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Children and Young People's Services
Scrutiny Committee
3 March 2010

Sexual Health Task Group: Final Report

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Devon County Council

Contents

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Preface

By Councillor Vanessa Newcombe

Chair, Sexual Health Task Group, Children & Young People's Services Scrutiny Committee

I am very pleased to be able to present this Scrutiny review on Sexual Health. It has been a great privilege to chair this Task Group, which has reviewed an extremely wide and complex area.

I would personally like to thank everyone who contributed to this review.

Councillor Vanessa Newcombe

Sexual Health Task Group: Final Report

1.0 Introduction

1.1 The Task Group — Councillors Vanessa Newcombe (Chair), Peter Bowden, Michael Lee, Saxon Spence, James McMurray (Health and Adult Services Scrutiny Committee) and Liz Wilson (Primary Parent Governor) — would like to place on record its gratitude to the witnesses who contributed to the review. In submitting its recommendations, the Group has sought to ensure that its findings are supported with evidence and information to substantiate its proposals.

1.2 This study into levels of teenage conception and young people's sexual health in the County links directly to the priority of the Council's Strategic Plan 2009–2013 in that 'Devon's children should have the best possible start in life and gain the knowledge and skills they need to lead happy, healthy and fulfilling lives'. One of the objectives under this remit is to support parents, families and carers to help children and young people enjoy learning, aim for excellence and achieve to the best of their ability.

1.3 This review does not pretend to be a detailed examination of teenage sexual health services and SRE in Devon. Time and resources necessitate that this review provide a snapshot approach to highlight significant issues facing the young people themselves, schools, social care and health services.

1.4 The Task Group's terms of reference:

- To examine the levels of sexually transmitted infections and the incidents of teenage pregnancy in Devon.
- To identify and explore in detail the current initiatives and actions in place to deliver sex and relationship education (SRE) with the aim of improving the emotional, physical and long term well being of young people, reducing teenage pregnancies and sexually transmitted infections (STIs).
- To examine the availability of access to contraception/family planning for young people in the County, outside standard school/working days, and in on-site education and training settings, including further education.
- To conclude on how far the needs of children and young people in the County are being met in terms of SRE, and consider any shortfalls within the current service provision, as well as proposed initiatives to address these.
- To identify good SRE practice from within Devon, and other local authorities. To assess how good practice can be built upon and shared with both school and non-school based settings.
- To explore the effectiveness of the provision of SRE for young people not in education, employment or training, children in care, children excluded from school and children with special education needs.
- To examine the funding available for SRE in the County.
- To make detailed recommendations to the Children and Young People's Services Scrutiny Committee on the findings of the Task Group.

2.0 Context

2.1 Sexual ill health, including unintended pregnancy, is a significant public health priority in the UK. It costs the NHS more than £700 million a year. The cost to individuals can also be great, ranging from a brief episode of discomfort and possibly embarrassment to long term and serious disability, including infertility and, in some cases, death as a result of HIV and AIDS. Against a background of rising sexually transmitted infections, there is a strong national and local drive to improve sexual health services.

2.2 A recent report, *Partner Exploitation and Violence in Teenage Intimate Relationships* (NSPCC / University of Bristol), revealed that a third of teenage girls in a relationship suffer unwanted sexual acts and a quarter physical violence. The survey of 13 to 17-year-

olds found that nearly nine out of ten girls had been in an intimate relationship, of these one in six said they had been pressured into sexual intercourse and one in sixteen said they had been raped. Others had been pressured or forced to kiss or sexually touch.

2.3 Overall Devon is doing relatively well when compared to the national picture. Since 1998, the teenage pregnancy rate in Devon has shown a slight decrease. Devon's under-18 conception rate was 32.5 per 1000, meaning there has been an overall reduction since the 1998 baseline of 1.4% (compared with 9% for the period 1998-2006). In 2007, there were 440 under-18 conceptions in Devon, 50% of which led to an abortion. The progress achieved masks noticeable variations in local areas. There are some areas with higher than average rates, notably Exeter. Out of the 20 wards across Devon with the highest numbers and rates of teenage conceptions, over the time period 2004-2006, six of these are in Exeter. There is a distinct correlation between teenage pregnancy and the wards of highest deprivation. The lowest rates in Devon are to be found in South Hams, West Devon and Mid Devon.

2.4 Devon's Children's Trust has mandated a Teenage Pregnancy and Young People's Sexual Health Partnership Board, in recognition of the cross cutting issues relating to teenage pregnancy and young people's sexual health. The Board's task is to provide the infrastructure to support partnership working that is focused on the reduction of teenage pregnancy and improvement in young people's sexual health, and to oversee the commissioning and assist in the development and piloting of those targeted projects.

2.5 In 2008, an independent national review of SRE was undertaken. During the review process, more than 1700 young people were interviewed by the Sex Education Forum to gain their views about the quality of SRE provided in schools. This consultation resulted in the production of the Sex Education Forum's 'Charter for Change' document. As a result of this review, Government declared that SRE would become statutory with effect from September 2010.

The independent review identified the following recommendations:

- Position of SRE/ personal, social and health education PSHE within the curriculum
- Improving the skills and confidence of those who deliver PSHE
- Encouraging the use of external contributors to support schools' delivery of SRE
- Further guidance and support for schools on SRE
- Involving young people in the design of SRE programmes
- Maximising the impact of wider Government programmes on improving SRE delivery
- Improving leadership on SRE

2.6 The Devon Teenage Pregnancy and Young People's Sexual Health Action Plan was published in September 2008 and revised following the National Support Team (Teenage Pregnancy) visit in November 2008. The current plan has five objectives, reflecting Devon's priorities:

1. *To develop and implement a data action plan to ensure a full understanding of the nature of teenage pregnancy to ensure robust engagement and effective commissioning.*

2. *To develop and implement a media and communications plan with an emphasis on both internal and external stakeholders, including young people and their parents and ensure that partners across the Children's Trust understand the importance of teenage pregnancy, know their role and implement their responsibilities.*

3. *To develop and implement a joint Young People's Contraceptive and Sexual Health commissioning plan to ensure universal and targeted provision which is performance managed through the Teenage Pregnancy Partnership Board.*

4. *To develop and implement, in partnership with young people, a Devon wide approach to universal and targeted Sex and Relationships Education provision.*

5. *To develop* specific, *preventative interventions to meet the needs of a range of vulnerable groups.*

3.0 Recommendations

The Task Group's recommendations have been drawn up using the evidence obtained from contributors and background material.

3.1 Sexual Health Service Provision (NHS Devon)

Recommendation 1

That the LA work closely with NHS Devon under the aegis of the Children's Trust to pool sexual health budgets and adopt an inclusive and planned approach to the provision of sexual health services in the County.

Rationale

It is imperative that there is a more coordinated approach between the LA and NHS Devon to young people's sexual health and teenage pregnancy services. At present, there are delays in providing services because of debate surrounding budget lines. There is a very limited dedicated budget for the provision of teenage pregnancy services. There could in many instances be scope for budgets to be pooled so that agencies can work together to tackle these issues.

