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Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 19 February 2013

Session 4

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HEALTH AND SPORT COMMITTEE
5th Meeting 2013, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Mark McDonald (North East Scotland) (SNP)
*Aileen McLeod (South Scotland) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Drew Smith (Glasgow) (Lab)
*David Torrance (Kirkcaldy) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Derek Allan (Kirkcaldy High School)
Sally Egan (NHS Lothian)
Marian Flynn (Glasgow City Council)
Cath King (Highland Council)
Bryan Kirkaldy (Fife Council)
Robert Naylor (Renfrewshire Council)
Tracey Stewart (Dundee City Council)
Carolyn Wilson (Scottish Government)

CLERK TO THE COMMITTEE

Eugene Windsor

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Tuesday 19 February 2013

[The Convener *opened the meeting at 09:45*]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning. I welcome everyone to the fifth meeting of the Health and Sport Committee in 2013. As usual, I remind those present to switch off all mobile phones, BlackBerrys and other wireless devices, as they often interfere with our sound system.

Agenda item 1 is a decision on whether to take in private item 3, which is our work programme and consideration of an approach paper. We usually take such items in private. Can I have the committee's agreement to take item 3 in private?

Members *indicated agreement.*

The Convener: Thank you.

Teenage Pregnancy Inquiry

09:45

The Convener: Agenda item 2 is a round-table evidence session as part of our inquiry into teenage pregnancy. I welcome all contributors to the panel. It will be useful if we go round the table and introduce ourselves. I am the MSP for Greenock and Inverclyde and the convener of the Health and Sport Committee.

Tracey Stewart (Dundee City Council): I am a quality improvement officer in the education department of Dundee City Council. I also have a corporate role in sexual health.

Bob Doris (Glasgow) (SNP): I am an MSP for Glasgow, and deputy convener of the committee.

Marian Flynn (Glasgow City Council): I am the strategic manager for young people's sexual health in Glasgow.

Gil Paterson (Clydebank and Milngavie) (SNP): I am the member for Clydebank and Milngavie.

Robert Naylor (Renfrewshire Council): I am the director of education and leisure services in Renfrewshire Council, and I am the corporate lead for sexual health.

Mark McDonald (North East Scotland) (SNP): I am an MSP for North East Scotland.

Cath King (Highland Council): I am the health improvement policy manager for Highland Council, working in the health and social care service, but also working very closely with the education service.

Nanette Milne (North East Scotland) (Con): I am an MSP for North East Scotland.

Drew Smith (Glasgow) (Lab): I am a member for Glasgow.

Derek Allan (Kirkcaldy High School): I am the rector of Kirkcaldy high school.

David Torrance (Kirkcaldy) (SNP): I am the MSP for Kirkcaldy constituency.

Bryan Kirkaldy (Fife Council): I am head of the education service at Fife Council.

Aileen McLeod (South Scotland) (SNP): I am an MSP for South Scotland.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): I am an MSP for Mid Scotland and Fife.

The Convener: Thank you. Our first question, to get us started, is from Dave Torrance.

David Torrance: My question is relevant for Derek Allan and Bryan Kirkaldy. Kirkcaldy high

school is running a pilot project with condom dispensing and pregnancy testing. What impact is that having on an area with a rate of 12.3 per 1,000 for under-16 teenage pregnancy, which is the highest rate in Europe? What effect and results is the project having? Are the data up to date? Could you also comment on the sharing of data across services?

Bryan Kirkaldy: Kirkcaldy high school is one of a number of schools in Fife in which we have offered targeted support, because of the rate of reported teenage pregnancy. We are trying a number of prevention and targeted prevention interventions at the targeted schools, and we hope that they will have an effect.

One of the challenges is that the data are always lagging behind. They are always something like two years out of date. If we could develop a more responsive data feedback system, that would be most helpful. We would like to explore, with colleagues in the national health service and nationally, whether we can develop techniques for sharing data more frequently and quickly.

Derek Allan: With particular reference to the Kirkcaldy high school pilot, I agree with Bryan Kirkaldy that the issue is multifaceted and does not just turn on the provision of condoms in school or a pregnancy testing service. Those are part of a broader strategy to tackle issues of self-esteem among girls and to join up services. It is based on particularly strong partnership working with the Kirkcaldy and Levenmouth community health partnership.

The school nurse service, in particular, has been very proactive in supporting our teaching staff to deliver a strong message to young people that it is possible to avoid this scenario. The service is underpinned by a clear understanding that the evidence points out that discussing sexuality and sexual health does not encourage promiscuity or early adoption of sexual behaviour—quite the opposite. That underpinning is also important.

Anecdotally, the data appear to show that the project is having some impact on our school community. We are waiting to see the latest data for Kirkcaldy shortly.

The Convener: Does anyone else want to respond to David Torrance's question about the targeting of particular areas or schools? Does anyone else use that model? If not, why not?

Tracey Stewart: In Dundee, although we do not have the same level of service—issuing condoms—we have generic health drop-ins in all our secondary schools. More recently, we have been looking at more targeted groups of young people for our off-site provision. That has come about because of a strong partnership with our colleagues in health and the voluntary sector, and strong signposting to local sexual health services.

David Torrance: How many pupils are actually using the service? Do you have those data?

Derek Allan: Data are available for the pilot, for August to October 2012. At Kirkcaldy high school, which has a population of approximately 1,100 pupils, 45 females and 33 males referred to the drop-in. All third-year pupils were targeted with single-sex, small group workshop sessions on relationships, safe sex, safer sex and other relevant issues such as sex and the law. The drop-ins were well used.

The number of condoms distributed was 373 to females and 252 to males. That was done without a great deal of fuss across the school, frankly. We did not find them lying in the corridors. Some people had been worried that the condom distribution would be done inappropriately.

As I said, the strong partnership working with and support from our school nurse team underpinned the exercise. The team was trusted in the community and, as Tracey Stewart said, contextualisation within wider health issues really mattered to the programme.

Mark McDonald: What are your views and those of the wider panel on the buy-in from parents to what you are doing in Kirkcaldy, and what is being done about the wider sexual health strategy? The school is responsible for the children for only part of the day, and the same goes for any other public sector service. For the majority of the time, children are the responsibility of their parents and their parents' attitudes and behaviours have a direct impact on the child. What effort is being made to engage parents in the process as well as the children? Parents have a key role to play in turning round some of the behaviours that we are discussing.

Derek Allan: In the past, we have had special focus parents events on sexual education in school. We intend to do that again shortly with the school nurse team.

The service was signposted discreetly and subtly to parents, because the last thing that we wanted to do was to inflame any unnecessary reaction. We were careful about the launch of the service; we described it as an enhanced service and invited parents to find out more about it.

You are right in thinking that the issue needs to be handled sensitively. The next stage is to have a special parents evening later this spring, probably in conjunction with our parent council, which is fully aware of the programme that we offer.

Mark McDonald: Just to follow up on that—

The Convener: Can we get a response from some more people to your first question, Mark? Marian Flynn has indicated that she wants to come in on this point.

Mark McDonald: Of course.

Marian Flynn: In Glasgow, we place great emphasis on involving parents. From the outset, we conducted a consultation with parents in which we asked them what they thought of education on sexual health and relationships—both what they had received themselves and what they wanted for their children. We have used that information to create a dedicated service called talk 2, which aims specifically to encourage parents to talk to their children from a very early stage about growing up, puberty and sexual health matters. We have been very successful in engaging a range of parents across the city in that programme. The good thing about the programme is that it has many strengths. There is a website, there is a book collection in all Glasgow City Council libraries and there is a group work programme that parents can dip in and out of as they see fit.

Linked to that is the work that we have done on the sexual health and relationships education programme in schools, in which there is strong emphasis on encouraging parents to be part and parcel of their children's learning. In Glasgow, we have very much tried to reframe some of the debate into a more general debate around sexual health and relationships, placing it within children's development. Within that, we have been able to engage parents in a meaningful way, promoting the idea that it is part and parcel of what children need to learn as they grow up, in an age and stage-appropriate way.

The Convener: Do parents engage with that process?

Marian Flynn: Very much so. When we initially go into schools, we have an effective means of implementing the new schools programme that we have developed in Glasgow. We try to engage parents by ensuring that the schools have an information evening to which they can come to hear more about the programme, look at the materials and ask questions. An information pack also goes home to all parents because we realise that not all parents will be able to attend the information evening.

In addition, we have built on the work that has been done elsewhere and have built in what we call home activity exercises whereby children take some work home to discuss it with their parents. The important thing about that is not whether they get the answers right or wrong, but that it prompts a conversation. Parents said to us that they want to work in conjunction with schools, but many of them did not know where to start. The schools programme gives them that prompt and the ability to get going.

The Convener: Does anyone else have any experiences similar to that, addressing Mark McDonald's initial question?

Tracey Stewart: In Dundee, we have been working with the speakeasy programme, which is similar to the programme that Marian Flynn has spoken about, to engage parents. Our local youth workers or other voluntary sector workers have undergone significant training and are meeting parents to go through an accredited pack. Some of those parents are now coming back and much more of a peer-on-peer model is being developed.

Mark McDonald: The convener talked about parents engaging. I remember, from my time as a local councillor, attending parent council meetings at which the headteachers would tell me that there is always a core parent group—a percentage of the parents—with whom it is difficult to engage or who choose not to engage with the school. Is there any correlation between those parents who choose not to engage or who are not engaging and the children who are more likely to engage in risky sexual behaviours and the kind of sexual behaviours that we are discussing here?

Bryan Kirkaldy: Yes, there is a correlation. One of the groups of young people who are at risk of becoming pregnant in the teenage years are children who engage in risk-taking behaviour and who are not always well supervised in the evenings.

In addition to what Marian Flynn and Tracey Stewart described—a universal approach, which we support and do—we expect, in the context of the getting it right for every child framework, our multi-agency teams to intervene with families when there is evidence that a young person is involved or potentially involved in risk-taking behaviour, which is often associated with alcohol and substance misuse. We are joined up with the voluntary sector, the police and detached youth workers, as well as our family support workers, to intervene in higher-risk situations.

10:00

Cath King: In Highland, we take sexual health and relationships education seriously. We take even more seriously the GIRFEC approach, which we now call the Highland practice model. Under that, we work in partnership, identify vulnerable children at a very early stage and hand responsibility back to their parents. That is effective in identifying issues at an early age, so that the young people can be targeted.

The role of school nurses is another issue. We know that two new sets of immunisation are coming up, which will take up more of their time. Parents and pupils often trust school nurses to speak to, but they are often busy with lots of other things. School nurses have almost two separate roles that run side by side.

Robert Naylor: It is fair to say that it is often difficult to engage with the parents of the most vulnerable children. The people who come to forums such as parent council meetings tend not to be the parents of the most vulnerable children. Similar to other areas, in Renfrewshire, our multi-agency teams—our home link workers and social workers who work on the ground—are much more likely to identify children who are likely to have other risk-factor behaviours. Those teams engage with parents on issues such as safe sex, avoiding pregnancy and so on. That involves local knowledge of circumstances for children and working with parents and families. My experience is that we need to do much more on that and to target communities that have high incidences of teenage pregnancy.

Cath King: Under the GIRFEC approach, we take the named person seriously. A child has a named person throughout their life, who is a midwife in the very early years, then a health visitor, the primary school head and a guidance teacher. That person should pull together the jigsaw of all aspects of the child's life. In addition to the wider interventions, that individual approach that ties everything together is important.

Mark McDonald: Nanette Milne and I had an enjoyable visit in Dundee, when we heard about practice that is taking place and saw at first hand work that is being done. In discussion there, the father's role in a teenage pregnancy was raised. We often focus on the mother, for obvious reasons, but she did not get pregnant by herself, and a father is often there.

