Haringey Council

NOTICE OF MEETING

Scrutiny Review - Sexual Health in Teenagers

THURSDAY, 21ST JANUARY, 2010 at 17:30 HRS - CIVIC CENTRE, HIGH ROAD, WOOD GREEN, N22 8LE.

MEMBERS: Councillors Bull (Chair), Newton, Santry and Scott

CO-OPTEES: Ms Y. Denny (church representative) plus 1 Vacancy, Ms M Jemide (Parent Governor), Mr J Efiofor (Parent Governor), Ms S Marsh (Parent Governor), Ms H Kania (LINk Representative)

AGENDA

1. APOLOGIES FOR ABSENCE

2. URGENT BUSINESS

3. DECLARATIONS OF INTEREST

A member with a personal interest in a matter who attends a meeting of the authority at which the matter is considered must disclose to that meeting the existence and nature of that interest at the commencement of that consideration, or when the interest becomes apparent.

A member with a personal interest in a matter also has a prejudicial interest in that matter if the interest is one which a member of the public with knowledge of the relevant facts would reasonably regard as so significant that it is likely to prejudice the member's judgment of the public interest **and** if this interest affects their financial position or the financial position of a person or body as described in paragraph 8 of the Code of Conduct **and**/**or** if it relates to the determining of any approval, consent, licence, permission or registration in relation to them or any person or body described in paragraph 8 of the Code of Conduct.

4. MINUTES (PAGES 1 - 12)

To approve the minutes of the meetings of 3 and 16 November 2009.

5. IMPROVING SEXUAL HEALTH IN TEENAGERS - EVIDENCE FROM STAKEHOLDERS (PAGES 13 - 14)

To consider feedback from NHS Haringey and the Children and Young People's Service on issues that have been identified by the Panel from evidence received to date (attached).

6. PROGRESS WITH THE REVIEW

To consider progress with the review and future arrangements.

7. NEW ITEMS OF URGENT BUSINESS

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13 January 2010

MINUTES OF THE SCRUTINY REVIEW - SEXUAL HEALTH IN TEENAGERS
TUESDAY, 3 NOVEMBER 2009

Councillors Bull (Chair), Newton, Santry and Scott

Co-opted Members: Ms. Y. Denny (Church representative), Ms. H. Kania (Haringey LINk) and Ms. S. Marsh (Parent Governor)

LC7. APOLOGIES FOR ABSENCE

None.

LC8. URGENT BUSINESS

None.

LC9. DECLARATIONS OF INTEREST

None.

LC10. MINUTES

AGREED:

That the minutes of the meeting of 5 October 2009 be approved.

LC11. IMPROVING SEXUAL HEALTH IN TEENAGERS - EVIDENCE FROM STAKEHOLDERS

The Panel received evidence from:

- Joan McVittie, the Vice Chair of the Secondary Heads Association
- Jan Dunster from the College of North East London
- James Lane, the Chair of the Primary Heads Association; and
- Belinda Smith from the Youth Service.

Ms. McVittie stated that, whilst the role of secondary schools in teaching SRE and promoting good sexual health was paramount, children needed to be introduced the subject at an earlier stage. The mechanics of sexual behaviour were dealt with at key stage 3 and beyond as part of the national curriculum. Sex within relationships and the emotional aspects were explored as part of PHSE. However, the messages that were put forward were not always supported within communities or individual homes.

The school promoted the message of safe and responsible sex and also focussed on implications. The school had used borrowed models of babies to work with students. Their use had proven to be very successful and they were now looking to buy some as none were available through PHSE. The school wished to ensure that all children got the chance to take one home. Some children had not realised before what caring for a baby entailed and many were very relieved to hand back the dolls. Sexually transmitted infections were covered in biology as part of the national curriculum and also included within PHSE lessons. Some work had also been undertaken within

assemblies, including one that students had chosen to do on the implications of unsafe sex.

The biological aspects were compulsory as part of the national curriculum but reference to relationships, values and morals was not and a small number of parents chose to opt their children out of this. Efforts were made to persuade those parents to change their minds. Many of these were from extreme religious backgrounds.

It was noted that a greater amount of sex education was now becoming compulsory due to changes in the national curriculum. The same challenges existed in primary schools and it was very difficult to get parents who decided to opt out to change their mind as this could mean them changing their entire belief system.