Recommendation 2

(a) That the provision and siting of sexual health services in the County be reviewed.

(b) That the implementation and overall effectiveness of the C-Card be reviewed with immediate effect.

Rationale

Easy access to contraception has been found to be the single most important factor in reducing teenage pregnancy rates, with access to condoms a key to a reduction in the transmission of STIs. The location of some sexual health services in the County, in particular GUM clinics, may currently put off young people from getting contraception and advice where they feel there is a lack of anonymity in their attending.

The Task Group is also concerned that rather than encourage easier access to condoms, the C-Card may in fact make it more difficult. Members are not convinced young men will use the C-Card scheme, and by doing so come into contact with a range of professionals who can provide advice, interventions and directions to other services. It is questionable how many teenage boys would have the confidence to talk in detail to an adult about their contraceptive needs.

Recommendation 3

That NHS Devon provides a school nurse for each of the 31 learning communities in Devon.

Rationale

The Task Group is concerned about the significant reduction in the number of school nurses. There are only 25 full time equivalents, some of whom have caseload numbers of approximately 5,000-6,000 children. This reduction in school nurses means their subsequent reduced involvement in providing sexual health services such as drop-ins as well as offering an additional source of SRE in schools in the County.

Recommendation 4 **That NHS Devon review its sexual health campaigns, giving stronger emphasis to all forms of STIs, not solely focus on Chlamydia.**

Rationale

STIs in Devon are not decreasing, nor are they nationally. According to young people who contributed to the review pregnancy is the number one concern among those who do have unprotected sex, ahead of any fear of STIs. There appears to be a lack of understanding of the risks of having sex without a condom, particularly when using hormonal contraception. Young people who contributed to the review felt that the volume of information on Chlamydia does highlight the risk of STIs, but it also gives a mixed message about STIs that with treatment they will go away rather than emphasise the potentially very serious long-term consequences. The Task Group expressed concern that HIV awareness is not focussed on enough in sexual health campaigns in Devon.

3.2 Local Authority/Schools

Recommendation 5 **That a programme of Apause be reinstated as soon as possible in secondary schools in the County.**

Rationale:

Members expressed concern at the lack of a coherent rationale in NHS Devon's decision to remove Apause funding, as a direct result of which there are young people in Devon not currently receiving adequately organised SRE. Apause should be offered as a complementary programme to augment the work of schools trained PSHE teachers and school nurses. The Task Group recognised that Apause is an internationally acclaimed programme which can evidence positive and statistically significant changes in health behaviours in young people – notably the delay of first intercourse and improved use of contraception. Apause's peer education element appears to be a particularly significant aspect of the programme, where young people are taught SRE by someone relatively close to them in age.

Recommendation 6 **That the County Adviser for Personal, Social, Health Education and Citizenship provide a detailed report on measures to improve the quality of SRE provision in the County, extending existing good practice in both the primary and secondary sectors to all schools in Devon. That good practice should include a recommendation to primary schools to begin SRE at Key Stage 2 and that SRE programs be coordinated through the transition from primary to secondary school to continue throughout Key Stage 3 and 4.**

Rationale

There are significant discrepancies in the provision of SRE in Devon schools, with the secondary sector causing serious concern. Measures are needed to improve the overall quality of SRE in Devon, with appropriate investment in management and leadership. There also appears to be a gap in terms of SRE in the transition from primary to secondary school, which urgently needs to be addressed. A number of professionals highlighted the need for SRE at an earlier stage in primary schools, working with younger children and making earlier interventions Evidence from countries such as the

Netherlands emphasises the benefit of starting an SRE programme from an early stage. Parents do also need to be helped and supported in providing SRE to their children.

Recommendation 7 **That secondary schools have trained teams of PSHE teachers providing SRE.**

Rationale

Some excellent work is being undertaken in schools in Devon, however across the County there is a need to improve the skills and confidence of those who deliver SRE. It is vital that it is delivered by trained, confident teachers who most importantly want to teach the subject. It is crucial to have trained teams of PSHE teachers, rather than the approach that some secondary schools have adopted, where form teachers provide SRE.

Recommendation 8 **That the LA produces guidelines for secondary School Governors on the provision of sexual health services within the secondary school sector, and for all School Governors on SRE provision.**

Rationale

Training should be provided to Governors on their responsibilities in ensuring a school's effective and comprehensive SRE programme. It is important Governors understand the SRE programme their school should be providing at each given year and robustly ensure that it is adhered to. Governors should also have a central role in liaising with parents, and be able to advocate their school's SRE commitment. They can also be vital in ensuring that sexual health services are provided within secondary schools.

Recommendation 9 **That any child with a social worker, or who is persistently not attending school be provided with SRE from an appropriately qualified person of the same sex.**

Rationale

Children in Care are in many cases not regularly attending school, and there is concern that some of the most vulnerable young people in the County may miss SRE altogether. There of course needs to be universal SRE provision but also targeted provision through the relevant professionals, for those young people most at risk of missing SRE altogether.

Recommendation 10 **That Devon Youth Parliament be invited to consider and make representations to CYPS Scrutiny on how to engage boys and young men in education, and in a wider social sense.**

Rationale

The Task Group is concerned that not enough attention is given to the responsibilities of boys and young men in sexual relationships.

A crucial element of reducing teenage pregnancies and STI levels has to be in raising young men's aspiration and engendering a sense of responsibility and consequence for their actions. Members want to utilise the Youth Parliament's skills and experience, asking for their ideas in this most difficult and complex of areas.

4.0 Summary

4.1 Sexual health and teenage pregnancy are complex issues requiring a multi agency response, with clear, strong messages conveyed by all partners. The problem cannot be looked at without considering its links to culture, aspiration, education and deprivation. Key is to switch young people onto education and learning; if young people are aspirational then there is a much lower chance of them becoming a teenage parent. Work is needed, to challenge assumptions about teenage pregnancies being acceptable and allow young people to make a positive and informed choice about postponing pregnancy and motherhood. It is impossible for schools to stop young girls from having babies, but by engaging with young people in a proactive way, while promoting positive sexual health, secondary schools can have an influence from a pastoral perspective. Evidence indicates that the standard of SRE taught in the County is in some cases extremely good, however there are significant discrepancies in the quality of provision offered across the County in both the primary and secondary sectors that need to be addressed.

4.2 Members are concerned that the Teenage Pregnancy and Young People's Sexual Health Action Plan focuses too much on a health perspective. There should be more attention to promoting educational aspiration. All agencies need to convey clearly the message that teenage pregnancy is strongly linked with poor outcomes for teenage mothers, young fathers and their children. Teenage pregnancy reduction is much broader than looking at individual cases of conception; it is about establishing a common direction in wanting something better for young people. This will mean a challenge to the acceptability of teenage pregnancy in some communities in Devon whilst continuing to provide advocacy and support for individuals as appropriate.

