Teenage pregnancy prevention and support:

Oxfordshire Children's Trust self-assessment toolkit for local performance management

October 2009

Oxfordshire self assessment contributors

Leads: Teenage Pregnancy Co-ordinator, Health Improvement Principal, Assistant Director of Public Health, Head of Joint Commissioning

Oxfordshire contributors:

- Strategy and Performance, OCC
- Joint Commissioning, OCC
- Public Health, PCT
- Decision Support and performance, PCT
- Contraception and Sexual Health, CHO
- Healthy Oxfordshire Schools Team, OCC

- Children's Universal Services, CHO
- You're Welcome lead, PCT
- Learning and Development, OCC
- Supporting Choices, OCC
- IYSS, OCC
- Connexions
- Job Centre Plus
- V talent, OCC
- Looked After and leaving care, OCC
- YOS, OCC
- Midwifery, PCT
- Parenting, OCC
- Framework I, OCC
- Health visitors, PCT
- Children's Centres
- Voluntary Sector professionals
- Childcare, OCC
- Learning and Skills Council (SE)
- 14-19, OCC
- Access and Inclusion, OCC
- Housing, OCC
- Oxfordshire Supporting People

Self Assessment

STRATEGIC	
Strategic leadership of the teenage pregnancy strategy lies with the LA and PCT. Accountability is through the Teenage equivalent body) through to the Children's Trust and LSP. Evidence suggests that senior managers being accountable f strategy is key to success, as is a senior strategic role of a Local Teenage Pregnancy Coordinator and strong engagem	
Criteria	**Gaps and Issues**
Champion: There are senior champions for teenage pregnancy in the LA and PCT, reflecting locality structures.	**Ongoing.** Senior leadership for delivery of t the Oxfordshire Children and Young People Assistant Director of Public Health. LA leadership through Head of Joint Comm Local leadership will be through 3 Area Trus newly established and the leadership of tee developed. A teenage pregnancy Task and established to oversee the delivery of the st local leadership arrangements are in place.
Accountable leads: There are high level accountable leads for commissioning and delivery in relation to teenage pregnancy.	**Achieved.** Accountable leads for OCC and Director of Children and Young People and Public Health
JSNA and planning: Findings from the teenage pregnancy self assessment feed into the Joint Strategic Needs Assessment, the CYP Plan, the PCT local Operational Plan and the LSP	**Achieved.** TP is currently feeding into the C The self assessment will feed into the Child operational plan and the LAA.

[1] **R:** requires SMART actions within 3-6 months; **A:** high importance for improvement within the year; **G**: important – maintain current levels

Commissioning arrangements: Teenage pregnancy is integral to the children's joint[2] commissioning arrangements.	**Achieved.** TP team are part of the Joint Co Fortnightly strategic leads meeting with age reporting to the Director of Public Health an People and Families
TP Coordinator / Lead: The TP Strategy Lead is placed within Children's Trust commissioning structures.	**Achieved.** the Assistant Director of Public H Commissioning are members of the CYPT The TP Coordinator is a member of the Join
Engagement: All key partners[3] understand the interconnectedness of the TP vision and their agency's contribution to its achievement	**Ongoing.** The recent teenage pregnancy c there is good interconnected work amongst
Governance / performance management: There is systematic review of performance of the local TP strategy using the *Local Monitoring Dataset* and other appropriate data from all partners (and that local targets have been set), with results reported to the Children's Trust, which reports to the LSP.	**Ongoing.** Confidential Inquiry, reports to Cl sub-group all monitoring. Further work is re performance management at a locality leve dataset will be used to monitor the delivery local minimum dataset has been agreed an sharing and reporting processes are not yet
Resources: *The New Performance Framework for Local Authorities and Local Authority Partnerships: Single Set of Na*	

DATA		
Detailed, accurate and up-to-date data and information are essential for determining need, planning, commissioning an targeted programmes. Additional local information is required to identify young people most at risk to allow effective targ school attendance, deprivation, ethnicity (with census categories tailored to reflect local populations) at ward level is crit The indicators in this section relate to local sources of conception data to provide more timely monitoring of impact. The be used for effective data intelligence.		
No.	**Local monitoring dataset indicator**	**Base**
1	Estimate of under-18 conceptions derived from local data sources to obtain a more timely and detailed picture of local teenage pregnancy numbers and rates	
2 (&29)	Proportion/rate of conceptions in (locally defined) geographical hotspots (neighbourhoods, Super Output Areas etc) Ward data 2004-6 total in hotspots 298 total conceptions 1087	39% (2
3	Proportion of conceptions from schools with pupil populations at high risk of teenage pregnancy	59% (2

Criteria	**Gaps and Issues**
Accountable lead: There is a senior accountable lead for teenage pregnancy data and intelligence	**Achieved.** A senior accountable lead has b

[2] LA and PCT (including sexual health)

[3] PCT, Education, Social Services, Youth Services / /Connexions, Maternity Services, Health Visiting, Children's Centres, Targeted Youth Support, Integrated Youth Support Services, Housing, CAMHS, sexual and reproductive health services, Reintegration of school age parents, Social Care, Looked after Children Lead, 14-19 Lead, Jobcentre Plus, Parenting Strategy Lead, CAF lead

[4] **R**: requires SMART actions within 3-6 months; **A**: high importance for improvement within the year; **G**: important – maintain current levels

Criteria	Gaps and Issues
Data collection: Protocols or agreements are in place for systematic collecting and sharing data and intelligence across sectors to contribute to planning and performance management.	**Ongoing.** Systematic collection and sharing agencies and services. Robust data collect Oxfordshire and work to achieve this is und
Capacity: There is capacity in the LA/PCT to use data effectively in planning and commissioning	**Ongoing:** The intelligence capacity exists Obstacles to data sharing need removing.
Data use: Collected data is analysed and used to inform planning, service delivery and review of elements identified in this toolkit and reflects the TPU's *Local Monitoring Dataset*[5] for prevention/ teenage mothers and young fathers), surveys of service users, practitioners, etc	**Ongoing.** Data including feedback from you planning and service delivery. There are ga some services the self assessment will be u is the first step in the process and we aim to cards in the long term. The Trust has confir accountability is the correct method but the as an obstacle.
Provider data: Contracts with all health and local authority providers, especially abortion, STI/GUM services / contraceptive services, include requirements for collection and sharing of age, sex, ethnicity and postcode (while adhering to confidentiality guidelines) to target development of services and interventions	**Achieved.** Yes in PCT and according to inc
Resources: TPU's *Local Monitoring Data Set* (May 2009) Annex 1 Teenage Pregnancy Data Guide expected June 2009 *Teenage Pregnancy: Working Towards 2010 Data Collection and Information Sharing toolkit* Young London Matters	

COMMUNICATION
Effective communication is central to effective strategy delivery. Communication should be directed to: internal stakehol pregnancy matters; the media to convey accurate information about the aims and actions of the local strategy; young pe local services and support. A media and communications strategy should be jointly developed and owned by the LA and

Criteria	Gaps and Issues
Lead: There is an accountable lead for teenage pregnancy communications.	**Ongoing.** The Teenage Pregnancy Coordin OCC, and PCT Communications teams offe
Strategy: There is a communication strategy and action plan for the commissioning and coordination of an effective communications across the LA and PCT to tackle teenage pregnancy and support teenage parents, which includes: • Communication to internal stakeholders, at strategic, service manager and front line levels across all relevant LA and PCT services, voluntary and community sector and elected members • Media handling protocol for both reactive and proactive media work • Local campaigns drawing on the research and resources of the national media campaign – RUthinking and Want Respect – with proactive publicity of local young people's services, including to young people most at risk • An accountable lead for regularly updating Ruthinking website	**Ongoing**. A multi agency Communications Oxfordshire Sexual Health Network**.** There in place at present. .

