Teenage Pregnancy Unit

Teenage Pregnancy: working towards 2010
Good practice and self-assessment toolkit

Department for Education and Skills

Department of Health

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Teenage Pregnancy: Good practice and self-assessment toolkit

1 Introduction

Aim: There are many policy documents, guides and resources providing advice to support achievement of the target of reducing the under-18 conception rate by 50 per cent by 2010. This resource aims to bring together the range of current advice and guidance on the partnerships, strategies and interventions that need to be in place locally if under-18 conception rates are to be reduced and the reduction maintained in the long-term. These resources are synthesised to highlight characteristics to aim for (and characteristics to avoid) in order to achieve the target. More in-depth sources of information will be signposted where appropriate.

Focus and background: Both prevention of teenage conceptions, and support for young parents are critically important. The focus of this resource is to help local authorities (LAs) and primary care trusts (PCTs) and their partnerships – local strategic partnerships (LSPs) and children's trusts – achieve the 50 per cent target to reduce the under-18 conception rate.

Further work is being undertaken on best practice in relation to support of teenage parents. A complementary resource to be produced later in 2006/07 will look at initiatives and commissioning issues to support teenage parents.

The following have been drawn upon for this resource:

- **DfES:** ***Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies.*** (July 2006) highlights the good practice identified through the Teenage Pregnancy Unit's *Deep Dives*. The Deep Dives were a series of in-depth reviews carried out in a number of areas with both good and poor performance in reducing teenage pregnancy, looking at the key features of local strategies in areas where rates have reduced significantly and comparing and contrasting their experience with what was happening in statistically similar areas where rates were static or increasing.

- **DfES:** ***Teenage Pregnancy: Accelerating the Strategy to 2010****.* (September 2006) called for a stronger focus on local areas where progress towards the target has been poor and a wider approach to teenage pregnancy that recognises more explicitly the "deeper underlying causes – poverty, exclusion and poor educational attainment".

- The guide also highlights points from the TPU's ***Guidance on 2004/05 Annual Review of Progress with Local Teenage Pregnancy Strategies and Forward Action Plan*****,** which set out what action needed to be taken to accelerate local strategies, framed within the context of the 5 Every Child Matters outcomes.

- Commissioned by the TPU, the Prime Minister's Delivery Unit carried out a review of the main barriers and incentives that impact on successful delivery of local strategies. The review built on *Deep Dive* findings and drew out supplementary elements to support achievement of the target.

Audience: This good practice and self-assessment tool has been designed for those working at regional and local levels with responsibility for teenage pregnancy:

- Regional and local Teenage Pregnancy Strategy leads
- Regional and local Directors of Children's Services
- Regional and local Directors of Pubic Health
- Local strategic partnership (LSP) leads for children and young people / teenage pregnancy
- PCT sexual health and children's services commissioners
- Strategic health authority / PCT leads for children and sexual health services

- Local authority education, Youth, Connexions, Early Years, Parenting and social services leads
- GO Directors of Children & Learners
- Children's Services Advisers
- Housing Authorities
- Learning and Skills Councils

The toolkit may be of use to inspectors involved in annual performance reviews (APAs), joint area reviews (JARs) and by School Improvement Partners until specific tools are developed to support those inspections. It is designed to support all those working in this area, with particular focus on those local areas at risk of not achieving the target.

How to use this resource: This resource is for annual use as a self assessment tool by those responsible for achieving the teenage pregnancy target. It is designed to help in planning and review processes. It should be used at least annually as part of the planning cycle; a further review mid-year may also be helpful.

Local TPCs or equivalent strategic leads should coordinate the self assessment with input from the Teenage Pregnancy Partnership Board (TPPB) or equivalent strategic level body with responsibility for the teenage pregnancy strategy. The assessment should be moderated by the Regional TPCs (or appropriate lead) or Children's Services Advisors (CSAs). Results should be passed to Directors of Children's Services (DCSs), PCT chief executives and SHA public health leads for performance management and to inform understanding of local performance. Self assessment should inform commissioning of LA and PCT services and feed into other self assessment and planning processes (such as the Annual Performance Assessment [APA], local development plan [LDP], Children and Young People's Plan [CYPP], Local Area Agreement [LAA]).

At a national and regional level, TPU and GOs/Regional Teenage Pregnancy Co-ordinators will use local areas' self assessments to gain a detailed understanding of the problems in under-performing areas, as part of the improvement cycle.

Both individuals and bodies can use the guide as a detailed checklist to consider whether the key components are in place in all areas. This will be particularly useful for those with direct responsibility for programme delivery, such as the Teenage Pregnancy Coordinator (TPC) or equivalent strategic lead and the TPPB/equivalent strategic body.

The whole resource can be used with the LSP or teenage pregnancy planning board. It can also be dipped into – individual elements can be used by appropriate partners – for example, Education going through the PSHE/SRE characteristics and self assessment. The self assessment tool is meant to enable partners to gain an overview of whether the key components are in place.

It may be useful to hold a workshop to go through the self assessment tool, with the key characteristics of successful programmes as back-up for smaller group sessions.

In reviewing work to reach young people most at risk of teenage pregnancy, areas may also find it useful to refer to the Targeted Youth Support online toolkit, available on the ECM website: www.everychildmatters.gov.uk/deliveringservices/targetedyouthsupport

What this resource does not do: This resource does not aim to reproduce information from all available guides and toolkits or provide detailed data and information on rates; these will be signposted.

2 Why reducing teenage pregnancy matters

Evidence clearly shows that having children at a young age can damage young women's health and well-being and severely limit their education and career prospects. Longitudinal studies show that children born to teenagers are more likely to experience a range of negative outcomes in later life, and are up to three times more likely to become a teenage parent themselves. The facts are stark:

- At age 30, teenage mothers are 22% more likely to be living in poverty than mothers giving birth aged 24 or over, and are much less likely to be employed or living with a partner.
- Teenage mothers are 20% more likely to have no qualifications at age 30 than mothers giving birth aged 24 or over.
- Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth.
- The infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers.
- Teenage mothers are three times more likely to smoke throughout their pregnancy, and 50% less likely to breastfeed, than older mothers - both of which have negative health consequences for the child.
- Children of teenage mothers have a 63% increased risk of being born into poverty compared to babies born to mothers in their twenties and are more likely to have accidents and behavioural problems.
- Among the most vulnerable girls, the risk of becoming a teenage mother before the age of 20 is nearly one in three.

Rates of teenage pregnancy are far higher among deprived communities. The poorer outcomes associated with teenage motherhood also mean the effects of deprivation and social exclusion are passed from one generation to the next.

There is also a strong economic argument for investing in measures to reduce teenage pregnancy as it places significant burdens on the NHS and wider public services. The cost of teenage pregnancy to the NHS alone is estimated to be £63m a year. Teenage mothers will also be more likely than older mothers to require expensive support from a range of local services, for example to help them access supported housing and/or re-engage in education, employment and training.

The challenge for local areas, therefore, is to provide young people with the *means* to avoid early pregnancy, but also to tackle the underlying circumstances that *motivate* young people to want to, or lead them passively to become pregnant or young parents at a young age.

3 Key risk factors for teenage pregnancy

The risk factors identified below are not exhaustive but reflect factors that local areas may be able to identify among its population of young people. Further details on risk factors for teenage pregnancy can be found in *Teenage Pregnancy: Next Steps*.

Where young people experience multiple risk factors their likelihood of teenage parenthood increases significantly. Young women experiencing five risk factors (daughter of a teenage mother; father's social class IV & V; conduct disorder; social housing at 10 and poor reading ability at 10) have a 31% probability of becoming a mother under 20, compared with a 1% probability for someone experiencing none of these risk factors[i]. Similarly, young men experiencing the same five risk factors had a 23% probability of becoming a young father (under age 23), compared to 2% for those not experiencing any of these risk factors.

Table 1: Factors associated with high teenage pregnancy rates

Risk factor	Evidence
Risky Behaviours	
Early onset of sexual activity	• Girls having sex under-16 are three times more likely to become pregnant than those who first have sex over 16.[ii] • Around 60% of boys and 47% of girls leaving school at 16 with no qualifications had sex before 16, compared with around 20% for both males and leaving school at 17 or over with qualifications. • Early onset of sexual activity is also associated with some ethnic groups (see below)
Poor contraceptive use	• Around a quarter of boys and a third of girls who left school at 16 with no qualifications did not use contraception at first sex, compared to only 6% of boys and 8% girls who left school at 17 or over, with qualifications. • Survey data demonstrate variations in contraceptive use by ethnicity. Among 16-18 year olds surveyed in London, non-use of contraception at first intercourse was most frequently reported among Black African males (32%), Asian females (25%), Black African females (24%) and Black Caribbean males (23%).[iii]
Mental health / conduct disorder/ involvement in crime	• A number of studies have suggested a link between mental health problems and teenage pregnancy. A study of young women with conduct disorders showed that a third became pregnant before the age of 17[iv]. • Teenage boys and girls who had been in trouble with the police were twice as likely to become a teenage parent, compared to those who had no contact with the police.[v]
Alcohol and substance misuse	• Research among south London teenagers found regular smoking, drinking and experimenting with drugs increased the risk of starting sex under-16 for both young men and women. A study in Rochdale showed that 20% of white young women report going further sexually than intended because they were drunk[vi]. Other studies have found teenagers who report having sex under the influence of alcohol are less likely to use contraception and more likely to regret the experience.[vii]
Teenage motherhood	• A significant proportion of teenage mothers have more than one child when still a teenager. Around 20% of births conceived under-18 are second or subsequent births
Repeat abortions	• Around 7.5% of abortions under-18 follow either a previous abortion or pregnancy. Within London this proportion increases to around 12% of under-18 abortions
Education-related factors	
Low educational attainment	• The likelihood of teenage pregnancy is far higher among those with poor educational attainment, even after adjusting for the effects of deprivation. On average, deprived wards with poor levels of educational attainment had an under-18 conception rate double that found in similarly deprived wards with better levels of educational attainment. (80 per 1000 girls aged 15-17 compared with 40 per 1000)
Dis-engagement from school	• A survey of teenage mothers showed that disengagement from education often occurred prior to pregnancy, with less than half attending school regularly at the point of conception. Dislike of school was also shown to have a strong independent effect on the risk of teenage pregnancy.[viii] • Poor attendance at school is also associated with higher teenage pregnancy rates. Among the most deprived 20% of local authorities, areas with more than 8% of half days missed had, on average, an under-18 conception rate 30% higher than areas where less than 8% of half days were missed.

