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Executive summary

Introduction

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 parenthood, including, increased risk of post-natal depression, and smoking in pregnancy, also means 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. It can 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, including increased risk of obesity and lower educational attainment, 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.[1]

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

Nottinghamshire's teenage conception rates have been declining alongside national and regional progress; however there are a number of smaller areas within the county where teenage conception rates are persistently high. These areas are actively being targeted with programmes and interventions.

<u>Unmet need and gaps</u>

A comprehensive service has been commissioned across all districts of Nottinghamshire, (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. There is however further work that could be done to continually review the targeted support for teenage parents the services provide along with collecting data to monitor access and use.

A service review carried out in 2013 on the National Healthy Schools Programme highlighted gaps and inconsistencies from schools in delivering sex and relationships education (SRE) programmes to pupils. It also stated that rather than existing school staff they would prefer an external provider to SRE. Currently the only provision to schools is given by C Card (young people's contraception scheme) in supporting with SRE delivery as well as C Card sessions. 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. From March 2017 it has become mandatory for schools to deliver Personal Social Health Education (PSHE) or Sex and Relationships Education (SRE), this ensures pupils are taught the knowledge and life skills they will need to stay safe and develop healthy and supportive relationships, particularly dealing with the challenges of growing up in an online world. [24] However, all schools are not fully equipped or have the tools to deliver SRE which is critical for the continued improvement of young people's sexual health. In light of this there would need to be a planned approach across Nottinghamshire in supporting schools to deliver on this agenda at a consistent standard.

Proactively engage pregnant teenagers and young fathers to increase their access to children centres and participation in children centre activities.

Despite there being a specialist teenage pregnancy midwifery team in some districts of the County, there needs to be more work done to ensure services are meeting the needs of pregnant teenagers across the whole of the County in the way its delivered and reaching more young mothers.

Increased early identification, early access and effective care for all hard to reach groups who may not access ante-natal care before 12 weeks of pregnancy, for example teenagers, gypsy roma traveller (GRT), refugees and asylum seekers.

There is no dedicated careers advice 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 practitioners in education and childcare settings.

Young fathers are often invisible to services with much of the support and focus given to young mothers. This is because often young fathers do not live with the mother, are disengaged as they feel 'left out' of parent services focused on mothers and also young fathers may present as single men. Further work needs to be done to engage young fathers in services as statistics show that:

- Children with highly involved fathers have better outcomes
- Young fathers influence the mothers smoking and breastfeeding choices
- Teenage mothers with a supportive partner are less likely to get post-natal depression
- Becoming a father can be a positive turning point in confidence and re-engagement with education and employment.[15]

Knowledge gaps

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 Provision

- Access to services for higher risk groups.
- Smoking prevalence and quitter rate data are not available by age or target group. Work needs to be done with Nottinghamshire's smoking cessation service, SmokeFreeLife, 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.
- Children Centre services have previously had a key role in engaging fathers, however in recent years, the needs of fathers have received a lower profile than the needs of mothers. It is currently unclear what the current needs and views of fathers are in relation to outcomes for young children

- A more holistic approach considering both the health and social needs of teenage parents needs to take place. The learning from this needs to be shared to ensure universal and targeted services to proactively engage this group.

Education

- School readiness is a measure of how prepared a child is to succeed in statutory education. The good level of development (GLD) is used to assess school readiness. Currently children are defined as having reached a GLD at the end of the Early Years Foundation Stage if they have achieved at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development, physical development and communication and language) and in the specific areas of mathematics and literacy. Currently there is no local data collected regarding GLD for children of teenage mothers.

Safeguarding

- There needs to be a better understanding on issues around sexual exploitation locally- a new Child Sexual Exploitation pathway is in place[20], but further work needs to done to grasp the complexities around this to best support young people.

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.

Table 1: Recommendations for consideration by commissioners

Priority	Recommendation	Suggested lead commissioners
Maternity & Early Years	• Ensure teenage mothers are accessing ante-natal care before the end of the twelfth completed week of pregnancy (12 weeks and 6 days) to ensure early access to antenatal care and screening options are discussed particularly for those from hard to reach backgrounds • Reduce the number of teenage mothers smoking in pregnancy working with key stakeholders to ensure a seamless pathway • There is further work needed to promote the Healthy Start Programme and the Healthy Start vitamin distribution centres across Nottinghamshire with all mothers not just teenage mothers.	Public Health, CCG's and Early Childhood Services, NCC
Improve childcare provision	• The Childcare Sufficiency Assessment identified demands for provision in school holidays, after school and before school are unmet. Work should be undertaken with key stakeholders to identify options for provision, which may include the right to request provision on schools sites, provider partnerships, and ensuring all available provision is recognised and promoted through the local authority's information duty, delivered by the Families Information Service. • Work should be undertaken with key stakeholders to ensure partners and staff are aware of what support for the costs of childcare is available, and how the free	Early Childhood Services, NCC

	entitlement can be used, and disseminate that information to their client groups. • There is a need to support the availability of childcare to meet changing working patterns (such as demand for childcare outside of traditional office hours 9-5 Monday – Friday) and with employers to support flexible working and awareness of support for childcare. • Explore flexible delivery models as a matter of urgency; and consider how these models of working can be applied across different types of provision for all age ranges of children to support young mothers return to employment, education or training.	
Ensuring pregnant teenagers & teenage parents are effectively supported by the services provided	• Continuation of FNP programme as part of the 0 -19 Healthy Families Programme service • Improve uptake of Care to Learn Grant for teenage parents • Implementation of Public Health England Framework for teenage parents and their families	Public Health, CCG's, NCC
Young people engagement	• Additional work is required to engage young people to inform commissioning intentions. • Gain a better understanding of which services teenage parents access and gain a better understanding of the local barriers for young people e.g. education support for 19-20 year olds	
Ensure robust data provision	• Review annually all teenage pregnancy/or for those at risk of teenage pregnancy commissioned services with a view that services are commissioned with clear targets and performance indicators.	Public Health, CCG's and Early Childhood Services, NCC
Joint working	The Young People's Health Strategy Steering Group has links with the Nottinghamshire Sexual Health Strategic Group – further progress activity together as well as with other services needs to continue	Public Health, CCG's and Early Childhood Services, NCC
Reducing the financial burden whilst improving health outcomes for parents and baby	The four key areas identified which can directly impact on this priority include: • Improve school readiness rates- Local data regarding GLD for children of teenage mothers is collected locally. • Ensure Mental Health services are skilled and equipped to support young parents with their mental health and emotional wellbeing pre and post pregnancy by linking with maternity services, FNP, specialist teenage pregnancy teams and the Healthy Families team.	

	• Ensure the services that are commissioned to support teenage mothers are offering the required support and advice in supporting young mums in returning back into education, training or employment (EET) • Work should be undertaken (steered by the young people's health strategy, steering group and action plan) to identify and work with key stakeholders to ensure partners and staff embed safeguarding policies, practice and training in service delivery to support young people at risk of teenage pregnancy or repeat pregnancies.	
Prevention	The recommendations for this priority link to the recommendations under 'prevention' in the Sexual Health JSNA chapter http://www.nottinghamshireinsight.org.uk/research-areas/jsna/adults-and-vulnerable-adults/sexual-health-2015/	Public Health, CCG's and Early Childhood Services, NCC

Full JSNA report

What do we know?

1) Who is at risk and why?

Table 2: 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 females 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 mothers are three times more likely to experience post-natal depression • Mothers under 20 have higher rates of poor mental health for up to three years after birth • Young fathers are more likely to have pre-existing serious anxiety, depression and conduct disorder. • 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 - linked to their risk taking behaviours[5].
Alcohol and substance misuse	• Alcohol and drug use is strongly associated with teenage conceptions and sexually transmitted infections, independent of deprivation. • An estimated 1 in 12 young women under 20 accessing drug and alcohol services are either pregnant or teenage mothers and 1 in 5, under 25, are young fathers • 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. Teenage mothers are: ➢ Twice as likely to smoke before and during pregnancy and three times more likely to smoke throughout pregnancy ➢ One third less likely to breastfeed and half as likely to be breastfeeding at 6 weeks ➢ Two in three teenage mothers experience relationship breakdown in pregnancy or the three years after birth ➢ Young parents are less likely to access services that are seemed as judgemental and not 'young people friendly'. Babies of teenage mothers have: ➢ 21% higher risk of premature birth for first baby ➢ 95% higher risk of premature birth for second baby ➢ 21% higher risk of low birthweight ➢ 13 % higher risk of stillbirth ➢ 56% higher risk of infant death

	➢ 3 times the risk of Sudden Unexplained Death in Infancy ➢ More likely to have delayed child development and poor educational attainment
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 than 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]. • 21% of estimated number of females Not in Educations, Employment or Training (NEET) 16-18, are teenage mothers[21] • 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[21]
Sexual exploitation	Young girls who are being exploited are more likely to not use contraception effectively due to hectic lifestyle, forgetfulness, depression, hopelessness or the abuser controlling the use of contraception. [11] Victims at risk of sexual exploitation are at increased risk of becoming pregnant and particularly those who do not receive good support from their family, are at risk of social isolation, poor life habits, low education attainment – which limits their employment prospects, re-victimisation, stress, and depression.[12] The pregnancy is also more likely to lead to a termination which has a mental, social, emotional and physical impact on the young person.
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.
Family / Background factors	
Looked After Children (LAC)	• 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. • Research has shown that by the age of 20 a quarter of children who had been in care were young parents[10]. • Children in the care system do poorly in education and have a poor level of development than that of their peers at Foundation stage. Though the number of 3 and 4 year olds that are LAC are low, attendance at Early Years provision by newly placed LAC children is poor, whilst they stay at home to develop attachments with carers.
Daughter of a teenage mother	• Research findings from the 1970 British Birth Cohort dataset showed being 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]
Gypsy, Roma and Traveller Families	• An area may be unfamiliar the family; parents have no local knowledge of services and arrive to a new area without a support network. • There is a reluctance to access services from GRT families and/or rural isolation is an issue, however more work also needs to be done • Lack of permanent accommodation makes it impractical to access services and for those services to track progress.
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

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 & Economic Wellbeing [21]

- 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.
- Men who were young fathers are twice as likely to be unemployed at 30
- 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. A reduction is first and subsequent pregnancies contributes to improving outcomes.

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.
- 79% 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 years after the birth.
  - Three times more likely to smoke during pregnancy than mothers over 30
  - 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 56% 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.
- Mothers under 20 are three times more likely to smoke throughout pregnancy resulting in poor health outcomes for the child
- Mothers under 20 are half as likely to be breastfeeding at 6-8 weeks
- Parental depression is the most prevalent risk factor for negative impact on poor child development outcomes
- Teenage mothers are at 21% higher at risk of premature birth for the first baby and 95% higher risk for the second baby

2) Size of the Issue Locally

Locally

2.1) Key Risk factors

Deprivation and Child Poverty
Deprivation levels for Nottinghamshire as a whole are comparable with England. However, within Nottinghamshire there are communities with both some of the highest levels of deprivation in the country and some of the lowest levels of deprivation **(IMD 2015).**

In Nottinghamshire there are 25 areas, known as LSOAs, in the 10% most deprived areas in England. The most deprived areas are concentrated in the districts of Ashfield (9), Mansfield (6), Bassetlaw (6) and Newark & Sherwood (3).