Ms. McVittie stated that children were given information sheets with details of a range of relevant websites. She had found that a lot of children did not have a GP and the school had therefore decided to bring in a nurse for three days per week, although this had since been reduced to two due to funding issues. 278 children out of the school roll of 946 had used her in the last year. It was not known specifically what issues the students had seen the nurse about as this was confidential. The nurse could help with information, refer students to 4YP and help them to register with a GP. Other schools did not have such a facility, which required significant investment. Only one student from the school had recently become pregnant and she had been a non attendee.

A lot of young people were inhibited from seeking advice due to embarrassment. Large numbers still relied on their peers for guidance. There were still cultural barriers in some communities against the use of contraception which could be considered as even worse then engaging in unprotected sex. It was difficult for young people from some communities to seek advice and they often felt it necessary to go to neighbouring boroughs to access services. Drugs and alcohol could loosen inhibitions and make the situation worse.

The least effective way of reaching young people was through older people. The most effective way was through the use of peers. They had on occasion invited young people attending college, some of whom had babies, to come back to the school and talk to students. This had proven very effective.

Woodside believed in using properly trained specialist teachers to deliver sex education. However, some schools still used form tutors. The healthy schools initiative was labour intensive but the school was nevertheless pursuing enhanced status. Support was provided by the LEA including regular training.

Home should provide the start for children but some parents found the subject difficult to approach and did not wish to explore it with their children. Many parents of children at the school were not educated in Britain and did not have an understanding of the health service.

She felt that the NHS needed a higher visibility within schools and their services made more accessible through, for instance, adopting opening hours that fitted in better with young people. A large number of young people did not like accessing services locally and efforts needed to be made to make it easier for them to be more open by reducing stigma.

One key area which could be improved was the availability of appointments with GPs. A large number still worked from 9 till 5 which could make it difficult for young people to get appointments. Another possible area of improvement would be to provide services in locations which were less stigmatising. For example, people often felt less stigmatised visiting their GP then attending a special sexual health clinic.

She felt that all secondary heads were likely to hold similar views to her own on the importance of teaching and promoting sexual health.

Ms Dunster reported that sexual health was covered at CoNEL as part of the tutorial system. This was provided as part of the enrichment programme. Amongst other things, advice on how to register with a GP was provided. The college had also held a sexual health week, drink awareness events and undertook collaborative work with the NHS. They had links with 4YP and had a nurse on site for one day per week. They also had a counsellor, who could make referrals to a range of services, and a dedicated youth worker. Work was undertaken with the teenage pregnancy team and the college was soon to get a Medi+vend machine.

The college had 15 peer mentors, one of whom was present at the meeting. Mentors provided a range information for students and had undertaken presentations. They could liaise with staff about referrals. The mentors undertook a two day training course to prepare them for work with their peers. Their brief was wider then just sexual health.

It was noted that the Children and Young People's Service was currently also developing a peer mentoring scheme. It was currently identifying suitable graduates from within its Teens and Toddlers scheme.

Ms Dunster felt that barriers to improved sexual health included language difficulties and cultural issues. Many ESOL students did not have a GP and did not understand the concept of one. They merely went to the hospital when ill. Measures could be taken by the NHS to encourage such young people to register.

It was noted that many young people did not realise they were carrying an infection and felt that periodic check ups might assist in addressing this issue.

Ms Dunster reported that there was high take up for tests from 4YP when they visited CoNEL and a lot of young people felt comfortable with the approach that they adopted.

She felt that services could be improved by better accessibility to services such as a dedicated phone line. The college provided details of where to get information, such as national websites. She felt that NEETs were probably the group at greatest risk. These tended to be boys.

Mr Lane felt that primary schools had an important role to play in educating younger children about sex and reproduction. However, they had more of a pastoral role then secondary schools. Children at risk often had low self esteem and schools tried to provide an environment where they felt valued and able to bring their concerns to an adult. At primary school level, the teaching mainly covered acknowledging parts of the body and feelings.

He felt that some primary schools were currently fulfilling their role well whilst others were not performing quite so well. He would be surprised if any schools were not covering the relevant issues in some way. However, it was a crowded curriculum and it could be difficult to fit in. The teaching was led by non expert staff. He felt that the quality of teaching could perhaps be improved if there was a core team that supported primary schools. Alternatively, support could be proved through secondary schools.

