Ad Hoc Scrutiny Review

LOOKING INTO

TEENAGE CONCEPTION

Kirklees COUNCIL

Scrutiny & Governance Team
2nd Floor, Civic Centre 3
Huddersfield
HD1 2TG

Telephone: 01484 221700
E-mail: scrutiny.governance@kirklees.gov.uk
Web Site: www.kirklees.gov.uk/scrutiny

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1.0 EXECUTIVE SUMMARY

1.1 According to a Department for Education and Skills document entitled '*Teenage Pregnancy Next Steps',* (2006) each year, around 39,000 girls under-18 become pregnant in England. Research suggests that teenage pregnancies are most likely to occur in areas where there is high socio-economic deprivation with nearly every local authority having at least one "hotspot" neighbourhood, where more than 6% of girls aged 15-17 become pregnant every year. The overwhelming majority of these conceptions are unintended and around half will result in a termination[1].

1.2 Evidence presented to the Scrutiny Review Panel showed that each year, in Kirklees, there are approximately 370 conceptions to girls aged 15-17 years and almost half of these result in a termination. Four Kirklees localities are referred to as 'hot spot' areas after being identified as having consistently high levels of young women between the ages of 15 and 17 years giving birth.

1.3 The Review Panel has acknowledged that the factors that contribute to teenage conceptions are wide ranging and complex and while deprivation is one of the factors, there are other indicators that are common in areas of high teenage conception rates. For example, in Kirklees, areas with higher teenage pregnancy levels correlate with issues relating to alcohol misuse and young people Not in Education, Employment and Training (NEET). It is also important to point out that while there is a high incidence of teenage pregnancy occurring in "hotspot" neighbourhoods, in Kirklees, they are not exclusively confined to these areas.

1.4 On a local level while there appear to have been many strategies aimed at preventing and reducing the numbers of teenage conceptions and improving sexual health; information presented to the Review Panel suggests that improvements in these areas have not had a significant impact in Kirklees. Indeed a recent inspection by OFSTED of Kirklees' Safeguarding and Looked After Children arrangements identified as an area for improvement within 6 months, *"a strengthening of the arrangements to tackle the high rate of teenage conception in Kirklees"*.

1.5 The Review Panel is however, optimistic that the Kirklees Teenage Pregnancy and Sexual Health Joint Commissioning Plan for 2010-2013, will be the underpinning strategy that enables local agencies to pool resources in order to produce more creative and innovative ways of tackling teenage conception, particularly in the 'hot spot' areas.

1.6 The Review Panel would like to thank everyone who contributed to the review by willingly sharing their experience and expertise.

[1] Guidance for Local Authorities and Primary Care Trust on Effective Delivery of Local Strategies - DfES

2.0 BACKGROUND AND CONTEXT FOR THE REVIEW

2.1 The issue of teenage pregnancy had been on the Children and Young People Scrutiny Panel's work programme as a monitoring item since April 2009, with the Scrutiny Panel receiving regular progress updates on National Indicator 112[2].

2.2 In January 2010, the Scrutiny Panel was presented with information from the Teenage Pregnancy National Support Team which highlighted that:

- *In 2007, Kirklees had an under 18 conception rate per 1,000 females aged 15-17, 10% higher than the England average of 41.7 per 1,000.*
- *Five (21%) of Kirklees' wards were "hotspots" with rates among the highest 20% in England (2004-06 data).*
- *In 2007, 44% of under-18 conceptions in Kirklees led to abortion – compared to the England average of 51%. Data on repeat under-19 abortions in Kirklees District PCT show 8.8% of under- 19 abortions were repeat abortions in 2008, compared with the England average of 11.0%.*
- *19% of 14 year olds reported having had sex – (local school survey data)*
- *There had been an overall reduction in teenage conception of 6% since the 1998 baseline rate of 48.6 per 1,000.*

2.3 The Scrutiny Panel felt that teenage conception rates in Kirklees warranted a more detailed and focused piece of work; however, did not have the capacity to undertake it at that time.

2.4 In January 2011, the Overview and Scrutiny Management Committee approved the establishment of an Ad Hoc Scrutiny Review Panel to look into teenage conception in Kirklees.

[2] 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.

3.0 TERMS OF REFERENCE AND METHODOLOGY

3.1 **The Scrutiny Panel members were:**

- Cllr Carole Pattison (Chair)
- Cllr Elizabeth Smaje
- Cllr Rochelle Parchment
- Linda Summers (Voluntary Co-optee)
- Richard Burge (Statutory Co-optee)

3.2 The Scrutiny Panel was supported by Scrutiny Officers Jenny Bryce-Chan and Beth Hewitt.

The terms of reference for the review were:-

1. To understand the picture of teenage conception in Kirklees – giving consideration to any trends which may include ethnicity and demographics.

2. To determine what is required under PSHCE ed in relation to sex education and to understand the impact of this on the teenage conception rate.

3. To assess what support is available for:

   - Preventing teenage conception,
   - Pregnant teenage mothers and young fathers to be
   - Teenage parents

4. To identify any gaps in provision.

5. To make recommendations as appropriate.

3.3 **Witness Interviews/Visits**

DATE	WITNESS
10 March 2011	Julie Walker – Operations & Development Manager Alan Laurie – Commissioning Manager (Joint Commissioning) Tom Brailsford – Joint Commissioning Manager
3 May 2011	Patricia Muramatsu – Health in Educational Settings Lead NHS
9 June 2011	Rachel Spencer-Henshall – Senior Public Health Manager NHS Graham Hofmann – School Improvement Officer – Kirklees Council Emma Thomas – Housing Support Worker – Fusion Housing (formally SHAP) Tasha Dyson – Housing Support Services Manager – Fusion Housing (formally SHAP)
22 June 2011	Visit to Homestart - Dalton
28 June 2011	Graham Crossley – Commissioning & Contracts Manager – Kirklees Council

	Steve Collins – Head of Service Calderdale & Kirklees Careers Connexions Jeremy Haigh – Royds Hall High School
29 June 2011	Visit to Huddersfield New College
8 July 2011	Visit to Flatts & Eastborough Children Centre
18 August 2011	Susan Greenwood – Young People's Support Manager - Kirklees Neighbourhood Housing Lynne Hoyle - Young Peoples Team Manager – Housing Options & Support Service Karen Poole - Family Nurse Partnership
12 September 2011	Martin De Bono – Divisional Director of Children and Women's Service Sajid Azeb – Assistant Divisional Director of Children and Women's Service Dr Susmita Ray – Consultant Gynaecologist Julie Dean – Teenage Pregnancy Midwife
26 September 2011	Visit to the CASH Clinic - Dewsbury

4.0 EVIDENCE AND FINDINGS

4.1 National Context

4.2 Over the years, the proportion of teenagers and in particular those under the age of 16 who have experienced sexual intercourse have increased dramatically. The 2001 survey of sexual attitudes and lifestyle[3] revealed that over 90% of teenagers had experience of sexual intercourse and around a quarter before the age of 16.

4.3 Teenage pregnancy in the United Kingdom is a long-standing issue with England having the highest teenage pregnancy rate in Western Europe. In June 1999, the government's Social Exclusion Unit (SEU) presented to Parliament its report on teenage pregnancy. It acknowledged the seriousness of the situation, in terms of damage to the educational and career prospects of the mothers and the health of their children. It committed the Government to a target of halving the number of conceptions occurring in women under 18 by the year 2010 (compared with 1999)[4].

4.4 In response, the Government set up the Teenage Pregnancy Unit (TPU) to carry out the recommendations of the Social Exclusion Unit's report. All Local Authorities and Health Authorities in England were required to produce a teenage pregnancy strategy for their area, stating what action they intended to take to help meet the target of a 50% nationwide reduction in under-18 conceptions by 2010. It is widely recognised that the 50% reduction will not be achieved.

4.5 Between 1998 and 2,000 the rate of teenage (age 15-17) pregnancy in England & Wales was 45.4 per 1,000 girls, whilst in Kirklees the rate was 46.3. By 2009

[3] National Survey of Sexual Attitudes and Lifestyles II (Technical Report)
[4] Why the governments teenage pregnancy strategy is destined to fail – Family Education Trust

(the last year for which ONS data is currently available); it had reduced to 38.3 while the figure for Kirklees was 48.5. The 2010 data will be available from the Office for National Statistics (ONS) in February 2012.

4.6 The Coalition Government's approach to public health however, is to place increased focus on early intervention and prevention to tackle teenage pregnancy, rather than stipulating reduction by a specific percentage target. Public health will be brought into the local authority which will provide an enhanced role for local authorities to deliver health improvement and preventative activities; and most sexual health services will be subject to local authority commissioning with the exception of primary care delivered contraception. One of three sexual health outcomes in the public health white paper is teenage pregnancy.

4.7 Local Context

4.8 In November 2009, the Teenage Pregnancy National Support Team visited Kirklees to identify recommendations and to work alongside senior colleagues in the PCT and the Council to support delivery of public health priorities to reduce teenage conception.

4.9 Following the visit, in Kirklees there has been a review of teenage pregnancy work and the adoption of a new strategic approach. It is important to highlight that many strengths were identified as part of the visit including;

- The senior commitment across the partnership to strengthen the local teenage pregnancy strategy,
- The excellent PSCHE toolkit available to Kirklees Schools,
- The 2 specialist Teenage Pregnancy Midwives and
- The re-launch of the C-card scheme in the delivery of the availability of condoms.

4.10 However a key number of challenges were also identified including:

- The risky lifestyle behaviours of young people in Kirklees
- The concentration in areas of deprivation
- The geographical diversity and;
- The existence of 5 Kirklees wards that are considered hotspots with conception rates amongst the highest 20% in England and Wales.

4.11 Kirklees Council has published its "Kirklees Teenage Pregnancy and Sexual Health Joint Commissioning Plan 2010-2013". The overall aim of the plan is to reduce the Under-18 teenage conception rate and work towards improving sexual health and well-being for young people in Kirklees. The Plan focuses on six strategic priorities[5]:

1 Prevention and Supportive Environments
2 Developed Contraception and Sexual Health
3 Relationships and Sex Education

[5] Kirklees Teenage Pregnancy and Sexual Health Joint Commissioning Plan

4 Protecting the sexual health and future wellbeing of teenage parents
5 Support for the most vulnerable and at risk groups
6 Establish a multi-agency service model

4.12 Kirklees has chosen to adopt a target of “a sustained downward trend in teenage pregnancy rates of 1% over a three year period”[6].

[6] Kirklees Teenage Pregnancy and Sexual Health Joint Commissioning Plan

5.0 SUMMARY OF EVIDENCE RECEIVED

5.1 The following sections of the report will set out each of the terms of reference and include a summary of the key evidence received as part of the review, followed by an outline of the Review Panel's views.

Term of Reference 1

To understand the picture of teenage conception in Kirklees – giving consideration to any trends which may include ethnicity and demographics

5.2 The Review Panel was presented with a wide range of information and statistical data that has helped build up a picture of teenage conceptions in Kirklees, including

- The numbers and prevalence of teenage conception,
- The geographical hotspots across Kirklees,
- Comparative information with neighbouring authorities,
- The connections between young people, their education, confidence and aspirations.

5.3 Statistical data and trends for Kirklees

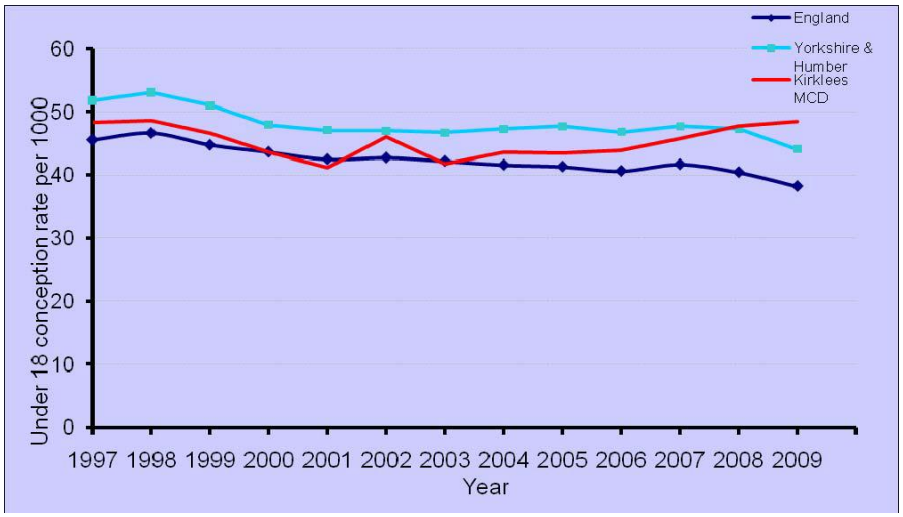
5.3.1 The statistical information and data provided to the Review Panel came from sources such as the Office for National Statistics (ONS), the locally compiled Health Informatics Service (HIS) and the Kirklees Joint Strategic Needs Assessment (JSNA) 2010. In addition, the Review Panel received information produced from the local year 9 school surveys. Additional background information includes the findings of the Marmot review and the Sexual Health Needs Assessment carried out by MBARC consultancy and commissioned by the PCT in April 2011.

5.3.2 ONS Data

ONS data is compiled from birth registrations and terminations. This means birth data is not available until 11 months after the event at which point ONS require a further 3 months to collate, input, validate and compile the data. This results in statistics being published 14 months after the end of the period to which it relates.[7]

5.3.3 The ONS data seems to suggest that over a 6 year period, 2003-2009 (see chart below) the conception rate in Kirklees had been going up against a national trend of decreasing numbers. The Office for National Statistic's provisional data for the first part of 2010 suggests a slight decrease.

[7] Kirklees Teenage Pregnancy and Sexual Health Joint Commissioning Plan



ONS under-18 conception revised data for 1997-2009 (3 year average shows 2% increase)

5.3.4 On the 24 May 2011, the ONS released provisional 2010 first quarter data for under-18 conception. Although, there is no specific information for Kirklees, the figure for Yorkshire and Humber showed that the rate of under-18 conception fell by 6.8% from Q1 2009. The rolling average has fallen since the previous quarter[8]. The Review Panel were encouraged by the predicted improvement but were cautiously optimistic.

5.3.5 <u>Local Data – Health Informatics Service</u>
More local Kirklees data from NHS Kirklees' Health Informatics Service (HIS) is based on the age of the mother at the time of birth or termination and comes from NHS providers only. It is important to note that the way data is collected locally and the way it is collected by the ONS differs resulting in a variation of approximately 12% between Kirklees and ONS data.[9]

5.3.5 Local HIS data showed that the overall conception rate in Kirklees fell to 28.97 in 2009 from a peak of 35.2 in 2008, one of the lowest levels over the past 5 years.[10] In 2009, of the 227 conceptions recorded for 15-17 years olds (recording 15-17 year olds is a national requirement) 48% resulted in births and 52% resulted in terminations. The majority of conceptions for this cohort were to 17 year olds however, there is a higher level of terminations amongst young women aged 15 than young women aged 16 and 17.

5.3.6 <u>Joint Strategic Needs Assessment (JSNA)</u>
The JSNA for Kirklees assembles a wide range of quantitative and qualitative data, and includes user views to provide an objective analysis of local current and future needs for adults and children.[11] The production of the JSNA has been a statutory duty for Primary Care Trusts and local authorities since 2007.

5.3.7 Information from the JSNA 2010 showed that Kirklees had more residents under the age of 15, than England and Wales, 21% verses 18%. Nearly 1 in

[8] Teenage Pregnancy Unit (TPU) Update: June 2011
[9] Kirklees Teenage Pregnancy and Sexual Health Joint Commissioning Plan
[10] Understanding Teenage Pregnancy in Kirklees 2010
[11] The Joint Strategic Needs Assessment

4 of the Kirklees population was aged less than 19 years[12]. Further information from the JSNA, showed that in 2008, there were 372 conceptions in girls aged 15 to 17.

5.3.8 This correlated with evidence presented by representatives from NHS Kirklees which suggests that there are approximately 370 conceptions each year to teenagers between the ages of 15-17 of which approximately 46% will result in a termination.

5.3.9 Year 9 Survey

In Kirklees, every 3 years a survey is conducted with year 9 students. The survey which was originally instigated by the School Nurse Service is a comprehensive survey which asks year 9 students a range of questions which includes health and lifestyle, sexual health, knowledge of the 'open door' service, emotions and feelings and drugs and alcohol. (A copy of the 2009 survey is attached at appendix 1)

5.3.10 Findings from the Young Person survey for 2009 highlighted that 19% of 14 year olds claimed to have had sexual intercourse, stating that their first sexual health experience was when they were 13 or 14 years old; the majority stating that they used some form of contraception. In addition the information revealed that they had a limited knowledge of the services to support young people including 'open door' services provided in schools.

5.3.11 Children and Young People Data

At the start of the academic year, schools across Kirklees receive an information pack which contains a wide range of statistical information and data. The pack includes information on achievement and attainment, key stage 3 and 4 information, student profiles including numbers of students on the roll and demographic information which is linked to the index of multiple deprivation.

It also includes information relating to special educational needs (SEN), free school meal eligibility, ethnicity, exclusions and financial information. While the Review Panel did not determine in detail how schools used this information, it was perceived that some schools used this information better than others.

5.4 Teenage conception in Kirklees

5.4.1 Between 2003-2007, there were distinct patterns of consistently high rates of teenage conception in Deighton, Newsome and Batley West.[13] Dewsbury East, Dalton and Dewsbury West were more variable across the time period but rates in those areas still remained reasonably high. Cleckheaton, Mirfield and Thornhill had seen a larger downturn and rates were becoming relatively lower. Dewsbury East and West have also seen decreases. There is an even split of wards with an increasing and decreasing rate. Although high, Deighton has seen a very small decline in its rate[14].

[12] The Joint Strategic Needs Assessment

[13] Joint Strategic Needs Assessment for Kirklees 2010

[14] In 2004, the ward boundaries in Kirklees were redrawn, with substantial changes been made to the Deighton Ward. Some of the ward went into Dalton and approx half went in to the old Birkby ward to create Ashbrow.

5.4.2 In Kirklees, the most concentrated localities have approximately 60 girls aged 15-17 who conceive every year[15]. Areas with higher teenage pregnancy levels in North Kirklees correlate with a number of indicators including, deprivation, pockets of high claimant rates and young people not in Education, Employment or Training (NEET). Areas with higher teenage pregnancy levels in South Kirklees correlate with a number of indicators including, benefits claimants, pockets of deprivation and NEET[16].

5.4.3 The Review Panel questioned whether any comparisons had been made with both geographical neighbours to Kirklees and those demographically comparable to Kirklees. Oldham which is demographically comparable to Kirklees had seen the number of teenage conceptions decline.

Area of usual residence	2009 Number	2009 Rate	2001 Number	2001 Rate
Bradford	430	41.0	498	47.4
Calderdale	184	47.4	189	51.2
Kirklees	**370**	**48.5**	**307**	**41.2**
Leeds	618	47.4	605	46.8
Oldham	190	42.3	276	59.3
Wakefield	309	49.3	290	47.1

5.4.4 Information provided to the Review Panel showed that a number of 'comparative neighbours' had provided Kirklees with examples of their teenage pregnancy strategies which had assisted in the development of the Kirklees Strategy.

5.4.5 It was also stated that Bolton and Rochdale provided valuable comparison around recording of NEETS to EETS which have also been adopted by Kirklees.

5.4.6 Although there may be predicted improvements with regard to the number of teenagers becoming pregnant in Kirklees, data suggests that four localities across Kirklees have consistently high levels of young women giving birth. Over the years, while some Kirklees wards have seen trends towards improvement there are localities referred to as 'hot spots' after being identified as having stubbornly high levels of young women between the ages of 15 and 17 years giving birth.

