Teenage Pregnancy
(including health and well being for young families)

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Executive Summary

Teenage pregnancy can be both a cause and a consequence of social exclusion and is more common in areas of deprivation. The poorer outcomes associated with teenage motherhood also mean the effects of deprivation and social exclusion are passed from one generation to the next.

Evidence clearly shows that having children at a young age can damage young women's health and emotional well-being, and severely limit their education and career prospects, resulting in increased levels of poverty and social exclusion. Research shows that children born to teenagers are more likely to experience a range of negative outcomes in later life, and are up to three times more likely to become a teenage parent themselves. Most young parents do not regret having their children but wish they had waited until they were older.

The challenge for Nottinghamshire, therefore, is to provide young people with the means to avoid early pregnancy, but also to tackle the underlying circumstances that motivate young people to want to, or lead them passively to become pregnant or young parents at a young age.

Full JSNA report

What do we know?

1. Who is at risk and why?

At risk groups

The risk factors identified below are not exhaustive but reflect factors that may be able to identify among its population of young people. Factors associated with high Teenage Conception rates[1] are as follows:

Risk factor	National Evidence
Risky Behaviours	
Early onset of sexual activity	• Girls having sex under-16 are three times more likely to become pregnant than those who first have sex over 16[2]. • Around 60% of boys and 47% of girls leaving school at 16 with no qualifications had sex before 16, compared with around 20% for both males and leaving school at 17 or over with qualifications. • Early onset of sexual activity is also associated with some ethnic groups (see below)
Poor contraceptive use	• Around a quarter of boys and a third of girls who left school at 16 with no qualifications did not use contraception at first sex, compared to only 6% of boys and 8% girls who left school at 17 or over, with qualifications. • Survey data demonstrate variations in contraceptive use by ethnicity. Among 16-18 year olds surveyed in London, non-use of contraception at first intercourse was most frequently reported among Black African males (32%), Asian females (25%), Black African females (24%) and Black Caribbean males (23%)[3].
Mental health /conduct disorder/ involvement in crime	• A number of studies have suggested a link between mental health problems and teenage pregnancy. A study of young women with conduct disorders showed that a third became pregnant before the age of 17[4]. • Teenage boys and girls who had been in trouble with the police were twice as likely to become a teenage parent, compared to those who had no contact with the police, very much linked to their risk taking behaviours[5].
Alcohol and substance misuse	• Research among south London teenagers found regular smoking, drinking and experimenting with drugs increased the risk of starting sex under-16 for

[1] Department for Children, Schools and Families (2007) *Teenage Pregnancy: Working Towards 2010 – Good practice and self-assessment toolkit*

[2] Wellings K, et al (2001) *Sexual Health in Britain: early heterosexual experience.* The Lancet vol.358: p1834-1850

[3] Testa A and Coleman L (2006) *Sexual Health Knowledge, Attitudes and Behaviours among Black and Minority Ethnic Youth in London.* Trust for the Study of Adolescence and Naz Project London

[4] Maskey S, (1991) *Teenage Pregnancy: doubts, uncertainties and psychiatric disorders* Journal of Royal Society of Medicine

[5] Hobcraft J (1998) *Intergenerational and life-course transmission of social exclusion: Influences of childhood poverty, family disruption and contact with the police.* CASE paper 15, LSE

	both young men and women. • A study in Rochdale showed that 20% of white young women report going further sexually than intended because they were drunk[6]. Other studies have found teenagers who report having sex under the influence of alcohol are less likely to use contraception and more likely to regret the experience[7].
Teenage motherhood	• A significant proportion of teenage mothers have more than one child when still a teenager. Around 20% of births conceived under-18 are second or subsequent births.
Repeat abortions	• Around 7.5% of abortions under-18 follow either a previous abortion or pregnancy. Within London this proportion increases to around 12% of under-18 abortions
Education-related factors	
Low educational attainment	• The likelihood of teenage pregnancy is far higher among those with poor educational attainment, even after adjusting for the effects of deprivation. On average, deprived wards with poor levels of educational attainment had an under-18 conception rate double that found in similarly deprived wards with better levels of educational attainment. (80 per 1000 girls aged 15-17 compared with 40 per 1000)
Dis-engagement from school	• A survey of teenage mothers showed that disengagement from education often occurred prior to pregnancy, with less than half attending school regularly at the point of conception. Dislike of school was also shown to have a strong effect on the risk of teenage pregnancy[8]. • Poor attendance at school is also associated with higher teenage pregnancy rates. Among the most deprived 20% of local authorities, areas with more than 8% of half days missed had, on average, an under-18 conception rate 30% higher than areas where less than 8% of half days were missed.
Leaving school at 16 with no qualifications	• Overall, nearly 40% of teenage mothers leave school with no qualifications[9]. • Among girls leaving school at 16 with no qualifications, 29% will have a birth under 18, and 12% an abortion under 18, compared with 1% and 4% respectively for girls leaving at 17 or over. • Leaving school at 16 is also associated with having sex under 16 and with poor contraceptive use at first sex (see below).
Family / Background factors	
Living in Care	• Research has shown that by the age of 20 a quarter of children who had been in care were young parents[10]. • The prevalence of teenage motherhood among looked after girls under-18 is around three times higher than the prevalence among all girls under-18 in England.
Daughter of a	• Research findings from the 1970 British Birth Cohort dataset showed being

[6] Redgrave K, Limmer M (2005) *'It makes you more up for it'. School aged young people's perspectives on alcohol and sexual health.* Rochdale Teenage Pregnancy Strategy: Rochdale
[7] Alcohol Concern (2002) *Alcohol & Teenage Pregnancy.* London: Alcohol Concern
[8] Hosie A, Dawson N (2005) *The Education of Pregnant Young Women and Young Mothers in England.* Bristol: University of Newcastle and University of Bristol
[9] National Statistics (2004) *Census 2001 table: C0069 Mothers under 19 at birth* (Commissioned by Teenage Pregnancy Unit, DfES)
[10] Barn R, Andrew L, Mantovani N (2005) *Life after care: the experiences of young people from different ethnic groups* Joseph Rowntree Foundation, London

teenage mother	the daughter of a teenage mother was the strongest predictor of teenage motherhood.
Ethnicity	• Data on mothers giving birth under age 19, identified from the 2001 Census, show rates of teenage motherhood are significantly higher among mothers of 'Mixed White and Black Caribbean', 'Other Black' and 'Black Caribbean' ethnicity. 'White British' mothers are also over-represented among teenage mothers, while all Asian ethnic groups are under-represented[11] • A survey of adolescents in East London showed the proportion having first sex under-16 was far higher among Black Caribbean men (56%), compared with 30% for Black African, 28% for White and 11% for Indian and Pakistani men. For women, 30% of both White and Black Caribbean groups had sex under-16, compared with 12% for Black African, and less than 3% for Indian and Pakistani women. • Poor contraceptive use has also been reported for some ethnic groups
Parental aspirations	• Research shows that a mother with low educational aspirations for her daughter at age 10 is an important predictor of teenage motherhood.

The impact on health and wellbeing

Evidence shows that having children at a young age can damage young women's health and wellbeing and severely limit their education and career prospects. Research shows that children born to teenagers are more likely to experience a range of negative outcomes in later life, and are up to three times more likely to become a teenage parent themselves.

Poverty

- At age 30, teenage mothers are 22% more likely to be living in poverty than mothers giving birth aged 24 or over, and are much less likely to be employed or living with a partner.
- Children of teenage mothers have a 63% increased risk of being born into poverty compared to babies born to mothers in their twenties and are more likely to have accidents and behavioural problems.

Education and Aspiration

- Teenage mothers are 20% more likely to have no qualifications at age 30 than mothers giving birth at 24 years or over.
- 70% of teenage mothers are not in education, training or employment.
- Children of teenage mothers are at increased risk of lower educational attainment and have lower economic activity in adult life.

Poor Health Outcomes

- Teenage mothers are three times more likely to get post-natal depression than older mothers; they are at a higher risk of poor mental health for three

[11] Viner R, Roberts H (2004) *Starting sex in East London: protective and risk factors for early sexual activity and contraception use amongst Black and Minority Ethnicity adolescents in East London* University College London, City University and Queen Mary, University of London

years after the birth, three times more likely to smoke during pregnancy than mothers over 30; and one third less likely to breastfeed. All of which have a negative impact on the child.

- The infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers aged 20-39.
- Teenage mothers, young fathers and their children are more likely to be in poor health and to live in poor housing.

There is also a strong economic argument for investing in measures to reduce teenage pregnancy as it places significant burdens on the NHS and wider public services. The cost of teenage pregnancy to the NHS alone is estimated to be £69m a year. Teenage mothers will also be more likely than older mothers to require expensive support from a range of local services.

Rates of teenage pregnancy are higher among communities affected by deprivation and poverty and are higher where educational attainment is lower. The poorer outcomes associated with teenage motherhood also mean the effects of deprivation and social exclusion are passed from one generation to the next. Teenage mothers and their children are less likely to do as well as their peers.

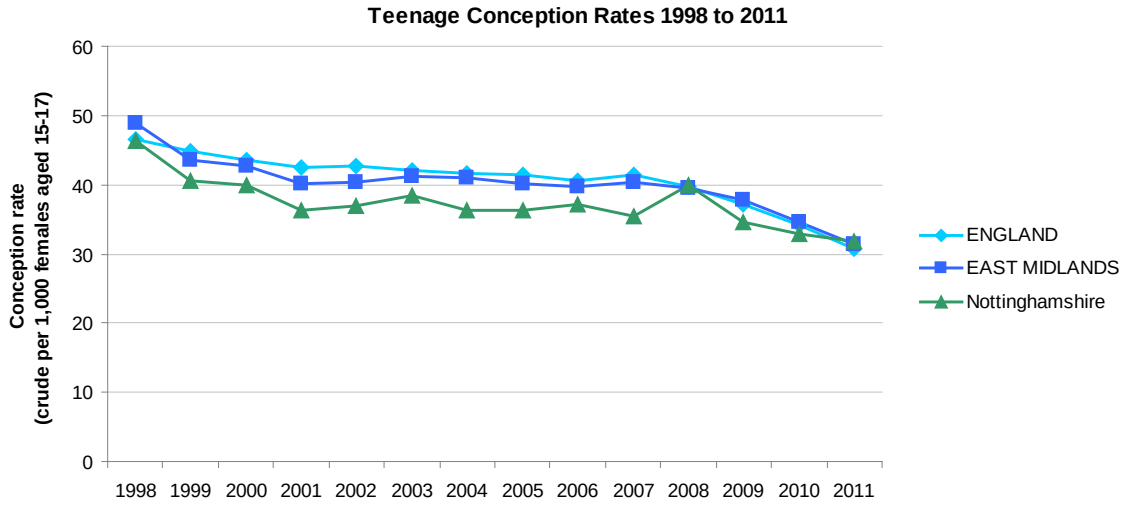
2. The size of the issue locally

Teenage Conceptions

Nottinghamshire historically has achieved well in reducing teenage conceptions, comparing well with statistical neighbours and across the region. The teenage conception rate is calculated by identifying the number of conceptions per 1,000 females aged 15-17 in an area. Conception data also includes those that resulted in a termination of pregnancy but does not include miscarriages. Under 16 conception data is also provided but is not used to assess progress nationally.