Leaving school at 16 with no qualifications	• Overall, nearly 40% of teenage mothers leave school with no qualifications.[ix] • Among girls leaving school at 16 with no qualifications, 29% will have a birth under 18, and 12% an abortion under 18, compared with 1% and 4% respectively for girls leaving at 17 or over. • Leaving school at 16 is also associated with having sex under 16 and with poor contraceptive use at first sex (see below).
Family / Background factors	
Living in Care	• Research has shown that by the age of 20 a quarter of children who had been in care were young parents, and 40% were mothers[x]. • The prevalence of teenage motherhood among looked after girls under-18 is around three times higher than the prevalence among all girls under-18 in England.
Daughter of a teenage mother	• Research findings from the 1970 British Birth Cohort dataset showed being the daughter of a teenage mother was the strongest predictor of teenage motherhood.
Ethnicity	• Data on mothers giving birth under age 19, identified from the 2001 Census, show rates of teenage motherhood are significantly higher among mothers of 'Mixed White and Black Caribbean', 'Other Black' and 'Black Caribbean' ethnicity. 'White British' mothers are also over-represented among teenage mothers, while all Asian ethnic groups are under-represented • A survey of adolescents in East London[xi] showed the proportion having first sex under-16 was far higher among Black Caribbean men (56%), compared with 30% for Black African, 28% for White and 11% for Indian and Pakistani men. For women, 30% of both White and Black Caribbean groups had sex under-16, compared with 12% for Black African, and less than 3% for Indian and Pakistani women • Poor contraceptive use has also been reported for some ethnic groups
Parental aspirations	• Research shows that a mother with low educational aspirations for her daughter at age 10 is an important predictor of teenage motherhood

4 Policy and performance drivers

In addition to the current policy drivers mentioned in the introduction, there are many Government policies that have prioritised teenage pregnancy and contribute to driving progress towards the target. In line with Government policy, a number of regulators have included teenage pregnancy within their assessments.

Policy:

Teenage Pregnancy **(1999):** Produced by the Social Exclusion Unit, *Teenage Pregnancy* prioritised two main goals:

- reducing the rate of teenage conceptions, with the specific aim of halving England's rate of conceptions among under 18s by 2010 (noted above as a public service agreement)
- by 2010, increase to 60% the proportion of teenage mothers in education, training or employment to reduce their risk of long term social exclusion

PSA/ floor targets were strengthened and new public service agreements were introduced to reduce health inequalities:

Reducing England's under 18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health (target shared by Department of Health and Department for Education and Skills).

Further targets on gonorrhoea and chlamydia (deferred to 2008) will also contribute as levers for improvement.

Department of Health: ***Choosing Health: Making Healthy Choices Easier*** (2004) / ***Delivering Choosing Health: Making Healthy Choices Easier*** (2005). These key policies prioritise teenage pregnancy within a broad public health approach to improve health and tackle teenage pregnancy.

DH: ***Better Prevention, Better Services, Better Sexual Health – The National Strategy for Sexual Health and HIV*** (2001) / ***National Strategy for Sexual Health and HIV Implementation Action Plan*** *(2003):* This first national sexual health strategy for England detailed key strategies and actions for improving sexual health.

DH: ***National Service Framework for children, young people and maternity services*** (2004) The Children's NSF is a 10 year programme that sets out standards for children's, young people's and maternity services to ensure services are designed and delivered around the needs of children and families.

Department for Education and Skills: ***Every Child Matters: Change for Children*** (2004): *Every Child Matters* identifies five key outcomes that services should be working towards for all children – being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well being. Reducing teenage conceptions is a key cross cutting element.

DfES: ***Youth Matters*** (2005) set out the vision for empowering young people, giving them somewhere to go, something to do and someone to talk to. *Youth Matters* – the Youth Green Paper – received over 19,000 responses from young people. The strategy aims for young people to have more choice and influence over services and facilities that are available to them. Young people are encouraged to volunteer and contribute to their local community.

DH/DfES: Healthy Schools Programme: The aims of the Healthy Schools Programme are to: help young people to develop healthy lifestyles; help raise pupil achievement; reduce health inequalities; and promote social inclusion. To achieve Healthy School Status, schools must

demonstrate evidence of effective practice in relation to healthy eating, physical activity, emotional health and well being and PSHE.

HM Treasury. DfES. DTI. DWP. ***Choice for parents, the best start for children: a ten year strategy for childcare*** (2004) / ***Sure Start Children's Centres*** Sure Start Children's Centres are a vital part of the Government's 10 year childcare strategy to enable all families with children to have access to an affordable, flexible, high quality childcare place for their child. The Government is committed to delivering a Sure Start Children's Centre for every community by 2010. Sure Start Children's Centres are places where children under 5 years old and their families can receive seamless holistic integrated services and information, and where they can access help from multi-disciplinary teams of professionals.

Department for Communities and Local Government*.* ***Supporting People*** Supporting People is a grant programme that enables the provision of housing related support services to help vulnerable people maintain or improve their ability to live independently. This needs local authorities, working in partnership with other service commissioners and with service providers, to make sure that all local services, including Supporting People services, are coordinated, integrated and focused around and involves the users.

Reaching Out: An Action Plan on Social Exclusion (September 2006) focuses on teenage pregnancy within its broader commitment to address social exclusion. Guiding principles in this document's approach are reflected in this resource and include

- Better identification and earlier intervention
- Systematically identifying 'what works'
- Promoting multi-agency working
- Personalisation, rights and responsibilities
- Supporting achievement and managing underperformance

DfES: Care Matters: Transforming the lives of Children & Young People in care (October 2006). A Green Paper setting out the Government's vision for children and young people in care, highlighting the issues affecting this uniquely vulnerable group and setting out what needs to be done to improve outcomes for looked-after children.

Regulation and inspection

A number of performance management mechanisms are in place, which include an assessment of progress towards the teenage conception target. National bodies with responsibility for regulation that has an impact on teenage pregnancy include the following:

Ofsted / Commission for Social Care Inspection: Annual performance assessment (APA). The APA looks at council children's services. The APA is based on a set of key judgements that are common with the joint area review (JAR) set and supported by data and indicators. The key judgements particular to the council's own services are specified. The APA includes self assessment by the council as well as inspection visits. In areas where a JAR has taken place, the APA will be 'proportionate' in that year to lessen the burden of inspection. Indicators include a range of issues, including outcomes for looked after children.

Detailed information on annual performance assessment (APA) can be found in the document *Arrangements for Annual Performance Assessment 2006*' published on the Ofsted website. Details of the 2006 inspection guidelines is on the following website: www.ofsted.gov.uk/publications/index.cfm?fuseaction=pubs.displayfile&id=4000&type=doc

Ofsted: Joint area review (JAR). JARs cover inspection, assessment and review of services for children and young people aged 0–18. JARs are designed to fulfil the requirements of the Children Act 2004 for integrated inspection. The arrangements have been devised by the 10 inspectorates and commissions which inspect settings and other services for children and young people to support improvement in the five outcomes identified in Every Child Matters:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic well-being.

Further details of JARs are available at http://www.ofsted.gov.uk/childrenandyoungpeople/.

Healthcare Commission: *Annual health check*: The Healthcare Commission is responsible for regulation of healthcare organisations – both NHS and independent. The annual health-check addresses both 'getting the basics right' and 'making and sustaining progress'. The annual health check inspects healthcare organisations against the Standards for Better Health (2006)[1], which includes core and developmental standards. A number of standards have impact on young people, including safety, and accessible and responsible care. Of key importance will be public health core standards 22 (partnerships) and 23 (disease prevention and health improvement, including sexually transmitted infections among a number of public health issues). Organisations' self assessment will be cross checked against nationally available data, including, for example, teenage conception data, healthy schools status.

As part of the making and sustaining progress element, healthcare organisations will also be assessed against new national targets (including teenage pregnancy, the 48 hour access to GUM services and gonorrhoea reduction targets). Public health developmental standard 13 will be used to assess progress in health improvement, particularly in relation to NICE guidelines (such as *Preventing Sexually Transmitted Infections and Reducing Under-18 Conceptions* due in February 2007).

At a regional level, Government Offices and Strategic Health Authorities contribute to performance management in relation to the teenage conception target, as part of the improvement cycle. Locally, performance management is through the Local Strategic Partnerships and children's trusts. While both the PCT and the local authority are assessed by regulators on performance in relation to achieving the teenage conception target, the local authority is the legally accountable body in relation to the funding grant.

[1] Earlier version: *National Standards, Local Action: Health and Social Care Standards and Planning Framework*:2005/06 – 2007/08 (2004)

5 Key characteristics of successful programmes

This section outlines key characteristics to aim for – as well as those to avoid – to enhance the potential of local areas to achieve the target. The section is divided into four areas:

- **Strategic:** looks at partnerships, planning, engagement and performance management
- **Data:** looks at data and information issues to help target programmes and improve performance management
- **Communication:** looks at communication with partners as well as communicating messages to young people, parents and communities
- **Implementation:** focuses on the Deep Dive factors as well as some additional elements:
    - Provision of young people focused contraception/sexual health services, trusted by teenagers and well known by professionals working with them
    - Strong delivery of SRE/PSHE by schools
    - Targeted work with at risk groups of young people, in particular Looked After Children and Care Leavers
    - Workforce training on sex and relationship issues within mainstream partner agencies
    - A well resourced Youth Service, with a clear remit to tackle big issues, such as teenage pregnancy and young people's sexual health
    - Work on raising aspirations
    - Work with parents

Performance management has been included within both the strategic and data sections.

A characteristic to avoid could have been developed for each of the characteristics to aim for. To avoid duplication, a few key points have been included. It is inevitable that there will be some overlap in some of the sections – for example delivery of SRE/PSHE and workforce training.

5.1 Strategic

Senior local sponsorship and engagement of all key partners: Accountability for achieving the teenage conception target lies with the local authority and PCT. Reporting mechanisms include the local strategic partnership (LSP) or children's trust, as well as the Teenage Pregnancy Partnership Board, or equivalent strategic level body with responsibility for the teenage pregnancy strategy. The Deep Dives – along with a number of other studies, including the National Evaluation – found that in high-performing areas, the seniority and personal commitment of key post-holders such as the chair of the Teenage Pregnancy Partnership Board (TPPB) or equivalent strategic level body with responsibility for the teenage pregnancy strategy, local TPC or equivalent strategic lead, and senior personnel within key partner agencies were critically important to success. Engagement is required by the four key mainstream agencies – PCT, Education, Social Services and Youth Services/Connexions – as well as the voluntary sector. A strong senior champion is also important.