5.4.7 These localities are:

- Batley, Birstall and Birkenshaw
- Dewsbury and Mirfield
- Huddersfield North
- Huddersfield South

[15] Kirklees Teenage Pregnancy and Sexual Health Joint Commissioning Plans
[16] Understanding teenage Pregnancy in Kirklees 2010

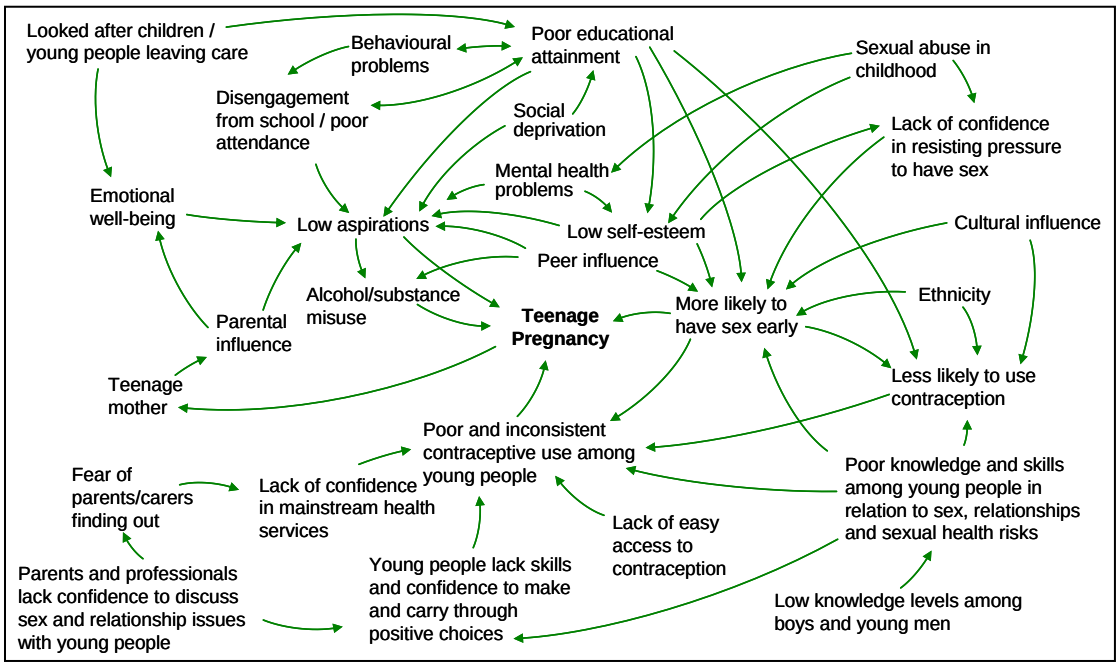
5.4.8 The Valleys, Spen and Denby Dale and Kirkburton have smaller numbers of young women giving birth. However, it is worth noting that there had been an upward trend at the end of quarter 3 2009/10 in all these areas, Spen Valley especially saw an increase after being relatively static for the previous few years.[17]

[17] Understanding Teenage Pregnancy in Kirklees

5.5 Factors Contributing to Teenage Conception

5.5.1 Factors contributing to teenage conception are varied and difficult to understand, however, there is sufficient evidence to show that contributory factors include: low self esteem, risk taking behaviour involving drugs and alcohol and a lack of knowledge with regard to sex education as well as ease of access to contraception services and disengagement from the education system. The JSNA suggests that teenage pregnancy can be both a cause and a consequence of social exclusion and that the number of teenage pregnancies is high in areas of deprivation, social housing and low educational achievement.

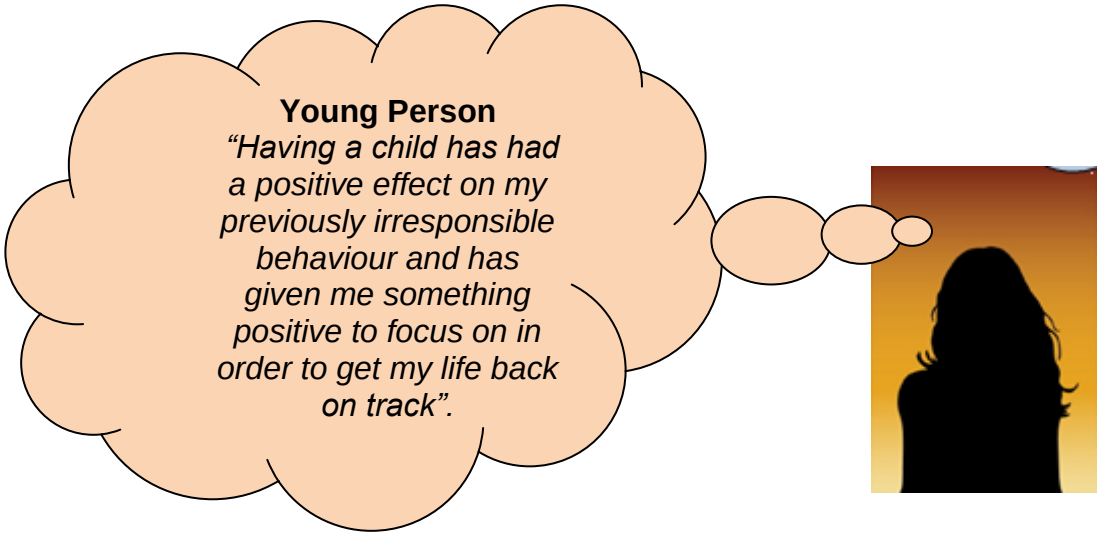
5.5.2 Understanding why teenage pregnancies occur is complex and there are a wide range of factors that contribute. The diagram below highlights how interconnected the factors are.



Slide from the Teenage Pregnancy Support Team presentation on the feedback of the November 2009 visit.

5.5.3 Evidence suggests that most teenage pregnancies are unintentional; however there are examples where some young people plan their pregnancies; although the statistical information presented to the Panel made no distinction between planned and unplanned pregnancies.

5.5.4 Explanations for a planned teenage pregnancy may include cultural reasons, where a girl marries at a young age. It could also include unmarried girls in stable relationships who decide to start a family. It is also understood that low self esteem and a lack of aspiration may lead some young girls to plan a pregnancy in the belief that having a child may fill a perceived gap in their life.



5.5.5 Witnesses were asked their opinion as to what they considered to be the key contributory factors to teenager conception. Responses included, a lack of parental control, peer pressure, individual ethics and risk taking behaviour involving alcohol and drugs. More sinister reasons such as sexual abuse and grooming were also mentioned.

5.5.6 Further information from the JSNA shows that:-

- *Teenage mothers are 20% more likely to have no qualifications at the age of 30.*
- *Teenage mothers are three times more likely to smoke throughout their pregnancy and 50% less likely to breastfeed.*
- *Nationally, there is a 60% higher infant death rate for babies born to teenage mothers.*
- *Children of teenage mothers have a 63% increased risk of being born into poverty, have more accidents requiring accident and emergency admission and suffer more psychological and behavioural problems*[18]*.*

Panel views

The Review Panel felt the year 9 survey was inconsistent around questions about contraception only mentioning condoms but no other methods of contraception. The survey gave reference to domestic abuse within the home but nothing relating to alcohol in the home which the Review Panel felt was a contributory factor to influencing a young person's attitude to alcohol and which could subsequently lead to a teenage conception.

The Review Panel felt that with regard to the hotspot areas there should be joint working with a cluster of schools pooling resources to deliver a more targeted response in order to tackle teenage conception rates and provide support to teenage parents, in a more proactive and cohesive manner.

The Review Panel felt it would be useful if an information pack was developed and provided to parents and carers to enable them to address sexual health issues in the home and that this should include all parents and children who lived in Kirklees but who may access their education in a neighbouring authority.

[18] Joint Strategic Needs Assessment

Term of Reference 2
To determine what is required under Personal Social Health Citizenship and Economic education (PSHCE ed) Programme in relation to sex education and to understand the impact of this on the teenage conception rate.

5.6 Personal Social Health Citizenship and Economic education (PSHCE ed)

5.6.1 The Scrutiny Review Panel sought to determine the approach taken by schools across Kirklees to deliver PSHCE ed and Relationship and Sexual Health Education (RSHE) programmes and to consider the effectiveness and impact of these programmes. In England, a review of the teenage pregnancy strategy identified strong delivery of RSHE and PSHCE ed by schools as a key feature of high performing local authorities where pregnancy rates had gone down[19].

5.6.2 In July 2011 the Government launched a review to determine how to support schools in improving the quality of teaching of PSHCE, including giving teachers the flexibility to use their judgement about how best to deliver PSHCE education. This review closed on 30 November 2011 and the final report is awaited.

5.6.3 PSHCE education itself does not have any statutory basis and is not part of the National Curriculum, which means that schools are not required to follow the frameworks or programmes of study at either primary or secondary stages. Some compulsory subjects are sometimes taught as part of PSHCE:

5.6.4 **Sex education**: secondary schools must provide sex education primarily around biology of reproduction, with Secretary of State guidance for it to be part of PSHCE programmes. The Government does not currently intend to change this legislation or parents' right of withdrawal.

5.6.5 **Careers education**: secondary schools must currently provide careers education. The Government's Education Bill currently before Parliament seeks to remove this duty and instead introduce a new duty on schools to secure access to independent and impartial careers advice.

5.6.6 **Work-related learning**: secondary schools must currently provide work-related learning at Key Stage 4. Following the Government's acceptance of Professor Wolf's recommendation, this duty will be removed, subject to Parliament's agreement. The Department seeks to achieve this in 2012.

5.6.7 In addition, there are elements within the statutory National Curriculum which some schools teach as part of PSHCE education (at both primary and secondary stages). These include, for example in National Curriculum science, they explore life processes and the reproductive cycle, and the effects of diet, drugs and disease.

5.6.8 In 2008, a secondary PSHCE ed toolkit was developed to enable schools across Kirklees to deliver a comprehensive PSHCE ed programme; this toolkit covers children and young people from the ages of 11 – 16, with a further toolkit being

[19] FPA talking sense about sex – fact sheet

developed for use in colleges and alternative providers. These programmes set out concepts, skills, process and opportunities that pupils should learn or experience by the age of 16 and covers:

- Personal well-being: including sex and relationships; drugs, alcohol and tobacco; emotional health and well-being nutrition; physical activity safety and

- Economic well-being and financial capability: including personal finance; work related learning and careers.

5.6.9 All primary schools in Kirklees have been provided with a copy of the primary PSHCE ed toolkit for children aged 5-11, which covers many of the topics above, taught in an age appropriate way.

5.6.10 Kirklees is one of only a few authorities that provide a comprehensive toolkit to support the delivery of PSHCE ed in both Primary and Secondary schools. The toolkit is intended to enable teachers, co-ordinators and those tasked with delivering the PSHCE ed programme to tailor sessions according to the age of the student and to the individual requirements of schools.

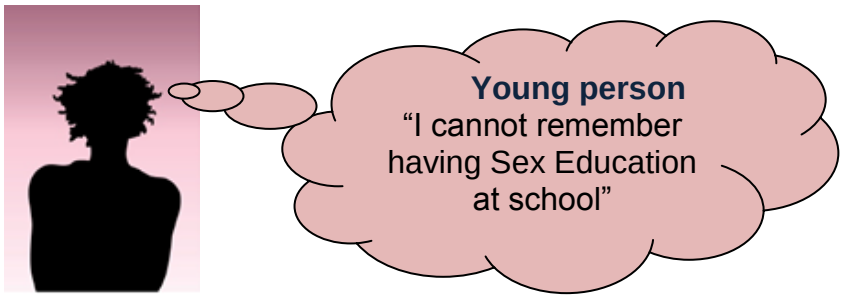
5.6.11 While this toolkit is available free of charge to all Kirklees schools, it is discretionary as to whether they use it; evidence submitted to the Panel suggested that information from monitoring visits and the Kirklees PSHCE ed annual conference during 2009-2011 showed that all Kirklees schools use the Secondary Integrated PSCHE education toolkit and that teachers found it helpful in their planning, however the Review Panel was unable to determine with any degree of certainty the actual level of usage within schools. The Panel however, acknowledges that the toolkit was valued by other local authorities and agencies that choose to buy and use the resource.

5.6.12 Schools that chose to use the toolkit were able to develop a clear lesson plan using a comprehensive DVD resource designed to support best practice in PSHCE ed. The toolkit includes; detailed lesson plans, national and local guidance and management and planning tools. It was not clear what approach was taken by those schools that chose not to use the toolkit.

5.6.13 An additional resource in the form of comprehensive guidance on Relationship and Sexual Health Education from an Islamic perspective is also available. A working group which included leading members of the Muslim community and Islamic scholars was established to address concerns about the need to cover relationship and sexual health education from an Islamic perspective[20].

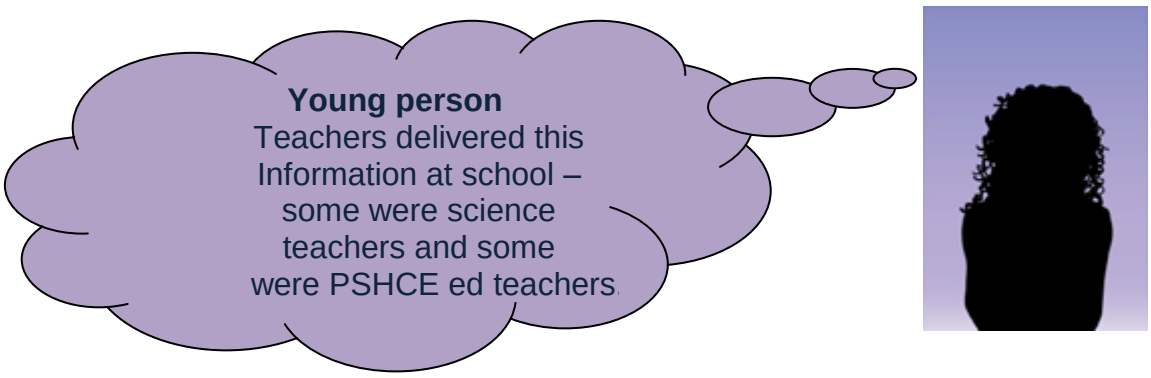
5.6.14 Evidence to the Review Panel suggests that there is no standard approach across Kirklees about how PSHCE ed is delivered. It is left to each individual school to determine how much time, effort and resource it allocates to the programme; and it therefore varies considerably. The issues that are expected to be covered as part of the programme include citizenship, rights and responsibilities, drugs and alcohol and sex and relationships.

[20] Relationship and Sexual Health Education from an Islamic Perspective



5.6.15 Although schools were not directly approached some witnesses who worked closely with schools in Kirklees felt that the most effective method of delivering PSHCE ed was by a regular sustained programme of learning built into the weekly timetable, with RHSE built into a comprehensive PSHCE ed programme. Evidence showed that while some schools preferred the weekly timetable approach, other schools preferred to deliver a 'collapse down' timetable, with possibly one or more concentrated sessions during the school year.

5.6.16 The collapse down time table approach however, was considered a less favourable option by some witnesses who felt that 'one off' sessions may be the only experience that students get of sexual and relationship education at secondary school and therefore was not adequate. Alternatively some schools preferred to deliver RHSE within the narrow confines of the national science curriculum in terms of biology, development and human relations which was still compulsory in that part of the curriculum. Again, witnesses felt that this may not be the most effective approach.



5.6.17 However, Ofsted reported in 2010 and have repeatedly confirmed that the curriculum model chosen had a direct impact on the quality of the provision for PSHCE. The most effective curriculum model seen was one in which discrete, regularly taught PSHCE lessons were supplemented with cross-curricular activities and delivered by well trained and supported teachers.

5.6.18 Evidence presented to the Review Panel suggested that the information on contraception and Sexually Transmitted Infections (STIs) was first introduced to Pupils in year 10 (14/15 years old), although the panel acknowledges that the development of underpinning knowledge, skills and attitudes throughout the PSCHE ed programme is evident at Key Stage 2 and 3 dependant on individual schools.

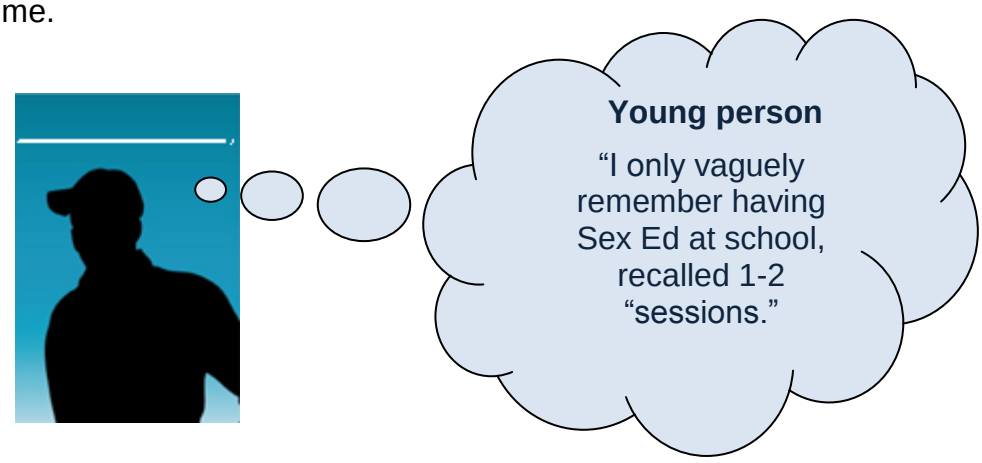
5.6.19 However, compounded with the information presented in the year 9 survey that young people aged 13 and 14 were claiming to have had sex, the Review Panel were concerned that the introduction of information on contraception and STI's at year 10 (14/15 year old) was possibly too late.

5.6.20 The commitment allocated by schools to the PSHCE ed programme is variable although most schools will have a dedicated PSHCE ed co-ordinator which is usually a teacher allocated to the role. It was felt by some witnesses that many co-ordinators struggle because of a lack of commitment from senior management. It was stated that the effectiveness of the PSCHE was very much down to confidence, capability and commitment of the co-ordinator and while there are some excellent co-ordinators there are some who are not necessarily comfortable with dealing with matters around sexual health.

5.6.21 Training is available for co-ordinators however they are under no obligation to take it up and with the introduction of a traded service it would mean that schools would have to pay for the training in the future, which may impact on uptake. However during 2011, all Kirklees secondary schools were offered free training on RSHE.

5.6.22 Examples were given of schools across Kirklees which witnesses considered as having good facilities because they provided a complete 'wrap around' service. This means that in addition to delivering a comprehensive PSHCE ed programme they also provide good welfare facilities by way of an 'open door' scheme which provide services such as counsellors, C Card condom distribution scheme and pregnancy and Chlamydia testing service.

5.6.23 An early review of schools delivering PSHCE ed by Learning Services showed that one school for example, when compared to other schools was one of the strongest in relation to PSHCE ed and linked to very good welfare facilities for students. The facility offers a range of sexual health support and guidance, including contraception; and in addition, the school also pays for extra school nurse time.



5.6.24 It was felt that in Kirklees there is real difficulty in trying to establish 'open door' facilities consistently across schools because while there is willingness from high schools, logistics such as staffing issues and protocols within health services seem to have made this more difficult. One witness expressed frustration that the comprehensive open door service offered in places such as Huddersfield New College and in some high schools was not replicated in all high schools across Kirklees. It was explained that one of the challenges for

schools is that historically it might have been the school nurse who would support such facilities however their role within schools appeared to be declining.

5.6.25 During the Review Panel's investigation a number of witnesses alluded to a review of school nursing service however could only provide very limited information about this. It was felt that the review was having a significant impact on school nursing resulting in many schools no longer having a school nurse regularly on site or that the role of nurses had fundamentally changed.

5.6.26 Upon further exploration the Review Panel learned that the review of school nursing service was a national review being led by the Department of Health (DoH). The DoH was proposing to create a development programme for school nurses which incorporated a "service vision" which will clearly set out the school nurses role within public health, with pupils and within the school as a community. It was anticipated that phase one of the DoH programme, which would include the service vision, model and commissioning product, would be completed by December 2011.

5.6.27 The Review Panel considered the delivery of the PSCHE and sex education generally by a range of individuals who have contact with young people. This included parents, support workers (youth/social) as well as their peers. The Review Panel recognised that girls who are at risk of getting pregnant are often the ones who are not engaged in education, and therefore felt that consideration should be given to delivering PSHCE ed in more creative and innovative ways in a wider range of settings and not just schools.

5.6.28 A number of witnesses spoke of the role and responsibility of parents in addressing sex and relationship advice in the home. Recent evidence from the Sex Education Forum 2011 states that children and young people are clear that parents are an important source of learning about sex education, with parents themselves seeing school and home as the two main sources of RHSE (Sherbet Research 2009).

5.6.29 Support workers tend to interact with young people in informal settings, such as youth clubs which are often conducive to building relationships that promote a more holistic approach to sex education. Support workers are also more inclined to work from a young person perspective using opportunities to respond to individual needs as a matter of course. The Review Panel therefore felt that Support Workers with the right basic training and knowledge of referral to local medical and support services are ideally placed to provide sex education in a number of settings.

5.6.30 In 2000 the DfEE, recommended that schools consider incorporating peer-led sexual health interventions into RHSE programmes noting that peer-led work is popular with both students and teachers and was a successful means of providing information which enhances a young person's understanding of sex and relationships.

5.6.31 The initial barriers to communication with young people that are often experienced by older professionals may not exist among peers, with certain young people relating positively to education from individuals who are similar in age and life experiences. The Review Panel felt that specific 'Peer educators' could help with sex education and teenage pregnancy prevention, especially if trained to refer young people to medical specialists or other support services.

5.7 Commissioning Framework for Schools and the Healthy Schools Programme

5.7.1 At the same time in Kirklees a commissioning framework for Kirklees schools and colleges (Commissioning for Health Outcomes) was being developed and two clusters of schools were identified to trial a new approach to health in schools. Evidence received by the Panel suggested that there were frustrations around this new commissioning framework.