Teenage conception data is measured annually and this annual teenage conception rate for under 18's has been the main target for teenage pregnancy strategies and Children's Trust partnerships. The latest annual data published is for 2011.

Figure 1: Teenage Conception Rates 1998-2011 for Nottinghamshire, England and the East Midlands

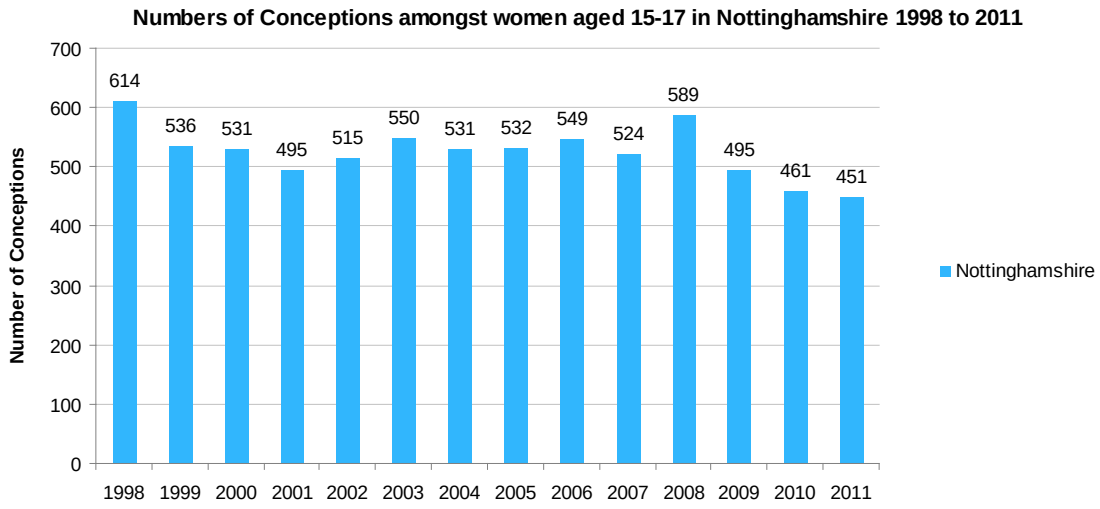


Source ONS 2013

The 2011 under 18 conception rate for Nottinghamshire was 31.9 per 1000 females aged 15-17 – a decrease from the 2009 rate of 32.9 per 1000, and a decrease in rates of 31.25% since the 1998 baseline year.

It is however useful to see how the numbers of conceptions rather than just the rate, the graph below shows the reduction in the numbers of conceptions from the 1998 baseline year to 2011, reducing the numbers of teenage conceptions by 163 conceptions.

Figure 2: Numbers of teenage conceptions Nottinghamshire 1998-2011



Source ONS 2013

Nationally it is estimated that 20% of all teenage conceptions are repeat conceptions - local data can be a challenge to source.

Termination of Pregnancy

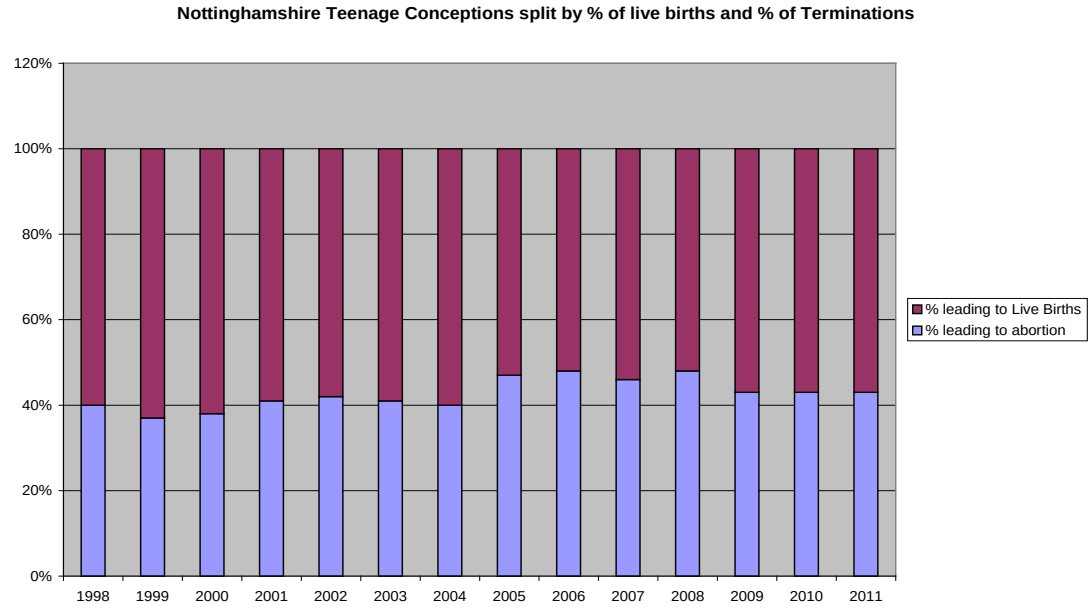
In 2011 42.6% of all teenage conceptions resulted in a Termination of Pregnancy (ToP) across Nottinghamshire. This can be compared with national statistics on the proportion accessing a ToP which stood at 49.3% for England and 43.6% for the East Midlands. The proportion of young women accessing a termination varies depending on a number of factors including, a young woman's aspirations, access and knowledge to appropriate services, early identification of pregnancy and ease of access to services.

Figure 5: Proportion of Teenage Conceptions resulting in a Termination 1998-2011 in Nottinghamshire

Nottinghamshire County	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
u18 conception numbers	614	536	531	495	515	550	531	532	549	524	588	495	461	451
% leading to abortion	*40%*	*37%*	*38%*	*41%*	*42%*	*41%*	*40%*	*47%*	*48%*	*46%*	*48%*	*43%*	*45%*	*43%*

Source ONS 2013

Figure 6: Proportion of Teenage Conceptions resulting in a live birth or termination across Nottinghamshire 1998-2011



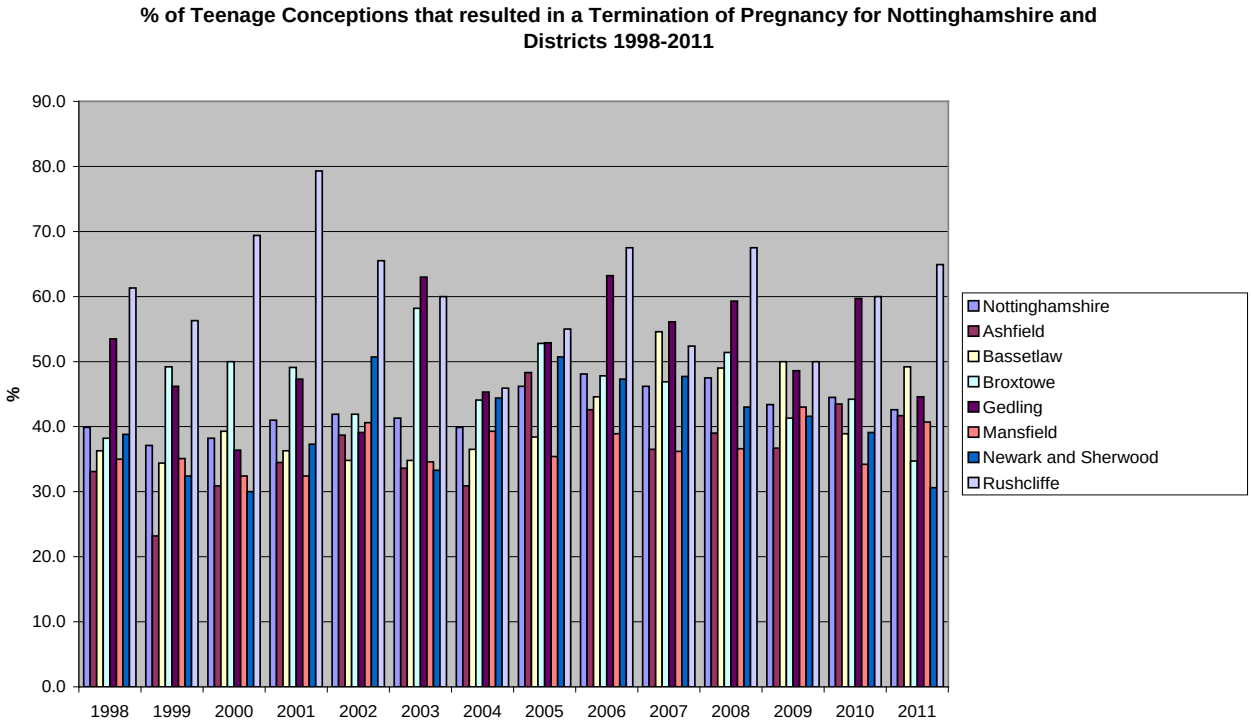
Source ONS 2013

Over time the proportion of teenagers who choose to terminate a pregnancy has remained fairly static for Nottinghamshire as a whole. The picture however is different for districts as can be seen in figure 7.

The proportion of teenage abortions varies across areas, Rushcliffe and Gedling districts having a higher proportion than Mansfield and Bassetlaw. The choice to terminate a pregnancy is strongly associated with the level of aspiration of a

young woman, to continue with a pregnancy is often seen as a positive choice for young women will poor educational attainment and no future career plans. Young women living in areas of greatest deprivation and lowest educational attainment are more likely to continue with a pregnancy rather than terminate.

Figure 7: Teenage conceptions leading to termination of pregnancy: % of under 18 conceptions for Nottinghamshire and districts 1998-2011



Source ONS 2013

Data also identifies the proportion of young women under the age of 19 who have repeat abortions. In 2010, 8% of young women within the old NHS Nottinghamshire County PCT boundary (excluding Bassetlaw) had repeat abortions compared with 11% for England and 9% for the East Midlands[12]. Data for Bassetlaw was not made available by the Office of National Statistics (ONS).

[12] ONS (2011) Repeat abortions to women aged under 19, by PCT of residence, England, 2010

District Level Teenage Conception Data

Teenage conception data varies across Nottinghamshire's districts as can be seen in the table below. Mansfield has the highest conception rate across Nottinghamshire closely followed by Ashfield.

