Royal Borough of Kingston-upon-Thames Young People's Risky Behaviour

Needs Assessment

2013

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Kingston Children & Young People's Trust
Making a Difference Together

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Introduction

Royal Kingston Borough Council (RBK) commissioned Anna Sewell Implementation Limited (ASIL), in partnership with Coventry University Applied Research Centre in Health and Lifestyle Interventions (ARC-HLI), to undertake a Risky Behaviours Needs Assessment (RBNA) in the Royal Borough of Kingston upon Thames. This was conducted between January 2013 and March 2013. The key focus of the assessment was to better understand the extent, and underlying causes of, risk-taking behaviour among young people in Kingston, and to make recommendations for the reconfiguration of services to enable an integrated approach to addressing these.

Aims

The aims of the RBNA were to:

- Evaluate the overall effectiveness and performance of current service providers in delivering integrated provision to address risky behaviours, with a view to informing future commissioning configurations
- Map current levels of risky behaviour across the borough
- Identify gaps in service delivery

Outcome

The expected outcome of this needs assessment is to inform local partnerships and commissioners on the effectiveness of local services, and to support commissioning decisions regarding current providers and contracting arrangements. The needs assessment will facilitate an accurate response to young people's health needs, as well as support the development of appropriate programmes that will ultimately lead to a reduction of health inequalities. The needs assessment will lead on to the development of an RBK Risk and Resilience Policy and a Risky Behaviour Protocol, and will contribute to the Early Intervention Adolescent Health Strategy and Action Plan. It is also anticipated that the needs assessment will act as a valuable source of information for other related activities, such as the Joint Strategic Needs Assessment (JSNA).

Future Direction of Service Provision

All Local Authorities are currently experiencing a prolonged period of transition as they re-structure and prioritise services across the breadth of public provision. Youth provision in its widest sense in Kingston has already undergone significant changes and there are likely to be more as RBK Council merges with The London Borough of Richmond upon Thames (LBRUT) and new commissioning frameworks and structures develop. This review takes account of the changing position and provides recommendations which can be considered and implemented in both the short and long term. Key to the recommendations, is the development of a more formal approach to commissioning based on agreed outcome measures which reflect reductions in risk taking activities and the promotion of positive well-being.

Method

The review drew on multiple methods. These are as follows:

- Meetings with the Early Intervention Adolescent Health Co-ordinator and Consultant in Public Health
- Development of an assessment tool (see appendix A) to assess prevention and early identification within service provision against quality standards
- 12 x in-depth interviews (supplemented by 4 opportunistic conversations) with professionals (see Appendix B for interview guided by the Tool and list of professionals interviewed)

- Four focus groups with young people (21 young people in total; see appendix C for schedule). The groups were as follows: LGBT (7), Young Parents (4), Young people with additional needs/disability (5) and young people experiencing disengagement with school (5)
- An on-line questionnaire[1] to obtain the views of wider groups of young people was developed and distributed by RBK to secondary schools and Looked After Children. 119 young people completed the survey.
- A blog set-up to get the wider views of professionals to input reflections/key thoughts as the needs assessment developed. Administration rights of the blog will be handed over to RBK following completion of the needs assessment so that it can be utilised for further consultation with professionals.
- A search of academic evidence regarding the causes of risk taking behaviour and the characteristics of effective interventions (for more detail on method see 'Review of the causes of risk-taking' and 'Characteristics of effective interventions' sections)
- Scoping examples of practice from other areas
- Scoping and summarising policy and quality standards in this area
- Drawing together the epidemiology and data available for Kingston
- Delivery of an Expert Opinion Workshop to present the findings of the needs assessment and obtain the opinions of local professionals to feed into the needs assessment.

Further detail about the processes undertaken is provided in the relevant sections of this report.

Utilisation of Local Documents

A range of work has been undertaken recently in Kingston which is related to this needs assessment. The review has taken account of this and attempts to pull together data, evidence and recommendations from a number of local sources. Where appropriate, these are referenced within this document.

[1] Although the original intention was to run a young people's blog where young people could post feedback on issues emerging from the review, the RBK Communications Team felt concerned that this may lead to inappropriate comments being posted due to the sensitive nature of the topic. There was also concern that whilst the comments could be screened and moderated before posting onto the blog that this should be undertaken by an outside agency and not RBK. It was therefore agreed that an on-line survey would be developed and distributed through schools, youth services and with Looked After Children.

The Policy Framework for Risk-taking Behaviour

Overview

All children's services, as well as many adult services, have a role to play in promoting children's health and wellbeing. This means that the relevant statutory and policy framework is broad and as yet there is not one overarching national policy document which draws this together under one umbrella. The following cross-cutting themes are evident across current policy areas and are shaping provision to promote child health and emotional well-being and address risk-taking behaviour:

- A commitment to prevention and early intervention with a view to improving outcomes
- Realising efficiencies primarily through reducing the need for high cost interventions
- Inter-related nature risk-taking behaviours
- Addressing the underlying causes of risk-taking behaviour and building young people's resilience
- Supporting young people to develop the skills to take a balanced approach to risk
- Families are highly influential in shaping young people's attitudes and behaviour regarding risk-taking

This section sets out the key policies, legislation, and recent reviews commissioned by the Government which are shaping the future of services.

Healthy lives, healthy people: our strategy for public health in England, 2010

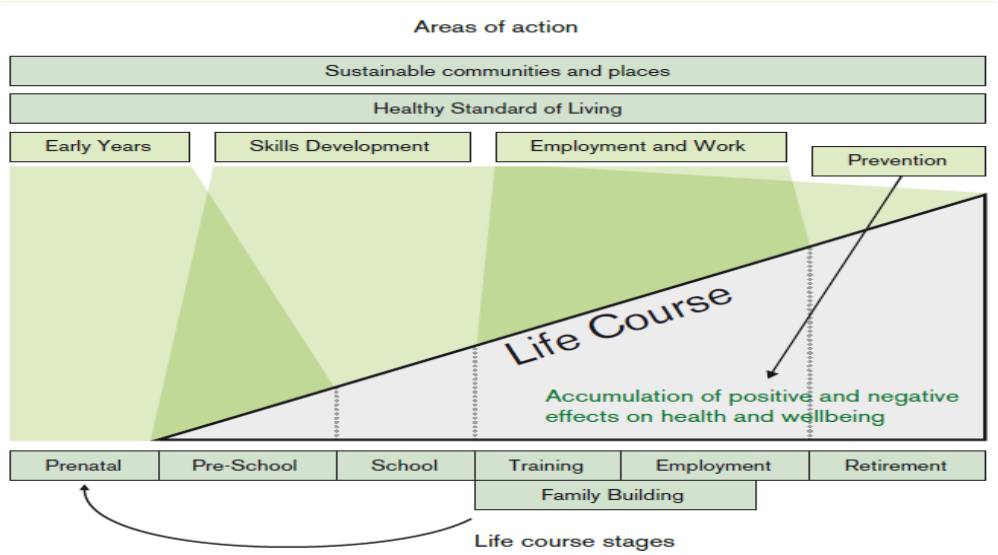
In 2010 'Healthy lives, healthy people: our strategy for public health in England' was published drawing on the independent review of health inequalities in England undertaken by Professor Sir Michael Marmot. The strategy highlights that material circumstance, social environment, psychosocial factors, behaviours and biological factors all influence health, with vulnerable groups experiencing poorer outcomes than would be expected based on their socio-economic status. The strategy focuses on addressing the wider determinants of health in order to tackle health inequalities. It highlights that a range of factors affect the health of individuals such as; social and cognitive development, self-esteem, confidence, personal resilience and wellbeing and that these are fluid and influenced by environmental factors, family and society.

The strategy takes a life-course approach to health (see Figure 1) and calls for a move away from addressing individual risk factors in isolation with priority given to key transition points:

> 'Starting well, through early intervention and prevention, is a key priority for the Government, developing strong universal public health and early education with an increased focus on disadvantaged families. This approach, proportionate universalism, was advocated in the Marmot Review into health inequalities.' (Department of Health 2010)

In addition from April 2013, a new duty will be in placed upon The Secretary of State for Health and Clinical Commissioning Groups under the Health and Social Care Act to 'have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service'. The expectation is that the new duty will ensure services will be directed towards who most need them.

Figure 1 Marmot: Action across the life-course



(The Marmot Review 2010)

Locally it is expected that Directors of Public Health will work with local authority children's services, schools and other key partners to develop integrated local strategies to improve child health and wellbeing by aligning services, outcomes and resources. A number of policy initiatives are outlined for the formative stages of the life-course with the following specific to risk-taking behaviours:

- High-quality universal services will form the foundation of provision for children and their parents to achieve good outcomes
- A focus on engagement with families where children are at risk of poor outcomes
- Tackling child poverty
- Pupil health premiums will ensure that funding is weighted to address inequalities and narrow the gap in health and education
- Strengthening young people's ability to take control of their lives and help reduce their susceptibility to harmful influences, in areas such as sexual health, teenage pregnancy, drugs and alcohol
- Easy access to trusted health services, for example those which are 'You're Welcome' accredited
- An early intervention grant, will allow local areas to develop a tailored approach that responds to the needs, age and vulnerability of the young person, and particularly targets at-risk groups.
- Improving self-esteem and developing positive social norms throughout the school years supported by information about effective behavioural interventions for self-esteem.
- School nursing service will support schools in promoting pupil health and well-being as part of a broader public health role (for further information Vision and Model for School Nursing, (http://www.dh.gov.uk/health/2012/03/school-nursing/)
- Promote mental health resilience and effective early treatment, including talking therapies, thus reducing the likelihood of problems extending into adulthood.
- Tackling violence and abuse that can damage the physical and mental health of children.
- Supporting young disabled people through adolescence and transition to adulthood (this is set-out in further detail in draft legislation on Reform of provision for children and young people with Special Educational Needs, HM Government.)

Early Intervention Next Steps, 2011

Early intervention is also the focus of the more recent Government report on Early Intervention Next Steps led by Graham Allen (2011) and reflects the approach presented by the Marmot Review. It states that:

'Early Intervention is an approach which offers our country a real opportunity to make lasting improvements in the lives of our children, to forestall many persistent social problems and end their transmission from one generation to the next, and to make long-term savings in public spending.'

(Allen 2011)

Report of the Children and Young People's Outcomes Forum, 2012

The Children and Young People's Outcomes Forum report outlines a number of proposals to improve health-related care for children and young people, and will inform the development of the Governments forthcoming Children and Young People's Outcomes Strategy. It highlights that whilst GPs, pharmacists, health visitors and school nurses are essential to the effective delivery of public health services and improving health outcomes for children, this also requires the involvement of key partners such as schools, youth service etc. The forum supports the move away from a focus on individual risk-taking behaviours towards a life-course approach with interventions at key transition points where children and young people are most likely to require additional support but may also be overlooked within the system.

'The Forum recommends that all organisations in the new health system take a life course approach, coherently addressing the different stages in life and the key transitions instead of tackling individual risk factors in isolation. …. Children and young people do not live their lives in silos, they are not one day a smoking risk and the next day an alcohol one.'

(Children and Young People's Health Outcomes Forum 2012)

Families Key to Addressing Risky Behaviour

The forum highlights that risk-taking behaviour is an incremental process with one behaviour leading to another and that action to address risky behaviour starts with families, ensuring that:

- families are aware of the implications of themselves as role models on the health behaviour of their children
- support services are in place for families and are able to act when families are motivated to do so
- young people at risk are identified early

The report also calls for integration of delivery and commissioning of service across the wider health system to ensure the best delivery and outcomes for young people:

'It means that children, young people and parents don't have to keep repeating their information, that records are not lost or duplicated, that individuals and their needs do not fall between gaps, and that resources are focused on the same goals.'

(Children and Young People's Health Outcomes Forum 2012)

Positive for Youth, 2011

Positive for Youth (Department for Education 2011) is the Government Strategy for young people. The strategy sets out a 'vision for a society that is Positive for Youth' and where young people enjoy the experience of their teenage years and develop the attitudes and skills to take responsibility for themselves as they transition into adulthood. The expectation is that all elements of society will promote this by promoting positive relationships, strong ambitions, and facilitating good opportunities for young people. The strategy outlines key priorities that will realise this vision and support a positive approach to managing risk in adolescence:

- **Supporting parents and families** – who have the potential to be the most significant influence in the lives of young people.
- **Building strong communities** – that have a strong stake in the lives of their young people and in which young people feel a strong sense of belonging, can socialise safely with their peers, enjoy social mixing, experience spending time with older people, and develop relationships with adults they trust;
- **Providing early help** – to inspire, support and protect those young people, particularly the most vulnerable and disadvantaged, who need more help than their families or communities are able to provide, or whose family situation puts them at risk.
- **Succeed in learning and work** – understanding the value of education and committed to developing their skills for employment;
- **Live safe and healthy lives** – having the confidence and resilience to make informed decisions and manage risk; and
- **Be active in society** – taking the initiative and demonstrating leadership to make a positive contribution to local communities and the wider world, with public and media recognition of their achievements.

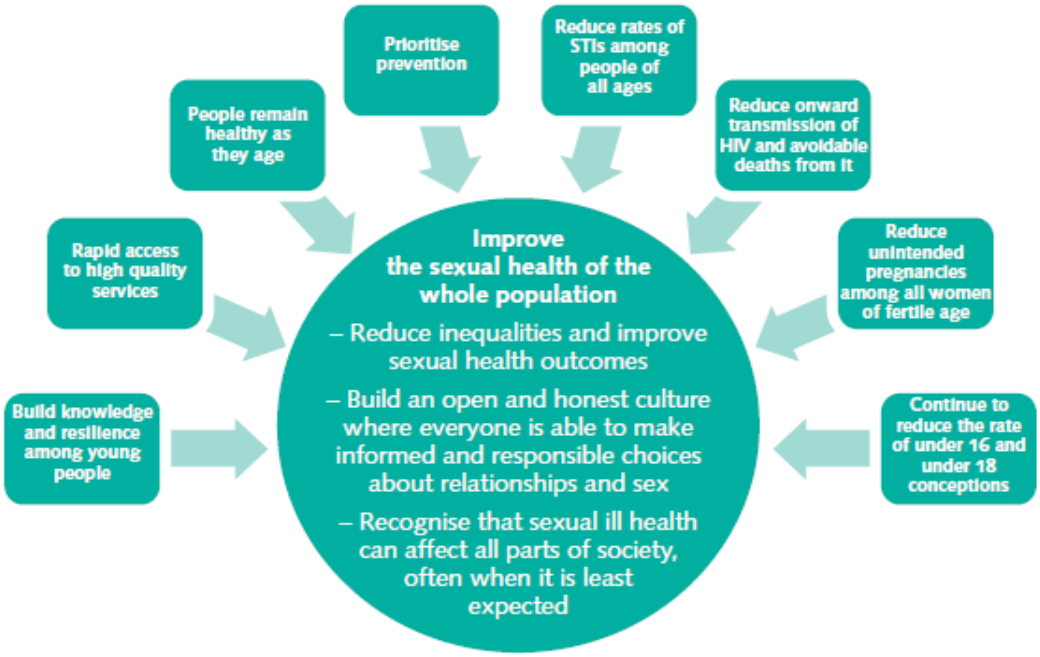
- **Education** – through excellent teaching, high standards, and training and courses respected by universities and employers.
- **Personal and social development** – through opportunities for personal challenge and responsibility – including work experience, and relationships with adults they trust that help them develop the character, qualities and capabilities that they need to learn, build relationships, make informed choices, and become employable; and
- **Voice in society** – through opportunities to express their views and influence public decision-making.

(Department for Education 2011)

A Framework for Sexual Health in England, 2013

This is the most recent policy related to sexual health and teenage pregnancy (Department of Health 2013). It highlights that changes in society have seen a shift in the way people live their lives and have relationships. It highlights that whilst relationships are personal in nature, sexual ill-health has a wider impact on society generally. The increased use and role of digital technology in relationships is recognised and there is a call for increased use of technology in the delivery of prevention, information and sexual health services. A range of different factors are drawn out as influential in relationships and sexual practices including: personal attitudes and beliefs; social norms; peer pressure; religious beliefs; culture; confidence and self-esteem; misuse of drugs and alcohol; and coercion and abuse.

Figure 2 sets out the key objectives of the framework.



Young People

Following the life-course approach, the framework sets outs an ambition for sexual health at each stage of the life course. Below are the ambitions and objectives for sexual health which are focused on the earlier stages of the life course.

Sexual Health up to age 16.
AMBITION: Build knowledge and resilience among young people

- All children and young people receive good-quality sex and relationship education at home, at school, and in the community.
- All children and young people know how to ask for help, and are able to access confidential advice and support about wellbeing, relationships and sexual health.
- All children and young people understand consent, sexual consent and issues around abusive relationships.
- Young people have the confidence and emotional resilience to understand the benefits of loving, healthy relationships and delaying sex.

(Department of Health 2013)

Young People Aged 16-24
AMBITION: Improve sexual health outcomes for young adults

- All young people are able to make informed and responsible decisions, understand issues around consent and the benefits of stable relationships, and are aware of the risks of unprotected sex.
- Prevention is prioritised.
- All young people have rapid and easy access to appropriate sexual and reproductive health services.
- All young people's sexual-health needs – whatever their sexuality – are comprehensively met.

(Department of Health 2013)

The Importance of Teaching, 2010

The Schools White Paper; The Importance of Teaching (Department for Education 2010) recognises the role that schools play in the pastoral care of pupils and emphasises the relationship between pupils' physical and mental health, their safety, and their educational achievement. It highlights that schools are in a strong position to:

- identify those needing additional support and provide a link into specialist services
- provide support to families and engagement with the community
- prevent and provide early intervention around risky behaviour.
- raise the aspirations of children which acts a buffer to potentially damaging behaviour

PSHE Curriculum Review, 2013

During 2012-13 an independent review of PSHE was undertaken with a view to informing the new national curriculum, this was completed in March 2013. A written ministerial statement was released on 21st March 2013 announcing the outcome of the review. Of key note is that whilst PSHE is seen as an important part of pupil education, PSHE overall will remain a non-statutory subject.

The key outcomes in respect of PSHE as set out by DfE are:

- PSHE will remain non-statutory
- Teachers will be fully empowered to decide the content of their PSHE programmes, according to the needs of their pupils. New or updated programmes of study for PSHE will not be developed.
- Teachers will be expected to build on content in the National Curriculum on drug, finance and health education, and also in the basic curriculum and statutory guidance on SRE.
- To support schools DfE have asked Ofsted to report on specific effective practice in PSHE, and they will provide grant funding to the PSHE Association to undertake work advising schools in developing curricula, improving staff training and promoting the teaching of consent in SRE.

No Health Without Mental Health: A cross-Government mental health outcomes strategy for people of all ages, 2011

Within this document (Department of Health 2011) the Government emphasises the importance of mental health and well-being in underpinning all aspects of health. This is a cross-Government strategy applicable to all ages with 6 high level aims:

- More people will have good mental health
  - *More people of all ages and backgrounds will have better wellbeing and good mental health.*
  - *Fewer people will develop mental health problems – by starting well, developing well, working well, living well and ageing well.*
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Healthy Lives, Healthy People: A Tobacco Control Plan for England, 2011

In March 2011, the government published *Healthy Lives, Healthy People: A Tobacco Control Plan for England* (HM Government 2011) Key priorities related to young people's smoking where to:

- tackle tobacco use amongst adults in order to reduce the number of young people who take up smoking
- reduce rates of regular smoking (defined as smoking at least one cigarette a week) among 15 year olds to 12% or less; and
- to reduce smoking during pregnancy to 11% or less (measured at the time of birth).

Planned Policy/Guidance/Quality Standards

The following is a brief summary of planned policy, guidance and quality standards which will relate to risk-taking behaviour among young people.

National Strategic Document for Adolescent Health

Under the new structure of Public Health England, future guidance on adolescent health is planned and is expected to take a similar approach towards addressing risk-taking as outlined in this needs assessment.

Quality Standards

The Outcomes Forum report recommended that NICE produce a Quality Standard for age and developmentally appropriate care of teenagers and young adults, including through transition.

Outcomes

The Children and Young People's Outcomes Forum report made a number of recommendations related to knowledge and intelligence which if implemented, will increase capabilities to evidence the effectiveness of prevention early intervention:

- By 2013–14, DH and the NHS CB should incorporate the views of children and young people into existing national patient surveys.
- A new survey to support measurement of outcomes for children with mental health problems.
- All data collected about children and young people are presented in 5 year age bands through childhood and the teenage years, as used by the World Health Organization (WHO)
- Further work is planned on indicators that would drive improvement to protect and promote the welfare of children and young people. This will include a focus on measuring the effectiveness of early help/early intervention.

Epidemiological Profile of Risk Behaviour in Kingston

This section of the report seeks to draw together data on the 0-19 population in Kingston and identify trends in risk-taking activity across the borough. Data related to the wider determinants of health are presented alongside trends in the adult population which are likely to have an influence on young people's risk-taking. Data has been updated where possible and comparisons made with Kingston's statistical neighbours; Richmond, Barnet, Merton and Surrey. Implications for commissioning of services are highlighted and gaps in data and knowledge identified.

Extensive work has been undertaken recently in Kingston to assess young people's needs in relation to a variety of different issues related to risk-taking behaviour, this report incorporates data from the following local reports and needs assessments:

- OneKingston Child Poverty Needs Assessment Refresh 2011-12, May 2012
- Kingston Borough Profile 2011, Kingston Data Observatory
- Joint Annual Public Health Report Kingston 2012
- Primary School Census Summary - Spring 2012
- KISH/ NHS South West London, Sexual Health Needs Assessment 2011-12 and RBK Sexual Health Needs Assessment Recommendations Action Plan 2012
- School nurse PSHE service audit, Kingston Public Health Department, NHS Kingston
- Kingston Sexual Health Services and Young Disabled People, Needs Assessment 2012
- Kingston SHARXX Review 2011-12
- The Royal Borough of Kingston-upon-Thames Young People's Substance Misuse Needs Assessment Final Report, October 2009

A Mental Health Needs Assessment and analysis of pregnancies to Looked After Children are underway in Kingston and will provide additional data on young people's risk-taking.

Population

The following is a summary of the population data and trends for Kingston drawn from the Kingston Borough Profile 2011. Kingston has:

- An estimated population of 162;167 in 2013
- Experienced a population increase between 2001 and 2011 of 8.7%, compared with an increase of 7.9% in England and Wales and 14.0% in the whole of London.
- An increasing general population, expected to increase by 10.4% between 2011-2031
- Seen the largest population growth in the 60-64 years age group (45%), followed by the 0-4 years age group (19%) and the 20-24 years age group (15%); slightly fewer men (48.8%) than women (51.2%)
- A 0-19 population which is expected to increase by 9.2% between 2011-2031 however, as a proportion of the overall population, this cohort is expected to remain relatively static at around 24% of the overall population

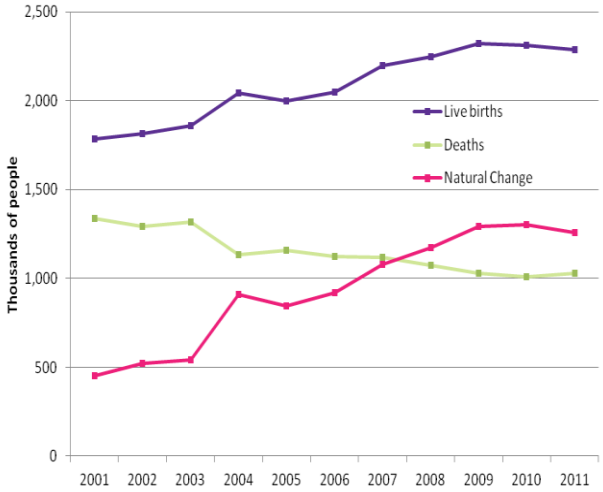
(Kingston Borough Profile, 2011-2012)

Population Change, 2001-2011

- The number of live births in Kingston steadily increased between 2001 and 2009 when the number of births has been stable. Large increases were seen in particular between 2003 and 2004 (9.8%) and 2006 and 2007 (7.4%).

- The general population of Kingston has increased in recent years and is expected to continue to grow into the future. **This will have a significant impact on services, increasing demand across provision for the early part of the life-course.**

Figure 3: Population Change in Kingston 2001-2011



Source: ONS Birth and Death registrations 2001-2011

GLA Population Estimates for Children and Young People

The table below provides the projected population figures for children living within the borough, broken down by age bands and by gender. The 2011 Census found that there were 38,335 children aged 19 and under living in Kingston in 2011, 30,270 children were aged under 16, and 33,692 children were aged under 18 (18.9% and 21.0% of the population respectively). This number is expected to reach 46,590 by 2021, with the largest growth expected in 5-9 year olds and the least in 15-19 year olds (ONS Subnational Population Projections 2011).

Table 1: Population Estimates for Children and Young People aged 0-19, 2011

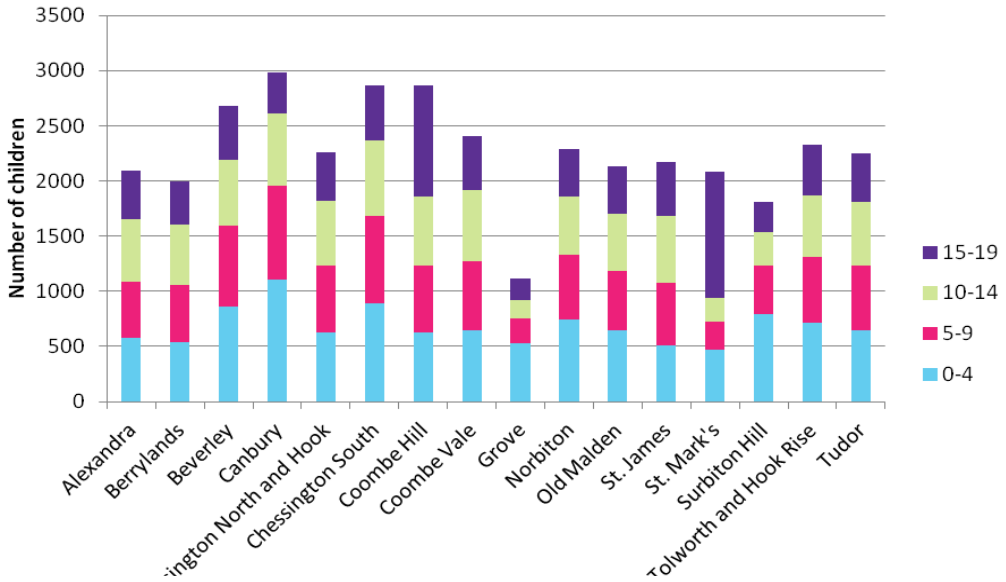
Age	Males	Females	Persons
0 to 4	5,616	5,348	10,964
5 to 9	4,546	4,420	8,966
10 to 14	4,186	4,355	8,541
15 to 19	4,858	5,006	9864
0 to 19	19,206	19,129	38,335

Source: 2011 Census, Office for National Statistics © Crown Copyright 2012

Population by Age

Figure 4 shows that Canbury, Chessington South and Coombe Hill wards have the largest population of children overall, whilst Grove and Surbiton Hill have the smallest number of children. Canbury, Chessington South and Beverly have more children under 9 years of age, with St Mark's and Coombe Hill having more young people aged 15-19 years. This reflects the location of university student accommodation which is predominantly located in this area.

Figure 4: 0-19 Population By Age Band and Ward



Source: GLA 2011 Round Projections

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0-19 Population Ward Level

Table 2 below shows the 2011 Census estimates of the 0-19 year old population in each ward and the 0-19 year old population as a percentage of the total population for that ward. Tudor, Chessington North and Hook, and Coombe Vale wards have the highest proportion of 0-19 year olds and Canbury, Chessington South and Coombe Hill have the highest number of 0-19 year olds per ward.

Table 2: 2011 Census estimates of the 0-19 year old population by ward

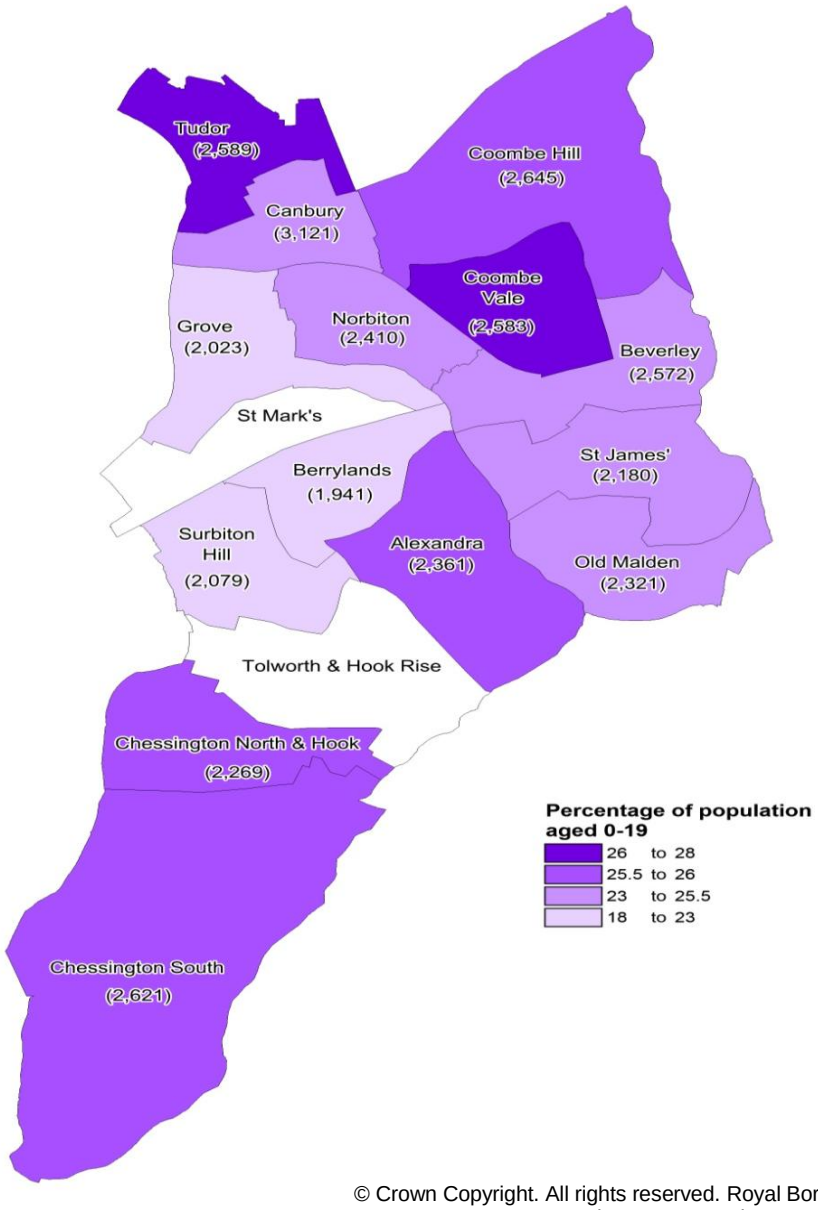
Ward	Numbers of 0-19s Census	0-19 population as % of ward population
Alexandra	2,361	25.5
Berrylands	1,941	20.6
Beverley	2,572	25.4
Canbury	3,121	25.2
Chessington North and Hook	2,269	**26.0**
Chessington South	2,621	25.6
Coombe Hill	2,645	25.5
Coombe Vale	2,583	**26.5**
Grove	2,023	18.5
Norbiton	2,410	23.8
Old Malden	2,321	24.6
St James	2,180	24.3
St Mark's	2,112	20.1
Surbiton Hill	2,079	19.9
Tolworth and Hook Rise	2,508	25.5
Tudor	2,589	**27.0**
Alexandra	2,361	25.5

Source: 2011 Census, Office for National Statistics © Crown Copyright 2012

Location of 0-19 year olds by Ward

The map below shows the percentage of each ward's population made up of 0-19 year olds, and includes the number of 0-19 year olds residing in each ward in brackets. Tudor and Coombe Vale wards have the highest percentage of 0-19 year olds in the borough, whereas Canbury and Coombe Hill have the highest number.