5.7.2 Locally, the Healthy Schools Programme which ran for 3 years and ceased in 2009, was a joint initiative from the then Department for Children Schools and Families and the Department of Health which provided schools with the opportunity of providing a programme comprising 4 key themes. Personal, Social & Health Education, Healthy Eating, Physical Activity and Emotional Health & Wellbeing. Although voluntary, the Healthy Schools Programme was deemed to be very successful in terms of schools recognising the brand and adopting and taking up the programme. There were 42 criteria that schools could work towards, covering those 4 themes, and if schools met those criteria, they would be awarded national healthy schools status. In Kirklees 85% of schools achieved the award.

5.7.3 In addition to the Pilot of the new commissioning framework, a complementary piece of work is being undertaken in schools by the NHS Kirklees Sexual Health team. This involves working with schools on an individual basis to conduct a rapid sexual health needs assessment to ensure that there is a whole school

community approach to meeting the sexual health needs of the student population.

Panel Views

- The impact of PSHCE ed Programme on the reduction of teenage conception in Kirklees cannot be determined due to the complexity and the wide range of factors that contribute to teenage conception.

- More creative thinking is needed with regard to PSHCE ed and where possible the use of youth workers and peer education on a more informal basis, may lead to more positive outcomes. The use of social media should also be considered as a way of delivering key messages to young people.

- Work should be undertaken to encourage schools, youth workers and other organisations working with young people to use the PSCHE toolkit as it provides an excellent and comprehensive resource covering sexual health, drugs and alcohol and other important issues that impact on the lives of young people.

- The effectiveness of the PSCHE ed Programme could be improved by looking at who is responsible for delivering the curriculum to young people. In order to better fulfil their role, those delivering PSCHE need more support from senior management. Although training is available for Lead Co-ordinators it is not obligatory and it would be helpful if more emphasis was placed on ensuring they had relevant training to undertake this fundamental role.

- Considering evidence as presented at paragraph 5.1.10 suggesting that young people as young as 13 and 14 are having sexual intercourse, the Panel believe that this must be acknowledged and addressed as a reality. The panel feel that year 10 (age 14-15) is perhaps too late to be informing young people about contraception and Sexually Transmitted Infections (STIs) and consideration should be given to covering these issues at year 7 (age 11-12). However, any change to the age in which schools address these issues with young people must be in full consultation with parents.

- While the Panel were encouraged by those schools and colleges which demonstrated good 'wrap-around' services and 'open door' facilities; there were concerns about the difficulty in establishing these facilities more widely across Kirklees. The Panel felt that the barriers that exist between Education and the Health Service related to historical clinical governance and staffing protocols which urgently needed addressing.

- The Panel also felt that for those young people who were disengaged in mainstream schooling, the effectiveness of sex education generally could be enhanced when delivered by youth workers, parents, and trained peers.

- A pilot commissioning framework for Kirklees schools and colleges (Commissioning for Health Outcomes) needs to be reviewed and revitalised to enable pilot schools to move on to commission the services they have identified as necessary and to enable all schools to adopt the systematic and evidence-based approach to identifying needs and commissioning services.

Term of Reference 3

To assess what support is available for:

- Preventing teenage conception
- Pregnant teenage mothers and young fathers to be
- Teenage Parents

5.8 Preventing teenage conception and Sexual Transmitted Infections (STI's)

5.8.1 The Review Panel looked in detail at a number of areas relating to both the prevention of teenage conceptions and the support available to both teenage mothers and fathers to be and teenage parents following the birth of their child. These areas are explored in more detail below, together with the views of the Review Panel.

5.8.2 Although the remit of the Review Panel was not focused on sexually transmitted infections the evidence gathered by the Review Panel revealed that Kirklees, in common with other areas, had seen a significant increase in STI's both diagnosed and treated and is performing less well nationally, ranked 104th out of the 152 enrolled PCT's.[21]

5.8.3 The Review Panel believe that although the information on STI's was non-age specific, the high numbers of teenage conceptions and the equally high numbers of STI's in Kirklees are interrelated and clearly indicate that young people are engaging in sexual activity. Therefore, the Review Panel felt that it would be remiss not to include as part of its investigation the support, information and messages that are being given to young people to encourage them to practise safe sex as this is fundamental in reducing the numbers of STI's and also preventing teenage pregnancy. It is important to remember that more community based testing programmes such as Chlamydia screening will result in a higher diagnosis of STI's in the short term as they are detected earlier.

5.8.4 Preventing teenage conceptions and improving sexual health are national as well as local priorities and require different organisations and agencies to come together to try and tackle the issues. On a local level while there appear to have been many strategies aimed at preventing and reducing the numbers of teenage conceptions and improving sexual health; information presented to the Review Panel suggests that improvements in these areas have not had a significant impact in Kirklees. There is also little evidence of the different initiatives and strategies being reviewed to ensure there is more focus on what works.

5.8.5 The Review Panel recognise that young people can get professional sexual health support, advice and information from a wide range of sources including General Practitioners, School Nurses, Pharmacies, Contraception and Sexual Health Clinics (CASH), educational establishments and from the Connexions Service. The Review Panel however, felt it was important to explore how young

[21] Kirklees Teenage Pregnancy and Sexual Health Joint Commissioning Plan

people access these services and whether there were any barriers to access which could lead them to turn to more informal support and advice for example from peers, family or from media sources, such as the internet.

5.8.6 Research into young people's risky sexual behaviour and alcohol use in the North East found that young people often seek information from the internet as this was considered to be more confidential. Young people would also gather information from friends and family.[22]

Legal position

5.8.7 Health Professionals in the United Kingdom may provide contraceptive advice and treatment to young people under 16, in their clinical judgement, if they believe it is in the young person's medical interests and they are able to give what is considered to be informed consent.

5.8.8 Therefore a doctor, a nurse or a pharmacist has the discretion to give contraceptive advice or treatment to a person under 16 without the knowledge or consent of the young person's parent or guardian, provided that in the opinion of the health professional the young person is capable of understanding the nature and consequences of the treatment or procedure[23].

5.8.8 The duty of confidentiality owed by a nurse or doctor to young people under 16 is as great as the duty they owe to any other person. School nurses must respect an explicit request from these clients, that information should not be disclosed to particular people, except in exceptional circumstances for example when a nurse believes that a young person is being abused or exploited. It is however considered good practice to inform parents that services are available on school premises.

5.8.9 Teachers in their role of delivering the PSHCE ed are not legally obliged to inform anyone if they learn or suspect sexual activity in pupils under the age of consent, unless they believe that the young person is at risk of physical or sexual abuse.

General Practitioners (GPs)

5.8.10 Most young people are registered with a GP where they can get confidential support and advice. GP's are able to prescribe all appropriate forms of contraception and girls under the age of 16 can access the contraceptive pill from their GP without parental knowledge or consent.

Pharmacies

5.8.11 Pharmacists can provide free and confidential advice on contraception and can signpost to more specialist advice if needed. Most pharmacists can supply emergency hormonal contraception when appropriate.

CASH

5.8.12 CASH Clinics are in locations across both North and South Kirklees including a satellite service located at Huddersfield New College. CASH provide a wide range of sexual health support, advice and information including clinics for young people under the age of 25. They provide screening for STI's,

[22] Understanding teenage pregnancy

[23] The role of school nurses in providing emergency contraception services in educational settings RCN

counselling and advice and support on termination of pregnancy and advice on contraception. Access to the services CASH provide can be by self referral or by a GP, either by drop-in or booked appointment. CASH outreach services in Further Education Colleges are well regarded. It was noted that they are particularly good at improving access for young men who do not feel well served by other sexual health services.[24]

School Nurses

5.8.13 School nurses provide confidential support and advice on a person by person basis, offering sexual health advice and provide appropriate follow up and referral to other health professionals.

5.8.14 The Royal College of Nursing (RCN) believes that school nurses are ideally placed to provide sexual health and contraception advice because of their relationship with young people as well as being able to assess, supply emergency contraception and condoms and provide an onward referral to family planning and sexual health services and ensure follow up with young people.[25] The RCN also believe school nurses with appropriate training and experience should be able to assess the need for hormonal emergency contraception.

Schools and Colleges

5.8.15 As highlighted in the previous section of the report educational establishments have a significant role to play with regard to delivering key sexual health messages as well as support generally to young people. Information from the Kirklees JSNA report (2009) states the need to increase access to sexual health services within Kirklees secondary schools by delivering school based drop-in sessions to include contraceptive and STI advice, support and Chlamydia screening.

5.8.16 A number of high schools in Kirklees provide a School Nurse Open Door service with access by drop in or appointment, however these facilities appear to be concentrated mainly in South Kirklees. These facilities are staffed by a nurse who can provide confidential advice and information on a wide range of issues including; contraception, Chlamydia screening and pregnancy testing.

5.8.17 Members of the Review Panel visited Huddersfield New College (HNC) which provides a comprehensive Open Door facility where students have access to qualified professionals such as a nurse, counsellor and a doctor. The facility offers students advice and information around a range of personal health issues as well as prevention of STIs and pregnancy and sexual health sessions are also included across all tutor groups.

Some of the services on offer at the college include:

- Condom distribution
- Chlamydia screening
- Pregnancy testing and advice
- Access to the contraceptive pill and free emergency contraception

[24] MBARC Kirklees Sexual Health Needs Assessment

[25] The role of school nurses in providing emergency contraception services in educational settings RCN

5.8.18 A representative from Huddersfield New College (HNC) stated that the college had made the decision to provide funding for these fundamental services and the services offered are unique and not replicated in other colleges. It was reported that in 2010/11 a total of 3,315 young people accessed the open door facility for advice and support on health and personal issues. It was further reported that 997 packs of condoms were issued, 68 emergency contraception was issued, 34 Depo injections (a long term form of contraception) were administered and 96 Chlamydia screening tests were conducted.

5.8.19 The Review Panel recognises that part of the barrier for other educational establishments providing similar open access services is due to budget constraints.

Connexions Service

5.8.20 While the primary role of Connexions Service is to ensure that young people are in employment, education and training the centres in Huddersfield and Dewsbury have received the Kirklees Young People Friendly (KYPF) kite mark which is accreditation for its sexual health services. The Personal Advisers in both centres have undertaken C-Card Training and are able to offer C-Card services. (see paragraph 5.5.25)

5.8.21 Representatives from Connexions Service stated that while all Personal Advisers could find themselves working with pregnant teenagers or teenage parents the service employs 2 specialist Teenage Parent Personal Advisers who have undertaken sexual health training, with one based in North Kirklees and the other in South Kirklees. Their role is to help young people avoid becoming pregnant in the first place and if they do become pregnant to help them maximise their life chances by helping them to engage in employment, educational or training.

5.8.22 Representatives from Connexions Services reported that between the 1 April 2010 and 31 March 2011, the service distributed 3,801 condoms and supervised 9 Chlamydia tests.

Parental responsibility

5.8.23 The Review Panel acknowledges that there is a role for parents in delivering key messages around prevention, safe sex and sexual health with their children. This was the view of a number of witnesses that gave evidence to the Review Panel. The Review Panel however felt that more support should be given to parents to allow them to confidently address these issues within the home.

Contraception Services

5.8.24 Contraception can be obtained from a wide range of sources including most general practices, CASH, Genitourinary Medicine (GUM) clinics and some pharmacists. However, it is available via the CASH clinic free of charge. Most methods of contraceptives do not provide protection from sexually transmitted infections however, male and female condoms, when used correctly and consistently, can help protect against STI's and pregnancy.

5.8.25 The C-Card Scheme is a national scheme allowing young people following a sexual health intervention to register and receive a card, which allows them to get condoms free of charge. As part of the scheme it provides confidential sexual health advice to young people under the age of 19. Since its launch in July 2009, with access via the Kirklees Young People's Service, the Kirklees C-Card Scheme has grown. Between July 2009 and April 2010, over 230 professionals received C-Card training. During 2011, there was an aim to train a further 150 professionals with a view to further increasing access to condoms and sexual health for young people.

5.8.26 There are now over 50 access points across a wide range of services including both health and non health settings. This has enabled over 3,700 young people under the age of 19-years to register with the scheme in the initial 15 month period of operation.

5.8.27 Some of the types of contraceptives available are listed in the table below:

Contraceptive type	**Description**	**Available from**
Oral Pill	Must be take daily, and works best when taken at the same time each day	GP's CASH Clinics
Emergency Contraception	Emergency Hormone Contraception. Some types must be taken with 72 hours after sexual intercourse to be effective. The CaSH service offer Ella One which can be taken up to 5 days after sexual intercourse. Emergency Inter Uterine Coil Device – it is difficult to define the exact timeline for this intervention however the sooner after sexual intercourse the better its effectiveness.	Some pharmacy Hospital walk-in centre GP's CASH
Male Condom	Condoms are number one for protection against STIs and 98% effective in preventing pregnancy if used correctly.	Some schools Some colleges Some pharmacy CASH C-Card
Female Condom	Female condoms are like male condoms except they fit inside the vagina instead of covering the penis. They are 95% effective in preventing pregnancy if used correctly.	CASH Clinics Some GP surgeries Family Planning Clinics
Long-acting reversible contraception (LARC)		
Contraceptive implant	A small flexible rod is put under the skin of the upper arm. It releases the hormone progestogen. Works for 3 years but can be taken out sooner	Some GP's CASH
Contraceptive injection	An injection which releases the hormone progestogen lasts 8 – 12 weeks depending on the type of injection.	Some GP's CASH
Intrauterine device (IUD)	A small plastic and copper device is put into the uterus. Can stay in for 5-10 years but can be taken out sooner.	Some GP's CASH
Intrauterine system (IUS)	A small T shaped plastic device which releases the hormone progestogen is put	Some GP's

	into the uterus. Works for 5 years but can be taken out sooner.	CASH

5.8.28 Research undertaken by MBARC suggests that Kirklees is performing less well than other parts of the region or the country in the uptake of LARC. It recommends that Kirklees should set itself the target of exceeding the national uptake over 12 months and work should be targeted on those communities most at risk of teenage pregnancy.[26] Some issues relating to the use of LARC can be that the young person doesn't have to attend any service to maintain their contraceptive needs and this situation can hold potential for them to be more likely to neglect their use of condoms.

Termination of Pregnancy (TOP)

5.8.29 Although the terms of reference for this review were specific to both the prevention of teenage conceptions and the subsequent support required as a result of teenagers becoming pregnant, the Review Panel were mindful that each year in Kirklees there are approximately 370 conceptions to girls between 15-17 years, approximately half resulted in termination. Therefore the Review Panel felt it was important not to overlook this area and sought to determine what support was available for pregnant teenagers requiring a termination, and how those services were accessed.

5.8.30 The pathways to termination services in Kirklees differ depending on whether a person lives in North or South Kirklees. This is partly because there are two different Hospital Trusts operating within the borough, each with their own pathway criteria. In South Kirklees, termination services are largely provided by the Calderdale and Huddersfield Foundation Trust (CHFT) and in North Kirklees terminations are via CASH (Locala) into either the British Pregnancy Advisory Service (BPAS) or the CHFT. The Review Panel therefore felt it was important to consider the contrast in services available across each of these Trusts.

South Kirklees - TOP

5.8.31 Prior to 2007, the majority of girls/women in Kirklees requiring a termination would travel to BPAS in Doncaster however, this arrangement changed and currently Calderdale and Huddersfield Foundation Trust (CHFT) perform the majority of terminations across Calderdale and South Kirklees.

5.8.32 The CHFT referral criteria for terminations require that the client is registered with a GP, the pregnancy test be positive, and that the pregnancy gestation is no more than 17 weeks and 6 days at the time of the procedure for medical terminations.

5.8.33 The pregnancy gestation must be between 7-12 weeks for the surgical procedure. Referrals for TOP can come from GPs, self referral, voluntary organisation, Kirklees CASH Clinic (LOCALA) or a midwife.

North Kirklees –TOP

5.8.34 In North Kirklees the criteria for access to services requires the pregnant women/girl to initially go to her GP, who would refer her to the CASH clinic for an assessment, counselling and dating scan. She would then be referred to

[26] Kirklees Sexual Health Needs Assessment

either the British Pregnancy Advisory Service (BPAS) in Doncaster and Leeds, or that Calderdale and Huddersfield Foundation Trust. At the time of writing this report the CASH clinic was only referring women and girls to BPAS in Leeds. Witnesses stated that there were no facilities available locally providing termination services.

Teenager's access to terminations

5.8.35 A young woman under the age of 16 can seek termination information without parental consent. A young woman under the age of 16 may also have a termination without parental consent if her doctors determine that she meets the Fraser Guidelines:-

- The young person will understand the professionals' advice
- That the young person cannot be persuaded to inform their parents
- That the young person is likely to begin, or continue having, sexual intercourse with or without treatment/contraception.
- That unless the young person receives treatment/contraception, their physical or mental health, or both, are likely to suffer
- That the young person's best interests require them to receive contraceptive advice or treatment with or without parental consent.

5.8.36 The Fraser guidelines refer specifically to doctors but it is considered to apply to other health professionals, including nurses. It may also be interpreted as covering youth workers and health promotion workers who may be giving contraceptive advice and distributing condoms. However, evidence from the Dewsbury CASH Clinic stated that it was unusual for a young girl not to have some form of adult support.

Medical and Surgical Terminations

5.8.37 Medical termination is a chemically induced procedure spread over 3 visits. Health professionals stated that the medical termination rate was very high but that it was the clients' choice. The procedure was considered the safest way for a young girl to terminate her pregnancy, due to the cervix having never been dilated. Any forced dilation of the cervix in young girls could compromise their future sexual health.

5.8.38 Surgical termination requires pre-operative assessment followed by a surgical procedure which is undertaken as Day Case surgery. Information was sought around the number of medical and surgical terminations taking place across South and North Kirklees. At the time of writing the report only figures for the Calderdale and Huddersfield Trust are available.

5.8.39 The figures below show the difference between Calderdale/Huddersfield across **ALL** age groups.

2010/11	**Calderdale**	**Kirklees**
Medical Termination	602	792
Surgical	11	33
Repeat Terminations	20	20

The under 16s figure showed that CHFT had an almost similar number of TOP in both 2009/10 and 2010/11, while the figure for under 19s showed a

downward trend (23.4% in 2009/10 and 22.3% in 2010/11). The figure for under 18s 2010/11 were 101 of which 5 were repeat terminations.

5.8.40 The Review Panel considered the specific support that was available for teenagers accessing termination services in Kirklees. Information provided to the Review Panel identified a post termination teenage pregnancy clinic run by CHFT and the counselling services available.

Post Termination Teenage Clinic

5.8.41 CHFT runs a post termination teenage clinic that was set up approximately 2 years ago. It was initially set up as a pilot for a year and proved to be successful. In Calderdale the clinic provides teenagers with post-natal and post- termination support, while in Kirklees they only receive post termination support. At the clinic teenagers receive full emotional one to one support and return to the clinic 2 weeks after the termination to discuss contraception with a further follow up visit after 3 months. Representatives from CHFT felt that the post termination teenage clinic is one way to reduce re-terminations in this vulnerable group. The clinic has now ceased in Kirklees however, negotiations are taking place with NHS Calderdale, Kirklees and Wakefield to permanently establish a service. CASH provide post termination advice and contraception as part of the TOP Pathway in North Kirklees, while in South Kirklees CASH is physically located in the same building as the termination service and provides termination advice and contraception.

TOP - Counselling Service

5.8.42 Counselling is offered as part of the termination of pregnancy service however, it is up to the individual whether to accept this or not. Witnesses stated that the uptake of counselling services is very poor and stated that once a woman had made her up her mind to have a termination counselling was seen as an unwelcome distraction. It is however, mandatory for those teenage girls aged 16 and under to be seen by an independent counsellor prior to attending the termination clinic. Those who are referred for termination via their GP may also be offered counselling from their GP.

Miscarriages

5.8.43 Whilst gathering evidence for the review the Review Panel heard that geographically, North Kirklees had a higher rate of miscarriage[27]. Whilst outside of the remit of the terms of reference the Review Panel were concerned that there was little support for teenagers who had experienced miscarriages and felt psychologically the loss of a child could impact on whether a teenager would try for a subsequent conception. However with little data and evidence around this, it makes it difficult to make such generalisations.

5.8.44 Dewsbury and Mirfield, Batley, Birstall and Birkenshaw and Spen have a high number of recorded miscarriages and a higher rate per all conceptions between 7.9%-9.4% compared with other localities which are around 3%.

Geographical Divergence

5.8.45 Evidence provided to the Review Panel suggests that there is a North-South Kirklees divide, which is evident in the referral pathways and processes for many of the services. Further evidence from the Kirklees Sexual Needs

[27] Understanding teenage pregnancy in Kirklees (HIS data)

Assessment carried out by MBARC research consultancy in April 2011 also highlights a sense of competitiveness between the North-South areas as opposed to a sense of coming together to provide a uniform service.

5.8.46 Witnesses suggested that this was in part linked to the historical commissioner-provider split and the sense that these very different pathways and procedure split between North and South was extremely challenging for service users. The CHFT representatives were positive that the development of the Calderdale, Kirklees and Wakefield cluster would foster a change of approach with the GP commissioning groups working together creating uniformity of policy and practice across the cluster patch.

5.8.47 The Kirklees Sexual Health Needs assessments highlighted that there were potentially confusing pathways between North and South Kirklees and that there are also differences in practice by different providers.

