

Be Healthy

Key Issues

- **Reduce the health inequalities** between the east and west of the borough.
- **Increase the uptake of immunisations** in Haringey which remain well below national target levels.
- **Reduce infant mortality.**
- **Reduce the high level of teenage pregnancy.**
- Increase the number of people tested for **Chlamydia** to identify young people that already have Chlamydia and work on the future spread by promoting wider use of condoms.
- Address the **mental health issues** which will affect 2650 children and young people by 2013, in particular for vulnerable children who are five times more likely to develop mental health problems.
- Reduce the level of **obesity** especially in the North and South Network areas.
- Address the **low rate of referrals into specialist services for drug users.**
- Take forward the **recommendations from the Scrutiny review of the early identification, assessment and referral** of children and young people with drug and alcohol problems.
- **Ensure greater read across to other relevant strategies** when dealing with children and young people with drug and alcohol problems, for example, teenage pregnancy, Child and Adolescent Mental Health Service (CAMHS), integrated youth support, safeguarding plan.
- Produce **data on smoking and eating habits at ward level** to better understand these behaviours and produce targeted interventions in high risk communities.
- **Develop care pathways** to improve the management of common childhood ailments; this is highlighted by the continued inappropriate use of A&E services.

1. Introduction

In order to achieve the broader outcomes described in this document it is important that all our children and young people are physically, mentally, emotionally, socially and sexually healthy. Some face greater challenges to achieve good health and it is important that they are given the necessary support to achieve their potential.

The “Be Healthy” and “Stay Safe” sections of this Children and Young People Needs Assessment come together as the Needs Assessment for Vulnerable Children and Young People.

This section covers:

The Early Years:

- Infant mortality
- Birth rate
- Birth weight
- Antenatal care
- Smoking during pregnancy
- Initiation of breastfeeding
- Immunisations

The Teenage Years:

- Healthy lifestyles
- School meals
- Reducing smoking
- Drug misuse
- Alcohol misuse
- Parental substance misuse
- Oral health
- Accidents
- A&E use
- Sexual health
- Chlamydia
- Teenage pregnancy
- Mental health in children and young people
- Statements of Special Educational Needs
- Children and young people with disabilities and general health status
- Health of children in care
- Deaths amongst children and young people
- Children and young people with additional needs
- Children and young people with additional needs aged 18-25 years
- Young carers

Implications

Gaps in data

Children's Network Summary

National Indicator Set

2. Context

Given the deprivation that some of our children and young people experience, health needs are very important. Infectious diseases, accidents and injuries are all risks for our children and young people. Other health risks are less obvious as they do not necessarily result in immediate effects, (for example, a poor diet or lack of physical activity) but are possibly as significant in the long term. A focus on prevention and early intervention, whilst at the same time seeking to reduce the effect of poverty and deprivation, could make a real difference to children's health into adulthood. Crucially this involves supporting families, mothers and children to ensure the best possible start in life, so breaking inter-generational cycles of ill-health. This support includes improving antenatal care and early years support especially in disadvantaged areas, reducing smoking, improving nutrition, supporting teenage and lone parents, and improving housing conditions.¹

a) Dr Foster Health Mapping

A recent study undertaken by Dr Foster for Haringey NHS segmented the Haringey population into three distinct groups and subdivided each of these three groups to create nine groups in total (see map 2.1). By using local data sources they were able to identify certain health risks within each group.

Whilst much of the information was focused on adult health, certain elements of the health of children and young people were analysed including teenage conceptions, obesity and admissions to hospital.

The report suggested that there was poor health among people in the "C" groups, who are mainly residents from the east of the borough. It highlighted high teenage conception rates in this group and high elective and emergency admissions compared relative to other parts of Haringey. High admission levels were found to be highest in the C01 and C03 groups. Obesity levels for children are highest in the C02 group.

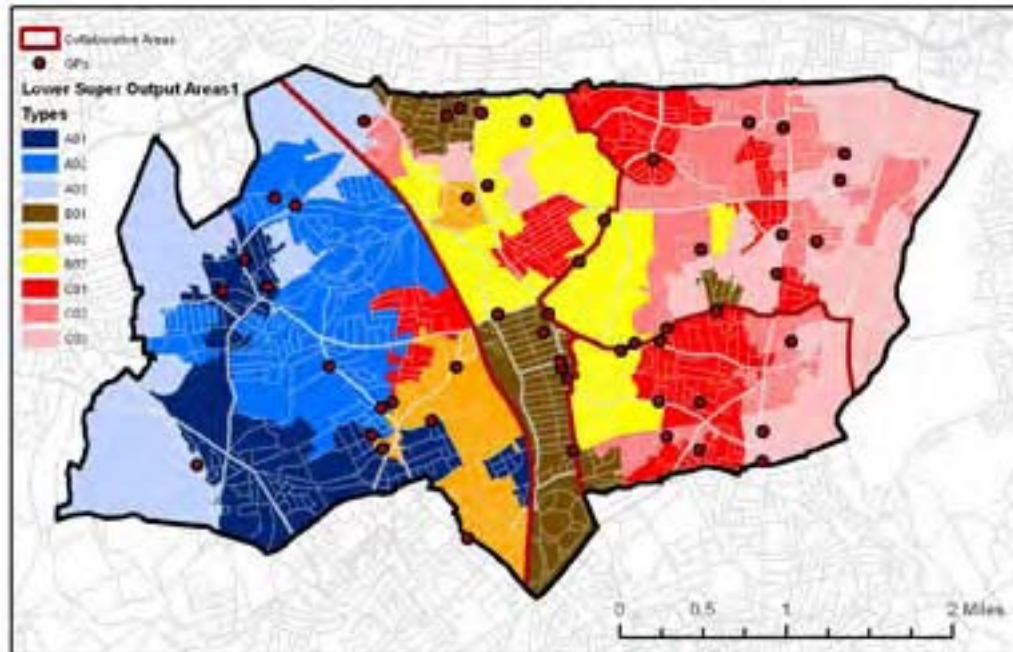
Amongst "B" groups, those in B1 have high emergency admissions, outpatient appointments and high levels of respiratory conditions. Young people in B3 have high elective admissions and high levels of respiratory conditions.

Although the east of the borough had the highest levels of admissions and so on compared with the west of the borough, the study highlighted high levels of

¹ Growing Up in Haringey, op cit. p.3.

childhood obesity within the “A” groups in the west, particularly those in A01 group. However, it should be noted that children from the west may access private school or schools outside Haringey that are not measured as part of the national weighing and measuring programme.

Map 2.1: Dr Foster Segmentation model



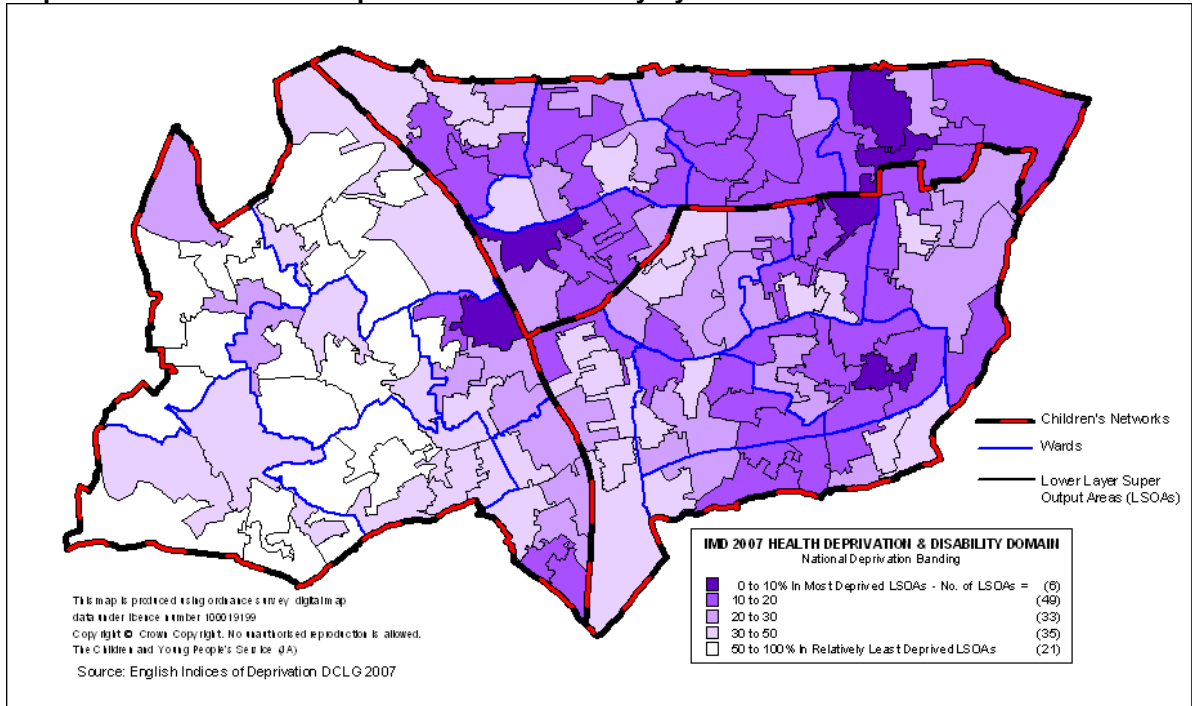
Source: Dr Foster (December 2008)

The views of children and young people on health issues can be found in the chapter ‘Make a Positive Contribution’.

b) Health deprivation and disability

- This domain is based on indicators for premature death, disability, and a variety of measures that reflect poor quality of life due to ill health.
- Only six Haringey Lower Super Output Areas (LSOAs) (approximately 4%) are amongst the 10% most deprived in the country. This is, however, an increase on the 2004 Index of Multiple Deprivation (IMD), when only two LSOAs fell within this group.
- 5% of LSOAs in London are amongst the 10% most deprived in the country.