Figure 5: Percentage and number of 0-19 year olds by Ward



Source: *Source: GLA 2011 Round Projections*

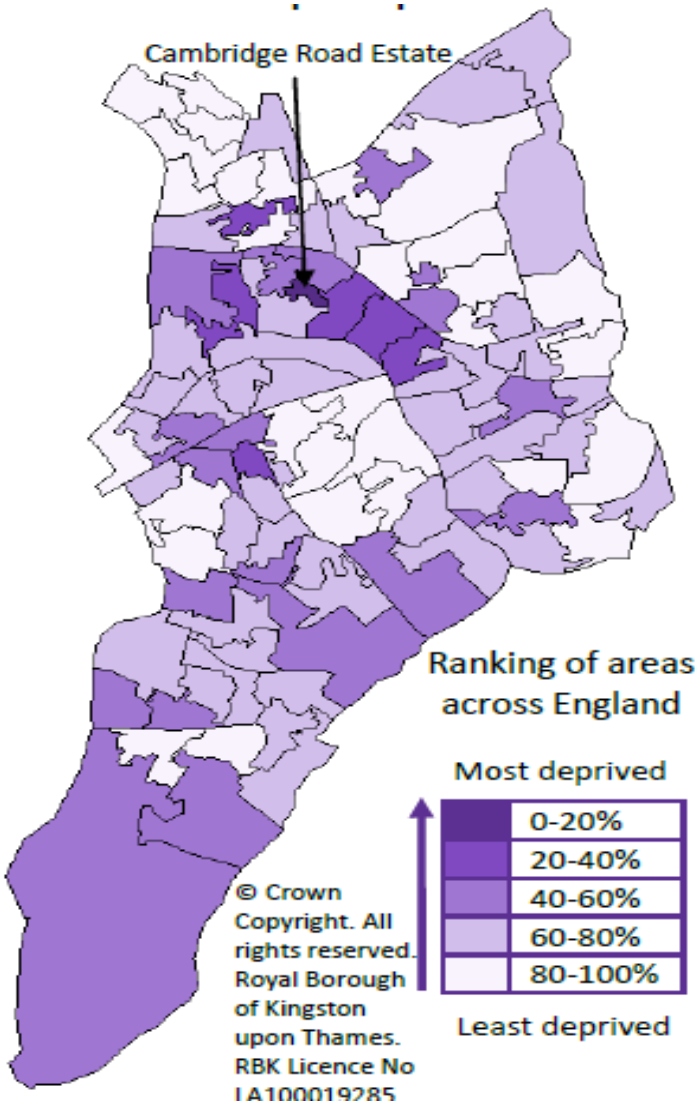
Indices of Multiple Deprivation (IMD) 2010

The English Indices of Multiple Deprivation (IMD) measures relative levels of deprivation in small areas of England called Lower Layer Super Output Areas (LSOAs). LSOAs have an average of 1,500 residents; there are 32,482 in England and 97 in Kingston. The concept of 'deprivation' aims to capture wider disadvantage by highlighting circumstances (not just financial) that negatively impact on the standard of living in certain areas.

The map below shows where each LSOA in Kingston falls within the national rankings, i.e. those falling within the 0-20% bracket are the most deprived relative to the rest of the country. Kingston is the third least deprived local authority in London, after the City of London and Richmond, and is ranked at 252 out of 326 Local Authorities in England (where 1 is the most deprived).

Levels of deprivation vary considerably across the borough. The Cambridge Road Estate in Norbiton ward is the most deprived area in the borough, and is the only LSOA in Kingston in the 20% most deprived in the country. The Kings Drive/Pine Gardens area in Berrylands ward is, in comparison to other areas in England, the least deprived in the borough (in the top 3% in England).

Figure 6: Index of Multiple Deprivation 2010



Source: DCLG 2010 IMD

Child Poverty

Data from HM Revenue & Customs Child Poverty Statistics 2010 suggests that 4,995 children in Kingston are living in poverty, defined by the national definition (Households with less than 60% of equivalised median household income, around £16,000 per annum). Kingston has lower levels of child poverty than the average for England and has the second lowest child poverty in London after Richmond. The levels in all the Surrey boroughs are lower than Kingston.

Table 3: Percentage of Children Living Poverty 2010

Local Authority	% of children in Poverty
Kingston upon Thames	**15.8%**
Merton	18.4%
Richmond upon Thames	10.7%
Sutton	16.7%
Wandsworth	23.1%
Average for Surrey's borough councils	10.2%
London	28.0
ENGLAND	**20.6%**

Source: HM Revenue & Customs Child Poverty Statistics 2010, published February 2012

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Variation across the Borough

Whilst overall Kingston has a low levels of child poverty, variation exists across the borough. Families with young children aged between 5-10 years have the highest number of children in poverty (1,610), followed by the 0-4 years age range (1,530),

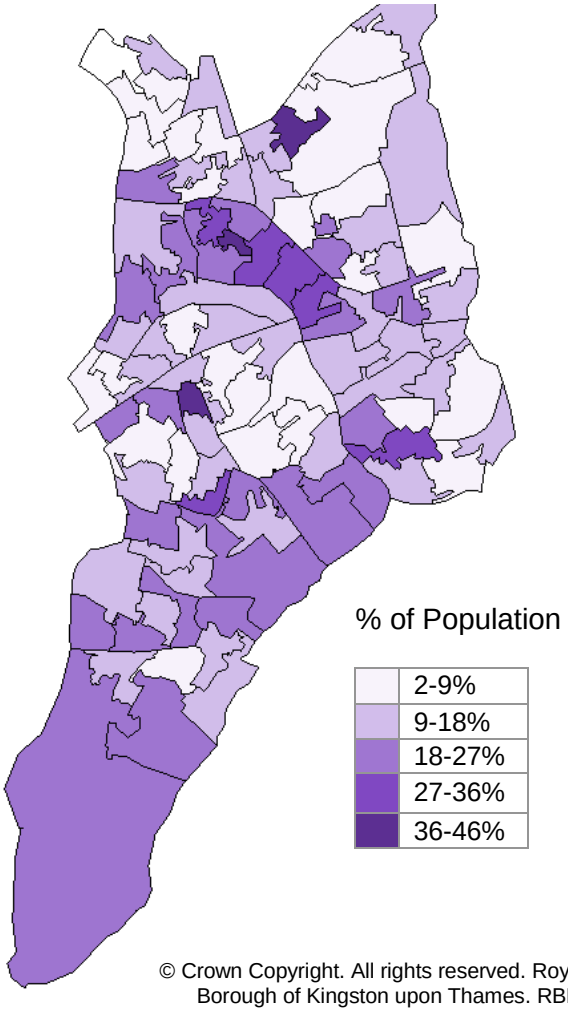
At ward level, Norbiton Ward have the highest percentage of children living in poverty (29.5%) and the highest number for number of children in poverty for children 0-4 years and 5-10 years. Tudor Ward has the lowest percentage of children living in poverty (8%). Within the wards at Lower Super Output Areas level (LSOAs have a resident population of around 1,500 people), there are further pockets of child poverty:

- The area with the highest percentage of children living in poverty (45.2%, or 210 children) falls within Norbiton Ward.
- The area with the second highest percentage of children living in poverty (43.4%, or 110 children) falls within Berrylands Ward.
- The area with the third highest percentage of children living in poverty (39.9%, or 170 children) falls within Coombe Hill Ward, and is surrounded by some of the most affluent areas in the borough.

Source: HM Revenue & Customs Child Poverty Statistics 2010

Kingston Child Poverty Needs Assessment provides further detailed analysis of child poverty and can be found at:
http://www.kingston.gov.uk/child_poverty_needssment_2012_final-2.pdf

Figure 7: Percentage of Children Living in Poverty 2010, by LSOA



Source: HMRC Child Poverty Statistics 2010

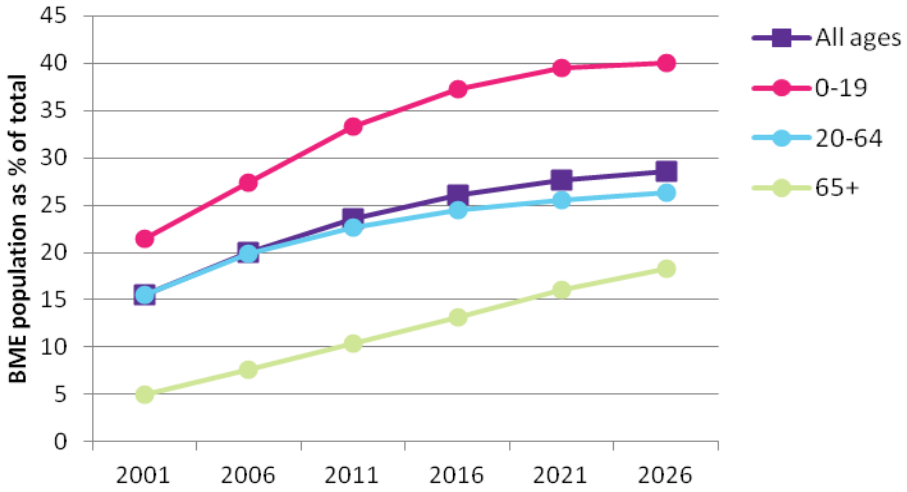
Family Homelessness

Kingston performs higher than most Local Authorities for the majority of indicators of child health. However, the rate of homelessness applications in Kingston for 2011-12 was 2.59 per 1,000 households. This is significantly lower than the London rate (3.92) but slightly above the rate for England (2.31). 176 households were accepted by Kingston Council as homeless and in priority need (i.e. needing to be housed by the Council) in the financial year 2011-12. This is up from 137 in the previous year, but below the average of approximately 185 households per year for the period 2006-12.

Ethnic Population

The proportion of Kingston's population from Black, Asian and Minority Ethnic (BAME) groups rose from 15.5% to 25.5% between 2001 and 2011. This is expected to increase to 28% by 2023. Young people constitute the group who are most ethnically diverse in Kingston.

Figure 8: Changes in the proportion of Kingston's Total Population Estimated to come from BAME groups over time (total in purple) and by age groups



Source: GLA 2011-Round Ethnic Group Population Projections

The table below provides further details of the ethnic minority profile of children living within the borough, broken down by age bands and shows that an estimated 33% of 0-19 year olds came from BAME groups in 2011.

Table 4: BAME Population by Age

Age	Black, Asian and Minority Ethnic (BAME) Population	% BAME
0 to 4	4,411	40%
5 to 9	3,259	36%
10 to 14	2,290	27%
15 to 19	2,128	27%
Total 0 to 19	12,088	33%

Source: GLA 2011, Round Demographic Projections

Location of Black, Asian and Minority Ethnic (BAME) population

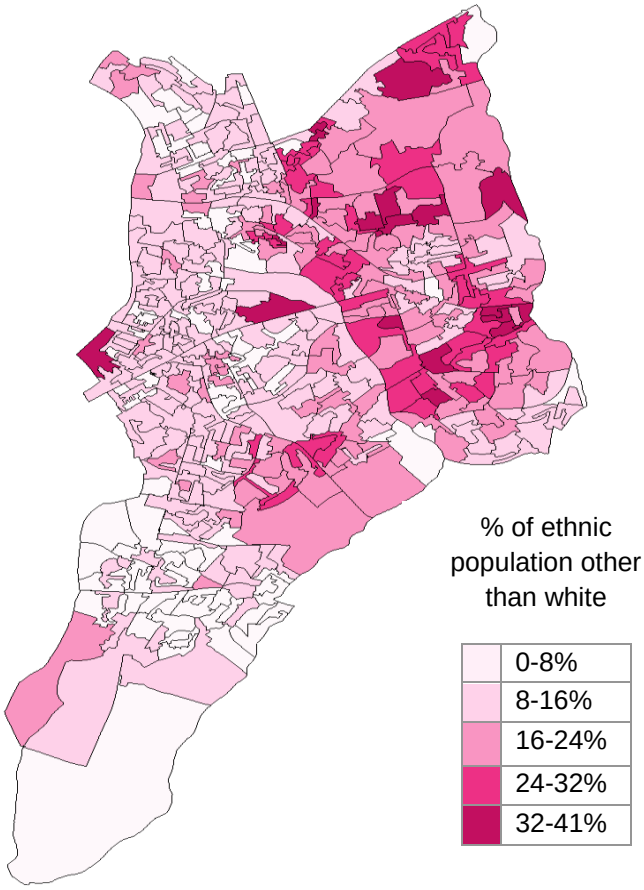
The table below shows the percentage of the population in each ward from BAME groups according to the 2001 Census. The map shows the BAME population by Output Area that came from BAME groups**.** There are 491 output areas in the borough. Each output area comprises of about 100 households with a resident population around 300. (2011 Census data unavailable).

Table 5: BAME by Ward

Ward	BAME Population as % of Total
St James	25
Coombe Hill	24
Coombe Vale	21
Norbiton	19
Beverley	18
Old Malden	18
Alexandra	16
St Mark's	16
Tolworth & Hook Rise	15
Surbiton Hill	12
Canbury	11
Berrylands	11
Grove	10
Tudor	10
Chessington North & Hook	7
Chessington South	6

Source: 2001 Census

Figure 9: BAME population by Output Area



Source: 2001 Census

- The largest BAME populations were concentrated in small areas in St James', Coombe Hill, Coombe Vale and Norbiton wards. Sunray Avenue in Alexandra and Gainsborough Road in Old Malden also had large minority ethnic populations compared to surrounding areas. Brighton Road/Victoria Avenue and Surbiton Cemetery in St Mark', the locations of university halls of residences, also have higher BAME populations

- Rates of BAME populations were lowest in the wards to the South of the borough (Chessington North and Chessington South), with lower rates also seen in the wards to the northwest of the borough (Tudor, Grove and Canbury)

- The main languages spoken within the borough. The top five are English (83.6%), Tamil (1.7%), Korean (1.7%), Polish (1.3%) and Arabic (1%). Source ONS 2011 Census.

RBK (2012) Joint Annual Public Health Report Kingston, RBK.

Special Education Needs

Table 6 shows that Kingston has a lower percentage of children with SEN compared to London, Outer London and England.

Table 6: Children with Special Education Needs

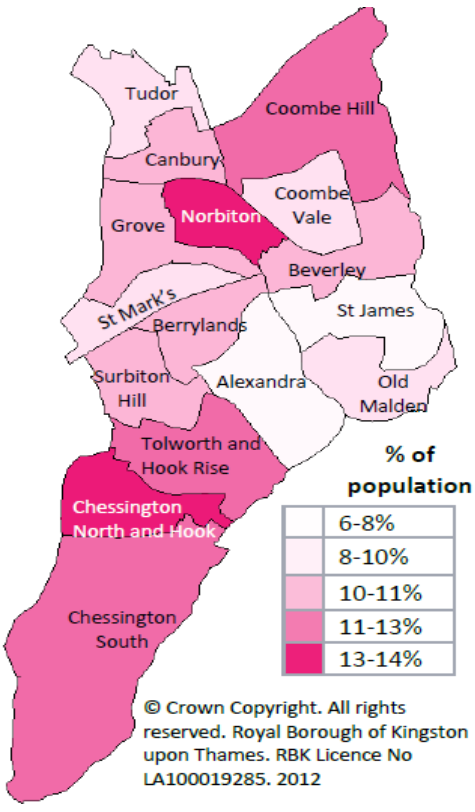
	Kingston	London	Outer London	England
% of children with SEN	13.8	20.5	19.6	19.8
% of primary school children with SEN	15.4	19.4	18.5	18.5
% of secondary school children with SEN	11.4	23.0	20.7	20.2
% of children with SEN with statements	18.0	13.1	13.5	14.0
% of children with SEN on School Action or School Action Plus	82.0	86.9	86.5	86.0
% of children with SEN claiming FSM	19.6	-	-	29.8

Source: DfE First Statistical Release, Results of 2011 School Census, January 2012

There are 3,398 children attending Kingston schools with special educational needs (SEN) the following is a summary of the characteristics of this population in Kingston:

- 67% are male across all schools, increasing to 71% in primary schools reflecting the national trend which shows more SEN amongst boys than girls (this varies by type of need).
- 14% of all children with SEN live out of borough
- A greater proportion of children with SEN have statements than children with SEN nationally.
- Pupils with SEN are more likely to claim free school meals (FSM) than those without (19.6% compared to 9.6%) this is the same as the national trend (29.8% compared to 17.0%) although fewer pupils are eligible for FSM in Kingston overall
- Wards with the highest percentage of children with SEN are Chessington North and Hook with 14.3% and Norbiton with 14.2%. (Data relates to primary and special school children because secondary school children are more likely to come from outside the borough)

Figure 10: Percentage of children with SEN by Ward



Source: DfE Results of School Census 2012

Sexual Orientation

The Integrated Household Survey (IHS) provides the biggest dataset on those people who are willing to identify as Lesbian Gay, Bisexual and Transgendered (LGBT) in the context of the household and is the only available source of information on sexual orientation. According to the HIS (2012):

- 1.5% of adults in the UK and 2.4% of adults in London identified themselves as Gay, Lesbian, or Bisexual
- By age 2.7% of 16-24 year olds, compared to 0.4% of 65 year olds and over identify themselves as lesbian, gay and bisexual

Kingston Borough Council estimates that there are between 8,000 and 11,000 lesbian, gay and bisexual people living in Kingston (Kingston Borough Profile, 2012).

It should be noted that the LGBT Sexual Health Needs assessment highlights that LGBT communities have higher levels of smoking, substance misuse and mental health issues compared to the general population. Younger LGBT who responded as part of the needs assessment also reported higher levels of eating disorders and self harm. (Kingston LGBT Needs Assessment, 2013).

Child Health in the Early Years

As highlighted in the Marmot Review (The Marmot Review 2010), early life experiences lay the foundations for future quality of life and health and well-being of all children. The better start a child has in life, the less likely they are to become involved in harmful levels of risk taking later in life (Allen 2011). The following summary highlights key indicators of child health in the early years of life and shows that children in Kingston on the whole do have a good start in life:

- In 2010-11 81.8% of pregnant women in Kingston accessed maternity services within 12 weeks and 6 days of pregnancy, improving the health care they and their baby receive and reducing the risk of complications
- Average life expectancy at birth in Kingston is **80.7** for males**, 83.7** for females, 2.8 and 0.6 years longer respectively than the UK
- Kingston has lower levels of smoking at time of delivery, 5.6% compared to 13.2% nationally for 2011-12
- The percentage of low birth weight babies is lower in Kingston (6.1% of babies weighing under 2.5kg at birth) compared to the England average (7.4%) in 2011
- There is a high rate of breast feeding initiation in Kingston (89.4% compared with 74% for England for 2011-12)
- Kingston has an infant mortality rate lower than the England average at 3.9 per 1,000 live births between 2009-2011 compared to 4.4 for England.

Source: Child and Maternal Health Observatory Child Health Profile [Online] Available from: http://atlas.chimat.org.uk/IAS/dataviews/ [Accessed: 16/03/2013].

Families

The following section is a summary of some of the key data relating to family circumstance in Kingston.

Reflecting the population increase over recent years, the table below highlights that:

- the number of households with dependent children in Kingston is higher in 2011 at 63, 639 households compared to 61, 426 in 2001; Kingston has a higher proportion of households with dependent children than England, and a similar proportion to London
- the percentage of households with dependent children aged 0-18 is also higher at 20.9% in 2011 compared to 32, 935 in 2001
- Households with dependent children (0-18) with no adults in employment was slightly lower in 2011, and is well below the London and England averages
- Newly available data shows that 2,490 households with dependent children included someone with a long-term health problem or disability

Table: 7 Characteristics of Households with Dependent Children in Kingston

Characteristics of households with dependent children (Figures in brackets show numbers as a proportion of total households)	**2001: Kingston**	**2011: Kingston**	**London** (%)	**England** (%)
Number of households	**61,426**	**63,639**	**-**	**-**
Number of dependent children aged 0-18	**32,935**	**35,677**	**-**	**-**
Households with dependent children aged 0-18 (%)	**17,452** (28.4%)	**19,690** (30.9%)	30.9%	29.1%
Households with dependent children aged 0-4 (%)	**7,205** (11.7%)	**8,610** (13.5%)	14.1%	11.8%
Lone parent households with dependent children (0-18)	**3,127** (5.1%)	**3,541** (5.6%)	8.5%	7.1%
Households with dependent children (0-18) and no adults in employment	**2,050** (3.3%)	**1,949** (3.1%)	5.7%	4.2%
Households with dependent children (0-18) and one person with a long-term health problem/disability	-	**2,490** (3.9%)	5.0%	4.6%

Source: 2011 Census Tables KS106, KS107: 2001 Census Tables KS21, KS22 adapted from the Office of National Statistics.
Source: Kingston Data Observatory RBK 2011 CENSUS SERIES: PART 1—POPULATION Children.

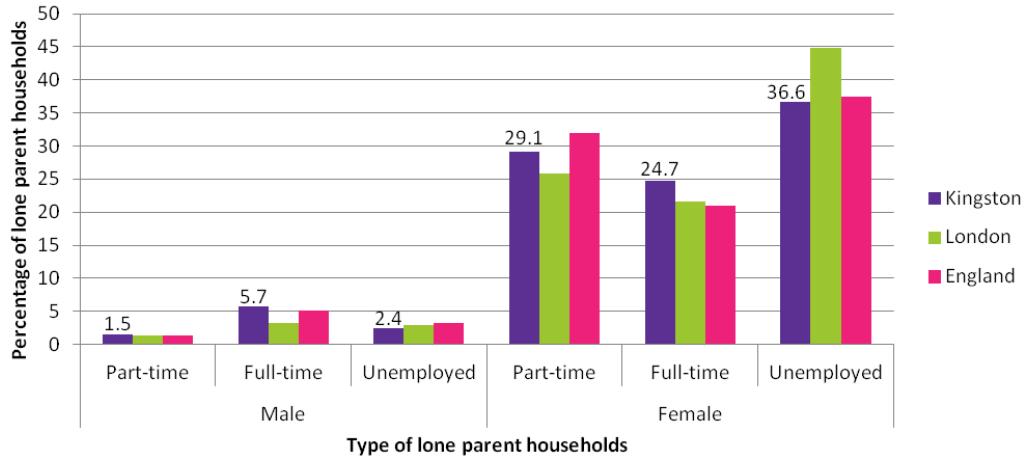
The percentage and number of lone parents households with dependent children (0-18) is higher in 2011 at 3,127 (5.1%) compared to 3, 541 (5.6%) in 2001, and they formed a slightly greater proportion of total households. However, this proportion is lower than the England (7.1%) and London (8.5%) average.

The following table provides a breakdown of lone parent households in Kingston by sex and employment status and shows that:

- **The majority of lone parent households** in Kingston were **female** (**90.4%**)

- Kingston had a higher proportion of both male and female lone parents in full-time employment than London and England
- **39% were unemployed**, much higher than the rate of unemployment in the general population

Figure 11: Lone Parent households in Kingston by Sex and Employment Status



Source: 2011 Census Tables KS106, KS107: 2001 Census Tables KS21, KS22 adapted from the Office of National Statistics.
Source: Kingston Data Observatory RBK 2011 CENSUS SERIES: PART 1—POPULATION Children.

Income Deprivation Affecting Children

The table below shows the percentage of children (0-15) in each LSOA that live in income deprived families which are classed as those in receipt of Income Support or Income-based Jobseeker's Allowance, or in receipt of Child Tax Credit or Pension Credit with income below 60% of the median. Whilst Kingston has a low number of LSOAs in the 20% most deprived nationally, there are significantly more within the 20-40% LSOAs in the most deprived in England for IMD.

Table 8: Number of Kingston LSOAs and National Deprivation

	Number of Kingston LSOAs in the 20% most deprived nationally	Number of Kingston LSOAs in the 20-40% most deprived nationally
Overall Index	1	6
Children's Index	7	2

(Kingston Borough Profile, 2012)

Income Deprivation affecting Children Index (IDACI) shows wide variation across Kingston which contains both areas ranked within the 2% most deprived and 2% least deprived nationally for this Index. Norbiton is the ward where children are most affected by deprivation but there also marked difference within ward. In the Kings Drive/Pine Gardens area in Berrylands, 1.7% of children live in income deprived households (with a rank of 31,790) compared to 60.7% of children living in the Cambridge Road Estate (with a rank of 720). Areas with pockets of social housing, including School

Lane in Surbiton Hill, Kingsnympton Park in Coombe Hill, Sheephouse Way in Old Malden, and Alpha Road in Berrylands also with higher levels of income deprivation affecting children.

Parental Influence

Parenting and family support play a key role in a child's early development which, in turn has long term implications for their future outcomes in terms of health and economic status (Huppert 2009). Research also highlights that the importance of parent child communication and parental monitoring in reducing the likelihood of a young person's engagement in risky behaviour (Wiefferink et al. 2006).

The table opposite provides 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. Children were logged on the ASKK system to enable the child and family to be monitored and a Common Assessment Framework (CAF) will also have been submitted for these children. The table shows that family breakdown and parenting skills were the top two reasons why young people were flagged on the system. This highlights that at an early age there are factors in place which affect the future likelihood of becoming involved in risk-taking behaviour and therefore there is a need to ensure that early identification and prevention work is linked to early years and support for families.

Table 9: Top Ten Risk Factors affecting Children aged 0-4 logged with ASKK, 2012

	Risk Factors Logged with ASKK 0-4 years
1	Family Breakdown
2	Parenting Skills
3	Financial Difficulties
4	Mental Health concerns
5	Domestic Violence
6	Emotional / Behavioural Difficulties
7	Lone / Unsupported Families
8	Family Isolation
9	Parental Health Need
10	Overcrowding

Source: RBK (2012) Joint Annual Public Health Report Kingston Chapter 3.

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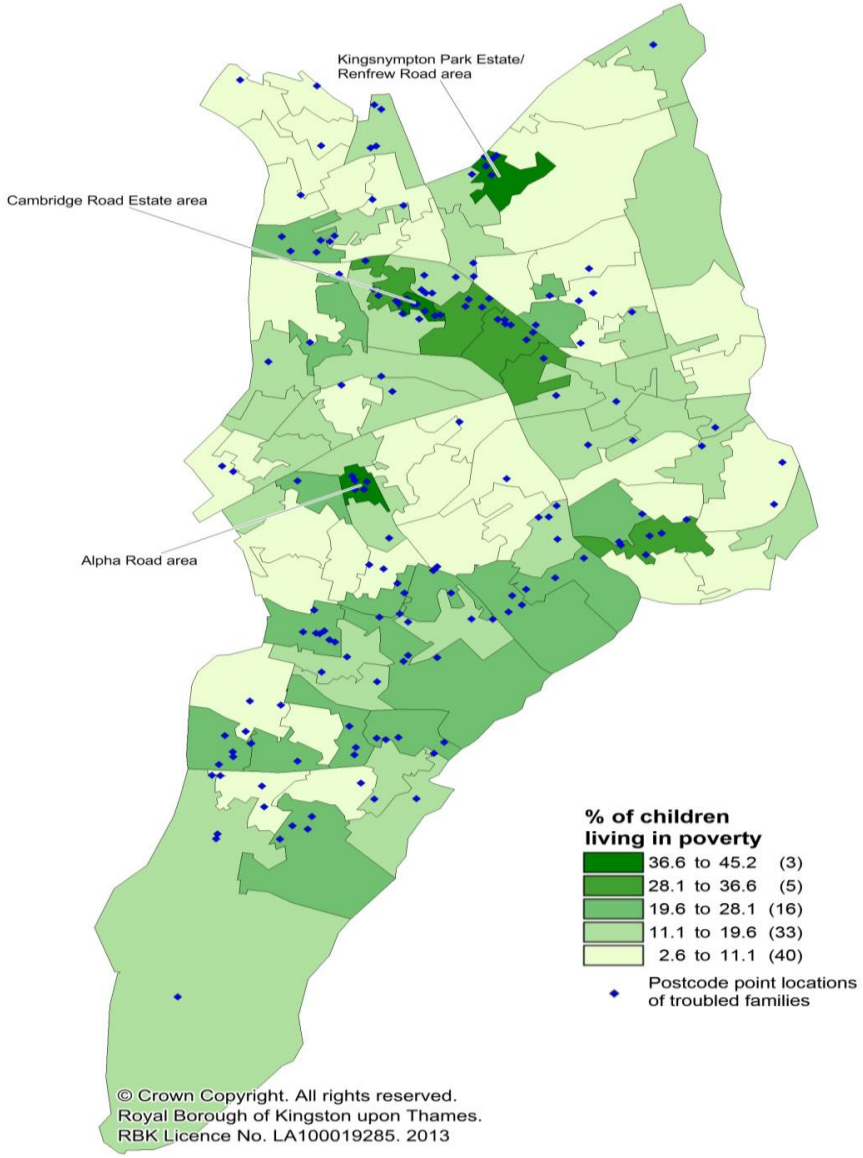
Troubled Families

The following map shows the location of 'troubled families' in Kingston. Troubled Families are categorised by the Government as families where there is no working adult in the family, children absent from school, and family members maybe involved in crime/anti-social behaviour with a risk of the children within these families repeating the cycle of disadvantage. Whilst the map clearly shows that troubled families are located across the borough and in areas where the percentage of child poverty is low, the largest concentration of troubled families is in the areas with a higher percentage of child poverty. In particular, the social housing estates of Kingsnympton Park Estate, Renfrew Road, Cambridge Road Estate and Alpha Road areas.

Figure 12: Child Poverty by LSOA and Troubled Families



Source: HMRC Child Poverty Statistics 2010,
Count of Troubled Families by LSOA and location of each household, RBK Kingston Troubled Families map supplied by Learning & Children's Services Strategic Business, 2013

Looked After Children

Kingston has a low proportion of looked after children (LAC) at 38.0 per 10, 000 population aged under 18 compared to the England average (59 per 10, 000). Whilst the rate of Looked After Children is in the lowest quintile for all local authorities, it has been increasing in recent years as illustrated in table 10. The rate is higher in Kingston compared to statistical neighbours with the rate of LAC lowest in Richmond at 19.0 per 10, 000 population aged under 18.

Table 10 Rate of Looked After Children under 18 years of age

	2005	2006	2007	2008	2009	2010	2011	2012
Kingston	29	28	25	28	33	38	33	38
Barnet	55	51	47	44	43	40	38	36
Merton	36	27	23	26	28	33	31	30
Richmond	27	24	22	24	22	24	22	19
Surrey	33	31	32	33	34	32	30	33
London	74	73	70	66	65	66	61	56
England	55	55	55	54	55	58	59	59

Whilst the rate has been increasing, so has the number of Looked After Children in Kingston over recent years as illustrated in table 11 below with the 125 LAC in Kingston in 2012 compared to 90 in 2005.

