs

Our Population:

- *The proportion of school pupils with social, emotional and mental health needs in Buckinghamshire in 2018 was 1.7%, which corresponds to 1,434 pupils. This is statistically lower than the England value.*
- *In 2016/17, 14.0% of secondary school enrolments were classed as persistent absentees (defined as missing 10% or more of possible sessions) which was worse than the national average (13.5%).*
- *The proportion of Buckinghamshire primary school pupils with fixed period exclusions in 2015/16 was higher than the England average value.*
- *The proportion of secondary school pupils with fixed period exclusions in 2015/16 statistically lower than the England value.*
- *Buckinghamshire hospital admissions as a result of self-harm was statistically better than the regional and England rate.*
- *The admission rate in Buckinghamshire is consistently higher in the most deprived areas than least deprived.*

You said we need:

- *To be able to talk to the clinicians and to have conversations outside of appointments (parents)*
- *To know the outcome of referrals and to find out what is happening (schools)*
- *To be able to be seen for mental health concerns without having to see the GP first*
- *Shorter waiting times and a simpler pathway for assessments for autism*
- *"More support and information for 16-18 years old's who will be moving to adult services is really important for their transition so they know what to expect. If there's an official process on how it should be done, then make sure it is followed".*
- *To improve transitions between services within mental health pathways and into adult services.*
- *Mental health services to be available 24/7 on a dedicated phoneline and as part of the NHS 101 number*

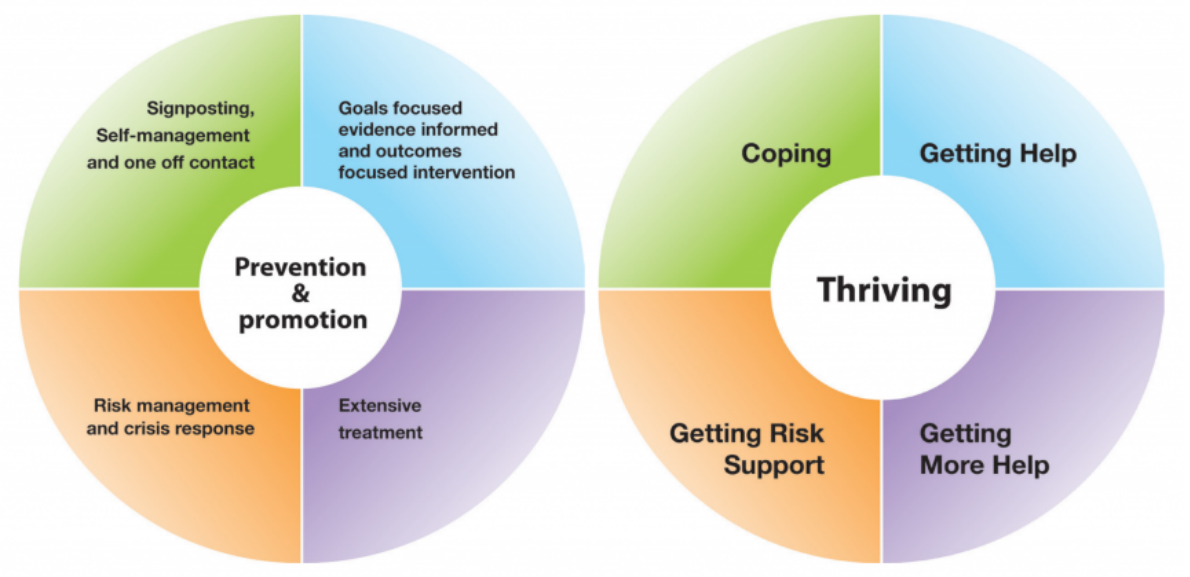
Buckinghamshire offer

The Buckinghamshire CAMHS Service Model

The model underpinning the specification has a core principle of providing appropriate early intervention though an accessible pathway that will allow children and young people's needs to be addressed as soon as possible at the lowest Tier of the system as is appropriate. The model builds on work in other therapeutic areas based on a Balanced System® framework which evidences the value of facilitating/ supporting the provision of comprehensive and robust Tier 1 and Tier 2 services in order to ensure that:

a) those whose needs can be appropriately met at Tiers 1 and 2 receive the appropriate support and
b) those whose needs require support at Tier 3 and beyond are able to access this quickly and efficiently .[6]

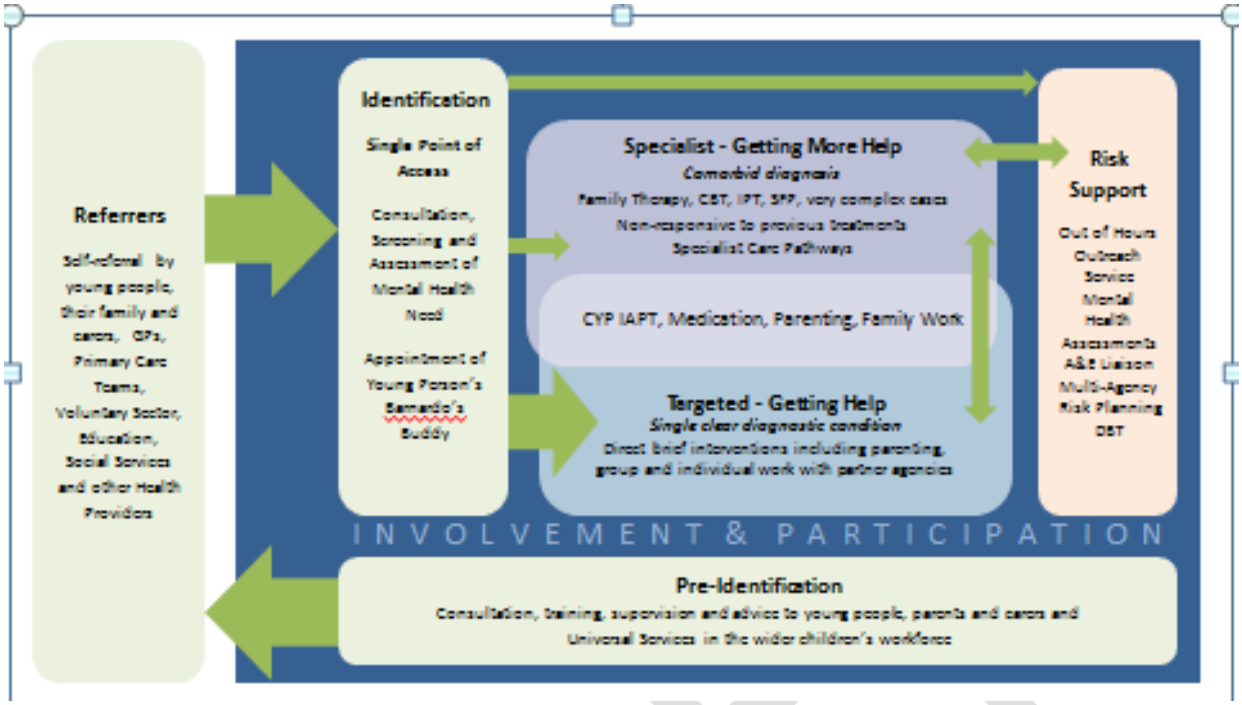
This has been reflected in the delivery model which is based on the thrive approach, a model developed by The Tavistock and Portman NHS Foundation Trust (The Tavistock) and the Anna Freud Centre (AFC)



CAMHS service model and Pathways

The CAMHS service model is based on a number of pathways that offer consistency and specialty

[6] More information about the Balanced System® can be found at http://www.bettercommunication.org.uk/the%20balanced%20system%20overview%20July%202013.pdf



Single Point of Access including self-referral

In order to promote access to a service for all children and young people with mental health needs, the single point of access (SPA) provides consultation, advice and signposting to ensure no young person with mental health needs is without support, guidance or advice.

The SPA is open Monday to Friday from 8am to 6pm with clinicians in the SPA to review referrals daily with a decision on further action to be taken. In line with the Crisis Care Concordat, the specification gives a waiting time requirement that all emergency referrals will be seen within 24hours of receipt unless medically indicated that this would be inappropriate, with an initial response expected within 4 hours.

Young People of 14 years and over are able to self-refer but no one phoning the Single Point of Access will be turned away without advice.

E- referrals are now accepted through the CAMHS website.

Referral data

	2014/15	**2015/16**	**2016/17**	**2017/18**
Number of referrals received- All CAMH services	3988	6091	5275	5943
Number of self – referrals				

Number of referrals accepted-All CAMH services	2396	4468	4153	4821
Number of initial assessments	2362	3226	3076	3617
Number of follow up appointments	27255	21608	29565	30167
Average total caseload (as at 31st March end of FY)	2481	3089	3261	3793
Average Waiting times	*57% of referrals seen within 4 weeks 76% tier 2 referrals seen within 8 weeks of referral 88% of tier 3 referrals seen within 8 weeks*	*48% of referrals seen within 4 weeks 69% tier 2 referrals seen within 8 weeks of referral 60% of tier 3 referrals seen within 8 weeks*	*50% of referrals seen within 4 weeks 42% tier 2 referrals seen within 8 weeks of referral 90% of tier 3 referrals seen within 8 weeks*	*52% of referrals seen within 4 weeks 54% tier 2 referrals seen within 8 weeks of referral 90% of tier 3 referrals seen within 8 weeks*
Outcomes		No data	4413 ROMS completed	7925 ROMS completed as at end March 2018

Current Waiting times 2018/19

Waiting times for assessment for routine appointments is set as a key performance indicator of 90% within 4 weeks which was achieved at end of April 2018 and has largely been maintained year to date for 2018/19. Young People waiting for a diagnosis of autism are currently waiting longer for this assessment due to the increase in demand. However significant work has been completed over the last 2 years to reduce the waiting time and all young people will receive a mental health assessment and intervention for any other presenting mental health concern whilst waiting for the specific autism diagnostic assessment.

Current Wait times for Assessment:
Getting More Help- Average April-July,95.5% seen within 4 weeks
Getting Help- Average April-July, 88% seen within 4 weeks.
Average total amount of assessments per month: 119

For anyone requiring intervention there is an expectation for intervention to start within 6 weeks of assessment, giving a total waiting time for referral to intervention of 10 weeks, however there is further work to do to ensure this is achieced and maintained.

Current average waiting times for evidence based treatment from assessment:
Getting More Help – 3.2 weeks, with 52 waiting at current time
Getting Help – 12.9 weeks, with 99 waiting at current time

Longest wait times for evidence based treatment:
Getting More Help - 29 weeks
Getting Help – 18 weeks

Assessments and interventions are offered at a range of venues, as requested by young people, where appropriate and safe to do so.

There is an expectation that all intervention offered will be evidenced based and in line with NICE (National Institute for Health and Care Excellence) guidance where available and where guidance is not available intervention should be in line with best evidence informed practice.

Dedicated named contact points

Each primary and secondary school has a named link worker and there is also a link consultant for GPs. These provide a contact point for consultation, requesting training and liaison.

In addition some children and young people and their families may have a Barnados "Buddy" to support them in their CAMHS journey.

Getting Help: Early intervention for children, young people and families in Buckinghamshire CAMHS

Barnardos staff deliver a three-strand delivery approach to children and families in their "buddy programmes" as follows;

1. ***Targeted Buddies***

Buddies will provide time limited, targeted support for CYP who have been assessed by a CAMHS clinician as being suitable for this help. For these CYP and their Families/Carers, the Buddy will be the primary worker delivering brief targeted

support programmes up to six sessions and will have responsibility for all recording processes including amending the Risk Assessments, Care Plans and ROMS.

Buddies will deliver evidence based work on either CBT informed or DBT informed work for six sessions. The work is currently delivered on a weekly basis all cases should be low to moderate mental health issues. Risks should be low when referring for Buddy intervention.

2. Getting More Help Buddies

Buddies will provide support for any CYP and their families/carers when requested. To do this they will enhance, revisit and aid understanding of clinical work taking place and offer reassurance to CYP and families/carers receiving more complex clinical therapy and interventions (specialist). This is achieved by providing planned support with 6 weekly reviews with the Care Coordinator. In addition, Buddies may be asked to provide step down support to CYP who are coming to the end of more complex interventions. This may also be provided by a suitable volunteer overseen by a team manager or buddy.

At all levels Buddies, will also offer support to maximise attendance at appointments by reminding CYP and their Families/Carers when appropriate. They may also be able to support them to attend if necessary.

3. Targeted Group Work

Barnardos Buddies deliver the following group programmes in CAMHS.

- *Mild to moderate depression and anxiety*
  Generally used as a first line intervention unless there are specific reasons following other interventions

- *Healthy Heads Lite (DBT informed) Group*
  For young people aged 12-17, assessed by OH clinicians either in a targeted assessment or GMH assessment.
  Young people who are struggling to manage their emotions (i.e. anger, anxiety, low mood) and/or behaviours (i.e. self-harming behaviours).
  Young people who engage in self-harming behaviours.
  They do not need to have a diagnosable mental illness.

- *PAC (Parent anxiety course) Parent only group*
  Parent Anxiety Course Criteria run by Buddies who have completed the Enhanced Evidence Based Practice CYP-IAPT course at Reading University.

- *ASD/Anxiety Programme run by Neuro Buddies*
  This programme is designed to be run over a course of 6 sessions consisting of 2 hours' session for both parent and young people. Age range 11-14 with an ASD diagnosis with low to moderate anxiety.

- *Cygnets Post diagnostic group Parent only*
  This programme is run over a course of 6 sessions consisting of 2 hours' session for the parent. Age range under 11 with an ASD diagnosis.

Drop In sessions

Since 2016 CAMHS have been offering bookable 15minute appointments as "drop ins" for the SPA and neurodevelopmental pathway. For SPA this enables a short assessment of need to help identify the right service for the young person. For the neurodevelopmental pathway, where there is a high level of demand, this has enabled face to face consultation in relation to children and young people already known to CAMHS. These have been well received with feedback from parents such as "*so helpful when you don't need a full review or you want to talk to a professional without your child with you. They are easily accessible and staffed by qualified clinicians who know what they are talking about."*

School Nursing and Mental Health in Schools: The Emotional Health Pathway

Public Health commissions Bucks Healthcare NHS Trust to provide the school nursing service, which delivers the Healthy Child Programme (DoH, 2009) to school age children across the state schools in the county. The school nursing service uses the Health Awareness Prevention Intervention (HAPI) online health assessment tool based on the Lancaster Model which assesses the health and emotional needs of children in Reception, Year 6 and Year 9, who attend mainstream schools. A school health profile is generated from the information gathered from the parents and children, which informs the delivery of appropriate services based on the identified need. In 2017-2018, School Nursing and CAMHS developed an emotional health pathway which identifies children at risk of mental health problems for all age groups. HAPI generates an alert for children who may have some emotional health needs. School Nursing respond to the alert by undertaking further assessment with the school, parent/carer and child to determine if further support is required. This may result in consultation with CAMHS or Children's Social Care as appropriate.

Counselling Services

Time to Talk

Time to Talk, delivered through Adviza, Buckinghamshire is a free confidential counselling service available to all young people in Buckinghamshire aged 11 to 25 years. Counselling is a talking therapy that allows a young person to talk about their problems and feelings in a confidential and safe environment.

15 out 34 secondary schools have dedicated Time to Talk counsellors commissioned by Buckinghamshire County Council.

The service received a total of 534 referrals in 2017/18 from a range of sources with the majority from young people, parents and GPs and has an average caseload of 271 young people.

School Counsellors
Some individual schools purchase their own pastoral or counselling services.

In addition voluntary services including Youth Concern, YES (Youth Enquiry Service), Buckinghamshire Mind offer youth counselling in locations across the county.

Peer Mentoring

The Peer Mentoring Development programme is being offered by Buckinghamshire Mind to Buckinghamshire Schools funded in part by Mind, individual schools and Buckinghamshire Public Health.

Buckinghamshire and Wycombe Mind also provide LGBT youth club, befriending and counselling.

The Youth Service (BCC Service)

The Youth Service is a referral based service and is part of the Early Help strategy in Buckinghamshire. The service works with young people at an early stage before issues escalate to a level where specialist support may be required and also supporting young people who have received a specialist intervention to provide a safety net to enable them to move forward once this work is completed.