Lead: LSP / Children's Trust
Key roles: TP Partnership Board; PCT/LA, GO, SHA, Children and Young People's Strategic Partnerships (CYPSP)

Characteristics to aim for		…and characteristics to avoid:
There is clear commitment / teenage pregnancy is a priority • Partners meet across levels (eg Government Office / Strategic Health Authority / LSP) and take a 'problem solving' approach • There is clarity about accountability for delivery of the under 18 conception target • There is understanding of the importance of teenage pregnancy in itself as well as of its links and impacts on other areas, as demonstrated by both specific plans to address teenage pregnancy and plans to addressits underlying causes. • Members of the TPPB / equivalent body represent the four key agencies as well as the independent sector (private and voluntary organisations), and occupy senior strategic positions within these agencies. • There is a champion for teenage pregnancy at a high level within the LSP or LA / PCT who takes the lead in driving the local strategy • TPPB/equivalent body meets regularly, with good attendance by key partners • TPC /equivalent strategic lead's post is at a level that allows them to work strategically and influence decisions (eg Assistant Director level) • Programmes to address teenage pregnancy and related wider issues are mainstreamed through local programmes.		• Lack of communication and joint planning - teenage pregnancy work not integrated in planning processes with other key programmes, such as education • Reliance on the TPC/equivalent strategic lead to take care of teenage pregnancy issues • There is no evidence of mainstreaming TP work to ensure sustainability and effectiveness of efforts • Members of the TPPB/equivalent body are largely operational staff with limited strategic input • One or more of the key agencies (PCT, Education, Social Services and Youth/Connexions) is not represented on the TPPB/ equivalent body, or is represented at an insufficiently senior level • The LSP does not drive improvement through its performance management role in relation to teenage pregnancy
Teenage pregnancy is integrated into planning • TP Strategy is integrated into other relevant strategies, plans and programmes including: CYPP; PCT Local Delivery Plans (including sexual health strategy implementation); Connexions business plans; plans for Information Sharing and Assessment; Housing Strategies; Supporting People Strategy; Homelessness Strategy; Early Years Development and Childcare Plans;		

Children's Centres; Extended Schools; plans for the National Healthy School Standard Programme; Neighbourhood Renewal Plans; and Sure Start Delivery Plans, with resources allocated and responsible bodies noted in plans.	
Progress is driven by performance management • Teenage pregnancy is a regular item on LSP / Children's trust agendas • LSP specifically focuses on teenage pregnancy as part of its performance management mechanisms • TPPB/equivalent has a place on and reports to an appropriate higher body, such as the Children and Young People's Strategic Partnership, and plans are integrated into the children's trusts / CYPP	
Other relevant factors: • It will be important to have joined up policy at national level, and clarity about roles, for example performance management arrangements.	
Resources: • ODPM / DH. *Creating Healthier Communities*. 2005	

5.2 Data

Detailed, accurate and up to date data and information are fundamental for use in determining need, planning and commissioning appropriately targeted programmes and performance management. As a result of the teenage pregnancy strategy, data collection in this area has provided a wealth of information to support generic programmes, such as PSHE/SRE and young people's sexual health services. Additional local information is required to identify young people most at risk to provide effective targeted programmes. Information on issues such as school attendance, deprivation, ethnicity (with census categories tailored to reflect local populations) at ward level is essential for targeting. Trajectories should be set and reviewed to help in planning.

Local proxy indicators will help to measure progress (see Annex 2).

Lead: PCT / LA
Key roles: TPC/equivalent strategic lead; DPH / PCT commissioners; LA Education; Youth Service

Characteristics to aim for		…and characteristics to avoid:
There is a systematic approach to knowing the local population and its needs in relation to teenage pregnancy • Data collection, analysis and use are prioritised by planning bodies in the areas and there are protocols or agreements in place for sharing data across sectors to contribute to planning and performance management • Data are collected from a variety of sources / services, including live births, terminations, Connexions, Sure Start Plus, schools, GUM services, abortion clinics • Where BME population of a local area is significant, census categories are further broken down to enable effective targeting to those communities most at risk.		• Accurate, up to date, locally tailored data and information are not consistently collected and shared across services • Data and information are not used to inform planning, commissioning and performance management of services
Data and information are used to inform provision of local services • Local conception data and information on individual young people facing multiple risk factors are used to help target strategies on high-rate neighbourhoods/young people most at risk • Data on usage of sexual health services (volumes) used to inform most cost-effective siting of services • Contracts with healthcare providers (especially abortion, STI / GUM services / contraceptive services) include a requirements for collection and provision age, gender, ethnicity and postcode (while adhering to confidentiality guidelines)		
Performance management is led by accurate data and information • Local proxy measures are in place to support performance management that are SMARTER[2] • Data from range of sources (see above) presented to TPPB at least bi-annually and used as part of performance management of strategy		

[2] Specific / Measurable / Agreed / Realistic / Timed / Evaluated and Reviewed

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- Performance against required trajectory to meet 2010 target is monitored quarterly and assessed annually
- The Teenage Pregnancy Local Implementation Grant terms and conditions are adhered to
- Representation on TPPB/equivalent body is in line with terms and conditions of the grant as set out in paragraph 8 of LAC(2004)18. Terms of Referenceare in place for the Board (and sub-groups), which are regularly reviewed

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Other relevant factors: it will be important that data collection fits with a range of national developments such as the Common Data Set for Sexual Health and HIV.

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Resources:

- GOL / Tanya Procter data resource edited for national relevance
- GOL BME resource edited for national relevance
- TPU. *Teenage pregnancy data and analysis toolkit*. March 2003.

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5.3 Communication

Effective communication is central to partnership working, access to services and informed choice. Information must be tailored to the needs of young people, parents and communities, ensuring they are culturally appropriate, as well as accurate and timely. It is important to have a media and communications strategy and to review communications for effectiveness.

Lead: LA / PCT
Key roles: media, TP lead, voluntary sector, faith groups

Characteristics to aim for		…and characteristics to avoid:
Partners receive appropriate information • Partners receive timely, accurate information that facilitates partnerships, planning and delivery, from data to agendas, minutes and reports		• Communication is not prioritised and there is no communication strategy. • There is little or no engagement with young people, parents and other community representatives in the development of communication / messages / programmes
Young people – including those most at risk – are involved and informed • There is proactive publicity of local services to young people most at risk • Plans are in place to ensure young people – including those most at risk - are consulted and involved in delivery of the TP Strategy, including on Youth Forums, NHS Patient and Public Involvement Forums, LA Scrutiny Committees. • Plans are in place to ensure young people's views influence the improvement of service delivery such as through mystery shopping of local services, training of professionals such as midwives, and peer education.		
Parents and communities are engaged and informed • Parents, carers and other key stakeholders representing the community are involved in development of communication messages • High quality, clear, accurate information is provided in appropriate community languages in a range of media, including print and internet • Parentline Plus Time to Talk materials are displayed in relevant community settings with information about local and national support		
There is a strategy for dealing with the media • The TPPB/equivalent implements a media and communications strategy to manage pro-active and reactive media work • Communications leads are identified in each PCT / LA and media protocols for promoting the local strategy and ensuring agreed consistent responses to media enquiries developed. • Arrangements are in place for co-ordination of TP media work with all relevant agencies, to ensure good links with Chief Executives, councillors, Director of Public Health, or others acting as local media spokesperson for the strategy.		
Communication programmes are assessed The effectiveness of media and communication		

programmes is assessed		
Other relevant factors: Support is required from the national media campaign		
Resources: *RU Thinking about the media enough? A hands-on toolkit to explain the National Teenage Pregnancy campaign and how you can make it work in your area.*		

5.4 Implementation

Provision of young people focused contraception/sexual health services, trusted by teenagers and well known by professionals working with them: *Next Steps* notes that this is the factor most commonly cited as having the biggest impact on conception rate reductions in high performing areas. The TPU's Best practice guidance on the provision of effective contraception and advice services for young people identifies features of successful practices, including those with a strong remit to undertake health promotion work as well as delivering reactive/treatment services, through, for example, outreach work in schools, work with professionals to improve their ability to engage with young people on sexual health issues and through highly visible publicity. Effective services also had a strong focus on meeting the specific needs of young men. All high-performing areas also had condom distribution schemes involving a wide range of local agencies and/or access to emergency contraception in non-clinical settings.

Lead: PCT
Key roles: LA (referrals), NHS community and acute services, voluntary sector

<table>
<tr><th>Characteristics to aim for</th><th></th><th>…and characteristics to avoid:</th></tr>
<tr><td>Accessible services are tailored for young people
• Service meets You're Welcome*[3] quality criteria, TPU Best practice guidance on the provision of effective contraceptive and advice services, DH Guidance on duty of confidentiality and are welcoming to gay, lesbian, bisexual and transgender young people
• A clear statement of confidentiality*
• Young people involved in design and monitoring of services*
• Services are delivered in settings (including schools and FE colleges) and at times that are convenient for young people*
• Services tailored to meet the needs of boys and young men</td><td rowspan="2"></td><td rowspan="2">Inaccessible, inappropriate services
• Services for young people delivered only as part of mainstream services and only in traditional clinical settings
• Services unwelcoming or staff judgmental
• Services are based in highly visible locations, not open after school or at weekends
• Limited choice of contraceptive methods, including condoms and EHC
Lack of promotion and outreach
• Lack of health promotion work, sole focus on reactive services;
• Lack of young people-appropriate advertising of services
Poor involvement of service providers
• Other health and non-health professionals unaware of services available; unclear about where to refer young people for specialist services; do not make referrals
• Contraceptive advice not provided by abortion providers, midwives, health visitors, etc</td></tr>
<tr><td>Full range of high quality services offered
• Full range of contraceptive methods (including long acting methods) available / promoted to young people*
• Easy access to well publicised free pregnancy testing, non-judgemental advice, and referral, as set out in the TPU Best Practice Guidance, is included in PCT commissioning plans and provided to ensure young women are enabled to make an informed choice about whether to continue the pregnancy
• Strong focus on sexual health promotion / outreach work
• Strong provision of contraceptive advice to young people after pregnancy to avoid subsequent births and repeat abortions
• Service providers skilled in delivery of sexual health services to young people
• Service providers contributing to health promotion work / PSHE in schools
• Arrangements are in place for seven day access</td></tr>
</table>

[3] Issues with * are addressed in the *You're Welcome* quality criteria

to NHS funded emergency contraception.	
Services are visible and highly promoted • Visible marketing, promotion and signposting of sexual health service, including in schools* with up-to-date details of local services on the database held by the ruthinking website and helpline to allow speedy referrals to local advice	
Involvement by a range of knowledgeable service providers • Clear referral systems for other service providers (e.g. substance misuse services, Connexions, Youth Service), to put young people in touch with services* • Condom-distribution scheme established and administered through wide range of appropriately trained partners, including Connexions PAs, youth workers, teachers, etc. • Emergency hormonal contraception available through pharmacies • Easy access to Long Acting Reversible Contraception for vulnerable young women (e.g. domiciliary service) • Staff provide training for other professionals (Connexions PAs, youth workers, teachers, etc) as part of outreach and health promotion work	
Services are adequately resourced • Young people's contraceptive and sexual health services are funded from mainstream resources and are part of mainstream provision • Services are resourced at a level to ensure adequate access for young people • Provision of young people focused contraceptive and sexual health services is explicitly included in commissioning, and developed in line with *Our Health , Our Care, Our Say*	
Other relevant factors: Strong links and signposting are needed between all sexual health and contraceptive services (pharmacies, GUM, family planning, abortion and general practice). It is critically important that all mainstream sexual health and contraceptive services are young people friendly, using *You're Welcome* or local equivalents.	
Resources: DH. *You're Welcome quality criteria. Making health services young people friendly*. 2005 TPU. *Best practice guidance on the provision of effective contraception and advice services for young people*. 2000. *Best Practice Guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health*. 2004 *Best Practice Guidance on developing services to reach boys and young men*. 2001 *Best Practice Guidance on developing services to reach young people from BME communities*. 2001. DH *guidance on duty of confidentiality for young people under 16* (2004) DfES. *Extended Schools 'know how' leaflet on developing on-site health advice services* (due to be put on ECM website October 2006). TPU. *Guidance on providing access to on-site health advice in FE colleges* (due Jan 07)	

Strong delivery of SRE/PSHE by schools: Systematic delivery of SRE/PSHE across primary and secondary schools, driven by the local education authority is critical to delivery of the target. *Next Steps* notes that, to support delivery, a number of related elements need to be in place, focusing on achieving Healthy Schools status; use of the DfES SRE Guidance (2000) (including planned programmes of training for Governors, LEA support to improve schools' PSHE delivery, including the development of exemplar lesson plans, and investment to support delivery, including resources and consultancy. Local authorities have a key role to play in driving improvement in this area. In some instances, further education colleges will have an important role to play.

