

Warrington

Joint Strategic Needs Assessment (JSNA)

Teenage Conception Chapter 2014 Update

December 2014

Version control

Version	Description of amendments	Date of amendment
1.0	Final version (replaces teenage conception chapter produced for JSNA 2011)	02/12/2014

The Joint Strategic Needs Assessment (JSNA) considers a wide range of factors that affect the health and wellbeing of the people of Warrington. The objective of the JSNA is to involve partner organisations, such as the local NHS, local authorities, Police, Fire and third sector organisations in order to provide a top level, holistic view of current and future need within the borough. The JSNA is used to agree key priorities to improve the health and wellbeing of all our communities at the same time as reducing health inequalities

EXECUTIVE SUMMARY

Introduction

Nationally, teenage pregnancy has received a great deal of focus in recent years and is regarded as a significant public health issue. Over the last 15 years, the number of young women becoming pregnant below the age of 18 has reduced substantially from the baseline set in 1998. Standards of sexual health and the promotion and awareness of it have improved, however, there is still work to be done on all fronts and it is still clear that further improvements can be made.

Addressing the problem of teenage pregnancy formed part of the previous government's policy to tackle health inequalities and social exclusion. The Social Exclusion Unit's report on Teenage Pregnancy was published in June 1999 (Social Exclusion Unit, 1999). The report set out two national targets relating to teenage pregnancy:

- To halve the under-18 conception rate in England by 2010¹.
- To increase the participation of teenage mothers in education, training or work to 60% by 2010 to reduce the risk of long-term social exclusion.

However, despite concerted efforts, progress on this target has been modest and the national target of a 50% reduction in teenage pregnancy rates by 2010 was not met. Despite falling rates since 1998 the UK still has one of the highest rates of teenage pregnancy in Western Europe. In England in 2012 just over 26,000 women under the age of 18 became pregnant.

¹ Based on conceptions occurring in 2010, data for which were made available in February 2012.

There are a number of factors that are reported to be associated with teenage pregnancy, including low self-esteem (Emler, 2001) and quality of sex and relationships education (Social Care Institute for Excellence, 2004). Teenage pregnancy is strongly associated with socio-economic deprivation. As stated by Botting et al. (1998), local areas experiencing high levels of material deprivation generally have the highest rates of teenage conceptions.

Dennison (2004) found that research suggests that teenage pregnancy is associated with a range of negative outcomes for both parent and child. The adverse outcomes affecting the child of teenage parents include poor health outcomes, low educational attainment and poorer long-term social and economic conditions (Moffitt, 2002).

There is a substantial economic argument for ensuring that young people have good sexual health. Poor sexual health places a significant burden on public services, in particular the National Health Service (NHS): the cost of teenage pregnancy to the NHS alone is estimated to be £63M a year. It is therefore crucial to ensure that prevention receives adequate investment, and those investments are targeted according to need.

Key Issues, Gaps and Progress since the last JSNA Chapter

Although long-term trends show a reduction in under-18 conception rates, within Warrington there is still work to do. Conception rates in the most deprived communities in Warrington are significantly higher than the rest of Warrington and that the rate of conception in the most deprived wards is showing a small, but steady increase. Positively however, the number of conceptions during 2012 was the lowest seen in Warrington over the 15 years this indicator has been monitored.

There is considerable variation in rates within Warrington, with some wards experiencing rates which are more than twice the Warrington average.

The proportion of conceptions leading to a termination is increasing, with over half of all conceptions to under 18's in Warrington teenagers currently resulting in a termination.

Area Based Grant funding for teenage pregnancy ceased in March 2011 and current financial constraints are likely to impact on the scale and range of delivery of interventions possible.

There has been a range of developments in this work area since the last JSNA Chapter was produced. The co-ordination of teenage pregnancy issues and work programmes has now moved from the Teenage Pregnancy Commissioners Group referred to in the previous JSNA Chapter, and this is now included within the remit of the Sexual Health Better Prevention Group Plan. This group has a broader remit around wider sexual health issues for both young people and adults and is taking the lead on devising strategies based on detailed needs assessments.

The Better Prevention Group consists of both commissioners and providers who possess the combined knowledge and skillset to really impact work on this agenda. Progress has been made on a number of issues relating to teenage conceptions:

- A detailed young person's needs assessment was undertaken in relation to sexual health during 2012 as per recommendations. This has led to a better understanding of young people's views of sexual health services;
- Social Marketing work was carried out by the Public Health Team, with youth service support, to gain a better understanding (via focus groups) the specific requirements of young people around service design, promotion and timing;
- Better Prevention Group was re-formed and established as the group to take forward the development of strategy and associated delivery plans;
A Young Person's Sexual Health Strategy 2013-2015 strategy was developed based on the findings from the needs assessment. The strategy has been ratified by partners and provides a clear direction for providers;
- The delivery plan has been developed, and identifies clear leads against the 5 key priority areas defined in the strategy. Work is under way to deliver the key aims set out in the strategy.

Recommendations for Commissioning

Recommendations from the last JSNA chapter suggested that a task group of key commissioners be established and accepted as the formal reporting route for teenage pregnancy issues to the Children and Young People's Partnership (CYPP).

This group was established, formulated a brief action plan and co-ordinated a variety of issues relevant to this work area to ensure that issues relating to teenage pregnancy had somewhere to be discussed. As has been outlined in the previous section, this work has now transferred to the Better Prevention group.

