A research report in collaborative partnership with Salford and Manchester Teenage Pregnancy Teams

The Manchester and Salford Sure Start Plus Pilot Programme

A Baseline Evaluation

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Thank You
This study required the co-operation, patience and sustained effort of a large number of individuals and organisations. Our most sincere thanks go to all of those involved.

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"…I think it's been really successful, a really positive piece of work, really valuable support to young people which has made a difference"

Participant / Interviewee

1. Foreword

Manchester and Salford's Sure Start Plus Programme is part of twenty original pilot projects in the country, targeting pregnant teenagers and teenage parents with the aim of reducing the risk of long-term social exclusion and poverty resulting from teenage pregnancy. The Sure Start Plus programme includes:

- Personal support and advice for teenagers who discover that they are pregnant, so that they can make responsible and well-informed decisions according to their individual circumstances.
- Co-ordination of support packages for young parents tailored to individual needs, including addressing issues such as healthcare, parenting skills, education, childcare and housing.
- Reshaping existing services to make them more user-friendly and sensitive to the needs of teenagers.

Salford

Sure Start Plus is at the centre of Salford's services for young parents, their children and young parents to be. The additional and targeted support packages delivered by the team have enabled many young people to make a successful transition to parenthood and remain engaged in Education, Training and Employment. The team have also been instrumental in the redesign of the Termination of Pregnancy Service at Hope Hospital and in the introduction of dedicated, welfare rights, emotional support, counselling and contraceptive/sexual health advice services set-up for young people.

Manchester

In Manchester, support for teenage parents is via a virtual multi-agency team which provides holistic support packages for young people across a number of key services. These include: the Reintegration Service for school aged mothers, Connexions, benefits advice, housing, midwifery, health visiting and school nursing. The programme has had an emphasis on capacity building within existing services to ensure that a sustainable and seamless model has been developed.

Although parenthood can be a positive and life-enhancing experience for some young people, there is evidence to suggest that, in the current social and political context, teenage parenthood can have negative consequences both for young parents and for their children. The National Evaluation of Sure Start Plus (2005) highlighted the added value that a specialist team of advisors can make and the evidence for effective interventions strongly suggests that a cross-sectoral approach will produce results. It is clear that appropriate education, social services, housing and health services, among others, are all required to make a real difference.

Sure Start Plus in both Manchester and Salford has continued to demonstrate innovation and good practice, examples of which have been nationally recognised. We are pleased to share the findings of our local evaluation (Wray and Hastings-Asatourian 2005) of the programmes.

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2. Glossary of Key Terms and Abbreviations

Abortion/Termination of Pregnancy
Whilst these terms mean the same thing i.e. medical or surgical termination of pregnancy (excluding miscarriage), for the purpose of this document the term 'termination' will be used throughout.

APAUSE
Added Power and Understanding in Sex Education is a nationally available sex and relationships education programme operating in Salford.

Black Health Agency (BHA)
A locally based charity committed to raising the profile and presence of black minority ethnic populations within health provision.

Brook
A charity dedicated to providing free and confidential sexual health services to young people (14 throughout the UK).

Children's Centres
Children's Centres were established nationally in disadvantaged areas to provide childcare with early education, family and health services and training and employment advice. The Centres integrate with Sure Start, Neighbourhood Nurseries and Early Excellence Centres.

Connexions
A local authority service set up to provide integrated support from a single source for all 13-19 year olds through access for every young person to a personal advisor.

Health Action Zones (HAZ)
These were part of a 3 year initiative set up in 1999 to address health inequalities involving £280 million government funding. HAZ were established where poverty indicators such as unemployment, low wages and poor housing, environmental pollution and crime and disorder were highest.

General Practitioner (GP)
Sometimes referred to as family doctor.

NATSAL (National Survey of Sexual Attitudes and Lifestyles)
A survey carried out every 10 years. Data used here is from survey carried out in 2000 Sure Start - a government funded initiative focused upon improving the lives of children (under 4 years), set up in deprived areas that met a criterion within the Social Exclusion Unit.

Social Exclusion Unit (SEU)
The SEU was set up in December 1997 within the cabinet office, steered by the Prime Minister. The Implementation of the recommendations made by the SEU in the Teenage Pregnancy Strategy is the responsibility of the Teenage Pregnancy Unit.

Standardised Mortality Rate (SMR)
SMR is calculated from the number of deaths that would occur in a standard population. Usually the national population is used as the standard.

Sure Start
Sure Start is a UK Government's “Tackling Inequalities” initiative to eradicate child poverty working with parents-to-be, parents and children. Sure Start works through community consultation and partnerships. Programmes are likely to include general health advice, ante-natal support, smoking cessation, home visits, early learning experiences for young children, childcare, more accessible baby clinics and advice, parenting groups and training for work.

Sure Start Plus Pilot (SSPP)
Sure Start Plus is another initiative addressing health and social inequalities, but specifically focuses on the needs of teenagers who are parents–to-be and parents. Sure Start Plus Pilot refers the original 20 pilot sites identified by the government where social disadvantage and teenage pregnancy rates were highest. Manchester and Salford became one such pilot.

Teenage Pregnancy Unit (TPU)
The Teenage Pregnancy Unit is a cross governmental unit located within the Department of Health (DH) launched by the Prime Minister in June 1999. The Head of the TPU reports to the ministerial task force chaired by the minister for public health. Many initiatives set up as part of the strategy are now being evaluated. Funding from the government relating to the Teenage Pregnancy Strategy comes up for review in 2006.

3. Executive Summary

This evaluation considers the implementation of the Sure Start Plus Pilot (SSPP) programme at the two pilot sites of Manchester and Salford and was commissioned by the teenage pregnancy teams in these cities. It is a local evaluation considering how the programme has been implemented in the context of the national objectives and targets for the two cities.

The principal investigators were Julie Wray and Barbara Hastings-Asatourian, supported by an expert project team. The team recognised that the impact of such an evaluation would not be absolutely evident in the short term and the impact of a service aimed at tackling the effects of poverty and levelling out inequality would only be successfully monitored over the longer term. However, short term objectives were set and the evaluation aimed to collect, examine and analyse data that reflected the extent to which SSPP had been implemented and monitored. This was achieved by both quantitative and qualitative methods – examining statistics and capturing the experiences and opinions of the SSPP team.

Findings identified marked diversity between Manchester and Salford in the way that SSPP was structured, organised and services provided. Variations existed in the staffing arrangements, partnerships, monitoring approaches and leadership styles.

Findings show that where quantitative data required nationally were rigorously collected by the teenage pregnancy teams at the sites, there was clear evidence of movement towards the targets and several examples of unique services and innovative practice. For example the uptake of support packages did increase over the 3 years, new roles with partnership agencies were established and the introduction of posts like the young father's worker began to have an impact.

There were some areas of incomplete data, and some areas where progress towards targets appeared to be less successful.

Following thematic analysis, focus group and face to face interview data have suggested why this is the case.

Key Messages

It became apparent throughout the course of this evaluation that many of the issues and lessons learned locally emerged as a consequence of issues which required addressing nationally. Several issues originating at the national level created problems in implementation and evaluation. Some of the issues could be avoided by:

- Involving local teams in target setting.
- Involvement of young people in the planning stage.
- Setting realistic targets.
- Designing realistic monitoring data collection instrument and piloting it *prior to* commencement of programmes.

The evaluators recommend the following:

- Many and varied channels of communication, and reinforcement of SSPP goals. This might include using newsletters, websites and discussion groups, as well as more traditional means of cascading information in formal meetings and briefings.
- That agencies identified in The Teenage Pregnancy Directory of Agencies be included in this communication process in both cities.

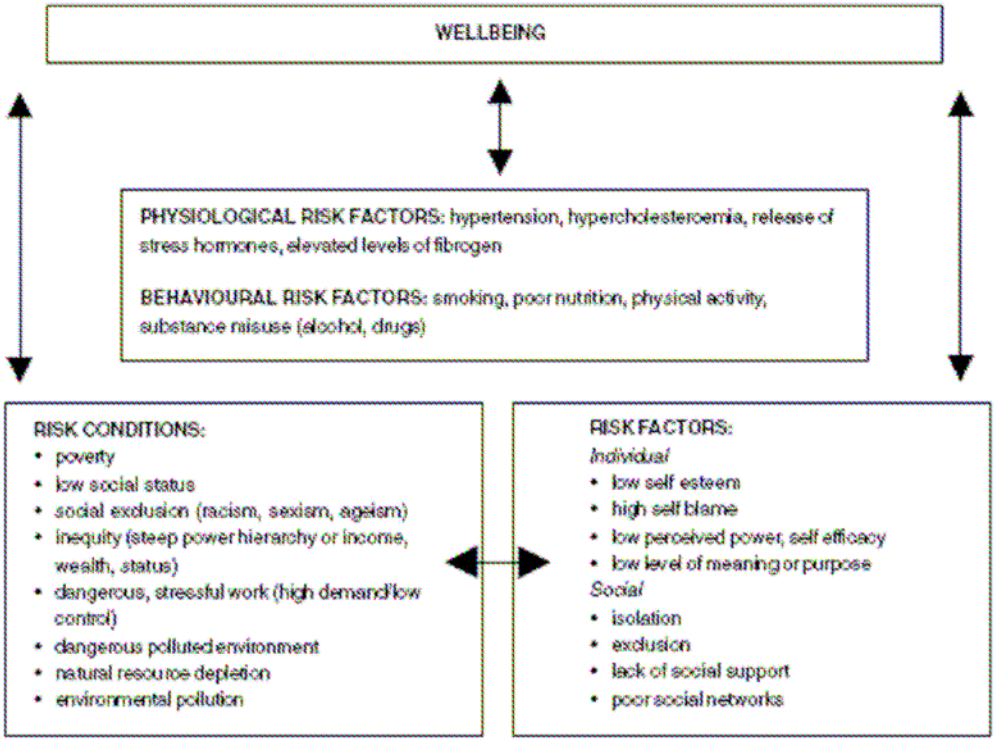
- That any changes taking place in the management and operation of the SSPP (e.g. monitoring, funding) also be communicated effectively. This should also include communication about the rationale behind the strategy, enabling open discussion and agreement before any future work begins.
- Recognition, publicity and joint writing up of innovative projects and good practice (especially for example those exemplified at national level the young mums group, the work of the young fathers' worker and work with BME groups).
- An increase in prominence given to the prevention of conceptions and repeat conceptions.
- Closer working and apparent sharing between the two teenage pregnancy teams, so that services highlighted as examples of innovative practice in the National Evaluation can be piloted *in both cities.*

4. Background

Socio-Economic Context

How poverty impacts on health and well being has been well documented over the centuries. Many government initiatives have been designed to address issues arising from poverty into the most deprived areas. Sure Start Plus Pilot is one initiative targeted originally at the 20 most deprived areas in the UK, specifically addressing the difficulties faced by pregnant teenagers and teenage parents already disadvantaged through poverty. Figure 1 demonstrates the relationship between wellbeing and social factors.

Figure 1:
The relationship between wellbeing and social factors as cited by the Teenage Pregnancy Unit



Source: Dr Jane Meyrick (2002) An Evaluation Resource to Support Teenage Pregnancy. Teenage Pregnancy Unit

Bearing this relationship in mind, some socio-economic contextual background follows for both areas under review. Data gathered nationally have been extracted from the DFES (2002, 2003a, 2003b) and National Statistics (ONS 2001a, ONS 2001b). Information specific to Salford has been gathered from the Salford Community Plan 2001-2006. Data specific to Manchester have been gathered from the Joint Health Unit (2005) Compendium of Statistics (www.manchester.gov.uk/health/jhu).

Salford Data

Salford's population is currently 225,950. Salford has some very wealthy wards, for example, Ellenbrook and Worsley known for better housing and socio-economic conditions and parts of Salford are becoming regenerated economic areas and residential locations for example, Chapel

Street and Salford Quays which are creating employment. Nevertheless, according to the English Indices of Deprivation (Office of the Deputy Prime Minister 2004) Salford is the one of the most deprived local authority areas both in the North West and nationally. In some wards the standard mortality rate (SMR) is twice the national average. In 2002/4 the life expectancy at birth of females was 78.3 years (2.39yrs below the UK average) and for males 73.4 years (2.85 years below the UK average) (ONS, 2005).

Crime

The Teenage Pregnancy Unit also reports an association between involvement with the police and teenage parenthood. Nationally a quarter of all known offenders are under 18 years of age. Though levels of crime show signs of reducing since the Crime and Disorder Act was introduced in 1998, fear of crime and anti-social behaviour in Salford continue.

Table 1:
Summary rates on crime and disorder in Salford as compared to England 2004/2005

Crime and disorder in Salford 2004/2005 (Rate per thousand)		
Burglary dwelling offences	Salford 12	England 6.4
Theft of vehicle	Salford 10	England 4.5
Theft from vehicle	Salford 13	England 10
Robbery	Salford 3	England 1.4
Sex offences	Salford 1	England 0.9
Violence against the person	Salford 20	England 16.5

Source: ***http://www.upmystreet.com/local/police-crime/figures/l/UMS4302.html***

Looked after children

Another indicator of poverty is an increase in the numbers of looked-after children as it signifies the extent of family and social breakdown. The proportion of children being looked after by local authority social services is much higher in Salford than in England and Wales as a whole. Of 59,700 children being looked after in England in 2002, 580 were from Salford (DfES 2002). This indicator of social need also correlates with higher rates of teenage pregnancy.

Educational attainment

Low educational attainment is also associated with teenage pregnancy. Performance at secondary school level is poor compared to national standards. In Salford LEA in 2003 36.8% of students achieved 5+ A*-C GCSE results compared to the England Average of 52.9% for that year (DfES 2003a).

Unemployment

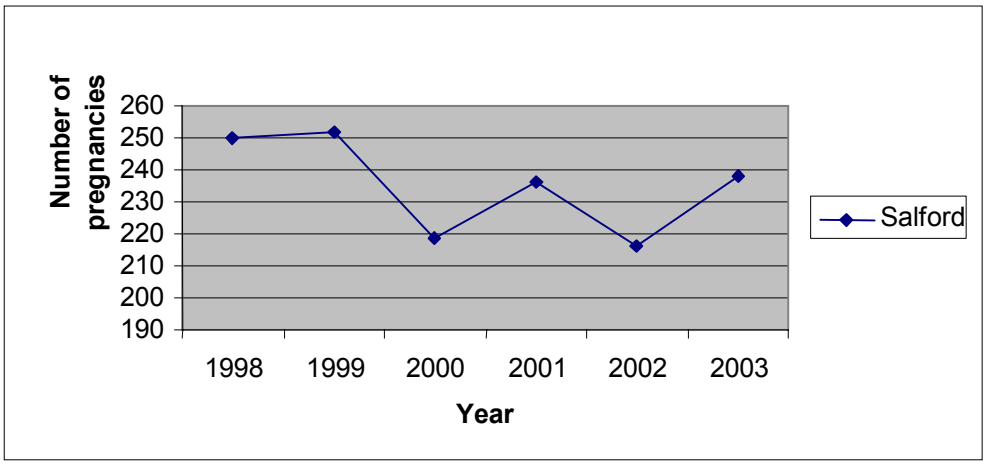
The Salford Profile reported in the Salford Community Plan 2001-2006 shows that Salford has recently lost almost a third of its traditional employment base. There is evidence of a strong link between teenage parenthood and not being in education, training or employment. Unemployment in Salford as a whole is declining from 4.3 % in 2000 to 3.6 in 2004, but this average unemployment rate disguises pockets of high unemployment in specific areas, for example high youth unemployment (8.3%) and long-term unemployment rates (18.91%).

Over 21,000 people claim income benefits and there are high numbers of lone parents. The housing market has collapsed in communities such as Seedley and Langworthy. Falling population levels, caused by people migrating from the traditional inner city areas, has led to significant numbers of vacant properties.

Salford's teenage pregnancy rate

In Salford the number of teenage pregnancies has recently reached a plateau. Salford experienced an increase in conception rates from 2002 to 2003, although this still represented a 5.3% reduction from the 1998 baseline, compared to a 9.8% reduction for England, a 10.7% reduction for the North West Region and a 4.3% reduction for Greater Manchester. Live births to all young women in Salford under 18 in 2004 also decreased by 20% from baseline and by 61.5% for those aged 15 and under. However, in 2003 and 2004 live births for those young women aged 16-17 began to increase. Salford's under 16s conception rate in 2003 decreased by 22.9% from the 1998 baseline. Births to under 16s for 2004 reduced to 5% representing a 61.5% decrease from baseline. Births for 16 and 17 years olds reduced to 14.2% and total births to under 18s decreased to 20.2%. Salford's Termination of Pregnancy (TOP) figures for 2002 showed a 10% increase from baseline 1998. The following chart illustrates the *numbers* of 18 years and under teenage pregnancies for Salford over the period 1998 to 2003.

Chart 1:
The number of teenage pregnancy in Salford for 1998-2003



Source: National Statistics 2005

All Salford wards except Worsley and Boothstown are in the top 40% nationally with the highest number of teenage conceptions. Further analysis places Langworthy, Little Hulton and Winton consistently in the wards with the highest number of teenage conceptions. These wards are in the 10% most deprived wards in the country and are Sure Start areas. Five of the 8 central Salford wards including Langworthy are ranked within the top 5% nationally of wards with high levels of deprivation. Salford's other most deprived wards include Ordsall, Blackfriars, Weaste and Seedley, Pendleton, Eccles and Walkden North. One anomaly however is that the *most* deprived ward in Salford, Broughton (based on 2004 Indices of Deprivation) does *not* have the highest teenage conception numbers in the city.

Manchester Data

The city of Manchester is also one of the poorest areas in the region, with a population of 422,900 (ONS 2001b). Manchester ranks third in the index of multiple deprivation, 20% of the population are receiving income support. The health difference between Manchester and the rest of England has been worsening over recent years. In 2002/4, the gap in life expectancy at birth between Manchester and the rest of the United Kingdom was 3.95 years for men and 2.79 years for women (ONS, 2005).

Crime
Crime in Manchester is twice as high as the national average in every category.

Table 2:
Summary rates on crime and disorder in Manchester as compared to England 2004/2005

Crime and disorder (Rate per thousand) population 2004/2005 (Manchester compared to England averages)		
Burglary dwelling offences	Manchester 17	England 6.4
Theft of vehicle	Manchester 11	England 4.5
Theft from vehicle	Manchester 21	England 10
Robbery	Manchester 8	England 1.4
Sex offences	Manchester 2	England 0.9
Violence against the person	Manchester 32	England 16.5

Source: http://www.upmystreet.com/local/police-crime/figures/l/manchester.html

Looked after children
The proportion of children being looked after by local authority social services is much higher in Manchester than in England and Wales as a whole. Of 59,700 children being looked after in England in 2002, 1,245 were from Manchester (DfES 2002).

