Section 2

Maintaining and improving the health and wellbeing of children in the “cold climate”

Heema Shukla

Introduction
The two overarching public health outcomes that local governments will be responsible for as they take on their new responsibilities from 2013 are:

- Increased healthy life expectancy
- Reduced differences in life expectancy and healthy life expectancy between communities

In this section, we provide insights into how this can be achieved in the ‘cold climate’ by enhancing and building on what is currently working in Hillingdon. We provide expert public health advice on areas where joint efforts between Local authority, Clinical commissioning groups (CCGs), and the wider society can realize health gains for the local population.

Why prevention in early life saves more lives?

The ‘Early Years’ period is key determinant of future health.

The foundations for virtually every aspect of human development - physical, intellectual, and emotional - are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being - from obesity, heart disease, and mental health, to educational achievement and economic status.

Marmot Review 2010

Past successes in children’s public health
One of the major successes of public health has been the improvement in maternal and child health worldwide which has resulted in improvements in life expectancy. The 2011 report of the World Health Organisation (WHO) on trends in child mortality estimates that the global under-five mortality rate has dropped by 35%—from 88 deaths per 1,000 live births in 1990 to 57 in 2010. Clean water, immunization against vaccine preventable disease, access to good quality health care and better maternal and child nutrition have
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contributed to better health outcomes for children under the age of five years.

Children’s public health programme

In the UK, the Healthy Child Programme (HCP) is a universal service. It is a public health programme for early intervention and prevention aimed at all children and their families. The HCP offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices – all services that children and families need to receive if they are to achieve their optimum health and wellbeing. At the same time, the HCP’s universal reach provides an invaluable opportunity to identify families that are in need of additional support and children who are at risk of poor outcomes.

One of the biggest successes in children’s health in Hillingdon in recent years has been the improvement in uptake of the childhood vaccination programme, with most vaccinations reaching a coverage of 95% required to achieve community immunity to vaccine preventable infectious diseases. The Chapter on vaccinations in a later section describes how this success was achieved through a public health approach of systematic investigation of data quality and measurement; needs based community outreach, and a balanced performance management process.

Marmot Review- call for the second revolution in early life

The Marmot review, whilst recognising the improvements in child health in the past, concluded that much more needed to be done to reduce the inequalities in health starting early in life, and called for the second revolution in early years. It recommended three policy objectives to meet the three key objectives for early life.

The Marmot Review key objectives for Early Years

1. Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills;

2. Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient;

3. Build the resilience and well-being of young children across the social gradient.
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Marmot’s three key policy objectives

1. To increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient.

2. Support families to achieve progressive improvements in early years development, including:
   • Giving priority to pre and postnatal interventions, such as intensive home visiting programmes, that reduce adverse outcomes of pregnancy and infancy
   • Providing paid parental leave in the first year of life, with a minimum income for healthy living
   • Providing routine support to families through parenting programmes, children’s centres and key workers, delivered to meet social need via outreach to families

3. Developing programmes for the transition to school. Provide good quality early years education and childcare proportionately across the gradient. This provision should be:
   • Combined with outreach to increase the take-up by children from disadvantaged families
   • Provided on the basis of evaluated models and must meet quality standards

New challenges in children’s public health

However, recent years have seen new challenges both in early years and school years as factors such as parental health, behaviours and income are becoming increasingly complex and impacting on physical, emotional and mental health of children. Secondly as young people approach adulthood and their sexually active years, they confront new choices and exposures. These include alcohol consumption, illicit drug and tobacco use, risky sexual behaviour, violence and injuries (including those from road traffic accidents).

What a child eats, what a child drinks, and what activity a child takes, all have a decisive impact on a child’s current health, and future development into an adult

Royal College of Paediatrics and Child Health

The improvements made in population nutrition in the last century are now being threatened with the shift to overnutrition related ill-health. With the rise in childhood obesity, we are facing for the first time in recent years, a public health issue that is threatening to reverse the gains made in life expectancy in the last few decades. On the other hand, we have seen the reemergence of nutritional deficiency disorders such as rickets in the UK. Paediatric orthopaedic departments report vitamin insufficiency in about 1 in 3 children and deficiency in about 8% of children, similar to that found in the national
nutrition and diet survey (NDNS). Iron deficiency was found in 1 in 3 pregnant women in a study of 11 maternity units in the UK. About 1 in 3 children are overweight/obese.

The chapter by Shikha Sharma, Consultant in Public Health, discusses the causes and consequences of childhood obesity and the impact of the recession on childhood obesity. She presents the evidence base for tackling obesity and describes the progress made by the Council and NHS in 'Making Hillingdon Fitter for the Future.' Sharon Daye, Public Health Consultant, describes the importance of the 'Healthy Start' programme in the cold climate and the importance of maximizing the benefits from the programme locally.

The World Health Organisation's Global Healthy Schools Initiative
Healthy Settings, the settings-based approaches to health promotion, involves a holistic and multi-disciplinary method, which integrates action across risk factors. The goal is to maximize disease prevention via a "whole system" approach. A health promoting school is one that constantly strengthens its capacity as a healthy setting for living, learning and working. The Initiative is designed to improve the health of students, school personnel, families and other members of the community through schools. The Chapter on Healthy Schools by frontline public health (Health improvement) practitioners, Tom Dunn, Tessa Pike and Malin Stenstrom, describe the Healthy Schools Programme in Hillingdon, the success stories in many schools and the challenges in rolling this out across Hillingdon in the cold climate. They make recommendations on future direction as local authorities become responsible for public health.

The cold climate and children’s public health
Past lessons from economic recessions have shown that the vulnerabilities of children increase during recession and unless policies are in place, the negative impacts of financial crisis on children’s' health and wellbeing can be long lasting. Evidence from other countries suggests that sudden unemployment and inadequate financial resources can lead to parental conflict, mental health problems, and less parental care. In addition to physical health, adverse changes were observed in social behaviors. Some children internalise (withdraw from social interactions) whilst others externalise (become aggressive). Whilst the effects depend to an extent on the development stage of the country, within the high income countries, social policies appear to have a buffering effect. Hence countries such as Sweden and Finland where there was not much need for families to downsize housing there were not significant adverse effects on children’s public health. The chapters by the front line ‘public health (Healthcare) practitioners’ Teresa Chilsolm, and Carole Page on improving health of looked after children, and reducing teenage conceptions provide insights on how the resident child
population in Hillingdon can be protected from the consequences of the ‘cold climate’ by enhancing the current evidence-based practice.

The key priorities in children’s public health for the next five years

The new responsibilities of local authorities on local public health outcomes and general practice on commissioning health services, provides opportunities to enhance what already been achieved on the wider determinants of child health and child healthcare in a more joined up approach through the Health and Wellbeing Board. To reduce the impact of the consequences of ‘cold climate’ on children’s health the priorities for next five years are provided in the box below.

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**Reduce child poverty**

**Improve child development in early years, that include all three dimensions – physical development, personal, social and emotional development and communication and language**

**Enable children and young people to achieve their potential through improved attendance at school and remaining in education, employment or training, respectively.**

**Ensure better health outcomes in later life by enabling healthy weights from birth and during childhood**

**Reduce risky behaviour in young people**

**Protect children against childhood infectious diseases by achieving ‘herd immunity’ (levels of immunity in the community that prevents the transmission of the infectious disease in the community) through vaccination**

**Protect and promote health and wellbeing of vulnerable children through safeguarding and youth justice system**

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**Conclusions**

Many of the early life programmes have a good evidence base and are well received by parents/guardians. There is sufficient evidence that interventions beyond the 0-5 years such as the family-nurse partnerships, healthy schools programmes and access to good quality education continue adding positive impact on the health and wellbeing of children. It is well established that a life course approach to good health ensuring that children have the best start in life – through good nutrition, immunization against vaccine-preventable diseases and environments that enable them to be safe and physically active – establishes a solid base for good health and contributes to healthy behaviour for years to come.
Childhood obesity - one of the most serious public health challenge of the 21\textsuperscript{st} century

Shikha Sharma

“Childhood obesity is proving to be one of the most pressing and unprecedented child health issues in 21st century Britain”

National Children Bureau

Introduction
Currently, a third of children in England are overweight. Obesity in childhood is a widely cross cutting issue, because both the aetiology and consequences are multi-factorial. The physical health risks that are associated with being overweight include increased risk of childhood diabetes, fatty liver, as well as heart disease and certain types of cancer in adults. Obesity contributes to the biggest killer diseases in adulthood. Around 10\% of all cancer deaths among non-smokers are related to obesity. The risk of coronary artery disease increases linearly with obesity. Also obesity is the biggest risk factor for diabetes and there is an increasing trend in diabetes in adolescence. A recent study (Gardner et al, 2009) showed that most excessive weight before puberty is gained before the age of five. The study also found that the metabolic markers of abnormal glucose metabolism, high blood pressure and high cholesterol were already present in children by age nine.

“Children and their parents needed to be aware of the hidden health risks and complications of weighing too much, given that fat could be stored around internal organs, as well as on the body surface”

Professor Dame Sally Davies, Chief Medical Officer for England

Heavier babies are at increased risk of later obesity, as are low birthweight babies who grow rapidly (but not necessarily overweight). Once a child is obese, higher risk continues into adulthood (Rudolf M, 2009).
Considering that young people who are obese have a 70% chance of becoming overweight or obese adults, the argument for tackling overweight and obesity as early as possible is a strong one as this will ultimately improve life expectancy. Some studies have shown that if current obesity trend continues life expectancy could drop by 11 years.

**Economics of childhood obesity**
The costs of obesity can be divided broadly into direct medical costs, costs related to reduced productivity due to absence and sickness, and costs related to transport and adapting transfer equipment. The estimated cost to the NHS of obesity related conditions was estimated at £4.2 billion in 2007, with a potential to rise up to £6.4bn in 2015 and up to £9.7bn in 2050. Need for specialist equipment in the NHS for example, stronger beds and trolleys, wider wheelchairs, examination couches, additional and specialist staff required for more complex births to obese mothers are examples of the additional costs.

A more recent analysis (Scarborough et al, 2011) of the current burden estimated costs to the NHS at £5.1bn per year. For London, the same cost based on 2007/08 prices is estimated at £110.8 million per year (GLA, 2011). But there are also costs to society and the economy more broadly – for example, sickness absence reduces productivity. Foresight estimated that weight problems already cost the wider economy in the region of £16 billion, and that this will rise to £50 billion per year by 2050 if left unchecked.

**Causes of childhood obesity**
Childhood obesity is a highly complex phenomenon. Poor dietary choices and physical inactivity offer the most simplistic and basic explanation – too much energy intake and less expenditure results into accumulation of excess calories as fat in our bodies, leading to overweight and obesity.

However, a wide range of spatial, demographic and cultural factors help determine a child’s intake of food and level of physical activity. The specific variables with the strongest correlation with childhood obesity are parental BMI and deprivation; links with participation in sports, fruit and vegetable consumption, breastfeeding and availability of open space are apparent.

In recent times, the Foresight report (2007) provides the most comprehensive evidence. The Foresight programme advises the government about how to ensure today’s decisions are robust to meet future uncertainties. By combining the latest scientific evidence with future modeling and analysis, it helps policy makers develop a better understanding of the potential opportunities and challenges that lie ahead.
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Detailed modelling and analysis done by the Foresight programme in relation to obesity demonstrated how the human biology became overwhelmed by the modern ‘obesogenic’ environment. As the human race evolved, our bodies adapted to becoming more finely attuned to food scarcity than food abundance. Hormonal physiology encourages us to seek food when we are hungry and to conserve energy when food is scarce; we do not seem to have comparable feedback loops to prevent us from overeating or to burn extra calories when food is abundant. While many years ago our ancestors would have spent a lot of energy to find some food; in the modern times, we are surrounded by energy dense, high calorie food and have much less need to be active.

Psychological forces also come into play. Many people use food not merely for sustenance but also as a reward (even after exercise), for emotional comfort, or as a way of relieving stress. Several mental disorders, including depression, increase the risk of obesity.

Changes in the economics of food production have also contributed to the pandemic. Advances in food production have markedly reduced the cost of many types of food, which has made it easier for people to overindulge. Therefore, adoption of a modern-Western diet full of nutrient-poor processed foods helps explain the coexistence of obesity and malnutrition (Algazy and Gipstein, 2010). Lifestyle changes in adults are also responsible for the rise in child obesity. Parental attitudes and behaviours related to activity / inactivity and types of food purchased and eaten at home and outside home impacts on their children’s habits.