Key recommendations moving forward are as follows (many of these are taken directly from the recent needs assessment findings and make up the priorities for action within the Warrington Young People Sexual Health Strategy (Warrington Borough Council, 2012)):

- In line with best practice, develop and pilot enhanced sexual health/risk taking behaviour drop-ins sessions in targeted secondary schools (starting with areas with highest teenage conception rates) to provide an all-round holistic service offer to young people;
- Review arrangements for sexual health services in relation to contraceptive access, teenage parenting and counselling/advisory

services to ensure that young women are getting all round support along the pathway;

- Utilise the main findings from service provider post termination audits to further improve the pathway/service offered to young women in relation to post abortion support, counselling, referral and contraceptive choice;
- Evaluate the impact of work with young mums/families to understand where we are successful and not;
- Develop a bank of 'Youth Health Champions' in schools to ensure we promote vital agendas such as teenage pregnancy and good all round sexual health;
- Develop a wider network of trained staff across the C&YP workforce who can provide sound sexual health advice;
- Improve the quality and consistency of Sex & Relationships Education as part of PSHE in schools beginning with a secondary school PSHE leads upskill;
- Devise a robust sexual health and risk taking behaviour communications plan based on young people's feedback to ensure that we structure the way in which we communicate and raise awareness;
- Ensure the maintenance of access to Emergency Hormonal Contraception (EHC) and effectively promote where it is available for those not utilising longer-term methods;
- Reduce the need for young women to attend Youth Advice Shop or any other sexual health satellite for Emergency Hormonal Contraception (EHC) as they have chosen longer term safe methods;
- Actively promote the use of LARC (Long Acting Reversible Contraception) to enhance take up across the town;
- Review Warrington's C-Card scheme to ensure it is located in sites that are successful and that sound signposting advice is being given out;

In relation to governance structures and reporting frameworks:

- Report progress on the strategy and associated performance to the Healthy Child Sub-Group of the Children & Young People's Partnership, in order to maintain a clear relationship between the council as commissioners of these services and the providers delivering on the strategies and subsequent plans;
- Ensure that accountability for the Young People Sexual Health Strategy rests with the C&YP Partnership;
- Further development of the young people's sexual health dashboard to include wider indicators is required (eg. Add more outcome based and qualitative data capture as well as KPI's, Public Health Outcome Framework Outputs/datasets);

1) WHO IS AT RISK AND WHY?

There are a range of factors associated with teenage parenthood. According to a Health Development Agency (HDA, 2001) report there are a number of vulnerable groups who are at particular risk of teenage parenthood:

- Young people living in deprived areas
- Young people who do not attend school
- Young people who are looked after by, or who are leaving, local authority care services
- Young people who are homeless
- Young people who are the children of teenage parents
- Young offenders

1.1) Education: Low levels of educational attainment are strongly associated with high rates of teenage pregnancy. Kiernan (1995) reported that results of a national longitudinal study found that low educational attainment was the single most powerful factor associated with becoming a teenage parent, with poor performance at age 16 being the strongest predictor. However, as stated by Geronimus et al. (1992), the relationship between educational attainment and teenage pregnancy is complex and it is often difficult to establish whether poor educational performance is a cause or a consequence of teenage pregnancy.

Teenagers who become pregnant are more likely to drop out of school, missing a key phase of their education, leading to low educational attainment and no or low-paying, insecure jobs without training (Department of Health, 2011).

Teenage mothers are 20% more likely to have no qualification at age 30 than mothers giving birth aged 24 or over. Young mothers are also more likely to be lone parents, with their children raised in a home with one income and often living in sub-standard housing or temporary accommodation (Department of Health, 2011).

1.2) Child Poverty and Worklessness: Ermisch (2001) states that poverty, like teenage pregnancy, follows intergenerational cycles with children born into poverty at increased risk of teenage pregnancy, especially for young women living in workless households when aged 11-15. As stated by Ermisch and Pevalin (2003), children of teenage parents are far more likely to become parents in their teens themselves, with women born to a teenage mother twice as likely to become teenage mothers themselves.

The majority of teenage parents and their children live in deprived areas and often experience multiple risk factors for poverty, ie. experiencing poor health, social and economic outcomes and inter-generational patterns of deprivation (Ermisch and Pevalin, 2003).

Hobcraft and Kiernan (1999) found that teenagers living in low-income households are far more likely to become pregnant than their more affluent

peers. The greater the level of poverty experienced during childhood the greater the likelihood of becoming pregnant as a teenager, with, as stated by Geronimus et al. (1992), the risk of teenage pregnancy declining as the income in the woman's parental household at age 16 increases.

Teenage mothers are more likely to partner with men who are poorly qualified and more likely to experience unemployment (Department of Health, 2011). Penhale (1897) found that economic inactivity is strongly associated with increased risk of teenage pregnancy and, in describing the link between unemployment and teenage pregnancy, it has been suggested that motherhood may be seen as a 'job description' for women with poor employment prospects.

Teenage pregnancy is strongly associated with socio-economic deprivation. In keeping with the national picture, within Warrington, the wards experiencing the highest levels of deprivation also have the highest rates of teenage conceptions.

1.3) Safeguarding: The Teenage Pregnancy National Support Team, Department of Health (2011) state that many young women suffer a high level of violence/abuse in their relationships. Ermisch and Pevalin (2003) report that international research findings demonstrate connections between sexual abuse, coercion, intimate partner violence and teenage conception rates. Recently published research from the UK, by Coy et al. (2010), has shown clear links between teenage pregnancy and non-consensual sex.

Girls who have been subjected to sexual abuse are more likely to become sexually active at a young age and have been found to be at specific risk of teenage pregnancy. The NHS Taskforce on Violence against Women and Children refers to teenage pregnancy as one of many impacts of abuse. Additionally, alcohol is often cited by young people as one of the factors that contribute to sexual activity they subsequently regretted.

