



Newcastle Teenage Pregnancy and Parenthood Strategy

January 2009 to March 2011



Newcastle 
Primary Care Trust

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1. INTRODUCTION

Being a parent is a demanding job. It requires emotional maturity, financial security and the support of partners, family and friends. Teenagers who become parents are less likely to be in this position and consequently are at higher risk of long-term social exclusion. They all too often end up raising their children alone, isolated from the support they need and in poverty. For many, particularly those who leave education when they become pregnant, their lack of qualifications can trap them in poverty for the rest of their lives.

Children born to teenage mothers generally face disadvantage too: they are more likely to die in infancy; have poor health; and do badly at school. Daughters of teenage mothers are more likely to become teenage mothers themselves, continuing the cycle of early parenthood and social exclusion.

Since its launch in 1999, the national teenage pregnancy strategy has been successful in most of the country in securing significant reductions in teenage conception rates, in Newcastle this has not been realised and since 1998, the baseline year, we have increased our rate by 1.1%. We have however seen a drop in rates in 2005 and 2006, but we will need to sustain this trend if we are to reach the government target for 2010.

The 2009-2011 Strategy and associated action plans is built on strong evidence, it specifies what is required locally as well as that which is evidenced by national research as being necessary to have in place to ensure we continue to reduce conception rates.

Catherine Fitt
Executive Director of Children's Services

2 BACKGROUND/CONTEXT

2.1 National Context

Why reducing teenage pregnancy matters

While individual young people can be competent parents, all the evidence shows that children born to teenagers are much more likely to experience a range of negative outcomes in later life, many of which are inextricably linked to poverty. Teenage pregnancy is regarded today as a serious social problem. Having children at a young age can damage young women's health and well-being and severely limit their education and career prospects. Children born to teenage parents are also much more likely, in time, to become teenage parents themselves. While the negative consequences of teenage pregnancy are felt most by young women and their children, it is important that strategies to reduce teenage pregnancy also impact on young men's attitudes and behaviour.

Each year, around 39,000 girls under-18 become pregnant in England. These pregnancies occur throughout the country – although they are much more likely to occur in deprived neighbourhoods. The overwhelming majority of under-18 conceptions are unintended and around half lead to an abortion.

The facts are stark:

- 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.
- Teenage mothers are 20% more likely to have no qualifications at age 30 than mothers giving birth aged 24 or over.
- Teenage mothers are less likely to finish their education, and more likely to bring up their child alone and in poverty.
- Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth.
- The infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers.
- Teenage mothers are three times more likely to smoke throughout their pregnancy, and 50% less likely to breastfeed, than older mothers - both of which have negative health consequences for the child.
- 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.
- Among the most vulnerable girls, the risk of becoming a teenage mother before the age of 20 is nearly one in three.
- Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing and poor health, and have lower rates of economic activity in adult life.

- Rates of teenage pregnancy are highest among deprived communities, so the negative consequences of teenage pregnancy are disproportionately concentrated among those who are already disadvantaged.

Teenage pregnancy is, therefore, a key inequality and social exclusion issue. The Teenage Pregnancy and Parenthood Strategy is a ten-year national strategy set out in the Social Exclusion Report on Teenage Pregnancy (1999).

2.2 Key risk factors for teenage pregnancy

The risk factors identified below are not exhaustive but reflect factors that can be identified within our population of young people. Where young people experience multiple risk factors their likelihood of teenage parenthood increases significantly. Young women experiencing five risk factors (daughter of a teenage mother; father's social class IV & V; conduct disorder; social housing at 10 and poor reading ability at 10) have a 31% probability of becoming a mother under 20, compared with a 1% probability for someone experiencing none of these risk factorsⁱ. Similarly, young men experiencing the same five risk factors had a 23% probability of becoming a young father (under age 23), compared to 2% for those not experiencing any of these risk factors.

Risk factor	Evidence
Risky Behaviours	
Early onset of sexual activity	<ul style="list-style-type: none"> • <i>Girls having sex under-16 are three times more likely to become pregnant than those who first have sex over 16.ⁱⁱ</i> • <i>Around 60% of boys and 47% of girls leaving school at 16 with no qualifications had sex before 16, compared with around 20% for both males and leaving school at 17 or over with qualifications.</i> • <i>Early onset of sexual activity is also associated with some ethnic groups (see below)</i>
Poor contraceptive use	<ul style="list-style-type: none"> • <i>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.</i> • <i>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%).ⁱⁱⁱ</i>