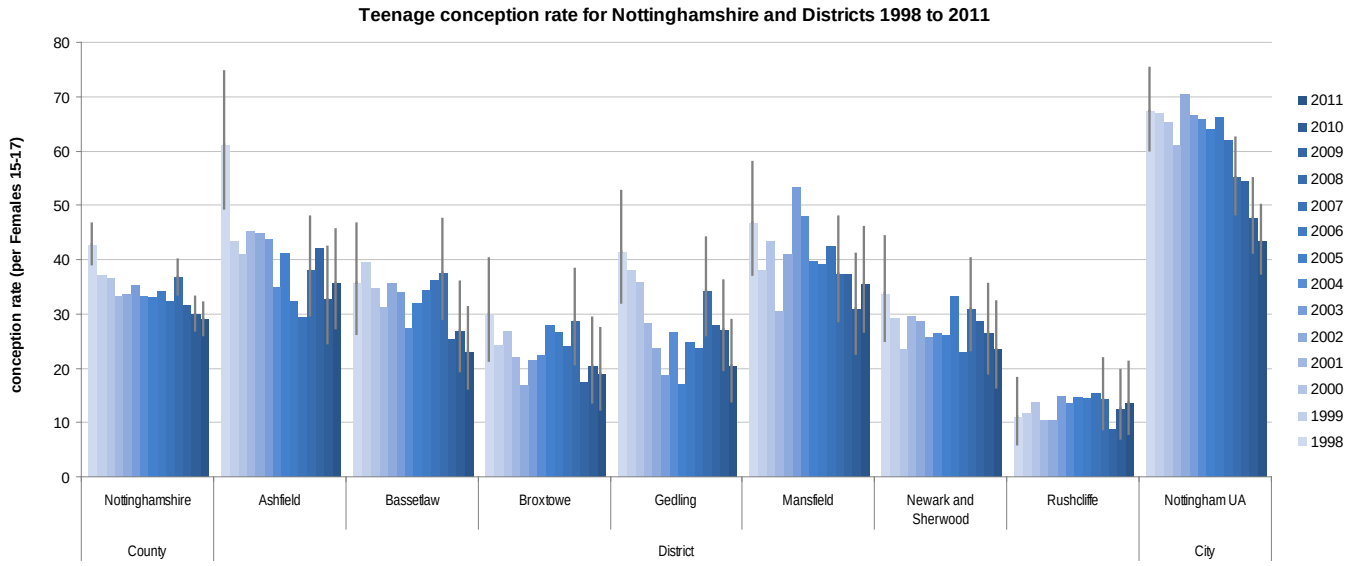
Figure 8: 2011 District level teenage conception data for Nottinghamshire and Districts

	Conception Rate (conceptions per 1000 15-17 yr old females)	Reduction since 1998 baseline (%)	No. of conceptions for 15-17 year old females	% leading to abortion
Nottinghamshire	31.9	-31.3	451	42.6
Ashfield	44.1	-39.6	96	41.7
Bassetlaw	29.8	-33.8	65	49.2
Broxtowe	25.7	-33.4	49	34.7
Gedling	27.3	-46.6	56	44.6
Mansfield	44.5	-21.2	86	40.7
Newark and Sherwood	30.8	-27.7	62	30.6
Rushcliffe	19.5	18.2	37	64.9

Source ONS 2013

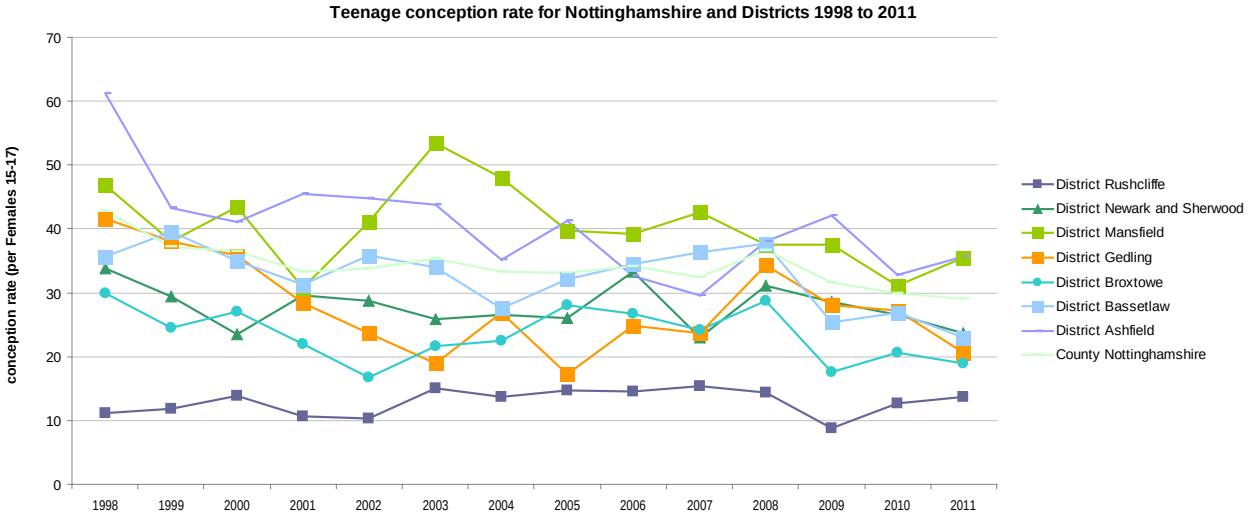
It is also important to assess the progress of reducing teenage conceptions across districts. No district has seen a consistent downward trend since the launch of the Nottinghamshire Teenage Pregnancy Strategy. Rates are starting to increase in Ashfield, Mansfield and Rushcliffe but rates do fluctuate over time as can be seen below.

Figure 9A: Nottinghamshire Under 18 conception rate: Change in rates over time 1998-2011: District level



Source: HSCIC (ONS, DfE)

Figure 9B: Nottinghamshire Under 18 conception rate: Change in rates over time 1998-2011: District level



Hot Spot Wards across Nottinghamshire

The wards listed below are included in the 20% of wards in England with the highest teenage conception rates (in 2009-11 this stands at 46.6 conceptions per 1,000 women aged 15-17). Please note that the population estimates used as the denominator in these rate calculations are estimates of the population of 15-17 year old females by ward, aggregated over a 3 year period. Some wards have smaller populations of women in this age group; rates for these wards fluctuate from year to year and the area may not be one with a *consistent* high incidence of teen pregnancy.

It is important to note, that as teenage conception rates reduce overall across England, a larger number of wards within Nottinghamshire have been identified as hot spots compared to 2008-10.

Figure 10: Nottinghamshire Wards with Under 18 conception rates in the top 20% of wards nationally

District	Wards in the top 20% of wards across England 2008-2010 (above 58.4 conceptions per 1,000 15-17 year old females)	Wards in the top 20% of wards across England 2009-2011 (above 46.6 conceptions per 1,000 15-17 year old females)
Ashfield	Hucknall East	Hucknall East
	Kirkby in Ashfield East	Kirkby in Ashfield East
	Kirkby in Ashfield West	Kirkby in Ashfield West
		Sutton in Ashfield Central
		Sutton in Ashfield East
		Sutton in Ashfield North
		Sutton in Ashfield West
		Woodhouse
Bassetlaw	Ranskill	Ranskill
	Worksop South East	Worksop South East
		Worksop North East
		Harworth
		Langold
Broxtowe	Eastwood South	Eastwood South
	Stapleford North	Stapleford North
		Chilwell West
Gedling	Killisick	Killisick
	Valley	Valley
	Netherfield and Colwick	Netherfield and Colwick
	Carlton	Daybrook
Mansfield	Eakring	Eakring
	Portland	Portland
	Ravensdale	Ravensdale
	Sherwood	Sherwood
		Lindhurst
		Pleasley Hill
		Meden
Newark and Sherwood	Bridge	Bridge
	Castle	Castle
	Devon	Devon
		Bilsthorpe
		Edwinstowe
Rushcliffe		Manvers

A map showing teenage conception data by ward is available in Appendix 1.

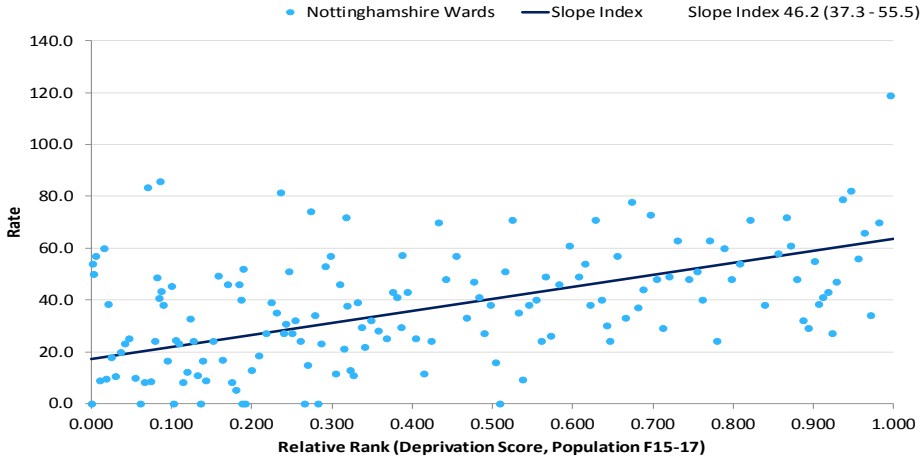
Slope Index of Inequality

The Nottinghamshire Teenage Pregnancy Integrated Commissioning Group aims that over time health inequalities are reduced by lowering teenage conceptions across the whole of Nottinghamshire but to a greater degree in more deprived wards.

Teenage conceptions are strongly associated with levels of deprivation in the population. The relationship between a health issue and deprivation can be quantified using the slope index of inequality (SII) and changes can be monitored over time. The SII takes into account the relative population size and the level of deprivation of each ward in Nottinghamshire. The SII shows the difference in conception rates between the most deprived wards and the least deprived wards.

The Slope Index score for 2008-10 was 46.2 which means that there were 46 more teenage conceptions per 1,000 in the most deprived ward compared to the least deprived ward.