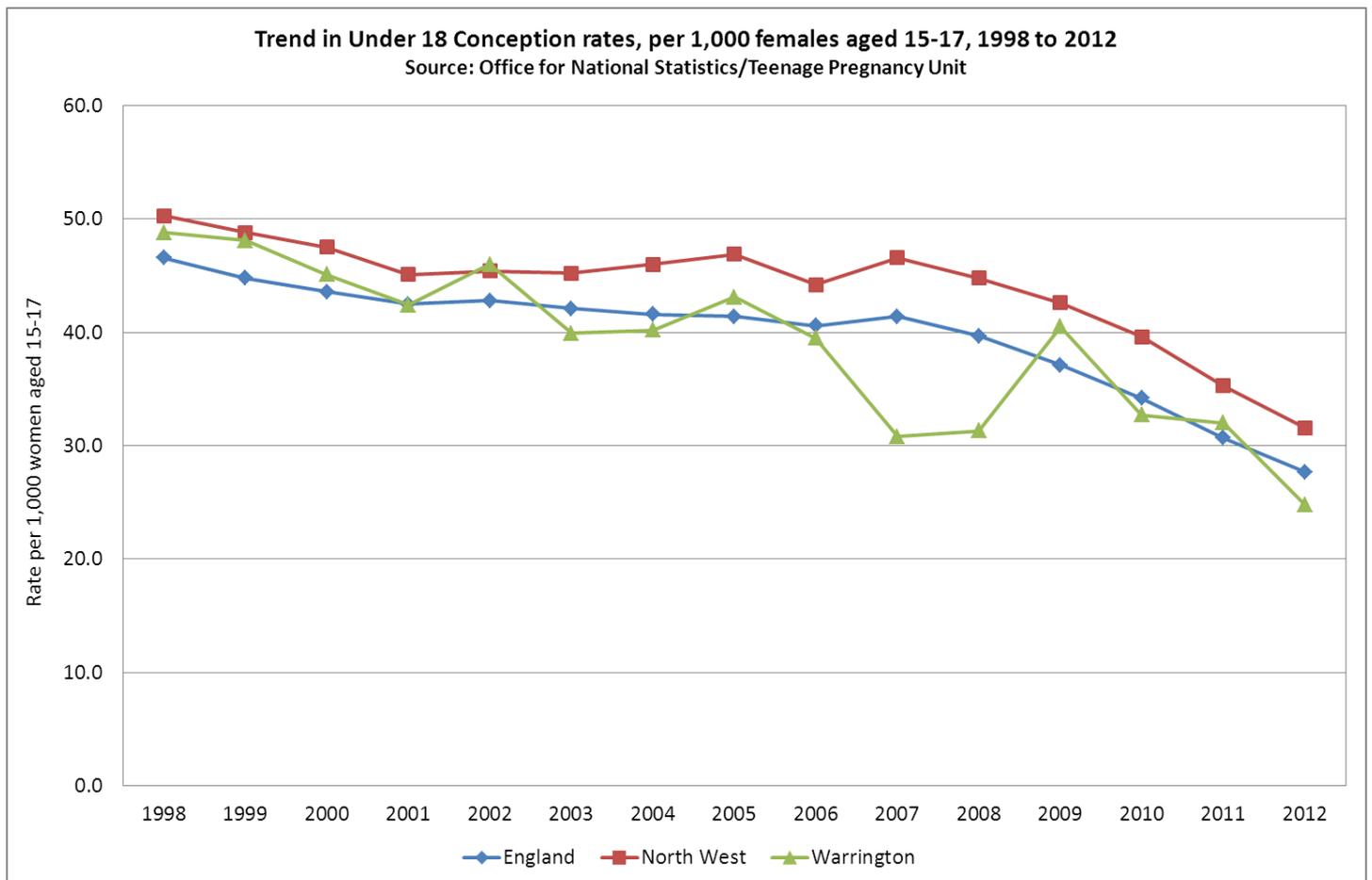
2) THE LEVEL OF NEED IN THE LOCAL POPULATION

2.1) Trend in Under-18 Conception Rates: In 2012, the under-18 conception rate for Warrington was 24.8 conceptions per 1,000 girls aged 15-17. This compares with a rate of 27.7 conceptions per 1,000 across England as a whole, and a rate of 31.6 per 1,000 for the North West.

Data for Warrington shows that the reduction in rates locally is similar to England and greater than regional averages. Measured using annual data (as was the previous National Indicator performance measure), there has been a 49% reduction in under-18 conception rates in Warrington over the period 1998-2012. This compares with a reduction of 37% for the North West, and 41% for England as a whole.

Care needs to be taken when interpreting recorded rates for individual years, given that the rate is based on relatively small numbers. On average, there are around 110 conceptions to females under the age of 18 in Warrington per year. As Chart 1 illustrates, this will result in annual fluctuations in rates. Although fluctuations are apparent in regional and national rates these are much less pronounced than those for Warrington, given the larger populations on which they are based.