Mental health / conduct disorder/ involvement in crime	<ul style="list-style-type: none"> • 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^{iv}. • 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.^v
Alcohol and substance misuse	<ul style="list-style-type: none"> • Research among south London teenagers found regular smoking, drinking and experimenting with drugs increased the risk of starting sex under-16 for both young men and women. A study in Rochdale showed that 20% of white young women report going further sexually than intended because they were drunk^{vi}. 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.^{vii}
Teenage motherhood	<ul style="list-style-type: none"> • A significant proportion of teenage mothers have more than one child when still a teenager. Around 20% of births conceived under-18 are second or subsequent births
Repeat abortions	<ul style="list-style-type: none"> • Around 7.5% of abortions under-18 followed either a previous abortion or pregnancy. Within London this proportion increases to around 12% of under-18 abortions
Education-related factors	
Low educational attainment	<ul style="list-style-type: none"> • The likelihood of teenage pregnancy is far higher among those with poor educational attainment, even after adjusting for the effects of deprivation. On average, deprived wards with poor levels of educational attainment had an under-18 conception rate double that found in similarly deprived wards with better levels of educational attainment. (80 per 1000 girls aged 15-17 compared with 40 per 1000)
Disengagement from school	<ul style="list-style-type: none"> • 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 independent effect on the risk of teenage pregnancy.^{viii} • Poor attendance at school is also associated with higher teenage pregnancy rates. Among the most deprived 20% of local authorities, areas with more than 8% of half days missed had, on average, an under-18 conception rate 30% higher than areas where less than 8% of half days were missed.

Leaving school at 16 with no qualifications	<ul style="list-style-type: none"> • Overall, nearly 40% of teenage mothers leave school with no qualifications.^{ix} • Among girls leaving school at 16 with no qualifications, 29% will have a birth under 18, and 12% an abortion under 18, compared with 1% and 4% respectively for girls leaving at 17 or over. • Leaving school at 16 is also associated with having sex under 16 and with poor contraceptive use at first sex (see below).
Family / Background factors	
Living in Care	<ul style="list-style-type: none"> • Research has shown that by the age of 20 a quarter of children who had been in care were young parents, and 40% were mothers^x. • The prevalence of teenage motherhood among looked after girls under-18 is around three times higher than the prevalence among all girls under-18 in England.
Daughter of a teenage mother	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 • A survey of adolescents in East London^{xi} showed the proportion having first sex under-16 was far higher among Black Caribbean men (56%), compared with 30% for Black African, 28% for White and 11% for Indian and Pakistani men. For women, 30% of both White and Black Caribbean groups had sex under-16, compared with 12% for Black African, and less than 3% for Indian and Pakistani women • Poor contraceptive use has also been reported for some ethnic groups
Parental aspirations	<ul style="list-style-type: none"> • Research shows that a mother with low educational aspirations for her daughter at age 10 is an important predictor of teenage motherhood

Table 1: Factors associated with high teenage pregnancy rates

2.3 Support for Parents

We want to ensure that young women who do become pregnant and their partners, who decide to go ahead with their pregnancy, receive the support they need to make successful futures for themselves and their children, and avoid any subsequent unplanned pregnancies whilst still teenagers. Twenty percent of births conceived to under-18s are to young women who are already teenage mothers.

Like all parents, teenage mothers and young fathers want the best for their children and some manage very well. But the demands of caring for a baby at a time when young people themselves are making the difficult transition from adolescence to adulthood are significant. That is why teenage mothers and young fathers need additional support – from family, partners and services – if they and their children are to avoid the poor outcomes that many of them currently experience:

- Their children have higher rates of infant mortality than children born to older mothers, are more likely to be born premature – which has serious implications for the baby’s long-term health – and have higher rates of admissions to A&E. In the longer term, children of teenage mothers experience lower educational attainment and are at higher risk of economic inactivity as adults;
- The pressures of early parenthood can result in teenage mothers and fathers experiencing high rates of poor emotional health and well-being – which impacts on their children’s behaviour and achievement; and
- They often do not achieve the qualifications they need to progress into further education and, in some cases, have difficulties finding childcare and other support they need to participate in Education, Employment or Training (EET). Consequently, they struggle to compete in an increasingly high-skill labour market.

