ITEM 6

Derby City Council
Children & Young People Commission

Reducing Teenage Conceptions In Derby

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• Introduction

1. Teenage pregnancy is a social exclusion issue and a public health issue for the United Kingdom. It's more difficult for the very young parent to earn a living wage so their child is more likely to be raised in poverty than if born to older parents. The child is also more likely to have accidents because the young parent is still an adolescent and more likely to be taking teenage risks their self.

2. In 1999 the Government set the target of reducing the rate of teenage conceptions by 50% - 55% for Derby - for the under 18's by 2010. The baseline in each local authority was the rate per 1000 of the 15-17 female population in 1998. A second target was to reduce the risk of long term social exclusion of teenage parents by increasing to 60% their participation in education, employment and training.

3. At the time of writing in March 2008 Derby had just received the good news that the rate of teenage pregnancy had fallen significantly. Provisional data for 2006 shows under 18 rates to be 46.1 per 1,000 – a fall of 27.8% from the 1998 baseline. The 2005 rate for teenage pregnancies had been 54.6 per 1000. While the 2005 figure was an improvement on the baseline of 63.8 in 1998, it did represent the stalling of earlier progress. It was that which caused the Commission to select teenage pregnancy for a focussed review. The terms of reference were:

Through a one day review, to:

- be appraised of local initiatives designed to achieve the national policy goal of reducing teenage conceptions,
- gauge the progress made in different parts of Derby,
- identify what works best here and for other local authorities and formulate any beneficial recommendations

Box A

Reasons for high rates in the UK [article on the Brook web-site]

The Social Exclusion Unit report *Teenage Pregnancy* identified three major factors for the UK's failure to reduce its teenage conception rates alongside those of other European countries.

Low Expectations. Teenage pregnancy is more common among young people who have been disadvantaged and have poor expectations of education or the job market. The UK has more young people who see no prospect of a job and foresee a future on benefits. As the report said 'put simply, they see no reason not to get pregnant.'

Ignorance. Young people in the UK lack accurate knowledge about contraception and sexually transmitted infections, they are uncertain of what to expect from a relationship and have an unrealistic picture of parenthood. Contraceptive use is low compared to countries like

Denmark and the Netherlands and young people tend to have a rosy view of what being a parent is about.

Mixed messages. Young people are surrounded by sexual images and messages which imply that sexual activity is the norm. Yet some parents and many public institutions are at best embarrassed about dealing with young people's sexuality or try to ignore it completely. This leads to the situation, described by one teenager quoted by the Teenage Pregnancy Report, where it seems as if sex is compulsory but contraception is illegal.

Risk factors

Poverty is a key risk factor for teenage pregnancy. Girls whose families are in social class V (unskilled manual) are ten times more likely to become teenage mothers than girls from professional backgrounds. They are also far less likely to have an abortion if they do become pregnant.

Children in and leaving care are at high risk of pregnancy. 25% of care leavers have had a child by the age of 16; almost half of care leavers are mothers within 18-24 months of leaving care.

Low educational achievement is also a major risk factor for teenage parenthood. A study of 150 teenage mothers in South London found that 40% had left school with no qualifications compared with national average of 6.6%.

4. Other materials provided ahead of the meeting showed that the Council and its partners treated the issue with due seriousness. Two current Policy Framework documents have clear references (see boxes B and C).

Box B

Corporate Plan

Priority: Helping us all to be healthy, active and independent

• Improving the health and well-being of our communities by:
○ reducing the number of teenage pregnancies and increasing the support available to teenage parents.

Box C

Derby Children and Young People Plan 2006-08 – Annual Review 2007

Key Challenges: Be Healthy *and* Make a Positive Contribution

- Giving confidence to young people in reducing risk, **including teenage pregnancy** and substance misuse

The full range of associated actions is set out at Appendix B

5. Because Derby was behind in meeting the challenging 2010 targets it's status was amber red, teenage pregnancy and sexual health services for children and young people was one of two issues (along with quality of accommodation for young people) identified for further investigation during the recent Joint Area Review. The relevant extract is included as Appendix C.

6. For the future, it has been agreed with GOEM that one of the suite of 35 national indicators selected from the 198 options shall be the under 18 conception rate. This will ensure focussed attention continues until 2011. The purpose of the review therefore was to see if there were obstacles or pinch points that impeded progress and which could be overcome through beneficial, practical recommendations.

7. The main evidence-gathering took place on 5 February and involved five Commission members conducting a series of interviews with practitioners and stakeholders. However, as a focussed scrutiny review there was necessarily only limited time to explore best practice in detail.

- # Conclusions and recommendations

Conclusion A. The twin protections against teenage pregnancies are a) raised aspirations and b) good Personal Health and Social Education, including Relationship and Sex Education when these are combined with accessible and responsive young people-friendly sexual health services.

Conclusion B. Education that promotes knowledge and self-confidence about relationships, emotions, bullying and sexual health can enhance resilience as these strands mutually reinforce each other.

Conclusion C. The positive work undertaken with young males is an important strand in reducing pregnancies and should be developed both in schools and other settings

Recommendation 1. a) There needs to be good quality, age appropriate Personal Health, and Social Education, including Relationship and Sex Education in every Derby school, b) a once a year event is not adequate and c) a city-wide, coherent 3-18 curriculum should be developed.

Recommendation 2. a) There should be a city-wide 'pledge' for schools, demonstrating commitments regarding Personal Health, and Social Education, including Relationship and Sex Education and the provision of services to reduce teenage pregnancies b) in recognition of the sensitivity of this issue and that there can be safety-in-numbers, the 'pledge' should become effective at a common future date for all the participating schools.

Recommendation 3. To promote sign up to the 'pledge' and associated commitments by the individual schools the case needs making: a) **at** the governor forum as well as the head teacher forum b) **by** a senior figure well respected by the audience

Recommendation 4. Pursuant to conclusion B there is a need for appropriate staff members in every primary school to engage with parents to explain what is taught and how and how this protects children.