Educational attainment
Low educational attainment is also apparent in Manchester's LEA statistics. In 2003 only 39.6% of students achieved 5 or more grades A-C compared with the significantly higher average of 52.9% in England as a whole (DfES 2003a).

Unemployment
There is evidence of a strong link between teenage parenthood and not being in education, training or employment. In July 1999, there were 1,680 unemployed young people aged 16-19 in Manchester. Sixty-four per cent of these were men. The youth unemployment rate in Manchester was 13.4% - well above the Greater Manchester average of 8.9%. Within Manchester youth unemployment rates ranged from just under 6% in Chorlton to over 20% in Longsight. This figure has since shown a downward trend and by 2005 the number had dropped to 1,330 and the percentage of all claimants to 10.6%. Table 3 outlines youth unemployment for 16-19 years old in Manchester compared with the North West of England and the UK.

Table 3:
Youth unemployment (16-19 year olds) as a proportion of all unemployed claimants

Location	**July 2005**		**July 2004**	
Manchester	1,330	10.6%	1,380	11%
Greater Manchester	5,280	6.4%	5,055	6.2%
North West	13,325	6.8%	12,540	6.4%
United Kingdom	103,705	N/A	93,850	N/A

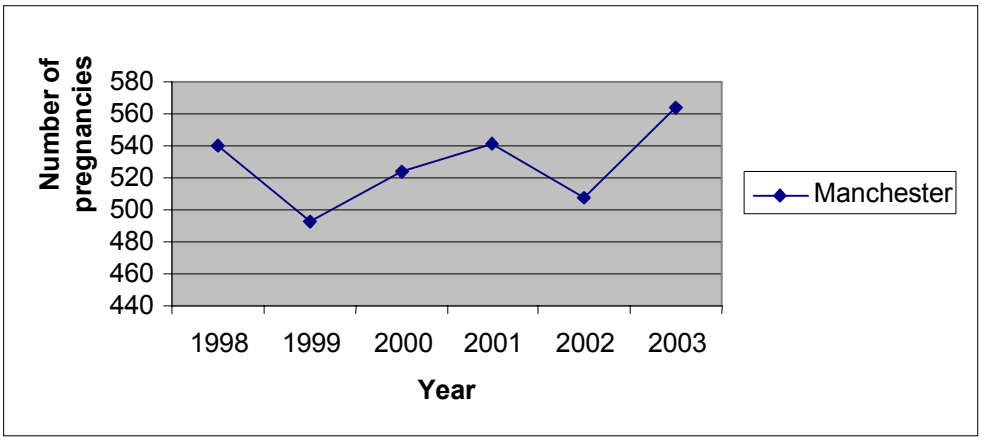
Source: © ONS (NOMIS) and © 2005 Manchester City Council

Manchester's Teenage Pregnancy Rate
National Statistics for Manchester showed that between 1998-2003 there were approximately 550 conceptions a year to teenagers in Manchester, a rate of over 60 per thousand. The average rate for England at that time was 45 per thousand. About 100 of Manchester's teenage pregnancies

(20%) were to girls under 16. Roughly two-thirds resulted in a live birth and around 30% led to termination, the England average for termination is around 45%. In contrast, the proportion of teenage conceptions ending in termination was nearly a third lower than the national average of 45%.

An analysis of 3 year rolling averages, used in order to smooth out year-on-year variations, showed that the under 18-conception rate in Manchester has fallen from 81.4 in 1992-1994, to 65.9 in 2000-2002 (a fall of around 19%). From 2001–2003 the number of under age 18 years conceptions rose from 1574 to 1614, although the actual *rate* fell slightly from 65.9 to 64.9 in that period. Chart 2 outlines the number of pregnancies in Manchester from 1998-2003.

Chart 2:
The trend in conceptions to teenagers aged under 18 years in Manchester 1998 to 2003



Source : National Statistics 2005

To illustrate further the relationship between poverty and deprivation on teenage pregnancy, Benchill the poorest ward in Manchester has the highest teenage pregnancy rate of 73 per thousand, compared to the more affluent Didsbury which has a teenage pregnancy rate of 17 per thousand.

Background to Sure Start Plus

In 1999 the Social Exclusion Unit (SEU) reported increased risks of poor health and social outcomes faced by teenage parents and their children, including a 60% higher rate of infant mortality; 25% increased risk of low birth weight babies; and three times the rate of postnatal depression. Furthermore, teenage mothers were reported to achieve less educationally. Several other contributing factors were identified such as; young people's low self esteem, how they learned through examples within the family, their educational aspirations and attainment, social norms and peer influences, housing and employment prospects and finally their contraceptive awareness and its accessibility.

Furthermore, in 1999 the government's ten-year national teenage pregnancy strategy was launched (SEU 1999). The main aims of the strategy were to:

- Reduce the rate of teenage conceptions with the specific aim of halving the rate of conceptions among under-18's and to set a firmly established downward trend in the rate of conceptions among under -16's, by 2010.

- Increase the participation of teenage parents in education, training and employment to 60% by 2010, to reduce their risk of long-term social exclusion.

The SSPP arose from the action plan of that report with the aim of reducing the risk of long-term social exclusion associated with teenage pregnancy by providing intensive support for parents and children to help them with housing, health care, parenting skills, education and child care. It was an innovative three-year pilot programme in 20 areas in the UK, now covering 35 sites. The pilot programme provided support for pregnant teenagers and teenage parents under 18 years of age. The SSPP was a key element of the Government's ten-year Teenage Pregnancy Strategy (launched in 1999) which is being implemented by the Teenage Pregnancy Unit, Sexual Health and Substance Misuse Business Area, at the Department of Health. SSPP were located to Health Action Zones (see glossary) which had at least one Sure Start Programme, in other words areas known to have higher than average levels of poverty and deprivation.

The main components of the programme were:

- Personal advisors to support and advise pregnant teenagers in making informed choices about the future of the pregnancy.
- Tailored support packages to be developed for young parents to help them access healthcare parenting skills, education, childcare and housing.
- Development of the role of young fathers.
- Advice on contraception.

SSPP also aimed to:

- Reshape existing local services to make them more user-friendly and sensitive to the needs of teenagers.
- Identify gaps in services and develop proposals for filling the gaps.
- Improve co-ordination between local agencies, including representation from local Sure Start partnerships, local teenage pregnancy co-ordinators, and Health Action Zones, plus other agencies and voluntary organisations involved in the provision of services related to teenage pregnancy and teenage parenthood.

In all SSPP areas, the SSPP partnership had to be represented on the Connexions (see glossary) local management committee.

The cost of individual pilot programmes varied depending on the size of the area covered. Grants ranged from £125,000 to £255,000 per year. Manchester and Salford received £200,000 per year, £85,000 was allocated to Manchester and £115,000 to Salford. As part of the 2002 Spending Review outcome, Sure Start Plus nationally extended the lifetime of the pilot from three to five years, and so the pilot was funded until March 2006.

A national evaluation was commissioned to establish how far the pilot programmes were achieving their aim, objectives and targets and how successful they had been in contributing to the Governments Teenage Pregnancy Strategy. The national evaluation has already been published and includes reference to two examples of innovative practice from Salford and Manchester. Recommendations from the National Evaluation have been published by Sawtell et al (2005).

5. Literature

The Sure Start Plus Objectives (Appendix 1) encompass a broad range of health and social issues relating to teenage health, teenage parenthood and the health and development of their children well documented in Fullerton et al (1997). The evaluation takes the Social Exclusion Unit (SEU 1999) and its associated teenage pregnancy targets as the key reference. A vast amount of the literature available on these subjects was also examined and much was found to be beyond the scope of this report. An overview of the four most relevant sections has therefore been included here under four main categories:

- Socio-economic circumstances
- Sexual Health
- Parenting
- Professional Input

The categories however are not wholly discreet as there are areas of both which overlap and overarch.

Socio-economic Circumstances

This evaluation examined historical references and the point well made in Teenage Pregnancy (SEU 1999) *that the risk of teenage parenthood is greatest for young people who have grown up in poverty and disadvantage or those with poor educational attainment.*

There is a growing body of evidence to suggest that poorer birth outcomes of teenage mothers appear to result largely from their adverse socio-economic circumstances, not from young maternal age.

Early life deprivation and low birth weight

Childbearing in young teenagers is associated with increased risk for infant mortality. According to DePlessis et al (1997) both maternal age and ethnicity are important. Women of young maternal age (10-13 years) were approximately 2.5 times more likely to have a low birth weight infant and 3.4 times more likely to have a pre-term birth than older teenagers. African-American women are 1.7 times more likely to have a low birth weight infant, and 2 times more likely to have a pre-term birth than white and Hispanic women. Phipps et al (2002) found rates in the UK of infant mortality are substantially higher for under 15-year-olds (8.1/1000 live births) compared with 16-17 year-olds (6.3/1000 live births) and 18-19 year-olds (5.4/1000 live births), even after adjusting for risk factors such as alcohol use, tobacco use, and poor uptake of attendance at ante-natal care.

The theory that deprivation in early life followed by relative affluence in later life correlated with the development of Coronary Heart Disease (CHD) was advanced by Forsdahl (1977). Barker et al (1986, 1987, 1989) showed a correlation between geographical patterns of CHD and maternal and neonatal mortality and morbidity in the early 20th century. They implicated poor maternal health and diet. Infants' body weight of less than 39.6kg at one year was suggested as predictive of heart disease in later life (Gregory et al 1990, Marmot et al 1991).

Kramer et al (2000) describe how low birth weight is an enduring aspect of childhood morbidity and a major factor in infant and adult mortality. They exemplify how the risk of low birth weight increases with lower social class, and they state that the major risk factors from a public health perspective are smoking and poor nutrition. The average reduction in birth weight associated with smoking 20 cigarettes a day is approximately 200 grams.

Housing
The relationship between poor housing and poor health is well established (DH 2002a). Tackling Inequalities (DH 2002a) illustrates how housing improvements result in improved self-reported physical and mental health as well as reductions in symptoms of a number of respiratory and other illnesses and the use of health services.

One of the goals of the Social Exclusion Unit (1999) was that by 2003 all teenage lone parents under 18 who were unable to live with their family or partner should be placed in supported housing not in lone tenancies. The Teenage Pregnancy Unit commissioned a review of existing supported provision for teenage parents, with the aim of identifying good practice. Researchers selected nine projects, spoke to residents and staff about their experiences and held a consultation event for young mothers and scheme managers. Guidance was drawn from their findings to inform those developing schemes.

Burchett and Seeley (2003) also found that housing has a considerable bearing on the quality of a teenager's diet. Those living away from home often had many obstacles to eating a nutritious diet, including access to affordable food and the knowledge of how to prepare it, whereas those living with their family had little or no control over the content of their diet, and often ate unhealthy foods because they were on offer.

Family breakdown
Family disruption and lower parental socio-economic status have also been associated with early sexual experience and pregnancy. A number of studies have demonstrated that there are many variables and interpretations in respect of family breakdown and teenage pregnancy. Recurring themes include abuse, depression, suicidal thoughts, absent fathers, school failure, alcohol, drug and tobacco use (Adams and East 1999, Kiernan 1995). There is evidence that a father's absence in a teenage girl's life was strongly associated with an elevated risk for both early sexual activity and teenage pregnancy (Ellis et al 2003).

Looked-after children
An important factor in early sexual intercourse documented by Carpenter and Clyman (2004) is a history of having been "in care" or "looked after" which is a marker for high-risk sexual behaviour. A consideration of the motivation for high risk sexual behaviour amongst this group by health and social care providers would help the development of interventions that aim to prevent the problems associated with early initiation of sexual intercourse and unintended pregnancy.

Education
There is an evidence-based academic perspective on sex and relationship education, and sexual openness that young people who leave school later, with qualifications, are less likely to have early intercourse, more likely to use contraception at first sex, be sexually competent, and that young well educated women are less likely to become pregnant (Rees et al 1997, Kane and Wellings 2003). Work such as this and that by Dennison et al (2003) underpins initiatives aimed at reaching young offenders.

Culture and ethnicity
Although SEU (1999) does use some language which identifies the role played by social inequality, there is also reflected in the report a representation of the prevailing culture in English society, that is an imposing aspect of moral judgment associated with the *teenage* element. Being engaged in education, training and employment in the teenage years is culturally more acceptable than parenting, and delaying childbirth has recently become more socially acceptable.

Popular press reports often advance the morals of the extreme right, and fundamentalist religious groups give insights into how and why openly discussing sex is still considered inappropriate, and

sometimes taboo. Reports from these organisations often focus on and exclusively promote the value of virginity. There is also a tabloid view that suggests pregnancy may be used by some to get "something for nothing" (meaning housing and benefits), however the Doncaster study found no evidence to suggest that girls become pregnant to secure benefits or housing (Tabberer et al 2000).

There is also sometimes a focus on regret and guilt of early teenage sex. According to the NATSAL survey (Wellings et al 2001), two in five men and four in five women in their late teens and early twenties who first had sex at ages 13 and 14 express regret, with women twice as likely as men to express regret and three times as likely to report being the less willing partner.

Berthoud (2001) analysed British age-specific fertility rates by ethnic group in child-bearing by women below the age of 20, and found that Caribbean, Pakistani and especially Bangladeshi women were much more likely to have been teenage mothers than white women, but Indian teenage parents numbered below the national average. Teenage birth rates have also been falling in all three South Asian communities.

Understanding the needs of people from Black and Minority Ethnicity has been identified nationally and internationally. The Teenage Pregnancy Unit (DH 2002b) includes examples of local work in settings such as Black churches and Catholic schools, as well as perspectives on teenage pregnancy from different faiths. Some young people from faith communities felt their views on sex and relationships were not addressed. Although teenage pregnancy rates are lower in some religious communities, the report found that access to health services and information can be a problem. Many young people could not confide in their GP about sexual matters, believing that their doctor would inform their parents (DH 2002b).

Sexual Health

Access and use of contraception

Teenage Pregnancy (SEU 1999) and UNICEF (2001) made international comparisons between countries with low and high teenage pregnancy rates. Generally speaking social inequality has been identified in both data sets. Knowledge of, access to and motivation to use contraception are all clearly all significant. More recent studies such as McVeigh (2002) found that just over half of the sample of 30 teenage mothers reported using contraceptives, less than a third using condoms to protect themselves from infection. Crosby et al (2002) found that *ambivalence* about becoming pregnant is associated with comparatively less frequent use of contraception. This appears to concur with other literature about aspirations, and the belief that some teenagers hold that having a baby might improve their status in society. Montgomery (2001) interviewed eight adolescent girls between the ages of 14 and 17 regarding their experiences of planning pregnancy. Emerging themes included financial, relationship, age-related goals, boyfriend involvement, environmental issues and the need for stability. In the NATSAL sample Wellings et al (2001) found there had been an increase in the number of young people using condoms the first time they had sex. However, they were less likely to use contraception the younger they were at first intercourse. There is still a disproportionate emphasis on pregnancy prevention, rather than sexual health, with many young women feeling "safe" because they are using short or long term hormonal contraception.

Risk taking, alcohol and other drugs

Highlighting the need for better education for younger people Bellis et al (2004) published data from a study of 1,500 young Britons aged 16-25 who travelled to Ibiza between 2000 and 2002. This destination is also associated with casual drug use and alcohol consumption, both associated with risky sexual behaviour. Researchers found a large proportion did not always use condoms and had sex with more than one person.

Studies confirm that early onset of sexual intercourse is also associated with drug use, alcohol intake and cigarette smoking (Ekeus and Christensson 2003) although this is also associated with social and aspirational variables. The Alcohol Concern & Drugscope Report (2002) illustrates how young people are more likely to have risky sex when they are under the influence of alcohol.

Albrecht et al (1999) sought to assess nicotine dependence in teenage parents, considering duration and quantity of smoking, and the recognition of smoking as physical addiction with clear implications for planning smoking cessation interventions during and after pregnancy. Older international studies have reported that between 28 and 62% of pregnant teenagers smoke (Cornelius et al 1995, Albrecht et al 1999).

Although there can be resistance to smoking cessation initiatives amongst professionals who feel empathy towards those with social disadvantages, the more serious side of smoking is expressed by its effect on pregnancy (Cornelius et al 1995). Smoking during pregnancy reduces fetal growth, and can cause miscarriage, prematurity and a number of conditions in the growing child and adult in later life.

Smoking in pregnancy is four times more prevalent among women in households in social class V than those in social class I. Teenage mothers are the most likely of all age groups to smoke in pregnancy – nearly two thirds of under 20s smoke before pregnancy and almost a half during it (DH, 2002a, Fried 2002). Even though the prevalence of smoking among both men and women has been declining overall since the mid 1970s, the decline is slower in women. In Western societies since the early 1990s, women have been adopting smoking and drinking behaviour formerly associated with men. The longer term public health effect of this is that life expectancy differences may narrow as the level of smoking related mortality among women rises.

Termination

Kane and Wellings (2003) reported a clear social class differentiation pre-SSPP of the teenagers seeking termination. Teenagers with parents from professional social classes were more likely to terminate their pregnancies and continue in education. Evidently the push towards early booking also opens up the choice for termination to young women who might otherwise have not been able to choose. Tabberer et al (2000) found that teenage girls may continue with unplanned pregnancies because their families and the community oppose termination. Her study in South Yorkshire implicated lack of information and advice and the influence of family and peers. A recent study by Clements et al (2004) using data from 1999-2000 reinforced Wellings (2002) perspective that fewer terminations are carried out in disadvantaged areas. Furthermore Clements' work demonstrates that teenagers' decisions are based on their situation rather than moral views. Young women who perceive their lives to be insecure are more likely to view having a child as positive move. Those wanting to continue to work or stay in education were more likely to seek termination.

Parenting

Social support

Stevenson et al (1998, 1999) studied 67 black and 43 white single pregnant teens and found that *support between parents* and the teens was correlated with increased life skills and satisfaction, and decreased depression and anxiety. A high quality relationship with the father of the child or partner was also associated with increased self-esteem of the teenager. An earlier study found that dropping out of school among pregnant teens may be more strongly related to socio-cultural factors than to emotional and psychological factors.

Breastfeeding

The McVeigh study (2002) in Australia found that 16 of their 30 teenage respondents (53%) breast-fed their infants, even though the pregnancies were largely unplanned, and social circumstances far from "ideal". It is uncertain that this trend is common in the UK as specific UK studies were unavailable.