Young people accessing the service all have additional needs which are sometimes complex and needing specialist support defined as Level 2 and 3 in the Buckinghamshire Safeguarding Children's Board Threshold Document.

Young people referred to Buckinghamshire Youth are provided with a package of support which can include:

- **One to One Support:** a safe space for young people to explore and work on a range of issues to improve their emotional well-being and increase their resilience to common life problems.
- **Group Work:** ongoing programmes for small groups that encourage young people to learn from each and develop the skills needed to successfully transition into adulthood. This type of support includes programmes that focus on building young people's resilience, independence and social responsibility and specific longer term interventions for young people who are NEET or at risk of NEET to develop their skills and attitudes to become ready for employment.

- **Mentor Support:** for young people who do not need more intensive One to One support but who would benefit from support to overcome issues or barriers and focus and direction to succeed. For example support for young people linked to confidence or work around motivation for those at risk of disengaging.

Of the 428 referrals received by the Youth Service in 2017/18, CAMHS were the fourth highest referrer and since April this year CAMHS have been the highest referrer.

Of all the referrals from CAMHS 50% are direct from the SPA (where a referral to CAMHS has not met criteria for an intervention from CAMHS). Approximately 40% have been a step forward to YS from CAMHS following a specialist intervention

Approximately 60% of all referrals to the Youth Service include young people who have some form of CAMHS involvement (ranging from ongoing intervention to overseeing care plan/ medication) and mental health is a factor in approximately 70% of all referrals into the Youth Service.

Special Educational Needs and Disability

SENDIAN project

There are a number of education led workstreams to support schools with inclusion, including working with Pupil Referral Units (PRUs) to facilitate behaviour network meetings and work with Youth Services. The SEND Pilot launched in November 2017 is one such project.
The project sees a different way of working to ensure schools and families are accessing earlier intervention and support to enable needs to be met in mainstream settings where appropriate, or progress quickly when an Education, Health and Care Plan is required. It was launched in Mid November 2017 across mainstream settings in Aylesbury.

The evaluation of the SENDIAN project is currently being completed with mixed findings. However schools have reported difficulty in access to CAMHS and paediatricians, which without this professional advice they do not feel they can provide the correct strategies to support children.

Reducing Admissions, attendances and out of area placements

Self-Harm Pathway

During 2014/15 the CCGs, accident and emergency, Buckinghamshire CAMHS and schools worked together to establish the Buckinghamshire Self harm pathway which span across the agencies. The project provided a toolkit and training across the agencies and enhanced multiagency working. This project has been further

developed to introduce a self-injurious behaviour toolkit and which was launched to the special schools in Buckinghamshire in 2016. Both of these information packs have been revised and updated and are planned to be relaunched in 2018/19.

This project won an award for the Positive Practice in training to l Health Awards in 2015 in the categories of Commissioning in Mental health and Innovation in Child, Adolescent and Young People's Mental Health.

Outreach Service for Children and Young people

The CAMHS Outreach Service for Children and Adolescents (OSCA) team evolved from the recognition that some young people needed improved access to mental health services, where a more flexible approach to engaging the young person and family can be taken. Such families often require a more intensive package of treatment & care than can be routinely offered by other teams within CAMHS.

Team statement – '*Supporting the mental health and emotional well-being of complex, vulnerable and high-risk young people and their families'.*

The OSCA team currently has four functions:

- Crisis and Home Treatment: typically used as an adjunct to existing care packages. Crisis offers a service to young people between the ages of 0 to 18, seven days a week, 24 hours a day within the Buckinghamshire area
- Assertive Outreach: focus on maintaining engagement with services and psychosocial support & interventions
- Dialectical Behaviour Therapy (DBT): a specific treatment for young people who may be experiencing heightened suicidal urges and self-harming behaviours and/or exhibiting signs of an emerging emotionally unstable personality disorder (EUPD); borderline type
- In-reach to and supported discharge from inpatient units

The staff team is made up of clinicians from nursing, psychiatry, psychology, social work and occupational therapy. As part of this, we also have specialist roles within the team including a Nurse Consultant/Lead for Deliberate Self-Harm, In-patient Liaison Lead and Social Care Consultant. These roles support the team to build up strong working relationships with partner agencies and providers as well as supporting the wider teams in CAMHS in specialist areas.

3 members of the OSCA team are currently fully trained in DBT and provide this therapy and intervention to young people within Buckinghamshire. In September 2018, 2 additional members of staff will be trained and will provide full DBT.

In 2017, the OSCA team were successful in achieving the Quality Network for Community CAMHS (QNCC) accreditation.

In relation to hard to reach groups that the OSCA team sees; the team will see all young people who present to the local hospital in relation to an acute presentation and this is regardless of status, home address, or any other contributing factor.

Crisis service

The Crisis service offers immediate support to young people out of hours 24/7 days a week. The team are trained in Dialectical Behaviour Therapy offering specialist skills in emotional regulation to reduce the risk of self-harm and suicide. There is 24/7 access to a consultant child and adolescent psychiatrist.

Psychiatric In Reach Liaison Service (PIRLS)

The Psychiatric In reach Liaison Service (PIRLS) will assess young people over 16 years attending A&E at Stoke Mandeville Hospital and support their needs, referring to CAMHS as required.

Calm Suite (health based place of safety)

During 2016 a calm suite was established at the Buckinghamshire adult inpatient site as an alternative health based place of safety. Difficulties in accessing Tier 4 inpatient and welfare secure beds for young people has meant that this has been used for longer than initially proposed for a number of young people. Social Care are developing an alternative provision that will be used as an assessment centre which is planned to be open by February 2019, it is proposed that the unit will have therapeutic mental health support integral to the unit.

Care Education and Treatment Reviews (CETR)

For children and young people with a learning disability and/or autism who display behaviour that challenges, Care Education and Treatment Reviews (CETR) were implemented from April 2017. CETRs have been developed as part of NHS England's commitment to transforming the services for people with learning disabilities and/ or autism who display behaviour that challenges, including those with a mental health condition.

The CETR ensures that individuals get the right care, in the right place that meets their needs, and they are involved in any decisions about their care. The CETR focuses on four areas: is the person safe; are they getting good care; do they have a plan in place for their future and can their care and treatment be provided in the community. The CCG is currently working on Guidance with stakeholders that will be shared when agreed.

Transitions between CAMHS & Adult Services

Transitions Policy

In CAMHS we are mindful of a young person's ongoing mental health needs post 18 years. We have developed a Transitions Policy to remove some of the artificial barriers that previously existed that led to delay or prevented that young person receiving a service when they turned 18 years. This policy ensures that all CAMHS clinicians liaise with Adult Mental Health team manager when the young person is 17 ½ years or earlier if a young person's mental health needs are very complex. If it is not clear whether a young person's needs would meet the threshold for adult services, a meeting is held with the CAMHS care co-ordinator, Adult Mental Health manager and relevant professionals.

A transitions assessment is carried out that includes the following;

- A full and current assessment of risks and associated management plan
- Access to the young person's CAMHS records
- Exploration of the individual service user's own views on their future needs and concerns, their hopes and strengths
- Carer's Assessment (where appropriate)
- A completed assessment of ongoing support needs to determine eligibility to hold a personal budget under Self Directed Support. (where appropriate)
- Consideration and agreement on any periods of joint working. It is recommended that there is a minimum of three appointments, with the first being at the CAMHS building to support engagement and reduce potential anxiety to the young person.

It is acknowledged that not all CAMHS service users will require transfer to secondary or tertiary Adult Mental Health Services. If a young person is in active treatment within CAMHS at the point of their 18th Birthday they may stay in the CAMHS service to complete the treatment if it is in their best interest. There is an expectation that transition to adult services can be fluid depending on the needs of the individual. It is possible that a service user may continue to have mental health care needs but do not necessarily require adult mental health community teams. In these cases, the Care Coordinator will consider what supports are available from primary care and other adult mental health services and other agencies.

All age mental health services

Both the CCG and OHFT have established management structures to support age inclusive services CAMHS, through adult to older adult. Pathway that have already started development as all age pathways include eating disorders early intervention in psychosis. Development is underway for all age pathways for behaviour that challenges, personailty disorders and neurodevelopmental disorders.

For 2018/19 and onwards we will:

Review the positive behaviour support offer across Buckinghamshire
CAMHS will lead a project working across children and young people and adult learning disability services to develop a consistent approach to behaviour management across all partners. This will support the wider county's aim to reduce school exclusions, out of county placements, involvement in criminal justice processes.

Ensure a robust 24/7 response to young people in crisis
People facing a crisis should have access to mental health care 7 days a week and 24 hours a day in the same way that they can get access to urgent physical health care. Getting the right care in the right place at the right time is vital. The Five Year Forward View for mental health proposes that by 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards as these are the unit's children and young people go to in the evening, during the night or at weekends. Therefore, we have looked to expand the age range seen by our established PIRLS (Psychiatric In-reach Liaison Service).

Develop work on Transitions to consider the mental health needs of care-leavers as they move out of care and into independent or supported living.

Develop network to support the mental health needs of those not in education, employment or training (NEET) and for those not attending a school through home education or absentees

Improve and extend the response to children and young people in mental crisis

Particularly outside of core hours and to those who may have complex presentations, including young people who may have autism and mental health problems leading to severe behavioural difficulties.

Improve the pathway for young people needing mental health services past their 18th birthday

To review the clinical pathway for young people presenting with emotionally unstable personality disorders and develop an all age pathway to support young people through transition.

5. Care for the most vulnerable

Our priorities for 2018/2019

Continue to embed whole system working to ensure services delivering to CYP work together to meet the mental health needs of this group of children and young people

Our Population

- *The proportion of children with an SDQ over 17 indicating cause for concern is higher than the average for the South East and England and all our statistical neighbours except for Cambridgeshire (44.6%)*
- *Research in 2013 identified that two children in the average primary class have experienced abuse[7]. The impact of this abuse on a child increases their risk of developing mental health problems.*
- *At the end of March 2018, 639 children were subject to a Child Protection Plan, an increase from 564 at March 2017.*
- *At the end of March 2018, 2560 children were identified as children in need (including those on CP plans and CLA). There were 1456 not including CP and CLA.*
- *Although the net number of children in care has seen a relatively stable increase the number of children coming into care and leaving care has increased over the last 3 years. There was a peak in 2016 with 245 children entering care, an increase of 50% compared to the previous year in 2015 (160).*
- *The UK estimate is that approximately one in 100 children has autism[8]. Applying this to the Buckinghamshire population would suggest that 1225 children in Buckinghamshire have autism.*
  Eating disorders

You said we need:

- *Shorter waiting times and higher priority for Children Looked After and those identified as in need*
- *More mental health support for those who have experienced sexual assault*
- *Better access to services to support young people who have been placed out of county*
- *Increased support and training to our foster and adoptive parents/carers*
- *Increased accessible mental health support to the residential units that are planned to reduce placing young people out of Buckinghamshire*

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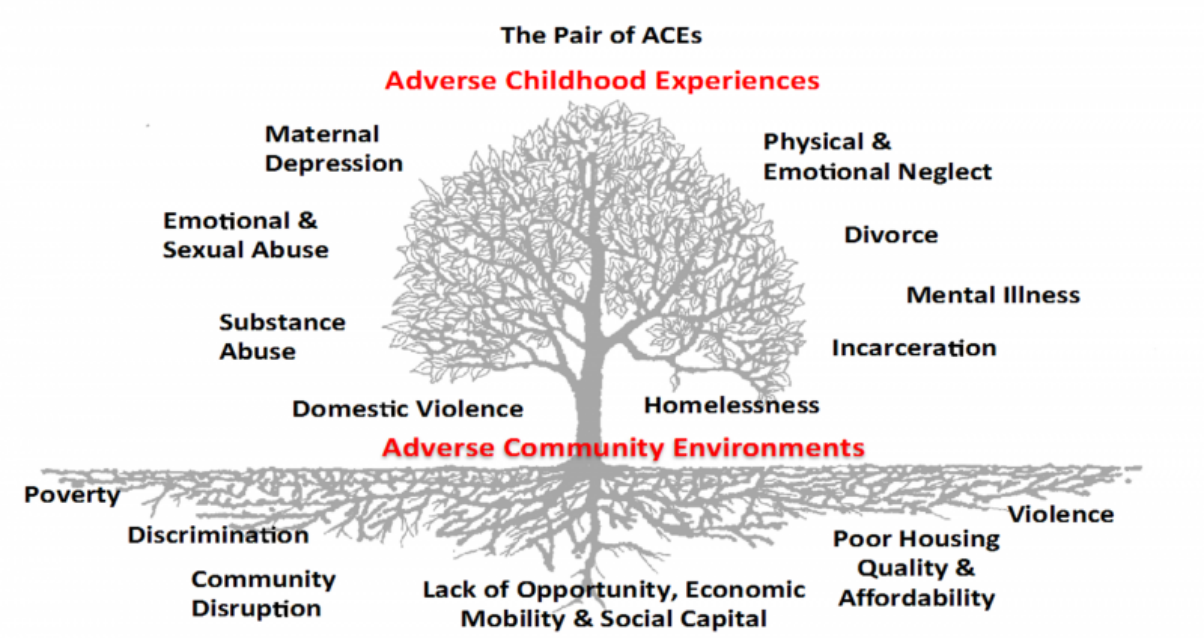
[7] Radford, L., Corral, S., Bradley, C., & Fisher, H. L. (2013). The prevalence and impact of child maltreatment and other types of victimization in the UK: findings from a population survey of caregivers, children and young people and young adults. , 37(10), 801-813.

[8] Office of National Statistics (2005), Mental health of children and young people in Great Britain, London: Palgrave Macmillan[1

Vulnerable Children and Young People

Adverse Childhood Experiences (ACEs)

It is well recognised that certain factors make some children and young people more vulnerable to mental ill health. These are referenced in the ACES model below:



Ellis, W., Dietz, W. (2017) A New Framework for Addressing Adverse Childhood and Community Experiences: The Building Community Resilience (BCR) Model. Academic Pediatrics. 17 (2017) pp. S86-S93. DOI information: 10.1016/j.acap.2016.12.011

Adverse Childhood Experiences have been linked to:

- risky health behaviors
- chronic health conditions
- low life potential
- early death

As the number of ACEs increases, so does the risk for these outcomes.

Future in Mind highlighted that some children are more vulnerable to developing mental health problems than others as demonstrated in the ACES model above. In addition a child who experiences or witnesses domestic abuse or who has been exposed to maltreatment or neglect or time spent in foster care is at greater risk of developing mental health problems or conduct disorders that can result in life-long reliance on services.

The *Future in Mind* report has emphasised that clinicians need to be alert to the possibility of abuse and neglect during mental health assessments and that ALL young people over the age of 16 years should be asked about abuse and violence including sexual exploitation as part of routine assessments.

The Government 2018 Green Paper *"Mental Health: Failing a Generation"* has highlighted that not enough action is being taken with meeting the needs of particular

vulnerable groups of children including children looked after /care-leavers, young people known to the criminal justice system, children in alternate education provision and children not in education, employment or training (NEET).

Buckinghamshire CAMHS has responded to the needs of the most vulnerable groups in the following ways;

1) *Setting up a specialist "Attachment & Vulnerable Young People" Pathway within CAMHS*
2) *Specialist Services for at-risk groups*
3) *Embedding Mental Health practitioners in teams responsible for vulnerable children and young people*
4) *Improving Transitions between CAMHS & Adult Services*
5) *Awareness of Abuse/Neglect in all mental health assessments*

Buckinghamshire offer

Health inequalities

BCCG and BCC jointly commission population based mental health services but acknowledge that there are groups of children and young people who experience a greater level of health inequalities and we are working to promote access for these groups.

The key groups, (but not limited to) are:

- Black and Minority Ethnic Groups
- Young LGBT people
- Young Carers
- Children who are Looked After (LAC) or on the Edge of Care
- Children who have been adopted
- Children with a learning disability and/or ASD
- Young people in the Youth Justice System
- Children who have suffered sexual abuse or sexual exploitation
- Children and young people who Self harm
- Children and young people who have suffered from neglect or trauma
- Children and young people with special education needs who have an Education, Health and Care Plan[9]

Attendance at appointments

Buckinghamshire CAMHS has a target to reduce non-attendance at appointments and has made some progress towards this since 2015.

