Introduction
Giving every child the best start in life to develop physically, psychologically and socially is crucial to reducing health inequalities across society.

Life long health inequalities have their roots in pregnancy and the early years and parents or carers play a pivotal role in influencing their children's future life chances; economically, socially and with regards to their physical and emotional health.

To give two examples:
- Research has demonstrated the advantages of breastfeeding in promoting resistance to a range of infections and reducing the risk of obesity in children.
- Immunising children against infectious diseases has proven to be one of the most effective strategies for saving lives and promoting good health.

Good parental mental health in the early years can also greatly influence health outcomes for children later on in life. It is estimated that 10% of mothers and approximately 4% of fathers experience post natal depression, which can affect a child's cognitive and behavioural development.

Why this is an important public health issue.
The universal promotion of children's health and positive experiences in the early years is important as good health promotion and early intervention can prevent and protect children from harm and poor health later on in life.

Ensuring children are immunised against infection, develop positive habits towards food and physical activity and avoid exposure to harmful practices such as cigarette smoking will reduce their likelihood of experiencing preventable childhood illness such as measles, obesity and the early onset of health problems in adulthood such as heart disease, respiratory problems and diabetes.
Breastfeeding

Evidence shows that breastfeeding has a major role to play in ensuring good public health. It protects infants against gastroenteritis and respiratory infections and, to a lesser degree, obesity. It also reduces the risk of children developing Type 2 diabetes in later life\(^5\)\(^6\). Breastfeeding also provides complete (and free) nutritional support for the development of healthy infants and is of benefit to the mother’s health by reducing the risk of developing breast and ovarian cancer\(^6\).

The rate of breastfeeding in Kingston is high as 85.9% of local mothers initiated breastfeeding at birth in January to March 2012, higher than the England average of 73.7% for the same period and close to the London rate of 87.1%. By six to eight weeks after birth 70.1% of Kingston mothers were still breastfeeding in January to March 2012 compared with just 46.9% in England and 68.6% in London as a whole. However, Kingston is well below the best performances on these indicators nationally which are an initiation rate of 95.7% and a six to eight week breastfeeding rate of 83.2%\(^6\). Therefore ensuring that Kingston figures improve further is an important local priority for staff across the health economy and particularly in Children’s Centres. This has been recognised by additional investment in a Breast Feeding Co-ordinator and Support Worker.

**Immunisations**

The overall aim of the routine childhood immunisation programme is to protect all children against preventable childhood infections. All children by the time they enter school should have received the following vaccines\(^8\):

<table>
<thead>
<tr>
<th>By four months</th>
<th>Three doses of DTap/IPV/ Hib Two doses of PCV and Men C</th>
<th>To prevent diphtheria, tetanus, whooping cough, polio, Haemophilus influenza type B, pneumococcal infections, meningococcal type C infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 13 months</td>
<td>A booster dose of Hib / Men C/PCV First dose of MMR</td>
<td>To prevent Haemophilus influenza type B, pneumococcal infections, meningococcal type C infections, measles , mumps, rubella</td>
</tr>
<tr>
<td>By school entry</td>
<td>Fourth dose of DTap/IPV Second dose of MMR</td>
<td>To prevent diphtheria, tetanus, whooping cough, polio, measles , mumps, rubella</td>
</tr>
</tbody>
</table>

These vaccines are designed to stimulate the body’s own immune system against infection. The optimal ages are chosen to immunise children in order to provide the maximum level of protection against the risk of disease and improving the timely uptake of immunisations particularly the MMR vaccine remains a priority in Kingston and in England as a whole.

The World Health Organisation (WHO) recommends that two doses of the MMR vaccine are required to provide satisfactory protection against mumps, measles and rubella. A study by Harling et al (2005)\(^8\) suggested that a single dose of MMR is only 64% effective against mumps. Between 2006 and 2010 Kingston had the second highest number of confirmed cases of mumps in South West London\(^9\). Table 3.1 indicates that although Kingston generally has higher immunisation rates than the London average, this is not the case when compared with the national average.

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\(^9\) South West London Health Protection Unit Enhanced Surveillance
### Table 3.1
Immunisation rates for Kingston compared with the London and England Average

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP/ IPV By 12 months</td>
<td>95.1%</td>
<td>94.0%</td>
<td>93.5%</td>
<td>90.7%</td>
<td>94.2%</td>
</tr>
<tr>
<td>Men C By 24 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Dose of MMR By 24th months</td>
<td>85.1%</td>
<td>83.7%</td>
<td>89.3%</td>
<td>83.8%</td>
<td>89.1%</td>
</tr>
<tr>
<td>Second dose MMR By Age 5</td>
<td>79.0%</td>
<td>82.2%</td>
<td>83.3%</td>
<td>76.6%</td>
<td>84.2%</td>
</tr>
</tbody>
</table>

### Local Action

There has been some local success with ‘Grab and Jab’ sessions in Children’s Centres which were the inspiration of the health visitor lead after attending a stay and play session. The sessions are co-ordinated by the immunisation lead with support from health visitors. These are opportunistic occasions when children from harder to reach families visiting the centres for other purposes are identified as needing immunisations by trained staff who can then explain the benefits of the relevant immunisations and offer them on the spot. This also includes providing a Saturday clinic targeting working parents.

### Healthy Lifestyles

Obesity is characterised by an excessive accumulation of body fat resulting from an imbalance between energy intake in food and the use of energy by physical activity. The reduced need to be physically active and the availability of food with a high calorific value has led to a rise in childhood obesity in the last 10 years. Once developed, obesity can be difficult to treat and puts children at greater risk of developing lifelong health problems and a reduced quality of life due to the social stigma and isolation associated with body size and shape.

Family habits and routines in the early years are significant factors in a child’s risk of developing obesity because their consumption behaviours are predominantly directed by their parents or carers who determine what kind of food is made available, the amount of food served, the timings of meals and a child’s exposure to passive entertainment and physical activity.

Some progress has been made to reduce obesity in Kingston. The number of children considered obese has reduced since 2008-9 and remains lower than the national average (Table 3.2).

### Table 3.2
Percentage of Obese Children aged 4-5 years (Reception Class)

<table>
<thead>
<tr>
<th></th>
<th>Kingston</th>
<th>England Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008-09</td>
<td>7.6%</td>
<td>10.2%</td>
</tr>
<tr>
<td>2009-10</td>
<td>6.8%</td>
<td>9.8%</td>
</tr>
<tr>
<td>2010-11</td>
<td>6.8%</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

Joint Annual Public Health Report for Kingston 2011/2012  Chapter 3: Pre School Age

Kingston’s approach is to offer a wide range of information sources and services in primary health care and Children’s Centres designed to provide parents with the right level of support at the right time. This support can include targeted individual support programmes, antenatal and postnatal classes, and evidence based parenting programmes. Whilst many parents will seek out such support of their own volition, others will be guided towards the support on offer by health, social care or education professionals.

There are a number of general factors relating to parental lifestyle and wellbeing that can impact significantly on parenting capacity to promote good health in the early years, Three of the most prevalent conditions amongst Kingston’s general population that have been shown to have an impact on child wellbeing are depression, smoking and adult obesity\textsuperscript{11}, and Table 3.3 gives estimated local percentages and numbers of people affected by these three issues.

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|}
\hline
\textbf{Issue} & \textbf{Number} & \% of Kingston’s Population & \% of England Average \% \\
\hline
Smoking & 33,699 & 17.9\% & 22.5\% \\
Obesity & 11,734 & 6.2\% & 8.1\% \\
Depression & 10,100 & 5.4\% & 8.1\% \\
\hline
\end{tabular}
\caption{Prevalence of factors affecting parenting capacity in Kingston 2011}
\end{table}

\textsuperscript{11} Kingston upon Thames Child Poverty Needs Assessment. 2011

A snapshot of the top ten risk factors affecting children aged up to four years logged with Advancing Services for Kingston Kids (ASKK) in June 2012 (Table 3.4) shows the significance of supporting parents to be the best possible role models for young children (see chapter 12 for details of the ASKK service). This figure is based on referrals made to ASKK for flagging and where a Common Assessment Framework (CAF) has been submitted.

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|}
\hline
\textbf{Issue} & \textbf{Number} & \textbf{England Average\%} \\
\hline
Family Breakdown & 116 & 117 \\
Parenting Skills & 9 & 9 \\
Financial Difficulties & 8 & 8 \\
Mental Health concerns & 7 & 7 \\
Domestic Violence & 6 & 6 \\
Emotional / Behavioural Difficulties & 7 & 7 \\
Lone / Unsupported Families & 6 & 6 \\
Family Isolation & 5 & 5 \\
Parental Health Need & 4 & 4 \\
Overcrowding & 3 & 3 \\
\hline
\end{tabular}
\caption{Top Ten Risk Factors affecting Children aged 0-4 logged with ASKK}
\end{table}

Table 3.4

Preparing for School

Health inequalities arise because of inequalities in society. An important aspect of breaking the cycle of underachievement and reducing health inequalities is ensuring that children are both physically and mentally ready to learn. This is supported through healthy eating, good sleeping patterns and acquiring the necessary skills and confidence. The home learning environment, encouragement of play and developing positive relationships with parents and carers are critical to securing this aim. Recent research also indicates that high quality early education impacts on children’s future achievement and wellbeing. This is effectively promoted and supported across all Kingston early years settings and in the Children and Young People’s Plan. A pilot over the last two years to offer free early education to disadvantaged two year olds will be extended in September 2013 to include 20% of the population. Final results from this will not be available until summer 2016 when these two year olds complete the Early Years Foundation Stage (EYFS), but their progress and use of services will be measured each year.

In 2009 the EYFS framework\textsuperscript{12} was introduced nationally to promote the learning, development and care of children from birth to five years. It currently covers the following areas of learning:

- Physical Development
- Personal, Social and Emotional Development
- Communication, Language and Literature
- Problem Solving, Reasoning and Numeracy
- Creative Development
- Knowledge and Understanding the World.

All chidminders and early years settings in Kingston work within the principles of the EYFS and are inspected by Ofsted against criteria set out in the framework. Partnership with parents is embedded across the framework and all settings work to promote positive relationships from the outset. This approach reflects the need for children in their early years to experience consistency across their environments, an essential pre-requisite for promoting good health.

There is a universal entitlement for all three and four year olds to access 15 hours of free early education. This is offered through different models across the maintained, private, voluntary and independent sectors. It is important that this is high quality provision and the RBK early years service supports quality improvement across all Kingston providers. In January 2012, 2,050 children aged three were accessing free early education. This equates to 89% of the cohort (Table 3.5). This has been increasing steadily since the EYFS was introduced. Parental choice and circumstance may explain why this figure is not currently higher.


12 Department for Education Early Years Foundation Stage Framework http://www.education.gov.uk/schools/teachingandlearningcurriculum/df/e068102/early-years-foundation-stage-eyfs
### Table 3.5

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of 3 year olds</td>
<td>88%</td>
<td>88%</td>
<td>82%</td>
<td>89%</td>
<td>89%</td>
</tr>
<tr>
<td>Numbers of 4 year olds</td>
<td>92%</td>
<td>93%</td>
<td>94%</td>
<td>86%</td>
<td>93%</td>
</tr>
</tbody>
</table>

Source: Department for Education Early Years censuses 2008-2012

### Table 3.6

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBK</td>
<td>44%</td>
<td>45%</td>
<td>50%</td>
<td>57%</td>
<td>66%</td>
<td>66%</td>
<td></td>
</tr>
<tr>
<td>London</td>
<td>43%</td>
<td>39%</td>
<td>43%</td>
<td>46%</td>
<td>50%</td>
<td>55%</td>
<td>60%</td>
</tr>
<tr>
<td>England</td>
<td>48%</td>
<td>45%</td>
<td>46%</td>
<td>49%</td>
<td>52%</td>
<td>56%</td>
<td>59%</td>
</tr>
</tbody>
</table>

Source: Department for Education, 2012

In Kingston, outcomes for children at the end of the EYFS are improving and above the national average in key aspects of development (see Table 3.6). Children are considered to have reached a good level of development if they achieve a score of 78 points. The majority of children in Kingston start school achieving the appropriate EYFS profile.