In support of teenage parents we need to ensure that:

- midwifery and health-visiting services provide tailored support for teenage parents – both teenage mothers and young fathers (who frequently report feeling ignored by midwifery and health-visiting services) – to address problems such as late ante-natal booking by young mothers, poor levels of nutrition and high levels of smoking during pregnancy, and low rates of breastfeeding – all of which contribute to the poor health outcomes experienced by children born to teenage mothers, such as low birth weight and higher rates of infant mortality and morbidity;
- Children’s Centres and other community-based children and young people’s services reach out to the most vulnerable teenage mothers and fathers, and provide them with easy access to a broad range of support in one place including targeted help to develop their

parenting confidence and skills which recognises that teenage parents often do not feel comfortable joining parenting groups for older people;

- Targeted Youth Support services help teenage parents to cope with the challenges of early parenthood, by providing co-ordinated support from a lead professional who can act as an advocate for the young mother and father and put them in touch with any specialist support they may need. This support will help to address any poor emotional health that leads to worse outcomes for them and their children;
- We offer high quality support to all mothers and fathers aged under 18, who cannot live with their own parents, in particular by seeking to avoid situations where young mothers become isolated by being placed in independent tenancies, without support;
- Ensure that services are more attractive to young fathers by recognising the implications of fatherhood when helping them to overcome barriers to engagement in education, employment and training;
- At the same time, we strengthen the focus on helping teenage mothers to re-engage in EET.

2.4 National Targets

The teenage pregnancy reduction target is a Public Service Agreement jointly held by DCSF and DH, National Indicator 112 and forms part of the PSA 14 (Increase the number of children and young people on the path to success) for Local Government. The Teenage Pregnancy and Parenthood Strategy targets for prevention and support are jointly shared with Connexions. As a national PSA, the local Teenage Pregnancy and Parenthood Strategy is an integral part of the Children and Young People's Plan.

The national targets are:

- ◆ Reduce by 50% the 1998 England under 18 conception rate (per 1000 females aged 15 – 17) by 2010, with an interim target of a 15% reduction by 2004.
- ◆ Achieve a well-established downward trend in the under 16 conception rate by 2010.
- ◆ Reduce the inequality rates between the fifth of the wards with the highest under 18 conception rate and the average ward by at least 25% by 2010.
- ◆ Increase to 60% the participation of teenage parents in education, training or employment to risk their long-term social exclusion by 2010.

- ◆ All under 18 teenage lone parents who cannot live with family or partner should be placed in supervised semi-independent housing with support, not in an independent tenancy.

Since the launch of the national Teenage Pregnancy and Parenthood Strategy in 1999, steady progress has been made overall on reducing under-18 and under-16 conception rates, to the point where both are now at their lowest level for 20 years. The national teenage pregnancy rate has dropped from 46.6 in 1998 to 40.6 in 2006 – 12.9%

2.5 Teenage Pregnancy Policy and performance drivers

2.5.1 Policy:

Teenage Pregnancy (1999): Produced by the Social Exclusion Unit, *Teenage Pregnancy* prioritised two main goals:

- reducing the rate of teenage conceptions, with the specific aim of halving England's rate of conceptions among under 18s by 2010 (noted above as a public service agreement)
- by 2010, increase to 60% the proportion of teenage mothers in education, training or employment to reduce their risk of long term social exclusion

PSA floor targets were strengthened and new public service agreements were introduced to reduce health inequalities:

- Reducing England's under 18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health (target shared by Department of Health and Department for Education and Skills).

Department of Health: *Choosing Health: Making Healthy Choices Easier* (2004) / *Delivering Choosing Health: Making Healthy Choices Easier* (2005). These key policies prioritise teenage pregnancy within a broad public health approach to improve health and tackle teenage pregnancy.

DH: *Better Prevention, Better Services, Better Sexual Health – The National Strategy for Sexual Health and HIV* (2001) / *National Strategy for Sexual Health and HIV Implementation Action Plan* (2003): This first national sexual health strategy for England detailed key strategies and actions for improving sexual health.

DH: *National Service Framework for children, young people and maternity services* (2004) The Children's NSF is a 10 year programme that sets out standards for children's, young people's and maternity services to ensure services are designed and delivered around the needs of children and families.

Department for Education and Skills: *Every Child Matters: Change for Children* (2004): *Every Child Matters* identifies five key outcomes that services should be working towards for all children – being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well being. Reducing teenage conceptions is a key cross cutting element.

DfES: *Youth Matters* (2005) set out the vision for empowering young people, giving them somewhere to go, something to do and someone to talk to. *Youth Matters* – the Youth Green Paper – received over 19,000 responses from young people. The strategy aims for young people to have more choice and influence over services and facilities that are available to them. Young people are encouraged to volunteer and contribute to their local community.

DH/DfES: *Healthy Schools Programme*: The aims of the Healthy Schools Programme are to: help young people to develop healthy lifestyles; help raise pupil achievement; reduce health inequalities; and promote social inclusion. To achieve Healthy School Status, schools must demonstrate evidence of effective practice in relation to healthy eating, physical activity, emotional health and well being and PSHE.