People living within the more deprived areas of Nottinghamshire have higher levels of unemployment, lower levels of qualifications, increased risk of teenage pregnancy, less healthy lifestyle choices and poorer health and wellbeing outcomes compared with those in less deprived areas.

In 2014 across Nottinghamshire 27,920 children and young people aged 0-19 were identified as living in poverty, which equates to 17.1% of the 0-19 population. There are fewer children in poverty in Nottinghamshire compared to England (18.0%) and the East Midlands (17.0%). Only Mansfield and Ashfield have higher child poverty levels than the England average (23.1% and 22.7% respectively). Child Poverty JSNA Chapter 2016

Education, Employment and Training
The proportion of the population in the School and Training Years varied very little within the County, ranging from 15.9% in Broxtowe to 17.5% in Rushcliffe and a County figure of 16.9%. The Employment and Family Building Years figures were also fairly consistent, with 57.0% in Newark & Sherwood, up to 58.8% in Broxtowe and 59% in Mansfield. The County proportion was 57.9%, compared with 58.3% in the Region and 58.9% in the Country.

The percentage of Nottinghamshire pupils in years 12-14 who are NEET (Not in Education, Employment or Training) remains low compared to the national average and compared to historical figures. 1.9% of Nottinghamshire pupils are identified as NEET compared to 4.8% nationally. The average of our statistical neighbours is 4.5% for the same period. Comparisons against our statistical neighbours show we are ranked first on this measure. The percentage of Nottinghamshire pupils in years 12-14 where their education destination is unknown is 9.0% compared to a national figure of 6.5%.

Within the County there is considerable variation in the qualification level of residents between the districts. In Ashfield the proportion of residents aged 16-64 with NVQ level 4 or above is 17.9%. This is considerably lower the averages for the East Midlands (30.9%) and England (35.7%). The population of Rushcliffe have a higher level of attainment with a rate of 54.9%.

Ashfield with 14.8% is the district with highest proportion of residents with no qualifications followed by Gedling with 11.4%. This compares with rates of 9.3% in the East Midlands and 8.6% in England. Rushcliffe has the lowest rate in the County with 5.1%. This again correlates with the County teenage conception rates are in districts with lower numbers accessing NEET and where conceptions rates are lower in districts such as Rushcliffe are linked to higher levels of aspiration.

Source: Annual Population Survey Jan 2013-Dec 2013

Crime and Safety
The Nottinghamshire Annual Residents Satisfaction Survey 2014 asked a number of questions relating to residents' perceptions of crime and safety in their local area both during the day and at night). 94% of respondents in Nottinghamshire feel very/fairly safe outside in their local area during the day. However at night, this figure drops to 75% and in some districts of the County such as Mansfield and Ashfield the figure drops to 56% and 63 % respectively. As highlighted in section 3 table 2 there was a link made between antisocial behaviour and high crimes rates and that of risk taking behaviour. The figures correlate to the higher pregnancy rates for the more deprived districts of the County.

Ethnicity
At the time of the 2011 Census, 92.6% of the County's population classed themselves as White British, with 2.9% being Other White and the remainder, 4.5%, belonging to the Black and Minority Ethnic (BME) Groups. In comparison, the East Midlands and England had significantly lower rates of the White populations, with 89.3% and 85.4% respectively, and consequently higher rates of the BME groups (11.0% and 15.2% respectively). In the County, Gedling had the highest Mixed and Multiple Ethnic Groups population (2.3%) as well as the highest rate of Black African and Caribbean and Black British ethnicities (1.6%). The largest proportions of Asian and Asian British people, were resident in Rushcliffe (4.2%), closely followed by Broxtowe (4.1%). This again links back to the where teenage conceptions are much higher amongst certain ethnic groups in more deprived wards compared to others.

Access to sexual Health services and Contraception use
A quality contraceptive service is vital in giving women and men of all ages' choice and control over their reproduction, and is key to avoiding unplanned pregnancies and planning families. Contraception is a highly cost-effective intervention, which plays an important public health role in improving the lives of individuals, families and communities.[25]

Condoms are available to young people through the C-card scheme (as described under current activity and service provision section). However figures for the level of condom use among young people in the county are not known. When considering the proportion of all first attenders for a sexual health screen at GUM clinics, Nottinghamshire County has a larger proportion of first attenders aged under 24 years, compared to the England average, for both males and females. This runs contrary to the age structure of the Nottinghamshire population, which is older than the England average. Sexual Health JSNA Chapter 2015

(Further information can be found under current activity and service provision section)

Termination
There were 1,830 terminations of pregnancy carried out in Nottinghamshire County in 2013, of which 145 were carried out in those under the age of 18. There was no statistically significant variation in termination rates at district level in the county and the termination rate for those aged under 18 was not significantly different than the national average

Sexual Abuse and Child Exploitation
The topic of sexual abuse and sexual violence is covered in detail under a separate JSNA chapter on Sexual Abuse and Child Sexual Exploitation is covered in Section 5 of the Children and Young People JSNA 2013.

Substance Misuse
The best available estimates indicate that there are 5114 young people (10-17 year olds) who are drinking at increasing and higher risk levels. [26]
The latest data also suggests that there has been a reduction in the rate of alcohol specific admissions in under 18s between 2006 and 2015. The rate in Ashfield is significantly higher than the England average. Further information is available in detail under a separate JSNA chapter on Substance Misuse JSNA Chapter 2017

2.2) 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. If teenage conceptions increase there will be a negative impact on a number of health outcomes for parents and children such as smoking in pregnancy, infant mortality and low birth weight. Not being provided with the appropriate support and the right time can have a profound effect on teenage parents and baby, therefore a multifaceted targeted approach is key in supporting young parents.

2.3) Teenage Conceptions

Nationally

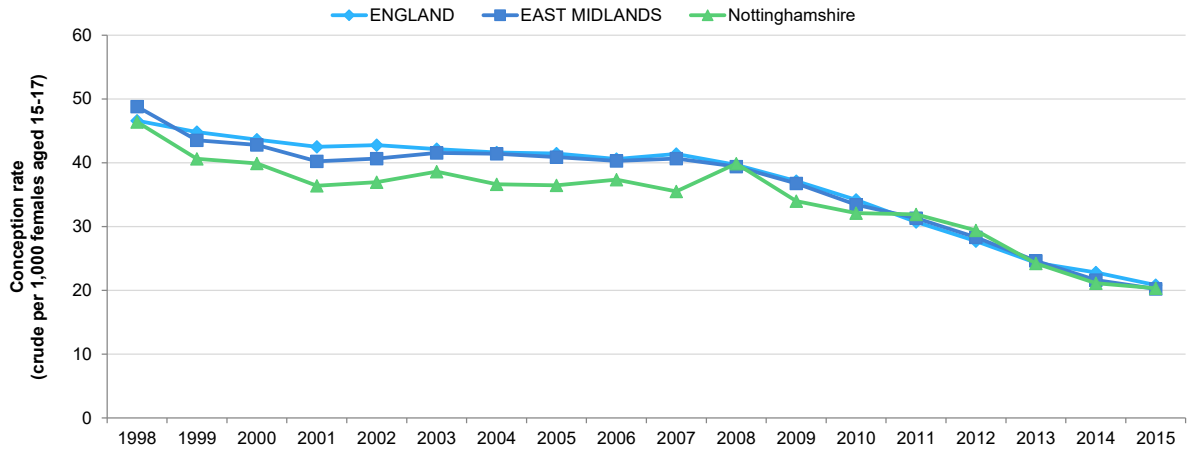
The provisional 2015 under 18 conception rate for England is 20.8 per 1, 000 girls aged 15-17, a decrease of 6.2% from 2013 rate and the lowest rate since 1998 (16 years ago). Since 1998 (baseline year), the under 18 conception rate has fallen by 55.4% (from 46.6 per 1000 in 1998).

Nationally it is estimated that 20% of all teenage conceptions are repeat conceptions- local data is not available.

Locally

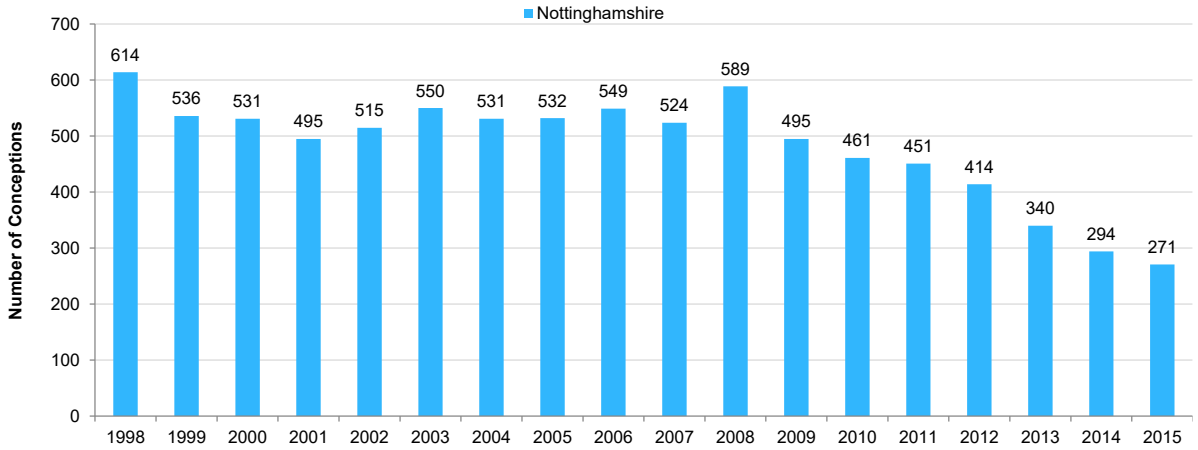
Nottinghamshire has achieved well in reducing teenage conceptions, comparing well with statistical neighbours and across the region. The teenage conception rate is calculated by identifying the number of conceptions per 1,000 females aged 15-17 in an area and the key indicator used in strategic planning. 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

Figure 1: Teenage conception rates 1998-2015 for Nottinghamshire and National, Regional comparators



Source: ONS Conceptions Statistics 2015 (published 2017)

Figure 2: Numbers of teenage conceptions Nottinghamshire 1998-2015



Source: ONS Conceptions Statistics 2015 (published 2017)

The 2015 under 18 conception rate for Nottinghamshire was 20.3 per 1,000 females aged 15-17 – a decrease of 12.2% from the 2013 rate of 24.2%, and a decrease of 56.3% since the 1998 baseline year. The number of under 18 conceptions in 2015 was 271, 343 fewer than in 1998 where the number was 614.

Currently Nottinghamshire's overall reduction of 54.5% against the 1998 base rate compares broadly similar with the national reduction of 51.1% and the East Midlands reduction of 55.7%.