Recommendation 5. To maintain focussed inter-agency commitment and momentum a) the new Director of Public Health* needs to continue providing direct, PCT Board level representation on the Teenage Pregnancy Board b) similarly other key partners need to be represented by their chief executive or board-level figure c) the practitioner perspective also needs its place at the table, which can be achieved either by a modest expansion of the Board's standing membership to supplement the executive representation or by making sure the right practitioners are invited to attend *and to be vocal* when specific items are to be discussed.

Recommendation 6. The Teenage Pregnancy Board members need to act to ensure that there is a comprehensive understanding of Derby's Information

Sharing Agreement and Inter-Agency Practice Guidance for Children and Young People within their own agency by i) communicating what it means to all the appropriate staff and ii) mainstreaming it into staff practice.

Recommendation 7. The Teenage Pregnancy Partnership should evaluate the Stoke referral form and risk assessment tool-kit for possible adoption or adaptation in Derby and report the findings to the Commissioning Board.

Recommendation 8. In order to make targeted interventions both more responsive and effective by the provision of more timely and accurate data, electronic recording should be used ***if*** that enables the information to be promptly shared.

Recommendation 9. While there is good commitment at both the apex and among most frontline staff within each partner agency, there is a need to increase understanding and ownership of the issues through all the tiers of the agencies; work force development can be a key means to achieve that.

Recommendation 10. The Commission would welcome a visit from the National Support Team as a constructive 'critical friend' and recommend Cabinet to seek to secure such a visit.

Recommendation 11. a) As the target is to reduce teenage pregnancies by 55% by 2010, the Commission is concerned that one dedicated co-ordinator with part time administrative support offers insufficient capacity given the scale of the challenge facing Derby and therefore propose i) enhancing efficiency by seconding or co-locating the appropriate EWO ii) that consideration be given to creating a multi-agency team.

Recommendation 12. There should be an analysis carried out to assess whether the mainstreaming of current time-limited projects is justified.

- # Section 1. Protecting Children and Reassuring Parents through Education

8. A concise review has by nature to be based on certain assumptions. In this case, that included acceptance of the broad national strategy. This short extract from OFSTED spells out why providing effective sexual and relationship education, advice and assistance is necessary.

> 14. 'There is no evidence, however, that 'abstinence-only' education reduces teenage pregnancy or improves sexual health. There is also no evidence to support claims that teaching about contraception leads to increased sexual activity. Research suggests that education and strategies that promote abstinence but withhold information about contraception can place young people at a higher risk of pregnancy and sexually transmitted infections (STIs)'. [Time for change? Personal, social and health education, OFSTED, April 2007]

9. Prior to the review Cllr Allen had visited Stoke-on-Trent and the draft write-up of the visit had been circulated prior to 5 February. Stoke did not claim to have got everything right, in fact although services to young mums had been good there had not been effective multi-agency preventive work until two years ago. With very high conception rates and the Government Office for the West Midlands expressing serious concern, the need was to catch up with other local authorities quickly. This produced wholesale buy in and co-operation from agencies and schools across the city. The information gained from the visit provided a useful comparison for members to use during our review. It is included as Appendix W.

10. The 5 February meeting began with a DVD 'Reality Check' made by young people who were or had been in care in Derby followed by a presentation by Liz Beswick and Sheila McFarlane plus comments also from GOEM's Sue Jablonskas. Almost their first words were that the national evidence showed the *twin* protections against teenage pregnancies are a) good Personal Health and Social Education, including Relationship and Sex Education and b) raising aspirations. Affluent areas generally have lower teenage conception rates than poorer ones. This was visually apparent because a map had been provided for the review. The map showed the high/average/low conception rates for 15-17 year olds on a ward-by-ward-basis, the colour coding largely corresponded with the relative wealth of the area.

11. Just as importantly, evidence also showed that two equally deprived areas can have dramatically different rates of teenage pregnancy and that this may well be associated with the quality of education:

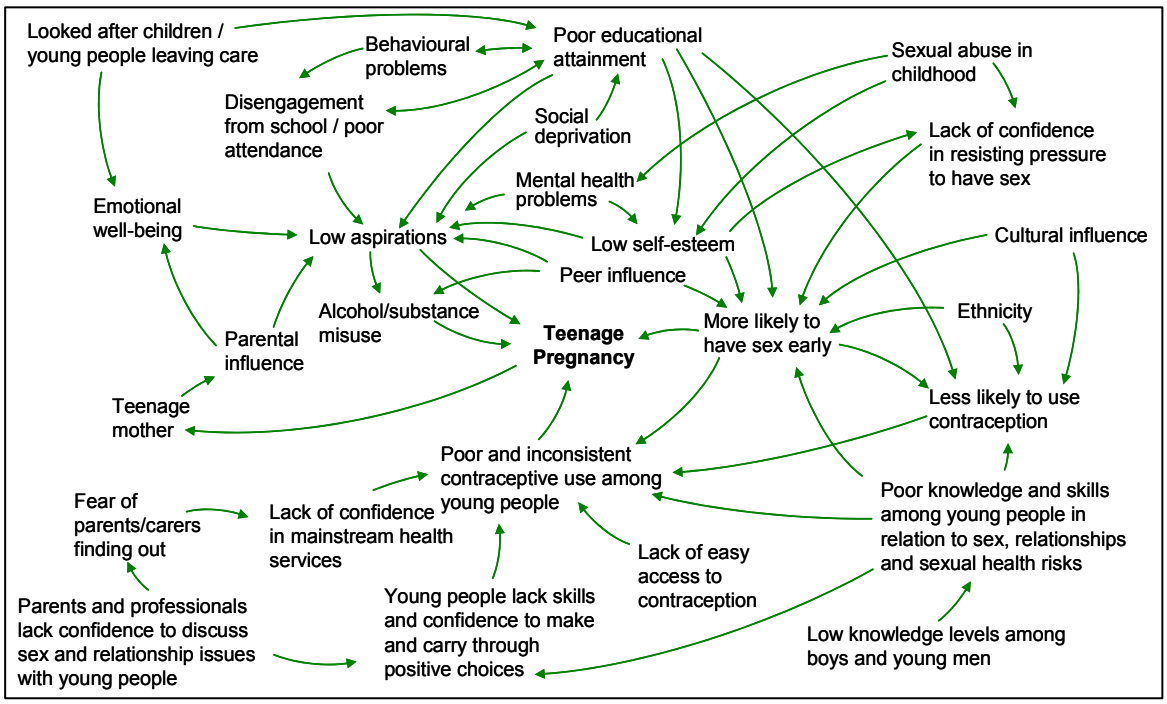
> Good attainment = higher aspirations = lower teenage pregnancies

