Maternity Service Update

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1. SUMMARY

1.1. To provide an update to Scrutiny Panel on Somerset Maternity Services and the local Maternity Transformation programme. The focus of this report is how maternity services are responding to the Betters Births report published in Feb 2016 and the quality measures we have in place to ensure monitoring of the key priorities.

1.2. In addition this update will include the Sustainability and Transformation Plan and the current discussion on the Local Maternity Service (LMS) priorities and the discussion with Dorset CCG.

2. ISSUES FOR CONSIDERATION / RECOMMENDATIONS

2.1. The Scrutiny Panel is asked to consider and comment on the maternity transformation programme including assurance provided on local activity of Maternity Services in Somerset. The CCG is commissioning an Independent review by the Clinical Senate to inform future service developments.

3. BACKGROUND

3.1 The report of the National Maternity Review, Better Births, was published in February 2016 and set out a clear vision: for maternity services across England to become safer, more personalised and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred on their individual needs and circumstances. It also calls for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries. Implementing the vision set out Better Births supports the Secretary of State's ambition to halve the number of stillbirths, neonatal and maternal deaths and brain injuries by 2030.

3.2. Better Births recommended that commissioners and providers work together across areas as Local Maternity Systems (LMS) across footprints of 500,000 to 1.5 million people. The national Maternity Transformation Programme aims to support and empower local transformation, through Local Maternity Systems and Maternity Clinical Networks.

Early Adopter

3.3. Somerset has been chosen as one of eight national an early adopter sites for Better Births, to support this transformational change in maternity services. The core Somerset bid is for the implementation of IT and Post-natal support, for **Somerset** this includes:

- A particular focus on working across organisational and professional boundaries, facilitating improvements in post-natal care for vulnerable women and the implementation of electronic maternity records for women and staff.
- Developing, during 2017, new "assistant practitioner" roles to work in the community. The roles will be accountable to a midwife and aimed at supporting vulnerable women and their families during the post-natal period. The assistant practitioners will undertake a structured education and training programme over two years, leading to a recognised qualification whilst working in the complex care team
- Integrating collaborative working across both provider organisations to have a single aligned maternity model of care by April 2018 (date TBC through agreement of more detailed project plan).
- Collaborating to produce a single electronic maternity record, accessible by all health professionals across the county by August 2018 (date TBC through agreement of more detailed project plan).
- Developing and using a county wide maternity app for women and families, providing timely essential information, by January 2018.
- Developing metrics and collating data to determine outcomes and measure success, which will include public health outcome measures, the views of women and families and staff experience, in order to drive further improvements.

4. SOMERSET FACTS

4.1 NHS Somerset Clinical Commissioning Group is the lead commissioner for maternity services from Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust.

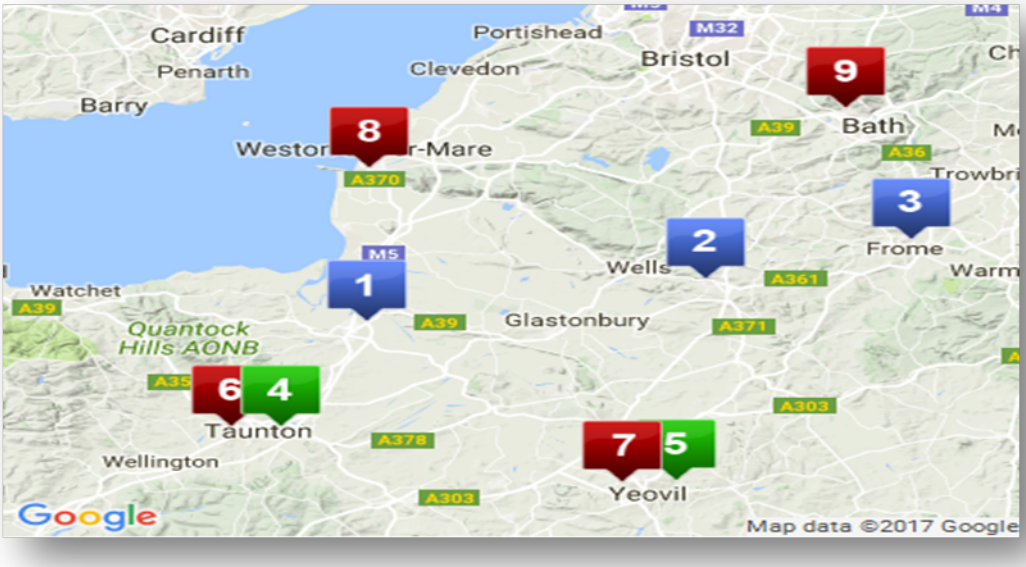
4.2. NHS Wiltshire Clinical Commissioning Group is the lead commissioner for maternity services provided by in the Princess Anne Wing of the Royal United Hospital Bath which provides maternity services for women in the Mendip area.