It is not possible to attribute a single intervention/service to the reduction in conceptions. Currently in Nottinghamshire there are several evidence based initiatives or services that are in place which have potentially contributed in the reduction of teenage pregnancy e.g. NICE evidenced based condom distribution schemes. In addition although the national strategy provided that structure and direction, this multifaceted approach is now steered by the Young People's Health Strategy Steering Group.

Termination of Pregnancy

In 2015 39.1% 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 51.2% for England and 43% 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.

Table 3: Proportion of teenage conceptions resulting in a termination in Nottinghamshire in 2015, one and three years previous and 1998

Period	Number of conceptions for 15-17 year old females	*Percent leading to abortion*	*Percent NOT leading to abortion*	Number leading to abortion (rounded)	Number NOT leading to abortion i.e. live birth (rounded)
2015	271	*39.1%*	*60.9%*	106	165
2014	294	*45.2%*	*54.8%*	133	161
2012	414	*43.5%*	*56.5%*	180	234
1998	614	*39.9%*	*60.1%*	245	369

Source: ONS Conceptions Statistics 2015 (published 2017)

Over time the proportion of teenagers who choose to terminate a pregnancy has remained fairly static for Nottinghamshire as a whole.

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

Young women living in areas of greatest deprivation and lowest educational attainment are more likely to continue with a pregnancy rather than terminate.

Table 4: 2015 District level teenage conceptions leading to live birth or a termination of pregnancy

Area of usual residence	Number of conceptions	Conception rate per 1,000 women in age group	Maternity rate per 1,000 women in age group	Abortion rate per 1,000 women in age group
Nottinghamshire	271	*20.3*	*12.3*	*7.9*
Ashfield	63	*29.8*	*22.2*	*7.6*
Bassetlaw	41	*19.9*	*11.6*	*8.2*
Broxtowe	27	*15.8*	*7.6*	*8.2*
Gedling	37	*18.8*	*10.2*	*8.6*
Mansfield	45	*27*	*16.8*	*10.2*
Newark & Sherwood	46	*23.6*	*14.9*	*8.7*
Rushcliffe	12	*6.3*	*2.1*	*4.2*

Source: ONS Conceptions Statistics 2015 (published 2017)

In 2011 8% of young women within the NHS Nottinghamshire boundary (excluding Bassetlaw) had repeat abortions compared with 11%for England and 8% for the East Midlands. NHS Bassetlaw data was not made available because numbers were too small and therefore potentially identifiable.

District Level Teenage Conception Data

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

Table 5: Under 18 conception rate by district of residence 2015

Area Type	Area Name	2015 No. of conceptions for 15-17 year old females	2015 Conception rate per 1,000 15-17 year old females	2014 %change in conception rate 2014 to 2015	2012 %change in conception rate 2012 to 2015	1998 %change in conception rate 1998 to 2015
County	Nottinghamshire	271	20.3	*-3.8%*	*-31.0%*	*-56.3%*
District	Bassetlaw	41	19.9	*-19.4%*	*-22.9%*	*-55.8%*
	Mansfield	45	27.0	*8.4%*	*-34.6%*	*-52.2%*
	Ashfield	63	29.8	*16.4%*	*-19.7%*	*-59.2%*
	Newark and Sherwood	46	23.6	*27.6%*	*-31.6%*	*-44.6%*
	Gedling	37	18.8	*-8.3%*	*-32.4%*	*-63.2%*
	Broxtowe	27	15.8	*-16.4%*	*-18.1%*	*-59.1%*
	Rushcliffe	12	6.3	*-55.3%*	*-66.5%*	*-61.8%*
City	Nottingham UA	152	31.2	*-4.9%*	*-17.2%*	*-58.2%*

Decrease	*-50.0%*
Increase	*50.0%*

Source: ONS Conceptions Statistics 2014 (published 2016)
Note: Colour scale for conception rate: white 0, Dark purple highest value
Note: Colour scale for % change: dark blue -50% and lower, dark red 50% and higher

It is also important to assess the progress of reducing teenage conceptions across districts. There is variation in rates across the districts with the highest rates seen in Mansfield, Ashfield, Newark and lowest rates seen in Rushcliffe, Gedling and Broxtowe. Most district rates are statistically similar to England with only the low rate in Rushcliffe is statistically different to the England rate, but rates do fluctuate over time as can be seen in Figure 3.

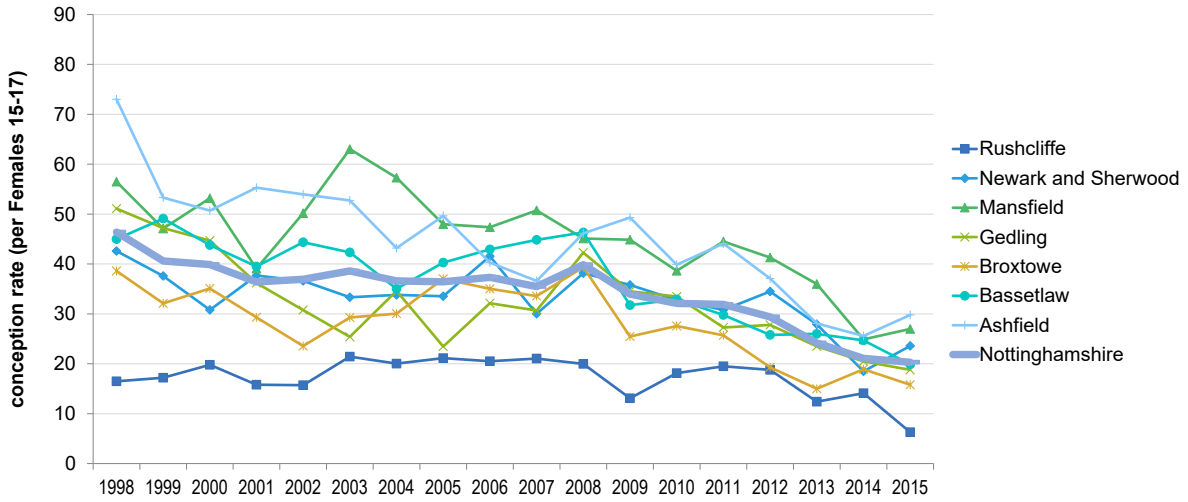
It is clear however that Districts in the north of the County continue to have the highest teenage conception rates compared to the rest of the County. This is in line with levels of child poverty and deprivation (measured by the Index of Multiple Deprivation).

There have been substantial reductions in the teenage conception rate since the baseline year (1998) for all Districts. This trend continues over the last three years.

More recently in the last year the story is mixed. Mansfield and Newark and Sherwood districts have seen rates decrease by over 30%. This is a positive situation for the north of the County where numbers and rates have been historically high.

Both Broxtowe and Rushcliffe have seen an increase in teenage conception rates. This is a notable change for the South of the County but as this area has historically relatively low numbers and rates, a positive, this increase relates to changes to numbers that are already low.

Figure 3: Teenage conception rates 1998-2015 for Nottinghamshire County and districts



Source: ONS Conceptions Statistics 2015 (published 2017)

Hot Spot Wards across Nottinghamshire

A ward is classed as a 'hotspot' if the ward rate lies within the top 20% highest rates nationally.

An additional statistical comparison is made to determine if the ward rate is statistically significantly higher than national rate (95% confidence interval). This method is sensitive to both the rate and the underlying number of conceptions so is useful to consider in addition to simply the value of the rate.

When considering the previous hot spot wards (identified because they have high conception rates), it is useful to examine how many teenage girls conceive not just the examination of rates.

Data regarding ward level teenage conception data is not publically available.

Table6 below shows Hotspot wards for 2011-13 and the previous period 2010-12 and includes details of conception rates, conception numbers, hotspot status (persisting, emerging, de-classified) and the significance compared to England.

There are 38 'hotspot' wards identified for 2011-13. 31 are so-called 'persistent' in the sense they were 'hotspots' in the last period too. The remaining 7 are 'emerging' in the sense they were not 'hotspots' in the last period. 12 wards have been de-classified as 'hotspots' since the last period.

Mansfield has 12 'hotspot' wards, Ashfield has 7, Newark and Sherwood has 8, Bassetlaw has 5, Gedling has 3, Broxtowe has 2 and Rushcliffe has 1 'hotspot' Wards.

Table 6: 2012-14 Teenage conceptions by ward. 2010-12 included for year-on-year comparison. Ward names shaded dark / red are 'persistent' hotspots, shaded intermediate / orange are 'emerging' hotspots, and shaded light / green are 'reverted' hotpots, compared to last period.

