Draft

Be Healthy Summary

The following needs have been identified:

Teenage Pregnancy

- We have taken action that has had a measurable impact on the quality of services and young people's attitudes and behaviour. There has been a noticeable improvement to the under 18 conception rate for 2009 compared to the 1998 baseline, although rates remain high relative to national and statistical neighbours.
- New national schemes are effective at a local area level: e.g. "You're Welcome" quality standard which 14 sites in Greenwich have now been awarded.
- Greenwich Sexual Health Website – is raising awareness amongst young people e.g. young men accessing the condom distribution scheme.
- Redesigning of care pathways for termination of pregnancy to support better use of contraception. Co-ordinating the care pathway of all "young parents" through use of the Team around the Child process.
- Mandatory SRE training for frontline youth support workers.

Obesity

- There is a high obesity prevalence amongst Greenwich pupils – in reception classes 12% classified as obese and in year 6 22.9% classified as obese (as reported by National Child Measurement Programme, 2008/09). Greenwich has high levels of free school meals entitlement and too few children are taking this up. We have achieved 2009-10 targets for the 5 hour offer (offering 2 hours of quality PE and sport in the curriculum, plus 3 hours extra curricula activity). Free swimming has been offered to all borough residents aged under 16.

Alcohol and Substance misuse:

- Numbers of young people accessing specialist treatment has improved in the last year, but referrals from Integrated youth support and schools remain low. We must continue to screen and identify the needs of looked after children, in order to increase numbers of vulnerable children benefitting from treatment. Too many young people leave treatment in an unplanned way. Although Tellus 4 did not show alcohol consumption to be a significant problem in Greenwich young people, we know from hospital admissions that young women's misuse of alcohol needs to be addressed. We have promoted services among the BME community, so BME groups are no longer underrepresented in treatment.
- We re-commissioned our specialist substance misuse provider. This is based in The Point.. Delays in the opening and publicity surrounding the Point have had an impact on the numbers of referrals to the service.

- We have worked with providers to identify the reasons for our relatively poor performance in the numbers of young people leaving treatment in a planned way. A new protocol is in development as a result with a 'step down' process at the end of treatment to a named lead professional.

In 2010-11 we will:

- Work to improve awareness of the risks of drug-taking in 2010-11;
- Provide training and support to youth workers to help them identify need and make appropriate referrals to treatment services
- Agree and implement better care pathways for looked after children and those leaving treatment

Emotional and Mental Health

- A training needs analysis and interviews with head teachers and with children and young people in conjunction with the Tellus 4 results (NI 50) indicate the need to take further action in 2010-11 to promote good mental health and emotional well-being. Issues relating to fear of crime and bullying (the fear rather than experience) and a lack of an

adult that young people feel they can speak to are key issues. In addition the relatively high incidence in some parts of the borough of domestic violence and parental substance misuse and mental ill health is having an impact on children's emotional well-being. Some of these children and young people will also be young carers.

- We have assessed our CAMHS services as being fully effective (16/16). Although the results of strengths and difficulties questionnaires for looked after children indicate an improvement (NI 58) in their emotional well-being, this vulnerable group remains a key focus for us.

Actions this year have included:

- Specifying requirements for our specialist CAMHS service, in particular for Children Looked After (CLA), disabled children and black and minority ethnic groups
- Front line professionals and CAMHS staff have undertaken liaison and consultation work which promotes emotional well being and targeted CAMHS input in schools
- Work with key partners and providers to strengthen contract and performance management to evidence impact
- The Tamhs project has been rolled out across 3 clusters of schools with the training phase completed. Through the Tamhs project and our work with the Young Carers' project we have promoted the use of the CAF to identify and assess these and other needs. This has begun to increase those schools' use of CAF/TAC.
- A comprehensive needs analysis of mental health and emotional well-being is ongoing

In 2010-11 we will:

- Complete our needs analysis and devise a new mental health promotion strategy and CAMHS commissioning strategy which will ensure that there is a coherent and progressive approach of service provision from universal to specialist services
- Roll out wave 3 of Tamhs and evaluate the project's impact.
- Continue our focus on workforce development.

Breastfeeding

- Breastfeeding status varied according to the ethnicity of the mother. For example, 80% of Chinese mothers but only 69% of the White British mothers had provided breast milk at either initiation or by discharge. In contrast, 97% of Black African and 96% of Asian mothers had done so.

  Young mothers in Greenwich are less likely to breast-feed. 42% of mothers aged under 20 giving birth at QEH during 2007 and 2008 were recorded as not having given any breast milk by the time of discharge while only 9% of mothers aged 30 or more had not done so. Mothers aged 20-24 were also less likely to breastfeed: 26% had not done so by the time of discharge.

  Infant feeding methods in use by the time of discharge show an even more worrying picture. For example, 63% of White British mothers aged under 20 and 52% 276 of White British mothers aged 20-24 were not breastfeeding at discharge.

Infant mortality

The following risk factors are cited in the JSNA

- Parents working in routine and manual work
- Infants registered solely by their mother
- Infants born to teenage mothers
- Infants born to mothers who were themselves born in West or East Africa, or the Caribbean (with a particularly high rate noted for mothers born in West Africa)
- Low birth-weight (less than 2.5 kg)
- Smoking during pregnancy and smoking in an infant's environment

Almost all causes of infant death have a socio-economic gradient, occurring more frequently in progressively poorer households.The gap in infant mortality between those in routine and manual groups and the population as a whole in a key indicator of the impact of deprivation on mortality in this age group.

In Greenwich, almost one-third of births (31.1%) were to mothers or couples with routine or manual occupations during 2001-03. UPDATE 40% of infant deaths in 2004-8 were to families from this group.