The role of parents was very important. There was clear evidence that they were considerably more effective at guiding their children on sexual issues then teachers. His school invited parents in, told them what the school was doing and tried to get them involved. Another initiative that could be undertaken was the development of a specific programme for schools involving active participation by parents.

He felt that training and support for primary school teachers could be improved. He could not recall any specific training that had been provided for primary school teachers. PHSE covered a large range of issues as did the Healthy Schools and SRE had to compete for space.

It was noted that new guidelines were being produced for schools on the teaching of SRE in the light of changes to the national curriculum. These would cover children between the ages of 5 – 16. There was a clear role for primary schools within these.

Ms Denny stated that it was important that faith schools were engaged as there was evidence that they were not playing as active a role as other schools. She stated the issue could be raised via the SACRE.

Ms Smith reported that youth service staff had received training on Chlamydia screening. The service worked closely with 4YP and this was written into their service plan. Connexions also referred to sexual health in their consultations. Medi+vend machines were being installed in two youth service facilities. The service also undertook specific work with teenage fathers and was involved in the Teens and Toddlers scheme. The effectiveness of the service in addressing sexual health issues was not specifically evaluated.

Her service came into contact with a high percentage of young people in the Borough between the ages of 13 and 19 and she felt that young people were generally well informed. However, there was always room for improvement. Peer educators could be effective as young people learnt well from each other. Assistant youth workers, between the ages of 18 and 25, had been appointed and were being trained in SRE so they could work with their peers. The least effective way of getting the message across to young people was from literature alone – there needed to be at least some dialogue. Some people accessed information on line but the numbers were comparatively small.

She felt that there was a need to improve the work that was undertaken with young people with special needs. The service was undertaking specific work with the Roma community. In addition, a lot of training had taken place on Chlamydia and its implications.

A lot of young people stated that they wanted good local provision and would prefer this to the option of going elsewhere. She also thought that greater parental involvement would assist although this was a sensitive issue and could put some

young people off. Some young people could learn more from webpages whilst others benefited more from group discussions. A range of options needed to be available to satisfy different preferences.

It was noted that the Teens and Toddlers youth development programme was a 20 week programme that involved participants working in a nursery. There was a mentoring aspect to the course with facilitators used to assist. There was also access to a life coach. The programme aimed to raise aspirations and asked to question of what was need to become a good parent? Referrals came form schools and youth workers. 84 young people had been on the course so far and only one had become pregnant, albeit before the course had begun. The majority of young people on the course were girls. There was a follow up session after 18 months.

The Panel thanked all the participants for their kind assistance.

LC12. PROGRESS WITH THE REVIEW

It was noted that the Chidren's and Young Peoples Service had been approached regarding a possible consultation with the Youth Council by the Panel.

Cllr Gideon Bull
Chair

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MINUTES OF THE SCRUTINY REVIEW - SEXUAL HEALTH IN TEENAGERS
MONDAY, 16 NOVEMBER 2009

Councillors: Bull (Chair), Newton, Santry and Scott

Co-opted Members: Ms. H. Kania and Ms. S. Marsh

LC13. APOLOGIES FOR ABSENCE

None.

LC14. URGENT BUSINESS

None.

LC15. DECLARATIONS OF INTEREST

None.

LC16. IMPROVING SEXUAL HEALTH IN TEENAGERS - EVIDENCE FROM STAKEHOLDERS

The Panel received evidence from the following:

- Mesfin Ali from the Pan African and Caribbean Sexual Health Project (PACSH)
- Adrian Kelly, the Regional Teenage Pregnancy Coordinator from the Government Office for London
- Claire O'Connor, the Head of Sexual Health, Contraception and Reproductive Services, NHS Haringey.

Mr Ali stated that his service was not directly aimed at reducing teenage conceptions. Its main focus was on addressing the issues of HIV and Aids within the African and African Caribbean communities and this was what the project was funded to provide. It provided a range of services including information, distribution of condoms and awareness raising across the community. It also provided support for those who had been recently diagnosed with HIV. Testing was actively encouraged. The main focus of the service was on outreach work and it did this by working closely with local businesses and services that were used by people from the range of communities in question.

They had approximately 50 fully trained volunteers working for them, whose role was to go out into the community and talk to people who were potentially at risk and build relationships and awareness. 70% of the volunteers were women. They had a card which they gave to people which could be taken to the GUM clinic to arrange a test. Their aim in promoting HIV testing was to reduce the number of people who were undiagnosed.