Fathers' involvement

In one North American report Wei et al (2002) found that young men with adverse social circumstances are also more likely to become teenage parents.

Holmberg and Wahlberg (1999) set about obtaining knowledge about the opportunities available to Swedish teenage boys and young men for obtaining advice and support during the process involved in making decisions on termination. The study was carried out in young person's clinics, where information about the staff's views of male attitudes and feelings regarding termination were elicited, with a view to developing models for advice and support. Findings indicated that both fathers and mothers-to-be require active care and information together with the partner, and individually. Individual support and information for male partners needed to come from appropriate professionals.

In a Scandinavian study of 132 teenage fathers Ekeus and Christensson (2003) found that young fathers were more likely to have had more compromised socio-economic backgrounds, to have used drugs, to be involved in crime, and often came from single-parent households themselves.

A study by Speak et al (1997) found that unemployment and poverty prevented young men being as involved as they wanted and identified the importance of grandparents in the development of the young man's relationship with his child, often helping with accommodation and financial support. This study provides a framework from which services for fathers could be developed, raising the issues of involvement, benefits advice, housing and their legal rights.

The study investigated a group of single fathers aged 16-24 who *did* want to be involved with their children. Speak et al found that fathers felt they were made to feel unimportant both during the pregnancy and after the birth and that little effort was made to encourage them to develop and maintain involvement with their child. However, the young men themselves saw 'being there' for their children as extremely important. They were keen to be 'better' or more involved fathers than their own fathers had been. Few young men, however, were aware of their lack of legal rights in relation to their child. There was an amount of misinformation both amongst fathers and those working with them. No information on rights was readily available to them.

Professional Input

Joined up working

Chambers and Boath (2002) compared the views of young people and professionals and found that young people want interventions to be young person-centred, whereas professionals stressed that re-organisation of sexual health and education services was pivotal. Young people suggested more creative ways of communicating health and education messages. Both groups advocated peer education and suggested that staff should be educated to be more sensitive with young people. Both groups advocated the locating of sexual health services for teenagers in youth settings.

Connexions (DfES 2003b) indicates how such young person-centred, innovative and creative solutions have been developed to meet teenage pregnancy targets. Multi-agency working and collaboration between the Connexions Service and other agencies, including Teenage Pregnancy Co-ordinators, Reintegration Officers (ROs) and Sure Start Plus Advisers was emphasised in this paper. The paper explains how Connexions Partnerships are working particularly to increase the

percentage of 16-19 year-old mothers in employment, education and training to 60% by 2010. The paper states that Connexions Partnerships have the lead role in collecting information about teenage pregnancy and in ensuring that systems are in place so that there is a more consistent approach in future years to monitor progress against the targets and identify the numbers of young people in education, employment and training.

The success of this initiative is thought to be dependent upon strength and cooperation between the Connexions Partnerships, Teenage Reintegration Officers and other Teenage Pregnancy Support Workers, Sure Start Plus Advisers and Health Service workers who work directly with teenage mothers. Other areas of work in which Connexions is involved include looking at ways of providing affordable childcare, access to information and advice on sexual health and contraceptive advice.

Conclusion

The background data for Salford and Manchester and the literature reviewed here have not only demonstrated and reinforced the impact of social deprivation on health but also enabled clarification of the purpose of Sure Start Plus, and the reasons behind the selection of the specific targets and objectives.

Evidence confirms that teenagers from socially deprived backgrounds are the least likely to have healthy babies and health lifestyles. The reasons included early life deprivation, which affects birth weight and growth and can cause Coronary Heart Disease in later life, housing, culture and ethnicity which may influence physical, mental and emotional well being, and smoking, alcohol and drugs, all of which are known to affect growth and mental and physical well being in many ways both during and after pregnancy. Family breakdown and domestic abuse also play a significant role in mental health breakdown in this already vulnerable group. Literature also focused on prevention of pregnancy and choices in early pregnancy. This included education, access to contraceptive services, the age of onset of sexual intercourse and factors influencing the choice to terminate a pregnancy, all of which are less available to young people with complex social needs.

Although in some areas, such as breast feeding, the literature was less available than others, nevertheless this review has served to confirm the complexity of teenage pregnancy and parenthood, and the imperative for understanding young people, bringing together and understanding the multi-disciplinary and multi-agency services involved in delivering care and providing a service which meets those complex needs. This evaluation begins to demonstrate how Manchester and Salford are working towards this end.

6. Evaluation Design and Approach

The evaluation of the Manchester and Salford SSPP was designed to provide a baseline so that later comparison could be made, findings shared, and lessons could be learned about the implementation of the SSPP within Manchester and Salford. It is a joint piece of work between researchers, teenage pregnancy coordinators and managers (each of the SSPP coordinators were stakeholders and members of the project management team) and SSPP employees.

The evaluation was underpinned by the following broad aim:

- **To determine how effective the SSPP programme was in achieving and delivering its aim, objectives and targets, and how successful the SSPP pilots have been in contributing to the Teenage Pregnancy Strategy.**

Therefore the key objectives of the evaluation were:

1. To collect, examine and analyse data that reflects the extent to which SSPP has been implemented and monitored.
2. To collect, examine and analyse baseline information about the partnership, the leadership and the strategy and costs.
3. To capture the experiences and opinions of the SSPP team.
4. To examine the extent to which SSPP is engaging with, listening to and responding to young people
5. To provide feedback and guidance about the monitoring processes.
6. To facilitate change based on the study findings within the SSPP, so that lessons can be learnt, best practice captured and the results shared more widely.

Components of the evaluation

The evaluation had six main components in order to address the broad aim and objectives:

1. On-going documentary analysis of published and grey literature. Literature reviews and information relevant to the project were an integral part of the evaluation process and supported by an information scientist.

2. Mapping phase (Objective 1)
The mapping phase reviewed and analysed data collection systems already set up by the partnership for its monitoring processes using routine data.

3. Documentary analysis (Objectives 1, 2, 3, 4)
Documentation about how the SSPP partnership was established and how it functions locally were reviewed and analysed, for example strategy documents, minutes of meetings and annual reports. These included details about how new and existing programmes of work had been integrated into the SSPP. Furthermore the analysis attempted to disentangle the effects of SSPP from other teenage pregnancy initiatives.
Attempts to analyse the costs of the SSPP were undertaken at a local level together with analysis of benefits in terms of conceptions avoided, pregnancies avoided, and other associated costs.

4. Focus groups (Objectives 3, 4)
Focus group and face to face interviews captured data on the extent to which the leadership and strategic input had had and is having an impact.

5. Data analysis (Objectives 5, 6)
Constant comparative thematic analysis of findings was integral to the development of the project. Data from each of the components of the mapping phase, documentary analysis, and focus groups was analysed separately then compared and contrasted to develop an evidence base to underpin feedback processes and enable service reconfiguration where appropriate. This included changes recommended by the National Evaluation of SSPP and also issues emerging from the presentation of preliminary findings (interim reports) to each pilot site.

6. Integrally evaluate change (Objectives1, 2, 3, 4, 5, 6)
Local feedback of the process and relevant findings of the evaluation occurred on a continuum. A key feature was raising awareness of the emerging findings within the local areas about the evaluation at each stage. The methods for doing this were as followings:

- Attendance at SSPP meetings
- Project management team meetings
- Opportunistic dialogues and contacts with SSPP or related organisations/agencies

Ethics

Ethical approval to undertake the evaluation was obtained from the Salford and Trafford Local Research Ethics Committees (LREC) and the University of Salford Research Ethics and Governance Committee. Permission to have access to all the monitoring forms and related documents was secured from the SSPP managers. In addition, this included access to some SSPP meetings and contacts with the national evaluation team where appropriate.

Sample and consent

The identification of staff to be included in the focus groups and face to face interviews was provided by the SSPP coordinators. The sample included those staff involved in the SSPP, in other words, all service providers and managers of the SSPP, both current and former staff members of the following groups:

- Manchester SSPP Project Team
- Salford SSPP Project Team
- Reintegration teams
- Connexions employees
- Voluntary and other groups engaged in implementation of SSPP proposals

Written and verbal informed consent were obtained from the participants prior to their involvement in the evaluation. An information letter outlining the evaluation was provided and was reinforced by a verbal explanation of the evaluation. After the initial letter, there was one follow up letter to non-respondents after two to three weeks. It was made clear in the follow up letter that no further attempts to contact them would occur.

At the beginning of each focus group or face to face interview the participants were asked for consent to participate and were informed that they could choose to withdraw at any time. All the participants were treated with respect and sensitivity during the focus groups and face to face interviews as they were designed to elicit views and opinions of local services rather than personal data. Paper copies of the SSPP objectives and targets were then distributed. These were used to facilitate the discussions and act as prompts for discussion (Appendix 1). Data were tape-recorded having secured permission from the participants.

In such a focused study involving a small number of participants, for example only a few personal advisors, extreme care has to be taken to ensure anonymity of those involved. Therefore, to minimise the identification of participants, quotes are presented in a broad manner.

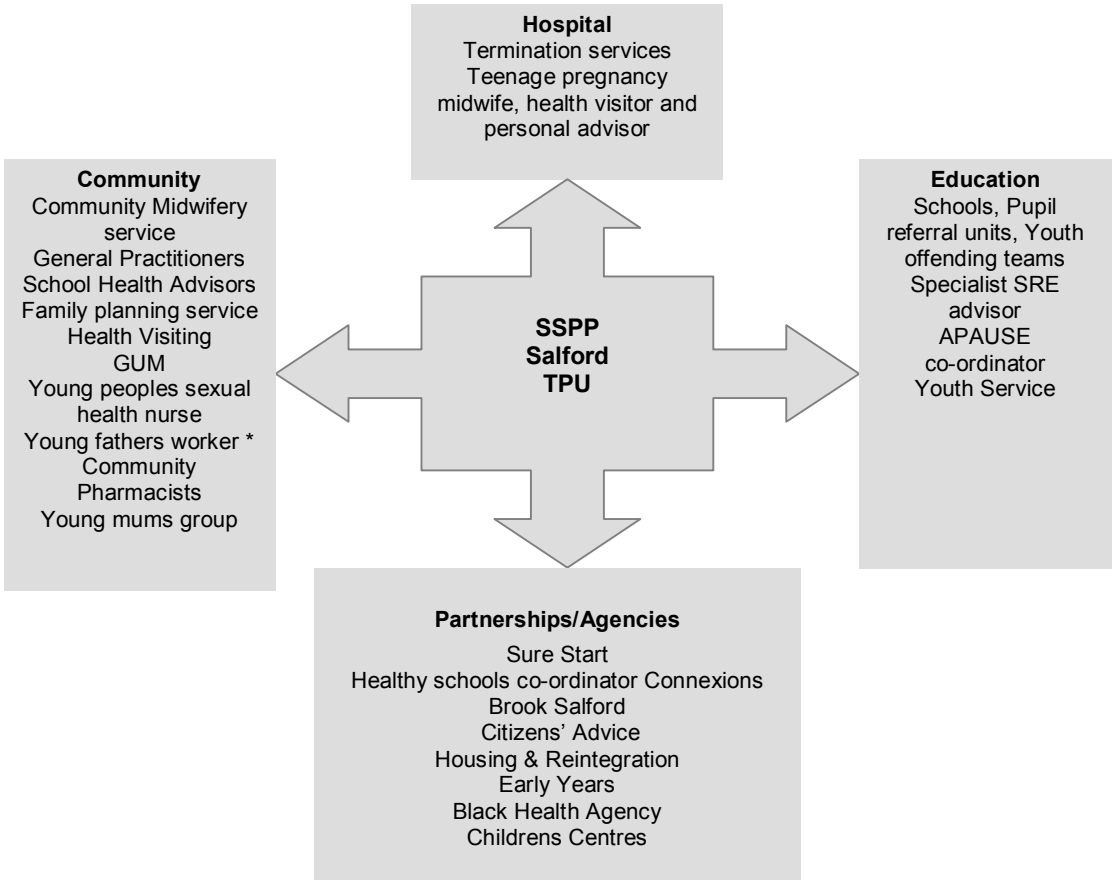
7. Findings

This section of the report presents findings and has been split into two parts. The first part contains findings from the mapping and documentary analysis of the monitoring forms (quantitative data) followed by a second part presenting the findings from the focus group and face to face interviews (qualitative data).

7.1 Mapping Phase

Whilst the initial funding for SSPP in 2001 was for both cities, from an operational perspective each took a different implementation approach. Essentially, this was in response to local need, population variation, NHS service configuration and pre-SSPP existing services for teenage pregnancy. Therefore, before presenting the monitoring data in detail it is worth considering the similarities and differences between Manchester and Salford SSPP. These have been mapped out in the following figures.

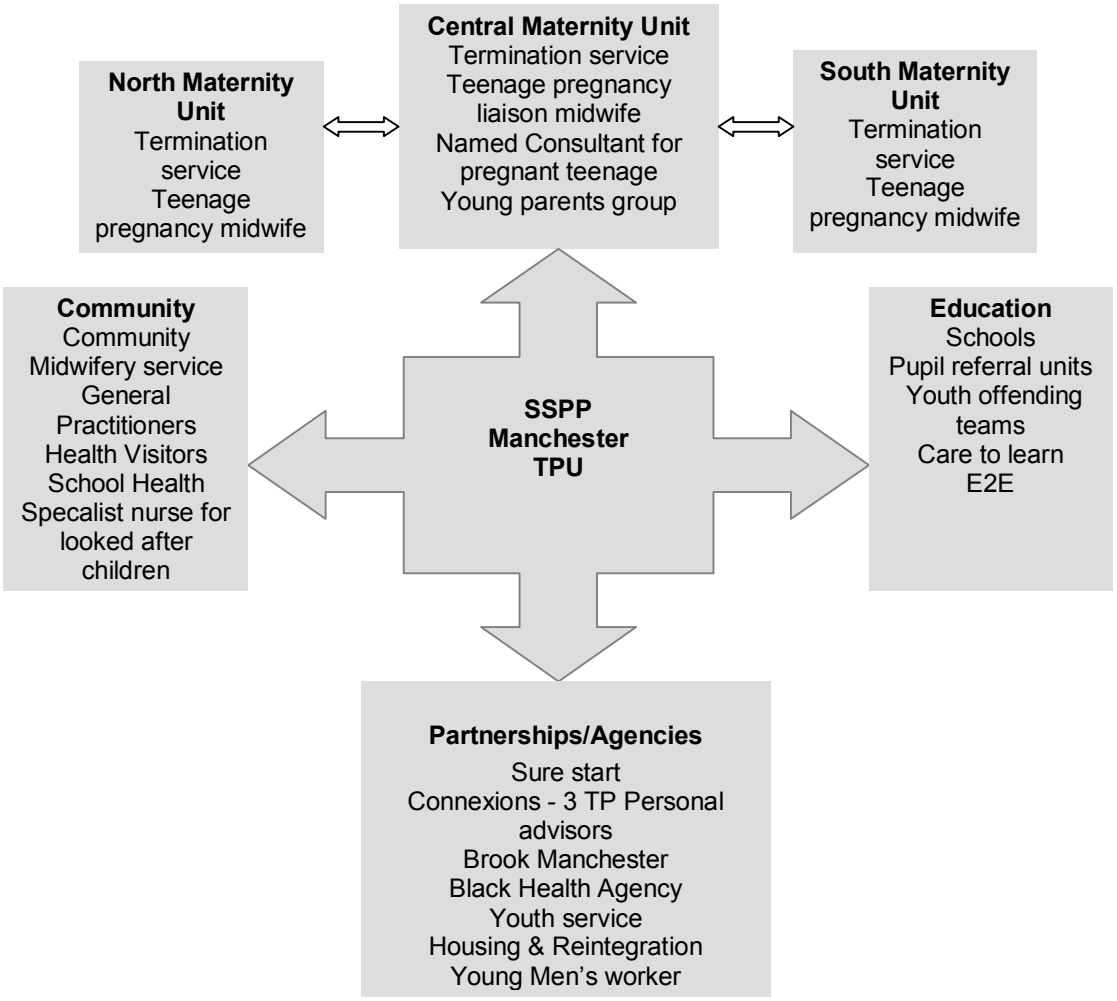
Figure 2:
Overview of the structure of SSPP in Salford



Note:

- Family planning service this included condom distribution scheme for young people.
- *Young Fathers Worker this post came on line in 2005 funded by Children's centres.
- Some terminations of pregnancy are provided privately – no data available on this.
- GUM, means Genito-urinary medicine.
- SRE, means sex and relationships education.
- Citizens' Advice offers an expectant families advice service (funded by Sure Start and PCT).
- Young mums group are funded from a range of sources.
- Generic Smoking Cessation is provided through Public health.

Figure 3:
Overview of the structure of SSPP in Manchester



Note:
- Some terminations of pregnancy are provided privately – no data available on this.
- Young Men's Worker based in the City centre project.
- Young parents group were funded from a range of sources including St Mary's Hospital Maternity Care Services.
- Generic Smoking Cessation is provided through Public health, a drop-in clinic is available at Wythenshawe hospital and community midwives train to be intermediate smoking cessation advisors.
- TP: teenage pregnancy.
- The reintegration officer supports teenage parents and pregnant teenagers and links into schools.
- E2E: an initiative to support young people moving from education to employment.

Both cities are coordinated by the respective teenage pregnancy co-ordinators.

The findings presented in this next part cover documentary analysis of the baseline data collected by each pilot site and the findings from the focus groups and face to face interviews.

7.2 Documentary Analysis

Monitoring forms

The evaluators made use of all the relevant monitoring processes adopted by each site. Numbers were extracted from copies of the monitoring forms submitted to SSPP nationally and entered onto a spreadsheet. Initially the forms used were the M1 Quarterly Information Report (Appendix 2) and the M2 Progress Report (Appendix 3). In 2002 the monitoring forms were changed nationally to the Six Monthly Monitoring Report (Appendix 4).

The monitoring forms posed difficulties both for the SSPP teams and the evaluators. In fact these difficulties had been identified in preliminary discussions with both teenage pregnancy teams, in the focus groups and at the National SSPP evaluators meeting in 2003.

The issues identified were:

- Baseline data did not match the categories on the monitoring forms and therefore comparisons were difficult.
- The initial M1 and M2 monitoring forms (2001 and 2002) did not elicit sufficient meaningful data.
- Of the early forms submitted the data were scanty and inconsistent.
- There was duplication with figures required by other organisations and therefore a lack of enthusiasm for gathering even more data.