PSHE that promotes knowledge and self-confidence about relationships, emotions, bullying and sex enhances resilience and the Commission believe

these strands can mutually reinforce each other. Young people become more confident in forming healthy relationships, making informed decisions and asking questions. They are probably less likely to get drawn into youth crime, get bullied or to have early, unsafe sex.

12. Given the widespread perception it is also important to record that the officers didn't believe teenagers get pregnant to get housing – and neither did other participants suggest otherwise. The DVD made by young people showed that some of their peers believed that getting pregnant was 'being unlucky' and was often not directly associated with having sex. There is not space here to discuss all the risk factors but a slide used during the presentation encapsulates the complexities

Box D



13. The presentation and dialogue, which also included Sue Jablonskas from GOEM, provided a very open and balanced picture of the strengths and the areas for development in Derby. The non-school services are a mix of city-wide and of those geographically targeted on the hot spots.

14. 'Spaceman' are contraceptive and sexual health sessions for young men 12 to 25, each held weekly lasting for two hours. City Spaceman is centrally located in The Space at The Spot. Run on a Friday from 4-6 pm means it can be attended after school, college or work. Others are held (times vary) at Allenton Youth Club, Sinfin Health Centre and in Roefarm and Derwent. This work with young men is making a significant contribution to reducing teenage conceptions. For girls there are generic young people's sexual health services at the Space. Weekly provided multi-agency services for young women include Time for Girls at Roe Farm Clinic (age 12 to 25) and Angels at First Steps Children's Centre, Cockayne St North, Allenton (13 to 18). For young

men and women CASH (contraceptive and sexual health) services are found at the new walk-in facility at the DRI. Young parents groups are also provided. 'Starz' is centrally located at St Peters Church. Mums-the-Word is based at First Steps.

15. The draft write-up of Cllr Allen's visit to Stoke-on-Trent was particularly useful when the review was learning from participants about school-based relationship and sex education, advice and services. It became apparent that there is not city-wide consistency in Derby and the Commission found that the continuum of practice ran from excellent to inadequate. One school cited was reported to deal with these sensitive issues by allocating one special day each year. It is difficult to reconcile that approach with the view of the Teenage Pregnancy Unit:

> **Prioritisation of sex and relationships education**
>
> High priority [be] given to PSHE in schools, with support from the local authority to develop comprehensive programmes of sex and relationships education (SRE) in all schools.

It was said that the same school cited also has a high rate of conceptions, whereas ones with an age-appropriate planned programme of SRE have low rates. The present variation between good and poor practice is the result of local choices, for under local management of schools it is the governing body (or head) that has the right to decide these issues. However, the Commission hopes that heads and governing bodies will see the value in subscribing to a common city-wide approach.

16. The recognition in Stoke that action was needed to demonstrably address GOWM's - and the Minister's – concerns meant primary and secondary schools have opted into a city-wide scheme of RSE. This involves making a commitment to providing a minimum range of services.

Box E

Note of a visit to Stoke City Council on 31 January 2008 [extract]

8. [part] On the sexual health side, schools must* sign a 'Pledge' to deliver the SRE scheme of work that is being rolled out across secondary and primaries at present and will be utilised in alternative education settings. The scheme of work, including lesson plans, links to resources etc has recently been developed in Stoke (from 5-19 years) and we have been commissioned by the National Support Team to provide guidance and an outline of the scheme to use with other Authorities. Compliance with the 'Pledge' is monitored by the Healthy Schools team and the work is performance managed by Tracy and then the Implementing Change Group for teenage pregnancy.

9. The 'Pledge' has been 'tweaked' for individual faith schools, but the problems that may have been expected 'just have not happened'. Further, a representative of the REC had been involved throughout which has helped factor in issues around cultural minorities

*must relates to making the public commitment after a governing body has *chosen* to join

17. While for some schools signing a Derby Pledge would – as intended – involve raising their game, for others it would simply be a public acknowledgement of current good practice. The Commission envisage a local Pledge being launched for all participants on a common future date. This would afford safety in numbers and should make it much easier for parents to accept – which should make it easier for governors to agree to.

18. It will be important for governors to hear directly about a city-wide strategy and associated pledge. Therefore the governors' forum as well as the head teacher forum should be used to convey the message. The Commission was told that the impact can hinge on who the messenger is. It is far better for the proposals to be conveyed by a well respected senior figure known to the audience, rather than even an expert guest speaker.

19. As Box E explains currently the age range for the SRE scheme in Stoke-on-Trent is 5 to 19 but the intention is to broaden to 3 to 19. At the younger end of the range it is mainly relationship education. There will be a need for appropriate staff members in every Derby school to engage with parents to explain what is taught, and how, and how this can protect their children.

Conclusion A. The twin protections against teenage pregnancies are a) raised aspirations and b) good Personal Health and Social Education, including Relationship and Sex Education when these are combined with accessible and responsive young people-friendly sexual health services.

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- # Section 2. Make up of Board

20. There was general agreement that the revised structures, comprising a Commissioning Board and a Reference Group, which came in with the adoption of a commissioning approach are working. However, one of two concerns raised was about the need for each agency's representation on the TP Board to be at the highest level. As with the DCP Board, that is for the reason that individuals at the apex of an organisation can carry the authority to commit their agency – and can quickly implement action within their own agency. Less highly graded officials have to refer back to achieve sign-up and negotiate with internal colleagues before action takes place.