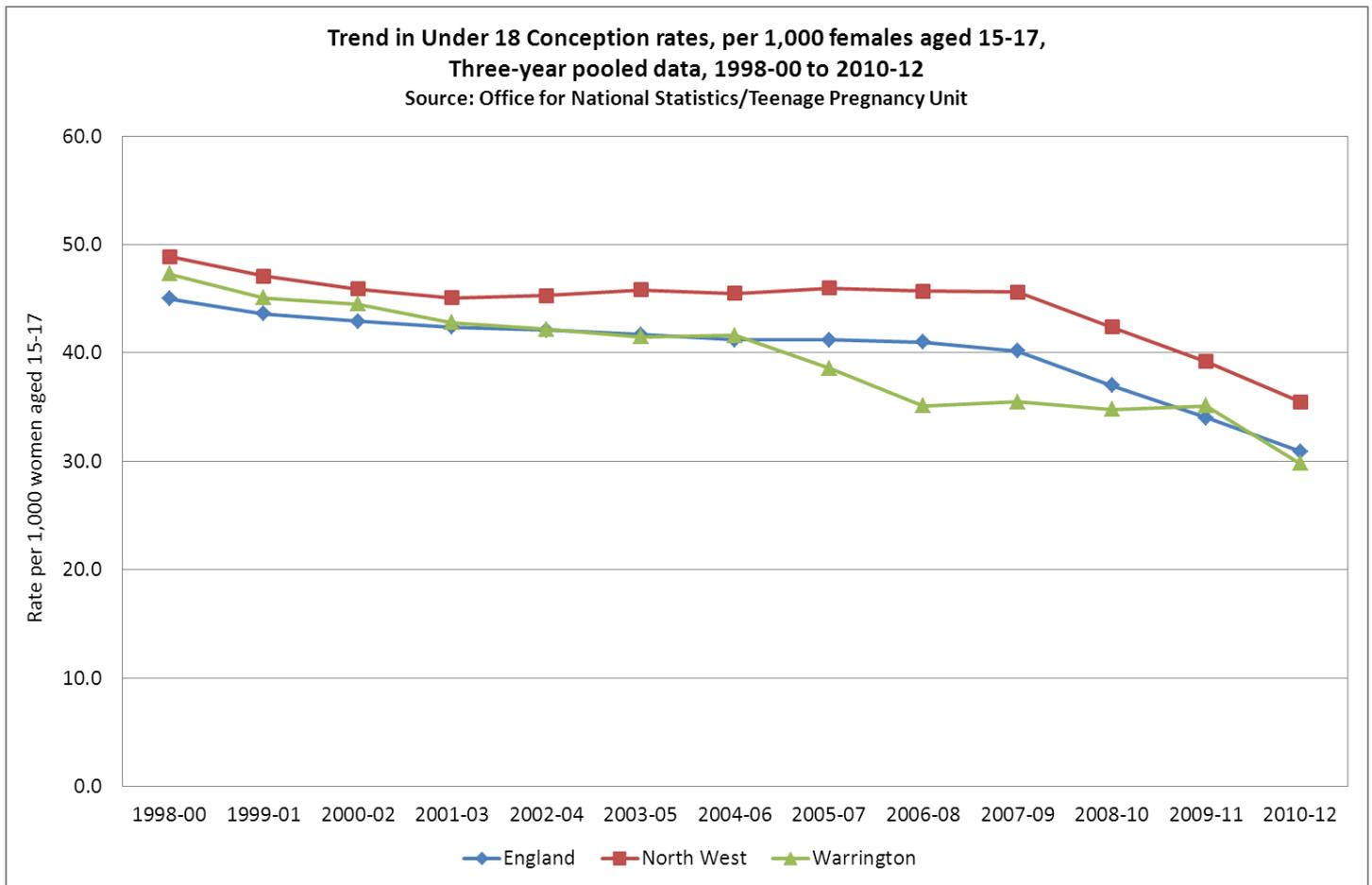
Chart 1: Trends in Teenage Conception Rates, 1998-2012



Monitoring teenage conception rates based on 3-year pooled data smoothes out some of the annual fluctuations and provides a greater number of events, thus narrowing the confidence intervals (CI²) and giving a more reliable estimate of the true underlying rate. Chart 2 presents the trend in teenage conceptions based on 3-year periods.

² Confidence Interval (CI) - Shows the range within which it is confident that the true result from a population will lie 95% of the time. The narrower the interval, the more precise the estimate. This is necessary because studies are conducted on samples and not entire populations.

Chart 2: Trend in Teenage Conception Rates, 3-year Periods 1998-00 to 2010-12



When percentage change is measured on 3-year pooled data, the picture locally is showing slightly better performance than what was that observed nationally. Across England the conception rate reduced by 31.3% between 1998-00 and 2010-12, whilst in Warrington the conception rate reduced by 37%.

2.2) Intra-Warrington Inequalities: The rate of teenage conceptions varies significantly at electoral ward level, mirroring the pattern of socio-economic deprivation. Electoral ward level teenage conception rates are released from the Office of National Statistics (ONS) on a three-year rolling aggregate basis.

The trend in the rate of teenage conceptions at ward level varies each year. This is due to the small numbers that occur at ward level each year. However, the teenage conception rate in the 20% most deprived wards in Warrington has consistently been statistically significantly higher than the overall Warrington rate. The following chart illustrates the trend in teenage conception rates in Warrington by deprivation quintile.

The chart also illustrates that there has been a steady (but not statistically significant) increase in the conception rate for girls from deprivation quintile 2.