Lead: LA / schools
Key roles: LEA, Healthy Schools Coordinator, TPC/equivalent strategic lead

Characteristics to aim for		…and characteristics to avoid:
Strong delivery by well-trained professionals • Dedicated PSHE coordinator and specialist PSHE teachers in post • SRE led by teachers with support from other key staff, such as health workers, teachers, sexual health promotion workers, drug and alcohol education advisors, learning mentors and others • Locally-tailored guidance, including exemplar lesson plans coordinated by the LEA • Guidance disseminated to teachers on discussing sexual health and related issues with pupils through the LEA • Training, support and supervision is prioritised for schools with under-18 conception hotspot wards in their catchment areas and Pupil Referral Units		**Inadequately trained staff** • No specialist PSHE teachers • Teachers not given access to PSHE CPD / Low take-up of PSHE CPD • Lack of dedicated school nurses or services are not trusted or well-regarded by students • No input from external professionals **Lack of commitment** • Senior decision makers do not prioritise or invest in PSHE • Governors / parents unsupportive of SRE • Low achievement of Healthy Schools status • Each school left to decide its own policies/programmes **Curriculum and delivery** • Infrequent, irregular classes, not provided to all age groups • Curriculum is narrowly focused on sex and biology • No/poor assessment of what students are learning in PSHE
Broad, thorough content • Strong focus on relationships, not just biology • Good signposting to sexual health advice / specialist services • Includes work on equalities issues such as gender roles /sexual stereotypes/ ethnicity • Emphasises building assertiveness, self-esteem and self-confidence • SRE seen as part of a holistic approach to improving health and wellbeing • Use of *SRE Guidance* (see below) • Students involved in design and delivery of SRE curriculum • Specific needs of boys/young men, BME communities, gay, lesbian, bisexual and transgender young people reflected • SRE curriculum promotes the benefits of delaying first sex, but provides information on safer sex and enables pupils to practise negotiation skills, recognising that minority will be sexually active		
Clear commitment to SRE • All schools have a sex education policy (statutory requirement) in place and in use • Head teacher shows clear commitment to SRE, for example, through ensuring staff have access to training, working towards healthy schools status. • Governors understand, and receive training on, the importance of SRE;		

• Parents/carers have been consulted on the school's SRE policy • Strong take-up of PSHE certification programme among teachers/nurses and provision of cover to ensure access to training and certification • There is systematic assessment of learning and programmes are planned and evaluated against the QCA end of key stage statements (published 2005) • Colleges and training providers deliver SRE programmes to their students, particularly to course groups known to be more vulnerable to teenage pregnancy. • Investment in SRE resources and consultancy support for schools	
Whole school environment contributes • Training for all teachers on basic SRE and guidance on discussing issues with pupils • Accessible and trusted school nurse • Strong focus on achieving Healthy Schools status	
Sustained provision throughout school years • PSHE delivered in primary schools • Timetabled classes provided regularly throughout secondary school	

Resources:
DfEE. *Sex and Relationship Education Guidance*. 2000: www.qca.org.uk
PSHE end of key stage assessment statements – KS1-4: www.qca.org.uk
Healthy Schools framework: www.wiredforhealth.gov.uk.
TPU are developing a menu of SRE programmes available to schools to invest in (2007)
Teenage Pregnancy: Accelerating the Strategy to 2010 includes a non-exhaustive list of SRE programmes.
QCA Assessment Guidance
PSHE framework
Sex Education forum website
PSHE Subject Association website [when live].

Targeted work with at risk groups of young people, in particular Looked After Children and Care Leavers: In addition to generic programmes (such as SRE/PSHE and access to services), there is a need for initiatives that focus on young people most at risk. This may include some Black and minority ethnic communities and some neighbourhoods or areas. *Next Steps* pointed out that high performing areas generally had examples of Social Services having a strong focus on sexual health issues (including targets for Looked After Children (LAC) having access to advice on contraception and sexual health). Also important is mandatory SRE training for all social work managers, family support workers, foster carers and relevant social workers.

Lead: LA
Key roles: Youth Service, social workers

<table>
<tr><th>Characteristics to aim for</th><th></th><th>…and characteristics to avoid:</th></tr>
<tr><td>Strong use of data and evaluation
• Use locally sourced data to identify who/where to target
• Able to utilise information about young people who are likely to be at risk in an ethical way (ie. addressing concerns about confidentiality and stigmatising)
• Monitor progress to understand which approaches are most/least successful and adapt programmes accordingly</td><td></td><td rowspan="3">Lack of understanding of targeted, preventative approach
• Poor understanding of targeted approaches /ineffective use of data for targeting
• Support services neglect the crucial role of prevention of subsequent unintended pregnancies and the contribution of this work to achieving the target
• Sole focus on boys with behavioural problems, at expense of girls with problems relating to low aspiration/self-esteem
• Work with LAC focuses exclusively on measures to improve attainment, without consideration of risk of other poor outcomes, including TP
Interventions not tailored to specific needs and run in isolation
• Targeted groups/individuals are all approached in the same way and are not tailored to suit their different needs
• BME issues are not addressed due to fear of accusations of cultural insensitivity
• No consultation of a range of experts or voluntary/community groups
• Programmes duplicate or run counter to existing interventions targeted at vulnerable groups</td></tr>
<tr><td>Specific preventative interventions target a range of vulnerable groups
Informal SRE policy (for Children's Services and youth and community settings): Selection of young people who require targeted support takes account of underlying risk factors for teenage pregnancy, such as low attainment, poor attendance, low aspirations. and includes
• Young men
• Different BME communities (considering variations within and between groups)
• Deprived estates/neighbourhoods
• Schools with high numbers of conceptions and /or in hotspot wards
• Looked After Children and care leavers
• Teenage parents
• Young offenders
• Asylum seekers
• Gay, lesbian, bisexual and transgender young people
• Other at risk individuals and their families</td><td></td></tr>
<tr><td>Interventions tailored to suit specific needs
• Range of interventions provided, covering relationships and aspirations as well as safe sex
• Specialist nurses provide tailored drop-in SH sessions / specialist health promotion staff working with BME communities (where appropriate)
• Range of members of BME communities and religious leaders consulted to ensure SRE and services are appropriate</td><td></td></tr>
</table>

Interventions involve a range of professionals and voluntary and community groups and complement existing programmes • SRE training for professionals working with at risk groups • Interventions involve a range of professionals and voluntary/community groups and complement other programmes/interventions aimed at vulnerable young people • Investment in targeted programmes that address risk-taking behaviour (such as Teens & Toddlers, Young People's Development Programme etc) • Aspiration work with vulnerable young men addresses attitudes towards sex, relationships and fatherhood		
Resources: TPU. *Enabling young people to access contraceptive and sexual health information and advice. The legal policy framework for social workers, residential social workers, foster carers and other social care practitioners.* 2004 (First published in 2001) TPU. *Enabling young people to access contraceptive and sexual health advice: guidance for youth support workers.* 2005. (First published in 2001)		

Workforce training on sex and relationship issues within mainstream partner agencies: *Next Steps* points to the extent to which service providers working within partner agencies have received training on SRE as an indicator of mainstream partners' engagement with the strategy. Many service providers- such as youth workers, Connexions PAs, social workers, housing support workers, Youth Offending Team workers – work with young people at risk of teenage pregnancy, and can use this opportunity to do preventive work to help young people delay early sex and access early advice. Systematic approaches include mandatory training of all relevant social workers, SRE training for youth workers to allow them to play a key role in initiatives during 'themed weeks' on sexual health and teenage pregnancy; and mandatory training for all Connexions PAs. While it is important to ensure training for the workforce throughout the system, it is essential to prioritise those in areas of greatest need.

Lead: LA
Key roles: Healthy Schools Coordinator, PCT public health/health promotion, TPC/equivalent strategic lead

<table>
<tr><th>Characteristics to aim for</th><th></th><th>…and characteristics to avoid:</th></tr>
<tr><td>Engagement with /guidance for all those working with YP
• LA provides key fact sheets for all those working with YP on:
  o legal issues
  o confidentiality
  o supporting and referring YP to specialist SH advice services
  o benefits of delaying sex
• LA ensures all those working with at risk young people (Connexions PAs, youth workers, social services, foster carers, and those working with boys and young men etc) receive sex and relationship training, ideally on joint multi-agency courses.
• Both induction and INSET days used to improve teachers' ability to support young people on sex and relationships issues
• Teachers and community nurses encouraged to participate in national PSHE certification programme
• Teachers are recruited to CPD PSHE certification programme from schools with 20% free school meals, low attendance and attainment, NHSS targeted schools, Pupil Referral Units, and schools targeted through Behaviour Education Support Teams.
• General practice is proactively engaged in PCT training to improve YPs' access to advice; based on RCGP/ TPU Getting it Right initiative and Confidentiality Toolkit.
• Health promotion staff have objective of raising sex and relationship skills & knowledge of professionals working with YP</td><td></td><td rowspan="2">Not all those working with YP receive sex and relationship training
• Mainstream partners do not make training available for the professionals they employ
• Lack of / inappropriate engagement with national PSHE certification programme (e.g. schools in hotspot areas are not targeted to participate)
• Health promotion colleagues do not prioritise work on improving knowledge/skills of other professionals
• Training is limited or not available for all relevant workers
• Staff are not made aware of training opportunities or do not take these up
• Teachers and other workers are reluctant to talk to young people about these issues or misadvise them
• Agencies run their own training without reference to each other.
• Agencies have no management support for staff to be involved in work around SRE, condom distribution, etc and do not support attendance at SRE training.</td></tr>
<tr><td>Staff follow good practice
• All those working with young people are working to an agreed confidentiality and SRE policy
• Agency Annual Performance Reviews for practitioners analyse their training needs,</td><td></td></tr>
</table>

including SRE. • All those working with young people promote messages on delay, and – for the sexually active – use of contraception and condoms and make supported referrals to contraceptive and sexual health services		

Resources:
Enabling young people to access contraceptive and sexual health information and advice. The legal policy framework for social workers, residential social workers, foster carers and other social care practitioners. 2004 (First published in 2001)
Enabling young people to access contraceptive and sexual health advice: guidance for youth support workers. 2005. (First published in 2001)

A well resourced Youth Service, with a clear remit to tackle big issues, such as teenage pregnancy and young people's sexual health: As noted in Next Steps, where Youth Services were well resourced, provision of positive activities for young people was strong. Youth workers should be equipped with skills and knowledge to support young people on sex and relationship issues. The Youth Service has an important leadership role to play, with a focus on addressing key social issues affecting young people, such as sexual health and substance misuse.