21. There was also a specific uncertainty as to whether the PCT would continue to be represented by an Executive Director after Maura Teager. Maura had chaired the Board since the departure of the last Director of Public Health but had herself just left to join the provider Trust and about the same time a new Director of Public Health was taking up post. It was unclear whether Dr Wakeman would join the Board or would delegate the representative role.

22. The second of the two concerns was that the Board needed to include some practitioner representation with a direct voice at the table, to ensure decision-making captures the realities of successfully engaging with sometimes disengaged teenagers. These two concerns are not obviously compatible and either:

- some modest expansion of the Board may be needed to accommodate both compelling cases or
- the Commissioning Board makes sure it brings in the right practitioner(s) when specific items are due to be discussed.

Recommendation 5. To maintain focussed inter-agency commitment and momentum a) the new Director of Public Health* needs to continue providing direct, PCT Board level representation on the Teenage Pregnancy Board b) similarly other key partners need to be represented by their chief executive or board-level figure c) the practitioner perspective also needs its place at the table, which can be achieved either by a modest expansion of the Board's standing membership to supplement the executive representation or by making sure the right practitioners are invited to attend *and to be vocal* when specific items are to be discussed.

*Post script: Dr Wakeman is doing so.

- **Section 3. Information sharing and workforce development**.

23. A very practical example that demonstrates why recommendation 5 is so important can be seen by the problems identified about agencies sharing information. Clearly every agency has to ensure that it complies with the data protection legislation. However, some anecdotal evidence suggested that an over cautious interpretation was being taken, perhaps the consequence of confusing the law, current agency practice and 'the way we do things here'. An agency's refusal – or at least that of its individual staff members - to share information when the young person has expressly authorised them to do so defeats a partnership approach.

24. This also links to recommendation 8, which addresses the concern is that while there good buy-in to the Partnership at the apex of organisations and among front-line staff there is a gap among middle tiers.

25. There is a real risk that pregnant teenagers could receive a sub-optimal response if agencies are not – despite having the young person's permission - sharing information, thereby delaying access to appropriate or quickly needed services.. There may also be the risk that avoidable pregnancies actually occur because appropriate education and other services are not offered. The third risk is that unless this problem is owned and addressed by the top management of agencies these problems will continue into the future.

26. As a practical example, although information sharing had been an issue in Stoke for a good number of years, senior sign-up to the teenage pregnancy agenda means that now "we don't have this problem". A range of data is provided to their co-ordinator, including live births, terminations, known miscarriages, Connexions data etc. Time has been invested to get full engagement by NHS staff regarding:

- *individuals* to gain a better understanding by NHS employees of when and how confidential records can be validly shared with other agencies and
- the *general population* to gain a sharing of relevant demographic data.

27. Members were struck by the time delay for the production of national data, which essentially serves for the purpose of retrospective reporting to, and by, government but not for the delivery of locally responsive services. Several other councils which have conducted similar reviews in recent years have made similar points including lobbying central government. As mentioned in the introduction at the end of February 2008 the data for 2006 has been released by central government. This will provide a comprehensive picture of teenage conceptions, including births and terminations – the thoroughness is partly why it takes so long to assemble. Yet it doesn't help at all with getting information and advice to young women at risk of pregnancy.

28. The improved Derby information sharing protocol proposed at recommendation 6 can facilitate a more joined up response for individuals, and if aggregated and anonymised it can also lead to a better targeting of limited resources. For example, it could help provide an early warning of a localised problem to Education Welfare Officers, Connexions personal advisers and Youth Workers, if say, several pregnancies were associated with a cohort of young women using a particular youth shelter, night club or associating with a new cool gang.

29. Cllr Allen brought back a copy of Stoke-on-Trent's inter-agency teenage pregnancy referral form and of its risk assessment tool kit 11 to 17 year olds. These were provided to the Commission ahead of the meeting. The tool kit uses a scoring system for each of 13 factors. High risk is a score of 30+; medium is 20 to 29 and while minimal means 0 to 19. This has been identified as a strength by the Rt Hon Beverley Hughes MP, Minister for Children, Young People and Families, and by GOWM.

30. The Stoke form must be completed with the young person in all cases and referrals will not be accepted where this is not the case. Because some of the questions could bring up difficult feelings for the young person it should be completed by a professional who a) already knows them and b) and who has received the relevant training. They can therefore be variously completed by mentors in school, youth workers, behaviour managers, education welfare officers, specialist advice workers and school nurses. High risk cases (a score of 30+) automatically lead to referral for 1:1 support unless alternative intense support is available to the young person.

31. Logically information can be transmitted more efficiently if it is computer based and - with the individual's permission - shared with the other agencies who can assist, as appropriate, with the prevention of pregnancy or the provision of support if a conception has. If this logic holds then electronic recording should be introduced. An alternative perspective brought to our attention during report drafting is that computer held records are more difficult to share than paper held data. Therefore whether recommendation 8 is beneficial may hang on whether recommendation 6 is fully delivered.

32. As an additional point, good old fashioned data is recorded by GPs about confirmation of pregnancy and by Midwives, Health Visitors and the Registrar's Office for the birth of babies. It is important that the Partnership finds mechanisms to ensure this gets shared, in order to provide an early warning of trends and hot spots to EWOs, Connexions personals advisers and youth workers.

33. With local agencies it was reported that the networking undertaken with staff who actually work with teenagers combined with the buy in achieved at chief executive or board level has generally gained good a commitment to the Teenage Pregnancy Partnership. It appears to the Commission that in some agencies there has not apparently been a continuous golden thread between high strategy and day-to-day operations because some among middle managers have not been made aware of (or won over to) the importance their

agency places on the joint tackling of teenage pregnancy. This suggests that although individuals at the apex of an organisation *can* quickly implement action within their own agency they may not have been successfully transmitting the message about *why* their agency places a high priority on the issue. It is therefore important for agencies to ascertain whether and why these blocks exist in their organisation and, if so, act to overcome them.