4.3 Easy access to contraception and sexual health services is the single most important factor in the reduction of teenage pregnancy and STIs. Ease of access to condoms for young people is crucial, and the Task Group is concerned that the C-Card initiative may make it more difficult. Young people in Devon do also seem to be receiving something of a mixed message about safe sex. The focus in the County is very much on preventing teenage pregnancy, and the use of hormonal contraception does not protect from STIs. There appears to be an alarming lack of awareness of the risk of contracting STIs. The extensive work promoting the risk of Chlamydia does appear to be to the detriment of educating young people about other more serious STIs and may in fact distract young people from the fact that many cannot be easily treated.

5.0 Current Position

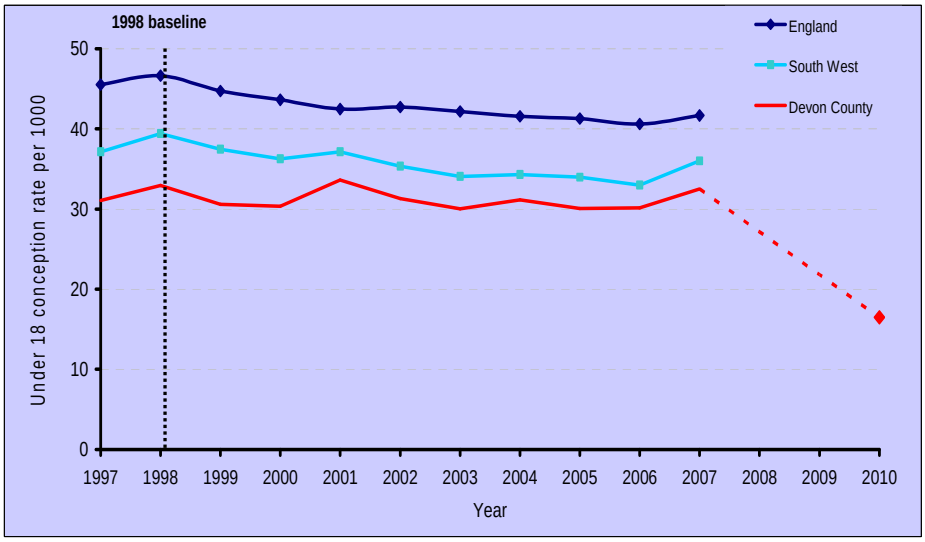
5.1 <u>Teenage Conceptions</u>

There is a significant problem in the UK with teenage pregnancies, which have serious health and welfare implications for both mother and child. Devon overall is below the national and south west teenage pregnancy rates; there are some deprived areas of the county which are well above. Half of under 18 conceptions occur in the 20% most deprived wards. The infant mortality rate for babies born to teenage mothers is 60% higher than for those born to older mothers. Figure 1 below shows the progress Devon is making towards the national target to reduce the under 18 conception rate by 50% by 2010. District data is shown in Figure 2.

Figure 1: Under 18 conception rates per 1000 15-17 years olds

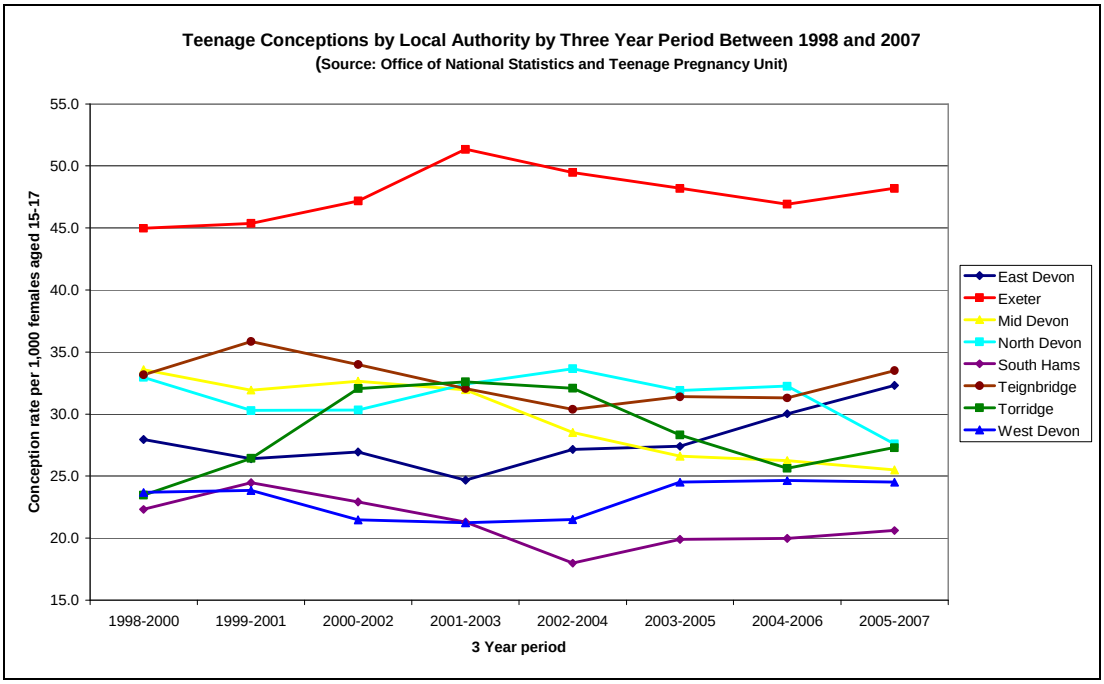
	Under 18 conception rates											Trajectory to meet target		
	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Devon County	31.1	32.9	30.6	30.4	33.6	31.3	30.0	31.1	30.1	30.1	32.5	27.2	21.8	16.5
% change in rate		*0%*	*-7%*	*-8%*	*2%*	*-5%*	*-9%*	*-5.5%*	*-8.7%*	*-8.5%*	*-1%*	*-18%*	*-34%*	***-50%***
South West	37.1	39.4	37.5	36.3	37.1	35.3	34.1	34.3	34.0	33.0	36.0	-	-	-
England	45.5	46.6	44.8	43.6	42.5	42.7	42.2	41.6	41.3	40.6	41.7	35.6	29.4	23.3
% change in rate		*0%*	*-4%*	*-6%*	*-9%*	*-8%*	*-10%*	*-11%*	*-11%*	*-13%*	*-11%*	*-24%*	*-37%*	***-50%***

Fig. 1



Source: Teenage Pregnancy Unit, Feb 2008. (Data for 2007 are provisional)

Figure 2: Under-18 conception rates per 1000 15-17 year old females for District Councils in Devon



5.2 Sexually Transmitted Infections

STIs in Devon, like elsewhere in the UK, are increasing overall. Young people experience higher rates of infection because they are more sexually active, more likely to partake in risky behaviours and may be more susceptible to infection. Chlamydia in particular is on the increase, and remains the most commonly diagnosed STI in the UK, in part due to the introduction of the national screening programme. Substantial and increasing numbers of Chlamydia diagnoses are made in community settings outside of GUM (genito-urinary medicine) clinics, associated with improved access to testing. In 2008, there were over 200,000 Chlamydia diagnoses reported in the UK. Although according to the Health

Protection Agency in 2008, new diagnoses of gonorrhoea and syphilis in UK GUM clinics appeared to be in decline or stabilising, syphilis numbers are still much higher than 10 years ago. Over the same period, new diagnoses of genital herpes and genital warts continued to rise.