Lead: LA
Key roles: voluntary sector

<table>
<tr><th>Characteristics to aim for</th><th></th><th>…and characteristics to avoid:</th></tr>
<tr><td>Commitment
• The Youth Service plays a leadership role in relation to social issues affecting young people, including sexual health
• All LAs have information about per capita spend on the Youth Service.</td><td rowspan="4"></td><td rowspan="4">• Youth workers ill-equipped to respond to young people's concerns about sex and relationships.
• Too strong a focus on providing activities (sports, drama etc), to the exclusion of discussion/debate about issues affecting young people's lives, including sexual health</td></tr>
<tr><td>Well trained youth workers
• All youth workers receive training on sex and relationship issues</td></tr>
<tr><td>Provision of advice and contraception
• Youth workers receive mandatory training on sex and relationships issues, talking to young people about sex etc.
• Youth workers are involved in condom distribution schemes
• Youth workers deliver information sessions to young people/engage young people in discussion on sex and relationships, including challenging negative sexual health attitudes among boys and young men
• Youth Service runs events (health fairs etc) during themed weeks to address local social issues such as teenage pregnancy</td></tr>
<tr><td>Sign-posting to specialist services
• Youth Workers have clear arrangements for referring YPs to specialist sexual health advice</td></tr>
<tr><td colspan="3">Resources:
Guidance For Youth Workers On Providing Information And Referring Young People To Contraceptive And Sexual Health Services [2005]</td></tr>
</table>

Work on raising aspirations: *Teenage Pregnancy: Accelerating the Strategy* emphasises the importance of improving attainment, behaviour and attendance and raising aspiration in young people at risk of a range of factors, including teenage pregnancy. Teenage pregnancy rates are higher in more socially deprived wards. The Government has organised a more targeted approach to tackle under-performance among particular groups of young people who are at greater risk of teenage pregnancy. The strategy points to a range of approaches, including implementation of Healthy Schools, New Deal for Communities initiatives, *Aiming High: Raising the Achievement of Minority Ethnic Pupils* and specific programmes such as Teens and Toddlers and Young People's Development Programme.

Lead: all partners
Key roles: Education, Youth Service, voluntary sector, faith groups

Characteristics to aim for		…and characteristics to avoid:
Priority: • Raising aspirations is viewed as integral to all other interventions and programmes of action • Programmes mapped by/known to Children's and Young People's Services / identified in Children's and Young People's Plan		• A culture of low aspiration is considered to be unavoidable and is not addressed through policies and programmes, either across boroughs or in communities or neighbourhoods. • Children and parents are not supported to develop hopes and goals. • Young people are prevented from making choices about their future or are not provided with information with which to make these decisions
Programme reaches young people most at risk • Selection of YP who would benefit from discrete work on raising aspirations takes account of underlying risk factors for teenage pregnancy • Service provision focuses on encouraging young people to value/respect themselves and the need to resist pressure until they are ready to have sex • Young parents are targeted for support in relation to positive aspirations for themselves and their children		
Programme combines raising awareness and raising self-esteem • Efforts are made to make clear to young people the real consequences of teenage pregnancy in both the short and longer term. The long term should include consideration of life and health outcomes identified in *Next Steps* and *Accelerating the Strategy*. This should be part of education on self esteem, relationships, delay and contraception (in a non-stigmatising way) • There is a focus within provision on valuing/ respecting themselves and the need to resist pressure until they are ready to have sex		
Schools are engaged in raising aspiration for most at risk young people: • Educational attainment and participation are seen as primary means of improving aspirations • Colleges/universities work closely with local schools and provide opportunities for engagement with young people • Opportunities through the 14-19 agenda are maximised to provide alternative education for young women identified as being at risk of teenage pregnancy • Young people are encouraged to continue with		

their education, even if it is not academically based • 'Difficult' students are not 'informally' excluded from school or made to feel unwelcome by teachers • Schools exploit opportunities to use alternative KS4 learning packages as a way to engage with young people most at risk • Extra small group or one-to-one tuition is available for pupils who have fallen behind peers in English and maths, particularly at KS3 • Primary schools are using SEAL or similar materials. • Secondary schools are using SEBS or similar materials	
Engagement with young people • Specific programmes are commissioned for those most at risk (see also targeted programmes) • A wide range of positive activities are available locally for young people, including sport, recreation, and the arts • Young people are provided with, and encouraged to seek out, practical vehicles for expression (e.g. performing plays or making DVDs about issues that affect them, including teenage pregnancy) • Young people are involved in the design of services (both advice and activity related) and are regularly asked for feedback • There is a strong focus on supporting young people to address/resist peer pressure and deal with insecurity and lack of self-confidence	
Community engagement: • Businesses are encouraged to provide opportunities for young people (e.g. work experience; part-time work; summer placements) • Actions are taken to provide positive role models for young people • Aspiration raising is seen an essential part of combating concerns that teenage pregnancy programmes criticise local community culture – improving individual choice rather than attacking traditional values and behaviour • Local faith and community groups provide positive activities for young people • Opportunities to do voluntary and community work are provided and young people receive individual support throughout this process • There are arenas for young people and their communities to discuss difficult local issues, such as teenage pregnancy • Local people with access to and influence in estates/communities are involved in outreach work to young people • Work is done to raise the aspirations of parents/ families	

Resources

Work with Parents: The national evaluation found that many young people still find it difficult to talk to parents/carers about sex and relationships, calling for more innovative approaches to improving communication between young people and parents/carers. It is also important to engage with parents on issues such as aspiration (see also communication / aspiration sections).

Lead: LA
Key roles: voluntary sector, faith groups, Children's Centres, Extended Service Schools, Health,

Characteristics to aim for		…and characteristics to avoid:
Make the most of existing programmes • Wider parenting support programmes include material on sex and relationships • Communities at risk of teenage pregnancy – for example, BME communities, local neighbourhoods – are informed about the risks of teenage pregnancy and engaged with on how to address the issues • All parenting course tutors given training on SRE strategies to include in courses where appropriate.		• Addressing teenage pregnancy is not undertaken to avoid possible offence to parents and local communities • There is little or no engagement with parents on SRE and related sexual health issues • No resources are focused on providing support to parents/carers
Range of stakeholder organisations contribute • Wider workforce is aware of and refers parents to support • Schools consult parents on the school's SRE policy/provision		
Provision reflects local characteristics • Discrete work with parents on sex and relationships is sensitive to culture/faith issues		
General as well as targeted provision • There is investment in community-based programmes that seek to engage hard-to-reach families, such as through children's centres, primary schools, GP practices, community centres • Good general parenting support available across local area with evidence that it is well accessed. • Factsheets are produced for professionals on benefits of parents having open discussions with their children about sex and relationships, including details of where to get information and support for this • YOT Parenting courses & other parenting courses which parents are required to attend by court orders include SRE issues. • Programmes such as Parentline Plus and the fpa Speakeasy are commissioned to provide support for parents		
Other relevant factors: Additional programmes are under development and outlined in *Teenage Pregnancy: Accelerating the Strategy to 2010*, including National Parenting Academy, Parenting Early Intervention Pathfinders.		
Resources		

6 Self Assessment

How to use this tool.

- **Read the key characteristics sections**: This self assessment tool reflects the 'characteristics to aim for' and 'characteristics to avoid', but does not repeat all characteristics highlighted in the good practice guide sections. To ensure assessments are undertaken with an awareness of the full range of characteristics, please refer to individual lists. You will need to have a copy of the characteristics to be able to assess whether you are meeting the best practice guidelines.

- **Note the scoring scale**: When assessing performance, please use the following scale:
  - **Fully**: All characteristics are in place.
  - **Nearly**: Most characteristics are in place and there is a plan to ensure they are
  - **Partially**: Few characteristics are in place and there is no plan to ensure they are in place. It is important to note whatever positive progress there is in these areas.
  - **Not at all**: None or virtually none of the characteristics are in place.

- **Fill in key characteristics sections:** Each key characteristics section should be filled, along with in an assessment of the overall score for each section. This should be carried forward to the summary sheet. It will be helpful to note areas of work for which there is evidence of impact. Services that are funded by mainstream resources should also be noted.

- **Fill in the summary sheet**: Review the findings from each of the key component sections and – as a group – agree the overall assessment and action plan.

Approach: This self assessment could be carried out in a workshop, with small group sessions assessing the individual key characteristics sections. A whole group discussion could consider scores from the key components to determine the overall assessment.

Teenage Pregnancy self-assessment
Summary Sheet

Date of assessment: **July 2007** **Covering period: 20.4.07 (Self Assessment Day, Essex Records Office)-- ongoing**

Area: **Essex** **Assessors: TPC Cordinated with partners across Essex**

Characteristic	Rating	Rationale summary	Action plan for next 6 - 12 months
Strategic • Restructure of ECC • Restructure PCTs • Relationship of Connexions Strategy • No Strategy group at beginning	N	Strategy Group in place. TP integrated into planning. Progress driven by performance management. TP Next Steps communicated to CYPSPs, LMC, YEA, Res Care Mgrs, LAAC, Youth service 06/07. TP Accelerating the Strategy communicated to 6/11 CYPSPs, LMC, YEA, Health Strategy Group Children Looked After and Local TP Strategy Groups. Essex TP Commissioing Plan 07/08 informed by Next Steps and Acc the Strat. Common Themes: Local Strategic Partnerships and Teenage Pregnancy	TPC to seek commitment from Secondary Headteacher from a hotspot district. Chair of TP Strategy Group to discuss with Senior Management within SCF possibility of reduction of under 18 conception rate becoming explicit within LAA. Ongoing. Mid point performance review meetings with providers planned for Autumn 07. Intended primarily for those in LSPs with responsibility for achieving the PSA target on neighbourhood renewal and in receipt of neighbourhood renewal funding 1. This beyond scope of TP Strategy. How is this to be taken forward?
Data • Data use/availability	N	Systematic approach to knowing population and needs	TPC to develop with partners, drawing upon the TP data toolkit,

Likelihood of delivery
Traffic light score based on trajectories and milestones AMBER/GREEN