34. It is suggested that this is largely an issue of communication to be addressed through work force development, which can be delivered to middle managers and appropriate support staff in a matter of months. If that then translates into a better understanding and support for operational staff, then a significant blockage to progress will potentially have been overcome.

Recommendation 6. The Teenage Pregnancy Board members need to act to ensure that there is a comprehensive understanding of the Derby's Information Sharing Agreement and Inter-Agency Practice Guidance for children and young people within their own agency by i) communicating what it means to all the appropriate staff and ii) mainstreaming it into staff practice.

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Recommendation 9. While there is good commitment at both the apex and among most frontline staff within each partner agency, there is a need to increase understanding and ownership of the issues through all the tiers of the agencies; work force development can be a key means to achieve that.

• Section 4. Welcoming a critical friend

35. Early on the review day it was said that Derby would struggle to achieve its target of a 55% reduction in under 18 conceptions by 2010 since early milestones had not been met. Significant early progress had stalled and annual returns started to regress. The final years would require ever steeper progress in order to hit the target. Sue Jablonskas from GOEM was therefore paying Derby close attention but was supportive of the steps being taken locally. Her suggestion that Lincolnshire be contacted as a successful model was followed up on our behalf by the co-ordination officer after the meeting and the write-up attached as Appendix Z.

36. Sue explained the role of the National Support Team, which has the capacity to visit a limited number of councils per year as a critical friend. She was bidding to have Derby included in the 2008 round. The Commission believe that makes sense. It may be seen – as we hope to be – as an ally in removing obstacles to progress. Certainly that was the experience in Stoke which had received such a critical friend visit.

Recommendation 10. The Commission would welcome a visit from the National Support Team as a constructive 'critical friend' and recommend Cabinet to seek to secure such a visit.

- # Section 5. Resources

37. Given the scale of the challenge facing Derby, to achieve a reduction in teenage conceptions by 55% comparing 2010 with 1998, the Commission is concerned whether one dedicated co-ordinator with part time administrative support offers sufficient capacity. The 2006 figure of 46.1 per 1,000 against the 2005 figure of 54.6 per 1000 is the best year-on-year gain since 1998 to 1999. It suggests that the government's 2010 target of 28.7 per 1000 is just attainable if progress continues at this rate.

38. Consideration should be given to creating a Lincolnshire-style multi-agency team, albeit on a smaller scale given the smaller population base. Naturally this hinges on the resources available, but the pending adoption of the LAA, which including the priority of reducing under 18's conceptions, makes this a timely moment for the partner agencies to discuss how best to deliver the target.

39. The review took place before the Council's budget was finalised. It was known that some funding eg in Derwent was due to time expire in March 2008. This had been a concern of Sue Jablonskas who had included in her September 2007 feedback letter that: 'Mainstreaming of projects/posts with time limited funding needs to be progressed as a matter of urgency'. Where evaluation has not yet been carried out, this needs to happen in order to assess whether the mainstreaming of current time-limited projects is justified. This is partly about value-for-money of individual schemes but also ensuring best practice is transferable to other localities. For example, the very variable statistical progress in different parts of Derby has seen Derwent as a notable success story. At the point of finalising this report it was learned that the boy's and young men's sexual health project in Derwent is to be continued and 're-modelled' through a combination of permanent and temporary funding.

Recommendation 11. a) As the target is to reduce teenage pregnancies by 55% by 2010, the Commission is concerned that one dedicated co-ordinator with part time administrative support offers insufficient capacity given the scale of the challenge facing Derby and therefore propose i) enhancing efficiency by seconding or co-locating the appropriate EWO ii) that consideration be given to creating a multi-agency team.

Recommendation 12. There should be an analysis carried out to assess whether the mainstreaming of current time-limited projects is justified.

Appendix A

Reducing Teenage Pregnancies Review
Note of a visit to Stoke City Council on 31 January 2008

Present: Tracy Kirk, Pam Loraine (Stoke), Cllr Les Allen, Rob Davison (Derby).

1. It was explained that Derby's Children and Young People Commission were to undertake a short review regarding the reduction of teenage pregnancies. As well as seeing local stakeholders, members wished to have a perspective from another authority. Keith Forrest, now Asst Director with Derby, had suggested Stoke-on-Trent, his previous authority, as a good example and provided Tracy's name.

2. Stoke had recognised strengths as regards post-natal reintegration of school age mums back into education. But the statistics for the rate of TP were very high and were a source of concern and monitoring by the Government Office for the West Midlands, GOWM. The 1998 rate had been 68.5 per 1000 and the 2005 figure was 68.0 per 1000. (the 2006 figure was 66 per 1000 representing a 3.6% reduction)

3. Tracy explained for 10 years the main lead agency for TP in Stoke had been Health. In November 2006 the key role had been given to Tracy. Initially this was in addition to her full time role of Social Inclusion Officer. Her post is now full time as Teenage Pregnancy Services Manager and part of the City Council. Previously, since 2000 she had been the Reintegration Officer and was also social Inclusion Officer from 2004. Pam Loraine was appointed to be the replacement Reintegration Officer. Both had EWO backgrounds so were well known to schools.

4. Prior to 2006 preventative services for this age group were just not provided. From Nov 2006 Tracy has worked closely with the National Support Team who are pleased with the range of what Stoke had since put in place over 12 months – and starting from a very low base.

5. The age range to access services is up to 18 but there is flexibility about going above this.

6. An initial development was 'clinic in a box', a mobile contraceptive and health service.

7. There has been a recent city-wide review of contraceptive services and the outcome has been to bring in other agencies to complement what the City Council has being doing. There is to be geographical targeting and related work has assessed what is needed and where. This is also linked to the developing IYSS/TYS. 'Touch point' services connotes where young people know they can go for basic services. Touchpoints covers sexual and relationship education, SRE, condom distribution, sexually transmitted

infections, STI, testing plus sign posting to other services. Training is being provided to staff in the Youth Service, Connexions etc.