Their *Love Safely* programme included specific reference to sexual health and infections and the provision of free condoms. If they came into contact with under 16s., they referred them onto either 4YP or the Teenage Pregnancy team. There was roughly an equal split between male and female clients on this programme. As part of it, they had so far handed out 50,000 condoms. They normally talked to clients before handing out condoms in order to ensure that they were aware of the correct way of

using them, how to spot counterfeit ones and the need to observe expiry dates. They also handed out female condoms and lubricants.

The stigma attached to STIs and, in particular, HIV was the biggest barrier that they faced in their work. In a number of countries where clients came from, homosexuality was illegal and this could provide an additional barrier in encouraging people to access services. There were also issues with some faith communities. In addition, there was denial of the problem in some communities.

The age range of the clients that they worked with was 16 – 50. They currently supported a number of teenagers in Haringey but most of their clients were in the 25-44 age range. The overall number of clients that they dealt had increased by 25%. There were currently more female then male clients. They had undertaken pieces of work with 6th. forms and CoNEL including presentations and workshops. Some work relating to sexual health and teenage pregnancy had also been undertaken with schools. They had also brought HIV positive speakers into schools to speak to young people. However, they were not directly funded to work with younger people and an appropriate project would need to set up and funded to address issues with them. In addition, outreach workers would need to be appropriately trained. Nevertheless, the service had the capacity and would be prepared to broaden its scope if need be.

He felt that services could be improved by better communication between services so people had a greater awareness of the range of services that were available.

Adrian Kelly from GoL outlined his role in relation to supporting London boroughs in addressing the issue of teenage pregnancy. He managed relationships between central government and London boroughs and provided support and challenge. For example, intensive one to one support could be provided to individual teenage pregnancy coordinators in boroughs and appropriate research commissioned.

He felt that the hostile attitude of the print media was a barrier to improving sexual health. However, 86% of parents were in favour of the teaching of sex education in schools. The mixed messages that young people received about sexuality could lead to confusion. Economic inequality and deprivation were the principal drivers behind teenage pregnancy. In overall terms, only the US has worse rates then the UK. There were limits to what could be done without addressing the issue of economic inequality as the relationship between it and teenage pregnancy levels was so strong. Haringey's conception rate currently exceeded its deprivation score so there was still some scope for improvement.

All local authorities were doing the ten things required by the government's teenage pregnancy strategy. It was therefore difficult to isolate particular factors that made a particular difference. It was nevertheless possible to identify some associated factors, such as girls who were absent from school. Work to reduce the risk of repeat conceptions through following up and providing appropriate contraception had nevertheless appeared to be particularly valuables.

He attributed the success in addressing the high rate of teenage pregnancy in Hackney, where he had previously worked, to a number of factors. Service commissioners and providers had been honest in saying what was wrong with services and schools had provided strong leadership. Peers had also been used successfully. Resources had been provided, with the local strategic partnership

providing £1 million in extra funding. Services had also been persistent and resilient in addressing the problem. Consultation had taken place with young people, whose view was that enough was enough.

He felt that Haringey's commitment amongst its leadership to addressing the issue, as evidenced by the attendance that he had recently witnesses at a Teenage Pregnancy Executive Board, was exceptionally good. He stated there had recently been a visit by the National Support Team for teenage pregnancy. Their view was that, in the light of the recent upheavals in Haringey, the progress that had been made despite this had been remarkable. There had also been recent reductions in the quarterly rates which were exciting. The authority had been unlucky with the increase in teenage conceptions that had taken place in 2007, which had been mirrored everywhere to some degree. A lot also depended upon the year from which the baseline had been set.

All authorities were doing the ten things that were required under the national strategy. Some outer London boroughs had been affected by population changes and, in particular, the size of the teenage population. The targets had been based on populations staying the same which had meant that those authorities affected by the demographic changes were having to "run to stay still".

Boys and young men tended to respond best to more explicit learning information, which was not appropriate in formal settings. It was easy to ignore the needs of boys, many of whom were anxious about their sexuality. One key aspect was that they wanted to know how to perform well. In addition, homophobia was often targeted at them. Boys also often had little sense of what it meant to be a man. One particular scheme that he had been impressed with was a Brazilian one called Pro Mundo which was aimed at young men in deprived and violent areas which sought to address sexual violence against women.