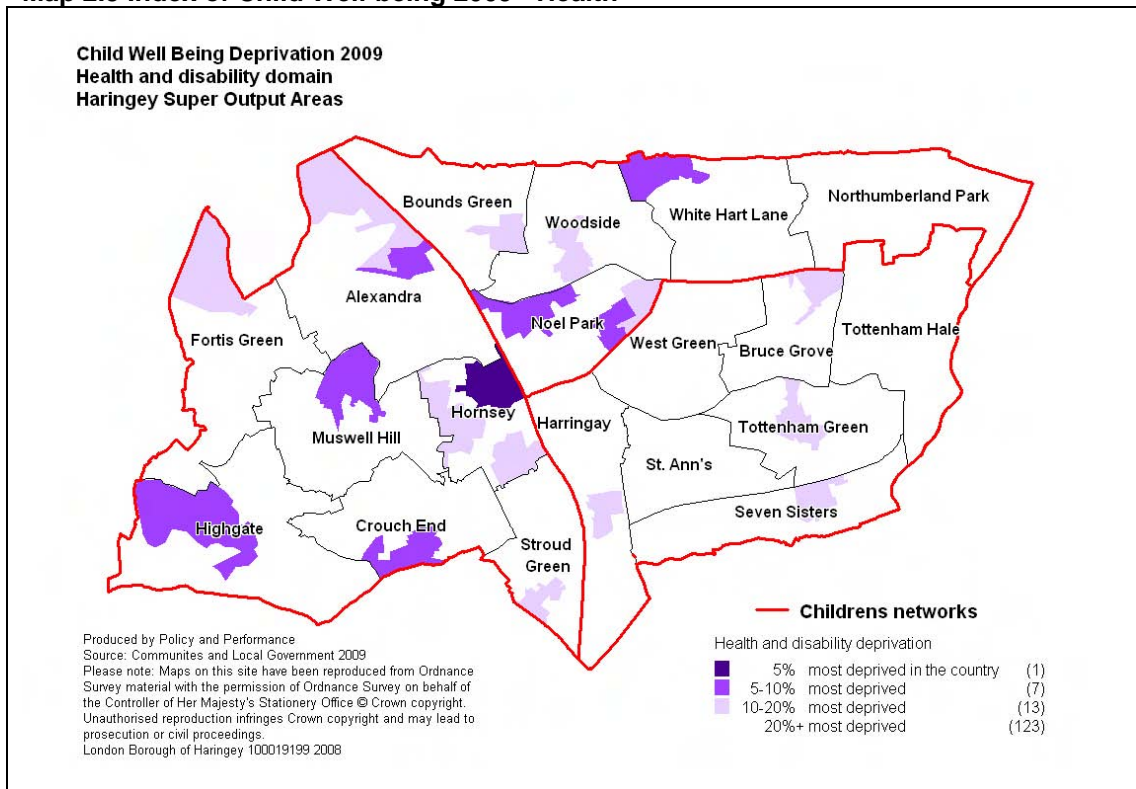
Map 2.2 IMD 2007 Health Deprivation and Disability by LSOAs



Source: English Indices of Deprivation DCLG 2007

c) Index of Child Well-being 2009: Health

Map 2.3 Index of Child Well-being 2009 - Health



Source: Local Index of Child Well-Being DCLG 2009

- Due to the shortages of data of this type at local level, this domain focuses on illness, accidents and disability, as represented by the use of health services and the uptake of disability benefits.
- 5.5% of Haringey SOAs fall into the 10% most deprived in the country.

3. Reducing health inequalities, improving health outcomes

A major challenge is to reduce health inequalities particularly between those living in the east and west of the borough. Many health indicators amongst adults suggest better health outcomes for those living in the west of the borough. Working on ensuring a good, healthy start for children in Haringey will help prevent these inequalities persisting in early years.

The following sections describe the health of children in Haringey from conception, through early years and into young adult life.

4. The Early Years:

a) Infant mortality

Infant mortality and the proportion of low birth weight babies are key indicators of health and inequality. The infant mortality rate for Haringey in 2007 was 4.2 per 1000 down from 6.4 per 1000 in 2006 and 7.7 per 1000 in 2005. This compares to rates of 4.5 and 4.8 for London and England respectively both of which dropped between 2006 and 2007. The infant mortality rate is higher in wards in the east of Haringey.

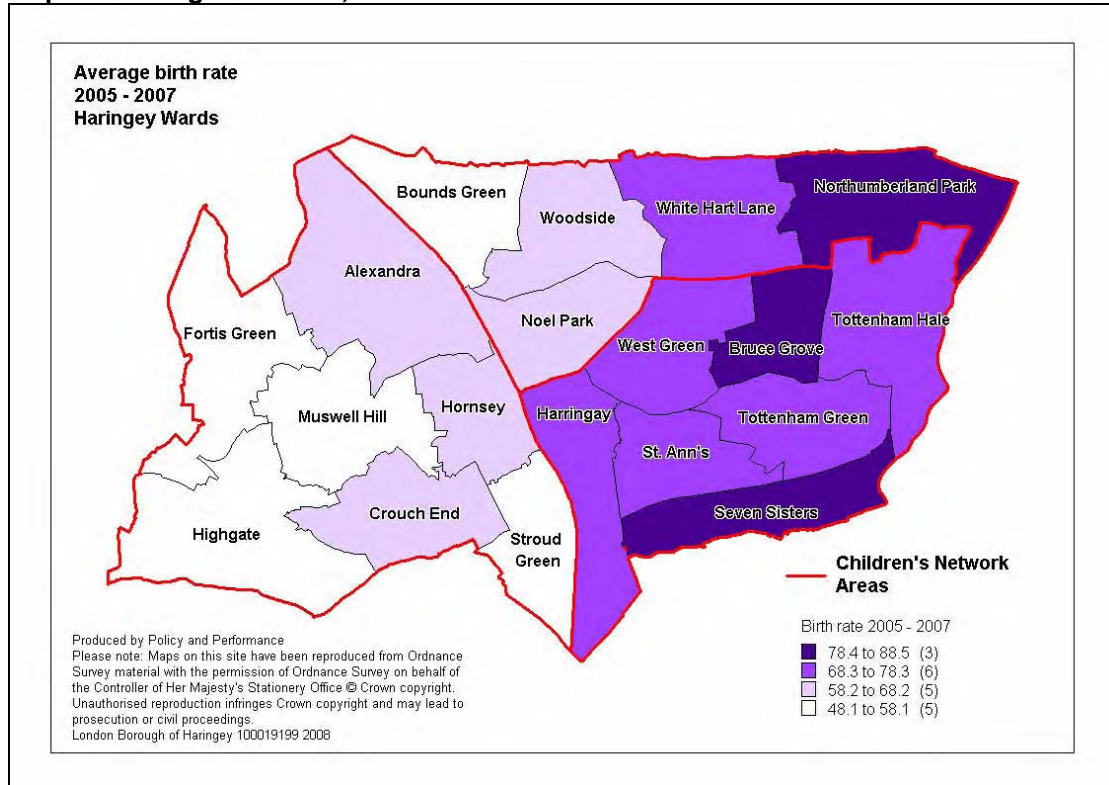
Although the infant mortality rate for 2007 is lower than that of London and England, other related indicators are higher. The still birth rate is higher at 6.4 per 1000 (compared to 6.2 and 5.2 per 1000 for London and England respectively). The perinatal rate (still births and deaths within seven days of birth) is also higher at 9 per 1000 (compared to 8.4 and 7.7 for London and England respectively).

The number of deaths per year is small and as a result it is inappropriate to describe differences across the borough. There are a number of indicators that can be used as a proxy measures that can be described at a local level. These include low birth weight and smoking in pregnancy. These are described in the following sections.

i) Birth rate

The general fertility rate measures the number of live births per 1000 women aged 15-44 years. In 2007 the general fertility rate was 74.2 in Haringey which was higher than the London Average (68.3 per 1000) and the National average (61.9 per 1000). Furthermore the rate in Haringey has risen quicker than both London and England and Wales from 69.1 per 1000. Between 2005 and 2007 the number of live births increased from 4026 to 4325 (7.4%).