Chart 3: Trend in teenage conception rates, by deprivation quintile

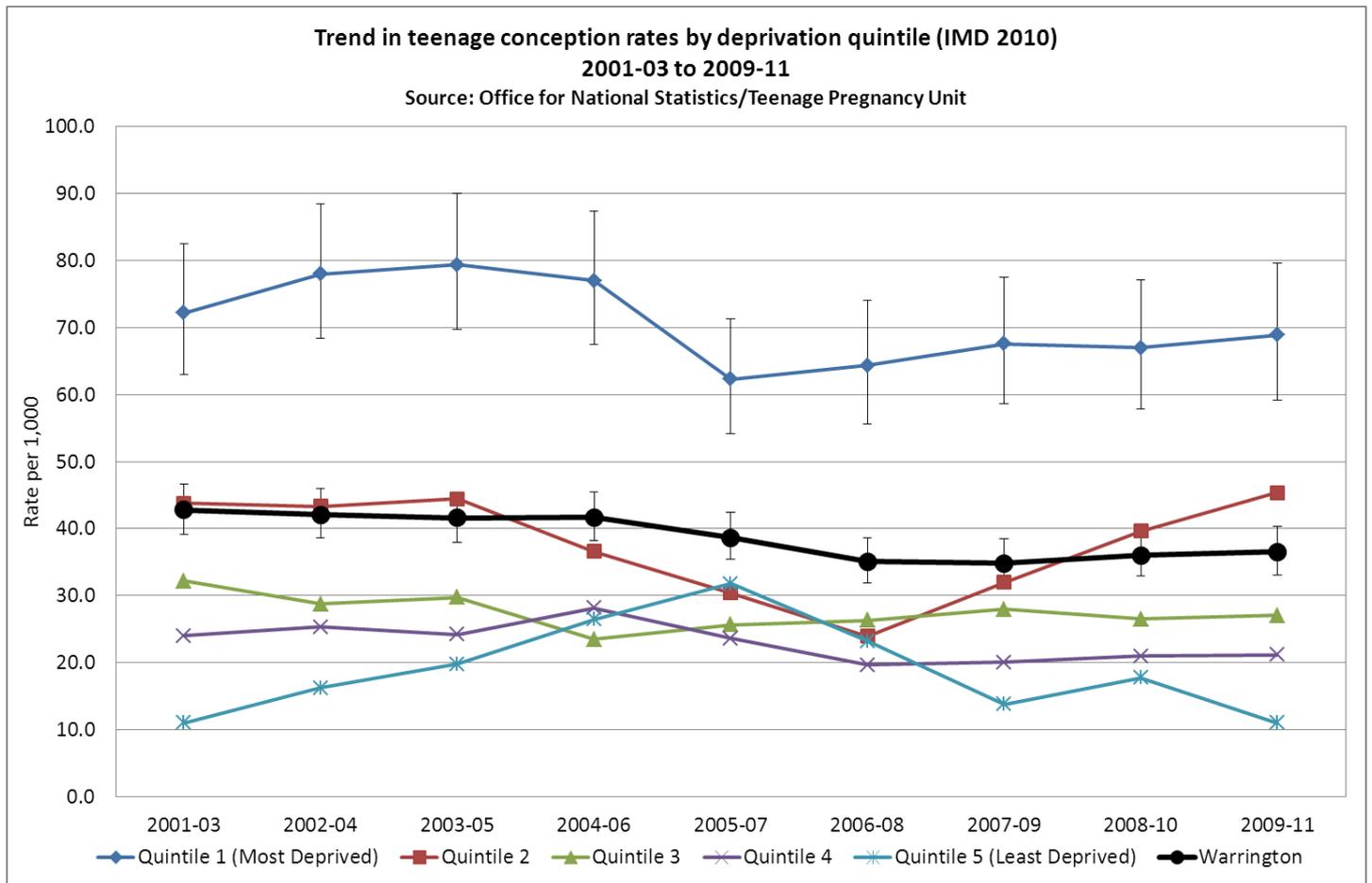
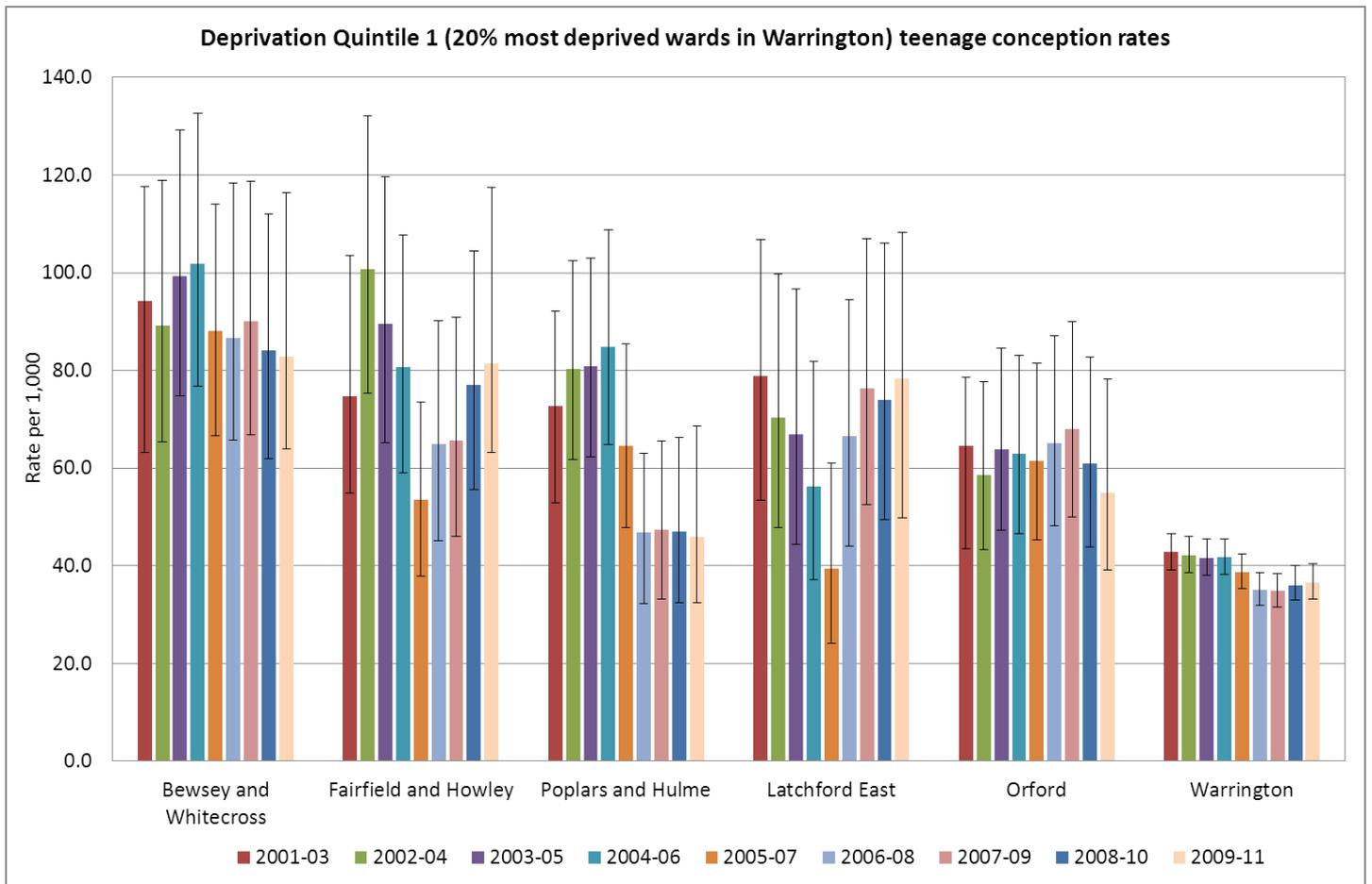