[5] See annex 1

[6] **R**: requires SMART actions within 3-6 months; **A**: high importance for improvement within the year; **G**: important – maintain current levels

Criteria	Gaps and Issues
service database and local websites with local service details • Regularly updating all children's workforce and appropriate service providers with service publicity and care pathways for young women and young men who need to access CASH services or who think they/their girlfriend may be pregnant • Ensuring effective links with other strategies and services (e.g. Parenting Strategy, Family Information Service) campaigns and information	
Effectiveness: Communications/media programmes are monitored consistently and evaluated regularly. Action plans are drawn up as a result of regular evaluations and agreed by the relevant accountable lead.	**Ongoing** Although some impact assessme needs to be conducted consistently and rep Area Trust Boards and the Oxfordshire Sex

IMPLEMENTATION: PREVENTING TEENAGE CONCEPTION

- **Strong delivery of SRE/PSHE**

Delivery of high quality SRE/PSHE, linked to accessible CASH services, is critical to effective local strategies. Local aut to play in driving improvement in this area. Schools need to prepare for the introduction of statutory SRE/PSHE in Sept SRE meets their statutory duty on pupil well being and safeguarding. *Next Steps* notes that, to improve delivery, action workforce training (including training for Governors); development of local schemes of work/lesson plans; provision of o the design of SRE programmes; investment in resources to support SRE delivery; use of external professionals and ag and maximising the impact of wider initiatives, such as the Healthy Schools Programme. FE colleges also play a key ro services, as part of tutorial and enrichment programmes.

No.	Local monitoring dataset indicator	Baseline	Target
4	Proportion of primary schools with a i) teacher certificated with the PSHE CPD accreditation ii) nurse certificated with the PSHE (SRE module) CPD accreditation	0	15%
5	Proportion of secondary schools with a i) teacher certificated with the PSHE CPD accreditation ii) nurse certificated with the PSHE (SRE module) CPD accreditation	0	50 % More trained fro targ
6	Proportion of special schools with i) teacher certificated with the PSHE CPD accreditation ii) nurse certificated with the CPD (SRE module) accreditation	0	20% targ
7	Proportion of pupil referral units (PRUs) with a i) teacher certificated with the PSHE CPD accreditation ii) nurse certificated with the CPD (SRE module) accreditation	0	**Action:** Train 1 c
8	Young person evaluation of PHSE/SRE: Proportion of secondary schools using the SRE pupil audit tool (annually)	Based on locally developed audit tool 91% of schools 17% of target schools	
9	TellUs indicator: proportion of secondary school pupils reporting SRE meets their needs	Our own focus groups tell us 24%	
10	Proportion of schools with Healthy Schools Status i) primary ii) secondary iii) PRUs	Total validated or working towards 98% P. v. 85% S. v.82% PR v.87.5%	Out of target v. 77.7 **Action:** Get a Healthy
11	PCT resource available to support schools' delivery of SRE: i) school nurses ii) sexual health professionals iii) health promotion workers	SHNs 18 Whole Time Equivalent (WTE) (2006)	

12	LA resource available to support schools' delivery of SRE: i) SRE/PSHE subject a ii) youth support worker iii) other		

Criteria	Gaps and Issues
Accountable lead: There is an accountable strategic lead for SRE/PSHE.	**Achieved.** Healthy Oxfordshire Schools Team Manager
Policy: All schools have a SRE policy (statutory requirement) in place and in use which has been consulted upon with governors parents/carers and young people	**Ongoing:** All schools with HS standard have SRE and conf
Delivery and assessment: There is systematic delivery and assessment of learning, and programmes are planned against the QCA End of Key Stage Statements (2005) and post 16.	**Ongoing.** Plans and assessment guidance has been sent t However, some schools have very limited SRE delivery and aspects of education
Clear pathways: There is clear signposting from SRE to contraceptive and sexual health services (CASH).	**Achieved.**
Alcohol risks: Schools address alcohol risks within SRE (as evidenced by schools' SRE policies)	**Achieved.** The Last Orders (LO) project feedback has shown studer awareness of alcohol risks especially those linked with se being rolled out to teenage pregnancy target schools ove have now had LO.
Effectiveness and engagement: Education providers monitor and evaluate the effectiveness of SRE and whether the provision meets young people's needs, in including using the SRE pupil audit toolkit. Programmes / services are monitored consistently and evaluated regularly. Action plans are drawn up as a result of regular evaluations, and agreed by the relevant accountable lead.	**Achieved.** • Focus groups: feedback given to individual schools with • Lesson plans sent to schools (Pri and Sec) and training • Advisory teacher monitors schools through observatio training. • Many schools send medium term plans for scrutiny to • Advisory teacher has assessments following every less • Training for teachers/nurses/ youth workers etc • Last Orders (LO) funding gave feedback via questionna • LO project questionnaires feedback show significant aw guide YP towards safer lifestyles • LO focus group feedback is useful tool to monitor SRE o • Assessment guidance shows LO lessons have been eff • Further training to all schools participating in LO project form each school participated. • Recent R U Ready training to 20 professionals with very professionals from a variety of settings)
Resources: *Are you getting it right? A toolkit for consulting young people on sex and relationships education* Sex Educ *Sex and Relationship Education Guidance* DfES 2000 (NB: Following the SRE review, revised guidance will be publis	

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PSHE end of key stage assessment statements – KS1-4
Healthy Schools Website
Sex Education Forum Website: guidance and best practice
PSHE Subject Association
Government Response to SRE Review
Teenage Pregnancy: Accelerating the Strategy to 2010 includes a non-exhaustive list of specific SRE programmes.

Implementation: Preventing teenage conceptions

- **Provision of young people focused contraception and sexual health services (CASH), trusted by teenagers parents and practitioners working with them**

Evidence[8] shows that improved uptake of effective contraception has the greatest impact on reducing conception rates. *Welcome* accredited, be commissioned to meet the contraception and sexual health needs of local young women and m young people most at risk. Given that the majority of teenage pregnancies are unplanned, it is crucial that young peopl about their pregnancy options with swift referral to NHS funded abortion or antenatal care. Service provision should incl to help reduce repeat conceptions. It is estimated that 20% of births conceived to under-18s are to young women who a abortions to under-19s are repeat abortions.

No.	Local monitoring dataset indicator	Baseline	Target
13	Number of (and proportion of estimated sexually active) new contacts for young people (under 19 years), resident in the LA at contraceptive and sexual health services provided in the LA (including young people services, GUM clinics school and college based service provision) (Note: requires data collection by age, sex and full postcode)	15% of all attendances at C&SH clinics are for <18s (number seen 2009/10 Q1 & Q2 = 1724). CASH outreach service (commenced Feb 09) - 112 new referrals during Q1 & Q2 09/10. 78% of referrals have been contacted and successfully followed up.	
14	Number and proportion of young people contraceptive/sexual health services in LA accredited with *You're Welcome* standard	0	For end of 2 C&SH ser engage
15a	Number and proportion of young people contraceptive/sexual health services on or linked to schools, providing: i) Basic (2 faith schools permit limited signposting to local services) ii) Advanced (SHNs extended role provides condoms & pregnancy testing (About 60% provide an enhanced service including EHC, ,condoms and pregnancy testing)) iii) Specialist (14 schools have Body zone clinics offering full range of contraception excluding IUD/IUS0 As defined in Sex Education Forum Mapping Survey of on-site Sexual Health Services in schools	34 20 14	
15b	Number and proportion of young people contraceptive/sexual health services on or linked to colleges and work based learning providers for 16-19 year olds, providing: i) basic ii) advanced iii) specialist services As defined in Sex Education Forum Mapping Survey of on-site Sexual Health Services in FE and 6th form colleges	0	**Actio** Commis advanced health serv three OCV
15c	Number of CASH services in non-clinical settings at Tiers 1, 2 and 3	88	
16	Proportion of NHS abortions to under-18s performed before 13 weeks current data relates to all TOPS.	90%	