5.8.48 Representatives from CHFT felt that the organisational structure within health care often caused divergence between geographical areas where pathways, referral routes, and practises differ. For example in North Kirklees, 40% of women had surgical TOPS whereas in the South the figure was 6%[28]. It should be noted that from April 2013 the Local Authority will have responsibility for the commissioning of comprehensive sexual health services in Kirklees.

5.9 Supporting Teenage Parents

5.9.1 This section of the report is concerned with identifying both support available to teenage mothers and fathers to be, but also the support available once their child has been born. This focuses particularly on those agencies that provide healthcare but also includes the associated support required as a consequence of a pregnancy such as housing, benefits and welfare support and the ongoing educational needs for teenagers.

<u>Teenage Midwives</u>

5.9.2 The Review Panel heard that across Kirklees there are two specialist midwives that work specifically with pregnant teenagers; although it is important to stress that midwives generally may have pregnant teenagers as part of their caseload. The information presented on teenage midwives again highlights the divergence that exists between North and South Kirklees.

5.9.3 In North Kirklees the specialist midwife works for the Mid Yorkshire Trust and presented evidence to the Review Panel which suggested that in North Kirklees there are approximately 240 under 19 conceptions and of that there are approximately 140 deliveries.

5.9.4 A 'buddy system' has been established which means that when a notification form has been received that a teenage girl is pregnant information would be passed on to the relevant Children Centre in the girl's particular area, if consent had been given by the young person. The teenage girl would then be

[28] MBARC Kirklees Sexual Health Needs Assessment

contacted by a 'buddy' from the area. The buddy works with the teenage pregnancy midwife to provide multi-agency working based on the girl's need.

The midwife undertakes 5 sessions which include:

- information on labour and pain relief,
- feeding the baby,
- child development,
- playing,
- healthy eating
- smoking cessation
- and anything else that the girls would like or need,

5.9.5 It was stated that an ante-natal clinic for teenagers was due to start that invited teenage girls at 25 weeks. The ante-natal clinic will carryout routine blood checks and make sure that they teenage girls are signposted to other agencies if they have needs in particular areas. The clinic will track those girls who persistently do not attend their appointments. And will allow those issues that the community midwives have not identified to be identified.

5.9.6 In addition, a closed Facebook Group has been established which is supported by Mid Yorkshire Hospital NHS Trust and is run in conjunction with health visitors, Children Centres and Connexions. The idea is that it is easier to maintain contact with the girls via Facebook, than by mobile phones due to the regular change of mobile phone numbers. It is also important to emphasise that only girls known to the teenage midwives are able to be a part of the Facebook Group. The Facebook Group is used to advertise events and trips that may be of interest to teenage mums but is only used in the North of Kirklees.

5.9.7 In South Kirklees the specialist midwife works as part of Calderdale and Huddersfield Foundation Trust's Eden team which was established approximately 2 years ago and consists of specialist midwives who work with vulnerable women and families. The team provides expertise and additional support to pregnancies that are as a result of circumstances which include domestic abuse, substance misuse, teenage pregnancy, homelessness, mental health and those pregnancies that are considered to be at risk. The team aims to try and improve their health outcomes of the women.

5.9.8 The midwife supports the post teenage clinic as outlined in 5.5.42 which conducts post natal and post termination support.

5.9.9 A notification system was jointly devised by midwives in both North and South Kirklees and enables referrals to come from a wide range of agencies including schools, the Youth Offending Team, CASH Clinics and Doctors. However, because of the volume, pregnant teenagers are assessed using a triangle of need for pregnant under 19 year olds using a 4 tier system. Only those who are in categories 3 and 4 will be seen by the teenage midwife. Tier 4 – includes teenagers involved with Social Services, self-harm and mental health issues or the victim of abuse. Tier 3 includes young people not engaging with services, those having Youth Offender involvement, those unsupported or those with significant disability.

5.9.10 Midwives felt that there was much less collaborative working between the midwives who work across the borough than there used to be and that it was only for purposes of devising processes and governance arrangements such as the notification system that joint working was apparent.

5.9.11 The Review Panel heard evidence which seemed to suggest that different agencies across Kirklees experience difficulty and reluctance when it comes to obtaining and sharing client based information with other agencies. For example, representatives from housing services were unable to obtain information from Social Services, due to client confidentiality.

5.9.12 The Panel learned that Kirklees Council Safeguarding and the NHS share the same universal agreement (Interagency Information Sharing Protocol), which is a generic long standing agreement involving a list of services. (See appendix 2) The Panel was concerned however, by the apparent lack of clarity amongst professionals with regard to information sharing which could potentially have a detrimental impact on vulnerable young people. (This existing agreement is due for review in February 2012.)

Family Nurse Partnership (FNP)

5.9.13 The Review Panel heard evidence from the Family Nurse Partnership (FNP) and the work carried out to provide support to teenagers both pre and post pregnancy.

5.9.14 The FNP undertakes an intensive programme that provides support to young women from early pregnancy until the child gets to the age of two. It is only offered to first time mums from the age of 13 up to the age of 19.

5.9.15 The Review Panel heard that in order for the best outcome to be achieved, it is important that young women engage with the programme as early as possible into their pregnancy, ideally if they know at 6 weeks. After 26 weeks gestation pregnant girls can no longer be taken onto the programme.

5.9.16 The FNP offers an intensive programme of support, starting with weekly, fortnightly and then monthly visits from a family nurse up until the child reaching the age of two. The FNP is a licensed programme that is signed up with the Department of Health and the licence conditions are very strict and must be adhered to. The programme covers ante-natal health, child health and development and is based on the nurse client relationship, where nurses work in depth with families to achieve positive outcomes.

5.9.17 It is delivered by nurses from health visiting, mental health, midwifery and child nursing backgrounds and having a mixture of nurses from different professional disciplines allows the sharing of skills across the team. Because the programme is so intensive each nurse has a caseload of no more than 25 young women.

5.9.18 The research into the FNP approach has a rigorous evidence base, which shows good practice and positive outcomes and is considered to be working well in Kirklees. There are 150 young girls on the programme at present, supported by 6 nurses and 1 supervisor. New targets set by the Department of Health will allow for the recruitment of one further nurse. The programme is almost full but has recently recruited 2 new nurses so the case load will increase by 50. Referrals currently come from midwives, GP's, Social Workers, Nurses and self referral.

5.9.19 The Family Nurse Partnership Board has representatives from a number of organisations including:

- Midwifery reps from CHFT and Mid Yorkshire,
- Safeguarding,
- Children Centres,
- Health Visiting,
- School Nursing,
- Education,
- and young people themselves.

5.9.20 A representative from FNP felt that having young people's involvement has been important in the design and running of the programme and has allowed young people to be influential in how the programme operates and what they would expect to find from services in Kirklees. Some of the outcomes of the programme have been around breast feeding, smoking cessation, NEET and child protection.

5.9.21 A representative from the Family Nurse Partnership stated that the programme is open to all residents in Kirklees who meet the criteria however; there is emphasis on capturing those in the vulnerable group such as young people leaving care. FNP is working with the Contraception and Sexual Health (CASH) service to look at how it can improve services for FNP clients.

ETHOS

5.9.22 Young women are supported by Key Stage 4 Pupil Referral Service (ETHOS) to continue to access learning in school wherever possible to remain with their peers and in the local community in order to access support from Children Centres. In cases where young women have increased vulnerability or have not been attending school, a place at ETHOS is provided to deliver an educational offer. This is continued after the birth of their babies, where young women are then supported into an education placement or with their post 16 choices.

Housing Information and Support

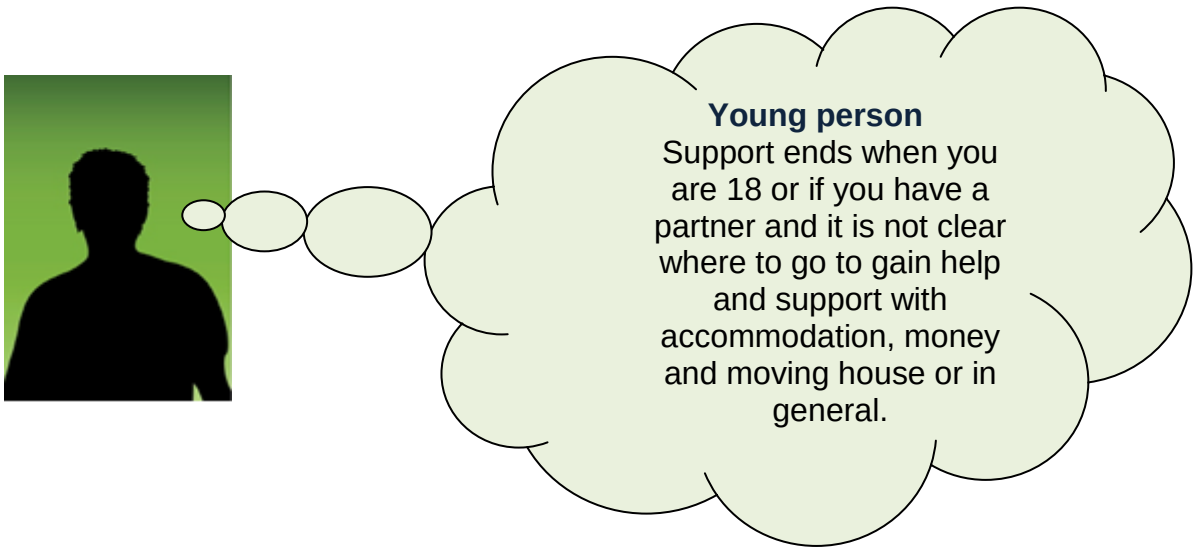
5.9.23 One of the issues the Review Panel sought to explore was in relation to a commonly held view which suggests that many young girls get pregnant

because it provides them with priority and easy access to housing. This view was challenged by witnesses who stated that it was their opinion that peer pressure, alcohol and ignorance were more significant factors as to why teenagers get pregnant, than those trying to access housing.

5.9.24 Witnesses explained that with regard to rules around priority for housing, all 16 and 17 year olds whether they are pregnant or not are automatically considered a priority for housing. This is national policy and not just local to Kirklees however, they are not legally allowed to enter into a contract until they are 18, any tenancies established for 16 and 17 year old require an adult trustee to sign the tenancy agreement a long with the young person. In addition, all pregnant teenagers are given priority for housing. The young person will receive up to 2 years of ongoing support while they are in their tenancies.

5.9.25 Teenage Parents sometimes become homeless due to family breakdowns. The Review Panel heard that when a young person presents to the service their circumstances are investigated by officers who gather information from any relevant party, including the young person, their family, school/college and other agencies such as, health services, support workers, Youth Offending team and the Connexions Service. This helps build a picture of their situation, and the events that may have contributed to a young person's situation and how it may be resolved.

5.9.26 When possible, families are encouraged to engage in mediation to help resolve areas of conflict and to prevent family breakdown. Housing Legislation gives guidance on the definition of intentional homelessness to local authorities. Every applicant is entitled to individual consideration of their application, and a decision is made on the circumstances of how they have become homeless. If it is deemed that the applicant's conduct has resulted in their homelessness, they would be given a lower banding and offered advice and information about alternative housing options. On-going support would be offered until their housing issue has been resolved. This applies to applicants of 16 and over.



5.9.27 The Council offers guidance and advice about housing options, and ensures that young people are referred on to another support agency, whether that is a

council owned tenancy support service or if is through another agency such as Fusion Housing (formally SHAP), Foundation or Connect housing.

5.9.28 In March 2010 KNH set up a tenancy service for 16/17 years olds which provides focused tenancy management to minors. In Kirklees this represents approximately 20% of the total of 15-17 year olds who give birth. The service works closely with other agencies including; the Family Nurse Partnership, the Youth Offending Team, the Children and Families Service and other housing support agencies.

Fusion Housing – (formerly – SHAP)

5.9.29 Representatives from Fusion Housing provided evidence to the Review Panel outlining the role they play in supporting pregnant teenagers, teenage parents and young people generally. Fusion Housing operates across Kirklees and has offices in both North and South Kirklees and was identified by Connexions Service and the local authority as providing a valuable service.

5.9.30 Fusion Housing offers a wide range of services including non age specific housing advice. Private rented accommodation is very difficult for young people to acquire because private landlords are often very reluctant to give properties to under 18 year olds; therefore they operate a bond guarantee.

5.9.31 Fusion Housing offers debt advice, housing support, private sector tenancy support, drop in service and deliver scheme training sessions aimed at teenage parents in conjunction with Connexions. They also provide Chlamydia screening, the C Card Scheme, CAF and the PSHCE ed toolkit to support vulnerable and at risk groups. A part of Fusion Housing's role is around education, training and guidance through a scheme called Fusion Training. Teenage parents are able to attend short courses to get them back into education specially those who have not achieved any educational attainment and may not be as familiar with or confident in the concept of learning.

5.9.32 Between April 2010 and April 2011, Fusion Housing worked with 149 young people under the age of 20 who either had a child or were expecting this includes both men and women. Seventy six of the 149 young people had accessed the drop in service to get immediate help, support and advice around issues to do with payments being stopped, housing arrears being harassed. Some young people accessed Fusion Housing with issues with regard to support for their children including being able to afford school meals.

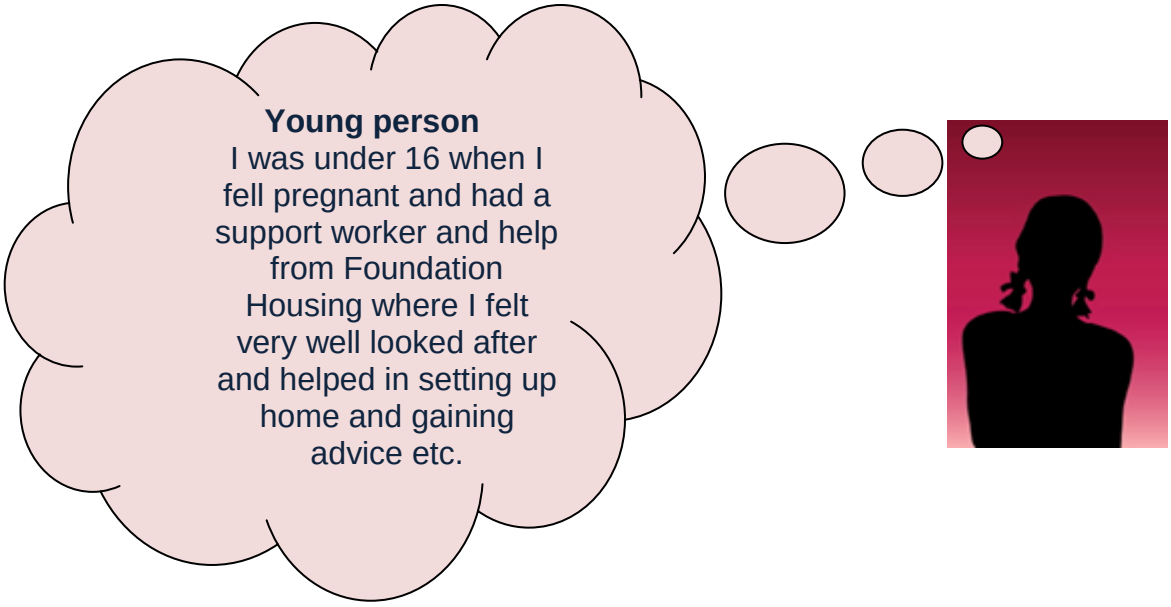
5.9.33 Young people often come to Fusion Housing when they are homeless or threatened with homelessness, alternatively, they could have their own tenancy which could be failing and they are at risk of becoming homeless. Fusion Housing help young people build skills to allow them to live successfully, independently and support is tailored to individual needs. This support can come by way of finding furniture once they have acquired a suitable property. There are a lot of young people living in tenancies struggling to get the basics together such as furniture.

5.9.34 Fusion Housing carries out a self assessment with the client to find out what their needs are, this not only includes housing but help with health issues, friends and family support, participation in culture and leisure activities,

education, training and parenting skills. Once this is complete they build a support plan which includes realistic and achievable goals for the young person, this goes towards helping them build their self confidence. Fusion Housing works with young men and fathers and tries to work with teenage couples with a child and work on their relationship, their housing and support needs to enable the couple to remain as a family. Fusion Housing also works with young men who are not residing with the mother to emphasise their role as a father and what it means to establish contact with their child.

5.9.35 Many teenage parents are homeless due to family breakdown, sometimes it's arguments with disapproving parents about the pregnancy. Overcrowding is a significant issue especially when the baby arrives. Equally, many teenage parents want to establish themselves independently. It was stated by Fusion Housing that they feel strongly that teenage parents should have the right to access independent accommodation where they choose to do so.

5.9.36 While Fusion Housing works in conjunction with a wide range of agencies they acknowledged that all agencies could work better together to ensure that clients are referred appropriately because a high majority of referrals to Fusion Housing are self referrals. It was felt that more agencies should be referring clients because there are a lot of young parents who are isolated and struggling to cope.



Children/Sure Start Centres

5.9.37 There are 32 Sure Start children's centres spread across the 7 localities in Kirklees delivering services to families with children under five years old. The services offered in Sure Start children's centres include integrated childcare and education, family support, child and family health services, family learning and support for training and employment. Sure Start children's centres aim to offer local advice and practical support for families. Some Sure Start children's centres will provide these services under one roof while others will have information points to signpost people to where they are being delivered locally.[29]

[29] Kirklees Website

5.9.38 The evidence presented suggests that Children Centres are frequently used by the Teenage Midwives in conjunction with the Family Support Workers. The Review Panel felt that the Children Centres could be used to provide more of the services specifically related to teenage parents, (e.g. housing, contraception, sexual health, support for boys and counselling).

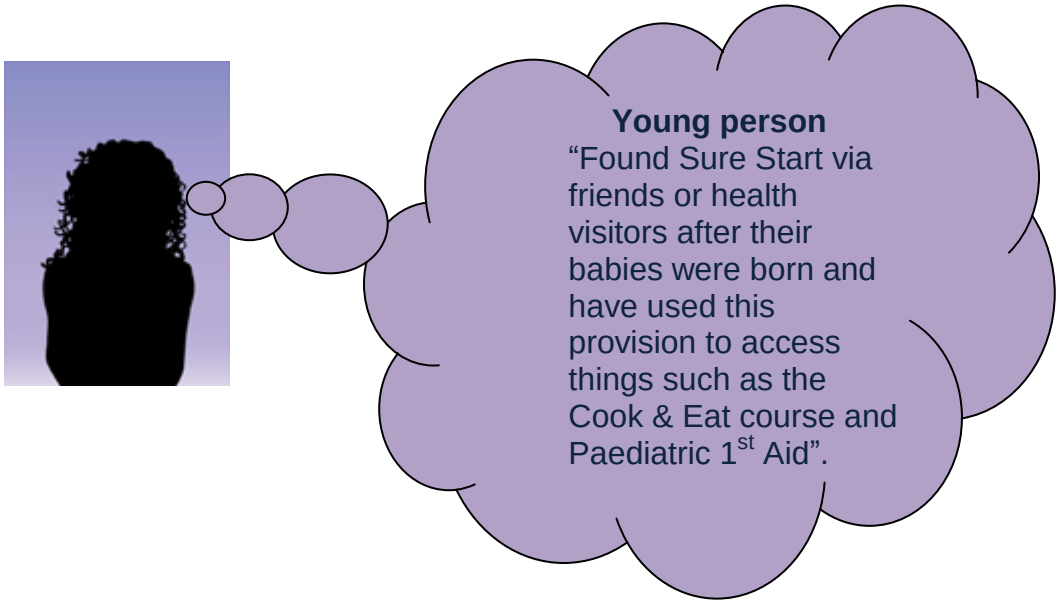
5.9.39 While there are no plans to close any of the existing children's centres across Kirklees at the time of writing this report a consultation is being carried out on the review of family support and children centre services.

Homestart & Dewsbury

5.9.40 Members of the Review Panel visited Flatts and Eastbourgh Children Centre and Homestart in Dalton as both these facilities offer services and support to young people, predominantly young mothers. Review Panel members had the opportunity to speak to the young women in attendance who said that they had heard about the facilities via friends or had been referred by health visitors, family nurses, school, college or self referral. They all valued the facility and said Homestart enabled their children to socialise with other children and it allowed them to compare notes with other young women in the same situation as them and gave them a break.

5.9.41 The young women who attend Homestart believed that fathers do not talk as openly about their needs and experiences in the same way as mothers do as this is not considered “macho” and therefore may not feel comfortable attending support groups such as Homestart.

5.9.42 Flatts and Eastbourgh Children Centre offers a weekly provision which is also open throughout school holidays and gives the young people the opportunity to go on trips. Some of the young people stated they had used the provision after their babies were born to access things such as the Cook & Eat course and Paediatric 1st Aid. The Birth & Beyond provision is available to all parents regardless of age.