Progress also needs to be made to narrow the gap between the lowest achieving 20% and the remainder of the school entrant population. An achievement gap is an index of the difference in an educational indicator (such as an examination pass rate) between two groups (such as boys and girls). For early years, the achievement gap is calculated as the difference between the median score for all children and the mean score for the lowest 20% and expressed as a percentage of the median score for all.

In Kingston some progress has been made to narrow the gap but the percentage reduction between 2005 and 2011 has been less than in London, although it should be noted that the gap in 2005 was considerably greater in London than in Kingston (Table 3.7).

### Table 3.7

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBK</td>
<td>33%</td>
<td>37%</td>
<td>34%</td>
<td>31%</td>
<td>31%</td>
<td>28%</td>
<td>29%</td>
</tr>
<tr>
<td>London</td>
<td>40%</td>
<td>40%</td>
<td>39%</td>
<td>37%</td>
<td>35%</td>
<td>34%</td>
<td>32%</td>
</tr>
<tr>
<td>England</td>
<td>39%</td>
<td>38%</td>
<td>37%</td>
<td>35%</td>
<td>34%</td>
<td>33%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Source: Department for Education, 2012

There is scope for further improvement and this is reflected in a focus on early intervention activity across Kingston delivered through Children’s Centres, free early education for the most disadvantaged two year olds and the ‘Let’s Talk’ initiative. ‘Let’s Talk’ has been developed locally from the earlier DfE sponsored ‘Every Child a Talker’ programme designed to boost language and communication skills in the early years.

With effect from September 2012 a revised EYFS statutory framework will be introduced that focuses on three prime areas of learning and development and four specific learning areas as set out here:

- **Prime areas**
  - Communication and language
  - Physical development
  - Personal, social and emotional development

- **Specific areas**
  - Literacy
  - Mathematics
  - Understanding the World, and
  - Expressive Art and Design

In addition a progress check of all children aged two to three years will be introduced. The aim of the progress check is to identify the child’s strengths and areas where the child’s progress is less than expected. If a significant concern is identified such as a special educational need or disability, it is expected that practitioners will develop a targeted plan to support the child’s future learning and development in conjunction with other relevant partner agencies and organisations. The early years service is now working with health visitors to join up the new progress check and health checks for children and families to avoid unnecessary duplication and to offer a holistic assessment of progress.

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13 Department for Education [https://www.education.gov.uk/publications/standard/AbouttheDepartment/Page1/DFE-00032-2011](https://www.education.gov.uk/publications/standard/AbouttheDepartment/Page1/DFE-00032-2011)

Local Action

Health Visiting

Health visitors play a key role in the promotion of healthy lifestyles and intervening early to prevent poor health outcomes for young children. The Health Visiting Service in Kingston provided by Your Healthcare has aligned its teams with the Children’s Centre cluster areas and each centre has a named health visitor facilitating co-working.

The government has stated that it wishes to expand health visitor capacity to better support the families of children in the early years, in line with the strategy of ease of access to advice and guidance and prompt early intervention when problems first manifest themselves. The local impact of this policy development will need to be incorporated into local planning.

Children’s Centres

There are 10 Sure Start Children’s Centres in Kingston and they offer a wide range of universal and targeted programmes in partnership with health and family support services. The aims are to ensure that all children aged 0-5 achieve good health and well being and that parents are supported to ensure their children develop well and in turn are ready for school. 3,134 children aged 0-5 (about 30% of all children in this age group) are actively attending the centres as at July 2012. This is an improvement on previous years and it is expected that this figure will continue to increase. There is a strong focus on promoting early intervention and the increasing numbers of children from hard to reach families attending demonstrates that progress is being made in this area.

Each Children’s Centre is strategically located on a primary school site, locally managed by the head teacher, to support a smooth transition into education. Each centre covers a reach area determined by the number of 0-5 year olds. Norbiton and North Kingston have the largest reach area followed closely by the New and Old Malden centres.

Year on year each centre has increased the number of hard to reach families attending Children’s Centres and accessing services. The Sure Start Children’s Centre Practice Guidance (September 2011), through its performance management framework, has identified target groups of families with particular characteristics who through successful engagement can derive significant benefit from attending Children’s Centres. Potentially hard to reach target groups refers to the following groups as identified in the management section of the Sure Start Children’s Centre Practice Guidance:

- Teenage mothers and pregnant teenagers
- Lone parents
- Children in workless households
- Children in Black and minority ethnic groups
- Disabled children and children of disabled parents
- Fathers
- Other groups that are priority vulnerable groups in the children’s centre area

Table 3.8 shows that increasing numbers of hard to reach families are attending Children’s Centres in Kingston.

### Table 3.8 Hard to Reach (HtR) Families attending Children’s Centres

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of HtR families attending Children’s centres</td>
<td>468</td>
<td>592</td>
<td>1318</td>
</tr>
</tbody>
</table>

Source: RBK E-start database

The co-location of five Community Midwifery Teams has been completed in 2011/12 and they are beginning to show positive examples of partnership working at centre level with an increase from 1,116 individuals seen by the midwifery service in centres in 2010 to 1,916 in 2011. The midwifery teams have attended Local Authority and centre based training and development opportunities. Systems have been developed to share information between services including records of attendance by parents at Midwifery delivered events in each centre. These include antenatal and postnatal talks and classes, and one-to-one bookable appointments which are recorded on the Children’s Centre database, eStart.

Health visitors have been aligned to centres for over a year and their input into centre development continues to improve as is evident in the increased number of individuals seen. In 2010 the Health Visiting Service saw 2,403 individuals in Children’s Centres which increased to 4,121 in 2011. Health partners continue to engage with both strategic and centre level planning of services and this area continues to show progression.

Children’s Centres regularly review and monitor children attending to ensure that those most in need of support are effectively targeted by their local centre. The methods of monitoring include cross referencing of all children known to Safeguarding Services aged 0-5 years to check if they are registered and actively attending and to liaise with the appropriate professional to encourage engagement with services. Centres are also informed of all children who are known to the ASKK service and those children who are participating in the 2:10 initiative (10 hours of free early years education per week provided to vulnerable two year olds). Children who are not known to centres are targeted via the appropriate professional to begin engagement.

15 Royal Borough of Kingston Children’s Centre Catchment Area Data Report April 2012
Children’s Centres also offer a wide range of health focussed activities which include:

- Cook & Eat programmes in partnership with Public Health and Family Learning.
- Stretching Stars physical health sessions for toddlers.
- Baby Massage which aims at increasing attachment and helps aid bonding which is often targeted towards families referred via the Health Visiting teams.
- A Post Natal Depression Group which is held at Surbiton.
- The provision of high quality accurate information, advice and guidance and the ability to signpost families to a broad range of services and support.

**Health Service Use Data**

In 2011/12 there were 5,346 first attendances at all hospital outpatient clinics by Kingston registered patients aged 0-5 years. 43% of first attendances resulted from GP referrals, 36% from consultant to consultant referrals, 4% from Accident and Emergency and the majority of the remaining 17% were from other health professionals. Figure 3.1 shows the percentage of attendances by specialty. One third of attendances by 0-5 year olds were to General Paediatrics followed by 13% to Trauma and Orthopaedics and 13% to Audiology.

1,581 GP referrals to outpatients were accepted by the Kingston Clinical Assessment Service (KCAS) in 2011-12 for 0-5 year olds. The percentage of GP referrals by specialty is shown in figure 3.2. This illustrates that the greatest proportion of GP referrals for 0-5 year olds were sent to General Paediatrics followed by Ophthalmology and ENT.

It should be noted that there is a discrepancy between the number of GP referred first attendances (2,299) and the number of GP referrals accepted by KCAS (1,581). Most of this difference is accounted for by children being on agreed clinical pathways that bypass KCAS.

**Figure 3.2**

GP referrals to outpatients accepted in 2011-12 for 0-5 year olds, showing percentage of referrals by speciality.
In 2011/12 there were 2,116 hospital admissions for Kingston registered patients aged 0-5 years. 69% of these admissions were to Kingston Hospital, followed by 12% to St George’s Healthcare NHS Trust and 8% to Epsom and St Helier University Hospitals NHS Trust. Figure 3.3 shows that over half the admissions were to General Paediatrics followed by 16% to Neonatology.

Since the majority of referrals, out-patient attendances and admissions are to General Paediatrics, which covers a wide range of conditions, it is difficult to draw conclusions on the appropriateness of service use or preventability of individual medical conditions.

**Recommendations**

- Continue to promote and raise awareness of the immunisation programme for young children with parents and carers.
- Review the effectiveness of the “Grab and Jab” initiative and target those areas where immunisation rates are lowest.
- Implement plans in 2012 / 13 for the EYFS progress check to be integrated and expanded to include a health check-up.
- Develop targeted programmes for families experiencing breakdown to promote positive co-parenting to ensure children continue to thrive and develop emotionally and socially.
- Continue to focus on closing the EYFS attainment gap and ensure children are ready for school.
- Support the pilot of free early education to disadvantaged two year olds in Kingston, and use findings from the health and education outcomes achieved by these children to inform future service development and targeting.
- Further analysis of patterns of service use for common causes of ill health in children should be undertaken to inform service developments and commissioning in the future.
Chapter 4: Primary School Age

Primary School Age

Elizabeth Brandill-Pepper, Joint Children’s Health Commissioner, Royal Borough of Kingston, Elizabeth.brandill@rbk.kingston.gov.uk

Introduction
This chapter is concerned with describing arrangements to promote the health and wellbeing of children in the primary school age range in Kingston, broadly defined as 5 to 11 years of age. Locally there is a strong emphasis on tackling obesity and ensuring good emotional wellbeing. Action to address these issues and the consequent impact are also highlighted.

Why is this an important public health issue?
Worldwide there is good understanding of the inextricable link between education and health, since it is well known that healthy children are more likely to learn effectively. In addition, young people who attend school regularly have better chances of maintaining good health. Children who feel good about their school and who are well connected to significant adults are less likely to undertake high risk behaviour and are also likely to have better learning outcomes1.

Schools are also able to provide opportunities for staff to model effective health promotion activities and there is good evidence that education has the power to impact on improving health outcomes. Whilst the cause and effect dimension may not be fully clear, and the complex interacting relationship between education and health not fully understood, there is enough knowledge and research evidence to support the promotion and delivery of focussed programmes within primary schools with the aim of building a healthy population in the long term1.

Local Issues
The 2011 Census indicated that there are 9,010 children aged five to nine living in the borough of Kingston.

There are 34 Primary schools in the borough (including Infant and Junior schools, some of which are linked but excluding private primary schools). As part of Kingston’s long-term strategy of providing additional school places to meet the growing demand of a rising school age population a new Primary School (the 35th in the borough) in Surbiton has just opened in September 2012. Initially this school (Lime Tree Primary School) will offer 60 new reception places, 26 part-time nursery places and support for up to three children with special educational needs. When fully open, the two-form entry school will cater for 420 pupils, including 21 pupils with special educational needs (SEN).