Map 2.4 Average birth rate, 2005-2007



Source: NHS Haringey

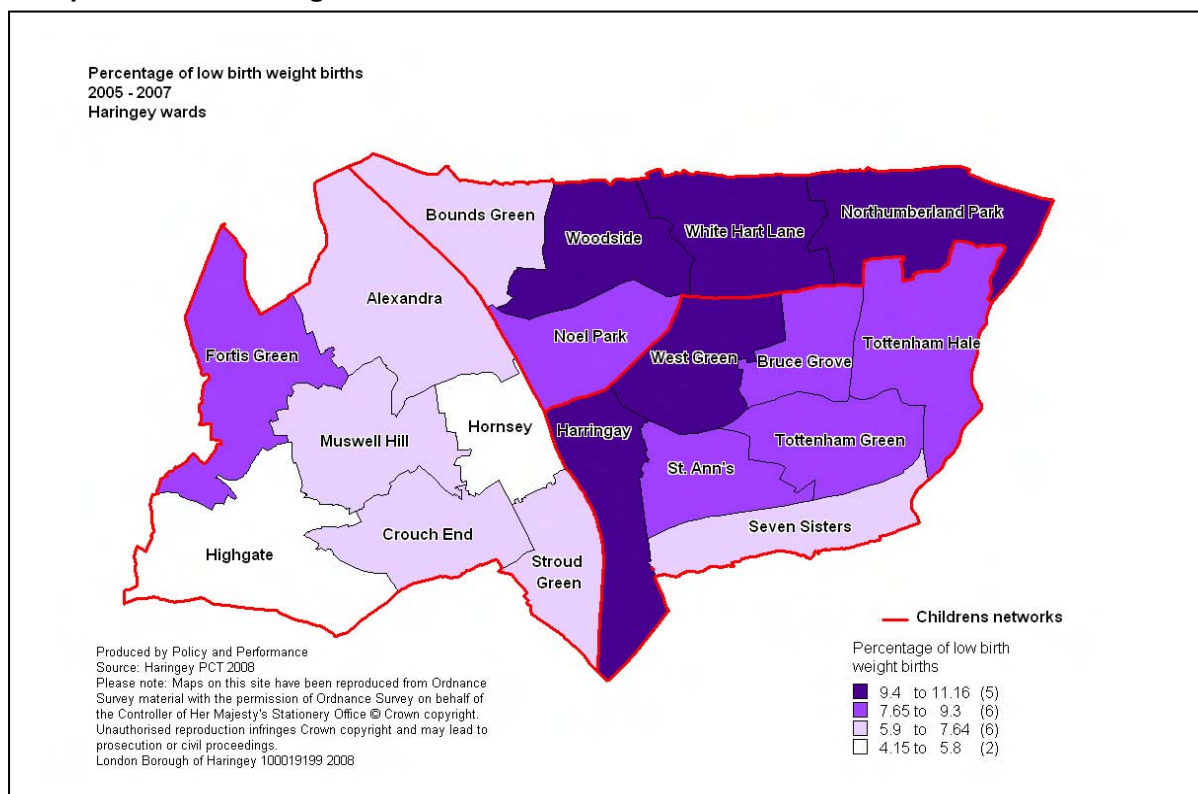
Locally, between 2005 and 2007, the birth rate was highest in the South Network Area and lowest in the West.

ii) Birth weight

Low birth weight plays a huge part to causes of infant mortality. The proportion of babies born with low birth weight (under 1500g and 2500g) has fluctuated over the last ten years. However, there has been a notable fall in the percentage of babies born with low birth weight less than 2500g from 8.6% in 1997 to 7.8% in 2007. The trend in the proportion of babies born under 1500g over the last decade has been erratic, with 2% of babies born in 1997 and 1.7% in 2007, going up from 1.5% reported in 2006.

Within Haringey there is a variation in the proportion of low birth weight babies across children's network areas. The West has the lowest proportion (6.4%) and the North has the highest proportion (9.6%). The South Network area proportion was 8.4%.

Map 2.5 Low birth weight babies 2005-2007



Source: NHS Haringey

iii) Booking antenatal care

It is important that women book antenatal care with their local hospital to ensure that they are given appropriate advice and care at an early stage to avoid complications during the pregnancy. It is recommended that women book before they are 12 weeks pregnant.

In Haringey it is estimated that 60% of women book before 12 weeks. A study is underway which will inform as to whether there are certain groups in the community that tend to book later than others, be this age, ethnicity or social class. NHS Haringey will then be able to promote early booking amongst these groups.

iv) Smoking during pregnancy

According to a meta evaluation of smoking cessation intervention research among pregnant women in 1998, women who reduced their smoking by half or more had babies on average 92g heavier. Women who had quit had infant birth weights on average 250g heavier. During Q3 2008/09 in Haringey, the percentage of mothers smoking during pregnancy was 8.57%, which is behind the local target of 5.0%. The percentage of mothers with smoking status not known was 1.14%, which is also behind the target of 0.0%. In addition, during Q3 2008/09, the percentage of women known not to be smokers at the time of delivery was 90.3%; and the percentage of women known to be smokers at time of delivery was 8.57%.

v) Initiation of breastfeeding

During Q3 2008/09 the percentage of mothers initiating breastfeeding in Haringey was 91.12%. Although the initiation of breastfeeding is important it is thought that to sustain the method of feeding to at least 6-8 weeks is a far more relevant measure. The interim methodology for collecting local data to record breastfeeding at 6-8 weeks is being developed and the data is therefore unreliable. However, current data returns suggest that approximately 52% of children are at least partially breast fed at 6-8 weeks. This falls some way short of the national target.

b) Immunisations

Measles is one of the most infectious diseases known. It is a viral illness and nearly everyone who comes in contact if not already immune will catch it. It causes significant morbidity and also mortality. The complications of measles affect one in every 15 children. They include chest infections, fits, encephalitis (swelling of the brain), and brain damage. 1 in 10 children who catch measles will require hospitalisation and 1 in 1000 will die.² In 1987 (the year before the Measles, Mumps and Rubella (MMR) vaccine was introduced in the UK), 86,000 children caught measles and 16 died. It is not possible to tell who will be seriously affected by measles.

The World Health Organization (WHO) recommends the vaccine uptake should be 95% to ensure adequate protection across the population.

During the late 1990s, following a now discredited study published in The Lancet, there was a lot of public concern about links between MMR and autism. These reports questioned the safety of the vaccine causing some parents to delay their child's MMR immunisation or not to have it at all resulting in outbreaks of measles.

The uptake of MMR fell from around 92% in 1995 to 78% in 2003 with much lower levels of below 50% in London. Rates are increasing slowly to around 85% nationally but are still much lower than this in London.

In Haringey we continue to have sporadic cases notified across the borough. There is no particular pattern with cases showing in every ward in the borough although slightly more cases in Seven Sisters ward than elsewhere.

Measles cases are reported equally in girls and boys. Cases are also reported across social and ethnic groups. The ethnic group with the most cases in London is the Orthodox Jewish community. This is thought to be due to the ability of this group to access services (in some part due to family size and busy lives) rather than parents' refusal to immunise.

Local studies suggest that the immunisation coverage is inadequate to prevent an outbreak and a significant amount of work is underway to ensure

² <http://www.mmrjab.com/>

that more children are fully vaccinated. This includes a catch up campaign across all of Haringey aimed at children up to 11 years that have missed vaccinations in the past.

A Human Papilloma Virus (HPV) programme has also been initiated in Haringey which is aimed at young women. A significant number of young women have now been immunised against the virus which could have an impact on the number of women developing cervical cancer in the future.

5. The Teenage Years

a) Healthy lifestyles

As part of a joint national campaign between the Department of Health and the Department of Education and Skills, every borough across the country is required to annually collect height and weight data of all children in maintained schools.

Children's height and weight are now obtained in all Haringey schools during the summer term. 2008 was the third year in which this data was collected. Information from all children in Year R (4-5 year olds) and Year 6 (10-11 year olds) are measured to identify those that are considered to be overweight or obese.

In 2008 17.3% of the children measured were classified as obese and a further 13.2% were classified as overweight. However, data from individual year groups and between genders reveals large differences between groups. Levels of obesity for 10-11 year olds (Year 6) indicate that over one third of children in this age group are either overweight or obese, compared to less than one quarter in reception year. These figures are currently above the national predicted levels for 2010.

Overall levels of overweight and obesity are higher in boys than girls, with particularly pronounced differences in levels of obese boys and girls in reception year. There is also large variation between data based on the ward that the children live in, with higher levels of overweight and obesity in the North and South Network areas.