4.3. North Somerset Clinical Commissioning Group is the lead commissioner for maternity services for the Weston catchment area, provided by Weston General Area Health Trust which provides maternity services for women in the North Sedgemoor area. The total number of births for Quarter 3 (2016/2017) is 1,9281 across the four trusts. Further information can be found in Appendix 2.

4.4. http://www.somersetintelligence.org.uk/pregnancy-maternity.html
There are three standalone midwife-led maternity units in Somerset operating from community hospitals across the county. Additionally, both acute providers have 'alongside' midwife led birthing units. The map below shows the location of each of the maternity provisions, both within the county and providing

services to residents of the county.

Stand-alone midwife-led maternity units	
1	Bridgwater Community Hospital, Bridgwater
2	West Mendip Community Hospital, Shepton Mallet
3	Frome Community Hospital, Frome
Alongside midwife-led birthing units	
4	Bracken Ward, Musgrove Park Hospital, Taunton
5	Yeovil District Hospital Maternity Unit, Yeovil
Consultant led maternity units	
6	Musgrove Park Hospital, Taunton
7	Yeovil District Hospital, Yeovil
8	Weston General Hospital, Weston-Super-Mare
9	Royal United Hospital, Bath



5. SUSTAINABILITY AND TRANSFORMATION PLAN

5.1. It is expected that the Local Maternity Services (LMS) will align with Sustainability and Transformation Plans (STP) footprints in Somerset, the challenge we have in Somerset is that the RUH, Weston and Dorset are outside our STP footprint and Local Maternity Systems will be expected to develop and implement a local vision for improved services.

- commissioners and providers are asked to work together across areas as local maternity systems (LMS)1, with the aim of ensuring women, their babies and their families have equitable access to the services they choose and need, as close to home as possible. In particular, the role of the LMS is to:
- bring together all providers involved in the delivery of maternity and neonatal care, including, for example, the ambulance service and midwifery practices providing NHS care locally
- develop a local vision for improved maternity services based on the principles of *Better Births*
- co-design services with service users and local communities
- put in place the infrastructure needed to support services working together

Dorset CCG

5.2. In September 2015, as part of its overall Clinical Service Review, Dorset CCG asked the Royal College of Paediatrics and Child Health (RCPCH) to conduct an Invited Review of the current service provision for maternity, neonatal and paediatric services. This review focussed on the services provided at Poole, Bournemouth, Dorchester and Yeovil Hospitals. The resulting report raised questions about the long-term sustainability of the current model of provision and proposed some high level future service options. The RCPCH report is publically available via the Dorset CCG website.

5.3. Following the publication of this report, the Boards of Yeovil District Hospital and Dorset County Hospital have agreed to work together to explore in more detail the options for the future model of maternity and paediatric services across the two sites. It was acknowledged that key to this work will be ensuring that the broader access implications for the populations of West Dorset and East Somerset are fully considered, recognising the responsibility of Yeovil District Hospital to work as part of the Somerset NHS. A data modelling exercise is underway to inform this.

5.4. The work is on-going and an options appraisal will be developed for consideration in the summer 2017. Any future service change will be subject to the NHS England requirements which would involve a full public consultation

6. MATERNITY VOICES SOMERSET

6.1. Somerset CCG and providers are currently working together to review the current format of the regional Maternity Services Liaison Committee (MSLC) in order to optimise service user input into service development/ performance and drive quality improvement across all maternity services. Somerset Local Medical Council (LMC) submitted proposals for HEE education and training funding to support the implementation of patient focused events called “Whose shoes”. The aim of the funding will be to refresh our Maternity
Services Liaison Committee (MSLC) and user engagement strategies and the recommendations from Better Births.