[9] An education, health and care (EHC) plan is for children and young people aged up to 25 who need more support than is available through special educational needs support. Children and Families Act (2014)

Non-attendance rate (DNA)	9.29%	7.86%	6.31%	7.79%

Initiatives have included the introduction of the Barnados Buddy and increased use of alternative venues for appointments. Any young person who does not attended will receive follow up contact from the service with an assessment of risk. The referrer and GP of any young person discharged from the service will be notified of the action taken.

The Attachment & Vulnerable Young People Pathway

The Attachment and Vulnerable Young People Pathway was established to consider the attachment needs of children and young people who are known to Social Care and to improve the security of the child's attachment relationship with their parent/carer. There are two specialist services within the pathway; the ReConnect service and the Looked After and Adopted Children's Service.

- ***ReConnect -Specialist CAMHS Service for High Risk Parents & Vulnerable Infants***

ReConnect was commissioned to work with parents who are known to Social Care and present as high risk to their children (e.g. domestic abuse, substance misuse, personality disorders, mental health problems, care-leavers or if they have had a previous child removed from their care). The service aims to reduce the risks of neglect/abuse and attachment difficulties between the parent and their child working with parents who are pregnant or who have a child under the age of 2 years.

Parents who experience mental health problems, personality disorder, domestic abuse, substance abuse or who have been in care are referred in to the service. Intensive therapeutic support is offered to parents to increase the security of the infant's attachment relationship with them and to reduce the risks of harm to the infant. The service offers intensive evidence-based treatments including Video Interaction Guidance, Individual and Group Mentalization-Based Treatments which aims to improve a parent's ability to regulate their emotions and to distinguish their child's needs from that of their own. Trauma work is also offered to parents where this may be a feature in their presentation. The service has gained national recognition for its work (Analeaf award for infant mental health services 2016; Big Lottery Transgenerational Service award 2017, Maternal Mental Health Alliance; Highly Commended for Equality and Diversity, Positive Practice in Mental Health Awards, 2017).

It is featured as an example of best practice in the Positive Practice in Mental Health Directory including being highly commended for its work in equality and diversity of service delivery.

- ***Looked After and Adopted Children's Service***

The Looked After and Adopted Children's Service is commissioned to meet the needs of LAC children and young people including care-leavers. The service offers a fast, responsive and flexible services which centre around the needs of the child rather than mental health diagnosis. Young people who are experiencing significant emotional and/or behavioural difficulties or who are struggling in their placement are seen by the team. Referrals are actioned within 5 working days and an extensive assessment is offered to the young person that includes screening for mental health difficulties, attention deficit hyperactivity disorder, autistic spectrum disorder as well as trauma. Assessments include liaising with the various professionals involved in that young person's care so that a holistic overview of that young person's difficulties is gathered. Interventions are offered that focus on improving the quality of life for that young person which can include direct work with the child, work on the carer-child relationship, an intervention within school or within the young person's residential home.

A Reflective Parenting group is offered to all foster-carers, adoptive parents and residential care staff so that the emotional needs of the young people in their care can be better understood and responded to in a way that meets those needs. The group utilises the Mentalization-Based Treatment model throughout its 12 week programme and includes psychoeducation on attachment theory and trauma. The group also raises awareness of a carer's own mental health needs and carers are signposted to adult services if needed. A follow-up booster session is offered to carers two months after the group has finished.

The team will travel out of county and complete mental health assessments of young people in care living in other local authorities. The team will make recommendations for getting that young person the right help in the county they are living in either by liaising with their local CAMHS team if they meet local CAMHS thresholds or advising commissioners on therapeutic treatments that need to be purchased through the private sector.

Embedding CAMHS practitioners in Social Care Teams

Children and Young People who have been sexually assaulted or exploited are at increased risk of developing mental health problems including Post Traumatic Stress Disorder and are vulnerable to further exploitation. As a result of funding from the Health and Justice Board, CAMHS have embedded practitioners within Social Care teams such as the Swan Unit that deals with young people who have been sexually exploited and SARC (sexual assault referral centre). By placing CAMHS practitioners within these teams, young people's mental health needs are identified at an early stage and the appropriate help given to young people with these difficulties which can range from eating disorders, to anxiety/depressive disorders or treatment for post-traumatic stress disorder.

Early Help Panel Partnerships

The CAMHS service is linked to partnership arrangements across agencies including working with the police and social care in the Multiagency Safeguarding Hub (MASH) and supporting the Early Help Panel process, chairing the panel, reviewing cases of those referred and accepting referrals or signposting as appropriate.

Mental Health Individual Funding Request Panel

Buckinghamshire CGG has established a funding request panel to manage requests for young people placed out of county or in need of specialist support that cannot be delivered by Buckinghamshire commissioned services.

The panel considers requests on an individual case by case basis with the support of specialist CAMHS staff to help identify providers and to review outcomes and progress when requested.

Designated worker within the Youth Offending Service (YOS)

CAMHS have an identified member of staff who works with the YOS to identify mental health support needs and to support young people who have entered the criminal justice system.

Children and Adolescents who engage in Harmful Behaviours (CAHBS)

The CAHBS service offers guidance and consultation to professionals, families and young people where there is a concern about that young person's sexual behaviour.

Forensic CAMHS

The forensic CAMHS team is a specialist service for young people under 18 about whom there are mental health concerns and who show high risk behaviours towards others. Young people may or may not be in contact with the youth justice system.

The service has strong links with many agencies working with young people both within the Thames Valley and beyond. It includes different professionals such as psychiatrists, psychologists and nurses and forms part of wider mental health services for children and young people (CAMHS).

The service has received 415 referrals in the past year.

Liaison & Diversion

The Liaison & Diversion service works with young people under the age of 18 who are involved in offending behavior or whom have come into police contact. Liaison and Diversion services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders.

The service supports people through the early stages of criminal system pathway, referring them for appropriate health or social care support and enabling them to be diverted away from the criminal justice system into a more appropriate setting, if required.

The team offers consultation to professionals as well as individual assessments of young people. Its aims are to improve overall health outcomes for people and to support people in the reduction of re-offending. It also aims to identify vulnerabilities in people earlier on which reduces the likelihood that people will reach a crisis-point and helps to ensure the right support can be put in place from the start.

Street Triage

Street Triage refers to a service where clinical mental health professionals accompany or assist police at incidents where the mental ill health of an individual gives rise to concern. The Street Triage Clinician assists in ensuring the best option for the individuals in crisis. They will do this by offering professional advice on the spot, accessing health information systems, and helping to liaise with other care services to identify the right kind of support required.

The service provides timely interventions and works to avoid unnecessary detention either in a police station or hospital, which will equate to a better experience for these individuals. The Street Triage service supports TVP in managing any incident that may be related to mental health concerns and has no age restrictions. The hours of operation are 13.00hours to 24.15 hours.

Substance Misuse Service

Buckinghamshire has recommissioned the substance misuse service with a new contract due to start in October 2018. A specialist mental health worker provides a link into the service from CAMHS ensuring communication between the agencies and diagnostic needs can be addressed.

Eating Disorders Service

	2014/15	**2015/16**	**2016/17**	**2017/18**
Number of referrals received	11	42	77	109
Average Waiting times urgent referrals (1 week target)		*zero Urgent referrals*	*60% of Urgent referrals seen within 1 week*	*100% of Urgent referrals seen within 1 week*
Average waiting times non urgent		*67% of non-Urgent referrals seen*	*95% of non-Urgent referrals seen*	*84% of non-Urgent referrals seen*

The Access and Waiting Time Standard for Children and Young People with an Eating Disorder Commissioning Guidance (NHS England 2015) clearly sets out the transformation required locally and regionally to improve access, waiting times and the provision of evidence based treatments for young people with an eating disorder. The additional funding linked to these standards has enabled the development of the community Eating Disorder Service for children and adolescents. The service consists of two linked teams across Buckinghamshire and Oxfordshire and was officially launched in October 2016. The Buckinghamshire part of the service has been accepting referrals for all young people with a suspected eating disorder since January 2016.

The service provides assessment and treatment for children and young people with eating disorders and their families. The service aims to provide NICE-concordant treatment to children and adolescents referred with a suspected eating disorder within 24 hours to 4 weeks depending on the urgency of the referral, in line with national standards. The service accepts referrals from young people, parents and professionals. Most of treatment is delivered in outpatient community settings, however the service also provides in-reach and crisis based support through the Child and Adolescent Outreach Service when a higher intensity of care, or admission to a Paediatric of Psychiatric bed is required. Close collaboration with local inpatient units and the adult service is well established to ensure smooth transition of patient care when necessary or appropriate.

The multidisciplinary workforce has been structured according to the NHS England Commissioning Guidelines and local service need. The service has completed recruitment of the planned workforce including the introduction of Paediatric Consultant time (May 2017). Incorporating paediatric sessions has transformed our interface with paediatrics, enabling better and seamless care for those at high medical risk. This year we have re-designed our clinical and management leadership structures to develop a Buckinghamshire all-Age Directorate. Our Eating Disorders service is our first service to become an all-age service that results in seamless integrated care for young people who present with an eating disorder. Both CAMHS and Adult Mental Health clinicians work closely alongside one another so that care is uninterrupted for that young person as they transition into adulthood.

All staff are trained to deliver NICE-concordant treatments and regular individual and team supervision is in place to maintain the standards of care. Throughout 2017-2018 service staff attended and helped to deliver the National Child & Adolescent Eating Disorder Training, commissioned by Health Education England and provided to all 79 child and adolescent eating disorder teams across England. The service was awarded overall team exhibition winner at the finale Eating Disorder Conference in London in March 2018 for presenting its work.

The service is registered with the national quality improvement programme for Child & Adolescent Eating Disorder services under the Quality Network for Community

CAMHS. We completed our self-review in August 2017 and are due to undergo a peer review in 2019. The service has worked hard to improve compliance with Access and Waiting Times Standards with 84% of referrals seen within 4 weeks in 2017-2018.

The service has established an active participation forum which enables service users and carers to regularly work with key staff to support ongoing service development and review. The service leads a regional best practice forum and holds annual meetings with representatives from key stakeholder groups which continue to help refine service access and delivery. The service is committed to research and audit to evaluate the service and interventions and enhance our understanding of eating disorders, involving multiple ongoing projects. As an example, the service recently published an evaluation of a carers' workshop, delivered with the Adult Eating Disorders Service (Jenkins et al., 2017).

Attention Deficit and Hyperactivity Disorder & Autistic Spectrum Disorder

Buckinghamshire CAMHS addresses the specific needs of children and young people who present with Attention Deficit and Hyperactivity Disorder (ADHD) and/or Autistic Spectrum Disorder through setting up a specialist Neurodevelopmental Pathway. Consultation, assessment and individual work is offered by the team including parenting support and skills training which is offered in a group setting post-diagnosis.

The demand for this service across paediatricians and CAMHS has led to longer waiting times for diagnostic assessment. In order to address this skill mixing has facilitated the appointment of additional staff to provide information gathering and support the clinicians in diagnosing autism and ADHD. A specialist worker has also been appointed provide support for young people who present with autistic traits to enable better management of the presenting needs and potentially reduce the need for a diagnostic assessment.

Children & Young People with an Intellectual Disability

The CAMHS pathway for Children and young people with an Intellectual Disability is a multidisciplinary team of clinicians who can offer consultation, assessment, intervention and care co-ordination for children and young people who require a specialist Intellectual disability service, due to moderate or severe, complex and enduring difficulties.

In line with recent legislation and good practice guidance the Buckinghamshire CAMHS-ID Pathway will work with and alongside the other Pathways in CAMHS to ensure that children with Intellectual disabilities have equal access to the range of

specialist CAMHS Services available to children and young people who do not have Intellectual disabilities. It is expected that in most cases, the mental health needs of children and young people with a mild Intellectual disability (IQ within the range of 50-70 and associated adaptive functioning difficulties) can be met within the other specialist CAMHS Pathways. This may require consultation from the Buckinghamshire CAMHS-ID Pathway to support assessment, formulation and making reasonable adjustments to interventions as appropriate. When assessment indicates that other CAMHS pathways are not able to meet the current need or if there are not the skills or competence available, the Buckinghamshire CAMHS-ID Pathway will offer an assessment to children and young people who meet both the following criteria:

- Child has an identified emotional, mental health or behavioural difficulty that requires a CAMHS assessment
- Child has a diagnosed Intellectual disability, or significant impairment of intellectual and social adaptive functioning, which significantly impacts their mental health presentation.

In additional to the above criteria children and young people may also meet the following criteria, (in addition to a history of chronic difficulties and unsuccessful interventions).

- Complex physical health needs and medication
- More than one family member with an Intellectual disability
- Highly-risky behaviour (i.e. high frequency and impact)
- Urgent safeguarding issues
- Complex co-morbidity in addition to a diagnosis of Intellectual disability.
- For Children and Young People who are using respite or residential placements, the placement is in danger of breakdown and in need of specialised support.

Following a comprehensive assessment and formulation of the young person's needs the team can offer a range of therapeutic interventions. Examples of interventions offered include psychoeducation usually in the form of workshops for parents around ASD, anxiety, and behaviours that challenge, Positive Behaviour Support, consultation with the system around the child to support the implementation of Positive Behaviour Support and if appropriate individual work (such as cognitive-behavioural therapy adapted to meet a child's needs), and pharmacotherapy.

The service works alongside the learning disability nursing service and with the adult community learning disability team to ensure timely and supported transitions between the services.

The service has developed letters and guidance in an easy read format such as an appointment letter with pictures of staff location. –Can wes add more of this sort of things that have been done please?

Early Intervention in Psychosis Service (EIP)

An Early Intervention service for Psychosis has been set up based on NICE guidance for young people age 14 plus who are presenting with Psychosis. This team consists of CAMHS and Adult Mental Health Staff to ensure the continuity of care for young people who present with this chronic disorder that is likely to continue to impact upon the young person as they move into adulthood.

Awareness of abuse/neglect during all mental health assessments

All staff within CAMHS receive mandatory training in recognising abuse and neglect during assessments of children and young people referred to the service. We have developed our assessment forms to include prompts for clinicians to consider the young person's history and particularly whether neglect/abuse is a feature.

All CAMHS staff teams receive regular supervision from our Trust Safeguarding Nurses to consider cases where maltreatment has occurred or where there may be suspected but undisclosed abuse/neglect. We have developed the role of Domestic Abuse champions within our teams to raise further awareness of young people who may have experienced or witnessed domestic abuse. We have developed greater links with third sector organisations that offer support to parents and to young people who have experienced domestic abuse (e.g. Freedom Project, Aylesbury Women's Aid Young People's service) and have contributed to the Domestic Abuse strategy and training programme that is offered to professionals within the county to raise awareness of children's mental health needs in families where domestic abuse has occurred.

Think Family Approach in Adult Services

OHFT have a Safeguarding Standard Operating Procedure which includes a "Think Family" approach to all staff working with service-users where dependent children under 18 years are recorded in the patient notes. Staff working in adult mental health services are required to assess the impact of that parent's mental health on their child and to consider child protection risks at every stage. Children are identified if they are carers to their parent and support offered in the form of a young people's carers group. Staff within adult services must also record if a service-user or their partner is pregnant and the risks to the unborn child are also taken into consideration with referrals made to Social Care where there are concerns about risk.

Collaborative Commissioning

CCG commissioners are working with NHS England Specialist commissioners to develop joint plans for collaborative commissioning of the pathway for those children and young people who may require in-patient care. This includes crisis response, admission avoidance and early discharge/ step down support. These plans are

advanced in Buckinghamshire in that we already have a crisis support and assertive outreach service in place including for those with a learning disability. In addition to those services the Eating Disorder Service for children and young people has an emphasis on treatment in the community and crisis support build into the model to avoid hospital admission where possible. For the Eating Disorder Service and the crisis/assertive outreach team transformation funding has enabled additional investment to improve capacity within services.

For 2018/19 and onwards we will:

Use text reminders for appointments

Buckinghamshire CAMHS will be trialling automated text reminder for appointments to further reduce the “Did not attend” rate. This has been used for individuals but this will see text reminders as part of the care notes system and therefore wider use of this.