Table 2.1 Obesity by Network Area 2006 to 2008

Network Area	Reception			Year 6		
	2006	2007	2008	2006	2007	2008
North	11.1%	15.6%	12.5%	24.5%	28.2%	26.4%
South	13.7%	16.8%	12.4%	24.6%	26.5%	28.2%
West	6.9%	9.2%	7.2%	12.5%	13.3%	16.1%

Source: NHS Haringey

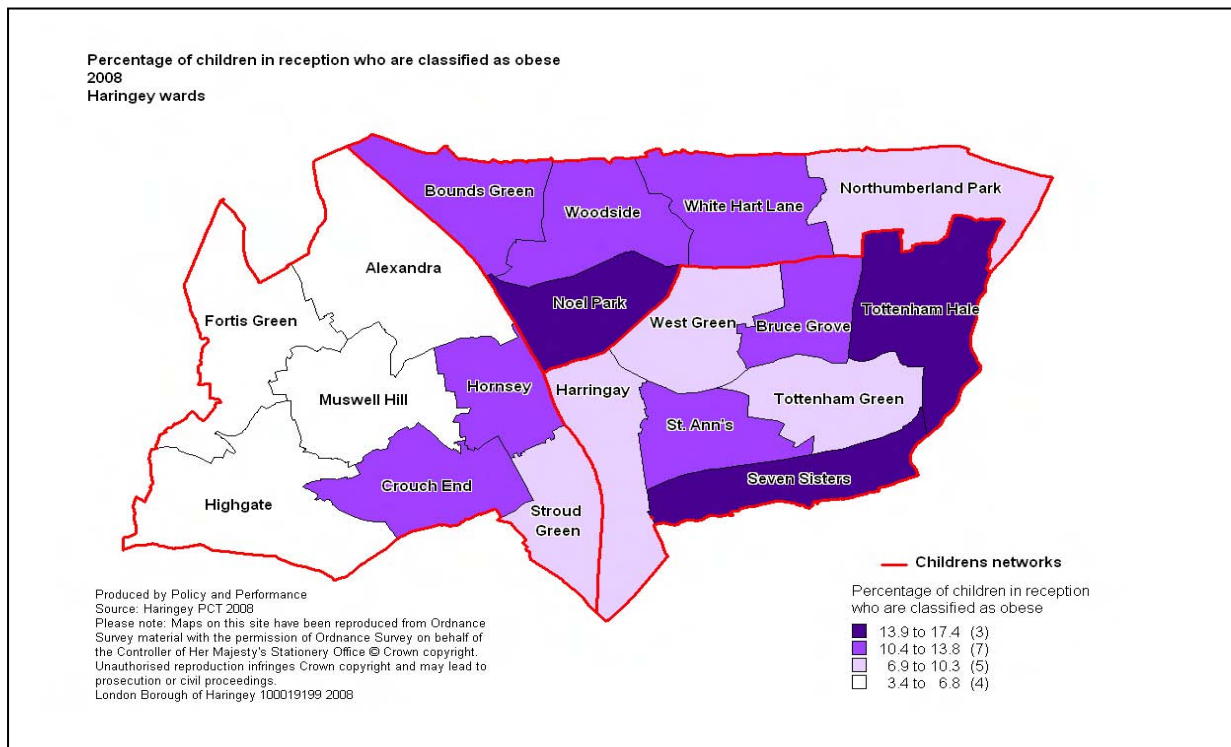
Work is underway with Children's Centres to promote healthy eating, physical activity and emotional health and well-being. There are also some good examples of small-scale initiatives, for example, Cook and Eat Schemes and the development of the Community Nutrition Assistant role.

The National Healthy Schools Programme which aims to promote health and raise educational attainment has been given a high profile locally through the Local Area Agreement (LAA). Healthy Schools is one of 12 council wide stretch targets with four key themes: Personal, Social and Health Education including Sex and Relationships Education and Drug Education; Healthy Eating, Physical Activity and Emotional Health and Well-being with sets of criteria for each that schools have to achieve in order to become accredited as a Healthy School. The stretch targets for the Haringey Healthy Schools Programme which represent a 10% stretch over the national targets are:

- 85% of schools to achieve Healthy School Status by December 2009
- 100% of schools to achieve new status by December 2010

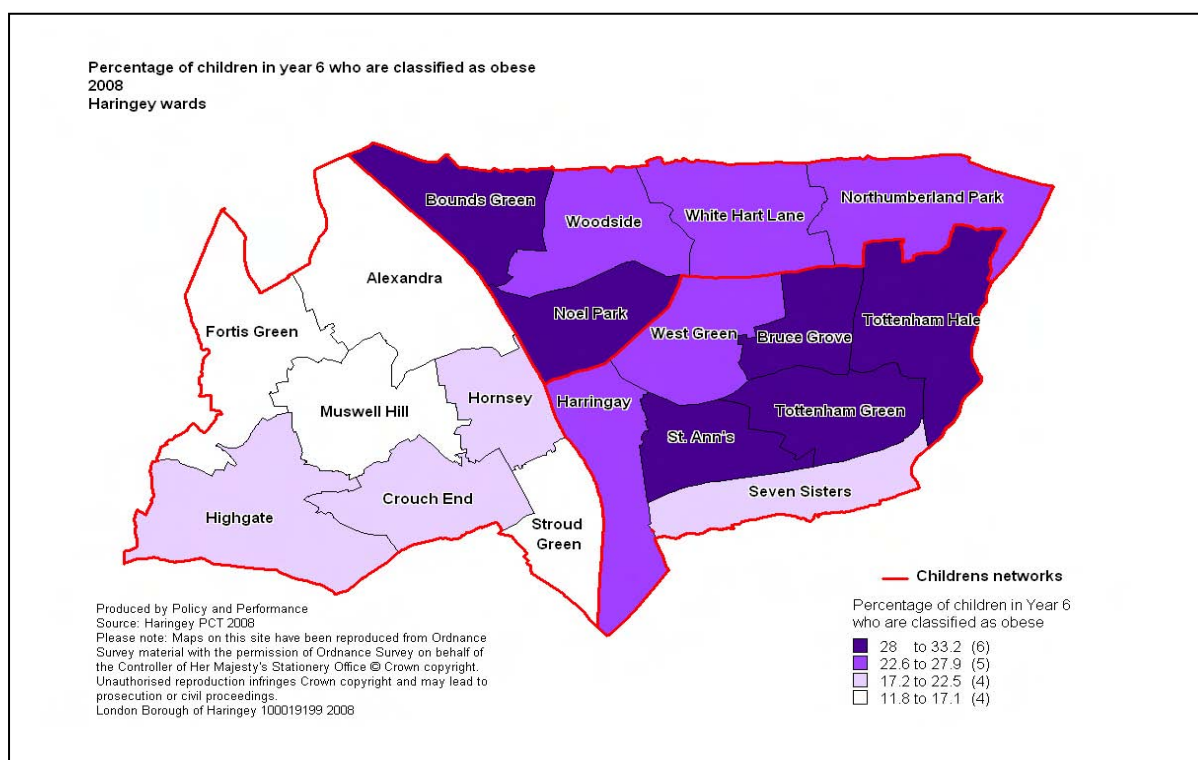
To date the Haringey programme has met all its annual stretch targets.

Map 2.6 Reception Year Obesity by ward 2008



Source: NHS Haringey

Map 2.7 Year 6 Obesity by ward 2008



Source: NHS Haringey

b) School meals

Recent investment means that the majority of meals served in Haringey schools use fresh ingredients, and fruit and vegetables are always available. New nutritional standards are currently being implemented.

c) Reducing smoking

The 2007 Health Survey for England shows that 11.7% of young people smoke – this equates to 1800 boys and 1734 girls in Haringey.

QUIT, the national charity that helps young people give up smoking, makes regular visits to our secondary schools. The charity gives talks to young people in school assemblies about the dangers of smoking.

d) Drug misuse

i) Extent of the problem

According to the Survey conducted by the National Centre for Social Research and the National Foundation for Educational Research on drug use, smoking and drinking among young people (aged between 11 and 15) in England in 2007, the prevalence of drug use remained constant between 2006 and 2007, however, there has been an overall decline in the proportion of pupils who had ever taken drugs from 29% in 2001 to 25% in 2007. Over

the same period, there have been decreases in the percentage of pupils who reported taking drugs in the last year (from 20% in 2001 to 17% in 2007) and the last month (from 12% in 2001 to 10% in 2007). In 2007, boys were more likely than girls to have ever tried drugs (26% and 24% respectively). The proportions of boys and girls who had taken drugs within the last year or in the last month were not considerably different. The prevalence of drug use increases with age. 11% of 11 year olds reported having ever taken drugs, compared with 41% of 15 year olds. Similar patterns were seen for drug use in the last year - from 6% of 11 year olds to 31% of 15 year olds, and in the last month - from 3% of 11 year olds to 17% of 15 year olds. From a wide range of drugs, pupils were most likely to have tried sniffing volatile substances (13%), cannabis (12%), and Class A drugs (5%). The prevalence of having sniffed volatile substances increased with age, but not as much as the possibility of having tried cannabis. Sniffing volatile substances was more prevalent for 13 year olds and cannabis more prevalent for 15 year olds.

Data from the British Crime Survey³ suggests that in the 2006/07 Haringey cohort there were around 4,500 young people aged 16-24 who had used drugs in the last month. Among these are probably around 1300 users of Class A drugs, including over 60 opiate users and approaching 1000 cocaine users.

The Home Office toolkit allows Drug and Alcohol Action Teams (DAATs) to estimate the prevalence of problematic drug use among young people deemed vulnerable. This formula uses absence, truancy and permanent exclusion data to estimate the number of young Problem Drug Users⁴ (PDUs) in the borough

Using the toolkit it is possible to estimate that among the frequent drug users in Haringey there are:

- nearly 400 arrestees under 18
- 24 of the frequent truants
- 194 of those excluded from school
- 21 young people who are homeless or have been in care

It is possible that there is overlap between the groups, and that an individual may appear in all four categories.