Table 11 Number of Looked After Children under 18 years of age

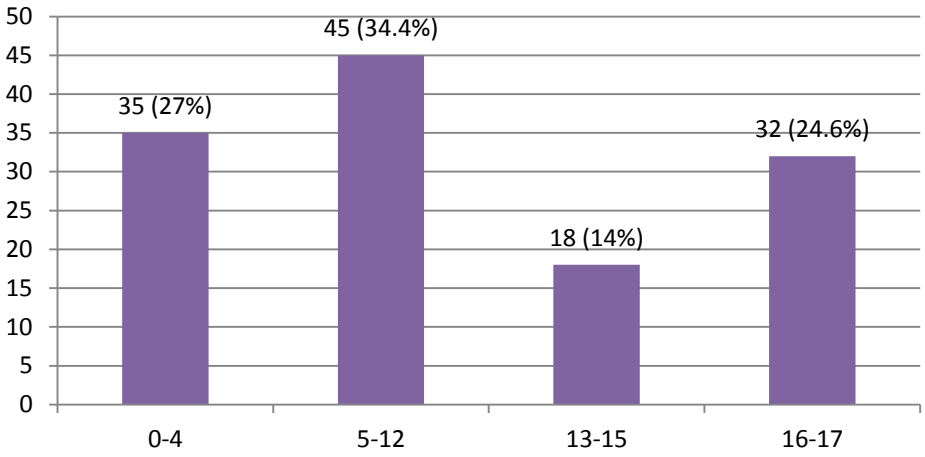
	2005	2006	2007	2008	2009	2010	2011	2012
Kingston	90	90	80	90	110	130	115	125
Barnet	400	370	345	325	330	310	300	300
Merton	90	90	80	90	110	125	115	125
Richmond	100	90	85	95	90	95	90	75
Surrey	780	730	750	800	820	765	730	805
London	11890	11770	11260	10710	10690	10690	10410	10250
England	61000	60300	60000	59400	60900	64410	65520	67050

Source: Department for Education, 2012

Whilst rates are low, children and young people in care are among the most socially excluded children and as such are one of the most vulnerable groups in terms of risk-taking behaviour. This is often a reflection of the experiences which have led them to be looked after and also due to the fact

that parental monitoring is often challenging due to the transient nature of placements which can lead to increased opportunities for risk-taking. There are significant inequalities in health and social outcomes compared with all children and these contribute to poor health and social exclusion of care leavers later in life (DCSF 2009). The following figure provides a snapshot of the total numbers of LAC in Kingston as of March 2013 and highlights the 16-17 years old group as forming a large percentage (33%) of the overall LAC population.

Figure 13 Total Number of Looked After Children in Kingston by Age March 2013



Source: figures provided by Jill Warn Looked After Children Nurse, March 2013.

Local analysis has identified that for 16-17 year olds there were major behavioural difficulties in the home, school and community that parents were struggling to manage prior to the entry into care. Anecdotal evidence suggests that this is reflected in the number of voluntary referrals 'Section 20s' made by parents into the LAC system for this age group. Further analysis of the data showing route of entry into the system by age would be useful in identifying need for work to be undertaken at an earlier stage with older children and their families.

School Population

Characteristics of Kingston's School Population

A focus on school populations is key to improving health and well-being of young people. Therefore, an understanding of the characteristics of the schools and pupils attending them is essential to understanding the needs of the population and planning and commissioning of services. The following data is drawn from the Spring 2012 School Census (January 2012) and shows characteristics of pupils attending Kingston schools. There are 35 primary schools, 10 secondary schools and three special schools in the borough (excluding independent schools). As of September 2012, two primary and nine secondary schools were academy schools (state schools funded directly by Central Government rather than Local Authorities). The remaining schools are maintained (local authority) schools.

Table 12 shows the percentage of children in primary, secondary and Special Schools who speak English as an additional language with the average proportion of children whose first language is not English in all schools being 32%.

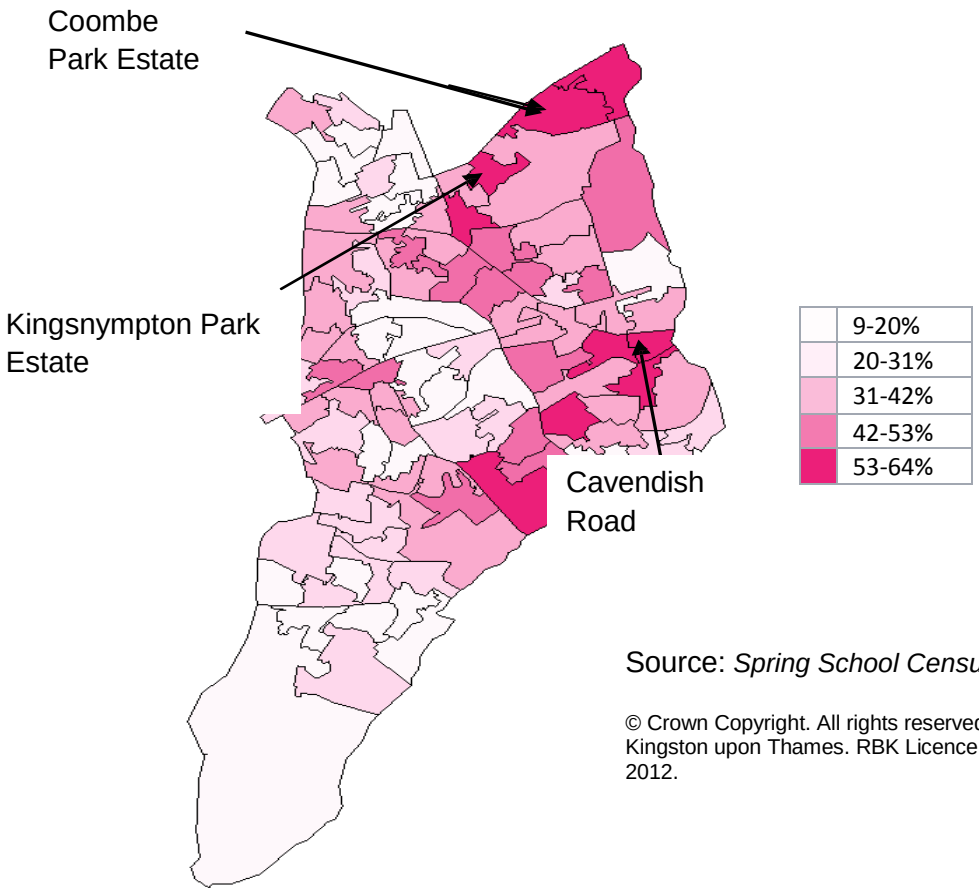
Table 12: Percentage of children in primary, secondary and Special Schools who speak English as an additional language

Phase of Education	% Non-White British	% English as an Additional Language	% with Special Educational Needs
Primary School pupils	48.5%	32.3%	15.4%
Secondary School pupils	47.5%	28.9%	12.6%
Special School pupils	41.2%	20.6%	99.6%
All Pupils	48.1%	31.2%	15.9%

Source: Spring School Census, January 2012

In accordance with the ethnic composition of the borough, the highest proportion of children who speak English as an additional language are located in the North East of the borough.

Figure 14: Children speaking English as an Additional Language by LSOA



Source: *Spring School Census, January 2012*

Coombe Hill (51%), St James' (50%) and Norbiton (44%) wards have the highest proportion of children whose first language is not English. Chessington South has the lowest (17%). Analysis at a

lower level shows that that Cavendish Road in St James' ward (64%) and Coombe Park in Coombe Hill (60%) have particularly high proportions.

All Schools Population Estimates and School Rolls

Table 13 provides a breakdown of the number and percentage of pupils who live and attend school in Kingston.

Table 13: Secondary School Age Population In and out of Borough Schooling, 2012

Secondary School	School Type	Total	In Borough	Out of Borough	% In Borough	% Out of Borough
Coombe Girls	Academy	**1377**	1131	246	82.1%	17.9%
Chessington Community College	LA	**758**	640	118	84.4%	15.6%
Southborough High	Academy	**708**	619	89	87.4%	12.6%
Tiffin Girls	Academy	**892**	297	595	33.3%	66.7%
Tolworth Girls	Academy	**1284**	1057	227	82.3%	17.7%
Tiffin Boys	Academy	**1078**	344	734	31.9%	68.1%
Richard Challoner	Academy	**983**	645	338	65.6%	34.4%
Holy Cross	Academy	**938**	504	434	53.7%	46.3%
Coombe Boys	Academy	**889**	537	352	60.4%	39.6%
The Hollyfield School	Academy	**1112**	1063	49	95.6%	4.4%
Total		**10019**	**6837**	**3182**	**68.2%**	**31.8%**

Source: Spring School Census, 2012

As of January 2012:

- 68.2% of secondary school aged pupils attend schools in the borough of Kingston however there are large differences between schools
- Hollyfield School has the largest number (1112) and percentage (95.6%) of secondary school children attending from in-borough, with Coombe Girls having a large number of pupils attending from in-borough (1131; 82.1%) and Tolworth Girls having 1057 pupils attending from in-borough (82.3%).
- Numbers of pupils attending Southborough High and Chessington Community College are lower than the other large schools however, both have a high proportion of children attending from in-borough with 87.4% and 84.4% respectively.
- Both Tiffin schools are selective reflected in approximately two-thirds of the pupils from each school being from out-borough.
- Richard Challoner and Holy Cross are both Catholic schools and therefore their admissions policy prioritises Catholic children. However, although both have similar overall numbers of pupils attending, the proportion of pupils in-borough at Richard Challenor is higher at 65.6% than from pupils at Holy Cross (53.7%).

The breakdown of schools serving pupils from within the borough needs to be considered when commissioning prevention and early intervention services to ensure that, particularly universal provision, is reaching Kingston residents. Likewise it would also be useful to undertake some analysis to understand the characteristics of pupils being schooled out of borough to assess if their information and support needs are being met.

Pupils Schooled Out of Borough

The following table provides a breakdown of the number of pupils schooled out of borough. It should be noted that when schools input the post-code information mistakes are understandably made, and this in part explains the high number of not knowns/out of borough.

Table 14 total number of children in Kingston schooled out of borough

Counties/Summary	Pupils
London Boroughs	1954
Surrey	684
All other Counties	11
Out of borough/not known	533
Total	3182

Source: Spring School Census, January 2012

Education and Attainment

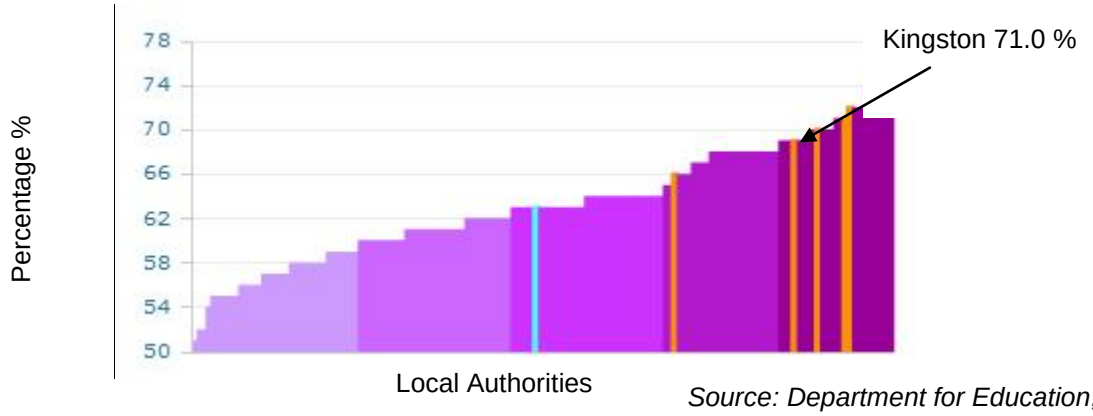
Sustained engagement with school and achieving a good level of literacy and numeracy are key to the long-term prospects of young people, and their overall levels of health and quality of life. Teenagers who disengage from school, miss a key phase of their education and have increased opportunities to participate in risk-taking behaviour. This in turn can lead to low educational attainment and reduced employment opportunities in no or low-paying and insecure roles.

Attainment levels in Kingston schools are high, with average results for the authority well above the average for England. The following series of graphs and charts shows that Kingston is in the top quintile of Local Authorities in England at key stages of educational development. Much of the data is drawn from the Kingston Data Observatory website and is available at: http://www.kingston.gov.uk/information/nhoodhome/kdo/childrens_data/kdo_education.htm.

Early Years Attainment

The early years foundation stage (EYFS) provides a measure of the proportion of children achieving a good level of development (a score of 78 points or above) at age 5. The graph below shows that majority of children in Kingston start school achieving the appropriate EYFS profile.

Figure 15: Percentage of Children Achieving a Good Level of Development in the Early Years Foundation Stage (2012)



Source: Department for Education, 2012

In 2012 71% of pupils in Kingston were achieving a good level of development working at Foundation Stage level (aged 5). This was similar to the Local Authorities of Richmond (72%) and Surrey (70%) and higher than in Barnet (69%) and Merton (66%).

Key Stage 2 (Year 6)

At the last year of primary school, all Key Stage 2 pupils are assessed for their level of attainment in English and maths. The table below shows the average percentage of pupils achieving Level 4+ in English and Maths across Kingston Primary Schools in 2012.

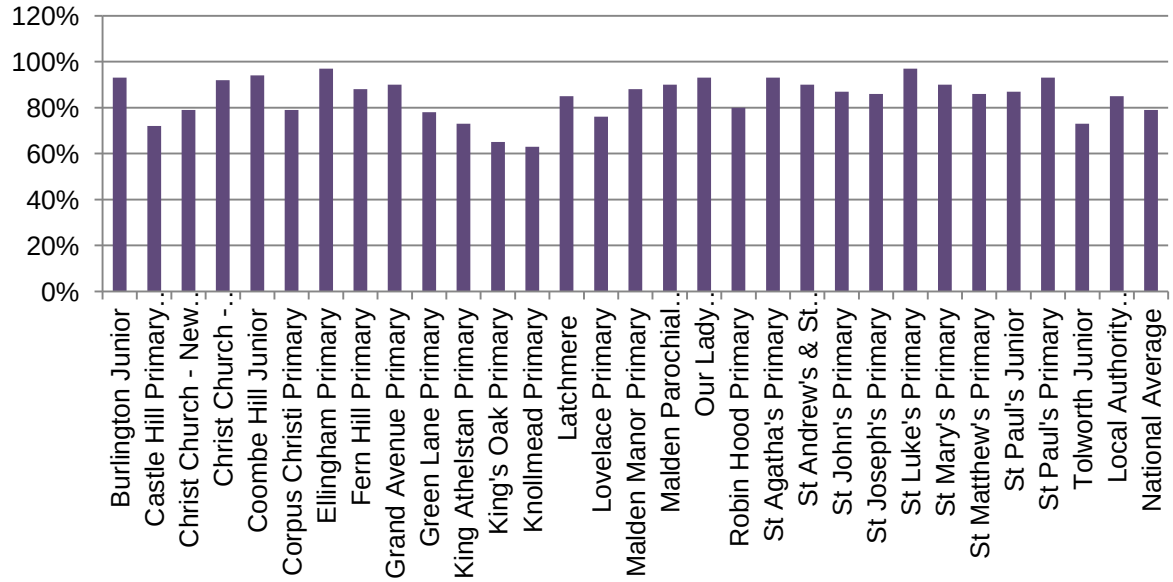
Table 15: Percentage of Primary School pupils achieving Level 4+ in English and Maths

% bands for those achieving Level 4+ including English and Maths in 2012	Number of Kingston Primary Schools
90-100%	12
80-89%	8
70-79%	7
60-69%	2

Source: Department for Education, 2012

In 2012 the average level of attainment for pupils at Key Stage 2 in Kingston was 85%. This is 5 percentage points higher than average attainment for pupils in Kingston between 2009 to 2011, and is 6 percentage points higher than the national average. The figure below shows the 2012 results for 29 primary schools in Kinston (other primary schools in the borough are infant schools).

Figure 16: Key Stage 2 Attainment in RBK Primary Schools, 2012

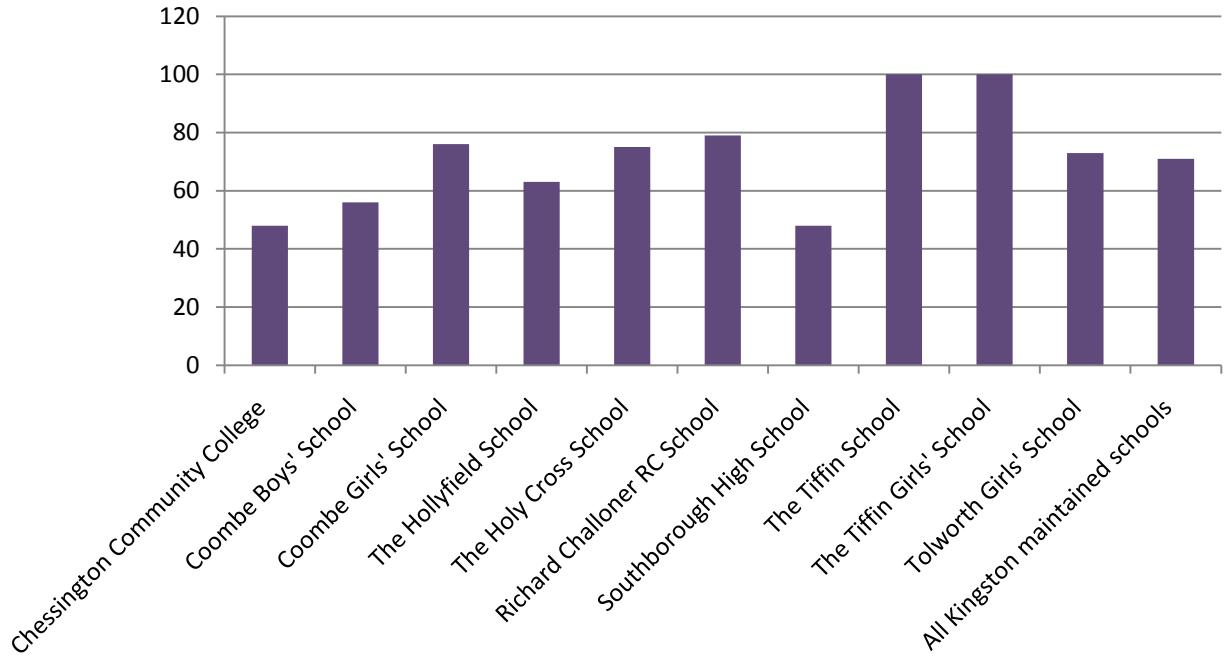


Source: Department for Education, 2012

Key Stage 4: GCSEs (Year 11)

Achievement at secondary schools level is also higher than the national average. In 2011 an average of 71% percentage of pupils attained 5 or more A*-C grade GCSEs at Key Stage 4. This is a 2% improvement on 2010 and 13% above the national average. Figure 17 below shows the average percentage of pupils achieving 5 A*-C GCSEs, including English and Maths, by Secondary School in 2012.

Figure 17: Percentage of Pupils % Achieving 5 GCSEs A-C (inc English and Maths), 2012



Source: Department for Education, 2012

Table 16 shows the average percentage of pupils achieving 5 A*-C GCSEs, including English and Maths, for all Secondary Schools. It highlights that in 2012 Chessington Community College and Southborough High School had the lowest levels of achievement at GCSE A*-C Grades both at 48% compared to 100% at both Tiffin Schools, however it should be noted that the around 30% of pupils attending Tiffin Schools are out of borough (see page 32).

Table 16: average percentage of pupils achieving 5 A*-C GCSEs, including English and Maths, for all Secondary Schools, 2012

School	% achieving 5 A*-C GCSEs including English and Maths in 2012
Chessington Community College	48%
Coombe Boys' School	56%
Coombe Girls' School	76%
The Hollyfield School	63%
The Holy Cross School	75%
Richard Challoner RC School	79%
Southborough High School	48%
The Tiffin School	100%
The Tiffin Girls' School	100%
Tolworth Girls' School	73%
All Kingston maintained schools	71%

Source: Department for Education, 2012

Gap in Attainment

Whilst overall the level of attainment is outstanding, there is a significant gap between the lowest achieving 20% and the average level for all children in Kingston. There is therefore a need to focus on the reducing inequalities in achievement between the lowest achieving 20% and the remainder of the school population. There has been some progress towards this in Kingston as shown in table 17. The gap between the lowest achieving 20% and the median score of all children at EYFS[2] in Kingston has narrowed between 2005-2011 however this narrowing has been less than in London overall. It should be noted that the gap in 2005 was considerably greater in London than in Kingston.

Table 17: Gap between the lowest achieving 20% and the median score of all children

	2005	2006	2007	2008	2009	2010	2011
RBK	33%	37%	34%	31%	31%	28%	29%
London	40%	40%	39%	37%	35%	34%	32%
England	39%	38%	37%	35%	24%	33%	31%

Source: Department for Education, 2012

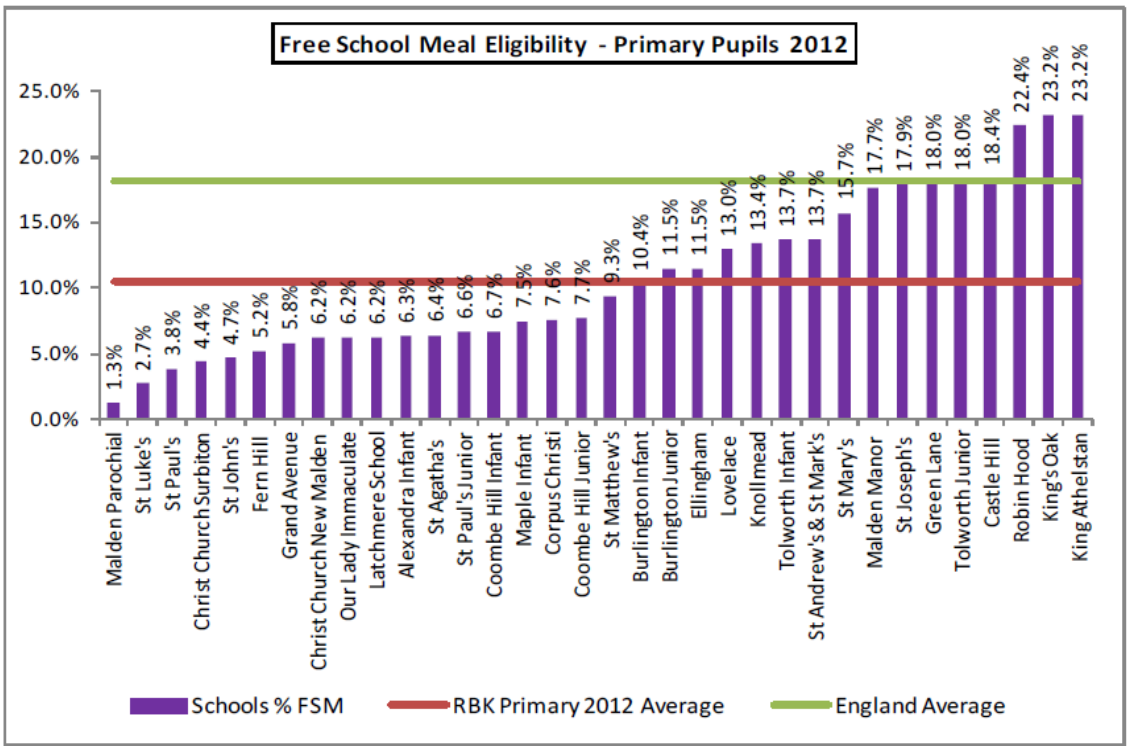
[2] the achievement gap is calculated as the difference between the median score for all children and the mean score for the lowest 20% and expressed as a percentage of the median score for all.

Eligibility of Children for Free School Meals

Eligibility for free school meals (FSM) is widely accepted as a good indication of the extent of child poverty and related health need. Analysis of this data provides a strong indication of which schools should be targeted to reduce inequalities across a range of issues.

The Marmot review (The Marmot Review 2010) showed that children eligible for free school meals achieve under the expected level at every level of education from Foundation Stage through to higher education. Understanding which schools have the highest proportion of children eligible for free school meals can support the planning of targeted services for young people who are likely to be at increased risk of a range of risk factors associated with risk-taking. The following figures show the proportion of primary and secondary schools with pupils eligible for free school meals and levels of attainment**.**

Figure 18: Proportion of Children in Kingston recorded as eligible for Free School Meals by Primary School 2012



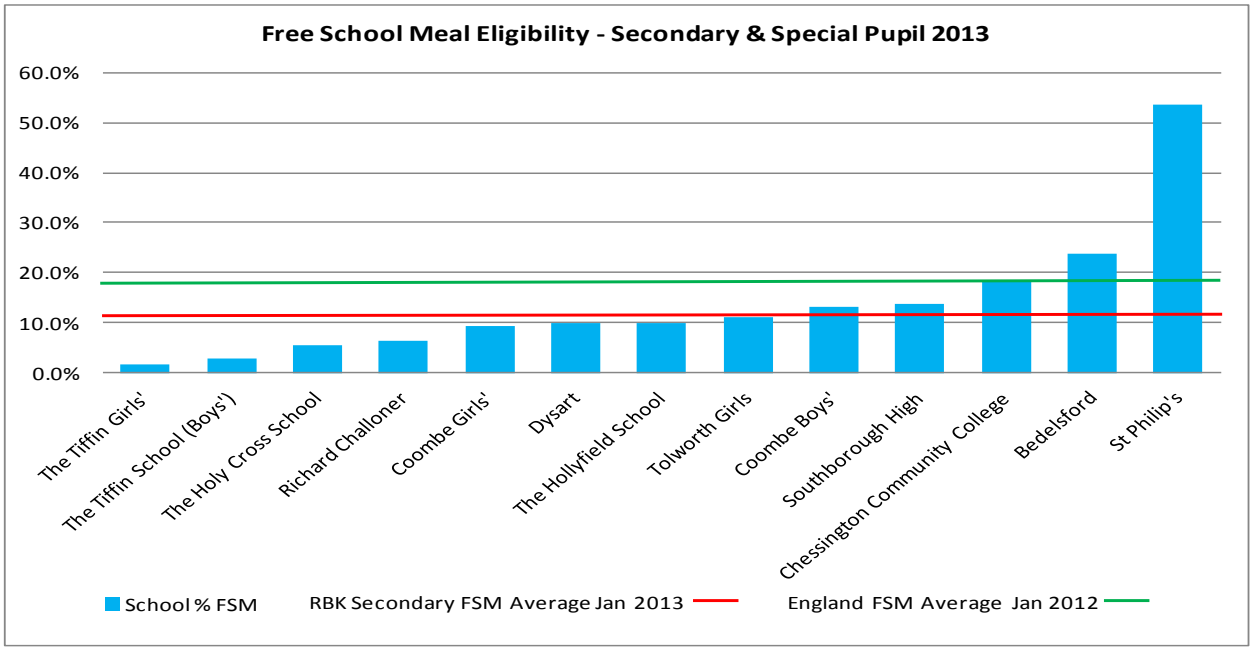
Source: Spring School Census, January 2012

Chart supplied by RBK, Strategic Business

Figure 18 shows that in 2012 there is wide variation across primary schools of pupils who are eligible for Free School Meals, with King Athelstan (23.2%) King's Oak (23.2%) and Robinhood (22.4%) primary schools having the highest percentage of pupils, and Malgen (1.3%), St Luke's (2.7%) and St Paul's (3.8%) having the lowest percentage.

Figure 19 shows the percentage of pupils attending secondary and special schools in 2012 who are eligible for Free School Meals. There is a marked difference across secondary schools with Chessington Community College having the highest percentage of pupils eligible for FSMs in 2013, followed by Southborough High. St Phillips Special School has by far the largest percentage of pupils eligible for FSMs overall followed by Bedelsford Special School however, these schools have a high percentage of out of borough pupils so this should be treated with caution.

Figure 19: Proportion of Children in Kingston recorded as eligible for Free School Meals by Secondary School 2012



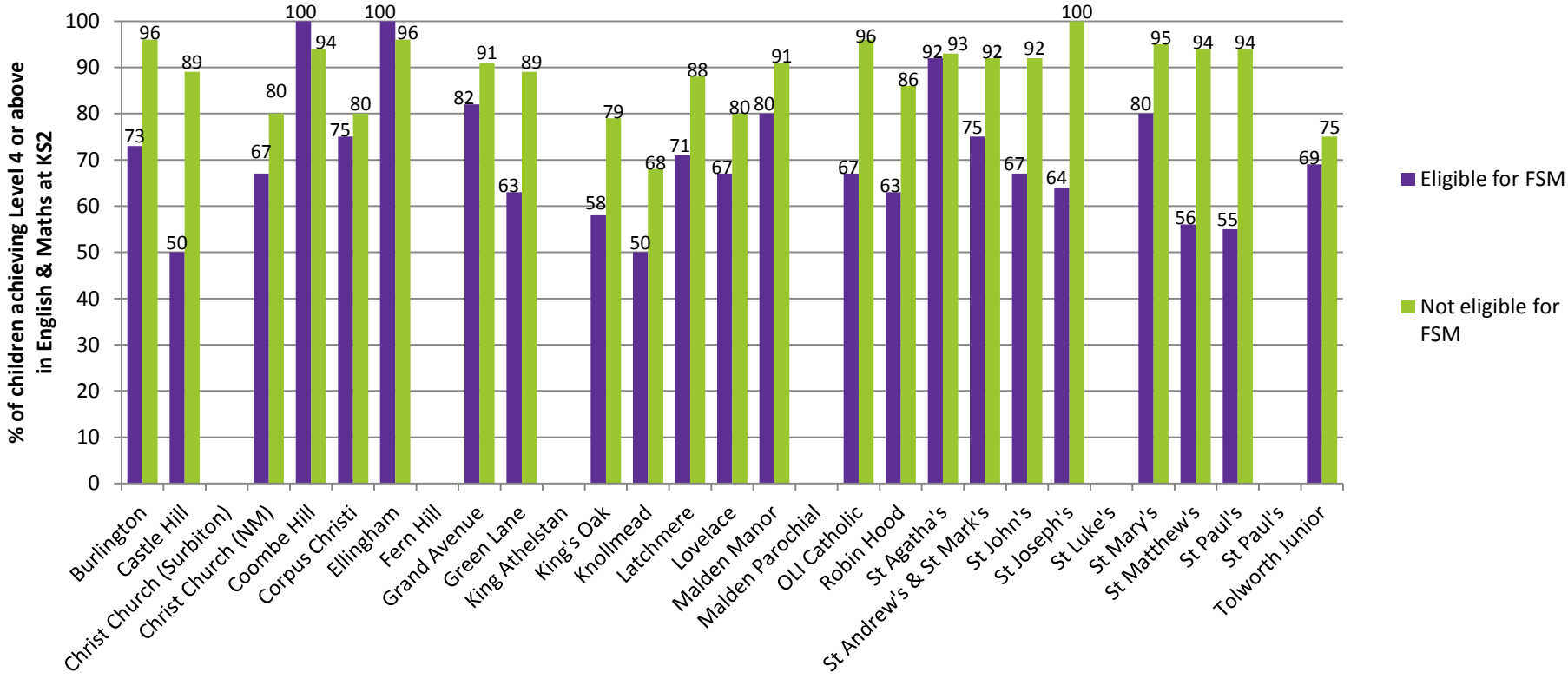
n.b. RBK data relates to Jan 2013, the England Average trend line is for all school types and from Jan 2012.

Source: Spring School Census, January 2012

Chart supplied by RBK, Strategic Business

Figure 20 shows the comparison of attainment at Key Stage 2 between pupils eligible for Free School Meals (FSMs) and those who are not. The pattern in Kingston reflects the national trend with pupils who are eligible for FSMs performing less well at Level 4 than those not eligible for FSMs, in the majority of primary schools (with the exception of Ellingham and Coombe Hill).