5.9.43 During the visit to Homestart it was felt by some of the workers that the lack of Education Maintenance Allowance support will have an impact on young mother's ability to return to education. The Review Panel also received anecdotal evidence to suggest that teenage parents may feel encouraged to plan a second or subsequent pregnancy in order to continue to receive benefits rather than pursue employment or training as a consequence of the welfare reforms.

Financial Support

5.9.43 The Education Maintenance Allowance (EMA) scheme closed to new applicants on 1 January 2011 however young people between the ages of 16 and 19 and in full-time education and training and facing financial hardship may be eligible to apply for a bursary.

Students in the following groups may receive the maximum bursary of £1,200 a year:

- Young people in care
- Care leavers
- Young people claiming income support in their own name
- Disabled young people who receive both Employment Support Allowance and Disability Living Allowance in their own name

5.9.44 Other students not in the groups listed above and who are facing genuine financial difficulties may be awarded a bursary at the discretion of their school, college or training provider.

5.9.45 Kirklees Providers and Connexions PAs help and advice young people regarding access Care to Learn support. Care to Learn provides financial support to teenage parents who want to continue their education, or return to learning, and need help with the cost of childcare and any associated travel. It pays up to £160 a week and is paid direct to the Childcare Provider. The scheme aims to improve opportunities for teenage parents, decreasing their risk of being NEET (not in employment, education or training) and improving the life chances of their children.

5.9.46 The Care to Learn scheme will continue to be available for parents in England who are under 20 when they start a course in 2011/12. Care to Learn will continue beyond this academic year. The Department for Education (DfE) need to consider what changes to Care to Learn might be necessary from September 2012 to ensure that support reaches those who most need it. The DfE is currently carrying out a consultation on some changes to the scheme that will ensure its sustainability into the future. They are consulting on four options:

- Moving to a discretionary fund;
- Changes to the maximum weekly rates payable;
- Linking support to income; and
- Changes to the age criteria.

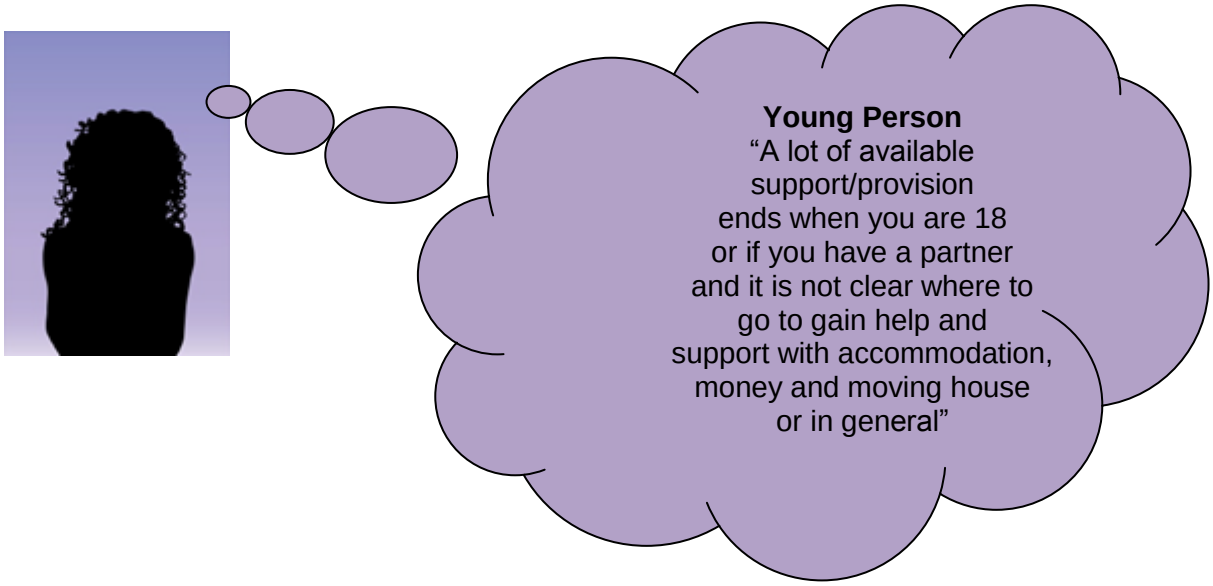
5.9.47 A more recent update from The Teenage Pregnancy Unit shows there will be no changes to the Care to Learn scheme in 2012/13. The scheme will

continue to provide childcare support to all parents in England who are under 20 when they start their course in 2012/13.

5.9.48 Benefits that are available for pregnant teenagers and mothers under 16 depend on different things such as how old they are and whether they live with their parents or not. During pregnancy if the young person is under the age of 16 and living with parents, they will not be eligible to receive benefits however, their parents or guardian can continue to get child benefit and child tax credit if applicable. After the birth of the baby the young person can claim child benefit but will not be able to claim Income Support as a lone parent until they are 16.

5.9.49 During pregnancy if the young person is under 16 and living apart from parents they will not be eligible to claim benefits in their own right but Social Services will be responsible for them.

5.9.50 After the birth of the baby and the young person reaches the age of 16, then they are eligible to claim child benefit, child tax credits and possibly income support as a lone parent.[30]



[30] Medway Council Welfare Benefits Unit

Panel View

- The Panel acknowledges that young people are engaging in sexual activity early and that regardless of the amount of interventions in place, it may be unrealistic to try to stop sexual activity in young people in its entirety. However, if there is to be any impact on STI's and unplanned conceptions, it may be more advantageous to place greater emphasis on ensuring that young people are constantly being given key messages around safe sex practices and contraception.

- The Panel are not persuaded that the messages around the prevention of teenage pregnancies and STI's are being promoted or displayed clearly or widely enough apart from within educational establishments; and questioned how young people who are disengaged from education would get the information they require.

- The Panel believed that more innovative, and high profile advertising on how to access local services in places where young people would see the information would be more beneficial.

- While there are many services that provide guidance, assistance and support to young people, the referral routes of pathways were not overly apparent to the Panel. Sexual health clinics should be more widely advertised in school and colleges and employment and training centres.

- The use of social media which most young people have knowledge of and use should be considered as a way of getting key messages to young people in a way that is engaging.

- Of significant concern to the Panel was that most of the emphasis about contraception, seemed to be on young women, and there appeared to very little evidence on the work that is being done with young men on their role in terms of taking responsibility for contraception and reducing the spread of STI's.

- More support and intervention work is needed with boys to educate them to have a greater sense of responsibility and tackle attitudes. In addition the Panel was also concerned about the lack of support generally for boys and young men.

- Whilst all teenage girls will have access to community midwives, the more intensive support offered by FNP and teenage Midwives are limited and therefore not all pregnant teenagers will meet the criteria for more specialist support and services.

- There are clearly differences between service provision and access to service in North and South Kirklees and the Panel are optimistic that with the formation of the cluster approach to commissioning and service delivery as outlined in paragraph 5.5.45 these differences will become less apparent.

- The Panel was concerned that the reality for many young women who go through a termination is that they tend to disappear out of the system with little or no follow up support; and feel that there should be some way of maintaining contact and a record of support and intervention that travels with them as it would if they had continued with their pregnancy.

- The role of parents in delivering the sexual health message cannot be underestimated and therefore a resource pack should be available for parents to be able to address these issues within the home.

Term of Reference 4

To identify any gaps in provision

5.10 Gaps in Provision

5.10.1 The Review Panel having considered all the evidence received have identified areas which it considers to be gaps in support and services in relation to addressing the high numbers of teenage conceptions in Kirklees.

Support for boys

5.10.2 Throughout the evidence gathering the Review Panel noted that there is a significant amount of support for young women and girls but less targeted support for young boys, specifically around contraception and understanding their responsibilities both pre and post pregnancy. Historically, there has been less of a stigma on young men who are promiscuous and engaged in sexual activity than their female counterparts; however the Review Panel felt that more targeted, innovative messages were needed to tackle the attitude of young men to sex.

5.10.3 The Review Panel felt encouraged by some young men being actively involved as fathers, however this seemed to be the exception rather than the rule and felt that young men should be encouraged to engage in some of the same kinds of services available to young women. For example, having support workers specifically available for young men within places like Homestart or Children Centres.

Sex Education

5.10.4 The onus of delivering sex education is very much focused towards education establishments and parental responsibility, however there are a wide range of services outside of educational establishments such as Youth Offending Team, Connexions, Fusion Housing the Young People Service and Homestart that work with young people; and therefore the Review Panel feel they should be involved in delivering sex education.

5.10.5 The Panel was aware that during 2011, all Kirklees secondary schools were offered free training on RSHE. As Lead Co-ordinators are given the responsibility of co-ordinating and delivering PSHCE ed in their schools and the standard of what is delivered is very much dependent on their confidence and the ability, Panel felt that co-ordinators should be actively encouraged and supported to access available courses.

5.10.6 Co-ordinators should also be supported and encouraged to share good practice not only in Kirklees, but also from neighbouring authorities where there have been improvements. The Review Panel felt that in hotspot areas a possible cluster school approach could provide more beneficial outcomes, including support and information targeting.

Information Sharing

5.10.7 The Review Panel are of the opinion that the reluctance of agencies to share information comes up time and time again and is often down to ignorance and a

lack of clarity about what information can and can't be shared. The Review Panel felt that while there are protocols in place there needed to be clarification of the information that can be shared between the local authority and partner agencies to ensure all parties are clear on the arrangements, especially front line staff having the knowledge and confidence to share information.

Evaluation

5.10.8 The Review Panel felt that while there was sufficient data that provides a comprehensive picture of teenage pregnancy in Kirklees, the evaluation of the various strategies and interventions both in Kirklees and nationally has not produced any definitive answers on how to tackle teenage pregnancy.

Miscarriages

5.10.9 The Review Panel did not find much information to show that there was support for young girls who had suffered a miscarriage, and there was little in the way of data generally.

6.0 Recommendations

Panel Recommendations

1. The Panel recommends that the local authority and NHS Kirklees take joint responsibility to strategically co-ordinate the ability for key agencies to share information. This is specifically in relation to clarifying the legal position around information sharing protocols and challenging cautious attitudes to address barriers to information sharing between professionals particularly frontline staff and those who work most closely with young people.

2. The Panel recommends that there should be continuous evaluation to identify areas of good practice from internal and external to the Council which can then be replicated across Kirklees; and that the Council works in conjunction with the Director of Public Health to ensure that good practice and key messages are promoted to all relevant agencies.

3. The Panel recommends that Children and Young Peoples Service give consideration to Children Centres being used to house additional services such as housing, benefits, contraception and sexual health and sex education to allow for a more comprehensive offer to more young people.

4. The Panel recommends that the Teenage Pregnancy Joint Commissioning Group undertake a piece of work to explore in detail the quality of support in relation to young men and transform services in relation to teenage conception, including

- their sex education
- young men understanding their role and accountability in teenage pregnancies
- identification of effective messages for young men to tackle teenage pregnancies and sexual transmitted diseases
- Improving data collection on young men and teenage pregnancies
- the provision of counselling and other support services for young men

5. The Panel recommends that in hot spot areas the local authority and partner organisations facilitate schools forming a cluster to work together to share resources and tackle the high rates of teenage conception and address the emotional health and well-being of young people. The Panel further recommends that in those areas, there is a partnership approach to ensuring that PHSCE ed forms an integral part of the school curriculum and that the PSHCE toolkit is actively used.

6. The Panel recommends that the Teenage Pregnancy Joint Commissioning Group seek to provide a ‘personal health record book’ for pregnant teenagers and teenage parents that documents both the services they have already accessed and those support services available to them. This would allow any service who comes into contact with the young person to have a clear history of a young person’s journey. The ‘personal health record book’ could include information relating to contraception, health, number of pregnancies, housing, benefits and any other relevant information.

Panel Recommendations

7. The Panel recommends that a resource pack specifically for parents and carers is developed by the Teenage Pregnancy Joint Commissioning Group to ensure that messages on sexual health can be discussed within the home.

8. The Panel recommends that there should be no diminution in the levels of support currently available to pregnant teenagers and teenage parents as outlined in sections 5.5.1– 5.6.48 of this report.

9. The Panel recommends that the services that provide support to teenage parents and young people should be easily accessible and should be actively encouraged to work towards achieving the Kirklees Young People Friendly kite-mark.

10. The Panel recommends that work is undertaken between education, health and schools to address the barriers that exist which prevent open-door and drop-in facilities for sexual health services being available in more educational establishments across Kirklees.

GLOSSARY OF TERMS

CAF	**C**ommon **A**ssessment **F**ramework
CaSH	**C**ontraception & **S**exual **H**ealth **C**linic
C-CARD SCHEME	National Scheme allowing young people to register to receive free condoms
Depo Injection	Depo Provera injection a long term form of contraception
GUM	**G**enito**u**rinary **M**edicine clinics - tests and treatment for STIs
HIS	**H**ealth **I**nformation **S**ervice – NHS Kirklees
STI	**S**exually **T**ransmitted **I**nfections
JSNA	**J**oint **S**trategic **N**eeds **A**ssessment
NEET	**N**ot in **E**ducation, **E**mployment, or **T**raining
PSHCE ed	**P**ersonal, **S**ocial, **H**ealth, **C**itizenship and **E**conomic education
PSHE	**P**ersonal, **S**ocial and **H**ealth **E**ducation – Citizenship being separate
PSHEE	**P**ersonal, **S**ocial, **H**ealth, and **E**conomic **E**ducation - Citizenship being separate
RSHE	**R**elationships and **S**exual **H**ealth **E**ducation

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Julie Walker – Operations & Development Manager
Alan Laurie – Commissioning Manager (Joint Commissioning)
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Rachel Spencer-Henshall – Senior Public Health Manager NHS
Graham Hofmann – School Improvement Officer – Kirklees Council
Emma Thomas – Housing Support Worker
Tasha Dyson – Housing Support Services Manager
Staff at Home-start Dalton
Staff at Flatts & Eastborough Children Centre
Julia Ingram – Voice & Influence Worker
Graham Crossley – Commissioning & Contract Manager Kirklees Council
Steve Collins – Head of Service C&K Careers – Connexions Service
Jeremy Haigh – Royds Hall High School
Kate Birch – Huddersfield New College
Susan Greenwood – Young People Support Manager - Kirklees Neighbourhood Housing
Lynne Hoyle - Young Peoples Team Manager – Housing Options & Support Service
Karen Poole - Family Nurse Partnership
Martin De Bono – Divisional Director of Children and Women's Service
Sajid Azeb – Assistant Divisional Director of Children and Women's Service
Dr Susmita Ray – Consultant Gynaecologist
Julie Dean – Teenage Pregnancy Midwife
Dr Shirley Tabner – Clinical Lead – CASH (Dewsbury)

<u>Documentation</u>
Understanding Teenage Pregnancy - Anna Bowtell

SCRUTINY ACTION PLAN

Project: TEENAGE CONCEPTION
Lead Scrutiny Officer: Jenny Bryce-Chan and Beth Hewitt

			FOR COMPLETION			
No.	**Recommendation**	**Directorate and Cabinet Member(s) asked to coordinate the response to the recommendation ?**	**Do you agree with the recommendation? If no, please explain why.**	**How will this be implemented?**	**Who will be responsible for implementation?**	**What is the estimated timescale for implementation?**
1	The Panel recommends that the local authority and NHS Kirklees take joint responsibility to strategically co-ordinate the ability for key agencies to share information. This is specifically in relation to clarifying the legal position around information sharing protocols and challenging cautious attitudes to address barriers to information sharing between professionals including; frontline staff and those who work most closely with young people.	Directorate for Children and Young People Service NHS Kirklees Cllrs Harris & O'Neill	**Yes – in part.** (Confidentiality and disclosure restrictions for many service providers are dictated by the established Fraser Guideline - legal directives which set the parameters they have to adhere to.)	Work will be undertaken to establish the best way forward to address this recommendation Existing data sharing agreements already support the production of locality focused updates annually in April 2012. A review of the existing council and NHS data sharing protocol is due in February 2012 and we will use the panel views to inform this review. Virtual team members can be asked to share their individual information sharing protocols to identify potential improvements which can address some of the	Teenage Pregnancy Commissioning Group	To be reviewed over the next six months in consultation with partnership services (Spring to Autumn 2012)

				sensitivities involved.		
2	The Panel recommends that there should be continuous evaluation to identify areas of good practice both internal and external to the Council which can then be replicated across Kirklees; and that the Council works in conjunction with the Director of Public Health to ensure that good practice and key messages are promoted to all relevant agencies.	Directorate for Children and Young People Service Cllrs Harris & O'Neill	**Yes**	This is directly linked into commissioning cycle frameworks and already forms part of the Teenage Pregnancy Joint Commissioning plan with associated recommendations included in the Kirklees JSNA We will continue to monitor and explore examples of good practice through national links with the Department of Education and our statistical neighbours.	Teenage Pregnancy Commissioning Group Public Health	To provide an update in August 2012
3	The Panel recommends that Children and Young Peoples Service give consideration to Children Centres being used to house additional services such as housing, benefits, contraception and sexual health and sex education to allow for a more comprehensive offer to more young people.	Directorate for Children and Young People Service Cllrs Harris & O'Neill	**Yes**	This recommendation needs reporting into the Early Intervention Review and on-going proposals for family support and Children's Centres, Integrated Youth Support Service (IYSS) and Healthy Child Programme. An update will be provided when it becomes available.	Cllrs Harris & O'Neill	To be reviewed over the next six months in consultation with the Early Intervention Review (Spring to Autumn 2012)
4	The Panel recommends that the Teenage Pregnancy Joint Commissioning Group undertake a piece of work to explore in detail the quality of support in relation to young	Directorate for Children and Young People Service Cllrs Harris &	**Yes**	Whilst the work described is important we have to consider the resources available and how they are most effectively used. Existing strategic plans are	Teenage Pregnancy Commissioning Group	To be reviewed over the next six months in consultation with NHS Kirklees and partnership

	men and transform services in relation to teenage conception, including - their sex education - young men understanding their role and accountability in teenage pregnancies - identification of effective messages for young men to tackle teenage pregnancies and sexual transmitted diseases - Improving data collection on young men and teenage pregnancies - the provision of counselling and other support services for young men	O'Neill		committed to delivering open and transparent services to all young people supported by commissioning frameworks. We can undertake a specific review of services to identify existing support for males and potential for transformation of services. The proposed provision of peer educators will include a specific requirement relating to engagement of young men.		services (Spring to Autumn 2012)
5	The Panel recommends that in hot spot areas the local authority and partner organisations facilitate schools forming a cluster to work together to share resources and tackle the high rates of teenage conception and address the emotional health and well-being of young people. The Panel further recommends that in those areas, there is a partnership approach to ensuring that	Directorate for Children and Young People Service Cllrs Harris & O'Neill	**Yes**	This is an integral element of our integrated commissioning developments. We monitor hot spot trends based on three year averages to evidence areas of most need. We will work towards drawing partners together into cluster groups to identify potential development opportunities in 'hot spot' areas.	Teenage Pregnancy Commissioning Group Traded Services	To be reviewed over the next five months in consultation with partnership services (Spring to end of Summer term 2012)

	PHSCE ed forms an integral part of the school curriculum and that the PSHCE toolkit is actively used.			A tendering process is currently underway for delivery of a Tier 2 Targeted mental Health Service for Children and Young People, the service once commissioned will provide support in 'hot spot' areas. We will explore the potential for reviewing the use of the PSHCE ed toolkit in hot spot schools using a toolkit designed for consulting young people on sex and relationships education, called 'Are you getting it right?'		
6	The Panel recommends that the Teenage Pregnancy Joint Commissioning Group seek to provide a 'personal health record book' for pregnant teenagers and teenage parents that documents both the services they have already accessed and those support services available to them. This would allow any service who comes into contact with the young person to have a clear history of a young person's journey. The 'personal health record book' could include information relating to contraception, health, number of pregnancies, housing, benefits and any	Directorate for Children and Young People Service Cllrs Harris & O'Neill IYCE	**No**. Confidentiality would prevent this from being a valid method of tracking patients through agencies. Certainly contraception advice and provision is confidential and if a patient accessed a GU service they are not obliged to give any personal information. This record would certainly not be	<u>Alternative Approaches</u> Public Health is designing a mobile phone APP as a new technology approach to communicate information to young people. Young Advisors are currently undertaking a review of services with KYPF standards and producing a public information video on CASH. The information for young people is currently made available online via 'Youth Fax'. The information contained within this website can be reviewed to ensure it is current and relevant to young people. Subject to current commitments	IYCE Public Health	Provide an update in August 2012

	other relevant information.		shared with other health professionals. Given the chaotic lives of some of our most vulnerable pregnant teenagers I think it's unlikely they would carry and keep hold of the record, let alone share it with other agencies.	Young Advisors and/or Youth Council could be tasked with undertaking reviews and suggest alternative appropriate young people communication approaches however any recommendations will need to be reviewed against budget constraints.		
7	The Panel recommends that a resource pack specifically for parents and carers is developed by Public Health to enable parents to ensure that messages on sexual health can be discussed within the home.	Directorate for Children and Young People Service Children's Trust Board Rachel Spencer-Henshall Cllrs Harris & O'Neill	**Yes**	A social marketing approach would be undertaken in order to ensure this resource meets the needs of parents and carers.	Public Health Rachel Spencer-Henshall	Launch September 2012
8	The Panel recommends that there should be no diminution in the levels of support currently available to pregnant teenagers and teenage	Directorate for Children and Young People Service NHS Kirklees &	**Yes**	The ongoing needs around teenage pregnancy and sexual health will continue to be identified and revised using the	Teenage Pregnancy Commissioning Group	Provide an update in August 2012

	parents as outlined in sections 5.5.1– 5.6.48 of this report.	Partner organisations Cllrs Harris & O'Neill		commissioning cycle to ensure we can maintain and also enhance the levels of support required. The Joint Commissioning Plan includes agreed indicators and priority actions which identifies that the resources across the partnership maintain the delivery of services to meet the needs of young people.	Tom Brailsford Alan Laurie	
9	The Panel recommends that the services that provide support to teenage parents and young people should be easily accessible and should be actively encouraged to work towards achieving the Kirklees Young People Friendly kite-mark.	Directorate for Children and Young People Service Children's Trust Board Rachel Spencer-Henshall IYCE	**Yes**	Existing service providers can be asked to identify individual challenges and support needs to achieve KYPF standards. Young Advisors are currently undertaking a review of services with KYPF standards which may assist in enhancing existing service provision and accessibility. Subject to commitments Young Advisors and/or Youth Council could be tasked with supporting services working towards achieving the required standards.	Public Health Rachel Spencer-Henshall IYCE	Provide an update in August 2012
10	The Panel recommends that work is undertaken between Public Health and schools to address the barriers that exist which prevent 'open-door' and drop-in facilities for sexual health services being available in more educational	Directorate for Children and Young People Service Children's Trust Board	**Yes** - **In part**. Services would need to be commissioned by schools according to need;	An assessment of need would be undertaken and a co-production approach to designing appropriate evidence based information.	Public Health Rachel Spencer-Henshall	Provide an update in August 2012

	establishments across Kirklees.	Rachel Spencer-Henshall	interventions may be then be provided through a drop in approach or through other approaches. Children and young people's involvement is crucial to ensuring whatever intervention is delivered is appropriate for the target group.			