Differs across Essex **TP Conception rate data 2 years behind**		**in relation to TP.** **Data and information used to inform provision of local services.** **Performance management led by accurate data.** **Gaps exist within LAC population and Young Parents Groups.**	**a useful indicator set to be used in local areas, to include young parents "reach" targets and BME population needs.** **Information sharing protocols to be developed between Midwifery Services and Connexions informed by guidance from DCFS and DH, to support development of Young Parents Support Strategy.**	
Communication • **Eastern Region structure in place** • **Essex leads meet reg** • **Communication of strategy to yp, parents and profs patchy**	**N**	**Partners receive timely and appropriate information from TPC.** **Parents and community engagement is patchy, however main barrier for this is the lack at present of a strategic lead for parenting.** **Professionals directory produced and currently in the process of being disseminated.** **Radio campaign planned for summer hols period.**	**Review media strategy. Work under way with colleague in Suffolk who is also reviewing strategy in light of FOI** **When parenting commissioner in place take forward as a priority.**	
Implementation				
• YP focused contraception/ sexual health services • • **Some areas v gd, others poor** • **Lot of services are single agency but good models exist and thrive** • **Threat to funding continues**	**N/P**	**All local areas reviewing provision against "deep dive" review findings and DH "You're Welcome" criteria.** **College provision patchy.**	**Report review findings to TP Strategy Group.** **Support local areas to develop action plans.** **Share best practice via workshops/visioning days, involving young people in the process.** **All areas carrying out audit of college provision to ensure that what is developed meets the**	

			needs of the 14-19 group as per guidance.	
• Strong delivery of SRE/PSHE by schools • **Healthy Schools v gd at KS 1 & KS2 but not so strong at KS 3&4** • **Risk re end of funds for 08/09**	**?**	**Healthy Schools are making good progress and a third of secondary schools already have HS status.** **Provision patchy as highlighted from self assessment process.** **SRE matrix developed by Suffolk to be used to clarify baseline data to inform action planning.**	**TPC and Healthy Schools Coordinator to populate SRE matrix and use it to monitor progress in delivery of SRE.** **Ensure that extended services are integrated within planning.** **TP Local area plans being aligned with Healthy Schools plans to avoid duplication.**	
• Targeted work with at risk groups of YP, especially LAC • **Provision varies** • **Some areas lack clarity over risk groups**	**?**	**Voluntary sector funding secured for Teens and Toddlers programme in Harlow.** **Peer education programme agreed for Children Looked After.** **Scoping exercise required for hotspot areas to identify vulnerable young people numbers.**	**Recruitment of facilitators from youth service and connexions highly desirable if the programme is to be sustained.** **Steering group to meet to progress. Baseline data required.** **To be part of local data indicator set toolkit for local groups.**	
• Workforce training on SRE in mainstream partner agencies • **Working group for training** • **Plan in place and delivery to all agencies**	**N**	**Sexual Health Awareness Foundation Training piloted in 5 areas and evaluated. 125 multi agency professionals attended.**	**9 training days planned re SHAFT for 07.08.** **Delay training commissioned for trainers. Delivery to follow.** **Need to ensure that workforce development around SRE/Delay accessible to Vol Orgs, Health and LA and that funding is mainstreamed provision from Statutory partners.**	**Assessment based on performance only**

			QA process to be refined and mainstreamed.
• Well resourced Youth Service • **Inconsistence of approach across the youth services sector; stat and vol** •		**Condom distribution scheme requires review and clarity for all professional within the emerging Targeted Youth Support Strategy.**	**SRE materials under development for Adolescent services curriculum template.** **Sexual Health policies under review.**
• Raising aspirations • **Some work developing**		**Building young parents groups standards as per Support Strategy Guidance** **CYPP 06/07 update reports 88.5% of teenage mothers known to EST Connexions participating in EET. 233 not available to labour market.** **Care to Learn update 13.7.07, LSC figures show 875 young parents aged under 20 with 61 (6.1%) using C2L (low take up) LA League table 138/150** **EMAs**	**Refreshed strategy will need to tackle (i) poor health outcomes (infant mortality rate, low birth weight) for children born to teenage parents** **(ii)Poor emotional health and wellbeing of teenage mothers and fathers** **(iii)Teenage mothers poor labour market prospects** **Included as performance indicator for young parents groups funded from LIF Grant**
• Work with parents • **Not a priority in most areas** • **Some good examples developing**	**P**	**Pilot delivery of "How to talk to your kids about sex" with parents on Parenting Orders with YOT.** **Positive parenting work led by Health, Vol Org and Youth Services with young parents**	**When parenting commissioner in post TPC to ensure that young parents are recognised as an important client group and that commissioning for parents of soon to be adolescents and adolescents includes discussion skills in sex and relationships.**

		groups funded from LIF Grant.	

Recent performance against trajectories and milestones	

Teenage Pregnancy self-assessment: Key characteristics: Strategic

Score | Fully | Nearly | Partially | Not at all

Strategic: ***Senior local sponsorship and engagement of all key partners***			
	Rating	**Comments, including main barrier to improvement**	**Action**
There is clear commitment / teenage pregnancy is a priority	N	At County level, there is a Teenage Pregnancy Interim Strategy Group, chaired by Service Development Manager in Adolescent Services. Membership includes, a DPH from one of the 5 PCTs representing Health, a Senior Manager from Social Care, Voluntary Sector representation, Connexions and the Teenage Pregnancy Partnership Coordinator. There is currently no representation from schools but this is being pursued. This group evaluate and monitor the work undertaken in the localities funded from the LIF Grant. The reduction of under 18 conceptions is priority 2 in the CYPP but not explicit within the LAA.	Pursue the involvement of a secondary headteacher to join the group to represent schools. Support the membership of the group to develop further the robust monitoring and evaluation processes. Discuss the possibility of the under 18 conception rate becoming explicit within the LAA with Senior Managers within Schools, Children and Families Service.
Teenage pregnancy is integrated into planning	N	TP Strategy is integrated into 11 TP CYPSP Locality Plans, PCT Local Delivery Plans, Connexions Business Plans, CYPP, Housing Strategies and some Homelessness Strategies. Alignment with Supporting People Strategy has begun to take place. Some work has begun in terms of parenting support but the post of the Parenting Commissioner is vacant. When this post filled, this may be pursued further and developed more	Link with the Parenting Commissioner when in post to develop this aspect of the strategy. Ensure that Children's Centres are integrated within the plans. Present TP Accelerating the Strategy to Housing Officer Group to inform their plans re their Homelessness Strategies.

		fully.	
Progress is driven by performance management	N	Teenage Pregnancy is a regular agenda item on the 4 hotspot district CYPSP agendas. It features twice yearly on the other agendas. The TP Interim Strategy Group evaluated and monitors the plans and work undertaken to support the plans. QA visits are carried out at the Young Parents Groups. Budget monitoring is robust. Reporting mechanisms are detailed in the SLAs taken up between the Local Authority and the providers.	Ensure that young people are involved in the evaluation of services that are delivered to them. Continue to develop agreed monitoring arrangements that meet the changing demands of local delivery.
Summary rating	N		

Teenage Pregnancy self-assessment: Key characteristics: Data

Rating	Fully	Nearly	Partially	Not at all

Data			
	Rating	**Comments, including main barrier to improvement**	**Action**
There is a systematic approach to knowing the local population and its needs in relation to teenage pregnancy.	N	Conception rate data from TPU, births and STI data from PCTs is available and used effectively in all areas. Provision and use of young parents' numbers requires further investigation. There are gaps in data relating to Children Looked After.	Connexions to support the data sharing in relation to young parents on their data base, both locally and at a County level. To support this, the Dept of Health has produced Maternity Matters Guidance, which will inform the development of information sharing protocols between midwifery services and Connexions. Performance management of local Young Parents Groups funded from the LIF Grant, will now include a percentage of the local parent population figure as part of the "reach" target. Accurate baseline data to be shared by social care with TP Strategy Group.
Data and information are used to inform provision of local services	N	Data is used effectively to target those most at risk of teenage pregnancy. The funding is allocated using a "hotspot" approach. Data on usage of young people's sexual health services used to inform development of provision.	Continue to develop local strategies that support high rate areas and those facing multiple risk factors. Ensure that where there are significant BME populations and changing demographics, that services effectively utilise data to target those communities most at risk.
Performance management is led by accurate data and information	N	Data presented to TP Strategy Group bi annually. Data presented to lead officer at LA for CYPP. LIF Grant conditions adhered to. Terms of reference for the strategy group are in place. SLAs with providers request accurate data reporting to support evaluation.	
Summary rating	N		

Teenage Pregnancy self-assessment: Key characteristics: Communication

Rating	Fully	Nearly	Partially	Not at all

Communication			
	Rating	**Comments, including main barrier to improvement**	**Action**
Partners receive appropriate information	N	Partners from across the range of agencies receive data, TPU updates in a timely and contextualised manner. Supporting statements are agreed between the main agencies to communicate clear messages. Minutes and reports and communicated within an agreed timeframe. Due to the restructure of the PCTs and the LA many of the key individuals within the partner agencies have changed roles. This has led to some delay in cascading information due to the lack of a named person for a period of time.	Review media strategy.
Parents and communities are engaged and informed	P	There is a limited amount of consultation with parents. Where work is delivered to parents on Parenting Orders via the YOS, consultation takes place. The lack of a strategic lead for Parenting is the main barrier.	When Parenting Commissioner in place, this is to be taken forward as a priority. Ensure that Parentline Plus Time to Talk materials are displayed in community settings.
Young people – including those most at risk – are involved and informed	N	Young people are involved via the YEA, local Youth Forums and as mystery shoppers. Peer education is developing to support local programmes. Peer education is part of the SRE delivery in secondary schools. Young parents groups train young people to become peer educators on a range of health issues.	Carry out an audit of local areas to see where best practice is and share across the county. Ensure that YEA are linked into Healthy Schools network to support peer led element of the SRE programme in schools. Supply the YES with all papers from the Strategy Group and ask them to comment on the proposals.

There is a strategy for dealing with the media	N	There is a media strategy in place but this requires reviewing. Media issues are dealt with via ECC Press office, with any information relating to the PCTs being agreed in advance with the Communications Leads within the respective PCTs. Radio used to good effect to promote key prevention messages within the citizenship model.	Review Media Strategy. Agree key message for each area of work with the key partner agencies. Update the use of ambient media.
Communication programmes are assessed	N	Regular review takes place and best practice models adopted.	Ongoing monitoring.
Summary rating	N		

Teenage Pregnancy self-assessment: Key characteristics: Implementation: Young people's sexual health services

Rating	Fully	Nearly	Partially	Not at all

Provision of young people focused contraception/sexual health services, trusted by teenagers and well known by professionals working with them			
Accessible services are tailored for young people	**Rating**	**Comments, including main barrier to improvement** **Populate local plans relating to the 5 PCTs Commissioning Plans for young people sexual health services.**	**Action** **Complete local area plans working with PCT Commissioning Leads to do so.**
Full range of high quality services offered			
Services are visible and highly promoted			
Involvement by a range of knowledgeable service providers		Services have access to local provision through partnership working and staff development programme	
Services are adequately resourced			
Summary rating	P		

Teenage Pregnancy self-assessment: Key characteristics: Implementation: SRE/PSHE

Rating	Fully	Nearly	Partially	Not at all

Strong delivery of SRE/PSHE by schools			
	Rating	**Comments, including main barrier to improvement**	**Action**
Strong delivery by well-trained professionals	P	Considerable variation from school to school. Characteristics are fully in place in some schools eg in some APAUSE schools. PSHE is still being squeezed and many secondary schools do not have trained specialist teams and rely on tutors. In "at risk" communities, schools are frequently required to focus their resources on the academic curriculum rather than the pastoral.	Seminar for SMT in secondary schools. Further guidance is PSHE/SRE in schools. Dissemination of the PSHE framework. Development of an APAUSE/Delay curriculum package. Provision of further school based training on SRE for secondary schools.
Broad, thorough content	P	Characteristics are strong in some schools. Others do have irregular classes and assessment of PSHE generally in need of improvement.	Seminar for SMT in secondary schools. Dissemination of the PSHE Framework which includes examples of how to assess PSHE. Development of an APAUSE/Delay curriculum package. Provision of further school based training on SRE for secondary schools.
Clear commitment to SRE	N	Policies are in place and headteachers are committed to the healthy school. Recruitment to the PSHE certification programme is strong but the drop out rate is too high. The certification programme is a poor substitute for comprehensive training in PSHE including SRE during initial teacher training. Ofsted have a "one size fits all" model of inspection. In "at risk" communities, the inspection of PSHE is often at best minimal. Ofsted need to develop a far more sophisticated and focused model	Seminar for SMT in secondary schools. Review the PSHE certification programme. Provision of further school based training on SRE for secondary schools.