6.2. We have been successful in our bid and have approached the “Whose Shoes” provider who will be training all three Somerset NHS Foundation Trusts and Royal United Hospitals Bath NHS Foundation Trust. We have been successful in securing further licensed copies through the South West Maternity & Children’s Strategic Clinical Network (**SWMCSCN**) to ensure that each Trust is able to continue to implement the learning from the event with colleagues, patient groups and commissioners. Weston Area Health NHS Trust has elected not to take part as they are linked to the joint event being run across North Somerset, Bristol & South Gloucestershire CCGs. This event is booked and due to take place on 12 April 2017 at Taunton Racecourse. “Whose Shoes?” event is intended to gather experiences from providers, commissioners, and members of the public. This will inform how maternity services are shaped moving forwards.

7. CCG IMPROVEMENT AND ASSESSMENT - MATERNITY

7.1. The CCG improvement and assessment framework 2016-17 (CCG IAF) baseline maternity assessment provides a perspective on the effectiveness of commissioning of maternity services, enabling CCGs, local health systems and
communities to assess their own progress, thereby assisting improvement. It also allows NHS England to target the support needed to assist CCGs and local maternity systems to improve.

7.2 The 2016-17 baseline maternity assessment has been designed to align with a number of the key themes from Better Births, the report of the National Maternity Review, published in February 2016. Four maternity-related measures have been included in the CCG Improvement and Assessment Framework:

- neonatal mortality and stillbirths
- maternal smoking (at time of delivery)
- women’s experience of maternity services
- choice in maternity services

7.3. The stillbirth and neonatal mortality indicator will help to gauge the success of CCG activities aimed at reducing neonatal mortality and still birth rates. This indicator currently uses ONS data and is unadjusted. The data used for this year's assessment is from 2014. It is recognised that using more recent data will make this indicator significantly more useful for CCGs; NHS England will therefore continue to develop the data source and methodology for next year's assessment to look for opportunities to make further improvements.

7.4. CCGs should use this indicator alongside information available locally and from other national sources to better understand the causes of mortality in their local populations and focus their activities towards reducing the rate. A high mortality rate warrants investigation as it may reflect shortcomings in the quality of care. However, mortality rates may be influenced by factors other than the quality of care, such as: random year on year variation; the proportion of women with high risk pregnancies giving birth to babies; and the proportion of mothers who choose to carry babies affected by severe congenital anomalies to term. Caution is therefore required when interpreting mortality rates in isolation from other sources of information.

7.5. The maternal smoking (at time of delivery) indicator will contribute to measuring the success of interventions to reduce smoking in pregnancy, as recommended by NICE guidance (PH26). Performance in this indicator will reflect the effectiveness of 'stop smoking' services and working relationships with local authorities through the Health and Wellbeing Boards. This indicator also relates to the effective screening by maternity services of pregnant women throughout their pregnancy through Carbon Monoxide (CO) monitoring, as required by the Saving Babies' Lives care bundle. The use of this indicator in the CCG IAF is intended to shine a light and encourage action to reduce smoking in pregnancy as there is strong evidence that doing so reduces the likelihood of stillbirth. It also impacts positively on many other smoking-related pregnancy complications such as premature birth, miscarriage, low birth-weight and Sudden Infant Death Syndrome (SIDS). Whether or not a woman smokes during her pregnancy has a far reaching impact on the health of the child throughout his or her life. The Experience indicator measures women's experiences of maternity services based on answers to the Care Quality Commission (CQC) 2015 National Maternity Services Survey.