District	CMW2011 Ward Name	District rate	Hotspot status	Conception rate 'Hotspot' (above a certain cutoff) Top 20% National		Conception rate signficance relative to England	
		2011-13	2010-12 to 2011-13	2011-13	2010-12	2011-13	2010-12
ENGLAND	ENGLAND	27.6	-	*	*	Similar	Similar
Nottinghamshire	Nottinghamshire	28.5	-	*	*	Similar	Similar
Mansfield	Mansfield	40.7	-	*	*	Higher	Higher
Ashfield	Ashfield	36.4	-	*	*	Higher	Higher
Newark and Sherwood	Newark and Sherwood	31.1	-	*	*	Similar	Similar
Bassetlaw	Bassetlaw	27.2	-	*	*	Similar	Similar
Gedling	Gedling	26.2	-	*	*	Similar	Similar
Broxtowe	Broxtowe	20.1	-	*	*	Lower	Lower
Rushcliffe	Rushcliffe	16.9	-	*	*	Lower	Lower
Mansfield	Newgate	40.7	Persistent	Hotspot	Hotspot	Higher	Higher
Mansfield	Carr Bank	40.7	Persistent	Hotspot	Hotspot	Higher	Higher
Mansfield	Ladybrook	40.7	Persistent	Hotspot	Hotspot	Higher	Higher
Mansfield	Broomhill	40.7	Persistent	Hotspot	Hotspot	Higher	Higher
Mansfield	Bull Farm and Pleasley Hill	40.7	Persistent	Hotspot	Hotspot	Higher	Similar
Mansfield	Ransom Wood	40.7	Persistent	Hotspot	Hotspot	Similar	Higher
Mansfield	Sandhurst	40.7	Emerging	Hotspot	-	Similar	Similar
Mansfield	Woodhouse	40.7	Persistent	Hotspot	Hotspot	Higher	Similar
Mansfield	Netherfield	40.7	Persistent	Hotspot	Hotspot	Similar	Similar
Mansfield	Warsop Carrs	40.7	Persistent	Hotspot	Hotspot	Similar	Similar
Mansfield	Park Hall	40.7	Persistent	Hotspot	Hotspot	Similar	Similar
Mansfield	Penniment	40.7	Emerging	Hotspot	-	Similar	Similar
Mansfield	Racecourse	40.7	Reverted	-	Hotspot	Similar	Similar
Mansfield	Oak Tree	40.7	Reverted	-	Hotspot	Similar	Similar
Mansfield	Brick Kiln	40.7	Reverted	-	Hotspot	Similar	Similar
Mansfield	Woodlands	40.7	Reverted	*	Hotspot	*	Similar
Mansfield	Kingsway	40.7	Reverted	*	Hotspot	*	Similar
Ashfield	Sutton in Ashfield East	36.4	Persistent	Hotspot	Hotspot	Higher	Higher
Ashfield	Kirkby in Ashfield West	36.4	Persistent	Hotspot	Hotspot	Higher	Higher
Ashfield	Hucknall Central	36.4	Emerging	Hotspot	-	Higher	Similar
Ashfield	Sutton in Ashfield Central	36.4	Persistent	Hotspot	Hotspot	Higher	Higher
Ashfield	Hucknall East	36.4	Persistent	Hotspot	Hotspot	Similar	Similar
Ashfield	Hucknall West	36.4	Persistent	Hotspot	Hotspot	Similar	Similar
Ashfield	Kirkby in Ashfield East	36.4	Persistent	Hotspot	Hotspot	Similar	Similar
Ashfield	Woodhouse	36.4	Reverted	-	Hotspot	Similar	Similar
Newark and Sherwood	Castle	31.1	Persistent	Hotspot	Hotspot	Higher	Higher
Newark and Sherwood	Bridge	31.1	Persistent	Hotspot	Hotspot	Higher	Higher
Newark and Sherwood	Devon	31.1	Persistent	Hotspot	Hotspot	Higher	Similar
Newark and Sherwood	Boughton	31.1	Emerging	Hotspot	-	Similar	Similar
Newark and Sherwood	Muskham	31.1	Emerging	Hotspot	*	Similar	*
Newark and Sherwood	Ollerton	31.1	Persistent	Hotspot	Hotspot	Similar	Similar
Newark and Sherwood	Balderton North	31.1	Persistent	Hotspot	Hotspot	Similar	Similar
Newark and Sherwood	Clipstone	31.1	Persistent	Hotspot	Hotspot	Similar	Higher
Bassetlaw	Carlton	27.2	Emerging	Hotspot	-	Higher	Similar
Bassetlaw	Langold	27.2	Persistent	Hotspot	Hotspot	Similar	Similar
Bassetlaw	Harworth	27.2	Persistent	Hotspot	Hotspot	Similar	Higher
Bassetlaw	Worksop North East	27.2	Persistent	Hotspot	Hotspot	Similar	Similar
Bassetlaw	Worksop South	27.2	Emerging	Hotspot	-	Similar	Similar
Bassetlaw	East Retford West	27.2	Reverted	-	Hotspot	Similar	Similar
Bassetlaw	Ranskill	27.2	Reverted	*	Hotspot	*	Similar
Gedling	Netherfield and Colwick	26.2	Persistent	Hotspot	Hotspot	Similar	Similar
Gedling	Valley	26.2	Persistent	Hotspot	Hotspot	Similar	Similar
Gedling	Killisick	26.2	Persistent	Hotspot	Hotspot	Similar	Similar
Gedling	Daybrook	26.2	Reverted	-	Hotspot	Similar	Similar
Broxtowe	Stapleford North	20.1	Persistent	Hotspot	Hotspot	Higher	Higher
Broxtowe	Eastwood South	20.1	Persistent	Hotspot	Hotspot	Similar	Higher
Broxtowe	Chilwell West	20.1	Reverted	-	Hotspot	Similar	Similar
Broxtowe	Brinsley	20.1	Reverted	*	Hotspot	*	Similar
Rushcliffe	Bingham West	16.9	Persistent	Hotspot	Hotspot	Similar	Similar
Rushcliffe	Keyworth South	16.9	Reverted	-	Hotspot	Similar	Similar

Source: ONS Conceptions Statistics 2010-2012 (published 2014)
Note on suppression: rates and numbers suppressed due to low counts (4 or less) are denoted ''.*

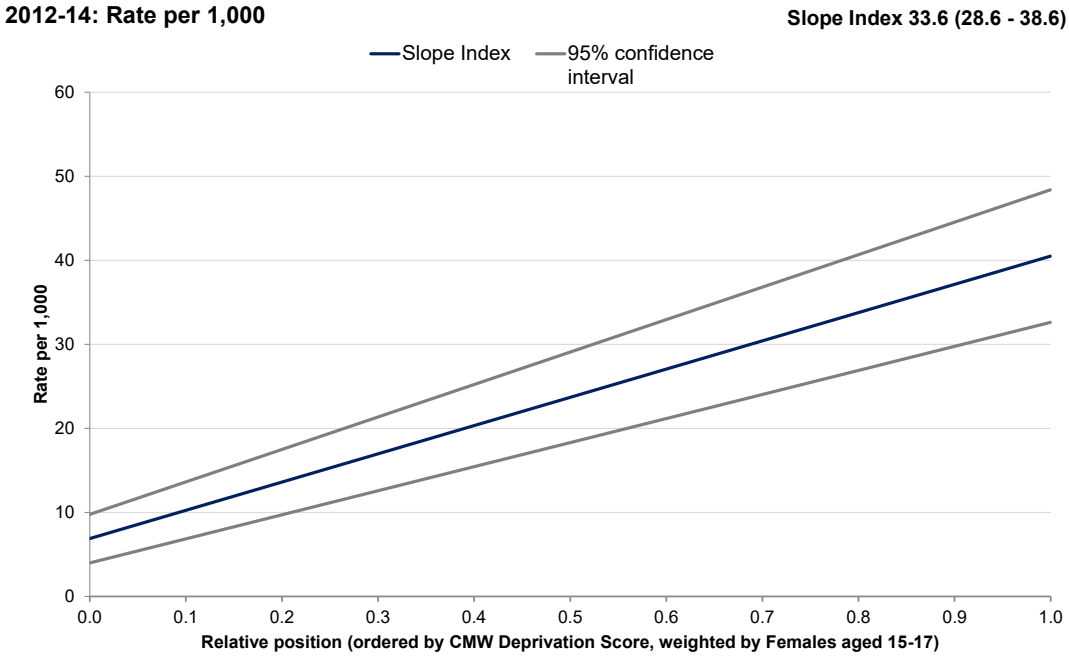
Slope Index of Inequality

The Nottinghamshire Young People's Health Strategy Steering 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 2012-14 was 33.6 which means that there were 33 more teenage conceptions per 1,000 females aged 13-17in the most deprived ward compared to the least deprived ward.

Figure 4: Slope index of inequality (SII) for under-18 conceptions by ward in Nottinghamshire 2012-14

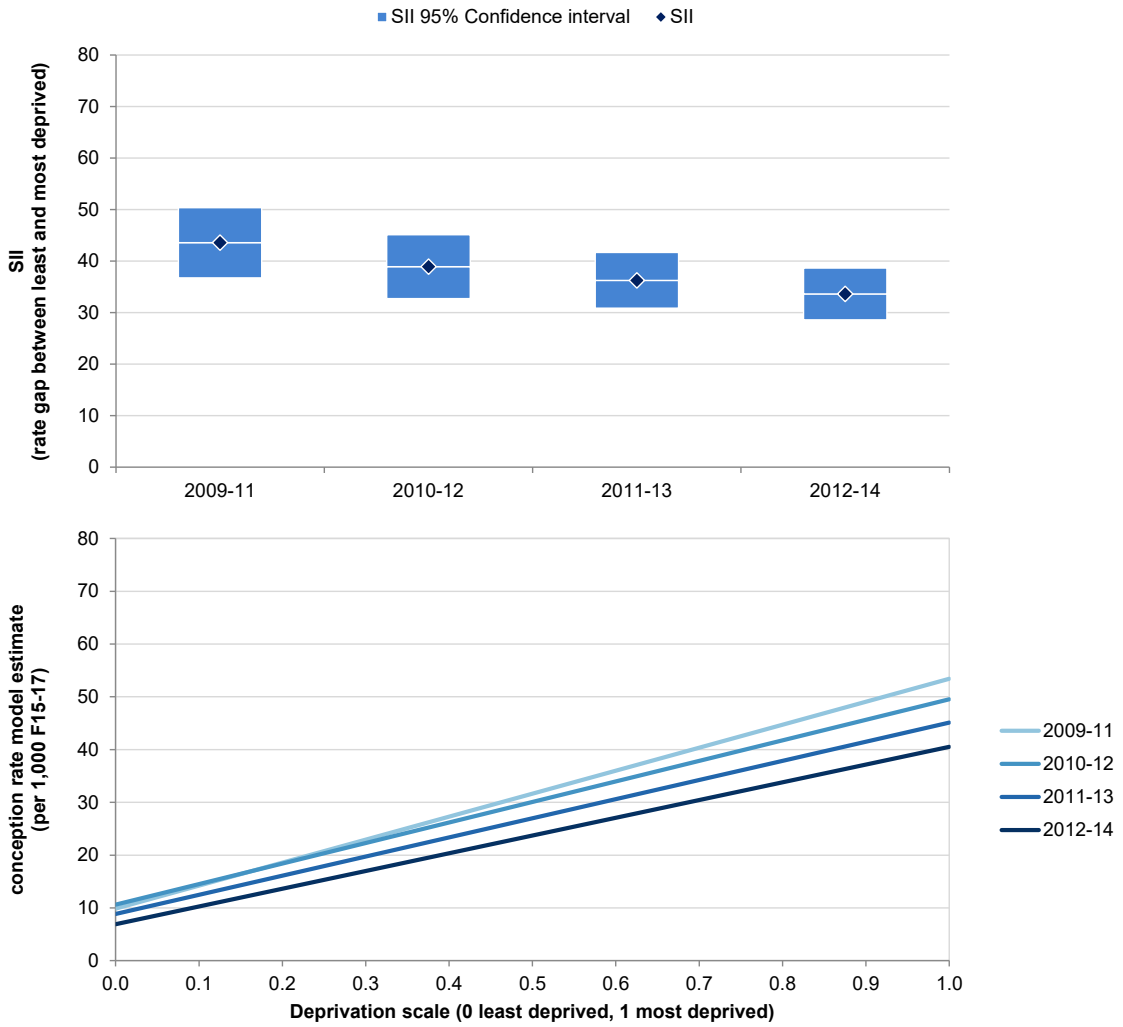


Source: Secondary analysis of ONS conceptions and population data, DCLG deprivation data (IMD 2010) (Nottinghamshire Public Health)

Note: SII is broadly well defined but the exact calculation is dependent on a number of factors including the deprivation measure and population denominator used. Variation can be expected between these values and those in earlier reports however the overall picture remains the same

Figure 5 below shows how the slope index of inequality (without the wards plotted) has changed over time (2009-11 to 2012-14). The slope index has reduced over four years, although the change is not statistically significant. Teenage pregnancy conception rates have reduced by a greater degree in the most deprived wards between 2009-11 and 2012-14 (top right end of slope), demonstrating that health inequalities have reduced over this period. This set against an overall County teenage conception rate that has been decreasing.