In Dundee, we learned that, often, the father is not of school age or is not in the school system, but sometimes he is. What work is done to encourage such fathers to have a role in their children's lives? When a teenage pregnancy is carried through, we must ensure that the best is done by the child who is born. If the child's father has a role in their life, that will help the child. What work is done to identify the father and encourage him to take responsibility and be involved in the child's upbringing?

Marian Flynn: The committee has visited the young parents support base in Glasgow. The emphasis in the work there is on ensuring that we talk about the issue in terms of not young mothers but young parents, and we try to engage fathers from an early stage. More could definitely be done to encourage fathers to be involved, but we have found that, when they are there—as in the majority of cases that we work with at the support base—they want to be involved, although they are sometimes sidelined by a series of professionals and the emphasis is very much on the mother.

Cath King: We are just introducing the family nurse partnership approach, which should encompass the whole family unit. We are working with young parents to break the cycle—teenage parents are often from teenage parents.

I wish to add something about the societal approach to young men. We have rightly focused on women and their view of themselves, but young men have been slightly sidelined. We need to do more work, nationally and locally, to encourage young men to take nurturing roles; to a great extent, that is currently absent.

Tracey Stewart: We have a family nurse partnership in Dundee, which is showing some early signs of impact. We are trying to engage with the family unit. I agree with the comments that have been made about doing more work with young fathers.

We have used a healthy community collaborative approach in Dundee. There are early signs that young fathers have been establishing some support groups using that approach, and young parents are coming together to support each other. We are trying to move things forward, and we will focus on that area.

The Convener: There have been a number of references to school nurses. Perhaps I am too long away from school, but does every secondary school have a school nurse, or do they work across different schools? Can you explain where they are, and how nursing can help in this area?

Marian Flynn: I do not know the detail—

The Convener: We might get some in a later evidence session.

Marian Flynn: The role of school nursing has been under review of late, just because of the demands on the service. There has been discussion about where the emphasis should be, and whether it should be more on things such as immunisation or various elements of child protection. Given the very large school estate in Glasgow, I am not sure that some of the services that have already been spoken about have sufficient personnel to work across those areas. Some school nurses are involved in health improvement activity in schools, but that is not the case across the piece in Glasgow.

The Convener: Is the situation similar elsewhere?

Bryan Kirkaldy: Each of our secondary schools has assigned to it a school nurse who works in the

context of the children's services plan. One of the priorities of the plan in Fife is a reduction in teenage pregnancy, so the nurses are working in the context of that strategic aim.

The Convener: Is that done in collaboration with the health board? Does it contribute to that work?

Bryan Kirkaldy: Yes—the school nurse is employed by NHS Fife.

The Convener: How many do you have in Fife?

Bryan Kirkaldy: I am not sure how many school nurses we have in total.

The Convener: But they are not in every school.

Bryan Kirkaldy: A school nurse is assigned to every secondary school in Fife.

Cath King: In Highland, we have integrated children's services, so we actually employ the school nurses as well. Each school has a school nurse assigned to it. The tension is between their health improvement role, their immunisation role and child protection—there are a whole raft of things there, and an increasing number of things to consider. Addressing the needs of vulnerable children has become more of a priority, rather than the wider health role.

The Convener: So there are competing demands.

Cath King: Yes.

Robert Naylor: The picture in Renfrewshire is similar. We have school nurses who work across the estate, but they are not individually assigned to a school. I echo what has just been said about the role and responsibility of school nurses, who are charged with a great many activities, only one of which relates to the issue that we are discussing.

We have had recent discussions about puberty talks, for example, which are no longer carried out by school nurses, although that had been the practice hitherto. Now, programmes are being developed whereby teachers will take on that responsibility because school nurses are tasked by the community health partnership to do important work in other areas. I suggest that the resource is limited.

Tracey Stewart: I echo what has been said. We have a school health nurse attached to each of our secondaries and their associated primary school clusters, as well as nurses for looked-after and accommodated children. The competing demands on them have meant that some of the proactive health promotion work has been put aside. However, we are having conversations around redressing the situation.

Our school health nurses support each of our secondary school health drop-ins, which take place on a weekly basis in each of our secondary schools.

Derek Allan: The drop-in service at Kirkcaldy high has a specific sexual health clinic every Friday, and other drop-in clinics dotted throughout the term. There are also focus weeks on issues such as teenage mental health, smoking cessation and diabetes awareness, and teachers are supported to deliver health messages, including sexual health messages, as part of the curriculum for excellence.

Having an effective school nurse service working in partnership with the education people is key to tackling the issue.

The Convener: We might raise that point with other witnesses. There has been a lot of publicity in the past couple of days about extending such services through school nurses. It seems that there is a question mark about how to do that. I might be getting this wrong, but there seems to be a patchy service that is seen as something of an add-on. There have been 24 hours of publicity about the morning-after pill being delivered by school nurses, as if that is their sole responsibility and they are sitting around waiting to be visited on an hourly basis. On your evidence, that is not the case.

Robert Naylor: That is certainly not the case. If the morning-after pill were to be made available in schools, a range of issues would have to be considered, not least that of denominational schools. There would also need to be a significant reconsideration of the allocation of health resources. If we wanted a nurse service that was dedicated to schools, resources would need to come to schools and we would need to focus clearly on what we expected to be delivered in schools in terms of that aspect of the health agenda.

The Convener: Would it be desirable for a nurse to be the key figure in the delivery of that service, or would it be better if other services did that?

Marian Flynn: That is a good question. Do young people feel that school is the most appropriate place to get that service? Is it confidential enough? Would it have the required level of anonymity?

In Glasgow, the approach has involved improving community-based health services so that young people have access to emergency contraception at an easy distance, whether through a dedicated sexual health service or through pharmacy provision. There is a difficulty in putting all the eggs in one basket and saying that school nurses alone will deliver the service. There

must be a range of forms of delivery so that young people feel comfortable approaching services.

The Convener: At the moment, there is a mechanism whereby young people can be directed to a place where they can access emergency contraception. Is that right?

Marian Flynn: Yes.

The Convener: But it is not at the school.

Marian Flynn: No.

The Convener: It is in close proximity to the school.

Marian Flynn: Yes.

10:15

Cath King: I agree that we should not confuse the administration of emergency contraception with the school nurse role. That role is as much about good signposting and confidential advice to help young people, and there is not enough of that as a resource.

We would target community pharmacies in areas of deprivation and also areas where lots of young people are bussed to school, because we have the rural issue to think about as well, and we need to consider how children and young people can access services confidentially.

The school nurse is pivotal in signposting and giving information. In surveys, young people have said that they prefer to have somebody other than their teachers giving them those messages.

Gil Paterson: This is an appropriate moment for me to come in, because my question is about those messages. I think that Mr Allan said that his pilot is for secondary 3 onwards. Is there any impact on or any reaction—in a preventative sense—from younger pupils in S1 and S2? Is anything happening there as a result of what is happening with the bigger boys and girls?

Derek Allan: The universal focus is for all pupils in the third year to be taught about, if you like, sexual relationships and given sex education in small single-sex groups, supported by the school nurse. However, we have a target group in S1 and S2—they are mainly girls, actually—who we think are at risk. Their families are also involved.

It is hard to say, but I would imagine that there is wider knowledge across the school population, given the assemblies that we have delivered, which have not been just for specific year groups. Again, the message has been communicated discreetly: rather than having big banners about the availability of condoms or whatever, little cards have been shared with pupils individually. The drop-in service has mainly been taken up by the third and fourth years. I do not think that I have records that show that anyone below those year groups has accessed it.

There has certainly been a culture change. We are bringing these matters to the fore, talking about them more openly and taking a more proactive and pragmatic approach, and that is helping us to tackle the issue.

Gil Paterson: Is that showing up in any meaningful way?

Derek Allan: Only anecdotally. Over the past three years, we have had three pregnancies that have gone to term in the school, which is fewer than in recent years. However, as Bryan Kirkaldy said, I would like to see the figures to confirm that.

Gil Paterson: Thank you.

Bob Doris: I am curious about the link between this issue and the committee's health inequalities inquiry. One thing that seems to be emerging from the health inequalities inquiry is that, whether people are 12, 22 or 50, preaching to them about lifestyle choices tends to be unsuccessful—it does not seem to work. The message that keeps coming through is that we must empower people—in this case, young people—to make positive choices.

Does the delivery of sexual health information and education in schools sit within a designated area? Do you say, "This is the sexual health bit", or is it woven and integrated into wider work on self-empowerment? If the latter approach is taken, you could start it as early as primary school, where you could talk to young girls about what their future career choices might be and what the barriers might be to their successfully achieving them, depending on whether they become young mothers or whatever.

Where does the idea of empowerment fit in? The phrase "self-respect" came up, and that is important. Where does the sexual health strategy sit with empowering young people to make aspirational choices for their future?

Bryan Kirkaldy: That is a good question. I would frame it slightly more widely even than that, because there is an association between social disadvantage and teenage pregnancy, and part of the responsibility of the education system and schools is to try to raise aspirations and expectations for the whole population of young people, but particularly those from more disadvantaged backgrounds.

We believe that, by improving educational outcomes and life chances through an educational process, we will have an impact on that sense of empowerment, which is important in relation to the choices that young people make at the ages of 13, 14 and 15 about what they are going to do. The whole approach around the prevention role that

education and school services can provide involves raising expectations, aspirations and outcomes, and the discussions about social relationships, health and sex are part of that bigger context.

Health and wellbeing is a key strand of curriculum for excellence—it is one of its three key strands, as you know. School staff and, indeed, parents now have a responsibility to think about health and wellbeing more holistically and to view it in the context of how the child is living and learning.

Cath King: I would consider the issue even more broadly. In Highland, our view is that any measures to tackle deprivation will tackle teenage pregnancy—it is as simple as that. We have invested £3 million in preventative work, some of which has gone into tackling deprivation and some of which has gone into early years provision. We have joined up with other local authorities in Scotland on the early years collaborative, improving early years interventions and working with young people. There should be lots of changes among young people in the next generation. Overall, measures to tackle deprivation will tackle the issue.

Robert Naylor: I echo that. Health and wellbeing measures under curriculum for excellence and the various programmes that have been devised across local authority areas involving relationships, sexual health, parenthood programmes and so on, which are embedded in the curriculum and which are delivered either discretely or as part of wider personal and social education programmes, make a difference and are delivered to all children. However, teenage pregnancy is probably far more of a social demographic issue than a health issue.

Regarding what has just been said about targeting approaches in communities where there are generational cycles of teenage pregnancies, single-parent families and unemployment, the way to tackle the issue is to target resources under a community planning approach, with all the agencies working much more closely together with the families of children who are likely to emerge into a risk situation because of what we know about their community. We need to work with them all the way through from age zero, making use of evidence-based programmes and parenting programmes such as the triple P—promoting positive parenting—programme and the incredible years programme, of which we now have some experience in Renfrewshire. It is a matter of working with families across the piece so that by the time children get to the age when it is conceivable that they could become pregnant, the inputs and the work that will have been done with them are far more likely to have taken them to a place where the suggestion that the way to become loved or recognised is to go with a boy or to start having sexual intercourse early is a considerable distance from the radar—and that is not the case at the moment.

Marian Flynn: The point about not preaching to young people is really important. Our schools-based programme is discursive, and it attempts to allow young people to think through the issues. We have put great emphasis on developing critical thinking throughout the piece. It is a primary 1 to S6 programme. At primary school, the building blocks for good sexual health and relationships are put in place. That involves talking to children about friendship and their rights to their own body and privacy. All those building blocks, which are important for children's assertiveness—saying what they want and do not want—can be built in at a very early age.

Tracey Stewart: I would echo everything that has been said on this point so far, and will highlight an approach that we have been taking in Dundee.