Figure 20: Percentage of children achieving Level 4 or above in English & Maths at KS2 by FSM eligibility

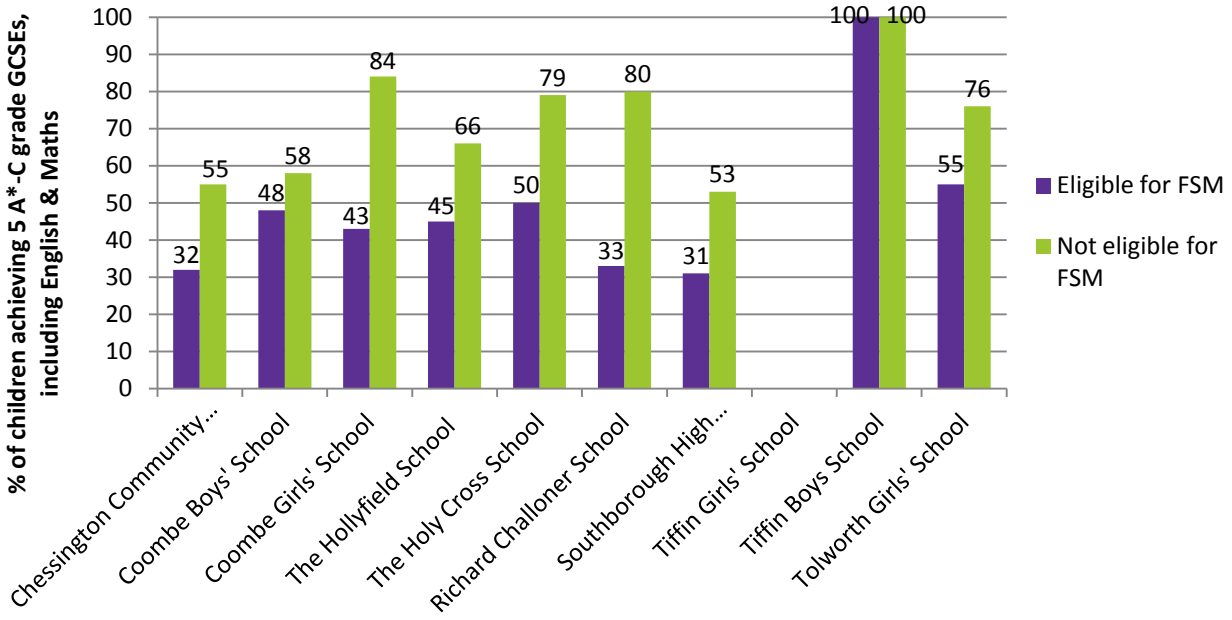


Source: Spring School Census, January 2012

Chart created by RBK Strategic Business.

Figure 21 shows the comparison of attainment at Key Stage 4 between pupils eligible for Free School Meals (FSMs) and those who are not. At secondary school pupils who are eligible for FSMs perform consistently less well at Level 4 than those not eligible for FSMs, with the exception of Tiffin Boys School (data unavailable for Tiffin Girls School).

Figure 21: Percentage of children achieving 5 A*-C grade GCSEs (inc. English & Maths) at KS4 by FSM eligibility



Source: Spring School Census, January 2012

Chart created by RBK Strategic Business.

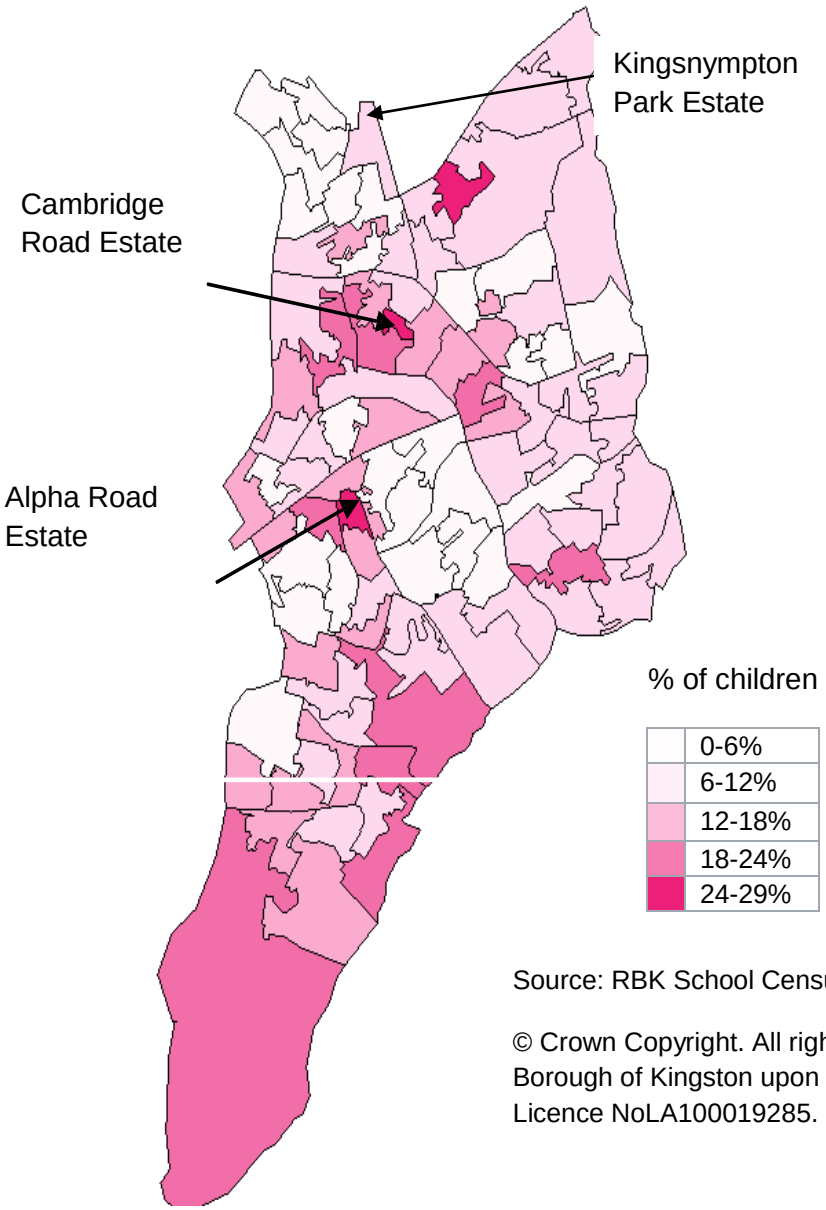
Eligibility of FSM by Ward

Edibility criteria for FSM are very similar to the measures used for Child Poverty and therefore ward 2evel data reflects this analysis:

- Wards with the highest proportion of children claiming Free School Meals are Norbiton (17.1%), Chessington South (14.7%) and Coombe Hill (14.0%), and those with the lowest proportion are Tudor (3.4%), Alexandra (6.1%) and Coombe Vale (6.1%).

- At a lower geographical level, Alpha Road Estate in Berrylands (28.7%), the Cambridge Road Estate in Norbiton (27.7%), and the Kingsnympton Park Estate in Coombe Hill (26.1%), have particularly high proportions of pupils eligible for Free School Meals.

Figure 22: Children Claiming Free School Meals by LSOA



Source: RBK School Census, January 2012

Destination of Young People Leaving School

The table below shows the destination of young people on finishing compulsory education at 16 years old. Initially the percentage of young people who are unemployed post-16 appears to be low at 1.1%. However, the destination of 10.6% of the young people was unknown at the time of the survey and this forms a significant proportion for whom there is little understanding of their current situation.

Table 18: Destination of Young People aged 16-17

Post 16 Destination	Total	Percentage
Full Time Education	1347	86.7%
Full Time Training	7	0.5%
Full Time Employment	9	0.9%
Part Time Learning and Employment	6	0.4%
Unemployed (including Personal Development Opportunities - available to the labour market)	17	1.1%
Not Active/Not Available to Labour Market	2	0.1%
Moved out of contact/Not Available/Refusal	165	10.6%

Source: South London Sub Regional Unit, Year 11 Destination Survey 2011

NEETs (Not in Education, Employment of Education)

Kingston has low levels of young people who are NEET aged 16 - 18 years. At the end of 2011, 3.3% of 16 - 18 year olds living in Kingston were reported as NEET compared to 4.5% in London as a whole. However, the proportion of young people aged 16-18 in Kingston whose destination is unknown is high compared to the London average as shown in the table below. A person is recorded as 'unknown' when a local authority has not been able to contact the young person for three months.

Table 19: Estimated proportion of 16-18 year old Kingston residents NEET and not known compared to London at the end of 2011

	Kingston		London	
	% NEET	% Not Known	% NEET	% Not Known
16 years	0.9%	10.3%	2.5%	8.8%
17 years	3.0%	9.1%	4.5%	11.1%
18 years	5.6%	18.8%	6.3%	20.9%

Source: Department for Education, 2011 Local Authority NEET figures.

NEETs at Ward Level

At ward level, youth unemployment (i.e. among ages 16-24) is most severe in Beverley ward at 10.5%, followed closely by Norbiton (10.4%) and Tudor (10.2%). This compares to a Kingston average of 5.9% and a London average of 10.7% (Kingston Borough Profile, Kingston Data Observatory, 2012, p.19)

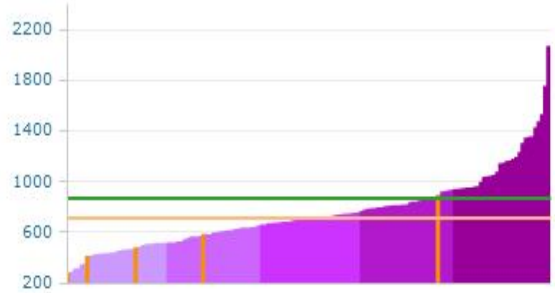
Youth Offending

The series of graphs below show the rate of young people entering the Youth Justice System in Kingston. The first graph shows that there has been a decline in the rate of first time entrants into the Youth Justice System in Kingston from 1,140 per 100,000 10-17 year old population in 2008-09 to 465 in 2011-12. This reflects the downward trend across England and London for the same period with the rate for England at 712 per 100,000 10-17 year old population in 2011-12 and 864 per 100,000 10-17 year old population in London. In 2011-12 the rate for Kingston was lower in comparison to its statistical neighbours for the same period. The rate of young people aged 10 -17 years receiving their first reprimand, warning or conviction in Kingston was lower than in Barnet (547) and Merton (881), and higher than in Richmond (339) and Surrey (267).

Figure 23: First time entrants into the Youth Justice System in Kingston 2008-09 to 2011-12

Source: Youth Justice Board, 2012

Figure 24: First Time entrants to the Youth Justice System 2011-12



Source: Youth Justice Board, 2012

Figure 25 and table 20 show that between 2010-2013, Tolworth and Hook Rise Wards had the highest number of First Time Entrants to the Youth Justice System 2010-13 (31) followed by Norbiton (30) and Chessington North and Hook (17). Please note data for 2012-13 covers the time period 01.04.2012 - 28.02.2013 as data for March 2013 was unavailable at the time of writing.

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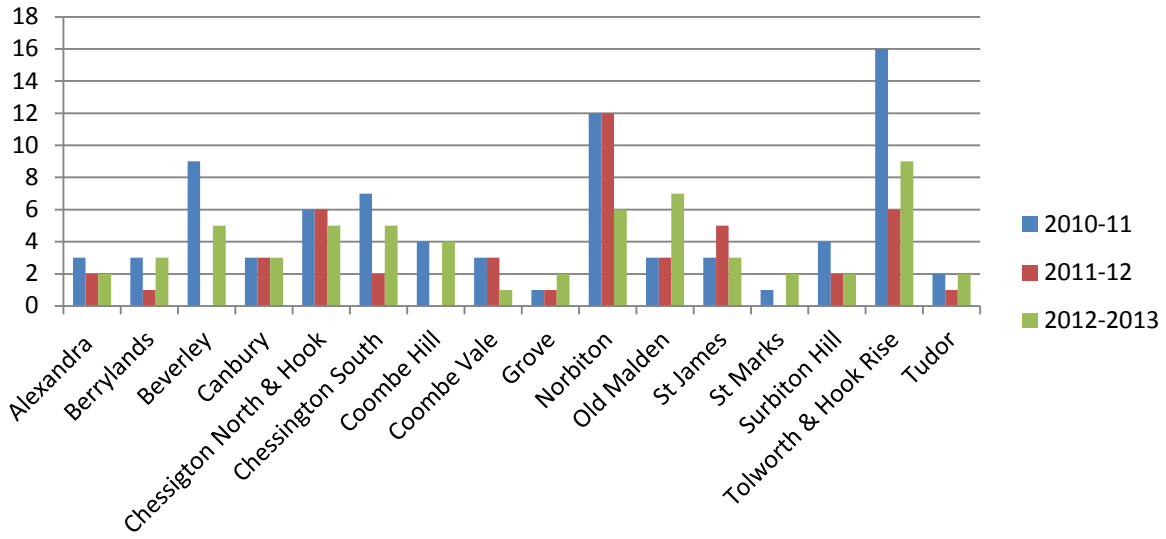
Figure 25: Numbers of First Time Entrants to the Youth Justice System 2010-13 by Ward



Source: Provided by Joe Bond, Kingston Youth Offending Service, 2013

Table 20 First Time Entrants to the Youth Justice System by ward 2010-2013

Ward	2010-11	2011-12	2012-13	2010-2013
Alexandra	3	2	2	7
Berrylands	3	1	3	7
Beverley	9	0	5	14
Canbury	3	3	3	9
Chessington North & Hook	6	6	5	17
Chessington South	7	2	5	14
Coombe Hill	4	0	4	8
Coombe Vale	3	3	1	7
Grove	1	1	2	4
Norbiton	12	12	6	30
Old Malden	3	3	7	13
St James	3	5	3	11
St Mark's	1	0	2	3
Surbiton Hill	4	2	2	8
Tolworth & Hook Rise	16	6	9	31
Tudor	2	1	2	5
Total	**80**	**47**	**61**	**188**

Source: Provided by Joe Bond, Kingston Youth Offending Service, 2013

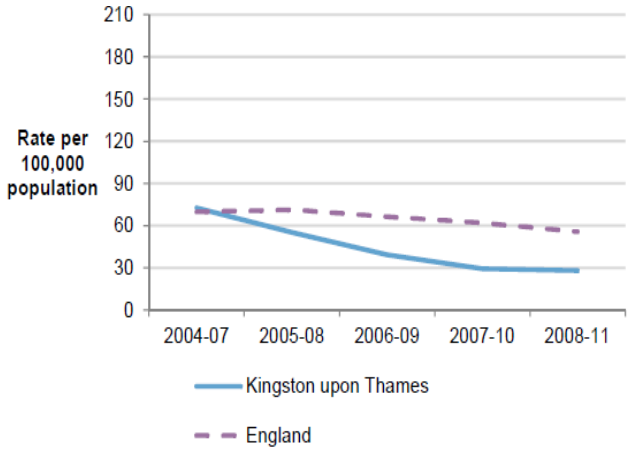
Substance Misuse

Hospital admissions for alcohol and substance misuse provide an indication of the levels of substance use in a population with the assumption that areas with higher rates of substance use will also have higher rates of admissions to hospital.

Alcohol

In comparison with the 2004-07 period, the rate of young people under 18 who are admitted to hospital because they have a condition wholly related to alcohol (such as alcohol overdose) has decreased in the 2008-11 period as shown in figure 26. Overall rates of admission in the 2008-11 period are lower than the England average. Table 21 shows that in 2008-2011 Kingston had an alcohol admission rate for young people of 28 per 100,000 population under 18, lower than Barnet (37.4), Richmond (40.8), Surrey (40.8) and Merton (42.8).

Figure 26: Young people aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years) 2008-2011



Data Source: Local Alcohol Profiles for England, North West Public Health Observatory, 2012

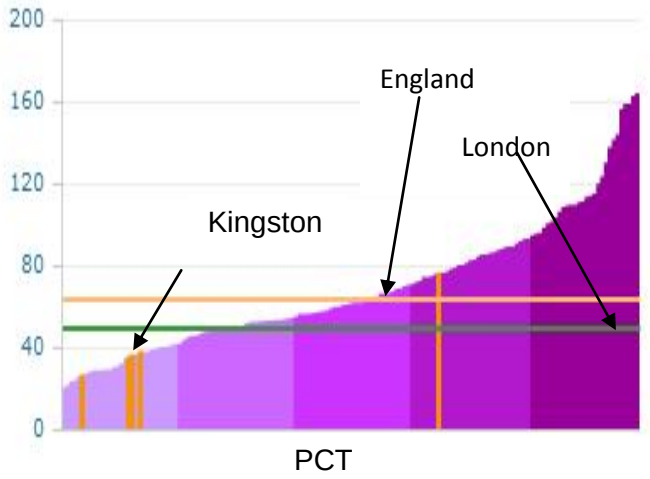
Table 21: Young People aged under 18 admitted to hospital with alcohol specific conditions (rate per 100,000 population aged 0-17 years) 2008-2011

Kingston	28	29
Barnet	37.4	9
Richmond	40.8	17
Merton	42.8	18
Surrey	40.8	99
London	-	-
England	55.8	-

Local Alcohol Profiles for England, North West Public Health Observatory, 2012

Table 22 shows that in Kingston the hospital admission rate for substance misuse between 2008-11 was 35 per 100,000 population aged 15-24 years. This is lower than the England and London average, higher than Merton (25.1), similar to Barnet (34.2) and Surrey (36.6) and lower than Richmond (75.2).

Figure 27: Hospital Admissions rate due to substance misuse per 100,000 population aged 15-24, 2008-2011



Hospital Episode Statistics, 2012

Table 22: Hospital Admissions rate due to substance misuse per 100,000 population aged 15-24, 2008-2011

Area	Rate	Number
Kingston	35	26
Barnet	34.2	41
Richmond	75.2	41
Merton	25.1	19
Surrey	36.6	140
London	49.3	-
England	63.5	-

Hospital Episode Statistics, 2012

Nationally, and in Kingston, the majority of young people who receive support from services for substance misuse, do so for alcohol and cannabis and few for Class A substances. Kingston Joint Annual Public Health Report Kingston 2012 provides a summary of an on-line survey consultation and focus group feedback undertaken with 282 young people of secondary school age in Kingston on substance misuse which highlighted that:

- 28% (78) of the respondents reported using an illicit drug and of these 45%reported using an illicit drug on average once per month whilst nearly a quarter reported usage of once a week or more. Of this group of 78 who reported usage, 92% reported using cannabis. (No Class A drug use was reported by young people under the age of 18).
- 75% (211 of the 282) reported consuming alcohol on a frequent basis with 25% (70) reporting consuming alcohol weekly
- Girls' alcohol consumption was generally greater than boys
- All respondents reported experiencing being drunk on at least one occasion by the age of 16

Royal Borough of Kingston 2011/12 Young People's Substance Misuse Treatment Plan Needs Assessment

It should be noted that pupils were selected on the basis that they were vulnerable to risky behaviour and therefore may not be representative of all young people.

Access to Services

The Youth Support Service (YSS) provides support to young people on substance misuse issues and confirm that the majority of substance they see among young people is alcohol and cannabis use. Figures of the number of young people supported by the YSS for alcohol and substance misuse were unavailable.

The Tier 3 specialist Young People's Substance Misuse Service in Kingston is operated as a partnership with Richmond upon Thames. Figures reported for the YPSMS in the RBK 2012 Joint Annual Public Health Report Kingston show that in:

2010-11

- 69 young people aged 13–17 years from Kingston received specialist interventions at Tier 3 with 39 (57%) completing and leaving treatment in a planned way.
- Of the 69 young people entering services 12 (17%) had previously received a tier 3 treatment service which is less than the national average of 22% (NTA, JSNA Support Pack for Kingston, March 2012)

2011-12

- 56 young people received Tier 3 treatment for substance misuse problems with 72% completing and leaving treatment in a planned way as compared with 75% nationally.
- No Tier 4 admissions were recorded solely for substance misuse reasons.

Referral Routes

For 2010-11 the main routes of referrals were:

- youth Offending Service (59%)
- mental and other
- health services (23%)
- education & social care (8%)
- self-referral or were referred by family and friends (5%)

This was also reflected in 2011-12 however these were unavailable at the time of writing.

Smoking

An accurate measure of smoking among young people at a local level is lacking. Previously the main source of information for local areas was the Tell Us survey undertaken in schools. This was last undertaken in 2009 and the number of respondents from Kingston was too low to draw any conclusions. In 2011 the Information Centre for Health and Social Care undertook a national survey on Smoking, drinking and drug use among young people in England its key findings were:

- a quarter (25%) of pupils had tried smoking at least once (a sustained decline and lower than at any time since the beginning of the survey began in 1982 when 53% of pupils had tried smoking)
- 5% of pupils smoked regularly (at least once a week) in 2011
- Prevalence of regular smoking among 11 to 15 year olds has halved since its peak in the mid 1990s – 13% in 1996
- Prevalence of smoking increased with age, from less than 0.5% of 11 year olds to 11% of 15 year olds
- Girls were more likely than boys to be regular smokers
- Black pupils were less likely than those from other ethnic groups to smoke regularly
- Regular smoking was also associated with drinking alcohol, drug use, truancy and exclusion from school.

Source: Information Centre for Health and Social Care, 2011

Access to Services

The Kick-It! Service was recently commissioned in October 2012 to provide smoking cessation services for young people in Kingston. The service is very new and unsurprisingly few young people or professionals are familiar with it as yet. Although available, Kick-It infrequently provides smoking cessation support to young people wherever it is operating. The view of Toby Fairs- Billam (Head of Kick-It!) is that this is because young people rarely view their smoking as a problem and are therefore not seeking support to quit at this age.

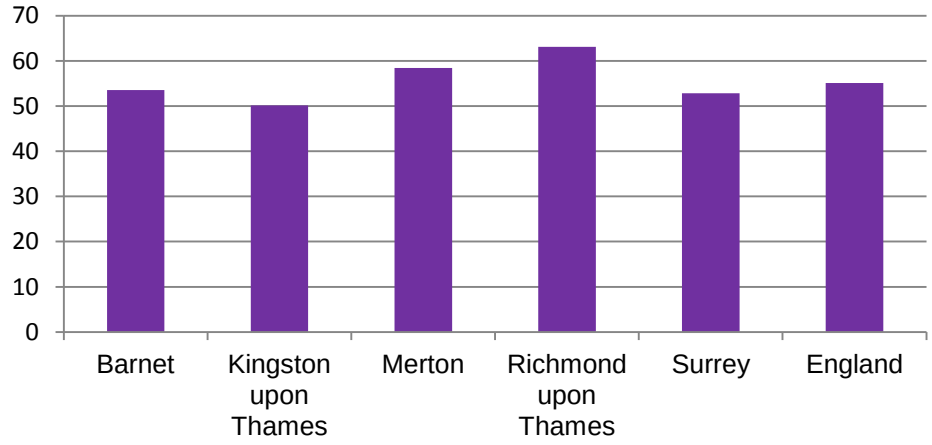
Mental Health and Well-being

A robust measure of the level of emotional health and resilience of young people is not currently in place at a national or local level and has been identified as a gap within the Young People's Health Outcomes Forum Report. The data presented here adds to the emerging picture of the emotional health of young people in Kingston but there is further work to be done to understand this area more fully.

Exercise and Young People

Exercise has a strong link with mental well-being and exercise. Kingston performs less well than other areas in young people's engagement in physical activity at school. In 2009-10 the percentage of school age children aged 5-18 years participating in at least 3 hours per week of high quality PE and sport at school age was 50.1 in Kingston. This is significantly lower than the England average of 55.1 and lower than Kingston's statistical neighbours Barnet (53.5), Merton (58.4), Richmond (58.4) and Surrey (52.8).

Figure 28: % children participating in at least 3 hours per week of high quality PE and sport at school age (5-18 years), 2009-10



Source: Department for Education, 2011

Obesity

Linked to levels of physical activity are level of obesity. The charts below show the percentage of children classified as obese or overweight in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) in Kingston compared to statistical neighbours. Kingston has a lower percentage in Reception and a lower percentage in Year 6 classified as obese or overweight compared to the England average but the level is higher among the older age group. This in turn is likely to be linked to levels of self-esteem and attitudes to body image which can affect mental health.

Figure 29: Children aged 4-5 years classified as obese or overweight, 2011/12 (percentage)[3]

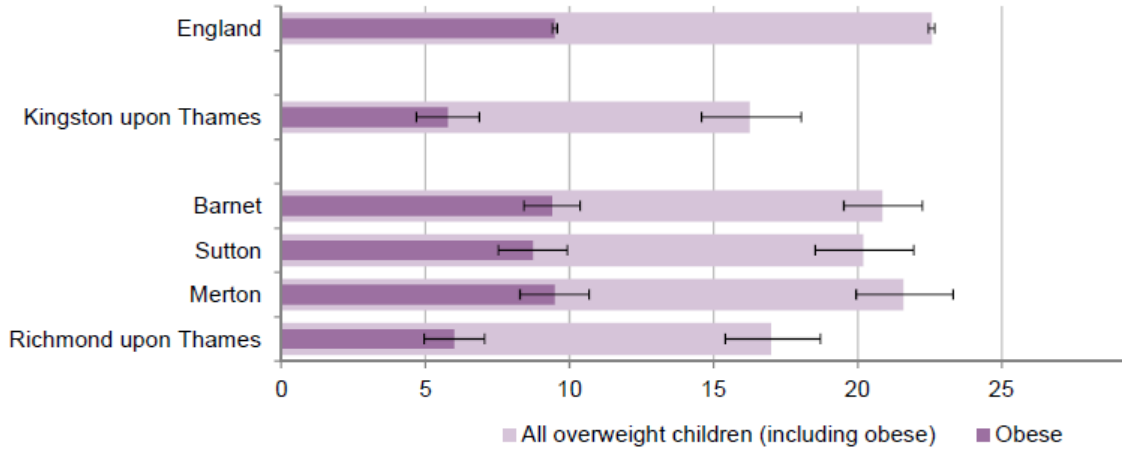
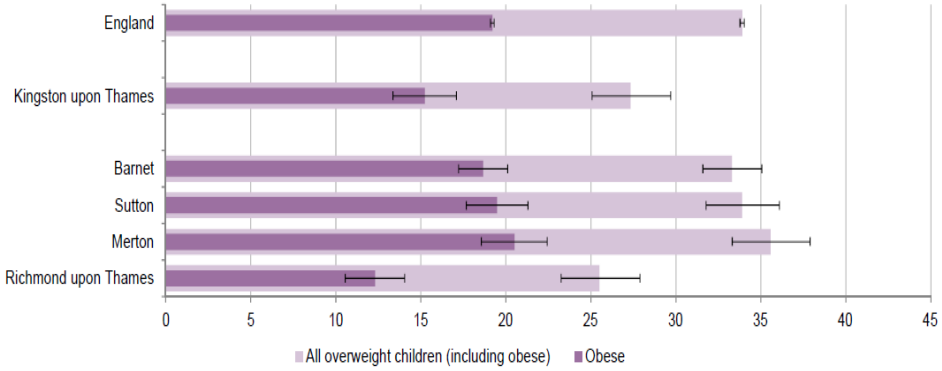


Figure 30: Children aged 10-11 years classified as obese or overweight, 2011/12 (percentage)



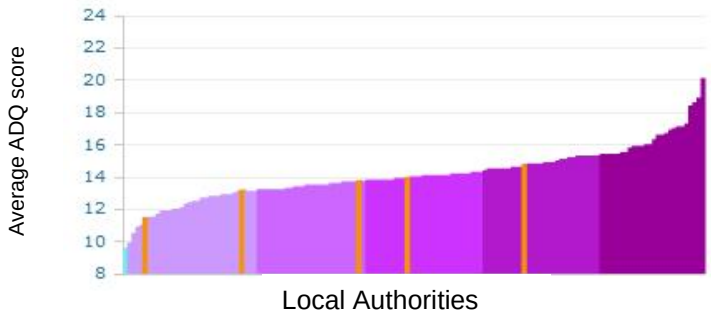
Source: National Child Measurement Programme (NCMP), The Information Centre for health and social care
Bar charts: Child and Maternal Health Observatory, 2013

Emotional Health of LAC

A measure is in place to assess the emotional and behavioural health of Looked After Children (LAC) using the average score for Strengths and Difficulties Questionnaire for looked after children aged 4 to 16 (inclusive), who have been in care continuously for 12 months at 31 March. A higher score on the SDQ indicates more emotional difficulties. A score of 0-13 is considered normal, a score of 14-16 is considered borderline cause for concern and a score of 17 and over is a cause for concern. In graph below shows that in 2010 the average SDQ score for LAC in Kingston was 13.7, similar to Richmond (13.1) and Barnet (13.9), higher than Merton (11.4) and lower than Surrey (14.7).

[3] Note: this analysis uses the 85th and 95th centiles of the British 1990 growth reference (UK90) for BMI to classify children as overweight and obese. I Indicates 95% confidence interval.

Figure 31: Average SDQ Score for LAC in Kingston, 2010

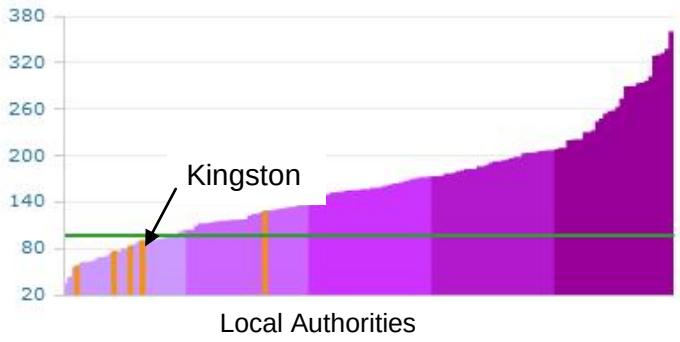


Source: Department for Education, 2012

Hospital Admissions Self-harm

Hospital admissions as a result of self-harm provide an indication of other levels of mental health among young people such as depression. In 2010-11 the rate of hospital admissions as a result of self-harm was 76.6 per 100,000 population aged 0-18 years in Kingston. This was higher than for Merton (53.6) Barnet (68.4) and Richmond (69.4) and lower than Surrey (105.7) and the London average (96.7) (figures unavailable for England).

Figure 32: Emergency Hospital Admission Rate for Self Harm age 0-18 years, 2010-11



Source: Hospital Episode Statistics, 2011

Table 23: Emergency Hospital Admission Rate for and Numbers for Self Harm age 0-18 years, 2010-11

Area	Rate	Number
Kingston	76.6	59
Barnet	68.4	30
Richmond	69.4	34
Merton	53.6	24
Surrey	105.7	312
London	96.7	-
England	Data	Data

Source: Hospital Episode Statistics, 2011

Figure 33: young people aged under 18 admitted to hospital as a result of self-harm 2006-09 to 2009-12

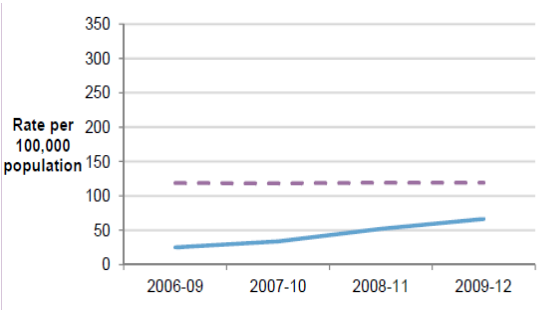


Figure 33 shows that in comparison with the 2006-09 period, the rate of young people under 18 who are admitted to hospital as a result of self-harm in Kingston has increased in the 2009-12 period.