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NHS Kirklees

Young people's survey 2009

OFFICE USE ONLY		
RESPONDENT No.	**DATA INPUT SURVEY No.**	**CODING HAND TAB No.**
JOB NAME:	**JOB NUMBER:**	**SCHOOL CODE:**
Kirklees Young Persons Survey	09076	

Helpful hints for completing this questionnaire

- This questionnaire has 71 questions and is split into two main parts – **part A** asks you about **health and lifestyle** and **part B** asks you about **your local area**.
- Please read each question carefully and tick the appropriate box ☑ or write your answer in the space provided. Please use black ink to complete the questionnaire.
- In most cases you will only need to tick one box, but please read the questions carefully as sometimes you will need to tick more than one box. If you make a mistake, please fill the box in. ■
- Answer the next question unless asked otherwise. Once you have finished, please take a minute to check your answers.
- If you have any other questions then please ask the school nurse.
- Your answers to this questionnaire are confidential. They will not be viewed by any school staff. Your answers will be sent externally to be analysed and results will be looked at on a school level.

Thank you for taking the time to complete this questionnaire

ABOUT YOU

Before starting on the main questionnaire, please complete these questions to help us to see if there are differences between the views of different groups of young people. All the information you give will be kept completely confidential.

Q1a Have you heard of the 'open door' service at your school?

Yes ☐1 → **Please go to Q1b** No ☐2 → **Please go to Q2**

Q1b If you have a problem would you use the open door/drop in service?

Yes ☐1 No ☐2

Q2 What sex are you?

Male ☐1 Female ☐2

Q3 Which ethnic group do you belong to:
PLEASE TICK ✓ ONE BOX ONLY

White British	☐1	White Other	☐2
Black Caribbean	☐3	Black African	☐4
Black Other	☐5	Indian	☐6
Pakistani	☐7	Bangladeshi	☐8
Chinese	☐9	Asian Other	☐10
Other (including Arab, mixed)	☐11		

Q4 Do you spend time at home caring for someone else?
PLEASE TICK ✓ ALL THAT APPLY

Parent with disability/ illness	☐1	Brothers or sisters with a disability/illness	☐2
Other relatives with disability/ illness	☐3		

Q5 Do you have a part time job?

Yes ☐1 No ☐2

Q6 What is your home postcode?
Fill in the boxes

☐☐☐☐ ☐☐☐

IF YOU DO NOT KNOW YOUR FULL POSTCODE PLEASE JUST PUT IN THE FIRST 4 DIGITS OR WRITE IN YOUR VILLAGE OR TOWN IN THE BOX BELOW [i.e. in which part of Dewsbury, Huddersfield, Halifax, etc. do you live?]

A. HEALTH AND LIFESTYLE

Q7 In general would you say your health is:
PLEASE TICK ✓ ONE BOX ONLY

Excellent	Very good	Good	Fair	Poor
☐1	☐2	☐3	☐4	☐5

Q8 Do you have any health problems and/or disabilities that affect your everyday life?

Yes ☐1 No ☐2

Q9 Do you have any of these health problems?
PLEASE TICK ✓ ALL THAT APPLY

Asthma	Attention Deficit Disorder (ADHD)	Epilepsy	Acne	Diabetes	None of these
☐1	☐2	☐3	☐4	☐5	☐6

FOOD

Q10 How often do you usually have something to eat before school starts?
PLEASE TICK ✓ ONE BOX ONLY

Hardly ever or never	☐1	3-4 days per week	☐3
1-2 days per week	☐2	5 days per week	☐4

Q11 How many portions of fruit do you <u>USUALLY</u> eat each day?
PLEASE TICK ✓ ONE BOX ONLY

None ☐1	One ☐2	Two ☐3	Three ☐4	Four ☐5	Five or more ☐6

Q12 How many portions of vegetables do you <u>USUALLY</u> eat each day?
PLEASE TICK ✓ ONE BOX ONLY

None ☐1	One ☐2	Two ☐3	Three ☐4	Four ☐5	Five or more ☐6

Q13 Do you usually drink FRESH fruit juice every day?

Yes ☐1	No ☐2

Q14 How often do you and your family sit down together at the table and eat your main meals?
PLEASE TICK ✓ ONE BOX ONLY

Every Day	☐1	Only at weekends	☐4
Twice a week	☐2	Only for special occasions	☐5
About once a week	☐3	Never	☐6

Q15 At present, are you on a diet or doing something to lose weight?

No, my weight is fine	☐1	No, because I need to put on weight	☐3
No, but I should lose some weight	☐2	Yes	☐4

Q16 How many times did you clean your teeth yesterday?

None	☐1	Twice	☐3
Once	☐2	Three times or more	☐4

SMOKING

Q17 Have you ever smoked a cigarette?

Yes ☐1 → **Please go to Q18** No ☐2 → **Please go to Q21**

Q18 If you have smoked, at what age did you first smoke a cigarette [more than a puff]?
PLEASE TICK ✓ ONE BOX ONLY

Less than 8	☐1	11 years old	☐5
8 years old	☐2	12 years old	☐6
9 years old	☐3	13 years old	☐7
10 years old	☐4	14 years old	☐8

Q19 How often do you smoke now? PLEASE TICK ✓ ONE BOX ONLY

Every day	☐1	Less than once a week but more than once a month	☐3
At least once a week, but not every day	☐2	Less than once a month	☐4
		I have stopped smoking	☐5 → **Please go to Q21**

Q20 Are you…? PLEASE TICK ✓ ONE BOX ONLY

Happy to keep smoking	☐1	Wanting to stop and will do it **my** own way	☐3
Thinking about stopping	☐2	Wanting to stop and would like some help	☐4

Q21 Do any of the adults you live with smoke?

Yes ☐1	No ☐2

ALCOHOL

Q22 Have you ever had an alcoholic drink – a whole drink, not just a sip?

Yes ☐1 → **Please go to Q23** No ☐2 → **Please go to Q28**

Q23 How old were you when you had your first alcoholic drink?

PLEASE TICK ✓ ONE BOX ONLY

Less than 8	☐1	11 years old	☐5
8 years old	☐2	12 years old	☐6
9 years old	☐3	13 years old	☐7
10 years old	☐4	14 years old	☐8

Q24 Have you ever had so much alcohol that you were really drunk?

PLEASE TICK ✓ ONE BOX ONLY

No, never	☐1	Yes, weekly	☐4
Yes, occasionally	☐2	Yes, more than weekly	☐5
Yes, monthly	☐3		

Q25 If you drink now, how often do you usually have an alcoholic drink?

PLEASE TICK ✓ ONE BOX ONLY

Every day	☐1	About once a fortnight	☐4
About twice a week	☐2	About once a month	☐5
About once a week	☐3	Only a few times a year	☐6
		I never drink alcohol now	☐7 → **Please go to Q28**

Q26 Do you ever drink alcohol alone?

Yes ☐1 No ☐2

Q27 Where do you usually get alcohol from?

PLEASE TICK ✓ ONE BOX ONLY

Friends of a similar age	☐1	Family/relatives living elsewhere	☐4
Older friends	☐2	Buy from supermarket	☐5
Family/relatives at home	☐3	Buy from local shop/off-license	☐6

Q28 Do you think any of your family or close friends drink too much?

Yes ☐1 No ☐2

DRUGS

Q29 a) Have you ever used illegal drugs?
PLEASE TICK ✓ ONE BOX ONLY

No Never ☐1 → **Please go to Q 31**
Yes Occasionally ☐2
Yes Monthly ☐3
Yes Weekly ☐4
Yes more than Weekly ☐5

b) Please tell us what you have tried and how often
PLEASE TICK ✓ ONE BOX FOR EACH ROW

	Never	Occasionally	Monthly	Weekly	More than weekly
Cannabis (Hash, Puff, Weed, Spliff, Ganga)	☐1	☐2	☐3	☐4	☐5
Solvents (Glue, Gas, Petrol)	☐1	☐2	☐3	☐4	☐5
Ecstasy (E's, Chiccas, Doves, Mitzis)	☐1	☐2	☐3	☐4	☐5
LSD (Acid)	☐1	☐2	☐3	☐4	☐5
Amphetamines (Speed, Whiz, Phet, Base, Paste)	☐1	☐2	☐3	☐4	☐5
Heroin (Brown, Test)	☐1	☐2	☐3	☐4	☐5
Cocaine/Crack	☐1	☐2	☐3	☐4	☐5
Benzodiazepines (Benzos, Diazepam, Temazepam, Etc)	☐1	☐2	☐3	☐4	☐5
Kake powder	☐1	☐2	☐3	☐4	☐5
Any illegal drug (which you did not know the name of)	☐1	☐2	☐3	☐4	☐5

Q30 Have you ever been out of control through illegal drug use?
PLEASE TICK ✓ ONE BOX ONLY

No, never ☐1
Yes, occasionally ☐2
Yes, monthly ☐3
Yes, weekly ☐4
Yes, more than weekly ☐5

Q31 Do any of your family or close friends use illegal drugs?

Yes ☐1
No ☐2

SEXUAL HEALTH

Q32 Are you worried about your sexual development?

Yes ☐1
No ☐2

Q33 a) If you have had sexual intercourse, was it…

I have never had sexual intercourse	☐1 → **Please go to Q34**		
Once or twice and I used contraception /protection	☐2	Often and I use contraception/protection	☐4
Once or twice and I didn't use contraception/protection	☐3	Often and I don't use contraception/protection	☐5
b) How old were you when you had sexual intercourse for the first time?			
12 years old	☐1	14 years old	☐3
13 years old	☐2	Other	☐4
c) Have you used a condom during sexual intercourse?			
Always ☐1	Sometimes ☐2	Never	☐3

APPEARANCE

Q34 **a) Are you worried about your physical development?**

Yes ☐1 No ☐2

b) Do you think your body is:

PLEASE TICK ✓ ONE BOX ONLY

Much too thin ☐1 A bit too thin ☐2 About the right size ☐3
A bit too fat ☐4 Much too fat ☐5

Q35 **Are you happy with the way you look?**

Yes ☐1 No ☐2

Q36 **Would you like to change the way you look?**

Yes ☐1 No ☐2

PHYSICAL ACTIVITY

Q37 **Has anything in the last 7 days stopped you from taking part in sports or physical activity, e.g. illness or injury?**

Yes ☐1 → **Please describe below then go to Q42** No ☐2 → **Please go to Q38**

The next few questions (38-42) ask you for more details about the physical activity you have done in the last 7 days, why you don't do physical activity and local facilities you want to see.

Q38 PHYSICAL ACTIVITIES INSIDE SCHOOL

Please tell us about the physical activities you have done within school in the last 7 days **– a)** in lesson time, **b)** during break/lunch and **c)** after school.
Please describe as many activities as you have taken part in and use a separate line for each activity, we have given you an *example* under each heading.

a) Lesson time activities

These activities would probably be on your timetable and would be led by a teacher. The activities may include sports such as football and hockey, as well as dance classes, drama activities etc.

Activity	**How many times have you done this in the last 7 days?**	**How long did this activity last (in minutes)?**		**How energetic did you find this activity?** **1**= Not at all energetic **2**= Not very energetic **3**= Quite energetic **4**= Very energetic	**How much did you enjoy this activity?** **1**=not at all **2**=slightly **3**=quite a lot **4**=very much	**On what scale did this make you breathe harder and sweat?** **1**=Breathed & sweated for over 10 mins **2**=Breathed & sweated for under 10 mins **3**=Didn't sweat or breathe harder
Swimming	2	*45*	*minutes*	*1☐ 2☑ 3☐ 4☐*	*1☐ 2☑ 3☐ 4☐*	*1☐ 2☐ 3☑*
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐

b) Lunch/break time activities

These activities may have been supervised by a teacher, but would also include physical activities that you organised yourself or with friends.

Activity	**How many times have you done this in the last 7 days?**	**How long did this activity last (in minutes)?**		**How energetic did you find this activity?** **1**= Not at all energetic **2**= Not very energetic **3**= Quite energetic **4**= Very energetic	**How much did you enjoy this activity?** **1**=not at all **2**=slightly **3**=quite a lot **4**=very much	**On what scale did this make you breathe harder and sweat?** **1**=Breathed & sweated for over 10 mins **2**=Breathed & sweated for under 10 mins **3**=Didn't sweat or breathe harder
Kicking a ball about	*3*	*15*	*minutes*	*1☐ 2☑ 3☐ 4☐*	*1☐ 2☑ 3☐ 4☐*	*1☐ 2☐ 3☑*
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐

c) Club or team activities after school

These 'organised after-school activities' would include training sessions and school team practices and matches where you play for the school, as well as any school clubs e.g. dance/circuit training.

Activity	How many times have you done this in the last 7 days?	How long did this activity last (in minutes)?		How energetic did you find this activity? **1**= Not at all energetic **2**= Not very energetic **3**= Quite energetic **4**= Very energetic	How much did you enjoy this activity? **1**=not at all **2**=slightly **3**=quite a lot **4**=very much	On what scale did this make you breathe harder and sweat? **1**=Breathed & sweated for over 10 mins **2**=Breathed & sweated for under 10 mins **3**=Didn't sweat or breathe harder
Netball practice	*2*	*30*	*minutes*	1☐ 2☑ 3☐ 4☐	1☐ 2☑ 3☐ 4☐	1☐ 2☐ 3☑
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐

Q39 PHYSICAL ACTIVITIES NOT ORGANISED BY SCHOOL

Please tell us about the physical activities you have done in the last 7 days that were not organised by school. Please describe as many activities as you have taken part in and use a separate line for each activity.

a) Organised activities

These activities would be led by someone outside your school and may include sports or activities such as dance classes or drama activities.

Activity	How many times have you done this in the last 7 days?	How long did this activity last (in minutes)?		How energetic did you find this activity? **1**= Not at all energetic **2**= Not very energetic **3**= Quite energetic **4**= Very energetic	How much did you enjoy this activity? **1**=not at all **2**=slightly **3**=quite a lot **4**=very much	On what scale did this make you breathe harder and sweat? **1**=Breathed & sweated for over 10 mins **2**=Breathed & sweated for under 10 mins **3**=Didn't sweat or breathe harder
Rounders	*1*	*30*	*minutes*	1☐ 2☑ 3☐ 4☐	1☐ 2☑ 3☐ 4☐	1☐ 2☐ 3☑
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐

b) Free time activities
These 'free-time activities' would include playing in the park or street, kicking a ball about, riding a bike, skate boarding or roller-blading.

Activity	How many times have you done this in the last 7 days?	How long did this activity last (in minutes)?		How energetic did you find this activity? **1**= Not at all energetic **2**= Not very energetic **3**= Quite energetic **4**= Very energetic	How much did you enjoy this activity? **1**=not at all **2**=slightly **3**=quite a lot **4**=very much	On what scale did this make you breathe harder and sweat? **1**=Breathed & sweated for over 10 mins **2**=Breathed & sweated for under 10 mins **3**=Didn't sweat or breathe harder
Biking	*2*	*45*	*minutes*	*1☐ 2☑ 3☐ 4☐*	*1☐ 2☑ 3☐ 4☐*	*1☐ 2☐ 3☑*
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐

Q40 ACTIVITIES AROUND THE HOUSE AND GARDEN

Please tell us about any physical activities that you have done around the house and garden in the last 7 days. Please list any activity that lasted **at least 10 minutes** and which involved pushing or pulling; like hoovering or sweeping up leaves.

Activity	How many times have you done this in the last 7 days?	How long did this activity last (in minutes)?		How energetic did you find this activity? **1**= Not at all energetic **2**= Not very energetic **3**= Quite energetic **4**= Very energetic	How much did you enjoy this activity? **1**=not at all **2**=slightly **3**=quite a lot **4**=very much	On what scale did this make you breathe harder and sweat? **1**=Breathed & sweated for over 10 mins **2**=Breathed & sweated for under 10 mins **3**=Didn't sweat or breathe harder
Mowing the lawn	*1*	*30*	*minutes*	*1☐ 2☑ 3☐ 4☐*	*1☐ 2☑ 3☐ 4☐*	*1☐ 2☐ 3☑*
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐

Q41 WALKING ACTIVITIES

Please tell us about any continuous walking that lasted for **at least 10 minutes** in the last 7 days. This could be walking to school, walking to the shops or walking for fun, e.g. hiking in the countryside.

Activity	**How many times have you done this in the last 7 days?**	**How long did this activity last (in minutes)?**		**How energetic did you find this activity?** **1**= Not at all energetic **2**= Not very energetic **3**= Quite energetic **4**= Very energetic	**How much did you enjoy this activity?** **1**=not at all **2**=slightly **3**=quite a lot **4**=very much	**On what scale did this make you breathe harder and sweat?** **1**=Breathed & sweated for over 10 mins **2**=Breathed & sweated for under 10 mins **3**=Didn't sweat or breathe harder
Walking to school	*4*	*15*	*minutes*	*1☐ 2✓ 3☐ 4☐*	*1☐ 2✓ 3☐ 4☐*	*1☐ 2☐ 3✓*
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐
			minutes	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐

Q42 REASONS FOR <u>NOT</u> DOING PHYSICAL ACTVITIES

This time we are interested in sports or physical activities **that you don't do.** There might be some sports that you would like to do but there are reasons why you don't get involved at the moment.

We have listed some possible reasons for not doing certain activities. Please mark down your **top three** reasons for not doing some sports or activities. 1 would be the biggest reason for not doing the sports or activity, 2 would be the second biggest and 3 would still be important but not as strong as reasons 1 or 2. **<u>Please only mark 3 reasons</u>**

Reason:	**Importance** (1, 2 or 3)
I don't have the time	
I don't enjoy it	
I can't afford it	
My friends don't do it	
I'm not good enough at it	
I can't get there (transport)	
I find it too stressful	
I have an illness or injury	
It is not available in the local area	
It is in an area I can't get to / bad location	

Q43 LOCAL FACILITIES YOU WANT TO SEE

We would also like you to tell us about any sports and physical activities that you would like to be available or improved locally, in or outside of school. Please give full details – we have given you an *example.*

Sport or activity:	**Are you involved in this at the moment?**	**How would you like to see this activity improved locally?**
Basketball	*Yes*	*An indoor court for competitions*

FEELINGS AND EMOTIONS

Q44 Do you have any problems sleeping due to being anxious or worried?