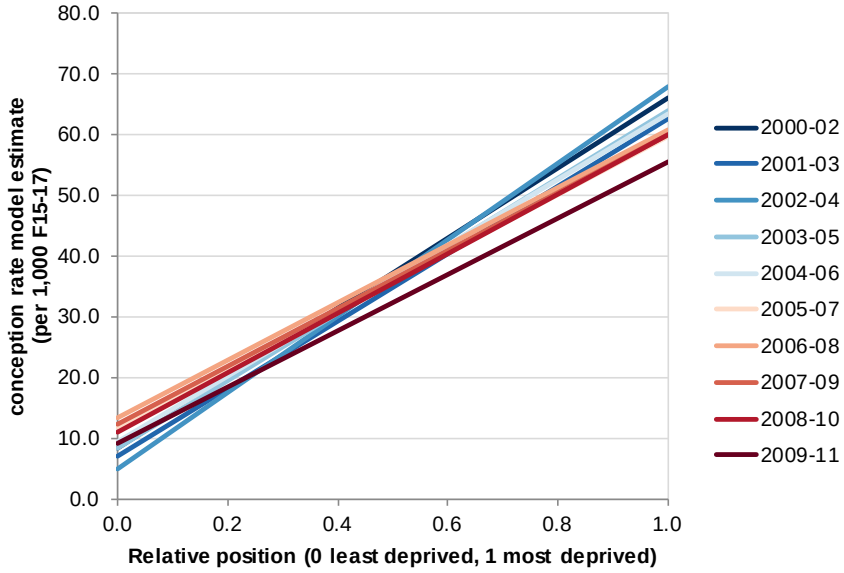
Figure 11: Under 18 conceptions: 2008-10: Slope Index of Inequality (SII)



Source: Secondary analysis of (ONS, DfE, DCLG) data
Note: where a rate has not been made available due to suppression of low counts a rate has been estimated using a random number within the suppression range

Figure 12 shows how the SII (without the wards plotted) has changed over different time periods (2001-03, 2004-06 and 2005-07, 2007-09 2008-10). This shows that the conception rate in the most deprived wards has reduced in 2008-10 from that of 2001-03 (top right end of slope) but the conception rate in the least deprived wards has increased. This implies that health inequalities have reduced slightly but not in the way we would want. The figures below demonstrate that the Slope Index Value has reduced and is going in the right direction, therefore health inequalities are reducing. However, this is mainly due to teenage conception rates in the least deprived area increasing slightly or remaining static rather than because they are reducing in the most deprived areas within the County.

Figure 12: Under 18 conceptions rates: Slope Index of Inequality (SII) change over time



Source: Secondary analysis of ONS Conceptions and Population/DCLG deprivation data)

Under 16 Conceptions

Under 16 conception data is provided on an aggregated basis over three years as numbers are relatively small and this prevents young women from being identified. Under 16 aggregated conception rates for Nottinghamshire increased in 2003-05 and have remained static since 1998.

The aggregated conception rate for under 16s for 2007-09 showed that there were 7.4 conceptions per 1000 females aged under 16. Over a three year period across Nottinghamshire there are approximately 300 conceptions to this age group, it is not known if any of these conceptions are repeat.

Young women under the age of 16 are more likely to have a termination of pregnancy. Over the aggregated period of 2007-09, 60% of all under 16 conceptions resulted in a termination. As with the overall teenage conception rate there is local variation with Rushcliffe and Gedling seeing the highest proportion of under 16s choosing to terminate.

Teenage Parents

When looking at data from Nottinghamshire Futures regarding teenage parents we know that the majority of teenage mothers aged 16-19 years in Nottinghamshire are not participating in education or training. Nottinghamshire Futures has identified that at the end of December 2012, 28.4% (66) of teenage mothers in the academic age years 12-14 cohort were in Education, Employment or Training (EET), 61.6% (106) were Not in Education, Employment or Training (NEET) and the status was not known for 25.9% (60) of teenage mothers. The Cohort in the county was 232.

3. Trends and projections

Using teenage conception data from the last 20 years we can work to predict the teenage conception rates and numbers for the next seven years until 2020.

The table below shows the forecasted conception rate for Nottinghamshire along with forecasts for England and the region. The confidence intervals for Nottinghamshire are shown in brackets after the rate.

Figure 13: Forecasted Under 18 conception rates for Nottinghamshire, East Midlands and England[13]

	Forecasted under-18 conception rate (2015)	Forecasted under-18 conception rate (2020)	Forecasted under-18 conception rate (2025)
Nottinghamshire	32.70 (28.30 - 37.70)	30.70 (26.40 - 35.70)	28.80 (24.50 - 33.80)
East Midlands	33.10	31.50	30.00
England	33.70	32.10	30.60

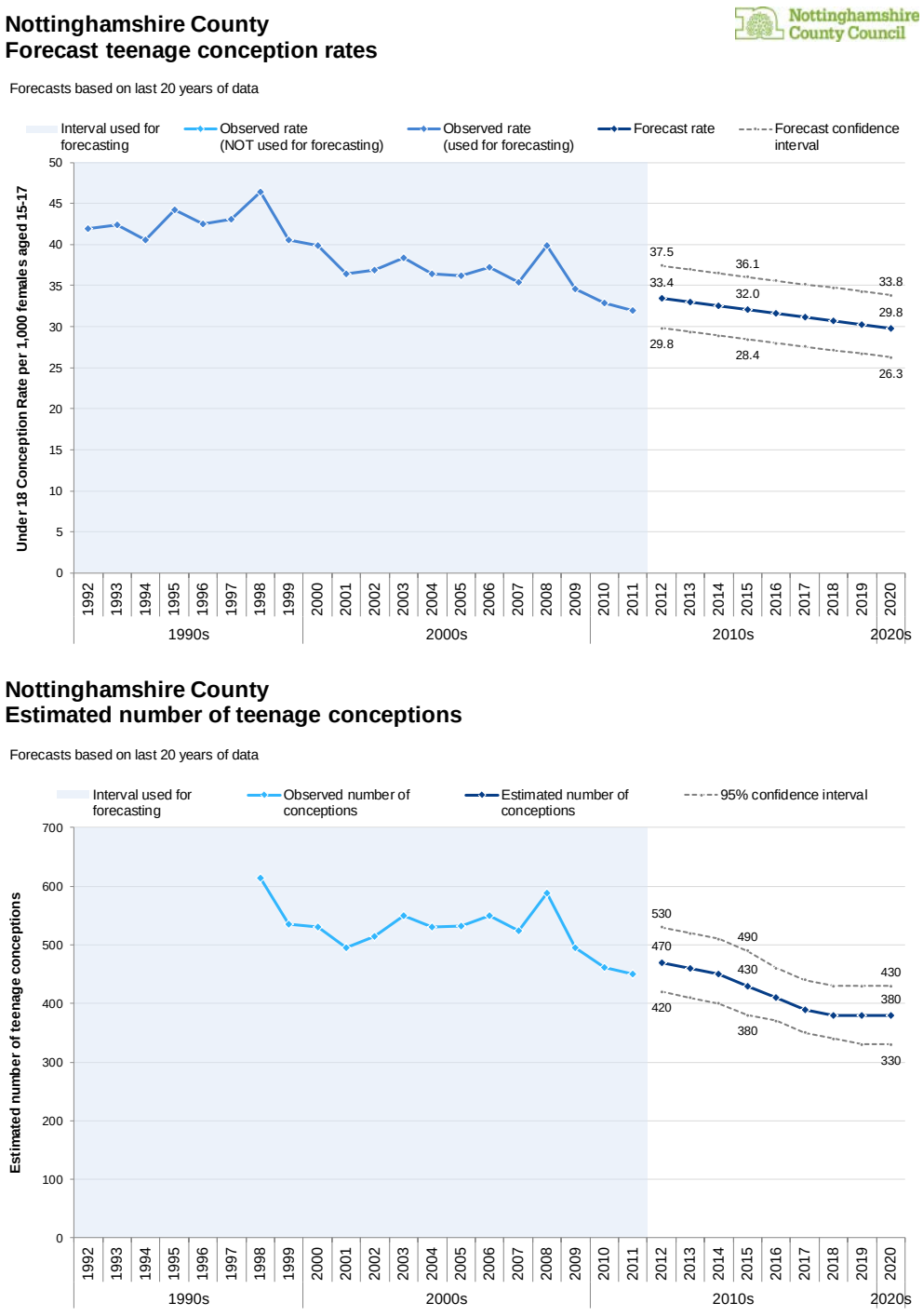
Source: EMPHO 2013

The forecasted rate shows a steady slow decline in teenage conception rates for Nottinghamshire, however experience from the last ten year teenage pregnancy strategy has shown us that fluctuations exist where there are changes in economic status, educational attainment and aspirations. It is also important to remember the high levels of teenage conception in some districts and wards across Nottinghamshire.

The graphs below show the projected teenage conception rate amd numbers for Nottinghamshire to 2020. Both graphs show that teenage conceptions will continue to decline based on the previous performance. However it is important to note that the latest confirmed data available is for 2011 and the economic climate at present may have a detrimental effects on future teenage conceptions.

[13] NHS Atlas of Variation in Healthcare for Children and Young People Service 'Snapshot - Teenage pregnancy Selection: Nottinghamshire Geographies: Top level local authority' sourced 11.2.13 http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=40&geoTypeId=4#iasProfileSection5

Figure 14: Projected teenage conception rates and numbers for Nottinghamshire to 2020



Source: Secondary analysis of ONS conception statistics ForecastPro software and ONS population estimates

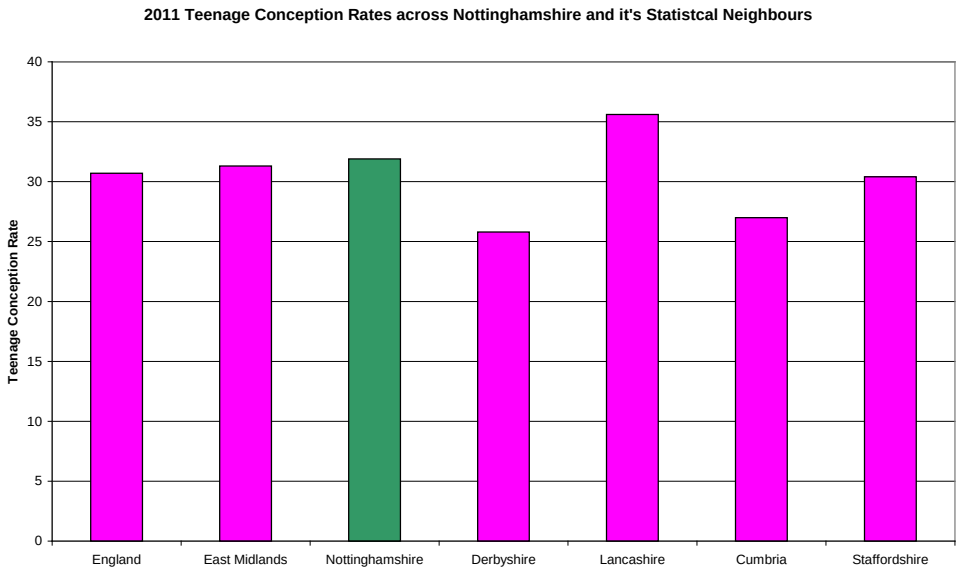
4. How we compare with others

In 2011, Nottinghamshire experienced a slightly higher teenage conception rate (31.9 per 1,000 girls aged 10-17) than both the England average (30.7) and the East Midlands rate (31.3), this is the first time since 1998 where progress nationally and regionally is slightly better than locally. Currently Nottinghamshire's overall reduction of -31.25% against the 1998 base rate no longer compares favourably with a national reduction of -34.12% and the East Midlands reduction of -35.86%.