Odds ratios of child obesity by parents’ obesity status in England

![Odds ratio chart for child obesity by parents' obesity status](image)

Source: Organisation for Economic Co-operation and Development (OECD) ‘Fit not fat’ – United Kingdom
Compounding this problem is the fact that in most countries, healthy foods (fresh fruits and vegetables, for example) are often more expensive than unhealthy choices; most inexpensive food is nutrient-poor and full of sugar, salt, and fat.

**Impact of the cold climate on childhood obesity**

The Marmot review (Marmot, 2010) showed how income, social deprivation, and ethnicity have an important impact on becoming obese. Recent local as well as national reports confirm a strong relationship between child obesity and socioeconomic status, with higher obesity prevalence in more deprived areas. Nearly 60% of the variation in obesity prevalence between local authority areas can be explained by the proportion of children living in low-income households. Obesity prevalence in this age group varies by around 10% on average between the most deprived and least. Reports from US and Wales suggest that families switch to cheaper fat and calorie rich foods during recession with adverse impact on levels of obesity. In Wales, there was an annual increase rise of 3% in obesity levels last year. There are also suggestions from elsewhere about reduced intake of readily available foods and increased activity through use of physical transport. The trade-offs will depend on the costs of foods locally and so the impacts of recession on childhood obesity differ between and within countries.

**A new ‘call to action’ on obesity**

The government paper ‘Healthy Lives, Healthy People: A call to action on obesity’, provides strategic direction by giving local authorities a lead role in developing and implementing strategies, and to integrate efforts with the NHS, Public Health England and other key partners. It outlined the importance of taking a life course approach to obesity, and set out two new national ambitions:

- A sustained downward trend in the level of excess weight in children by 2020
- A downward trend in the level of excess weight averaged across all adults by 2020

The new strategy is based on the new public health system. The Health and Wellbeing Boards will be key driver to bring a range of partners together to agree a local strategy that has a balance between treatment, to support those already obese or overweight to achieve healthy weight, and prevention to help maintain healthy weights. The approach is shown in the figure below.
Tackling obesity in London

The London Mayor and the Greater London Authority (GLA), via the London Health Improvement Board (LHIB), is planning to support the ‘refreshed’ Healthy Schools programmes called ‘Healthy Schools London’ which will build on current healthy schools’ achievements and bring the added value of GLA involvement, and links with the opportunities afforded by the Olympics. On a long-term basis, the LHIB will provide strategic and practical support to Local Authority action through developing a London Obesity Framework.

Evidence base: what works to reduce the levels of obesity?

The obesity epidemic has developed more recently and therefore, to some extent evidence about dealing with it at population as well as individual level is in its infancy. There is consensus from recent literature that broadly based societal interventions are needed to tackle the problem of increasing overweight and obesity (Rice et al, 2011). However, distinction between prevention and treatment is important when reviewing literature on ‘what works’.

National and international studies make recommendations (Gortmaker et al, 2011) that include policies to improve food and built environments, cross-cutting actions, such as leadership, healthy public policies, and monitoring, and much greater investment in preventative programmes which have higher cost effectiveness over time.
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The Foresight Report (2007) further provided evidence on population based programmes and strategies shown to be effective in tackling obesity such as the French EPODE project on town planning and Barnsley4health. The report outlined ‘Top Ten Tips’ for Local Governments, which can be adapted by Health and Wellbeing Boards. The ‘Well London’ programme encompassed some aspects of EPODE, as did the ‘Healthy Borough’ project in Tower Hamlets, which targets children and families to be more active, eat more healthily and covers the design of physical environment, parks, open spaces, active travel and workplace based initiatives. The GLA report ‘Tipping the scales’ concluded its analysis of evidence by suggesting that it is important to address multiple contributory factors simultaneously and the involvement of families is vital. Parental obesity needs to be addressed alongside childhood obesity.

**Foresight Top Ten Tips for Local Authorities**

1. **Rise to the challenge** - We are on the verge of an obesity epidemic even though there are mixed messages from the media. Get a better understanding of what this means for your residents locally.

2. **Prioritise obesity prevention** – take a holistic approach to tackling obesity and the obesogenic environment. For example, connect the obesity strategy to other strategies such as reducing carbon emissions where possible – resist the simplistic individual lifestyle choice explanations and focus on the environment. The personal changes will follow with less resistance.

3. **Target children and vulnerable groups in raising obesity awareness and providing opportunities**

4. **Don’t do it alone.** Local strategic partnerships have been developed to bring partner agencies to work together on local issues, such as obesity prevention.

5. **Identify ‘obesity champions’.** This might be the lead for public health or the lead for children’s health or a local mayor or lead councillor. They can capture support with their passion to tackle obesity.

6. **Stay local.** The Sustainable Community Strategy is intended to generate local action and solutions to obesity prevention.

7. **One size does not fit all.** Work with individuals at the grass roots level to find out what activity projects people would attend.

8. **Practice what you preach.** Be a model employer and develop healthy workplace objectives.

9. **Don’t re-invent the wheel.** There is a lot of evidence out there to show what works to combat and prevent obesity, this can be tailored to fit local circumstances. Learn from good practice elsewhere make information available to all agencies and signpost people to the evidence.

10. **Make information accessible.** Help people understand practical examples of an unhealthy energy imbalance, for example, how much extra walking is needed to burn off a chocolate bar or a glass of wine.
The National Institute for Health and Clinical Excellence produced evidence-based guidance on obesity prevention and management for adults and children (CG43 NICE, 2006) which is being updated (NICE Dec 2011).

**New Evidence since 2008**
A recent report (Rudolf, 2009) outlined a compelling case for intervening in early years. The report based on critical review of evidence provided guidance and practical direction on strategies to reduce the risks of obesity for babies, toddlers, and preschool children. Nineteen themes for action are outlined that have the potential to encourage the development of a lifelong healthy lifestyle and reduce the risk of obesity. These provide a framework for practitioners who work with parents and carers; offer some clear messages for parents on how to develop a healthy home environment for their young children, and provide a basis for guiding public health strategy.

### A Framework for Action

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<th>Development of a healthy lifestyle</th>
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<td><strong>Parenting</strong></td>
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<tr>
<td>1. Encourage parents and carers to model a healthy lifestyle</td>
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<td>2. Help parents enhance their parenting skills and develop an authoritative approach to shaping their children’s lifestyles</td>
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<td>3. Encourage parents and carers to take a whole family approach</td>
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<td><strong>Eating and Feeding Behaviour</strong></td>
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<td>4. Encourage responsive feeding</td>
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<td>5. Encourage positive mealtimes</td>
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<td>6. Find alternatives to food for comfort and to encourage good behaviour</td>
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<td><strong>Nutrition</strong></td>
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<td>7. Encourage exclusive breast feeding for six months</td>
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<td>8. Introduce solid foods at six months</td>
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<td>9. Ensure portion sizes are appropriate for age</td>
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<td>10. Increase acceptance of healthy foods – including fruit and vegetables</td>
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<td>11. Reduce availability and accessibility of energy dense food in the home</td>
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<td>12. Reduce consumption of sweet drinks and increase consumption of water</td>
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<td><strong>Play, inactivity and sleep</strong></td>
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<td>13. Encourage active play</td>
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<td>14. Create safer play-space at home</td>
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<td>15. Reduce sedentary behaviour and screen time</td>
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<td>16. Ensure children get a good night’s sleep</td>
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**Enhancing practitioners’ effectiveness**

1. Recognise babies and toddlers who are at particular risk for obesity
2. Provide training on how to help parents make lifestyle changes
3. Encourage practitioners to model healthy lifestyles

The cost effectiveness of childhood prevention programmes

According to a recent OECD report, prevention can improve health at a lower cost than many treatments offered today by OECD health systems. In England, all of the prevention programmes examined will be cost-effective in the long run – relative to the commonly used standard of £30 000 per year of life gained in good health. However, some programmes will take a longer time to produce their health effects and therefore will be less cost-effective in the short run. Individual prevention programmes could avoid up to 40,000 deaths from chronic diseases every year in England. Deaths avoided could increase to 70,000 if different interventions were combined in a comprehensive prevention strategy. An organised programme of counselling of obese people by their family doctors would also lead to an annual gain of over 100 000 years of life in good health.

Cost per life year gained in good health of interventions to tackle obesity

Source: Organisation for Economic Co-operation and Development (OECD) ‘Fit not fat’ – United Kingdom

Health economic evaluation of obesity programmes

Some of the programmes developed in recent years combine approaches highlighted in national and international studies and show evidence of cost effectiveness.
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**MEND (Mind, Exercise, Nutrition...Do it!), UK**
Mend is a community based weight management programme for overweight children and their families providing nutritional education and physical activity. MEND has been the subject of a Randomised Controlled Trial (RCT) of 300 overweight and obese children aged 7-13 years by the MRC Childhood Nutrition Research Centre, UCL Institute of Child Health and Great Ormond Street Hospital for Children NHS Trust. Significant improvements were observed in waist circumference, BMI, cardiovascular fitness and self-esteem in the MEND sample group.

Cost per quality adjusted life year (QALY) based on weight loss among child participants was £1,700.

**Planet Health, USA**
Planet Health aims to introduce a multi-disciplinary health-based curriculum into schools, enabling teachers to promote healthy food choices and exercise.

Cost per QALY is US$4,300.

**CATCH (Coordinated Approach to Child Health), USA**
A school based programme that promotes healthy eating, physical activity, including classroom education, intensive PE, healthier school food and parental involvement.

Cost per QALY is US$900.

**Reduction in television viewing, Australia**
A school based programme for teachers to instruct pupils in intelligent television viewing, including a weekly TV budget for children.

Cost per disability adjusted life year (DALY) is AU$3,000.

**Regulation of television advertising, Australia**
Advertising of food and drink high in fat and sugar aimed at children under 14 was precluded at certain times.

Cost per DALY is £3.70.

**Medical Interventions, Australia**
Surgical interventions to reduce calorific intake such as gastric banding and pharmaceutical therapy.

Cost per DALY is AU$ 4,000 – 8,000.
Obesity in Hillingdon: the story so far…

In previous years, the Hillingdon Overview and Scrutiny (OSC) examined the issue of obesity in Hillingdon and made 30 recommendations based on research evidence and local evidence presented by local stakeholders. Those recommendations align well with the ‘Ten Tips’ from the Foresight report and the NICE guidance. Fourteen of the recommendations are aimed to tackle obesity in resident children from birth to adolescence. One of the recommendations was in anticipation of an appointment of a joint director of public health

**Recommendation 4**

*That Cabinet ensures the new Director of Public Health focuses on obesity as one of her/his main priorities in recognition that this over-arching health challenge will address many other health conditions such as diabetes and heart disease.*

Hillingdon introduced MEND to pilot a partnership model between NHS, Leisure Services of the Council, and a local school to test the efficacy of MEND as a treatment programme for obese children within local settings. Sport England sponsored this pilot. The evidence from this pilot showed that the partnership model using school nurses and trained PE teachers’ added benefit to the programme above that of weight loss. School nurses were able to support the improvement in emotional wellbeing and PE teachers introduced other physical activities within the locality to the children. The programme achieved significant reductions in participants’ BMI, waist circumference, blood pressure, and sedentary time, while children’s self-esteem and time spent on physical activity increased.

The Council and NHS Hillingdon, through the Local Area Agreements further rolled this programme across the Borough to gain significant disability adjusted life years’ worth over £600K to the local health economy. NHS Hillingdon embedded the programme within the school nurse service through mainstream commissioning budgets.

**The prevalence of childhood obesity in Hillingdon**

The latest data from the NCMP programme shows that more than 1 in 5 children are overweight or obese by age 5 (year R), and 1 in 3 by age 11 (year 6). In Hillingdon, childhood obesity rates have been steadily increasing in line with national increases. Based on a tool using the Health Survey for England 2006, Hillingdon is estimated to have roughly 9,000 obese children aged 15 years under; and many more are overweight.
Issues faced by health professionals

Practitioners face barriers in effectively tackling childhood obesity, firstly due to a level of acceptance and ‘visual conditioning’ of the society where large or big might be considered normal. Our experience of providing feedback to parents on their children’s BMIs as part of the National Child Measurement Programme (NCMP) confirms that for some parents with overweight and obese children, this topic stirs emotions. Some of the other parents may consider their child’s size or their own as a metabolic issue, which is not true for the majority of overweight and obese children (Reilly, 2009). It is therefore important that the frontline staff in healthcare, social care, early years, and educational settings is adequately trained and skilled to address the issue of weight with children and parents, so that those professionals feel enabled and supported to refer to local programmes.

