NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 23 March 2017 from 13.31 - 15.11

Membership

Present	Absent
Councillor Merlita Bryan (Vice Chair)	Councillor Anne Peach
Councillor Patience Uloma Ifediora	Councillor Jim Armstrong
Councillor Ginny Klein	Councillor Ilyas Aziz
Councillor Dave Liversidge	Councillor Corall Jenkins
Councillor Chris Tansley	Councillor Carole-Ann Jones

Colleagues, partners and others in attendance:

Lucy Anderson	-	Director of Quality Governance, Nottingham City CCG
Owen Bennett	-	Head of Patient Safety, Nottingham University Hospitals
Marie Cann-Livingstone	-	Teenage Pregnancy Specialist/Lead commissioning Manager
Helene Denness	-	Public Health Consultant
Jane Garrard	-	Senior Governance Officer
Dr Lucy Kean	-	Head of Service, Midwifery and Gynaecology, Nottingham University Hospitals
Kate Morris	-	Governance Officer
Charlotte Reading	-	Nottingham City CCG
Laura Rumsey	-	Deputy Head of Midwifery, Nottingham University Hospitals
Becky Stoner	-	South Nottinghamshire Clinical Commissioning Groups

43 APOLOGIES FOR ABSENCE

Councillor Jim Armstrong	- Personal
Councillor Ilyas Aziz	- Personal
Councillor Corall Jenkins	- Personal
Councillor Carol Jones	- Personal
Councillor Anne Peach	- Personal

44 DECLARATIONS OF INTEREST

None.

45 MINUTES

The minutes of the meeting held on 23 February 2017 were confirmed as a correct record and signed by the Chair.

46 REDUCING UNPLANNED TEENAGE PREGNANCIES

Marie Cann-Livingstone, Teenage Pregnancy Specialist and Helene Denness, Consultant in Public Health presented a report on reducing unplanned teenage pregnancies and the work being done in Nottingham City. They highlighted the following points:

(a) national evidence suggests that for the majority of girls who conceive under 18 years there are no specific risk factors, however there are a number of common factors, not seen as causal, that make some young people more at risk of teenage pregnancy. These include:

- eligibility for free school meals
- living in a deprived area
- persistent absence in year 9
- slower than expected progress between Key Stage 3 and Key Stage 4
- attending lower performing schools
- low maternal aspirations
- experience of sexual abuse
- previous pregnancy

(b) studies across the UK show that outcomes for teenage mothers and their children are more likely to be poorer:

- teenage mothers are twice as likely to smoke before and during pregnancy and three times more likely to smoke throughout the whole of their pregnancy;
- teenage mothers are a third less likely to initiate breast feeding and half as likely to be breast feeding at 6-8 weeks;
- teenage mothers have babies that are at 56% higher risk of infant death and are 3 times more likely to die from sudden unexplained death in infancy;
- children born to teenage mothers are twice as likely to be hospitalised due to accidental injury or gastroenteritis;
- at age 5 children are more likely to be behind on spatial ability, non-verbal ability and verbal ability
- mothers are three times more likely to experience postnatal depression and have higher risk of poor mental health for up to three years after birth;
- two in three teenage mothers experience relationship breakdown in pregnancy or in the three years following birth;
- children have a 63% higher risk of living in poverty;
- one in five girls aged 16-18 not in education employment or training are teenage mothers;
- women who were teenage mothers are 22% more likely to be living in poverty at age 30;

(c) recently released statistics show that teenage conceptions in Nottingham City were down from 160 in 2014 to 152 in 2015. There had been a 62.2% decrease from 2004 to 2015. Despite this reduction, Nottingham City's

teenage pregnancy rate was the 17th highest in the UK and the 2nd highest amongst the Core Cities;

(d) if the numbers continue to fall then the Council is on target to reduce teenage pregnancy by a further third as stated in the Council Plan 2015-19;

(e) between 2012-2014 Aspley had the highest teenage pregnancy rates with Arboretum and Bulwell also being higher than the City average whilst Wollaton West had the lowest published figures;