Source: Hospital Episode Statistics, 2011

Access to Services

There are few services in Kingston specifically providing counselling support for young people with low level mental health concerns such as depression, anxiety and stress. The third sector organisation Relate is the only dedicated service although other services e.g. Youth Support Service and School Health Service also provide support to young people. The relate service offers 20 sessions of counselling for young people in Kingston per week. Eight of these sessions are funded by a grant from RBK with the remaining hours funded by Children In Need and other charitable trusts. The top 3 top issues for young people attending Relate counselling are:

- family and relationship breakdown
- self esteem
- bereavement

Young people in Kingston fill the 20 sessions every week. Most YP who are not suitable for Relate are referred to CAMHS or other specialist services i.e. eating disorders, drug and alcohol services however, there is a continual waiting list and such is the demand that the service could fill an additional 20 sessions per week.

Support for young people with low level mental health needs was highlighted by young people and professionals as the most significant gap in service provision for young people in Kingston. As mental well-being and resilience is key to prevention of future risk-taking activities, it is paramount that further support is identified for young people as a matter of urgency.

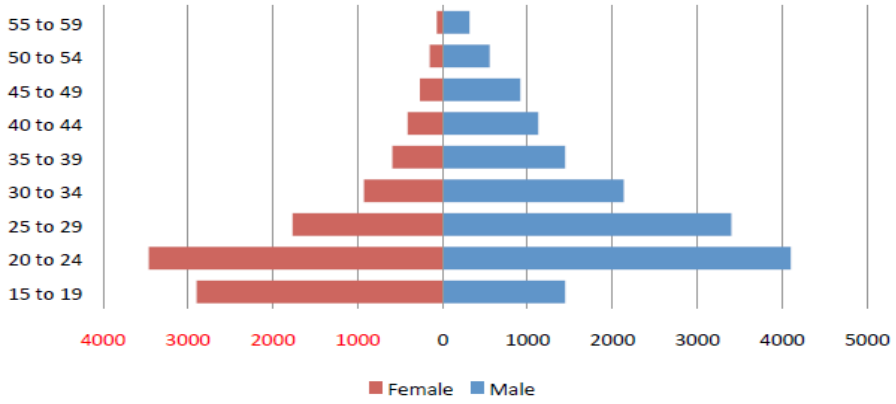
Sexual Health and Teenage Pregnancy

The following section presents key sexual health data specific to young people and where possible, updates the information available in Kingston Sexual Health Needs Assessment 2012 (SHNA) which provides a detailed analysis on sexual health in Kingston. To enable cross-referencing with the SHNA, the same statistical neighbours are used here and differ from those used in the rest of this needs assessment.

Sexually Transmitted Infections

Figure 34 illustrates the affect Sexually Transmitted Infections have by age and gender. Young women aged 15-19 are disproportionately affected compared to young men but there are higher rates of STIs among men from age 20. The difference between the rate of infections among men and women then increases with age.

Figure 34: Rates of acute STI diagnosis, per 100, 000 population by Gender, Kingston



Source: GUMCAD disaggregate dataset (April 2012)

Chlamydia

Chlamydia is the most common sexually transmitted infection among young people. Table 24 presents the rate of chlamydia diagnosis per 100,000 PCT population aged 15-24 years and shows that the rate for Kingston PCT in 2009, 2010 and 2011 was lower than for Kingston's statistical neighbours of Croydon, Sutton and Merton, and Wandsworth. This may be a reflection that Kingston has lower percentage of screening for chlamydia in non-GUM settings compared to these statistical neighbours and in comparison to the England and London averages.

Table 24: Rate of Chlamydia diagnosis among individuals aged 15-24 years, per 100,000 PCT population aged 15-24 years, in 2009, 2010 and 2011.[4]

	2009		2010		2011	
Ward	**Number**	**Rate**	**Number**	**Rate**	**Number**	**Rate**
Kingston PCT	475	1922	382	1545	399	1647
Croydon PCT	1,485	3504	1,539	3631	1453	3449
Richmond and Twickenham PCT	323	1773	292	1602	272	1502
Sutton and Merton PCT	921	2046	946	2101	436	2,001
Wandsworth Teaching PCT	913	3011	933	3077	917	3, 088
London	**24,125**	**2437**	**24,821**	**2507**	**-**	**-**
England	**150,977**	**2199**	**152,365**	**2219**	**-**	**-**

Source: Sexual Health Balanced Scorecard. Available at: http://www.apho.org.uk/default.aspx?RID=96528&TYPE=FILES

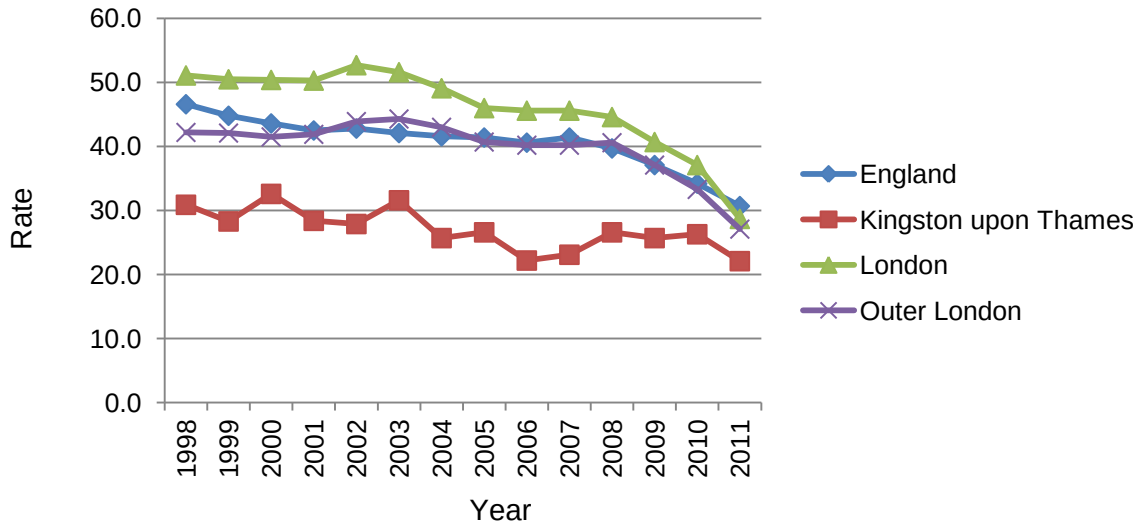
Teenage Pregnancy

In 2011, the under-18 conception rate for Kingston was 22.1 under-18 conceptions per 1,000 population (15-17 years), this is lower than the national average of 30.7 per 1000. [5]

[4] Includes diagnoses made by the NCSP, GUM clinics and sexual health services outside these settings e.g. GPs not registered with the NCSP, youth settings, pharmacies.

[5] Areas with low incidence of under 18 conceptions are susceptible to small changes in the number of conceptions which can lead to random variation as reflect in the graph above.

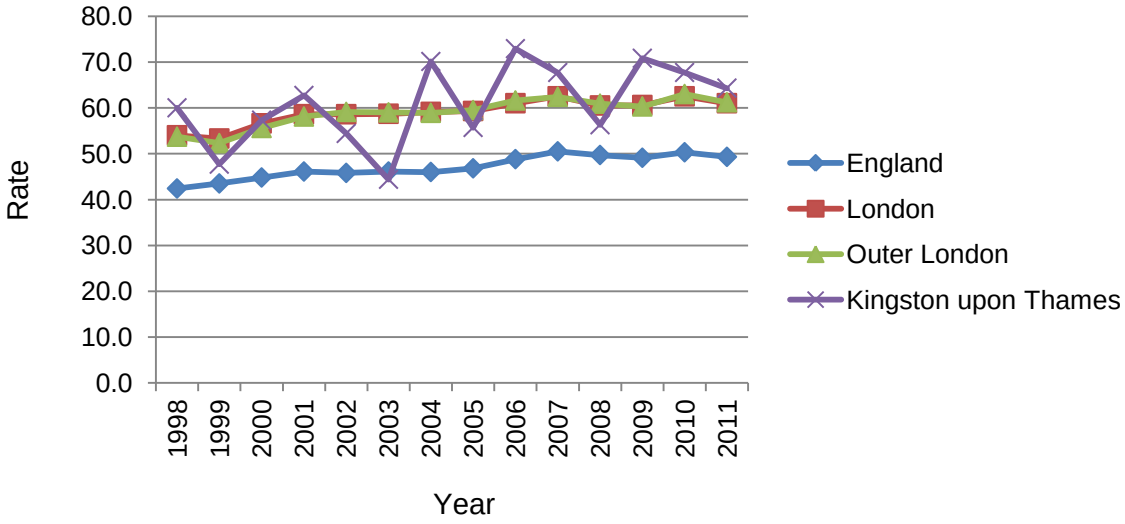
Figure 35: Under 18 Conception Rate per 1000 young women under 18 (15-17 years), 2011



Source: ONS, 2012

Of the under 18 conceptions in 2011, 64.3% led to termination of pregnancy, compared with the England average of 49.3%. The graph below shows that the percentage of conceptions leading to abortion is consistently higher in Kingston than for London, Outer London and England.

Figure 36: Percentage of under 18 conceptions leading to abortion 1998-2011



Source: ONS, 2012

The latest available data for under 16 conceptions is for three year aggregate figures for 2008-10 and 2009-11. Table 25 shows that the under-16 conception rate for Kingston remained stable at 4.4 per 1000 young women aged under 16 for 2008-10 and 2009-11. This is lower than for London, Outer London and England. Of the teenagers aged under 18 years who conceived, 4.3 per 1,000 were aged under 16 years. The percentage leading to abortion was 75.8% between 2008-10 and 84.4% in 2009-11 higher than for London, Outer London and England.

Table 25: Under 16 conceptions (numbers and rates and outcome) three year aggregates, 2009-2011 and 2008-2010.

	2008-2010			2009-2011		
	Number of Conceptions	Conception rate per 1,000 women in age group	Percentage of conceptions leading to abortion	Number of Conceptions	Conception rate per 1,000 women in age group	Percentage of conceptions leading to abortion
Kingston upon Thames	33	4.4	75.8	33	4.4	84.8
Outer London	1,720	7.3	67.2	1,571	6.4	67.0
London	2,828	8.0	67.6	2,560	6.9	67.9
England	20,153	7.2	61.6	18,683	6.7	61.1

Source: ONS 2012

Repeat Abortions

Latest available data for this age group on repeat terminations relates to 2010 when the count for Kingston was suppressed due to low numbers (less than 10). Prior to this, data for 2009 shows that 15% of abortions in females aged under 19 years in Kingston were repeat abortions.

Table 26: The number and percentage of abortions in females aged under 19 years in 2009 and 2010 where individuals have had a previous abortion in any year.

	2009			2010		
Area	**Number of Repeat Abortions**	**Percentage (%)**	**95% CI**	**Number of Repeat Abortions**	**Percentage (%)**	**95% CI**
Kingston PCT	12	15.0	8.8 - 24.4	suppressed	suppressed	-
Croydon PCT	44	17.2	13.1 - 22.3	57	24.5	19.4 - 30.4
Richmond and Twickenham PCT	suppressed	suppressed	-	11	17.7	10.2 - 29.0
Sutton and Merton PCT	33	14.8	10.7 - 20.1	34	18.9	13.8 - 25.2
Wandsworth Teaching PCT	18	17.1	11.1 - 25.5	23	20.4	14.0 - 28.7
London SHA	812	17.4	16.3 - 18.5	748	16.9	15.9 - 18.1
England	2985	11.1	-	2,757	11.0	-

Source: Sexual Health Balanced Scorecard. Available at: http://www.apho.org.uk/default.aspx?RID=74102&TYPE=FILES

The low proportions of repeat conceptions and consistently high proportions of terminations, for both the under-18 and under16 age groups, is an indication that the conceptions were predominantly unintended. This highlights the need to provide strong relationship and sex education and improve uptake and use of contraception among under 18s. It should be noted that the number of implants removed at the Wolverton clinic is equal to the number fitted, this is explored further on page 109). However, the sexual health needs assessment 2012 notes that there is a lower percentage of abortions occurring in those living in socially disadvantaged areas.

Under 18 Conceptions by Ward

There is variation in the **number** of conceptions and the **rate** of conceptions between wards. The numbers of under-18 conceptions per ward in 2007-09 shows that Chessington South and Norbiton wards have the highest number of conceptions (Figure 37). The rate of under-18 conceptions per 1,000 women aged 15-17 by ward in 2007-09 (Figure 38) shows that Norbiton, Chessington South, and Grove wards have the highest rates of under-18 conception in the borough. It is of note that Grove ward has one of the lowest 15-17 female populations in Kingston.

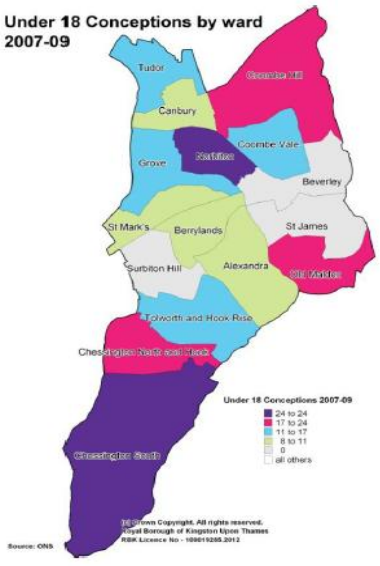


Figure 37

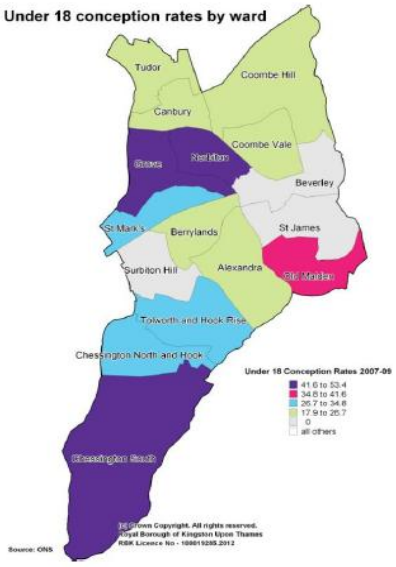


Figure 38

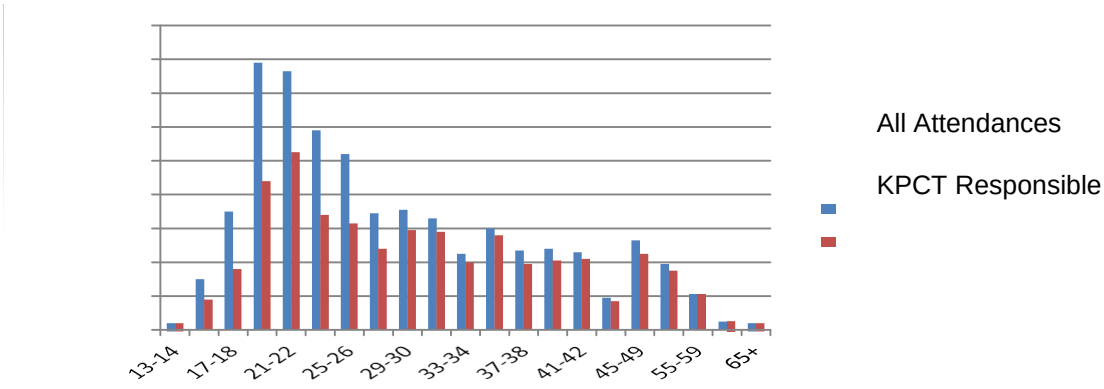
Source: ONS, 2011

Access to Services

There are a wide range of services providing sexual health services within Kingston and significant steps have been taken to increase the availability of condoms and chlamydia testing, and to integrate Level 3 sexual health services to provide a more holistic approach. This is fully documented in the Kingston Sexual Health Needs Assessment 2012 and what are presented here is key data drawn from the needs assessment.

The following figure shows that young people aged people between the ages of 21-16 had the highest number of attendance at Community Contraceptive Clinics for 2010-11.

Figure 39 provides a breakdown by age of people accessing Community Contraceptive Clinics by age for 2010-11 services (Total number of attendances and number of attendances by KPCT responsible clients.)



Source: RiO. Provided by Mary Taylor, Your Healthcare, 22.11.11

KU19 Service

The KU19 service is a free and confidential walk in health service for young people aged 19 years and under provided by the School Health Service. It provides sexual health and contraception services and general health advice. KU19 clinics are held at four sites in Kingston. Drop-in services are in every school and enhanced drop-in sessions are provided at 5 schools.

Figure 40 shows the number of attendances at KU19 clinics and enhanced school drop-ins for 2010-11 and Quarters 1-2, 2011-12. Of the KU19 clinics, the YMCA in Surbiton had the most attendances during this period. The Connexions clinic closed in 2010/11 and has been replaced by the clinic at Guildhall 1. Overall there were a total of 1237 attendances at KU19 services during 201-11 and 684 for Q1-2, 2011-12.

Attendance at KU19 enhanced school drop-ins is very low at Chessington Community College and Coombe Boys' School with only 17 attendances in total in Quarters 1 & 2 of 2011/12. The School Health Service is currently working with the schools to address this.

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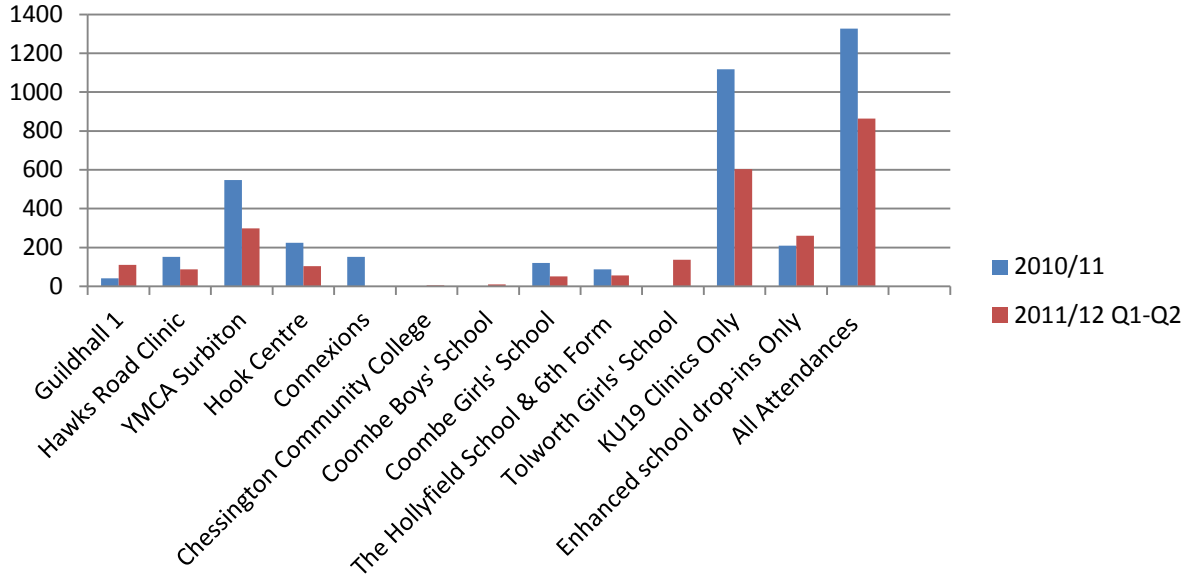
Figure 40: Number of attendances at KU19 Clinics and Enhanced school drop-ins.



Source: RiO. Provided by Mary Taylor, Your Healthcare, 28.10.11

Further analysis within the Sexual Health Needs Assessment shows that for KU19 clinics:

- 80% of young people attending were female
- attendance peaked in 16 - 18 year olds (2010/11)
- attendance peaked in 14-15 year olds (Q1 and Q2 of 2011/12)

Further analysis of the remaining quarter's data for KU19 would be useful combined with an understanding of the areas of residence for the young people attending this service. This would ascertain if the YMCA continued to have the most attendances and provide an understanding of the population accessing the service. Following this, it may be worth considering extending this to an enhanced drop-in service if the environment at the YMCA can accommodate this.

Table 27 provides a breakdown of activity at the KU19 service for 2010-11 and 2011-12. The activity over this period is predominantly sexual health related however young people have also received support for smoking and substance misuse, with the largest proportion receiving 'health promotion'. A further breakdown of what is recorded as health promotion and the issues covered within this would be useful to better understand the needs of the young people accessing the service.

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Table 27: Summary of activities performed by the KU19 service, in all clients, including KPCT non-responsible clients.

Activity	2010/11	2011/12 Q1&2
Male condoms	887	626
Female condoms	12	4
Oral contraceptive - combined preparation	435	255
Oral contraceptive - progestogen only	65	39
Injectable contraceptive	57	34
Implant consultation	0	1
Emergency contraception - oral hormonal	100	46
Subtotal contraception services	**1556**	**1005**
Chlamydia Test	235	118
STI Consultation	15	36
Pregnancy test only	166	89
Termination of pregnancy referral	19	8
Psychosexual consultation	4	4
Health Promotion	163	463
Smoking information given	18	2
Substance Use	6	0
Subtotal other services	**626**	**720**

Source: RiO. Provided by Mary Taylor, Your Healthcare, 28.10.11. Analysis by K Hunter.

Young Livin' Bus and SHARXX

The Young Livin' bus attends eight of the ten secondary schools 4-5 times a year. The youth workers can provide verbal sexual health advice at these sessions and signpost young people to the SHARXX service when required. SHARXX is a sexual health drop-in service for young people aged 13-19 years which takes place on the YoungLivin' bus on Thursday afternoons.

Table 28: Number of attendances and activity on SHARXX bus. (Includes Kingston and non-Kingston residents.)

	2009/10 Q1 & Q2	2009/10 Q3 & Q4	2010/11 Q1 & Q2	2010/11 Q3 & Q4	2011/12 Q1 & Q2
Number attending SHARXX bus	324	185	235	395	281
Number of new registrations for C-card	N/A	101*	152	97	137
Number of Chlamydia test kits provided	21	31	30	56	26
Number of Pregnancy test kits provided	N/A	N/A	0	1	6
Reasons for fluctuation in activity		Bus off the road for 2 months for major works.	Pregnancy Test training completed.		Bus not in operation during Summer Holidays.

N/A = service not available

*paper C-card scheme. Electronic C-card scheme commenced in March/April 2011.

Source: Provided by Gillian Hall, Service Manager - Youth Support Service, Directorate of Learning & Children's Services, Royal Borough of Kingston 2.11.11

'The Point' at The Wolverton Centre

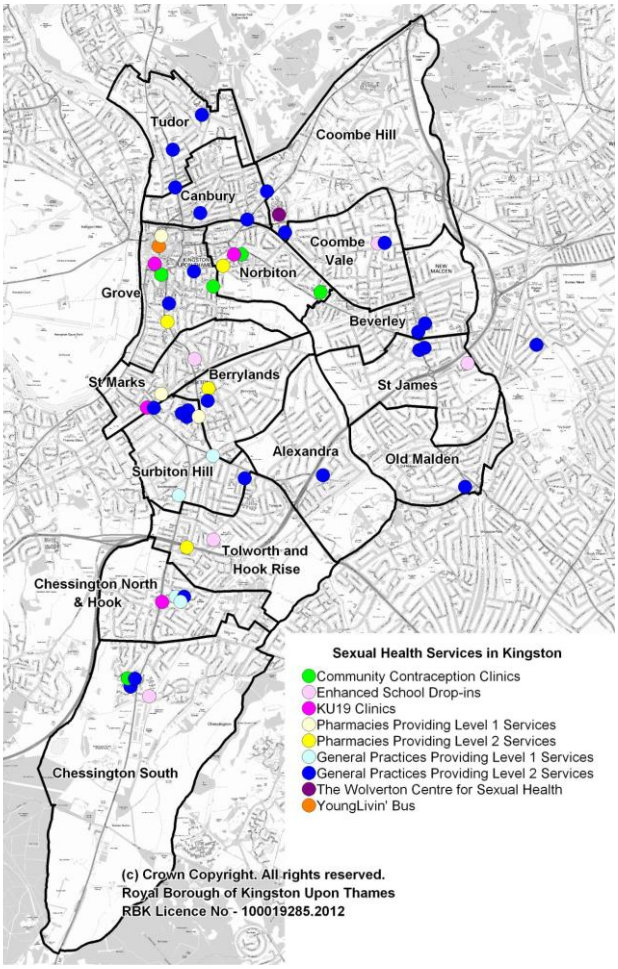
This is a specific walk in sexual health and contraceptive service for young people aged 18 years and under. It runs on a Tuesday from 4-6 pm. All services are delivered on location and it provides a full Level 3 sexual health service for young people.

An interview for this needs assessment with Clinical Nurse Specialist at The Wolverton highlighted that very few young people attend from Hook and Chessington areas where they would expect to see a higher level of attendance from young people. There were also some schools where there was low level attendance from young people including: Chessington Community College, Surbiton High, Surbiton Grammar (previously Kingston Grammar) and Tolworth Girls School. Schools with high levels of attendance at the Wolverton include: Kingtson College, Esher College, Richmond College, Coombe Girls School, Holy Cross and schools outside of Kingston. Data for inclusion in the needs assessment was requested however the Wolverton were unable to provide data at the time and this should be pursued.

Location of Services

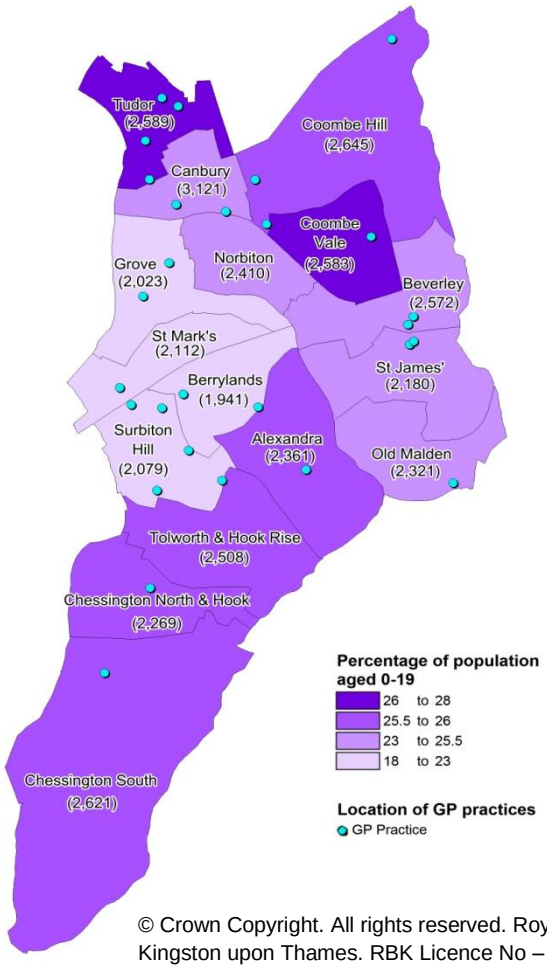
General Practices record little data in relation to children and young people which can be analysed at an aggregate level. What data is available can provide a general sense of the reach of practices. Figure 41 shows the location of sexual health services in Kingston by ward. Figure 42 shows the percentage of each ward's population made up of 0-19 year olds. The number of 0-19 year olds residing in each ward is dispalyed in brackets, with the location of GP surgeries also indicated. Kingston's distribution of heath provision on the whole reflects the distribution of the 0-19 people with Tudor and Coombe Vale having the highest percentage of 0-19s and access to a range of services. Areas requiring consideration are Tolworth Hook and Rise with a relatively high percentage of 019s (25.5-26%) but few sexual health services and one General Practice (GP) which is on the border with Surbiton Hill and Alexandra with a similar percentage of 0-19s and only one GP.

Figure 41: Sexual Health Services in Kingston 2012



*Map replicated from the Sexual Health Needs Assessment, p.15 original source David Holloway, Strategic Business, Royal Borough of Kingston 19.3.*12

Figure 42: Location of 0-19 year olds and GP Practices by Ward



Source: ONS 2011 Census

The following table is a summary of the support and services provided in schools by the School Health Service and Youth Service. In particular this highlights gaps in provision at Special Schools and boys schools. Sessions have been tried by the SHS at the boys schools and these have been discontinued due to low attendance. There is therefore a need to consider alternative methods of the SHS delivering support to young men. Texting services are one example that has proved effective in reaching young men in other areas of the country (e.g. Shropshire).

Table 29: School Health and Youth Service in Kingston Schools

	School Health Service			Youth Service		
Secondary School	PSHE Sessions	School Health Service Offer	Enhance Drop-ins	Destinations Programme	Targeted Youth Support 1-1	Young Livin Bus/ SHARXX Drop-in
Coombe Girls School	✓		✓	✓	✓	✓
Coombe Boys School	✓	-	✓	✓	✓	✓
Chessington Community College	✓		✓	✓	✓	✓
Southborough High Scholl	✓		-	-	✓	✓
Tiffin Girls School	✓	✓	-	-	No Service	✓
Tolworth Girls School	✓		✓	-	-	✓
Tiffin Boys School	✓	-	-	-	No Service	✓
Richard Challoner School	✓	-	-	-	-	✓
Holy Cross School	✓	✓	-	-		No Dro-pin

Hollyfield School and 6th Form Centre	-	-	✓	✓	✓	No Drop-in
Meclanberg PRU	✓	-	-	✓	✓	-
PRU Malden Oaks School	✓	✓	-	✓	✓	-
SS - St Philips – YP LD Bhr	-	-	-	Specialist work with LGBT	-	-
SS - Beadisford	-	-	-	-	-	-
SS - Dicehart	-	-	-	-	-	-

LGBT - Lesbian, Gay, Bisexual, Transgendered

SS - Special Schools

DP - Destinations Programme - Year 11 support to schools to help identify where young people who are not expected to get GCSE's will go post 16 looking at future possibilities and courses. Aimed at Year 11s who could possibly disengage. Focus on destination but youth workers will address any issue that would reduce there continuation / engagement in education.

Young Livin Bus Drop-ins to raise awareness to services and health promotion. School drop-ins are held every week on a rota basis – schools get 2-3 visits per term.

The following is a summary of the indicators related to risk-taking behaviour and the 3 ward with the highest levels of these to inform targeting of provision.

Table 30: Summary of the indicators related to risk-taking behaviour and the 3 ward with the highest levels of these[6]

	Highest % 0-19s (2011 Census)	Highest Number 0-19s (2011 Census)	Child Poverty (HMRC 2010)	Eligibility for FSMs (2011 Census)	SEN (Primary & Special Schools) (2011 Census)	NEETs (DfE, 2011)	1st Time Entrants Youth Justice 2010-13 (YJB, 2011)	Under 18 Conception Rate 2007- 09 (ONS, 2011)
Alexandra								
Berrylands								
Beverley						X		
Canbury		X						
Chessigton North & Hook			X		X		X	
Chessington South		X		X				X
Coombe Hill		X		X				
Coombe Vale	X							
Grove								X

[6] Exceptions are: SEN for which was unavailable and highest percentage 0-19s as a number of wards have a similar percentage which would rank 3rd of all words.

Norbiton			X	X	X	X	X	X
Old Malden								
St James								
St Marks								
Surbiton Hill								
Tolworth & Hook Rise			X				X	
Tudor	X					X		

Vulnerable Groups

The following section provides a summary of the vulnerable groups in Kingston identified through the needs assessment from a combination of the epidemiology, interviews with professionals and
feedback from young people.