The revised data monitoring forms gathered more extensive data, mirroring more (although not all) of the SSPP objectives and measures. However, in the process of transferring the data to the spreadsheet it became apparent that there had been modification of the national monitoring categories over time, making some of the data difficult to record or analyse meaningfully.

Salford official monitoring data were relatively complete, and demonstrated an evident progression towards meeting the objectives and targets of SSPP. Manchester's formal quantitative data collection did not begin until the second monitoring form was implemented in 2002. However, Manchester submitted narrative data which has proved a valuable and informative description of the reasons. Manchester data submitted before July 2003 has been extracted from a number of these narrative documents.

Annual reports

Since the start of the SSPP, in addition to the quantitative data collected 6 monthly, local Teenage Pregnancy Partnership Boards were required to submit an Annual Report to the Government Office each year. The reports have been evaluated by the Regional Teenage Pregnancy Co-ordinator (RTPC), the Teenage Pregnancy Unit and regional leads for Sexual Health, Connexions, Social Services, Healthy Schools, Early Years and Housing.

To complete this cycle, written feedback on each area of the strategy was provided each year with areas identified for action either immediately or to be raised at the six monthly monitoring reviews. The content of these reports provided information vital for the mapping process.

Baseline

The mapping exercise and documentary analysis provided details of how the two sites implemented the SSPP and its associated monitoring processes. The baseline shows two very different models were applied locally.

Salford

Salford set up their team and service within the local hospital and began to gather monitoring data at the outset of the SSPP. In Salford the Teenage Pregnancy service was headed by a Teenage Pregnancy Strategy Coordinator, and the team consisted of a Team Coordinator, an administrator, a teenage pregnancy advisor, a teenage pregnancy health visitor, a teenage pregnancy midwife, a Connexions New Deal Communities Personal Advisor, a teenage pregnancy development worker (South Asian Communities in Salford) and a young fathers' worker. The Salford SSPP team coordinator from inception carried a full caseload. Other relevant wider team members included a young people's sexual health nurse, a sexual health advisor, an APAUSE coordinator, the Connexions Teenage Pregnancy Personal Advisor, and a Sex and Relationships Education (SRE) Development "Out of Schools" worker. The Salford model was showcased in the National Sure Start Plus Evaluation as has the part funded "Expectant Families Advice Worker" based in the hospital Citizens Advice Bureau, and the young mums group (Appendix 7).

Salford baseline data

As Salford began to gather monitoring data at the outset details of the data collected in their first year give useful insight into the service at its inception. This baseline data comprised a sample of 100 records extracted from local maternity unit hospital files, with no mention of fathers' involvement, education and depression data. These records were of young women under the age of 18 at the time of conception and sampled by the SSPP Personal Advisor. These data, however did not fall in line with the most recent 6 monthly monitoring data collection forms, and so cannot be directly compared.

Table 4:
A summary of the Salford baseline data collected in 2001 relating to SSPP targets

Contact with the Health Service
• The percentage of women who were in contact with the health services by 13 weeks was 67%. 62% were 16-17 years 4% were 14-15 years 1% was under 14 years old
Smoking Cessation
• Those seen and advised by smoking cessation advisors had not been recorded on a regular basis. 52% had been given smoking cessation advice. 46% were aged 16-17 4% were 14-15 1% was under 14 years old
Birth Weight
• The proportion of babies weighing less than 2500 grams was 9%. 7% aged 16-17 years 2% aged 14-15 years
More than one child
• The proportion of teenagers under the age of 18 with one or more children was 8%. All were 16-17 years
Education, training and employment
• 10% were employed • 36% attending school, college or training • 46% were unemployed
Child protection data not available
Attendances at parentcraft classes
• 72% were referred • 37% attended
Recognition of post-natal depression
• 5% of 16-17 year old mothers had mental health problems identified • 2% had a previous history of post-natal depression

Manchester

Figures like this are not available for Manchester, although narrative was submitted by the coordinators outlining the extent of the problems in existence in Manchester. To fill in the gaps left by the absence of M1 and M2 progress reports (Appendix 2 and 3) from Manchester, the narrative in the annual report has been used and relevant data extracted.

In contrast Manchester spent the first few months planning how to implement the SSPP to ensure that it was embedded in the Teenage Pregnancy programme for Manchester. With over 500 under 18 conceptions a year in Manchester, the Manchester team felt it was important that the worker did not get overwhelmed by referrals. Much existing activity already addressed many of the SSPP objectives. The activity was partly funded by the Local Implementation Fund and partly by other funding streams.

These included:

- Teenage Pregnancy Liaison Midwife in Central Manchester
- 'X Factor' Parenting Project for Teenage Parents
- Reintegration Officer for School Aged Mothers

The priority for the SSPP was explained as ensuring that any new, SSPP funded activity integrated and enhanced the existing local teenage pregnancy strategy.

Manchester's SSPP Adviser took up post in January 2002 and spent three months networking with agencies across Manchester within the established teenage pregnancy strategy, linking into that work and identifying specific gaps in provision to inform development of the SSPP post. A pure 'adviser' role seemed less appropriate to the Manchester Team where there was already considerable activity addressing SSPP objectives. Manchester's SSPP Adviser role became more strategic with two key elements:

- Co-ordination and development to address specific gaps in current services/support for pregnant young women and teenage parents.
- 'Specialist' one-to-one support for those whose needs were more complex and were not met within existing provision.

Consequently, it was proposed that the SSPP Adviser for Manchester would maintain a relatively small caseload of young women with specific needs. All SSPP activity continues to be an integral part of the wider Teenage Pregnancy Strategy. The SSPP adviser is line-managed by the Teenage Pregnancy Co-ordinator and any strategic or developmental work within the SSPP framework will contribute to and complement the whole teenage pregnancy programme. Strategic planning led the Manchester Team to focus on providing a bridge with the new Connexions Service, which became live in September 2002.

Starting the process of data collection and monitoring presented the Manchester Team with a number of issues.

Difficulties identified included:

- Data collected by the agencies did not reflect the SSP targets.
- Geographical configuration of services in 3 separate areas.
- Data Protection Issues made sharing of data difficult.
- Data collection placed an extra burden on workers, who felt they lacked support with data collection nationally.

The team found that some data were just not being collected by relevant agencies reflected in the quality of data available from Manchester for the local evaluation. There were problems specific to Manchester in trying to manage data collection over three PCT areas, three Hospital Trusts and a large voluntary sector. There were barriers to collection due to national guidelines relating to Caldicott and Data Protection. It was found that the data collection process placed a burden on the adviser who also had to co-ordinate the project and see clients. There had been no support from the national unit to set up a database to ease the process of data collection.

One innovation described in the Manchester narrative was specifically aimed at joining up existing services and providing a central point of access for clients. The Teenage Pregnancy Directory of Agencies provides a description of all services or agencies which might help pregnant teenagers and teenage parents and gives direct contact details for each. It is available on-line at http://www.northmanchesterpct.nhs.uk/pregnancy/index.htm

Summary

Overall the documentary analysis revealed a number of limitations and problems associated with the way in which the SSPP had been structured and organised. These were on a local and national level. The limitations are outlined below:

- Locally there was a renaming of the project to distinguish it from Sure Start, this cause confusion and lack of identity initially.
- Local SSPP Advisors did not stay in post for the full length of the project bringing issues of recruitment and reorientation.
- There were differences in management style and implementation between Salford and Manchester. This caused problems in collection of monitoring data.
- That SSPP has a crowded agenda encompassing health, housing, child care, and access issues, which were hard to monitor in the short term
- That there were problems communicating the extensive information to all staff involved directly and indirectly with SSPP.
- The organisation of SSPP nationally changed throughout the course of the pilot. Twenty original sites became 35 with this reorganisation.
- National staffing changed, which led to a lack of continuity in communication to the local teams.

These factors delayed the progress of understanding the scope of the project and its implementation.

Quantitative Data Analysis of the Monitoring Form

The data presented below taken from the monitoring forms largely focus on the two year period July 2003 - July 2005 which contained the most complete data. Both sites' figures increased in the period January - June 2005 and this may reflect changes in the way the data were collected and expansion of the teenage pregnancy teams. However, difficulties in collating these figures (as outlined earlier and in the national report) mean that these figures and any inferences taken from them should be treated with caution.

However, in Manchester some essential teenage pregnancy services funded from other sources have been omitted from the SSPP monitoring data (Appendix 6). All data do not include those young people who had attended Brook.

The following subheadings relate to the main data collection items contained in the monitoring forms.

Ethnicity

Census data (ONS 2001a) for Salford illustrates that 96.1% of Salford's population is white, less than 1% mixed race, 1.38% Asian and 0.58% Black and 0.91% Chinese or other ethnic group. Salford's Black and Minority Ethnic Communities have increased by 1.8% since the 1991 census. Since 2001 a number of Asylum Seekers and Refugees have moved to Salford and there are now 37 nationalities and 21 languages spoken in Salford schools.

This is in contrast to Manchester where 80.96% of the population is white, 3.23% mixed race, 9.13% Asian and 4.52% Black and 2.17% Chinese or other ethnic group. Manchester has a larger diverse black and minority ethnic (BME) population compared to Salford.

This provides a challenge of ensuring that services are delivered in culturally sensitive ways (Teenage Pregnancy Unit 2000). Very little is known about the relationship between ethnicity and conceptions within the under 18-age group. There is some evidence that cultural and religious differences may contribute to younger marriage and high levels of teenage pregnancy for some ethnic groups (Botting et al 1998; Elam et al., 1999). One study in Coventry identified that conservative attitudes to early sexual behaviour and virginity at marriage are prevalent in young Asian culture (Wallace et al 2003).

More data are needed about sexual behaviour and attitudes towards accessing contraception and pregnancy tests. One Birmingham study WMPHO (2004) suggests that the patterns of teenage pregnancy in ethnic minority populations are different to those in the white population, in particular that cultural influences in some ethnic groups are stronger than the influences of deprivation and education. The monitoring data are therefore very important for planning of culturally appropriate services.

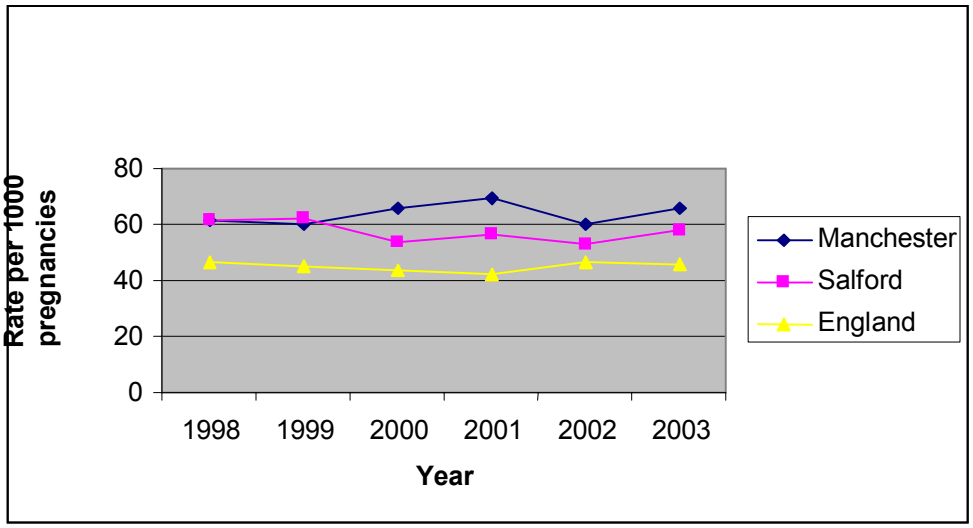
The SSPP's monitoring form contained details of the ethnic background of recorded contacts. Whilst the monitoring data were incomplete, the figures are illustrative of the people served by SSPP in each location. As the table shows those accessing SSPP in Salford are predominately white (93%). Whilst three out of four people accessing Manchester SSPP are white other ethnic backgrounds are represented.

Table 5:
Recorded percentages of total SSPP contacts by ethnicity (Manchester and Salford)

Ethnicity	Salford (% of total)	Manchester (% of total)
White: British, Irish, Other White	639 (93%)	310 (76%)
Mixed: White/Black Caribbean, White/Black African, White/Asian, Other	7 (1%)	18 (4%)
Asian: Indian, Pakistani, Bangladeshi, Other	0 (0%)	7 (2%)
Black or British Black: Caribbean, African, Other	5 (1%)	48 (12%)
Chinese or Other Ethnic Group	7 (1%)	3 (1%)
Ethnic Origin Unknown	29 (4%)	19 (5%)

To put all of the Manchester and Salford Monitoring data into context Chart 3 provides an overview of teenage pregnancy rates in Manchester, Salford and England as a whole for the seven year period up to 2003. Rates for both Manchester and Salford are around 60 per thousand, whereas the national average is just over 40 per thousand, with a range nationally of 15 - 75 per thousand.

Chart 3:
Teenage pregnancy rates: comparison between Manchester, Salford and England for 1998-2003



Source: National Statistics (2005)

People in contact with SSPP

Over the two year period July 2003-5 Salford recorded 982 pregnant teenagers, fathers to be, teenage mothers and teenage fathers in contact with SSPP. The figures for each six monthly period remained fairly steady averaging around 230 contacts but this increased by 24% to 286 during January - June 2005. A breakdown of these figures is available for the 18 month period January 2004 - June 2005. Of the 743 people in contact with SSPP during this period 54.8% (407) were pregnant teenagers, 39.4% (293) teenage mothers, 3.8% (28) fathers to be and 2% (15) teenage fathers. When compared to National Teenage Pregnancy statistics which show an annual number of teenage pregnancies at around 250 in Salford, the recorded uptake of SSSP is very high.

Manchester recorded 467 people in contact with SSPP. The figures were fairly steady for the first 18 months (around 110 per six month period per 6 month period) but again saw an increase, this time of 28%, in the period January - June 2005 to 140. Again, due to changes in data collection methods a breakdown of these contact is only available for the 18 month period January 2004 - June 2005. Of the 369 people seen during this period 34.1% (126) were pregnant teenagers, 61% (225) teenage mothers, 1.4% (5) fathers to be and 3.5% (13) teenage fathers. Those in contact with the SSPP represents approximately one third of the total number of known teenage pregnancies in Manchester.

It appears from these findings that Salford SSPP sees a higher proportion of pregnant teenagers than Manchester. In Manchester over 60% of the contacts recorded are teenage mothers and less than 35% are pregnant teenagers. In both sites neither sees many fathers or fathers to be, which appears to confirm both the literature and anecdotal evidence that young men find it harder to access services.

Advice in pregnancy

Over the two year period Salford recorded a total number of 473 pregnant teenagers advised by SSPP. This figure includes teenagers who suspected they were pregnant but subsequently found that they were not; in fact this group comprised 44% (207) of the total number and was split evenly between the period July 2003 - June 2004 (107) and July 2004 - July 2005 (100). The remaining pregnant teenagers advised by SSPP were further sub-divided by the time at which they were

advised in their pregnancy. A substantial number (111, 23%) were given advice by SSPP early in their pregnancy (before 10 weeks). The remainder were given advice either between 10 and 14 weeks (60, 13%) or at 14 weeks or later (95, 20%). Curiously very few contacts were recorded for the period July 2004 - Jul 2005 (8, 3, and 8 respectively).

Manchester recorded a total of 202 pregnant teenagers who were given advice over this two year period. However, unlike Salford, the proportion of teenagers given advice in respect of a suspected pregnancy who found they were not pregnant was only 6% (11) of the sample. A number of reasons have been offered for this, including split sites for hospital services, contacts with Brook not being included and care taken not to include in the count teenage pregnancy services available prior to the start of SSSP funding. Two thirds of the teenagers (131) were given advice at or after the 14th week. But this figure covers an anomaly in the data. Of the 131 teenagers recorded in category, 77 (59%) were in the six month period July - December 2003. With the exception of this figure the rest of the contacts were evenly distributed over the two year time period and between the categories. Nevertheless, this still demonstrates that Manchester SSSP is seeing a higher proportion of teenage mums than pregnant teenagers.

Pregnancy status

Data for teenagers advised by SSPP were kept to determine the status of their pregnancy. These figures provide an indication of the status of the pregnancy in each of the SSPP locations. For some this meant recording that they were no longer pregnant due to miscarriage or termination; for those who had given birth whether they had kept the child, the child had been adopted or if they had had a still-birth; or if they were still pregnant. Completed data were held for both Salford and Manchester for the 18 month period January 2004 - June 2005 and is presented below.

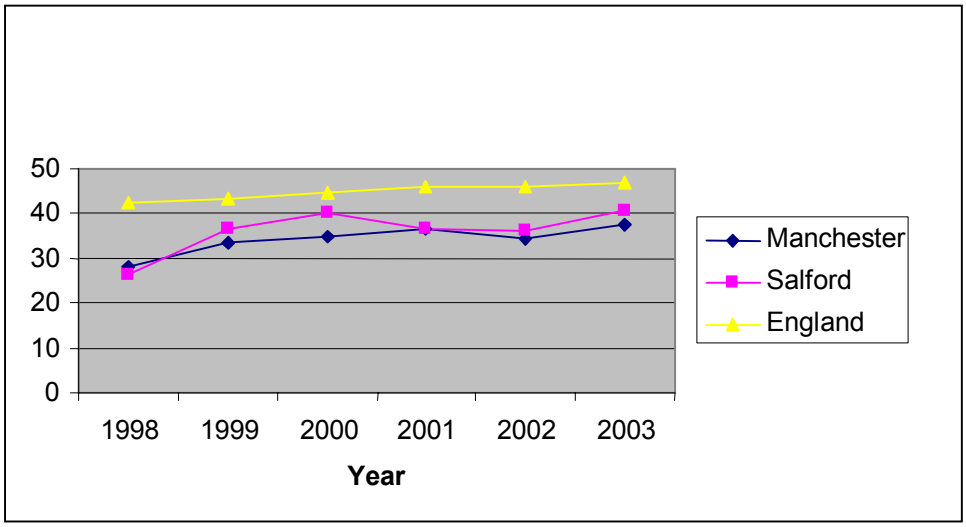
Table 6:
The Salford and Manchester SSPP recorded pregnancy status and outcomes January 2004-June 2005 (as requested by national SSPP)

Pregnancy status	Salford (% of total)	Manchester (% of total)
Termination	68 (18%)	2 (2%)
Miscarriage	11 (3%)	2 (2%)
Birth: parent kept child	153 (40%)	46 (51%)
Birth: adoption	2 (0.5%)	2 (2%)
Still-birth	2 (0.5%)	0 (0%)
Pregnancy on-going	146 (38%)	31 (34%)
Unknown	0 (0%)	8 (9%)

These figures show a higher proportion of terminations in Salford than in Manchester (18% and 2% respectively). Possible explanations of this are the higher proportion of teenagers in Salford who received advice in the first 10 weeks of their pregnancy, and the location of Salford's SSPP advisor in the same hospital as both maternity and termination services. Both medical and surgical terminations are sometimes carried out at other locations, for example private providers and charitable organisations. Only a small proportion of teenagers in Manchester were in contact with SSPP in the first 10 weeks of their pregnancy. For anyone seeking termination early booking is important and Kane and Wellings (2003) suggest that early booking is much less likely to occur in poorer areas.