Figure 5: Change in slope index of inequality (SII) for teenage conception rates in Nottinghamshire County wards from 2009-11 to 2012-14. Change over time (upper panel), SII conception rate deprivation model curve change over time (lower panel)



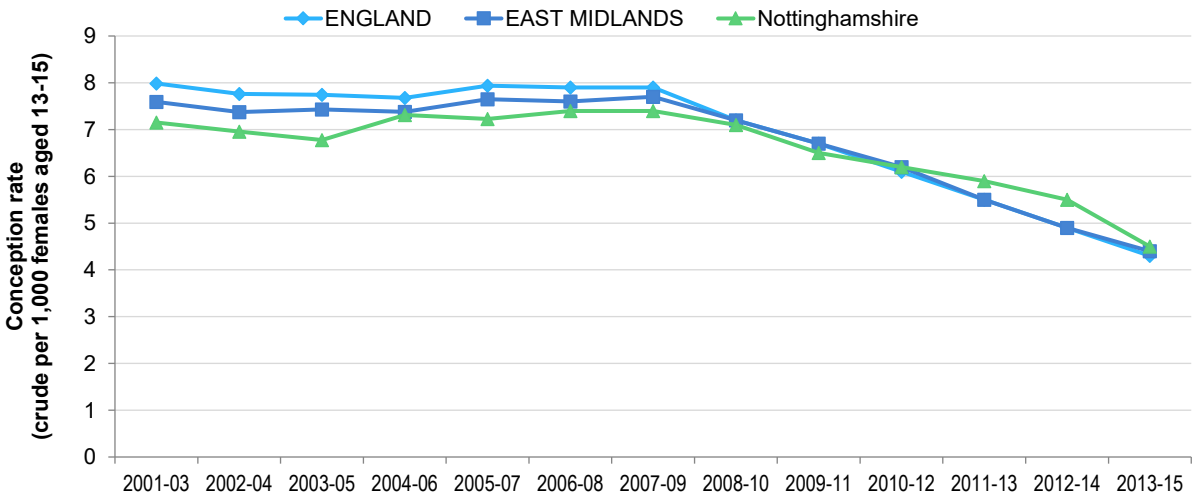
Source: Secondary analysis of ONS conceptions and population data, DCLG deprivation data (Nottinghamshire Public Health)

Note: The periods analysed are restricted to those from 2009-11 to ensure any variation is due only to the underlying pattern in rates rather than to methodological changes (i.e. change in geographic unit, change in deprivation measure).

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 then from 2007-09 onwards there has been a steady downwards trend. This is shown in figure 6

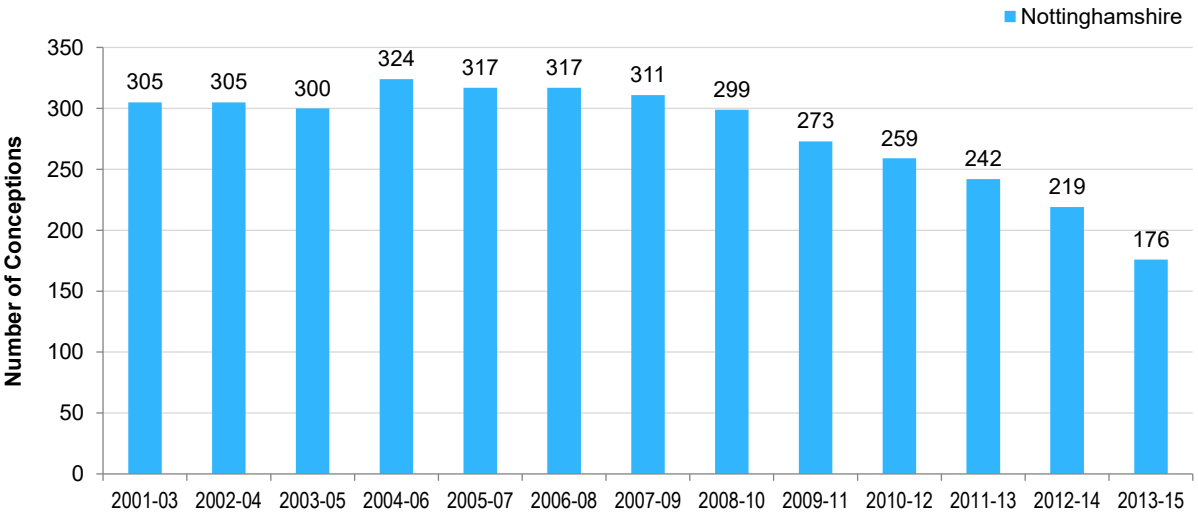
Figure 6: Nottinghamshire aggregated under 16 conception rates 2001-03 to 2013-15



Source: ONS Conceptions Statistics 2015 (published 2017)

When considering the numbers of conceptions Figure7 below identifies that over 3 year aggregated periods there are recently less than 300 conceptions to young women under the age of 16 in Nottinghamshire. The graph below highlights there has been no year-on-year increase in numbers since 2004-06 and that the numbers of under 16 conceptions have seen a steady decrease from 2008-10 onwards to their current level in 2011-13 of 242.

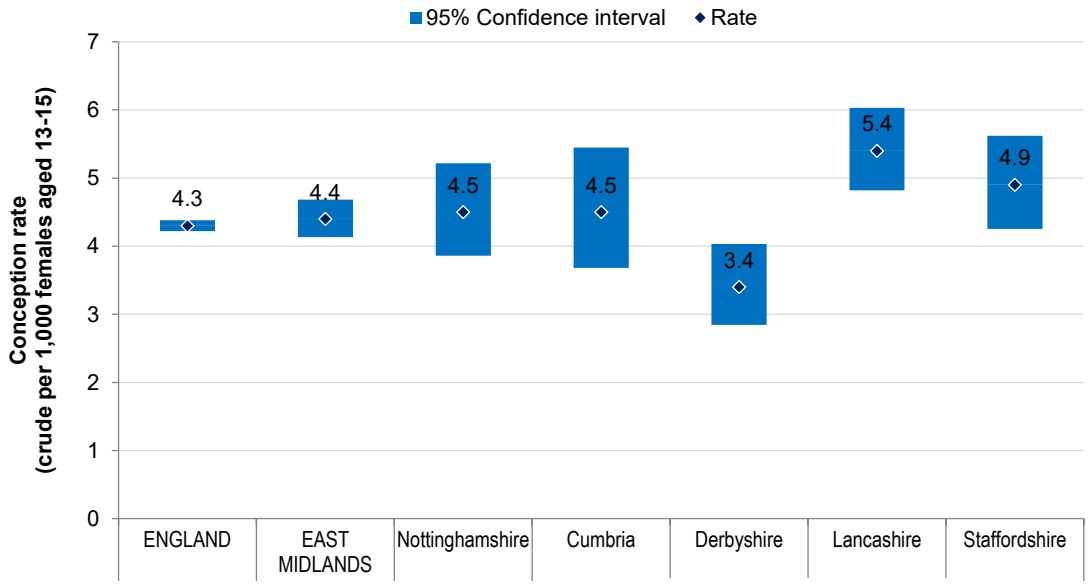
Figure 7: Nottinghamshire under 16 conception numbers 2001-03 to 2013-15 (three year rolling totals)



Source: ONS Conceptions Statistics 2015 (published 2017)

Nottinghamshire under 16's conception rates are statistically similar to National, Regional and Statistical neighbours. This is shown in figure 8.

Figure 8: Nottinghamshire under 16 conception rates compared to National, Regional, and Statistical neighbours 2013-15



Source: ONS Conceptions Statistics 2015 (published 2017)

Trends and projections

Using teenage conception data from the last 20 years it is possible to predict the teenage conception rates and numbers for the next seven years, until 2020.

Table 7 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.

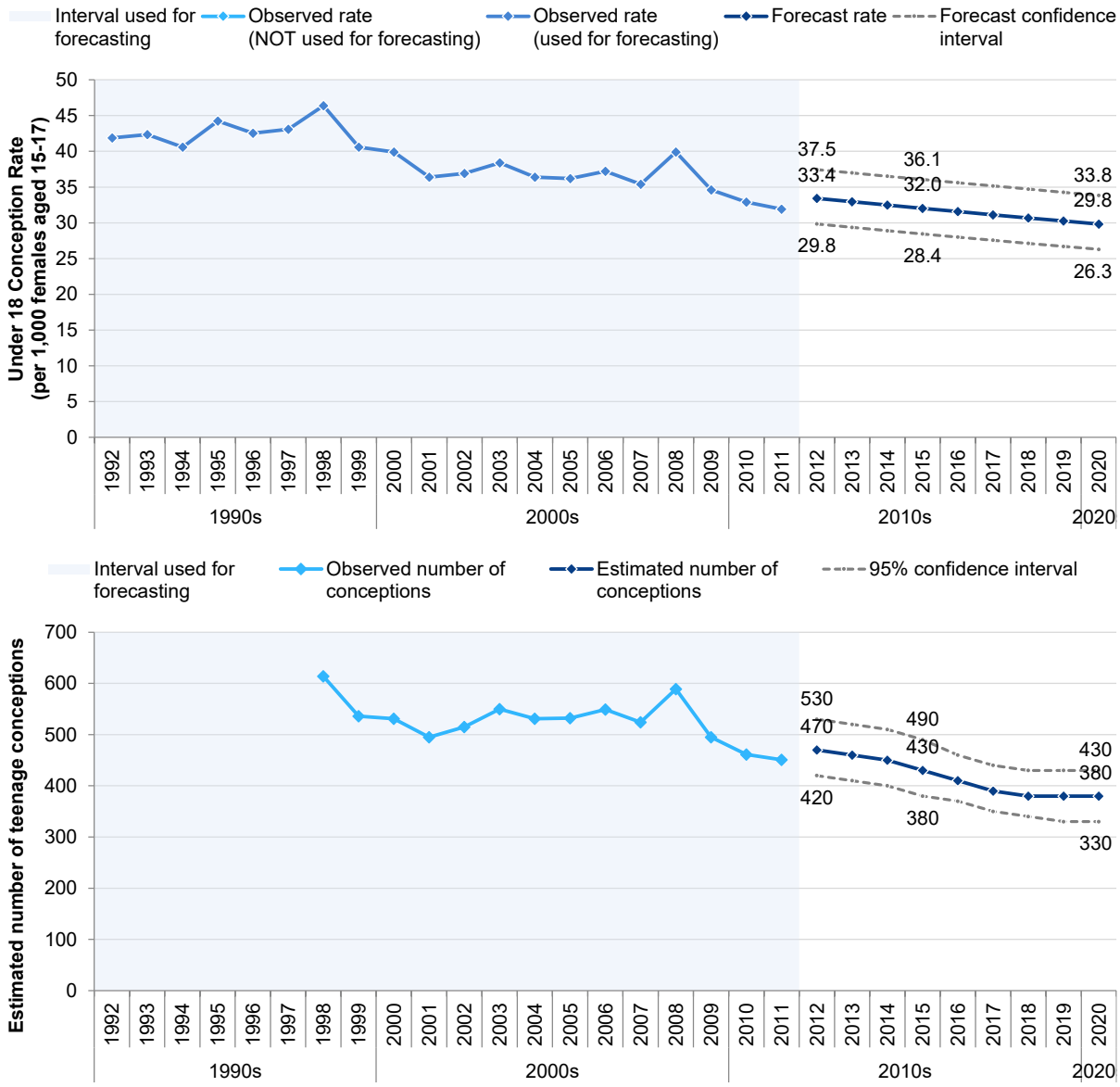
Table 7: Forecasted Under 18 conception rates for Nottinghamshire, East Midlands and England[13]

	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

The forecasted rate shows a steady slow decline in teenage conception rates for Nottinghamshire, however experience from the last 10 year National Teenage Pregnancy Strategy: Beyond 2010 has shown us that fluctuations exist where there are changes in economic status, educational attainment and aspirations. It is also important to remember that there are the high levels of teenage conceptions in some districts and wards across Nottinghamshire which are related to levels of deprivation.