7.6. The Choice indicator uses the same CQC survey to specifically look at the choices offered to users of maternity services. Each of these two indicators are composite indicators, calculated as an average of scores from six questions from the survey reflecting several points across the care pathway (antenatal, intrapartum and postnatal). The experience and choice indicators have been adjusted for age and for parity (the number of times a woman has given birth). This assessment is intended to provide an initial baseline, a snapshot of how CCGs are performing in the areas measured by the indicators. However, it is important to note the assessment is limited by the small number of metrics selected and is not intended to provide an overall picture of the quality of maternity services within the CCG area. In future years, a more comprehensive assessment will be undertaken, drawing on wider measures and qualitative information, assessed by an independent panel of experts with the ability to examine what is going on behind the data.

Outcomes Monitoring

7.7. The CCG receive data on a range of outcomes and quarterly highlight reports directly from the Trusts, and use additional data from NHS England/Public Health England, Hospital Episode Statistics (HES) and the Office of National Statistics (ONS), both to validate the figures received from the Trusts and to benchmark against other core sites and national data The South West Strategic Clinical Network for Children and Maternity has agreed a framework for benchmarking against other, similar services and will apply statistical process control methods to the data to help discern between normal and abnormal variation.

7.8. In March 2015 the South West Maternity and Children's Strategic Clinical Network launched the first regional maternity dashboard across the South West region. Fourteen maternity services provide data on a monthly basis to an agreed set of metrics and criteria. Whilst the dashboard is still in a developmental stage, we now have enough data to enable us to compare and identify areas of variation. This data will enable the benchmarking of maternity services across the region, underpinning the quality improvement work of the Network. Development of the dashboard remains ongoing, with a focus on data quality. Annex 1 shows the December 2016 summary maternity dashboard

Perinatal Mental Health

7.9. Ensuring appropriate services for women who experience mental health problems during and after their pregnancy is a high priority both locally and nationally. This work is led through the CCG Mental Health Programme Board. Women with mild-moderate depressive illness and anxiety can be supported through the Somerset Talking Therapies service, which has just launched its own website, allowing self-referral for those patients who have access to the internet. Expectant mothers and those with a child under one year old are already a priority group, under the referral criteria for the service.

Actions

- Liaison, Crisis and Home Treatment Teams to receive specialist training to better understand the distinctive features and risks of perinatal mental illness. The CCG is working to source training through specialist Mother & baby Units in Bristol, for the relevant staff teams within Somerset Partnership
- Talking therapies services to be integrated into the peri-natal mental health pathway (work is already underway and representatives from the service attended a recent peri-natal mental health working group meeting).

Right Care

7.10. The NHS Right Care programme is about improving population-based healthcare, through focusing on value and reducing unwarranted variation. It includes the Commissioning for Value packs and tools, the NHS Atlas series, and the work of the Delivery Partners.

Improvement opportunities for Somerset include:

- Flu vaccine take-up by pregnant women

7.11. The table below shows the benchmarking data for flu vaccine take up women at risk at all

Flu Vaccine take up rate

	Pregnant Women: **At-Risk**	Pregnant Women: **Not At-Risk**	Pregnant Women: **All**
Bristol	63.5	41.6	44.1
North Somerset	60.1	44.3	46.5
Somerset	58	41.8	43.7
South Gloucestershire	68.4	54	55.9

Smoking at the time of delivery

Smoking at the time of delivery	2014/15* from August 2014	2015/2016	206/ 2017 (up to November 2017)
T&S	13.66	14.58	13.15
YDH	15.55	13.28	12.43
RUH	11.00	8.63	8.61
Somerset Average	14.61	13.93	12.79

8. NEXT STEPS

8.1. Success in 2020:

- Personalised care, centred on the woman, her baby and her family, based on their needs and their decisions, where they have a genuine choice informed by unbiased information.
- Continuity of carer, to ensure safe care based on relationships of mutual trust and respect, in line with the woman's decisions.
- Safer care, with professionals working together across boundaries to ensure rapid referral and access to the right care in the right place; leadership focussed on a culture of safety across organisations and investigation leading to honest and open discussions and learning when things go wrong.
- Better postnatal care and perinatal mental healthcare, to address under provision in these two vital areas.
- A culture of multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.

8.2. Ultimately, success will be measured by improvement in outcomes for women, babies and their families, and services will need to be commissioned to deliver improvements against these outcomes.