8. A major initiative had been the recent development of 6 MACs Places in local high schools – the short name derived from multi-agency centres. These are pilots but the hope is to roll out the model to high schools and colleges. The aim is to provide a wide range of information and advice eg about careers, positive activities, sexual health advice, condom distribution, pregnancy testing, mental health services etc. plus signposting – MACs like to say they can answer everything, not just contraception. Having PSE guidance as just a bit of what's offered, that avoids the stigma and makes it more likely that young people will make use of the service – not least those from cultural minorities. Ahead of a MACs Place starting training has to be undertaken by school's staff – a minimum of 4, but some have significantly more. At minimum the school must provide pregnancy testing, chlamydia screening and condom distribution

On the sexual health side, schools must sign a 'Pledge' to deliver the SRE scheme of work that is being rolled out across secondary and primaries at present and will be utilised in alternative education settings. The scheme of work, including lesson plans, links to resources etc has recently been developed in Stoke (from 5-19 years) and we have been commissioned by the National Support Team to provide guidance and an outline of the scheme to use with other Authorities... Compliance with the 'Pledge' is monitored by the Healthy Schools team and the work is performance managed by Tracy and then the Implementing Change Group for teenage pregnancy.

9. The 'Pledge' has been 'tweaked' for individual faith schools, but the problems that may have been expected 'just have not happened'. Further, a representative of the REC had been involved throughout which has helped factor in issues around cultural minorities.

10. Some extended schools funding has been made available and the wish is to develop MACs Places into evenings and during school holidays.

11. Drop-ins with a member of the preventative team present are held at lunchtimes, both at the 6 schools with MACs Places and at those that haven't. It was recognised that the introduction of new services, like the drop-ins, had the potential to alienate school nurses, so effort was put into explanation and liaison. All schools have been keen to take up support available. This service has recently been recognised as a strength by Beverly Hughes.

12. Six staff are now employed for preventative work. Three are part of Tracy's team and some of the team also work from youth service settings.. They provide group work on positive relationships and sexual health for medium risk young people. Delivered through three sessions, there is a maximum of 8 per group. If a participant is identified as really vulnerable they will be referred to 1:1 (see under).

13. The other three staff are intensive 1:1 case workers who deal with young people assessed as very vulnerable to becoming teenage parents. They may be referred by schools, Youth Service or other agencies but the young person's own signed assent is required. The intensive prevention officers always encourage the young person to talk with parents – but it's always their choice. These workers have been shocked by the lack of basic knowledge held by some of the young people eg about the physical changes that are part of normal growing up.

14. A copy of both the TP referral form and risk assessment toolkit for 11 to 17 year olds was provided. This uses a scoring system for each of 13 factors. High risk is a score of 30+; medium is 20 to 29 and while minimal means 0 to 19. This has been identified as a strength by Beverly Hughes and GOWM.

15. The form should be completed with the young person in all cases and referrals will not be accepted where this is not the case. Because some of the questions could bring up difficult feelings for the young person it should be completed by a professional who already knows them and if they have received the relevant training. They can therefore be completed by mentors in school, youth workers, behaviour managers, MACs workers, education welfare officers and school nurses. High risk cases (a score of 30+) automatically go to Pam who will refer to 1:1 support unless alternative intense support is available.

16. The preventative work has been rated as very positive by parents and agencies and in feedback from young people i) participating in the group work and ii) exiting from 1:1.

17. DASH, developing adolescent sexual health, is a scheme being rolled out to create surgery-based young people-friendly GP services.

18. Currently the age range for SRE scheme is 5 to 19 but the intention is to broaden to 3 to 19. At the younger end of the range it is mainly relationship education. Tracy and Pam believed the concept of MACs Places could in future be adapted for primary schools.

19. Every effort has been made to ensure the range of professionals who deal with young people knows about the services now available. Each school is being asked to nominate a TP co-ordinator. Within Children's Services as part of workforce development, every team now has to have a minimum of two hours training on sexual and relationship education.

It is now possible for a teenage girl to access good support after a termination.

20. Time has been invested to get full engagement by NHS staff, regarding:
    - *individuals* to gain a better understanding by NHS employees of when and how confidential records can be validly shared with other agencies and
    - the *general population* to gain a sharing of relevant demographic data.

21. Pregnant teenagers stay in mainstream schools until the birth. 6 to 8 weeks after the baby's birth re-integration into education begins, with the pace partly depending on the family support available.

22. A distinct young mum's group is attached to Newcastle-under-Lyme College, but located at a Children's Centre to provide a crèche facility.

Curriculum hours at N-u-L College delivered at Children's Centre:

Tuesday	9 am – 3 pm
Wednesday	9 am – 3 pm
Friday	10.30 am – 3 pm

21. After one year, if ready, they then continue at the main college site. If not ready they can stay with the group for a second year, but not longer. The course also offers a transition group for parents due to progress to mainstream courses on the main college site.

22. The baseline data for teenage mums GCSE achievement had been 0. Now, of the ones able to do so, 96% achieve:

5 A*-G GCSEs	96%	(above general population of this age)
5 A-C GCSEs	32%	(cf about 50%)

23. 'Care-to-Learn' has enabled much of this, funding the crèche (free for users) and some transport (ie taxi) costs – which has made it possible for so many of the young mums to stay in mainstream schools.

24. Since September, when the screening/assessment procedures were started the through put of young people has exceeded expectations. The target to March 2008 for participation in the preventative sessional groups and 1:1 had been 80 but was already 300. [Update as 3 March: now over 400]. Although they were very cautious about the effects, they did comment that usually around 30 referrals of pregnant teenagers are received in December but this year it was 12. The teenage pregnancy screening tool has also been identified as good practice by GOWM and Beverly Hughes.

25. Stoke won't give a flat to a young mum – she may get a supported place. That may act as a disincentive because it means monitoring rather than independence.

26. Another practical example of discouraging pregnancies is taking a high risk teenager shopping to 'buy' all the necessaries to look after a baby for a week – many are surprised by just how costly it is.