A local strategy to tackle obesity

A local partnership chaired by public health, called the ‘Hillingdon Obesity Strategy Group’ has representation from council’s policy team, leisure, education, health promotion and local NHS providers. Based on the recommendations of an Overview and Scrutiny Committee report ‘Making Hillingdon Fitter for the Future’, the group prioritised action on early years to tackle the ‘conveyor belt effect’ where a fifth of children starting school (Reception Year) are already overweight or obese, and obesity rates more than double during school life. The Public Health team produced a report (Ross, K, 2011) on the children’s centres in Hillingdon, which highlighted how to reach out to families with young children, especially those who are vulnerable through the early years’ settings.

The recommendations which involve the Council, the NHS and business partners are incorporated into action plans for children’s centres and the obesity strategy group. A children’s obesity care pathway is being piloted with NHS providers and MEND programme targeting the 2-4 year age group. The Public Health Team currently commissions MEND for children aged 7-13, 5-7 and the LBH Leisure Team provides a locally developed ‘Fit-Teens’ programme for children aged 13 and above.

The Hillingdon Healthy Schools Programme has developed local tools to support schools to maintain standards around four themes: Personal Social and Health Education, Healthy Eating, Emotional Health and Wellbeing and Physical Activity. The new model for Healthy schools aims to improve health and wellbeing for all children including those in challenging circumstances and improve joining up of provision by supporting closer partnership with other agencies. Under the Enhanced Healthy Schools model, 14 schools have submitted plans, out of which: 8 schools are addressing Oral Health,
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addressing Healthy Weight, 7 Healthy Lifestyles (combining elements of the above), and 1 school committed to Increasing physical activity.

Obesity reduction interventions including those that have been implemented in Hillingdon may have benefits beyond their perceived impact on overweight and obesity; for instance, cutting down of sugary drinks in children’s diet, and ‘breast/bottle to cup’ initiative would improve dental health of under 5s. The ‘Walk to school’ programme may help to reduce traffic congestion and pollution. Sports clubs, walking schemes for mums with pushchairs may be effective at improving social inclusion.

Hillingdon is in the process of producing a Physical Activity Strategy, which brings together partners from transport, leisure, planning, community safety, mental health, and the NHS. One of the key aims is to maximize the opportunities provided by the 2012 Olympic Legacy to increase physical activity rates in the borough. Use of multimedia social networks might have a role to play. Evidence around the use of internet, twitter, and Facebook is currently being explored.

CONCLUSION

Clinical and public health responses to the obesity epidemic have been overtaken by the speed and scale of the increase in obesity. Even if the current rates persist with no further increases, the number of overweight and obese children growing into overweight and obese adults poses a serious challenge to the society and economy, with serious consequences for everyone.

Childhood obesity has increased considerably in prevalence across the country. In Hillingdon, over 20% of children are overweight or obese before they enter school, and obesity rates more than double by age 11. Child obesity has important impacts on short and long-term health that are not fully understood by parents, families, local planners, or health professionals.

The Hillingdon OSC committee report initiated action in Hillingdon, which needs to continue with support from the Joint Director of Public Health and partners from leisure, transport, planning, education, and the NHS. The evidence base on strategies for prevention and treatment is limited but growing. Large-scale societal actions aimed at making the environment less “obesogenic”, and action on early years seem necessary if the current year on year rate of childhood obesity prevalence is to be reduced. Despite weaknesses in the evidence base, there is sufficient guidance on prevention and treatment in the UK, which has been used to provide local programmes like breastfeeding promotion, MEND and Healthy Schools.
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Hillingdon has a strong history of working in partnership demonstrated through successful delivery of Local Area Agreement Targets, including one on obesity. The latest government strategy ‘A call to action on obesity’ gives local authorities the leadership role. Hillingdon Well Being Board provides a local framework for working in partnership. Some of the existing treatment and prevention strategies seem promising models on which future responses to this important public health issue can be built.
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Healthy Start: Improving nutritional health and choices early in life

Sharon Daye

Women from disadvantaged groups have a poorer diet and are less likely to take folic acid or other supplements than those who are better off. They are more likely to be overweight or show low weight gain during pregnancy and their babies are more likely to have a low birth weight. Mothers from these groups are also less likely to breastfeed and more likely to introduce solid foods earlier than recommended. Because of many of these factors, their children are more likely to be under-weight as infants while also being more prone to obesity later in childhood.

NICE Public Health Guidance (PH11)

Introduction
Poverty predisposes childbearing women and children to poor nutrition, whether measured in terms of food intake, nutrient intake, or nutritional status (Dowler et al, 2007). A number of studies have found that women with low incomes have reference values for most nutrients, which are far below what they should be. Their consumption of healthy foods such as vegetables, fruit, milk, and fruit juice is low, resulting in a range of adverse health, developmental and educational outcomes with both short and long-term consequences for not only maternal, infant and child health, but also ultimately adult health (Dyson et al). A good diet in childhood can help to protect against chronic disease normally associated with adult life such as diabetes, cancer, cardiovascular heart diseases, and stroke, in later life. There is also growing evidence that excessive weight gain in the first few years of a child’s life could increase the likelihood of obesity in later years. In addition, poorly nourished children, in particular those overweight and obese can experience social and psychological problems (Hardman and Stensel, 2003).

Evidence based guidelines
NICE published public health guidance to address the issues of poor nutrition in low-income families ‘improving the nutrition of pregnant and breastfeeding mothers and children in low income families’ (PH Guidance
11). NICE identified six areas that were identified as key priorities for implementation, based on these criteria:

- impact on health inequalities
- impact on health of the target population
- balance of risks and benefits
- cost effectiveness
- ease of implementation
- Speed of impact.

**Healthy Start**

**Vitamin D**

**Training**

**Folic Acid**

**Breast feeding**

Healthy Start and Vitamin D are the focus of this chapter.

**Healthy Start - A nutrition welfare scheme**

In 2006, the DH Healthy Start Scheme aimed to address nutritional issues in pregnant women from low-income groups and disadvantaged households, through the receipt of vouchers free milk and fresh fruit and vegetables, in addition to Folic Acid and vitamin supplements containing vitamin A, C, D. Healthy Start is a statutory scheme which aims to provide a *nutritional ‘safety net’* and encouragement for breastfeeding and healthy eating for over half a million vulnerable pregnant women, breastfeeding women and children up to age four in low income and disadvantaged families across the UK. Healthy Start is regarded as key to reducing health inequalities, as it provides targeted support to the nutritionally vulnerable.

Healthy Start has its roots set squarely in the Welfare Food Scheme (WFS) that was introduced in the UK 1940, as a wartime measure to help ensure the provision of an adequate diet under rationing conditions. The WFS was replaced by Healthy Start in 2006 following the independent Acheson Enquiry (Acheson, 1998) into health inequality in 1998 which highlighted the problem of poor health in low-income families, and a scientific review in 2002 (COMA, 2002) which recommended that the predominantly milk-based WFS should give way to one that promoted healthy eating more broadly (Dyson et al 2007).
As shown, in Table 1, free vitamin supplements are intrinsic to both programmes, although the formulations have changed.

**Table 1: Comparison of national Healthy Start and Welfare Food Schemes**

<table>
<thead>
<tr>
<th>WELFARE FOOD SCHEME (1940)</th>
<th>HEALTHY START (2006)</th>
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</thead>
<tbody>
<tr>
<td>‘Means tested’ – Applied via benefits</td>
<td>Remains ‘Means Tested’ – Applied via health professional (midwife, health visitor or GP); All pregnant teenagers eligible.</td>
</tr>
</tbody>
</table>
| Weekly tokens to exchange for milk or infant formula, which could be exchanged for seven pints of milk per week from retailer, or 900g of infant formula (from child health clinic) | Weekly vouchers worth £2.80 to use at registered retailers to pay for:  
  • Milk  
  • Fresh fruit and vegetables (since April 2011)  
  • Infant formula. |
| Pregnant women and children under 5 got one token per week | Pregnant women and children aged from 1 year up to end of third year get one voucher/week: Children under 1 get two vouchers per week: Children aged 4 and over get no vouchers. |
| Free vitamin drops | Free vitamin drops (different formulation) |


Within the Healthy Start programme women are entitled to receive free vitamin supplements (tablets) from the time they are pregnant and up until their baby is a year old. Children receive free vitamin supplements (drops) from 6 months until their fourth birthday.

There are three key differences between the programmes,

- Whereas the WFS provided milk tokens to eligible women for the purchase of cow’s milk, the Healthy Start vouchers enable eligible women to purchase fresh fruit and vegetables, as well as cow’s and/or infant formula milk.

- Women’s applications for Healthy Start are supported by a health professional, (e.g. Midwife, Health Visitor) as opposed the benefits system, which serves to encourage earlier and closer contact between health professionals and families from disadvantaged groups.

- The Scheme is available to all teenagers under 18 years of age who are pregnant or mothers of children.
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It is important to note that despite the provision of vouchers for milk the scheme recognises the importance of breast feeding. The rationale behind the Healthy Start programme was that it would encourage pregnant women and families from low income groups to eat a more nutritious diet.

Who Qualifies for the Scheme?
Healthy Start is open to pregnant women and families with children under the age of four who are on:

- Income Support
- income-based Jobseeker’s Allowance or
- Child Tax Credit (but not Working Tax Credit unless their family is receiving Working Tax Credit run-on only) with an income of £16,190 a year or less (2008/9)
- All pregnant women under the age of 18 also qualify, whether or not they are on benefits.

How does Healthy Start work?

**Fresh Fruit and Vegetables**

Once accepted onto the scheme, pregnant women and families receive a set of vouchers through the post every four weeks. Each voucher is worth £3.10 and can be exchanged for any combination of milk, fresh fruit, fresh vegetables and infant formula milk in registered shops. As of 6th April 2011, women and families supported by Healthy Start should also be able to spend their vouchers on plain frozen fruit and vegetables as well as the existing products on the scheme; milk, fresh fruit and vegetables and infant formula.

**Vitamin Supplements**

The scheme emphasises the important role that health care professionals (midwives, health visitors, GPs and nurses) have, in discussing with women the importance of vitamin supplements even though they may have a healthy, balanced diet. Vitamins A and D for children and vitamin D and folic acid for women are the particular vitamins that women and children may not be getting in adequate quantities.

**Health Advice**

As well as their vouchers, beneficiaries also receive health advice about healthy eating, breastfeeding, infant feeding, and using the vouchers.
Primary Care Trusts (PCTs) are charged with making Healthy Start vitamin supplements available to eligible women. Beneficiaries are able to claim their vitamins from the distribution points at their local community health care provider venue, e.g. reception staff at health centres, clinics, or children’s centres.

Those not eligible for the Healthy Start Programme/Non-Healthy Start Beneficiaries are able to purchase Healthy Start branded vitamin supplements at a differential price.

- Healthy Start Children's vitamin drops: £1.77 per bottle
- Healthy Start Vitamins for women: 90p per pot

Reducing the public health burden of vitamin deficiency
The benefit that the implementation of the national Healthy Start scheme is that it aims to address the significant public health issue of vitamin D insufficiency and deficiency. Vitamin D deficiency is a common problem in the UK. It is not necessarily solely related to low income. A survey undertaken in 2007 among the white UK population showed a 50% prevalence of insufficiency and 16% Vitamin D deficiency in the winter and spring (Hypponnen and Power, 2007). Populations with pigmented skin (i.e. Asian, black African, Caribbean) have even higher rates of deficiency.

Rickets in children and osteomalacia in adults are the ‘classic’ manifestations of profound vitamin D deficiency. However, in recent years, it has been recognised that there are many other adverse health consequences (North of Tyne PCT). Cancer, metabolic syndrome, infectious and autoimmune disease are all associated with moderately low vitamin D levels (Holick MF, 2008). In a western European population, higher pre-diagnostic circulating vitamin D concentration was inversely associated with risk of colorectal cancer in a dose-response manner. In subgroup analyses this association was noted for colon cancer but not rectal cancer (Jenab et al 2009). However, the International Agency for Research on Cancer (IARC) stressed that public health advocacy on calcium supplementation as opposed to balanced diet with regular, moderate exposure to sunlight is not merited, yet.

Similar associations (Dobnig at al 2008; Ginde et al, 2009) have been found with several autoimmune and infectious conditions including Tuberculosis, Type 1 diabetes (Pittas et al, 2006, Forouhi et al, 2008, Zipitis and Akobeng, 2008) multiple sclerosis and rheumatoid arthritis (Smolders et al, 2008). In the North East of England, it is stated that over recent years, childhood rickets has had resurgence, particularly among infants and children with pigmented skin. However, these children are said to represent only the ‘tip of the iceberg’ of morbidity caused by the poor vitamin D status that is
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endemic in sections of the population. London has also seen resurgence in rickets.