National termination statistics in the under 18's demonstrate that the national average percentage of pregnancies ending in termination is around 45%. Teenage termination rates in Manchester and Salford have slowly increased from around 28% in 1998 to around 40% in 2003. Compared to these national averages the figures recorded by the SSPP are very low (see Chart 4).

Chart 4:
Percentage of pregnancies to under 18 year olds ending in termination, national comparison with Salford and Manchester (1998-2003)



Source: National Statistics 2005

Support packages for pregnant teenagers/teenage mothers

A vital component of the SSPP remit was to put into place support packages for pregnant teenagers and teenage mothers. The SSPPs reported both how many support packages were in place in each six month time period and how many of these were new packages that had been put into place. The following table (7) summarises data from both Manchester and Salford from 2003-2005.

Table 7:
The total number of pregnant teenagers/teenage mothers for whom support packages were in place in both Salford and Manchester

Time period	Salford Total support packages (new packages)	Manchester Total support packages (new packages)
July – December 2003	58 (48)	91 (76)
January – June 2004	156 (75)	93 (55)
July – December 2004	188 (79)	96 (46)
January – June 2005	150 (59)	114 (67)

Support packages were also put in place for teenage fathers/partners. The numbers of these types of packages was far smaller than those for the pregnant teenagers/mothers as can be seen in Table 8 below. In Salford however, in the period January-June 2005, a young fathers' worker was employed to support young fathers and fathers to be. In this period the number of support packages for young men more than doubled. This appears to demonstrate a positive effect of the focus on fathers.

Table 8:
The total number of teenage fathers/partners for whom support packages were in place in both Salford and Manchester

Time period	Salford Total support packages (new packages)	Manchester Total support packages (new packages)
July – December 2003	10 (4)	3 (1)
January – June 2004	0 (0)	2 (2)
July – December 2004	10 (1)	6 (5)
January – June 2005	22 (not known)	7 (5)

Contact with health services

The SSPPs collated data on the numbers of pregnant teenagers who had been in contact with SSPP during the time period and in contact with health services. In Salford 339 of the SSPP pregnant teenagers were in contact with health services prior to their 14th week and 249 at or after their 14th week. These figures show, that for those for whom we have data indicating they have been in contact with health services, around 58% made this contact prior to their 14th week.

In comparison Manchester had 72 teenagers in contact with health services prior to 14 weeks and 39 after. This shows a higher proportion (65%) who were in contact with health services prior to their 14th week. However, any inferences must be regarded with caution as the data set is not complete.

There was in the course of the evaluation a national meeting and discussion by all the evaluators in 2003, where the contentious SSP measures were discussed. This discussion was based on some SSPP workers' opinions of the SSP objectives, targets and measures. Some were ambivalent about the breastfeeding and smoking targets and measures. Interestingly, the following quantitative analysis demonstrated little movement particularly in these two contentious areas

Smoking

The SSPPs collected data indicating the number of pregnant teenagers in contact with them who smoked during pregnancy and who smoked after birth in each time period. In the 18 month period January 2004 - July 2005 of the 407 pregnant teenagers in contact with Salford SSPP 218 (53.6%) smoked. In the same period 97 of the 293 teenage mothers (33.1%) smoked after the birth. Over the same period in Manchester the SSPP recorded 36 of the 126 pregnant teenagers smoked (28.6%) and 50 of the 225 teenage mothers smoked after the birth (22.2%).

As yet there is no discernable pattern, or evidence of success in smoking cessation services. The proportions have not reduced in each successive period.

Breastfeeding

In the 18 month period January 2004 - June 2005 Salford recorded that they were in contact with 293 teenage mothers. Data on breastfeeding were recorded for 41 of these mothers. The data show 33 breastfed before six weeks and eight continued at or after the six weeks. Manchester recorded 225 teenage mothers and gave details of breastfeeding for 32; of these mothers 25 breastfed before six weeks and seven at or after six weeks. Manchester also recorded 16 unknown. Again any inferences made should be treated with caution due to the large amount of missing data.

Education, training and employment

The SSPPs were asked to record details of teenage mothers participating in education, training or employment to map against the SSSP target: *to increase the numbers of teenage parents in education and training, and to increase the numbers achieving NVQ level one.* Data collected on

this target are incomplete and appear to have been derived from different sources. Therefore no findings are available or can be commented on.

Childcare

A comparatively small number of young people in contact with the SSSP made use of available child care packages, and those who did are generally recorded as having children under 2 years old. However, as the most accurate data is from the period 2003 onwards data for older children may not yet be available, and the picture may become very different in the next 12 months.

Housing

Attempts were made to gather data to show the numbers of young people living with parents, living alone and living in supported housing. Data for the type of housing accessed by the total number of SSPP contacts were largely incomplete. Therefore no general findings can be commented on. However, although the figures are incomplete, over the period of SSPP data collection 2003-2005 there were 38 young mothers recorded housed in lone tenancies in Salford and in Manchester 92. This was falling clearly falling short of the SEU target (SEU 1999).

Costs & Benefits

Overview: costs and cost savings

The long term gains of improving the physical and mental health of young families, providing adequate housing, raising self esteem and aspirations and realising good education and childcare cannot easily be measured in financial terms. It is nevertheless recognized that there are financial as well as social implications of initiatives which drive down unwanted pregnancies and support young families. For this reason an attempt was made to address the costs and the cost effectiveness of the SSPP.

The cost and cost effectiveness literature were reviewed to explore the possible costs and benefits associated with the aims of SSP; to determine the cost of care during pregnancy and the cost of child rearing. The estimates presented are just that, estimates, taken from differing sources and years. They do however provide a context for both the SSPP and the evaluation.

In the area of costs associated with pregnancy, the literature focuses mainly upon evaluations of competing technologies and their comparative costs. Indeed many evaluations were concerned with different screening techniques/methods during early pregnancy. However, Varney and Guest (2004) recently estimated the average cost of pregnancy care to the health service, without subsequent child care or child rearing at £21,000 per pregnancy but stress that the figure estimated can vary due to the variety of different ways pregnancy care can be delivered.

Any cost of raising a child clearly is even less generalisable to a whole population, as there is such a wide gap between rich and poor and diverse experiences of parenting and utilisation of state versus private provision. However, a survey conducted by the Centre for Economics and Business Research, commissioned by the Liverpool Victoria Insurance Company, gives one such *average* cost of bringing up a child from birth to 21 years as approximately £140,000 per child, with highest costs in the first 5 years of a child's life, and then in higher education (Womack 2003). In respect of those pregnancies that are terminated Nixon et al (2002) report the average cost of a medical termination estimated at £400 and the average cost of a surgical termination at £700.

Embedded in the SSPP remit is providing contraception advice. In order to cost contraception a USA study by Trussell et al (1995) calculated that costs for contraception ranged from $285 (£161) per person per year for injectable contraceptives, to $2,554 (£1444.80) for female sterilisation. The average total five-year costs ranged from $540 (£305.48) for copper-T Intra-Uterine Device to $5,730 (£3241.50) for cervical cap. Over 5 years contraceptive use was estimated to prevent

approximately 4.2 pregnancies per person. These findings concur with recent guidance from the National Institute for Health and Clinical Excellence (NICE) (NICE 2005) who recommend long acting reversible contraceptives such as contraceptive injections, implants and intrauterine methods. Their guidance reports that an increasing uptake of such contraceptives will reduce the numbers of unintended pregnancies resulting in cost savings to the health service and are more cost effective than many other methods because of this reduction.

Encouraging smoking cessation is another objective of SSPP. NICE (2002) report that 25 out of every 100 15 year olds are regular smokers and overall smoking related disease costs the NHS about £1.5 billion per year (NICE 2002). The smoking cessation intervention analysis suggests that the NHS smoking cessation services have cost-effectiveness of better than £800 per life year saved, representing good cost effectiveness (ASH 2001).

Funding

In terms of the individual pilot programmes, funding allocated to each varied depending on the size of the area covered. Grants ranged from £125,000 to £255,000 per year. Manchester and Salford received £200,000 per year, £85,000 was allocated to Manchester and £115,000 to Salford. As part of the 2002 Spending Review outcome, Sure Start Plus nationally extended the lifetime of the pilot from three to five years. Further funding was allocated until March 2006. Further information about funding is available in appendix 5.

The structure of each SSPP is shown in figures 2 and 3.

Cost effectiveness

Whilst it was outside the remit of the evaluation to carry out a full cost effectiveness analysis it was intended that a primary analysis of the costs and benefits of the SSPP would be conducted at a local level.

A full economic evaluation typically requires a comparison of the cost and effectiveness or benefits of competing interventions or methods of service delivery. The costs of providing the SSPP can be measured in terms of the funding allocated (using a top down approach). Possible cost savings emanating from the programme were demonstrated in the literature, but the effectiveness data was somewhat elusive.

The aim of the SSPP is to secure long term gains for those accessing the service. These included improving the physical, emotional, social and mental health of young families, helping them to access adequate housing, raising aspirations and achieving a good education. The targets assigned to the SSPPs provided a method by which the effectiveness of the programme could be measured. Thus, the effectiveness of the programme would be reflected in areas such as:

- Number of pregnancies avoided/ contraception provided and contraception advice given.
- Number of terminations of pregnancy carried out.
- Numbers of mothers breastfeeding.
- Numbers of teenagers partaking in smoking cessation initiatives.

It was anticipated that data would be readily available from the SSPP monitoring sheets. As outlined earlier, given the difficulties associated with these monitoring forms and the incomplete data the forms captured unfortunately even the evaluation of costing is an area of continuing work. As such no conclusion can be drawn at the present time.

Summary

The quantitative data provided a broad picture of the services available and the numbers taking up the service. The slow initiation of the monitoring process, the low numbers accessing SSPP and low numbers being recorded illustrated gaps for which the reasons were not always clear.

In spite of all of the difficulties outlined in the data collection processes and in the small numbers of data available for several of the measures, data have been collected more consistently over the last 18 months. At the end of the SSSP, young people had accessed and were continuing to access the services in increasing numbers. Over 1,500 young people had used the service at the time of this report, and the number of integrated packages in place was increasing. The Young Men's service has started to grow, particularly in Salford.

The following part of the evaluation, focus group interviews, provided the means for closing those data gaps and providing explanation and rationale for some of the differences and similarities in quantitative data available.

7.3 Focus Group Interviews

The following section outlines the findings from the focus groups and face to face interviews. These are presented to correspond with the broad objectives for collecting these data; to capture information on the experiences and opinions of the SSPP team, the extent to which SSPP was engaging with, listening and responding to young people and the extent to which the leadership and strategic input had had an impact. A final section will discuss and draw conclusions from this part of the evaluation.

The focus groups and face to face interviews were collected at two points in time, in the first year of the evaluation (phase 1 in 2003/4) and then again in the final year (phase 2 in 2005).

Who responded?

In total 8 focus groups and 12 face to face interviews were conducted with 41 staff participants. Table 9 outlines the number of focus groups and face to face interviews undertaken in both Salford and Manchester and the total number of participants. The focus groups were carried out with either managers or SSPP providers and partners including other agencies. This resulted in 12 managers (29% of sample) and 29 service providers (71% of sample) attending the focus group or a face to face interview. Given the nature of the teams any further specific details of the participants could lead to identification of the participants and is therefore not disclosed.

Table 9:
A summary of the total number of focus groups and face to face interviews undertaken and number of participants (n=41) involved in phase one and two

When	Method	Salford	Manchester
Phase 1 in 2003/4	Focus group 1	4	5
	Focus group 2	3	5
	Face to face interviews	3	1
	Sub total of participants	*11*	*11*
Phase 2 in **2005**	Focus groups 1	3	2
	Focus group 2	3	n/a
	Focus group 3	3	n/a
	Face to face interviews	4	4
	Sub total of participants	*13*	*6*
	Total number of participants (n=41)	**24**	**17**

Those declining to participate often said they did so because they did not feel they would be able to offer anything constructive to the process, not knowing enough about the project, or feeling that the project had not got underway sufficiently to comment. Others were too busy, or the timing was inconvenient.

Setting the context

At this stage it is worth setting the context, as the participants' involvement in and experience of the SSPP during its first year varied according to their roles and length of time in their post as a manager, personal advisor or service provider.

Overall managers, personal advisors, service providers and staff from partner organisations (e.g. Connexions, Reintegration and Voluntary groups) who participated had different levels of awareness and insight into the SSPP key objectives and targets. In phase 1 a lack of clarity existed amongst participants as to what the actual targets were for SSPP and why such targets had been chosen i.e. a lack of understanding about the origins. This lack of awareness changed by phase 2, as most participants became familiar with them. The focus groups in particular provided a forum for information sharing and useful discussion amongst the participants from this they began to network and play a part in information exchange. For example, in phase 1 this was the 'first time' that the participants had met with one another as a group. But by phase 2 some of the participants were familiar with one another through SSPP work, whereas others were new recruits to SSPP and had not met prior to the focus groups.

Findings from Manchester and Salford phase and 1 and 2 are presented together but where appropriate differences and key points are highlighted. Quotes have been selected according to which best represent the data regarding that theme. The selected quotes are coded as Manchester (M) and Salford (S) and square brackets within quotes denote that the authors have interpreted or added a phrase to enhance the clarity.

Experiences and Opinions of the SSPP Team

Attitudes towards SSPP

Common to both phase 1 and 2 participants was a positive attitude toward SSPP supporting young people and enabling them to have better life chances. The overall view was that SSPP was a real *opportunity* and that SSPP was an exciting government policy for the benefit of young people in both Manchester and Salford. There was talk of a *feel good factor* and a genuine desire to engage specifically with young people as part of the teenage parenthood debate. As the following comments highlight from phase 1:

> *'Scope exists to set up schemes that work with young people and young mothers in groups or on their own; I am really keen to be working on this project..'* (M)
>
> *'… as I said before that I am quite enthusiastic and idealistic about it because I do think if they* [young people] *become pregnant and they choose to continue with the pregnancy, we need to support them throughout the pregnancy and support them with the children subsequently and to try and help with their family and partnership support and you know all of those things I would support wholeheartedly…'* (S)

and from phase 2:

> *'Yes, I mean Sure Start Plus is a very good support network which you can offer and we think it's great...'* (M)

Sure Start Plus is ideally placed because they are there [SSPP team] *and can carry these things on all the time and it's very good that the other support networks know they are there and know that they carry on referring to these people because the supports there'* (S)

However, the main or overarching theme to emerge focused on the SSPP targets and objectives.

SSPP targets and objectives

For many the focus groups provided the first opportunity to the SSPP to see the targets and objectives. There was a consensus that targets themselves were rather *superficial* and unrealistic in respect of the real issues pertaining to teenage pregnancy and parenting in the two cities. In addition, it was considered that such targets had to be *shared aims* and addressed by a range of practitioners, services and organisations, the expectation that the local SSPP could achieve all of these targets alone and in isolation was considered to be ill thought-out, unachievable and perhaps would not be sustained.

'I was aware of what some of these targets were, but I've never seem them like identified for each objective. No' (M)

'I always felt they [targets] were loose, I am not aware how they are measured, for me this then means I lose the importance of the meaning, they are not tangible really' (S)

'you just hope that you don't get a change of government, who decides to completely scrap the whole project which is obviously always been the downside on these sort of projects isn't it. ... You know sometimes you might be talking five, ten years before you get proper results' (S)

Another dimension that emerged was the authenticity of counting data and the tension about whether data were being shared, or whether risks existed in *doubling up* the same data from the same families. It was known that some of the targets were also included within other policies and strategies. The targets were considered to be open to interpretation and lacked meaning for some staff as uncertainty existed as to whether they had been interpreted in the right way.

'I can't produce management information or demonstrate progress or allocate resources to support young mothers if I don't know who they are and this is a problem with a lot of government targets and initiatives at the moment' (M)

Furthermore, concerns emerged around the appropriateness of such targets for young people and questions emerged as to how the health targets related to all mothers, irrespective of age, as opposed to being focused on young mothers only.

'We produce our statistics every month and I don't think our statistics actually go a long way to demonstrate in either our success or failure, what they actually do from our point of view is say how many of this we've done, how many of that and we did with this and that seems to be as far as we go' (S)

'One of my biggest frustrations is the monitoring form…. It's time consuming and wasteful and I can't understand why it can't be a standard method of collecting information by age' (M)

The expectation that the local SSPP could achieve all of these targets alone and in isolation was considered to be unrealistic. The real test was considered to be effective team working and inter-agency collaboration. In phase 1 the entire sample showed a real determination to work hard towards achieving this goal. By phase 2 findings suggested that this had occurred. This dimension is covered in more detail later.

Health targets

The health targets stimulated debate around the complexity of placing these under SSPP. It was considered that overall responsibilities lay with midwives and heath visitors primarily in health. In contrast there was a view that health was more closely connected to the wider socio-economic factors as these play a much more powerful role in young people's lives. For example, state benefits were highlighted as being instrumental in the meeting the nutritional needs of teenage mothers, including access to and knowledge of their entitlement to state benefits.

> *'One mum I know had been eating only eggs for about 5 weeks, not for any other reason than she had no money or proper cooking facilities and sometimes other residents take their stuff - steal from their rooms [like her food] '* (M)

In addition, housing and the living conditions were highlighted as being very much associated with health and well being of teenage mothers. On visits made by the evaluators to accommodation for young mothers it became apparent that the standards of such accommodation varied. The locations were often far removed from the home and community of the young mother, and the involvement of the father was not only not encouraged, but in some instances seen as problematic.