Co-locate CAMHS and Social care

During 2018/19 it is planned that partnerships with social care will be enhanced through colocation of CAMHS workers with the social care team. Discussions are also taking place with regards to how mental health services can support the new care homes being developed in county and how the services can support each other to ensure timely and appropriate access to services for children and young people who are in crisis.

Further develop all age eating disorder services

Further implementation of the revised clinical and management leadership structures underpinning the move to an all-age service. In 2019, the child & adolescent team is due to complete the next, peer-review, stage of QNCC accreditation. In line with Access and Waiting Time Standard, the service plans to improve early access to specialist treatment and further reduce waiting times. Most referrals (almost 60%) to the service are still received from GPs. Through further stakeholder liaison, training events and website development, the service aims to facilitate earlier access to treatment through other groups, namely school staff and parents. Within treatment, a key priority is to continue to work with the local Paediatric and Psychiatric wards to implement consistent and well-integrated care pathways which minimise time spent in hospital and improve outcomes.

Develop system wide Positive Behaviour Support

In response to increasing exclusions and out of area placements, Buckinghamshire needs to develop consistent Positive Behaviour Support across the county including supporting the increase of knowledge and skill in this area for parents/cares and the county’s special education provision and social care. Working in close liaison with

our adult services to support the transitions for young people with complex needs between services and in line with the Transforming Care Agenda ensuring that this vulnerable group of young people receive the appropriate support to remain with their families reducing the need for residential or hospital placements.

Continue to develop the system wide pathway and support young people with autism and their families and carers.

Co –production work has been ongoing to an autism toolbox with advice and guidance to support professionals, parents and carers of young people with autism. Through 2018/19 the service will be further working with the paediatricians to establish a single point of access for all neurodevelopmental referrals through the CAMHS SPA and a joint pathway so that referrals are seen by the most appropriate professional rather than using the current criteria of age.

Co-locate CAMHS staff with social care teams (Looked After and adoption teams and court team)

By placing CAMHS practitioners within these teams, young people's mental health needs are identified at an early stage and the appropriate help given to young people with these difficulties which can range from eating disorders, to anxiety/depressive disorders or treatment for post-traumatic stress disorder.

Develop the in county provision for young people presenting in crisis

Work with social care in developing the in county provision and assessment unit to ensure environment and resources to best support young people presenting in crisis who are not detainable within a mental health setting but are unable to stay with their parents/carers.

Ensure mental health is integral to the Early Help review

To work with BCC in the early help review to consider how MH can be integral to the early help strategy and pathways.

6. Accountability and Transparency

Identification of Needs for Buckinghamshire Childrens Mental Health and Wellbeing Service and the Joint Strategic Needs Assessment (JSNA)

The last Joint Strategic Needs Assessment[10] (JSNA) for Buckinghamshire was completed in October 2016 and a new children and young people's mental health JSNA will be completed in 2018/19 utilising the revised national prevalence data that is due for publication later this year. A refresh of data has been completed and is included in Appendix X

Investment and Spend

	2015/2016	2016/2017	2017/2018	2018/19
CAMHS pooled budget (BCC and BCCG)	£5,423,400	£5,423,400	£5423,400	£5,423,400
Additional CCG investment	£784,426	£1,298,426	£1,140,426*	£1,590,426 *
BCC Youth Counselling Public Health MH support	£270,000 £58,000	£270,000 £58,000	£200,000 £58,000	£135,000 £58,000
Total CYP MH Budget	£6,535,826	£7,049,826	£6,891,826	£6,892,426

* Includes £56,000 from NHSE Health and Justice

Buckinghamshire CAMHS Pooled budget

The designated pooled budget for Buckinghamshire CAMHS contract is £5,423,400 per annum. This is made up from contributions across Buckinghamshire County Council (29.5%) and NHS Buckinghamshire CCG (70.5%).

Since 2015 through transformation funding Buckinghamshire CCG has invested an additional £1,590,426 in Buckinghamshire children and young people's mental health services through Oxford Health as the prime provider.

[10] http://www.healthandwellbeingbucks.org/what-is-the-jsna

The CAMHS contract holds a 5% incentive scheme paid on the achievement of 5 Key performance indicators.

The indicators for 2018/19 have been agreed as:

- Maintaining 4 week referral to assessment
- Increasing access in line with the requirements of the FYFV
- Reporting on outcomes
- Delivery of the parent training and support offer
- Development of positive behaviour support offer in Buckinghamshire

NHSE Health and Justice

NHSE Health and Justice have invested £56,000 through the CCGs to enhance the support offer to young people who attend the Sexual Assault referral Centres (SARCs). The service has identified a named link to work into the SARCs and into the Buckinghamshire Child Sexual Exploitation (CSE) Swan Service.

Oxford Health are commissioned by NHSE Health and Justice to provide a Liaison and Diversion service to young people presenting in police custody.

The Youth Counselling service,

Time to Talk is currently commissioned by Buckinghamshire County Council (BCC) however the BCC contract is ending on 31 March 2019 and Adviza, the provider is working closely with Buckinghamshire CAMHS to facilitate continuation of this service.

Public Health

Public health has a programme of work to promote mental health and wellbeing in school age children. The public health team support and coordinate the emotional wellbeing and mental health strategy group. This programme includes the annual Emotional Wellbeing Conference for schools, the commissioning of training opportunities for school based staff for example Penn resilience programme, support to school peer mentoring programmes and the production and dissemination of resources to support schools such as Whole School Approach informational resources, suicide prevention resources and related newsletters, training and briefing sessions.

Inpatient beds (NHS England responsibility)

In 2014/15 NHS England spent £2,651,870 on mental health inpatient stays for Buckinghamshire Young People, detail of spend since this date has not been provided by NHS England. Buckinghamshire utilises beds in the Highfield Unit in Oxfordshire for inpatient stays where possible, however nationally it is recognised that there continues to be pressures on inpatient beds with many young people travelling further afield to access a bed. Young people staying in private hospitals

incur costs to the originating local authority for their education provision whilst receiving treatment.

New Care Models (collaborative Commissioning)
OHFT has been invited by NHS England to submit a business plan for wave 2 of the New Care Models Programme[11]. The New Care Models are part of the delivery for the FYFV and are designed to ensure young people can access in-patient care when they need it and in a local setting. The FYFV describe the New Care Models in following terms:

"Bringing patients closer to home helps people to maintain a better connection with their families and friends, and improve how they interact with local services. This programme aims to reduce length of stay and the number of out-of-area placements in a number of specialised mental health services. It also aims to reduce expenditure, by delegating responsibility of the budget for inpatient services to local providers. Pilots in this programme:

- Use a multi-disciplinary team approach, with providers taking ownership of their patient population
- Develop a wide range of therapeutic interventions across a whole pathway
- Focus on recovery through accommodation, community activities, social networks and employment advice
- Work proactively with the criminal justice system, local authorities and secondary care providers
- Expand both liaison support and community follow-up provision
- Develop local capacity and capability to manage all types of patients

It is anticipated that the new partnership will go live later this year with OHFT as the lead provider of the partnership. The partnership covers Inpatient Acute Child and Adolescent Mental Health Services (Tier 4 CAMHS).

Within the scope of this application are:

- General Adolescent inpatient units (GAU's)
- High Dependency units
- Psychiatric Intensive Care Unit (PICU)
- Specialist eating disorder inpatient services
- Low secure adolescent inpatient services.

Tier 4 CAMHS General Adolescent Services deliver tertiary level care and treatment to young people with severe and/or complex mental disorders usually necessitating Inpatient or Day patient intervention.

The T4 CAMHS Network is formed between:

[11] https://www.england.nhs.uk/blog/bringing-specialist-mental-health-services-closer-to-home/

- Oxford Health NHS FT (OHFT)
- Berkshire Health NHS FT (BHFT)
- Avon and Wiltshire NHS Partnership Trust (AWP)
- 2Gether NHS FT
- Weston Area Health NHS Trust (WAHT)
- The Huntercombe Group (THG)
- Priory Healthcare
- Southern Health NHS Foundation Trust (SHFT) – whilst not a formal part of this network will provide access to their low secure beds CAMHS beds and provide input into the network when required

Managing both acute inpatient and Eating Disorder beds will complement the comprehensive CAMHS community services delivered within the geographical footprint identified above. This bid intends to have a direct impact on crisis care arrangements for young people in mental health distress who present at Emergency Departments and social care seeking emergency placements.

Buckinghamshire's crisis response, admission avoidance and early discharge/ step down support plans support the new care model approach. The county already benefits from the crisis support and assertive outreach service including for those with a learning disability. The Eating Disorder Service for children and young people has an emphasis on treatment in the community and crisis support build into the model to avoid hospital admission where possible. For the Eating Disorder Service and the crisis/assertive outreach team transformation funding has enabled additional investment to improve capacity within services.

Monitoring of performance

The service is now in year three of a five year contract. Monthly project meetings are held to track continued transformation in addition to monthly performance monitoring meetings. The CAMHS service is monitored against access, waiting times and annually agreed Key Performance indicators (KPIs).

Improved data and the National Mental Health Minimum Dataset

The National Minimum Mental Health Data set has been mandatory from April 2017 and we are currently working with Oxford Health NHS Foundation Trust on ensuring accurate reporting is in place to capture data to monitor the performance of the service and report on KPIs that are nationally mandated such as the Eating Disorder Service and the CAMHS Access Trajectory. Reporting on both of these is currently in place.

Development of the plan

The Five Year Forward View for mental health is led across Buckinghamshire Integrated Care System (ICS) through a multiagency group, using expertise from Buckinghamshire CCGs, Buckinghamshire County Council, Public Health, Oxford Health NHS FT, Voluntary sector partners and NHSE. There is an all age mental health joint commissioning team supported by Clinical Directors in the CCG and close partnership working with NHS Oxfordshire CCG.

The CYP MH plan is supported by the Emotional Wellbeing and Mental Health Strategy Group whose own plan supports the delivery of the Transformation plan (appendix 2).

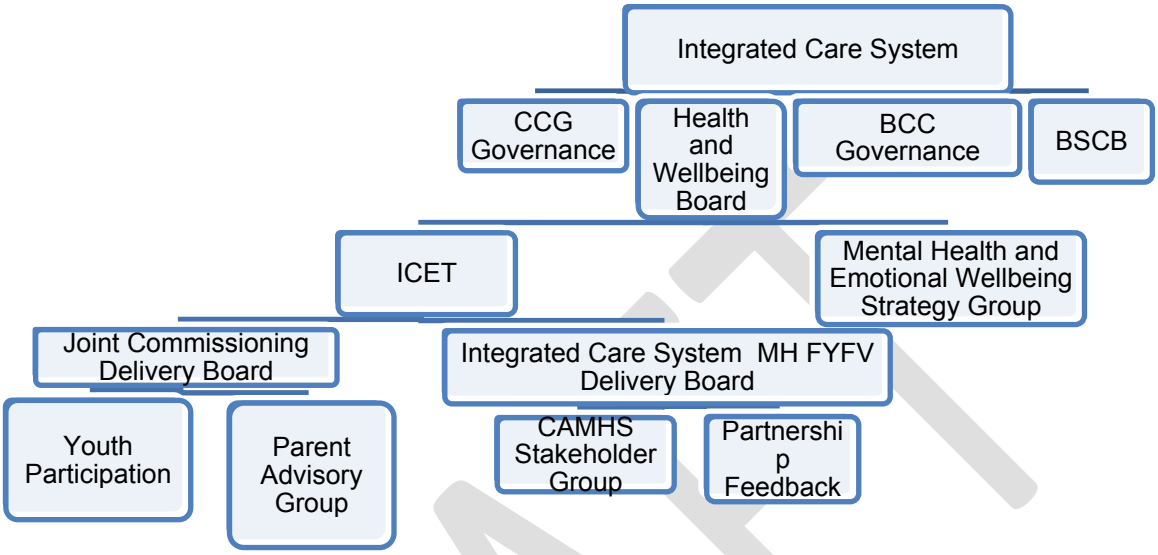
Monitoring and oversight is provided through:

- CAMHS monthly project group meetings attended by commissioners and provider, which provides oversight and assurance of the progress towards the changes. It is tracked by an implementation plan and includes an active risk register.
- Monthly contract monitoring meetings for commissioned services.
- Feedback from the CAMHS Stakeholder group (to increase meetings to termly from annual)
- The Emotional Wellbeing and Mental Health strategic group
- Quarterly reporting to the ICET S75 JMG meeting

Any issues identified through monitoring are escalated through the Joint Commissioning Delivery Board that meets monthly, with further escalation of issues to the Integrated Care Executive Team (ICET) which includes representatives from the CCGs and BCC Children and Adult services and Public Health.

The Health and Wellbeing Board has delegated responsibility for oversight of the plans to ICET but has received updates of progress. These will also be provided to the Buckinghamshire Safeguarding Children's Board.

Governance Structure



Evaluation of the new model

An approach to evaluating the new model has been agreed and will involve collaboration between OHFT, the Academic Health Sciences Network and Oxford University. The evaluation will help us validate the model, identify areas for development and share our learning to promote effective and evidenced based mental health service for children and young people. The details of the evaluation research approach can be found in appendix three.

7. Developing the Workforce

The CAMHS service through Oxford Health's partnership with Barnardo's consists of a skill mixed team. The Barnardo's staff receive training and regular supervision through the Oxford Health staff team. Working with Barnardo's has brought opportunities to develop a volunteer workforce with an average of 22 volunteers collectively providing 627 hours support over the last 6 months.

The Time to Talk service is largely provided by a large volunteer workforce of approximately 100 counsellors.

Please refer to Appendix 4 for more details of overall establishment.

Buckinghamshire faces challenges in recruitment as, alongside a national shortage of qualified staff, its close proximity to London means the area is expensive to live without the benefit of additional allowances for London or High Cost area allowance.

OHFT have developed a workforce strategy across the adult and children's services they deliver in Bucks to review workforce and consider ways to attract employees to the area.

Buckinghamshire as an Integrated Care System (ICS) continues to have a clear priority to ensure that it works with all providers to develop a shared workforce strategy.

This work is supported by the Thames Valley SCN workforce working group, which has brought all key strategic partners together as well as providers and commissioners of children's mental health services.

This has provided an initial benchmark of gaps and issues and some possible solutions .The initial focus of the workforce strategy has been to focus on the key areas of CYP IAPT, EIP, PPEP care and eating disorders, while the scope of the wider system is being considered (STP and Integrated Care Systems[12])

Doing this with the Thames Valley NHSE Strategic Clinical Network will also ensure that this will align to the work being undertaken by the STP and Integrated Care Systems[13].

This local transformation plan aligns to the overall mental health FYFV delivery plan for Buckinghamshire CCG, which will continue to align to the developing mental health delivery plan for the BOB STP and relevant Integrated Care Systems.

Difficulties in recruitment in Buckinghamshire have provided the opportunity to explore innovative approaches to the workforce including developing partnerships with third sector providers and reviewing skill mix within teams, developing nurse prescriber posts and enhancing clinical leadership. The introduction of the Third Sector as a partner in delivering CAMHS is developing a new workforce whilst retaining clinical oversight and ensuring clear governance structures. A specific training programme is in place and continues to be delivered to further expand on capacity and enhance skill levels in line with CYP IAPT. CAMHS continue to evaluate the third sector roles to establish the impact on young people and ensure ongoing positive outcomes.

The local workforce plan includes not only plans for CAMHS staff and the Third Sector Partners, but also the wider children's workforce. The service has a clear remit around developing capacity in the wider workforce. The aim is to foster early intervention and for staff to feel confident and having the skills when dealing with children and young people who show signs of distress, emotional difficulties and

[12] https://www.england.nhs.uk/accountable-care-systems/
[13] https://www.england.nhs.uk/2017/06/nhs-moves-to-end-fractured-care-system/

knowing how to identify mental health problems in children and young people. Training plans have therefore been developed to build capacity in:

- ✓ *Primary care*
- ✓ *Primary schools*
- ✓ *Secondary schools*
- ✓ *Colleges*
- ✓ *Children's services*
- ✓ *The Third sector*

A further training plan is being developed to support the Transforming Care agenda with a particular emphasis on a Positive Behaviours Approach[14]. The training plan aims to support more CAMHS staff (including in-patient services) to develop skills, knowledge and evidenced based interventions for children and young people with LD and/or ASD whose behaviours that challenge. The plan will look to develop a train the trainer model to ensure sustainability. The plan will also include training for specific Children's Services to develop capacity in the wider system.