“During the reign of Queen Victoria, James Greenwood wrote in the broadsheet newspapers of the era that children in the capital were increasingly afflicted with weak leg bones or rickets. The disorder of rickets, described two centuries before by Francis Glissen, was evident in over a quarter of London’s children, particularly among the poor.

Over a century later similar numbers of children in London are being diagnosed with vitamin D disorders, and critically it is no longer just the children of the poor that are affected.”

Mitche 2010

Vitamin D is mostly made in the skin by exposure to sunlight. Most foods contain very little vitamin D naturally, although some are fortified, (enriched) with added vitamin D. Food that contain Vitamin D include for example: liver, oily fish (trout, tuna, salmon, herring, mackerel, sardines) egg yolk, cheese, milk, fortified margarine, some breakfast cereals, red meat, and mushrooms. Vitamin D deficiency impairs the absorption of dietary calcium and phosphorus, which can give rise to bone deformities in children, bone pain, and tenderness because of osteomalacia in adults (SACN, 2007).

Economic case for reducing Vitamin deficiency

Vitamin D insufficiency to 17 European countries with a total population of 363 million has been estimated to be 187000 million Euros annually. If this sum is apportioned according to population size, D insufficiency disease costs some £27,000 million in the UK (Grant et al, 2009). From this perspective, working to increase the uptake of vitamin D supplements for both pregnant women and children less than 4 years would be deemed cost effective for PCTs. It is must surely be more cost effective to provide supplements of Vitamin D, than to treat the problems caused by the deficiency, such as rickets.

Who is at risk from vitamin D deficiency?

Those at risk of vitamin deficiency include:

- Pregnant and breastfeeding women [Note: In the last two decades, the number of studies reporting an increase in maternal vitamin D deficiency has risen (Sharma et al, 2009)]
- Breastfed babies whose mothers are deficient
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- People whose skin is covered outside
- Institutionalised or housebound
- People with dark skins or of south Asian origin (Note: The action of the sunlight on the skin makes vitamin D, however, the darker an individual’s skin, the more sunlight is required to make a given amount of vitamin D)
- Those with a family history of vitamin D deficiency.
- Habitual sunscreen use
- Northern latitude
- Vegetarian (or fish free-diet)
- People with Coeliac disease, Crohn’s disease and some types of liver or kidney disease.

Table 2 details the clinical features of Vitamin D deficiency in both children and adults:

**Table 2: Clinical features of Vitamin D deficiency in Children and Adults**

<table>
<thead>
<tr>
<th>Symptom, Sign, Biochemistry</th>
<th>Children</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seizures</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Tetany</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Hypocalcaemia</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Irritability</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Leg bowing</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Knock knees</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Impaired linear growth</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Delayed walking</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Limb girdle pain</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Muscle pain</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Proximal myopathy</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Source: East Lancashire Health Economy Guideline Diagnosis and Management of Vitamin D Deficiency for Non-Specialists

**Vitamin D recommendation**

In 1991, Committee on Medical Aspects of Food and Nutrition Policy (COMA) recommended that all pregnant and breast-feeding women should receive Vitamin D.

- In 2005 the Department of Health (DH) and the Scientific Advisory Committee Nutrition (SACN) in 2007 reiterated the COMA recommendation.

- In 2008, in response to the re-emergence of vitamin D deficiency in the UK, National Institute of Clinical Excellence (NICE) modified 2003
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its recommendations. As of 2008 NICE has classified vitamin D as a high priority recommendation:

- Dieticians and public health nutritionists should educate health professionals about the importance of vitamin D supplements for all pregnant and breastfeeding women.

- During the booking appointment at the beginning of pregnancy, midwives should offer every woman information and advice on the benefits of taking a vitamin D supplement (10 micrograms [μg] per day) during pregnancy and while breastfeeding. They should explain that it will increase both the mother’s and her baby’s vitamin D stores and reduce the baby’s risk of developing rickets.

- Health professionals should take particular care to check that women at greatest risk of deficiency are following advice to take a vitamin D supplement during pregnancy and while breastfeeding. These include women who are obese, have limited skin exposure to sunlight or who are of South Asian, African, Caribbean or Middle Eastern descent.

- Midwives and health visitors should advise all pregnant and breastfeeding women about the availability of suitable vitamin D supplements such as the Healthy Start vitamin supplements. Women who are not eligible for Healthy Start benefit can obtain the vitamin supplement from their local community pharmacy.

- Manufacturers should include information with their products on the importance of vitamin D supplements during pregnancy and while breastfeeding. Relevant products may include pregnancy tests and breast pumps.

The debate around vitamin D supplementation has not abated. Currently within London there are some PCTs, given the increasing number of babies presenting with rickets and hypocalcaemic seizures at 1-2 months old, who are urging the DH to support the issuing of children’s vitamin vouchers from one month old (for the Asian, Black Caribbean African and middle eastern babies), as opposed to the current 6 months for all babies. In other parts of the UK some local health economies have extended Healthy Start Scheme to all pregnant women and children under 4 years of age.
IMPLEMENTATION OF THE HEALTHY START PROGRAMME

The Current Position in England
Data collection on the Healthy Start Scheme focuses on: (a) eligibility data and (b) the uptake of vitamin supplements. Currently there are:

- 478,038 women and children supported by Healthy Start in England
- 2.6 million vouchers are issued every four weeks
- The claim rate for the vouchers scheme (which can be spent on fruit, vegetables, liquid and formula milk) is approximately 80%, which is in line with the uptake of other means tested benefits. However, there is no hard data available on what the vouchers in England are actually being spent on (Kitt A, 2010).
- Vitamin uptake is measured by the number of vitamins claimed from the Department of Health. Currently, nationally the uptake of vitamins is very low at between 1% and 3%.

Evaluations of the Healthy Start scheme (including voucher usage) are being undertaken at Bristol and York Universities. It is expected that they will report in 2012.

The Current Position in London
In London the estimated number of beneficiaries for Healthy Start is 93,220 (including women and children). Eighty percent of eligible households claim Healthy Start Scheme. However, whilst evidence shows that approximately 90% of the vouchers are redeemed (i.e. for infant milk, or fruit and vegetables) only 1% of vitamins are claimed in London.

In seeking to understand the possible reasons for the very low uptake of vitamins supplements the DH Healthy Start Team have identified what they regard as the key challenges which the scheme is currently facing:

- The supply and distribution of Vitamins
- The sale of Healthy Start vitamins at Health Centres/Children Centres
- Training for health and other professionals working with children and families
- Public awareness raising
- Historical problems of supply

The Current Position Locally
The total number of estimated beneficiaries (Eligible women and children), in Hillingdon for the Healthy Start Scheme by the DH healthy Start Team at Q2 of
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2010/11 is 3009. Uptake figures for the Healthy Start Scheme in Hillingdon for the period 2010/11 are as follows:

<table>
<thead>
<tr>
<th>QUARTERS 2010/11</th>
<th>PERCENTAGE UPTAKE OF SCHEME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 1</td>
<td>78% (TBC)</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>76.6%</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>79.1%</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>78.3%</td>
</tr>
</tbody>
</table>

Within North West London Cluster, at Q4, Hillingdon PCT had the second worst uptake rate. The best performing PCT in the Cluster was Westminster PCT (84.1%), followed by Ealing PCT (80.5%). The worst performing was Harrow PCT (76.3%). Data regarding the local uptake of vitamin supplements for Hillingdon beneficiaries is not available for this period from the DH.

A Continuing Public health challenge

What are the reasons for the persistence of vitamin D deficiency in infants and children in the UK despite the existence of public health initiatives such as Healthy Start? The answer to this question would seem to be linked the fact that nationally, London-wide and locally, the uptake of the vitamin supplements for mothers, infants and children is poor. Why should this be the case? There is ample evidence as to the efficacy of vitamin D supplementation in terms of prevention of vitamin D deficiency/insufficiency and deficiency related illnesses.

Cost effectiveness of Vitamin D supplementation

In their costing review of the NICE guidance on vitamin D supplementation for pregnant women, infants and children, NICE state that the cost of:

“Approximately 95,000 women are eligible for Healthy Start vitamins, based on the number of households receiving Healthy Start vouchers for a pregnant woman or a child aged under 1 (Department of Health). The number eligible through receipt of certain benefits is unknown.

The number of women taking these free supplements is believed to be fairly low. The cost to the NHS of increasing uptake is not likely to be significant (52 weeks supplementation costs £3.83 per woman, totalling less than £400,000 annually, based on 95,000 eligible women.”
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On the other hand consideration needs to be given to the fact that the number of eligible women and children may represent a lower percentage of actual need. As mentioned above, factors other than low income and socio-economic deprivation can lead to vitamin D insufficiency/deficiency i.e.:-

- Breastfed babies whose mothers are deficient
- People whose skin is covered outside
- Institutionalised or housebound
- People with dark skins or of south Asian origin
- Those with a family history of vitamin D deficiency.
- Habitual sunscreen use
- Northern latitude

If we as a local health economy were to extend the provision of maternal supplements to include all pregnant women and not just those on welfare benefits there may well be, as NICE point out in their costing report, an impact on local resources.

Effectiveness of the Scheme
The Department of Health hold quarterly update workshops with PCTs and considerable time is spent considering how uptake of the Healthy Start Scheme and vitamin supplements – in particular vitamin D -, can be improved. A range of approaches has been adopted some of which include:

*Improving Awareness of parents*
How parents find out about the scheme affects their relationship with the scheme – it is believed that health professionals (Midwives, Health Visitors) can make a significant difference. Health professionals are given key tasks to fulfill:

- Signposting women to the scheme
- Supporting applications
- Signing application form
- PCTs have a duty to make healthy start vitamin supplements available

- Training for health professionals (hospital, community and primary care), reception staff at clinics.
- Increase the ‘reach’ of the scheme via community outreach workers/Health Trainers
- Improve access to vitamin supplements by addressing issues regarding systems and processes locally.
- Marketing of collection points
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- Extend collection sites to include: Children’s Centres (Islington/Devon); community pharmacies (Rotherham); paediatric dietetics departments (Rotherham)
- Make Healthy Start and vitamin supplementation a local priority. Establishment of time-limited Project Group to include key stakeholders to undertake review of the pathway and identify bottlenecks, problem areas and agree solutions
- Put in place robust system for submitting quarterly returns to the DH
- Investigate how families are using vouchers

RECOMMENDATIONS

The Healthy Start Scheme has been running in the London Borough of Hillingdon since 2006. Although there is evidence that the Healthy Start vouchers for fruit and vegetables are being redeemed by the beneficiaries there is less information available regarding the uptake of the Vitamin supplements. Consequently, little can be said at this stage regarding the effectiveness of this aspect of the Scheme. It is unlikely that uptake of vitamins for both indeed near that of the best performer in London - Westminster PCT with an uptake rate of vitamin supplements for women and children of 13.9% and 14.9% respectively.

There is evidence to suggest that in London (Mitchie, 2010), that vitamin D deficiency is evident in children who present to district general hospitals. The rising numbers of cases of diabetes, pulmonary tuberculosis, and hypocalcaemic seizure suggest that other effects of vitamin D deficiency may be present.

In the context of the above, the following recommendations are made:

Healthy Start
- To undertake a review of the implementation of the Health Start Scheme, in Hillingdon with a particular focus on four key areas:
  - Systems and process that have been put in place to manage the supply and distribution of the vouchers and vitamin supplements
  - To assess the accessibility of the service and to determine whether access to the supplements is uncomplicated and consistent for all eligible women
  - To gain a clearer understanding of the the role played by local health professionals within primary care (GPs and community pharmacists), the community (health visitors, breast feeding advisors), midwifery and paediatrics, as well as the potential role of social care providers, Children’s Centres and Health Trainers in
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- raising with women the importance of vitamin D supplements in infants and young children
- Arrangements put in place by the CCG to claim for the vitamins given out to beneficiaries

Vitamin D deficiency

- To undertake a scoping exercise to ascertain a clearer understanding of the burden of vitamin D deficiency/insufficiency in Hillingdon population, by obtaining the following information:
  - Number of Children with rickets (2002 to 2010)
  - The number with tuberculosis who had vitamin D deficiency (2002 to 2010)
  - Number of children who had a hypocalcaemic seizures at 1-2 months old (including the number that required PICU and/or had long-term complications). (2002 – 2010)
  - Number of infants who had cardiac failure due to vitamin D deficiency (2002-2010)
  - Percentage of paediatric fracture patients who were vitamin D deficient
  - Financial impact of the above in terms admissions, outpatient attendances, prescribing

CONCLUSION

As stated at the beginning of this chapter the national Healthy Start Scheme aims to provide a nutritional ‘safety net’ and encouragement for breastfeeding and healthy eating and to reduce vitamin D deficiency amongst vulnerable pregnant women, breastfeeding women and children up to age four in low income and disadvantaged families across the UK. Healthy Start is an important public health intervention, which is not hugely costly to the local health economy, and if fully and effectively implemented could, not only improve the health and wellbeing of pregnant women infants and children living in the borough, but also produce savings for the local health economy by tackling the hidden disease burden of vitamin D deficiency.
The Health of Hillingdon’s Looked After Children

Teresa Chisholm

“In terms of their overall outcomes, looked after children are one of the most vulnerable groups in our society as they ‘have experienced – and continue to experience – significant disadvantage and inequality’”

(NICE/SCIE 2010:4)

Introduction

The term looked after children (LAC) were established in the 1989 Children Act (DoH 1989) and refers to children who are taken into care by a voluntary agreement or subject to care orders. The Children Act provided a framework for caring for children who are placed away from home. In comparison with their peers, LAC often experience poor educational, social and health outcomes. A significant factor may include the reasons or situations why they came into care and how they cope with those experiences. In addition, some of the issues they encounter whilst in care, such as high numbers of placement changes, change in school and adult support, may result in instability and a lack of consistency. Young people also experience difficulties in areas such as housing, independence and finance when they leave the care system.