The same process indicates that over 600 of the nearly 1900 10-17 year olds arrested for notifiable offences will be users of drugs to some extent. Nearly 400 will be frequent drug users and just over 150 will be Class A drug users – this last figure represents about 8% of those arrested.

³ 'Drug Misuse Declared: Findings from the 2006-07 British Crime Survey.

⁴ Defined as opiate and/or crack users

ii) Drug type

Nationally, Cannabis use is much more common amongst young people than Class A drug use, and local needs assessment suggests that Cannabis use is also common in Haringey. Extrapolation of data from the British Crime Survey (2006/07 cohort) would suggest nearly 3750 cannabis users among the Haringey population aged 16-24. It is recognised that many cannabis users regard their behaviour as non-problematical, although this is not universal. There were 14 young people recorded as receiving treatment with Cannabis as either a primary or secondary drug in Haringey during the period up to the second quarter of 2008/09.

iii) Referrals

The most recent needs assessment clearly indicated that both the number of referrals and the number of individuals in specialist treatment is very low. These findings suggest that many of the young people involved do not require the types of interventions that require recording for the National Drug Treatment Monitoring Service (NDTMS). This perception needs to be examined in detail as it may represent a barrier to appropriate referral, preventing young people accessing necessary specialist service.

During 2007/08, Haringey made a concerted effort to ensure its data from young people's services is timely, relevant and appropriate. Despite this, current reporting to the NDTMS remains poor and will therefore continue to be a priority in the year ahead.

Service providers report that some young clients are withholding their consent to being recorded on NDTMS and therefore are not reflected in numbers in treatment. This situation is confirmed by the specialist agency, In-volve, who indicate that only around half of their clients consented to have data recorded for NDTMS. Those who work with young people need to make every effort to secure consent to anonymous NDTMS reporting and have systems in place which enable service monitoring in the event of refusal. Record keeping must be seen as fundamental to good service planning and to effective case management.

The Senior Practitioner in Leaving Care received 13 referrals. All these cases were managed as part of an overall care package rather than requiring specialist intervention. A review by In-volve of the Senior Practitioner's caseload found this to be the case and not appropriate for NDTMS recording. A similar picture occurred with the Vulnerable Young Person's Worker for school age children. This should remain under review to ensure that opportunities for effective treatment are not missed.

It seems that many universal service providers are choosing to deal with young people with drug problems 'in-house'. Despite the estimate of 60 excludees and 12 frequent truants being Class A drug users, only two referrals to treatment service came from education services in the first six months of 2008/09. Similarly there were an estimated 13 Class A drug users

among Looked After Children, yet only one referral to treatment services. Whilst universal children's and young people's services have a role to play in providing early intervention as part of an holistic social plan, this must not be allowed to be a barrier to appropriate onward referral where necessary, and onward referral should not be seen as excluding holistic approaches. It is important to examine the extent to which workers in universal services are using assessment tools appropriately and making appropriate deductions about the need for and value of specialist treatment.

Referrals from YOS

Data from the YOS indicates that 28 young people required a specific substance misuse intervention. A review undertaken by the YOS data manager uncovered extensive under reporting. This underreporting is an issue which has been addressed. YOS assessment identified only four clients requiring onward referral to the specialist agency as most clients were managed by the specialist workers in the YOS, which is registered as a Tier 3 service. This accounts for the low number requiring onward referral.

Referrals from the criminal justice system

In the first half of 2008/09 NDTMS data indicates the criminal justice system provided over 64% of the referrals into treatment. However, this high proportion of referrals from the criminal justice sector equates to only 14 young people. When the arrest data was reviewed this indicated that 95 young people arrested should be reaching drug services. This suggests that only about 14% of arrestees who would benefit from treatment actually receive it. There are different levels of treatment.

A recent Scrutiny Review by elected Members into treatment services for young people misusing drugs and alcohol made some initial recommendations which included the need to undertake a review of systems for identification and possible early interventions available within Haringey primary and secondary schools as well as examining the individual roles of staff working with young people to identify any training needs that they may have.

Key to the success of increasing referrals into specialist treatment will be training for relevant staff on the appropriate use of the Common Assessment Framework (CAF) and its link to the more detailed substance misuse screening tool for young people with substance misuse issues (DUST: Substance Misuse Screening Tool).

The Practitioners' Forum conducted a brainstorming exercise into ways of improving the referral and engagement of young people into the treatment system. This, and subsequent discussions with practitioners, have identified a number of avenues which can usefully be addressed to improve engagement. This work will be further developed and used to inform commissioning arrangements and plans over the coming year.

Findings from focus groups with young people in the Pupil Referral Unit (PRU) and YOS (2009) suggest that they are unwilling to go to a specialist service for a variety of reasons mostly centred around anonymity and confidentiality. Whilst embarrassment and anxiety about confidentiality is understandable, it is important that this is addressed and is not accepted as a legitimate reason not to access treatment.

Where a preference for a particular type of intervention was expressed, it was for workers to be available in settings like youth clubs/youth centres, school and as mentors. This was again supported by the Commissioning Review which indicated that schools were frequently dealing with issues holistically in the school environment through counsellors.

iv) Focus group feedback

Focus group participants felt that young people “telling other young people about themselves” was the most effective deterrent.

The focus groups identified that we are faced with a problem of how to break through cultural/family ties to the local drug economy. This is an area requiring further investigation and more direct work with young people and families, possibly incorporating the Communities and Availabilities agenda.

The focus group work provides valuable insight into the opinions of young people in the PRU and YOS. Further focus group work with young people from other backgrounds, for example, specialist service users and former users would help identify issues within the service and inform work to lower barriers to access, reduce unplanned discharge and improve retention.

In summary, referral routes into specialist services appear not to be working. Low referrals result in low numbers in treatment. Meeting this potential unmet need will be one of the key challenges in the year ahead. In addition we need to understand if young people are having their needs met in universal and targeted services, and if this is the case, in what ways does the treatment model and reporting mechanisms need to be adapted.

e) Parental substance misuse

i) Extent of the problem

In 2007/08, 42% of adults in drug treatment⁵ in Haringey were parents. This equates to over a third (36%) of all women and almost half (46%) of all men. Only a small minority (7%) reported living with their children. According to the latest data available, during the 2008 calendar year, 245 parents started drug treatment.⁶ Between April and October 2008, 22 of the referrals to Haringey Children’s Services identified drugs misuse as a presenting need.⁷ Crack,

⁵ % of the 958 who reported their parental status. In 25% of all 1273 records this value was missing.

⁶ Source: Drug Strategy Priorities Supplementary Data published 19/02/2009. Data from the treatment outcome profile (TOP) tool.

⁷ The information relates to issues identified as a presenting need at time of referral. Currently there is no system in place to update the record if drugs and alcohol appear as an issue at a later stage in the

cannabis and heroin were the main problem drugs.⁸ To put this in context, as at October 2008, Haringey Children's Services had a total of 247 children in need and 187 subject to child protection plans. Substance misuse is therefore likely to be underreported as a presenting problem.⁹

Substance misuse is a broad social issue *'disproportionately to be found among the poor, the jobless, the homeless, young people who have been in care and those who are in one way or another socially excluded'* (RSA:2007: 12). National research suggests that a significant number of children, around a quarter, are on the child protection register as a result of parental substance misuse (ACMD:2003). Other research suggests that this figure may be even higher – between 50% and 90% of families on social workers' child care caseloads (SCIE:2005). Parental misuse often leads to a lack of practical and emotional care for children (Bancroft, Wilson et al: 2004). Many adult substance misusers are likely to have experienced parental substance misuse as a child, confirming further the need to intervene earlier to prevent children of substance misusing parents developing these same types of 'coping mechanisms'. Services need to be able to help break this cycle of generational substance misuse. It should be noted, however, that substance misuse is not necessarily the root cause of problems at home. As the Social Care Institute for Excellence (SCIE) (2005) acknowledges, studies often fail to take into account other aspects of disadvantage in relation to substance misuse and parenting capacity, such as poverty, unemployment or depression.

ii) Treatments

The current national drug strategy (2008) outlines actions that should be taken to *'intervene early to prevent harm to children, prioritise parents' access to treatment where children are at risk, provide intensive parenting guidance and support family members'* (HO:2009). The *Hidden Harm* report by the Advisory Council of Misuse of Drugs (ACMD:2003) recognised that the number of children affected will only decrease if parents receive appropriate support and treatment. Haringey drug treatment agencies see over 1200 adults a year in effective drug treatment¹⁰. Around half complete treatment successfully.¹¹ However, there are barriers to treatment. SCIE recognises that parents who need help are worried about losing their children (2005). Representatives of service users in drug and alcohol treatment in Haringey believes that a number of women may be absent from treatment due to

assessment. Therefore it is likely that the figures are higher. Haringey Children's Services had a total of 247 children in need and 187 subject to child protection plans as at October 2008.

⁸ Numbers are low and therefore suppressed for data protection

⁹ The information relates to issues identified as a presenting need at time of referral. Currently there is no system in place to update the record if drugs and alcohol appear as an issue at a later stage in the assessment. Therefore it is likely that the figures are higher.