HM Treasury. DfES. DTI. DWP. *Choice for parents, the best start for children: a ten year strategy for childcare* (2004) / ***Sure Start Children's Centres*** Sure Start Children's Centres are a vital part of the Government's 10 year childcare strategy to enable all families with children to have access to an affordable, flexible, high quality childcare place for their child. The Government is committed to delivering a Sure Start Children's Centre for every community by 2010. Sure Start Children's Centres are places where children under 5 years old and their families can receive seamless holistic integrated services and information, and where they can access help from multi-disciplinary teams of professionals.

Department for Communities and Local Government. *Supporting People* Supporting People is a grant programme that enables the provision of housing related support services to help vulnerable people maintain or improve their ability to live independently. This needs local authorities, working in partnership with other service commissioners and with service providers, to make sure that all local services, including Supporting People services, are coordinated, integrated and focused around and involves the users.

DfES: *Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies* (July 2006). This document sets out the findings from in depth reviews carried out by the TPU in 2005 and focuses on the action which will help LAs and PCTs achieve the 50%conception rate reduction target.

DfES: *Teenage Pregnancy: Accelerating the Strategy to 2010*. (September 2006) called for a stronger focus on local areas where progress towards the target has been poor and a wider approach to teenage pregnancy that recognises more explicitly the “deeper underlying causes – poverty, exclusion and poor educational attainment”.

Reaching Out: An Action Plan on Social Exclusion (September 2006) focuses on teenage pregnancy within its broader commitment to address social exclusion. Guiding principles in this document’s approach are reflected in this resource and include

- Better identification and earlier intervention
- Systematically identifying ‘what works’
- Promoting multi-agency working
- Personalisation, rights and responsibilities
- Supporting achievement and managing underperformance

DfES: *Care Matters: Transforming the lives of Children & Young People in care* (October 2006). A Green Paper setting out the Government’s vision for children and young people in care, highlighting the issues affecting this uniquely vulnerable group and setting out what needs to be done to improve outcomes for looked-after children.

DfES/DOH/TPU: *Teenage Pregnancy: working towards 2010 Good Practice and self assessment toolkit* (October 2006). This resource is for annual use as a self assessment tool and is designed to help in planning and review processes.

DCSF/DOH: *Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts* (July 2007) and *Self Assessment Toolkit* (February 2008). This guidance looks at how we can improve outcomes for teenage parents and how this is part of the long term effort to reduce further teenage pregnancies, narrow social and health inequalities and tackle child poverty.

DCSF/DOH: *Getting maternity services right for pregnant teenagers and young fathers* (June 2008). This publication provides a practical guide for midwives, doctors, maternity support workers and receptionists and outlines principles of a teenager friendly maternity service.

DCSF/DOH: *Teenage Parents: who cares? A guide to commissioning and delivering maternity services for young parents second edition* (July 2008). This revised edition explains how improving maternity services for pregnant teenagers and young fathers can help PCTs and Local Authorities to meet a range of targets and policy goals e.g. early access to maternity services, prevalence of breast feeding at 6 – 8 weeks. It places renewed emphasis on multi-agency working in the commissioning and delivery of services. It outlines the minimum standards for a high quality maternity service for teenagers.

2.5.2 Regulation and inspection

A number of performance management mechanisms are in place, which include an assessment of progress towards the teenage conception target. National bodies with responsibility for regulation that has an impact on teenage pregnancy include the following:

Ofsted / Commission for Social Care Inspection: Annual performance assessment (APA). The APA looks at council children's services. The APA is based on a set of key judgements that are common with the joint area review (JAR) set and supported by data and indicators. The key judgements particular to the council's own services are specified. The APA includes self assessment by the council as well as inspection visits.

Healthcare Commission: *Annual health check*. The Healthcare Commission is responsible for regulation of healthcare organisations – both NHS and independent. The annual health-check addresses both 'getting the basics right' and 'making and sustaining progress'. The annual health check inspects healthcare organisations against the ***Standards for Better Health*** (2006)¹, which includes core and developmental standards. A number of standards have impact on young people, including safety, and accessible and responsible care. Of key importance will be public health core standards 22 (partnerships) and 23 (disease prevention and health improvement, including sexually transmitted infections among a number of public health issues). Organisations' self assessment will be cross checked against nationally available data, including, for example, teenage conception data, healthy schools status.

As part of the making and sustaining progress element, healthcare organisations will also be assessed against new national targets (including teenage pregnancy, the 48 hour access to GUM services and gonorrhoea reduction targets). Public health developmental standard 13 will be used to assess progress in health improvement, particularly in relation to NICE guidelines (such as ***Preventing Sexually Transmitted Infections and Reducing Under-18 Conceptions***).