A particular feature of this development is a strong partnership with local health services since the site on which the school has been built is currently owned by NHS Kingston. Phase two of the overall building project will include co-location of GP surgeries and other health services and this is due to open in March 2013.

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1 Promoting Health in Schools; from evidence to action, International Union for Health Promotion and Education (IUHPE), 2010
Figure 4.1 shows the number of children on roll in 2010 by each Kingston Primary school which when totalled equals 10,514 children. This information only relates to children aged 7 to 11 and excludes children aged 4 to 7 at infant school. There were a further 119 pupils on roll at Bedelsford and Dysart Special schools. This data is collated from the School Census and so does not include data for children who attend private schools or information about children from Kingston who attend schools outside the borough. However, it does include children living outside the borough who attend schools in Kingston.

The range of the number of children on the school rolls in Kingston is between 208 and 712, the average primary school roll size being 362.

The most recent data available on the primary school population shows that 11% of the total population are eligible for Free School Meals, 15% of the cohort have special educational needs, (data regarding special educational needs (SEN) is included in chapter 10), and 32% speak English as an additional language.

Figure 4.2 shows the proportion of Black and minority ethnic (BME) children in Kingston primary schools. On average 51% of the children attending primary schools in the borough belong to BME groups, with the highest proportion in the North East of the borough.
English as an additional language

Figure 4.3 shows the proportion of children in each primary school who speaks English as an additional language. The average proportion of children whose first language is not English in all schools is 32%, and as for ethnicity the highest proportion of children who speak English as an additional language are located in the North East of the Borough.

Figure 4.3
Proportion of children who speak English as an additional language

Free School meals

The provision of free school meals (FSM) is a good indication of both the extent of child poverty and the health needs that may accompany this. Figure 4.4 shows the proportion of children recorded as being eligible for free school meals in each primary school. Overall, 11% of children receive free school meals in Kingston primary schools. Figure 4.5 shows the proportion of children receiving free school meals in each of Kingston's electoral wards. As expected given the level of disadvantage in the ward, Norbiton has the highest proportion of children receiving free school meals.

Figure 4.4
Proportion of children recorded as being eligible for free school meals in Kingston primary schools

Source: School Census, Spring 2012
For all children starting primary school in Kingston, the School Nursing Service with specialist partners offers a School Entry Health Check. All children have key indicators of health assessed at primary school entry when they are four to five years old. This health check consists of three parts:

- **Growth** – a height and weight check with onward referral to the GP or paediatrician if significantly outside of normal ranges.
- **Vision** – a standard visual acuity test is offered with onward referral if there are problems found. This health check provides an essential universal benchmark which helps to identify local needs as well as providing a baseline against which to measure individual and cohort progress over time.
- **Hearing** – a hearing test is offered to determine hearing at different frequencies with onward referral if problems are found.

Healthy Lifestyles and Obesity

Obesity is one of the most significant health challenges facing the UK as a whole with over half of adults and a third of children nationally being either overweight or obese. Without action this could rise to almost nine in ten adults and two-thirds of children by 2050. Reducing rates of child obesity is both a national and local Kingston priority. There is a particular focus on intervention and support programmes in the primary school age range.

The Healthy Schools programme which allowed health promotion work to be co-ordinated and quality assessed in schools was stopped recently when funding ceased. Across London there are discussions about reinstating this, which would allow more streamlined and planned health promotion activities to take place.

Kingston has an excellent overall 2010/11 National Child Measurement Programme participation rate (99%) which is higher than both the London (93%) and national (93%) averages (Table 4.1). This demonstrates the commitment of Kingston schools to achieving reliable measurement of height and weight and hence body mass index (BMI) of local children. Kingston has the highest participation rate in South West London.

<table>
<thead>
<tr>
<th>Participation Rate</th>
<th>Reception</th>
<th>Year 6</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>93.4%</td>
<td>91.8%</td>
<td>93.0%</td>
</tr>
<tr>
<td>London</td>
<td>93.0%</td>
<td>92.2%</td>
<td>93.0%</td>
</tr>
<tr>
<td>NHS Kingston</td>
<td>99.2%</td>
<td>98.3%</td>
<td>99.0%</td>
</tr>
<tr>
<td>NHS Richmond &amp; Twickenham</td>
<td>91.3%</td>
<td>90.0%</td>
<td>90.7%</td>
</tr>
<tr>
<td>NHS Wandsworth</td>
<td>93.1%</td>
<td>94.8%</td>
<td>94.0%</td>
</tr>
<tr>
<td>NHS Sutton &amp; Merton</td>
<td>87.9%</td>
<td>92.0%</td>
<td>90.0%</td>
</tr>
<tr>
<td>NHS Croydon</td>
<td>92.7%</td>
<td>92.7%</td>
<td>92.7%</td>
</tr>
</tbody>
</table>

Source: National Obesity Observatory

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2. Healthy Lives, Brighter Futures, DoH/DCSF, 2009


Locally, 17.5% of children (n=290) in Reception (aged 4-5) are above a healthy weight\(^7\). Each year, the National Child Measurement Programme (NCMP) measures a new cohort of children and therefore, the year-on-year data cannot fully represent the change in the prevalence of overweight and obesity in Kingston children. However, a look back over the previous five academic years (see Table 4.2 above) does illustrate that the percentages have plateaued; this is very positive in that the year-on-year rise in obesity prevalence has been halted but also highlights the continuing need for more work in this area to reduce the percentages over time.

Recent analysis of the Reception NCMP data at ward level in Kingston (Figure 4.6), shows that St James has the highest levels of obesity in Reception year children (11.3%), with Norbiton the second highest (9.8%) followed by Alexandra ward and Tolworth and Hook Rise (9.6%). The prevalence in these wards is higher than the national average (9.4%).

<table>
<thead>
<tr>
<th>Participation Rate</th>
<th>2006-07</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>England Overweight</td>
<td>13.0%</td>
<td>13.0%</td>
<td>13.2%</td>
<td>13.3%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Obese</td>
<td>9.9%</td>
<td>9.6%</td>
<td>9.6%</td>
<td>9.8%</td>
<td>9.4%</td>
</tr>
<tr>
<td>London Overweight</td>
<td>12.0%</td>
<td>12.0%</td>
<td>12.4%</td>
<td>12.7%</td>
<td>12.4%</td>
</tr>
<tr>
<td>Obese</td>
<td>11.3%</td>
<td>10.9%</td>
<td>10.9%</td>
<td>11.6%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Kingston Overweight</td>
<td>9.7%</td>
<td>10.3%</td>
<td>10.2%</td>
<td>9.9%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Obese</td>
<td>7.7%</td>
<td>7.6%</td>
<td>7.6%</td>
<td>6.8%</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

Source: National Obesity Observatory, online data tables

Table 4.2
Reception year data for the last 5 years compared with London and England

<table>
<thead>
<tr>
<th></th>
<th>2006-07</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>England Overweight</td>
<td>13.0%</td>
<td>13.0%</td>
<td>13.2%</td>
<td>13.3%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Obese</td>
<td>9.9%</td>
<td>9.6%</td>
<td>9.6%</td>
<td>9.8%</td>
<td>9.4%</td>
</tr>
<tr>
<td>London Overweight</td>
<td>12.0%</td>
<td>12.0%</td>
<td>12.4%</td>
<td>12.7%</td>
<td>12.4%</td>
</tr>
<tr>
<td>Obese</td>
<td>11.3%</td>
<td>10.9%</td>
<td>10.9%</td>
<td>11.6%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Kingston Overweight</td>
<td>9.7%</td>
<td>10.3%</td>
<td>10.2%</td>
<td>9.9%</td>
<td>10.4%</td>
</tr>
<tr>
<td>Obese</td>
<td>7.7%</td>
<td>7.6%</td>
<td>7.6%</td>
<td>6.8%</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

Source: National Obesity Observatory, online data tables

Figure 4.6
NCMP Reception year estimated prevalence of obesity at ward level in Kingston based on combined data from 08/09, 09/10 and 10/11.

Ward values have been suppressed where the number of children classified as obese is less than or equal to five or the number of children measured is less than 50 to provide as robust an indicator as possible.

The number of children considered obese or overweight at the end of year 6 remains lower than the national and London average (Table 4.3). However, as can be seen from Tables 4.2 and 4.3, the percentage of children who are obese locally more than doubles between the reception year and year six.

Table 4.3
Year 6 data for the last 5 years compared with London and England

<table>
<thead>
<tr>
<th></th>
<th>2006-07</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td>England Overweight</td>
<td>14.2%</td>
<td>14.3%</td>
<td>14.3%</td>
<td>14.6%</td>
<td>14.4%</td>
</tr>
<tr>
<td>Obese</td>
<td>17.5%</td>
<td>18.3%</td>
<td>18.3%</td>
<td>18.7%</td>
<td>19.0%</td>
</tr>
<tr>
<td>London Overweight</td>
<td>14.8%</td>
<td>14.7%</td>
<td>14.7%</td>
<td>15.1%</td>
<td>15.1%</td>
</tr>
<tr>
<td>Obese</td>
<td>20.1%</td>
<td>21.6%</td>
<td>21.3%</td>
<td>21.8%</td>
<td>21.9%</td>
</tr>
<tr>
<td>Kingston Overweight</td>
<td>14.6%</td>
<td>14.7%</td>
<td>13.3%</td>
<td>14.5%</td>
<td>15.1%</td>
</tr>
<tr>
<td>Obese</td>
<td>15.4%</td>
<td>16.4%</td>
<td>16.4%</td>
<td>16.4%</td>
<td>15.8%</td>
</tr>
</tbody>
</table>

Source: National Obesity Observatory, online data tables
From 2010 onwards one of the key objectives for weight management services in Kingston was to develop a multi-component weight management service for children and their families\(^8\). These are known as the Factor programmes and have been developed locally to meet the needs of Kingston families. They are designed to help families and children to learn how to embrace healthier habits and lead an active lifestyle. They embed key nutrition, physical activity and behavioural change principles to help children grow into a healthier weight for their age and gender and prevent excessive weight gain. DC Leisure was commissioned by NHS Kingston to help develop and implement the Factor programmes across Kingston for 18 months from August 2010 until March 2012 and due to successful evaluation, the contract has been extended until March 2013. There are three programmes for different age groups, encouraging consistency for families with children of different age groups. The Fun-factor, Fwd-factor and 4U-factor, are run at various DC leisure sites across the Borough (see Table 4.4).

Preliminary evaluation of all three programmes is promising with positive changes in dietary and mealtime habits, an increase in time spent being physically active and an increase in parental confidence in feeding their child (this has included tackling issues such as fussy eating). Key demographic, output and outcome information for the fun-factor programme is highlighted in Table 4.5.

![Table 4.5: Key participation and clinical outcomes for the Fun-factor programme.](image)

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**In respect of schools meals, the Institute for Social and Economic Research (ISER) examined the impact of introducing healthy school meals on educational outcomes. The report of the Feed Me Better campaign suggests that improving school meals, and the specific provision of hot school meals, is a highly cost-effective way to raise attainment\(^9\).**

All Kingston schools provide hot food and all Kingston Primary Schools now have the national ‘Healthy School’ status. The four schools that previously only provided cold free school meals have changed their school meal provision and provisional data for 2012 is showing an increase in uptake.

It is estimated that 26% of the school population take packed lunches. Nationally, aiming to ensure that children’s lunch boxes contain healthy foodstuffs has received a mixed response from parents, so locally action must continue to reflect a consistent advisory and supportive approach.