Chart 4 examines the trend in teenage conception rates for the wards that belong to deprivation quintile 1.

Chart 4: Teenage conception rates for wards in the most deprived quintile (deprivation quintile 1)



Source: Office of National Statistics

The wards which make up the most deprived quintile, presented in Chart 4, have been ordered from most deprived (Bewsey and Whitecross) to the least deprived (Orford) within deprivation quintile 1. The ward of Bewsey and Whitecross has experienced significantly higher teenage conception rates when compared to Warrington for every time period examined (2001-03 to 2009-11). The same is also observed for the ward of Fairfield and Howley, with the exception of 2005-07, when the conception rate was higher than Warrington, but not significantly.

The ward of Latchford East has seen an increase in conception rates in recent years. In Latchford East, a reduction in conception rates was observed between the years 2001-03 to 2005-07, but the conception rate increased, and has been significantly higher than Warrington since 2006-08.

Positively, the conception rate in Poplars and Hulme has reduced. For this ward, over the period 2001-03 to 2005-07 rates were significantly higher than Warrington, but since 2006-08 the conception rate for Poplars and Hulme has reduced and although still higher than Warrington, the difference has not been statistically significant.

2.3) Percentage Leading to Abortion: There has been an increase in the percentage of under-18 conceptions that lead to an abortion. Locally, during 1998, 38.5% of teenage conceptions resulted in a termination, whereas during 2012, this had increased to 53.3%. Across England as a whole, there have also been increases; approximately 42% of teenage conceptions ended in a termination during 1998 and the latest figures highlight that this has increased to 49%.

2.4) Under-16 Rates: There has been very little change in the rate of conceptions to girls under the age of 16 within Warrington. Over the period 2001-2003, there were 66 conceptions, equating to a rate of 5.8 per 1,000 girls aged 13-15. This was lower than the England rate for the same period (8.0 per 1,000). The latest data available for under-16 conceptions is for the period 2010-2012. Over this three year period there were 75 under-16 conceptions across Warrington, giving a rate of 6.8 per 1,000. For England as a whole, over the same period, the rate was 6.1 per 1,000. This suggests that in Warrington there has been a small but not statistically significant increase against a national decrease in under 16 conceptions.

2.5) LARC: The importance of access to appropriate contraception and sexual health services for young people has been emphasised in national guidance and best practice documents. LARC has the lowest failure rate compared to all other contraceptive methods as it does not rely on daily compliance and is cost effective. The percentage of females aged under-18 choosing Long Acting Reversible Contraception (LARC)³ at Community Sexual and Reproductive Health (CSRH) services is used as a proxy measure for wider access to the range of contraceptive methods.

3) CURRENT SERVICES IN RELATION TO NEED

Work on teenage pregnancy across Warrington has been overseen in previous years by the Children and Young People's Partnership (formerly the Children and Young People's Trust). Currently the planning and co-ordination has been guided by The Better Prevention Group as overseen by the Sexual Health Implementation group that monitor plans, progress, practice etc. The Warrington Sexual Health Implementation Group (SHIG), which has representatives from partner agencies across Warrington, continues to meet regularly and provides direction and oversight regarding the operational aspects of services related to teenage pregnancy. A small task group was established to review strategic and operational processes for teenage pregnancy and to establish an investment plan for 2012 onwards. This

³ *Long-acting, reversible contraceptives (LARCS) are a group of contraceptives that can provide longer-term cover (from a few of months to up to 10 years) with minimum maintenance. Examples include sub dermal implant, injection and hormonal coil.*

working group disbanded once the Young People sexual health strategy was approved.

A substantial amount of funding to support work around teenage pregnancy came from Area Based Grants. This funding ceased on 31st March 2012. Certain aspects of the teenage pregnancy work programme have been incorporated into mainstream funding. These include the Teenage Pregnancy Coordinator and Teenage Pregnancy Worker posts, which are both only on a part-time basis, thus reducing their capacity. In addition, the provision around Youth Advice drop-in sessions and information provision continue to be delivered from four sites across Warrington. The sites are fairly geographically spread, covering Central, East and South neighbourhoods. The central locations are good in terms of both the higher rates of conceptions in the central area of Warrington and the greater accessibility of the town centre area, given the current bus routes. The four sites are: the town centre Connexions building (Central), Birchwood High School (East), Priestley College (South), and the Orford Youth Base. Only two of these locations offer a full youth support and nurse led service (Priestley and the Town Centre). The other two sites are youth work led, Youth Advice sites with no clinical element.