There is evidence that links young people's involvement in youth development programmes with a continual raising of their aspirations and their development of a sense of belief in themselves and of where they want to go in life. We have introduced the health buddies programme, in which we train third-year pupils to deliver aspects of education on relationships, sexual health and parenthood to their peers in S1. We are certainly seeing an impact from that, particularly on those young people who have been trained in the peer-education approach, in respect of their raised aspirations and beliefs about themselves for the future.

Bob Doris: It was encouraging to hear Marian Flynn say that the programme is a P1 onwards programme. That gave me comfort that sexual health is placed in a much wider context, which is something that I want to ask about again—we keep widening things out in this discussion.

Schools seem to be seeking not to preach to young people, but to empower them, which is very positive. However, no matter how wonderful programmes and initiatives are, for some of the most excluded young people, school is still school. Is active work going on in communities in youth programmes outwith schools—with organisations in the voluntary sector, for example, that work with young people—to talk to young people, hang out where they are and get the message over? School can be seen as alien territory by the most excluded young people, no matter how well-intentioned and well-thought-out courses are. Is work going on via the voluntary sector or in youth programmes outwith the education service as part of the overall sexual health strategy?

Bryan Kirkaldy: Yes. We take a partnership approach. Our sexual health strategy group at the Fife level comprises people from the voluntary sector, the police, the NHS, education, detached youth work, social work and so on. That approach is also reflected the local level.

The extent to which young people access drop-in services is an issue. The Kirkcaldy high school example that has been described is one example, but we have other examples in Fife. For our targeted schools, the drop-in service is provided near the school, in a community centre. We listen to what young people say about what they would find accessible, and we listen to what staff and parents say about what they would find acceptable. That means that we have a range of sources of advice and support.

Marian Flynn: It is important to raise the issue that this is not just about what happens in schools. We try to address the issues with young people through youth health services and youth provision in Glasgow, but there is a gap, and we need to work on that in the city.

The Convener: What is the gap?

Marian Flynn: There need to be more targeted programmes outwith school that take a youth work approach, in which there can be meaningful talk with young people about what relationships and friendships mean to them, and a look at issues to do with assertiveness and how young people are dealing with a cultural backdrop that is very different from the cultural backdrop that there was when most of us were growing up. We are not doing that in a sufficiently targeted way.

Bob Doris: My final point is more of a comment than a question.

I am encouraged by the work that is going on in schools, but the more I work with youth organisations in Glasgow, the more I find out how powerful meeting young people on their own territory and turf is. As much as we want school to be their territory, it is not for many of the most excluded. We cannot overestimate the good work that youth groups in Glasgow and beyond do in building relationships with young people. I know how difficult it can be to get some people to trust in schools, despite all the good work that is going on, and I am keen that we follow up on the work that is happening outwith traditional educational routes.

I thank the witnesses for their comments.

Tracey Stewart: I should have emphasised that the health buddies programme that I mentioned involves a joint approach that includes community learning and development, the health service and education. There has been strong partnership working, and as a result some young people who have gone through the programme have done volunteering work or gained accreditation through youth achievement awards. The programme is just one example.

10:30

The Convener: We often hear that lots of resources are being directed at an issue. We have heard about the family nurse partnership. We heard about school nurses, teachers, sexual health workers and youth workers, who all have separate jobs. Where is the partnership that brings all those people together, to maximise the resource and secure a better outcome? In some areas the pregnancy rate among under-16s is double the national average, despite all the work that is going on. Who is in control of all the resources? Who ensures that there is a coherent approach?

Cath King: I cannot speak for all services. We are putting a lot of store by the named-person approach for the individual child or young person. The named person should be able to highlight a young person's becoming vulnerable, so that they can alert the right services and signpost the young person to services when something happens. That is important.

The Convener: Does that happen?

Cath King: The approach is in its early stages, but yes, it does happen.

The Convener: Why are the figures for under-16s in some areas in Scotland double the national average? Why have we not made progress, when we are spending so much money and there are groups of workers in different fields who are working hard to prevent teenage pregnancy? My question is for everyone.

Cath King: I should say that I do not think that every area uses the named-person approach yet. It is part of the forthcoming children and young people bill, but we have already gone ahead with the approach.

Robert Naylor: In Renfrewshire, the sexual health planning and implementation group brings together education services, the community health partnership and various agencies, including voluntary sector agencies, to develop consistent approaches and try to use the combined resource that is available to us. Youth workers, community learning and development and various outreach programmes are also involved and are working directly with children, in and outwith school.

The convener asked why the rate is double the average in some areas. The services that we seek to provide are generally provided on a universal basis. There needs to be much more targeting towards the areas in which rates are double—or sometimes treble—the rates in other places.

As I said, this is a social issue. It is about deprivation in certain communities, where there has been poor modelling behaviour by parents and there is often serious drug and alcohol misuse. We are talking about communities in which children are often unable to access school and community resources in the way that we would hope they could do. We can tackle the problem only by developing much more cogent family-centred approaches from the earliest stage, ensuring that the resource goes into the communities in which we can make the most difference.

The Convener: I am familiar with what you are talking about. My area, Greenock and Inverclyde, has some of the most deprived areas outside Glasgow. The rate in Greater Glasgow and Clyde among under-16s is 6.9 per 1,000 young women. However, in Dundee it is 14—more than double—although we are talking about communities with similar levels of deprivation. Money is going into those communities and all the people I talked about are working in them. How can the committee come to a conclusion about what we should recommend?

Bryan Kirkaldy: I return to my initial point about data. Since the current national data was published, we in Fife have been very conscious of the place that we occupy in the league table—it is not where we want to be. That is why we have introduced a lot of innovations and strengthened partnership working locally, which is a priority in our children's services plan. We are doing things that we think will have an impact. Given the way in which the data is cycled, the best information that we have is the 2010 data, which is what the committee has. We would like to know whether what we have been doing since 2010 is making a difference. More than that, we would like to know which parts of it are making the most difference. We want to become more intelligence led and we want to see whether what we are doing in Kirkcaldy high school is making a bigger or lesser difference than what we are doing in Auchmuty high school. One of the things that the committee would be well advised to consider is whether we can get a more responsive data-sharing and feedback mechanism, ideally with data disaggregated to community and school levels.

The Convener: We might come back to that issue, but Richard Simpson wants to come in now. Are we gathering all the data that we need? Does just counting terminations and pregnancies give us a good guide to what is going on?

Dr Simpson: I want to make a quick point about that. On my visit to Oldham, I was impressed by the fact that statistics are collected there by school and by locality. The schools all know what their own rates are—they know them very quickly—and have managed to reduce their levels from twice the national average to just below the national average. They have a problem now in that the level is flatlining, but they have made a very good start.

Is the provision like it is in general practice, where there is a general practitioner for every patient even though every patient's needs are different? In deprived areas, patients need a hell of a lot more than patients in other areas do. Are we distributing the resources on a basis that is equal but not equitable? In other words, does it meet the real needs out there?

We are pinning all our hopes on the family nurse partnership programme. It is a good programme and I have no criticism of it, but it is very resource intensive—it is very expensive. I note that, in Dundee, programmes such as baby bumps and young mothers to be, which were previously available to support young mothers, no longer meet. The FNP programme focuses on a much smaller group, but there is another group beyond that who also need help. We might be beginning to tackle the very problematic families, but if we focus all our resources on the FNP programme and lose other programmes that offer peer-group support for young mothers, will we not run into problems?

Tracey Stewart: We are conscious of the figures in Dundee and are trying collectively to do something about them. As Bryan Kirkaldy has said, it would be helpful to have more recent local data and intelligence. We have an indication from our health colleagues that the interventions that we are making are bringing the figures down over a five-year period.

Something else that we have in Dundee is total place, which is an approach to the whole range of aspects of deprivation. We have targeted resources at an area of Dundee that has high levels of teenage pregnancy. That work has to be evaluated and we will learn from it to see how to roll it out across the city.

As Bryan Kirkaldy has said, we have a local action group, incorporating a range of partners, that looks at local intelligence and tries to move things forward. We commissioned some local research in 2011, for which the report has still to be published. However, the evidence seemed to mirror national and international evidence, except perhaps in the area of social norms and the generational cycle of recurring themes. The launch of the report will be another means of moving things forward.

Marian Flynn: On Dr Simpson's point about the FNP, it is a tried and tested programme, but some of its limitations arise from its being a universal programme. Young people who become parents

do not all have the same needs. Some young people have good family support and community-based support, so they need only a light-touch approach. However, young people who do not have that wider support need a more intensive service. The difficulty with a prescribed programme such as the FNP is that it is a one-size-fits-all programme. We all try to get the best value for our money in times of resource constraint, so I believe that services for teenage parents should be a bit more nuanced and responsive to need, as opposed to treating all teenage parents in the same way.

Dr Simpson: I am sorry, but I do not understand that, because the FNP programme is very focused. In the Edinburgh pilot, only 180 families were supported by the programme, which ran from diagnosis of conception through to when the child was two. It was therefore a very expensive, highly focused programme, which is beginning to show quite good results. It was not a universal programme at all, so I do not know what you are referring to when you talk about a universal programme. Surely the universal programme is just the general health visiting programme.

Marian Flynn: As it has been implemented in Glasgow, the FNP is not a targeted resource. It does not identify the young people with the greatest need but is just open to young parents. Granted, the programme is open only to a limited number at this time, because it is in its early phase, but it is not targeted at young parents with the greatest need.

Dr Simpson: So every pregnant teenager in Glasgow gets an FNP.

Marian Flynn: No, not every one. As I said, the programme is limited because it works on a quota basis, given that there are only so many nurses and that they can carry only a certain case load.

Dr Simpson: But there were specific criteria for selection for the FNP.

Convener, this is perhaps another example of what happens when we start with a focused programme that is carefully prepared and properly evaluated, which the FNP is as a copyrighted programme that is supposed to have specific criteria. If that costly programme, which is supposed to produce good results, is now being used much more widely and without the original selection criteria, we are wasting an awful lot of money.

Marian Flynn: My understanding is that the basic selection criteria for attending the FNP programme are that a young woman must be pregnant for the first time and be 16 to 20 weeks pregnant.

The Convener: Does Tracey Stewart have some experience with the FNP programme?

Tracey Stewart: Yes. It is my understanding that the family nurse partnership is open to all young women under the age of 20 in their first pregnancy.

Bryan Kirkaldy: That is the point that Marian Flynn was making about the programme being universal, because it is the age and first-pregnancy criteria that allow admission to the programme. The general point for me is that we need to become more confident in Scotland about evaluating the impact of programmes that we develop here. The FNP is limited and so expensive because we must maintain fidelity to that model in order to get its demonstrated outcomes, which is fair enough if we want to take an outcome-focused, evidence-based approach. However, we need similar programmes to be targeted at the higher-risk groups and those predicted to be at more risk in our social context. We need to be able to demonstrate the outcomes from such work and become more confident at spreading it across our communities.

10:45

Robert Naylor: The family nurse partnership will impact on the lives and life chances of infants who are born to teenage parents. That fits with the work of the early years collaborative and the early years strategy and in time will, we hope, lead to a generational change in the outcomes for such young people. However, the family nurse partnership will not do anything about the rate of teenage pregnancy. It will deal with teenage pregnancies as they arrive and secure better outcomes for the children who are born, but it is not about what we have been discussing this morning, which is preventing teenage pregnancy.

Bob Doris: That is partially the point that I wanted to make. Family nurse partnerships are about positive health and social outcomes for teenage women who have a child. We could be comparing apples with oranges by looking at the family nurse partnership in this inquiry.