Children and Young People's IAPT (CYP IAPT)
The CYP IAPT training continues to be rolled out for CAMHS staff and this is part of an ongoing plan to implement CYP IAPT across CAMHS. Oxford Health NHS Foundation Trust is in one of the leading partnership in the country that has been involved in developing and implementing CYP IAPT. Due to workforce issues the Trust is now recruiting to training posts as a way of skilling up the workforce and finding backfill to release staff is proving difficult. This approach will ensure that the roll out of IAPT continues and aspects of IAPT will also be made available to third sector partners as part of their training opportunities. The commitment to the delivery of CYP IAPT is a requirement of the contract and will continue to be a priority over the lifetime of the contract.

CAMHS staff have been trained in CBT, Interpersonal Psychotherapy for Adolescents (IPT-A), Systemic Family Practice and Enhanced Evidence Based Practice (EEBP).

4 members of staff joined the CYP Psychological Wellbeing Practitioner (PWP) accreditation and finished in April 2018.

Future Workforce requirements

We advertised for CBT trainee posts for 2017/18 (through CYP IAPT recruit to train) but unfortunately were not successful in appointing to these. We are currently advertising two CBT trainee posts for 2018/19 as well as three CYP Psychological Wellbeing Practitioner (PWP) posts. We have one member of staff completing the Systemic Family Practice training.

[14] http://www.challengingbehaviour.org.uk/information/information-sheets-and-dvds/keymessagespbs.html

5 Barnardo's staff completed the EEBP training in 2017/18, and 3 are currently undertaking this for 2018/19.

8. Engagement

Engagement for development of the plan has been through a number of sources including those indicated below.

8a. The voice of the Young person in developing the Service

Children and Young people from a range of backgrounds and experiences were involved in the recommissioning process in a number of ways; reviewing and completing the survey, setting a question for the method statement and commenting on provider responses and having their own presentation by the providers with opportunities for questions and discussion which was then fed into the evaluation process.

A full-time participation lead has ensured that the young person's voice continues to be heard and service-user groups have been set up such as Article 12 and the Parent Advisory Group.

Article 12

The commissioned service includes a requirement for engagement of Children and Young People and a full time participation worker supports this work with children and young people and parents and carers. The service user group, Article 12, have provided input to the transformation plans and have become an integral part of the CAMHS service.

Article 12 meets on a monthly basis and have been busy on a number of projects which are outlined in appendix (X).

A member of Article 12 who was involved in the original consultation in 2015 and has written an outline of Article 12 involvement since that time which is attached as appendix (X).

Buckinghamshire Youth Voice

Youth Voice is for young people 11 to 19 year olds (or up to 25 years old for young people with a disability or learning disability) from Buckinghamshire. Youth Voice is a place where young people can have their voices heard to benefit the community around us and raise the issues that they are most passionate about. Youth voice consists of three groups, The Executive Committee, Youth Voice for SEND, and Youth Voice for children and young people in care.

The national 'Make Your Mark' campaign sees young people from across the country voting for the issues that are most important to them. The Buckinghamshire results from Make your Mark 2017 demonstrated the local interest in regards to mental health with young people voting for "Mental Health - Services should be improved with young people's help" with the highest level vote out of the 10 categories (437 out of 3236 votes, 13.5% of the votes)

The group has chosen to actively promote mental health awareness and has provided feedback to guide initiatives to promote mental health services to young people. Through 2018 they have been consulted on developing the mental health strategy for Buckinghamshire and work will be progressed to ensure further engagement with this group.

8b. Parent Advisory Group (PAG)

Over the last two years within Buckinghamshire a thriving Parent Participation Group that meets 4 times a year has been established. The group includes parents from various backgrounds whose child has needed to use mental health services in Buckinghamshire. The group helps to develop the CAMHS service by offering insights of their experiences and identifying how services can be improved.

The PAG has been a huge support in guiding developments including what useful information should be included in the Annual Review, as well as helping to guide how the service can offer effective support to our parent/carers.

Parents and carers from the PAG have been involved in delivering training for Oxford Health staff so clinicians can learn more about a parent/carer experience as well as being involved in the Trust 'I care, you care'[15] initiative.

8c. Stakeholder Engagement

Stakeholder engagement within Buckinghamshire has taken a number of forms including surveys, question of the week in reception at the centres, feedback from schools, GPs, social care and through the Emotional Wellbeing and Mental Health strategy Group.

An annual stakeholder event has been held to launch the Buckinghamshire CAMHS service annual report and to enable feedback and engagement in future planning of mental health services for children and young people. The most recent was in July 2018 and attendees included representatives from social care, education services and schools, FACT Bucks, County Council members, Public Health, GP Clinical Directors. It has been planned to host this more frequently to ensure ongoing engagement with a wider range of stakeholders.

8d. The Emotional Wellbeing and Mental Health Strategy Group

The Emotional Wellbeing (EWB) and Mental Health (MH) strategy group is a multiagency group established to link the work around emotional wellbeing and mental health in Bucks. The group enables links between organisations and a forum to identify priorities for development. The action plan for this group is aligned with the transformation plans. Appendix X

[15] https://www.oxfordhealth.nhs.uk/support-advice/support-for-carers/i-care-you-care-family-friends-and-carers-strategy-2017-2020/

Promotion of the Buckinghamshire Transformation Plan

The plans will be shared in an easy to read version through the websites for Buckinghamshire CCG and Buckinghamshire County Council, Buckinghamshire Family Information Service by 31st October 2018 with awareness raising through a variety of media across the providers, BCC and the CCGs

9. Links to National and Local strategies

Further details in Appendix X Links to National and Local Strategies

In addition to Future in Mind and the Five Year Forward View for Mental Health developments in Buckinghamshire have been guided and informed by the following national papers published in 2017.

- **Public Health England Prevention Concordat**
- ***Transforming children and young people's mental health provision: a green paper***

Mental health is embedded within across the Buckinghamshire system through a number of plans with oversight provided by the Buckinghamshire Health and Wellbeing Board and Safeguarding Children's Board.

- **Buckinghamshire Joint Health and Wellbeing Strategy 2016- 2021** [16]
- **The Buckinghamshire Children's Strategy 2015-18**[17]
- **Buckinghamshire Suicide Prevention Plan**
- **Buckinghamshire Crisis Care Concordat**[18]
- **Special Educational Needs and Disability (SEND) Strategy**[19]
- **Adult Mental Health Strategy**[20] **((currently being refreshed to all age strategy)**
  Autism *Strategy (currently being refreshed to all age strategy)*
  Transforming Care Partnership Board
  Buckinghamshire, Oxfordshire and Berkshire Sustainability and Transformation Partnership (BOB STP)

Mental health services are represented on the **Buckinghamshire Safeguarding Children's Board**[21] and the Transforming Care Partnership Board.

This local transformation plan aligns to the overall mental health delivery plan for Buckinghamshire CCGs, the developing mental health delivery plan for the BOB STP and Buckinghamshire Integrated Care System (ICS).

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[16] https://www.buckscc.gov.uk/media/4509402/jhws2017april.pdf

[17] https://www.buckscc.gov.uk/media/4509876/childrens-strategy-2016-18.pdf

[18] https://www.crisiscareconcordat.org.uk/areas/buckinghamshire/#action-plans-content

[19] https://www.buckscc.gov.uk/services/council-and-democracy/our-plans/our-strategic-plan/childrens-services-strategies/

[20] https://www.buckscc.gov.uk/services/care-for-adults/policy-and-strategy-care-and-advice-for-adults/

[21] http://www.bucks-lscb.org.uk/

10. Priorities and Future Plans for 2018/2019

Promoting Resilience, Prevention and Early Intervention

Develop resources and skills in universal services to enable improved early support and advice for CYP with mental health concerns

Over the last two years within Buckinghamshire a thriving Parent Participation Group that meets 4 times a year has been established. The group includes parents from various backgrounds whose child has needed to use mental health services in Buckinghamshire. The group helps to develop the CAMHS service by offering insights of their experiences and identifying how services can be improved.

This means that there is more work to do and investment is needed in good resources that are more likely to appeal to young people and their families.

Additionally the service will be working with a group of young people who use the service to develop more videos and webinars. This will offer training and groups for promoting mental health wellbeing as well as particular conditions. The increasing use of IT will increase the accessibility for parents who find it difficult to attend groups due to a variety of reasons including carer responsibilities or work commitments and avoid children and young people needing to have time away from school. The development of these resources will help to ensure there are fewer barriers to accessing mental health support.

Increase access to NHS commissioned service

The Five Year Forward View for Mental Health[22] set the target of: *35% of those with a diagnosable mental health condition receive treatment from an NHS-funded community MH service by 2021*

Bucks Population 5-17 years	90,824
Applying national estimate of 1 in 10 with diagnosable MH condition	9,082

Buckinghamshire Objective	2016/17	2017/18	2018/19	2019/20	2020/21
At least 35% of CYP with a diagnosable MH condition receive treatment from an NHS-funded community MH service.	28%	30%	32%	34%	35%
Target for Bucks	2543	2725	2906	3088	3179

Future in Mind focuses on prevention at key moments in life, whereby Children and young people are a priority group for mental health promotion. Future in Mind recommended that by 2020/21 70,000 more children and young people should have access to high quality mental health care they need and that waiting times should be substantially reduced, significant inequalities in access should be addressed and support should be offered while people are waiting for care. In order to provide increased reach Buckinghamshire CAMHS will develop more partnerships with both voluntary and other organisations who offer face to face and telehealth interventions, providing more choice of media for children and young people and families. This will offer a wider system approach and will show measurable improvements in children and young people's mental health outcomes.

We will extend our reach by partnering with other agencies and work into schools to provide wider access for those needing support, and continue to provide timely access for routine assessments for specialist care in CAMHS within 4 weeks.

Care for the most vulnerable

Ensuring CYP in crisis have access to timely support to prevent/minimise escalation to more complex needs

People facing a crisis should have access to mental health care 7 days a week and 24 hours a day in the same way that they can get access to urgent physical health care. Getting the right care in the right place at the right time is vital. Future in Mind states that by 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards as these are the unit's children and young people go to in the evening, during the night or at weekends. Therefore, we have looked to expand the age range seen by our established PIRLS (Psychiatric In-reach Liaison Service).

This Trust guidance is in line with NICE guidance on EUPD issued in 2009 and with the key messages contained in Safer Care for Patients with Personality Disorder issued by the National Confidential Inquiry into Suicide and Homicide by people with Mental illness in February 2018.
Whilst the Trusts Complex Needs Service offers excellent evidence based treatment, funding is not meeting demand and a lengthy waiting list has developed. Plans are in place to review the clinical pathway for people with emotionally unstable personality disorders across the age range, including involvement of primary care and this review will also include training plans and support mechanisms for staff. In order to help develop a more consistent approach from 14 and through transitions (be that into adulthood or from inpatient to community settings the service will develop clinical nurse specialist roles which will in reach into wards as well as advise, support and actively work with colleagues in the community teams. This will ensure a consistent and therapeutic relationship in which a real sense of partnership can develop

Continue to embed whole system working to ensure services delivering to CYP work together to meet the mental health needs of children that exhibit challenging behaviour in the context of poor mental health

Since the Winterbourne report there has been an emphasis on Transforming the care that people with Learning Disability receive, one of the emphasis has been on reducing the time spent in hospital beds and trying to provide care within the persons' community in the least restrictive setting.

Over the last 6 months Buckinghamshire has had several young people who have been in crisis who have been unable to stay in their family home. This has led to difficulties in identifying a suitable placement for the young person when they are assessed as not detainable under the Mental Health Act. In order to address this work is needed to better inform behaviour management in county, additionally commissioners will be working with social care to identify ways of working together to support young people and identifying what provision is needed to prevent the situations that we have been faced with over recent months.

As a priority, we have looked at evidence based approaches to support a Young Person with a LD. Positive Behaviour Support is an evidenced based approach that enables the Young person and their support network to manage their behaviour before it escalates and leads to hospital admission, offending behaviour or exclusion from school. The plan is to work together with our adult colleagues, schools and partner agencies to introduce PBS as an approach that is used to manage our complex challenging users with a learning Disability.

The joint work will include training, research and audit. It will be led by a Consultant Child Psychologist working alongside the other services. The aim is to ensure all age users have the same experience and approach.

Moving towards Integrated Care

As we continue to work more closely with our partner agencies, we want to build on the work of embedding staff within social care teams so that the mental health needs of young people in vulnerable groups can be identified and responded to at a much earlier stage. By having CAMHS staff in social care and youth offending teams, helps raise awareness of young people's mental health issues and challenges the stigma of mental health which is identified as a factor in "the toxic trio". We are piloting the placement of CAMHS staff in Social Care's Looked After and adoption teams and in their court team as these are teams with the most vulnerable groups of children and young people. We will deliver training in mental health to staff in these groups so that there is a better understanding of a young person's needs. We want to develop a Virtual Mental Health Lead post as recommended by the expert working group at the Social Care Institute for Excellence so that we can ensure that every young person and child in the system is getting the right support for their mental health and emotional well-being.

Wider approach to Transitions

We will continue to develop our work on Transitions not just within mental health services but to broaden this out to consider the mental health needs of care-leavers as they move out of care and into independent or supported living.

Understanding the mental health needs of NEET

The mental health needs of young people who are NEET remains unknown and this is an area for development. CAMHS will contribute to work with social care and education to meet the needs of this group.

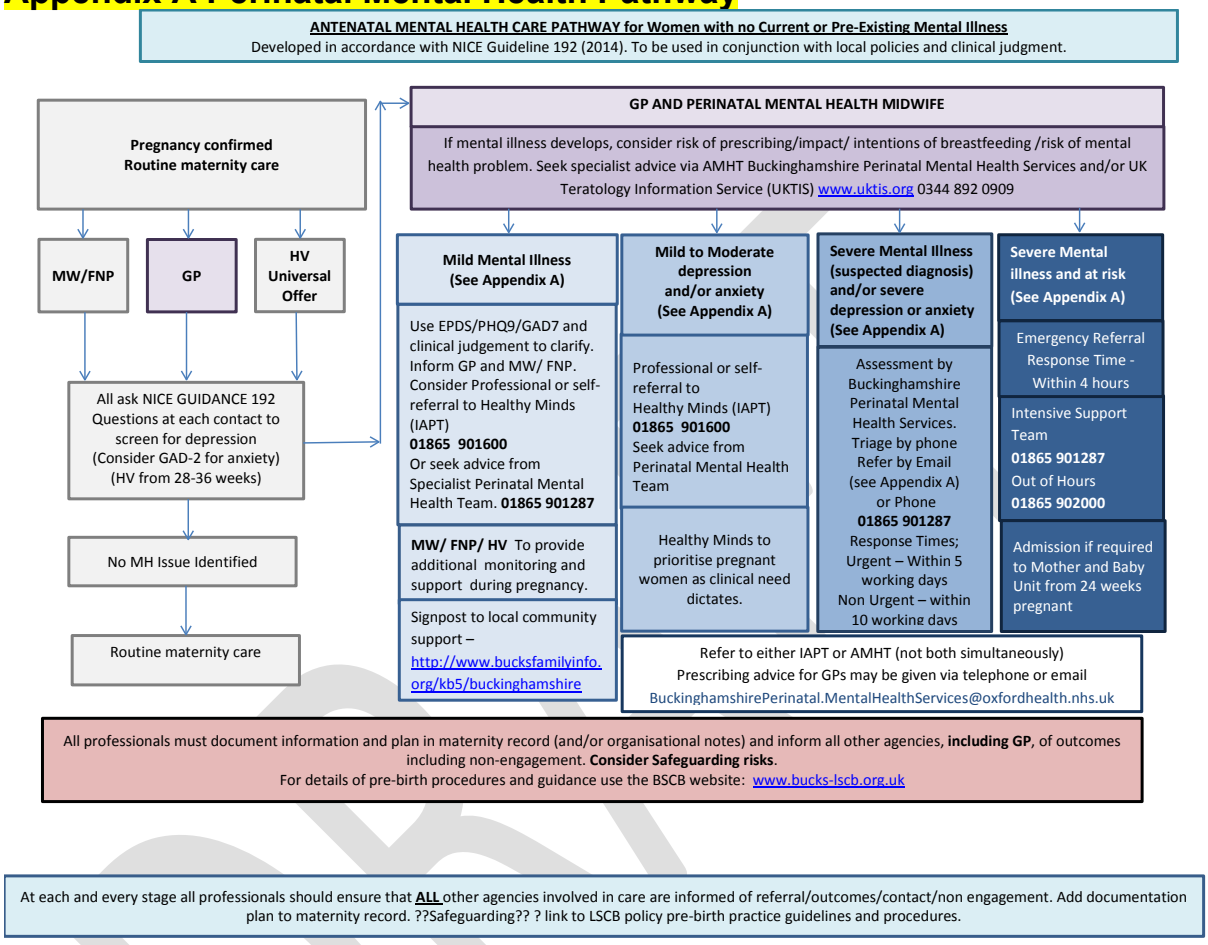
11. Priorities and Plans (to be tidied up)