NHS Devon reported that in Devon their targets on a maximum 48-hour wait for being offered GUM appointments are being 100% met. This is a major improvement, as 5 or 6 years ago the wait in some areas was 6 weeks. Under 25s represent around of 50% of service users of GUM clinics. It was reported to the Task Group that the reduction in GUM waits to 48 hours will, from a public health perspective, help reduce STIs.

GUM diagnoses of Gonorrhoea annual comparison

PCT	GUM Clinic	2006	2007	2008
Devon	Exeter GUM clinic	53	28	36
Devon	North Devon District General Hospital	25	16	34

GUM diagnoses of Chlamydia annual comparison

PCT	GUM Clinic	2006	2007	2008
Devon	Exeter GUM clinic	359	456	674
Devon	North Devon District General Hospital	224	250	547

GUM diagnoses of infectious Syphilis annual comparison

PCT	GUM Clinic	2006	2007	2008
Devon	Exeter GUM clinic	10	15	15
Devon	North Devon District General Hospital	*	*	*

5.3 Budget

2 years of funding, at £148,750 in Year 1 and £111,60 in Year 2 has been secured by NHS Devon from the NHS South West Strategic Health Authority to improve access to contraception services across Devon for all ages. This is allocated to:

- Devon Provider Services to develop an outreach service in Tiverton, and to train GPs in Long Acting Reversible Contraception (Year 1 - £50,000; Year 2 - £35,192)
- North Devon Health Care Trust to develop contraception services, which include support to services for young people (Year 1 - £63,750; Year 2 - £51,700)
- NHS Devon to support workforce development training on sexual health and relationship issues, which is administered through the auspices of the Teenage Pregnancy Board (£20,000 per annum)
- Branding (Year 1 - £15,000; Year 2 - £4,000) (commissioning developed under Teenage Pregnancy and Young Person's Sexual Health Board Action Plan)

Elements of provision for young people's sexual health are included within the wider commissioning of sexual health services. This includes all universal provision accessed in community sexual health clinics, which many young people use regularly. The differentiation comes when there is a specific or enhanced services for young people that requires additional attention and is not available to the general population. It is these specific elements that are funded (though not exclusively) through the Area Based Grant. The work of the Children's Trust Devon Teenage Pregnancy and Young People's Sexual Health Partnership Board is funded through an Area Based Grant set at £169,000 for both 2009/10 and 2010/11.

NHS Devon commissions £84,699 dedicated Young People's Sexual Health Service support through Health Promotion Devon (Devon Provider Service). Additionally, the NHS provides Public Health Nursing services, of which a proportion is directed to supporting children and young people's sexual health. Devon hosts the employment of the partnership Teenage Pregnancy Coordinators, and also dedicates senior

management leadership time and administrative support to both Teenage Pregnancy and Sexual Health and You're Welcome, the Department of Health's criteria for making health services 'young people friendly.'

6.0 Findings

Sex and Relationship Education

6.1 Provision of SRE in schools (Recommendation 3, 5, 6, 7, 8, 9)

SRE is a continuing and developmental process, which allows children and young people to make positive choices about relationships. SRE is about:

- Providing information that is relevant and appropriate to the age and developmental stage of the children;
- Developing personal skills of assertiveness, communication and effective dialogue in relationships;
- Encouraging the exploration and clarification of values and attitudes;
- Fostering self esteem, positive self-image and confidence.

A training programme is provided for schools, covering:

- County wide SRE CPD for teachers and governors in all phases
- School based and Learning Community SRE CPD
- SRE awareness sessions for parents/carers
- Involving young people in the design of schools' SRE programmes
- 'Health for Life' framework
- HEADON resources

The Task Group received evidence to indicate that there are significant gaps in SRE provision across the County, with reports that some schools may not have the staff to deliver an effective programme. A number of representations were made about the lack of SRE in Years 6 to 9, with some schools reported to be offering a very limited and in some cases virtually non-existent provision. It is beneficial to have trained teams of PSHE teachers, rather than the approach that some secondary schools have adopted with form teachers providing SRE. There are concerns where schools are being encouraged to identify volunteers to undertake SRE training and these teachers then have to have space in their timetables allocated and freed up to allow for SRE teaching. SRE needs to be properly timetabled. Concern was raised about whether school programmes have an effect on changing types of behaviour, because it is difficult to get enough trained teachers. Schools are judged on academic results and indicators such as exclusions, not on SRE. It is therefore not an area in which schools always recognise the need to invest staff resources.

The emphasis of SRE needs to be on teaching young people about equality and respect. Respect for each other and for themselves is crucial to tackling issues relating to sexual health. Some witnesses felt that SRE focuses more on the 'mechanics' of having a baby and not enough on self esteem, and relationships. The introduction of SEAL has certainly helped give young people a chance to develop the underlying attitudes and behaviours to help them form and maintain positive relationships. SRE should be developed through a whole school approach involving governors, parents, teachers, children and young people. Schools should be encouraged to draw on support from external professionals and agencies to enhance their delivery of SRE. It is vital that teachers have the appropriate skills to deliver it. Partners are encouraged to work with staff in schools to assist them to deliver quality SRE. The headteacher's role in SRE and leading on the provision of sexual health services in schools is extremely important. Training courses are provided for heads, senior management team and governors.

In a generic session, it is not always easy to engage teenage boys in SRE, however it is certainly the case that boys do engage with visual materials — photos of various STIs for instance. The Task Group received some representations to suggest that young people benefit from a more direct approach in terms of the use of language, imagery and overall way in which they receive SRE.

6.2 SRE in Primary Schools (Recommendation 6, 8, 9)

Evidence from young people contributing to this review suggested a limited SRE provision in the Devon primary sector. A number of professionals highlighted the need for SRE at an earlier stage in primary schools, working with younger children and making earlier interventions. It was felt by some of the young contributors that a moderate SRE programme starting as early as Year 3 would be helpful as children are at a receptive age. Primary and secondary schools should provide joined up SRE in order to get a better consistency of approach, and to manage more effectively the transition from primary to secondary SRE.

It was highlighted to the Task Group that sexual health cannot be separated from wider lifestyle, health and well being. The key is emotional well being and resilience and this needs to start in education at the earliest opportunity, in the primary schools. The problems of STIs and increased incidence of teenage pregnancy are multifaceted and cannot be easily narrowed down. The focus however should be on encouraging a young person's emotional intelligence; this should be the central thread running through their education.

6.3 SRE Provision for young people not in school (Recommendation 9)

Often the young people most at risk are not attending school regularly, or when they are they may not be keen to listen and take part; some have very chaotic lives. It is not apparent that schools follow up SRE sessions for those who have truanted or have for some reason missed school. Those very vulnerable young people in Link Education and PRUs need to be targeted as do those who are out of the school system whether through exclusion or home education, or those ostensibly in the school system but truanting. These groups may miss SRE altogether.