Participants felt specifically that a young person's access to money or lack of (i.e. experiencing poverty), the level of independence and support were major factors in a young person's life rather than health per se. Scenarios from participants' caseloads were offered to illustrate such points as can be seen by the following comments:

> *'we don't engage with them about smoking at all. ….engagement is generally around whether they would be keeping the child or whether they would be terminating and there again the majority of pregnant teenagers who come to us are in the end going to terminate the pregnancy. So the issue of smoking during the pregnancy is not a big issue for us'* (S)

The health targets were considered to be exclusively about the baby's health and not around the young mother's health and well-being. As such some felt that they were rather limiting especially for the partner agencies and non-health sector workers.

There were strong views expressed about the purpose and need for all the health targets, although comments on smoking and breast feeding were the most prevalent and triggered extensive in-depth discussions amongst the participants. Personal views and anecdotes were in abundance, with a diverse set of opinions on the pro- versus anti-smoking and breast feeding spectrum. Disagreement existed as to what was right or wrong and what people's roles were in the context of SSPP in achieving the targets on smoking and breast feeding in particular. Many felt that they, as SSPP staff, were in no position to dictate or promote either target per se. In contrast others felt that a holistic approach to health was the only way forward in tackling such health matters, as it was *everyone's responsibility*. Agreement did occur in regard to one fact, in that it was considered to be a personal right to choose whether or not to smoke and whether or not to breast feed rather than it being a government target or objective for state control.

Smoking

> *'I don't know about smoking, I know it is a government issue for all mothers, never mind teenage mothers but I don't know anything specific about that'* (S)

Questions were raised as to the good sense and value of including smoking interventions because it was considered that smoking maybe the only constant thing in the lives of young people during pregnancy and motherhood. Participants felt there were tensions in attempting to reduce the potentially harmful smoking of young pregnant women when they clearly derived pleasure and

temporary relief of stress from it. The list below summaries some of the main points that were raised by the Manchester and Salford participants:

- Professionals engaging with young people were asking *'do we want to be the person who says stop (linked to health messages) you should not be doing this'* e.g. smoking – '*if we are pushing on this it can affect the relationship and the ways in which we want to work together later with young people'.*
- They also asked *'Do we make them feel guilty?'.*
- They noted that how smoking cessation is approached is important *'If you addressed it without it being like you're dictating to them and that I mean it's a very, very important thing but again a lot of will power'.*
- Whose role is it? Maybe more about the Governments role *'I think we do all we can do but I think there is a lot of pressure to do more from the government'.*

In some cases participants reported that they had mixed feelings about the value of smoking cessation, and there was an almost fatalistic attitude of some participants towards the smoking cessation package. A few commented that they knew that the numbers of smokers was high (anecdotal evidence).

A further point noted in both phase 1 and 2 data was that many SSPP staff were not trained in health care. It was questioned whether or not all SSPP staff needed to be a generic worker or specifically skilled in key elements of working with young teenagers. This was versus the need to recruit and train staff to be able to signpost young people to the most appropriate person e.g. midwife in the case of health. The following comment captures the essence of this shared view:

> *'…. the Connexions Sure Start Plus part of our service that would be a weakness because we don't have any medical input, so again they're* [Connexions staff] *actually not trained to deal with the smoking aspect of it'*

Breast feeding

Alongside emotive and subjective talk a shared ideology for including breastfeeding as a target in SSPP existed. Overall it was agreed that health benefits did exist in relation to breast feeding. These included improved child health and development. However, divisions and disagreements in the views of participants did unfold and at times took up much time in the focus groups. There was no difference between Manchester and Salford or in phase 1 or 2, viewpoints were consistently diverse and constant over time.

Opinions were strong that young mothers should not be singled out or be barraged with pro-breast feeding messages. There existed a consensus amongst the service providers and managers that the message needed to be balanced, timely and appropriate to the young person. Like smoking this was an individual decision and a personal one given the context, it was considered a more sensitive topic for young people than smoking.

Extensive debate took place about the knowledge base on the topic of breast feeding ranging from the 'ideal' number of women who breast feed, the UK national target, benefits, side effects, social influences and support mechanisms both professional and lay people. For example it was noted that health workers were more knowledgeable about some aspects and Sure Start Plus advisors insightful about other aspects, as the following two comments highlight:

> *'..there's a lot more* [young mums] *that start breast feeding, but quite a few, and that's only while they're in hospital and I still feel they get very little support even though we've got a breast feeding midwife I don't feel that there's still a lot of support given to any women, I don't just mean young people'* (S)

'I think it's just very hard to put that [breast feeding] *as a target for the Adviser because ultimately it's not their choice, you know, however you might feel about it'* (M)

No one generally knew the national rate or trend or had insight into how the UK rate compared to other countries, or how the two cities faired. There was however an agreed perception that Salford had a very low uptake rate and that breast feeding was not popular amongst most Salford families. Discussions with young people about breast feeding were selective. Mostly this was linked to skills in assessing young mothers and listening to their priorities. For many young women breast feeding is not on the agenda. However, participants reported that appropriate information and promotion of breast feeding was positive and balanced as can be seen from this comment:

'I don't chat to all young parents or parents to be about it, but the ones I do chat to I kind of stress how cheap it is, how easy it is and good it is for the child, and you end up having some interesting discussions because often it seems that it hasn't been done in their family for a few generations, and it's something they're interested in and we have some interesting discussions and I think quite a lot of them go away and have a think about it' (S)

Overall, all agreed that support was a key feature in all aspects of the debate related to breast feeding. That whilst health professionals played a role they were not the main source of support nor had they the full remit for breast feeding sustainability. This whole topic of breast feeding was considered to be difficult for all women, but more so for young mothers. Thus a very challenging one for SSPP to achieve and in the context of young people and teenage pregnancy rates perhaps not the most important to focus upon.

Accessing young people

A specific target to be achieved related to teenagers making early contact with health services i.e. *to increase in numbers of pregnant teenagers in contact with health services by 12th week of pregnancy* (Appendix 1). In the initial national SSPP documentation this was set at 12th week of pregnancy and later set at 10th and 14th week. Irrespective of either figure Manchester and Salford SSPP were seeking to improve early contact rates and make a difference. All participants deemed this target as sensible, possible and less contentious. It was felt that this target had great potential for bringing together all the different agencies and scope to promote all the services for the benefit of young people. Furthermore, that early or earlier contact could facilitate positive relationships with service providers and young people and their families.

It was already known that differences in how and when young people access services existed. However, in seeking to make earlier contact more understanding about the culture of young people and what was happening to them would unfold. In particular, awareness about financial support from the beginning of a pregnancy was considered to be a real issue and one that was a priority when working with young people.

'I am not aware of how successful it has been this far but I do understand I think that the referral from midwives or from GPs to the teenage pregnancy team is quite successful' (M)

In both phase 1 and 2 insights into why young people do what they do, their attitudes, values, feelings and beliefs were being realised and understood, this then was resulting in young people having trust and respect for services and providers. Although some sectors of the community were perhaps not benefiting as much as others. This was noted in the differences in the referral processes that existed prior to SSPP. For example, in Salford the community midwifery service had well established systems to make early contact with all pregnant women, regardless of age. This early contact with midwifery service was grounded in healthcare practice and well known in the community.

'So as I say it's a good indicator, I wouldn't say it's something we definitely work to but it's a good indicator. And I think we in Salford do quite well with that one, we've got a very good scheme' (S)

In contrast Manchester's early referral system was reliant upon setting up new processes across the city and with 3 different core maternity care providers. Additionally, there were no dedicated teenage pregnancy midwives until much later into the pilot. Mechanisms for streamlining data collection within the city such as Brook and termination services were much less developed and towards the end of the pilot challenges remained.

There was much debate about the needs of young Asian women in accessing services. Both Manchester and Salford had sought to explore the needs of young Asian women through a specific project, yet not all the participants were aware in phase 1 that this was happening. Comments were made that tensions existed for young Asian women in particular as mostly they avoid access through their GP. This was primarily linked to confidentiality and privacy, as their GP may well be Asian, but also a lack of understanding as what was available and needed.

'the majority of Asian girls don't want to go to speak to somebody that's Asian because then it becomes judgmental and they're thinking what is this Asian person thinking of me I must be really, you know, they'd feel even more disgraced within themselves. So it's not about putting somebody Asian just to represent the South East Asian community, it's about educating Counsellor's, Personal Adviser's' (M)

'There are Asian girls out there that do fall pregnant but they fall out of the gaps they don't go through the system and that is my job to look at why that is. Why is there teenage parents that are Asian falling through the gaps – and the majority of the cases are due to being Asian and the fact that all the constraints and what the community would put on them for being young, being pregnant, so therefore they seem to go to a lot more private clinics, find a way of not trying to get through the right areas as NHS because it won't be recorded' (S)

By phase 2 participants were much more aware about young Asian women's needs and BME needs overall. Compared to the early stages of SSPP where the participants as a whole were not so clear or as well informed. In the latter stages of SSPP many participants were aware that the Black Health Agency was involved in SSPP, that service development had taken place in some parts of the cities and that a more explicit approach was being adopted by the SSPP coordinators to address the needs of all young people.

Social and emotional wellbeing

Within this broad target viewpoints and opinion were again diverse and insightful, with no difference verified over time (phase 1 and 2). Whilst an integral part of this target was focused upon postnatal depression this was not how the participants perceived or interpreted this objective. They agreed that detection of postnatal depression was useful and of importance to all mothers, again not just young mothers. However, some felt that screening for this condition was and should remain the health visitor's role. For some training (basic) was brought up as a requirement for non-health SSPP staff with clearer knowledge of the appropriate services to refer to and insights into the condition.

'we've not had any training specifically or any targets to specifically look at that issue, we might see occasional mums with post-natal depression but the way the organisation [a charity] works we would need to refer them [young mums]' (S)

'it's not something we are fully asked to do [pick up postnatal depression]but I think it is something we need to be more aware of, we do make some referrals to 42nd street and young mums groups' (M)

Conversely, in building a relationship with a young mother through SSPP other ways of noticing emotional wellbeing were considered important, but may not mean depression.

'sometimes you'll be visiting somebody and you know when things are just not right, you go at lunch time and the curtains are still closed, you [staff member] just need somebody to talk to about this' (S)

The transition to motherhood was considered to be challenging for all but for younger mothers perhaps more so. It was felt that SSPP offered more scope to extend the relationship with workers and offer a support programme tailored to young people and their families (longevity), than had been the case before. In essence the overwhelming finding within this target was *support*.

'I am not aware how they [targets] are measured, for me this means I lose the importance of the meaning, they are not tangible really, and how do we know we make a difference? I tick the boxes but my work is emotional support and that is just lost' (S)

The reality of reducing the incidence of domestic violence, related to the target on strengthening families and communities, was seen as ambitious and fraught. It was considered to be an important area of preventative work and devastating for family life. The challenge was enormous. It was seen as being closely associated with child protection and family break up. Participants took their role seriously in trying hard to address this issue:

'*I really don't think we make a dint really reducing domestic violence because often it is so entrenched in the family violence, you know. I mean the problem that we have is that we don't have enough time to work with some of the young people, some young people you could do with meeting them every week or every other week and you just can't do that'* (S)

Support

Having access to support, resources and good relationships with SSPP team and related staff was viewed as the lynchpin to young people's adaptation to parenting. Although, this professional support was underpinned and reliant upon good family and economical support in the first instance. Support networks for young people were considered to be complex and challenging, but staff worked very hard to increase all types of support for the benefit of young people. In phase 2, data anxieties were expressed that with the end of SSPP that many of the established support mechanisms and pathways to accessing support would disappear.

'Young people I meet they feel their needs are being met, whilst I still feel they are being judged [by society as whole] but they not as isolated as they were. Families too are more supported now and supportive. Fear is things will all go away, residents are nervous all the good will go when Sure Start Plus is over…' (S)

There was an awareness that many of the support initiatives were geographically specific in both cities and as such inequalities then seemed to emerge. For example if a young mother lived in a Sure Start area there may well be more support available. Some parts of the cities had regeneration monies and this could benefit young mothers in those named areas but not others. Or if a young person was 19 years old (and just over) much less support is available through SSPP, due to age cut off. This said there was a strong drive to engage in preventative work where possible whilst known to be complex and tensions exist around having to wait until something happens until specific support can be provided. Or that many preventative measures are not

appropriate for young parents examples here were, parenting classes (ante-natal), support groups, ante-natal visits and mother and baby groups. Young person friendliness and support dedicated to young people was known to be effective and beneficial in the long term to their lives.

> '*I can only think that a better awareness by the young person about services in general, about help, support and advice that they can have must have been improved'* (M)

Feedback

In phase 2 the *lack of feedback* in relation to all the targets was mentioned by both Manchester and Salford participants. This lack of feedback and sharing of information with staff regarding the SSPP performance and progress in meeting the targets was marked. Whilst there was recognition that monitoring had occurred and that the targets existed, there was very poor insight into what impact the SSPP teams were having. Without exception staff providing the service could not report or quote any details as to how well either city was doing to achieve the targets. Most had a sense that improvements had happened with the implementation of SSPP but detail was scant.

> *'I don't know the statistics, but certainly erm, anecdotally there's definitely been an increase'* (S)

> *'there's always been a lack of clarity all the way through as to exactly how we are going to achieve the outcomes'* (S)

> *'I mean I don't know statistically the numbers but I would say there's not a big number…erm don't really know for sure, anyway the targets are mother focused and much less for fathers'* (M)

Educational aspirations

This theme emerged from the discussions regarding the SSPP target on improving learning for teenage parents and their children. But moreover in general participants had strong views about educational aspirations for young people regardless of whether they were pregnant or parents. For the most part it was considered worthwhile to encourage teenage mums and dads, back into education. The educational system was discussed in its broadest sense, with criticisms revolving around how school can often fail many young people. That for young parents it can be a huge struggle to go back into education. Great care is needed in handling this subject as young parents have many things to grapple with in returning back to education. As well as confidence, self esteem and motivation, there are the more practical aspects such as childcare, money and finding time to study, all key considerations.

> *'See this is an issue that we have explained to the mum and it might be low pay but if they want to go out to work, or maybe have a job, we've had a few that are actually working already but it's low paid work'* (S)

There was an overwhelming view that the workload involved in caring for a child was huge, demanding and chaotic at times, that for young people this workload could come as a shock. As such *timing* was a distinct factor, timing in terms of the young person feeling ready to take this on but also timing in terms of the age of the child. For example young babies required parent's attention and input and the idea of 'leaving' a young infant were not that appealing to most young mums.

A further finding was the notion that NVQ level one, a minimum requirement, was viewed as a rather poor aspiration. Connexion's staff in particular, felt that this was a low standard and did not represent a *positive government message* about the potential of young people to attain educationally.

'And I think it's an interesting one because I think, I would say, there are more teenage mums going back into education, but isn't NVQ level one a bit of an insult? Young people are very capable and this says we don't expect much, it is very disappointing …' (M)

However, generally education and learning were considered to be important to young parents, they wanted the best for their child and worked hard to aspire to being good parents. Involvement in play and reading to children was said to be activity embraced and undertaken by young parents.

In summary, there was total agreement that such targets were on the one hand noble, optimistic and idealistic. Yet there was an awareness that such targets were not wholly embracing of the range of social factors that impinged upon young people's lives. For many of the SSPP staff and service providers their involvement with young people was more than achieving such targets. Such work included support and confidence building, information giving and signposting to other services of agencies. Importantly housing, money and the living conditions were consistently highlighted as being closely connected to health and well being of teenage mothers and the work of many of the participants.

Extent to which SSPP is engaging with, listening and responding to young people

Many respondents had a great deal to say about this objective and five main themes emerged; responding to young people, young fathers, culture and ethnicity and making choices.

Engaging with young people

Many comments were made in relation to the complexity of actively involving young people versus paying *lip service* to consultation. Services been based upon assumptions of the professionals about what young people needed. The principle of encouraging young people to take up existing services, as good as they might be, was not always 'ideal', as barriers existed for young people, for example:

'it's very difficult in the fact that certainly you know on the house park area [a locality] there's a number of young parents and there's lot of provision there but those young parents don't want to accept that provision because they feel that the parents who go there are quite old' (S)

Many of the participants talked about how they listened to young parents on an individual basis. Few examples of specific work to capture the views of young people were known or cited. Although one Asian women's project that did feature in phase 1 focus groups (Manchester) was project Jeena. It was mentioned that as SSPP had progressed over time the voices of young people were coming through as in response specific initiatives had emerged. It was well known that groups had been set up, such as young mum groups, dedicated ante-natal clinics, post-natal groups and activities with young dads.

'But as always difficult to engage and get young people to participate say in focus groups [thinks Sure Start did a focus group] not sure …OK for us to say what works, we assume a lot about young people, but not sure how we successfully get young people and consult with them.. Very hard work' (S)

'There's that classic dilemma of young parents groups with some of the ways in which we can reduce isolation and reduce some of the sort of social, clinical causes which can have an impact on. But then it's getting them to those groups' (M)

Coordination based upon more effective communication with other organisations could improve the extent to which this was met. It was raised that other organisations maybe further on in the way in which they engage with young people, for example have established forums or collected data from

working with young people and that these could be incorporated into the SPPP work. The thinking here was organisations such as charities, education and youth service. Even though it is known to be challenging, efforts to *actively* engage with young mums and parents and then respond, was considered to be crucial. Although some success has been achieved with young mums groups, with further active engagement more could be achieved.
Of note one participant did say that they had undertaken some work *with* young parents to get some insight and feedback from them:

> *'I did a bit of a consultation with teenage parents that are living in full time supported accommodation and one of the things that they brought out as big issues were boredom, depression, lack of opportunity, lack of opportunity to meet other young parents, people their own age to develop friendship group, lack of things to do basically'* (M)

Young fathers

Based on phase 1 data, there was much talk about the absence of young dads in the government policies on teenage pregnancy. This included the local SSPP and the work that had already been started, which was viewed as young mum focused. Many recognised the fact that pregnant teenagers and young mums did not always equate with having a young partner, that the two did not necessarily go hand in hand. Often young mums had older partners or none, but where the partner/dad was a teenager then their involvement with SSPP was not the norm. Views about whether efforts to work with both young people as a *couple* were divided. On the whole participants felt that young mums were the priority in the first instance:

> *'We've got to do some work with young men but at the minute resources are stretched enough. And you know that's kind of like a bit of a wish list thing'* (S)

A worker focused upon young men/dads was one way that participants felt could begin to address and embrace the issues of including young men. Many expressed support for a dedicated young man's service being integral to the service. Many said that the current service was not reaching young men. In contrast some reservations were added that a young man's service might divide the service, but the upshot was that it was still *important.* The following comment illustrates the essence of these apprehensions:

> *'Ideally, you wouldn't kind of have a separate worker working with the young men, you'd have people working all together really …….I feel like it's definitely an area of work that is needed although our experience is that they're [young men are] less enthusiastic to work with us. Whereas the young mums themselves are quite open to working with the support workers, the young men tend to be a little bit harder to engage with'* (S)

> *' I'm not saying that's a large percentage [of young dads] but we have some of the young lads, the reason why they come for condoms because they are going to take responsibility for not being fathers'* (M)

Data from phase 2 reflects some of the impact that the young father's worker was having in Salford and the young man's worker from the Manchester City Centre Project. There was an awareness of these new roles and many hopes of SSPP staff were expressed regarding the potential impact. Greater insights into young dads and ways to include them in parenthood were seen as a great step forward. Already information was available that the young father's worker had identified differences in the way young men and young women feel about group work:

> *'For young men they see [attending] group participation as an esteem and identity issue'* (S)

and

*'young men when alone express pride at being parents, but in groups are struggling with "other" male identities and joining a group causes role and identity conflict' (*S)

The young fathers' worker was largely working with communities where there was most disadvantage; those who did not attend school, those in prison and those with complex social needs. One example of excellent practice by the young fathers' worker was a reading project in a local prison. Young men in the prison recorded stories onto tape to send to their families in order to maintain relationships. This is evidence of very innovative working aiming to increase the number of parents reading to their children. Such innovation links to the target on improving the involvement of father and family.