At a regional level, Government Offices and Strategic Health Authorities contribute to performance management in relation to the teenage conception target, as part of the improvement cycle. Locally, performance management is through the Local Strategic Partnerships and children's trusts. While both the PCT and the local authority are assessed by regulators on performance in relation to achieving the teenage conception target, the local authority is the legally accountable body in relation to the funding grant.

3 Linked Strategies

Teenage Pregnancy is a key priority in the Local Area Agreement (LAA) Sustainable Communities Strategy and is linked to all local plans for young people and parents including:

- Alcohol Harm Reduction Strategy
- Behaviour and Attendance Strategy
- CAMHS Strategy
- Children's Centres Strategy
- Children and Young People's Health and Physical Development
- Commissioning Framework
- Connexions Newcastle Delivery Plan
- Domestic Violence and Abuse Strategy
- Early Intervention and Prevention Strategy
- Extended Services through Schools
- Health Improvement Strategy
- Homeless Strategy
- Inclusion Strategy
- Integrated Childcare, Early Education and Learning Strategy
- Integrated Youth Strategy
- Local Area Agreement and Sustainable Communities Strategy
- Looked After Children Strategy
- NEET Preventative Strategy for young people in Education
- NEET Preventative Strategy Education Timeline
- Newcastle Plan
- Newcastle Children and Young People's Strategic Plan
- Parental Mental Health Strategy (draft)
- Participation strategy for children and Young People
- Participation strategy for parents and carers
- Parenting Support Strategy
- Promoting Mental Health and Emotional Wellbeing in Newcastle
- Sex and Relationship Education Strategy
- Sexual Health Strategy
- Social Inclusion Strategy
- Supporting People Strategy
- Sustainable communities/LAA
- Workforce Strategy
- YOT Strategy

4 DEFINITION

National Indicator

There is a national target, **NI 112**, to reduce the under 18 conception rate by 50% by 2010 (compared to the 1998 baseline rate) as part of a broader strategy to improve sexual health. This target is shared between the Department of Health and the Department for Children, Schools and Families. This is measured by the change in the rate of under-18 conceptions per 1,000 girls aged 15-17 years resident in the area for the

current calendar year, as compared with the 1998 baseline rate, shown as a percentage of the 1998 rate.

Under 18

The rate includes all conceptions under 18 but uses the ONS mid-year population estimates for females aged 15-17 as a denominator to calculate the rate (as 95% of under 18 conceptions occur within this age group).

Conception rate

This is defined as the number of conceptions under 18 per 1000 females aged 15-17

National target

The national target will be assessed following the release by ONS of annual conception data in February each year. A final assessment of the target will be made in February 2012 [reflecting data for 2010].

5 VISION

The Teenage Pregnancy and Parenthood Partnership Board's vision is to achieve the 2010 target of 23.8 conception rate (per 1000 females aged 15 – 17) by focusing on the priorities set out in the DES/DOH *Teenage Pregnancy: working towards 2010 - Good practice and self-assessment toolkit, October 2006*. This document outlines key characteristics of successful programmes see below 5.1 to 5.4 for an overview.

Newcastle's strategy is divided in to four areas Communication, Sex and Relationship Education, Access to Sexual Health Services and Support for Parents; in achieving the objectives set out in the action plans Newcastle will be fully compliant against all of the government's key characteristics by March 2011. A number of key successful initiatives will be mainstreamed by relevant agencies.

DES/DOH Teenage Pregnancy: working towards 2010 - Good practice and self-assessment toolkit, October 2006.

5.1 Strategic

The LSP and Children's Trust is seen as providing essential leadership with key roles for the TP Partnership Board, PCT/LA, Government Office (GO), Strategic Health Authority (SHA) and Children and Young People's Strategic Partnership (CYPSP).

- There is clear commitment / teenage pregnancy is a priority
- Teenage pregnancy is integrated into planning
- Progress is driven by performance management

5.2 Data

The PCT / LA should provide leadership with key roles for the Teenage Pregnancy Coordinator (TPC), Director of Public Health (DPH) / PCT Commissioners, Education and Youth Service.

- There is a systematic approach to knowing the local population and its needs in relation to teenage pregnancy
- Data and information are used to inform provision of local services
- Performance management is led by accurate data and information

5.3 Communication

The PCT / LA should provide leadership with key roles for the media Teenage Pregnancy Coordinator (TPC), voluntary sector and faith groups.