[8] NICE, J. Santelli American Journal of Public Health, US 2006

17	Proportion of secondary schools in the local authority with designated school nurse	100%	
18	Emergency Hormonal Contraception (EHC) free NHS pharmacy provision to under-18s: 2008/9 i) proportion of pharmacies in LA providing EHC ii) number of EHC issued to young women under-18	2005 0	
19	Number of young women under-18 in LA having LARC fitted i) Proportion of under-18s choosing LARC as primary method of contraception ii) Proportion of under-18s in abortion services receiving LARC iii) Proportion of under-19s mothers receiving LARC	45% of CASH outreach clients	
20	PCT chlamydia screening rate 2008/9 PCT chlamydia positivity rate (when prevalence data is available)	10.1% Positivity rate 6.5%	25%
21	Performance against GUM 48 hours access target (seen not offered) i) for under-18s/under-20s	100% offered 80.36% (ytd) seen	
22	Number of outlets targeted at young people distributing condoms as part of a condom distribution scheme (and potentially number of condoms distributed by each outlet within last 12 months)	(Data taken from October 08 - 09) 25 outlets, more than one member of staff in some outlets. 23,346 condoms distributed	
23	Number of young people registered with a C-card scheme (and potentially age, sex, ethnicity & postcode within last 12 months and also number of times C-cards used within last 12 months)		
24	Proportion of repeat births under-19	15.5%	
25	Proportion of repeat under-19 abortions	11%	

Criteria	Gaps and Issues
Accountable lead: There is an accountable commissioning lead for young people's sexual health services.	**Achieved.**
Sexual Health Needs Assessment – is undertaken within the last three years, with involvement of YP (including those most at risk) and informs commissioning of CASH services	**Achieved.** Was undertaken April 2007

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Effectiveness: YP's CASH and abortion services are commissioned to address the above indicators and are in line with relevant guidance, including *You're Welcome* (see resources, below) to ensure services for young people, including teenage mothers and young fathers, that: • is sufficient and based on need, including access to services in hotspot areas • cover a range of integrated provision (including, for example, free pregnancy testing, unbiased advice on pregnancy options, condom distribution, the full range of contraceptive choices including long acting reversible contraception [LARC], emergency hormonal contraception [EHC], accessible information and sexual health promotion) • have clear patient pathways • enable swift referral as required (e.g. to antenatal care or NHS funded abortion services) • provide contraception with clear follow-up and support arrangements after abortion and maternity, including publicity to young people about the risk of repeat pregnancy	**Achieved.** In the last year additional fund increase SHN services outside term times schools **Achieved.** Additional funding has been us provision and to raise awareness of LARC young people **Achieved** **Achieved** **Achieved.** C&SH outreach service comm to support vulnerable young women in ord pregnancies. Vulnerable groups include: p after and care leavers, unaccompanied as who offend and those post termination.
Services are monitored consistently and evaluated regularly, including by young people in line with *You're Welcome* criteria. Action plans (including actions to address gaps included in service development plans) are drawn up as a result of regular evaluations, and agreed by the relevant accountable lead.	**Ongoing.** There are robust contract monitoring arra C&SH and GUM services Contract monitoring of SHN is less robust improve monitoring processes.

Resources:

Good practice guidance for commissioning contraception and abortion services DH to be published 2009
Prevention of sexually transmitted infections and under 18 conceptions NICE guidance 2007
Long acting reversible contraception: the effective and appropriate use of long-acting reversible contraception NICE gu
You're Welcome quality criteria; Making health services young people friendly DH 2007
Healthy lives, brighter futures – The Strategy for children and young people's health DCSF/DH 2009
Extended Schools: Improving Access to Sexual Health Advice Services DCSF 2007
Schools and Services Resource Pack Sex Education Forum 2009 available from sexedforum@ncb.org.uk
Improving Access to Sexual Health Services for Young People in Further Education Settings DCSF/DH 2007
Sexual Health Outreach – Why, What and How Brook 2008 www.brook.org.uk
Care of Women Requesting Induced Abortion Royal College of Obstetricians and Gynaecologist (2004)
Best Practice Guidance for doctors and other health professionals on the provision of advice and treatment to young pe and reproductive health DH (2001)
Best Practice Guidance on developing services to reach boys and young men Teenage Pregnancy Unit (2001)
Best Practice Guidance on developing services to reach young people from BME communities Teenage Pregnancy Un
Sure Start Children's Centres Practice Guidance DCSF (2007)
Multi-agency working to support pregnant teenagers: A midwifery guide to partnership working with Connexions and oth

Implementation: Preventing teenage conceptions

- **Workforce development: Workforce training on teenage pregnancy and sex and relationship issues in main**

Next Steps points to the importance of providing SRE training to key professionals in touch with young people at risk to referrals to specialist CASH services as appropriate. Key professionals for SRE workforce training include: Youth Suppo Youth Support Lead Professionals, Information, Advice and Guidance (IAG) providers, social workers, residential and fo housing support workers. SRE and sexual health training should be included in all partner agencies workforce developm

No.	Local monitoring dataset indicator	Baseline	Target	Progress to target
26	Number and proportion of professionals in each local agency working with vulnerable young people receiving training on SRE/sexual health			Multi Agency Training – (Sex in the City) 116 **Summary of attendance Jan 09-Oct 09** School PCT Health Visitor School health Nurse Youth Services YOS Connexions Social Services Mentoring Children's Centre Home School link Leaving care Supported lodgings Oxpens college Abingdon/Witney Housing Vol Youth Substance Young Carers Homestart Fostering PCT general Probation Family Information service Training workforce team CAMHS OCC Early Years and Support OCC Access to Education Vol. Youth Sector Family and Children Early Intervention 13.8% Of Connexions professionals in 2009 11% Youth Workers this year Safety Condom Card workshop training -128 One-off sexual health promotion workshops 100 professionals attended a sexual health a RU Ready training - 19

Criteria	Gaps and Issues
Training Needs Assessment: A training needs assessment of the workforce – undertaken within the last two years – informs the commissioning of training on understanding teenage pregnancy, SRE, contraception and sexual health (CASH) and needs of teenage mothers and young fathers	**Ongoing.** A new assessment will happen in training needs assessment, new training op programme of events.
Training delivery: A training programme is developed that provides an incremental approach to learning and skills. The programme is integrated into the local Children's Workforce Development Strategy, including mandatory induction training, with recruitment targeted to: • prioritised areas of teenage pregnancy hotspots • those working with YP identified as being most at risk: youth support workers, Connexions Pas, TYS Lead Professionals, IAG providers, social workers/foster carers/residential workers, YOTs, housing support workers, Learning Mentors, Parent Support Advisers and relevant VCS organisations Training is part of service level agreements and specifications with service providers to enable practitioners to update knowledge and skills.	**Ongoing.** There has also been a sexual health and te in October training 100 professionals on top pregnancy strategy, sexual health and alcol safeguarding, LARCs and contraception, w simulator baby dolls.
Accountability for monitoring training provision and uptake is held by senior managers of each agency and reported to the Teenage Pregnancy Partnership Board.	**Ongoing.** Accountability is held by senior managers. Board is suspended in its current form but w 2010.
Monitoring: The impact of training is monitored consistently and evaluated regularly. Action plans are drawn up and agreed by the relevant accountable lead, with gaps addressed in the Children's Workforce Development Strategy	**Ongoing.** Evaluation commissioned