The Nottinghamshire Teenage Pregnancy Integrated Commissioning Group has not set forward trajectory targets to reduce teenage conceptions but have agreed to compare progress in reducing teenage conceptions against the progress of statistical neighbours. Local Authority Children's Service statistical neighbours are used when comparing teenage conception rates.

In a comparison with four of our statistical neighbours, Nottinghamshire's progress was very positive; however 2011 data indicates that Nottinghamshire's teenage conception rates are the highest across local authorities with the exception of Lancashire.

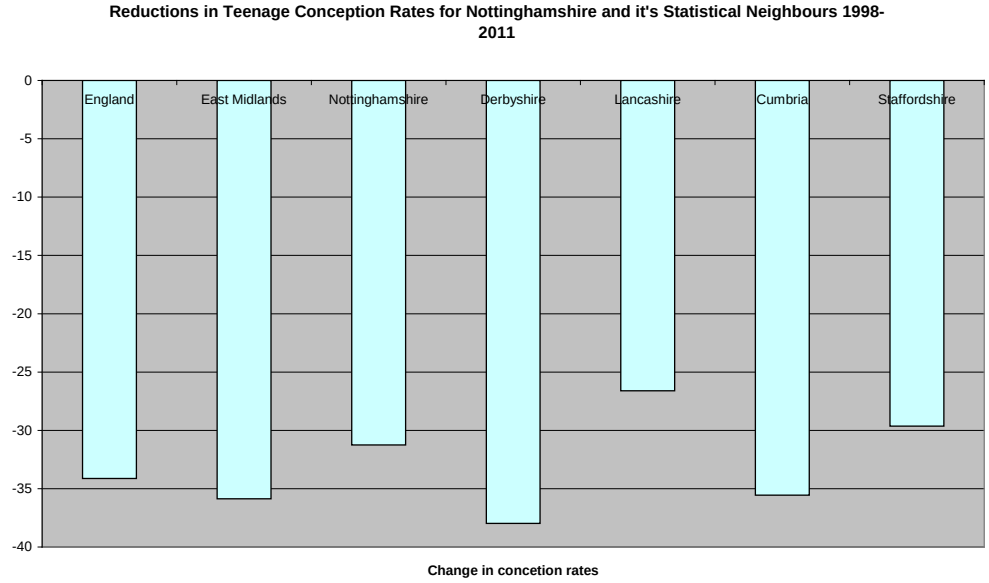
Figure 15: 2011 Teenage Conception Rates for Nottinghamshire and Statistical Neighbours



Source ONS 2013

The graph below indicates that Nottinghamshire's reduction in teenage conception rates from the 1998 baseline year to 2010 is moderate compared to statistical neighbours.

Figure 16: Changes in Teenage Conception Rates for Nottinghamshire and Statistical Neighbours from the baseline year of 1998 to 2011



Source ONS 2013

5. Targets and Performance

Following the national 10 year teenage pregnancy strategy which aimed to reduce teenage conception rates by 50% by 2010, indicators for the reduction of teenage conception remain in the national Public Health Outcomes Framework so Local Authorities will be held to account for performance in reducing teenage conceptions.

The Teenage Pregnancy Integrated Commissioning Strategy includes a detailed action plan with a number of milestones and outcomes to achieve that will contribute to the prevention of teenage conceptions as well as improved outcomes for teenage parents and their children.

6. National and local strategies

Following the ten year National Teenage Pregnancy Strategy there is an established evidence base of what works. The Nottinghamshire Integrated Commissioning Group for teenage pregnancy has prioritised the following activity:

- Effective young people friendly contraception and sexual health service provision which prevents teenage conception and poor sexual health.
- Ensuring Children and Young People have access to information and education about sexual health and relationships.
- Workforce development.
- Improving outcomes for teenage parents and their children.

A detailed integrated commissioning plan is in place which breaks down activity under each priority action. This is available to access from www.nottinghamshire.gov.uk/teenagepregnancy.

7. Current activity and service provision

There are a range of services and interventions available to support the reduction of teenage conception rates and support young parents and their children. These include (as at December 2013):

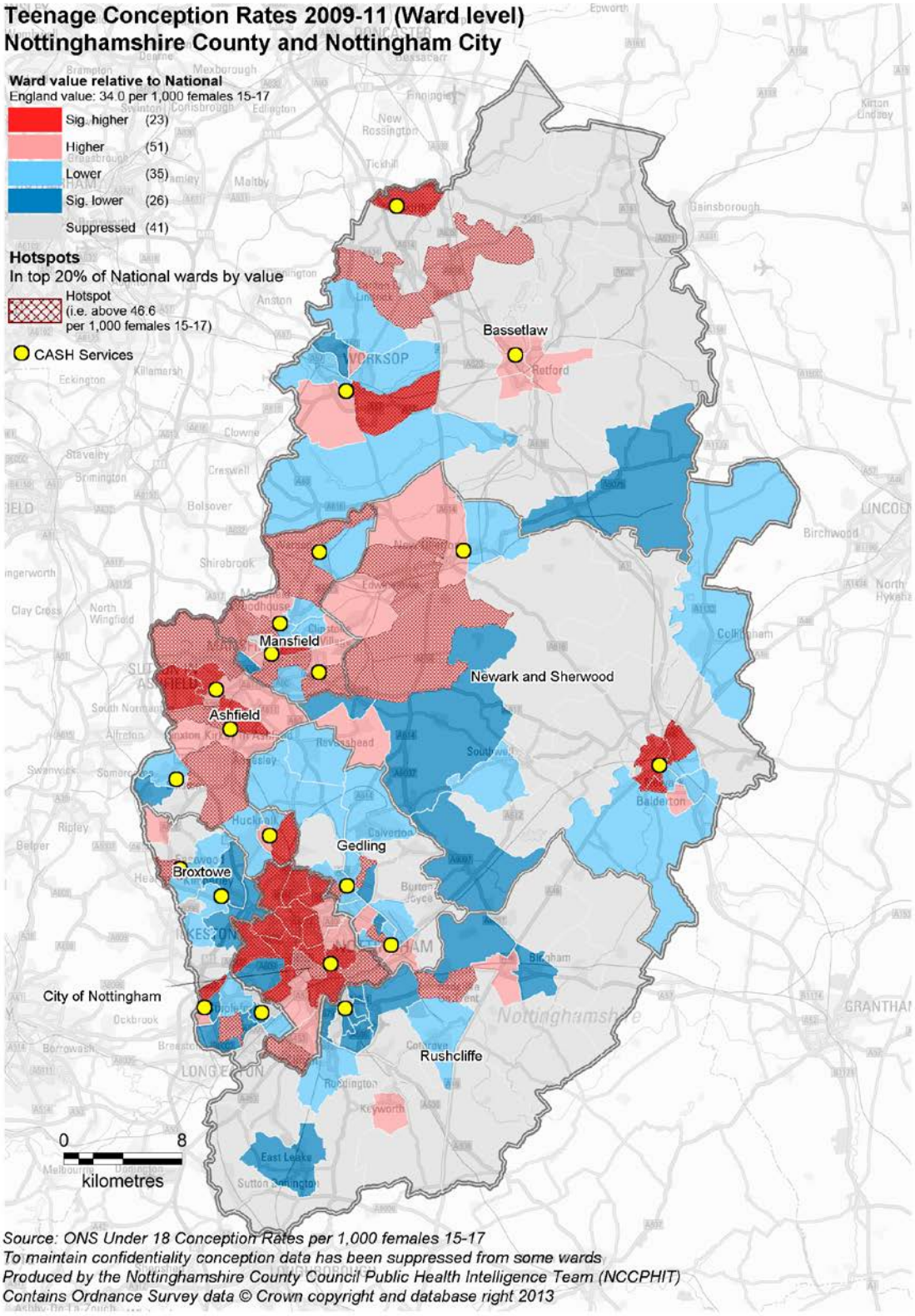
Health Services and Interventions

Contraception and Sexual Health (CaSH) Services offering a range of contraception and advice for young people in a number of localities and settings including West Nottinghamshire College and secondary schools in Bassetlaw. The map below shows the location of all CaSH services with the exception of school based services.

There are 54 different contraceptive clinics available to people of all ages, which provide the full range of contraceptive methods across the county. The majority of these services also provide screening for Chlamydia.

There are 20 clinics specifically targeted at young people across the county. There are higher numbers of specific Children and Young People clinics in the Northern Clinical Commissioning Groups (Mansfield, Ashfield, Newark & Sherwood and Bassetlaw). Bassetlaw offer specific clinics for young people onsite in 5 out of their 6 secondary schools and also provide specific small group work for those children with learning difficulties/challenging behaviour.

Figure 17: Nottinghamshire CaSH overlaid onto teenage conception ward level data for 2008-10