Although over the years there has been a drive to rectify this situation ‘there remains a significant gap between the quality of their lives and those of all children’. (DCSF 2007a:5)

The National Picture for LAC

Nationally, a total of 59,500 children were looked after by local authorities in England in the year ending 31 March 2008, of whom:
- 56% were male and 44% female
- 5% were under 1, 15% 1-4, 17% 5-9, 42% 10-15 and 21% over 16 years
- 62% came into care because of abuse or neglect
- 71% of children were placed in a foster placement
- 74% were of white ethnicity, with 8% mixed, black or black British groups
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- 3,500 children were unaccompanied asylum seeking children of which 81% were male and 19% were female. (DCSF 2008)

Over the past five years the age and gender of looked after children has remained constant, as is the reason why most of these children have come into care. The national data shows that there has been a slight increase in the use of foster placements during this time. The figures show that there is an overrepresentation of minority ethnic groups within the looked after children population compared to the total child population.

Figure 1 shows the outcome indicators for looked after children for the 12 month period to 30 September 2007 (DCSF 2007b). It shows that looked after children are much more likely to be unemployed, be involved in crime and be identified as having a substance misuse problem.

Figure 1: Outcomes for Looked after Children

![Figure 1: Outcomes for Looked after Children](image)

**Health of LAC**
In terms of health outcomes ‘Looked after children and young people share many of the same health risks and problems as their peers, but often to a greater degree. They often enter care with a worse level of health than their peers in part due to the impact of poverty, abuse and neglect.’ (DCSF 2009:1).
Physically, the looked after children have a higher level of poor physical health with health issues, such as, asthma, language development, and dental caries impacting upon their lives. In one study, Meltzer et al (2003) showed that 66% of looked after children had at least one physical health problem, with many having two or more. In addition, they have higher levels of poor emotional and mental health difficulties, such as poor attachment, stress, and depression and conduct disorders. Meltzer et al (2003) highlighted that 55% of boys and 43% of girls in their teenage years had an identifiable mental health problem, compared to 10% within their peer group.

The looked after children are also more vulnerable to risk taking behaviours such as self-harm and misuse of substances. Research has shown that they ‘are four times more likely than their peers to smoke, use alcohol and misuse drugs’ (DCSF 2007a:90). Other risk taking behaviours such as early sexual activity mean that looked after children are more likely to become teenage parents. A range of studies have shown that 25% of looked after children were parents within a year of leaving care, with almost 50% of girls becoming pregnant within two years of leaving care (DCSF/DoH 2009).

Unaccompanied asylum seeking children are also a highly vulnerable group of looked after children whose health status may be poor. They will often arrive in the country with an incomplete medical history and may have a number of physical health issues such as tuberculosis, hepatitis B and HIV infection. In addition, they may have suffered traumatic events, experienced loss, or sexual violence, which will impact upon their physical, emotional and sexual health (Chase et al 2008).

It is important to recognise that good physical and emotional health provides young people with greater opportunities to achieve their full potential within society. For example, good health will provide young people with more opportunity to achieve academically (DCSF/DoH 2009). In addition those who reach a higher educational attainment have better health than those whose academic achievement is poor (Marmot 2010). It is our aim within Hillingdon to provide a health service to the looked after children which will improve their physical and emotional wellbeing, and reduce those inequalities.

**Looked After Children in Hillingdon**

Having considered the national picture, it is important to look at Hillingdon’s looked after children population. Figure 2 contains three charts which show Hillingdon’s looked after children gender, age and asylum data compared to national data.
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In the year ending 31 December 2010, a total of 517 children were looked after by Hillingdon Local Authority of whom:

- 62% were male and 38% female
- 3% were under 1, 10% 1-4, 10% 5-9, 33% 10-15 and 44% over 16 years
- 39.3% were of white ethnicity, 16.1% any asian, and 11.6% black British African (33% represented by 14 other ethnic groups)
- 34% of Hillingdon’s looked after children were unaccompanied asylum seeking children

Figure 2a: LAC by gender in Hillingdon and nationally

These figures show that both nationally and in Hillingdon, more males are looked after than females. The age comparison of looked after children are similar, Hillingdon having a greater number in the 16 years+ group. In terms of ethnicity, the largest single group of looked after children in Hillingdon are of white ethnic background, however, a wide range of ethnicities are represented in the looked after children data. The high proportion of unaccompanied asylum seeking children looked after by Hillingdon is due to Heathrow airport being located within the borough.
Having considered the general profile of Hillingdon’s looked after children, it is important to highlight their health needs. All looked after children are offered a statutory health assessment on an annual basis or six monthly for those under 5 years. Of a small sample group of 73 Hillingdon looked after children in 2009, 84% had identified health needs and most of these were complex involving both physical and behavioural needs (Figure 3). Physical health needs included asthma, eczema, developmental concerns, and
obesity. Behavioural needs varied and included substance use such as smoking.

**Figure 3**

**Health Achievements and Successes for Hillingdon’s Looked After Children**

In order to meet the health needs of Hillingdon’s Looked After Children, a team of five health professionals including doctors, nurses and administrative staff, coordinate and work in partnership with others to promote positive health. This health team is actively involved in working with a range of health staff such as school nurses and health visitors to ensure quality health services are delivered to looked after children and their carers. During the year ending March 2010, work was undertaken based upon the principles of the London pledge for children in care (YLM 2008). Several successful initiatives have been achieved in the following areas.

**Training professionals and carers:**

To ensure that the specific needs of looked after children are understood by all health staff, the looked after children health team trained 47 health professionals, such as school nurses, health visitors and doctors. This training will help staff to provide an effective and informed service to looked after children and their carers.

The health team have also delivered training sessions to social workers who work with looked after children. In total 7 sessions were offered and 50 social workers attended.
workers attended. In addition, residential care workers in three children’s homes were offered training prior to direct delivery of sexual health and substance use information for young people resident in the homes. Other carers, such as foster carers have been supplied with information on a range of health issues via foster carer representatives and the foster carer newsletter. The outcome of this work is that well trained and skilled staff and carers provide better services to our looked after children.

Direct delivery of health promotion to looked after children
During 2009/10 the looked after children health team coordinated 580 requests for health assessments of which, those in Hillingdon were completed by school nurses, health visitors, paediatricians and the looked after children health team. Health promotion advice and support is a key component of the statutory health assessment. Of 32 young people, completing a client satisfaction questionnaire 94% stated that they had received helpful information from their health assessment.

During this year, guidelines were produced so that condom demonstration could be offered to all young people aged 13 years as part of their health assessment. The outcome of this initiative is to provide information to young people to reduce levels of sexually transmitted infections and rates of teenage pregnancy.

Other direct work with young people has taken place in collaboration with the contraceptive and sexual health services and youth services in Hillingdon. A new initiative of targeted work with young people in children’s homes was commenced and five sessions of sexual health and drug awareness training were offered.

The overall outcome of direct work with young people is to empower them to make informed decisions on their health and to provide information on how to access health services.

Partnership working
The looked after children health team work with a range of partners in order to best support the needs of looked after children. Within health, close links have been made with sexual health and mental health services. Other partners include staff within Hillingdon Local Authority, Education Services, and Local Councillors. The team is involved with the Hillingdon Youth Council to ensure that young people’s opinions are heard and valued. As many of Hillingdon’s looked after children are placed out of borough, the health team works with national looked after children services in order to provide a
seamless service to Hillingdon’s children. The outcome of good partnership working is to ensure that services are not fragmented, repetitive, and costly.

**Performance indicators**

It is essential that looked after children receive their statutory health assessments and that these are of a high quality. In addition, they should also attend for routine dental checks and receive timely immunizations. The looked after children health team have ensured that 93% of Hillingdon children received their statutory health assessment. However, it is essential that these health assessments be of a high quality. A small audit of 73 health assessments, noted that 56% were considered to be of a good quality, with 33% satisfactory and 8% graded as poor (Figure 4).

**Figure 4**

<table>
<thead>
<tr>
<th>Quality of Health Assessments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good 58%</td>
</tr>
<tr>
<td>Satisfactory 34%</td>
</tr>
<tr>
<td>Poor 8%</td>
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</tbody>
</table>

In order to ascertain if the health assessment was of a high quality to our looked after children, a client satisfaction audit was undertaken. Of 32 young people who took part, 97% stated that the venue for their appointment was good, 94% stated that they had received helpful information and 97% stated that their health assessment experience had been good or satisfactory.

Dental checks are also a health indicator for looked after children. Of a sample group of 73 children, 87% of eligible children were registered with a dentist and had a recent dental check. Nationally, data shows that 89% of all
Section 2

looked after children receive a dental check and a health assessment (DCSF 2008).

To ensure our looked after children receive their required immunizations, the health team has worked closely with the local authority to share information regarding a child’s immunization status. This ensures that information is accurate and up to date, and highlights those children whose immunisations are not completed. In order to meet this need, a monthly immunisation clinic has recently been established within Hillingdon. This clinic has been developed so that looked after children with unknown or incomplete immunisations can have easy access to the immunisation service. These initiatives will help to protect our children from preventable illness.

Celebrate achievements
It is important to recognise the successes of young people in care. An annual award ceremony has been established in Hillingdon to celebrate the wide ranging achievements of looked after children. The ‘Kids In Care’ Award (KICA) group is a multi-agency group chaired by young people. This group organizes the annual event and the ceremony promotes positive messages to children who achieve despite their disadvantages.

Young people have also been actively involved in ensuring health services are young people friendly. The ‘You’re Welcome’ quality standards (DoH 2007) have been implemented within one of the young people clinics where our looked after children attend for health assessments. This means that young people visiting this venue can be assured of a high quality, young person friendly service when they attend.

Recommendations for Future Action
Several areas can be improved based on the successes outlined.

Work will need to be completed based upon the new Statutory Guidance (DCSF/DoH 2009) and other government best practice (NICE/SCIE 2010). This will include ensuring that a greater need for strategic joint working to meet the needs of looked after children takes place. In order to reduce inequalities, partnership working across agencies is paramount (Marmot 2010). One specific area involving good partnership working will be the commissioning of high quality health services for children placed within and out of borough (DCSF/DoH 2009).

The looked after children health team will aim to ensure that our children get a good start in life and that this is sustained whilst they are in care (Marmot
2010). An area that could be improved is the quality of the statutory health assessment. The health team plans to provide in depth and ongoing training to health visitors, school nurses and other professionals who complete these assessments. In order to review quality issues, an audit of a larger sample of health assessments and analysis of information will take place. Looked after children will also be involved in quality review and the views of children will be incorporated within service development to ensure that health services meet their needs.

Two specific areas identified in government guidance (DCSF/DoH 2009, NICE/SCIE 2010) are the emotional needs of looked after children and the general needs of care leavers.

Nationally, local authorities are required to monitor the emotional needs of looked after children by completion of a Strengths and Difficulties Questionnaire (SDQ). This work has recently been implemented in Hillingdon, and social workers are working to supply information to health services in order to identify mental health needs. By gathering this data, there will be opportunity to ensure that sufficient services are provided to the looked after children who suffer from emotional and mental health problems. The health team are also beginning to work with Hillingdon Hospital A&E staff to identify the numbers of looked after children attending the hospital for emotionally related incidents. In addition, work needs to be undertaken to look at the specific needs of unaccompanied asylum seeking children’s emotional needs, and how these needs are being met (NICE/SCIE 2010).