Culture and ethnicity

Both in phase 1 and 2 there was a lack of explicit understanding in the SSPP of the culture of young people and ethnicity. This was more pronounced in the early stages but by 2005 there had been some improvements. This included work with the Black Health Agency (BHA) and Brook. A number of comments were made on the prevalence of assumptions about young people and what they expected from services. These comments related to policy makers, service managers through to the press. As one participant commented:

'we assume a lot about young people they are more knowledgeable than we give them credit sometimes, they can be amazing and make great mums and dads, it's not all bad' (M)

Other comments reflected the fact that in some cases and for some families supporting and encouraging teenage parenthood is prevalent and encouraged. Some families and young people believe that it can be a good thing to engage in childbirth between 16 -19 years of age, that having kids young is positive and can be the norm.

'it can be the making of some young people, it gives them identity, purpose and responsibility..' (S)

A related and frequently mentioned issue was ethnicity and the need to be far more inclusive and respectful of the diverse communities within Manchester and Salford. Staff were keen to improve their reach and appeal. Overall, partnership working with services that had expertise such as the Black Health Agency was seen as one way to widen the appeal. Although the converse was the recognition that all SSPP workers needed to have knowledge and skills to engage with and be approachable and appealing to young people from the Black and Minority Ethnic populations.

Making choices

A theme that ran throughout both phase 1 and 2 was the need to take account of the rights of young people, their right to choose for themselves and make their own decisions. The talk was zealous and insightful, but the principle that young people are capable of making their own choices was reinforced. One concern that did come up from a minority in phase 2 was whether young people should be given the choice (and thus informed consent) about being involved in SSPP as opposed to mainstream services for parents. SSPP may not be suitable for all young teenagers and this maybe be reflected in the uptake rates.

'young people I meet they feel their needs are being met, whilst they still feel they are being judged [young people] are not as isolated as they were' (S)

In summary, this objective raised the principle of responding to local young people and then shaping services. The findings were clear that a national policy does not necessarily mean *one size fits all*. Being aware of the diverse needs of young people from all backgrounds has also been mirrored in Diverse Communities (DH 2002b).

Overall, what was clear was an enthusiasm and commitment of the participants to enable young mums and dads to make choices based on sound information and appropriate services.

Extent to which the leadership and strategic input has had an impact

Within these final objective four key themes were identified by the participants in terms of location, style of leadership, success and interagency working.

Location

The location of the Sure Start Plus teams was different between the two cities. Salford chose to be located within the local maternity care hospital and whilst in phase 1 data suggested that this could be problematic. By phase 2 this view had been reversed as the following comment highlights:

> *'Being in the hospital initially I thought it was negative but overall I think it has been very positive, in terms of meeting needs of young people as this is where they go. It is a neutral place as antenatal care is here and most of them come, so we can then manage young people in a dual role. I know that it is not positive for all young people, for example if they have no antenatal care then we miss people. Accessing services can be a challenge for some young people wherever we are'* (S)

Manchester chose to be located at the city town hall. The personal advisors were located in the community covering three sections of the city; north, south and central.

Style of leadership

Manchester and Salford SSPP took different implementation approaches, as the managers and coordinators responded to their own communities and existing services. Respondents mentioned in the initial stages that they were not aware of this but as the pilot progressed this became better understood. In an 'ideal world' some participants felt it would have been beneficial to have met more as a team to have collectively come together when setting up SSPP.

Findings from phase 2 showed that the leadership style and coordination of the SSPP were considered to be crucial to the local success of the pilot. When it *had* been good then this resulted in effective team working within SSPP and strong links with external agencies. Over time inter-agency working had improved and particularly access to and development of health services for young people had improved. Together team working and inter-agency working, meant that gaps in service provision could be identified and addressed more easily. A more united response to young people's needs could then occur.

Co-ordination was perceived to be many different things. It could be viewed as co-ordination across the whole project undertaken by the co-ordinators or that which occurred between SSPP team members and other agencies. Alternatively it was also considered to be that which occurred with other local SSPP and the national Sure Start Plus team. Given that this was a pilot, participants believed that they had missed an opportunity for developing by sharing information and experiences with others. The participants expressed a desire to have learnt from what other areas have found and from others' mistakes. For many of the participants this principle had not been fully achieved and there was no sense of the *bigger picture* as the following comment suggests:

> *'it is about good co-ordination between our local Sure Start Plus and all others nation wide Sure Start Plus, to get a wider perspective, but there has been no such co-ordination which is something we have missed out on really. Would have been interesting to know what works, doesn't work and I feel we have missed this opportunity for learning. It is pilot and surely then we should be learning from each other, we could have but it has not happened I think that is a shame really'* (S)

Throughout the 2 phases a degree of conflict was evident. This conflict arose as a result of tension between addressing the 'imposed targets' and 'getting it right' for young people locally. In phase 2 it became more apparent that the initial aspirations of working on the pilot were clouded by the pending completion. As could be expected some participants were most concerned about their role and future as short term funding reached its end.

Success

Improvements in and success with services for teenage mothers and their families were much more visible amongst the findings from phase 2. In particular, Salford felt that success could be seen with the improved availability of its termination service. Whilst the improvements have benefited all women, it was clear that young people were part of such benefits.

Another widespread success was perceived to be ante-natal care which was felt to be much better for young women and their families in both Manchester and Salford.

The most frequently cited success was support.

> *'I know young people's needs are different and so are families, but the support now for families are a huge part of the work. Maybe this is something that can be mainstreamed, the support'* (S)

As a result of implementation of the roles dedicated to young fathers a more inclusive and responsive support package is emerging. However, participants were pessimistic about the ways in which the type, and impact, of support was captured in the context of monitoring processes. Support was viewed as complex to measure and yet formed a large part of the participants work. These two comments highlight that every bit of support can help and is worthwhile:

> *'We have a teenage pregnancy team there to work along side us.. it's extra support ... that person that makes you think... Ok, we are still limited in the amount of time and resources we've got but it may be just enough to keep that person living in their own tenancy and not having to move out to another area'* (M)

> *'So I think a lot of my role is about …be really proud about being a dad, it's a really positive thing and I can support you in this, this is something that other young men have done, have a think about this, this is something that might come up here'* (S)

Ways to facilitate young people learning from one another and being together were seen as a success. In particular, opportunities to meet up after having the baby were viewed as being positive and enabling, if they were young person friendly:

> *'Groups for young people have been a success the young mums group as it is dedicated to them, under 20 yrs and is for them, this is very positive, as normally young mums won't go to mainstream groups'* (S)

Many of the participants commented that they spend a considerable amount of time providing positive affirmations about being a young parent. Key to their role was having good attitudes towards teenage pregnancy and treating young people with respect. There was a consensus of opinion that too often assumptions are made about young people, these stemmed from all sectors of society and appeared to represent prevailing "anti-youth" culture from the media to government and individuals. As a consequence much time was often spent boosting a young mother's confidence and self esteem. Encouraging young mothers to value and respect themselves is an everyday occurrence. In some ways the current policy climate is considered to be too focused on young mothers. The volume of such attention has contributed in part to judgments and assumptions

about their capacity to be a *good mum.* The role and involvement of the father can be even more complex, as highlighted by this comment:

> *'Quite a big part of my role is about me saying this is the value of being together as a family unit, and this is the value you've got as a father and the role you've got in bringing up your child, it's not just your partner's role. And a lot of lads take that on board and a lot of lads almost want someone to say that as well It gives them a bit of an identity, on top of the identity they've got in different aspects of their lives'* (S)

Another success was seen in relation to the preventative aspect of SSPP notably in sexual health and contraceptive advice. Some staff had received training and updates which had resulted in an enhancement of staff knowledge and confidence so that more opportunistic advice was given to young people. Comments were positive when specific training had been done in this area:

> *'we did a lot of sexual health sessions around contraception with existing parents so we always aim to do just as much work around sexual health, you know the usual condom testing, condom demonstrations, looking at different types of contraception methods'* (S)

> *'they [young people] tend to embrace it quite well, I think, a lot of them tend to be more enthusiastic about it, you know, especially if they don't want to have another child and I feel they [young people] are just entitled to know about sexual health because they didn't know about it before hand'* (M)

Interagency working

Participants reported that interagency working had been difficult in the beginning but that as SSPP had progressed and working with other agencies had improved. This collaborative working with other agencies was considered to be reliant upon having inside knowledge about one another's functions and personnel. An issue that impacted upon the continuity of this desired team working was the retention of SSPP staff. Some key SSPP staff had left their posts midway and at varying points through the pilot. Conversely in some cases the newly appointed staff who replaced the leavers, invigorated and motivated the teams.

Some of the comments from the participants demonstrated that despite the SSPP structures and operational barriers the actual job was meaningful and rewarding. All participants wanted to do the job but many of the structures hindered them or indeed in some cases personalities of people handling the structures posed challenges. Caution was expressed about sharing core information and not wasting young people's time with same questions:

> *'Inter-agency working has improved I would say with the hospital and health but others we [the SSPP team as a whole] have done by other means. But with this there is loads of duplication e.g. questions we ask, they are all the same for agencies, we all more of less ask the same, e.g. housing we all look at this so to a young people everybody is asking the same and young people say why are you involved? Even I sometimes wonder this.. What is my role? I duplicate myself'*

Overall, data show that participants were responsive to team working and adapting to changes in the SSPP programme of work. Although concerns were raised regarding staff having the right skills to deal with everything that young people are grappling with when facing parenthood:

> *'One of the things that we felt would help young parents would be to have a housing specialist work fully [they] are really aware of the needs of young families and young mums because it seems to be that they are being dealt with by generic workers all the time. Who really don't*

seem to have a grasp of any of the issues and really don't take account of the fact that they are very very young and inexperienced when it comes to such major issues' (S)

and

'On the positive side one of the things that has been appointed in Manchester, as Connexions service we have small pot of money to buy a small supply of condoms and train a small number of staff...if our personal advisors are working with young people who are socially excluded and are non-attenders' (M)

In summing up, the full impact of the SSPP strategy and its leadership can be seen through a range of activities and initiatives. In part many of the effects are rather subtle and not necessarily captured within the monitoring process such as the quality of team working and staff cohesion. Further, the amount of time needed to *set up the operational element* and then subsequently establish a presence within the community and existing services for young people was considered to have been under-estimated. The local successes showed that many were proud of their achievements and input into the lives of young parents on an individual basis. Less was known about the broader impacts and successes, more learning from within the pilot would have been useful to many of the informants. This final comment illustrates the reflectivity of many informants:

"I think [Sure Start Plus] does really well…quite a comprehensive service to a really broad range of young people – not everyone, but a lot of them [young people] get a lot from it…

Summary

In bringing together these findings, in particular those from phase 1 and 2 of the focus groups and face to face interviews it can be seen that team working over the life of the project improved. Positive initiatives were well underway that were attributed in part to SSPP staff comments and views, such as the appointment of a young fathers worker, addressing ethnicity and training in sexual health and contraception.

Overwhelmingly the SSPP staff, despite some frustrations, have been dedicated and motivated towards improving young people lives as parents. Their commitment did not dwindle and despite some of the staff recruitment and retention challenges, all wanted to do a good job. However, there is no direct link and correlation between this staff commitment and effectiveness. So this finding should be treated with caution.

8. Discussion and Recommendations

This evaluation has identified marked diversity between Manchester and Salford in the way that SSPP was structured, organised and services provided. Variations existed in the staffing arrangements, partnerships, monitoring approaches and leadership styles. It has provided important information on the current provision of a dedicated support service for teenage parents, and contributed towards informing and refining future services to support young parents. Additionally, the evaluation offers a picture of what has been achieved. For example the uptake of support packages did increase over the 3 years, new roles with partnership agencies were established and the introduction of the young father's worker has begun to have an impact on fathers' involvement with pregnancy and parenting.

Many of the findings are perhaps predictable and understandable given the nature of short term pilots and the set up costs. Notably key limitations and constraints were experienced by; the 'imposed' government targets and measures in particular those which were health focused.

Monitoring was contentious, and for several participants became such a stumbling block that the real work of SSPP became overshadowed at times. On-going feedback on local performance with the targets could have facilitated their worth. Indeed communication within and across the SSPP teams progressed over time, although there were opportunities overlooked. For example Salford and Manchester chose to work separately even though as neighbouring cities they could have perhaps capitalised more on their proximity.

The notion of holistic support was viewed as being more important and for many the targets compromised this part of their work. Participants appeared to need to know more about the targets and expressed concern that they did not know why they had been chosen or what they were and what they meant. However, in aiming to implement and be successful with SSPP it cannot be seen in isolation from many external factors such as housing, living conditions, money and culture of young people. These factors play a pivotal and distinct role in the lives of young parents.

A tremendous amount of progress has been made in improving the services to young parents, although the emphasis on preventing conceptions and preventing repeat conceptions did not appear to be receiving the profile anticipated by the original health target. Whilst it could be a complex and challenging process to collect data on pregnancy prevention, ways of sharing and exchanging such information with other service providers such as those outside the NHS, for example Brook, could have been worthwhile.

One of the biggest disincentives to innovation and enthusiasm appears to have been the fear of not having a job after a certain length of time, so attention is needed to the staff morale when short term funding of innovative posts is the norm, and ideally mainstreaming of the post as soon as there has been validation of its success.

It has become apparent throughout the course of this evaluation that many of the issues and lessons learned locally emerged as a consequence of issues which required addressing nationally.

The evaluators recommend the following:

- In order for all participants to become actively involved in the tracking of progress towards achieving the targets, we recommend the use of many and varied channels of communication, and reinforcement of the anticipated goals. This might include using newsletters, websites and discussion groups, as well as more traditional means of cascading information in formal meetings and briefings.

- We would recommend that all of the agencies identified in The Teenage Pregnancy Directory of Agencies be included in this communication process in both cities.

- We recommend that any changes taking place in the management and operation of the SSPP (e.g. monitoring, funding) also be communicated effectively. This should also include communication about the rationale behind the strategy, enabling open discussion and agreement before any future work begins.

- To maintain staff morale, especially those most affected by short term funding, *and* to reward everyone for their achievements, we recommend recognition, publicity and joint writing up of innovative projects and good practice (especially for example the young mums group, the work of the young fathers' worker and work with BME groups).

- Whilst the excellent progress in improving the services available to young parents should not diminish at all, we would recommend an increase in energy in prevention of conceptions and repeat conceptions.

- As many of the services and agencies available for Manchester are used by Salford teenagers, we recommend closer working and apparent sharing between the two teenage pregnancy teams, resulting in setting up and mirroring those services highlighted as examples of innovative practice in the National Evaluation in *both cities.*

9. References

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APPENDIX 1

SURE START PLUS OBJECTIVES AND TARGETS

Objective 1: Improving health

By working with relevant agencies to ensure that pregnant teenagers and teenage parents have access to appropriate healthcare, including access to contraceptive advice.

By ensuring pregnant teenagers have access to advice and counselling during the early stages of pregnancy so they are able to make informed decisions whether to continue with the pregnancy, adoption or abortion according to their individual circumstances.

By supporting teenage parents in caring for their children to promote healthy development before and after birth.

Target
Increase in numbers of pregnant teenagers in contact with health services by 12th week of pregnancy
Reduction in numbers of teenage mothers smoking during and after pregnancy.

Objective 2: Improving learning of teenage parents and their children

By ensuring teenage parents return to or continue education or training; by encouraging stimulating and enjoyable play for, and improving the language skills of children of teenage parents; and through early identification and support of children with learning difficulties.

Target
Increase the percentage of teenage mothers participating in education and obtaining qualification at NVQ Level 1 or above.

Objective 3: Strengthening families and communities

By helping teenage parents to be effective parents by involving both their families in supporting them and their children.

Target
Increase percentage of teenager mothers who report involvement of their family, father of their child, or partner in their child's upbringing.

Objective 4: Improving social and emotional well-being

By supporting early bonding between teenage parents and their children, by helping teenage parent families to function and by enabling the early identification and support of children with emotional and behavioural difficulties.

Target
Increased identification and support of all teenage mothers with postnatal depression.

APPENDIX 2

SURE START PLUS PILOT PROGRAMME

Form M1: Quarterly information report
Refer to accompanying notes for guidance on accurate completion of this form.