MATERNITY DASHBOARD: 2015-16 PRIORITY INDICATORS

Appendix 1

Reference	Maternity Measure	Threshold	Provider	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
1 (A3a)	Number of births		T&S	254	279	295	228	266	271	313	268	295	262	290	305	241	224
			YDH	128	133	128	122	114	98	124	124	134	131	135	120	106	135
			RUH	-	409	405	371	391	368	422	388	415	398	398	386	384	-
			WAH	-	23	14	15	21	6	19	15	16	-	22	19	8	-
2 (A10)	% of caesarean sections	25.5% (England 2012/13)	T&S	20.47%	20.79%	23.73%	20.18%	21.80%	27.70%	24.90%	23.90%	23.10%	21.80%	25.50%	30.80%	22.80%	29.90%
			YDH	17.19%	23.88%	25.78%	22.13%	32.46%	15.30%	27.20%	28.80%	21.60%	30.80%	22.80%	20.80%	32.10%	26.50%
			RUH	-	20.30%	22.80%	24.40%	21.90%	23.40%	22.90%	22.60%	18.50%	19.20%	20.20%	25.70%	27.60%	-
			WAH	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5 (L32)	% of women who breastfed at the time of delivery	tbc	T&S	80.63%	85.66%	81.63%	81.14%	83.33%	79.30%	86.90%	76.50%	80.60%	83.60%	81.40%	83.90%	81.30%	80.00%
			YDH	72.66%	76.69%	78.91%	76.23%	71.05%	73.50%	78.20%	84.00%	84.00%	81.00%	83.00%	77.80%	75.50%	75.40%
			RUH	-	80.80%	82.60%	77.20%	91.00%	86.10%	82.10%	82.90%	82.80%	87.80%	87.90%	84.40%	88.50%	-
			WAH	-	69.60%	57.10%	73.30%	76.20%	66.70%	78.90%	86.70%	93.80%	-	71.40%	84.20%	87.50%	-
6a (A30)	% of women who smoked at the time of booking	tbc	T&S	8.58%	10.28%	10.06%	7.93%	11.20%	16.10%	13.30%	18.30%	20.20%	16.80%	14.10%	19.20%	14.50%	18.70%
			YDH	14.84%	17.16%	14.06%	22.13%	17.54%	19.40%	15.20%	12.80%	13.40%	15.80%	15.40%	20.00%	13.20%	13.20%
			RUH	-	-	-	-	-	-	-	-	-	-	-	14.40%	15.60%	-
			WAH	-	-	-	-	-	-	-	-	-	-	-	14.50%	19.50%	-
6a (L14)	% of women who smoked at the time of delivery	14.5%	T&S	11.46%	11.83%	11.90%	12.28%	15.53%	13.30%	12.50%	16.80%	15.60%	11.80%	8.60%	12.10%	12.40%	13.60%
			YDH	14.84%	14.18%	10.16%	15.57%	7.02%	14.30%	8.00%	7.20%	9.70%	14.30%	15.40%	20.00%	10.40%	13.20%
			RUH	-	10.90%	8.50%	10.30%	5.20%	8.80%	9.50%	9.40%	10.90%	9.30%	6.60%	6.50%	7.90%	-
			WAH	-	37.50%	14.30%	20.00%	47.60%	33.30%	31.60%	0.00%	6.30%	-	13.60%	15.80%	12.50%	-
7 (A6)	Midwife to birth ratio	1 WTE midwife to 29.5 births	T&S	1:32.0	1:32.0	1:32.0	1:28.0	1:32.0	1:32.0	1:37.0	1:32.0	1:35.0	1:31.0	1:34.0	1:35.0	1:28.0	1:27.0
			YDH	1:26.9	1:27.3	1:26.0	1:23.4	0.00	1:25.4	1:27.2	1:25.1	1:25.7	1:22.5	1:23.5	1:21.0	1:18.3	1:23.0
			RUH	-	1:32.0	1:32.0	1:29.0	1:29.0	1:29.0	1:33.0	1:30.0	1:32.0	1:31.0	1:31.0	1:30.0	1:30.0	-
			WAH	-	-	-	-	-	-	-	-	-	-	-	-	-	-
8 (A7)	% of induced labours	23.3% (England 2012/13)	T&S	33.86%	29.39%	31.86%	35.53%	27.82%	26.60%	30.40%	31.30%	30.20%	31.70%	27.60%	29.80%	29.00%	37.10%
			YDH	19.53%	27.61%	34.38%	33.61%	24.56%	37.80%	28.80%	30.40%	29.10%	27.10%	31.60%	30.80%	29.20%	30.10%
			RUH	-	23.00%	22.10%	23.80%	22.70%	22.90%	26.70%	25.70%	27.50%	23.00%	21.90%	23.90%	21.80%	-
			WAH	-	-	-	-	-	-	-	-	-	-	-	-	-	-
10b	Friends and Family Responses Rate: Birth	22.87%	T&S	53.85%	25.98%	27.12%	26.07%	28.36%	18.18%	25.40%	22.26%	32.11%	22.96%	24.58%	17.95%	22.54%	22.69%