- LAC & Care Leavers
- Young people with low level mental health concerns
- Young people with Mild Disability – e.g. Aspergers, ADHD, LD
- First tie entrants into the Youth Justice System
- Young Parents
- Young people for whom risk behaviour is a family norm; parents, siblings

It should be noted that **young carers** where not identified as a group who are vulnerable to risky behaviours however this maybe due to their hidden nature and may require further investigation.

Further discussion is provided on these groups is provided through out the report.

Sources of data

National

Child and Maternal Health Observatory: http://www.chimat.org.uk/

Department for Communities and Local Government (DCLG), for the Indices of Deprivation: www.communities.gov.uk

Department for Education (DfE), for School Performance Tables and national School Census results: www.education.gov.uk

Department for Work and Pensions (DWP), for data on benefits claimants: statistics.dwp.gov.uk/asd

Her Majesty's Revenue and Customs (HMRC), for child poverty data: www.hmrc.gov.uk/thelibrary/national- statistics.htm

Hospital Episode Statistics, http://www.hesonline.nhs.uk/

Health Protection Agency, http://www.hpa.org.uk/webc/hpawebfile/hpaweb_c/1317132268970

NHS Information Centre: www.ic.nhs.uk

Office for National Statistics (ONS), for a wide range of statistics and results of the 2001 and 2011 Censuses: www.ons.gov.uk; www.neighbourhood.statistics.gov.uk

Sexual Health Balanced Scorecard. Available at: http://www.apho.org.uk/default.aspx?RID=96528&TYPE=FILES

Regional

North West Public Health Observatory: http://www.nwph.net/nwpho/

South London Sub Regional Unit, www.rbksru.org.uk/reports.htm

Local Data Sources

GLA, http://data.london.gov.uk

Greater London Authority (GLA), statistics and population projections: data.london.gov.uk

London Health Observatory, : www.lho.org.uk

Royal Borough Kingston (2012) Joint Annual Public Health Report Kingston Chapter 3

Royal Borough Kingston, Strategic Business, Royal Borough of Kingston

Royal Borough Kingston, Kingston Youth Offending Service (Joe Bond)

Your Healthcare, (Mary Taylor)

Looked After Children's Nurse (Jill Ward)

Maps

All maps provided by Kingston Data Observatory, Strategic Business, Royal Borough of Kingston.

Please note, as of 1st April the HPA and ChiMat are moving to Public Health England and data can be accessed through the PHE website as yet unavailable.

Review of the causes of young people's risk behaviour

A key aim of the needs assessment was to:

- Identify the causes and links between the specified behaviours that lead to poor health outcomes for young people

This section of the report responds to this aim.

Note: Evidence concerning the causes of health issues tends to focus on the relevant behaviour concerned. This piece of work identified five health issues of interest: teenage pregnancy, sexual health, smoking, substance misuse (drugs and alcohol), and emotional health and wellbeing. For the purposes of consistency it was necessary to categorise the first two issues as health behaviours. There is a large overlap in the health behaviours associated with teenage pregnancy and sexual health (condom use, contraceptive use, frequency, number and concurrency of partners), and many studies/reviews focus on behaviour alone without specifying a health outcome. As a group, the health behaviours for teenage pregnancy and sexual health all represent 'sexual risk behaviour' and will be referred to as such throughout the remainder of this section. Categorising 'emotional health and wellbeing' is more problematic. This is more accurately classified as a health status/outcome, but unlike for teenage pregnancy and sexual health, there isn't an established single behaviour or group of behaviours associated with this. This had implications how this health issue was treated in our review (see method below).

Our approach to addressing the above aim was both to identify links between the health behaviours themselves, and also amongst their causes. This is because a clustering of risky health behaviours (whereby individual's engaging in one health risk behaviour tend to also engage in others) suggests that there is potential to identify and target those at risk of multiple problems. Furthermore, evidence that these risk behaviours have common determinants suggests that modifying these may result in favourable changes across multiple behaviours. Such an approach would fit well within an integrated programme focusing on early intervention and prevention, and is particularly attractive under current economic conditions in which services are becoming increasingly stretched. It is also novel given that interventions targeting health improvement are largely health-behaviour specific, focusing for example on smoking, sexual behaviour or substance misuse in isolation. Moving in this direction would enable RBK to demonstrate innovation in addressing adolescent health risk behaviour which is likely to be of interest to Public Health England (PHE) who have indicated that this will be their future approach [personal communication with author].

Method

Four literature reviews (one each for sexual risk behaviour, smoking, substance misuse and emotional health and wellbeing) were conducted to identify existing reviews which examined their determinants (see appendix D for example search strategy). For sexual risk behaviour, smoking, and substance misuse the search strategy included search terms related to behaviour. For emotional health and wellbeing, the search strategy used terms relating to relevant health outcomes such as 'wellbeing', 'happiness', 'depression'. Searching for existing reviews in this way constitutes a review of reviews. This is a strong approach as the

findings of reviews, which have already identified and synthesised available evidence, are combined. It does however mean that important studies not yet included within reviews will have been missed. Limits were put on the search to make it manageable. All searches were limited to the database PsycINFO. For all health issues except emotional health and wellbeing, the searches were also limited to papers published from 2000 onwards. We only included papers which were immediately accessible (i.e. available electronically or through the university library). No date limit was put on the search for papers relating to emotional health and wellbeing as the evidence base on this health issue is markedly smaller. These limits mean that reviews published prior to this 2000 (for three of four issues) or made available through other databases will not have been captured in this search. These limits were necessary due to the time constraints of this piece of work. The findings should be interpreted in the light of these limitations. The authors contributed further reviews in the field of sexual health and smoking through their own existing knowledge in these areas (some of which dated back prior to the year 2000).

In addition to the evidence review, determinants of the health issues were also identified through interviews with professionals, focus groups with young people, and a survey completed by young people (as described in the introduction section). This new data collection was used to supplement the evidence review and also to identify whether there were any particular local issues that needed addressing.

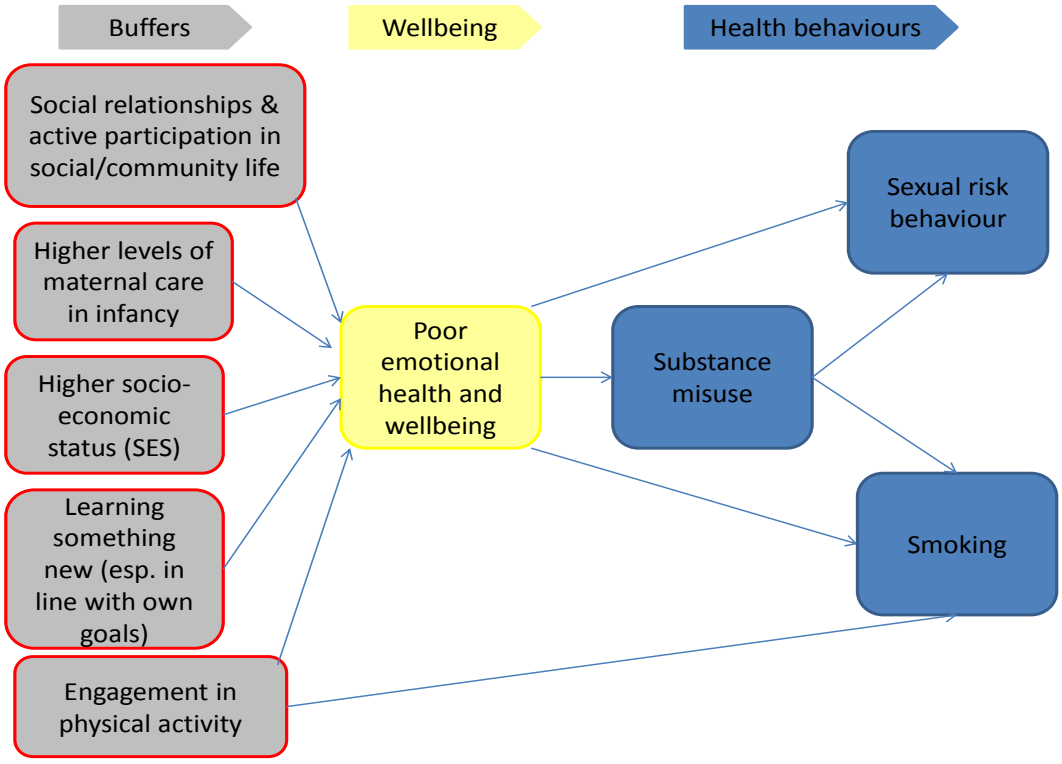
Do the health issues of interest cluster?

Our review of reviews aimed to identify the causes of the health issues of interest. A number of these reviews identified engagement in other risky health behaviours as a risk factor in itself. Specifically, substance misuse was found to be associated with engagement in sexual risk taking and smoking. Strong clustering between alcohol and smoking has been reported elsewhere (Wiefferink et al. 2006). Poor emotional health and wellbeing was found to be a strong predictor of all of the other health behaviours.

It has been suggested that young people who have poor emotional health and wellbeing use drugs, alcohol and sex to fill the void of their lives, and that these behaviours only serve to exacerbate the problem (Huppert 2009). Much of the available evidence regarding the predictors of wellbeing is correlational in nature meaning that the direction of association has not been substantiated. It may well be that poor emotional health and wellbeing is both the cause and consequence of the health behaviours of interest. Interventions targeting improvements in the emotional health and wellbeing of young people are likely to have a positive knock-on effect on sexual risk behaviour, smoking and substance misuse. Improvements in these behaviours may then also further raise emotional health and wellbeing.

The relationship between the three health behaviours and emotional health and wellbeing is demonstrated in figure 43. The ‘buffers’ shown have been identified from the review as predictors of positive emotional health and wellbeing and give an indication of what may constitute a successful intervention.

Figure 43 clustering of the health behaviours and their relationship with emotional health and wellbeing



The evidence around clustering of health issues suggests two things. Firstly the clustering between sexual risk behaviour, smoking and substance misuse suggests that approaches should attempt to identify and target individuals at risk of one or more of these in order to have maximum impact. Secondly, the strong link between poor emotional health and wellbeing and all of these behaviours indicates that improving the emotional health and wellbeing of young people could have a positive knock-on effect across all of the remaining health behaviours.

Are there links between the causes of the health issues?

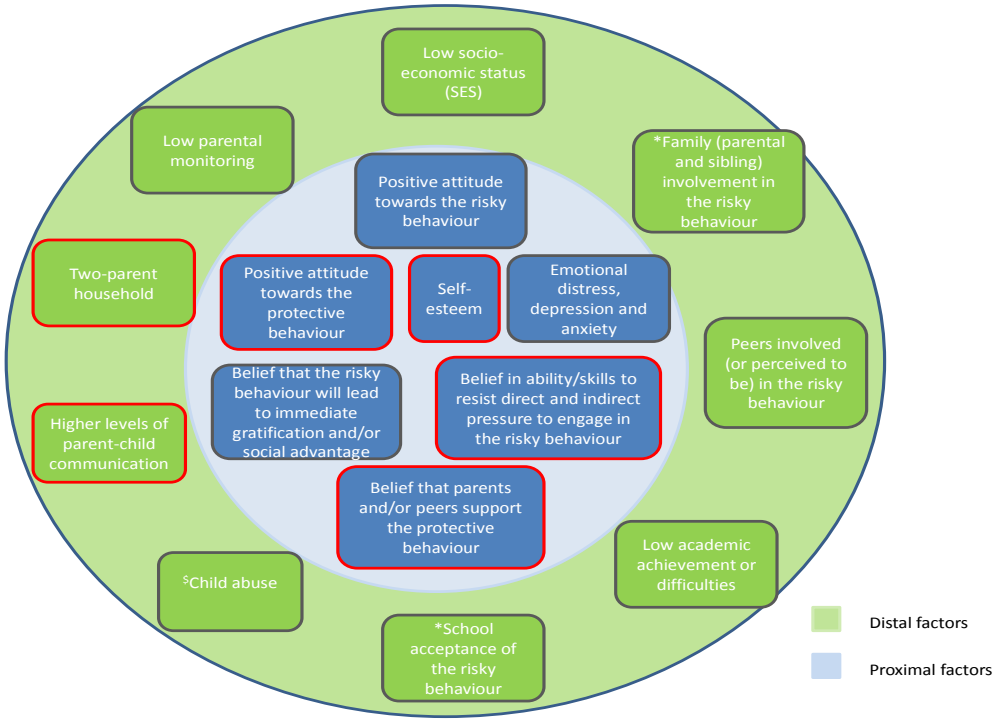
Determinants of health behaviours can be categorised at the proximal level and at broader distal and ultimate levels (Flay, Snyder and Petraitis 2009). Those at the ultimate levels (e.g. cultural and social environment) are thought to predict multiple health behaviours but also to be almost un-modifiable. Those at the distal and especially the proximal levels (e.g. knowledge, beliefs), tend to have less predictive value but to be more amenable to change. Note: whilst proximal determinants tend to have less predictive value than those at ultimate/distal levels, this is not to say that they there is not a strong relationship; evidence suggests that in some cases there is and that developing interventions to change them is worthwhile.

Following identification and reading of relevant reviews, determinants listed in the papers were categorised as ultimate/distal or proximal. For ultimate/distal determinants, we derived

suitable overarching categories such as 'family dynamics'. For the proximal factors, determinants were categorised according to Michie et al's (Michie, Atkins and West In preparation) COM-B model components. The COM-B model is a theoretically derived model which describes 'essential conditions required for behaviour change to occur: capability, opportunity and motivation' (Michie, Atkins and West In preparation). This approach was taken as categorisation of proximal factors as COM-B components enables identification of suitable Behaviour Change techniques (BCTs) to target them. Determinants were categorised in this way under columns for each of the health issues (see appendix E). Whether evidence was drawn from narrative or systematic / meta-analytic reviews was denoted using colour coding (see key with table) as the latter represents greater strength of evidence.

Whilst there were few shared determinants between emotional health and wellbeing and the health behaviours (sexual risk behaviour, smoking or substance misuse)[7], there was a high degree of overlap amongst the health behaviours. Overlap between these behaviours has also been documented elsewhere (Peters et al. 2009b). Determinants shared across two or more of these were identified. These are depicted in figure 44 below.

Figure 44 Shared determinants of sexual risk behaviour, smoking and substance misuse at the ultimate and distal/proximal levels



$ Sexual abuse associated with sexual risk behaviour (boys and girls); sexual/physical abuse associated with substance misuse
* Smoking and substance misuse only

[7] This is unsurprising given the distinction between the other issues which are all classified as health behaviours.

Cells with a red outline represent protective factors (i.e. reduce the likelihood of risk behaviour) and those with a black outline represent risk factors (i.e. increase the likelihood of risk behaviour)

The overlap of determinants across the three health behaviours as shown in figure 44 indicates that there are opportunities for a more integrative approach. Those depicted should be the target of health education/promotion initiatives aiming to have an impact across two or more of the targeted behaviours.

Interviews with professionals and focus groups with young people confirmed the findings of the evidence review. In particular young people spoke about the influence of friends, family, school and society/the media.

Friends and family:

'I used to hate smoking and I always wanted my mum to quit smoking, ... then everyone was doing it and I thought why not ..... and then I tried it and thought "well it's not that big a deal" 'my dad buys my tobacco' ...how do you feel about that?... 'I'm thankful, I don't have the money to buy it for myself' [Young female]

'I do smoke. I started in college, peer pressure again. Everyone was outside having a fag and I was the only one inside on my lonesome. So I went outside.' [young male]

'I know when I got into the wrong social group I did wrong things when I was younger'. How do friends influence you? 'Pressure ... trying drugs, having sex things like that.' [young female]

Influence of school:

'How do schools deal with smoking drinking etc. Do they come down hard on it? ....'No not really. They know we do it. We go to the back of the fields and they now we're there and they tried to ban it but they don't monitor it' [young female]

The pressure of media and society was also mentioned:

'Young people on the whole feel a lot of pressure to have sex. Whether it comes from TV, film, magazines, the media. Society has pressured young people into having sex early, access to porn is easy and that leads to pressure from boys and expectations of body image' [health professional]

'Young people in general are under so much pressure to have sex. Our society is so sexualised it's ridiculous. Everywhere you look there's something about sex or a half naked woman modelling underway at a bus stop. I think that's wrong. I don't agree with it. If she [child] came to me at 16 and asked me for a boob job I'd go mad. It's disgusting.' [Young Mother]

Whilst pressure from media and society did not come out directly from the evidence review, this may be because of the limitations of the search strategy. Alternatively, this may not have

a strong relationship with actual behaviour even if perceived as such. When pressure from media/society was mentioned it was always in the context of sexual behaviour and not smoking or substance misuse. Pressure from media/society may be having an effect indirectly through perceptions of peer norms which was identified in the review, i.e. a sexualised culture increases perceptions that early sex is the norm amongst peers which puts pressure on young people to have sex at a young age. Either way there is certainly a role for school, parents and other trusted sources to counter unhelpful messages portrayed by the media. In some cases it may be helpful to remind young people of the true picture e.g. that the large majority of school age pupils (75% aged 13-16 years) have not had sex yet (Newby et al. 2012).

In our survey we asked young people to indicate the top three things that influenced whether they engaged in risky health behaviour. The results are displayed in figure 45.

Figure 45. Proportion of survey respondents who endorsed each factor as one of the top three things which influenced whether they engaged in risky health behaviour (based on 118 responses)

	Percent	Count
What people my age are doing	19.5%	23
What my friends will think	28.8%	34
What my parents/carers are doing	11.0%	13
What my parents/carers will think	50.0%	59
The pleasure or enjoyment I will get out of it	46.6%	55
The health consequences	**68.6%**	**81**
Whether I feel confident to make informed choices	43.2%	51
That it will help me feel better about myself	21.2%	25
Other (please specify) Show replies	11.0%	13

Other responses were as follows:

- ONLY: If I feel it is appropriate for ME to do, depending on my age. (the others are because I have to)
- Ignorance towards the consequences

- If I get caught the consequences would be bad.
- Willpower to make the right moral decision i.e. say no to drugs; and abide to it (not be influenced by peers)
- Legality
- I know what is stupid and what isn't
- Common sense
- Cost
- Religion
- If it is safe
- Future prospects e.g. jobs
- What the Bible tells me
- Whether an ephemeral good feeling is worth possible repercussions

The influences listed in figure 45 largely reflect proximal determinants from figure 44:

Survey 'influences'	**Determinants from evidence base**
Belief that parents/peers support the protective behaviour	What my friends will think What my parents/carers will think
Family involvement in risk behaviour	What my parents/carers are doing
Peer involvement in risk behaviour	What people my age are doing
Attitude towards risk/protective behaviour Belief that risky behaviour will lead to immediate gratification/social advantage	The health consequences That it will help me to feel better about myself The pleasure or enjoyment I will get out of it
Belief in ability/skills to resist pressure to engage in risky behaviour	Whether I feel confident to make informed choices

The findings from the survey give some indication of the relative importance to young people of the different influences on their behaviour. Beliefs about the consequences of behaviour (whether health, enjoyment, feeling good about oneself) reflect 'attitude' towards risky behaviour. As a group these were frequently selected by respondents as one of the top 3 influences on their behaviour. Also frequently endorsed were confidence in making informed choices and what parents/carers will think. Given that few additional influences were reported in the 'other' category, the survey data supports the evidence-based selection of determinants.

Of importance, the new data collected from all sources as part of this needs assessment does not indicate that there were any specific localised issues that warrant attention. We can therefore be confident in using figure 44 to guide decisions about intervention focus.

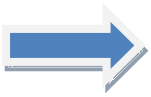
Reducing risky health behaviour through targeting shared determinants

Addressing Proximal Determinants

Distal determinants of the three risky health behaviours represent broad family, social and community factors. Whilst distal determinants are powerful influences, they are not closely linked to the context of specific health behaviours. Proximal factors on the other hand are. For example, one of the proximal factors shown in figure 44 above is 'positive attitude

towards the risky behaviour'. This factor has been derived from evidence that young people who smoke have a positive attitude towards smoking, and young people who misuse alcohol have a positive attitude towards alcohol etc. Interventions targeting multiple behaviours through shared determinants therefore need to adopt a transfer oriented approach in order to transfer the learning from one health issue to another.

The 'Transfer Oriented Approach' (Elshout-Mohr, Van Hout-Wolters and Broekkamp 1999) is a method in which the target audience moves through the following process:



Contextualization (learning new skills etc in one context e.g. refusing sex without a condom)

Decontextualization (deducing a general principle e.g. refusal skills)

Recontextualization (examining its application in other contexts e.g. refusing to accept cigarettes)

It is important that an intervention targets change in a determinant by relating it to a specific behaviour first, before drawing a general principal and applying this in another context. This is because relating it to a specific behaviour gives the principal meaning and depth. Furthermore, beliefs (e.g. about behavioural consequences, norms, ability to perform a behaviour) are most predictive when applied to a specific behaviour (Ajzen 1991).

The first step of developing an intervention to target the specified multiple behaviours, is to identify the active ingredients required to bring about a change in the shared determinants. These active ingredients are known as Behaviour Change Techniques (BCTs). As part of our exercise to identify shared determinants, we categorised proximal factors as domains from the Theoretical Domains Framework (TDF). This is just simply a way of reducing the many potential behavioural determinants into broader domains using an established categorisation system. Using Michie and colleagues' Behaviour Change Wheel guidance for developing health behaviour change interventions (Michie et al. In preparation), we linked the proximal factors from figure 44 to BCTs through their relevant theoretical domain and associated intervention function. This linking is shown in table 31 below.

Table 31. Recommended BCTs to target each of the proximal determinants and suggested strategies for delivering these

Proximal Determinant	Domain	Intervention Function	BCT	Strategies
Positive attitude towards the protective behaviour	Beliefs about consequences	Education Persuasion	• Information about social and environmental consequences • Information about health consequences • Information about emotional consequences • Salience of consequences • Credible source	Encouraging a positive attitude towards an alternative healthy behaviour could be achieved though highlighting the positive consequences of that behaviour (health, emotional, social and environmental), this would be enhanced if presented by a credible source e.g. school nurse, other health professional or other admired/trusted individual, and if powerful methods used to emphasise these (e.g. visuals; methods that encouraged personalisation of info)
Belief that parents and/or peers support the	Social influences	Environmental restructuring Enablement	• Restructuring social environment • social support practical • social support emotional	If important individuals within a young person's social environment

protective behaviour			• social support unspecified • valued self-identity • identification of self as role-model	(parents, friends, siblings etc) are engaging in risky behaviour then they unlikely to be sending out messages that they are supportive of protective behaviour (unless along the lines of 'don't make my mistake' etc). Need to try and break the cycle of generational risk taking behaviour. One way to do this is to introduce strategies that encourage the target audience to engage with more positive social influences (new friends, role models etc) and to draw support from them. Changing/strengthening an individuals' identity as someone who performs healthy behaviour and encouraging them to consider themselves as a role model to important

				others (e.g. siblings) may also be effective.
Belief in ability/skills to resist direct and indirect pressure to engage in risky behaviour	- Beliefs about capabilities - Physical skills - Cognitive and interpersonal skills	Education Persuasion Modelling Enablement Training	• Focus on past success • Verbal persuasion about capability • Instruction on how to perform behaviour • Demonstration of the behaviour • Behavioural practice/rehearsal • Graded tasks • Feedback on the behaviour	Beliefs about ability to resist pressure can be enhanced by focussing on past success and being told/persuaded that they can do it. They then need to be given the opportunity to observe and practice the behaviour (e.g. drama workshops, role-play) to build on these. Instruction and practice could start with easier skills (e.g. saying no in non-threatening environment) building up to more difficult ones (e.g. saying no to coercive friend, partner). Behaviour can be shaped through feedback. If training over successive periods then individuals may have a chance to practice skills in the 'real-world' and then to have feedback on how they got

				on. In addition to learning appropriate responses, young people should be taught to recognise the signs of when being put under pressure to engage in a risky behaviour, and also to recognise when they are putting pressure on others (how this makes others feel, why this is wrong)
Self-esteem	Beliefs about capabilities	Education Persuasion Modelling Enablement	• Focus on past success • Verbal persuasion about capability • Self-talk • Re-attribution • Reduce negative emotions	If low self-esteem with regards to performance of a particular behaviour (e.g. ability to give up smoking; i.e. low self-belief) then this could be built through encouraging individuals to focus on occasions in past when they had success in performing the behaviour (or parts of it), encouraging them to believe in their ability to do it, and

				encouraging the use of positive self-talk before and during the behaviour. If an individual has a tendency to attribute difficulties/problems to their own failings, then encouraging them to think of alternative (e.g. external) explanations may help If low self-esteem is a more global issue then additionally it may be helpful to refer individuals to a suitable talking therapy etc.
Emotional distress, depression, anxiety	Emotion	Persuasion Incentivisation Coercion Modelling	• Reduce negative emotions • Pharmacological support	Refer individual to services that can help reduce distress, depression and anxiety through talking therapy and/or pharmacological support

		Enablement		(e.g. anti-depressants)
Positive attitude towards the risky behaviour	Beliefs about consequences	Education Persuasion Modelling	• Information about social and environmental consequences • Information about health consequences • Information about emotional consequences • Salience of consequences • Credible source	Encouraging a reduction in positive attitude towards a risky behaviour could be achieved though highlighting the negative consequences of that behaviour (health, emotional, social and environmental), and suggesting alternative ways of achieving the positive consequences (e.g. if smoke in order to facilitate communication in social environments, suggest other ways of doing this; if condoms thought to reduce sexual pleasure then offer advice on range available and suggest trying different brands, sizes, lubricants etc). This would be enhanced if presented by a credible source e.g. school nurse, other health professional or other

				admired/trusted individual, and if powerful methods used to emphasise these (e.g. visuals; methods that encouraged personalisation of info).
Belief that the behaviour will lead to immediate gratification and/or social advantage	Beliefs about consequences	Education Persuasion Modelling	• Information about social and environmental consequences • Information about health consequences • Information about emotional consequences • Salience of consequences • Credible source	Identify and encourage individuals to focus on immediate positive consequences of healthy behaviour (e.g. how good will feel if have strength to refuse cigarette) and negative consequences of unhealthy behaviour (e.g. anticipated regret after unprotected sex); also methods to increase the salience of long-term consequences and to personalise these maybe effective.

The above table provides strategies, grounded in our review of the evidence, which we recommend for targeting shared determinants of the three health behaviours. Thought needs to be given as to how these strategies could be delivered, and in particular how to deliver these using the above Transfer Oriented Approach. The most obvious vehicle for delivery is via school Personal, Social and Health Education (PSHE), but youth services could also adopt a similar and complimentary model, for example for focussed work with young people identified at increased risk. Whilst the time dedicated to PSHE in schools is restricted, this approach, which covers a number of health issues in conjunction, is an efficient way to do this and as such likely to appeal to schools. Given that school nurses are quite well embedded across schools in Kingston and are already delivering elements of PSHE that address multiple health risks in conjunction (see section 'Prevention, including PSHE' within the section 'Kingston integrated practice to address risk taking behaviours), it is suggested that in the first instance RBK look at how this provision can be further enhanced.

There is also scope for core work within PSHE to be complemented by services across RBK. For instance service providers working with young people could offer brief supportive interventions. Once more, thought would need to be given as to exactly how this could work in practice, but professionals could be trained to provide brief advice to encourage change in a particular factor identified as driving unhealthy behaviour, to identify other risky behaviour that the individual is engaging in, and then to encourage them to transfer that learning.

Addressing Distal Determinants

With reference back to figure 44, there are some distal determinants which are beyond the scope of public health to influence. These include socio-economic status and child abuse. There are others however that should be considered.

Familial environment: evidence suggests that risky health behaviour is more likely if other members of the family e.g. parents, siblings perform that behaviour. Parents/carers should be made aware of this link and encouraged to use this as a motivation to change their own behaviour and to provide messages that support healthy alternatives. Parents/carers should also be made aware that higher levels of parent-child communication (quantity and quality) and parental monitoring are protective of health risk behaviour amongst their children. Consider providing advice to parents of pupils transitioning from primary to secondary school on communication and monitoring.

School environment: evidence suggests that schools which have a level of acceptance of smoking and substance misuse can facilitate this behaviour. It is recommended that schools develop and promote strong anti-smoking and substance misuse policies (i.e. zero tolerance) and reduce opportunities for these behaviours on site. Processes should be in place to ensure that those at risk of risky health behaviour are indentified (see 'early identification and screening' within the section 'Kingston integrated practice to address risk taking behaviours') and receive more focussed and personalised interventions.

Community and youth development programmes

There are a number of promising programmes which have been developed (predominantly with the aim of reducing teenage pregnancy) which target broader social and environmental factors. For a review see Kirby and Coyle (). Specifically they aim to reduce teenage pregnancy by focussing on

education, employment and life skills. The theory is that by providing greater opportunities, and encouraging and supporting young people to take them, that young people will be more motivated to avoid pregnancy. It may well be however that these same programmes could be effective in reducing motivation to engage in a range of other unwanted behaviours such as smoking and substance misuse. Kirby and Coyle (Kirby and Coyle 1997) describe these programmes as follows:

'A youth development framework provides mechanisms for youths to fulfil their basic needs, including a sense of safety and structure, a sense of belonging and group membership, a sense of self-worth and contribution, a sense of independence and control over one's life, a sense of closeness and relationships with peers and nurturing adults, and a sense of competence. Once these needs are fulfilled, youths can more effectively build competencies necessary to become successful and productive adults, and they may become more motivated to avoid early childbearing'.

It is recommended that RBK examine the range of existing youth development programmes and their effectiveness, and consider adapting one for their own use. Such a programme could help to address and/or negate the impact of distal determinants of risky health behaviour such as socio-economic status and its associated restriction of opportunities, low academic achievement/difficulties, single-parent families, and low emotional investment from parents.

Recommendations

RBK should target an increase in young people's emotional health and wellbeing as a priority. In the short-term, young people could be referred to existing online resources such as 'MoodGym' (a CBT programme developed for young people). It is however strongly recommended that RBK look to extend their existing CAMS service (The Family Advice and Support Service FASS) to include an IAPT Children and Young People's Project (see http://www.iapt.nhs.uk/cyp-iapt). Applications are currently invited for funded support DEADLINE 30th April. In terms of prevention, it is recommended that RBK see to provide opportunities for young people in the area to achieve the 'Five ways to Wellbeing' (http://www.neweconomics.org/projects/five-ways-well-being).

- Develop a working group involving those delivering PSHE in schools (e.g. PSHE programme leads, school nurses, youth service) to consider ways in which programmes can address the core determinants of risky behaviour.
- Explore ways in which services could deliver brief interventions that aim to identify and then change a key behavioural determinant for an individual and then to encourage them to transfer that learning.
- Raise awareness amongst parents/carers that parental monitoring and parent-child communication can help to protect their children from risky sexual behaviour. Consider doing this when parents engaged in education system as pupils transition between primary and secondary school (e.g. open evenings, within school information packs).
- Schools to develop policies of zero tolerance for smoking and substance misuse and reduce opportunities for these behaviours on site.

Characteristics of Effective Interventions

Published reviews and meta-analyses sometimes focus on synthesising evidence regarding the determinants of health behaviour. Other reviews focus on synthesising evidence concerning existing interventions to determine whether they are effective and if so to identify the key characteristics of those which work.