Does targeting teenage mothers by definition mean that the family nurse partnership is weighted towards mothers from more deprived areas and those more at risk? I would be keen to know whether the statistics show that. I am not personally wedded to one model over another, but if we target what we do, could we stigmatise some young women who might wonder why they are given this additional support in bringing up children? I would be keen to know people's views on that. If the statistics show that young mothers are more likely to be from socially disadvantaged areas, by definition the family nurse partnership

will be targeted to a degree. If the programme were not universal for people within the targeted group, would people on it not be stigmatised? I am open minded on that but, given that Dr Simpson mentioned that point, it would be good to know people's opinions.

Marian Flynn: There is no doubting the evidence that teenage pregnancy occurs in more deprived communities. In that group, and in the young parents whom we work with in Glasgow, there are different needs, abilities and support mechanisms.

Some young women will be able to maintain their school place, have good family support and manage to maintain links with their peers. They get a very light-touch approach from us. We get involved in parenting, ensuring that they remain engaged with their education and peer support, but it is a different level of support from that given to those young parents who need something more. Support needs to be nuanced, even accepting that teenage pregnancy is closely allied to deprivation.

We have tried to avoid stigmatising services by having a universal service and calling it a young parents support service. Within that, we can target and deliver different levels of support and no one necessarily needs to know the different packages. People just know that we are supporting all young parents.

Bob Doris: That is interesting. Thank you.

Cath King: The family nurse partnership is targeted by the nature of the target group it is looking at. We know that through the number of terminations in more affluent groups compared with in lower socioeconomic groups. Also, it is very important that, as Mr Kirkaldy said, if you have an evidence-based programme, you have to have fidelity to that programme to get the results. There is no point in using evidence-based programmes if we are just going to adapt them.

The Convener: Richard, do you want to come back?

Dr Simpson: No, those comments were very helpful.

Cath King: On Dr Simpson's point, people in deprived areas may need a bit more. We would certainly target our deprived areas, but I would not want the rural aspects to be missed. Given that Highland Council delivers services across a wide geographical area, it would be wrong of me not to make the point that the cost of rural service provision is significant and that it is much more difficult. For example, we use the Brook centre on a Saturday afternoon in Inverness, which is miles away from some people in Highland. However, we know that lots of young people go to Inverness, so they might be able to access something there at some point. Locally, they could go to a GP or a community pharmacy—if there is one—but in small communities the receptionist or whatever might be their mum's friend, for example. We need to bear that aspect in mind as well.

The Convener: Are there any other questions for the panel?

Aileen McLeod: I am conscious that we have not touched on the area of looked-after children, which involves young people in care and those leaving care. In their written evidence, the centre for excellence for looked after children in Scotland and Who Cares? Scotland said that young people with care experience tend to be at a higher risk of having a child at a young age and that some of that is down to their wanting to be loved and to have someone to love. Looked-after children are perhaps disengaged from school or excluded from school, and are more likely to experience disrupted education. I represent South Scotland, which is a large rural area that includes Dumfries and Galloway. The challenge in such an area is to ensure that young people can access the appropriate services, but there is an added challenge for looked-after children in that respect.

Marian Flynn: The main way in which we have tried to tackle that issue in Glasgow is through skilling up the workforce who work with looked-after and accommodated children. In that regard, we have done significant training with residential workers and families for children staff. The talk 2 parenting programme, to which I referred earlier, has been adapted for foster carers. Again, the idea is to talk early with young people in a way that is appropriate to their age and stage of development. The other point is about having specific health teams for looked-after and accommodated children, which can provide services to young people in a holistic way that includes discussing sexual health.

As I said, it has been very much about trying to skill up individuals around young people so that they feel confident in talking with young people about the various issues in their lives.

Tracey Stewart: I echo what Marian Flynn has said. We take a similar approach in my local authority. With regard to the speakeasy programme, we have been upskilling our workforce, foster carers and residential workers in Dundee. We have also introduced school health nurses who are specifically aligned to looked-after and accommodated young people. There is also engagement with the voluntary sector to provide interventions for sexual health and relationships.

Derek Allan: At school level, a frequent feature is the school liaison group of community partners, who meet regularly in our school and in all

secondary schools in Fife—in fact, they also meet with all primary clusters now. The needs of looked-after children are always part of that agenda. The named looked-after children are discussed in terms of the GIRFEC framework and the SHANARRI—safe, healthy, achieving, nurtured, active, respected, responsible and included—indicators. Health needs at that point may be part of the input to the children's plan, which all looked-after children will have.

Robert Naylor: We take similar approaches. Looked-after children are assigned key workers and there are targeted and supported inputs for not just sexual health education but a range of outcomes for looked-after and accommodated children. To pick up on what Ms McLeod said, the point is that the educational attainment and health outcomes for looked-after and accommodated children are generally pretty bad across the piece.

We are working to change the culture in our schools through the inclusion agenda. It was mentioned that, far too often, looked-after and accommodated children end up being excluded from school. We are developing a culture in which there is a presumption that those children will not be excluded, because the best place for them to be is school. The best that we can do is to quickly organise our extended support teams and our multi-agency frameworks around children whose behaviours are leading them to be excluded from school, and to get appropriate supports in place immediately so that they do not end up back in the community where they are likely to be most vulnerable, not least by getting involved in behaviours that could lead to pregnancy.

The Convener: The committee has been on a number of visits, and we have seen very good projects in Glasgow that support young mothers. However, the committee briefing states that there are a significant number of abortions among the under-20s. How do we see young people through that process? What supports are in place for them? Do you know about those young women or not? Are they picked up and supported by the system?

Marian Flynn: The majority of young women seeking a termination are dealt with through the health service. Sandyford services specifically deal with young women in Glasgow, and they play a key role, along with GPs and other services.

From a council's point of view, issues are sometimes picked up in schools by pastoral care teachers, and such issues would be dealt with sensitively. There is also a link midwife for teenage pregnancy in Glasgow who would get early indications of pregnancy and who would talk to the young person about how they wish to proceed. Occasionally, the young parents support base provides support, too. By the time it is notified of a young women's pregnancy, she may still be having doubts about whether she wishes to proceed, so there would certainly be discussion and counselling throughout.

The Convener: I am wondering about confidentiality. We have discussed what information can be exchanged so that young women can be supported. Is that how we would handle the situation in Dundee, the Highlands or anywhere else?

Bryan Kirkaldy: Yes, it is similar in Fife. It is a confidential matter at the individual level, and specialised services would support the young person and their family. Schools would not usually be directly engaged in that.

The Convener: The other causal aspect is the influence of alcohol and drugs. Does anyone wish to put anything on the record on their significance in relation to unplanned teenage pregnancies?

Marian Flynn: They all go together; it is a list of risk-taking behaviours. We know that alcohol—I would suggest more so than substances—is often involved in many young people's early sexual experiences. Some of that is about young people's behaviour in general, although their behaviour is not that much different from adult behaviour. Generally speaking, how we deal with sex and sexuality in which there is that association with people needing Dutch courage or using alcohol to excuse behaviours is a cultural issue.

11:00

Robert Naylor: We have instances in Renfrewshire in which our home link workers are working with young women who have self-esteem issues and who might be involved at weekends in offering sexual favours in return for drugs or alcohol.

There is a cycle in which we need to work with young people on their self-esteem and sense of self-worth, as well as steering them away from alcohol and drugs.

I agree that, as has been said, these things often go together, particularly where drink is involved. Often young women get themselves into situations because of drink and the desire to belong to and fit in with a peer group that is leading them into that kind of behaviour. That is partly driven by the modern media and the depiction of women and how they ought to behave. Although there is a broader cultural issue, the behaviour is fuelled and driven to some degree by alcohol and drugs.

Tracey Stewart: The agendas are all connected and we need to get better at looking holistically at risk-taking behaviours. Some of the interventions that we are working on are not about putting

young people into a silo of just sexual health or teenage pregnancy. It is a much bigger picture and it is everyone's responsibility to address the issue.

Nanette Milne: In Aberdeen, Inverness and one or two other cities there is an active group of street pastors who speak to young people who might become vulnerable as a result of drinking alcohol on Fridays and Saturdays. Is there any role or training for such people in advising on sexual behaviour? I know that they do not want to preach at young people, but I wonder whether there is a role for them, if it does not already exist.

The Convener: I suppose that there are connections. If a young person is admitted to hospital because they have taken a dangerous amount of alcohol, how does that feed back into the system? If someone is stopped in the street, has their name taken by the police and alcohol confiscated, again, how does that feed back into the system? If we are targeting that risk-taking behaviour, how can we ensure a more positive outcome from those experiences?

Derek Allan: Fife operates a programme called MAIT—the mobile alcohol intervention team—which involves youth workers and police officers. There is now a link back to schools from that particular reporting mechanism so that we can get involved and follow up any alcohol confiscations. The programme has a team that concentrates on hot spots and tours certain areas in Kirkcaldy on certain evenings. It is a way of tying everything up and involving the youth workers in counselling on sexual health and other matters, as well as risk-taking behaviour generally.

Bryan Kirkaldy: I will echo that. We have a multi-agency approach. We see alcohol and substance misuse at the top of the risk pyramid, as part of a bigger challenge. Any information that comes to the police or to the NHS is shared with other members of the partnership, including the education and community services to see what part we can all play. That happens at the Fife, area and school levels.

Mark McDonald: Nanette Milne mentioned street pastors. I have been out with them in Aberdeen and their focus tends to be more on those who are out in the nightclubs and pubs.

It brought to mind that the churches also have a role. In Dyce, the community where I live and which I used to represent as a councillor, the local church has the red bus project. Unsurprisingly, it is a big red bus in which teenagers have an opportunity to get involved in youth and diversionary activities on weekend evenings. That takes them away from some of the risk-taking behaviours that they might otherwise get involved in.

I am sure that there will be other examples that members can cite from their local areas. The role that the churches are playing bears consideration as part of the inquiry.

The Convener: As members have no other questions, I offer our panellists the opportunity to put on the record issues that they wanted to cover and which have not been mentioned. The witnesses might have observations or ideas about what the committee needs to look at as it proceeds with the inquiry. We could cover again what information should be collated—is it good enough simply to list the numbers of pregnancies, deliveries and terminations or do we need to examine the issue through other health statistics that indicate risk-taking behaviour or whatever? I do not know.

You have your chance now, but it is not a final chance, because you can write to or email the committee. We welcome further submissions or comments on the evidence that we take before we produce our report. Does anybody wish to put anything on the record?

Robert Naylor: We have heard about a great many multi-agency approaches and about people working in partnership across services to tackle the issue. The responsibility for being the lead agency and taking a strategic lead has moved towards councils as providers of universal services, not least of which is the education service. In these straitened times, I would have liked consideration of resource transfer, if councils are now driving forward the agenda, albeit with their partners. We have moved away from the idea that teenage pregnancy is simply a health issue towards thinking that it is a social and demographic issue, but no resources have been transferred, as far as I have seen.

Tracey Stewart: The data that the convener referred to should not be seen in isolation from other statistics that are available. We need to take a more holistic approach and bring together performance measures.

Marian Flynn: I echo Robert Naylor's view about transferring resources. I know that such a cry might not be popular in this day and age, but a measure of resource is needed sometimes to pump prime and start initiatives, which can then become embedded in common practice.

A lot of the focus in Glasgow to date and more broadly has been on the younger group of young parents—those who are still of school age. I think that a greater focus is needed on older teenage parents, because many of the social issues that relate to parenting arise once a young parent leaves home, has their own tenancy and is engaged in a world that they struggle to deal with. The young parents who become involved in child

protection issues tend to be older teenage parents—they need more attention.

I echo Bryan Kirkaldy's point that we need to look at how we evaluate home-grown strategies. I speak only for Glasgow, but the initiative that we have developed—the young parents support base—is a good model. It would be useful to look at how that develops and how we can evaluate it to the extent that it can be classed as an evidence-based approach.