Reference	Maternity Measure	Threshold	Provider	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
			YDH	0.00%	2.21%	0.74%	1.64%	32.00%	17.20%	Insufficient response to derive positive response rate			4.58%	Insufficient response to derive positive response rate	Insufficient response to derive positive response rate	1.01%	Insufficient response to derive positive response rate
			RUH	25.94%	29.20%	25.70%	11.70%	22.20%	21.40%	23.60%	20.30%	22.00%	23.30%	22.00%	15.60%	14.70%	11.50%
			WAH	47.10%	50.00%	64.30%	66.70%	47.60%	66.70%	73.70%	21.40%	81.30%	50.00%	38.10%	47.40%	100.00%	53.80%
10b	Friends and Family Positive Responses Rate (extremely likely & likely): Birth	96.65%	T&S	98.57%	100.00%	100.00%	98.36%	97.37%	98.00%	100.00%	98.36%	96.88%	98.39%	97.26%	96.43%	100.00%	96.30%
			YDH	Insufficient response to derive positive response rate				78.13%	93.75%	Insufficient response to derive positive response rate			100.00%	Insufficient response to derive positive response rate			
			RUH	99.00%	100.00%	99.00%	98.00%	98.00%	99.00%	98.00%	99.00%	98.00%	100.00%	100.00%	100.00%	100.00%	100.00%
			WAH	88.00%	100.00%	100.00%	100.00%	100.00%	Insufficient response to derive positive response rate	100.00%	Insufficient response to derive positive response rate	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Public Health England

Child Health Profile

March 2017

Somerset

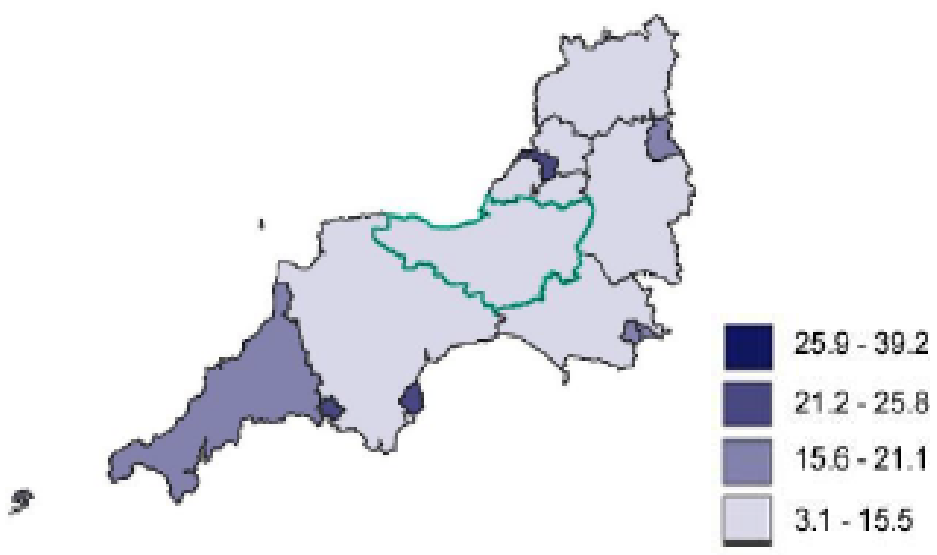
This profile provides a snapshot of child health in this area. It is designed to help local government and health services improve the health and wellbeing of children and tackle health inequalities.