In addition to our review of causes, we also sought to identify characteristics of effective interventions. Consistent with our other review, we specifically looked to identify characteristics that were shared across the three health behaviours: sexual risk behaviour, smoking and substance abuse. This means if RBK wishes to develop an integrative programme that aims to address these three behaviours in conjunction, that evidence is available on what key elements should be in place to optimise the chance of effectiveness. Note that whilst we searched for reviews of interventions aiming to improve emotional health and wellbeing, we only found a handful. Rather than drawing conclusions regarding characteristics of those which work, they instead summarised existing approaches. This is likely to reflect 'positive psychology' being an emerging field and that at present there a few interventions which aim to prevent or intervene early with depression, anxiety etc amongst young people.

Method: the search for reviews of interventions was conducted simultaneously with the search for reviews of causes. When the search strategy for each health issue was developed, we omitted a search term to identify causes (e.g. 'cause, determinant, factor etc) or to identify interventions (e.g. intervention, programme etc) so that database hits returned both. When reviewing hits for relevance, reviews that had either focus were therefore identified and saved in separate folders. In order to identify characteristics of effective interventions for this section of the report, we read the reviews of effective interventions and recorded characteristics of interventions which had a positive impact of risky health behaviour as identified by the author. These characteristics were recorded in a number of tables where rows represented characteristics and columns represented each of the three health behaviours. Different tables were created to represent different types of characteristics e.g. those which focused on design, content or delivery. Displaying the characteristics in this way facilitated identification of characteristics which had a greater amount of evidence-based support. Note: this process of review is subject to the limitations as discussed in the previous section 'review of the causes of young people's risk behaviour').

Whilst conducting the review, an existing paper which had taken the same approach to identifying common characteristics of effective interventions across health behaviours was identified (Peters et al. 2009a). In this case the health behaviours were healthy eating, sexual behaviour, and substance misuse (which included smoking, alcohol and drugs). Due to the degree of cross-over, we decided to include their findings when making decisions about which characteristics to draw out and recommend.

The table is displayed in appendix F. Characteristics in bold are those identified in the Peters et al review as common of effective interventions across their three health behaviours (emotional health and wellbeing was not included for the reasons stated above). Those with an asterix are those identified in the current review as being important across at least two behaviours. There was a high degree of cross-over between the two.

Characteristics identified by the Peters et al review (Peters et al. 2009a) and/or our review are as follows:

- Use of theory in development (i.e. interventions developed which aim to change behaviour by addressing theoretical determinants - as identified in the review of cause; proximal level)
- Addressing social influence through content e.g. peer pressure
- Addressing social norms (what perceive others doing) through content
- Teaching skills (practical e.g. condom use, and interpersonal e.g. condom negotiation) through content
- Teaching 'life skills' (e.g. self-management, decision-making, social and assertive skills, anxiety management) through content
- Use of interactive methods e.g. discussion, role-play, drama, small group work
- Delivery by a trained facilitator
- Multi-component programmes (i.e. those that address proximal and distal/ultimate determinants of behaviour simultaneously)
- School wide activities (e.g. PSHE complemented by additional work such as assemblies, events, new school policy)
- Programme delivered across a number of sessions

Note: characteristics within the table shown in appendix F that are absent from the above list should not be considered as ineffective. They were all identified by at least one review as a key element of successful interventions. It is rather that those listed above have been drawn out because they have consistently shown this across the three behaviours of interest in a number of reviews.

Recommendations

- If RBK wishes to develop a programme aiming to reduce risk behaviour across all three behaviours simultaneously, they should aim to incorporate the above characteristics into its development, delivery and content.
- In order to evaluate the effectiveness of new interventions delivered across Kingston as part of the risky health behaviour prevention and early intervention programme, RBK should repeatedly measure self-reported health risk behaviour, targeted psychosocial (proximal) determinants, and where possible record relevant objective data and health outcomes, in order to properly assess the effectiveness of their work.

Kingston Integrated Practice to Address Risk-taking Behaviours

Quality standards for integrated services to address risk taking behaviours amongst young people do not currently exist as a single overarching national document. Instead what are available are quality standards for particular themed areas of work or services. In order to assess local services against these standards, an assessment tool was developed which draws on the common areas of integrated working that are specified to the 6 health areas in current policy, standards and guidance. In summary these draw on guidance and standards from the following;

- NICE (National Institute of Clinical Excellence)
- National Treatment Agency
- British Association for Sexual Health and HIV
- Child and Adolescent Mental Health Support Team Programme

Other relevant local and regional documents were also utilised to inform the tool for example; the North West Government Office quality standards for integrated working to address alcohol and teenage pregnancy, and Medway Stop Smoking Service: Procedures for Dealing with Young People. A copy of the assessment tool and full reference list is provided in Appendix A.

Current Structure of Provision to Address Risk-taking Behaviour and Future Developments

Royal Borough Kingston, like all other Local Authority areas, is facing a period of continuous change. This has seen the depletion of some of the services which would previously have provided support on risk-taking behaviours to young people e.g. Connexions Service, Targeted Mental Health in Schools (TAMHS). It should also be noted that the majority of professionals involved in the review continue to be concerned about the future of services and felt that prevention and early intervention services continue to be vulnerable in the context of efficiency saving measures and merger with The London Borough of Richmond upon Thames *(*LBRUT*)*. Currently however, there is a range of provision available for young people which provide support to prevent risk-taking behaviours and provide early intervention these include:

- KU19
- School Health Service drop-in's in school
- Young Livin' Bus / SHRAXX
- C-Card Scheme
- Substance Misuse Service
- Relate
- Kick It!
- The Wolverton Centre
- BPAS (british Pregnancy Advisory Service)
- Pharmacist/Chemist
- Doctors

Approach to Risk-taking in Kingston

Historically the development of services has led to a themed approach to provision with services focussed on specific health issues such as smoking, substance misuse and sexual health. Like

many other Local Authorities, services have evolved overtime, under separate management structures, funded by a range of different sources. This has led to disparate provision rather than an integrated approach to address the underlying causes of risk-taking behaviours as recommended in the section 'Review of the causes of young people's risk behaviour'. However, pockets of good practice are emerging with services recognising the need for more integrated approaches. Some of the key developments are listed below:

- The development of the **C-Card scheme** delivered in a range of youth settings
- **CAMHS worker seconded to the Substance Misuse Service** to provide support on mental health issues and a link into the CAMHS service
- The **Substance Misuse Service** has a has a physical presence at the young people only GUM session called **'The Point' at The Wolverton Centre** (Integrated Genito-urinary Medicine and Contraceptive Sexual Health Service) on a Tuesday afternoon so can provide direct support to young people for whom alcohol and/or substance misuse are an issue
- School Health Service provide **drop-ins at school on a range of adolescent health issues** and have begun to develop PSHE sessions which address risk-taking as a whole rather than theme based by health issue
- The **Young Livin' Bus** delivered by the Youth Service provides support to young people on a range of adolescent health issues
- **Mental Health First Aid** training for font-line professionals

There are also planned developments including:

- Appointment of 2 x **Health Link Workers** whose main focus will be to provide support on health issues for young people within interested schools
- Updating of '**Healthy Lifestyles' booklet** for young people (completion April 2013)
- Piloting of the **BOND (Better Outcomes New Delivery) programme** to provide support to local areas to implement new approaches to the provision of early intervention in mental health or emotional/behavioural problems in children and young people
- Re-instatement of the **Healthy Schools Scheme** as part of Healthy Schools London launching on 25th April. Tools and training will be available on the website for schools to self assess, schools will upload the evidence for the standard they are applying for and Public Health (RBK) will assess the evidence and award the standards.
- A business plan is currently being developed for a **LAC Specialist Worker** to undertake work with 13-16 year olds within Social Care to do specific work on self-esteem and building positive relationships.
- Implementation of the **Young Inspectors programme** will be rolled out and provide additional insight into the quality of service delivery alongside the You're Welcome Quality Criteria.

To build on these developments going forward it is essential that RBK begin to shape the structures and systems that underpin service delivery such as commissioning strategies and approaches, networks, workforce development and processes for identifying young people at risk. The following section is structured using the key areas of the assessment tool to discuss the current position of services commissioned within RBK in respect of the essential components required for the delivery

of integrated services. The evidence has been gathered through interviews with professionals (formal and opportunistic), feedback from young people, local needs assessments and documentation . Recommendations relating to each element are recorded at the end of each section for consideration by RBK. These are also drawn together in a summary of recommendations in Appendix G to support planning locally.

Strategic Approach and Multi-agency Commissioning

Quality Standards

- Local partnership structures should be aligned in such a way that they are able to strategically address issues of 'risk and resilience' amongst young people as a whole, rather than addressing separate risk areas in isolation (e.g. substance misuse, teenage pregnancy)
- Locally available data is combined with service users data to build a local profile of the target population, understanding of local need / gaps in relation to the risk behaviour and to target prevention and early intervention approaches accordingly (this should include age, factors that make them vulnerable, geographical location)

A strategic approach to addressing risk-taking behaviours has previously been lacking in RBK. RBK are now taking steps to move towards an integrated programme that focuses on prevention and early intervention with the aim of improving adolescent health and tackling the behaviours that impact on young people's health. This needs assessment will facilitate this and will lead on to the development of an RBK Risk and Resilience Policy, Risky Behaviour Protocol and Early Intervention Adolescent Health Strategy and action plan.

An Early Intervention Adolescent Health Governance Board is planned to take forward these developments and this will need to feed into the Health and Well-being Board structure. The Board will need to ensure that commissioners and providers across a range of services are working towards a shared understanding of the importance of addressing risk-taking behaviour and that all parties are committed to developing a systematic approach to needs assessment, data collection, performance management, quality assurance and workforce development.

A key challenge of the Board will be to ensure that it is aligned in such a way that it is able to strengthen and drive commissioning to address issues of 'risk and resilience' amongst young people across the breadth of services facilitating a shift away from addressing separate risk areas in isolation (e.g. substance misuse, teenage pregnancy) to a common approach to the young person as a whole.

Kingston Integrated Sexual Health Network (KISH) started in 2010 and has undertaken a process of drawing together sexual health providers under one network to deliver integrated sexual health services. Future commissioning arrangements need to ensure that they linked into this network and that all commissioning takes a holistic approach to risk taking to broaden and build on the existing commissioning networks.

Performance Management / Outcomes

Quality Standards

- Managers of services to prevent risk taking and provide early intervention, work collaboratively with other service providers and commissioners to identify need and develop appropriate outcomes/ targets/ performance management of services.
- A standard data set and monitoring process are in place to monitor the core Governance / performance management: of the RBK Risk and Resilience Policy and a Risky Behaviour Protocol and the Early Intervention Adolescent Health Strategy using the *Local Monitoring Dataset* and other appropriate data from all partners
- Service user data is collected to build an understanding of: referral route, first/repeat activity, additional risk taking activities screened for/ identified, characteristics of client groups, postcode (while adhering to confidentiality guidelines), type of service/intervention provided, time of access etc.

Services are currently working to a variety of different performance measures mainly focused on levels of activity. For example, the SNS are measured on number of contacts, the substance misuse service on activity levels and Sexual Health Services on 48-hour access target, uptake of HIV testing etc . They also all collect slightly different data related to the specific health areas making understanding of what support young people get from each service in respect of the range of risk-taking behaviours difficult. For example the Youth Offending Service record substance use activity but not sexual health related activity although support on these issues is provided to young people.

The development of common outcome measures that assess the factors which underpin risk-taking would support the development of a common language across services concerned with the prevention and early identification of young people's risk-taking. This would enable a standard approach to monitoring the levels of risk-taking activity amongst young people accessing services. Crucially, this would enable an understanding of how services are contributing to the overall level of health and well-being amongst young people which is vital to reducing risky behaviours.

Recommendations

- Local partnership structures should be aligned in such a way that they are able to strategically address issues of 'risk and resilience' amongst young people as a whole, rather than addressing separate risk areas in isolation (e.g. substance misuse, teenage pregnancy). *This would be reflected in children and young people's plans/strategies which combine 'risk' work streams into one overarching programme of work.*
- An outcomes based model of commissioning is developed which incorporates a clear rationale for prevention and early identification of young people at risk, addressing the underlying causes of risk behaviours to achieve desired outcomes, underpinned with strong performance management, reporting and quality assurance arrangements across all agencies.

- Commissioners of services to prevent risk-taking and provide early intervention should work collaboratively to co-ordinate needs assessments, commissioning strategies, SLAs, KPIs and performance management of commissioned services. *As part of this, commissioners should work together to identify key areas of overlap and develop shared outcomes for risk taking behaviour services, for example this may include a requirement to undertake chlamydia screening with a proportion of under 18s attending alcohol services and with a shared outcome to reduce chlamydia amongst young people.*

- A standard data set and monitoring processes are in place to monitor the core Governance / performance management of: the RBK Risk and Resilience Policy and a Risky Behaviour Protocol, the Early Intervention Adolescent Health Strategy using the *Local Monitoring Dataset,* and other appropriate data from all partners

- Commissioners and service providers collect and present data based on the World Health Organization (WHO) 5 year age bands as recommended by the Children and Young People's Outcomes Forum for young people in the teenage years, this would incorporate: 10–14, 15–19 and 20–24 years.

Prevention, including PSHE (Personal and Social Health Education)

Quality Standards

- A core programme of PSHE is delivered and evaluated across primary, secondary and special schools and relevant out of school settings (PRUs, Youth Centres, YOS etc) which is based on evidence-based practice across the 6 health areas and prevents uptake of risk-taking activity
- PSHE programmes draw out the linkages across the key areas of risk-taking activity (sexual health, teenage pregnancy, alcohol and substance use, smoking and mental health) rather than these elements taught in isolation
- Partnerships should ensure that prevention and targeted interventions for young people are evidence based
- An understanding of 'teachable moments' for young people (Cairns, 2010) is in place along with evidenced based practice at these points to utilise available opportunities
- A range of programmes are in place designed to raise aspiration among targeted groups and communities. These programmes are linked to agendas for worklessness and skills, and building social capital, and ensure:
    - Programmes reach young people most vulnerable to risk taking
    - Programmes combine raising awareness of the consequences of risk taking behaviours
    - Schools are engaged in raising aspiration for young people most at risk
    - Engagement of communities to support aspiration among young people

PSHE in Schools

Professionals interviewed found it difficult to make a judgement about the content and quality of PSHE delivered by secondary schools. Most professionals felt that it was variable between schools, that there was a tendency for schools to use drop-down days, and that there was little opportunity

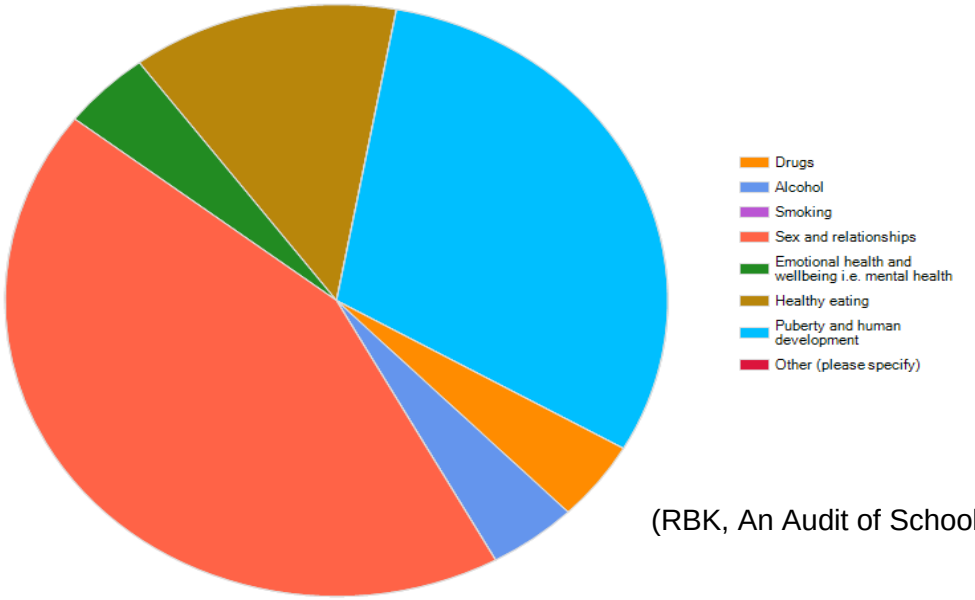
for young people to catch-up on sessions that they had missed. Whilst the scope of this work meant that this view could not be substantiated, it does reflect previous reviews of PSHE content and delivery (Sewell and Newby 2011).

The School Health Service (SHS) delivered by school nurses, provide sessions on puberty to year 5 and 6 pupils in primary schools. This is taken up by 50% of primary schools. A core offer is provided for secondary schools in Kingston and is available to state funded schools and Academies; this is taken up by all secondary schools. The core offer includes delivery of a PSHE programme to two out of five year groups of each schools choice, alongside school drop-in clinics. The main elements of the PSHE programme are as follows:

- Puberty - body changes and emotions
- Reproduction - how a baby is made, game around what babies need and lots of questions and answers
- Contraception – methods of including emergency contraception, where to access help and advice
- STI's – types of, prevention, treatment and where to go for help
- Lifestyles – e.g. smoking, substance misuse

An Audit of School Nursing provision in schools was undertaken in 2012 by Kingston Public Health Department. As part of the audit a survey was completed by 20 schools of which, 13 were primary schools and 7 were secondary schools. Figure 46 taken from the PSHE Audit provides a breakdown the areas of the curriculum that school use School Nurses to deliver. It shows that the main areas are Sex and Relationship Education and Puberty and human development. However, where required and capacity allows, the team also work with the PSHE co-ordinators to tailor programmes to the schools needs.

Figure 46: School Nursing Delivery of PSHE Curriculum in Schools by Topic Area



(RBK, An Audit of School Nursing, 2012).

It was noted that some schools would benefit from more in-depth and incremental support from the SHS on PSHE which built on learning year after year. It may therefore be timely to consider how this could be managed on a more formal basis, providing additional support to schools where young people have greatest need. Where additional PSHE teaching is provided by schools on top of that provided by the SHS, it would also be advantageous for the SHS and schools to work together to ensure that that their teaching is complementary and opportunities to reinforce learning are taken.

The SHS also delivers an optional session in secondary schools. This takes a holistic approach to risk-taking behaviour rather than the more specific themed based work of the core package. Based on the premise of going to a party, young people are prompted to consider the potential for risk-taking activities at a party and to work through how they might identify risks, and how they might feel and respond to situations that could arise. Unfortunately, the SHS are not currently able to deliver this as fully as they would like but it is reflective of effective practice in this area and could be expanded through the core package to lay the foundations of work to prevent / minimise risk taking behaviour and promote health and well-being. This was highlighted in the recent School Nurse PSHE Audit (Kingston Public Health Department, 2012) which stated:

'... The consensus about what constitutes best practice in PSHE is moving away from teaching PSHE in a topic-based fashion towards an integrated programme which is provided across the curriculum.... School nurses are relied upon to teach specific topics in a very specific way i.e. SRE and puberty and human development in the form of isolated classroom tutorials.'

The PSHE programme delivered by the SHS draws on evidence based practice which could be further enhanced by using evidence of what works in encouraging protective health behaviour. The SHS has found it challenging to evaluate its programme due to concerns that this would encroach on limited teaching time, although the need for evaluation has been recognised. Rather than evaluation being conducted during lesson time, the SHS should consider alternatives such as use of tutor periods. Evaluation materials should measure changes in targeted behaviour and psychosocial (proximal) determinants (see section 'review of the causes of young people's risk behaviour'), and use minimal items in order to minimise completion time.

Youth Service Support to Schools

The youth service has made an offer to all secondary school in Kingston to work with pupils at risk of disengagement. At-risk pupils are identified as those with low attendance and achievement. This offer has been taken up by six schools. Work with these individuals includes:

- identifying health risk taking behaviour
- additional PSHE provision
- providing opportunities to be involved in positive activities
- work around self-esteem, communication, peer pressure

More focussed intensive work on a one-to-one basis such as this has the potential to be highly effective. This is because it provides the opportunity for personalised intervention addressing each individual's psycho-social barriers to protective health behaviour. Furthermore this work provides young people with the opportunity to have positive experiences which can raise aspirations and may negate some of the negative effects of the wider social and environmental health determinants.

Ideally this one-to-one work should complement the broader PSHE programme offered by the SHS. It would also be preferable for pupils to be identified through a more detailed risk assessment (see 'Early identification and screening' within the section 'Kingston integrated practice to address risk taking behaviours') as low attendance and achievement are not the only indicators of health risk. As with the SHS, provision would benefit from being evidence-based and evaluated in order to maximise impact. In order to strengthen elements of provision which target the wider determinants of health, the youth service should consider adopting elements of existing effective youth development programmes e.g. The Teen Outreach Programme (TOP; http://advocatesforyouth.org/publications/1133?task=view; see also the example of mentoring programme presented in appendix I).

Provision in other settings

- A School Nurse is in post to deliver PSHE within Pupil Referral Units (PRUs).
- A PSHE programme is not currently in place with LAC but is planned
- A PSHE programme is not currently in place within the YOS
- The youth service run the 'Young livin' bus' which goes to secondary schools in the borough and is stationed at two regular venues on Tuesdays and Thursday afternoons (Malden Manor and Kingston town centre). The bus is a collection point for condoms via the C-Card scheme and houses SHARXX (sexual health drop-in). From this location youth workers also offer support around other issues e.g. Alcohol/drugs, bullying, staying safe, stress, depression.

Transition Points and Teachable Moments

Research suggests that services should capitalise on 'teachable moments' for young people by providing evidenced based practice interventions at key points when young people are more receptive to messages and behaviour change (Cairns 2010). These might include brief interventions in pharmacy services (emergency contraception), targeted (small group based) work with school pupils in transition to secondary schools, 'Quick response arrangements' to provide targeted work with young people (individually or in groups) following a relevant local incident (e.g. attendance at A&E, overdose of friend).

During the needs assessment there were a number of points identified by professionals and young people which locally could be capitalised upon including:

- All children in Year 7 should receive a basic catch-up session to ensure that there is a common level of knowledge and understanding going into secondary school.
- Targeted interventions with young people leaving the care system
- Targeted interventions with young people who are first time entrants into the Youth Justice System
- Targeted work with pupils/students on transition from secondary schools to colleges/university
- Transition between young person centred services and adult focused services to reduce the vulnerability of young people at this time of transition. The SNS for example work with adult sexual health services where a young person needs to be transferred e.g. to continue a regular method of contraception. Substance Misuse Services approach age flexibly

depending on the capabilities of the young person and sometimes if they feel a young person is not confident to access adult services, they will continue to provide support to them.

Sources that young people in Kingston want information and support on health issues from

Within our survey we asked young people where they would you most like to get information and support on smoking, drugs, and contraception and other health topics. They were advised to tick all applicable options. The results are displayed in figure 47 below.

Figure 47 the proportion of young people who endorsed each item as a source from which they would like to receive health information and support (based on 118 responses)

	Percent	Count
Face-to-face with a health professional (e.g. nurse)	36.4%	43
Digital communication (e.g. text, email) with a health professional	28.8%	34
From a local website	31.4%	37
From lessons in school (e.g. PSHE)	**50.8%**	**60**
From leaflets/booklets	31.4%	37
From an app that provides personalised info/advice	28.8%	34
From parents/carers	17.8%	21
From friends/other young people	37.3%	44

School was by far this most popular source as has frequently been found before (Coleman and Testa 2007, Newby et al. 2012, Selwyn and Powell 207). The findings also support the existing evidence that friends make an important contribution to knowledge (Coleman and Testa 2007, Newby et al. 2012). Although there is an appetite for digital sources of information amongst young people (digital communication 28.8% and app 28.8%), it is clear that face-to-face contact with a health professional is valued.

In the survey, young people were also asked, ‘if there was one thing that would make support for you better around these topics [i.e. the health issues], what would it be? This was an open-ended response. All of the responses are presented in appendix H but have been categorised below in table 32 to summarise the main themes.

Table 32 summary of main themes from open-ended question asking what one thing would make support around the health issues better (based on 113 responses)

Theme	Number of responses
More confidentiality and privacy	15
More information on available services; more information about consequences of risky behaviour; more information about sex and relationships in general	14
A more open and supportive environment, less stigma, more talking and advice	13
More PSHE	12
More advice and info delivered by credible people e.g. teachers or those from services	11
Apps/websites	10
Somewhere to go which deals with other issues affecting young people not just sexual health and more info about substance misuse and emotional health	6
People closer to their age to talk too and people who have been through it themselves	5
More accessible resources that are relevant to young people	6
Don't know	4
Nothing	10
Other (e.g. talk to specific students, legal, help from friends, mixed sex classes)	7

Recommendations

- A review is undertaken of the approach of secondary schools to developing an ethos which promotes pupil health and well-being through policy, culture and practice within PSHE and the wider school environment and to identify the support needs of Academies.
- Develop and pilot a programme of PSHE with the SHS which aims to promote healthy behaviour by targeting common proximal (psycho-social) determinants. This would be in-line

with current thinking around how best to address health risk behaviour, make good use of limited PSHE teaching time, and enable focussed evaluation.

- Further develop one-to-one support provided by the youth service so that it complements the broader programme of PSHE provided by the SHS. Consider providing individualised programmes that target psychosocial determinants and evaluate efficacy. Also consider adopting elements of existing effective youth development programmes.

- Consideration is given to the potential for the SHS to provide more in-depth PSHE programmes to schools serving young people from areas with greatest need

- Once established, the Early Intervention Adolescent Health Governance Board should identify the key teachable moments to address risky behaviours and ensure that evidenced based interventions are in place at these points

Early Identification and Screening

Quality Standards

- A clear framework is in place, supported by care pathways, that illustrates the roles and responsibilities of universal, targeted and specialist services in identifying and supporting young people vulnerable to risk-taking behaviour.

- A holistic screening process should exist which enables identification of risk factors for all 6 key issues: sexual health, teenage pregnancy, alcohol and substance use, smoking and mental health. This should be linked to more in-depth screening processes.

The Common Assessment Framework is currently in place for use when there is an identified need for intervention and a young person requires multi-agency support. At present however, there is not a formal process used across agencies providing universal services to identify young people who are vulnerable to risk-taking behaviour and for whom preventative work would be appropriate. Identification of these young people is reliant on the individuals within universal services (e.g. schools, youth service, general practice) having an awareness of the factors that might make a person vulnerable and then taking action based on this. In addition, a range of professionals expressed **concern at the discontinuation of the ASKK system** which they felt was a key mechanism to record and monitor low level concerns or issues happening in a child's life and to identify who else was working with them and may also have flagged concerns. The Single Point of Access (SPA) system has been adopted and the general feeling is that this will capture young people who do require support but won't pick-up the early signs that a young person may need intervention to prevent the involvement in potentially damaging risk-taking activity. It should be noted that the SPA system is welcomed by General Practice who found the purpose of the ASKK system confusing.

There is therefore, potential for the support that young people receive to be inequitable and dependant on the individual professional's knowledge and personal judgement about the factors affecting risk-taking and their knowledge of the services available for them to access.

There are a number of processes in place within universal and specialist services, which do enable an assessment of risk-taking behaviour and response as outlined below. These provide a starting point to consider the development of a standard process:

- CAMHS, SMS and GUM all have their own tools for assessing risk and these often contain overlap for example the DUST tool used by SMS also contains questions around mental health and well-being and sexual activity.
- The SHS currently has a formal process to record and provide support to young people who are identified as needing support. There are three levels before the Safeguarding threshold is initiated 1) vulnerable child - a child who needs monitoring 2) cause for concern - a child who does not meet the criteria to initiate Safeguarding proceedings 3) Safeguarding procedures.
- A new tool has been developed by Banardos to assess young people at risk of sexual exploitation and is being used by small number of professionals locally
- Some schools have processes in place to discuss and provide support to young people who are seen as vulnerable. For example Coombe Girls School hold termly meetings about children for whom there is concern. Similar in process to a case review, they draw in all professionals working with the young person and discuss their support needs and appropriate intentions if needed.
- All children entering the care system have a yearly health check within which questions are asked about risk-taking behaviour and an action plan to address all issues arising is put in place.

Work in Development

There are a number of developments currently taking place to improve working across General Practice and Social Care which should be noted and which provide opportunities to develop a more integrated approach to assessing risk-taking within General Practice.

- LAC Team are strengthening the follow-up of action plans working towards a position where all the actions within a LAC's plan are followed-up at 3-6 months to check on progress and make sure further action is taken.

- The Children's Clinical Lead for the Clinical Commissioning Group (also the Child Protection Lead for Kingston) is leading a number of initiatives with General Practice to improve identification of young people at risk.

- To improve targeting of LAC, Social Services are currently compiling a list of all LAC and their registered GP. This will be shared with the relevant practice so they can audit who they are in touch with and who they need to make contact with. A letter will be written to all registered LAC and their carers to offer a review of their health needs. The development of a proforma which will guide the review is planned and offers an opportunity to ensure that key factors underpinning potential risk-taking are incorporated.

- Training is also being provided to GPs on recognising risk and vulnerable children. This will include utilising patients notes more effectively to record relevant information such as the presence of Domestic Violence in the family, cross referencing family notes to highlight concerns, recording more detailed notes and passing notes on quickly when a young person moves to a new practice.

- Work is also being undertaken to improve communication between Social Care and General Practice.

Recommendations

- The Early Intervention Adolescent Health Governance Board develop links with the Children's Clinical Lead for the Clinical Commissioning Group to inform the development of the GP proforma for LAC ensuring key factors which underpin risk-taking are incorporated.

- A universal system of digital communication is established between all agencies working across prevention and early intervention to enable front line staff to see the network of practitioners working with a child or family. This in turn would enable professionals to access contact details for specific workers supporting the young person and discuss any concerns with the relevant professional. An example of a current system called Patchwork which is already developed and used in Brighton and Hove and Staffordshire, and is currently being installed locally in Surrey, is available through this link: See http://wearefuturegov.com/case-study/patchwork/

- Develop a standardised risk-assessment tool and process of assessing young people who are vulnerable to risk-taking across all relevant universal services (including schools). Provide mandatory training in using the tool to all front-line professionals.

- Build on the current practice within the Youth Support Service to strengthen the role of this team in providing 1-1 and group work to young people who are vulnerable to risk-taking. This could potentially be widened to be a multi-disciplinary prevention team and provide a Single Point of Contact for all young people to receive appropriate support managed by a single professional.

The last two recommendations should be viewed in conjunction and are drawn from an effective model of provision in Stoke which is captured in the examples of practice summary in Appendix I.

Access to Information and Advice

Quality Standards

- Information on risk-taking activities is available for young people in a variety of formats (including digital) and languages and is tailored to address specific cultural perspectives if appropriate.

- Processes are in place to regularly update all children's workforce and appropriate service providers with service publicity and care pathways for young people at risk.