The needs of care leavers will also be a priority area for the looked after children health team. The health of those leaving care can deteriorate and there is a need to provide these young people with more health information to prevent ill health. The health team will aim to address the unique needs of care leavers so that they will be empowered to care for themselves once they leave care. Government guidance (NICE/SCIE 2010) recommends that a health summary be provided for all care leavers. Other creative ways are being considered so that these young people will have easy to access information on available health services.

Both in terms of meeting the emotional needs of looked after children and the health of care leavers, it is more cost effective to prevent poor health than for young people to access expensive long term health care when poor health occurs. The cost of doing nothing is not economically viable (Marmot 2010).
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Conclusion

This chapter has shown that looked after children suffer health inequalities compared to their peers. The information provided explores the health and general outcomes of looked after children and how Hillingdon is aiming to reduce the inequality of needs for this vulnerable group. Many successes were achieved; however, several areas are in need of improvement. In order to meet these needs, recommendations for future action have been outlined and the reasons why these actions are necessary have been given.
"Health is created and lived by people within the settings of their everyday life: where they learn, work, play, and love."

The Ottawa Charter (1986)

Introduction
Healthy Settings, the settings-based approaches to health promotion, involve a holistic and multi-disciplinary method, which integrates action across risk factors. The goal is to maximize disease prevention via a "whole system" approach. A health promoting school is one that constantly strengthens its capacity as a healthy setting for living, learning and working. World Health Organisation provides a set of principles and outcomes for a health promoting school.

A health promoting school:-
- Fosters health and learning with all the measures at its disposal.
- Engages health and education officials, teachers, teachers' unions, students, parents, health providers and community leaders in efforts to make the school a healthy place.
- Strives to provide a healthy environment, school health education, and school health services along with school/community projects and outreach, health promotion programmes for staff, nutrition and food safety programmes, opportunities for physical education and recreation, and programmes for counselling, social support and mental health promotion.
- Implements policies and practices that respect an individual's wellbeing and dignity, provide multiple opportunities for success, and acknowledge good efforts and intentions as well as personal achievements.
- Strives to improve the health of school personnel, families and community members as well as pupils; and works with community leaders to help them understand how the community contributes to, or undermines, health and education.

Health promoting schools focus on:
- Caring for oneself and others
- Making healthy decisions and taking control over life's circumstances
- Creating conditions that are conducive to health (through policies, services, physical / social conditions)
- Building capacities for peace, shelter, education, food, income, a stable ecosystem, equity, social justice, sustainable development.
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- Preventing leading causes of death, disease and disability: helminths, tobacco use, HIV/AIDS/STDs, sedentary lifestyle, drugs and alcohol, violence and injuries, unhealthy nutrition.
- Influencing health-related behaviours: knowledge, beliefs, skills, attitudes, values, support.

The Healthy Schools Programme in Hillingdon

Food and diet

Nutrition in early years and childhood has an impact on the child’s immediate health as well as creating a potential legacy of ill health. Within Hillingdon there has been great emphasis in improving school meals and access to healthy food. Pilot work is extending the reach to early year’s settings and to parents and children in targeted communities. The potential in early year’s settings to improve nutrition education and access to healthy schools is large due to large numbers of children’s centres, community groups and nurseries.

The nutritional status of children in the UK is poor considering the advanced economy and universal health care. Current evidence is that at Year 6, one-third of primary pupils are overweight or obese, dental health in young children is deteriorating, rickets caused by vitamin D deficiency has re-emerged (School Food Trust, 2011). There is increasing evidence that poor nutrition in early life is involved in behavioural and cognitive problems in children, adolescents, and older people (British Medical Association, 2009).

The economic costs of unhealthy lifestyles are currently evident as 10% of the NHS budget is spent on Diabetes treatment and 1 in 15 residents in Hillingdon have type 2 diabetes. The cost benefit of improved childhood nutrition has been modelled by London Economics and they estimated that a 0.45-point improvement in attainment at key stage 2 could have a benefit of £1330 per person across the life course (London Economics, 2008).

Evidence base

NICE recommends that promotion of healthy eating highlights:

- The role of Public sector organisations as important providers of food and drink to large sections of the population and their ability to lead improvements in food quality.
- Ensuring publicly funded food and drink provision contributes to a healthy, balanced diet.
- Ensuring public sector catering practice offers a good example of what can be done to promote a healthy, balanced diet.
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- Enabling children and young people to have a healthy diet and lifestyle. This includes helping them to develop positive, life-long habits in relation to food.

The Call to Action (DH, 2011) recommends that local needs are met with local services. Local activities such as Enhanced Healthy Schools, Love Local Food and Community nutrition sessions have reported changes in dietary patterns and experiences if cooking. Nationally Food for Life, MEND and Mini MEND (2-4 y/o) has measurable changes in family cooking, confidence and knowledge of nutrition.

The Food in Schools Team and SHPT

Hillingdon had a successful Food in Schools Team that over a 5 year period reintroduced hot meals to 21 Schools and supported ‘inhouse’ catered Schools to provide nutritious and affordable meals. Due to changes in funding this team no longer operates. However the Specialist Health Promotion Team (SHPT) has taken on health promotion and support for schools. The SHPT offers individual support to Schools that opt into an SLA in 2011-12 15 schools opted in.

Twelve schools out of fifteen are working towards an Enhanced Healthy Schools status, which have diet, and nutrition identified as a priority. The team played an active role in health promotion and ran workshops for parents, pupils, and staff. The learning from hundreds of hours of group working developed school age resources. These have expanded to be used in children’s centres and community centres. Due to the diverse cultural makeup of the borough, different topics and different approaches have been used.

Good Practice and achievements

Laurel Lane Primary

The School was referenced in the 2011-12 JSNA as an example of best practice. The school is a flagship for healthy and sustainable sourced meals. The school provides meals for 850 children across 7 schools.

The catering team run parent and child cookery clubs and embed cooking into the curriculum. There are 15 opportunities for a child to access one of their 5 a day across the school day. If children have breakfast and lunch at the school they will receive their 5 a day.

British Heart Foundation

Haydon Academy is one of 30 schools in the UK piloting a healthy vending intervention for secondary schools. The school are launching the machines with a variety of healthy and nutritious foods.
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Food for Life Partnership
Food for life partnership is a school based cooking, growing and food education intervention. It has been fully evaluated by The University of West London (Orme et al, 2011) which found that the intervention results in a 28% increase in fruit and vegetable consumption in children and 45% of parents reported eating more fruit and vegetables. There are three levels of award: Bronze, silver and gold. In Hillingdon, seven schools have bronze and 2 are working towards silver.

Love Local Food
Love Local food is a program funded by Groundworks. It aims to link schools, communities, and food producers together. Schools are supported to grow food crops with the children, visit farms, and learn about food production. 12 schools have joined the program. Year one schools have successfully grown a large range of crops. These have been used for cooking clubs and school lunches.

Area Based Approach
Using depravation indicators two distinct areas Hayes and Yiewsley/West Drayton are targeted by the SPHT. Within the Glebe estate in West Drayton a community food hub has been set up in partnership with a community cafe the Com.Cafe. Training was made available to the centre manager, equipment was purchased and a set of resources where developed. The sessions have been well received and all of the service users have reported they have cooked new recipes and foods at home. The Cafe has outreached the service to a local Children’s centre and a Christian community centre.

The community food hub is to be set up in Hayes following the success of the pilot.

Children’s centres
Three children’s centres have been selected to run a pilot food and nutrition course. “Feed My Family” has been developed as a 5 week course for parents with preschool children. Some of the parents are referred by the centre staff but the sessions are open to all. The course takes a supportive role and offers practical advice to eat a balanced diet as well as using household economics as a driver to cook healthier meals.

Recommendations and future plans

- Diet and Nutrition interventions to extend to workplaces and food businesses which require collaboration with Environmental Health, Planning and Transport teams is needed to help adults make healthy choices.
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- Expand reach into Early Years Settings with free resources and ensure all staff are ‘on message’ and have the skills and support to run food and nutrition sessions.
- Continue to develop community based cookery and nutrition sessions and find vehicles for the delivery.
- Develop a community nutrition model based on the enhanced healthy schools framework that incorporates clinical, social and environmental indicators of good nutrition.
- Work with targeted schools based on deprivation indicators.
- Encourage schools to become centres of excellent food as part of Enhanced Healthy Schools and Food for Life.

Sexual Health

Applying community learning principles to Sex, Relationships and Education
Applying the principles of participation, equity and shared learning to Sexual health promotion (Sex and Relationships Education SRE) has helped transform the way schools address this vital but difficult aspect of the curriculum. Although SRE is a core element of the National Curriculum and the Healthy Schools programme, children’s experience of the way it is taught can vary even within the same school. Staff changes alone mean that children do not necessarily experience age appropriate SRE programme work that is relevant and confidently delivered. Use of external Sexual Health specialist staff by some schools may not be coordinated with relationships education across the school curriculum. In some cases, schools are unsure about parental attitudes to SRE especially with regard to possible differences in culture and religious belief.

Health economics of SRE
The cost benefit of making improvements to quality and consistency of SRE provision are indicated by the NICE estimate of cost of clinical services related to teenage sexual health needs. A 20 minute 1-1 consultation is estimated to cost an average of £17.82p. The cost of avoiding STI re-infection is calculated at to £28. The cost of pregnancy termination is given as £909 and the cost of delivery of a baby is £1,774 (NICE, 2007). Although considerable these charges do not in any way, reflect the real value of ensuring that young people are enabled to develop into mature adults that enjoy a fulfilling sense of sexual wellbeing.

To address this need and to minimise unnecessary costs, instead of relying on conventional sexual health campaign approaches targeted at young people in secondary schools and teachers at primary levels, an alternative has method has been developed in Hillingdon focussing on work with
peergroups in Secondary schools and with parents at primary level. In both cases work is based on the principle of developing preventive resilience, through of shared learning, shared responsibility for programme development and recognition of cultural approaches to relationships, education and sexuality.

**The primary school setting- empowering parents and staff**

At primary level instead of directing health messages at teachers, the approach simply involves starting work by asking parents to choose the SRE resources and content that they feel are appropriate for their children. In each of the six participating schools, parents meet on a weekly basis to review and discuss teaching resources produced for SRE in primary schools. The outcomes have exceeded expectations. In some cases, parents have used the programme to discuss the importance of discussing SRE with their children at home – enabling the supportive family learning environment identified by NICE as protecting against teenage pregnancy.

The programme has helped teaching staff understand and value minority ethnic community approaches to relationship education and sexual maturation. The value of the approach has been recognised by School Nurses, enabling them to work more effectively, confident that their input takes place within a supportive framework (NICE, 2008). In some schools, parents have decided to continue meeting to look at other areas of the curriculum. The materials selected by the parents have now been stocked by Hillingdon Library services making them accessible to all parents.

**Outcomes achieved so far**

The programme has helped to develop the skill, understanding, and confidence of over 65 parents from a range of different community groups who act as advocates for improved SRE teaching and learning in their school community. Although it was initially anticipated that schools would require support to sustain the programme the value of the approach has led them to continue using the approach for SRE and other areas of parental engagement. Most significantly, the programme has shown that it is possible to bring about the cultural shift in approaches to teaching and learning.

Other benefits of settings approach are:

- Raising primary school staff awareness of the value of working with families to support young people as they grow and mature
- Improved school confidence in working with parents
- The resource selection has constructively challenged the value of centrally selected and distributed resources by choosing teaching resources from alternative sources that are more appropriate and more affordable.
Parents feeling they have a constructive voice in the school to address concerns and contribute to learning

Parents reporting that engagement in the process has improved their confidence in general and for some has helped improve their English language skills

Secondary School Setting — the CLEAR programme

In secondary schools, the CLEAR programme has been developed to engage young people studying in year 10, in age appropriate learning that develops their confidence and cognitive skills relating to healthy relationships and informed use of support services. Additional objectives of the programme include informing the development of youth friendly support for young people from parents, carers, schools, and services, and clear communication of information that promotes the sexual wellbeing of young people. The method used by CLEAR involves participants in the production of an evidence based sexual wellbeing communication programme with input from teaching staff and health service professionals.

Achievements so far

With fourteen schools participating over three years, CLEAR has trained 82 peer educators (year 11) each year and delivered information sessions to 980 students in year 11 and above. The programme has been valued by schools as contributing to PSHE and SRE curriculum delivery. Informal assessment of CLEAR information communicated by participants to friends suggests the reach of the programme extends to two additional discussions about the content of the programme, indicating a total reach of 1890.