Finally, there is a discussion going on at the young people's sexual health steering group on the broader issue of the sexualisation agenda. Linda Papadopoulos did a report for the Scottish Government in 2010 that looked at a range of issues, such as the commercialisation of sex, the commercialisation of childhood and how difficult it is for young people to operate in a world in which there is a great deal of pressure on them, and at an increasingly early age. It is not uncommon now for primary school children to talk about dieting and to be very conscious of appearance. There is a range of cultural issues underneath what we have been talking about today, which put pressure on young people to engage in sexual activity at an earlier and earlier age. I would like to see some emphasis on that.

The Convener: Thanks for that. We could have another session about those three points. We understand that it is a difficult area.

Bryan Kirkaldy: I echo Marian Flynn's point about the evidence-based approach. We are actively working on innovations and we are developing a lot of progressive initiatives that will have impact. If we can demonstrate the evidence that is associated with those innovations, it puts us into a different position with regard to the social and political context in which schools and local authorities have to operate.

If community planning partnerships and local authorities are going to have a lead role in this area, and if we want to develop further our approaches, we need to be able to agree those approaches with our communities. It is a controversial area. As people know, if we develop innovations in the field of sex, relationships and young people, we potentially create a backlash politically and in the community. The more evidence that we can cite that innovations work and have an impact, the better.

Cath King: One of the things that we do not want is short-term projects that are not picked up when they end. Taking an assets-based approach in communities is probably the best way forward. We can look at what is already there and what we can build on. That would be the most cost-effective way of doing it and of keeping committees on board.

Tracey Stewart: I echo that. In the past year, some of the biggest innovations in Dundee have been developed using an assets-based approach and by looking at what we already have in the community. Some social enterprises, some innovative practice and a lot of peer support groups have been established as a result. It is about evaluating what we already have and using it as a strong evidence base for moving forward.

The Convener: It is interesting that Marian Flynn mentioned 18-year-olds. Our focus has been on the figures, which show that we have a problem with 16-year-olds. Although we have access to those young people through schools and so on, once they are 18, we no longer have that access. Although the figures have gone down, it does not mean that the problem is less challenging; indeed, it was pointed out that it may be more challenging. It would be useful if the Scottish Parliament information centre or our witnesses could provide the committee with figures on that. Perhaps our witnesses have views on the issue.

Thank you for giving us your time this morning and for the evidence that you have provided. Your attendance is appreciated. We encourage you to continue your participation by looking at the other evidence sessions. If issues are raised that you strongly disagree with—or even agree with—please let us know. We value your continued input until we draw up our final report.

11:14

Meeting suspended.

11:21

On resuming—

The Convener: We continue agenda item 2 and welcome our new witnesses: Sally Egan, women and children's health commissioner at NHS Lothian; and Carolyn Wilson, operational policy manager in the child and maternal health division of the Scottish Government.

We will go straight to questions.

Bob Doris: We had an interesting discussion at our earlier round table. Some of those themes may come up again, for example the work going on in schools to raise self-esteem and empower young females to make positive choices not to have pregnancies, unplanned or otherwise. We heard about a variety of measures to support young mothers, including family nurse partnerships.

We also heard about the possibility of a gap in provision, in which the most socially excluded young people, who may be most at risk of having

an unplanned pregnancy, may be less likely to engage, even with high-quality school services. What work is being promoted in the community, outwith traditional education routes, to support young people most at risk of unplanned pregnancies? That would be a useful starting point.

Sally Egan (NHS Lothian): As was said earlier, we do not need only one thing; we need a whole joined-up approach. The issue is cyclic and intergenerational and we must tackle it through more than just the sexual health strategy. That is something that we have encompassed in NHS Lothian, the four local authorities and wider partnerships. Our approach is about what we need to support children into education, what we need to prevent unwanted pregnancies and pregnancy at an early age and what we need in order to support parents. It is a holistic approach, in which the aim is to join up all those different strategies.

People say that the family nurse partnership comes in after the child is born. We have learned from FNP that it is a challenge, in the early stage, to engage some of these young people. The programme is not compulsory, and it involves a lot of work on the part of the family nurses to get eligible pregnant women to accept being put on to the programme. However, we have a very good rate of uptake.

As Lothian was the first pilot site, it gave us a chance to look at case studies and at why, for some of these kids, things got to the stage at which there was an unplanned—or planned—pregnancy before there was any real intervention. That does not apply to all cases. As we heard earlier, some children could probably have gone it alone with their families, although that would involve a decision about their resilience.

For other children, it was a matter of concern that they had reached that stage in their life—14, 15 or 16-years-old—before there was any real, positive, recognisable intervention. I think that that has changed over the years, and I think that we will see big changes in the future.

Our early years collaborative work encompasses the whole maternity phase so that if a young person gets pregnant, we know about it early on, can tackle it and, by involving other agencies—including voluntary sector organisations—can help them to make an informed choice about whether to continue the pregnancy. If they decide not to continue it, we think about how we can support them. The family nurse partnership programme is available in Edinburgh but not across the whole of Lothian, although we have other programmes.

To return to early intervention, if we identify children's needs at the earliest opportunity, we can work with those children to improve their self-esteem and with teachers and parents to promote resilience in children at the earliest opportunity. The local authorities that I work with have certainly moved away, as far as possible, from exclusion. That will be a last resort. They will work with children to prevent them from being excluded within school or from being formally excluded from school altogether.

It is difficult to put this into words; I just want to make the point that a lot of work is being done, which I do not think that we will see the benefit of for another 10 years, because it will take that length of time for evidence to come through. We will see some differences and some reductions in teenage pregnancy rates, but a multi-agency, early intervention approach involving multiple interventions will be necessary if we are to see a real turnaround in the situation.

Carolyn Wilson (Scottish Government): I will clarify what I do. I am the policy lead for the family nurse partnership programme in the child and maternal health division. Our division has a focus on supporting women when they enter maternity services, as well as on child health and development. In our area of Government, we do not have a focus on the sexual health elements or on preventing teenage pregnancy. Our work is more to do with supporting teenage and all other mothers when they become pregnant and helping them to access the services that are available to them.

To respond to Bob Doris's question, an area that we have done a lot of work on recently is access to antenatal services. We know that teenage parents, in particular, are one of the most vulnerable groups when it comes to being able to access those services. A number of measures have been put in place to address the fact that they are among the least likely groups to access such services. The refreshed maternity services framework has brought that to the fore with a view to allowing health boards to create an environment in which such services are more accessible and to encourage people across all the deprivation quintiles to access them on an equal basis.

Bob Doris: I have a specific question on the family nurse partnership programme, given that you are the policy lead on that. One of the issues to do with teenage pregnancy is that if the proper support is not put in place, a family of one child can become a family of two children and larger families can develop. Is there monitoring of that? Do you expect one of the outcomes of the family nurse partnership to be that the young women whom you are working with will be far less likely to have a second or third child in the years ahead? I appreciate that that will need to be tracked over a number of years. Is that one of the outcomes that

you are keen to see an evidence base for? Will you say a bit more about that?

The extent to which we can look to the longer term depends on how long we remain wedded to the family nurse partnership model. I have a question about the kids of the young mums who are on the programme at the moment. The 13, 14 and 15-year-old daughters of young mums have traditionally been at higher risk of becoming teenage mums. Politicians are always accused of going for short-term gains. In the long term—in 10 to 15 years' time, when I suspect that most of us around the table will not be sitting here—

Mark McDonald: Speak for yourself.

Bob Doris: Mark McDonald says that he will certainly not be here—through choice, I am sure.

Should we expect to see a dramatic turnaround? Progress over such a period seems glacial in political terms, but in social terms 10 to 15 years is a fairly short period of time. What are your hopes for the statistics over that period?

11:30

Carolyn Wilson: The evidence base for the family nurse partnership has come through the randomised controlled trials in America. One of the outcomes that we expect is a wider spacing of subsequent pregnancies, and a longer period and more planning between the first birth and the second birth. We would expect young mothers to give more thought to their goals and aspirations, and to consider how having a number of children very quickly at a very young age could impact on their ability to meet their aspirations.

We have evaluated the family nurse partnership programme in Lothian to allow us to understand whether and how the model could be implemented in Scotland, and it has been very positive. One piece of data from the most recent report relates to subsequent pregnancies and births. There have been some data on that, but we do not have the amount that we would have expected at this stage. As we go on with the family nurse partnership, however, we expect the evidence base to show those outcomes appearing and being maintained, because we are implementing the model with fidelity. We expect wider spacing and better planning of pregnancies, with a longer period between the first and second births, as we roll out the programme across Scotland.

The evidence on the children of mothers who have gone through the family nurse partnership programme in America includes evidence on the behaviours of those children, which shows that their behaviour is different from that of their parents. They are less likely to become teenage mothers themselves or to get involved in violence, including domestic violence, alcohol-related crime and so on. There is now a very strong evidence base on breaking the intergenerational cycle of poor outcomes and poor behaviours.

Bob Doris: You can obviously only make medium to long-term projections relating to second and third births for teenage mothers based on evidence from the family nurse partnership in the United States of America, but we can probably get data about the spacing or frequency of births in Scotland quite quickly. What would be a fair time for the committee, the Government or whoever analyses the scheme to get some meaningful data? Would it be following three years of the scheme running, for instance? Perhaps you could suggest how many years. If we are going to find out, through randomised controlled trials, about the spacing between first and second pregnancies increasing, with fewer second pregnancies, what would be a fair time at which to start to examine the data to find out whether the measures in Scotland have had the same effect as those in the States?

Carolyn Wilson: A randomised controlled trial is proceeding in England, and we are using the evidence from that trial to inform implementation in Scotland. We will not carry out a randomised controlled trial in Scotland, not least because there are not enough clients coming through in order for us to do so effectively. We expect the English randomised controlled trial to produce some evidence on pregnancy spacing within the next two to three years. There are high numbers of people on the programme in England, whereas we still have relatively small numbers for drawing out trends and examining outcomes. With such small numbers here, that would not be the best thing to do. We will probably have to wait at least two to three years before ascertaining whether the specific outcomes have been shown to be the same in Scotland as they are in America.

The fact that we are implementing the same programme is important, and the fidelity of the model is being maintained across all the sites in Scotland—everyone is implementing the programme in the same way. The support is tailored to meet the needs of the individual client and to address any issues that they have at any point in time, but the core programme is the same for each client. We would not expect the outcomes to be any different than they were in the research trials in America.

Bob Doris: Obviously, you cannot compel people to take part in the family nurse partnership. Someone might decide not to do so for a variety of reasons, one of which might be their vulnerability and lack of willingness to engage. Is any follow-up work done, or alternative support service put in place, at that point?

Carolyn Wilson: I will speak about engagement and let Sally Egan talk about the follow-up services.

The eligibility criteria for the family nurse partnership programme are broad. People should be 19 or under, have had no previous live birth and be living within the geographical reach of the programme. That means that we can offer the programme on a universal basis to all eligible women in a given area.

We know that at least 75 per cent of teenage mothers are within the first two deprivation quintiles, so we know that we have the potential to reach the most vulnerable people. We also know, from evidence from Lothian, Tayside and the new areas that are taking the programme, that we have at least a 75 per cent uptake among those who are offered the programme. In Lothian, the uptake rate is nearly 80 per cent.

We know that we are reaching all the women who are in need of additional support. We also know that some of the women who come on to the programme are, in some ways, self-selecting. Those who are in most need and appear most vulnerable on paper are those who are most likely to engage in the programme and will benefit most from it. The ones who are least likely to engage in the programme could well have a wider support network available, as they come from more affluent families, although they themselves are unlikely to have a high level of income, in common with most teenage parents. The majority of the women we are dealing with live within a deprived income base.