It is estimated the gap between those potentially eligible for school meals and those claiming them is over 1,500 children across primary and secondary schools in Kingston\(^10\). This would indicate a significant amount of unmet need, and a vigorous campaign to urge take up of FSM was launched in the autumn of 2011. By December 2011, 1,907 children were taking up free school meals, an increase of 14.7% on the previous year.

NHS Kingston has also developed the Chef’s Club programme which is run in local schools as a breakfast, lunchtime or after school club. This programme has been available since 2008 and teaches cooking skills over a six week period to children and parents. It aims to improve cooking skills, confidence and knowledge as well as tackling issues such as fussy eating and how to cook healthily for the family on a restricted budget. During 2010/2011, this programme has been taken up by a number of local primary schools in the Malden & Coombe area.

Between September 2011 and June 2012, eight schools provided 24 Chef’s Club programmes targeting a total of 112 families. These programmes have been very successful

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\(^{9}\) Healthy school meals and educational outcomes M Belot and J James Institute for Social and Economic Research January 2009

\(^{10}\) One Kingston Child Poverty Needs Assessment Refresh 2011/12 Royal Borough of Kingston upon Thames
Promoting mental wellbeing in primary school children

Children’s social and emotional wellbeing is important in its own right but also because it affects their physical health (both as a child and as an adult) and can determine how well children perform at school. Good social, emotional and psychological health helps protect children against emotional and behavioural problems, violence and crime, teenage pregnancy and the misuse of drugs and alcohol\textsuperscript{11}.

Schools responsibilities

NICE has provided guidance on best practice promoting emotional wellbeing in primary schools\textsuperscript{12}. In summary this recommends that:

- Commissioners develop and agree arrangements to ensure all primary schools adopt a comprehensive, “whole school” approach to children’s social and emotional wellbeing.
- All primary schools should provide a comprehensive programme to help develop children’s social and emotional skills and wellbeing.
- Teachers and practitioners working with children in primary education are trained to identify and assess the early signs of anxiety, emotional distress and behavioural problems among primary schoolchildren.

Kingston takes these recommendations very seriously and has actively promoted a number of initiatives over recent years to boost children emotional resilience. The Social and Emotional Aspects of Learning programme (SEAL) is still used in most borough primary schools. There are regular SEAL networks used to provide a forum for discussion and development of the Personal, Social and Health Education (PSHE) curriculum. There is no training currently offered to schools on “Promoting emotional well-being in school” although this has been offered in the past and was provided to one primary school in 2010-11. This is an area for development in future years.

In 2011/12 six teachers were trained as instructors in ‘Young People Mental Health First Aid’ courses which are designed to increase knowledge, change attitudes and model good helping behaviour towards young people with mental health problems\textsuperscript{13}. Instructors will provide courses for professionals and community members who work with young people, particular those at higher risk of mental health problems. There will be an on-going evaluation of this programme.

Current risks to mental wellbeing in primary school children

Children in their primary years can be exposed to difficult situations such as bullying or racism or may be coping with socially disadvantaged circumstances. These may include being a looked after child (including those who have been subsequently adopted) those living in families where there is conflict or instability, those who persistently refuse to go to school, those who have experienced adverse life events such as bereavement or parental separation and those who have been exposed to abuse or violence\textsuperscript{14}.

The Victim Support Safespace Project employed a Children’s Worker to support children between the ages of five and eleven who had witnessed or experienced domestic abuse. The project has supported 200 children on a one-to-one basis since April 2010, working across 19 schools, and feedback from Head Teachers, Special Educational Needs Co-ordinators


\textsuperscript{12} National Institute for Health and Clinical Excellence - Social and emotional wellbeing in primary education (PH12) March 2008.


\textsuperscript{14} There are currently available in Kingston include:

- Parkrun – free weekly community 5km events (walk, jog or run) starting at Canbury Park Gardens (children need to be accompanied by an adult).
- Walk4Life Kingston – free social weekly walks for families and communities (under 16s must be accompanied by an adult).
- Bike4Life Kingston – free social cycle rides for families and communities (under 16s must be accompanied by an adult). A new cycle hire scheme is under development to ensure those who don’t have a bike can also join in.

NHS Kingston and the Royal Borough of Kingston are currently developing the new Healthy Weight and Physical Activity Strategy for Kingston (2012 – 2015). This is discussed in more detail in Chapter 5.

although there are specific challenges to overcome such as a lack of kitchen facilities large enough for group programmes and the full completion of monitoring questionnaires to improve data quality. The evaluation of the programme has shown an increase in children’s confidence in cooking, an increase in parental confidence in cooking healthily for the whole family, and an increase in both knowledge and emotional wellbeing in primary education (PH12) March 2008.
(SENCOs), agencies, children and parents about the difference the support has made to children has been extremely positive. Although the programme was initially designed for children with mid-level needs and limited access to statutory support, the Safeguarding Service was increasingly referring children into the programme as part of Child Protection Plans. The funding for this project ended in April 2012.

There are additional areas of concern that are emerging. Firstly, evidence suggests that some primary aged pupils may be exposed to cyber-bullying, a phenomenon normally associated with adolescence. Currently training for professionals in Kingston is geared towards working with those aged 11 and over so a programme needs to be developed that meets the specific needs of a younger population.

Secondly, some of the issues which affect secondary school age children (see Chapter 5) may also affect some children in primary school.

Oral Health

Maintaining good oral health remains a local priority and is strongly related to a healthy diet with limitations on sugar intake to avoid tooth decay. Children’s oral health has also been improving and far fewer children experience tooth decay than they did 30 years ago. Older children in England now have the best oral health in Europe. However, in spite of this overall improvement, national surveys of dental health still highlight inequalities which are strongly associated with social background.

The 2003 National Survey of Child Dental Health highlights inequalities by social background, for example, the probability of having obvious decay experience in primary teeth was about 50% higher in the lowest social group compared with the highest social group.

From a survey carried out in 2007/08, it was found that the majority (75%) of children entering primary school in Kingston had no experience of tooth decay. However, dental decay (as defined as decayed, missing or filled teeth) occurred in an identifiable sub-group of the 5-year-olds locally, with one quarter (25%) suffering decay in their primary teeth. These children had high levels of disease, with an average of over three teeth affected, most of which were untreated.

There is currently good availability of NHS dental services in Kingston with 83 Dentists within a five mile radius of the centre of Kingston reporting that they were accepting new NHS child patients in October 2012. The Primary Care Trust has been running a range of successful campaigns aimed at improving access to NHS dental services, particularly by children. Uptake of NHS dental services (measured as the proportion of Kingston children seeing an NHS dentist in the previous 24 months) has risen from 67% in 2006 to 74% in June 2012 (which is higher than the England average of 71%). As a patient, children will benefit from an individual assessment, treatment and prevention advice.

There is a limited dedicated Oral Health Promotion specialist service delivered to Kingston residents totalling six sessions each week through the local Special Care Dental Services. The overall Oral Health Promotion activities include some programmes aimed at young mother groups, young children in nurseries and targeted schools. In school based education sessions, children are taught about oral health, tooth brushing and diet. Training sessions are also provided for teachers to reinforce oral health to their pupils throughout the school year. In the period April 2011 to March 2012, 17 primary schools in Kingston were visited and oral health education was delivered to 3,454 children and their teachers.

Health Service Use Data

In 2011/12 there were 2,151 first attendances at all hospital outpatient clinics by Kingston registered patients aged 6-10 years. 35% of first attendances resulted from GP referrals, 29% from consultant to consultant referrals, 13% from Accident and Emergency and the majority of the remaining 22% were from other health professionals. Figure 4.6 shows the percentage of attendances by specialty. 18% of attendances by 6-10 year olds were to General Paediatrics followed by 16% to Trauma and Orthopaedics and 15% to Audiology.

Figure 4.7
First Outpatient Attendances of 6-10 year olds in 2011/12 showing percentage of attendances by specialty.

16 NHS Dental Epidemiology Programme, results available at The Dental Observatory http://www.nwph.net/dentalhealth/
17 NHS Choices http://www.nhs.uk/

Source: SUS
677 GP referrals to outpatients were accepted by the Kingston Clinical Assessment Service in 2011-12 for 6-10 year olds which is fewer than the total number of GP referrals for first attendances. The percentage of GP referrals by specialty is shown in figure 4.7. This illustrates that the greatest proportion of GP referrals for 6-10 year olds were sent to General Paediatrics followed by Ophthalmology and ENT, which is the same pattern as GP referrals for 0-5 year olds.

In 2011/12 there were 566 hospital admissions for Kingston registered patients aged 6-10 years. 51% of these admissions were to Kingston Hospital, followed by 18% to St George’s Healthcare NHS Trust and 16% to Epsom and St Helier University Hospitals NHS Trust. Figure 4.8 shows that one third of the admissions were to General Paediatrics with the next highest specialties being Paediatric Dentistry at 14% and ENT at 9% of all admissions.

**Figure 4.8**
GP referrals to outpatients accepted in 2011-12 for 6-10 year olds, showing percentage of referrals by speciality.

**Figure 4.9**
Hospital admissions of 6-10 year olds in 2011/12 showing percentage admitted by speciality.
The high proportion of admissions and referrals to specialties such as ENT, where passive smoking related conditions are common problems in childhood, and to dentistry, suggest that there is potential to reduce the burden of ill health due to common preventable conditions in Kingston.

**Recommendations**

- Fully implement the Healthy Weight and Physical Activity Strategy for Kingston.
- Develop an effective communications and marketing strategy to inform the public of opportunities around health improvement maximising the potential use of social marketing.
- Produce a mental health promotion resource pack for schools to use in health events.
- Develop an action plan to offer Mental health first aid training to all relevant frontline staff in schools and community setting.
- Consult head teachers about how they would like to be supported to promote emotional wellbeing in their schools and provide appropriate guidance.
- Examine the scope for sustaining the work of the Victim Support Safespace Project.
- Develop a multi-agency partnership training programme to raise knowledge of cyber-bullying amongst front line professionals enabling them to better advise and support primary school age children.
- Develop local plans to promote better dental care amongst target population groups.
- Consider reinstating the Healthy Schools agenda in Kingston, either in collaboration with boroughs across London or within Kingston.
- Undertake further analysis of health service use related to preventable conditions, in order to target prevention services more effectively.
Secondary School Age

(To contact chapter authors please email jonathan.hildebrand@kpct.mhs.uk)

Why is adolescent health an important public health issue?
Entry into secondary school is an important milestone in the lives of young people. It marks the start of adolescence which is the transition from childhood to adulthood. During this period adolescents experience physical, emotional and social changes. Adolescents’ future health, wellbeing and health behaviours in adulthood are influenced by the opportunities they experience at home, school and in wider society. Whilst British adolescents today enjoy better health and development than those of earlier generations, they engage in more high risk behaviours than their peers in Western Europe and North America. Health risk behaviours that adolescents engage in include tobacco, alcohol and drug use, physical inactivity, unhealthy diets, sexual activity, and exposure to injury and violence.

A significant minority of adolescents do not enjoy good health outcomes, with those from disadvantaged backgrounds at greater risk of dealing less well with the challenges of adolescence. Adolescents require knowledge and skills in order to take responsibility for their own health. Prevention and early intervention is an effective approach to reversing poor health outcomes and improving health in adulthood, therefore focusing on adolescent health is an important public health issue.

Joint Annual Public Health Report for Kingston 2011/2012

Chapter 5: Secondary School Age

Demographics of adolescents in Kingston

Figure 5.1 provides an estimate of the population of young people in Kingston.