The child population in this area

		Local	Region	England
Live births (2015)		5,624	58,033	664,399
Children aged 0 to 4 years (2015)		29,600 5.4%	307,400 5.6%	3,434,700 6.3%
Children aged 0 to 19 years (2015)		121,200 22.2%	1,216,700 22.2%	13,005,700 23.7%
Children aged 0 to 19 years in 2025 (projected)		128,600 22.1%	1,311,400 22.4%	14,002,600 23.8%
School children from minority ethnic groups (2016)		5,451 9.0%	81,843 12.8%	2,032,064 30.0%
Children living in poverty aged under 16 years (2014)		15.3%	16.1%	20.1%
Life expectancy at birth (2013-2015)	Boys	80.2	80.1	79.5
	Girls	84.1	83.8	83.1

Children living in poverty

Map of the South West, with Somerset outlined, showing the relative levels of children living in poverty.



Key findings

Children and young people under the age of 20 years make up 22.2% of the population of Somerset. 9.0% of school children are from a minority ethnic group.

The health and wellbeing of children in Somerset is mixed compared with the England average. Infant and child mortality rates are similar to the England average.

The level of child poverty is better than the England average with 15.3% of children aged under 16 years living in poverty. The rate of family homelessness is better than the England average.

Children in Somerset have better than average levels of obesity: 8.4% of children aged 4-5 years and 15.3% of children aged 10-11 years are classified as obese.

In 2015/16, children were admitted for mental health conditions at a higher rate to that in England as a whole. The rate of inpatient admissions during the same period because of self-harm was higher than the England average.

The rate at which children and young people were killed or seriously injured in road traffic accidents is lower than the England average. 27 children were killed or seriously injured on the roads in 2013-2015.

Somerset Child Health Profile — March 2017

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average.

- ↔ No significant change
- ↑↓ Increasing / decreasing and getting better
- ↑↓ Increasing / decreasing and getting worse
- ▪ Trend cannot be calculated

- Not significantly different from the England average
- Significantly better than England average
- Significantly worse than England average

England average | Regional average | 25th percentile | 75th percentile

		Indicator		Local no. per year*	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	1	Infant mortality	↔	*23*	4.2	3.9	7.9	2.0
	2	Child mortality rate (1-17 years)	▪	*9*	8.5	11.9	20.7	5.3
Health protection	3	MMR vaccination for one dose (2 years)	↑	5,326	93.8	91.9	69.3	97.7
	4	Dtap / IPV / Hib vaccination (2 years)	↔	5,474	96.4	95.2	73.0	99.2
	5	Children in care immunisations	↑	295	88.1	87.2	26.7	100.0
Wider determinants of health	6	Children achieving a good level of development at the end of reception	▪	4,135	68.7	69.3	59.7	78.7
	7	GCSEs achieved (5 A*-C inc. English and maths)	▪	3,040	56.4	57.8	44.8	74.6
	8	GCSEs achieved (5 A*-C inc. English and maths) for children in care	▪	-	-	13.8	6.4	34.6
	9	16-18 year olds not in education, employment or training	↔	730	4.0	4.2	7.9	1.5
	10	First time entrants to the youth justice system	↓	171	345.9	368.6	821.9	126.6
	11	Children in low income families (under 16 years)	↓	14,200	15.3	20.1	39.2	7.0
	12	Family homelessness	↓	284	1.2	1.9	10.0	0.1
	13	Children in care	↑	505	46	60	164	21
	14	Children killed and seriously injured (KSI) on England's roads	▪	*9*	9.4	17.0	49.3	1.4
Health improvement	15	Low birth weight of term babies	↔	136	2.6	2.8	4.8	1.3
	16	Obese children (4-5 years)	↔	466	8.4	9.3	14.7	5.1
	17	Obese children (10-11 years)	↔	743	15.3	19.8	28.5	11.0
	18	Children with one or more decayed, missing or filled teeth	▪	-	23.1	24.8	56.1	14.1
	19	Hospital admissions for dental caries (0-4 years)	▪	*50*	169.0	241.4	1,143.2	9.2
	20	Under 18 conceptions	↓	169	17.2	22.8	42.4	8.4
	21	Teenage mothers	↓	44	0.8	0.9	2.2	0.2
	22	Persons under 18 admitted to hospital for alcohol-specific conditions	↓	*58*	51.5	36.6	92.9	10.9
	23	Hospital admissions due to substance misuse (15-24 years)	▪	*71*	122.6	95.4	345.3	34.1
Prevention of ill health	24	Smoking status at time of delivery	↓	720	13.5	10.6	26.0	1.8
	25	Breastfeeding initiation	↔	4,398	80.8	74.3	47.2	92.9
	26	Breastfeeding prevalence at 6-8 weeks after birth	▪	2,562	46.4	43.2	18.0	76.5
	27	A&E attendances (0-4 years)	↑	17,778	600.2	587.9	1,836.1	335.0
	28	Hospital admissions caused by injuries in children (0-14 years)	↔	1,078	120.6	104.2	207.4	53.5
	29	Hospital admissions caused by injuries in young people (15-24 years)	↑	1,085	166.5	134.1	280.2	72.0
	30	Hospital admissions for asthma (under 19 years)	↓	171	147.6	202.4	591.6	84.3
	31	Hospital admissions for mental health conditions	↔	119	109.0	85.9	179.8	33.8
	32	Hospital admissions as a result of self-harm (10-24 years)	↑	643	726.3	430.5	1,444.7	102.5