¹⁰ 1265 in the latest data available, between Nov 2007-Oct 2008. "In effective treatment" includes all individuals in contact with tier 3 or 4 services during the period who are recorded as having begun a drug treatment intervention and who fulfil either of the following criteria: They were retained in treatment for 12 or more weeks from their triage date; or they were subject to a planned discharge following a planned exit from their treatment within 12 weeks of their triage date. A planned exit is denoted by use of the discharge codes; 'Treatment completed' and 'Treatment completed-drug free'.

¹¹ 51% 1265 in the latest data available, between Nov 2007-Oct 2008.

childcare difficulties and the fear of being stigmatised, thus jeopardising the custody of their children.¹²

iii) Support for the children of substance misusing parents

Support for the children of substance misusing parents is equally as important. National research has shown that children often do not know where to seek professional help and that the quality of help is mixed. Children need non-judgemental support and someone to talk to without feeling they need to take responsibility and make any decisions about their circumstances (Gorin:2004).

The key recommendations by the ACMD (2003) for reducing the 'hidden harm' were to ensure that:

- drug or alcohol use is routinely assessed and recorded by maternity units, children's services, and CAMHS with respect to confidentiality but enabling accurate assessment
- there is a co-ordinated range of resources locally and better integrated services
- child protection policies includes parental drug or alcohol misuse. Substance misuse should be explored in all cases of suspected child neglect, sexual abuse, non-accidental injury or accidental drug overdose
- identification and management of substance misuse issues is included in staff training, assessment and case management procedures, and inter-agency liaison
- schools have critical incident plans and clear arrangements for liaison with their local social services team and area child protection committee. They should identify at least one trained designated person able to deal with the problems that might arise with the children of problem drug users
- there is a sufficient provision of foster care and respite care suitable for children of problem drug users and efficient arrangements for adoption when considered as the best option
- there is access to residential care that provides a genuinely caring environment for those children for whom this is the only realistic option
- drug and alcohol agencies provide accessible and effective support for parents and their children, either directly or through good links with other relevant services
- the training of staff in drug and alcohol agencies includes a specific focus on learning how to assess and meet the needs of clients as parents and their children
- all non-statutory organisations dedicated to helping children or problem drug or alcohol users carefully consider whether they could help meet the needs of the children of problem drug or alcohol users.

¹² A little over a quarter (27%) of the drug treatment population are women. This is generally consistent with the proportion of women problem drug users appearing in other data sources, except in the criminal justice system where men are even more prominent.

The Hidden Harm report recommendations also included that Drug Action Teams (DATs) should *'explore the potential of involving non-statutory organisations, in conjunction with health and social services, in joint work aimed at collectively meeting the needs of the children of problem drug or alcohol users in their area'* (ACMD:2003:85).

Accordingly, Haringey DAAT commissions a service, COSMIC, to meet the needs of parents misusing substances and their children. From 2009/10 the funding for this project will be picked up by a mixture of mainstream council funding and the Area Based Grant.

f) Alcohol misuse

The 2007 Health Survey for England shows that 35% of boys and 34% of girls aged 8-15 years reported having experience of drinking alcohol down from 36% (both boys and girls) in 2006. The proportion who have had experience of drinking alcohol increased with age, with 7% of boys and 8% of girls aged 8 having done so, compared with 79% of boys up from 77% of boys in 2006 and 74% of girls aged 15 down from 79% of girls aged 15 in 2006. On the whole, 4% of boys and 3% of girls aged 8-15 years reported usually drinking once a week or more. The prevalence of drinking at least once a week increased with age. The proportion who reported drinking at least once a week increased from less than 1% of both boys and girls aged 8 to 21% of boys and 13% of girls aged 15. 15% of both boys and girls aged 13-15 reported drinking alcohol in the last 7 days. During 2007/08 there were 105 children and young people in treatment for drugs and alcohol problems. These were looked after by several services within Haringey, the YOS, agencies outside the borough and with In-volve.

g) Oral health

Tooth decay is one of most prevalent diseases in children and young people, despite enormous improvements in children's dental health.

As at 30th September 2008, 86.8% of Haringey Children had been seen in the previous 24 months, compared to 64.2% for London and 69.1% for England. This represents an increase of 3.2% from the percentage of Haringey Children that had been seen in the 24 months up to September 2007 (compared with a fall of 1.7% nationally and a fall of 1.6% in London for children's access between those two periods).

h) Accidents

The main cause of death and emergency admission for young people is as a result of children having accidents either in the home or in the wider environment. When children experience significant injury they are normally admitted into hospital, either for treatment or observation.

In the year 2007/08, there were 470 recorded admissions to hospital which were the result of an accidental injury (up from 388 in 2006/07). The largest numbers of these (163) were for those children and young people living in the West Network Area. The lowest were for those living in the North (158) and South 158.

i) A&E use

A recent study of A&E attendances at the North Middlesex and Whittington hospitals suggested that over an 18 months period there were over 27000 attendances by children and young people under 18 years. However, it is estimated that over 50% of these were inappropriate and could have been dealt with elsewhere.

j) Sexual health

Surveys¹³ suggest that young people are becoming sexually active at an earlier age. Young people who are becoming sexually active may be particularly vulnerable to sexual ill-health, including unwanted pregnancy or abortion, and exposure to sexually transmitted infections (STIs) and HIV. Improving the sexual health of young people is a key national and local priority. In 2007 there were 1556 attendances at the young people's sexual health drop-in clinic at St Ann's Hospital in Haringey (70% female). A comprehensive Sexual Health Strategy and Action Plan has been agreed by the Sexual Health Partnership Board and the forthcoming sexual health needs assessment will enable the strategy and action plan to be reviewed. There is commitment to ensuring that sexual health promotion in schools forms an integral part of local preventative work and that all primary and secondary schools have a sex and relationship policy.

k) Chlamydia

During 2007 approximately 1550 young people were screened for Chlamydia. Amongst these a total of 277 persons (17.8%) had a positive diagnosis. The rate of positive tests has increased from 15.1% in 2004 to 17.8% in 2007 – approximately 1 in 6.5 new cases to 1 in 5.5 new cases. Nearly twice as many young men were diagnosed with Chlamydia in 2007 (89) as in 2004 (47); the rate also increased from 14.5% to 19%, indicating a true increase in the number of attending young men infected with Chlamydia. The number of Chlamydia positive young women also increased by 115 between 2004 and 2007, a 71% increase. The rate increased from 15.4% in 2004 to 17.3% in 2007.

At present, NHS Haringey is working with its partners to test as many young people as possible. This is identifying people who may have had Chlamydia for some time. Work is underway to reduce the positive diagnosis of Chlamydia in future years through widening the availability of condoms for

¹³ Erens, B. et.al, 2003, national survey of sexual attitudes and lifestyles II: reference tables and summary support. NatCen, as quoted in Growing Up in Haringey, op cit. p.33.

young people. The 4YP¹⁴ service currently provides a condom distribution service. However, a wider reaching scheme is being planned for Haringey.