Figure 9 show the projected teenage conception rate and numbers for Nottinghamshire to 2020. Both graphs show that teenage conceptions are expected to decline, based on the previous trends. However it is important to note that the latest confirmed data available is for 2015 and the economic climate at present may have a detrimental effects on future teenage conceptions.

Figure 9: Projected Teenage Conception rates in Nottinghamshire from 2011 to 2020. Projected conception rates (top panel) and estimated consequential number of conceptions (bottom panel)



Source: Local secondary analysis of ONS conceptions data, ONS population projections, Forecast Pro software

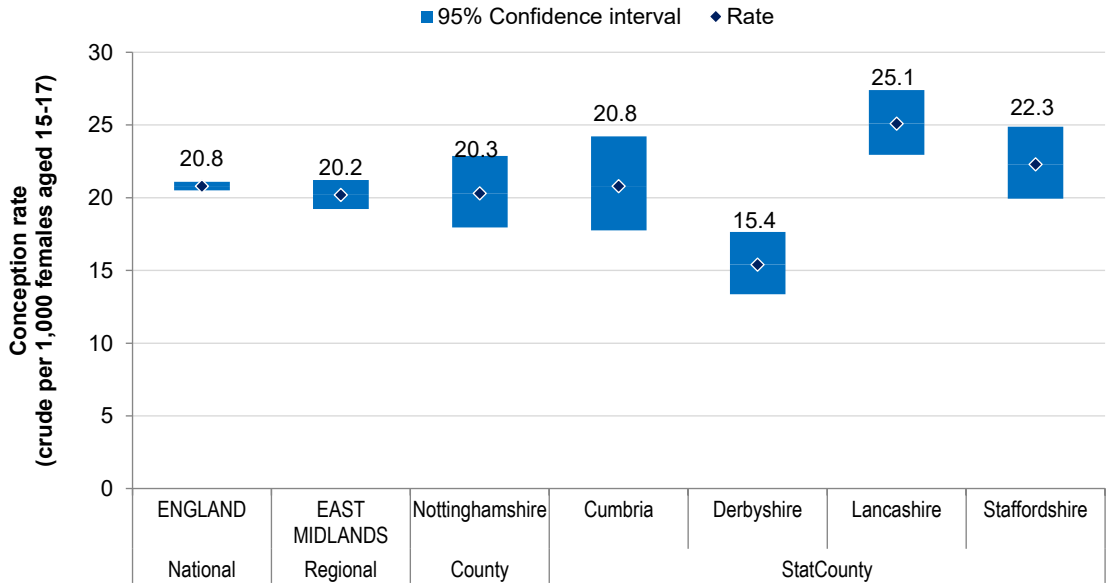
3) Targets and performance

Following the national 10 year Teenage Pregnancy Strategy (Teenage Pregnancy Strategy: Beyond 2010) 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 agenda for Nottinghamshire is now under the umbrella of the Young People's Health Strategy (Young People's Health Strategy) which 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.

How we compare with others

Figure 10: 2015 Teenage Conception rates for Nottinghamshire and statistical neighbours



Source: ONS Conceptions Statistics 2015 (published 2017)

Figure10. Shows that Nottinghamshire's 2014 teenage conception rates were similar to the East Midlands average, the England average and all of Nottinghamshire's statistical neighbours (at the 95% statistical confidence level).

National and Local Strategies

Following the ten year National Teenage Pregnancy Strategy: Beyond 2010, (Teenage Pregnancy Strategy: Beyond 2010) there is an established evidence base of what works. The Nottinghamshire Young People's Health strategy has prioritised the following activity:

• Effective young people friendly contraception and sexual health service provision which prevents teenage conception and poor sexual health.

• Ensure that these services are fully embedded into the 0-19 universal public health nursing service

• Ensuring children and young people have access to information (including online), advice and education about sexual health and relationships.

• Workforce development. - Regular training offered, CPD opportunities.

• Ensure that the views and opinions of young people are proactively sought when planning, developing and implementing health services

• Supporting and equipping schools in order to deliver/have access to high quality sex and relationships education.

• Improving health and social outcomes for teenage parents (including young fathers) and their children.

4) Current activity, service provision and assets

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:

Sexual Health and Contraception Services

In April 2016, the provision of STI and contraception services across Nottinghamshire changed, in that all the previous Genitourinary Medicine (GUM) and Contraception and Sexual Health (CaSH) services were combined so as to provide an integrated model of care – Integrated Sexual Health Services.

The integrated Sexual Health Services (ISHS) provides free and confidential sexual health service that includes sexually transmitted infection (STI) screening and treatment, information and advice on sexual health matters and the full range of contraception including long acting reversible contraception (LARC) methods and access to emergency contraception and the C Card scheme. The ISHS also provide health promotion and outreach services that are targeted to reach more vulnerable groups (including those at higher risk of teenage conceptions) and those at greatest risk of sexual ill health. One of the services offered is SEXions aimed at young people aged 13 – 19 (up to 24 with a learning disability). The service provides confidential one to one advice and support to young people at a place of their convenience on issues such as puberty, body changes and periods, being ready and delaying first time sex, contraception, pregnancy, termination of pregnancy, healthy relationships, sexuality, online safety and Sexually Transmitted Infections. The SEXions team is able to able to offer young people a choice of either a male or female advisor. Young people can self-refer into the service using the mobile numbers provided or can use the text service to ask questions or to arrange appointments at related sexual health.

The C-Card Scheme, commissioned by the Local Authority, offers condoms and sexual health and relationship advice to young people under the age of 25 in a wide number of settings including youth clubs, health centres, supported housing, pharmacies etc. There are sites located in teenage pregnancy hot spot wards and settings targeting groups at risk.

To date 13,781 young people aged 13-25 years are registered to use the scheme and the location of C-Card sites is included in the map below (Appendix, Map 1). The scheme aims to increase the number of access points across settings in hot spot wards.

Map 1.0 in the appendix also shows the 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. To date there are:

- 211 Issue points
- 488 trained staff
- 7,578 young people aged 13-25 registered on the C-Card scheme
- Average of 2,000 active C-Card Users per year
- 59% of C-Card users are registered within a hot spot ward district

Healthy Families Programme

From April 2017 the Healthy Families Programme combines care previously provided by Health Visitors, School Nurses, the Family Nurse Partnership Programme and the National Child Measurement Programme. Public health practitioners support all children, young people and families in twenty locally based Healthy Family Teams. Teams have the knowledge and skills to work with all children and young people from the age of 0-19 and all children, young people and families receive care from this service from before birth to their late teens, receiving the support they need, when they need it, regardless of where they live in Nottinghamshire. Where children, young people and families need additional support, appropriate care ranging from brief interventions to evidence based, time limited programmes of support will be delivered by the most appropriate member of the Healthy Family Team.

There will be drop-in sessions for young people in or near each secondary school including provision of sessions in school holidays. The offer to young people attending these clinics has been extended to include additional public health interventions such as general consultation and advice about sexual health and prevention, pregnancy testing, C card and Chlamydia screening. The targeted offer for young people in the ten highest need communities will be extended with more frequent sessions available.

Education Services

The service commissioned to support schools is the Nottinghamshire Schools Health Hub.

The aim of the Schools Health Hub is to support schools to improve health and wellbeing and educational outcomes, resulting in safe, healthy, happy, resilient children and young people who are able to achieve their potential, as well as assisting more schools in achieving an 'outstanding' Ofsted result through broadening of their curriculum.

The Hub acts as an umbrella for children's and young people's evidence-based health promotion services, supporting a joined up partnership approach, whilst maintaining a schools focus and bringing together key health and wellbeing related visitors to schools.

As well as this the hub focuses on supporting schools with the identification of local health and wellbeing concerns, and to provide advice, guidance and information for schools in relation to policy development, PSHE planning and training (including signposting to existing training and services).

Family Nurse Partnership

The Family Nurse Partnership (FNP) is an evidenced based, intensive nurse-led prevention and early intervention programme for vulnerable first time young parents and their children. 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. It is the first part of the preventive pathway for the 2-5% of most disadvantaged children.

FNP aims to:

- Reduce the impact of deprivation;
- Improve the short and long term health and wellbeing outcomes for young parents and the children born to vulnerable, young, first time mothers
- Reduce the short and long term cost of ongoing care, and enhance economic self-sufficiency by improving the life chances of FNP clients and children's

This is achieved by supporting young women and their partners to:

- Have a healthy pregnancy
- Become knowledgeable and responsible parents
- Provide babies with the best possible start in life
- Develop positive outcomes for themselves and their children.

The Nottinghamshire programme was launched in April 2013. FNP is currently commissioned by Nottinghamshire County Council. The FNP programme commissions 375 places and the service is currently in a position where it is has capacity to offer the programme to all young women referred who meet the eligibility criteria as determined by the Department of Health.

There are key areas where Nottinghamshire FNP is demonstrating a significant improvement, these include:

- significant, sustained change in smoking cessation with year on year improvements in pregnancy and early infancy
- significant, sustained improvements in breastfeeding, with year on year improvements in breastfeeding at initiation, 6-8 weeks and 6 months infancy.
- year on year improvements in child immunisation rates
- improvements in reducing second pregnancies and in increasing use of LARC
- significant numbers of mothers with children over 12months in the program are supported into employment, education or training

Children's Centres

Children's centres bring together childcare, early education, health and family support services for families with children under 5 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 Ofsted registered children's centre services in Nottinghamshire. They are commissioned by Nottinghamshire County Council and delivered by a partnership of Nottinghamshire Healthcare Trust, Rotherham and North Nottinghamshire College and Family Action.

Children centres worked with 606 teenage parents (under the age of 20) with children under 5 years in 2015/16. There is, however, variation across districts, as it is unclear what proportion of the teenage parent population have engaged with children's centres by district.

Youth Service

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. Currently data is available on the total number of young people who engaged with youth services, which was 13,138 in April 2016-March 2017. There are planned improvements in data collection for teenage parents accessing this service.

Youth support workers can help pregnant teenagers access early and unbiased pregnancy options and advice as well as supporting young parents to access local services such as antenatal care and children's centres. They also help in building aspirations to support young parent's enter/re-enter education, employment or training.