Transformation plan priorities	Plans
Develop resources and skills in universal services to enable improved early support and advice for CYP with mental health concerns.	Produce/Invest in a resource to promote good mental health and self-help resources and self-referral. To be available through schools, youth services and voluntary partners
	Deliver training sessions as requested by parents and support parents in establishment of parent support group
	Delivery of training on mental health to young people through schools
Increase access to NHS commissioned service	32% of CYP with diagnosable MH condition accessing a NHS commissioned service. (300 CYP)
	Work with voluntary sector partners to explore maximising workforce to deliver mental health support into schools particularly to support younger children
	Ensure sustainability of waiting time standard of 90% referral to assessment within 4 weeks
	Continue to develop pathway for all age neurodevelopment presentations with aim to reduce waiting times in CAMHS to offer assessment in less than 6 weeks from receipt of full required pre-referral information
	To develop engagement strategy to raise awareness and support under-represented groups to access mental health services.
Ensuring CYP in crisis have access to timely support to prevent/minimise escalation to more complex needs	Improve and extend the response to CYP in mental crisis – particularly outside of core hours and to include those who may have complex presentations, including young

	people who may have autism and mental health problems leading to severe behavioural difficulties.
	Colocation of CAMHS staff into social care teams (Looked After and adoption teams and court team)
	Work with social care in developing the in county provision and assessment unit to ensure environment and resources to best support young people presenting in crisis who are not detainable within a mental health setting but are unable to stay with their parents/carers.
	To work with BCC in the early help review to consider how MH can be integral to the early help strategy and pathways.
	To review the clinical pathway for young people presenting with emotionally unstable personality disorders and develop an all age pathway to support young people through transition
Continue to embed whole system working to ensure services delivering to CYP work together to meet the mental health needs of this group of children and young people	Positive behaviour support for Children that exhibit challenging behaviour in the context of poor mental health for those with a learning disability. – OHFT to lead on project to review the positive behaviour support across Buckinghamshire– working across CYP and Adult LD services to develop a consistent approach across all partners – to support the wider county's aim to reduce in school exclusions, out of area county placements, involvement in criminal justice processes. Will also have a positive impact on adult CHC spend.
	Develop work on Transitions to consider the mental health needs of care-leavers as they move out of care and into independent or supported living.
	Develop network to support the mental health needs of those not in education, employment or training (NEET) and for those not attending a school through home education or absentees

12. Appendices (need to be reordered according to text)

Appendix A Perinatal Mental Health Pathway

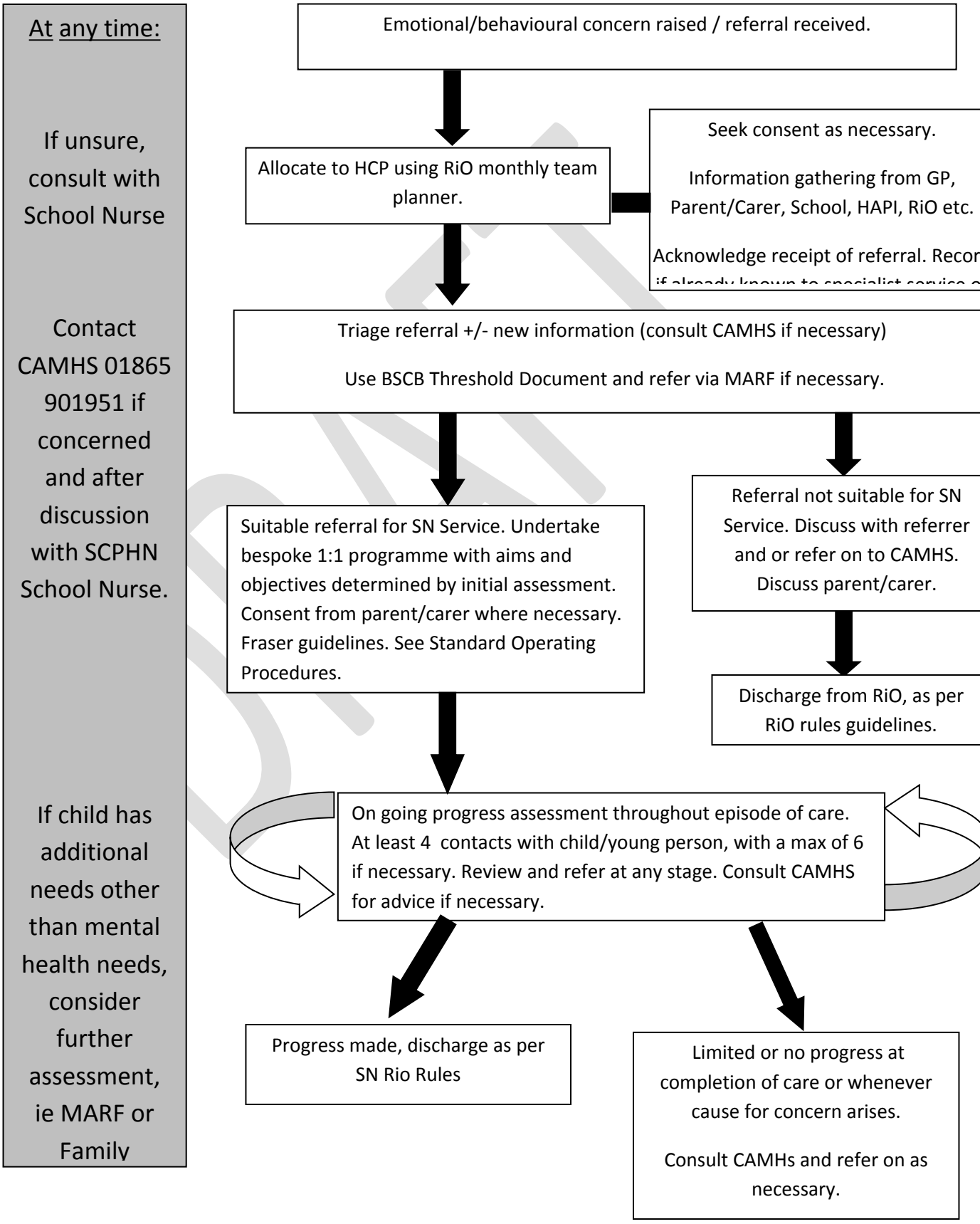


1. EWBMH strategy group action plan

CYP Emotional Wellbeing Plan 18.do

Appendix school Nurse Pathway

High Impact Area 1: Resilience and wellbeing



Appendix
Identification of Needs for Buckinghamshire Childrens Mental Health and Wellbeing Service and the Joint Strategic Needs Assessment (JSNA)

The last Joint Strategic Needs Assessment[23] (JSNA) for Buckinghamshire was completed in October 2016 and a new children and young people's mental health JSNA will be completed in 2018/19 utilising the revised national prevalence data that is due for publication later this year.

The population of 0-17 year olds registered with a GP in Buckinghamshire is 122,520 with 90,824 young people between 5 and 17 years.

Key statistics from Child Health profile[24] June 2018 provides the following high level sociodemographic data.

Demographic	Buckinghamshire	Buckinghamshire(%)	South East (%)	England (%)
Livebirths (2016)	6,102			
Children 0- 4 years (2016)	33,100	6.2%	6.0%	6.2%
Children 0 – 19 (2016)	133,500	25%	23.8%	23.7%
Children 0 – 19 (2026 - projected)	144,300	25.0%	23.8%	23.8%
School Children from minority ethnic groups (2017)	24,007	33.1%	23.5%	31.0%
Child living in low income families under 16 (2015)	1 in 10	8.9%	12.5%	16.8%
Life Expectancy at birth (2014-16) **Boys** **Girls**		81.9yrs 84.9yrs	80.6 yrs 84.0 yrs	79.5 yrs 83.1yrs

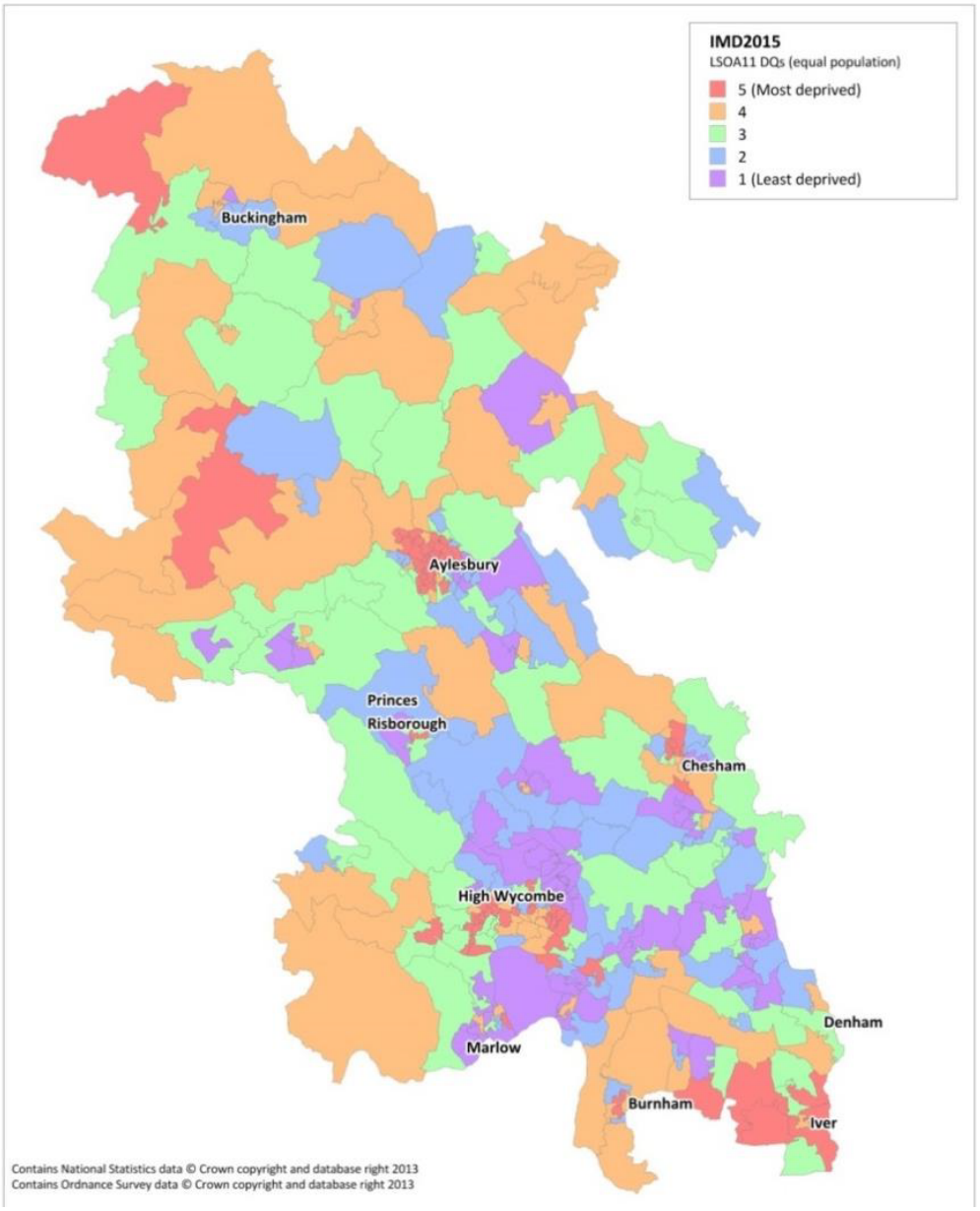
Buckinghamshire is the second least deprived county council in England according to the 2015 index of multiple deprivation. However there are areas of deprivation centred around the towns of High Wycombe, Aylesbury and Chesham as indicated in the Income Deprivation Affecting Children Index Map below.

[23] http://www.healthandwellbeingbucks.org/what-is-the-jsna

[24] https://fingertips.phe.org.uk/profile/child-health-profiles/supporting-information/overview-of-child-health

2. ***Map showing deprivation quintile of LL-SOAs in Buckinghamshire compared with the rest of the county, Index of Multiple Deprivation 2015.***

Buckingamshire County, showing LSOA11 IMD2015 quintiles



General mental health prevalence data can only be estimated, and unfortunately this is based on data which is now in need of updating. Further breakdown such as by gender is available in the existing JSNA chapter.

The table below compares Buckinghamshire to the South East and England and shows lower than average rates of mental health in the area.

Estimated prevalence in percentage for population aged 5-16 years	**Buckinghamshire**	**South East**	**England**
Mental health disorders in children and young	7.9%	8.5%	9.2%
Emotional disorders in children and young people	3.1%	3.3%	3.6%
Conduct disorders in children and young people	4.6%	5.0%	5.6%
Hyperkinetic disorders in children and young people	1.2%	1.4%	1.5%

Estimates Based on ONS survey *Mental Health of children and young people in Great Britain* (2004)

Whilst the above table indicates that overall child mental health compares well to national figures, analysis of the data shows evidence of a social gradient and that some young people are at greater risk of mental ill health.

Prevalence of Perinatal MH disorders 2015/16 in Buckinghamshire

Perinatal MH disorders based on 6100 live births	
Post-partum psychosis	15
Chronic serious mental illness	15
Severe Depression	190
Mild/moderate anxiety/depression	610 - 915
Post-Traumatic Stress Disorder	190
Adjustment Disorder/Distress	915 – 1,825

Source: Public Health England Fingertips Data

Eating Disorders Prevalence

The onset of eating disorders typically occurs in adolescence or young adulthood and they are a serious cause of mental ill-health in this age group. It is estimated that about 1 in 250 females and 1 in 2000 males will experience anorexia nervosa in their lifetime, and about five times that number will suffer from bulimia nervosa. (NICE Guidance 2004).

Applying this to the Buckinghamshire population, it is estimated that:

Eating Disorder	Females	Males
Anorexia nervosa	123	16
Bulimia nervosa	615	

Autism prevalence

The UK estimate is that approximately one in 100 children has autism[25]. Applying this to the Buckinghamshire population would suggest that 1225 children in Buckinghamshire have autism. The diagnostic services have received an increasing number of referrals over the last 3 years, resulting in increased waits despite increased investment.

Hospital Admissions for mental health conditions

In 2016/17 84 children and young people in Buckinghamshire under the age of 18 were admitted to hospital for a mental health condition, a rate of 68.7 per 100,000 populations compared with the national rate of 81.5 admissions per 100,000 and South East regional rate of 82.0 admissions per 100,000. Although there appears to be an upward trend there is no statistical significance in these changes due to small numbers and rates for Buckinghamshire have remained below or similar to the national average.

Table 1 Hospital admissions for mental health conditions, 0-17 year olds, rate per 100,000 population, 2011/12 - 2016/17

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Buckinghamshire	28.6	59.0	46.7	46.3	66.3	68.7
South East	119.1	106.2	96.1	76.7	81.1	82.0
England	91.3	87.6	87.2	87.4	85.9	81.5

Source: PHE fingertips, Child Health profile 2018

[25] Office of National Statistics (2005), Mental health of children and young people in Great Britain, London: Palgrave Macmillan[1

Note: this is admissions NOT persons so a young person presenting more than once will be counted at each presentation

The hospital admission rate for mental health conditions in under 18 year olds is higher in the least deprived population quintile in Buckinghamshire than that in the most deprived quintile, although this is not a statistically significant difference.