(f) Nottingham's Sex and Relationship Education (SRE) Charter was launched in 2016 and the team has now had 50% schools in the City sign up to the Charter. They are also working with faith schools to offer an approach suited to their needs;

(g) there is a wide range of primary prevention services within Nottingham City, these include:

- Nottingham City Sexual Health Services - delivers accessible, integrated services within the community and offers advice and support alongside a full range of contraceptive services. There are a number of clinics across the city that offer these services;
- C-Card Scheme – offers free contraceptive services to 13-24 year olds alongside SRE. The scheme requires the young person to register for the scheme before being able to collect contraception from over 50 points across the city;
- General Practitioners and Pharmacies – provide a full range of contraception and information including long acting reversible contraception, pregnancy testing and emergency hormonal contraception;
- Public Health Nurse for school age children and young people service, formally known as the School Nursing Service – offers information and practical support;

(h) there are two termination of pregnancy clinics in Nottingham City. These services include support and counselling whilst young people are making a decision and after the decision has been made. In 2015/16 1401 elective terminations took place. 3% were aged 13-16 years and 21% were aged 17-20 years;

(i) there are a number of support services available for teenage mothers:

- Accommodation services – 16 units of self-contained hostel accommodation for vulnerable teenage mothers and their children alongside a further 4 units for teenage fathers and mothers ready for semi-independent living;
- Family Nurse Partnership (FNP) – a programme of support and guidance for up to 200 pregnant teenagers and mothers each year. It is an intensive health visiting programme involved with girls from early pregnancy through to the child's second birthday. The programme aims to enable teenagers to have a healthy pregnancy and improve the child's health. The programme also works with the

mother to improve aspirations. 38% of cases have social care intervention;
- Education Officer – works to provide support for pregnant teenagers and teenage parents to engage with education;
- Teenage Pregnancy Midwifery Service – is available to support all under 18 pregnancies offering flexible and one to one support. The aim of the service is to increase self-esteem, promote self-worth and boost confidence as a parent;

(j) a new Joint Strategic Needs Assessment (JSNA) chapter on reducing unplanned teenage pregnancy has recently been published and the following challenges were identified:
- provision of comprehensive SRE across all schools. Currently there is some reluctance from some schools, a number of which are in areas with high teenage conception rates;
- equitable access to sexual health services on school sites. Some pupils have access to emergency hormonal contraception and pregnancy testing on their school site, some schools do not find it acceptable to provide these services, and others are not able to due to insufficient numbers of public health nurses able to deliver the provision;
- Need for increased focus and service adaptation to match the diverse demographic of the city;
- Encourage services to record accurate ethnicity information to assess teenage pregnancy in the migrant population, for example there is currently very little information on the Roma population who are increasingly featuring in the under 16 conception statistics;
- Establish ways to gather more timely data at a local level. National statistics are 18 months old by the time they are released and as such makes assessing the impact of services and future commissioning decisions difficult;
- Adaptation of services to better support teenage fathers;
- Reducing levels of poverty by increasing the number of teenage parents in education, training or employment;
- Investigate the reasons behind the slower reduction in under 16 years conception;
- Establish whether a reduction in traditionally risky behaviour is linked to the fall in teenage pregnancy rates;
- Gather more information about teenagers who's pregnancy does not end in a live birth, including terminations and miscarriages, as these girls are more at risk of having further pregnancies;
- Establish reasons and barriers to the use of contraception following a termination to enable services to support girls in the choice of a suitable contraception;
- Understand the relationship between the use of long-acting reversible contraception and condom use and the rise in sexually transmitted infections;
- Establish why so many teenagers choose not to return to education, employment or training;

- Research why teenagers decide to either continue or not continue their pregnancy;

(k) in 2015 Professor Yamamoto from the University of Osaka held a number of focus groups in schools across Nottingham to find out about attitudes to sexual risk taking. Pupils in the west area raised concerns that they did not know where to go to get advice and contraception. All focus groups discussed the importance of consent and use of contraceptives and personal experience was the measure against which judgements were made;

(l) There has been a sustained reduction in the number of teenage pregnancies over the last 10 years but there is still much work to be done to ensure service equality across Nottingham City;