Name of programme: Salford Sure Start Plus (Teenage Pregnancy Team)
Quarter: 3 (October 1 – December 31) **Year:** 2001

Numbers of teenage girls advised *before* 14th week of pregnancy (Up to and including week 13)							
	No conception	Abortion	Miscarriage	Birth - parent kept child	Birth - adoption	Still-birth	**TOTAL**
Under 14							
Under 16							
Under 18							
TOTAL							

Numbers of teenage girls advised *after* 14th week of pregnancy (Week 14 onwards)							
	No conception	Abortion	Miscarriage	Birth - parent kept child	Birth - adoption	Still-birth	**TOTAL**
Under 14							
Under 16							
Under 18							
TOTAL							

Number of teenage mothers and fathers for whom support packages are in place	
Under 14	
Under 16	
Under 18	
Under 20	
TOTAL	

Number of <u>new</u> support packages in place for teenage mothers and fathers in this quarter	
Under 14	
Under 16	
Under 18	
Under 20	
TOTAL	

Number of teenage mothers and fathers accessing a childcare place				
	By age of child			
	Under 1	1-2	2-3	3-4
Under 14				
Under 16				
Under 18				
Under 20				
TOTAL				

[See note 5 for definition of childcare place]

January 2002

APPENDIX 3

SURE START PLUS PILOT PROGRAMME

Refer to accompanying notes for guidance on accurate completion of this form

Form M2: Progress report against quarterly milestones

Name of programme Quarter Year

National targets	**Quarterly milestones (for this quarter, taken from your Sure Start Plus plan)**	**Progress towards milestones (tick which applies)**			**Add notes or explanation here if you have ticked *Partially achieved* or *Not achieved* in the previous column**
Objective 1: Improving health		***Achieved***	***Partially achieved***	***Not achieved***	**Notes/Explanation**
Objective 2: Improving learning of teenage mothers and fathers and their children		***Achieved***	***Partially achieved***	***Not achieved***	**Notes/explanation**
Objective 3: Strengthening families and communities		***Achieved***	***Partially achieved***	***Not achieved***	**Notes/explanation**
Objective 4: *Improving social and emotional well-being*		***Achieved***	***Partially achieved***	***Not achieved***	**Notes/explanation**

Partnership Chair's Name _____

Signature _____

Date _____

Please return by the 20th of the month following the quarter the information covers, to:
Samantha Akita, Sure Start Plus Programme Manager
Sure Start Unit
Level 2, Caxton House
Tothill Street
London SW1H 9NA
E-mail: Samantha.akita@dfes.gsi.gov.uk Fax: 020 7273 1374

APPENDIX 4

SIX MONTHLY MONITORING FORM

Please refer to the *Guidance for completing the Six Monthly Monitoring Report* when filling in this report.

Name of pilot programme: _____

Period covered (indicate the appropriate 6-month period and year):

Jan - Jun		Jul - Dec	
2003	2004	2005	2006

1. Advice in pregnancy

NUMBER OF PREGNANT TEENAGERS ADVISED BY SURE START PLUS IN THIS PERIOD				
Age	Total number of pregnancies suspected but teenager not pregnant	Total number of pregnant teenagers advised *before* 10th week	Total number of pregnant teenagers advised *at* or *after* 10th week but *before* 14th week	Total number of pregnant teenagers advised *at* or *after* 14th week
*Under 16**				
Under 18#				
TOTAL				

2. Pregnancy outcomes

NUMBER OF PREGNANCY OUTCOMES FOR TEENAGERS ADVISED BY SURE START PLUS IN THIS PERIOD						
Age	Abortion	Miscarriage	Birth: parent kept child	Birth: adoption	Still-birth	Pregnancy outcome unknown
*Under 16**						
Under 18#						
TOTAL						

* Under 16s are those aged 15 and under
# Under 18s are those aged 16 & 17

3. Support packages for pregnant teenagers/teenage mothers

NUMBER OF PREGNANT TEENAGERS/TEENAGE MOTHERS FOR WHOM SUPPORT PACKAGES ARE IN PLACE		
Age	Number of *new* support packages	Total number of *new* and *existing* support packages
*Under 16**		
Under 18#		
*Under 20^*		
TOTAL		

4. Support packages for teenage fathers/partners

NUMBER OF TEENAGE FATHERS/PARTNERS FOR WHOM SUPPORT PACKAGES ARE IN PLACE		
Age	Number of new support packages	Total number of new and existing support packages
*Under 16**		
Under 18#		
*Under 20^*		
TOTAL		

* Under 16s are those aged 15 and under
# Under 18s are those aged 16 & 17
^ Under 20s are those aged 18 & 19

5. Ethnic breakdown

NUMBER OF PREGNANT TEENAGERS, TEENAGE MOTHERS AND TEENAGE FATHERS/PARTNERS WHO HAVE BEEN IN CONTACT WITH SURE START PLUS IN THIS PERIOD BY ETHNIC GROUP			
(a) White	Pregnant teenagers	Teenage mothers	Teenage fathers/partners
British			
Irish			
Other White			
WHITE TOTAL			
(b) Mixed			
White / Black Caribbean			
White / Black African			
White / Asian			
Any other mixed background			
MIXED TOTAL			
(c)Asian			
Indian			
Pakistani			
Bangladeshi			
Any other Asian background within (c)			
ASIAN TOTAL			
(d) Black or Black British			
Caribbean			
African			
Any other Black background within (d)			
BLACK OR BLACK BRITISH TOTAL			
(e) Other ethnic group			
Chinese			
Other ethnic group			
CHINESE OR OTHER ETHNIC GROUP TOTAL			
(f) **ETHNIC ORIGIN UNKNOWN TOTAL**			

6. Contact with health services

NUMBER OF PREGNANT TEENAGERS WHO HAVE BEEN IN CONTACT WITH SURE START PLUS IN THIS PERIOD AND IN CONTACT WITH HEALTH SERVICES BY 14th WEEK		
Number in contact *before* 14th week	Number in contact *at* or *after* 14th week	Number unknown

7.Smoking

NUMBER OF PREGNANT TEENAGERS/TEENAGE MOTHERS WHO HAVE BEEN IN CONTACT WITH SURE START PLUS IN THIS PERIOD WHO ARE SMOKING			
Number smoking during pregnancy	Number unknown	Number smoking after birth	Number unknown

8. Breastfeeding

NUMBER OF TEENAGE MOTHERS WHO HAVE BEEN IN CONTACT WITH SURE START PLUS IN THIS PERIOD WHO ARE BREASTFEEDING			
Number breastfeeding *before* 6 weeks	Number unknown	Number breastfeeding *at* or *after* 6 weeks	Number unknown

9. Participation in education, training or employment

NUMBER OF TEENAGE MOTHERS WHO HAVE BEEN IN CONTACT WITH SURE START PLUS IN THIS PERIOD WHO ARE PARTICIPATING IN EDUCATION, TRAINING OR EMPLOYMENT				
Age	Number participating in education, training or employment	Number *not* participating in education, training or employment	Number unknown	Number achieving NVQ Level 1 or above
*Under 16**				
*Under 20^*				
TOTAL				

10. Childcare

NUMBER OF TEENAGE PARENTS WHO HAVE BEEN IN CONTACT WITH SURE START PLUS IN THIS PERIOD WHO ARE ACCESSING A CHILDCARE PLACE			
	Age of child		
Age of parent	*Under 1 year*	*1-2 years*	*Over 2 years*
Under *16**			
Under *20^*			
TOTAL			

* Under 16s are those under compulsory school leaving age
^ Under 20s are those over compulsory school leaving age, but under 20

11. Housing

NUMBER OF TEENAGE MOTHERS WHO HAVE BEEN IN CONTACT WITH SURE START PLUS IN THIS PERIOD BY TYPE OF ACCOMMODATION				
Age	Lone tenancy	With family or partner	Supported housing	Other
*Under 16**				
Under 18#				
*Under 20^*				
TOTAL				

12. Comments

Completed by: _____ Position: _____

Tel: _____ e-mail: _____

Date: _____

The report should be submitted by 31 July and 31 January. It should be emailed to:

- **your Regional Teenage Pregnancy Co-ordinator**
- **Samantha Akita, Sure Start Plus Programme Manager (Samantha.Akita@doh.gsi.gov.uk)**

APPENDIX 5

SOURCES OF ADDITIONAL FUNDING FOR TEENAGE PREGNANCY WORK IN SALFORD

Purpose	Source	Timescale	Amount p.a.
Sex and relationships Education (SRE)			
0.5 SRE Consultant	LEA	Ongoing commitment	£20,000 (approx)
School Health Advisor (SRE/Sexual Health)	PCT	Ongoing commitment	£35,000 (approx)
Healthy Schools Co-ordinator	PCT	Ongoing commitment	£35,000 (approx)
Just Youth Sexual Health Education Project (Catholic High Schools)	Connexions VCS funding	2005/6	£4,500
All schools teach SRE as part of Personal Health Social Education Curriculum	LEA	Ongoing commitment	£ impossible to estimate
Sexual Health Services			
Young People Sexual Health Nurse	PCT	Ongoing commitment	£35,000 (approx)
Condom Distribution Scheme	PCT	Ongoing commitment	£3,000
Brook (Eccles)	PCT	Annually reviewed	£100,000
Community Pharmacists/General Practice/Family Planning Clinics and Genitary-Urinary Medicine Clinic contribute to the Teenage Pregnancy Strategy	PCT	Ongoing commitment	£ impossible to estimate
Termination of Pregnancy Services including private providers contribute to the Teenage Pregnancy Strategy	PCT	Ongoing commitment	£ impossible to estimate
Brook (Eccles) Counselling Service	Connexions VCS funding	2005/6	£5,500
Support for Young Parents and their children			
Young Mums To Be Training Co-ordinator and course	PAYP	2005/6	£40,000
New Deal for Communities Teenage Pregnancy Personal Advisor	NDC	2005/6	£40,000 (approx)
Young Fathers Post	Children's Centres	2005-2007	£16,000
Duchy Youth Project –Virtual Babies	PAYP	2005/6	£5,000 (approx)
0.5 Teenage Pregnancy Midwife	Salford Royal Hospitals Trust (SRHT)	Ongoing commitment	£25,000 (approx)

0.5 Reintegration Officer	LEA	Ongoing commitment	£20,000 (approx)
Citizens Advice Bureau Expectant Families Advice Service	Surestart Local Programmes	2005/6	£10,000 (approx)
Citizens Advice Bureau Expectant Families Advice Service	PCT	2005/6	£10,000 (approx)
Office, heat/light/phones etc	Youth Service/SRHT/ Education Inclusion Service	2005/6	£15,000 (approx)
Management cost	SRHT/Education Inclusion/PCT/Next Steps/Youth Service/Black Health Agency/Connexions	2005/6	£10,000 (approx)
Health Visiting, midwifery, Surestart Local Programmes/Early Years/Supported tenancies etc all contribute to the Teenage Pregnancy Strategy	PCT/SRHT/ Surestart Local Programmes/Early Years/New Prospects	Ongoing commitment	£ impossible to estimate
TOTAL			**£429,000 + (approx) excluding impossible**

APPENDIX 6

THE MODEL OF JOINT WORKING AND ITS IMPACT ON NATIONAL MONITORING REQUIREMENTS

Rationale

This report has been compiled to highlight the issues facing Manchester in terms of its data collection and will be used as an explanatory tool to accompany the 6 monthly monitoring reports that are sent to the Teenage Pregnancy Unit.

Context

The size and complexity of Manchester both geographically and in terms of service delivery resulted in a caseload that was too large for the one Sure Start Plus Worker planned in the original bid. Therefore, following the publication of Working Together: Connexions and Teenage Pregnancy in 2001 and the subsequent launch of the Connexions Service in Manchester in September 2002, Manchester Sure Start Plus took steps to establish a jointly funded service with Connexions. The service is as follows:

Worker	**Managed by**	**Based at**	**Funded by**
SS+ Co-ordinator	TPC	Joint Health Unit	100% SS+
Teenage Pregnancy Pas (TP PAs)	Connexions (CX)	Connexions' offices	50% SS+/ 50% CX

It should be noted that:

The Sure Start Plus Co-ordinator's role includes:

Co-ordination of the TP PA team through regular meetings - to enable to direct the input of PAs into TP mechanisms.
Data collection, statistics, quality assurance and reporting back to Sure Start Plus Unit.

The TP PA role includes:

50% one to one casework with teenage parents aged 16-19 years old (the existing Reintegration Service supports those of school age).
50% acting as a Teenage Pregnancy resource/support to other generic PAs within their Connexions team and other agencies. This part of the TP PA role is crucial because it increases the learning and the capacity of the wider Connexions' teams to support teenage parents and pregnant teenagers – thereby mainstreaming the learning from Sure Start Plus and enabling more young people to access support. This part of the service is included in the 6 monthly stats reports under the section 'advice in pregnancy'.
Working closely with existing agencies such as Reintegration Service, Benefits Advice, housing, midwifery and health visiting.
Engaging with the Teenage Pregnancy Strategy via Implementation Groups.

Activity not funded by Sure Start Plus

There is much relevant activity in Manchester which is already established within the TP Strategy and which meets SS+ objectives. However, due to monitoring guidelines, this cannot be counted for SS+ purposes as it is not funded by SS+. Some of examples are:

Reintegration Officer for School Aged Mothers (LEA)
funded via LEA Standards Fund for Reintegration
supports school-aged parents and pregnant young people

Teenage Pregnancy Liaison Midwife
funded via LIG, based at St Mary's Hospital (Central Manchester NHS Hospital Trust)
includes ante natal Young Parents' Groups (within the hospital and community settings)
Specialist Benefits Advice Worker for Teenage Parents (Manchester City Council's Advice Service)
funded by LIG, based with Manchester Advice Service (Manchester City Council)
provides one-to-one advice and consultancy service around benefits, debt and housing issues for teenage parents / pregnant teenagers

Joint Protocol for Pregnancy Testing in Schools by School Nurses
citywide initiative, joint agreement between Central PCT and the LEA
extended school nursing hours via LIG

Implications for monitoring reports

Manchester has taken a considered and strategic approach towards the implementation of the Sure Start Plus programme to ensure that Sure Start Plus:

Is embedded within the Teenage Pregnancy Strategic Programme.
Enhances existing provision, develops innovative practice and utilise current learning to inform new developments.
Uses LIG alongside other relevant funding streams to inform and develop practice in a meaningful way.
Engages all relevant partners at strategic and operational levels to deliver effective seamless services and to promote the idea of mainstreaming for 2006.
Avoids misuse and waste of financial and human resources.
Addresses issues of capacity building, sustainability and mainstreaming.

However, as a result of this strategic approach:

Data for 18/19 yrs cannot be included despite the national guidance in 2001 (Working Together: Connexions and Teenage Pregnancy).
The 6 monthly reports from Manchester are likely to show nil returns for under 16s as the Reintegration Service (which isn't funded by Sure Start Plus) supports pregnant teenagers/teenage parents of school age. This joint approach between Reintegration, Sure Start Plus and Connexions has been agreed locally.
Other non-Sure Start Plus funded initiatives (see examples above) cannot be reported on in the 6 monthly reports, despite meeting Sure Start Plus objectives.

APPENDIX 7

INNOVATIVE WAYS OF WORKING

Extracts from "Reaching Out" (Wiggins et al 2005)

The partnership work in **Manchester** between Sure Start Plus (co-ordinated via the Manchester Joint Health Unit) and The Brook Advisory Service means that all new teenage mothers have been supported in making a decision about contraception before they leave the postnatal ward.

While **Salford** Sure Start Plus took the route of appointing a Teenage Pregnancy Health Visitor in 2003. Already an experienced family planning sexual health nurse, this health visitor currently staffs a sexual health clinic as part of her Sure Start Plus role. She is also active in referring, and often accompanying, young women to family planning clinics. Salford Sure Start Plus and the local Teenage Pregnancy Implementation Grant are also supporting the funding of family planning training for midwives, health visitors and school health advisers.

Manchester Sure Start Plus (co-ordinated via the Manchester Joint Health Unit) funds two posts to support boys and young men within the Teenage Pregnancy Programme. One of these posts forms part of a local peer education project targeting young black people at the Black Health Agency. This post holder's role includes: delivering sexual health awareness and personal development sessions to young black men; delivering sexual health programmes accredited by The Greater Manchester Open College; and developing a fathers' group for men aged 16-25.

Development work with South Asian young people

The **Salford** Sure Start Plus pilot programme has funded two development workers for South Asian young people. In terms of teenage pregnancy, they have both a prevention and a support remit. In the former, for example, they work in schools delivering sessions within the Sex and Relationships Education (SRE) programme. They make discussion of relationships, rather than sex, the main focus of their work. This maximises the acceptability of the work to young people and their carers, reducing the numbers withdrawing from sessions. The support role is primarily additional support for pregnant and parenting teenagers to enhance the work of the advisers.

In **Manchester**, there is the 'Babes and Babies' group which is a partnership project between Sure Start Plus and Connexions and was set up in response to many of the young parents experiencing domestic violence and needing more support.

A combined antenatal/teenage mothers group

Salford runs an antenatal/teenage mothers group on an informal drop-in basis one morning a week. The Sure Start Plus team in Salford consists of a core support staff team of a teen pregnancy midwife, a health visitor and an adviser. Additional team members include a co-ordinator, administrator, a development worker for South Asian communities and a young fathers worker. The drop-in group is run by two of the three members of the core team on a rota basis and covers issues such as managing debt; childcare options; arts and crafts; and healthy eating. The workers strive to balance informality with structure.

The aims of the group are for its members to gain:

- Support from each other and from the workers present.
- Useful information for themselves and their child.

A feature of this group that is considered key to its success is the venue – a thriving local women's centre. The group brings the young women into contact with activities and services at the centre such as IT and cookery classes, which they can access outside of group sessions. The centre is conveniently located with good transport links and it provides a crèche, which can be used by group participants.

Achievements include:

- Average of nine young people attending each week;
- Active involvement of members in decision making about the group;
- General use of the women's centre by group members; for example taking part in courses and make use of the café.

Teenage pregnancy advice worker

In **Manchester** there is a partnership project between Sure Start Plus (co-ordinated via the Manchester Joint Health Unit) and Manchester Advice (the City Council's in-house provider of advice on matters such as welfare rights, debt and housing). Sure Start Plus partly funds the service, which comprises two fulltime advice workers delivering a specialist advice service purely to teenagers who are pregnant or parents. The advice workers work on an outreach basis and offer sessions at a number of venues such as antenatal and postnatal groups and Connexions centres. Home visits can be offered and referrals are taken from a wide range of agencies.

Examples of their work include:

- Prevention of homelessness through: ensuring clients are registered for housing; ensuring Housing
  Benefit claims are made and processed promptly; and negotiating with landlords;
- Supporting clients in debt by negotiating with creditors;
- Making applications to charities for cash, tokens or necessary items such as furniture.
  Achievements over a recent one year period include:
- 1,400 clients advised;
- More than £600,000 generated in additional benefits.

In **Salford** midwives complete notification forms in the antenatal booking clinic so that pregnant teenagers are identified and their expressed needs communicated to the Sure Start Plus team. In addition detailed information packs on services for professionals and for young people have been developed by the Sure Start Plus midwife and other members of the team.

In the **Salford** Sure Start Plus programme a young person friendly, accessible pregnancy testing and counselling service was already being offered by the Brook Advisory service, with clear referral links to the Sure Start Plus team. However, it needed enhanced capacity. Sure Start Plus therefore funded two additional counsellor led sessions (paying for the time of counselling and reception staff) enabling the service to open six days a week.