With regard to the women who do not engage with the programme or do not remain engaged with the programme, we have good links with the universal services, such as maternity services and the health visiting services, so we can ensure that the clients transition back into the universal services and continue to be supported in an effective way that meets their needs.

Sally Egan: In Lothian, we have been lucky—with the first cohort, and I expect it to continue with the second cohort—in that the family nurses can identify the young women at the earliest opportunity. They are not dependent on referral from a midwife but they work closely with midwives throughout the pregnancy phase.

We have what we call the Scottish woman-held maternity record system—e-SWHMR—which is connected to the getting it right for every child approach. The health improvement, efficiency and governance, access and treatment target for booking is 80 per cent, and we have no problem getting the majority of people booked, because they want to get their scan. It is not hard to reach that target, but we need to concentrate on why we are not getting the people we are not getting.

The family nurses are able to identify the young women as early as 10 weeks. Sometimes, there is a subsequent pregnancy loss but, again, they handle that sensitively. They get most of them signed up by about 14 or 15 weeks, although it can go up to 16 weeks.

That is an intensive period, and our experience makes us wonder how other professionals manage to engage with people who are not pregnant, such as those who are having behavioural problems at school or experiencing other issues in the family. It is difficult to get a young person to engage with a professional in any discipline in that intensive period.

In our case, the midwife is involved, because it is midwifery-led care at that period. If the young person does not want to sign up to the programme, we sell it by saying, “This is a good thing for you and for your baby.” We know that most children and young people want the best for themselves and their baby. Really, it is not that hard to sell it once they are engaged, but getting them engaged is the hard bit. It would be easy to give up. In my previous professional life, it would have been easy to give up after two or three contacts if someone did not want to engage with the service. There is something that we need to learn in general about that engagement period.

During the whole pregnancy phase, we work closely with the midwives. If a young mother-to-be wanted to leave the programme for any reason, the midwife would still be involved. If there were any cause for concern or child protection issues, a wider network of people would be involved. However, whatever the role of those services, we are identifying the person at an earlier stage.

My own experience in working with the programme is that the other agencies get involved much earlier as well, so that we build up a resilience for the individual and their wider family at an early stage. We have attrition but the rate is low and the people leaving the programme are few and far between. If someone leaves after their baby is born, there is the health visitor. If we think that there is a risk that someone will leave the programme, we will try to introduce them to the health visitor and the health visitor will take on the role. Some people prefer that, but the evidence is that the attrition rates are quite low.

Usually if someone leaves the programme it is for a good reason: either they are very self-sufficient and resilient, or they are moving to another area. It is generally not because they fall out with the service.

Bob Doris: Thank you.

Dr Simpson: I wonder about the percentage of women who present late. Those young women are often the most vulnerable—they sometimes do not even know that they are pregnant. Is there a cut-off point by which they have to present before you can include them in the programme? That was one of the criteria that concerned me, as those young women are among the most vulnerable.

Sally Egan: We try to get them into the programme by 16 weeks rather than after 26 to 28 weeks. Because of what the programme is trying to deliver across the various domains, we have to start early on in the pregnancy.

Dr Simpson: To deliver it with fidelity.

Sally Egan: Yes. In the first cohort, because we were recruiting very quickly to get the numbers up, some young women of a later gestation were recruited. We had to explain our reasons to a couple of parents—it was more the parents than the kids themselves—who were arguing about why their child could not get into the programme. We had to be quite strict about that because we had to deliver the programme as per the licence. We would not have got the results if we had brought in those young people at that stage.

That is not to say that we would ignore those kids. We would make sure that they had some other intensive support during their pregnancy.

Dr Simpson: I would like to explore that point a bit more in policy terms. Given that we are trying to create a programme that has fidelity so that we can see the results, what is your current policy at a Scotland-wide level to deal with those who are not eligible for the programme but who are undoubtedly among the most vulnerable?

Carolyn Wilson: That is a valid point. Young mothers are more likely to have concealed pregnancies and present late to services, and they are a very vulnerable group.

We have always had pregnant teenagers and there has always been a level of support. What we have learned through introducing the family nurse partnership programme is that there was not any specific, tailored support available for the young women. They were just treated as part of the wider services available to all pregnant women.

We have learned a lot and have shared a lot with services, and I am sure that Sally Egan would endorse my view that in Lothian and in Tayside we now have a better understanding of how to engage young mothers in universal services. We also have a better understanding of how to get services to understand what the needs of each individual are and how to tailor their support to meet those needs, as well as allowing young women to access services in a more flexible way rather than just through the standard channels.

We hope that with the family nurse partnership there will be fewer late presenters and concealed pregnancies, because the services are now waking up to the fact that they need to work together to identify these young women and to support them early on.

Richard Simpson made a point about maintaining the fidelity of the licences. One criterion is that women can join the programme only up to 28 weeks' gestation, and we would not change that because we do not have the ability to do that as part of the licence. The strongest evidence shows that we need to engage by that point for there to be benefit from the pregnancy part of the programme.

11:45

Dr Simpson: I will ask a separate question. One issue that was touched on in the first evidence session this morning was problems with drugs and alcohol. I know that Lothian has a specific team to deal with women who have such problems when they are pregnant, but I wonder whether services are connected. When I worked in the Gorbals in Glasgow, Mary Hepburn was kind enough to allow a sexual health nurse to be attached. We were able to reduce the level of teenage pregnancies in that particular population, which is severely at risk. In Lothian and nationally, what is the policy on making sure that there is effective sexual health input to all drug and alcohol teams?

Sally Egan: The service that you refer to is an Edinburgh service that is called prePare, and we also have a young teenage pregnancy support service in West Lothian. The people who design the strategy and implementation plans are all very much interconnected through various Lothian and community planning networks.

The prePare team is a dedicated service for severe substance using mothers. A dedicated midwife and health visitor are attached to that team, as well as social workers and nursery nurses. Very often, the women who access that service, or who are signposted to the service and whom we pick up and encourage into it, are much further on in their pregnancy. They also tend to be older: some have had pregnancies before, and they might have other children in care. They are highly complex individuals.

We tend to see less of that complexity in the age group that we are talking about in family nurse partnership. However, the same strategic planning teams are involved, the operational managers cut across the two services, and there is healthy dialogue.

We spoke about the intervals between pregnancies. The nurses in FNP and the prePare

programme are highly trained in contraception. If they are not trained to deliver contraception themselves, they will get the woman they are working with into a sexual health clinic so that she can get long-acting reversible contraception inputs at the earliest opportunity.

The services are very much joined up. As I said, we try not to say that there is a sexual health strategy here, an early years strategy there, and a substance and alcohol use strategy over there. I happen to work closely with all the strategic leads in health, who cut across those programmes, and we have a joined-up group to take things forward in a cohesive and planned way. The work by the early years collaborative is beginning to prove how important it is for all those services to work together.

Carolyn Wilson: At a national level, as we said, there is the refreshed maternity services framework. One of its aims is to encourage midwives to look more broadly at the social factors that relate to poor pregnancy outcomes and link in with other services to create a holistic approach to supporting women.

Another piece of on-going work that fell out of that is the maternity care collaborative, which is linked to the early years collaborative. A lot of work is on-going. There may be other wider policies around alcohol and drugs, but I am not familiar with them.

Sally Egan: In our maternity in-patient service at the Simpson hospital, we have just introduced the opportunity for our most vulnerable mothers who have delivered to have long-acting reversible contraception before they leave hospital. That is a recent innovation in Lothian.

Dr Simpson: That last point is quite important. It is important to allow long-acting reversible contraceptives to be much more widespread.

At the other end, in its submission to us, Community Pharmacy Scotland talked about the longer-acting emergency contraception, which has been approved by the Scottish Medicines Consortium but is not yet generally available. Would you like to make any comment on that? It works for 72 hours rather than the 24 or 36 hours of the traditional, levonorgestrel approach. It is called ulipristal or something like that.

Sally Egan: Yes. I cannot give you all the details about that, but I know that we are certainly planning to introduce it in Lothian. Discussions are taking place with GPs and pharmacists at the moment.

Dr Simpson: Thank you.

Mark McDonald: Earlier, I asked some questions about the role of family and fathers. Obviously, the young females about whom we are talking do not get pregnant by themselves. What work is being done, where possible and appropriate, to involve the father in the process? Obviously, there will be circumstances in which that is not appropriate—for example, when the pregnancy arises as a result of an abusive relationship or a relationship that is built around drugs or alcohol.

There is another factor, which was picked up during the visit that Nanette Milne and I undertook in Dundee: often, the father is willing to be involved in the upbringing of the child but the family of the mother resists any involvement because of the stigma that is attached to a teenage pregnancy.

What work is being done to encourage fathers to be involved—when that will be beneficial to the child who is the product of the pregnancy—and the family of the mother to accept the father's involvement and allow him to be involved in the child's upbringing?

Carolyn Wilson: The family nurse partnership programme is delivered to the mother, but every effort is made to involve the father in the sessions and more generally. That can be the biological father and/or the mother's new partner if she no longer lives with the biological father.

One of the key aspects of the family nurse partnership is allowing the young mother to explore and understand her relationships—not only those with the biological father and/or her new partner but her relationships with her parents and peers. One focus of the programme is to allow her to explore those issues with her family, to bring the father or father figure—whichever it may be—into the programme and the child's life, and to make decisions on when the engagement can happen if the father does not live with her.

More generally, there is a lot of evidence that the father is not involved in visits to maternity services and even in health visiting in the early days after birth. On some occasions, he is almost actively excluded from any discussions on the child's wellbeing or, indeed, the pregnancy as it progresses.

One of the key points that has been brought through from the refreshed maternity services framework and other work that is taking place concerns involving the father more in those aspects of the child's journey and making him feel more involved. We know that fathers want to be involved, to be part of their children's lives and to understand what they need to do to help to shape the children's outcomes, but they lack information or support to understand the information that they are given.

Sally Egan: From a general perspective, the midwives will try to involve the fathers from as

early as possible but, if the dads are fortunate, they are in employment and are often unavailable at the time that their partner or wife attends clinics. However, as the pregnancy progresses and we get into its later stages, we try to involve both partners and let them know what to expect. For example, we let fathers see videos of the birthing suite and the unit, and we try to do home visits that suit them so that the dad will be there. The health visiting service will also be involved.

The way in which our universal services are designed means that they are not always conducive to that involvement. However, we try to take the father's view into account, and increasingly, where it is deemed that a more targeted parenting programme is appropriate, we definitely involve the father. Sure start schemes, for which there are various models, involve fathers, and the voluntary sector projects in and around Lothian that work both in the pregnancy phase and the early years or toddler phase—projects such as stepping stones—also take into account the father's views.

When midwives do their early antenatal assessment and get the woman booked up for the services, they do a number of maternal risk questionnaires, one of which is related to routine inquiry for gender-based violence. It is important to recognise that, with some relationships, we might want to start to intervene early and consider whether it is appropriate for the father to be involved. Sometimes we have to encourage women to make disclosure and we work with them to get a plan that is safe for everyone, including the father. It is important to get the father the help that he needs at an early stage as well. He might want to be involved, but there might be risk factors as well.

The Convener: In your pilot, and as the programme is being rolled out, what results have you had with increasing a positive role for the father? Is that one of your objectives or is it someone else's objective?

Carolyn Wilson: It is certainly our objective. On the engagement of fathers, we collect a lot of data in relation to the implementation and delivery of the family nurse partnership programme. The data is used both locally in delivering the service and nationally in shaping our understanding of the outcomes. We gather data on fathers' involvement and we have not only photographic evidence that fathers are actively involved in caring for their children but a lot of evidence that, at the majority of sessions between the nurse and the client, the father or significant other is present.

The Convener: Is there information that you can share with us, rather than photographs?