27. Changes were made to the inter-agency oversight of TP reduction. Until 2006 there had been a TP Partnership Board which had had 8 chairs in 9 years. It had not been very efficacious and senior agency representatives

routinely failed to attend. When TK took on her present role she went to see the Director of Children's Services and explained the need for high level sign-up. The Director took on the chairing role of the renamed TP Strategy Group, which began routinely reporting upward. These changes meant it started being taken much more seriously. The Director of Public Health, Head of the Youth service and Director of Connexions began attending – followed by the heads of nearly all the agencies. It became so large the membership had to be pared down from about 45 to 13.

28. TK had inherited 65 priorities which were reduced down to 10 more manageable work streams which TK performance manages. A copy of the latest two and a half page summary report was provided. The strategy's elements link into the other Council and LSP policies, including: Safeguarding, NEET (acronym for not in education, employment or training), targeted youth support work. The LSP Director has become involved and there will also be links in the new LAA with themes on life expectancy, and worklessness.

29. There is no mainstream funding and the current funding expires from the end of March. Tracy was unconcerned about this as she had been reassured the money would be found to continue the activity. MACs Places have been funded by NRF monies but from April it is likely to be Area Based Grant.

RD
3/2/8

Appendix B

Derby Children and Young People Plan 2006-08 – Annual Review 2007

Key Challenges: Be Healthy *and* Make a Positive Contribution

- Giving confidence to young people in reducing risk, including teenage pregnancy and substance misuse

Be Healthy [page 11 extracts]

Health Led Parenting Project. This supports the targeting of our 100 most vulnerable parents and will operate across five wards with highest deprivation factors. This work will also directly support strategic work to reduce teenage pregnancies.

There has been an overall reduction of 14.1% in the teenage pregnancy rate since the 1998 baseline with particular success in the Derwent area of Derby, but the target of a reduction by 55% by 2010 remains challenging. There are some excellent partnership projects such as Angels and Spacemen, targeting girls and boys and young men respectively. Early indications from the latest 2006 data show a more positive reduction in the under-18 conception rate. The partnership has commissioned a strategic review if its Teenage Pregnancy Strategy and delivery structure.

Achievements April 2006 – March 2007 and new activity [page 14 etc extracts]

BH6.1 Increase in capacity of multi-agency sex and relationship training:

- In 2005 the number of conceptions to under18s was 248. Provisional under 18 conception rate for 2005 shows a 14.1% fall from the 1998 rate of 63.8 per 1,000 (15-17 year old females) this is little change form 204. Final data for 2005 available autumn 2007
- Latest 2006 Quarter One data shows early indications of a more positive reduction in the under 18 conception rate.
- Three multi agency Delay training courses delivered.

BH6.2 Increase access to sexual health services:

- Sexual health services provided, additional funded outreach projects for advice, information and support. Angels (girls group), Time for Girls Extra and Spacemen (information services for boys and young men)

BH6.3 Development of sex and relationship education and sexual health services with training providers and college.

- Derby College Students Union theme days on SRE. SRE drop in sessions for boys and young men at the College.

- Young Person's Substance Misuse Coordinator, Teenage Pregnancy Coordinator and Derby College have together set up "Healthy Bytes", web-based "pop-up" health messages.

Specific and measurable targets: 2007 – 2008

BH6.1 Increase in capacity of multi-agency sex and relationship training:

- Three Delay trainers trained by December 2007
- Deliver eight multi-agency Delay training course by 31 March 2008
- Complete strategic review of Teenager Pregnancy Strategy and implement outcomes

BH6.2 Increase access to sexual health services:

- Consultation with young people in hotspot areas
- Finalise the PCT sexual health commissioning structure
- Consultation with all secondary schools heads on development of extended services

BH6.3 Development of sex and relationship education and sexual health services with training providers and college

- Multi-agency meeting with Derby College to strengthen strategic commitment to PHSE work August 2007
- Healthy Bytes pilot held April-June 2007

New key action for 2007-08

BH6.4 Provide Delay training for parents, carers and corporate parents through the Respect Parenting bid. [To] provide 12 targeted Delay training sessions.

Appendix C

Other issues identified for further investigation

The contribution of local services to the access and effectiveness of sexual health services for children and young people, including teenage pregnancy support

60. The contribution of local services to the access and effectiveness of sexual health services for children and young people, including teenage pregnancy support is adequate.

Major strengths	Important weaknesses
The good range of initiatives to reduce teenage pregnancy and promote sexual health. Good interagency and service user collaboration in this area.	The rates of teenage pregnancy which remain above the statistical neighbour and England averages. Limited formal evaluation and measurement of impact and outcome of projects.

61. Despite some recent improvement, in the under 18 conception rate, the city remains above the averages nationally and for statistical neighbours. The authority recognises this and has worked with its partners to produce a good range of initiatives to tackle the situation. However, the impact of these is unclear, either because they have only recently been introduced or because of insufficient rigour in evaluating their effectiveness.

62. In August 2007, a strategic review of the teenage pregnancy partnership was completed. The plan was reviewed and refocused, taking account of the views of young people. The commissioning structures at all organisational levels, and in partner agencies, have been strengthened and there is now clear accountability to the Children's Trust Board. Dedicated health posts have been established to improve work in this area. These include a clinical nurse specialist post for abortions and a number of community matrons. The impact of their work has not yet been evaluated.

63. Good work is being undertaken by both the family nurse partnership practitioners and youth workers in educating young people about safe sexual health behaviours. Evaluations of case histories show that this is having a positive effect on the lives of individuals. Other initiatives include: SPACEMAN, a boys and young men's sexual health project; the Angels project for girls; and Delay training, focused on preventing teenage pregnancies and promoting good sexual health. These have proved popular with young people. In 2006-07, for example, over 200 young men from across the city attended

SPACEMAN sessions. However, these projects have not been fully evaluated to show whether they are having any impact on reducing teenage pregnancy rates or reducing risky sexual activity.