*Numbers in italics are calculated by dividing the total number for the three year period by three to give an average figure

Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box

Notes and definitions

1 Mortality rate per 1,000 live births (aged under 1 year), 2013-2015

2 Directly standardised rate per 100,000 children aged 1-17 years, 2013-2015

3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2015/16

4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2015/16

5 % children in care with up-to-date immunisations, 2016

6 % children achieving a good level of development within Early Years Foundation Stage Profile, 2015/16

7 % pupils achieving 5 or more GCSEs or equivalent including maths and English, 2015/16

8 % children looked after achieving 5 or more GCSEs or equivalent including maths and English, 2015

9 % not in education, employment or training as a proportion of total 16-18 year olds known to local authority, 2015

10 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2015

11 % of children aged under 16 years living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2014

12 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2015/16

13 Rate of children looked after at 31 March per 10,000 population aged under 18 years, 2016

14 Crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2013-2015

15 Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2015

16 % school children in Reception year classified as obese, 2015/16

17 % school children in Year 6 classified as obese, 2015/16

18 % children aged 5 years with one or more decayed, missing or filled teeth, 2014/15

19 Crude rate per 100,000 (aged 0-4 years) for hospital admissions for dental caries, 2013/14-2015/16

20 Under 18 conception rate per 1,000 females aged 15-17 years, 2014

21 % of delivery episodes where the mother is aged less than 18 years, 2015/16

22 Persons admitted to hospital due to alcohol-specific conditions – under 18 year olds, crude rate per 100,000 population, 2012/13-2014/15

23 Directly standardised rate per 100,000 (aged 15-24 years) for hospital admissions for substance misuse, 2013/14-2015/16

24 % of mothers smoking at time of delivery, 2015/16

26 % of mothers initiating breastfeeding, 2014/15

28 % of mothers breastfeeding at 6-8 weeks, 2015/16

27 Crude rate per 1,000 (aged 0-4 years) of A&E attendances, 2015/16

28 Crude rate per 10,000 (aged 0-14 years) for emergency hospital admissions following injury, 2015/16

29 Crude rate per 10,000 (aged 15-24 years) for emergency hospital admissions following injury, 2015/16

30 Crude rate per 100,000 (aged 0-18 years) for emergency hospital admissions for asthma, 2015/16

31 Crude rate per 100,000 (aged 0-17 years) for hospital admissions for mental health, 2015/16

32 Directly standardised rate per 100,000 (aged 10-24 years) for hospital admissions for self-harm, 2015/16