Never ☐1 Weekly ☐3

Monthly ☐2 Daily ☐4

Q45 During the last school year have you:
PLEASE TICK ✓ ONE BOX FOR EACH ROW

	Never	Occasionally	Monthly	Weekly	More than weekly
Had sudden changes of mood	☐1	☐2	☐3	☐4	☐5
Felt miserable	☐1	☐2	☐3	☐4	☐5
Felt panicky	☐1	☐2	☐3	☐4	☐5
Felt angry	☐1	☐2	☐3	☐4	☐5
Felt lonely	☐1	☐2	☐3	☐4	☐5
Gone off food or overeaten	☐1	☐2	☐3	☐4	☐5

Q46 During the last school year, how often have you worried about:
PLEASE TICK ✓ ONE BOX FOR EACH ROW

	Never	Occasionally	Monthly	Weekly	More than weekly
Bullying	☐1	☐2	☐3	☐4	☐5
Name calling	☐1	☐2	☐3	☐4	☐5
Being teased about your colour	☐1	☐2	☐3	☐4	☐5
Being teased about your gender	☐1	☐2	☐3	☐4	☐5
Being disliked	☐1	☐2	☐3	☐4	☐5
How you look	☐1	☐2	☐3	☐4	☐5
The future	☐1	☐2	☐3	☐4	☐5
Your sexuality	☐1	☐2	☐3	☐4	☐5
Eating problems	☐1	☐2	☐3	☐4	☐5
Violence at home	☐1	☐2	☐3	☐4	☐5

Q47 Do you feel happy at school?

Never ☐1 Sometimes ☐2 Often ☐3 Always ☐4

Q48 Do you get on well with:

	Never	Sometimes	Often	Always
Your family at home	☐1	☐2	☐3	☐4
Most staff at school	☐1	☐2	☐3	☐4
The other pupils	☐1	☐2	☐3	☐4

Q49 Are you happy with yourself as a person?

Never ☐1 Sometimes ☐2 Often ☐3 Always ☐4

Q50 Do you have someone you can talk to about your problems?

Yes ☐1 No ☐2

BULLYING AT SCHOOL

Q51 Have you ever been bullied at school?

Yes ☐1 → **Please go to Q52** No ☐2 → **Please go to Q53**

Q52 Have you been bullied at school in the last couple of months?

It has only happened once or twice ☐1 About once a week ☐3

2-3 times a month ☐2 Several times a week ☐4

Q53 Have you ever bullied other people at school?

Yes ☐1 → **Please go to Q54** No ☐2 → **Please go to Q55**

Q54 How often have you taken part in bullying another student in the last couple of months?

It has only happened once or twice ☐1 About once a week ☐3

2-3 times a month ☐2 Several times a week ☐4

Q55 Do you ever feel afraid of going to school because of bullying?

Never ☐1 Sometimes ☐2 Often ☐3 Very often ☐4

Q56 In the last couple of months, how often have you been…?

	Never	Occasionally	Monthly	Weekly	More than weekly
Teased, harassed or intimidated about your **colour**	☐1	☐2	☐3	☐4	☐5
Teased, harassed or intimidated about your **gender**	☐1	☐2	☐3	☐4	☐5
Teased, harassed or intimidated about your **ethnic background**	☐1	☐2	☐3	☐4	☐5
Teased, harassed or intimidated about being **disabled**	☐1	☐2	☐3	☐4	☐5
Teased, harassed or intimidated about your **sexuality**	☐1	☐2	☐3	☐4	☐5
Teased, harassed or intimidated about your **religion or faith**	☐1	☐2	☐3	☐4	☐5

Q57 How well does your school deal with bullying?

Very well ☐1 Not at all well ☐4

Quite well ☐2 Bullying is not a problem in my school ☐5

Not very well ☐3 Do not know ☐0

B. YOUR LOCAL AREA - General views on your area

Q58 **Overall, how satisfied or dissatisfied are you with your local area as a place to live?**
PLEASE TICK ✓ ONE BOX ONLY

Very satisfied	☐1	Fairly dissatisfied	☐4
Fairly satisfied	☐2	Very dissatisfied	☐5
Neither satisfied nor dissatisfied	☐3		

Q59 **To what extent do you agree or disagree that your local area is a place where people from different backgrounds get on well together?**
PLEASE TICK ✓ ONE BOX ONLY

Definitely agree	Tend to agree	Tend to disagree	Definitely disagree	Don't know	Too few people in local area	All the same background
☐1	☐2	☐3	☐4	☐5	☐6	☐7

Q60 **To what extent do you agree or disagree that your local area is a place where people of different ages get on well together?**
PLEASE TICK ✓ ONE BOX ONLY

Definitely agree	Tend to agree	Tend to disagree	Definitely disagree
☐1	☐2	☐3	☐4

CRIME AND SAFETY

Q61 **Thinking about this local area, how much of a problem do you think each of the following are…**
PLEASE TICK ✓ ONE BOX ONLY FOR EACH STATEMENT

	A very big problem	A fairly big problem	Not a very big problem	Not a problem at all	No opinion
Noisy neighbours or loud parties	☐1	☐2	☐3	☐4	☐0
Teenagers hanging around the streets	☐1	☐2	☐3	☐4	☐0
Rubbish or litter lying around	☐1	☐2	☐3	☐4	☐0
Vandalism, graffiti and other deliberate damage to property or vehicles	☐1	☐2	☐3	☐4	☐0
People using or dealing drugs	☐1	☐2	☐3	☐4	☐0
People being drunk or rowdy in public places	☐1	☐2	☐3	☐4	☐0
Abandoned or burnt out cars	☐1	☐2	☐3	☐4	☐0

Q62 **a) How safe or unsafe from being hurt by other people do you feel:**
PLEASE TICK ✓ ONE BOX FOR EACH ROW

	Very safe	Quite safe	A bit unsafe	Very unsafe	Donít know
Around the local area	☐1	☐2	☐3	☐4	☐0
On public transport	☐1	☐2	☐3	☐4	☐0
Going to and from school	☐1	☐2	☐3	☐4	☐0
In school	☐1	☐2	☐3	☐4	☐0

b) Does it make you feel safer when you see a PCSO or police officer?

Yes ☐1 **No** ☐2

Q63	**How well do you think the Police are doing in the following areas:** PLEASE TICK ✓ ONE BOX FOR EACH ROW				
	Very well	**Quite well**	**Not very well**	**Not well at all**	**Don't know**
Reducing crime	☐1	☐2	☐3	☐4	☐0
Reducing anti-social behaviour	☐1	☐2	☐3	☐4	☐0
Arresting criminals	☐1	☐2	☐3	☐4	☐0
Solving crime	☐1	☐2	☐3	☐4	☐0
Making you feel confident that they will help you if you need them	☐1	☐2	☐3	☐4	☐0

ACTIVITIES IN YOUR AREA

Q64 What do you think of the parks and play areas in your area?

Very good	**Fairly good**	**Neither good nor poor**	**Fairly poor**	**Very poor**	**Don't know**
☐1	☐2	☐3	☐4	☐5	☐0

Q65 Overall, what do you think of the activities and things to do in your area?
PLEASE TICK ✓ ONE BOX ONLY

They are good enough	**Need a little more or better things to do**	**Need a lot more or better things to do**
☐1	☐2	☐3

Q66 If some new activities opened up in your area, how would you most like to find out about them?
PLEASE TICK ✓THE ONES THAT YOU MOST PREFER.

From family	☐1	Leaflets through your door	☐7
From friends	☐2	Local paper	☐8
From school or teachers	☐3	Internet/websites	☐9
From youth club or groups	☐4	Text message	☐10
From youth workers	☐5	Other	☐11
Posters	☐6	Do not know	☐12

GETTING INVOLVED

Q67 In the last year, have you ever given your views about the local area, such as about local problems or local activities and facilities in any of these ways?

PLEASE TICK ✓ ALL THAT APPLY

Filled in a questionnaire (not including this one)	☐1	Been to a meeting outside school about making things better in my local area	☐3
Been a member of a youth parliament	☐2	None of these	☐4

Q68 Which of the things below, if any, have you done in the last four weeks to help other people?

PLEASE TICK ✓ ALL THAT APPLY

Helped an elderly or disabled person	☐1	Done something else to help a neighbour or someone else in the local area	☐5
Helped care for a relative who is disabled or sick	☐2	Raised money for a charity or local group	☐6
Helped care for someone else who is disabled or sick	☐3		
Done something else to help family or friends	☐4		

Q69 How much are children and young people's views listened to in decisions about:

	A great deal	A fair amount	Not very much	Not at all	Do not know
Your local area	☐1	☐2	☐3	☐4	☐5
Running of your school	☐1	☐2	☐3	☐4	☐5

IMPROVING YOUR LOCAL AREA

Q70 Which of these things, if any, would do the most to make your area a better place for you to live?

READ ALL OPTIONS CAREFULLY BEFORE CHOOSING. THEN TICK THE ONES THAT ARE MOST IMPORTANT TO YOU. PLEASE TICK ✓ ALL THAT APPLY

More or better shops	☐1	Safer area or less crime	☐7
Cleaner and less litter	☐2	More or better parks and green spaces	☐8
More or better sports clubs or centres	☐3	Less young people hanging around	☐9
Better public transport (such as buses, trains, tubes)	☐4	Something else	☐10
Safer roads	☐5	Do not know	☐11
More or better activities for children and young people	☐6	None (the area is fine as it is)	☐12

Q71 Thinking about all of the things that have been covered in the survey today, what if anything, would do most to make your life better? PLEASE TICK ✓ ONE BOX ONLY

More organised activities and things to do	☐1	More help to do better at school	☐6
More places where I can go to hang out with my friends	☐2	More help to plan for my future	☐7
More chance to have a say in how things are run at school or in the local area	☐3	More help to feel safer at school and in the local area	☐8
More ways I can volunteer or help people	☐4	None of these	☐9
More or better advice about being healthy	☐5	Do not know	☐0

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. PLEASE NOW RETURN IT TO YOUR SCHOOL NURSE.

Appendix 2

INTER-AGENCY INFORMATION SHARING PROTOCOL

DOCUMENT CONTROL

Author	**SWYMHT in conjunction with the Information Sharing Protocol Review Group**
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Contents Page

Glossary of Terms:

Agencies
Used in the context of this document to relate to the organisations specified within appendix iv which details the organisations that are signatories to this protocol.

Anonymised Information
This is information which does not identify an individual directly, and which cannot reasonably be used to determine identity. Anonymisation requires the removal of name, address, full postcode and any other detail or combination of details that might support identification.

Disclosure
This is the divulging or provision of access to data.

Explicit Consent
This means articulated agreement and relates to a clear and voluntary indication of preference of choice, usually given orally or in writing and freely given in circumstances where the available options and the consequences have been made clear.

Implied Consent
This means agreement that has been signalled by the behaviour of an individual with whom a discussion has been held about the issues and therefore understands the implications of the disclosure of information.

Information Sharing Protocol
The protocol is the high level document setting out the general reasons and principles for sharing data. The protocol will show that all signatory agencies are committed to maintaining agreed standards on handling information and will publish a list of senior signatories. It should be underpinned by information sharing agreements between the organisations who are actually sharing the information.

Information Sharing Agreement
The agreement is a more detailed document the intention of which is to spell out how the organisations involved will operate the approach to information sharing. Agreements will be produced where organisations specifically identify a purpose to share information across organisational boundaries. The agreement should state whether partners are obliged to, or are merely enabled to, share data.

INTER-AGENCY INFORMATION SHARING PROTOCOL

1. Purpose of the Protocol

Local agencies are increasingly working together. To work together effectively agencies need to be able to share information about the services they provide and the people they provide these services to.

This protocol covers the sharing of person-identifiable confidential information, with the individual's express consent, unless a legal or statutory requirement applies for the following purposes:

- Provision of appropriate care services
- Improving the health of the population
- Protecting people and communities
- Supporting people in need
- Supporting legal and statutory requirements
- Managing and planning services (where information has been suitably anonymised)
- Commissioning and contracting services (where information has been suitably anonymised)
- Developing inter-agency strategies
- Performance management and audit
- Research (subject to the Research Governance Framework)
- Investigating complaints or serious incidents
- Reducing risk to individuals, service providers and the public as a whole
- Clinical Audit
- Monitoring and protecting public health
- Common Assessment Framework
- Staff management and protection
- To fulfil responsibilities in law such as; Data Protection Act (1998), Human Rights Act (1998), Common Law, Crime and Disorder Act (1998), Mental Health Act (1983), Fertilisation and Embryology Act (1990), NHS (Venereal Diseases) 1974 Regulations and the Children Act (2004).

This is not intended to be an exhaustive list. If, as a result of policy changes or other developments, additional information sharing requirements arise these will be added to the protocol.

This protocol does not give carte blanche licence for the wholesale sharing of information. Information sharing must take place within the constraints of the law and relevant guidance and service specific requirements.

This protocol will be underpinned by service specific operational agreements that are designed to meet the specific information sharing needs of that service.

The purpose of this protocol is:

- To provide the basis for an agreement between the local agencies, and other associated organisations, to facilitate and govern the effective and efficient sharing of information. Such information sharing is necessary to ensure that individuals, and the population as a whole, can and do receive the care, protection and support they may require.

- To identify the purposes for which information may be shared. This document is supported by local operational policies and procedures within each agency that underpin the secure and confidential sharing of such information

- To promote and establish a consistent approach between the agencies to the development and implementation of information sharing agreements and procedures.

A further purpose of the protocol is to establish arrangements for the sharing of large datasets between organisations. Following the Government's publication in 2006 of the 'Information Sharing Vision Statement', and as part of the Service Transformation Plans, a cross-government programme has been established with the aim of overcoming barriers to information sharing within the public sector.

The key areas where information sharing could be beneficial include:

1. sharing for the purposes of law enforcement and public protection

2. sharing to provide or improve services in the public, private and voluntary sectors

3 sharing to facilitate statistical analysis and research.

Consent to share should be sought through agreements at the point of data collections. Data-sharing practices and schemes should be published and maintained as required under the Freedom of Information Act. Organisations should publish and regularly update a list of those organisations with which they share and exchange personal information.

Examples of where large datasets may need to be shared includes the management of Contact Point, where responsibility for the data supplied to the national system rests with the Local Authority, but data is supplied from a wide number of agencies, including Health and the Voluntary Sector. A Data Sharing agreement would cover the purposes, accountability, restrictions imposed and secure transfer arrangements where data has been shared for this purpose. Each occasion of data sharing of this type will need its own Data Sharing Agreement.

Requests to share datasets must relate to one or more of the three key areas identified above and should contain only demographic details, such as a geographical reference, age, gender and possible ethnicity information.

As such this document:

- **Informs** about the reasons why information may need to be shared and how this sharing will be managed and controlled by the agencies concerned.

- **Identifies the local agencies** that are party to this protocol.

- **Sets out the principles** that underpin the exchange of information between agencies.

- **Defines the purposes** for which agencies have agreed to share information.

- **Describes the policies and procedures** that support the sharing of information between agencies and will ensure that such sharing is in line with legal, statutory and common law responsibilities.

- **Promotes a standard approach** to the development of information sharing agreements and procedures.

- **Sets out the process** for the implementation, monitoring and review of the protocol.

2. BACKGROUND

2.1 Legislative context and national guidance documentation

All agencies are subject to a variety of legal, statutory and other guidance in relation to the sharing of person- identifiable or anonymised information.

For all agencies the key legislation and guidance affecting the sharing and disclosure of information includes (but is not necessarily an exhaustive list): -

Legislation:

- Access to Health Records 1990
- Data Protection Act 1998
- Crime and Disorder 1998
- Human Rights Act 1998
- Freedom of Information Act 2000
- The Children Act 2004
- Safeguarding Vulnerable Groups Act 2006
- Education Act 2002
- Mental Capacity Act 2005
- Local Government Act 2000
- Homelessness Act 2002

Appendix I provides summary details of the above-mentioned, and related, legislation and guidance.

2.2 Local Context

All agencies face similar requirements with regards to the development of information sharing agreements with their local partners. While the requirements remain similar the number of partners with which an agency must have such agreements differs. This number is dependent on the geographical area covered by an agency and the nature of its work.

This protocol is a recognition that consistent information sharing agreements now need to exist across the local government boundaries .

The intention of this protocol is to support and build on existing agreements in order to provide a common process for the development and implementation of future information sharing agreements across the patch.

The protocol is aimed at the information sharing agreements required between agencies and provides a framework within which agencies

3. Principles guiding the sharing of information

The following key principles guide the sharing of information between the agencies:

3.1 Agencies endorse, support and promote the accurate, timely, secure and confidential sharing of both person identifiable and anonymised information where such information sharing is essential for the provision of effective and efficient services to the local population.

3.2 Agencies are fully committed to ensuring that if they share information it is in accordance with their legal, statutory and common law duties, and, that it meets the requirements of any additional guidance.

3.3 All agencies have in place policies and procedures to meet the national requirements for Data Protection, Information Security and Confidentiality. The existence of, and adherence to, such policies provides all agencies with confidence that information shared will be transferred, received, used, held and disposed of appropriately.

3.4 Agencies acknowledge their 'Duty of Confidentiality' to the people they serve. In requesting release and disclosure of information from other agencies employees and contracted volunteers will respect this responsibility and not seek to override the procedures which each organisation has in place to ensure that information is not disclosed illegally or inappropriately. This responsibility also extends to third party disclosures, any proposed subsequent re-use of information which is sourced from another agency should be approved by the source organisation.

3.5 An individual's personal information will only be disclosed where the purpose for which it has been agreed to share clearly requires that this is necessary. For all other purposes information should be anonymised.

3.6 Where it is agreed that the sharing of information is necessary, only that which is needed and relevant will be shared and that would only be on a "need to know" basis.

3.7 When disclosing information about an individual, agencies will clearly state whether the information being supplied is fact, opinion, or a combination of the two.

3.8 There will be occasions when it is legal and necessary for agencies to request that information supplied by them be kept confidential from the person concerned. Decisions of this kind will only be taken on statutory grounds and must be linked to a detrimental effect on the physical or mental wellbeing of that individual or other parties involved with that individual. The outcome of such requests and the reasons for taking such decision will be recorded.

3.9 Careful consideration will be given to the disclosure of information concerning a deceased person, and if necessary, further advice should be sought before such information is released.

3.10 Agencies will ensure that all relevant staff are aware of, and comply with, their responsibilities in regard both to the confidentiality of information about people who are in contact with their agency and to the commitment of the agencies to share information.

3.11 All staff will be made aware that disclosure of personal information, which cannot be justified on legal or statutory grounds, whether inadvertently or intentionally could be subject to disciplinary action.

3.12 Organisations/agencies are responsible for putting into place effective procedures to address complaints relating to the disclosure of information, and information about these procedures should be made available to service users.

4. Consent

4.1 Information is provided in confidence when it appears reasonable to assume that the provider of the information believed that this would be the case, or where a person receiving the information knows, or ought to know, that the information is being given in confidence. It is generally accepted that most (if not all) information provided by patient/clients is confidential in nature. All agencies, which are party to this protocol accept the duty of confidentiality and will not disclose such information without the consent of the person concerned, unless there are statutory grounds or an overriding justification for doing so. In requesting release and disclosure of information from members of partner organisations, staff in all organisations will respect this responsibility and not seek to override the procedures which each organisation has in place to ensure that information is not disclosed illegally or inappropriately, this includes third party disclosures.

4.2 Agencies are fully committed to ensuring that they share information in accordance with their statutory duties. They are required to put in place procedures that will ensure that the principles of the Data Protection Act and

requirements of other relevant legislation are adhered to and underpin the sharing of information between their organisations.

4.3 As is required by the fair processing requirements of the Data Protection Act 1998, individuals in contact with agencies will be fully informed about information that is to be obtained, held or disclosed about them. The individual has the right to request that processing of their information cease if there is undue damage or distress caused to them.

4.4 As a **minimum**, individuals will be informed that information may be shared and the circumstances in which this could happen unless this poses a risk of harm or danger. Fair processing notices should always be in place. Consent can often be inferred from the circumstances in which information was given. However, it is always important that the person giving consent understands who will see their information and the purpose to which it will be put. If there is any doubt as to whether a disclosure is supported by a legal, statutory requirement or an immediate serious risk explicit consent should be sought. Where an agency has consent forms the service user should be requested to sign one. Consent can be given verbally and recorded on the casenotes.

4.5 The individuals right to confidentiality are not absolute and may be overridden if evidence that disclosure for specific purposes is necessary in exceptional circumstances. Such as;

- Where it is required by statute
- Where not to share the information poses a public health risk
- Where there is a risk of harm to any person
- Where sharing is required to prevent serious crime.

Where the individual chooses to exercise their right not to provide express consent for information sharing, they must be advised of any constraints that this will put upon the service that can be provided, however the individuals wishes must be respected unless there is a statutory requirement or a significant risk of harm to an individual to override those wishes as indicated above.

4.6 Where the individual is unable to provide express consent due to incapacity, the professional concerned must take decisions about the use of information. This must take into consideration the individual's best interests and any previously expressed wishes, or the wishes of anyone who is authorised to act on behalf of the individual. Information must only be disclosed that is in the individuals best interest, and only as much information as is needed to support their care.

4.7 Where the individual to whom the information relates is a child, e.g over the age of 12, and it is determined that the individual has the competency to make decisions regarding the sharing of information they have provided in confidence, their wishes must be respected. In other cases where the individual does not have the capacity to consent, express consent must be sought from the individual with parental responsibility (parent or guardian). Young people aged 16 or 17 are presumed to be competent for the purposes of consent to treatment and are therefore entitled to the same duty of confidentiality as adults.