		of inspection for PSHE and rigorously apply it. Secondary staff find it difficult to be released from school.	
Whole school environment contributes	N	There is a strong commitment to healthy schools. School nurse support is variable. Secondary staff find it difficult to be released from school.	Continue to provide primary school support days for PSHE/SRE. Continue to provide school based workshops for parents, governors and staff in primary schools. Provision of further school based training on SRE in secondary schools.
Sustained provision throughout school years	N	Lack of commitment to providing regular timetabled sessions in some secondary schools.	Seminar for SMT in secondary schools. Maintain requirements for National Healthy Schools Status.
Summary rating	P/N		

Teenage Pregnancy self-assessment: Key characteristics: Implementation: Targeted work

Rating	Fully	Nearly	Partially	Not at all

Targeted work with at risk groups of young people, in particular Looked After Children and Care Leavers			
	Rating	**Comments, including main barrier to improvement**	**Action**
Strong use of data and evaluation	P	ONS district and ward data used to inform targeting of resources and interventions. No data from social care to act as a baseline in respect of CLA.	Social Care to provide data to the TP Board relating to conceptions and young parents in respect of CLA agreed ethical process to address concerns about confidentiality. Develop use of a range of data sets to scope vulnerability effectively and use to inform interventions.
Specific preventative interventions target a range of vulnerable groups	N	Hotspot approach taken within Essex TP Commissioning Plan. PCTs Sexual Health and HIV Strategies to address local area vulnerability scoping and commission services to provide appropriate response. No evidence of SRE delivery to CLA population	Local delivery plans to reflect targeting of specific high risk and socially excluded groups working closely with voluntary sector providers in support. Social Care to complete own version of self assessment exercise to target interventions and to monitor progress against implementation plan through the agreed strategy group reporting to the TP Board
Interventions tailored to suit specific needs	P	In some settings this is the case but in others a are for development. Some PCTs have recruited BME workers within Public Health to access minority groups within the community to assess need and respond. Increase in numbers of unaccompanied minors requiring specialist intervention. Little experience of some of the issues faced and limited research. Shortage of interpreters creating additional barriers to consultation with these groups.	Share good practice through workshops and CPD events. Share practice across Public Health Forums. Seek out best practice and research recommendations to inform most appropriate intervention.
Effective Interventions involve a range of professionals and	N	SRE Training is offered to staff working with at risk groups, however take up is inconsistent.	Ensure training events are communicated widely and service area take up monitored via the Workforce Development Group.

voluntary and community groups and complement existing programmes		Teens and Toddlers Programme agreed by Harlow CYPSP and funding secured. Aspiration work that address self esteem, sexual health relationships and fatherhood with boys and young men almost non existent.	Evaluate impact. Identify pilot area and develop programme. Evaluation to inform further developments
Summary rating			

Teenage Pregnancy self-assessment: Key characteristics: Implementation: Workforce training

Rating | **Fully** | **Nearly** | **Partially** | **Not at all**

Workforce training on sex and relationship issues within mainstream partner agencies			
	Rating	**Comments, including main barrier to improvement**	**Action**
Engagement with / guidance for all those working with YP	N	Sexual Health Awareness Foundation Training,(SHAFT), pilots to be evaluated and rolled out across the county delivering in localities to multi-agency professionals. Build capacity in the trainer team to deliver the one day Delay Training. Risk: Recruitment of trainers from PCT Providers and LA fails to occur. Continue to deliver C Card Assessor and Outlet Training to support the development of the C Card Scheme. Work wih partners in Public Health, Health Improvement and Healthy Schools Coordinator to develop tiered training routes for workforce. Inset days are used in SRE training but there is strong competition for time. Recruitment of PSHE Certification initially targeted areas of deprivation but not recently. The true cost of releasing a teacher from a school including a supply cover is substantial. School based parents, Governor and teacher joint workshops have been held to review, explore and rewrite policy.	Carry out SHAFT evaluation. Set dates for delivery for 2007/08. Commission 4 day Delay Training to train the trainers. Commission fp, Moving the Goalposts training for those working with boys and young men. Monitor progress trough the Training Action Group, a sub group of TP Board. Produce structured training routes in line with Workforce Development Strategy. Ensure equality of access to voluntary sector partners. Promote school based training and support packages for PSHE/SRE. Review distribution of certificated teachers and nurses re areas of deprivation and take action if necessary. School based workshops can only be provided "on demand" by schools. Schools need to have prioritised this issue and Healthy Schools Team do not have sufficient human resources should the demand significantly increase.
Staff follow good practice	N	All programmes informed by DH Guidance on Sexual Health Training, SET Procedures and Sexual Offences Act 2003. Audit of service area SRE Policies to	Carry out audit. Make recommendations to the Board for action. Seminar for SMT in secondary schools.

		inform development of refreshed policies.	Produce and disseminate further guidance on PSHE/SRE. Develop and disseminate the new Essex SRE Framework curriculum package. Target secondary schools that have not been involved with APAUSE or related initiatives.
Summary rating	N		

Teenage Pregnancy self-assessment: Key characteristics: Implementation: Youth Service

Rating | **Fully** | **Nearly** | **Partially** | **Not at all**

A well resourced Youth Service, with a clear remit to tackle big issues, such as teenage pregnancy and young people's sexual health			
	Rating	**Comments, including main barrier to improvement**	**Action**
Commitment		ECC Youth Work focuses on programmes to increase the confidence of individuals and provides information to enable them to make informed choices. Vol orgs have been sent out the self assessment via Chief Exec of YMCA, TP Board member nut not returned.	Use local area information to map vol org involvement which is extensive in some areas.
Well trained youth workers (SRE)		Training developed with TP Coordinator. Not mandatory for ECC Youth Workers.	SRE training to be included in the Youth Work Training calendar.
Provision of advice and contraception		Trained youth workers can issue condoms as part of a youth work intervention. ECC youth workers do not issue condoms under the Essex C Card scheme although other service providers do attend the provision.	
Sign-posting to specialist services		ECC Youth workers signpost to specialist services.	
Summary rating			

Teenage Pregnancy self-assessment: Key characteristics: Implementation: Raising aspiration

Rating	Fully	Nearly	Partially	Not at all

Work on raising aspirations			
	Rating	**Comments, including main barrier to improvement**	**Action**
Priority		Seems to be true at a strategic level and very much endorsed by the healthy schools programme at a local level. ECC Youth Work enables 60% of young people it works with to achieve recorded outcome from a youth work intervention, 25% gained an accreditation.	
Work combines raising awareness and raising self-esteem		YOS delivers a range of individual and group based programmes. There are a number of objectives, ultimately about reducing offending, but doing so by improving life chances. At present there is nothing specifically about sexual health and wellbeing, but inevitably this key issue comes up and is addressed by the facilitator. Some specific groups have had specific input from Sexual Health Workers from the PCTs.	Ensure delivery of FP training Moving the Goalposts relating to sexual health work with boys and young men. YOS in the process of implementing a risk management framework with a revamped group work programme with room for inclusion of SRE and emotional wellbeing. Develop gender specific work for the increasing number of young women that are entering the criminal justice system for violent offences.
Work reaches young people most at risk		ECC Youth Work does this through partnership working with schools, young carers, YOS, Connexions etc	
Schools are engaged in raising aspiration for most at risk young people		Certainly true of some schools but not all.	
Engagement with young people		Integral part of ECC Youth Work.	
Community engagement		ECC Youth Work, integral part of detached youth work and strategic partnerships.	
Summary rating			

Teenage Pregnancy self-assessment: Key characteristics: Implementation: Work with parents

Rating | **Fully** | **Nearly** | **Partially** | **Not at all**

Work with Parents			
	Rating	**Comments, including main barrier to improvement**	**Action**
Make the most of existing programmes		ECC Youth Work: An area for improvement. Parenting Commissioner to populate when in post.	Move into SCF Directorate will assist. Curriculum developments will increase the sharing of good practice and contribute to improving the quality of delivery. Parenting Commissioner to lead on this with support from TPC and colleagues in Health.
Range of stakeholder organisations contribute			
Provision reflects local characteristics			
General as well as targeted provision		YOS Parenting Coordinator working with TPC and PCTs to develop " Speakeasy" style sexual health programme for parents.	Evaluate and develop programme for roll out across the 4 YOT Teams.
Summary rating			

7 Next steps

Further resources and support are available to help areas in achieving the target. Some are available for all areas, such as TPU website, support through the CSAs/RTPCs, and regionally coordinated events, such as statistical neighbours sharing good practice. Additional support is available for areas with high and increasing conception rates, including the 21 local authorities identified in *Teenage Pregnancy: Accelerating the Strategy to 2010*.

Additional support may include:

Neighbourhood Renewal Advisors and other support through DCLG	Experts who provide hands on support to local areas on one of six neighbourhood renewal themes. Areas' needs are identified though neighbourhood renewal performance management process and support usually commissioned by LSP and GO. Other support includes training and information on renewal.net
DCLG's nine regional centres of excellence	Provide support to local government through regional centres that support local authorities in improving efficiency in the overall delivery of their services. Examples of work covered include partnership effectiveness and data collection and sharing.
Government Office specialist support	Government Offices can provide areas with a range of support, through the regional teenage pregnancy co-ordinators or by buying in specialist support where an issue has been identified.
Improvement and Development Agency (IDeA)	Provide publications, websites and e-learning modules, development courses, peer reviews and tailored support through consultancy. They have programmes around social care and healthy communities (focused on tackling health inequalities) and could be contracted to provide support on teenage pregnancy.
Department of Health. Teenage Pregnancy National Support Team (NST)	Areas requiring intensive support will be identified by GOs with areas' agreement. The NST will help diagnose problems and find solutions to improve performance. That work will build on this self-assessment toolkit and information from RTPCs/CSAs.

Annex 1 Frequently Asked Questions

Q Why is teenage pregnancy an important issue?

A Evidence clearly shows that having children at a young age can damage young women's health and well-being and severely limit their education and career prospects. Longitudinal studies show that children born to teenagers are more likely to experience a range of negative outcomes in later life, and are up to three times more likely to become a teenage parent themselves. The poorer outcomes associated with teenage motherhood mean the effects of deprivation and social exclusion are passed from one generation to the next.

Q Why is the data on TP 14 months out of date?

A ONS usually release annual conception statistics around *14 months* after the end of the year to which they relate. The reason for this time-lag is that to be able to record a conception ONS require *information on the birth or abortion resulting from that conception*. As birth registration can legally be undertaken up to 6 weeks after birth, information on a birth may not be available until *11 months* after the date of conception. When all birth and abortion data are available, ONS require *3 months* to compile the conception statistics. ONS usually release conception data in February each year (i.e. 2004 data was made available in February 2006).

Q For some communities, teenage pregnancy isn't considered to be a problem. Why should they be told not to have babies?