Figure 5.1
Population structure of young people in Kingston

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
<th>18</th>
<th>19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living In Borough</td>
<td>14,719</td>
<td>12,070</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living outside the Borough</td>
<td>4,933</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>17,652</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SOURCE: Greater London Authority (2011)

Secondary education in Kingston

High levels of education are associated with good health and wellbeing, greater social mobility and lower levels of deprivation. Education is essential to changing life chances and schooling can boost health through raising self-confidence, self-esteem and wellbeing in an environment that promotes learning, development of knowledge and skills, and healthy lifestyle choices.

Kingston has ten state funded secondary schools and three special schools. Eight of the schools are single sex, four for boys, four for girls, whilst two are mixed. Two schools are selective and two are faith based schools which are Catholic. There are also five independent secondary schools in the borough.

The estimated number of pupils on the Kingston secondary state (aged 11-18 years) and independent (aged 4-19 years) education school roll studying in Kingston in 2011 was 12,754 (Table 5.1).

5.1% of pupils registered in state secondary education locally had special educational needs (SEN) statements or had been provided with School Action Plus interventions and 9% of the state secondary school population were eligible for free school meals in Kingston.

23 children aged 11-15 years are being educated at home in Kingston in 2012.


Table 5.2
Pupils in state secondary education in Kingston (2010/11)

<table>
<thead>
<tr>
<th>Pupils in National Curriculum (NC) Years 7 – 11</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living In Borough</td>
<td>5,581</td>
<td>72 %</td>
</tr>
<tr>
<td>Living outside the Borough</td>
<td>2,120</td>
<td>28 %</td>
</tr>
<tr>
<td>Total</td>
<td>7,701</td>
<td></td>
</tr>
</tbody>
</table>

Source: Spring school census, 2011, RBK

Table 5.2 presents data on pupils in years 7 to 11 who were registered in state secondary school education in 2010/11. 72% were borough residents compared to 28% who were from outside Kingston.

Table 5.3
Pupils in state secondary education in Kingston by ethnicity (2010/11)

<table>
<thead>
<tr>
<th>Ethnicity (Pupils in NC Years 7 - 11)</th>
<th>White</th>
<th>Black</th>
<th>Asian</th>
<th>Mixed</th>
<th>Chinese</th>
<th>Any Other</th>
<th>Not Obtained/Refused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>4868</td>
<td>318</td>
<td>1417</td>
<td>583</td>
<td>101</td>
<td>349</td>
<td>65</td>
</tr>
<tr>
<td>%</td>
<td>63.2</td>
<td>4.1</td>
<td>18.4</td>
<td>7.6</td>
<td>1.3</td>
<td>4.5</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Source: Spring school census, 2011, RBK

Table 5.3 provides the ethnic breakdown of pupils attending state secondary education in Kingston (years 7 to 11). 63.2% are from the White ethnic group and 35.9% are from Black and minority ethnic (BME) communities. Please note that these are different ethnicity categories to those used in the national census.
Educational attainment

Overall pupils in Kingston achieve higher educational attainment compared to the national and London average. In 2011, 71% of Kingston pupils achieved 5 or more GCSE A* - C (or equivalent) including English and Maths, compared to 58% in England (Table 5.4). However, the performance between schools in Kingston varies.

Table 5.4
GCSE comparisons with Kingston’s statistical comparators (2011)

<table>
<thead>
<tr>
<th>Borough</th>
<th>Percentage of pupils achieving 5+ GCSE A* – C including Maths and English in state funded schools (%) #</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>58</td>
</tr>
<tr>
<td>Kingston</td>
<td>71</td>
</tr>
<tr>
<td>Barnet</td>
<td>69</td>
</tr>
<tr>
<td>Bromley</td>
<td>67</td>
</tr>
<tr>
<td>Merton</td>
<td>60</td>
</tr>
<tr>
<td>Richmond</td>
<td>63</td>
</tr>
<tr>
<td>Sutton</td>
<td>75</td>
</tr>
</tbody>
</table>

Table 5.4 also provides overall GCSE performance for Kingston in comparison with its statistical comparators. Kingston performed better than all boroughs except Sutton.

Table 5.5 illustrates the attainment gap between pupils in Kingston who are eligible for Free School Meals (FSM) compared to those who are not. Although pupils in Kingston who are eligible for FSM have higher attainment than the national average for FSM pupils, there is a wider attainment gap in Kingston compared to nationally, due to the high overall performance of Kingston pupils. However, the gap in attainment of five or more GCSEs at A* to C has closed in the last 3 years largely due to an improvement in achievement for those receiving FSM.

Table 5.5
Key Stage 4: Pupil Attainment 2011. Performance of those eligible for Free School Meals compared to those not eligible for FSM

<table>
<thead>
<tr>
<th>FSU Eligibility</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>FSM Eligibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kingston FSM %</td>
<td>49</td>
<td>62</td>
<td>68</td>
<td>35</td>
<td>35</td>
<td>38</td>
</tr>
<tr>
<td>Kingston non FSM %</td>
<td>80</td>
<td>85</td>
<td>89</td>
<td>70</td>
<td>71</td>
<td>74</td>
</tr>
<tr>
<td>Attainment Gap %</td>
<td>-31</td>
<td>-23</td>
<td>-21</td>
<td>-35</td>
<td>-36</td>
<td>-36</td>
</tr>
<tr>
<td>Kingston Average %</td>
<td>78</td>
<td>83</td>
<td>87</td>
<td>67</td>
<td>69</td>
<td>71</td>
</tr>
</tbody>
</table>

| National FSM % | 48   | 58   | 65   | 27   | 31   | 35   |
| National non FSM % | 73   | 79   | 83   | 55   | 60   | 62   |
| Attainment Gap % | -25  | -21  | -18  | -28  | -29  | -27  |
| National Average % | 70   | 76   | 81   | 51   | 56   | 58   |


#Includes all pupils in maintained schools and academies

Table 5.6 illustrates the attainment gap between pupils in Kingston from BME groups compared to the Kingston average. The blue shading shows groups where attainment was lower than the Kingston average and the green shading shows groups where attainment was higher. No colour coding has been used where the number of children in the cohort was less than ten.

Table 5.6
Key Stage 4: Pupil Attainment 2011. Performance of Black and Minority Ethnic (BME) Groups compared to Kingston and National average

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>FSM Eligibility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>80</td>
<td>67</td>
<td>100</td>
<td>80</td>
<td>67</td>
<td>67</td>
</tr>
<tr>
<td>Black African</td>
<td>66</td>
<td>88</td>
<td>89</td>
<td>47</td>
<td>63</td>
<td>59</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>80</td>
<td>71</td>
<td>89</td>
<td>40</td>
<td>47</td>
<td>56</td>
</tr>
<tr>
<td>Black Other</td>
<td>43</td>
<td>50</td>
<td>92</td>
<td>43</td>
<td>**</td>
<td>25</td>
</tr>
<tr>
<td>Gypsy/Roma</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mixed White/Black African</td>
<td>85</td>
<td>77</td>
<td>91</td>
<td>69</td>
<td>77</td>
<td>82</td>
</tr>
<tr>
<td>Mixed White/Black Caribbean</td>
<td>82</td>
<td>77</td>
<td>86</td>
<td>82</td>
<td>64</td>
<td>48</td>
</tr>
<tr>
<td>Pakistani</td>
<td>70</td>
<td>81</td>
<td>92</td>
<td>55</td>
<td>56</td>
<td>81</td>
</tr>
<tr>
<td>Traveller Irish Heritage</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Kingston Average</td>
<td>78</td>
<td>83</td>
<td>87</td>
<td>67</td>
<td>69</td>
<td>71</td>
</tr>
<tr>
<td>National Average</td>
<td>70</td>
<td>76</td>
<td>81</td>
<td>51</td>
<td>56</td>
<td>58</td>
</tr>
</tbody>
</table>

#No pupils in this cohort. ** = data suppressed as less than 5. Source: Annual Report: School Improvement, Standards of Attainment and Pupil Progress Part 2: Closing the Gap 2011, RBK
Adolescents and health inequalities

Adolescent health is largely influenced by social and economic determinants with inequalities in health becoming more profound as adolescents become older. Vulnerable adolescents are more likely than other adolescents to engage in risky behaviour. Vulnerable adolescents include looked after children, young offenders, disabled young people, those not in education employment and training (NEET), young carers, unaccompanied minors and some BME young people. Poverty not only intensifies the risk of poor health, it also increases the risk of reduced cognitive development and under achievement leading to cycles of disadvantage in the next generation. Focusing on the daily lives of adolescents with their families, peers, at school and in the wider community is crucial to addressing health inequalities.

Table 5.7 illustrates characteristics of young people that are vulnerable to poor outcomes in health. Similarities and overlapping issues in health and social circumstances can be observed among specific groups of young people.

Table 5.7 Characteristics of adolescents at risk of teenage pregnancy, substance misuse or offending

<table>
<thead>
<tr>
<th>Teenage Pregnancy</th>
<th>Substance misuse</th>
<th>Young Offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual factors</strong></td>
<td><strong>Young Offenders</strong></td>
<td></td>
</tr>
<tr>
<td>Early onset of sexual activity</td>
<td>Low self esteem</td>
<td>Attention Deficit Hyperactivity Disorder</td>
</tr>
<tr>
<td>Poor contraception use</td>
<td>Mental health problems</td>
<td>Impulsivity</td>
</tr>
<tr>
<td>Mental health problems</td>
<td>Behavioural conduct disorders</td>
<td>Cognitive Impairment</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>Involved in crime</td>
<td>Aggressive behaviour</td>
</tr>
<tr>
<td>Involved in crime</td>
<td>Early onset of sexual activity</td>
<td>Mental health problems</td>
</tr>
<tr>
<td>Alcohol and substance misuse</td>
<td>Previous abortion or pregnancy</td>
<td>Alcohol and substance misuse</td>
</tr>
<tr>
<td>Previous abortion or pregnancy</td>
<td></td>
<td>Teenage parenthood</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Education related factors</strong></th>
<th><strong>Family background</strong></th>
<th><strong>Community factors</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low educational attainment</td>
<td>Living in care</td>
<td>Live in areas of high deprivation</td>
</tr>
<tr>
<td>Disengagement from school</td>
<td>Ethnicity</td>
<td>From marginalised and disadvantaged communities</td>
</tr>
<tr>
<td>Leaving school at 16 with no qualifications</td>
<td>Daughter of a teenage mother</td>
<td>Availability of drugs</td>
</tr>
<tr>
<td></td>
<td>Low parental educational aspirations</td>
<td>Peer group pressure to misuse substances</td>
</tr>
<tr>
<td></td>
<td>Homeless</td>
<td>Living in a deprived neighbourhood</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of social cohesion</td>
</tr>
</tbody>
</table>

Secondary school children in Kingston have previously participated in the National Tellus surveys and responded to questions on their involvement in health risk behaviours. The 2009 survey was completed by 1,597 pupils attending Kingston schools (School Years 6, 8 and 10). Table 5.8 provides information on their responses to selected health behaviours.

Table 5.8
Adolescent health behaviours

<table>
<thead>
<tr>
<th>Question/ Statement</th>
<th>% of pupils responding Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you take part in any organised sport or keep fit activities last weekend?</td>
<td>48% 46%</td>
</tr>
<tr>
<td>Have you ever had an alcoholic drink - a whole drink not just a sip?</td>
<td>32% 42%</td>
</tr>
<tr>
<td>I have never smoked</td>
<td>79% 77%</td>
</tr>
<tr>
<td>Have you ever taken drugs*</td>
<td>8% 9%</td>
</tr>
</tbody>
</table>

* Years 8 and 10
Source: Tellus4 (2009)

Pupils in Years 8 and 10 were also asked to comment in the Tellus4 survey on how useful they found information and advice given in school on particular topics. Table 5.9 reports that they did not have access to specific information regarding sexual health and relationships. The sexual health of young people in Kingston is discussed in greater detail in Chapter 6.