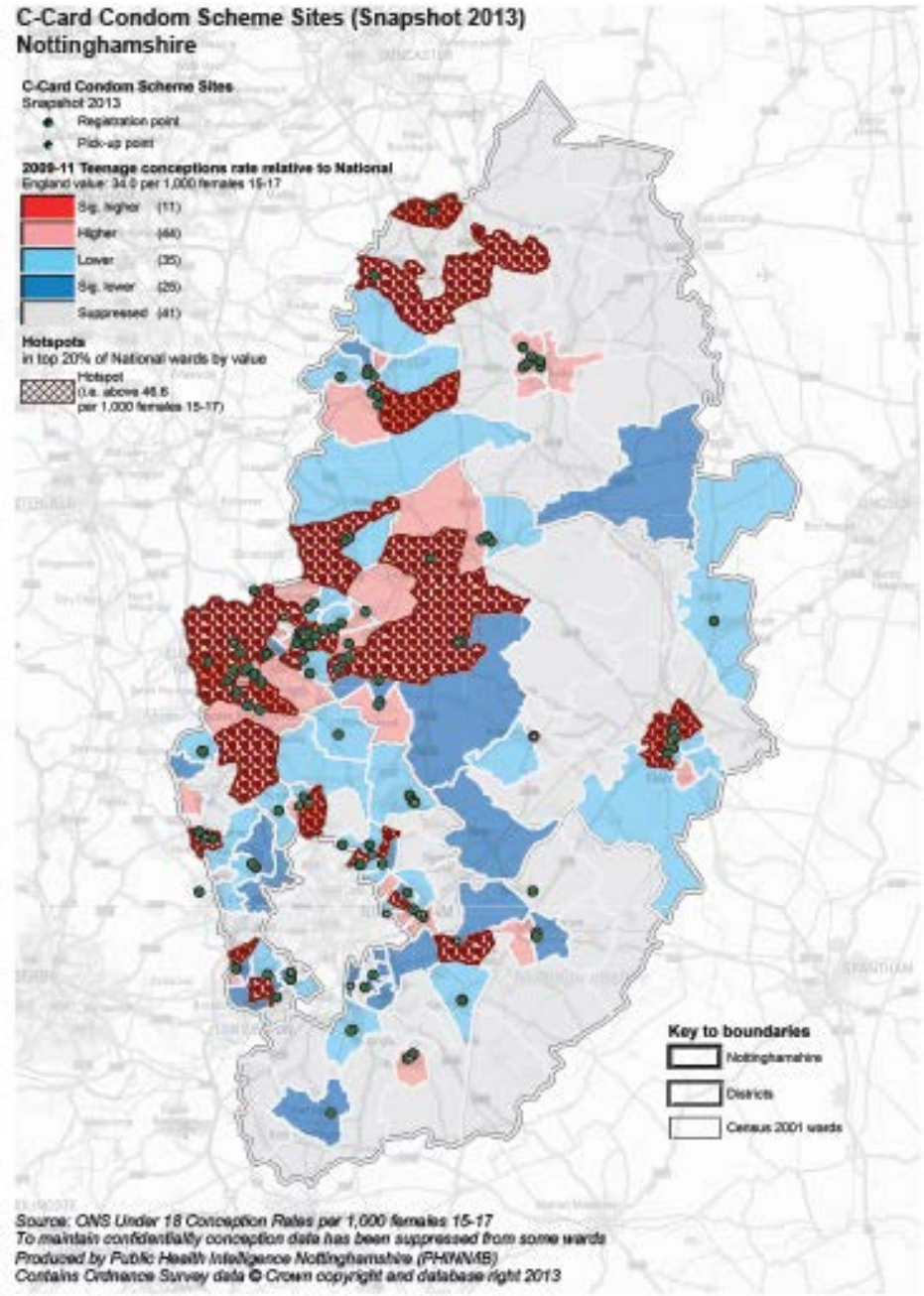


The C-Card Scheme offers condoms and advice to young people under the age of 19 in a wide number of settings including youth clubs, health centres, children's centres etc, there are sites located in teenage pregnancy hot spot wards and settings targeted groups at risk.

The scheme is commissioned by the Local Authority. 13,781 young people aged 13-19 years are registered to use the scheme and the location of C-Card sites is included in the map below. There are targets for the scheme to increase the number of access points across settings in hot spot wards.

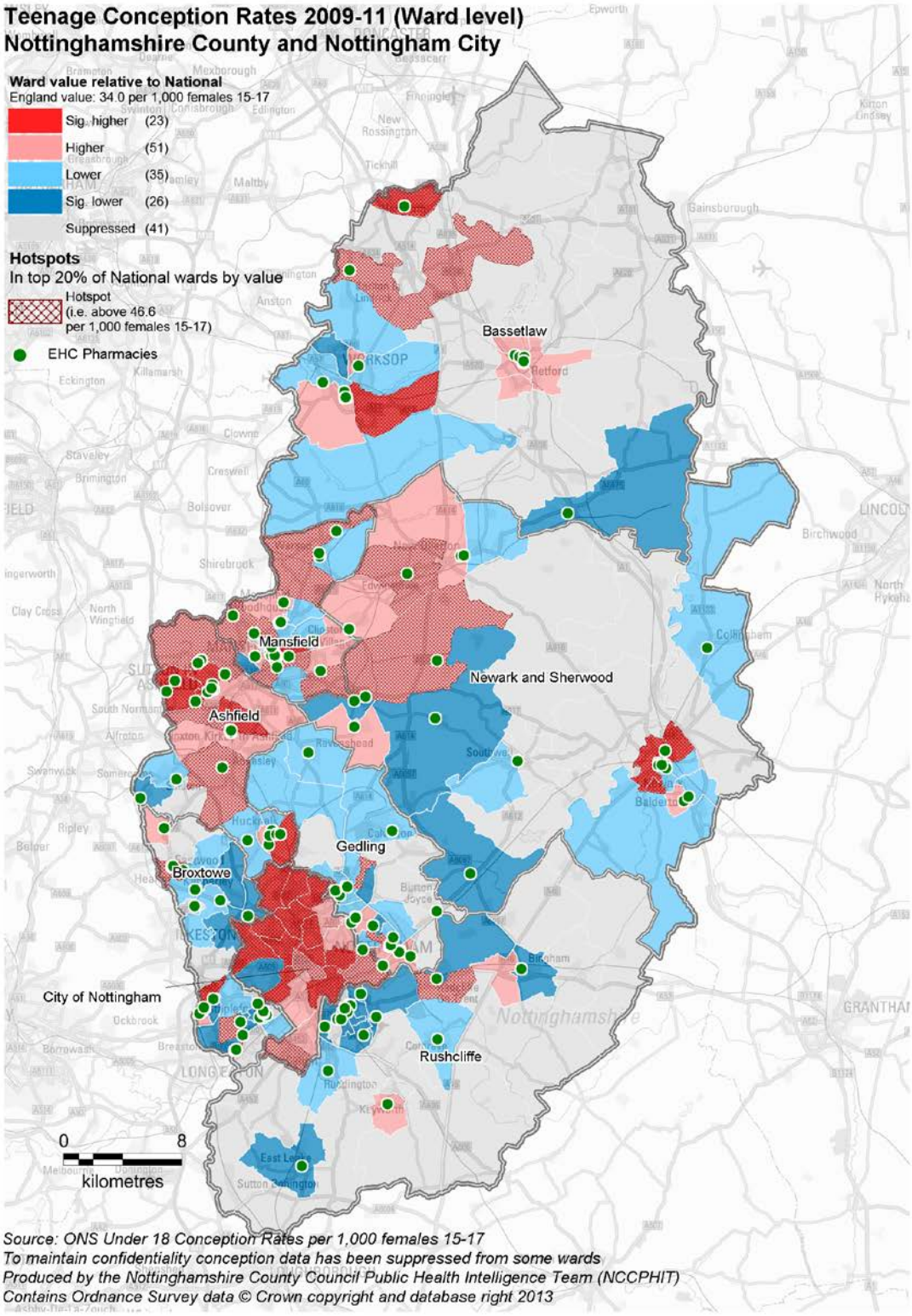
The map below shows there are gaps in the current coverage of the C-Card scheme across targeted localities and further work is being progressed to establish more sites in pharmacists, youth centres, and schools.

Figure 18: Nottinghamshire C-Card sites overlaid onto teenage conception ward level data for 2009-11



Community Pharmacists offer a range of services free to young people including pregnancy testing, the C-Card condom scheme and Emergency Hormonal Contraception (EHC). The location of the pharmacists that offer EHC is included in the map below and plans are under way to encourage more pharmacists to offer the service throughout Nottinghamshire in particular in teenage pregnancy hot spot wards.

Figure 19: Nottinghamshire Community Pharmacists offering EHC to under 19s, overlaid onto teenage conception ward level data for 2008-10



The School Nursing Service offers a range of interventions to young people to support the reduction of unintended teenage conception including the provision of Sex and Relationships Education (SRE) through drop-in sessions in schools, contraception support, signposting to specialist services and one to one support. The service costs just over a million pounds a year and is commissioned by Public Health. Performance data is not yet available for the service so it is impossible currently to assess the impact of how school health teams impact on teenage pregnancy.

Education Services

The Healthy Schools Programme, also delivered by school nurses, supports all schools to achieve and maintain a healthy schools standard. The programme aims to encourage health promoting schools to improve the health of the school community. Schools are offered advice in the development of SRE; they also offer an enhanced programme where schools can select a health topic to focus on. The programme is commissioned through public health.

Schools offer a range of interventions for children and young people including the provision of Personal Social Health Education (PSHE). Schools are encouraged to deliver effective age appropriate SRE to young people. Provision is at the discretion of each school.

Workforce Development

Teenage Pregnancy Training is offered for free to practitioners working across Nottinghamshire. The training is commissioned by the Teenage Pregnancy Integrated Commissioning Group from Local Authority funding. Training encourages take up and addresses the need to build and maintain the skills of the local workforce.

Bespoke training is targeted specifically to those working with at risk groups and in hot spot wards. The training also offers a range of courses focusing on working with pregnant teenagers and teenage parents. 388 local practitioners participated in training activities from April 2012 to the end of March 2013, all training courses have been evaulated well and plans to target those working with at risk groups are well under way. 57 local practitioners attended more than one teenage pregnancy training course.

Services for Pregnant Teenagers and Teenage Parents

The Family Nurse Partnership (FNP) is a licensed, evidenced based, intensive nurse-led prevention and early intervention programme for vulnerable first time young parents and their children. It is the first part of the preventive pathway for the 2-5% of most disadvantaged children. The Nottinghamshire programme was launched in April 2013. FNP is currently commissioned by NHS England.

The FNP provides structured home visiting from early ante-natal until the child is 2 years of age, by the same Family Nurse to ensure consistency of support. Families in receipt of FNP support will be supported to access wider service provision, including children's centre activities.

Children's Centres bring together childcare, early education, health and family support services for families with children under 12 years old. They aim to tackle child poverty and social exclusion by working with parents-to-be, parents, carers and children to promote physical, intellectual and social development of babies and young children so they have the best start in life.

There are currently 58 children's centre services in Nottinghamshire. They are commissioned by Nottinghamshire County Council and delivered by a partnership of County Health Partnerships, North Nottinghamshire College and Family Action.

764 teenage mothers (under the age of 20) were accessing children's centres across Nottinghamshire in 2011/12. There is, however, variation across districts, as it is unclear what proportion of the teenage parent population have engaged with children's centres across each district.

Targeted Youth Support Service is for young people who are vulnerable but who are not at immediate risk of harm. The service offers a structured holistic intervention package including whole family work when appropriate. The service is made up of multi-agency teams led by the County Council, offering a holistic support package to groups such as teenage parents.

There are plans to increase the engagement of teenage parents to support their access to education, training or employment in addition to holistic interventions. The service also leads on ensuring that homeless young people are offered appropriate packages of care including supported accomodation when required.

The Special Educational Needs Team in Nottinghamshire County Council supports educational packages for pregnant young women of school age as well as teenage mothers with a view that they can maintain or reintegrate with their education. Schools are offered funding to support education at school or through a specialist PRU or alternative education provider. The team was launched in April 2012 and so far 14 school aged young women have received support to remain or reintegrate into education.