6.4 Apause (Recommendation 5)

The Health Behaviour Group is a charity providing resources for SRE for those aged 11-18 both in and out of mainstream education. Their best known programme is Apause (Added power and understanding in sex education) which is teacher and peer delivered in secondary schools with the option of support from health professionals. Apause was initially funded through Department of Health/local health money, and the programmes were developed using rigorous academic methods and evaluation. Apause has been included in an international study of all SRE programmes that achieved sufficient rigour in programme evaluation. Of the 83 programmes included, Apause was the only study in the UK to show positive and statistically significant changes in health behaviours – notably the delay of first intercourse and improved use of contraception.

A number of witnesses to the review expressed concern about the cancellation of Apause funding by NHS Devon, at a time when teenage pregnancy rates were rising, without any real warning, or obvious justification. In 2008/09 Devon schools received a total of £96,706 from NHS Devon to deliver Apause. Headteachers received a letter on 8 December 2008 advising that NHS Devon was no longer able to fund the programme with immediate effect (from January 2009). It was felt that cessation caused significant damage to schools' sexual health programmes. Witnesses expressed disappointment that a programme developed locally, known internationally and of proven benefit could be dropped without evidence to support such a major change of direction. The Headteacher at Holsworthy advised that Apause provided the school with a successful SRE scheme and the older peer element from North Devon College worked particularly well. Apause had provided a unified approach, now all schools had to undertake different SRE programmes. It was still offered to schools directly and 7 in Devon have found enough money to fund it in their own right.

6.5 School Nurses (Recommendation 3)

School nurses were recognised as an essential part of delivering SRE. They have relationships with children and their families which are crucial for early intervention and dealing with problems before they escalate. There are 25 full-time equivalent school nurses and 9 staff nurses in Devon — a significant decrease in numbers over the last 15 years. This reduction, and the increase in their targeted work with vulnerable children, is a cause for concern both locally and nationally. School nurses are now rarely based in schools and accordingly there has been loss of access to the service for children, young people, parents and teachers. If nurses are not based in schools, it is very difficult for them to have any significant role in SRE.

A recent survey of Devon school nurses (September 2009) identified that they spend between 40% and 60% of their time with children with safeguarding plans, between 20% and 40% with other children who are vulnerable and approximately 10% with those who are in care. There are approximately 160 school-age children with safeguarding plans and 400 school-aged children in care. There are also approximately 2500 young people per year who have had contact with CYPS but who do not have social work involvement. For many school nurses there is currently little scope to do any other work other than safeguarding and targeted work with vulnerable children. They often have too many of these 'at risk' children to make adequate intervention. Caseload numbers in some, but by no means all, areas of northern and eastern Devon localities are as recommended by Government guidelines but are much higher in most clusters in the southern locality. Generally, a whole-time equivalent school nurse in the southern locality will have a caseload of approximately 5,000-6,000 children. There is a named nurse for each school, although some have responsibility for more than 30 schools.

6.6 Parents

The Government has set out its intention to legislate to make PSHE education a statutory subject within the National Curriculum in key stages 1-4. There would continue to be a right for parents to withdraw their children from SRE, but that would no longer apply when a child attained the age of 15 (at present the right of withdrawal applies to all school pupils up to the age of 19). Currently parents have the right to withdraw a child from aspects of SRE that are not part of the national curriculum. While there is undoubtedly, an issue of parents removing children from SRE in schools, there is not necessarily a correlation between teenage pregnancy and a child being removed from SRE. There is a need to support parents to give them the knowledge to initiate conversations with young people about SRE. Much of a young person's learning about relationships comes from role modelling.

Access to Contraception

6.7 Access to Condoms (Recommendation 2)

The Department of Health initiative Your Welcome quality criteria set out principles that help health services become 'young people friendly', which is significant in terms of access to services. Easy access to contraceptive services has been found to be the single most important factor in reducing teenage conception rates. Access and availability to free condoms is one of the key factors in the prevention of STIs and teenage pregnancy. In consultation exercises in relation to the development of the Devon Young People's Sexual Health Strategy, one of the issues raised by young people was concern as to where to access free condoms and sexual health advisory services.

C-Card scheme allows for the supply and distribution of free condoms to young people aged 13-25 in Devon. As with the current distribution system a young person can go to youth workers or school nurses to get their condoms, and a number of other outlets are also now available, such as Connexions NHS Devon reported that they anticipate the C-Card will improve access to free condoms among young people who find it difficult or lack the confidence to approach a clinical setting. This is based on experience from other Local Authority areas which have introduced C-Card schemes and found that they increase access to condoms, sexual health advice and signposting to local specialist services for young people. The implementation of the Devon wide C-Card condom

distribution scheme is particularly looking to engage boys and young men. NHS Devon advised that the C-Card scheme also enables better reporting and monitoring of uptake, for example in target groups and areas. The C-Card has a built-in registration process with approximately 20 minute interview and discussion which provides an important opportunity for the worker to engage with the young person about being ready for sex and how to use a condom. The C-Card can have up to 10 tick boxes to be filled in each time the young person accessed condoms with the card, after the boxes are completed, the young person can get a new card.

Some professionals however expressed concern about the implementation of the C-Card scheme. The C-Card is reasonable for those young people who are responsible, but the process that the C-Card necessitates may put some young people off from accessing condoms.

6.8 Long-Term Contraceptive Methods

Information and consultations about the range of contraceptive options available are offered in a variety of settings in Devon, including many schools. Supply of Emergency Hormonal Contraception (EHC) is not a panacea for teenage pregnancy prevention. In addition to regular condom use, it is important to promote the long-term contraceptive methods (hormonal contraception) for those young people in consensual relationships. The prescription or supply of EHC or any other method of contraception to under-16s is subject to assessment by a professional that the young person is competent to make an informed choice. Those under 16 will be encouraged to speak to their parents or another adult if appropriate. Teenage pregnancy and sexual health appear at times to be being addressed in isolation from one another which is alarming.

There has been an issue with FE colleges having nurses who are not employed by NHS Devon and cannot prescribe EHC. However, nurses have been able to get around this by having contracts working for the PCT. Members expressed concern that there was an outstanding issue at Exeter College where the nurse was still not able to provide EHC. This was however resolved following the Task Group's interim recommendation to the September 2009 CYPS Scrutiny meeting:

That CYPS, working alongside Devon PCT, address as a matter of urgency the anomaly in service provision in the County that currently prevents nurses at Exeter College from being able to prescribe emergency hormonal contraception.