Activities in Kingston
Focusing on prevention and early intervention during adolescence ensures that needs are identified and addressed so preventing health problems from escalating. One Kingston’s Early Intervention Strategy and Framework (2012 – 2015) for children and young people aims to:

- Close the gap in attainment and achievement.
- Promote healthy physiological and psychological development.
- Reduce the impact of family relationship breakdown.
- Reduce risky behaviour.
- Reduce the impact of poverty and economic inactivity.

The strategy advocates an integrated approach to meet these aims. The top 10 reasons for children aged 10 – 16 years to be referred into Advancing Services for Kingston Kids (ASKK - which is discussed in greater detail in chapter 12) in June 2012 are provided in Table 5.10.

An Early Intervention Adolescent Health Coordinator post has been established to ensure a strategic and co-ordinated approach to tackling adolescent health risk behaviours focusing on:

- Sexual health (teenage pregnancy, sexually transmitted infections, sexual violence, bullying and exploitation) and promotion of healthy relationships.
- Drug and alcohol misuse, tobacco use.
- Mental health (emotional health and well-being, raising aspirations and self-esteem).

Personal, social, health and economic (PSHE) education is a planned programme of learning opportunities and experiences that help children and young people grow and develop as individuals, as members of families and of social and economic communities. PSHE education makes a major contribution to schools’ statutory responsibilities to promote children and young people’s wellbeing, achieve curriculum aims and promote community participation in health risk behaviours.
cohesion. PSHE is delivered in all secondary schools in partnership with a wide range of partners. A recent survey of PSHE delivered by the Kingston School Health Team showed that provision was not sufficient to meet demand in some of the secondary schools across the borough.¹⁴

You’re Welcome

You’re Welcome Quality Standards is a framework to enable health services to become more accessible and responsive to the needs of young people; thereby supporting improved health outcomes for young people. The aim of You’re Welcome is to address the following issues that have been raised by young people:

- Young people lack confidence, knowledge and information about how to access and navigate health pathways.
- Young people perceive services to not be confidential or designed to meet their needs.
- Young people have had a range of negative experiences when communicating with health staff and felt that their voice is not heard.

Currently, six services have achieved You’re Welcome Status in Kingston and another ten are working towards this.

Kingston School Health Team

The school health teams play a pivotal role in reducing health inequalities in children and promoting health in the school and the wider community.¹⁶ They undertake a key role in reducing adolescent risk taking behaviours.

Their position in the school community contributes to universal health services and ensures early identification and management of health issues through the provision of rapid care interventions or by referral or signposting to specialist treatment and advice. In Kingston, school health is provided in state funded schools by Your Healthcare.

Commissioning arrangements for school health are changing from 2013 and this service will be commissioned by Public Health.

The team provide a wide range of services to state secondary schools including:

- Contribution to the delivery of PSHE in schools and encouraging and enabling adolescents to start taking responsibility for their own health. Sex and relationship education (SRE) is the main topic schools ask the School Health Team to support them with. They have also contributed to healthy eating, drugs education and emotional health and wellbeing sessions on request.
- Delivery of immunisation programmes in schools (which will be commissioned by the National Commissioning Board in the future).
- Provision of guidance and support to schools, parents/carers and the wider community on health issues affecting the school population.
- Accepting referrals from schools and supporting children with complex health needs to prevent social exclusion and promote educational achievement.

- Standard school drop-ins at lunchtimes once a week at Holy Cross School, Tiffin Girls’ School and Southborough High School for boys. These provide an opportunity for young people to discuss with the school nurse any issues affecting them including personal problems, health and school issues. Due to low uptake at The Tiffin School (boys) and Richard Challoner School the service is no longer available at these schools on a weekly basis, however pupils can see the school nurse by requesting an appointment.

In addition to the above services the school health team deliver the KU19 service, a free and confidential walk-in nurse led health service for young people aged 19 years and under in community settings in Kingston. The KU19 service also provides enhanced school drop-ins during lunchtimes at five secondary schools in Kingston (Chessington Community College, Coombe Boys School, Coombe Girls School, Hollyfield School and Tolworth Girls School). The nurse can provide information, advice and support to young people on health issues as well as free condoms, emergency hormonal contraception, chlamydia screening, pregnancy testing and referral for abortion. The school nurse will signpost pupils to a KU19 clinic or other clinics or services as required.

The use of enhanced school drop-ins in 2011/12 is shown in Figure 5.2. Service uptake varies between schools. There was very low uptake at Chessington Community College in 2011/12 due to accommodation problems.

**Figure 5.2**

**Number of attendances at enhanced school drop-ins (April 2011 – March 2012)**

Kingston Youth Support Service

The Kingston Youth Support Service offers universal and targeted preventative services to young people aged 11 – 19 years. Programmes and activities take place in youth centres and other venues across the Borough, including the Young Livin’ Bus. The service aims to empower young people, support them in making informed lifestyle decisions, engage them in positive activities, contribute to their learning in ways that enable them to maximise their potential and provide early intervention and preventative programmes.

The service contributes to the provision of PSHE in out-of-school settings by offering group work and one to one sessions on relationships, sexual health, substance misuse, smoking and emotional health and wellbeing. A Youth Support package is provided to young people experiencing persistent problems particularly those engaged in or at risk of risky behaviour, under-achievement, offending, and exclusion, with referrals taken through ASKK, schools and other professions.

Young people also have the opportunity to participate in programmes and projects that offer accreditation including the Duke of Edinburgh Award, Assessment and Qualification Alliance (AQA) Unit Awards and the Youth Achievement Award.

Kingston Youth Support Service supports an enhanced year 11 Curriculum targeted at disengaged students. The programme is designed to develop confidence and boost self-esteem through creative activities. In 2011/12 it successfully supported 22 pupils to access further education or pursue other training paths.

The service runs a mobile service, the Young Livin’ Bus which provides a drop in service across Kingston’s secondary schools. This offers young people the opportunity to access information, support and advice on health issues.

The Youth Support Service leads on young people’s participation across the Children’s Trust and has good links with a wide range of partners, including schools and other young people’s teams, to ensure that young people have a voice in service planning, development and implementation. The service facilitates and co-ordinates the activities of Kingston Youth Council, School Council Forums and workshops. The service has also been a key partner in the local implementation of You’re Welcome, recruiting and training young people to mystery shop health services, as part of the You’re Welcome assessment process.

Emotional health and wellbeing

Young people’s social and emotional wellbeing is influenced by a range of factors, from their individual make-up and family background to the community within which they live and society at large. Some groups are at higher risk of mental health problems than others as shown in Table 5.11.

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Increased risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children with learning disability</td>
<td>6.5 fold increased risk of mental health problem</td>
</tr>
<tr>
<td>Children with physical illness (e.g. diabetes, epilepsy, asthma, cerebral palsy)</td>
<td>1.7 fold increased risk of emotional disorders over a three-year time period</td>
</tr>
<tr>
<td></td>
<td>2.9 fold increased risk of conduct disorders over a three-year time period</td>
</tr>
<tr>
<td>Homelessness in young people</td>
<td>8 fold increased risk of mental health problems if living in hostels and bed and breakfast accommodation</td>
</tr>
<tr>
<td>Young lesbian, gay, bisexual and transgender</td>
<td>Young lesbian, gay, bisexual and transgender (LGBT) people are at increased risk of mental health problems. Depression was the most common mental health problem[17]. Young LGBT people are more likely to have attempted suicide than their heterosexual peers[18].</td>
</tr>
<tr>
<td>Young offenders</td>
<td>18 fold increased risk of suicide for men in custody aged 15–17, 40 fold increased risk of suicide in women in custody age ≥ 25 3 fold increased risk of anxiety / depression 4 fold increased risk of suicide attempts as an adult</td>
</tr>
<tr>
<td>’Looked after’ children</td>
<td>5 fold increased risk of childhood mental disorder 6–7 fold increased occurrence of conduct disorder 4–5 fold increased risk of suicide attempts as an adult</td>
</tr>
<tr>
<td>Children of prisoners</td>
<td>3 fold increased risk of antisocial outcomes</td>
</tr>
<tr>
<td>Adolescent dating violence</td>
<td>8.6 fold increased risk of suicide attempts</td>
</tr>
<tr>
<td>High level use of cannabis in adolescence</td>
<td>6.7–6.9 fold increased risk of developing schizophrenia</td>
</tr>
<tr>
<td>Domestic violence</td>
<td>The longer-term effects of domestic violence on children include lack of self-confidence and social skills, violent behaviour, depression, difficulties in forming relationships, disrupted education, and youth homelessness[14]</td>
</tr>
<tr>
<td>Young carers</td>
<td>Surveys of young carers found substantial numbers reporting stress, anxiety, low self-esteem and depression[20]</td>
</tr>
</tbody>
</table>

Source: New Horizons Confident Communities, Brighter Futures: A framework for developing well-being, DOH 2010

Promoting mental wellbeing in secondary school age children

Parents
Children of secondary school age continue to need a stable and nurturing environment that supports them to develop independence. Parents, peers and the community can reinforce positive or negative patterns of thinking and behaviour.  

The National Survey of Parents and Children in 2008 found that children who said they had engaged in at least three risky or anti-social behaviours in the previous 12 months were characterised by very low self-esteem and strained family relationships - lacking a close bond with their parents and a marked absence of enjoyment, affection and respect within the home.

RBK Learning and Children’s directorate provides the Triple P teen programme. Triple P – Positive Parenting Program® is an evidence-based parenting programme that aims to prevent severe behavioural, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents. There are various levels of Triple P according to need and age. Teen Triple P is aimed at parents or carers with concerns about their teenager’s behaviour. There are also parent support advisers in Kingston who work with school staff and local services to help families to overcome the problems they face.

Schools
Education and lifelong learning promote wellbeing and resilience and reduce the risk of mental illness. Educational attainment in Kingston is generally very good and targeted support is provided to reduce attainment gaps.

Secondary schools can provide an environment that fosters social and emotional wellbeing. Organisation-wide approaches in secondary education help all young people to develop social and emotional skills, as well as providing specific help for those most at risk of problems.

NICE guidance recommends that commissioners and providers of services to young people in secondary education should:

- Help secondary education establishments to develop the necessary organisational capacity to promote social and emotional wellbeing.
- Ensure secondary education establishments have access to the specialist skills, advice and support they require.

Head teachers, governors and teachers should:

- Demonstrate a commitment to the social and emotional wellbeing of young people.
- Provide a curriculum that promotes positive behaviours and successful relationships and helps reduce disruptive behaviour and bullying.
- Work in partnership with young people, parents, carers and other family members to promote young people’s social and emotional wellbeing.
- Ensure practitioners have the knowledge, understanding and skills they need to develop young people’s social and emotional wellbeing.

The educational psychology service provides support to schools based on concerns raised. This includes work on resilience and the recent Emotional Literacy Support Assistants (ELSA) programme to help schools meet the needs of emotionally vulnerable pupils.

Volunteering
Volunteering is known to increase wellbeing. Both the volunteer and the recipient of help can benefit. There is limited data on the types of young people volunteering in Kingston. In the Tellus4 survey in 2009, 19% of pupils in school years 6, 8 and 10 in Kingston reported that they had given their free time outside school lessons to help a charity, a local voluntary group or done some organised volunteering in the previous four weeks, compared to 17% nationally.