There tended to be higher spending in areas with higher rates of teenage pregnancy and this could be a contributory factor to reducing rates. It was currently difficult to benchmark spending but the Department of Health was currently undertaking some work on this with the aim of developing a consistent way of approaching the issue. It was particularly important to be able to target effectively those most at risk. Particular groups that were at risk included young women on the CAF threshold and those in contact with youth offending teams and or who had undertaken recent abortions.

The "You're Welcome" quality criteria scheme aimed to make health services, including sexual health services, more accessible to younger people and could be particularly effective in respect of GP surgeries. Hackney and City PCT had appointed a GP champion to assist in this process, which had proven to be of assistance. A number of GPs did not feel comfortable talking to young people about sex and therefore needed to be encouraged to be more proactive.

As things stood, it was currently not possible to force schools to teach sex education. However, new legislation would address this issue and it would soon be compulsory for all schools to teach sex education, including areas which some schools currently preferred to avoid covering.

Mr Kelly was of the view that young women did not often get pregnant on purpose – it was more down to carelessness. They tended to justify their inaction by saying that

they had got pregnant in order to get a house, although it had not been premeditated and was not strictly true. The media tended to portray such women as hate figures. The fathers in many cases were much older then the mothers. In the past, follow up on abortions by services had not tended to be very good. Services were now a lot more assertive in their approach, often using outreach. It was very important to ensure that the right women accessed services.

Social networking had been used by some authorities to get their message across but it was difficult to get right. One particular scheme had involved the use of pop ups to distribute “health bites” across schools and colleges, which covered a number of health issues.

There were a number of areas where there was scope for improvement. The chlamydia rate in London was the highest in the country and was showing amber on the relevant target. It was essential to ensure that core services, such as GPs, contraception services and pharmacists, were getting it right. Even if authorities were doing everything possible, including the ten actions referred to in the strategy, it was still possible for things to go wrong. Particular issues of concern were the fact that chlamydia appeared to be being regarded as a rite of passage by some young people, the lack of role models for some boys and the migration to Britain of some children who had been traumatised by witnessing sexual violence in their homelands.

Ms O'Connor reported that the 4YP bus provided sexual health advice and limited treatment in a range of locations. 26 visits were made per month to a range of sites across the borough. Some of these were regular visits whilst others were one-offs. They were also drop in sessions. Condoms were available on the bus. The services also ran clinics that provided level 1 and 2 services in leisure centres and other settings. These provided basic contraception and LARC (long acting reversible contraception). In addition, there was a sexual health clinic at St Ann's Hospital that was open from 2:30 to 5:00 during the week. There was also 4YP+ at Lordship Lane Health Centre which was aimed at young women up to the age of 20. The service also provided training for GPs and practice nurses. Some GP’s now also prescribed LARC but the majority only prescribed the pill.

More women then men tended to access the clinic and very few young men came in for contraceptives. Boys were more likely to use the bus and mainly came in for condoms.
Family planning was now referred to as contraception services.

The service currently met the target for 48 hour access to GUM services and was typically achieving 90 - 95% compliance. There were high “did not attend” rates and the service sometimes overbooked to compensate for this. It was likely that services were currently not working to their full capacity. 50% of service users were from Haringey and the service was trying to increase this to 60%

She acknowledged that the opening hours of the afternoon clinic at St Ann’s were not convenient for young people and it was therefore planned to change the hours to between 3:30 p.m. and 7:00 p.m. The service for men who have sex with men (MSN) would also have to be moved. It was also aimed to introduce an additional session and to be open for six days per week. STI testing would also be available at all outlets.

The choice of locations for the bus was based on known hotspots and local intelligence. Word of mouth information was also used. Locations also needed to be able to take the bus, with sufficient parking space. Those who were not close to where the bus stopped could access services through the clinics. Outreach work was also undertaken with looked after children and the Roma community. Two new nurses had been appointed to work with hard to reach groups. Services were publicised via the 4YP website, posters and leaflets. These were placed in a range of locations including GP surgeries.

4YP had been decommissioned by Enfield a few years ago. Following this, the service had been mainstreamed. School visits were now more limited then previously, although they still took place. There was also some limited work that took place with the Youth Service. The limitations were due to the small number of staff – 4.5 – that the service had. The service did, however, undertake training of youth workers, all of whom were now trained. However, youth workers and teachers could sometimes feel uncomfortable talking to young people about sex as they felt that it could cause barriers between them and the young people that they worked with.