A Teenage pregnancy is a key inequality and social exclusion issue, affecting every individual young person involved, their families and their local communities. It places avoidable burdens on the NHS and wider public services. Even taking into account the relationship between teenage pregnancy and poverty, the children of teenage parents face an *additional* risk of suffering poor health and educational failure.

Q Many young people in our area who get pregnant are married, which isn't a problem, right?

A The vast majority of teenage pregnancies are unplanned, with almost half ending in abortion, and many teenage parents report that they wished they had waited. Our ambition is that all young people should have the skills, confidence and motivation to delay parenthood until they are in a better position – emotionally, educationally and economically – to face its challenges.

Q Do you agree that a lot of money has been spent on the strategy, but it has achieved only limited results?

A The UK has had high rates of teenage pregnancy since the late 1960s but we are turning this around. Reducing teenage pregnancy requires significant changes in service provision, attitudes and behaviour - sometimes deep rooted and spanning several generations - which take time and investment to achieve. Teenage pregnancy is strongly associated with a wide range of poor outcomes – for children and for young mothers. The health and social costs are far-reaching, so tackling it is cost-effective. Calculations of the cost effectiveness of the Teenage Pregnancy Strategy estimate a saving of around £4 for every £1 spent.

Q Why should we put all this money into supporting teenage parents – surely we are making it too easy and encouraging more to become teenage mothers?

A Most teenage pregnancies are unplanned and more than half end in an abortion, so we don't believe benefits provide teenagers with an incentive. While our aim is to reduce the number

of teen pregnancies, we also need to provide good quality support for young women who do have children. That's about improving outcomes for their children as well as the mothers themselves.

Q Does the Government support school based sexual health services?

A The Government continues to support the provision of school based health services where the school identifies a need, through both our Healthy Schools and 'Extended Schools' programme. The decision to provide such services, and the content of that service, is for the individual governing body in consultation with pupils, parents and the school community.

The aim of school based health services is to improve young people's access to professional advice and support on a range of health, relationship and emotional issues which may be troubling them. These issues include bullying, eating disorders, depression and sexual health. The type of professionals providing advice is at the discretion of the individual school. It may be a single school nurse or GP, or a team which might include a local GP, school nurse, nurse from the Child and Adolescent Mental Health Services (CAMHS), the local practice nurse and family planning trained nurse, usually with input from Connexions PAs working in or closely with the school.

Q Is the strategy working?

A Yes. Between 1998 (the baseline year for the strategy) and 2004 (the latest year for which data are available) the under-18 conception rate has fallen by 11.1% and the under-16 rate has fallen by 15.2%. Both rates are now at their lowest level for 20 years.

Q Why doesn't the Government promote abstinence or 'just say no' programmes?

A There is little or no reliable evidence that abstinence only education is effective. A recent review concluded that there is some evidence that abstinence approaches may actually increase pregnancy rates. Analysis by researchers at the US Alan Guttmacher Institute calculate that the vast majority of the reduction in pregnancies is due to more effective contraceptive practice, with a minority attributable to reduced sexual activity

In contrast there is strong evidence concerning the effectiveness of comprehensive sex and relationship education, linked to accessible services, which encourages young people to delay sexual activity but also encourages them to use contraception if they do have sex. This is the approach of our Strategy. In addition, research does not suggest that providing young people with sex and relationships education and contraceptive advice increases sexual activity.

Q Does the Government support school based sexual health services?

A The Government continues to support the provision of school based health services where the school identifies a need, through both our Healthy Schools and 'Extended Schools' programme. The decision to provide such services, and the content of that service, is for the individual governing body in consultation with pupils, parents and the school community.

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Q Can under 16s get contraception without their parents knowing?

A Health professionals can provide contraception including emergency contraception to young people under 16 provided that they are satisfied that the young person is competent to fully understand the implications of any treatment and to make a choice of the treatment involved. Health professionals work within an established legal framework which involves assessing the young person's competence to understand the choices they are making and encouraging them to talk to their parents (but they do not have to do so). All professionals are bound by their professional codes of confidentiality. A young person's request for confidentiality is respected unless there are serious child protection issues, in which case professionals should work to the 'Working Together' guidelines. The safety profile of emergency contraception is considered to be similar for under-16s as for older women.

Q Doesn't your Strategy encourage young people to have sex?

A There has been <u>no change</u> in levels of under age sex since the start of the Strategy. The strategy does not promote sex among young people. Helping them resist peer pressure to have early sex has always been an important theme of the strategy. We consistently promote the message that teenagers having sex before 16 are significantly more likely to:

- report regret;
- not use contraception;
- get pregnant before 18.

Q Don't these young women just get pregnant in order to get a house or flat?

A This is a simplistic assumption about a complex issue. Many young women may seek independent living for a variety of reasons such as: homelessness, overcrowding in parental home, family breakdown, abuse or leaving Local Authority care. Housing is not the prime factor for becoming pregnant but does become an issue once the baby is born. The Social Exclusion Unit Report on Teenage Pregnancy (1999) felt it improbable that teenagers consciously become pregnant for material reasons.

Q Why aren't we doing more about making sure the law about under-age sex is adhered to?

A The purpose behind the offences in the Sexual Offences Act is to enable the prosecution of abusive and exploitative sexual activity. To achieve this, the Act includes a number of offences that criminalise sexual activity between under 18s and under 16s. However, this will not lead to the prosecution of mutually agreed sexual activity within normal adolescent behaviour, where there is no evidence of exploitation. Guidance issued by the Director of Public Prosecutions to custody officers under the provisions in the Criminal Justice Bill will provide that the decision whether children under 18 should be charged with sex offences will be reserved for Crown Prosecutors, rather than the police. A charge will only be brought if it is in the public interest to do so.

Annex 2 Sample local performance indicators

The following is a list of possible performance indicators that could be considered for use locally as measures of delivery.

Good SRE

- Percentage of primary and secondary schools engaged in the Healthy Schools Programme
- Percentage of primary and secondary schools that have had a teacher who has completed/is undertaking the PSHE CPD programme
- Percentage of primary and secondary schools including external health professionals (school nurse/health promotion worker) in the delivery of their PSHE programme
- Percentage of primary and secondary schools that have had an INSET day on SRE/PSHE

Improving young people's access to contraceptive/sexual health advice

- Percentage/number of secondary schools with on-site services
- Percentage of FE colleges/Sixth Form colleges with on-site services
- Number of 16-19 year olds accessing local contraceptive/sexual health services
- Number of NHS-funded sessions offering contraceptive/sexual health for young people
- Number of condoms being distributed through condom distribution schemes
- Percentage of pharmacies providing access to EHC
- Percentage of schools providing the Extended Schools core offer

Targeted Work with at risk young people

- Increase over time in the number of consultations with LAC nurse
- Numbers of 'at risk' young people accessing aspiration building programmes, such as YPDP

Workforce training

- Numbers of professionals working with at risk YPs who have received SRE training
- Numbers of community nurses who have completed/are undertaking the PSHE CPD programme

Youth service

- Numbers of Youth Workers who have received SRE training
- Number of specific SRE/Sexual Health 'events' run by the Youth Service

Parents

- Number of community-based parenting programmes delivered
- Increase over time in the number of parents accessing parenting programmes
- Increase over time in the number of young people reporting that they receive information on sex and relationships from their parents (potentially included as a question in any local survey of young people?)

Resources

Cabinet Office	*Reaching Out: An Action Plan on Social Exclusion.* (2006) www.
Department for Education and Skills. Teenage Pregnancy Unit	*Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies. Every Child Matters / Change for Children.* 2006. (Non-statutory guidance) www.
DfES TPU	*Best Practice guidance on the provision of effective contraception and advice services for young people.* 2000 www.
	Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health. (DH, 2004) www
	Guidance For Youth Workers On Providing Information And Referring Young People To Contraceptive And Sexual Health Services [2005] www]*s*
	You're Welcome Quality Criteria: making health services young people friendly. (DH, 2005) *www*
Department of Health	*Better prevention, better services, better sexual health: The national strategy for sexual health and HIV.*2001 www
	Choosing Health: Making healthy choices easier. 2004 www
	Delivering Choosing Health: making healthier choices easier. 2005. www
	Effective Sexual Health Promotion: A toolkit for Primary Care Trusts and others working in the field of promoting Good Sexual Health and HIV prevention. 2003. www
	Effective Commissioning of Sexual Health and HIV Services: A Sexual Health and HIV Commissioning Toolkit for Primary Care Trusts and Local Authorities. 2003. www
	National Service Framework for Children, Young People and Maternity Services. 2004. www
	National Standards, Local Action: Health and Social Care Standards and Planning Framework, 2005/06 – 2007/08. 2004 *Standards for Better Health.* 2006 www
	National strategy for sexual health and HIV implementation action plan. 2003 www
	You're Welcome quality criteria. Making health services young people friendly. 2005 www
Medical Foundation for AIDS & Sexual Health	*Recommended standards for sexual health services (for all settings providing NHS-funded sexual health services including general practice, hospital and community-based clinics, pharmacies, voluntary and independent sector organisations).* 2005. www
NICE	*Preventing sexually transmitted infections and reducing under-18 conceptions* (publication expected November 2006). www
NHS	*Competencies for providing more specialised sexually transmitted infection services within primary care.* 2005 www
NW London SHA	*London-wide sexual health framework. (no date: 2004?)*(on behalf of the London Strategic Health Authorities) www
Royal College of Obstetricians and Gynaecologists	*The Care of Women Requesting Induced Abortion. Evidence-based Clinical Guideline Number 7.* 2004. www
Social Exclusion Unit	*Teenage Pregnancy.* Presented to Parliament by the Prime Minister by Command of Her Majesty. 1999. www

Abbreviations and acronyms

AIDS	Acquired Immune Deficiency Syndrome
APA	Annual Performance Assessment
BASHH	British Association for Sexual Health and HIV
BME	Black and minority ethnic
CCS	Community contraceptive services
CDSSHH	Common Data Set for Sexual Health and HIV
CPD	Continuous professional development
CSA	Children's Services Advisor
CYPP	Children and Young People's Plan
DCL	Director of Children and Learning
DCLG	Department for Communities and Local Government
DCS	Director of Children's Services
DfES	Department for Education and Skills
DH	Department of Health
ECM	Every Child Matters
GP	General practice
GUM	Genitourinary Medicine
HIV	Human Immunodeficiency Virus
HMT	Her Majesty's Treasury
HPA	Health Protection Agency
IMD	Index of Multiple Deprivation
KS4	Key stage 4
LAA	Local area agreement
LDP	Local development plan
MedFASH	Medical Foundation for AIDS & Sexual Health
NCSP	National Chlamydia Screening Programme
NHS	National Health Service
NICE	National Institute for Health and Clinical Effectiveness
PCT	Primary care trust
PSA	Public Service Agreement
PSHE	Personal, Social and Health Education
RTPC	Regional Teenage Pregnancy Coordinator
SEAL	
SEBS	
SfBH	Standards for Better Health
SH	Sexual health
SRE	Sex and Relationship Education
STI	Sexually transmitted infection
TOP	Termination of pregnancy
TPC	Teenage Pregnancy Coordinator
TPPB	Teenage Pregnancy Partnership Board
YP	Young people
YPDP	Young People's Development Programme

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