64. Young people have a choice of different facilities and venues where they can obtain sexual health advice and contraception, including the emergency contraceptive pill which school nurses can administer under a patient group directive. Young people interviewed reported that they welcomed the services on offer, especially the school nurse drop-in sessions, and felt less intimidated using these than when attending traditional clinics.

65. Regional rates for chlamydia increased from 71.3 per 100,000 in 2004 to 80.7 in 2005. A dedicated chlamydia screening co-ordinator has been employed to implement the national screening programme. This involves a range of innovative approaches aimed at increasing the screening rates for under-25 year olds. Uptake of this pilot programme is monitored by the Health Protection Agency.

66. The Healthy Schools initiative, in which the partnership has achieved Beacon status, includes provision for relationship and sexual health education. Because of the success of work in this area, further funding has been secured for the 'body image' project in targeted schools for Year 6 pupils. This is designed to improve young people's feelings of self-worth. The theatre in education sessions, used to support personal health and relationship education amongst Year 10 pupils, have proved very successful. The evaluation of the specific sexual health plays by 144 pupils showed that they felt more able to resist peer pressure to have a sexual relationship and were more aware of how they could obtain contraceptive advice. The greatest impact was amongst girls.

67. Other strategies to educate young people about sexual health risks and teenage pregnancy have included involving them in the production of a DVD on the subject. No boys were prepared to take part and attempts to find male actors were unsuccessful. However, young men's experiences were used in the script writing. The effect that this may have on the effectiveness of the DVD, when used for professional training and to educate young men, has not been assessed as it has only recently been launched and its impact has not yet been evaluated.

68. The education welfare integration officer provides good support for school-age parents to be and their families and remains in contact with them after the baby is born. This officer enables the young women to continue with their education and gain access to a range of on-going support through good referral processes with other partner agencies

69. Derby City was one of 10 successful authorities to bid for the national pilot of the family nurse partnership project. The aim of the project is to improve the health and well-being of the most disadvantaged families and children and prevent social exclusion. The programme has successfully

recruited 100 first-time mothers under the age of 24, many being teenage parents. This is a two-year programme and will be externally evaluated. Early feedback from those involved with the project is positive, with some mothers having the confidence to return to education or employment while successfully caring for their babies.

70. Derby College, in partnership with the Drug and Alcohol Team, has introduced an electronic health messaging system for young people, called 'health bytes'. This system is a series of planned 'pop up' boxes, which appear when a young person uses a college-based computer terminal. The messages include advice on safe sex, contraception and alcohol reduction. There has been no evaluation of the impact of this approach. The college has recently secured funding for a dedicated college nurse who will focus on promoting good sexual health practices.

71. A sexual exploitation strategy has recently been launched. Since 1998, Derby City has had a specialist child sexual abuse unit. The service works closely with other agencies such as Safe and Sound, which supports young people under 19 years old who are at risk of, or are being, sexually exploited. The individual service user evaluations show that it is rated highly and felt to be effective. However, there has been no authority-wide evaluation of the impact this service is having on the population it serves.

Appendix D

Discussion with Alison Poxon, Project Manager, Lincolnshire County Council

Contacted by phone as Lincolnshire had been identified by Sue Jablonskas, GOEM, as successful in reducing TP numbers through a team approach.

The team comprises one:

- full time project manager, PM
- full time Secretary whose role includes administrating the C scheme
- project manager for preventative services
- Project Leader post which includes media and communications, consultation and campaigning
- health manager post providing support for teenage parents
- health worker for yp's in residential care in order to promote holistic health (currently 13 hours but funded for full time)

The latter post is because LCC operates 5 residential children's homes whose residents are seen as particularly vulnerable. After these the next priorities would be ranked as: LAC in foster care, clients of the Youth Offending Service, permanently excluded school children and then those temporarily excluded.

The team came about gradually, starting with a requirement in 2000 to have a dedicated TP co-ordinator plus secretarial/admin.

A needs based assessment identified there needed to be frontline engagement over the issues. Campaigning included the PM starting a newsletter and building up promotional materials.

The PM was able to fund prevention work through NRF money, as Lincoln has some of the highest deprivation wards in the country and is a high conception area. Lincoln was the pilot area for the C-Card condom scheme, which includes one-to-one work with young people to talk about sexual health and delay and giving free condoms as appropriate.

The C-Card was expanded to include free pregnancy testing and made available across Lincolnshire in all 13 Connexions centres, in the full-time and part-time youth centres and in the public libraries. Provision has also been made for young people excluded from school, in residential housing projects for 16/17 year olds using floating support. The Scheme will expand to include Chlamydia screening funded through Choosing Health money. Choosing Health funding (from the Primary Care Trust) also funds the Pharmacy Emergency Hormonal Contraceptive Scheme where pharmacists give out the morning after pill to young women under-20 free of charge. A project has also been developed to work with schools to develop school accessible health services alongside school nurses, youth workers etc. Some schools are opting to have services on site, others are arranging links with their local GP

surgery or local Health Centre. One Lincoln school has already seen, over a 6 month period, a reduction in their teenage pregnancies. Another aim of the project is to improve school attendance and attainment through improved health outcomes for young people. The project also involves the development of a multi-agency health team including school nurse, youth worker, pastoral staff, heads of years, drugs worker. They meet twice per term. This model is developing countywide in targeted schools in high conception areas. An example of a health issue which has arisen at a multi agency meeting was a group of young women were visiting older men, thought to be trading sex for cigarettes. Work was done with the young women on self esteem and self confidence and this decreased the visits to the men. A Connexions adviser and school nurse were involved in delivering this. Emotional intelligence work has been undertaken with young men. Alison's team encourage schools to work in targeted ways to avoid duplicated effort and unnecessary expense.

The Secretary's post and Prevention Project Manager is now 50% funded by the PCT through Choosing Health.

The health manager's post was created because it became apparent there was a need for a professional who could advise professionals working with teenage parents on how to link teenagers who are pregnant to the appropriate services. This role is funded on a 50%/50% basis by Connexions and the LCC. A specific development has been ante-natal courses for this age group. A personal adviser delivers accredited courses for young parents to help NEET targets.