Implementation: Preventing teenage conceptions

• **Integrated Youth Support Services (IYSS) with a clear remit to tackle teenage pregnancy**			
Integrated Youth Support Services – information advice and guidance (IAG), positive activities and volunteering – need relationships and sexual health, including information and links to local contraception and sexual health services IYSS and knowledge to support young people on sex and relationship issues. The Youth Service has an important leadership key social issues affecting young people, such as sexual health and substance misuse.			
No.	**Local monitoring dataset indicator**	**Baseline**	**Targ**
27	Number and proportion of youth support workers and Connexions PAs receiving training on SRE	Sex in the City: 13.8% Of Connexions professionals in 2009 11% Youth Workers in 2009 Teenage pregnancy conference attendees Connexions 6.9% IYSS 20.3% Vol youth/parents 8 people YOS 5 people	
28	TellUs indicator: participation in positive activities	08/09 71.8%	

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Criteria	Gaps and Issues
Accountable lead: There is an IYSS lead for the commissioning and coordination of work to reduce teenage pregnancy, with clear links to the Teenage Pregnancy Partnership Board or equivalent body.	**Ongoing.** There is an accountable lead in I significantly improved.
IAG: All young people are provided with information about local contraception and sexual health services as part of the universal IAG offer. Arrangements are in place to ensure IAG providers are regularly updated with service information and relevant publicity materials to give to young people.	**Ongoing.** Sexual health information is part Survival Guide, C-card and Spired.com web in each area. Gaps – Connexions PAs' knowledge varies PAs regularly attend training. There is a gap in the consistency of recordi is difficult to quantify the number of contacts sexual health IAG.
Positive activities: There is a wide range of positive activities advertised to young people and accessible to all, particularly those living in teenage pregnancy hotspots, groups of young people vulnerable to teenage pregnancy, teenage mothers and young fathers. Planning of positive activities includes information on local CASH provision and opportunities to develop informal learning about SRE issues	In IYSS this cannot yet be quantified; how for positive activities is to increase particip 85% by 2010/4 (NI110).
Volunteering: Volunteering opportunities are advertised to young people and accessible to all, particularly those living in teenage pregnancy hotspots, young people vulnerable to teenage pregnancy, teenage mothers and young fathers. Activities include involvement in the local TP strategy and local *You're Welcome* accreditation.	**Ongoing.** V talent does offer childcare and present. It is only for 16-25 year olds but is with 14-16 year olds. Some good targeted w Leys, Cowley and Bretch Hill Banbury – all According to the C&YP survey 75% of chi volunteer
Sign-posting to specialist services: IYSS workers have clear arrangements for referring YP to specialist contraception and sexual health advice.	**Ongoing.** SH champions in each area mee committed. Now need to sustain momentum
Resources: *Youth Matters Next Steps* DfES 2007 *Aiming High for Young People: A ten year strategy for positive activ*	

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Implementation: Preventing teenage conceptions

- **Targeted work with at risk groups of young people**

In addition to universal provision of SRE/PSHE and access to CASH, there is a need for targeted work that focuses on y informed by local data that identifies both geographical hotspots and where young people at risk 'live their lives' – e.g. w and developed in the context of Targeted Youth Support (TYS). Targeted work may involve specific intensive SRE/PSH key professionals is also integral to ensuring support reaches young people at risk.

No.	Local monitoring dataset indicator	Baseline
29 (&2)	Proportion/rate of conceptions in (locally defined) geographical hotspots (neighbourhoods, Super Output Areas etc)	27%
30	TellUs indicator: Proportion of secondary school pupils identifying trusted adult	43%
31 (&45)	Proportion of young women and young men in LA aged 15-19 i) in care - or ii) care leavers known to be mothers or fathers	i) Looked after children: 423 (A Rate = 30.9 per 10,000 (or Aged 15-18 =164 (33 were (on 30/09/09) Care Leavers 16-21 (or 25) a ii) <5
32	Number of YOT/YOS clients known to be i) young fathers; ii) teenage mothers	i) Fathers < 5 ii) Mothers <5
33	TellUs indicator: The proportion of young people in year 10 who have been drunk twice or more in the last 4 weeks	3%

Criteria	Gaps and Issues
Accountable lead: There is an accountable lead (e.g. TYS lead) for commissioning and coordinating work for the early identification of young people at risk of teenage pregnancy.	**Ongoing.** There is an IYSS lead for early in pregnancy but more work is needed to fully
Early identification: A wide range of risk factors for early sex and teenage pregnancy (e.g. alcohol use, poor school attendance, low self esteem, etc) are systematically included in local TYS arrangements for early identification of young people with additional needs.	**Ongoing** <u>Numbers benefitting from early interventio</u> • 912 children / young people have had is in progress <u>Analysis of risk and protective factors</u> • Oxfordshire resilience and vulnerabili • Oxfordshire threshold of needs matrix • Consultation with Locality Co-ordinato appropriate • Majority of CAFs are for boys current had CAF or CAF is in progress) but a of girls increasing and in one locality CAFs for girls is now greater than nu • Majority of CAFs are completed for ch -11 followed by children aged 11-16. A great deal of work however is under numbers of CAFs for younger children Visitors and children's centres also wo Support to increase numbers of CAFs

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Criteria	Gaps and Issues
	Targeted Youth Support Change Tear CAF/TACs for older young people. • Certain professional groups are not c example, Midwives.
Targeted support: Support for young people at risk to develop safe and healthy relationships, and prevent STIs and early pregnancy, is systematically included in TYS arrangements through CAF and the Lead Professional. Support includes a range of intensive interventions, and advice on contraception and sexual health as needed (e.g. an intensive SRE/PSHE module for young people at risk of disengaging from school).	**Ongoing.** CAF doesn't always address sex developing to improve this. Some good wor care team and in Youth Offending team. **IYSS preventative health work:** Reliable data on targeted groups not yet a ability to identify vulnerable groups of young likely to conceive as teenagers and track su
Supporting access to contraception: There are arrangements in place to ensure staff working with vulnerable young people proactively support young people to access local CASH services and are involved in local condom distribution schemes.	**Ongoing.** Staff encouraged to attend the S which incorporates the Safety Condom Car training is mentioned as part of new staff in process. IYSS have Sexual Health Champi There main role is to keep sexual health on work. They will also provide support to colle topic or be a signposting point with local kn Follow up for the Safety Card happens' eve yearly. During this follow up staff are remin and encouraged to share any challenges th health with young people. We have invested in a CASH outreach nurs and preventing second conceptions and 1.5 work with the 2 area YOTs and have a parti and support for sexual health. Gaps – Need to increase the numbers of IY training up from 11%.
Monitoring and evaluation: Targeted work is monitored consistently and evaluated regularly – including the meaningful participation of young people – to identify effective approaches. Action plans are drawn up as a result of regular evaluations and agreed by the relevant accountable lead.	**Ongoing.** Good monitoring of C&SH outreach and YC Quality Assurance - see comments above CAF yes
Resources: *Targeted Youth Support and Teenage Pregnancy – working together to reduce teenage pregnancy rates a* Targeted Youth Support: A guide TYS case studies and other resources *Enabling young people to access contraceptive and sexual health information and advice. The legal policy framework fo workers, foster carers and other social care practitioners* Teenage Pregnancy Unit 2005 *Enabling young people to access contraceptive and sexual health advice: guidance for youth support workers* Teenage	

Implementation: Preventing teenage conception

- **Work on raising aspirations**

Teenage Pregnancy: Accelerating the Strategy emphasises the importance of raising aspiration in young people to tack pregnancy. TP rates are higher in more socially deprived wards. Raising aspiration is central to the Children's Trust effe including the reduction of teenage pregnancy and improving outcomes for teenage mothers and young fathers.