In 2016/17 there were 294 hospital admissions as a result of self-harm among those aged 10-24 years in Buckinghamshire . This gives an age-standardised rate of 329.2 per 100,000 people aged 10-24 years. This rate is than the rate in England of 409.3. In 2016/17, Buckinghamshire had the 3rd lowest rate among its CIPFA[26] peers.

The admission rate has been consistently higher in the most deprived areas (DQ5 see map above) compared to the least deprived (DQ1). Although the difference between areas has become less marked over the last 10 years, there was still a 41% higher admission rate in the most deprived areas (232 per 100,000 population) compared with the least (137 per 100,000 population) over the three year period 2010/11 to 2012/13, which was a statistically significant difference.

Hospital admissions for substance misuse 2016/17 (per 100,000 population)

	Buckinghamshire	South East	England
Admission episodes for alcohol-specific conditions - under 18s	24.6	34.2	100.0
Hospital admissions due to substance misuse (15-24 years)	53.8	89.8	339.0

Child Health Profile June 2018

School Pupils with Education, Health and Care Plans where social, emotional and mental health (SEMH) needs is identified as the primary need.

Primary school % of school pupils with social, emotional and mental health needs.	2016 Buckinghamshire 1.41% South East 2.05% England 2.08%	2017 Buckinghamshire1.44% South East 2.08% England 2.12%
Secondary Schools % of school pupils with social, emotional and mental health needs.	2016 Buckinghamshire 1.37% South East 2.39% England 2.36%	2017 Buckinghamshire1.29 % South East 2.25 % England 2.27%
School Age	2016	2017

[26] Chartered Institute of Public Finance and Accountability benchmark against 15 similar local authorities

% of school pupils with social, emotional and mental health needs. (NB number of pupils with statements of SEN where primary diagnosis is SEMH needs divided by total all school pupils x100)	Buckinghamshire 1.53% South East 2.37 % England 2.34%	Buckinghamshire 1.54% South East 2.32% England 2.33 %

The proportion of school pupils with social, emotional and mental health needs in Buckinghamshire in 2018 was 1.7%, which corresponds to 1,434 pupils. This is statistically lower (by 33.8%) than the England value of 2.39%.

Disabled children are significantly at greater risk of physical, emotional and sexual abuse and neglect than non-disabled children (NSPCC report "We have the right to be safe" 2014). In particular, disabled children who display challenging behaviour or conduct problems are the most at risk of abuse.

5.4 Life Satisfaction

What About Youth (WAY) Survey (conducted by HSCIC, 2015)

In Buckinghamshire the What About youth (WAY)[27] Survey on 15 year olds in 2014/15, revealed the percentage of 15 year olds reporting low life satisfaction as 11% compared to a national average of 13.7%. The proportion reporting having been bullied in the last couple of months was 54.2% compared to a national average of 55% and the proportion that had bullied others was 10.5% compared to a national average of 10.1%.

Percentage of children in Buckinghamshire Primary Schools Year 6 (aged 10-11yrs) with possible cause for concern

The school nurse health surveillance data collected through TLM/HAPI allows collation of anonymised aggregated data.

The year 6 (age 10-11yrs) aggregated Strengths and Difficulties Questionnaire (SDQ) score card data is shown below. (NB this is completed by young people themselves and so is indicative data)

Item	2014/15	2015/16	2016/17
Completion rate Bucks	80.4%	75.7%	79.1%
Cause for Concern	6.6%	6.8%	7.9%

[27] *The WAY survey was designed to produce data on young people's wellbeing at LA level as such estimates are not available elsewhere*

An increasing number (6.6%, 6.8% and 7.9%) had ‘cause for concern’ scores and this was a significant increasing trend. There was a significant social gradient in 2014/15 and 2015/16 where this was higher in more deprived areas.

Comparing these figures with the mental health findings from the Millennium Cohort Study published in 2015 (UCL 2015), it can be seen that overall children (of approximately 11years) in Buckinghamshire compare favourably. It was found in the MCS, based on the SDQ scores reported by parents in 2012, the proportion of 11-year-old children in the UK with “cause for concern” regarding mental health problems in 2012 was just over 10%.

School Exclusions

The proportion of primary school pupils with fixed period exclusions in 2015/16 was 1.3%, equivalent to 595 pupils. This is 11.4% higher than the England value of 1.2% and the difference is statistically significant. In 2015/16, Buckinghamshire had the 8th lowest proportion of fixed period exclusions among its CIPFA peers. Provisional data for 2016/17 suggests that this figure has risen slightly to 617 pupils.

The proportion of secondary school pupils with fixed period exclusions in 2015/16 was 5.0%, or 1,847 pupils. This is statistically lower (by 40.9%) than the England value of 8.5%. In 2015/16, Buckinghamshire had the lowest proportion of fixed-period exclusions among its CIPFA peers. Provisional data for 206/17 indicates a rise to 2288 pupils which suggests that this figure has risen slightly.

Persistent absentees – secondary school

In 2016/17, 14.0% of secondary school enrolments were classed as persistent absentees (defined as missing 10% or more of possible sessions) which was worse than the national average (13.5%). For a number of young people poor attendance is due to anxiety related difficulties.

Children attending school in other local education authorities (OLEA) and Independent placements as at July 2016,2017 & 2018.

July 18 - BCC Funded EHCPs

	OLEA mainstream	OLEA Special	Independent/ Non-maintained	Independent Specialist Post 16	**Total**
ASD	37	37	67	11	**152**
MLD	8	37	10	6	**61**
SEMH	14	18	35		**67**
Other	8	17	4		**29**

July 18 - BCC Maintained EHCPs

	OLEA mainstream	OLEA Special	Independent/ Non-maintained	Independent Specialist Post 16	**Total**
ASD	37	36	67	10	**150**
MLD	8	33	10	6	**57**
SEMH	14	16	32		**62**
Other	3		1		**4**

July 17 - BCC Funded Statements/EHCPs

	OLEA mainstream	OLEA Special	Independent/ Non-maintained	Independent Specialist Post 16	**Total**
ASD	28	42	56	8	**134**
MLD	5	48	11	3	**67**
SEMH	10	19	39	2	**70**
Other	1	1			**2**

July 17 - BCC Maintained Statements/EHCPs

	OLEA mainstream	OLEA Special	Independent/ Non-maintained	Independent Specialist Post 16	**Total**
ASD	28	41	54	8	**131**
MLD	5	37	10	3	**55**
SEMH	7	13	35	2	**57**
Other	1	1			**2**

July 16 - BCC Funded Statements/EHCPs

	OLEA mainstream	OLEA Special	Independent/ Non-maintained	Independent Specialist Post 16	**Total**
ASD	31	33	50	5	**119**
MLD	7	41	11	1	**60**
SEMH	14	19	39	2	**74**
Other			2		**2**

July 16 - BCC Maintained Statements/EHCPs

	OLEA mainstream	OLEA Special	Independent/ Non-maintained	Independent Specialist Post 16	**Total**
ASD	32	32	49	5	**118**
MLD	6	31	10	1	**48**
SEMH	11	17	33	2	**63**
Other			2		**2**

The figures above demonstrate a slight increase in children with autism placed outside of Bucks. There is a fairly static picture for those with social, emotional and mental health (previous categorised as Behaviour, emotional and social difficulties')

Children Looked After, on Child Protection Plans and Children in Need

Research in 2013 identified that two children in the average primary class have experienced abuse[28]. The impact of this abuse on a child increases their risk of developing mental health problems.

A study[29] in 2003 estimated that 45% of Children Looked After (CLA) (aged 5 -17) had a mental health disorder, 37% had clinically significant conduct disorders, 12% had emotional disorders such as anxiety or depression and 7% were hyperkinetic. This indicates a level of need higher than the population overall.

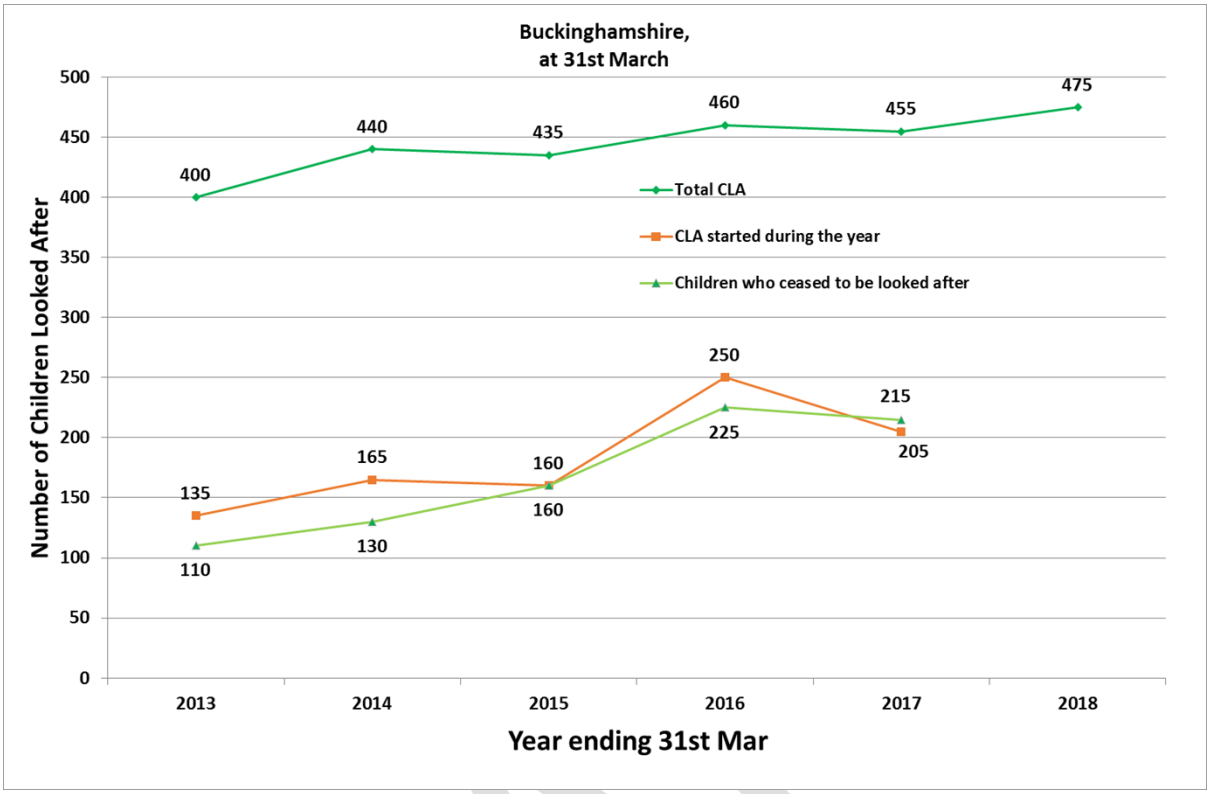
Number of Buckinghamshire Children on Child Protection plans
At the end of March 2018, 639 children were subject to a Child Protection Plan, an increase from 564 at March 2017.

Number of Buckinghamshire Children in Need
At the end of March 2018, 2560 children were identified as children in need (including those on CP plans and CLA). There were 1456 not including CP and CLA.

Further details are included in the BSCB annual report[30] and Children Looked After and Placement Sufficiency Strategy [31]

Number of Buckinghamshire Children Looked After at 31st March 2018

[28] Radford, L., Corral, S., Bradley, C., & Fisher, H. L. (2013). The prevalence and impact of child maltreatment and other types of victimization in the UK: findings from a population survey of caregivers, children and young people and young adults. , 37(10), 801-813.
[29] Meltzer M, Gatward R, Corbin T et al. The Mental Health of Young People Looked After by Local Authorities in England. TSO (The Stationary Office), 2003.
[30] http://www.bucks-lscb.org.uk/wp-content/uploads/About%20the%20BSCB/Annual%20Reports/BSCB-Annual-Report-2016-17.pdf
[31] https://www.buckscc.gov.uk/media/4509821/looked-after-children-and-placement-strategy.pdf



Although the net number of children in care has seen a relatively stable increase the number of children coming into care and leaving care has increased over the last 3 years. There was a peak in 2016 with 245 children entering care, an increase of 50% compared to the previous year in 2015 (160).

Reason for Referral to Children's Social Care (April 2016 – March 2017)

Percentage of Referrals with MASH Enquiries Reason	No of referrals	% of referrals
Domestic abuse	1199	15.93%
Physical abuse	923	12.27%
Neglect	641	8.52%
Behavioural problems	619	8.23%
Sexual abuse	472	6.27%
Socially unacceptable behaviour	347	4.61%
Mental health (another person)	302	4.01%
Drug misuse (parent/carer)	242	3.22%
Child sexual exploitation	205	2.72%
Emotional abuse	183	2.43%

Unaccompanied asylum-seeking children (UASC)

Children Looked After at 31 March, who were unaccompanied asylum-seeking children (UASC) during the years ending 31st mar 2013-2017

	2013	2014	2015	2016	2017
England	1,950	2,060	2,750	4,300	4,560
South East	410	450	680	1,360	1,070
Buckinghamshire	**10**	**15**	**15**	**20**	**15**

Strengths and Difficulties Questionnaire for Children looked after in Buckinghamshire

The proportion of children with an SDQ over 17 indicating cause for concern is higher than the average for the South East and England.

	2014	2015	2016	2017	2018
Percentage of children aged 5 to 16 looked after continuously for at least 12 months with an SDQ completed	41%	73%	50%	69%	70%
Proportion of children with a score of 13 or less	58.8%	51.1%	46.7%	46.2%	44.4%
Proportion of children with a score between 14 and 16	7.2%	13.7%	15.6%	12.4%	12.7%
Proportion of children with a score of 17 or more	34.0%	35.2%	37.7%	41.4%	42.9%

Interpretation considers a score of 13 and below as normal, 17 or above as a cause for concern and 14 – 16 as borderline.

Percentage of children in care with SDQ completed who show cause for concern (PHE mental health profile for Buckinghamshire**) 2016/17**

% of children aged 5-16yrs who have been in care for at least 12months on 31st March whose score in SDQ indicates cause for concern.

Item	Buckinghamshire	England	South East
% cause for concern	43.1%	38.1%	41.3%

NB there is **no statistical difference** between local regional and national figures.

The proportion of children with an SDQ over 17 indicating cause for concern is higher than the average for the South East and England and all our statistical neighbours except for Cambridgeshire (44.6%)

Percentage of Children Looked After (CLA) known to Buckinghamshire CAMHS

In June 2018 49% of the 481 CLA were placed in county, 113 of these children (20%) were known to Buckinghamshire CAMHS, this is an increase from 11% in 2015. This figure suggests that over 40% of the CLA placed in Buckinghamshire were receiving intervention from CAMHS. Work is in progress with Social Care to further increase the referrals in line with the SDQ evidence of need.

Mental Health of Young Offenders

The mental health of young offenders has been found to be three times higher than that in the general population with prevalence rates ranging from 25% to 81% with the highest being associated with those held in custody (Mental Health Foundation, 2000). The needs of this group of young people are complex with difficulties such as extremely low IQ (23% with an IQ under 70 and 36% IQ 70-79), speech and language difficulties, poor literacy, ¼ being victims of crime themselves, and substance misuse. A review of young offenders needs by the Prison Reform Trust & Young Minds "Turning Young Lives Around" has found that young people who offend often have complex background histories with exposure to domestic abuse and child maltreatment. A large proportion of young offenders have experienced being in care (42%) or known to social care by being placed on a child protection plan (17%). Early detection of mental health problems can reduce repeat offending behaviour and chronic mental health difficulties.

Early Help Panels

The early help panel is a multiagency panel whose aim is to enable positive outcomes for children and families with complex issues, who require a co-ordinated multi-agency response. This is achieved by creating tailored plans that strengthen protective factors in the family and mitigate against risk factors. The panel aims to offer help and support to a family to prevent the need for statutory intervention. A member of the CAMHS team is on the panel and is one of the panel chairs.

In the year June 2015 to June 2016 a total of 459 families, including 1,113 children, were considered at the Early Help Panels. Ethnicity and location were in line with the population data and its geographical spread across the county.

Whilst behaviour was identified as the primary reason for referral in 28.57% of referrals, there was an average of 5.11 problems in the Level 3 Early Help Panel families.