4.8 Safeguarding Children

- Safeguarding children is everyone's responsibility
- Mistreatment of any child is not acceptable
- Doing nothing is not an option
- Your actions can make a difference,

The over-riding principle that the welfare of the child is paramount must be central to any consideration about whether to share information. It is assumed that in all instances where there are concerns about a child's safety it is better to share the information than not. A failure to pass on information that might prevent a tragedy could expose professionals to criticism in the same way as an unjustified disclosure. In general the law will not prevent reciprocal sharing of information between practitioners if:

- Those likely to be affected have given consent; or
- The public interest in safeguarding the child's welfare overrides the need to keep information confidential; or
- Disclosure is required under a court order or other legal obligation

Safeguarding Adults

- Safeguarding adults is everyone's responsibility
- Mistreatment of any adult is not acceptable
- Doing nothing is not an option
- Your actions can make a difference

Vulnerable adults are part of our community and have specific needs that require us to work in a partnership with other agencies that also have responsibilities for their welfare. We share the responsibility to develop, implement and enforce policies and procedures in relation to 'Safeguarding Adults' issues. We are committed to providing training and development for all staff to support them in their safeguarding responsibilities.

4.9 Where professionals request that information supplied by them be kept confidential from the people who use services the outcome of this request and the reasons for taking the decision will be recorded. Decisions of this kind will only be taken on statutory grounds.

5. SUPPORTING POLICIES, PROCEDURES AND GUIDANCE

5.1 Supporting policies

For members of the public and staff from different agencies to have confidence that information sharing takes place legally, securely and within relevant guidance all agencies have in place policies which meet the requirements for:

- Data Protection
- Confidentiality
- Information Security

These policies must cover manual, verbal and computer-based information.

Processes must be in place within agencies to regularly monitor and improve the effectiveness of these policies.

5.2 Access and Security Procedures

All agencies will look to implementing technological solutions to support the safe transfer of data. Risk assessments will be carried out before the transfer of data is carried out and all reasonable steps to mitigate any risks identified will be taken Supporting documentation relating to the secure transfer, receipt, access to, storage and disposal of shared information should be made available to staff.

Each organisation will keep a log of all requests for information sharing received.

Each organisation will instigate a system of reporting back to the originator of information where actions have been taken on the basis of the information shared.

Agencies should put into place policies, procedures or guidelines covering:

- Communication by fax
- Communication by phone
- Electronic communication
- Verbal communication
- Written communication
- Use of personal information for purposes other than that agreed
- Access arrangements to shared records and databases
- Secure storage and disposal of confidential information

These policies, procedures or guidelines should be subject to regular monitoring.

5.3 Induction and continuing education

To support the implementation of the above-mentioned policies and procedures appropriate staff induction and training programmes must be made available within the agencies.

5.4 Data Quality

Good data quality is an essential requirement to all data users and underpins the timely and effective delivery of services to those in need. Several characteristics of good data quality have been identified and in summary they are:

Accuracy – Data should be sufficiently accurate to present a fair picture of circumstances and enable informed decision-making at all appropriate levels. Definitions for data should be specific and unambiguous.

Validity – Data should represent clearly and appropriately the intended result and should be used in accordance with the correct application of any rules or definitions.

Reliability – Data should reflect stable and consistent data collection processes that need to be fit for purpose and incorporate controls and verification procedures.

Timeliness – Data input should occur on a regular ongoing basis rather than being stored to be input later. Verification procedures should be as close to the point of input as possible.

Relevance – Information collected should comprise the specific items of interest only. Sometimes definitions need to be modified to reflect changing circumstances in services and practices, to ensure that only relevant data of value to users is collected, analysed and used.

Completeness – All the relevant data must be recorded. Missing or invalid data can lead to incorrect judgement and poor decision-making.

6. Approval, implementation and review

6.1 Agreeing the protocol

This Protocol proposes a consistent approach to the development of information sharing agreements.
Appendix III provides outline of the formal agreement format.

6.2 Implementation

Following approval of the protocol agencies will need to take action, either individually or jointly, on the following issues:

Agencies	Actions
All agencies	• Promoting ownership of responsibilities associated with the protocol • Ensuring dissemination and appropriate implementation • Reviewing existing support policies, procedures and guidance. • Agreeing training programmes • Monitoring implementation/compliance • Establishing review processes • Joint work to develop standard service specific agreements • Ensuring amendments to existing agreements • Agreeing audit processes • Maintaining local registers of agreements.
Chief Officers/Boards of each organisation or department/Caldicott Guardians	• Annual review

6.3 Monitoring and review processes

Where not already in place processes will be set up in each agency to adopt a risk management approach to breaches/problems in relation to the implementation of this agreement. Formal review of the protocol should be held at three yearly intervals unless legislative changes require immediate action.

Prior to the review date, agencies should submit feedback on the use of the protocol and propose options for addressing problems or amending procedures.

It is proposed that reviews would, in the first instance, be co-ordinated through the Information Sharing Protocol Review Group.

7. Conclusion

All agencies are in the position of having to balance the conflicting demands of the need and requirement to share information with other agencies with the responsibility to maintain highest level of confidentiality.

This protocol acknowledges these competing demands and provides a means whereby members of the public, staff and the agencies can be confident that where information is shared it is done so appropriately and securely.

APPENDIX I

SUMMARY OF KEY LEGISLATION AND GUIDANCE

(detailed guidance should be available in all agencies for staff)

Access to Health Records Act 1990

This Act provides rights of access to the health records of deceased individuals for their personal representatives and others having a claim on the deceased's estate. In other circumstances, disclosure of health records relating to the deceased should satisfy common law duty of confidence requirements. The Data Protection Act 1998 supersedes the Access to Health Records Act 1990 apart from the sections dealing with access to information about the deceased

Data Protection Act 1998

The key legislation governing the protection and use of identifiable patient/client information (Personal Data) is the Data Protection Act 1998. The Act does not apply to information relating to the deceased.

This Act gives seven rights to individuals in respect of their own personal data held by others. They are:

- Right of subject access
- Right to prevent processing likely to cause damage or distress
- Right to prevent processing for the purposes of direct marketing
- Rights in relation to automated decision making
- Right to take action for compensation if the individual suffers damage
- Right to take action to rectify, block, erase or destroy inaccurate data
- Right to make a request to the Commissioner for an assessment to be made as to whether any provision of the Act has been contravened.

In addition, the Act stipulates that anyone processing personal data comply with eight principles of good practice. These principles are legally enforceable.

Principle 1 – Personal data shall be processed fairly and lawfully
Principle 2 – Personal data shall be obtained only for one or more specified lawful purposes
Principle 3 – Personal data shall be adequate, relevant and not excessive in relation to the purposes for which they are processed.
Principle 4 – Personal data shall be accurate and, where necessary, kept up to date.
Principle 5 – Personal data processed for any purpose or purposes shall not be kept longer than is necessary for that or those purposes.
Principle 6 – Personal data shall be processed in accordance with the rights of data subjects under this Act, including the right to access their own record.
Principle 7 – Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss.
Principle 8 – Data shall not be transferred outside of the European Economic Area

Detailed information for staff about the requirements of the Act in relation to information sharing are available in each agency.

Crime and Disorder Act 1998

The Crime and Disorder Act 1998 introduces measures to reduce crime and disorder, including the introduction of local crime partnerships around local authority boundaries to formulate and implement strategies for reducing crime and disorder in the local area. Section 115 of the Act provides that any person has the power to lawfully disclose information to the police, local authorities, probation service or health authorities (or persons acting on their behalf) where they do not otherwise have the power but only where it is necessary and expedient for the purposes of the Act. However, whilst all agencies have the power to disclose, Section 115 does not impose a requirement on them to exchange information and responsibility for the disclosure remains with the agency that holds the data. It should be noted, however, that this does not exempt the provider from the requirements of the 2nd Data Protection principle.

The Criminal Procedures and Investigations Act 1996 requires the police to record in durable form any information that is relevant to an investigation. The information must be disclosed to the Crown Prosecution Service, who must in turn disclose it to the defence at the relevant time if it might undermine the prosecution case. In cases where the information is deemed to be of a sensitive nature then the CPS can apply to a judge or magistrate for a ruling as to whether it should be disclosed.

Human Rights Act 1998

Article 8.1 of the Human Rights Act 1998 provides that "everyone has the right to respect for his private and family life, his home and his correspondence". This is however, a qualified right i.e., there are specified grounds upon which it may be legitimate for authorities to infringe or limit those rights and Article 8.2 provides "there shall be no interference by a public authority with the exercise of this right as it is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety, or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals or for the protection of the rights and freedom of others".

In the event of a claim arising from the Act that an organisation has acted in a way which is incompatible with the Convention rights, a key factor will be whether the organisation can show in relation to its decision to take a particular course of action: -

- That it has taken these rights into account
- That it considered whether any breach may result, directly or indirectly, from the action, or lack of action
- If there was the possibility of a breach, whether the particular rights which might be breached were absolute rights or qualified rights
- Whether one of the permitted grounds for interference could be relied upon
- Whether there was proportionality

The Act also requires public bodies to read and give effect to other legislation in a way that is compatible with these rights and makes it unlawful to act incompatibly

with them. As a result these rights still need to be considered, even when there are special statutory powers to share information.

Common law duty of Confidentiality

All staff working in both the public and private sector are aware that they are subject to a common law Duty of Confidentiality and must abide by this. The duty of confidence only applies to identifiable information and not to aggregate data derived from such information or to information that has otherwise been effectively anonymised i.e., it is not possible for anyone to link the information to a specified individual.

The Duty of Confidentiality requires that unless there is a statutory requirement to use information that has been provided in confidence it should only be used for purposes that the subject has been informed about and has consented to. This duty is not absolute but should only be overridden if the holder of the information can justify disclosure as being in the public interest (e.g., to protect others from harm). Whilst it is not entirely clear under law whether or not a common law Duty of Confidence extends to the deceased, the Department of Health and professional bodies responsible for setting ethical standards for health professionals accept that this is the case.

Unless there is a sufficiently robust public interest justification for using identifiable information that has been provided in confidence then the consent of the individual concerned should be gained (deceased individuals may have provided their consent prior to death). Schedules 2 and 3 of the Data Protection Act 1998 apply whether or not the information was provided in confidence.

Where it is judged that an individual is unable to provide consent (for example due to mental incapacity or unconsciousness) other conditions in schedule 2 and 3 of the Data Protection Act 1998 must be satisfied (processing will normally need to be in the vital interest of the individual).

Whilst under current law, no-one can provide consent on behalf of an adult in order to satisfy the common law requirement, it is generally accepted that decisions about treatment and the disclosure of information should be made by those responsible for providing care and that they should be in the best interests of the individual concerned.

All agencies are subject to their own codes or standards relating to confidentiality.

Caldicott Report 1997

The Caldicott Committee (which reported in 1997) recommended a series of principles that should be applied when considering whether confidential information should be shared. The principles have been developed with the aim of establishing the highest practical standards for handling confidential information. They apply equally to all routine and ad hoc flows of patient information whether clinical or non-clinical, in manual or electronic format. The principles are:

- Justify the purpose(s) for using confidential information

Every proposed use or transfer of patient-identifiable information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed, by an appropriate guardian.

- Only transfer/use patient-identifiable information when absolutely necessary

  Patient-identifiable information items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose.

- Use the minimum identifiable information that is required

  Where use of patient-identifiable information is considered to be essential, the inclusion of each individual item should be considered and justified so that the minimum amount of identifiable information is transferred or accessible as is necessary for a given function to be carried out.

- Access should be on a strict need to know basis

  Only those individuals who need access to patient-identifiable information should have access to it. They should only have access to the information items that they need to see. This may mean introducing access controls or splitting information flows where one flow is used for several purposes.

- Everyone with access to identifiable information must understand his or her responsibilities

  Action should be taken to ensure that those handling patient-identifiable information, both clinical and non-clinical staff, are made fully aware of their responsibilities and obligations to respect an individual's confidentiality.

- Understand and comply with the law

  Every use of patient-identifiable information must be lawful. Someone in each organisation handling patient information should be responsible for ensuring that the organisation complies with legal requirements.

All NHS and Social Services Department are now required to apply these principles and to nominate a senior person to act as a **Caldicott Guardian** responsible for safeguarding the confidentiality of patient information.

Freedom of Information Act 2000

This Act provides clear statutory rights for those requesting information together with a strong enforcement regime. Under the terms of the Act, any member of the public will be able to apply for access to information held by bodies across the public sector. The release of personal information remains protected by the Data protection Act 1998.

The Children Act 2004

The Act provides a legislative spine for the wider strategy to improve children's lives. This covers the universal services which every child accesses, and more targeted services for those with additional needs. The overall aim is to encourage integrated planning, commissioning and delivery of services as well as improve multi-disciplinary working, remove duplication and increase accountability. There is a duty to cooperate between relevant partners in the making of arrangements to improve the well being of children.

Other relevant legislation

Criminal Procedures and Investigations Act 1996

Regulation of Investigatory Powers Act 2000

Health and Social Care Act 2001 (Section 60)

Homelessness Act 2002

Safeguarding Vulnerable Groups Act 2006

Education Act 2002

Mental Capacity Act 2005

Local Government Act 2000

There are statutory restrictions on passing on information linked to:

NHS (Venereal Disease) Regulations 1974
Human Fertilisation and Embryology Act 1990
Abortion Regulations 1991

Further Guidance

HM Government Publications:
Information Sharing: Guidance for practioners and managers
Information Sharing: Pocket Guide

Available at www.teachernet.gov.uk/publications or Phone: 0845 60 222 60 for copies

Appendix II

INFORMATION SHARING AGREEMENT

This agreement is to be used in conjunction with the Inter Agency Information Sharing Protocol and complies with all the guidance therein.

1. Parties to this agreement

Agency Name	
Address	
Responsible Manager	
Contact Details	
Source/Recipient?	
Authorised Signatory/Date	

Agency Name	
Address	
Responsible Manager	
Contact Details	
Source/Recipient?	
Authorised Signatory/Date	

Agency Name	
Address	
Responsible Manager	
Contact Details	
Source/Recipient?	
Authorised Signatory/Date	

Date of Agreement	

2. Specific purpose(s) for which the information sharing is required

3. Type and status of information shared

Is the information 'person identifiable'?	**Yes/No**
Has explicit consent been given and recorded?	**Yes/No**
Has implied consent been recorded?	**Yes/No**
Is the subject aware that sharing will take place?	**Yes/No**
Is the information anonymised?	**Yes/No**

4. Legal basis for sharing where no consent given

5. Information Items shared

This list must be comprehensive and include ALL data items that are to be shared

6. Information Transfer Method

All parties to this agreement are responsible for ensuring that appropriate security and confidentiality procedures are in place to protect the transfer and use of the shared, person identifiable information.

Regular flow (specify frequency)	
Ad hoc	

More than 50 items per flow	
Less than 50 items per flow	

Give full details of how the transfer will be made and what security measures will be in place e.g. encryption, registered post

Face to face	
Telephone	
Safe haven fax (or faxed following procedure)	
Electronically (state method)	
Royal Mail	
Secure Courier	
Encrypted removable media	
Other	

Has a risk assessment been carried out on the chosen methods of transfer?	**Yes/No**

What are the identified risks?	

7. Audit and Review

Agency Name	
Address	
Responsible Manager	
Contact number	
Review Date	

APPENDIX III

INTER-AGENCY PROTOCOL FOR SHARING INFORMATION

MEMORANDUM OF AGREEMENT

The signatory agencies to this agreement endorse the vital importance of the sharing of information between the agencies to support the provision of effective and efficient services to the populations of the local area.

The signatory agencies are committed to working in partnership on this and future information sharing activities and recognise that without such sharing the increasing amount of initiatives requiring a multi-agency approach cannot be fully achieved.

The signatory agencies accept and support the principles and processes identified in the Inter-Agency Information Sharing Protocol.

The signatory agencies are committed to ensuring that their agencies have in place the appropriate policies, procedures and training to maintain the security and confidentiality of shared information.

The signatory agencies are committed to the monitoring and review of the information sharing processes arising from this protocol.

The signatory should be either the Chief Executive or the Caldicott Guardian of the organisation.

INTER-AGENCY INFORMATION SHARING PROTOCOL

I …….. (name of signatory)

On behalf of …….. (name of agency/authority)

Hereby agree to the following:

- To subscribe to the principles contained within the Protocol
- To work to the principles contained within the Protocol
- To ensure that the Protocol is fully implemented within the agency/authority and all relevant staff are trained in the principles and legal requirements
- To contribute to the development of trust between the signatory agencies by working within the framework of the Protocol

Signature …… Name …….

Position …… Date ……..

Appendix IV

Current Signatories as at February 2009

Calderdale and Huddersfield NHS Foundation Trust
Calderdale Metropolitan Borough Council
Calderdale Primary Care Trust
Kirklees Metropolitan Council
Kirklees Primary Care Trust
Mid Yorkshire NHS Trust
National Children's Centre
Oakdale Group
Probation Service
South West Yorkshire Mental Health Trust
Wakefield District Primary Care Trust
Wakefield Metropolitan District Council
West Yorkshire Fire Service
West Yorkshire Police Force
Yorkshire Ambulance Service

Kirklees Council Directorate for Children and Young People

Teenage Conceptions: Response to issues raised on the Scrutiny Panel Report

This note sets out a response to the discussion at Cabinet Briefing in March of issues raised by the Scrutiny Panel Report on Teenage Conceptions in Kirklees.

Analysis of recent statistics from Public Health and 2010 Office of National Statistics (ONS) data identify a reduction in Kirklees conception rates in since 2005.

The Scrutiny Panel report recognises the value of the range of services available to support Kirklees young people; it is anticipated by commissioning appropriate services and support the downward trend in rates will continue in 2012 and beyond.

The Scrutiny Panel report provides a valuable overview of teenage conceptions and future challenges which includes sustaining and enhancing existing approaches which need linking into local needs and national directives; and national changes in April 2013. These changes propose that Local Authorities will commission comprehensive sexual health services including, open access and supply of Sexually Transmitted Infections (STI's) testing and treatment services, Chlamydia screening, reasonable access to all methods of contraception, teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies.

The Kirklees Teenage Pregnancy & Sexual Health Joint Commissioning Group continues to co-ordinate the delivery of the Joint Commissioning Plan which delivers the shared priorities of the Kirklees Young People Plan and Children's Trust Board. The plan covers the period of 2010 to 2013 and focuses on 6 strategic priorities with identified actions; this will be reviewed to take account of changes in 2013.

Performance is monitored against the following indicator:

- KI 058 - Percentage change in the number of conceptions amongst 15-17 year olds. This Performance Indicator measures a rolling reduction over 3 yearly % calculated changes.

On the 22 March 2012 the Children's Trust Board agreed their continued endorsement and support of the joint commissioning plan and widening the focus from conception rates to also take greater account of sexual health and emotional health and wellbeing issues. The following were agreed by the Board as priority focus areas:

a. Explore development opportunities which encourage delivery of Relationships and Sexual Health Education (RSHE) and Personal, Social, Health, Citizenship and Economic education (PSHCE ed) in areas identified as having relatively high levels of teenage conceptions.
b. Enhance easy access to Kirklees Young People Friendly contraception and sexual health services

c. Increase support for teenage parents
d. Focus on addressing unwanted or unplanned pregnancies
e. Consider approaches which can help reduce the social stigma around teenage parents and termination of pregnancy.

Early actions which align with the Scrutiny Panel report include the following.

- Release in March 2012 of a Further Education Wellbeing Toolkit which has been distributed free of charge in Kirklees to 6th form schools, colleges and alternative providers. The toolkit has borrowed from the best practice principles of 'The Kirklees Secondary Integrated PSHCE education Toolkit' and provides teachers with everything required to facilitate sessions on: Alcohol and sexual behaviour; illicit drug use; with a focus on cocaine; emotional health and wellbeing; identity / respect with a focus on sexual orientation; Sexual health; Risk taking and E Safety.

- Bringing together five schools from the localities which have been identified as having relatively high levels of teenage conceptions. Discussions will explore opportunities to enhance delivery of PSHCE ed and Relationships and Sexual Health Education and provide easy access to services and support.

- An annual PSHCE conference led by Traded Learning Services is taking place in May 2012 where all Kirklees high schools are invited to explore opportunities to enhance delivery of Relationships and Sexual Health Education lessons.

- Further research involving members of the Teenage Pregnancy Operational Group to gain a clearer understanding of the demographics and context of planned and unplanned conceptions including associated issues which impact on teenage conceptions and terminations.

- The Kirklees Young Advisors have recently completed a review of north Kirklees contraceptive and sexual health services with Kirklees Young People Friendly status. Their findings will used in reviewing and commissioning of services.

There will be a continual review of priorities and delivery of appropriate services including exploration of examples of good practice which will support the identified needs of young people, particularly vulnerable or at risk groups. Emphasis will be on prevention of unplanned pregnancies, early intervention and support and improving the life chances for parents and children after birth.

Alan Laurie & Andrew Pennington
Directorate for Children and Young People
May 2012