No.	Local monitoring dataset indicator
34	TellUs indicator: Leaving School Intentions (Years 8 and 10) Other/don't know (National – 15)

Criteria	Gaps and Issues
Strategy: The LSP and Children's Trust have a strategic, coordinated approach to commissioning and delivery of a range of programmes designed to raise aspiration among targeted groups and communities. These programmes are linked to agendas for worklessness and skills, and building social capital, and ensure • Programmes reach young people most at risk of teenage pregnancy • Programmes combine raising awareness of the consequences of teenage parenthood and raising self-esteem • Schools are engaged in raising aspiration for young people most at risk of teenage pregnancy • Practitioners champion high aspirations for young people • Engagement of communities to support aspiration among young people	**Ongoing.** The Children's Trust works collaboratively t people. Connexions have a service spec to raise as vulnerable groups including young people ta mothers. IYSS have targeted and Success how many are not being reached. There is a lot of Raising Aspirations and Ra Schools and IYSS with all young people. W teenage pregnancy rates are amongst the i risk. Also target YOF, In care/Leaving Care/ in learning/ NEET and those who show poo poor sexual health outcomes. However, the those most likely to conceive (see above).
Resources: *Aiming High for Young People: A ten year strategy for positive activities* DfES 2007	

[13] **R**: requires SMART actions within 3-6 months; **A**: high importance for improvement within the year; **G**: important – maintain current levels

Implementation: Preventing teenage conceptions

- **Work with parents/carers on preventing teenage pregnancy**

Evidence shows that when children can talk openly and without embarrassment to their parents/carers about sex and re sex and use contraception at first sex. Evidence also shows that low parental aspiration for their children is a risk factor important to engage with parents on issues such as aspiration and supporting emotional resilience. Strong, supportive to reducing risk taking behaviour by young people.

No.	Local monitoring dataset indicator	Baseline	Target	Progress to target
35	The number of parents of teenagers attending a parenting course with an SRE element in the last year			Sept.08-Aug. 09 Group base One to one c
36	Number of parenting courses offered in LA Parenting Strategy and Children's Centres which include SRE			Courses run through the Parenting Strateg courses cover talking to young people about parents of teenagers also cover sex and se specifically devoted to this unless parents w Family Links courses, of which at least 7 w and sexual health for prim SRE is often identified as a specific need an Parent

Criteria	Gaps and Issues
Accountable lead: There is an accountable lead for coordinating and commissioning work for parents/carers on preventing teenage pregnancy.	**Ongoing.** Parenting Commissioner (PC) in all parenting strategy including early interve works collaboratively with Teenage Pregnar The PC is also on the Family Intervention P Early Intervention Programme (PEIP) group
Parenting strategy: The parenting strategy includes • information and advice for all parents on talking to their children about sex and relationships through family information services (FIS) and other health and community settings (e.g. GP practices, children's centres) • specific SRE programmes for parents (e.g. Speakeasy), prioritised to parents with children at risk of early pregnancy • SRE, included in parenting programmes, particularly intensive parenting programmes for families at risk (e.g. Family Intervention Programme [FIPs], Think Family projects). • Parent Support Advisors engage with parents about young people's risk taking behaviour in relation to teenage pregnancy. • Training for parenting practitioners/parent support workers on risks in relation to teenage pregnancy and SRE	**Ongoing.** FIS has publications for parents of teenage Speakeasy training starts January 2010 SRE elements exist but more could be done Intervention Programme etc Parent Support Advisors normally Home Sc linked to Parenting Development Workers (made. Attendance on training is low and could be i
Monitoring & evaluation: Progress is monitored consistently and evaluated regularly through the Parenting Strategy, using relevant TELLUS indicators of parents' views and any local surveys of parents. Action plans are drawn up as a result of regular evaluations, and agreed by the relevant accountable lead	**Ongoing.** The Oxfordshire Family Informati information from all providers of parenting p those organisations which are commissione regular meetings with a designated monitor evaluations of the programmes are collated and provision. Local parenting networks als involve them in planning local provision. Bespoke programmes are being developed

[14] **R**: requires SMART actions within 3-6 months; **A**: high importance for improvement within the year; **G**: important – maintain current levels

Criteria	Gaps and Issues
	PEIP is monitored with CEDAR at Warwick Parents fill in questionnaires at start and en
Resources: *Teenage Pregnancy: Accelerating the Strategy to 2010* *Teenage Pregnancy Parents Campaign resources* *National Academy of Parenting Practitioners: training, resources and guidance*	

IMPLEMENTATION: SUPPORTING TEENAGE MOTHERS AND YOUNG FATHERS

Maternal and child health
○ **Antenatal care: early booking and use through pregnancy**
Late booking and poor attendance at antenatal sessions contribute to the health problems teenage mothers experience in pregnancy, as well as the poor health outcomes for the child. As well as often booking late, teenage mothers often do not regularly attend antenatal sessions or drop out of them.

No.	Local monitoring dataset indicator	Baseline	Target	Progress to target
37 (&46)	Number of teenage parents case loaded with specialist/designated Teenage Pregnancy Midwife for one to one work			100%
38	Proportion of under-19 mothers who have seen a midwife or maternity healthcare professional, for assessment of health and social care needs, risks and choices, by 12 completed weeks of pregnancy		100%	

Criteria	Gaps and Issues
Commissioning: There is an identified commissioning lead for Maternity Services, which are commissioned in line with *Teenage Parents: who cares?*	**Achieved.**
Early booking: Services proactively and positively encourage teenage mothers-to-be to book early and continue to use antenatal services throughout their pregnancy. Services are inclusive of young fathers-to-be.	Mothers – **Achieved** Fathers – **Ongoing**
Lead midwife: A lead midwife for teenage mothers (if a specialist post does not exist) is designated by each maternity service, to ensure that teenage mothers' needs are met.	**Achieved.** Oxfordshire has one Teenage P number of link posts too.
Training, support and supervision: Ongoing training, support and supervision of maternity staff are undertaken, including receptionists, on the specific needs of teenage mothers and young fathers and the importance of not deterring their attendance at services through perceived judgmental or stigmatising attitudes and behaviours.	**Ongoing.** Mandatory study days are well at at specialist care of teenage mothers trainin Receptionists not currently trained.
Information: Appropriate information about what to expect during antenatal appointments and classes, what happens during pregnancy and what to do to prepare for the arrival of the baby is provided in an easily accessible format	**Achieved**
Monitoring and evaluation: Maternity services are monitored consistently and evaluated regularly with meaningful participation of teenage mothers and young fathers. Action plans are drawn up as a result of regular evaluations, and agreed by the relevant accountable lead, with gaps addressed through service improvement plans.	**Ongoing.** Midwifery well monitored but few for teenage mothers. Midwifery conducted a mothers in 2008. But there is little sustainab parents.
Resources: *Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts* DCSF/DH 2007 *Teenage Parents: who cares? A guide to commissioning and delivering maternity services for young parents (2nd ed)* D *National Service Framework for Children, Young People and Maternity* (NSF) DH 2007 *You're Welcome quality criteria; Making health services young people friendly* DH 2007 *Getting maternity services right for pregnant teenagers and young fathers* DCSF/DH 2008	

[15] 1: requires SMART actions within 3-6 months; 2: high importance for improvement within the year; 3: important – maintain current levels

Criteria	Gaps and Issues
Supporting Young Fathers Network *Including New Fathers: A Guide for Maternity Professionals* Fathers Direct (now Fatherhood Institute) 2007 *Sure Start Children's Centre Practice Guidance* DCSF 2007 *Multi-agency working to support pregnant teenagers: a midwifery guide to partnership working with Connexions and oth* Midwives 2007	

- **Maternal and child health**
  - **Smoking, alcohol and drugs**

45% of all teenage mothers smoke throughout their pregnancy compared to 17% of older mothers. Smoking during preg in the poor health outcomes of teenage mothers and their children.