Current and future plans

CLEAR is now being developed further as a core element of the social care studies programme in one school. The value of the approach is also evident in the shift in focus in the content of sexual health information that participants have developed. A key concern for many of the young people was that their experience of sexual health campaigns has been that they focussed on the diseases and medical risks associated with sexual intercourse. As such, they felt that young people were labelled as a risk. Additionally they felt that at a time in their lives when they were trying to make sense of feelings, emotions and relationships in the adult world many existing resources seemed to teach stereotypical concepts of sexual activity and sexuality. In particular, while they recognised the need to be aware of health risks, they felt that their experience of conventional sexual health campaigns had failed to address their need for deeper understanding of the skills involved in sustaining valued relationships that may or not involve intimate relationships.
Changing relationships and responsibilities
The key factor in these programmes has been a shift in thinking about the way health and wellbeing are promoted. Instead of focussing on health problems and attempting to raise public awareness of the cause of the problem, efforts have centred on developing relationships between people and resources that enable health and wellbeing. A key element in establishing the programmes has been work with service professionals, teachers, nurses, strategy planners, and commissioners, changing the language used to discuss health, and valuing people as informed participants (Neuberger J, 1999) in the promotion of health and wellbeing.

Future Application of the settings approach
Although the examples cited have focussed on sexual health promotion, the learning gained from these programmes has been reflected in Hillingdon’s range of health promotion programmes for adults as well as children. With lifestyle programmes ranging from work with mothers and toddlers exploring language and local environments through to older adults’ social networks, engaging through libraries and health walks, the following factors have been seen to be common to promoting health and wellbeing:

1. Small projects that inform wider scale programme development - where staff and residents work together, identifying opportunities and establishing solutions to health needs

2. Recognise that the determinants of health include the cultural and physical context in which people live.

3. Systemic commitment to achieving equality as an outcome - reflected in direct involvement of residents and service staff - embedding equality in the way programmes are run, encouraging informed decision making at personal and local levels.

4. Recognise the value of planning as a 'learning process' within communities, enabling the evolution of relevant services.
Section 2

Why is Teenage Pregnancy an Important Public Health Issue?

Carol Page

Introduction
Teenage Pregnancy is a significant public health issue in England. The UK has one of the highest teenage pregnancy rates in the Western Europe and the importance of addressing this issue has been recognised by subsequent governments.

The Social Exclusion Unit (SEU) established in 1998 was tasked with producing the national Teenage Pregnancy Strategy, which was launched in 1999, with two main goals:

i. to reduce the rate of teenage conceptions by halving the rate of conceptions among under-18s by 2010, and establish a firmly downward trend in conceptions to under-16s; and

ii. to get more teenage parents into education, training or employment, to reduce their risk of long term social exclusion with a target of 60% participation by 2010

Significant progress has been made against the above targets that resulted in a drop of 17.5% in the national rate of conceptions to under 18s since the 1998 baseline. More needs to be done to drive the teenage pregnancy rate down further and maintain progress made to date. England still has the highest rate of teenage pregnancy in Western Europe, with 38,633 conceptions in young people aged 18 years and under in 2010, most of which were unplanned, more than half ended in abortion.

The key principles to achieving the reduction in teenage pregnancy rates were firmly placed with the local Health Authorities and the UK Government, with a strong message that “joint partnership working” would be the key to any successful Teenage Pregnancy Strategy to reduce teenage pregnancy rates. The principles and activities to achieve reductions in teenage pregnancy would include reducing deprivation and inequalities, and eradicating child poverty, which are important public health issues.

In order for local areas to fulfil a commitment to the Teenage Pregnancy Strategy limited ring-fenced funding was devolved to local partnerships via local authorities.
Section 2

Why is Teenage Pregnancy a Public Health issue?
Teenage Pregnancy increases health inequalities and leads to poor long-term outcomes for young parents and their children.

- Tackling Teenage Pregnancy helps to reduce child poverty, which is a top government priority.

- Addressing Teenage Pregnancy alongside work to reduce Sexually Transmitted Infections (STI’s) is a government public health priority as stated in Healthy Lives, Healthy People (DH 2011)

Teenage mothers are defined as those who conceived before their 18th birthday and are often unemployed, having disengaged from statutory education. Babies of teenage mothers have worse health outcomes than those of older mothers (DCfES/DH, 2010).

These babies are:-
- more likely to be born prematurely or have low birth-weight.
- 60% more likely to die in the first year of life than babies of mothers aged 20-39.
- twice more likely to be admitted to hospital because of an accident or gastro-enteritis.

Teenage mothers also have specific problems, which are as follows:
- They are three times more likely to get post-natal depression than older the mothers are.
- They are at higher risk of poor mental health for three years after the birth.
- They are three times more likely to smoke during pregnancy than mothers over 35 are.
- They are less likely to breastfeed.
- Likely to struggle to complete their education and find it difficult to gain employment.

Are young people having more sex?
The average age of first sexual intercourse in the UK is 16 years (Wellings K et al 2001). Young people and parents both expect that most young people will have their first sexual experience between 16-17 years of age. However, as stated in the the Teenage Pregnancy Strategy the majority of under16 year olds have not had sex. There were more young people in England in 2010 than in 1998 when the baseline was established. Teenage Pregnancy rates have made allowances for this and adjusted the rates over time.
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Which young people are getting pregnant?

*Nationally (TPIAG Briefing, 2010)*

- Nationally half of all under 18 conceptions occur in the 20% most deprived wards.
- Nationally one fifth of births amongst under 18s are repeat pregnancies
- Nationally over one third of teenage mothers have no qualifications and 70% are Not in Education, Employment, or Training (NEET).
- Nationally teenage mothers and fathers and their children are more likely to be in poor health and to live in poor housing

*Hillingdon (NEET 2009, Maternity Audit THH)*

- Hillingdon’s teenage mothers are the largest cohort of NEET’s overtaking learning disabilities.
- Hillingdon’s young parents consist of 39% NEET this equates to 10.9% of the overall NEET cohort.
- The majority of pregnancies in Hillingdon occur to white working class girls in the south of the borough, which clearly demonstrates the link between teenage pregnancy and deprivation.
- The trend in Hillingdon for planned second pregnancies continues.
- There has been a significant rise in the number of teenagers living with their parents.
- The Hillingdon trend for more teenagers being unemployed rather than attending college or working continues.

What are the potential reasons for early sexual activity?

Teenagers are at a complex stage of their development due to the hormonal, physical, and emotional changes they are undergoing, and the reasons for getting pregnant are complex. Puberty commences at different ages and can start from 10 years in girls and 12 years in boys (Gordon et al 2005). Fertility among other changes is dependent on fat stores. As our young people are experiencing increasing levels of obesity puberty onset will become even earlier. According to the national survey of sexual attitudes, young people have sex for a variety of reasons, which include.

- Experimenting
- Pushing the boundaries
- Pleasure
- Hormonal urges
- Stress relief (it has highlighted that when humans experience stress we have sex more often 1970's electricity strikes increases in the birth rate was noted)
- Social norm
- Gang initiation
The scale of the challenge

The scale of the challenge to reduce teenage pregnancy is complex and relies on all partners involved working together and often in innovative ways which suit young people and not services (Young D, 2010).

The strategy depends on strong local leadership and effective joining up of multi-agency services such as education and health - each owning the agenda for teenage pregnancy prevention and not assuming it’s someone else’s responsibility.

Below is not an exhaustive list but some of the challenges faced by Hillingdon:

- To achieve a 50% reduction by 2010, the number of under-18 conceptions in Hillingdon needs to reduce from 191 in 2008 to 136 in 2010 – a difference of 55 conceptions (this will not be known until 2012 due to the 14-month time lag).
- 2008 Public Health data shows that Yiewsley had a rate that was over double that of the borough average, and Harefield and Heathrow village also now have very high rates and previously un-targeted.
- There are huge financial restraints facing the public sector.
- The national policy and commissioning landscape is changing.
- The issue is complex as there are a range of factors that are associated with whether a teenager becomes pregnant.

Hillingdon received £169k per annum until 2008 when the ring fencing was removed. Locally, teenage pregnancy work continued to be funded until Autumn 2010 when £17k was removed to contribute to the London Borough of Hillingdon (LBH) in-year savings. For 2011/12 the newly formed Early Identification Grant (EIG) will be the source of funding for any Teenage Pregnancy work being undertaken by the borough. This funding encompasses Teenage Pregnancy prevention work, which includes Sex and Relationship Education (SRE); improved access to contraception and sexual health advice; improving communication between parents and young people around SRE and other related issues, such as drugs and alcohol.

The National Position

In 2010 there were 34,633 teenage conceptions in England compared to 38,259 in 2009. This represents a significant progress that has been made towards reducing rates in England.

If the teenage pregnancy rates had remained at the 1998 level, there would have been 42,000 extra conceptions, so the impact of intensive work around the country has been significant.
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Under 18 Conceptions
The Office of National Statistics (ONS) presents the rate for 15-17 year old females per 1,000 population across England. The 2010 data released shows that England had a 24% change in the rate from 1998-2010 resulting in a 35.4 rate, whilst London had a 27.4% reduction resulting in a rate of 37.1.

Under 16 Conceptions
- The under-16 conception rate is 6.7% lower than in 2009 (7.5 conceptions per 1,000) and 20% lower than in 1998 (8.8 conceptions per 1,000).

- There were 6,256 under-16 conceptions in England in 2010. This equates to an under-18 conception rate of 7.0 conceptions per 1,000 girls aged 13-15.

Local Picture – Hillingdon
In Hillingdon, teenage conception rate has fallen from 43.9 per thousand females aged 15-17yrs in 1998 to 36.2 per thousand females in 2010, which reflects a 17.5% reduction (see figure 1). Hillingdon exceeded the 15% reduction target for 2004, but unfortunately did not achieve the 50% reduction target in 2010, which was thought to be too ambitious in the first place due to a relatively lower baseline rate in Hillingdon compared with some of the other London boroughs.

Figure 1: Trend in Teenage Conception Rates for Hillingdon, London and England

Source: ONS 2010
Hillingdon continues to be below the London rate 37.1 and slightly above the England rate 35.4. The majority of the progress has been seen in the last two
years of the strategy 2008-10 and we want to continue our efforts and build upon some of the recent good work. Hillingdon ranks 15th out of the 32 London Boroughs in terms of overall rates and 23rd for percentage change in rates which is similar to the outer London boroughs. Statistical neighbours: In ranking order with our statistical neighbours looking at the lowest conception rate to the highest, Hillingdon came second out of five between Coventry 50.2, Reading 40.9, Bedford Borough 40.8, **Hillingdon 36.2**, and Sutton 24.6.

**Teenage Pregnancy and hotspot wards**
The three high TP rate wards are Harefield, Brunel and Yiewsley 2007-09 ward level data.

**Figure 2: Ward Level Data 2007-2009**

![Figure 2: Ward Level Data 2007-2009](image)

*Source: ONS 2007-09*
Section 2

- The **number** of conceptions in a ward relates to their impact on the borough rate ONS 2007-09: Harefield, Brunel and Yiewsley had significantly higher teenage conception rates compared to England (see figure 2).
- However, in terms of performance and reducing the rates Yeading (30), Hillingdon East (37) and Pinkwell (32) were better performing ward with high numbers:
- Poorer performing ward with high numbers: were Botwell (50), Yiewsley (44), South Ruislip (34), Brunel (32) and West Drayton (37)

**Birth versus Termination Rate/Teenage Pregnancy and Abortion**

In Hillingdon, 64% of under 18 years conceptions choose to have an abortion in 2010. This clearly demonstrates that the pregnancy was not wanted, intended or was a mistake i.e. contraception failure. The majority of conceptions/abortions occur between 16-17 years. This abortion rate reflects the national picture (Young D, 2010).

- It is difficult to draw any firm conclusions without making assumptions. However, one main assumption could be that the girls/young women never wanted to be pregnant in the first place, which is a cause for concern on a number of fronts, for example what proportion of these pregnancies were as a result of non-consensual sex (Coy M et al, 2010)?

- There are communities which exist within Hillingdon where it is acceptable to be pregnant and have a child in the teenage years. Early marriages in some Asian, Travelling, and some Black African communities are the norm and therefore getting pregnant and having children at a young age might not be viewed as a problem. However, this does not negate the potential negative health outcomes for both the young mother and baby as outlined below.

- Where a cultural norm such as the above exists, it is extremely difficult to influence and change behaviour. This is also true of some communities where there is an entrenched view that young people/adults will live off the state on benefits and therefore do not aspire to be anything different to their parents and grandparents, which perpetuates the cycle of deprivation.