4) PROJECTED SERVICE USE AND OUTCOMES

Service uptake is dependent on a number of factors and the relative contributions of the different elements of local strategies and action plans and their effect over time.

If the level of sexual activity in the population remains constant, increased uptake of effective contraception should reduce conceptions and the overall need for other services, such as terminations, housing and support. However, effects will be mixed, depending of the timing of the intervention and other trends, such as the increasing proportion of young women choosing to have a termination.

The population of young women is projected to decrease very slightly over the next five years. Population projections are not sensitive or accurate enough to be produced at electoral ward level by age-band. Thus, it is not possible to identify whether the projected decreases are within those wards with the highest teenage conception rates.

Projecting on existing trends in conception rates helps to show how future rates **might** be expected to change, based on past trends alone. Based on annual data for 1998 to 2009, this projection analysis suggests that rates within Warrington are decreasing at an average of approximately 1.11 conceptions per 1000 females per year, and that, by 2015, rates may be expected to be around 30 per 1,000 females aged 15-17.

There are, however, considerable limitations to these projections. The R-squared value for this analysis is 0.57, indicating that the regression model is

not perfect, given the annual fluctuations in rates, and that projections may not be reliable⁴.

In addition, projections on the basis of past trends will only serve as a predictor of future values if determinates of teenage conceptions remain static over time. This method clearly does not take into account the impact of future local interventions and policies.

Further work is needed to look at the level of service activity undertaken locally, with the aim of better understanding potential, future levels of service, and the impact of this upon outcomes such as education and employment, as well as on teenage conceptions.

5) EVIDENCE OF WHAT WORKS

Assessing the impact of local interventions aimed at reducing teenage conceptions is difficult as there is an unavoidable delay in reporting conception rates and many of the important interventions are expected to impact over the medium- and longer-term. However, there is national and international evidence on what aspects are most effective in reducing teenage pregnancy.

The factors influencing teenage pregnancy are complex and there is no single intervention which is effective in reducing teenage pregnancy. Instead, it is recommended that a strong partnership approach is needed to drive and deliver a range of local interventions. The Department of Health's report in 2011, by the Teenage Pregnancy National Support Team (TP NST), lists a number of essential factors that need to be in place to reduce teenage pregnancy rates as part of work to improve a range of outcomes for young people (Department of Health, 2011). These factors are discussed below.

5.1) Strategic Leadership, Performance Management and Governance of the Teenage Pregnancy Strategy: *The Teenage Pregnancy Strategy: Beyond 2010* (Department of Health and Department for Children, Schools & Families, 2010) set out the plan to build on the previous strategy and work to meet the 2010 target, in order to achieve a sustained reduction in rates post-2010. The Strategy highlights that the three most important aspects of what works in reducing teenage pregnancy are high quality Sex and Relationships Education (SRE), easy access to youth-centred contraceptive services, and early intervention to target young women that are at the greatest risk of pregnancy. The TP NST (Department of Health, 2011) cites Brighton and Hove as a good example of how to do this.

⁴ In a regression analysis, the R-squared value is a statistical measure of how well the regression line fits real data points and, therefore, how accurate the predictive model might be. A value of 1 indicates a perfect fit and a reliable predictive model. A number nearer to zero indicates a poor fit.

5.2) Effective Use of Data to Support Commissioning: Whilst it is recognised that assessing the impact of local interventions aimed at reducing teenage conceptions is difficult, the TP NST (Department of Health, 2011) recommends the approach taken in Salford, where a Teenage Pregnancy and Sexual Health Dashboard has been developed. The dashboard has a collection of key proxy indicators aimed at monitoring progress in the shorter term.

5.3) Youth-Centred Contraceptive Services: The TP NST report (Department of Health, 2011) mirrors the Teenage Pregnancy Strategy finding that one of the three key aspects of what works is easy access to youth-centred contraceptive services. A number of examples of services are given including school services (Bradford), young people's sexual health outreach services (Bristol) and specialist nurse outreach (Berkshire West PCT) and the county-wide condom distribution scheme (Nottinghamshire).

A review of reviews has established that increasing the availability of contraceptive clinic services for young people is associated with reduced pregnancy rates (Jepson, 2000).

Research reported by the NHS Centre for Reviews and Dissemination (1997) and Kirby et al. (1994) shows that availability of youth-based contraceptive services in a locality is associated with lower conception rates.

The Health Development Agency (HDA, 2001) state that successful service interventions will be those which improve the quality of provision in the following areas (Meyrick and Swann, 1998; Aggleton et al., 1996; Peckham et al., 1996):

- Confidentiality – This is a key concern for young people. Services should be confidential and be perceived as such by young people.
- Awareness – Promotional materials should accurately describe the services available and must be needs-based, i.e. specifically designed for and effectively disseminated to local young people.
- Acceptance – Policies, practices and staff attitudes should be non-judgemental, friendly and supportive of young people's choices.
- Flexibility – Young people should be able to attend with friends and should be able to access a wide range of services without having to make an appointment.
- 'Time to Talk' – Access to a trained counsellor or health advisor should be routinely available for young people who wish to discuss any health and relationship issues.
- Targeted – Services should be targeted for boys and young men, to increase uptake.

5.4) Workforce Development: The TP NST review found two examples of good practice in relation to workforce development. These were multi-agency tiered training programmes (Hampshire) and Workforce Development in Relations and Sex Education and Supporting Teenage Parents (Warwickshire).