No.	Local monitoring dataset indicator	Baseline
39	Smoking prevalence and quit rate among pregnant teenagers under 20 Measured as Smoking at time of delivery (SATD)	2006 U18 36.8% 18-19 27%
40	Proportion of low birth weights in babies born to under-20s. Local Maternity Data System	
41	Infant mortality: level of infant mortalities in babies born to mothers under 20	

Criteria	Gaps and Issues
Stop smoking services: Stop smoking services are commissioned to take into account the needs of pregnant teenagers, teenage mothers, their partners and other household members – and include access to nicotine replacement therapy (NRT)	**Ongoing.** There is now a worker in the smoking cessa working with pregnant women and to trainin Centre staff. There has been approx. £240k Children's Centres to deliver Choosing Hea cessation and targeting high risk groups inc
NRT protocol: Local stop smoking programmes have a protocol with midwifery services to provide NRT under Patient Group Directions (PGDs) as part of maternity care.	**Achieved.** Policy is to refer to GP they don'
Drug/alcohol use: Maternity services are commissioned to provide information and clear, non-judgemental support to teenage mothers and young fathers on the effects of alcohol and drugs on foetal and child health.	**Achieved.** Maternity services are commissi guidelines standards including on drugs and
Referral protocols: Local protocols are in place with specialist services to enable swift referrals of young mothers, and if possible their partners, who have a specific drug or alcohol problem.	**Achieved.**
Resources: *Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts* DCSF/DH 2007 *Teenage Parents: Who Cares? A guide to commissioning and delivering maternity services for young parents. (2nd ed)*	

[16] **R**: requires SMART actions within 3-6 months; **A**: high importance for improvement within the year; **G**: important – maintain current levels

- **Maternal and child health**

  - **Maternal nutrition and breastfeeding**

Good maternal nutrition is critically important, because the foetus competes with the mother for nutrients. This is particu may not have stopped growing themselves and are likely to have additional needs for nutrients. There is compelling evi advantages for both baby and mother. It is a key concern that teenage mothers have 50% lower rates of breastfeeding much less likely to continue it than older mothers.

No.	Local monitoring dataset indicator	Baseline	Target
42	Proportion of under-20 mothers breastfeeding at 6-8 weeks Measured as 'Percentage of mothers who initiated breastfeeding' (BFI)	2006 U18 44.7% 18-19 46%	2% year on y increase

Criteria	Gaps and Issues
Commissioning: Antenatal and postnatal care is commissioned in line with NICE guideline *Guidance for midwives, health visitors, pharmacists and other primary care services to improve the nutrition of pregnant and breastfeeding mothers and children in low income households* with a specific focus on meeting the needs of pregnant teenagers and young fathers. This includes support to access Healthy Start vouchers, Health in Pregnancy grant [18], any local vitamin schemes and healthy eating support programmes.	**Achieved.** Care is commissioned in line wit against NICE guidelines by clinical governa pathway is robust and good quality. .
Support for breastfeeding: Commissioned services to improve breastfeeding rates include a specific focus on teenage mothers. This includes intensive support to overcome initial problems and continuing support through community midwives, family nurses under the Family Nurse Partnership programme, health visitors and peer support. Family members, partners and peers are made aware of the positive effects of breastfeeding and supported to encourage the young mother to start and continue breastfeeding.	**Ongoing.** Figures show a significant proble rates for under 18s. We have invested a quarter of a million of C Children's centres and one main focus is or mothers including teenage mothers. We hav breastfeeding support service to provide int weeks, focussed in Oxford and Banbury, te areas. We are also about to begin the FNP Bicester has a Teenage and pregnant midw breastfed which can be used as good practi
Resources: NICE (2008) *Guidance for midwives, health visitors, pharmacists and other primary care services to improv breastfeeding mothers and children in low income households. Pregnant teenagers and diet. A guide for professionals w do not have specialist training in nutrition. Tommy's (Let's Talk Baby) 2008* Baby Friendly Initiative: WHO/UNICEF ww *Women's Guide to Pregnancy* (2008) - not available electronically	

- ***Maternal and child health***

  - ***Improving teenage mothers' and young fathers' emotional health and wellbeing***

Teenage mothers are three times more likely to suffer postnatal depression than older mothers and to suffer mental hea birth. Poor emotional health not only affects the wellbeing of the young mother but also affects her ability to be an attent

[17] **R:** requires SMART actions within 3-6 months; **A:** high importance for improvement within the year; **G**: important – maintain current levels

[18] Health in pregnancy grant: which came into force in April 2009 http://campaigns.direct.gov.uk/hipg-stakeholders/index.html

to an increased risk of accidents and behavioural difficulties for her child.				
No.	**Local monitoring dataset indicator**	**Baseline**	**Target**	**Progr**
43	Proportion and number of mothers under 20 referred to CAMHS in last 12 months			
44	Proportion and number of mothers under 20 identified by health visitors as suffering postnatal depression in last 12 months			

Criteria	**Gaps and Issues**
Commissioning: Maternity and child health services are commissioned in line with NICE guidance: *Antenatal and postnatal mental health: clinical management and service guidance*; and *Postnatal care: Routine postnatal care of women and their babies*, with a specific focus on meeting the needs of teenage mothers.	**Achieved.** We have commissioned a perina alongside additional tier 1 and 2 services in through children's centres to promote attach health which has a focus on young mothers health.
Parenting and Early Years and CAMHS strategies: The emotional and mental health support needs of teenage mothers and young fathers are included in the local Parenting and Early Years and CAMHS Strategy and work of the children's centres. This includes early mediation and relationship support to help resolve family breakdown, partner conflict and domestic abuse.	**Achieved.** We have developed a comprehe network and family assessment and safegu
Referral protocols: Local protocols are in place with specialist services to enable swift referrals of young mothers and if possible their partners who have emotional health problems.	**Achieved.** Local protocols are in place. We health network.
Resources: *Postnatal care: Routine postnatal care of women and their babies* NICE 2006 *Antenatal and postnatal mental health: clinical management and service guidance* NICE (2007)	

[19] **R**: requires SMART actions within 3-6 months; **A**: high importance for improvement within the year; **G**: important – maintain current levels

- **Supporting teenage mothers and young fathers to achieve better outcomes**

  - **Lead professionals and multi-agency support**

Teenage mothers and young fathers – and particularly care leavers – should have coordinated support to access a wide parenting support and health-related information, advice and treatment. Any specialist service for teenage mothers or y integrated into multi-agency support arrangements.