- Partners receive appropriate information
- Young people – including those most at risk – are involved and informed
- Parents and communities are engaged and informed
- There is a strategy for dealing with the media
- Communication programmes are assessed

5.4 Implementation

5.4.1 *Provision of young people focused contraception/sexual health services, trusted by teenagers and well known by professionals working with them*

The PCT should provide leadership with key roles for the LA (referrals), NHS community and acute services and voluntary sector.

- Accessible services are tailored for young people
- Full range of high quality services offered
- Services are visible and highly promoted
- Involvement by a range of knowledgeable service providers
- Services are adequately resourced

5.4.2 *Strong delivery of SRE/PSHE by schools*

The LA and schools should provide leadership with key roles for the Healthy Schools Coordinator and TPC.

- Strong delivery by well-trained professionals
- Broad, thorough content
- Clear commitment to SRE
- Whole school environment contributes
- Sustained provision throughout school years
- SRE Strategy and developing SRE Quality Mark

5.4.3 Targeted work with at risk groups of young people, in particular Looked After Children and Care Leavers

The LA should provide leadership with key roles for the youth service and social workers.

- Strong use of data and evaluation
- Specific preventative interventions target a range of vulnerable groups
- Interventions tailored to suit specific needs
- Interventions involve a range of professionals and voluntary and community groups and complement existing programmes

5.4.4 Workforce training on sex and relationship issues within mainstream partner agencies

The LA should provide leadership with key roles for the Healthy Schools Coordinator, PCT public health/health promotion and the TPC.

- Engagement with /guidance for all those working with YP
- Staff follow good practice
- Family Planning Association “Train the Trainers” Programme for key individuals in the local authority across services with commitment to carry out at least four training sessions for other colleagues this year.

5.4.5 A well resourced Youth Service, with a clear remit to tackle big issues, such as teenage pregnancy and young people’s sexual health

Leadership from the LA with a key role for the voluntary sector.

- Commitment
- Well trained youth workers
- Provision of advice and contraception
- Sign-posting to specialist services

5.4.6 Work on raising aspirations

All partners to provide leadership with key roles for education, youth service, voluntary sector and faith groups.

- A priority
- Programme reaches young people most at risk
- Programme combines raising awareness and raising self-esteem
- Schools are engaged in raising aspiration for most at risk young people:
- Engagement with young people
- Community engagement

5.4.7 Work with Parents

Leadership from the Parenting Commissioner within the Children's Trust to review the delivery and impact of all parenting support designed:

- to enable parents to develop the confidence to discuss sex and relationship issues with their children in an age appropriate way
- to support teenage parents to be the best parents they can possibly be with key roles for the voluntary sector, faith groups, Children's Centres, Extended Service Schools and health. This work will ensure that we:
- Review and measure the effectiveness of all existing work with parents relevant to the Teenage Pregnancy and Parenthood Strategy
- Make the most of existing parenting support programmes and develop the evidence to embed and sustain those that demonstrate greatest impact on positive outcomes for children and young people
- Ensure that a wide range of relevant stakeholder organisations contribute to the review and development of these services
- Ensure that provision reflects local characteristics and both builds on community strengths and responds to local need
- Provide a relevant range of universal, targeted and specialist provision

6 HOW WAS STRATEGY DEVELOPED

A review of the existing Strategy by:

- Teenage Pregnancy and Parenthood Board
- Stakeholders (partners, agencies, children and young people, parents and carers)
- Task Groups
- Self Assessment
- National Support Team visit and recommendations
- Priority Setting following engagement with Ministers

Evidence and data collected has informed the new Strategy 2009 – 2011, consultation with partners July – November 2008.

7 WHAT DO CHILDREN AND YOUNG PEOPLE SAY? WHAT DO PARENTS AND CARERS SAY?

When consulted as part of the development of the Parenting Support Strategy, Parents and Carers wanted more help to know how to talk to their children about a whole range of issues, including sex and relationships. Ensuring that we have embedded relevant parenting support into our

universal services is a key element of our approach to early intervention and prevention in relation to all of the priorities in our Children and Young People's Plan, including the reduction of teenage pregnancy. Building the capacity of parents to establish authoritative approaches to their parenting role is seen as a crucial factor in developing resilience and reducing risk of poor outcomes for children and young people.

Children and Young People wanted services that were young person friendly.

8 CURRENT SITUATION/PERFORMANCE

8.1 LOCAL DATA

Newcastle conception rate has risen from 52.8 (under 18 conceptions per 1000 females aged 15 - 17) in 1998 to 53.4 in 2006, an increase of 1.1%. Since 2004 we have achieved a reduction each year and rates have dropped from 58.9 in 2004 to 53.4 in 2006 this represents a 9% decrease against a national decrease of 4% for the same period.