Following questions and comments from the Committee the following points were highlighted:

(m) 50% of schools have signed up to the SRE charter with more coming on board all the time. Almost every school in Nottingham City has some kind of input from the SRE team and the team is working hard to engage faith schools, in particular Catholic schools in the city. Those schools that are not already engaged with the SRE team and are in areas with the highest teenage pregnancy rates have been written to individually with the hopes of engaging them;

(n) the SRE team does not deliver SRE directly in schools but instead work with teachers to ensure that they can access appropriate training and resources to deliver effective SRE which is accessible to all pupils on a sustainable basis. The SRE team can also facilitate, where appropriate, parent involvement;

(o) there are a handful of schools who have achieved a “gold” standard in SRE. These schools are now offering help, advice and support to other schools to deliver effective SRE;

(p) SRE will be compulsory in all schools by 2019;

(q) teenage pregnancy rates in Bristol are very low compared to other Core Cities. The reasons for this and the work that they are doing would be worth investigating to see if lessons can be learnt for Nottingham;

(r) it is currently too early to assess if the provision of the new clinic in Aspley has had an impact on the teenage pregnancy rates there. It would be possible to look at the use of the clinic and establish how many people are using the service, however it is common for teenagers to access services at a clinic away from their home area in order to protect anonymity;

(s) the reasons for the high teenage pregnancy rate in Aspley are numerous and complex. There are no specific risk factors, but many of the common risk factors are present. Bulwell also has a comparative demographic with similar risk factors and a high teenage pregnancy rate;

(t) although the national focus on teenage pregnancy may not be as sharp as in recent years the work currently being done within Nottingham City will continue and the Council is committed to reaching its target to reduce teenage pregnancy by a further third by 2020;

(u) indications suggest that the FNP has been successful in reducing the number of second teenage pregnancies although the number of cases is very small. Evidence suggests that where there are subsequent teenage pregnancies the mothers are making a more informed choice. Anecdotal evidence suggests that some of these girls are choosing to have their family at an early age;

(v) there are a number of services being recommissioned. The focus of the recommissioning will be more effective joined up work that will also allow more extensive data to be gathered to inform future work plans;

(w) there are a number of services that teenage fathers can access for support and advice but there are no targeted prevention services available for teenage boys within the city aimed at raising aspirations.

(x) it is traditionally difficult to engage with central and eastern European Roma families however a new online service has been established and included access and signposting to sexual health and contraceptive advice. Although numbers are small it does appear that the number of teenage pregnancies in this group is declining.

RESOLVED to:

(1) thank Marie Cann-Livingstone and Helene Denness for their attendance and for their report on the work being done in Nottingham to reduce unwanted teenage pregnancy;

(2) recommend that colleagues speak to Bristol City Council to identify if any lessons can be learnt for reducing unplanned teenage pregnancies in Nottingham;

(3) recommend that commissioners utilise frontline practitioners e.g. health visitors as a source for gathering local evidence to inform future commissioning decisions;

(4) request that a review of local activity and provision to reduce unplanned teenage pregnancies in the Aspley and Bulwell areas is carried out and the findings reported back to an informal meeting of health scrutiny councillors; and

(5) request that information be provided to councillors about available evidence of the impact of the Family Nurse Partnership on subsequent pregnancies.

47 MATERNAL HEALTH

Lucy Anderson, Director of Quality Governance, Children and Learning Disabilities, Nottingham City Clinical Commissioning Group and Helen Denness, Consultant in Public Health introduced a report on maternal health in Nottingham City. They highlighted the following points:

(a) Following the publication of Better Births: Improving Outcomes of Maternity Services in England (2016) a local maternity transformation programme was established and a steering group has evolved to cover Nottingham City and Nottinghamshire County to look at improving maternity services;

(b) Following a review of the local maternity services in 2013/14 some progress has already been made towards the priorities outlined in Better Births including:

- Personalised Care – Nottingham has introduced the "pocket midwife" app developed by Nottingham University Hospitals (NUH) which is locally targeted and give users free access to maternity advice and signposts to services;
- Continuity of Carer – A pilot in St Anns undertook the continuity of care model of working and this was evaluated positively by both staff and patients. The pilot scheme has been further rolled out to a wider area and is being continually evaluated;
- Safer Care – pathways and services are being improved for women assessed as having complex social factors. This work requires a multi-agency approach to encourage early access to maternity services;
- Better postnatal and perinatal mental healthcare – A steering group was established in 2016 to implement an improved pathway across Nottingham and Nottinghamshire;
- Multi-professional working and working across boundaries;

(c) In 2016/17 there was an assessment of maternity services using four indicators for maternity services. Nottingham City performance on still births and neonatal deaths and for smoking in pregnancy were not at the expected standards and require focused work to improve. This related to data on stillbirths in 2014/15. Performance in the Care Quality Commission survey of women's experience and choice is on par with national rates and is considered good;

(d) Smoking in pregnancy and specifically smoking at the time of delivery continues to be a challenge. In Nottingham in 2015/16 18.7% of mothers were smokers at the time of delivery, which is higher than the regional and English average. The rate of smoking varies greatly across the city with some areas being significantly higher than others;

(e) Currently women who smoke during pregnancy are automatically opted into cessation services but a very large percentage of those do opt out of the services. Of those that access smoking cessation services approx 70% do stop smoking by the time they deliver. However there is a high percentage of women who do start smoking again following delivery;

(f) Of those women who were still smoking at the time of delivery almost 70% were white British although information on smoking status at the time of delivery by ethnicity is not well recorded;

Following questions and comments from the Committee the following information was highlighted:

(g) there is very little data around pregnancy and homelessness. Once a woman presents as pregnant and homeless they are generally fast tracked into accommodation;

(h) there is a dedicated midwife for those women who are homeless and pregnant. They are centrally based but provide a service to women city wide and are able to maintain contact with the mother where ever she moves within the city to ensure continuity of care;

(i) homeless women and those seeking asylum are less likely to present to maternity services early in pregnancy;

(j) there are a number of different pieces of work that could be adopted in Nottingham to improve smoking cessation:

- Risk perception work – including education and visually show the mother how smoking affects her baby in pregnancy and work towards helping the mother understand the long term risks of smoking for their child.
- Carbon Monoxide monitoring – making monitoring a standard test done at each antenatal appointment and training all midwives to actively engage women who do not want to stop smoking with risk awareness work.

(k) currently maternity services and midwives cautiously advise women that use of e-cigarettes and vaping is better for them and their child than smoking, but that the best is to stop smoking entirely. The use of e-cigarettes and vaping is a way to reduce harm, not to eliminate it;

(l) at all face to face, non-emergency appointments women who used English as a second language have the opportunity to have translation services. Most translation work is over the telephone with a specialist contractor who are also used in hospitals and emergency situations;

(m) flu vaccination uptake is still low in pregnant women. Every year there are a number of cases where mothers and/or babies die as a result of contracting flu during pregnancy;

(n) reasons that flu vaccination uptake is low nationally include:

- women are cautious what they put in their bodies during pregnancy;
- reticence to use vaccinations due to the “Wakefield effect”;
- family and friends influence;
- lack of risk awareness;
- access to the vaccine or knowledge of the vaccine;

- poor fit of vaccines in previous years influencing a mother's perception about effectiveness;

(o) the "pocket midwife" app is being developed for use by the NHS UK-wide enabled to be configurable at a local level to ensure local services are accessible. The app can be configured to send reminders about issues such as smoking cessation services and flu vaccinations;

RESOLVED to

(1) thank Helene Denness and colleagues for their attendance and input into the report to the Committee on work being done on maternal health in Nottingham City; and

(2) request that information be provided to the Committee about available data on pregnant women who are homeless and/or asylum seekers and their access to maternity services.

48 HEALTH SCRUTINY COMMITTEE WORK PROGRAMME

Jane Garrard, Senior Governance Officer, outlined the Committee's future work programme for the final meeting in 2016/17.

RESOLVED to note the work programme for the remainder of 2016/17.