Youth Service provides youth work interventions (Called the Early Help Offer) with small groups of young people, and may be delivered in partnership with schools or other local services working with young people, this is based on local need, and may have a focus on Teenage Pregnancy and Sexual Health. Each site will deliver a 'Health, relationship and well-being' session.

The service also leads on ensuring that homeless young people are offered appropriate packages of care including supported accommodation when required.

Support for Schools

The Support for Schools Service 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 alternative education provider. The team was launched in April 2012 and so far 105 school aged young women have received support to remain or reintegrate into education of which 99 were under 16 and 6 post 16 within mainstream school, 6th form.

Teenage Pregnancy Team

The Teenage Pregnancy Team is offered by Nottingham University Hospital (NUH) based with the Specialist Community Midwifery Team. Clients are offered extra appointments at home throughout their pregnancy with a named midwife in the team regardless of moves in the City or County. Sherwood Forest Hospital Trusts do not have a dedicated team however offer support based on individual need. Maternity services are now commissioned to provide an enhanced service for mothers under 20 years of age, who are now classed as intermediate (those under 20 are offered an 'enhanced' package of care*)* on the maternity pathway.

Care to Learn

Care to Learn is a childcare grant for all teenage parents under the age of 20 (including fathers and under 16's), to enable them to access education or training.[14] The grant pays for all childcare costs,

including travel costs for teenage parents. Only young parents in education or training can access the grant. www.gov.uk/care-to-learn

Take up rates in Nottinghamshire have consistently been low compared to statistical neighbours.

In most Local Authorities, it seems that the greatest proportion of teenagers accessing the Care to Learn Grant are under the age of 18, this includes under 16's who are more likely to take up the grant as they are of statutory school age and already in education which makes them eligible for the grant. However as data regarding age is cumulative, the under 18 percentage take up is more useful to measure progress. The data used however is a snapshot and changes depending on the time of year and when education and training provision is available.

It is unclear what the barriers are for young parents and this could be linked to disengagement from education, lack of accessible and appropriate education or training provision, lack of childcare provision on or near a place of education or training e.g. an FE college; a misconception about what the grant is for and who is eligible, and/or a lack of proactive promotion. It is important to note that young people who do conceive at a young age are more likely to have been disengaged from school, left school with no qualification and for 16-19 year olds are more likely to be NEET (Not in Training or Education); although local NEET data for teenage parents is no longer available as there is no longer a duty to collect and analyse this data. [21]

Healthy Start

The Healthy Start Programme is a statutory scheme providing a nutritional safety net and encouragement for breastfeeding and healthy eating for over half a million pregnant women and children under four in low income and disadvantaged families across the UK. One element of this is the provision of vouchers to buy fresh fruit and vegetables and the other focused on free vitamin supplements. The key challenge locally is to improve the uptake of the Healthy Start children's drops and the Healthy Start vitamins. The Healthy Start vitamins are important as we know 8% of children under five do not have enough vitamin A in their diet and families in lower income groups tend to have less vitamin C in their diet. All pregnant and breast feeding women and young children are at risk of vitamin D deficiency (Department of Health 2012).

The Healthy Start Programme is promoted by midwives, health visitors, the family nurse partnership and children centres. Increasing the ease of accessing Healthy Start vitamins, currently available from children's centres, should be considered as a way to increase access to the scheme.

The uptake of the Healthy Start vitamins nationally is very low which highlights that a number of eligible women and babies are not receiving free vitamin supplements. In Nottinghamshire between May 2015 and June 2016 74% of eligible women accessed the Healthy Start scheme though it is not clear how many of these accessed the vitamins. Two studies referenced by NICE suggest that less than 10% of Healthy Start claimants redeem their vitamin coupons due to a range of reasons including lack of awareness and limited collection points.

Supported Accommodation

All Providers are able to work with pregnant women and teenage parents and suitable accommodation is available in all localities

Supported Lodgings and Nightstop - hosts offer a room within their home for young people to stay. Some hosts are willing to accommodate pregnant teenagers or teenage parents. A matching process will be completed so the young person and host have opportunity to meet each other before the young person moves into the host's home.

The supported accommodation providers are: Framework Housing Association, NCHA in partnership with New Roots, and HomeGroup. All providers offer a package of support that is tailored to the individual's needs and is reviewed regularly. Accommodation is provided in a range of settings including a core service with staff on site 24 hours a day, self-contained accommodation or shared accommodation with visiting support.

Providers are able to offer support around many areas such as: budgeting, alcohol or substance use, benefits of breastfeeding, sexual health and contraception, weaning, healthy relationships, access to universal and additional services, preparing for a tenancy and independence skills. Staff will be involved in Child in Need or Child Protection plans and will help the young person to understand the process and their need for compliance.

The current provision includes 220 units of accommodation plus 7 emergency bed spaces for homeless young people aged 16-21. In June 2016 it was recorded that there were 24 teenage parents or pregnant teenagers within the supported accommodation service. Pregnant young people can access emergency accommodation, but there is no provision for emergency accommodation for teenage parent. Pregnant young people usually have to move out of the core service prior to having their baby. Typically they would move into self-contained accommodation, this may be a flat or house with visiting support.

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.

Four Key areas where a reduction in the financial burden can be directly targeted include:

- **Safeguarding** – for every child prevented from going into care, social care would save on average £65K per year. Every domestic violence incident prevented saves the police, LAs, the Criminal Justice System and the NHS £2,700.
- **School Readiness** – every child who is 'school ready' who would not otherwise be, saves schools £1,000 per year.
- **EET** – every teenage mum who returns back into education, training or employment (EET) saves agencies £4,500 per year.
- **Mental Health** – for every individual who does not develop a mental health issue saves a Local Authority £2,000 per year

A teenage mother who does not work until her child is three can be entitled to benefits of up to £20,000 and more than 40% of teenage parents are allocated social housing. [21]

Poor Health Outcomes

Although not projected to, 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.

5) 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 access to young people friendly 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 un-intended. 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.

From March 2017 Sex and Relationship Education (SRE) is mandatory in schools. It involves teaching children about reproduction, sexuality, healthy relationships and sexual health. It doesn't promote early sexual activity or any particular sexual orientation. Some parts of sex and relationship education are compulsory - these are part of the national curriculum for science.

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].

In 2014 a mystery shopper evaluation of local sexual health services commissioned by Nottinghamshire County Council and carried out by young people, identified a number of areas for further development across a range of health services and services offering health interventions, such lack of young people friendly websites. As an outcome of this since January 2017 Health for Teens, the first Young People's Health & Wellbeing focussed website for Nottinghamshire was launched. The website, funded by Public Health at Nottinghamshire County Council, and the Nottinghamshire Safeguarding Children Board, aims to support young people aged 11 and over with their emotional and physical health and wellbeing. As well as the website, there are also a number of excellent examples where services take time to listen and engage young people in assessing and supporting their needs.

Long Acting Reversible Contraception (LARC)

The National Institute of Clinical Effectiveness (NICE) issued guidance[18] in 2014 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 12% of contraceptive usage nationally in 2008–09, compared with 25% for the oral contraceptive pill and 25% for male condoms.). 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, 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 becoming 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.

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

6) 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].

'Work to tackle teenage pregnancy' is a key element embedded in priority areas of work including Public Health, Child Poverty and Early Help across Nottinghamshire County Council Services.

Furthermore continuing to develop young people friendly health services is a key priority for the Young People's Health 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 re-assessment of services by seeking user feedback and scrutiny of policies and processes.

Changes the provision of services across the county continue to evolve including the provision of Integrated Sexual Health Services (2016) and the Healthy Families Programme (2017), will ensure families and young people will receive a more integrated evidence based support thus resulting in improved health outcomes. Also with continuing improved data recording, further service improvements can made going forward.

7) Local Views

A local review of school nursing services in 2013, identified that young people in Nottinghamshire want public health practitioners (school nurses) to offer information and advice about relationships and sex, and a key priority role for public health practitioners 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

The Children's Integrated Commissioning Hub (ICH) commissioned Nottinghamshire County Council's Youth Service to undertake a mystery shopper exercise of key health services. Visits by trained mystery shoppers took place between March and September 2014.

The mystery shopper exercise aimed to evaluate services with a view to sharing best practice, making health services and interventions young people friendly, improving access to these services and consequently encouraging improved health and wellbeing amongst young people.

Visits took place at:

- GP Practices
- Contraception and sexual health services in community and hospital settings
- Pharmacies offering Emergency Hormonal Contraception
- A selection of C-Card sites including those in youth centres, pharmacists and health centres

Key Findings included:

- Young people are still very concerned about confidentiality and this can prevent them from accessing services or asking for help.
- Young people evaluated services 'well' when staff were friendly and took their time to listen to them. Even a smile can make young people feel more comfortable.
- Young people are disappointed by the lack of information available in settings about a range of health concerns e.g. eating disorders, which in turn makes it hard to be signposted to appropriate services and access advice and guidance.
- Generally websites were not young people friendly, were often out of date and did not include information re location, access by public transport and what services are offered. Young people want maps and photographs of the building to help them locate services.
- Young people suggested the need for one website for all young people health needs and services to enable them and professionals to find information easily.

Further consultations with young people took place as well as a survey aimed at young people to gather views around young people services and it was the findings from these along with the outcomes of the mystery shopper exercise that helped define Nottinghamshire's Young People's Health Strategy (September 2015) http://www.nottinghamshire.gov.uk/media/114108/youngpeopleshealthstrategy.pdf. The strategy intends to define where commissioners want to get to regarding improving the health of young people in Nottinghamshire, as well as detailing some of the elements of how that will happen.

A survey conducted as part of the Partners in Maternity services with fathers (including teenage fathers but not exclusive too), and their views of pre-natal and maternity services from a fathers/partners

perspective gave interesting insight into, what works well, what some of the gaps and barriers and what further could be done. Below are a few examples of some of the themes recorded:

- 96% of birth partners felt included in their partners pregnancy
- More information on specific topics included: complicated deliveries, development of baby, help with breastfeeding
- 89% found antenatal classes useful
- 41% not provided with relevant information on smoke free homes /smoking cessation –and 22% said they were not aware of it
- Additional information requested that would be helpful included: an App for fathers, understanding the father's role in pregnancy, booklet for dads, more information when moving on to the ward, step by step guides, father specific antenatal classes, information on 'what's normal?'
- Majority of respondents liked receiving information through leaflet format followed by Apps and groups
- 53% did know how to access mental health support if required with 44% saying weren't sure on how to access mental health support
- Overall comments on service received were very good

What does this tell us?

9) Unmet needs and service gaps.

A comprehensive service has been commissioned across all districts of Nottinghamshire, (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. There is however further work that could be done to continually review the targeted support for teenage parents the services provide along with collecting data to monitor access and use.