However Newcastle still has a significant challenge to achieve its target reduction to 23.8 by 2010. Comparative data for statistical neighbours, core cities, regional and national performance is identified in the tables below.

Statistical Neighbours	1998	2006	% change
South Tyneside	64.9	40.5	-37.6
Liverpool	57.9	42.1	-27.2
Middlesbrough	66.5	50.8	-23.7
Gateshead	57.1	48.7	-14.7
Hartlepool	75.6	64.5	-14.7
Sunderland	63.1	55.5	-12.1
Salford	61.5	58.8	-4.4
Sheffield	50.5	49.0	-3.0
Leeds	50.4	50.9	0.9
Newcastle	52.8	53.4	1.1
Halton	47.1	48.8	3.6

Core Cities	1998	2006	% change
Liverpool	57.9	42.1	-27.2
Birmingham	58.3	53.2	-8.9
Sheffield	50.5	49.0	-3.0
Bristol	51.0	49.8	-2.3
Nottingham	74.7	73.8	-1.2
Leeds	50.4	50.9	0.9
Newcastle	52.8	53.4	1.1
Manchester	61.3	67.0	9.3

Regional and National	1998	2006	% change
South Tyneside	64.9	40.5	-37.6%
Middlesbrough	66.5	50.8	-23.7%
Redcar and Cleveland	58.3	48.3	-17.1%
North Tyneside	58.4	48.9	-16.2%
Hartlepool	75.6	64.5	-14.7%
Gateshead	57.1	48.7	-14.7%
Durham County	54.4	46.6	-14.3%
Northumberland	41.8	35.9	-14.1%
Darlington	64.0	55.3	-13.6%
Sunderland	63.1	55.5	-12.1%
Newcastle upon Tyne	52.8	53.4	1.1%
Stockton-on-Tees	48.3	52.1	7.8%

England	46.6	40.6	-12.9%
North East GONE	56.5	48.8	-13.6%
Tyne and Wear	59.0	50.4	-14.6%

8.2 Annual Self Assessment

The local authority uses an annual self assessment tool to monitor its performance against a national criteria set. Our current self assessment (May 2008) indicates performance against a four point scale of Fully, Nearly, Partially or Not at all. ([For full details see weblink](#))

Characteristic	Rating
Strategic	Fully
Data	Nearly
Communication	Fully
Implementation	Nearly
<ul style="list-style-type: none"> YP focused contraception/ sexual health services 	Nearly
<ul style="list-style-type: none"> Strong delivery of SRE/PSHE by schools 	Nearly
<ul style="list-style-type: none"> Targeted work with at risk groups of YP, especially LAC 	Nearly
<ul style="list-style-type: none"> Workforce training on SRE in mainstream partner agencies 	Nearly
<ul style="list-style-type: none"> Well resourced Youth Service 	Nearly
<ul style="list-style-type: none"> Raising aspirations 	Fully
<ul style="list-style-type: none"> Work with parents 	Partially

8.3 2006 – 2008 Strategy Progress

A significant number of the objectives of the 2006 – 2008 Strategy have been successfully achieved ([full details of progress are available via the web](#)). Any remaining objectives have been carried forward into the 2008 – 2011 Strategy and these are clearly indicated by the code PS in the action plans.

Key successful outcomes from Newcastle's 2006 – 2008 Teenage Pregnancy Strategy

8.3.1 Co-ordination

- Robust performance management system which provides regular progress updates on teenage pregnancy performance indicators and comprehensive data set
- Comprehensive risk register

8.3.2 Communication

- A number of media and promotional campaigns for young people promoting issues such as 'Delay', 'Plan B'
- Development of a 'Sex sense' leaflet listing all support available for young people around sex and relationships and how to access this support
- Mint magazine
- Local research with young people to ensure campaigns were built on evidence

8.3.3 SRE

- The board achieved funding from the Neighbourhood Renewal Fund to employ the 'Teenage Kicks' dedicated SRE Outreach Team. This team works with key partners to deliver a comprehensive, high quality SRE programme targeted at young people most at risk of becoming teenage parents and those living in 'hotspot' areas of the city. The team delivered SRE to 1,964 young people in Newcastle in 2007 - 2008.
- Innovative SRE Conference for BME Community Leaders and parents provided a valuable opportunity to work together on how best to meet the SRE needs of BME young people and their parents / carers.
- Comprehensive SRE work with LAC and Care Leavers
- Significant training for youth workers
- Work with parents embedded in Parenting Strategy
- Foster care training