Carolyn Wilson: There is information in the current evaluations. What the programme does not do at present is collect a lot of data on fathers' histories, their background and any previous children that they have had. That might come up anecdotally in conversation and it might be put into the evidence and the evaluation if the client discloses it, but we do not specifically gather detailed demographic and characteristics information on fathers.

The Convener: I presume that it is a desirable objective. It is something that is important.

Carolyn Wilson: Yes.

The Convener: So why would you not do all of—

Carolyn Wilson: It is important to understand whether the father is present, is engaging with the family nurse partnership programme and is using the skills, information and support that are provided by the nurse in caring for their child. There is certainly evidence of that. I am not sure what else it is that you—

The Convener: I am just searching for some idea about whether the programme is working. It would be your objective to collect any evidence that exists. Rather than somebody else doing that job, it can be done better in the family nurse partnership.

I heard you talk about some of the objectives in which we are investing a lot of money. The programme has been rolled out across the country, but the most difficult people in terms of chaotic lifestyles are not included in it. There is a 25 per cent opt out. That could mean that people are getting good family support, but they could be opting out for negative reasons.

Why are we investing all this money in family nurse partnerships and the involvement of the midwife and health visitor, and so on? How did we come to evaluate that as a better model than investing seriously in some of the service providers that we heard at the earlier evidence session? Who made that equation?

12:00

Carolyn Wilson: I will just recap some of the things that you have said. As part of implementing the programme, the stretch goal is to have at least 75 per cent of those who are offered the programme taking it up.

The Convener: And 25 per cent will not.

Carolyn Wilson: I will just explain that. At least 80 per cent of those who were offered the programme take it up, and there are a number of reasons for people not taking it up. They do not necessarily refuse the programme. They might

have had a miscarriage, chosen to terminate the pregnancy, moved out of the area or taken up employment.

The Convener: So they all leave the programme for good reasons.

Carolyn Wilson: The majority of people who do not take up the programme do not actively refuse it because they do not want it, although some do not want it.

The Convener: How many refuse to take part for negative reasons?

Carolyn Wilson: It depends on what you mean by negative reasons and whether you are asking if they do not want to take part in the programme because they do not feel that they will benefit from it. That percentage of those who refuse the programme because they feel that they have enough support is probably less than half of those who refuse the programme. There are those who do not take up the programme because of all the other reasons, but I would not class those reasons as negative.

The Convener: I am just trying to get a contrast. The picture that you are painting is that everyone who says no to the programme is getting equal or better support. You say that 10 to 15 per cent of people do not engage for either unknown reasons or good reasons—is that right?

Carolyn Wilson: We capture the reasons why clients choose not to engage with the programme and, as I say, there are a number of different reasons. It could partly be because they choose not to go on the programme. It is a voluntary programme and we offer it as something that people are eligible to receive. The majority of people take it up. In comparison with initial engagement and sustainability of engagement with other services and programmes, the uptake is very high.

The Convener: I am trying to get at whether those people who are responsible and have their partner's involvement and who take part in the scheme would get good outcomes irrespective of the family nurse partnership. Why do we need the family nurse partnership?

Carolyn Wilson: A range of people go on the programme, but the majority of them come from deprived backgrounds and have two or more other factors that make them vulnerable. They are already vulnerable because of their age.

We are giving the parents of those children who have the least chance in life the greatest potential to make a change in those children's lives. That is the reason for the family nurse partnership. The answer to the question about why they engage with the programme is that the evidence shows that those who do engage with it get better outcomes.

The Convener: We visited a very good project in Glasgow that, although it is struggling with funding, looks as if it is doing the trick. There is a similar project in Dundee that is helping young mothers by keeping them in education, and again it is struggling with local authority funding.

Why are we investing in family nurse partnerships when the outcomes do not seem to be any clearer? Why are we not giving more money to those school projects that are struggling for money and could support even more young women? Why should we support family nurse partnerships as opposed to the alternatives? If there is a good reason, I will be happy to hear it.

Sally Egan: The family nurse partnership is in the Government's manifesto, and it is a licensed and proven programme. I was invited to appear before the Finance Committee when it debated the programme. I apologise if I do not have all the evidence today—I can start to give you some—but I thought that today's session was more about teenage pregnancies and that my role was to talk about preventing teenage pregnancies.

There was a lot of debate and scepticism about the programme's added value, even across our professions in Lothian when it was the first pilot site. People said that we are not America and that we provide a universal health visiting service, so they asked why we could not intensify that. However, there are big differences between the family nurse partnership and what our health visiting service does. In Lothian, our health visitors have case loads of about 350 kids, not all of whom are as vulnerable as some of the children who are involved in the family nurse partnership, but who range from nought to five, not just nought to two. We are not really comparing like with like.

I am not convinced that we could say—unless a randomised controlled trial or comparison with another cohort was done—that the outcomes in the first and second evaluations could not be replicated with a universal service, because many variables are involved. However, we know from speaking to the young people involved—a lot of them are children; they are 15, 16 or 17 years old—that a lot were leaving school without ticking the positive destination box, although at 18 they can be entering nurse training. A lot of stuff is beginning to come through that is not collected in the tick boxes and really needs to be examined.

From January 2010, we have included some of the families in the growing up in Scotland longitudinal study. When we start to examine that, we will have more of a feel for whether the programme is making a difference. We know that some outcomes are improving early doors, such

as breastfeeding conversion rates. Among young kids—15 and 16-year-olds who did not want to entertain the idea of breastfeeding—the conversion rate on breastfeeding has been 33 per cent. That might not be maintained to achieve the HEAT target of six to eight weeks, but those young people have the skin-to-skin contact with their baby at delivery. Even if they do that for only 24 hours, they are proud as punch. Little things such as that are beginning to come through.

If the choice was made to divert the money elsewhere, that would be a decision for the Government and Parliament—it would be for senior civil servants to decide whether the use of the money was right. However, Lothian is delivering the licensed programme as was requested, and we are just about to enter our second cohort.

We are working with universal services. Other small things are happening, such as tenancies being maintained. Because of the protective factors that the FNP brings, through working with a young person and their wider family, children of 16 to 18 years of age can maintain tenancies when they previously might not have done so. That is not to say that they would not have done so, but they now have a much better support mechanism around them and they are becoming more resilient.

The Convener: I am not suggesting that you are not doing a good job; I am just asking what the difference is with the job that other people, such as those whom we have visited, are engaged in. We are rolling out the programme across the country. As has been pointed out, it is expensive. We have people on the ground who are working to objectives that are similar to yours. As I said, a lot of people are working in the field.

Carolyn Wilson: The cost is about £3,000 per year, per client, for the programme's duration. Whether that is expensive depends on how that is added up. The costs of a special care unit for a baby who is delivered early, of care if a child is given up for adoption and of a range of health and education services all mount up and can be balanced and offset against the FNP's cost.

The Convener: I understand that there are negative outcomes, but Smithycroft secondary school, which we visited, keeps young women in education. Their health is looked after, they do not deliver early and they engage in education. That programme meets all the outcomes. How much does it cost to deliver? Should it be expanded? I have said too much on the subject.

Nanette Milne: My question, which is for Carolyn Wilson, follows on from that. I was interested to know what the human resource implication of the family nurse partnership is. How many family nurses have been involved in the pilot projects? How many do you envisage being needed when the programme is rolled out across Scotland? Is it sustainable?

Carolyn Wilson: The family nurse partnership is about developing specialised roles and skills for nurses to support young women to maintain outcomes not only in the short term but in the long term. The power of the programme is that it demonstrates sustained outcomes—there is a lot of evidence of that.

We have 50 nurses on the programme; by the end of this year, we will have about 70 nurses. If we were to create a sustainable programme that was offered to every eligible woman in Scotland, we would need about 360 nurses.

On maintaining the programme, the demographics are that slightly more than 50 per cent of the nurses come from generic case-holding health visitor backgrounds. We are working closely with the nursing directorate and the workforce planning people to look at how we can sustain and develop the workforce without having a significant impact on universal services.

We are not taking a big-bang approach to rolling out the programme. We have taken a gradual approach, not least because we have had to learn as we go along how to implement an evidence-based programme well with fidelity, which is different from just delivering an evidence-based programme. We have had a lot of learning to take on board. In addition, because it is a licensed programme, we cannot take a big-bang approach and roll it out to everybody in, for example, the next year or so because we must abide by the licence and demonstrate that we are getting the expected outcomes from the programme. We are looking at where we might want to make adaptations or augmentations if those outcomes are not being achieved; we are also working closely with the licence developers to ensure that the programme is being implemented well.

Nanette Milne: That is useful information. I have a concern about the general nursing service given that a lot of nurses are coming up for retirement and nursing services have been cut.

Mark McDonald: I have an observation to make rather than a question to ask. I would be reluctant to look at this as family nurse partnerships in competition with other work that is going on. The evidence that we received when we went to Dundee was that the family nurse partnership is complementing and not competing with the other work—that was certainly the message that came across to me.

Carolyn Wilson made a point about the costs were the interventions not taking place. People may say that the programme is expensive, but

there is also the question whether it is a price worth paying in view of the costs that might arise otherwise. I wanted to put that on the record.

The Convener: Thank you for that, Mark.

Dr Simpson: I do not think that anyone—including the convener—is debating the efficacy of the FNP programme. The long-term outcomes justify us going ahead with it. We will see what the English trial shows.

To follow up on what Nanette Milne said, the concern is that the programme applies only to women before 28 weeks of gestation and there is a particularly vulnerable group of women who present late and will not be eligible for the programme. There is also a concern about taking 175 health visitors out of the system in the next two to three years. They will not be trained quickly. In fact, we are not training more health visitors; we are training very few health visitors. The impact on the universal service, which has to deal with the most vulnerable group, could be highly negative.

I do not want to be perceived as being critical of the FNP programme, but I want us to ensure that the particular group of vulnerable young women who present late with teenage pregnancies will not suffer and that we have programmes in place for them that may not fall within the FNP licence but which will provide similar services with similar intensity, because they are the most vulnerable group.

There is also the question of what will happen to the universal services. Perhaps Carolyn Wilson can give us the workforce figures later. If we take 175 health visitors out of the system—particularly given that, as Nanette Milne said, the average age of health visitors as a group is higher than the average in many other areas of the profession and that many more of them are at a later stage in their career—what effect will that have?

12:15

Carolyn Wilson: As I said, we are working closely with our nursing colleagues in the Government and with the workforce planning people. We are not going to make decisions that will have a very big impact on the universal services without taking into account all the other factors. During my time working in the family nurse partnership programme, a piece of work has been produced on modernising community nursing. A strand of that looks closely at the role of health visitors and school nurses in terms of how they can work more intensively with younger groups or more distinct groups of families, rather than taking the public health nurse approach of working across all the age groups. So—

Dr Simpson: I am sorry to interrupt, but we have cut the nursing student intake by 20 per cent and have reintroduced a 36-week universal health visiting test. Our Conservative colleagues were quite rightly concerned that we are losing quite considerable pick-up through that. Given that we have a cut in the intake and an additional burden on the health visitors, I am concerned that we are going to have some major problems.

Carolyn Wilson: I totally take on board your comments. However, the evidence so far in the areas in which we have implemented the FNP is that it has not had an impact on the universal health visiting service. Either posts have been replaced or services have been reshaped to take account of the reduction in the number of generic health visitors. As I said, we will take cognisance of the impact. We will not move forward with a programme that is going to have a very detrimental effect on the wider health visiting services. I do not lead on the nursing services or workforce side, so I cannot say much more than that. Sally Egan can give you some information about what is happening locally in Lothian, but we are confident at the moment that we are keeping pace and maintaining existing services.

Dr Simpson: Thank you.