No.	Local monitoring dataset indicator	Baseline	Targe
45 (&31)	Proportion of young women *and young men* in LA aged 15-19 i) in care – or ii) care leavers known to be mothers *or fathers*	i) Looked after children: 423 (All) Sept 09 Rate = 30.9 per 10,000 (or 0.31%) Aged 15-18 =164 (33 were UASCs) (on 30/09/09) Care Leavers 16-21 (or 25) approx 400. ii) <5	
46 (&37)	Number of teenage parents case loaded by a Health Visitor for one to one work		
47	Number of teenage mothers, and young fathers, with Targeted Youth Support Lead Professional		
48	Number of pregnant teenagers, teenage mothers and young fathers with whom Children's Centres have contact	243 Mothers 171 Fathers 3 Pregnant young women 69	
49	Number of first-time teenage mothers, with FNP Family Nurse (applies in FNP areas only)	Not applicable	

50	Proportion of children (babies) born to mothers under 20 on child protection plan (register)

Criteria	Gaps and Issues
Care pathway: There is a systematic care pathway starting from antenatal booking that includes: • *Arrangements based on need*: Each teenage parent's (male/ female) needs have been assessed via CAF/other assessment process as appropriate, and a lead professional has been agreed where required. Assessments are revisited as situations change and arrangements reviewed. • *Handover***:** There is a systematic process for handover of lead professional role between services where appropriate (e.g. midwifery to targeted youth support to housing support) • *Family Nurse Partnerships*: Where there is a family nurse partnership in place, it is systematically linked to the CAF process and designation of a lead professional with access to specialist multi-agency support and exit strategy when the child reaches age 2.	**Ongoing.** Care pathway is in place but imp A Pre-CAF pilot about to be evaluated. Maternity services have developed a new h grading mothers 1-4 4 being of most concer be 3 or 4. CAFs do not have specific Sexual health qu Handover is good from midwives to health v wider support services could be improved.
Contraception and sexual health (CASH): Starting at antenatal booking, each stage of the care pathway includes sexual health advice and provision of contraception to reduce repeat conceptions, including information to young people about the risk of repeat pregnancy.	**Ongoing.** A contraception assessment is fe pathway but we need to review and change to CASH. More work needs to be done to m implemented. The CASH outreach nurse is U18.
Commissioning: Services supporting teenage mothers and young fathers are commissioned in line with *You're Welcome* to be easily	**Ongoing.** See p.14 point 14

[20] **R**: requires SMART actions within 3-6 months; **A**: high importance for improvement within the year; **G**: important – maintain current levels

Criteria	Gaps and Issues
accessible, using a mixture of appropriate venues, specialist services, support groups and drop in arrangements and staff are aware of the issues faced by teenage mothers and young fathers.	
Monitoring and evaluation: Arrangements for coordinated support are monitored consistently and evaluated regularly – with meaningful participation of young parents – to ensure the needs of teenage mothers and young fathers are met. Action plans are drawn up as a result of regular evaluations, and agreed by the relevant accountable lead	**Ongoing.** Not being monitored at present a involved but are consulted.
Resources: *The Children's Centres Practice Guidance* (2006) DfES *You're Welcome* (2007) DCSF (2007) *Care Matters: Time for Change*	

- **Helping teenage mothers and young fathers to achieve their learning potential and economic wellbeing**

  - **Childcare**

The biggest barrier to engaging in learning for young mothers is the cost of childcare. The Care to Learn programme[21] h
young parents need for childcare and in the academic year 2007-08 involved over 8000 young mothers and some youn
learning. However, take-up of Care to Learn varies significantly between LAs – from around 50% of eligible mothers to

No.	Local monitoring dataset indicator	Baseline	Ta
51	Number of Care to Learn applications by: i) LA (or by locality within LA where appropriate) ii) Learning provider (school/college)	i) Total 48 <19 22.5% <20 10.8% ii) OCVC 19 Independent training/skills providers 4 Schools 10 Supported housing 7 Abingdon and Witney college 6	
52	Number of childcare providers, including childminders, signed up to the Care to Learn Code of Practice (required by all childcare providers receiving Care to Learn funding). Not required – places just need to be Ofsted registered	1220	

Criteria	Gaps and Issues
Childcare Strategy: The LA's childcare sufficiency strategy needs assessment takes into account the current and future childcare needs of teenage mothers and young fathers. This includes the additional childcare needs arising from 2013 when the Raising of the Participation Age legislation will require 17 year old young people, including those who are parents, to remain in learning	**Needs further work.** Childcare strategy do teenage parents or raising the education pa team are keen to develop this and will actio
Promotion of Care to Learn: Arrangements are in place to actively promote Care to Learn through relevant agencies: Maternity and Health Visiting services; Family Nurse Partnership; Family Information Service; Learning Providers	**Ongoing.** More promotion needed. Connex included in the maternity care pathway but are likely to be a) lack of pathway including C2L and usage professionals • b) concern from professionals or young
Care to Learn Lead: There is an accountable strategic lead to promote and monitor uptake of Care to Learn – with links to the 14-19 lead.	**Needs further work.** Accountable strategi
Resources: *www.direct.gov.uk/en/EducationAndLearning/14To19/* *Care to Learn Code of Practice*	

- **Helping teenage mothers and young fathers to achieve their learning potential and economic wellbeing**

[21] Note: does not provide help for waged training, such as apprenticeships or for publicly funded learning in HE
[22] **R**: requires SMART actions within 3-6 months; **A**: high importance for improvement within the year; **G**: important – maintain current levels

○ **Engagement in education, employment and training (school age mothers)**			
Most school age mothers have their babies in Year 11 which is a crucial time for taking GCSEs, so it is important to ens compulsory education. Participation rates for teenage mothers remain low, in part due to their low level of prior qualifica availability of foundation level courses and the difficulty of finding courses that are flexible enough to accommodate thei			
No.	**Local monitoring dataset indicator**	**Baseline**	**Target**
53	Number (and proportion) of 16-19 year old mothers in education, employment or training (through Connexions CCIS information)	21.77% 64 EET out of 294 Proportion 25.7% compared to overall population	County w is 30% Localitie vary from 50%
54	**CCIS**: Young men who are NEET are routinely asked by Connexions/IAG provider if they are a parent and this information is included in the Client Caseload Information System (CCIS).	No	100%
55	Proportion of female NEETs who are teenage mothers (national estimate is 20%)	29.7%	
56	Proportion of teenage mothers achieving 5 or more A*-C grades at GCSE or equivalent	Level 2 = 36 out of 289 12.4%	
57	Proportion of teenage mothers and young fathers achieving: i) a level 2 qualification by age 19 ii) a level 3 qualification by age 19	level 2 - Inc 19 year olds 11.8% 36 out of 305 Level 3 - 1% 3 out of 305	

Criteria	**Gaps and Issues**
Support: A Reintegration Officer or nominated officer (in all areas including counties) ensures school age mothers and fathers receive the education they need to achieve their potential up to and beyond the current school leaving age.	**Ongoing.** There is reasonable coverage bu working. Schools undertake a needs asses on vulnerable CYP with Connexions. Howe comprehensive enough or contain enough
Education for school age parents: Education is provided in line with DCSF *Guidance on Education of School Age Parents* – and no school age mother is excluded on grounds of pregnancy or health and safety concerns related to it.	Policies are in place but implementation is v
September Guarantee: Pregnant pupils and young mothers aged 16 and 17 benefit from the September Guarantee that every young person leaving compulsory education is offered an appropriate place in learning by the end of the September after they leave full-time education and that they are supported to access Care to Learn funding and find appropriate childcare.	**Ongoing.** The September Guarantee is nov mothers. We have seen in the majority very guarantee and it shows a significantly bette year. Years 11 and 12 – 66 young mothers 14 Conditional offers 4 No offer 11 Personal circumstances prevent offer 33 Already in EET
EMA: The 14-19 Lead ensures that there is adequate information and support for teenage mothers and young fathers to access the Education Maintenance Allowance (EMA), including advice for students with a dependent child that household assessment of income does not apply to their parents' income (even if they are living with them). Learning providers apply flexibility when monitoring teenage mothers' and young fathers' compliance with EMA contracts and ensure that pastoral support arrangements take into account the pressures of combining learning with the responsibility of looking after a child.	**Ongoing.** EMA is becoming the pathway fo anecdotally, young mothers report barriers
Learning provision for teenage mothers and young fathers: There is sufficient provision of accessible and flexible learning for teenage mothers and young fathers, including provision for those with low attainment as well as part-time and taster courses at FE colleges to	**Needs further work.** There is provision in p enough to meet the needs of young mother enough flexible starts, the majority of start September and not staggered throughout th

[23] **R**: requires SMART actions within 3-6 months; **A**: high importance for improvement within the year; **G**: important – maintain current levels

Criteria	Gaps and Issues
support decisions about courses of study with clear routes for progression.	flexible programmes too.
Resources: *Guidance on Education of School Age Parents* (DfES/2001/0629 – to be revised in 2009) *Raising Expectations: Enabling the System to Deliver* DCSF/DIUS 2008 *September Guarantee – guidance for local authorities and delivery partners (2009)* *Improving Access to Sexual Health Services for Young People in Further Education Settings* DCSF. DH (2007)	

- ***Helping teenage mothers and young fathers to achieve their learning potential and economic wellbeing***
  - ***Reducing child poverty***

It is essential that teenage mothers and young fathers are able to access good quality housing, if they cannot live with t have a considerable impact on achieving better outcomes in terms of their parenting, re-engagement with learning, and Improving support for teenage mothers means that they will not need to claim means tested benefits in the long term as themselves. However, young mothers often need benefits when the baby is born, particularly if they have no partner or has adequate care and nutrition.