Purpose and Participation
An opportunity to influence decisions, feel involved, have a valued role, and maintain independence and autonomy all promote mental wellbeing. In Kingston most schools have school councils. There is a youth parliament and pupil voice. There are plans to promote best practice on participation to local staff working with young people and to give children and young people more opportunities to influence decisions about their local area.

Prevention of child emotional and conduct disorder
International evidence shows that participants in school-based Social and Emotional Learning programmes demonstrate significantly improved social and emotional skills, attitudes, behaviour, and academic performance. The Social and Emotional Aspects of Learning (SEAL) programme has been used by every school in the borough in the past but work on this area is no longer comprehensive or coordinated. Approximately five of the ten state funded secondary schools currently use the SEAL programme but the proportion of the programme used by each school is unknown.

Tackling debt and improving financial capability has been shown to improve mental wellbeing. Kingston Citizen’s Advice Bureau offer financial capability courses for some schools. The Children and Young Peoples Plan (CYP) consultation revealed that children and young people want support to gain skills around managing money and bills.

There is a growing amount of evidence that body image dissatisfaction is high and on the increase and is associated with a number of damaging consequences for health and wellbeing. Body image dissatisfaction is seen to undermine self-confidence, contribute to depression, and lead to the onset of a range of physical, emotional and societal problems. A recent report recommended interventions at secondary school to offer on-going protection and support.

Research has established a clear link between bullying and reduced emotional wellbeing. High risk groups include children being brought up by a lone father, of Black ethnicity, from low income households, children with disabilities, young lesbian, gay and bisexual people and children of parents with mental health promotion and mental illness prevention: The economic case. PSRU, London School of Economics and Political Science


23 New Horizons Confident Communities, Brighter Futures A framework for developing wellbeing, DfH 2010

24 Promoting young people’s social and emotional wellbeing in secondary education, NICE public health guidance 20, September 2009


health problems\(^{30,31}\). Whole school programmes are the most effective ways of reducing the prevalence of bullying\(^ {32}\). Effective work is being undertaken in Kingston to tackle bullying and to ensure that the incidence of bullying remains low. Children and young people are actively involved in developing anti-bullying policies and in school projects such as peer mediators\(^ {32}\).

The most successful preventive interventions to reduce the risk of aggressive behaviour and conduct disorders focus on improving the social competence and pro-social behaviour of children, parents, peers and teachers\(^ {34}\). These have been shown to be very effective at preventing future problems including adulthood antisocial personality disorder\(^{30,34}\). These interventions include family intervention projects (FIP) and multi systemic therapy (MST)\(^ {35}\) which are both being provided in Kingston. The newly introduced Troubled Families’ initiative will support vulnerable families in Kingston\(^ {36}\).

**Local interventions for young people at high risk**

There are psychologists in a number of teams for young people at higher risk of mental illness including the Children with Disabilities team, the Youth Offending team and the Looked after Children team, however there are no psychologists in the Asperger’s service for over 13s.

There are plans to reduce housing related poverty to ensure families have sustainable accommodation arrangements and the child’s environment supports them to thrive\(^ {37}\) however there is no dedicated mental health support for young homeless people in Kingston.

**Early treatment of common mental health problems**

Psychological therapies have been shown to be effective in reducing mental illness and promoting mental health and well-being. A report on counselling in schools for the Welsh Assembly highlighted the importance of appropriately qualified counsellors, clinical supervision, external monitoring and evaluation, and counsellors working with other services and agencies\(^ {38}\). NICE recommends that school counselling services should be provided as part of a wider school strategy on mental health promotion\(^ {34}\).

The Family Advice and Support Service (FASS) support children and young people with social and emotional difficulties in school. Relate provides the ‘Relateen’ counselling service for young people. An audit of school counselling services in Kingston in 2010 found that there was an inconsistent approach to identifying and meeting the needs of pupils and recommended providing guidance on evidence-based best practice for schools\(^ {39}\). The standard and enhanced school drop-ins and the KU19 community clinics can provide advice on emotional and mental health issues, however the number of children attending for this reason is not known as this category is not included in data recording the purpose of visits. There are plans to introduce a psychological therapy service (Improving Access to Psychological Therapies, IAPT) for young people in Kingston in 2014.

**Adolescents and obesity**

As outlined in Chapter 4, reducing rates of child obesity is both a national\(^ {40}\) and local priority. Locally, 31% of children (n=438) in Year 6 (aged 10-11) were above a healthy weight in 2010/11\(^ {41}\). This indicates an alarming number of children living in Kingston who are already carrying excess weight that could adversely impact their health as they grow up into adulthood if nothing is done to tackle it. The sharp increase (shown in Figure 5.3) in the number of children being above a healthy weight between Reception (17.5%, n=290) and Year 6 (31%) demonstrates the importance of tackling overweight and obesity in secondary school aged children (as well as primary school aged children). The National Child Measurement Programme (NCMP) participation rates, as reported in Chapter 4, demonstrate the commitment of local schools to reduce the levels of overweight and obesity in Kingston’s children.

Recent analysis of the Year 6 NCMP data at ward level in Kingston (see Figure 5.4) shows that Norbiton ward has the highest levels of obesity (23.0%), Old Malden has the second highest (20.7%) and Chessington North and Hook the third (20.1%). These levels are not only higher than the average in Kingston but also higher than the national average (19.0%) for Year 6 children. This data will help to identify the areas of highest need when planning child obesity services in Kingston.

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32 Kingston OFSTED Safeguarding report 2012
33 Prevention of Mental Disorders: effective interventions and policy options, World Health Organization 2004
34 No Health Without Mental Health: The economic case for improving efficiency and quality in mental health outlines 35 No health without mental health. Delivering better mental health outcomes for people of all ages. DOH 2011
As part of a multi-dimensional approach to tackle overweight and obesity, Kingston has designed and commissioned a locally developed, evidence-based set of children’s weight management programmes referred to as the Factor programmes. The Fwd-factor and 4U-factor programmes target different age groups and run at various DC leisure sites across the borough (see Table 5.13).

Preliminary evaluation of these programmes is promising with positive changes in dietary and mealtime habits, an increase in time spent being physically active, an increase in parental confidence in feeding their children and an improvement in self-esteem reported by the young people attending the 4U-Factor. Key participation and clinical outcomes for the Fwd-factor and 4U-factor programmes are outlined in Table 5.14.

Table 5.14
Key participation and clinical outcomes for Fwd-factor and 4U-factor

<table>
<thead>
<tr>
<th>Type of evaluation</th>
<th>Outcome measure</th>
<th>Fwd-factor</th>
<th>4U-factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td>Average age (years)</td>
<td>9.9 years</td>
<td>13.2 years</td>
</tr>
<tr>
<td>Demographics</td>
<td>Sex (% females v males)</td>
<td>57% v 43%</td>
<td>74% v 26%</td>
</tr>
<tr>
<td>Demographics</td>
<td>% participants from BME groups</td>
<td>38%</td>
<td>28%</td>
</tr>
<tr>
<td>Output</td>
<td>Average no. children per programme</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Output</td>
<td>Attendance (average no. sessions)</td>
<td>8 out of 10</td>
<td>Not available</td>
</tr>
<tr>
<td>Clinical</td>
<td>Average BMI (kg/m2) change</td>
<td>-0.4</td>
<td>-0.7</td>
</tr>
<tr>
<td>Fitness</td>
<td>Average RHR (BPM) change</td>
<td>-11 BPM</td>
<td>-11 BPM</td>
</tr>
</tbody>
</table>

RHR = resting heart rate  BPM = beats per minute  no. = number of

Table 5.13
The Fwd-factor and 4U-factor programmes in Kingston

<table>
<thead>
<tr>
<th>Programme</th>
<th>Age group and target audience</th>
<th>Venue</th>
<th>Programme Length</th>
<th>Contact time per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fwd-factor</td>
<td>8-12 years (Parent &amp; child)</td>
<td>Kingfisher Leisure Centre, Kingston</td>
<td>10 weeks</td>
<td>1hr 45mins</td>
</tr>
<tr>
<td>4U-factor</td>
<td>13-16 years (Young person)</td>
<td>Tolworth Recreation Centre, Tolworth and Kingfisher Leisure Centre, Kingston</td>
<td>12 weeks</td>
<td>1hr 30min (+ optional 1hr Junior Gym)</td>
</tr>
</tbody>
</table>

Note: Fun-factor programmes target 5-7 year olds with their parents and these are covered in Chapter 4.
There are a number of local physical activity and sport programmes available for both children and families in Kingston. Local programmes currently available include:

- **Zumba** - free weekly (Thursday evenings) beginner sessions involving Zumba, Salsa and dance at Piper Hall on the Cambridge Road Estate for anyone 10 years and over (under 16s must be accompanied by an adult).
- **Parkrun** - free weekly community 5km events (walk, jog or run) starting at Canbury Park Gardens (children need to be accompanied by an adult).
- **Walk4Life Kingston** - free social weekly walks for families and communities (under 16s must be accompanied by an adult).
- **Kingston Junior Cycle Club** - low cost cycle club run on a ‘pay-as-you-go’ basis. Different sessions for 6 to 8 year olds and 9 to 16 year olds. Children must have a bike and helmet to join in.
- **BikeLife Kingston** - free social cycle rides for families and communities (under 16s must be accompanied by an adult). A new cycle hire scheme is under development to ensure those who don’t have a bike can also join in.
- **Sky Rides** - free community bike rides, led by local people who have been trained to lead rides that offer an easy way of getting out and exploring the local area and meeting like-minded people.
- **Special Olympics Surrey** - low cost, year-round sports training and competition programmes for children and adults with learning disabilities. Athletes currently train in Athletics, Boccia, Golf, Kayaking, Skiing & Ten Pin Bowling.
- **INSPIRE** - Low cost multi-sports sessions open to children and adults with a disability aged 8 to 80.
- **Inclusive Basketball** - low cost recreational basketball sessions led by coaches from Kingston Wildcats Basketball Club for disabled people aged 10 to 25 years.

NHS Kingston and the Royal Borough of Kingston are currently developing the new Healthy Weight and Physical Activity Strategy for Kingston (2012 – 2015) which is due to be launched in 2012. As part of this work, a review of services available for young people is currently underway. To date, this process has highlighted that whilst there are many varied programmes available for young people up until the age of 16, there is a lack of services available for 16 to 18 year olds and a need for more targeted approaches for young people from high need groups such as low income families where the cost of programmes is often the most significant barrier. One issue that has come to light is the need for a communications strategy to accompany the new Healthy Weight and Physical Activity Strategy. Current marketing techniques are not fully achieving their objectives and whilst new avenues of disseminating key information are routinely explored, further work is required to find methods of marketing the services available in Kingston that are more effective. This may require partners to think differently in terms of funding allocations and priorities.

Recent focus groups and electronic consultations have highlighted a lack of knowledge, skills and confidence to cook and eat healthily, and schools have requested further support to improve services available to children and families in Kingston. 84% of survey respondents indicated a need for healthier vending machines at secondary schools.

The consultation has also indicated that 93% would like more after school physical activities and sport to be provided. Current provision of services such as Bikeability is good in Secondary Schools but there is a need to look at more innovative ideas for increasing active travel to schools.