Sally Egan: I am a nurse by profession. I was a community nurse, so I can speak with some sort of authority on the issue. I think that there are concerns across Scotland about the impact on universal services—there certainly are within the Royal College of Nursing and the Royal College of Midwives. I am not speaking on their behalf, but I know their views on the impact on community nursing.

Within our wider children and young people strategy in Lothian, we have a workforce plan. I have concerns about how we maximise the workforce both in the short term and in the long term. I have been fortunate to secure from our health funding additionality for the health visiting service for next year to support the introduction of the 27-month assessment and the population rise of children in Lothian.

We heard in the earlier evidence session about school nursing. The desired ratio of school nurses in Scotland is one qualified public health school nurse to 1,700 pupils, but our ratio in Lothian is one to around 2,300. It will therefore be difficult for our school nurses to take on much more. As we also heard in the earlier session, we will see over the next three years almost a doubling of child immunisations from pre-school up to S3. There will therefore be implications at both the local level and the national level. Ros Moore leads the work at national level, and Deirdre McCormick, the nursing officer, has been heading up a group looking at modernising the health visiting

workforce and the school nurse workforce, with a recognition that they are two very different professions now. We tried for years to say that there was just one public health nurse role, but the jobs that they do are quite different.

We have been training an additional six public health nurses each year in Lothian. Around three years ago, the number was down to four, but since the FNP came on board, we have been fully funding people at whatever band they are on. If a person is on band 5 or 6, we fund them on their substantive grade through Queen Margaret University. We therefore have six people qualifying each year, but we recognise that a number of people are choosing to retire at 55, so we have to keep on top of the workforce plan. People do not need to tell us five years in advance when they will retire.

We are also looking at what other professionals and support workers we can bring in. We are looking at maternity care assistants, health visitor assistants and nursery nurses, how we can work more with the voluntary sector and sure start agencies, for example, to provide some of our early years services, and how we can redesign case loads. That is part of the wider early years workforce issue, but we also have issues around community paediatricians, so we cannot look only at the public health nursing workforce in isolation.

I reassure members that we are certainly looking at the matter at the local level, but it is fair to say that, if we aspire to deliver what we have talked about in the early years, there needs to be the workforce skill and capacity to do that.

Bob Doris: To return to the targeting of family nurse partnerships, the convener alluded to concerns that some of the most vulnerable may not be captured by them. My understanding is that, by their design, they target the most vulnerable. I want to clarify that my understanding is right. Is it correct to say that a person under 20 who has a child is more likely to come from a deprived area and be vulnerable?

Carolyn Wilson: Yes.

Bob Doris: Right.

On the attrition in the scheme, we heard in the previous evidence session that a person who refuses assistance from a family nurse partnership is more likely to be from a non-deprived area. Do you have information on that? A person is therefore less likely to be vulnerable and refuse assistance.

Carolyn Wilson: That is correct. As I said, we know that at least 75 per cent of first-time teenage mothers are from the most deprived backgrounds. If 25 per cent of the people to whom we offer the programme do not take it up for one reason or another—indeed, closer to 20 per cent do not take it up—the proportion of them who are more likely to have higher levels of vulnerability is much smaller because, by definition, most of the mothers come from deprived backgrounds and have more vulnerability factors.

We have information. As I said before, people not in the programme are more likely to come from more affluent areas, but that does not by itself mean that the individuals are not deprived. Unless a teenager is a millionaire, they do not have a lot of access to benefits, particularly if they live in a household and they are under 16, specifically. They do not really have access to any benefits for themselves.

Sally Egan: We need to be careful not to make assumptions, because people can be vulnerable in different ways. Inequality is a large part of that, but I know of two girls in the FNP who came from very affluent backgrounds, but whose vulnerabilities were probably tenfold those of most of the kids on the programme. That is why we should not make assumptions. We should not assume that everything in the garden is rosy because somebody lives in a nice neighbourhood and their parents drive two cars. The person has still had an unplanned pregnancy and still perhaps needs support, and there may be other factors around them. It is not just about the pregnancy; it is about the wider holism around the whole assessment process.

Carolyn Wilson: We certainly have evidence on that for clients who are in the programme, but the challenge is that we cannot get a lot of evidence for people who do not take up the programme, because we cannot collect and keep the data on them. We can get only high-level demographic information on them.

Bob Doris: The reason for asking the question is to do with the integrity of the programme and the need for it to be universal, because where the vulnerabilities are cannot be identified. You have illustrated that. I am merely teasing out the point that, by definition, people in deprived communities are more likely to be vulnerable, and therefore uptake is more likely to be significant in those communities. There is therefore a form of targeting, but universality is important to ensure that we capture all need irrespective of where young mothers stay.

The convener made a fair point about those who cannot access the scheme because of its integrity. For example, under the licence, it has to be done before the 26-week point up to which, according to the evidence base, it will work. Is it 26 weeks?

Carolyn Wilson: It is 28 weeks.

Bob Doris: Okay. We cannot be talking about a huge number of people, and it would be helpful if

we could get some quantification to know the numbers that we are talking about.

As for the question whether there is any strain on nurse provision in the system, it would be reasonable for us to make that case with regard to workforce planning to give some surety in that respect. What the committee would like clarified for the record, however, is whether you have seen an additional strain on the system because of family nurse partnerships. Have you been able to meet all of your statutory and policy obligations as well as the partnership's requirements?

Sally Egan: We will be recruiting the second team of nurses in the near future, and I should point out that it will be a national advertisement and that we will be seeking to recruit not just from Lothian. That said, if the successful candidates were to come from health visiting, it would have an impact that would need to be carefully managed and if all the nurses were to come from, say, Edinburgh, the chief nurse would have to look at how she would support that. As I have said, nurses will be qualifying come June and July, and we are training six health visitors at the moment. We cannot predict how many people might take early retirement—we could have two or three, or indeed none—but we are planning as far ahead as possible. Of course, it is not all to do with family nurse partnerships; people choose to leave or move on for all sorts of reasons.

The public health nursing workforce is very vulnerable because there are certain things that only health visitors can do. As I have said, next year will be very important with the reintroduction of the 27-month review for all children—another universal measure—and the decision to up the immunisation programme, and there will be a big impact on health visitors and school nurses.

Bob Doris: I will not ask anything else after this, convener, because I know that Mr Smith has a question, but the point that I am trying to tease out is that this is a workforce management issue rather than a resource issue. There will always be peaks and troughs with early retirements, nurses deciding to take their career into one discipline rather than another and so on, and those undertaking workforce planning have to be attentive to all that. I am content that that will happen—indeed, the committee can always check up on that—but I am trying to clarify whether this is a workforce planning issue rather than a resource issue.

Sally Egan: It is a resource issue at the moment because the people need to be trained. To become a health visitor, a person must be a registered general nurse and have done a year's public health nursing postgraduate degree at a university. To be a family nurse, however, a person does not necessarily have to be a health visitor, so we have a bigger pool of nurses who can be pulled into FNP training. Because we cannot put just anyone who is qualified as a nurse into a health visitor job, we have less of a resource to pull on. As important as workforce planning is, the fact is that Scotland might not have the human resources to fill all the posts that become vacant.

Bob Doris: We might be talking a bit at cross-purposes. What I am suggesting is that you have the resources to advertise the appropriate post, which then feeds into wider workforce planning.

Sally Egan: Yes.

Bob Doris: So the financial resources are there; the question is how we deploy them strategically.

Sally Egan: That is correct.

12:30

Drew Smith: I want to return briefly to the issue of school nurses. In both evidence sessions, we have discussed certain proposals that have been made in written evidence about the role that school nurses can play in contraception, how they might be involved in family nurse partnerships through, say, supporting young parents who are still at school and linkages in that respect. However, the proposal has been challenged; for example, it has been suggested that, because there are not enough school nurses to do that work as well as we might like, they might not necessarily provide the right route. From your general experience and your experience of the FNP, do you think that young people themselves want a health or health-related service to be delivered by school nurses in school? That question seems more important than whether we have enough such nurses, whether they are supported or whether they are charged to do the right things. Surely if the demand is there, that is where we should make the investment.

It has also been suggested to me that, as far as contraception is concerned, some young people might not want to go to their GP for a range of reasons, a simple one being that the service is not available to them because they are at school at that time. As a result, one might argue that it would be reasonable to have such provision in schools. What is your understanding of demand from young people?

Sally Egan: It certainly exists. However, our school nurses tend to work in drop-in centres because they cover more than one school; they do not sit in schools, easily accessible to pupils. I would have to check what has been gleaned locally, because there is a lot of involvement with children and young people across the four Lothian partnerships and in health.

Anecdotally—it has to be anecdotal because of confidentiality issues—many children do not want to do these things in school; they would rather go somewhere else, as long as it is easily accessible. Some children will not even be able to say who their named school nurse is—it will not be the named person under GIRFEC, because that will be their headteacher—although others might be.

Drew Smith: Before I leave an issue that we have already discussed and will no doubt hear more of throughout the inquiry, I wonder whether it is worth trying to find out that information. The evidence that we are getting from both sides is anecdotal, but it seems that children are saying that they do not want to go to the GP but, equally, they do not want people at school to get involved in their business. Given the amount of money involved and the priority that the issue has been given, should we not just look at data from existing programmes and see what young women's needs and demands might be?

Sally Egan: It might be worth finding that out. About five years ago, a Government-led piece of work on healthcare in schools looked at what school nurses did, what was needed and who else was needed to support the programmes. That work reached a conclusion, but I do not think that the Government ever produced an implementation plan for its recommendations. I know that there were four pilots looking at what school nursing brought to wider education; for example, one in Armadale in West Lothian focused on bereavement and children who had lost a parent through death, as a result of relationship issues or whatever.

I know that my education colleagues, headteachers and so on see the value of school nurses and in knowing that they can contact them if they need advice. However, the school nurse is not always available on site and, in any case, the kids in secondary school might associate them more with, say, getting immunised for human papillomavirus or whatever instead of seeing them as someone that they go and talk to. Some schools have auxiliary workers who children might think is the school nurse and whom they go to if they need something.

Carolyn Wilson: The piece of work that Sally Egan referred to was the health and wellbeing in schools project, which also looked more broadly at where children wanted to access health and wellbeing information and the best model for taking that forward. Part of it also informed some of the work on curriculum for excellence.

That work also considered the use of non-professionals or paraprofessionals in delivering certain services. As Sally Egan said, there were four pilot areas; the Government put quite a bit of investment into the project, but I am not entirely sure where things stand just now.

Sally Egan: As I have said, I am not sure what happened to the recommendations.

The Convener: I have a final question about the context in which we are working. At the end of the previous evidence session, someone mentioned a Government-sponsored report in 2010 on the sexualisation of young women. How has that issue influenced general work in this area? After all, we are engaging with people who are having to deal with the consequences of risky behaviour or poor decision making and a significant element of our inquiry is about how we support young mothers and so on. Are you aware of that report? I think that you were present for the earlier session.

Carolyn Wilson: I am aware of it, but it has not necessarily informed the family nurse partnership programme in which I am involved. That programme has been and is still being informed by emerging evidence on adolescent brain development, adolescent decision making and how all of that informs some of their reactions to and connections with what is going on in wider society and how they deal with peer pressure, react to societal norms and make decisions. I suppose that we take cognisance of other work that is going on, but we have not looked specifically at the element you highlighted.

The Convener: The message that I am taking from this session is that we are all working in partnership and that you do not stand alone. I was just wondering whether the report that I mentioned had had any influence, what the Government's response was and whether any of that could inform the committee's inquiry and report.

Carolyn Wilson: Some of my colleagues in the child protection and GIRFEC sections will be able to respond to that question, because they led on part of that report.

The Convener: As members have no more questions, I thank our witnesses for their attendance and evidence.

We now move into private session for item 3, which is consideration of our work programme.

12:36

Meeting continued in private until 13:01.

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