6.9 School Based Sexual Health Services (Recommendation 2 and 3)

Following the November 2008 visit to Devon by the Government's National Support Team for Teenage Pregnancy, recommendations for action included the need to develop a universal level sexual health service in secondary schools. Secondary schools in Devon are assessed in terms of need and their level of service provision is determined accordingly. School-based sexual health services are generally run by the school nurse, and provide confidential, one-to-one advice for young people, encouraging them to look after their own health. School drop-ins in some areas are also supported by the Youth Service. Often these drop-ins provide level one sexual health services (sexual health advice, condoms, pregnancy testing and Chlamydia screening). Evidence received by the Task Group suggested that young people felt that sexual health clinics in schools, alongside counselling services, are helpful although there are some concerns about anonymity and confidentiality.

The Healthy Youth Programme looks at SRE in terms of data and targeting work at Christmas and at the start of the summer holidays, when there is the highest incidence of conception, which although this may be in part be to do with the increased use of alcohol during this time, may also be affected by access to condoms in school holidays, if a school is a young person's main source.

6.10 Walk-in-Centre / Sexual Health Clinics (Recommendation 2)

High quality sexual health services are needed across the County and these must be well promoted if they are to be used. Anonymity and confidentiality are important factors

if young people are to use sexual health services, and evidence indicates that they become increasingly difficult out of Exeter, in more rural areas. Young people reported that the Exeter walk-in-centre in was an important place for young people to go to about sexual health. The anonymity of attending that particular centre is significant. Young people advised that they did not feel comfortable going into a GUM clinic or sexual health centre where they might be seen by family or friends.

Agencies

6.11 NHS Devon (Recommendation 1, 2, 3, 4, 5)

NHS Devon reports that it is moving towards a more consistent, standardised delivery of sexual health services in the County. As there were different service providers operating across Devon under the former six PCT arrangement, historical differences in provision persist as sexual health services develop and augment. NHS Devon advised that they will not be looking to stop a service that is working well, simply for the sake of unification. Recognition will be given to schools, GPs or youth centres who may have been developing excellent services within a locality. The strategy's emphasis is on providing much more integrated services across Devon, offering as many opportunities as possible for young people to get services.

Amid current financial restraints, NHS Devon recognised the challenge to establish which services should be universally provided in the County and which should be commissioned over and above that to address specific areas of need. It is utilising a local monitoring dataset to identify areas with high rates and numbers of teenage pregnancies and inform targeted local commissioning of services.

The services NHS Devon provides for teenage pregnancy and sexual health are largely clinical and therefore mainly at the point of intervention. NHS Devon raised concern about whether by producing one strategy, *Devon Young People's Sexual Health Strategy 2008–2012*; the focus was too clinical and medical. It is vital that the social and educational strategies are not ignored in terms of sexual health.

There are issues as to whether the NHS should be supporting curriculum development in terms of SRE. NHS Devon advised that its role was about funding sexual health services, although the NHS does still have a role to play in schools through supporting school nurses. SRE is part of the curriculum and therefore an education issue. NHS Devon advised that SRE work within a school needs to be continuous, with staff on site to provide advice as necessary, answer follow up questions etc.

6.12 Youth Service

Devon Youth Service frequently works with young people outside mainstream education providing SRE, and may in many cases be responsible for these young people's only SRE. Programs are carried out in youth work settings and through drop-ins run by youth workers. The Youth Service has staff trained to provide condoms, as well as pregnancy and Chlamydia tests. If there is not a trained member of staff on site then youth workers will refer a young person to a local clinic. The Youth Service also has a programme of SRE workshops that they can provide schools and other youth settings with on request, tailored according to the needs of the young people.

The Youth Service runs groups for young mothers and fathers. These group sessions provide welfare information in terms of SRE. The groups also play an important role in ensuring these young parents are made aware of how they can access opportunities in terms of education, training and employment so that they can move their lives forward in a positive way. These sessions are also about challenging the young person concerned to help them to realise their potential. The groups are set up when it is felt that they are needed following liaison with social care and health services.

6.13 Connexions

Connexions advisers offer help and support to teenage mothers. It also has a dedicated member of staff who devotes 3 days a week to working with teenage mothers, and

advising on relationships and sexual health. Connexions staff give sexual health training to groups of young people on the Activity Agreement programme, which covers contraception.

Connexions concentrates on encouraging young people to go back into education and therefore to raise their aspirations. Engagement in learning and work reduces the likelihood of teenage pregnancy and second pregnancies. There are some courses available in Devon to help this: 'Young Mums to Be' and 'Young Mums with Prospects' for instance. Often young mothers are quite isolated and meeting other young mothers is attractive for them. The aim nationally is to have, by 2010, 60% of teenage mothers in education, employment or training. Currently about 16% of teenage mothers in North Devon, 19% in Exeter and 34% in Newton Abbot are in education, employment or training. In order to re-engage teenage parents in education or work, specialist childcare provision and clear pathways back into education are needed. There is some good practice run by Family Education Development Trust, but it is short term money that is not sustained, and therefore difficult to match provision to need.

6.14 Devon Drug and Alcohol Action Team

A considerable number of teenage pregnancies coincide with areas exhibiting high substance and alcohol misuse levels. In Devon, the issues relate primarily to alcohol and cannabis, as there are few teenagers presenting with a dependency on Class A drugs. The Devon Drug and Alcohol Action Team (DDAAT) have 14 staff across the County, with their main bases in Newton Abbot, Tavistock, Barnstaple and Okehampton. The DDAAT undertake targeted prevention work with the most vulnerable young people about substance misuse, operating in PRUs and social inclusion units within schools. The substance misuse training package includes alcohol and sexual health. Schools have differing approaches. Some claim not to have any problems with alcohol or substance misuse, while in others there are parents who do not seem to want to have problems highlighted and addressed. There are yet other schools which welcome DDAAT's involvement. There are obvious links between alcohol and teenage pregnancies, although it seems to have taken a while for a similar link with substance misuse to be properly recognised.

Targeted Intervention

6.15 Sexually Transmitted Infections (Recommendation 1, 2, 4)

NHS Devon reported that they commission The Eddystone Trust and Positive Action South West to undertake numerous targeted HIV and AIDS health promotion campaigns and events. They also commission a full time, outreach worker to address lesbian gay and bisexual sexual health. However the Task Group expressed concern that there does not seem to be a clear enough countywide message about safe sex and HIV prevention, with awareness of HIV much lower than it was. It may be that the message about safe sex being sex with a condom is not as apparent as it was, when in the late 1980s and 1990s there was a greater fear of STIs and HIV in particular. There is considerable emphasis on Chlamydia with its increasing incidence (the Chlamydia Screening Programme is a National directive that all PCTs are required to adhere to), but much less information provided on HIV. The Task Group was told that young people, certainly in the Exeter area, do not seem concerned by HIV which is seen as something that they are not at genuine risk of contracting.

6.16 Aspiration (Recommendation 10)

A crucial element in the reduction of teenage pregnancies is in raising young people's aspirations. Early motherhood is often a natural progression and an attainable ambition or a status symbol, for young women in some communities – this is often generational. Teenage parents told the Task Group that young women get pregnant for the following reasons:

- to have something to love, an emotional attachment, a source of love and attention they may not have had in their own childhood;

- Lack of ambition; nothing to do in their lives and therefore nothing to lose by having a baby;
- boredom;
- fashion; if everyone else has a baby then others may want to start following suit, as they may feel jealous about not having a baby and want to copy their friends;
- to prevent a relationship breakdown;
- to create a new relationship;
- to raise a child well;
- a focus in life;
- housing needs.