8.3.4 Access to Services

- Free Emergency Hormonal Contraception available in a wide range of pharmacies across the city
- Significant reduction in waiting times for Termination of Pregnancy
- Training group established and training pathway finalised
- Your Welcome criteria piloted successfully
- Clarity re under 16 and under 13 confidentiality achieved
- C Card extended across a large number of outlets and linked with Chlamydia testing

8.3.5 Support for young parents

- Full time Dad's worker providing a wide range of excellent support for Young Dads
- Comprehensive Contraceptive Plans in place for all young women post birth
- Delivery of Becoming a Parent courses for teenage parents by Barnardos
- Increasing focus on parenting programmes and the development of parenting support for mothers, fathers and carers wanting to develop their ability to parent their children more effectively. This work can be expected increasingly to become a key feature of a wide range of parenting practitioners within providing targeted work within universal settings or services including Parent Support Advisors, health visitors, Children's Centres, Extended schools, youth workers and a range of voluntary sector providers.
- Increased parent take up of IAG for education training and employment
- All young parents assessed for housing need and referred to relevant service

8.4 2009 – 2011 STRATEGY

The 2009 – 2011 Strategy builds on these successful outcomes and is informed by:

- what young people, parents and carers and practitioners working in Newcastle tells us they need;
- research and recommendations from the TPU;
- “working towards 2010” annual self assessment;
- priorities set from meetings with Government Ministers;
- visits and communications with successful local authorities;
- support and challenge from the National Support Team;

The Teenage Pregnancy and Parenthood Partnership Board are confident that all key partners will work together to implement this strategy and achieve a significant reduction in Newcastle's under 18 conception rates.

Each Action Plan for 2009 - 2011 focuses its key objectives on the new work we will implement to meet key priorities in reducing conception rates. However there is a lot of excellent work across the five key areas of the Strategy happening already in Newcastle. It is crucial that this work continues to be built upon to meet the needs of young women and young men, to support the new objectives in this strategy and turn the curve to reducing conception rates for Newcastle.

9 WHAT DO WE KNOW WORKS?

Successful local areas were characterised by the following factors:

- active engagement of all of the key mainstream delivery partners who have a role in reducing teenage pregnancies – Health, Children's and Adults Services– and the voluntary sector;
- a strong senior champion who was accountable for and took the lead in driving the local strategy;
- the availability of a well publicised young people-centred contraceptive and sexual health advice service, with a strong remit to undertake health promotion work, as well as delivering reactive services;
- a high priority given to PSHE in schools, with support from the local authority to develop comprehensive programmes of sex and relationships education (SRE) in all schools;
- a strong focus on targeted interventions with young people at greatest risk of teenage pregnancy, in particular with Looked After Children;
- the availability (and consistent take-up) of SRE training for professionals in partner organisations (such as Connexions Personal Advisers, Youth Workers and Social Workers) working with the most vulnerable young people; and
- a well resourced Youth Service, providing things to do and places to go for young people, with a clear focus on addressing key social issues affecting young people, such as sexual health and substance misuse.

10 HOW AND WHO WILL MANAGE THE STRATEGY/ACTION PLANS

The Strategy and Action Plans will be managed by the Task Groups and the Teenage Pregnancy and Parenthood Partnership Board. They will provide a six monthly report to the Stay Healthy Partnership who will also provide a sixth monthly report to the Children and Young People's Strategic Partnership Executive.

11 KEY CONTRIBUTORS

For a full list of contributors to this Strategy see Appendix 1.

12 STAFF DEVELOPMENT

A Sexual Health training group has developed a training pathway for staff who engage with children and young people and this is outlined in the Sex and Relationship Education action plan.

13 RESOURCES

The Board receives an annual Teenage Pregnancy grant of:

£171,000

The PCT provides Health Equalities funding of:

£ 65,000

The Board has also been successful in acquiring Working Neighbourhood funding until March 2011

£125,000

This funding is being matched by PCT funding until March 2011

£125,000

14 MONITORING AND EVALUATION

14.1 Action Plans

The action plans are managed by Task Groups. Each group has a Chair who is a Board Member. On a quarterly basis the group evaluates and reports on progress against the action plan. An exception report is presented by each Chair to the Coordination group chaired by the Director of Public Health. The exceptions report is translated into a risk register and actions to move these areas forward is finalised. Red traffic light risks are presented to the Teenage Pregnancy and Parenthood Board on a quarterly basis; partners action areas of concern.

14.2 Teenage Pregnancy and Parenthood Board Self Evaluation

The Board is required to carry out an annual self assessment which highlights the strengths of the Newcastle Strategy; areas for improvement are written into the action plans.