The Teenage Pregnancy midwifery team is offered by Nottingham University Hospital (NUH) and covers Gedling, Broxtowe, Rushcliffe as well as the city. The team is commissioned by clinical commissioning groups. Performance data is not available for this service. Maternity services are now commissioned to provide an enhanced service for mothers under 20 years of age, who are now classed as *intermediate* on the maternity pathway.

Care to Learn is a national scheme that provides financial support to teenage parents who want to continue their education and need help with the cost of

childcare and any associated travel. It pays up to £160 a week for each child. Childcare payments are made directly to the childcare provider and travel payments are made to the learning provider.

In July 2012[14], 92 teenage parents under the age of 19 were using Care to Learn in Nottinghamshire however this reduced to 14 by September 2012; which may be linked with young people starting new training courses and not having their Care to Learn forms completed. In August 2013[15], 12 teenage parents under the age of 19 were using Care to Lean. This low uptake could be linked to the time of year as most education providers do not offer classes or training in August. This data implies that less than a quarter of teenage parents under 19 years were accessing the scheme, When comparing take up data with statistical neighbours, one can see that Nottinghamshire must do more to raise awareness and take up of the grant to enable teenage mothers to remain in education or training.

Healthy Start is a national scheme that aims to improve the health of low-income pregnant women and families on benefits and tax credits. Women qualify during the whole of their pregnancy if they are under 18 when they apply, even if they do not receive welfare benefits. Vouchers can be spent on milk, plain fresh or frozen fruit and vegetables, or infant formula milk in a wide variety of local shops and supermarkets and with milkmen that have registered to take part in the scheme. Beneficiaries also get vitamin coupons with their vouchers, which they can swap for Healthy Start vitamins in their local area.

Nottinghamshire (excluding Bassetlaw) saw 78.5% uptake of the scheme in September 2012, compared to 76.5% in Bassetlaw for all eligible parents. However this figure drops to 4.7% uptake of Children's vitamin drops for Nottinghamshire (excluding Bassetlaw) and 11% update of children's vitamin drops in Bassetlaw.

The scheme is promoted across Nottinghamshire by FNP, children's centres, maternity services and health visitors with plans to increase the awareness and access to the scheme by pregnant teenagers and teenage parents. Data on uptake by teenage parents is not known for Nottinghamshire as the data is not broken down by age.

Health Visiting and Midwifery services are offered to all pregnant teenagers and teenage parents in Nottinghamshire.

8. Evidence of what works

Reducing Teenage Conceptions

There is clear evidence of what works in reducing teenage pregnancy. Evaluation of work in England and in other countries has shown that the three most important aspects are high quality sex and relationships education (SRE), easy

[14] DfE and ONS (2012) National Figures – all Care to Learn take up 2011/12. July 2012
[15] DfE and ONS (2013) National Figures – all Care to Learn take up 2012/13. August 2013.

access to youth-centred contraceptive services and early intervention to target young women at greatest risk of pregnancy[16].

High quality sex and relationships education (SRE)

The majority of teenage pregnancies in England are accidental. High quality SRE gives young people the information and skills to make informed choices about relationships, sex, contraception and protection against sexually transmitted infections. It has a vital role in equipping young people to handle pressure to have sex as well as helping them recognise inappropriate behaviour.

There is a broad consensus in favour of SRE. In 2008 more than 22,000 young people signed a petition organised by the UK Youth Parliament in favour of improving SRE in schools. Research by the National Centre for Social Research published in 2010 showed that 62% of parents thought school sex and relationships education was 'essential or very important' which rose to 82% of parents at secondary school. This data was derived from a survey of 3,500 adults in 2009.

Access to young-people centred contraceptive services

There is international evidence that contraception is the key factor in reducing rates of teenage pregnancy, as opposed to programmes based on abstinence. Researchers found that 86% of the decline in teen pregnancy in the USA was due to improved use of contraception, with increased use of the pill and condoms. Only 14% of the drop amongst 15-19 year-olds was linked to reduced sexual activity[17].

Long Acting Reversible Contraception (LARC)

The National Institute of Clinical Effectiveness (NICE) issued guidance[18] in 2005 which promoted the use of Long Acting Reversible Contraception (LARC) for teenagers amongst other groups.

The NICE clinical guideline on LARC offers the best-practice advice for particular groups, including women who have HIV, learning disabilities or physical disabilities, or are younger than 16 years.

NICE recommends the use of LARC for sexually active young people because the effectiveness of barrier and oral contraceptive pills is dependent on their correct and consistent use. By contrast, long-acting reversible methods have high effectiveness that does not depend on daily compliance which is useful for teenagers.

Currently there is very low uptake of long-acting reversible contraception (around 5% of contraceptive usage nationally). A number of factors contribute to this. Issues for providers include the initial cost, which may be thought of as too high particularly if the methods may not be used or required for the intended duration,

[16] Hansard, 10 January 2011. www.publications.parliament.uk DCSF. (2010) Teenage Pregnancy Strategy: Beyond 2010. DCSF. Teenage Pregnancy Unit, DfE, unpublished data.

[17] Santelli, J., et al (2006), *Explaining Recent Declines in Adolescent Pregnancy in the United States: the Contribution of Abstinence and Improved Contraceptive Use American Journal of Public Health*.

[18] NICE (2005) Clinical Guidance 30 http://publications.nice.org.uk/ifp30

the need for specific clinical skills (including awareness of current best practice, insertion practice and ability to give information or advice on the methods available) and facilities. Further work is required to enable young people to access LARC methods from a range of accessible sites including GP practices located in hot spot wards who are able to offer one-to-one support.

Early intervention

Early intervention can prevent teenage pregnancy and help teenage mothers avoid getting pregnant again too quickly. A number of studies have shown that many young women wished, in retrospect, that they had waited longer before becoming parents.

Many local area projects have evidence to show that early intervention has been a success. For example in Stoke-on-Trent, dedicated teenage pregnancy prevention officers use a screening toolkit to identify young people at risk. They run sessions to boost self-esteem of young people, train professionals to identify risk and they deliver sexual health services at various sites including schools.

Early intervention also helps increase young parents' take up of work, education or training. If young parents are offered the right support at the right time – for example supported housing – it can increase their rates of participation in society and improve the long term outlook of both parent and baby. Initiatives such as the Family Nurse Partnership support young mothers and fathers in their parenting for two years, to prevent a second pregnancy and to continue education or gain employment.

Supporting Young Parents and their children

The following factors are the most effective in ensuring positive outcomes for teenage mothers[19]:

- Early access to high quality antenatal care improves outcomes and is cost effective.
- Home visiting and support can improve the health and welfare of the mother and baby.
- Education and career development programmes providing support for childcare can be effective in encouraging young parents back into education or employment.

The Family Nurse Partnership is well evidenced as improving outcomes for teenage parents and their children. National outcomes include:

- Improved pregnancy outcomes
- Reduced child abuse and neglect
- Improved school readiness
- Reduced youth crime

[19] NHS Atlas of Variation in Healthcare for Children and Young People Service 'Snapshot - Teenage pregnancy Selection: Nottinghamshire Geographies: Top level local authority' sourced 11.2.13 http://atlas.chimat.org.uk/IAS/profiles/profile?profileId=40&geoTypeId=4#iasProfileSection5

- Improved employment for mothers, and fewer subsequent pregnancies with bigger gaps between births.

9. User Views

A local review of school nursing services in 2013, identified that young people in Nottinghamshire want school nurses to offer information and advice about relationships and sex, and a key priority role for school nurses would be to provide contraception (including condoms), pregnancy testing and Emergency Hormonal Contraception (EHC).

When asked what school nurses should provide the following sample of comments shows the need for young people to have someone accessible that they can go to for information and advice.

- *Provide the pill etc for those too scared to go to GP*
- *More contraception available not just condoms and morning after pill*
- *Give advice on personal and sexual life*
- *PSHE lessons*
- *Advice on sexual relationships*
- *Providing contraception and pregnancy tests*
- *Provide the C-Card scheme*
- *Give out contraception*
- *Advice on pregnancy*

Further work to assess user views in relation to the C-Card scheme is ongoing.

What does this tell us?

10. What are the key inequalities?

Teenage Pregnancy disproportionately affects those experiencing poverty and social exclusion. For some young people, becoming a parent is a positive choice especially if the young person has low aspirations. The following groups are considered most at risk of teenage pregnancy:

- 16-17 year old age group.
- Looked after Children and Care Leavers
- Young people disengaged from school
- Young people leaving school with no qualifications
- Young people excluded from school.
- Young People Not In Education, Training or Employment
- Young people involved in offending behaviours
- Young people with poor mental health
- Young people with low aspirations and those who have parents with low aspirations of their children
- Some BME groups
- Children of teenage mothers – this is the strongest predictor of teenage motherhood.
- Teenage mothers - Around 20% of births conceived under-18 are second or subsequent births.
- Young people involved in alcohol use
- Young people involved in drug use
- Young people living in teenage pregnancy the most disadvantaged localities

<u>Equality Impact Assessment</u>

An Equality Impact Assessment was published alongside the Teenage Pregnancy Integrated Commissioning Strategy in January 2012. It's summary findings are listed below:

Age: The teenage pregnancy strategy actively targets children and young people under 19 years.
Disability: There is no evidence to suggest that children and young people with physical disabilities are at risk of teenage pregnancy so the strategy does not target this group actively. There is however emerging evidence that children and young people with Special Educational Needs (SEN) are often at risk because they face a number of risk factors as stated previously. Young carers will also be engaged in universal elements of the strategy.
Gender (includes gender reassignment, pregnancy and maternity): Both genders are actively targeted within the strategy when working to prevent teenage

conceptions so there should be no adverse impact on different genders. Because historically pregnancy and sexual health work focused on young women there has in fact been an increased emphasis on young men.
Race: There is evidence that suggests that young people from some ethnic groups are much more or less likely to experience teenage pregnancy than others. Children and young people from BME backgrounds are a key target group within the strategy so there should be no adverse impact on people of different races, ethnicity, colour or nationality.
Religion or belief: There is no evidence to suggest any particular faith group is at risk of teenage pregnancy so no specific groups will be targeted for interventions.
Sexual orientation: The need to address homophobia and support the needs of Lesbian, Gay, Bisexual and Transgender (LGBT) children and young people is important in Sex and Relationships Education and through contraception and sexual health services.

11. Where are the gaps in service?

There are a number of gaps in service provision (both coverage and type of service/intervention), including the provision of Contraception and Sexual Health Services, Emergency Hormonal Contraception (EHC) provision from Pharmacists and C-Card sites in accessible settings within hot spot wards across Nottinghamshire. Plans are in place to explore the development or relocation of services/sites as appropriate.

A number of schools would prefer an external provider to deliver SRE programmes to pupils rather than existing school staff. Further work is required to understand what the challenges are for schools to deliver age appropriate SRE and whether an SRE package is commissioned for target schools or training is targeted to teaching staff to equip them with the skills and confidence to deliver programmes in a sustainable way.