Risk factors associated with adolescent smoking include low socio-economic status, low parental education, parental smoking, peer and sibling influence, female gender, poor academic performance, mental illness, engaging in risk taking behaviour, exposure to tobacco marketing activities, and exposure to portrayal of smoking in television and films. The Tellus4 (2009) survey provides information on smoking in secondary school pupils. Table 5.15 shows national and Kingston data based on the Tellus4 survey. It should be noted that these figures are based on a sample of 1,597 pupils attending Kingston schools and may not provide a full picture of the local situation.

### Table 5.15
**Information on smoking in pupils in Years 6, 8 and 10 in Kingston in 2009**

<table>
<thead>
<tr>
<th></th>
<th>Kingston</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have never smoked</td>
<td>79%</td>
<td>77%</td>
</tr>
<tr>
<td>I have only ever tried smoking once</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>I used to smoke sometimes but I never smoke a cigarette now</td>
<td>2%</td>
<td>4%</td>
</tr>
<tr>
<td>I sometimes smoke cigarettes now but I don’t smoke as many as one a week</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>I usually smoke between one and six cigarettes a week</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>I usually smoke more than six cigarettes a week</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>I do not want to say</td>
<td>4%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: Tellus4 (2009)

Shisha smoking is increasing in Kingston particularly among young people as it is believed to be a healthier alternative to smoking. Shisha also known as ‘hookah’ or ‘hubble bubble’ is a fruity scented tobacco that is inhaled through a water pipe. Shisha smoking originated in India and the highest rates of use occur in Africa, the Middle East and South-East Asia. It is viewed as a social activity with friends and family after a meal. Shisha smokers may inhale as much smoke during one session as a cigarette smoker would inhale from 100 cigarettes. Shisha smokers are exposed to increased risks of cancer, respiratory and cardiovascular disease, and may also develop nicotine addiction. Shisha smoking also causes harm to the foetus in pregnancy and second-hand smoke from shisha increases the risk of the above diseases in non-smokers.

Local action
Anecdotal evidence locally suggests that some adolescents would like to give up smoking due to the expense involved but are not aware of where to get appropriate support.

Kingston and Richmond Stop Smoking Service works with a wide range of partners locally to prevent individuals starting smoking and support those who want to quit smoking. The service also recruits and trains professionals to deliver a smoking cessation service to quitters.

The service works with all schools to create awareness of the negative impacts of smoking. A web-based interactive programme ‘Operation Smoke Storm’ is currently being promoted as best practice for effectively educating 11 – 14 year olds on key issues around the dangers of smoking and the activities of the tobacco industry. Schools are also targeted annually as part of No Smoking Day campaigns and talks are provided to pupils on invitation.

Youth Support Service staff have received smoking cessation training and work with young people to deliver stop smoking group sessions and one-to-one sessions in schools and youth centres. The school nursing team also offer information and advice to young people accessing school health drop-ins. Members of the team have been trained to deliver smoking cessation advice. The young people’s substance misuse service offers young people support to quit smoking.

Kingston Trading Standards Service regularly carries out interventions to deter under age sales of tobacco and underage smoking at Shisha bars. The service has produced and distributed a leaflet highlighting the dangers of Shisha smoking.

Immunisation
Immunisations are essential to the wellbeing of communities because they provide protection to individuals and the general population against diseases that can cause long-term ill health or death. Immunisation is the best and safest public health measure in protecting children and young people from preventable infectious diseases.

School leavers’ booster
In Kingston, the School Health Team is commissioned to vaccinate school aged children in line with the Department of Health’s immunisation schedule. The School Health Team works in collaboration with schools to ensure all young people aged 13 to 18 in schools are offered vaccination against tetanus, diphtheria, and polio. In addition, the opportunity is used to offer a second MMR vaccine if they have not received this in the past. Additional immunisation sessions are also offered outside school to those who may have missed out on school HPV immunisation. Those missing out on school leavers boosters will be offered this at their GPs. Children attending private schools are immunised by the School Health Team in collaboration with their school nurse, while those that are home schooled receive immunisation from their GPs.

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45 The packaging of tobacco products, The Centre for Tobacco Control Research Core funded by Cancer Research UK (March 2012).

and co-infection with other sexually transmitted infections including HIV.47

One in 136 women is estimated to have a lifetime risk of developing cervical cancer. The incidence and mortality rates for cervical cancer in the UK are low compared to most European countries and have been declining since 1991.48 The decline in incidence in the UK, like most European countries, is largely due to having cervical cancer screening programmes in place. If detected early cervical cancer is treatable, making it a remediable public health issue. Many cases of cervical cancer are preventable by immunisation against HPV before young people embark on sexual activity.

HPV
Human Papillomavirus (HPV), a sexually transmitted infection, has been established as the main cause of cervical cancer.49 Factors that increase the risk of cervical cancer include multiple sexual partners, starting sexual intercourse at an early age, early pregnancy, smoking, long term use of oral contraception and attending state and private schools. The school health team works in collaboration with schools to create awareness of HPV as well as providing advice to parents.

The uptake of HPV vaccine by dose for the academic year 2010/11 is shown in Table 5.17. Uptake in Kingston was lower than the London and England average and lower than its statistical comparators. However investigation by the PCT has revealed that this was due to an issue with data processing and did not reflect the actual rates in Kingston. Provisional data for 2011 / 12 displayed in Table 5.18 shows a significantly improved uptake in Kingston.

### Table 5.16
Uptake of school leaver’s booster for year 10s in Kingston, 2011/12

<table>
<thead>
<tr>
<th>Immunisation</th>
<th>Total No. in cohort</th>
<th>(% of cohort)</th>
<th>(% Dose 1)</th>
<th>(% Dose 1 &amp; 2)</th>
<th>(% All 3 doses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diptheria, Tetanus and Polio Booster</td>
<td>1,910</td>
<td>69%</td>
<td>88.9</td>
<td>87.5</td>
<td>84.2</td>
</tr>
<tr>
<td>Percentage</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Table 5.17
HPV vaccine uptake in school year 8 in Kingston compared to England and statistical comparators in academic year 2010/11


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48 National Cancer Intelligence Network (2011) National Cancer Incidence and Screening Coverage: NOIN Data Briefing
Joint Annual Public Health Report for Kingston 2011/2012

Chapter 5: Secondary School Age

Table 5.18
HPV vaccine uptake in school year 8 in Kingston in academic years 2010/11 and 2011/12

<table>
<thead>
<tr>
<th></th>
<th>2010/11</th>
<th>2011/12*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total no. in cohort</td>
<td>1,026</td>
<td>1,056</td>
</tr>
<tr>
<td>Dose 1 (%)</td>
<td>64.7</td>
<td>81.7</td>
</tr>
<tr>
<td>Dose 1 &amp; 2 (%)</td>
<td>63.5</td>
<td>81.3</td>
</tr>
<tr>
<td>All 3 doses (%)</td>
<td>61.1</td>
<td>77.4</td>
</tr>
</tbody>
</table>

*provisional data submitted by NHS Kingston
Source: HPV Annual Uptake survey 2010/11 and 2011/12, Immform

Health Service Use Data
In 2011/12 there were 1,898 first attendances at all hospital outpatient clinics by Kingston registered patients aged 11-15 years. 33% of first attendances resulted from GP referrals, 28% from consultant to consultant referrals, 21% from Accident and Emergency and the majority of the remaining 18% were from other health professionals. Figure 5.5 shows the percentage of attendances by specialty. Nearly one third of attendances by 11-15 year olds were to Trauma and Orthopaedics with 15% attending General Paediatrics.

![Figure 5.5: First Outpatient Attendances of 11-15 year olds in 2011/12 showing percentage of attendances by speciality](source)

515 GP referrals to outpatients were accepted by KCAS in 2011-12 for 11-15 year olds which is fewer than the total number of GP referrals for first attendances. The percentage of GP referrals by specialty is shown in Figure 5.6. This illustrates that the greatest proportion of GP referrals for 11-15 year olds were sent to General Paediatrics followed by Orthopaedics and ENT.

![Figure 5.6: GP referrals to outpatients accepted in 2011-12 for 11-15 year olds, showing percentage of referrals by speciality](source)

In 2011/12 there were 564 hospital admissions for Kingston registered patients aged 11-15 years. 58% of these admissions were to Kingston Hospital, followed by 18% to St George’s Healthcare NHS Trust and 9% to Epsom and St Helier University Hospitals NHS Trust. Figure 5.7 shows that over one third of admissions were to General Paediatrics followed by 11% to Trauma and Orthopaedics.

![Figure 5.7: Hospital admissions in 2011/12 for 11-15 year olds, by specialty](source)
Recommendations

- Engage with academies to maintain work to improve the health and wellbeing of pupils attending local schools.
- Ensure that PSHE is evaluated and that provision is based on identified needs.
- Public Health to work closely with Education Kingston and local schools to ensure a co-ordinated and consistent approach to the delivery of PSHE.
- Maintain school health work through the impending commissioning changes to ensure no detriment to service delivery.
- Improve links with independent schools to ensure that there is appropriate access to and provision of health services for pupils.

- Work with Kingston Youth Support Service to ensure the sustainability of the mystery shopping project for You’re Welcome.
- Offer mental health awareness training to all relevant frontline staff.
- Consult head teachers about how they would like to be supported to promote emotional wellbeing and provide guidance in light of this.
- Ensure that data is collected by all agencies on children attending with emotional or mental health issues.
- Consult with young people to ensure that the planned IAPT service for young people meets their needs for example in terms of location and opening times.

- Offer secondary schools support to review the content of current after school cooking clubs and appropriate adaptation of the successful Chef’s Club programme that currently runs in primary schools as an after school, breakfast or lunchtime club.
- Expand Cook & Eat programmes (6-week cooking skills courses currently targeted at specific community groups) to include groups specifically for young people to ensure they leave school with a good level of cooking skills, confidence and knowledge around cooking healthily.
- Offer schools guidance to assist them in the development of healthy school food policies e.g. healthier vending machines.
- Develop a new communications strategy to support the recommendations of the new Healthy Weight and Physical Activity Strategy. Seek communications expertise to consider appropriate branding, key messages and partnership approaches.
- Ensure that information is shared on diet and exercise resources to ensure that schools, family support services and other community settings know where they can access free expert support and guidance as well as local programmes and services.
- Evaluate the new Healthy Schools’ Newsletter (launched in September 2011) to establish if this new method of informing schools of local services has been successful.
- Encourage schools to work with their children and families to increase the opportunities for after school physical activities.
- Offer further support to schools to develop active travel plans.
- Promote NICE guidelines on school based interventions to prevent uptake of smoking amongst children and young people.

- The school health team should undertake enhanced smoking cessation services as part of both the enhanced school drop in service and in KU19 clinics.
- Ensure community pharmacies offering enhanced services for young people, for example by providing Emergency Hormonal Contraception and Chlamydia screening, are also offering smoking cessation advice and support to young people under 18 years.
- Develop and implement an awareness campaign on Shisha to coincide with No Smoking Day.
- Deliver a targeted campaign aimed at parents in areas with high prevalence of smoking. This campaign should also reinforce that it is illegal to sell tobacco to under 18s.
- Develop a pathway to enable services working with adolescents in schools and other settings to refer to stop smoking services.
- Roll-out participation in Operation Smokestorm across all secondary schools in Kingston.
- Increase commissioning of tobacco control and stop smoking advice for young people e.g. local KickButt web-based service or equivalent.
- Monitor uptake of immunisation to ensure that inequalities in access are identified and addressed. Target young people identified at risk of poor health outcomes, including those from Black and minority ethnic communities, children who are excluded or NEET, young carers, young offenders and LAC / Care Leavers to increase their uptake of immunisation.