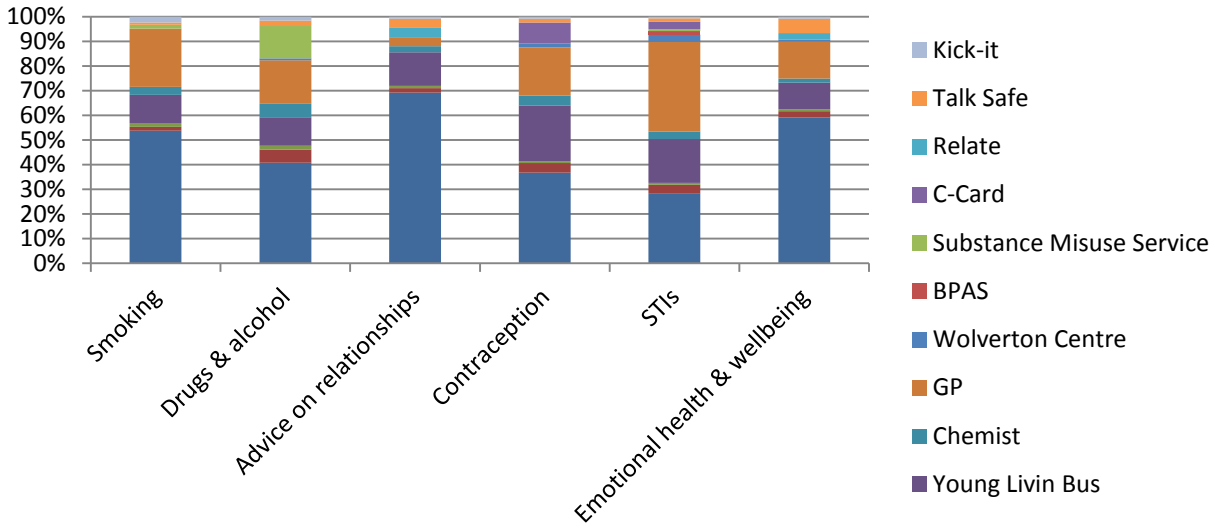
- Communications/media programmes target motivations for engaging in risk-taking behaviour are monitored consistently and evaluated regularly. Action plans are drawn up as a result of regular evaluations and agreed by the relevant accountable lead.

- Partnerships should consider social marketing techniques as a means to promote positive messages to address imbalances of perceptions amongst young people and families.

RBK has been proactive in developing information for young people in a variety of forms including written leaflets and posters and web based information. The images below provide a flavour of some but not all of the different services and sources of information available for young people about the services they can access.

Feedback from young people through the focus groups and on-line questionnaire showed that there were varying degrees of knowledge about what services are available, how to access them and what they provided. The stacked bar chart below shows **proportion of young** people who reported that they would go to each service for advice and support for a specified health issue.

Figure 48: proportion of young people who reported that they would go to each service for advice and support for the specified health issue



Key findings:

- For all but one health issue the vast majority of young people said that they didn't know where they would go. The only exception was for STIs where 41.5% said they would go to GP (32.2% responded that they didn't know).
- GP across the health issues is strongly endorsed (with the exception of 'advice on relationships') as is Young Livin' Bus
- A very small proportion of young people reported that they would visit SHARXX for contraception, STIs, or advice on relationships. As this is housed within Young livin' Bus which is strongly endorsed, it suggests that this is not a strong 'brand'
- The Wolverton Centre was not frequently selected by young people as somewhere they would go for information and support on contraception (1.7%), STIs (3.4%), or relationships (0%). As this service would appear to be popular with those who do use it (as evidenced from focus groups) it suggests that this service should be more strongly promoted

School Nurse feedback and feedback from young people in the focus groups highlighted a need to actively promote services in schools by representatives from services going out to local areas to: show they are young person friendly, highlight what they offer; who the service is for and to promote confidentiality. Feedback from the focus groups shows that young people are also concerned about parents, schools and GPs finding out that they have accessed services and why. There is therefore a constant need to stress confidentiality policies and practice with each new cohort of young people.

Feedback from professionals highlighted that with changing structures and criteria between services, it is difficult to keep up to date with the services available. There are a wide range of services available however if young people are unable to identify services by name, they are unlikely to know what those services provide. This could lead to confusion and prevent some young people from accessing them. There is scope to re-assess the information available to young people and to consider how young people and professionals access this information.

Recommendations

- An audit is undertaken of current service information and websites for young people with a view to drawing this information together in one place.

- A service is developed that can provide advice and signposting to young people at time appropriate to their needs with availability at evenings and weekends, via text for example. This service could also act as a point of contact for professionals to access information and could potential be a web based tool (see www.respectyourself.info/services for example of web tool used to locate sexual health services by young people and professionals in Warwickshire).

- Consideration is given to how best to raise the profile of services within schools e.g. by services visiting schools or young people having a visit to services such as The Wolverton Centre.

Links and Referral between Agencies

Quality Standards

- Clear referral/care pathways should exist in all partnerships between:
  - Universal services: such as schools, General Practice, Youth Advice Services
  - Targeted: PRUs, YOS, Counselling, midwifery, Health Visiting, HV and A&E, housing, Social Care
  - Specialist services: inc. contraceptive, sexual health/GUM, termination providers, alcohol & substance misuse, smoking cessation, and CAMHS, SARC

- Outreach provision is in place in settings where there are high numbers of vulnerable young people e.g. YOS, LAC, Paediatrics, Substance Misuse, Housing providers and other appropriate settings locally

- Self referral processes are in place where appropriate, with digital technology used to facilitate young people's access.

Referral between Agencies

Data was unavailable for the main routes of referral into services, however the following summarises feedback from service providers:

- SHS appear to have strong links and routes into the main specialist services. Referrals for SHS are predominantly made via schools and occasionally by email from General Practice.
- Youth Support Service receive the majority of referrals from schools.
- The Wolverton are accessed predominantly by self-referral although some young people are referred by the LAC nurse
- Relate (Young People's Counselling Service) – self referral
- Substance Misuse Service receives referrals from the Youth Offending Service and families of young people. Few referrals are made from the Youth Support Service (YSS) to SMS as YSS are often able to provide support to young people directly on alcohol and cannabis use which are the main substances used by young people.

Referrals and Barriers to Services

Concerns were raised about the criteria for accessing some services with high thresholds resulting in young people not always able to get support they needed easily.

Family Advice and Support Service

Consistent **concerns were raised about young people with low level mental health needs such as anxiety, mild depression, eating disorders or behavioural issues that were not attributed to a medical condition**. There were cases reported where young people had been referred backwards and forwards between FASS and other services because they didn't quite fit the criteria for access. This reflects the wider issue that there is a lack of service provision for young people with low level mental health concerns (as described within the 'Mental Health and wellbeing' subsection of 'Epidemiological profile of risk behaviour in Kingston').

Youth Support Service

The requirement for young people to have a CAF to access Targeted Youth Support was also felt by some to be excessive and time consuming, and a barrier to access for this service.

Links between Agencies

A care pathway for prevention and early intervention is not currently in place although individual services (e.g. the Substance Misuse Service) have their own care pathway. Development of a care pathway would be a beneficial process and would further highlight strengths and gaps in provision. When considering the care pathway it may also be timely to consider where there is overlap between agencies. There is significant cross over between what is provided between the Youth Service's Young Livin' Bus, SHARXX and school drop-ins for example. All of these services provide condoms, chlamydia screening, support on relationships and low level mental health concerns, and have workers trained in smoking cessation. Therefore there is the potential to reconsider providing a robust tiered level of holistic health service provision for young people with a core offer.

There is a need to improve knowledge and understanding amongst General Practice and Pharmacies about community based support services which are available for young people (including those provided by the SHS and Youth Service). At present, whilst a young person may attend a Practice or Pharmacy, they may not be referred on to services they could access for follow-on support purely due to practitioners lack of awareness of what is available.

Bridges into Services for Young People

In order to support young people, particularly those who are most vulnerable, to access services, it is important that areas have mechanisms which act as a bridge into services. There are a number or examples of this locally:

- Youth workers and school nurses actively taking young people to services that they have referred a young person to overcome barriers about attending new services. However, there was a sense that other service providers e.g. GPs, Pharmacists are unaware that this support is available
- Text messages are sent via The Wolverton Centre and Substance Misuse Service to remind young people to attend appointments
- The Young Livin' website has a facility to ask questions to professionals on any issue and receive a response however this is not advertised strongly to young people and is under used (Warwickshire's Respect Yourself website www.respectyourself.info has a similar function and receives on average five questions a day just about sex and relationships).

There is potential to strengthen the support provided to young people to help them access services. Digital technology could be harnessed further by services to provide a bridge into services and to provide continuation of care once a young person leaves the physical service e.g.:

- Digital technology could be used to send a friendly text message to a young person from the agency the young person has been referred on to encouraging them to come, adding the name of the person they will be meeting etc
- Text reminders to come for a repeat prescriptions of contraception
- Option to text a service following an appointment to get follow-up support

- A local app that young people could use to input which services they need and it would highlight where the nearest places are to get support, opening times etc (a Sexual Health Service App 'ASK Sam APP' has been developed with the KISH stakeholders group and there maybe potential to build on this platform)

Recommendations

- A prevention and early intervention pathway for young people is developed which documents how young people access services and the role of each service in providing support/referral. As this develops, consultation could be sought through the professionals blog.

- Develop a core offer from all prevention and early intervention services that provides as a minimum support to promote well-being, talk through problems/feelings, offers condoms, pregnancy testing and chlamydia screening.

- Develop a 'No Wrong Door policy' attached to the core offer, which includes the ability for any service to physically arrange support to help a young person access services (such as arranging for a School Nurse or Youth Worker to go with a young person to an appointment or making the telephone call themselves).

- Consideration is given to developing a generic name and brand for all services providing prevention and early intervention health services which is linked to You're Welcome Quality Standards. This would be easier to market to young people and for them to understand what they can access where.

Quality Standards for Themed Areas

The following section relates to the quality standards which are specific to specialist agencies as outlined in Services, Smoking and Mental Health provision.

Quality Standard	Kingston Current Position
Sexual Health and Teenage Pregnancy	
Support for young people at risk to develop safe and healthy relationships, and prevent STIs and early pregnancy, is systematically included in TYS arrangements through CAF and the Lead Professional. Support includes a range of intensive interventions, and advice on contraception and sexual health as needed (e.g. an intensive SRE/PSHE module for young people at risk of disengaging from school).	• Youth Support Service provide support to young people identified as at risk through the destinations programme. PSHE content will be delivered as part of the 1-1 support provided if a need arises therefore it is not currently a systematic component of targeted support. • A School Nurse is in post to deliver PSHE within Pupil Referral Units (PRUs) • A PSHE programme is not currently in place for the Youth Offending Service • A PSHE programme is not currently in place for LAC but is planned The provision of sexual health services (e.g. c-card condom scheme, SRE, and chlamydia screening) within youth service settings and education settings for more marginalised and excluded groups is being further developed and expanded for 2013/14.
Young people's sexual health, CASH and abortion services are commissioned to ensure that services for young people, including teenage mothers and young fathers: • are sufficient and based on need, including access to services in hotspot areas by vulnerable groups • cover a range of integrated provision (including, for example, free pregnancy testing, unbiased advice on pregnancy options, condom distribution, the full range of contraceptive choices including long acting reversible contraception [LARC], emergency	• Services have been planned based on geographical need and provide a good distribution across Kingston • A wide range of provision is available providing condoms, chlamydia testing and contraception. LARC is available though General Practice and The Wolverton • Young people accessing EHC have Alcohol assessment as part of this process • The Wolverton has an ISVA (independent sexual violence advisor) post - although funding arrangement still needs to make this post substantive • RBK currently provide early intervention to those young people accessing The Wolverton with possible risk of excessive alcohol intake.

hormonal contraception [EHC], accessible information and sexual health promotion, advice on alcohol and substance misuse) • have clear patient pathways • enable swift referral as required (e.g. to antenatal care or NHS funded abortion services) • provide contraception with clear follow-up and support arrangements after abortion and maternity, including publicity to young people about the risk of repeat pregnancy.	• Clear referral pathways are in place with BPAS for terminations and midwifery for pregnancies and a trained midwife forms part of the multi-disciplinary team at The Wolverton. Whilst midwives will cover the need for contraception in postnatal discussions with young parents, there is not currently a formal process of referral following a birth from midwifery or health visiting service, to the Wolverton who can then undertake follow-up with young women to ensure they have a regular method of contraception, preferably LARC. *Formality and use of referral from BPAS to The Wolverton for partner notification needs clarification as this was unclear.*
Ensure that sexual health services, including contraception and abortion services, are in place and include arrangements for the full-range of contraception, STI testing, treatment and follow-up of partners of people who have an STI (partner notification). With clearly defined roles and responsibilities of each service in relation to partner notification.	• An integrated model of service delivery is in place and provides a full Level 3 service • Partner notification is undertaken by nurses but trained Health Advisors are not in place
At least 60% of Chlamydia Screening is delivered via primary care, SHS, GUM services (per PCT or upper tier/ unitary Local Authority from April 2013) with referral for full screening and partner notification for all cases testing positive.	• In order to increase the number of screens performed in primary care, Kingston PCT has worked with Kingston GPs to develop the new Primary Care Chlamydia Screening Pathway. The new pathway has been in operation since 1st July 2011. 27 out of the 28 practices have signed up to the Sexual Health LES to provide chlamydia screening.
Smoking	
Activities within schools and community based settings for young people which are proactive in promoting a culture of anti-smoking.	• Information about smoking prevention activities and policies in schools was unavailable. The new Health Schools Scheme may provide future information on this. • Information about Kick It! the young people's smoking cessations service is

	available however young people and professionals had very limited knowledge of the service. Kick It! Is a new service and is currently scoping out needs in Kingston (and specifying KPI), it is anticipated that Kick It! Will provide the following for young people: o Delivering education in schools using a role-play exercise called 'operation smoke storm' and training up teachers to deliver this in future o Going into schools with the Kick It! vehicle to offer road shows and promote the service • Youth advocacy work – going along to youth groups etc to raise awareness of underhand tactics of tobacco companies to promote cigarette use to young people and garnering support for counter momentum e.g. protests, spreading the word amongst friends.
Information, advice and support is available for young people aged 12–17 on how to stop smoking with referral processes in place to NHS funded Stop Smoking Services providing details on when, where and how to access them.	• Kick It! only delivers a small amount of smoking cessation work as there is low demand. They run a few location based clinics preceded by health promotion work to raise awareness and encourage drop-in • SHS and YSS also have a number of nurses who are smoking cessation trained however the skills of these people maybe being underutilised as professionals are unaware of this being offered through the SHS.
Alcohol and Substance Misuse	
Group-based behavioural therapy is provided over 1 to 2 years for children aged 10–12 years who are persistently aggressive or disruptive and assessed to be at high risk of substance misuse. This should be offered before and during the transition to secondary school. Offer the parents or carers group-based training in parental skills. This should take place on a monthly basis, over the same time period (as described above for the children).	• The Substance Misuse Service (SMS) offers group based therapy in accordance with NTA guidelines. • SMS also offers assessment & brief intervention (4-6 sessions) on 1-2-1 basis, psychosocial drug education, support to parents (see them or offer support over telephone incl parents of children who don't want to engage with the service), group work (e.g. just setting up some group work with youth clubs; there is a group 7-8 young male cannabis users who need some targeted work), where young people about to go into custody as part of good practice try to see young person (don't always get referred in though which is part of challenge)

Vulnerable and disadvantaged children and young people aged under 25 who are problematic substance mis-users (including those attending secondary schools or further education colleges) are offered one or more motivational interviews according to the young person's needs. Family-based programmes of structured support over 2 or more years are drawn up with the parents or carers of the child or young person (11-16) who are problematic substance mis-users. These should be led by staff competent in this area.	• Tear 3 service includes: assessment, care planning, risk management, motivational interviewing, CBT, family support, pharmacological intervention where required (very rare in RBK) and needle exchange. This is undertaken within the context of holistic support for other risk-taking activities and referral pathways are in place to sexual health services and CAMHS. • SMS also undertake crisis management: solution focussed work, try to adapt support to YPs learning styles, try to flexible in terms of what YP likes or needs, also work with YP with special needs. • Also see above.
Mental Health and Well-being	
Young people exhibiting evidence of significant or serious substance misuse receive joint treatment between CAMHS and substance misuse services, or drug and alcohol services for children and young people.	• A CAMHS worker is seconded to the SMS and provides direct support to young people and referral into the FASS service • SMS offer C-card, smoking cessation, needle exchange, chlamydia screening, drug testing, pregnancy testing, pre- and –post counselling required for testing (e.g. chlamyida or pregnancy), mental state screening (eating, self harm, suicide, and then of course drug related problems e.g. hallucinations).
Young people who have mental health problems and are or have been involved in criminal offences have access to a range of CAMHS interventions via youth offending service (YOS).	• SMS refer directly to CAMHS via the CAMHS worker based in the SMS who they liaise with • YOS make recommendations whether anyone needs putting into medical wing or whether need drug intervention but no medical intervention needed.

Themes Areas - Key Issues

Targeted Support for Young Parents

The cyclical nature of teenage parenthood makes it essential for prevention and early intervention to start prior to conception, continue during pregnancy and through the post-natal period (TPU, 2006). Poor health of the mother is the single most important factor in predicting poor outcomes for children at age 5 in respect of health, learning and development and behaviour (Kiernan and Mensah, 2010). The nature of teenage pregnancy is that it has occurred as a result of risk-taking behaviour which is often linked with substance misuse. This was reflected in the focus group with young parents and discussions with professionals. It was evident that young parents had specific support needs in particular for coping with stress, managing relationships, contraception and smoking advice.

Mental Health

The extent to which services are meeting mental health needs was difficult to ascertain. However, it is likely that given the general feedback about mental health provision, that young parents may also find it difficult to access formal support for issues such as stress and depression.

Contraceptive Needs

Data from the Wolverton Centre has highlighted that young women are unprepared and ill-informed about the procedures and side effects of different methods of contraception. This is reflected in the fact that the number of removals for implants amongst young women is equal to the number fitted, this is because young women are uncomfortable with the initial side effects of this method e.g. irregular bleeding. This is clearly of concern and suggests a need for more in-depth support to young women on the experience of different methods, what to expect and how long these will last for with the context of the benefits of LARC. Walsall NHS had a similar experience when first introducing LARC but have increased the adherence of young people to LARC methods by providing longer consultation sessions that allow time to go through these issues.

Smoking

High levels of smoking amongst young parents suggests that smoking cessation support is not currently being targeted or is ineffective, perhaps as it is often used as a mechanism for coping with stress. It does highlight a need to consider how smoking cessations services are targeted at and provided to this group.

Mental Health Provision for Looked After Children

The LAC nurse reported that almost all LAC of teenage years are sexually active and smoke cannabis as well as cigarettes, and that young people's ability to use contraception effectively and undertake harm minimisation approaches to substance misuse is of concern. There are links between the LAC Nurse, the Wolverton and the Substance Misuse Service, and the LAC nurse does offer support to take young people to both sites. Despite this, attendance of LAC at both Services is lower than would be expected for these groups and there is a need for services to work more closely together to consider new approaches to engaging with LAC. There are two key barriers to LAC attendance 1) how to get initial engagement of the young person when they feel let down by statutory agencies 2) how to reduce the need for a young person to have to tell their story

over and over to different agencies. The Wolverton Centre receives very few referrals from Social Care and although they do not formally record the looked after status of young people attending the service, they see very few young people who are LAC despite their level of vulnerability.

Despite sexual health and substance misuse issues being of concern, most young people entering the Social Care system have a mental health need and this is seen by the LAC Team as the biggest factor underpinning the involvement of LAC with all risk-taking behaviour. As the LAC Nurse described:

> 'With Looked After Children once you take off one layer you often find there's another right underneath. … If we can increase their self-esteem and confidence in themselves, they are not as susceptible to grooming and don't do things like expose themselves or feel the need to self-harm'.

Many young people entering the system are 'damaged' and experience low self-esteem and self-confidence which in turn manifests itself in self-abusive behaviours and potentially involvement in exploitative relationships where risk-taking is the norm. The mental health provision that is available for young people both in and out of borough is inadequate for the level of complex need. There is a CAMHS specialist working with the LAC Team however this post is overwhelmed and cannot provide the in-depth 1-1 support that a number of children need. In response to this, a limit of 6 weeks has been put upon the length of time the worker can provide an intervention to an individual LAC. There is concern that this will not be enough for some young people who need far more time to be fully supported.

More dedicated work is needed with all LAC to ensure that they receive support to gain the basic life skills needed to measure, assess and respond to risk especially as these young people are acknowledged to be one of the most vulnerable groups at risk and require bespoke packages of 1-1 support in most cases. A business plan is currently being developed for a Specialist Worker to undertake work with 13-16 year olds within Social Care to do specific work on self-esteem and building positive relationships.

Young People with Disabilities

Feedback from professionals and young people during the needs assessment highlighted that there are two key issues in relation to young people with disabilities and risk-taking. Firstly, that young people with moderate to severe disabilities are less likely to be involved in risky behaviours because they are often monitored more closely and therefore have less opportunity to engage in such. Secondly, that young people with mild disabilities, such as Autism, ADHA etc are at increased risk of becoming involved in risk taking particularly if their behaviour has resulted in them disengaging from school. These young people can often find accessing services and understanding the information provided to them difficult. There is therefore a need for workforce development with front-line staff and service providers to raise awareness of these issues as outlined on page 113.

Recommendations

- A Health Visitor undertakes the role of Family Nurse Partnership to provide intensive support to young parents for a sustained period which is holistic and addresses the factors that impact on the parents life as well as the child.

- Targeted smoking cessation support for young parents is reviewed.

- Further investigation is undertaken to understand the origin of the service (GP, Wolverton) which fitted the implants which are being removed.

- Work is undertaken to consider the effectiveness of the consultation process with young people prior to opting for LARC methods and how this can be improved to increase the retention of implants in particular.

- Formalise procedures between, midwifery, Health Visiting and Children's Centres to ensure the direct referral of young women who have given birth for contraception and follow-up.

- A review of the services and links into specialist 1-1 support for LAC is undertaken to ensure that they receive support to gain the basic life skills needed to measure, assess and respond to risk.

Involvement of Young People

Quality Standards

- Partnerships should actively engage young people (particularly those most likely to be involved in 'risky' behaviour) in the development/delivery and commissioning of services and ensure these processes are evaluated regularly.

- Structures are in place to implement and continually monitor the Your Welcome Quality Criteria. Young people should be at the core of processes to monitor standards of provision in service settings in accordance with You're Welcome Quality Standards.

- Services are utilising digital technology to enable young people to provide feedback on services for example through the use of QR codes to provide service ratings and comments

Services currently engage young people in providing feedback on services through ad hoc surveys and focus groups and using evaluation forms following PSHE workshops. Informal feedback is also received from young people by staff. The introduction of You're Welcome Quality Standards has provided the opportunity for services to examine their practice and accessibility to young people. KISH accreditation will provide a similar process to You're Welcome but for Sexual Health Services. It should be noted that engaging young people who are attending services associated with risk-taking can be challenging and there are some service providers such as YOS and SMS whose clients can be reluctant to provide feedback.

The following table provides a summary of the services that have achieved You're Welcome status, and those which are currently going through this process or plan to.

Table 33: Services and You're Welcome Status

Achieved	Working Towards	To begin
KU19 x 4 clinics	BPAS	Other pharmacies signed up to the Sexual Health Enhanced Service
The Wolverton Centre	Relate	GP's
Ace Pharmacy	CAMHS - Woodroofe House	
	Newman Pharmacy	
	Hawks Rd Pharmacy	
	Boots Bentalls	
	Hawks Rd Clinic	
	Hook Surgery	
	Claremont Surgery	

The You're Welcome and Young Inspectors programme, soon to be in place, provides a strong platform from which to ensure that standards are maintained and adhered to. There is potential to take these programmes a stage further to involve young people in needs assessments and commissioning of services. An area which has already done so is Hammersmith and Fulham Borough Council who, as part of their status as an Innovation Zone, have developed a Youth Commissioners programme.

The PASS Survey (Pupil Attitudes to Self and School) has replaced the previous data collected through the TellUs survey. Local feedback suggests that this does not adequately capture health behaviours. It may be worth considering how to capture data of the health of school age children ensuring that the needs of young people with disabilities are also reflected.

Recommendations

- KISH accreditation processes to continue to be closely linked with You're Welcome Quality Standards.
- Investigation is undertaken into the potential to utilise a digital method to enable young people to provide feedback on all services, e.g. a QR code (for use with smart phones) developed for each site which takes young people directly to a webpage where they can leave feedback on the service they have just accessed.
- Explore the potential to involve young people in the commissioning of services through the Children and Young People's Forum.

- Consider how to capture data of the health of school age children which reflects the needs of vulnerable groups.

Workforce

Quality Standards

- All staff in universal and targeted services should be trained to a level, appropriate to their role, which allows them to identify risk taking behaviours and take appropriate action e.g. to assess children and young people who may be at risk of smoking, alcohol and substance misuse, depression etc or provide direct support.
- A training programme is developed that provides an incremental approach to learning and skills. The programme is integrated into the local Children's Workforce Development Strategy, including mandatory induction training, with recruitment targeted to:
    - prioritised areas of geography with high levels of risk taking behaviours
    - those working with young people identified as being most at risk: youth support workers, Connexions Pas, TYS Lead Professionals, IAG providers, social workers/foster carers/residential workers, YOTs, housing support workers, Learning Mentors, Parent Support Advisers and relevant VCS organisations
- Recruitment of staff working in universal and targeted settings for young people should ensure staff have the right competencies and attitudes to work with young people on a range of sensitive issues.

There was a general sense that Safeguarding training enabled the majority of the frontline workforce to identify young people at severe risk. However, there is not currently a standard approach to ensuring that front line workers are able to identify early signs of young people at risk and therefore be able to put prevention support in place and/or refer a young person for follow-up support.

In addition, an issue raised by a number of respondents was that some staff delivering front line services to young people did not have the approach required to talk to young people about issues of a sensitive nature associated with risk-taking activity. This is of concern and best practice would suggest that staff working in universal and targeted settings for young people should have the right competencies and attitudes to work with young people on a range of sensitive issues.

An interview with the Clinical Nurse at The Wolverton highlighted that nurses do not feel qualified and able to provide in-depth support to young people who are experiencing difficult relationships. The expectation is that these issues will be picked-up by the School Health Service, however the likelihood that a young person who has approached one service and divulged such personal issues, will then attend another is low. This needs exploring with a view to providing more specialised training for nursing staff at The Wolverton (and other front-line professionals) and/or reviewing the links between these services to avoid young people slipping through the net.

Recommendations

- All staff in universal and targeted services should be trained to a level, appropriate to their role, which enables them to identify risk taking behaviours and take appropriate action e.g. to assess children and young people who may be at risk of smoking, alcohol and substance misuse, depression etc and provide direct support. This needs to incorporate an understanding of the complexities of risk-taking for vulnerable groups for example young people exploring their sexuality and present as LGBT and young people with disabilities.

- A training programme is developed that has an incremental approach and is integrated into the local Children's Workforce Development Strategy, including mandatory induction training, with recruitment targeted to:

    - prioritised areas of geography with high levels of risk taking behaviours
    - those working with YP identified as being most at risk: youth support workers, Connexions Pas, TYS Lead Professionals, IAG providers, social workers/foster carers/residential workers, YOTs, housing support workers, Learning Mentors, Parent Support Advisers and relevant VCS organisations

- Young people are always involved in the recruitment process for professionals who will be providing front line services to children and young people

Think Family

Quality Standards

- Local partnerships should ensure that their local Parenting Strategies and 'Think Family' developments specifically target parents and families. This should include information, support and training for parents/carers on preventing, recognising and responding to risk taking behaviour among young people that leads to poor outcomes.

- Additional and more intensive support (for example, family therapy) is offered to families who need it (NICE).

Whilst there is acknowledgment that more work with parents is needed to support them to talk to their children and shape their involvement in risk-taking activities, it was acknowledged that this can be difficult in terms of engagement of parents and capacity to work with families. Some agencies who do not have a specific remit to work with families, such as the Youth Service, do work with families if the need is there and families are receptive.

There was a sense that there was a gap in provision for parents of young people requiring support. As noted in the section 'Epidemiological profile of risk behaviour in Kingston', analysis of the LAC data supports this as there are a significant number of LAC entering the system as teenagers, when parents have found they are unable to cope with their child's behaviour. This is reflected in a significant number of voluntary referrals made by parents to Social Care known as Section 20s. An Educational Psychologist works with parents of LAC in this situation to enable them to develop strategies to respond to their child's behaviour. A lot of parents in this situation also have issues themselves, in particular depression, mental health issues and substance misuse needs (Royal Borough Kingston, 2012). However, parents do not always recognise these issues themselves, and likewise do not recognise them within their own children. The LAC Team are currently working with

the Health Visiting workforce to develop more robust ways of supporting parents to complete the parental history form rather than relying on self-completion by parents where issues can be missed. In addition, plans are proposed for a worker with the LAC Team to provide support to families whose children are registered on the child protection register and have a Child Protection Plan.

School nurses within the School Health Service also work with children in primary schools on a 1-1 basis if there are concerns about the child, for example safeguarding concerns, if parents have substance misuse issues or mental health issues, which takes a family approach.

Recommendations

- The Early Intervention Adolescent Health Governance Board works with Commissioners of services providing support to young people and commissioners of Early Years provision to develop an integrated approach to the prevention of risk-taking from 0-19 years.

- The Early Intervention Adolescent Health Governance Board works with Commissioners of adult services to develop a process of identifying families with a history/current risk-taking behaviour and providing appropriate interventions to prevent this becoming inter-generational.

- A scoping exercise is undertaken to provide a comprehensive understanding of what support is provided to families, by which agencies, with which children and young people, and at which point on the spectrum of prevention/early intervention support.

- Undertake further work to ensure the engagement of parents in processes to support young people in prevention of risk-taking and ensure parents are consulted as part of on-going needs assessment.

- Intensive family support is provided to families of children who are registered as Cause for Concern with Social Care, and the need for parent support is assessed for children who are classed as vulnerable and require monitoring.

- A pilot project is developed to provide a health assessment for birth parents whose child becomes subject to a Child Protection Plan.

Appendix I (Examples of Practice) provides two examples of integrated 0-19s prevention and early intervention structures within Children's Services for Salford City Council and Suffolk County Council.

Common Characteristics of Prevention and Early Intervention Services

RBK are currently merging with Richmond Borough Council (RBC) and re-structuring is currently in process. Richmond Borough Council have already begun to establish prevention and early intervention services and learning from this will inform the direction of developments in RBK. In addition, Appendix I provides a summary of the approach that four other Local Authorities have

taken to prevention and early intervention. Whilst the models are all different, as they are shaped by local structures and services, they share common characteristics that Kingston may wish to consider going forward including:

- Cultural shift to support prevention and early identification – Whole scale change has been achieved through leadership and extensive work with all parts of the system to develop a culture that thinks prevention and values early identification. This can present both challenges and opportunities for new ways of working.
- Multi-agency commissioning and strong partnership working
- Shared outcomes framework
- Using national and international research around what works in terms of interventions and programmes of work to drive the agenda forward and make the case for change
- Focus in areas of need – move to cluster arrangements in the future
- Workforce development which is seen as key to successful frontline delivery
- Single point of contact where families and young people can receive an integrated response
- Joint referral, assessment and case management procedures
- Shared reporting criteria and performance management arrangements focused on demonstrating outcomes and results for children and families

Summary

Re-structuring within Kingston is moving towards a model of integrated service provision which, it is expected, will lead to improved outcomes for children and young people. It is important going forward that this takes a broad approach to prevention and early intervention starting in the early years of the life course through to adolescence, and within the context of family life and support for parents. This should draw on best practice in delivering behavioural interventions which are targeted at addressing the underlying causes of risk-taking behaviour. Children and young people have good outcomes in Kingston and overall have low levels of risk-taking in comparison to England and London averages, and similar or lower levels compared to their statistical neighbours, for many indicators related to risky behaviour. However, services are currently disparate and there is a need to provide more integrated support at a universal level building on existing work. This is particularly the case with respect to promoting health and well-being which is key to prevention of risk-taking behaviours overall. A strategic approach to prevention and early intervention among targeted groups is required with a systematic process of identification to enable consistency and ensure that young people do not fall through the net.

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