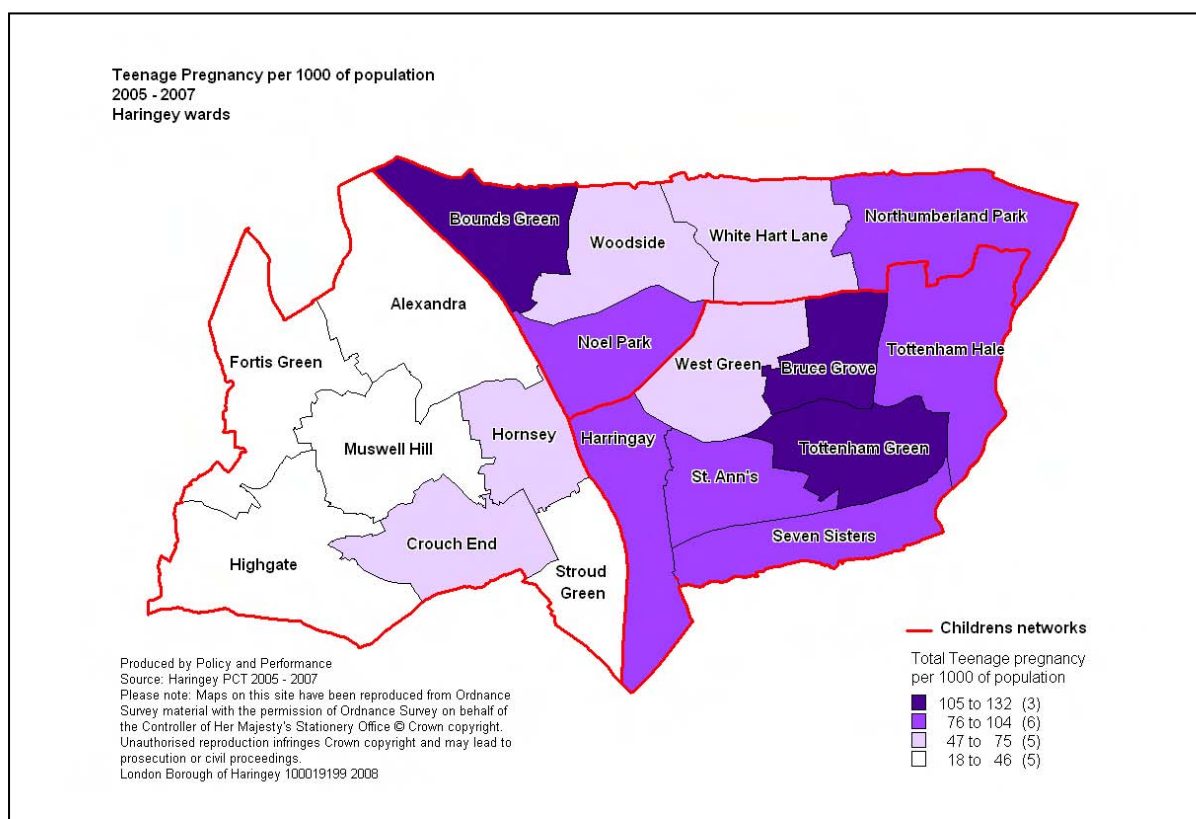
I) Teenage pregnancy

The teenage conception rate in Haringey has fluctuated over recent years. In 2007 the rate was 70.0 per 1000, going up from 63.7 per 1000 in 2006. This is behind the Local Delivery Plan target of 40.51 per 1000. The teen abortion rate in Haringey has risen and fallen in the past few years and has been higher than London and England as a whole. In 2007, 139 abortions were carried out at the rate of 39.2 per 1000, with significant increase from 32.4 per 1000 in 2006.

The teenage pregnancy rate varies between Children's Network Areas. The rate of conceptions between 2005 and 2007 was highest in the South Network Area (94 per 1000) and lowest in the West (40 per 1000). The South Network Area also had a rate that was higher than the Haringey Average (83 per 1000).

In 2007 there were 248 conceptions to girls aged 15-17. Of these 65% resulted in an abortion (161) and 87 continued with the pregnancy.

Map 2.8 Teenage Pregnancy per 1000 of population 2005-2007



Source: NHS Haringey

¹⁴ 4YP is a sexual health initiative providing young people friendly, confidential and safe sexual health services for young people in Enfield and Haringey

m) Mental health in children and young people

The risk factors for mental health disorder in children can be categorised into four main groups: child, family, environment and life events. Some of these risk factors interact, therefore increasing the risk of mental health problems for some young people.

A national survey was undertaken in 1999 and 2004. The results from them have been used to extrapolate estimates for children in Haringey. The survey included approximately 12,000 children aged 5-16. The prevalence of mental health need in England increased over 5 years between surveys from 9.5% to 10.2%. In Haringey it was estimated that 1344 5-16 year olds are suffering from conduct disorders, 538 have hyperkinetic disorders and 926 have emotional disorders (see table below for further information).

Table 2.2 Estimated prevalence of mental health disorders amongst children and young people in Haringey

Age group	Condition	Inner London Prevalence (%)	Haringey Estimate (number)
5-10 years	Emotional disorders	2.1	333
	Conduct disorders	3.1	492
	Hyperkinetic disorders	1.4	222
	Less common disorders	0.7	111
	Any disorder	6.4	1015
11-16 years	Emotional disorders	4.3	602
	Conduct disorders	6.2	868
	Hyperkinetic disorders	2.3	322
	Less common disorders	0.7	98
	Any disorder	11.0	1540
All Children*	Emotional disorders	3.1	926
	Conduct disorders	4.5	1344
	Hyperkinetic disorders	1.8	538
	Less common disorders	0.7	209
	Any disorder	8.6	2568

Source: NHS Haringey

Based on inner London prevalence estimates, there are currently 2568 children aged 5-16 with mental health problems living in Haringey (1015 aged 5-10 and 1540 aged 11-16). Boys experience mental health problems more than girls (1826 boys and 824 girls). If population trends continue and the rates remain the same by 2013, there will be 2650 children aged 5-16 with mental health problems in Haringey, an increase of 8.1%.

The proportion of children within care of the Local Authority is greater than the London average. Looked After Children are five times more likely to develop mental health problems suggesting that there is significant potential need for these children.

Overall in Haringey, it was estimated that 45-67% of Looked After Children aged 5-16 years old are suffering from mental health disorders, 28-37% are suffering from conduct disorders and 26% have post traumatic syndrome. In addition, an increased level of mental health need among Haringey's refugee and asylum seeking children and young people (unaccompanied minors) has been highlighted. On the whole, there is evidence to suggest that many forms of mental health problems in young people are becoming more frequent.

n) Children and young people with disabilities and general health status

Disability is complex term to define. Limiting longstanding illness is often used as the core definition in literature. This definition mainly covers those with a longstanding illness or disability, which substantially impacts on their day-to-day activities. This definition is different from those who are claiming disability benefits – such as Disability Living Allowance (DLA) which is assessed at the point of claim and which represents only a sub-group of disabled people. General health refers to individual's perception of health over the previous 12 months. According to Census figures in 2001, 4.5% of children under 18 years in Haringey have limiting long-term illness and 7% of all people with limiting long-term illness were children under 18 years. The 2001 Census figures also showed that 49% of children under 18 years with limiting long-term illness reported having good health, 31% fairly good health and 20% not good health over the previous 12 months. It should be noted that these figures are subjective. More recently, in 2007, children under 16 years accounted for 11% (1055) of people in Haringey who claimed disability living allowance (DLA).

o) Health of children in care

For details about the health of children in care please refer to the 'Stay Safe' chapter.

p) Deaths amongst children and young people

The number of children that die each year in Haringey is small. In 2007 there were 31 deaths of children and young people aged under 19 years (38 in 2006 and 42 in 2005).

Of the 111 deaths between 2005 and 2007, 75 (66%) were to those under one year and are classified in our infant mortality figures. The number of deaths to under 1s has dropped from 31 in 2005, to 26 in 2006 and 18 in 2007.

The number of deaths amongst children aged 1-19 years has remained consistent over the same period (2007 = 13, 2006 = 12 and 2005 = 11). Of these 36 deaths, nine were the result of cancer, nine as a result of accidents, six nervous system, three infectious and parasitic disease, two circulatory disease, two congenital malformations and one each for respiratory disease, blood disease, endocrine and metabolic, mental and abnormal laboratory findings.

Since April 2008, data on child deaths has been collected locally through the Child Death Review Panel. There is only one year of data collected so far (25 deaths) and any analyses need to be treated with care because of the small numbers. Over the last 12 months, more deaths have occurred in the north east and south east of the borough; about a third of all deaths are perinatal deaths (within the first seven days, of which about half are explained by very premature babies); about a quarter of deaths are sudden and unexpected deaths (SUDI) mostly as a result of SIDS (Sudden Infant Death Syndrome i.e. "cot death") or as a result of a serious illness or a problem that the baby may have been born with. This detailed data collection by the Child Death Review Panel over the coming years will allow more in-depth analyses and a better understanding of child deaths locally.

q) Children and young people with additional needs aged 18–25 years

- Haringey has a total of 86 learning disability service users aged between 18 and 25.
- There are 64 mental health service users of the same age group and 33 physical and sensory disability and frailty service users
- South Children’s Network has more clients for all three primary client types

Table 2.3 Total number of service users with additional needs aged 18 – 25 2009

Childrens Network	Primary Client Type		
	Mental Health	Learning Disabilities	Physical and Sensory Disability and Frailty
North	22	33	11
South	26	43	19
West	16	10	3
Haringey Total	64	86	33

Source: ACCS Haringey Council

r) Young carers

For information about young carers please refer to the ‘Stay Safe’ chapter.

IMPLICATIONS

This section has described the health needs of children and young people in Haringey. A major challenge is to **reduce health inequalities**, particularly between those living in the east and west of the borough, for example, through reducing infant mortality in the east of the borough.

We have seen that **uptake of immunisations** in Haringey remains well below national target levels and that our children and young people need to be supported in making healthier choices about their lifestyles. We are working to reduce obesity, smoking, alcohol and substance abuse amongst our children and young people and to improve their physical health and knowledge of healthy eating. At the same time we are working to provide good quality mental health services for children and young people within the borough.

We have seen evidence of improved outcomes in some areas – for example Haringey has better than average standards of oral health amongst children and we have noted the need to try and collect more and better more local data, for example, in relation to the mental health of children and young people. We have highlighted a number of successful targeted initiatives such as the Healthy Schools Programme and the roll out of the HPV programme.

Teenage pregnancy continues to be a challenge. We have strengthened the Teenage Pregnancy Strategic Partnership Board and refocused our priorities. We will increase contraception use through extending access to condoms and reviewing and promoting the uptake of long acting reversible contraceptives; we will improve the quality of sex and relationship education in schools; and we will strengthen and target work with young people at greater risk. These three areas will be underpinned by the development of a more timely reporting system on conceptions and proxy indicators for performance management.

We have seen NHS Haringey achieve the **Chlamydia target** for 2008/09 and approximately 4370 young people were screened. This has been achieved through a co-ordinated multi-agency plan involving primary care, education and the voluntary sector.