A range of agencies needs to be available to pick up vulnerable young women, and provide advice on other options available to them, through services such as Connexions, rather than decide that they want to have a baby. Confidence and self-worth are extremely important factors, with young women from certain socio-economic groups needing to be more assertive and higher achieving. A message needs to be conveyed to young people about the impact of having a child and the profound effect this will have on their life chances. There is a cycle in the families of teenage parents, of having children at such a young age which needs to be broken, and raising aspiration is central to achieving this.

There is however also a small group of young people who, after they have had a baby, become more focussed on getting on with their lives and improving their education, attainment and general life chances. The Task Group received evidence from some young parents who had tried to turn their lives around since having their babies. One advised that having her child was the catalyst to getting her qualifications and wanting a career. She has now retaken her GCSEs, and wants to go to college to make a better life for herself and her daughter.

6.17 Young Men (Recommendation 10)

It was reported to the Task Group that there is not enough resource targeted at teenage boys and their responsibilities. There is a certain grouping of young men with very low aspirations, often lacking any kind of positive role model in their life, who may not be doing well at school or be unemployed, to whom fathering children is a certain way of asserting themselves. Often it is the same male who has fathered children with a number of teenage girls. Some young men have no understanding about contraception or STIs at all, while others make a conscious decision not to use condoms.

Witnesses to the review reported that girls are susceptible to being manipulated by their boyfriends, with a particular higher risk factor being those girls with older partners, and these men may pressure a girl into having unprotected sex. In the NSPCC and University of Bristol study, *Partner Exploitation and Violence in Teenage Intimate Relationships* it is claimed that a third of teenage girls in a relationship suffer unwanted sexual acts and a quarter physical violence, with one in six girls being pressured into sexual intercourse.

6.18 Children in Care (Recommendation 9)

Children in Care will often have many problems and may not regularly attend school. Consideration needs to be given as to how they are provided with SRE. The issue was raised to the Task Group that if a girl in care has a male social worker it is unlikely that she will want to speak to him about sexual health, and may miss SRE entirely.

6.19 Teenage Parents (Recommendation 1, 2)

The Youth Service runs groups for young parents. These sessions provide welfare information in terms of health and safety. The groups also play an important role in ensuring young parents are made aware of how they can use opportunities for education, training and employment so that they can move their lives forward positively. These

sessions are also about challenging the individual concerned to help them to realise their potential. The sense of identity and self-worth of young people is greatly enhanced when they are involved in positive activities and interests. Young parents can however be a difficult group to engage; often the young people feel that they have an existing support network and do not need to be in such a group, which may in some way feel intimidating.

6.20 Peer Education (Recommendation 5, 6)

It is helpful for young people to be taught about sex by someone young and relatively close to them in age, as it is easier for them to engage (see *Apause* p.14). There is also scope for young mothers to go into schools and speak about the reality of having a baby as a teenager. Virtual babies are a good way of trying to give a young person an understanding of the reality of child care, as well but it is extremely advantageous to have young parents speak to groups of young people about the reality of becoming a teenage parent. A project is being set up by a teenage mother through Young Commissioners working with teenagers about the reality of having a baby. Workshops intend to give the young people concerned an idea about what day to day life with a baby is like. *Here by Right* is also a project from NHS Devon on the realities of being a teenage parent for young people aged 14–20, although they can on occasion be younger, typically with support from a school nurse.

6.21 Assertiveness Skills (Recommendation 6)

Assertiveness is very important. It is vital that young people develop their capacity to assert themselves and be able to say no, and that children from the earliest school age are taught in their own language about appropriate touching and the right to stop anyone from invading their personal space. At the age of 8 or 9 this is extended to include mention of sexual abuse, advising children to speak to a school nurse or teacher if they have any concerns. Children and young people need to be given the options and opportunities of exit routes.

6.22 Underage Sex

Officers advised that although the media may suggest that more children are having underage sex, evidence indicates that the average age is still 16/17. Delay messages about sex do have an important role to play, as do information campaigns highlighting the consequences of actions and risky sexual behaviour. The delay approach model for professionals working with young people centres on giving information about delaying sex and how some people, particularly girls, may regret having sex if they do not feel as though they are ready. Also, it conveys the idea to e that having had sex, there is no need nor should there be pressure exerted to continue having sex. It is however not an approach encouraging abstinence like that often deployed in America.

Other Issues

6.23 Information Transfer

There is an issue with schools and health practitioners working to different mandates for the passing on of information. This does place schools and headteachers in a difficult position where they are made aware for instance of a girl being prescribed hormonal contraception on implant and parents not knowing. There is a duty for the school to inform parents but this is something of a judgement call. There are issues for headteachers in having the confidence to act on information. If it is a child protection, or safeguarding issue then confidence cannot be maintained. Headteachers do feel that it would be helpful if guidelines were established to remove the grey areas and provide a more unified approach across the County. There are some schools that do feel they are unsupported and very much on their own and a strong policy statement would give governing bodies a clear context within which to operate.

6.24 Termination of Pregnancy

All abortions must take place in approved premises either automatically as in the NHS, or through a registration process as in non-state/private sector facilities. There is a

requirement that abortions are notified within 7 days to the Department of Health. It is unlikely that there are illegal abortion practices in Devon now. However, the Task Group is concerned by the disparity in abortion rates in the County. There is a significant variation in the number of teenage girls having terminations depending on where they live: in the South Hams 61% of teenage conceptions lead to abortion compared to only 38% in Exeter. Terminations tend to be lower in socially disadvantaged areas and Exeter does have more deprivation than the South Hams.

6.25 Vulnerable Adolescents (Recommendation 1)

It is imperative that everyone across the system working with young people has a role to play. That is why the Devon Teenage Pregnancy and Young People's Sexual Health Partnership Board is linked in with all key professional groups and settings; including strong links with the Vulnerable Adolescents Development Group. Every agency with a duty to co-operate, and participate in the Devon Children's Trust has a responsibility to contribute to improvement - the governance arrangements have been set up to achieve this.

6.26 Media

In the UK, there remains a lot of confusion about sex fuelled in many ways by the media, where the tabloid press will castigate teenage pregnancies, and on the next page have a semi-naked girl. Young people learn about sex from the media: there is a considerable amount of information on SRE available at all times of the day in soap operas, while children also have access to the internet through computers and also now with mobile phones. Many young people are accessing pornographic sites on the internet and research has shown that for some this is the way they are receiving their SRE.