No.	Local monitoring dataset indicator	Baseline	Target
58	Number of tenancies allocated to lone parents under 18 years	08 Temporary accom – 15 09 temporary accom – 0 (indicating they have moved on) Supported housing – approx 24	
59	Number of lone parents under 18 allocated a tenancy without a support package in place	0	0
60	Number of lone parents under 18 allocated a tenancy with: i) on-site support ii) floating support	 24 15	
61	Proportion of teenage mothers in housing need achieving independent living (sourced from National Indicator (NI) 141: Number of vulnerable people achieving independent living)	2007-8 94.1% 2008-9 97.9%	
62	Proportion of teenage mothers in housing need supported to maintain independent living (sourced from NI 142: Number of vulnerable people who are supported to maintain independent living	2007-8 98.8% 2008-9 NA	
63	Proportion of children of teenage parents living in poverty (sourced from data informing National Indicator 116)		

Criteria	Gaps and Issues
Commissioning: The Supporting People (SP) or housing support commissioning plan addresses the accommodation and housing support needs of teenage mothers and young fathers – as one of the 22 Supporting People or housing support client groups. As SP and housing support services are managed at County level, in the case of two tier authorities, accommodation needs of teenage mothers and young fathers are discussed and agreed with District Councils who make housing allocations in two-tier areas. There is a strategic lead for linking with Jobcentre Plus.	**Achieved.**
Aligned support: SP funded/contracted housing-related support is	**Achieved.**

[24] **R**: requires SMART actions within 3-6 months; **A**: high importance for improvement within the year; **G**: important – maintain current levels

Criteria	Gaps and Issues
linked to, or part of, care pathways. Support is delivered in liaison with the lead professional where allocated.	
Flexible support arrangements: Teenage mothers and young fathers with parenting responsibilities who cannot live at home, are placed in either a dedicated housing project, or have an intensive floating support package informed by a CAF assessment and action plan	**Ongoing.** Intensive floating support not alw better linked to CAF.
Benefits: Jobcentre Plus staff have clear arrangements in place for dealing with claimants under 18 who are expecting a baby or who have responsibility for a child, including correct payment of benefits they are due (including if they live with their parents or are in learning) and speedy referral to Connexions for a learning focused interview and referral to a lead professional for ongoing, holistic support.	**Ongoing.** Protocols are in place as per guid practitioners indicates service varies from v dedicated or specialist post in place to extre
Monitoring and evaluation: Supported housing arrangements for teenage mothers and young fathers who cannot live at home are monitored consistently and evaluated regularly – including meaningful participation of young parents. Action plans are drawn up as a result of regular evaluations, and agreed by the relevant accountable lead	**Ongoing.** There has been a new housing c which has redesigned targeted support for t stuck to a challenging criteria to ensure high working towards being very rigorous and ro
Resources: *Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts* DCSF/DH 2007 *HSSA data published annually by Communities and Local Government*	

Annex 1: Teenage pregnancy self assessment summary sheet

Area: Oxfordshire
Name of key contact: Lucy Russell **Date: October 2009**

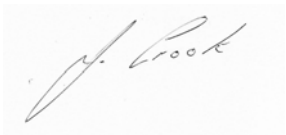
Summary of red and amber gaps and issues: it may be useful to bring together the red and amber gaps and issues to identify common themes for action (e.g. lack of involvement of YP across a range of toolkit elements).

Gaps and Issues
Need a new action plan
Champions
Data sharing
Communications
PSHE CPD training
SRE delivery gaps
Training
IYSS Sexual Health Champions
IYSS data and targeted activities
Targeted support - CAF and sexual health
Parenting
Maternity Care Pathway
Childcare strategy
Care to Learn
EET – college places

Actions grid to address red and amber RAG gaps and issues: the following actions can be taken forward for inclusion in the appropriate local plans (e.g. Children and Young People's Plan, PCT Operational Plan)

	Accountable lead
TP strategy and create new action plan based on self assessment	Teenage Pregnancy Coord
and finish group including champions in Area Trust Boards	Assistant Director of Publi Health
ring agreement across PCT/OCC	Health Improvement Principal
unications strategy across OCCC and PCT	Teenage Pregnancy Coord
in PSHE CPD from TP target schools and PRUs	Healthy Schools Team
people and parents in SRE delivery	Teenage Pregnancy Coord
s assessment of staff working with young people	Teenage Pregnancy PDO
aining package with promotional materials	Teenage Pregnancy PDO
exual Health Champions and Network. Begin with plan.	IYSS and TP teams
database monitoring and create ability to identify young women most likely to conceive	Strategic lead for IYSS
ual health pathway for CAF/PreCAF	CAF Lead/CASH/TPC
etween parenting strategy and TP strategy and roll out Speakeasy training	TPC/Parenting Commissioner
ate Maternity Care Pathway and ensure promotion and application	Midwifery Lead
age parents maternity services consultation group linked to Maternity Services Liaison	Midwifery Lead
arents into existing Childcare strategy including preparing for raising Education age	TPC/Childcare Strategy Lead
ead and create a C2L promotion strategy	Care 2 Learn Strategic lead
s with more flexible starts and more flexible college opportunities	14-19 Strategic Lead

Signed off on behalf of Oxfordshire County Council



Signed:
Position: Interim Director for Children Young People & Families 02/11/09

Signed off on behalf of Oxfordshire Primary Care Trust:

Jonathan McWilliam

Position: Director of Public Health, 02/11/09

Annex 2: Acronyms and abbreviations

CAA	Comprehensive Area Assessment
CAF	Common Assessment Framework
CAMHS	Child and adolescent mental health services
CASH	Contraception and sexual health
CLG	Communities and Local Government
CPD	Continuing professional development
DCSF	Department for Children, Schools and Families (formerly DfES)
DfES	Department for Education and Skills (now DCSF)
DH	Department of Health
EMA	Education Maintenance Allowance
FIS	Family Information Service
GO	Government Office
IAG	Information and guidance
IYSS	Integrated Youth Support Services
JSNA	Joint Strategic Needs Assessment
LA	Local authority
LAA	Local Area Agreement
LARC	Long-acting reversible contraception
LSP	Local strategic partnership
NICE	National Institute for Health and Clinical Excellence
NIS	National Indicator Set
NRT	Nicotine replacement therapy
PCT	Primary care trust
PGD	Patient Group Directions
PRU	Pupil referral unit
PSHE	Personal, social and health education
QCA	Qualifications and Curriculum Authority
RAG	Red / Amber / Green (RAG rating)
SHA	Strategic Health Authority
SP	Supporting People
SRE	Sex and relationships education
STI	Sexually transmitted infection
TP	Teenage pregnancy
TPU	Teenage Pregnancy Unit
TYS	Targeted youth support
VS	Vital signs
WCC	World class commissioning
YOT	Youth Offending Team
YP	Young people

Department for Children, Schools and Families