The numbers of teenage parents accessing children‘s centres should be higher and it is hoped that the new provider of the centres will proactively engage pregnant teenagers and teenage parents to increase their participation in children centre activities.

Despite there being a specialist teenage pregnancy midwifery team in the South of the County, there is no similar service in central or north Nottinghamshire.

There is no careers service in Nottinghamshire so the need to support pregnant teenagers and teenage parents to access training or employment remains a challenge, this is apparent in the poor take up of the Care to Learn grant which is a key contributor to increasing engagement.

Uptake of the Care to Learn childcare grant for teenage parents is low and further work is required to promote the grant to young people and local practiutoners in education and childcare settings.

12. Where are the gaps in knowledge?

There are a number of gaps in knowledge and further work is required to identify data and knowledge in order to progress a successful strategy.

Health Commissioners do not routinely receive performance data from key services such as Contraception and Sexual Health services (CaSH), Genitourinary Medicine (GUM), school nursing, and community pharmacists. Performance data would include service usage and outcomes. Without this data we are unable to assess if young people access these services and the reason behind their visit. Data would also support the identification of young people friendly services.

Smoking prevalence and quitter rates data is not available by age or target group. Liaison is underway with New Leaf, Nottinghamshire'a smoking cessation service, to understand if and how pregnant teenagers and teenage parents access the service.

Infant mortality data is limited because the numbers are relatively small. Further work is required to aggregate data to understand any local issues for teenagers and their children.

Education

There is a refreshed Ofsted inspection regime for schools which no longer includes the specific focus on the delivery of Personal Social Health Education (PSHE) or Sex and Relationships Education (SRE), this means there is no way of knowing if and how schools deliver SRE which is critical for the continued improvement of young people's sexual health.

Safeguarding

Anecdotal evidence from local services state that many young people seeking support for contraception or a sexual health screen are experiencing sexual exploitation. A better understanding of sexual exploitation locally is required and a new Child Sexual Exploitation pathway is in place[20].

Childcare

Nottinghamshire requires an improved understanding of uptake of childcare opportunities for teenage mothers to access education or training. A greater understanding of local barriers would be required by engaging young people in local research.

[20] http://www.nottinghamshire.gov.uk/caring/protecting-and-safeguarding/nscb/informationprofessionals/procedures-practice-guidance/

13. What are the risks of not delivering?

Poor Economic Outcomes

Teenage pregnancy is a cause and consequence of child poverty. If teenage conception rates increase there will be a greater number of children and young people across Nottinghamshire who experience poverty and disadvantage.

Teenage mothers are also more likely to need and receive targeted support than older parents. They may get help with parenting, budgeting on a low income and support to get back into education, employment or training. This will increase the burden on a number of services.

Financial Burden

If teenage conceptions increase there will be a greater financial burden on Central and Local Government and the NHS in terms of housing, welfare benefits, and health interventions. The cost of teenage pregnancy to the NHS alone is estimated to be £63m a year.

There is a strong economic argument for preventing teenage pregnancy. For every £1 the NHS spends on contraception, £11 is saved in abortion, ante-natal and maternity costs, as well as additional welfare costs[21].

A teenage mother who does not work until her child is three can be entitled to benefits of up to £20,000. More than 40% of teenage parents are allocated social housing.

Poor Health Outcomes

If teenage conceptions increase there will be a negative impact on a number of health outcomes for parents and children including smoking in pregnancy, infant mortality, low birth weight; admissions to hospital as a result of accident or gastro enteritis; obesity, and post natal depression to name but a few.

14. What is on the horizon?

Despite the ending of the national teenage pregnancy strategy, there is still a focus on reducing teenage conceptions included in the Public Health Outcomes Framework[22] and Sexual Health Framework[23].

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[21] Teenage Pregnancy Independent Advisory Group (2010) 'Final Report; Teenage Pregnancy: past successes – future challenges' https://www.education.gov.uk/publications/eOrderingDownload/Past%20successes%20-%20future%20challenges.pdf

[22] Department of Health (2012) *Healthy Lives, Healthy People. Improving Outcomes and Transparency – a public health outcomes framework for England 2013-2016* http://www.rcpsych.ac.uk/pdf/The%20Public%20Health%20Outcomes%20Framework.pdf

[23] Department of Health (2013) ***A Framework for Sexual Health Improvement in England*** https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england

Work to tackle teenage pregnancy is a key element embedded in priority areas of work including Child Poverty and Early Help across Nottinghamshire.

Furthermore the development of Young People Friendly Health Services is a key priority for the Teenage Pregnancy Strategy. Young people often state that they are embarrassed to access services because they fear that staff are judgemental and will not maintain confidentiality. Plans are underway for services and commissioners to enable the assessment of services by seeking user feedback and scrutiny of policies and processes. There is no additional funding for the work as plans to assess services will be embedded into core provision and commissioning.

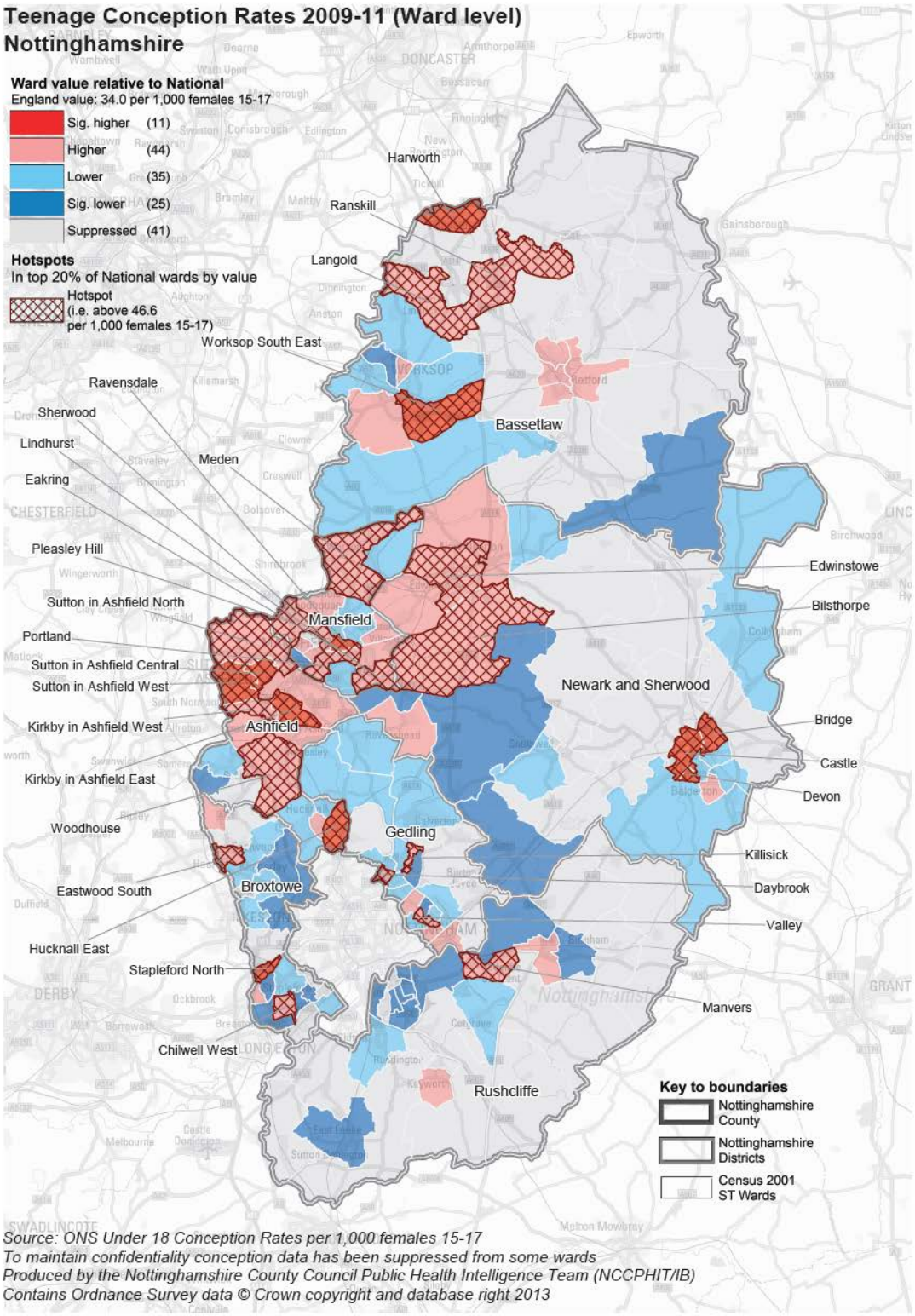
What should we be doing next?

- The findings from the Joint Strategic Needs Assessment are owned by the Nottinghamshire Teenage Pregnancy Integrated Commissioning Group, they have been tasked to progress a local strategy which includes the need to further address gaps in local knowledge.
- The Teenage Pregnancy Integrated Commissioning Group has a strategy and action plan in place which also aims to source performance data from a number of services including CaSH services.
- This local partnership has already prioritised activity to ensure services are effective at meeting identified needs in localities and amongst young people most at risk.
- The Teenage Pregnancy Integrated Commissioning Group has links with the Nottinghamshire Sexual Health Strategic Group and will progress activity together.
- The partnership will be reviewing all commissioned services with a view that services are commissioned with clear targets and performance indicators.
- Further work is required to progress the gaps in knowledge and services within the commissioning strategy.
- Additional work is required to engage young people in the commissioning cycle to inform commissioning intentions.
- There is a need to develop a teenage pregnancy pathway with a focus on support for young parents.

Supporting documents

Nottinghamshire Teenage Pregnancy Joint Commissioning Strategy
http://www.nottinghamshire.gov.uk/caring/childrenstrust/developmentwork/teenage-pregnancy/
Teenage Pregnancy Joint Commissioning Strategy Equality Impact Assessment
http://www.nottinghamshire.gov.uk/thecouncil/democracy/equalities/eqia/
Nottinghamshire Child and Family Poverty Strategy 2011-2020
www.nottinghamshire.gov.uk/childpoverty
Nottinghamshire Early Intervention and Prevention Strategy 2011-13
http://www.nottinghamshire.gov.uk/caring/childrenstrust/pathway-to-provision/earlyinterventionpreventionstrategy

APPENDIX ONE
Ward Level Teenage Conception Rates 2009-2011



Source: ONS Under 18 Conception Rates per 1,000 females 15-17
To maintain confidentiality conception data has been suppressed from some wards
Produced by the Nottinghamshire County Council Public Health Intelligence Team (NCCPHIT/IB)
Contains Ordnance Survey data © Crown copyright and database right 2013