6.27 Netherlands

The Dutch have the lowest teenage conception rate in Western Europe. As a nation in the 1980s, the Netherlands had a mature open discussion about their high level of teenage conceptions. As a result, the Dutch made the decision to educate children from an early age and bring SRE into primary schools from the age of 8. Another key part of the plan was to provide easy access to SRE for all young people and encourage discussion about sex as being part of a relationship. Also, ease of access to contraception was a factor, and it is still quite normal for children aged 12 to be carrying condoms. The Dutch also do not have the same separation of the genders in early adolescence as we often do in the UK. There is this sense of young people developing relationships with the opposite sex from early childhood that is perhaps slightly different again from what happens in the UK.

Vanessa Newcombe
Peter Bowden
Michael Lee
Saxon Spence
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Electoral Divisions: All
Executive Member: Councillor Andrea Davis (Cabinet Member for Children's Health and Well Being)

Local Government Act 1972 List of Background Papers		
Report originated by:	Dan Looker	
Room:	G.36	
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Background Paper	Date	File Reference
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Appendix 1:

Information from Chief Executive, SOS Global

SOS Global is a not for profit organisation aiming to educate and create behavioural change. The emphasis of SOS's work is in promoting positive decision making. SOS Global has been running workshops in schools in Exeter, and has gathered information from over 2000 young people.

1. 38% of students thought that they needed parental consent to go on the pill.
2. 5% of students obtain free condoms.
3. 73% know where to get tested for an STI.
4. 5% of students state that they have been tested.
5. 10% of students said that they had received information on STI's.
6. 40% of students stated that young people get pregnant intentionally to get council accommodation.
7. 93% of students state that they know what contraception is.
8. 41% say use a condom, 59% abstain from sex.
9. 88.2 % of students did not know they could get free condoms from walk-in-centres.
10. An increase on students views from 41.8% to 84.8% that alcohol misuse was the most important factor in the scenario.
11. 36% of students thought that an unwanted pregnancy was directly attributed to alcohol misuse.
12. 82.8% of young people did not know that they could access free condoms from NHS walk-in-centres.

Appendix 2:

Task Group Activities

A2.1 The first meeting of the Task Group took place on **27 July 2009**. The aim of this initial scoping meeting was to determine the focus for the investigation, gauge members' viewpoints and plan the next steps for the review. The session was attended by a Consultant in Public Health, Devon PCT, who provided background information to the Task Group.

A2.2 On **2 September 2009** the Task Group received evidence from the Head of Health Improvement, PCT; Teenage Pregnancy Co-ordinator, PCT; Cabinet Member for Children's Health and Well Being and the Assistant Director of Public Health.

A2.3 On **9** September **2009** the Task Group met with Exeter Area Manager, Connexions Cornwall & Devon; Head of Integrated Youth Support Service, CYPS and the Head of School Nursing, Devon PCT

A2.4 On **24 September 2009** the Task Group met with Manager, Devon Drug and Alcohol Action Team; Young Persons Plan Co-ordinator, Devon Drug and Alcohol Action Team; Adviser for Personal, Social, Health Education and Citizenship, CYPS; Executive Officer, Devon Association of Governors; Head of Health Policy, Devon PCT; Youth Worker, CYPS and the Devon Teenage Pregnancy Co-ordinator, Devon PCT.

A2.5 On **8 October 2009** the Task Group received evidence from Inclusion Development Officer, CYPS / Mother of a teenage parent; County Councillor for Ottery St Mary Rural and Young Persons Health Advisor, Devon PCT.

A2.6 On **2 December 2009** the Task Group met with Chief Executive, Health Behaviour Group and Apause; Trustee Health Behaviour Group / Chair of Governors for ISCA / Exeter 4 Learning Group; Director, SOS Global and Chair, DASH / Principal, Holsworthy Community College

A2.7 On **25 January 2010** the Task Group met with Youth Participation Worker (Children in Care) / Sophie and Charlotte, former Children in Care and teenage mothers and the Head of Commissioning and Procurement, CYPS.

A2.8 On **11 February 2010** the Task Group convened to discuss its findings and possible recommendations.

A2.9 On **16 February 2010** the Task Group met to further discuss its findings and recommendations.

Appendix 3:

Contributors / Representations to the Review

A3.1 Witnesses to the review (in the order that they appeared before the Task Group)

Witness	Position	Organisation
Sara Gibbs	Consultant in Public Health	NHS Devon
Becky Carmichael	Head of Health Improvement	NHS Devon
Julia Loveluck	Teenage Pregnancy Coordinator	NHS Devon
Councillor Andrea Davis	Cabinet Member for Children's Health and Well Being	DCC
Steve Brown	Assistant Director of Public Health	NHS Devon
Anne Beveridge	Exeter Area Manager	Connexions Cornwall & Devon
Dillon Hughes	Head of Integrated Youth Support Service	CYPS
Betsy Allen	Head of School Nursing	NHS Devon
Kristian Tomblin	Manager	Devon Drug and Alcohol Action Team
Maureen Muckersie	Young Persons Plan Coordinator	Devon Drug and Alcohol Action Team
Dr Annette Lyons	Adviser for Personal, Social, Health Education and Citizenship	CYPS
David Tall	Executive Officer	Devon Association of Governors
Ian Tearle	Head of Health Policy	NHS Devon
Amy Bickford	Youth Worker	CYPS
Glynis Bath	Devon Teenage Pregnancy Coordinator	NHS Devon
Liz	Parent of a teenage mother	
Councillor Roger Giles	County Councillor for Ottery St Mary Rural	DCC
Jennifer Moss	Young Persons Health Advisor	NHS Devon
David Evans	Chief Executive	Health Behaviour Group
Matthew Macan	Trustee / Chair of Governors	Health Behaviour Group / ISCA / Exeter 4 Learning
Dawn Dines	Director	SOS Global
David Fitzsimmons	Chair / Principal	DASH / Holsworthy Community College
Emma Hall	Youth Participation Worker (Children in Care)	CYPS
Sophie	Teenage mother	Former Child in Care
Charlotte	Teenage mother	Former Child in Care
Brain Grady	Head of Commissioning and Procurement	CYPS

A3.2 Written Representations (in the order that they were received)

Witness	Position	Organisation/District
4 Young Mothers aged 16 - 22	Newton Abbot Young Parents Group	Newton Abbot
6 Young Mothers and 1 Father	Combe Martin Teen Parents Consultation	Combe Martin

Appendix 4:

Bibliography

- Children and Young People's Plan 2008-2011 (DCC, 2008)
- Devon Children and Young People's Plan 2006 – 2009 (DCC, 2006)
- Devon Teenage Pregnancy Action Plan (DCC / Devon PCT, 2009)
- Devon Young People's Sexual Health Strategy 2008 –2012 (Devon PCT, 2008)
- Every Child Matters: Change for Children (DfES, 2004)
- Government Response to the Report by the Sex and Relationship Education (SRE) Review Steering Group (DCSF, 2008)
- Partner Exploitation and Violence in Teenage Intimate Relationships (University of Bristol / NSPCC, 2009)
- Review of Sex and Relationship Education (SRE) in Schools: A Report by the External Steering Group (DCSF, 2008)
- "The Condom Broke!" Why do Women in the UK have Unintended Pregnancies? (Marie Stopes International, 2009)