**Preventing Teenage Pregnancy – Evidence of What Works**

**Early Intervention**

Evidence (Allen G, July 2011) shows that early intervention is very cost effective, for example targeting those at greatest risk of a teenage pregnancy, which includes:

- Young people excluded or truanting from school, or underperforming in education
- Young people in care or leaving care
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- Daughters of teenage mothers
- Young people involved in crime
- Some minority ethnic groups
- Vulnerable young people
- Young women who have had a previous pregnancy
- Any young woman who is sexually active is at risk of pregnancy whether or not they fall into an at risk group (TPIAG, 2010)
- Alcohol and drugs misuse (DfES/DH, 2010)

Education

Research shows that young people who have high aspirations and expectations are more likely to avoid teenage pregnancy than those with low aspirations and low expectations. Indeed, if those girls with high expectations do get pregnant, they will often opt for an abortion rather than keep the pregnancy, whilst girls with low aspirations and expectations will often keep the pregnancy. In Hillingdon there has been steady progress of teenage mothers aged 16-19 participating in education, employment or training. The latest figure taken in November 2011 (29%) suggests an increase of 7.0 percentage points since 2009 (22%). However, the level of performance is far below of achieving the 60% target.

Contraceptive services

Contraception is the key to preventing teenage pregnancy, reducing repeat births and abortions. As such, it is essential that accessibility of sexual and reproductive health services for young people is maintained and improved. Young people should have frontline help and support where and when they need it most. The independent national Teenage Pregnancy Advisory Group have recommended the following as being essential key elements to young people specific contraceptive services:

- Consulting young people about what works for them and what doesn’t.
- Be confident about talking with teenage girls and boys about sex and relationships.
- Empower them to make decisions for themselves including delaying early sexual activity.
- Equip them with negotiating skills and tips to resist peer pressure.
- Promote the fact that young people can see nurses in confidence without a parent - even if they are under 16.
- Make sure young men are welcome, included and participating in services.
- Let young people know what services are available at the practice/school/clinic.
- Offer information on a full range of contraceptive methods and inform young people where they can get them.
- Have fast-track arrangements in place for emergency contraception.
- Be alert to young people who might be at risk of teenage pregnancy, including vulnerable young people.
Work with your colleagues to discuss how to become more young people friendly.

Preventive measures implemented in Hillingdon
Following the evidence from the USA (Santelli et al., 2007) the key intervention to what works in preventing teenage pregnancy is the use of contraception when having sex. Key attributes to help this happen are being actively engaged in education with high aspirations and expectations of achievements, easy access to contraceptive services and sexual health advice and having a trusted adult to confide in.

Of all the ‘interventions’ previously developed in the UK such as Peer Education, Youth Participation, Targeted Youth Support, it has been proven in the USA that abstinence does not prevent Teenage Pregnancy in the long term. It is true that while the young person practices abstinence they will not get pregnant, but when they do start becoming sexually active they do not have sufficient information, skills or knowledge to prevent pregnancy/sexually transmitted infections such as Chlamydia.

The significant and ongoing challenge to reduce teenage pregnancy in Hillingdon has been a steady one. The sign up and interest in the agenda by partners has been overwhelmingly evident since 2001. What has been more difficult is the translation from strategy in to practice with clear indicators that work has made a difference. However, great progress has been in made in the last couple of years and below are a selection of that areas of work that are making a difference.

Interventions to prevent Teenage Pregnancy
Hillingdon like many other areas has struggled to achieve the target reduction. However, since 1998 we have applied the following evidence based strategies:
- Life Education - Drugs and Alcohol in Primary Schools
- Triple P Parenting Programme
- Self Esteem Raising Project for young women
- Young People Friendly Contraceptive services
- Seasons for Growth Bereavement Programme in schools
- Workforce Development Training

KISS (Keep It Safe and Sorted): A young person’s drop-in service which provides sexual health advice and signposting to local services. This service works for young people, because it is a non-clinical setting youth setting where they experience and are assured of confidentiality and anonymity and experience a non judgemental attitude.

- Hillingdon Community Health Service, Sexual Health outreach service – ‘Clinic in a Box’: There are six ‘Clinic in a Box’ (CiB) sites situated in non-
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health settings such as Uxbridge College and Youth Centres. This model works particularly well for boys/young men. The CiB in Uxbridge College attracts a better than average attendance by boys/young men.

- **Targeted Youth Support Team (TYST):** When working with a young person and their family, an intervention is more successful than working with the young person in isolation.

- **You’re Welcome Quality Standards:** The service at Uxbridge Health Centre was judged by young people to have reached the quality standards (DH, 2009). These included being young people friendly, clear sign posting with a selection of age/gender appropriate magazines. An increase in the uptake of contraceptive and sexual health advice services has been noted.

KISS and CiB services have had good uptake by young people in the borough, however, work remains to be done in order to site services in the areas where young people live their lives.

**Workforce training**
Workforce training in early identification has been prioritised so teams know how to identify and support young people in helping them access sexual and reproductive health services.

For the future, given the period of austerity that we are moving into, a slimmed down workforce needs to take on new responsibilities.

**Performance management**
The Children’s Trust Board and PCT Performance and Effectiveness Committee have both been performance managing the teenage pregnancy strategy more astringently. The positive impact of this has resulted in a higher profile of teenage pregnancy with senior managers. As teenage pregnancy is integrated into wider programmes the local performance management has been strengthened by both the PCT and LBH.

The core data set should be used to monitor under-18 conceptions and proxy indicators such as repeat abortions and contraceptive uptake data.

**Condom distribution scheme**
Young people are a mobile population and socialise, attend education and shop outside of the borough in which they live. The Terence Higgins Trust was commissioned by NHS Hillingdon in 2010 to deliver a local condom distribution scheme - part of the London Wide Scheme Come Correct.

There are 30 outreach services (including for example – CiBs, youth centres, and youth hostels) that have joined the scheme and are actively promoting
access to Condoms and Chlamydia screening. The scheme has been evaluated to inform the commissioning priorities for 2012/13.

**Emergency hormonal contraception**

Emergency Hormonal Contraception (EHC) is provided free to girls under 18 years to prevent unplanned pregnancies.

There are currently nine out of 63 pharmacies participating in the EHC scheme with 16 community pharmacists trained to provide the service. The pharmacists offer counselling and follow a strict protocol before offering the EHC pills. Specific criteria are listed in a PGD (Patient Group Direction). The PGD include client confidentiality, inclusion/exclusion criteria, referral criteria, cover for supply to under 16 year olds, data collection and full counselling requirements.

There are varying degrees of uptake, with the pharmacy in the Uxbridge Town Centre being the most accessed by young women and a community pharmacy located in a hotspot area has the least accessed service.

**What Young People and Parents Have To Say?**

Over the past four years a number of consultation exercises have been undertaken to ascertain the views of young people and parents regarding SRE, Clinic in a Box outreach service and parental support to teenage parents. Table 4 details the key issues raised via the consultation:

<table>
<thead>
<tr>
<th>Hillingdon Youth Council (a)</th>
<th>Teenage Parents (b)</th>
<th>Parents (c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Poor delivery of SRE</td>
<td>▪ Lack of availability of information about contraception</td>
<td></td>
</tr>
<tr>
<td>▪ SRE is too biologically focused</td>
<td>▪ Fears about weight gain with LARC (Long Acting Reversible Contraception)</td>
<td></td>
</tr>
<tr>
<td>▪ Not enough information about relationships and feelings</td>
<td>▪ More information available regarding sex and the realities of becoming a young parent.</td>
<td></td>
</tr>
</tbody>
</table>

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Prevention in the Cold Climate

Teenage pregnancy is a key inequality and social exclusion issue. There is a strong economic argument for investing in measures to reduce teenage pregnancy, which places significant burdens on the NHS and wider public services:

- The cost of Teenage Pregnancy to the NHS alone is estimated to be £63m a year.
- Benefit payments to a teenage mother who does not enter employment in the three years following birth can total between £19,000 and £25,000 over three years.
- Teenage mothers will be much more likely than older mothers to require targeted support from a range of local services, for example to help them access supported housing and/or re-engage in education, employment and training.

Broad estimates by the DfES/DH Teenage Strategy suggests that for every £1 spent on investment in the strategy saves approximately £4 to the public purse, when assessed over a period of 5 years.

An independent advisory group estimated that the NHS can also save money by reducing teenage pregnancy. Every £1 invested in contraception saves the NHS £11.

We know if we do not intervene early to provide effective support and help this group of young people are less likely to make a successful transition to adult life, and can go on to cost the public purse significant amounts:

- Alcohol Concern estimate that young people attending Accident and Emergency departments cost the NHS £19m per year (2010).
- The additional lifetime cost of being NEET, per young person is estimated at £56,000 in public finance costs compared to the average person (Audit Commission 2010).
- Estimates suggest that intervening effectively with just one in ten young offenders could save the state £94m (Independent Commission on Youth Crime).
- Research by the Sainsbury Centre for Mental Health suggests that children with the most common form of mental health problem, conduct disorder, cost ten times more than their peers and that effective early treatment can lead to savings of up to £150,000 per child.

Recommendations

The recommendations and future actions below recognise the limited budget availability in the future. With this in mind, the actions below are based on the evidence of best practice, what works and areas specific to Hillingdon that need to be strengthened to achieve further improvements in reducing teenage pregnancy.
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Culture of aspiration is the norm
Young people should grow up to achieve have high aspirations and expectations which results in higher achievements.

SRE in schools
Consistent SRE responding to pupils/parents/carers needs. Include parents/carers as partners in SRE from Early Years – Secondary School.

Parents and carers
Commission services to support parents/young parents as part of the Parent Support Strategy.

Children’s centres
Involving young parents will ensure that services are designed to meet the needs of vulnerable and hard to reach groups. If we reduced second pregnancies, we would reach our target (Kelly A, 2009).

Capacity building and workforce training
A well commissioned and co-ordinated sexual health training programme, which clearly integrates sexual health with alcohol and substance use and links closely with training on risk and resilience and early identification, should be in place for the Children and Young People’s Workforce (including NHS, local authority, education and voluntary and community services staff) to ensure a confident and skilled workforce.

Integration
- Effective strategic partnerships in place between Hillingdon Council, NHS Hillingdon, Hillingdon Community Provider Services and the Voluntary and Community Sector would contribute to the Teenage Pregnancy strategic objectives being incorporated into all key partners’ plans. (Teenage Pregnancy Rapid Review highlights this is not currently happening)
- Integrate the Teenage Pregnancy strategy into Early Intervention and Prevention work to ensure it is not a stand alone programme.

Child poverty strategy
Child Poverty Strategy and the prevention of Teenage Pregnancy and support for young parents are to be included in Hillingdon plans. Teenage Pregnancy has been highlighted as a priority in the Hillingdon Needs Assessment Toolkit (LBH, 2010).

Identification of vulnerable young people
- Young people (and localities) at risk of Teenage Pregnancy need to be identified early and those identified as being at risk should be offered targeted support and interventions to address identified needs.
- Young parents’ (both young mothers and young fathers) additional support needs need to be identified through the CAF to ensure that co-ordinated packages of support can be offered to them.
Rationalisation of current strategic and sub groups

- This is a recommendation from the TP Rapid Review Rationalising the amount of meetings attended will create cost savings in professional’s time to do more frontline work with the young people/parents.
- The focus, will, and determination needs to continue in addressing the risks factors contributing to teenage pregnancy.

Contraceptive services

It is absolutely vital that sexual and reproductive health services are maintained and improved, so young people have the frontline help where and when they need it.

Continuing to prevent teenage pregnancy

- Young people should be encouraged to have the expectation that sexual relationships are healthy, safe, consensual and respectful.

“It makes you more up for it" School aged young people’s perspectives on alcohol and sexual health,”2009

Cost effectiveness

Work with C4EO (the Centre for Excellence and Outcomes in Children and Young People’s Services) is being developed to calculate the cost effectiveness of work around teenage pregnancy – prevention and support. The dedicated team works on a Social Return on Investment model (SROI) which helps make the case for continued investment in effective programmes (DH, 2010).

Conclusion

Teenage Pregnancy is an Important Public Health Issue due to the poorer outcomes and lack of opportunities available to young parents and their babies as a result of a teenage pregnancy. A large proportion of unplanned teenage pregnancies could be avoided with better use of contraception, accessibility which should be improved for young people. The challenge will be for Hillingdon to enable/facilitate young people to have high aspirations and achievements as the norm, who then go on to become part of a strong, knowledgeable and well developed workforce/community. Able to make informed choices about their future and are confident, to delay parenthood until they choose the time to be right for them.

In the ‘Cold Climate’ we need to concentrate our efforts on improving the quality and consistency of SRE in schools specifically targeting scarce resources to young people identified as being at risk of Teenage Pregnancy. Improving access, information, and sign posting to high quality contraceptive services that offer a range of contraception choices and are actively promoting Long Acting Reversible Contraception (LARC) should be prioritised.
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