A service review carried out in 2013 on the National Healthy Schools Programme highlighted gaps and inconsistencies from schools in delivering sex and relationships education (SRE) programmes to pupils. It also stated that rather than existing school staff they would prefer an external provider to SRE. Currently the only provision to schools is given by C Card (young people's contraception scheme) in supporting with SRE delivery as well as C Card sessions. 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. From March 2017 it has become mandatory for schools to deliver Personal Social Health Education (PSHE) or Sex and Relationships Education (SRE), this ensures pupils are taught the knowledge and life skills they will need to stay safe and develop healthy and supportive relationships, particularly dealing with the challenges of growing up in an online world. [24] However, all schools are not fully equipped or have the tools to deliver SRE which is critical for the continued improvement of young people's sexual health. In light of this there would need to be a planned approach across Nottinghamshire in supporting schools to deliver on this agenda at a consistent standard.

Proactively engage pregnant teenagers and young fathers to increase their access to children centres and participation in children centre activities.

Despite there being a specialist teenage pregnancy midwifery team in the County, there needs to be more work done to ensure services are meeting the needs of pregnant teenagers in the whole of the County in the way its delivered and reaching more young mothers.

Early identification, early access and effective care for all hard to reach groups who may not access ante-natal care before 12 weeks of pregnancy, for example teenagers, gypsy roma traveller (GRT), refugees and asylum seekers.

There is no dedicated careers advice 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 practitioners in education and childcare settings.

Young fathers are often invisible to services with much of the support and focus given to young mothers. This is because often young fathers do not live with the mother, are disengaged as they feel 'left out' of parent services focused on mothers and also young fathers may present as single men. Further work needs to be done to engage young fathers in services as statistics show that:

- Children with highly involved fathers have better outcomes
- Young fathers influence the mothers smoking and breastfeeding choices
- Teenage mothers with a supportive partner are less likely to get post-natal depression
- Becoming a father can be a positive turning point in confidence and re-engagement with education and employment.[15]

10) Knowledge gaps

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 Provision

- Access to services for higher risk groups.
- Smoking prevalence and quitter rates data is not available by age or target group. Work needs to be done with Nottinghamshire's smoking cessation service, SmokeFreeLife, 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.
- Children Centre services have previously had a key role in engaging fathers, however in recent years, the needs of fathers have received a lower profile than the needs of mothers. It is currently unclear what the current needs and views of fathers are in relation to outcomes for young children
- A more holistic approach considering both the health and social needs of teenage parents needs to take place. The learning from this needs to be shared to ensure universal and targeted services to proactively engage this group.

Education

- School readiness is a measure of how prepared a child is to succeed in statutory education. The good level of development (GLD) is used to assess school readiness. Currently children are defined as having reached a GLD at the end of the Early Years Foundation Stage if they have achieved at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development, physical development and communication and language) and in the specific areas of mathematics and literacy. Currently there is no local data regarding GLD for children of teenage mothers collected locally.

Safeguarding

- There needs to be a better understanding on issues around sexual exploitation locally- a new Child Sexual Exploitation pathway is in place[20], but further work needs to done to grasp the complexities around this to best support young people.

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.

What should we do next?

11) Recommendations for consideration by commissioners

The findings from the Joint Strategic Needs Assessment are to inform commissioners of where the need to further address gaps in local knowledge lies. The owner of these recommendations will be the Young People's Health Strategy Steering Group which will feed in the strategic action plan and overseen by the group. Several key recommendations will also feed directly into the Public Health Sexual Health Strategic Action Plan where appropriate.

Priority	Recommendation	Suggested lead commissioners
Maternity & Early Years	• Ensure teenage mothers are accessing ante-natal care before the end of the twelfth completed week of pregnancy (12 weeks and 6 days) to ensure early access to antenatal care and screening options are discussed particularly those from hard to reach backgrounds • Reduce the amount of teenage mothers smoking in pregnancy working with key stakeholders to ensure a seamless pathway • There is further work needed to promote the Healthy Start Programme and the Healthy Start vitamin distribution centres across Nottinghamshire with all mothers no just teenage mothers.	Public Health, CCG's and Early Childhood Services, NCC
Improve childcare provision	• The Childcare Sufficiency Assessment identified demand for provision in school holidays are unmet for after school and before school provision. Work should be undertaken with key stakeholders to identify options for provision, which may include the right to request provision on schools sites, provider partnerships, and ensuring all available provision is recognised and promoted through the local authority's information duty, delivered by the Families Information Service. • Work should be undertaken with key stakeholders to ensure partners and staff are aware of what support for the costs of childcare is available, and how the free entitlement can be used, and disseminate that information to their client groups. • There is a need to support the availability of childcare to meet changing working patterns (such as demand for childcare outside of traditional office hours 9-5 Monday – Friday) and with employers to support flexible working and awareness of support for childcare. • Explore flexible delivery models as a matter of urgency; and consider how these models of working can be applied across different types of provision for all age ranges of children to support young mothers return to employment, education or training.	Early Childhood Services, NCC
Ensuring pregnant teenagers & teenage parents are effectively supported by the services provided	• Continuation of FNP programme as part of the 0 -19 Healthy Child Programme service • Improve uptake of Care to Learn Grant for teenage parents • Implementation of Public Health England Framework for teenage parents and their families	Public Health, CCG's, NCC
Young people engagement	• Additional work is required to engage young people to inform commissioning intentions.	

	• Gain a better understanding of which services teenage parents access and gain a better understanding of the local barriers for young people e.g. education support for 19-20 year olds	
Ensure robust data provision	• Review annually all teenage pregnancy/or for those at risk of teenage pregnancy commissioned services with a view that services are commissioned with clear targets and performance indicators.	Public Health, CCG's and Early Childhood Services, NCC
Joint working	The Young People's Health Strategy Steering Group has links with the Nottinghamshire Sexual Health Strategic Group – further progress activity together as well as with other services needs to continue	Public Health, CCG's and Early Childhood Services, NCC
Reducing the financial burden whilst improving health outcomes for parents and baby	The four key areas identified which can directly impact on this priority include: • Improve school readiness rates by ensuring data regarding GLD for children of teenage mothers is collected locally. • Ensure Mental Health services are skilled and equipped to support young parents with their mental health and emotional wellbeing pre and post pregnancy by linking with maternity services, FNP, specialist teenage pregnancy teams and the Health Families team. • Ensure the services that are commissioned to support teenage mothers are offering the required support and advice in supporting young mums in returning back into education, training or employment (EET) • Work should be undertaken, (steered by the Young People's Health Strategy, Steering Group and action plan), to identify and work with key stakeholders. This would ensure to ensure partners and staff embed safeguarding policies, practice and training in service delivery to support young people at risk of teenage pregnancy or repeat pregnancies.	
Prevention	The recommendations for this priority link to the recommendations under 'prevention' in the Sexual Health JSNA chapter http://www.nottinghamshireinsight.org.uk/research-areas/jsna/adults-and-vulnerable-adults/sexual-health-2015/	Public Health, CCG's and Early Childhood Services, NCC

Supporting Documents

Young People's Health Strategy September 2015
http://www.nottinghamshire.gov.uk/media/114108/youngpeopleshealthstrategy.pdf

Nottinghamshire Child and Family Poverty Strategy 2011-2020
www.nottinghamshire.gov.uk/childpoverty

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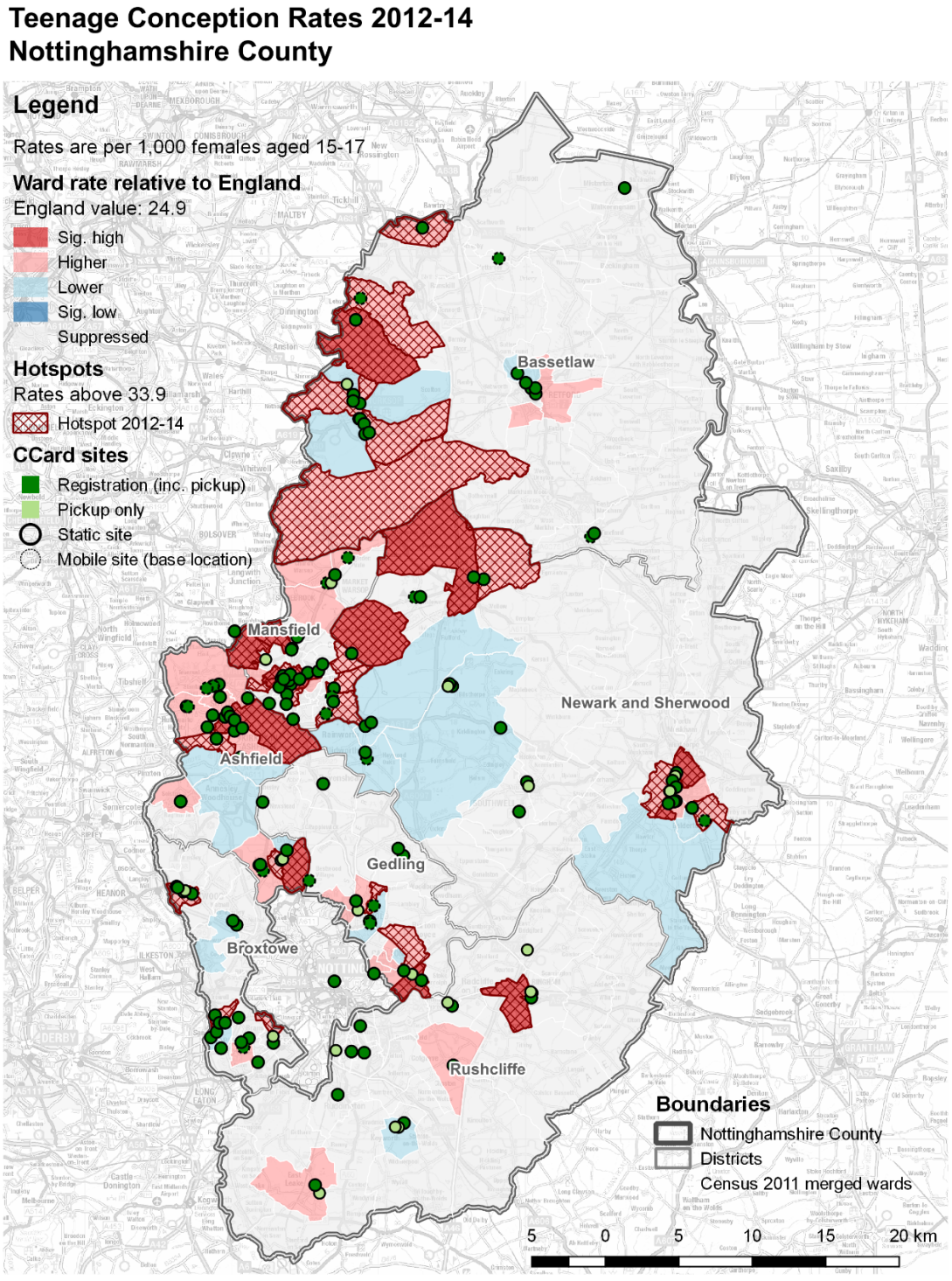
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Appendix

Map 1: Teenage Conception Rates 2012-2014 against C Card registration and pick up points, Nottinghamshire County



Source: ONS Under 18 conception rates per 1,000 females aged 15-17
To maintain confidentiality data has been suppressed for some wards where counts are low

Produced by Nottinghamshire Public Health Intelligence Team (NPHIT/IB)
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