The key actions within the plan have been:

- The training of the workforce to promote and give out test kits which has included primary care health professionals, youth workers and voluntary sector workers
- Raising awareness of the programme through colleges, schools, outreach workers and a media campaign

This year the target is 7025 Chlamydia screens. This will be challenging and will require an increase in activity by all partners. NHS Haringey has almost completed a piece of social marketing and along with the findings of the 'Turning the Curve' exercise this will inform the plan for this year.

The **Drug and Alcohol Team's key priorities** for 2009/10 have been achieved through the use of the Red, Amber, Green RAG rating and through the findings of the needs assessment:

- Ensure that membership of the **Young Persons' Substance Misuse Commissioning Group** includes appropriate leads from across the partnership
- Appoint a **Young Persons' Substance Misuse Commissioner** who has good understanding of and involvement with wider Children and Young People's Service (CYPS) strategic planning and who can ensure the effective planning, commissioning and delivery of young people's services within wider service agendas
- **Funding and commissioning responsibilities** for young people's substance misuse services will be transferred from the Drug and Alcohol Partnership to the Children and Young People's Service by 2010
- Strengthen arrangements for young people's substance misuse **needs assessment** in order to improve the knowledge base for commissioning young people's substance misuse services with particular emphasis on improving referral to and retention in specialist services. This will include involving children and young people from the full range of relevant backgrounds and reviewing effectiveness and value for money (VFM) of current provision
- To take forward the recommendations from the **Scrutiny Review of the early identification, assessment and referral** of children and young people with drug and alcohol problems
- To ensure that **all five "essential elements" of the treatment system** are available to young people in Haringey
- To ensure that **care pathways, referral arrangements and service provision** meet the needs and expectations of young people and those who care for them, make most appropriate use of available skills and expertise and achieve optimum desired outcomes within available resources, involving young people and those who care for them where relevant
- To ensure effective **clinical governance systems** and arrangements to address underperformance are established and working well
- To ensure that **workforce development** and training equips workers to competently and effectively deliver commissioned services
- To review **data collection arrangements** in line with data protection and monitoring protocols being developed elsewhere in order to improve and strengthen reporting to the National Drug Treatment Monitoring Service (NDTMS) and other relevant agencies by specialist, children and young people's services and mainstream services who deal with children and young people
- To audit **Tier 3 service** against the National Institute for Clinical Excellence (NICE) guidelines and relevant sections of the 'Drug misuse and dependence – UK guidelines on clinical management'

Gaps in data

- The methodology for collecting local data to record **breastfeeding** at 6-8 weeks is being developed and the data is therefore unreliable.
- A comprehensive needs assessment will be undertaken to inform the **commissioning strategy** to help better meet the needs of Haringey's children and young people
- Substance misuse: Further **focus group work** with young people from other backgrounds, for example, specialist service users and former users would help identify issues within the service and inform work to lower barriers to access, reduce unplanned discharge and improve retention
- A **sexual health needs assessment** is planned for 2009/2010
- A CAMHS needs assessment has highlighted the need to **collect more robust information/data for children with mental health problems**
- A new **child health surveillance system** will be introduced in NHS Haringey during 2009. This will enable Health to monitor more closely areas such as breast feeding and the uptake of MMR

Sources of Information

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Summary of information at Children's Network level

Every Child Matters Outcomes	Children's Network North	Children's Network South	Children's Network West
Be Healthy	<ul style="list-style-type: none"> ▪ Health deprivation and disability: In 2007, nearly 8% of CN North was in the 10% most deprived in the country. Most of this falls in the Northumberland Park ward. ▪ Low birth weight babies: In 2007, 9.6% of all babies born in the North Network area were low birth weight. Highest proportion came from the Northumberland Park ward (11.2%). ▪ Obesity (reception year): In 2008, 12.5% of all reception year children living in the North Network were obese. Highest proportion came from the Noel Park Ward (17%). ▪ Obesity (year 6): In 2008, 26.4% of all year 6 children living in the North Network were classified as obese. Highest proportion came from the Bounds Green ward (29.8%). ▪ Teenage pregnancy: In 2007, the ward with the highest rate was Bounds Green (107.1 per 1000). ▪ Additional needs (aged 18–25 years): There are 34.3% of all young people with additional mental health needs; 38.4% of young people with additional learning disabilities and 33.3% of young people with physical and sensory disability and frailty living in the North Network area. 	<ul style="list-style-type: none"> ▪ Health deprivation and disability: In 2007, nearly 4% of CN South was in the 10% most deprived in the country. These are two small areas of Bruce Grove and Tottenham Green. ▪ Low birth weight babies: In 2007, 8.3% of all babies born in the South Network area were low birth weight. Highest proportion came from the West Green ward (10.6%). ▪ Obesity (reception year): In 2008, 12.4% of all reception year children living in the South Network were obese. Highest proportion came from the Tottenham Hale Ward (17.3%). ▪ Obesity (year 6): In 2008, 28.2% of all year 6 children living in the South Network were obese. Highest proportion came from the Tottenham Hale ward (33.2%). ▪ Teenage pregnancy: In 2007, the ward with the highest rate was Bruce Grove (131.6 per 1000). ▪ Additional needs (aged 18–25 years): There are 40.6% of all young people with additional mental health needs, 50% of young people with additional learning disabilities and 57.6% of young people with physical and sensory disability and frailty living in the South Network area. 	<ul style="list-style-type: none"> ▪ Health deprivation and disability: In 2007, 2% of CN West was in the 10% most deprived in the country. This is one super output area that is in the Hornsey ward. ▪ Low birth weight babies: In 2007, the highest proportion from this Network came from the Fortis Green ward (7.9%). ▪ Obesity (reception year): In 2008, 7.2% of all reception year children living in the West Network were classified as obese. This has decreased 2% since 2007. The highest proportion came from the Hornsey Ward (13.2%). ▪ Obesity (year 6): In 2008, 16.1% of all year 6 children living in the West Network were classified as obese. Highest proportion came from Hornsey ward (20.2%). ▪ Teenage pregnancy: In 2007, the highest rate was in Hornsey ward (66.8 per 1000). ▪ Additional needs (aged 18–25 years): There are 25% of all young people with additional mental health needs; 11.6% of young people with additional learning disabilities and 9.1% of young people with physical and sensory disability and frailty living in the West Network area.

National Indicator Set

The National Indicators detailed below are taken from the Every Child Matters (ECM) Outcomes Framework and cover quality of life indicators and quality of service indicators.

Indicator	Indicator Name	2006/07	2007/08	2008/09		2009/10
		Value	Value	Value	Target	Target
BV197 NI 112	Rate of under-18 conceptions (per 1000 girls aged 15-17 as compared with the 1998 baseline rate)	2.7%	2.2%	tbc	-5.3%	-18.1%
NI 39	Rate of Hospital Admissions per 100,000 for Alcohol Related Harm	1,342	1,342		1,579	1,654
NI 51	Effectiveness of child and adolescent mental health (CAMHS) services	Not collected in 2006/07	13	13	13	15
NI 53a	Prevalence of breast-feeding at 6-8 wks from birth - Percentage of infants being breastfed at 6-8 weeks	Not collected in 2006/07	40%	66.49%	50%	52.9%
NI 58	Emotional and behavioural health of looked after children	New indicator 2008/09 will set baseline				
NI 113a	Prevalence of Chlamydia in under 25 year olds - Part 1 - Chlamydia screens/tests	600.0%	3.3%	15.61%	15.0%	25%
NI 126	Early Access for Women to Maternity Services	Not available		53.39%	50.0%	82%
NI 55(v)	Obesity in primary school age children in Reception: Line 5	10.5%	12.9%	10.6%	12.9%	13%
NI 56(x)	Obesity in primary school age children in Year 6: Line 10	21.5%	23.8%	24.0%	23.8%	24%
NI 120a	All-age all cause mortality rate - Females	Not available		458	471	454
NI 38	Drug related (Class A) offending rate	No data for this range		No data for this range		No data for this range
NI 50	Emotional health of children	New Indicator		56.5%	No target	No target

Indicator	Indicator Name	2006/07	2007/08	2008/09		2009/10
		Value	Value	Value	Target	Target
NI 52a	Take up of school lunches - primary schools	New Indicator		Data to be published by School Food Trust in July 2009		
NI 57	Children and young people's participation in high-quality PE and sport	New Indicator for introduction in 2009/10				No data for this range
NI 115	Substance misuse by young people	No data for this range		2.2%		No data for this range
NI 127	Self reported experience of social care users (measured by survey every 3 years)	New Indicator		Annual survey due to take place in 2009/10		
NI 54	Services for disabled children	Indicator not finalised- no collection before 2009/10				
NI 120b	All-age all cause mortality rate - Males	Not available		792	756	729
NI 52b	Take up of school lunches - Secondary schools	New Indicator		Data to be published by School Food Trust in July 2009		No data for this range
L0004 LAA stretch	Number of schools achieving Healthy School Status (2007 - 2010 stretch target)	13%	66%	76%	75%	85%
L0123(LAA Local)	Victim Support Services for children & young people - No. of 1:1 appointments	No data for this range			36	36