Stigma and embarrassment were key factors in discouraging young people from using sexual health services when needed. In addition, schools who refused to distribute condoms and teachers who would not cover sex education were also a barrier.

National statistics showed that 80% of people received their contraception from their GP. This was mainly the pill. Many young people did not like to their GP to receive sexual health services. This was partly due to the perception that their GP might not keep information confidential. They also could feel that their GP was more likely to be judgemental then 4YP. I

Getting through to young men was challenging. 4YP was originally set up due to the fact that young men were not accessing services. The services had some male staff and they had discussed setting up a young mens clinic at Lordship Lane Health Centre but this could not be staffed solely by male staff.

4YP used to have a peer project as part of a particular scheme but this was no longer running. She felt that schools could take on a more assertive role with more use made of class tutors and other teachers who children saw every day. Developing primary care was also important and the sexual health in practice (SHIP), which as being set up locally, could be effective in persuading GPs to take a more active role. As an incentive, it offered them the opportunity to undertake testing themselves and access to free condoms. Only one GP had opted out entirely from providing sexual health services. She felt that GPs should be the main gateway to services. However, it was difficult for single handed male GP services especially when a chaperone was needed.

The service could refer people with mental health problems onwards, although it was sometimes difficult to identify that such issues. There was currently nothing specific in place to address the needs of people with learning difficulties.

The Panel thanked Mr Ali, Mr Kelly and Ms O'Connor for their participation.

Cllr Gideon Bull
Chair

MINUTES OF THE SCRUTINY REVIEW - SEXUAL HEALTH IN TEENAGERS
MONDAY, 16 NOVEMBER 2009

Scrutiny Review – Sexual Health in Teenagers

Issues for Meeting on 21 January

NHS Haringey

1. **Joint working with other PCTs:** Given that 50% of service users do not come from Haringey and that many Haringey residents prefer to access services in neighbouring boroughs, are there any plans to collaborate with other PCTs in the commissioning and providing of sexual health services?

2. **School nurses:** How many Haringey schools have school nurses and how many schools on average does each school nurse cover? What role do they currently have in promoting sexual health?

3. **Haringey PCT spend on sexual health:** Do current spending levels reflect adequately the level of local need?

4. **You're welcome scheme:** What current plans are there to make health services more young people friendly through the "You're Welcome" scheme and how many services have so far been given accreditation?

5. **Availability of condoms to GPs:** Why do GPs currently not have access to free condoms?

6. **GP services:** In addition to the SHIP initiative, what measures have been taken to encourage all GPs fulfil their responsibilities to deliver sexual health services?

7. **Integration of services**: What is the timescale for introducing full integration of sexual health services in Haringey?

8. **4YP Clinic:** When are later opening hours scheduled to begin at the 4YP clinic at St Ann's so that it is more accessible for young people?

9. **Services for boys and young men:** Are there any specific plans yet to open a separate sexual health clinic aimed at boys and young men?

C&YPS

10. **Peer training and mentoring:** Are peer mentors currently being used in Haringey schools to help promote better sexual health? What current plans are there to introduce them, how many will there be, at which schools and by what date?

11. **Participation of schools:** What further initiatives are planned to encourage all schools and especially faith schools to participate more actively in promoting better sexual health?

12. **On site facilities:** Has consideration been given to the provision of on site services for young people in schools and other education and youth service settings, such as extended schools?

13. **Teens and Toddlers:** Has an evaluation been undertaken of the Teens and Toddlers initiative? What are the current plans to extend the scheme and to what timescale?

14. **Governor training:** Is the value of SRE emphasised in training to school governors?

15. **The role of parents:** Given the important role of parents in teaching their children about sex and relationships, what work is currently undertaken with them to generate greater confidence in communicating with their children? How many parents have so far completed the Speakeasy course?

16. **Diversity:** What specific work is undertaken to promote good sexual health amongst young people in hard to reach communities? In what ways are the community and voluntary sector utilised?

17. **Consultation with young people:** What regular and ongoing mechanisms are there to obtain the views of service users and potential service users?

18. **Training and support for primary school teachers:** What training and support do primary school teachers receive in the teaching of SRE?

19. **Health check:** Has consideration ever been given within Haringey to the introduction of a young persons health check?