Primary Reason for referral to Early Help Panel	Proportion
Behavioural Problems	28.57%
Mental Health	14.71%

Parenting	9.24%
Domestic Abuse	6.72%
Risk of Family Relationship Breakdown / Family Relationship Breakdown	6.09%
School Attendance	5.04%
Substance Misuse	2.94%

Changes to data

Any changes to need identified through the revised JSNA or through new data on prevalence will be reflected in the service developments.

Appendix

The voice of the young person in transformation plan

We said, we did…

Three years ago, as volunteers of the Article 12 Youth Forum we were involved in giving our feedback on what the future of Buckinghamshire CAMHS looked like to us. We had to think about what needed to change to make it a better experience for young people visiting CAMHS. We all had different experiences of CAMHS, some good and some not so good but because of this we were able to give lots of ideas to the Commissioner for CAMHS who listened to our feedback when writing the Transformation Plan for Buckinghamshire CAMHS. We all wanted to help with making our ideas happen so since then we've worked on lots of different projects to help improve CAMHS and also raising awareness about mental health in schools and our community. Three years later, we have looked back at what we said to see if our ideas have been put into action through our own projects as well as though the work Buckinghamshire CAMHS have been doing over the last few years.

"We would like a person in school to raise awareness, offer support for young people and training for teaching staff on understanding mental health and how to support students with mental health needs.

As well as CAMHS doing lots of useful training for school staff across Buckinghamshire and the school link workers offering support to staff in schools. Some of us from the Article 12 Youth forum have also trained teachers and support staff through the Emotional Wellbeing Conference. We wanted to help teachers understand a bit more from a student's perspective, what it's like being in school whilst being under CAMHS as it can be really tough especially when teachers treat mental health more like a behaviour issue. A young person from our group wrote a poem about what it's like coming for a day in school suffering from anxiety, depression and self-harm. We had lots of really positive feedback from teachers who were there. We also got them to pledge to celebrate Mental Health Awareness Week 2018 in their schools and gave them some of our ideas on how they could do this like assemblies, mindfulness activities etc.

"More support and information for 16-18 years old's who will be moving to adult services is really important for their transition so they know what to expect. If there's an official process on how it should be done, then make sure it is followed".

A few of us in Article 12 have experienced leaving CAMHS and going to Adult Services and some of us are about to transition and have heard that the transition between CAMHS and adult's services is really difficult and a big jump. To try and make a difference to this, we have been working as a group to review the transitions process with the CAMHS lead for Transitions who has been working with adult services to put some of our ideas into action. We suggested ideas such as having joint appointments in the adult mental health team building so young people have a chance to get used to the new setting. We also suggested having letters from young people who have already made the transition to help put the person transitioning more at ease

and know what to expect. As a result of this, feedback from Article 12 has been incorporated in to the new Transitions Policy.

"We need more resources like apps, websites, films, self-help online and a self-help podcast designed with young people and staff together.

We've researched and tested out resources to develop to be used in schools across Buckinghamshire as well as created our own films, handouts and lesson plans that can be used as resources in schools or by anyone who works with young people. We have put lots of information on the CAMHS website around apps and useful self-help info. At the start of Article 12 we spent time reviewing the current website, we put forward our ideas for a new website and then helped test out the new website to make sure it was user friendly. This is something we are always doing work on as it's important to keep information up to date and relevant. We also have an eating disorder youth forum and we've been involved in creating and designing our own eating disorder area for the website with information that we would have found helpful when we started with CAMHS. We also created letters by young people for young people explaining what CAMHS is all about. This letter is used by GPs' and SPA as well as being available for referrers to print from the website.

"Review the service young people/parents/guardians/professionals are receiving over the phone.

When the SPA first started up a few of us from Article 12 volunteered to ring the SPA with our questions and scenarios to help train the staff so we could give them our feedback of how useful we found the support offered over the phone and if any improvements could be made. Since then, we have helped the SPA with creating a new online self-referral form which we tested out and helped with the wording to make sure it didn't put off any young people who might be referring themselves to CAMHS. We have also helped the SPA in creating presentations to deliver in school assemblies so it's not clinical and makes CAMHS and the SPA seem more approachable for young people. We think it's great that the SPA will be using our presentation to raise awareness about CAMHS in assembles as it might make more young people feel comfortable about making self-referrals or contacting CAMHS if they need help. Our next project with the SPA is helping them to create their own logo.

"Need to make sure that young people have the chance to give their feedback on this".

In the waiting rooms there is an electronic survey set up on an ipad for children, young people and their families to confidentially and anonymously leave feedback and suggestions on the support they've received

from CAMHS. Article 12 fed back this is a better way of asking for feedback rather than in an appointment in front of your worker as you feel more able to be honest.

To promote the importance of confidential feedback, we also made a video about this to share at a training session held at the Royal College of Psychiatrists.

What it's like being a member of Article 12:

"It's nice to know that you can use your past experience to make a difference to a new service. I attend monthly meetings as well as getting involved with other opportunities that interest me such as; interviewing staff, specialist forums such as the Eating Disorder Forum, training and reviewing resources. You can be as involved as you want to be, there is no pressure and it's good to meet other people who have had similar experiences to me. The group is like a big family where you can share your opinions without feeling judged".

What's next for Article 12:

"I would like to see a more friendly waiting area for young people at the Sue Nicholls Centre and feel like the Article 12 group could help with this from our experience doing the Harlow House waiting area. I would like to be more involved in training and giving assemblies in schools, I think this is important because young people will relate more to young people/young adults who have experienced a mental health condition and been supported by CAMHS during their time at school".

Appendix

Article 12 Youth Forum engagement report 2018/19

The commissioned service includes a requirement for engagement of Children and Young People and a full time participation worker supports this work with children and young people and parents and carers. The service user group, Article 12, have provided input to the transformation plans and have become an integral part of the CAMHS service.

Article 12 meets on a monthly basis and have been busy working on some of the following projects this year:

Article 12 Youth Forum present at the Royal College of Psychiatry -
Article 12 Youth Forum had a very exciting opportunity to deliver some training at the Royal College of Psychiatrists. The training they delivered was around services who work with young people using participation to engage the young people to improve their services. They delivered presentations, videos and speeches around the benefits of participation. Their presentation was called "the smallest changes make the biggest of differences."

Outside therapeutic space at Harlow House

The Forum re-designed the Harlow House waiting area, and whilst working on the project the group saw the potential of using some outdoor space at the back of Harlow House for children and young people who might need a break or some time out during a session. Article 12 came up with some ideas of how the space could be made into a calm environment including: a small water feature, stepping stones representing steps young people take, a curved seating area, and scented plants

Eating Disorder Young People's Forum
The Eating Disorder Team has been working with a small group of young people around improving information and communication within the eating disorder pathway. Young people have been reviewing letters and information booklets distributed at the initial assessment stages.
For example, as a young person, would YOU know what multi-disciplinary meant? Or what was the difference between seeing a psychologist and psychiatrist? Simple vocabulary should be used to ease understanding for patients.

The young people also fedback that videos should be shown more as resources for helping patients because they are simple to understand and easy to watch.

Experts by experience – Young people speak out at a key European Parliamentary conference on Mental Health:
In November 2017 Young Ambassadors from Article 12 participated in a seminar on Children's Mental Health and Child-Friendly Justice in Parliament bringing together young people, legislators, experts and practitioners. The event was organised by the UK Parliament led by Baroness Doreen Massey in cooperation with the Parliamentary Assembly of the Council of Europe. It was opened by the Rt Hon John Bercow MP, Speaker of the House of Commons with a keynote address by Jackie Doyle-Price M.P Parliamentary Under-Secretary of State for Health, and Chaired by Stella Kyriakides, President of the Parliamentary Assembly of the Council of Europe (PACE).

- *Training in mental health for non-specialists and for professionals such as GPs and social workers; more funding for training mental health professionals. Young people should be involved in delivering the training.*
- *There should be up-to-date Apps and virtual training for teachers*
- *More counsellors in schools (in one of the schools there was one counsellor for 1000 children)*
- *Awareness campaigns on a regular basis for the public; schools and other agencies matched by funding –one off big campaigns were not enough*
- *Information for schools and G.P surgeries which is in an accessible form that helps young people recognise their symptoms and those of their friends and siblings which ask questions such as'do you feel sad on most days?' These should be placed in accessible places in schools such as the reception and the canteen.*
- *Every school should have a full-time nurse with the option of an educational psychologist who is full-time*
- *Young people need to be adequately supported to participate in forums locally and nationally. In the UK there needs to be a coming together of the various youth forums so that there is opportunity for structured dialogue which can influence policy.*

One of the young people said that young people must be listened to and were "experts by experience"

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Article 12 Youth Forum Member wins a Teen Award!
Ellie inspires others by sharing her story about her transgender journey and first presented her story at an emotional wellbeing conference to over 100 staff from primary and secondary schools. Ellie wants schools to be more inclusive environments for children having explorative thoughts around gender and sexuality. Oxford Health's Equality and Diversity Lead is working with Ellie and Buckinghamshire CAMHS to help the service in become more inclusive in implementing gender neutral facilities at our CAMHS centres.

***Buckinghamshire County Council's Emotional Wellbeing Conference*:**
For the second year running, young people from our CAMHS service planned and designed their own workshop which they delivered to primary and secondary school representatives from across the County. The young people's workshop educated participants on:

- Spotting the signs of mental health early
- How school can support young people around mental health and LGBT
- Ideas for celebrating mental health awareness week and LGBT week in school

Appendix CAMHS Evaluation Research

CAMHS evaluation
1st report October 2(

CAMHS Workforce (CAMHS to update)

Year	2015/16		2016/17		2017/2018	
A&C	Band	WTE	Band	WTE	Band	WTE
Band	WTE	6.9	3	3		
3	3	1	4	6.9		
4	6.9	1	5	1		
5	1	7.3	Consultant	7.3		
Consultant	7.3	0.4	6	0.4		
6	0.4	0.5	7	0.5		
7	0.5	1.2	8a	1.2		
8a	1.2	0.8	8c	0.8		
8c	0.8	5.6	6	5.6		
6	5.6	12.16	7	12.16		
7	12.16	0.5	8a	0.5		

8a	0.5	0.7	5	0.7		
5	0.7	6	7	6		
7	6	5.3	8a	5.3		
8a	5.3	2.2	8b	2.2		
8b	2.2	2.38	8c	2.38		
8c	2.38	1	8d	1		
8d	1	0.5	7	0.5		
7	0.5	1.2	8a	1.2		
8a	1.2	0.8	8b	0.8		
8b	0.8	3.6	8a	3.6		
8a	3.6	1	8b	2		
8b	2	1				
		4	6	4		
6	4	0.5	4	0.5		
4	0.5		4	4		
4	4	36		36		
	36 110.54	103.54		110.54		

2018 Staffing

POST	BAND	WTE
A&C	3	3
	4	10.3
	5	1
Consultant Psychiatrist	Consultant	7.4
Dietician	6	0.4
Family Therapist	7	1.5
	8a	0.6
	8c	1
Nurse	6	7
	7	10.6
Primary Hlth worker	5	0.7
Nurse Consultants	8a	2.5
Specialist Practioner	7	1

Psychologist	**7**	**2**
	8a	**5.5**
	8b	**3**
	8c	**2.95**
	8d	**1**
Psychotherapist	**7**	**0.5**
	8a	**0.8**
	8b	**0.8**
CBT THEARAPIST	**7**	**1.6**
Snr Mgr.	**8a**	**3.9**
	8b	**2**
Social Worker	**6**	**1.5**
	7	**6.5**
	8a	**1**
Ass Psychologist	**4**	**4.5**
	5	**1**
PWP	**4**	**0**
Barnardos		**32**
Grand Total		**117.55**

13. Bibliography

- Future in Mind (March 2015)
- Tier 4 CAMHS Specification (2013/14)
- Model Specification for Child and Adolescent Mental Health Services: Targeted and Specialist levels (Tiers 2/3) (Dec 2014)
- Model Specification for Transition from CAMHS (Jan 2015)
- Supporting people with a learning disability and / or autism who have a mental health condition or display behaviour that challenges - draft service model (July 2015)
- Mental Health Crisis Care Concordat - Improving outcomes for people experiencing mental health crisis (Feb 2014)
- Buckinghamshire Crisis Care Concordat Action Plan
- Access and Waiting Time Standard for Children and Young People with an Eating Disorder (July 2015)
- DfE Counselling in schools: a blueprint for the future (March 2016)
- DfE Behaviour and discipline in schools: guidance for headteachers and staff (Jan 2016)
- Five Year Forward View (Oct 2015)
- Achieving Better Access to Mental Health Service by 2020 (Oct 2014)
- Local Transformation Plan Toolkit (March 2018) www.nspcc.org.uk
- Transforming Mental Health Services Children Experienced Abuse www.nspcc.org.uk

The workshop covered the 3 key themes that have been standing themes since the initial stakeholder engagement in 2015; Accessibility, Communication, Collaboration.

In response to the concerns raised through the recommission and subsequent stakeholder engagement opportunities, the following actions were taken.

Accessibility – thresholds for access and waiting times
You said ….. There are long waits and it's difficult to know who will be seen.

We….

- Established a Single Point of Access (SPA) – for consultation and advice, referrals and signposting
- Set targets for waiting times
- 90% within 4 weeks of routine referral (year 3 of contract onwards)
- Allowed anyone to refer including young people (14+)
- Expanded the designated Looked after children and Adoption team
- Provided short bookable "drop in" appointments

Communication – parents reported they were unable to speak to the clinicians and stakeholders indicated that they didn't know the outcome of referrals

You said ….. It's hard to find out what is happening and to speak to CAMHS

We provided….

- SPA – one number to call
- E-referrals through the website
- Newsletters
- Named Link mental health workers to all schools
- Link consultant to GPs – Dr Pal
- More consistent feedback to referrer by letter after referral

Collaboration – it was felt the service was working in isolation

You said ….. We need to work together more

We

- Enabled direct conversations with clinicians through the SPA
- Established a training offer to all workforce through planned programme and adhoc requests
- Established a Parent advisory group (PAG)
- Provided a designated worker in Swan (CSE) unit
- Maintained link workers into Youth Offending Service (YOS) and substance misuse services

- Improved transition pathway into adult services
- Facilitated very active engagement with Article 12 young person participation
- Reviewed and began changes to the Autism pathway

The recent Stakeholder workshop focused on the same 3 themes and identified ways to further progress services in this context. Suggestions have included further publicising the SPA and self-referrals/consultation, working in primary care and school settings, increased and closer working with children's social care. These suggestions are being developed and built into plans for 18/19 and beyond.

Health & Wellbeing Board Buckinghamshire

Status on Health and Wellbeing Board meeting actions:

27 September 2018

Date	Action	Lead officer	Update/ progress	Status
29.3.18	Carried forward: A meeting to be arranged between the Chairman and Fiona Wise		A request has been made to Fiona Wise and a meeting is being arranged	Complete
29.3.18	A date had been set for May 2018 for a debrief on the winter planning arrangements for 2017/18. Neil Macdonald to invite healthwatch and report back to the Board.	Neil Macdonald	Invite sent. Whole system winter planning on the December agenda	Complete
29.3.18	Dr Sutton confirmed that the detailed data broken down by age relating to the emergency admissions for 0-19 year olds indicator would be obtained and shared with the Board.	Dr Sutton	Information circulated to the Board	Complete
29.3.18	Ms McDonald to looking at what data was reported in other forums and the expectation for Health and Wellbeing Board's nationally to come to the May meeting	Ms K McDonald/ Dr Williamson/ All members of the Board	This would be taken forward in the dashboard review report in December. Action for Board members to report to Dr Williamson on HWB dashboard indicators that are included and reported in other forums.	Target date for completion: December 2018
29.3.18	Ms Baker to progress the inclusion of a patient engagement metric in the HWB dashboard with Healthwatch England.	Ms J Baker	Ms Baker to progress the dashboard indicator with the support of public health colleagues. Planning in place to progress with Healthwatch England and will be included as part of the dashboard review report in December.	Target date for completion: December 2018
29.3.18	Ms Bowie to provide break down information on the "NHS reasons for delay" in the next BCF update to the Board	Ms Bowie	The next detailed update on the BCF is included in the September 2018 agenda	Target date for completion September 2018.