5.5) Sex & Relationships Education: Another TP NST finding (Department of Health, 2011) that mirrors one of the three key aspects of the Teenage Pregnancy Strategy, in relation to what works, is the sex and relationship education database (North Lincolnshire). Previously, a review of reviews carried out by the Medical Research Council demonstrated that school-based sex education can be effective in reducing teenage pregnancy, especially when linked to access to contraceptive services (Jepson, 2000).

Educational interventions can reach most young people under the age of 16 and can be associated with a delay in first intercourse and with increased condom and other contraceptive use (Jepson, 2000; NHS Centre for Reviews and Dissemination, 1997).

A review of the most reliable evidence shows that school-based sex education does not increase sexual activity or pregnancy rates (Department of Health & Department for Children, Schools & Families, 2010).

A review of effective sex education programmes in the USA' by Card (1999) showed that they shared nine important characteristics:

- Focus clearly on reducing one or more sexual behaviours that lead to unintended pregnancy or STI/HIV/AIDS infection.
- Incorporate behavioural goals, teaching methods and materials that are appropriate to the age, sexual experience and culture of students.
- Are based on theoretical approaches that have been demonstrated to be effective in influencing other health-related risky behaviours.
- Allow sufficient time for presentation of information.
- Provide basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse.
- Use a variety of teaching methods designed to involve the participants and help them personalise the information.
- Include activities that address social pressures related to sex.
- Provide models of, and practice in, communication, negotiation and refusal skills.
- Select teachers or peers who believe in the programme and then provide them with training, which includes practice sessions.

In 2001, the HDA found that the best available evidence (Oakley et al., 1994; Oakley et al., 1995) also suggests that successful approaches to school-based risk-reduction interventions are:

- **Timely**, initiated early, before patterns of behaviour are established. One large-scale survey in this country undertaken by Wellings et al., (1996) found that two-thirds of the population thought they should have been better informed about sex before they started being sexually active. In July 2000, the Department for Education and Employment issued guidance to all schools, including primary schools, recommending that they should have an age-appropriate sex and relationships education programme which is rooted in the PSHE framework.
- **Positive** about young people, about sex and sexuality, and about young people's relationships.
- **Integrated** education about sexual and reproductive health issues is planned and delivered as a comprehensive and cohesive programme, with strong links between services and 'joined-up' service planning and provision. Effectiveness has been clearly demonstrated when school sex education is linked with local contraceptive services;
- **Practical**, up-to-date information about local contraceptive and sexual health services is included (i.e. what is available, when and where, who can use the service, how to get there).
- **Set in a Social Context**. Activities are designed to address gender issues, social and cultural stereotypes, and power inequalities.
- **Needs-Led** content, approach and direction are determined by what young people say they need.

Peer education (young people imparting information to others of a similar age) has been recognised as a promising approach in sexual health education. One review has found some evidence to support the effectiveness of peer-delivered health promotion for young people (EPI Centre Report, 1999). However, there is considerable variation in the way it is used (such as one-off sessions, theatre presentations and conferences), which, along with the fact that the effectiveness of peer sex education has not been extensively researched, means that it should be used with caution.

The HDA (2001) found that successful projects appear to be fairly small and focused on clear outcomes, with clearly stated aims and objectives. It is also thought that peer education can be an effective strand in a multi-component programme (Peckham et al., 1996).

5.6) Targeted Prevention Work with Young People at Risk: This is a restatement of one of the three key aspects of the Teenage Pregnancy Strategy (early intervention to target young women at greatest risk of pregnancy), in relation to what works. There are two examples cited by the TP NST; one is the early identification of (and intervention with) young people in Stoke-on-Trent and the other is the teens and toddlers programme from the London Borough of Brent.

Research evidence suggests (Jepson, 2000) that interventions that are tightly focused and targeting one particular vulnerable social group are likely to be effective.

5.7) Issues in Contraception: The National Institute for Health and Clinical Excellence (NICE, 2005) state that there is evidence that Long Acting Reversible Contraceptive methods (intrauterine devices, such as the coil, the intrauterine system, injectable contraceptives and implants) are more cost effective than the combined oral contraceptive (OC) pill, particularly in the client group least likely to comply effectively with oral contraception.

The NICE guidance has been problematic to implement in practice as, although it is undoubtedly true that LARC is not only likely to be more effective than OC, and more likely to be cost effective, it does require large resources to pump prime its implementation. Most of the costs are related to training primary care workers to deliver the intervention widely enough to deliver significant volume.

6) (TARGET) POPULATION/SERVICE USER VIEWS

Warrington Youth Council's Manifesto (IMPACT, 2010) provided key 'User Views' that highlighted the needs and experiences of young people in Warrington (key points below):

- 1,618 young people cited better promotion of Sex and Relationships Education (SRE) as the most pressing issue that needs tackling to effectively provide key information and advice around sexual health (including teenage pregnancy related issues).
- Sexual health services, such as the Youth Advice Shop (YAS), need to be better published and promoted to young people. Key advice and support, including access to free contraception, is provided here.
- There is a need to greater promote the YAS in schools where need is high in relation to teenage pregnancy.
- There is a need to encourage all schools to deliver drugs and alcohol awareness, SRE, teenage pregnancy and mental health awareness by a specialist worker.
- School Health Advisers should be available in all schools on a regular basis and should be approachable to young people.
- More accessible health advice and counselling needs to be in place in schools across Warrington. This should include advice around teenage pregnancy and contraception.
- Standardise job criteria of School Health Advisers so they are able to provide first aid, counselling, support and, crucially, advice around sex and contraception.
- 95% of respondents to a recent health improvement (HIMP) survey (16-17 age category) felt that colleges, schools and youth centres were the most effective way to raise awareness of sexual health issues and services.

Further pieces of work have been undertaken to more effectively understand what young people want and how they wish services that impact this agenda to be delivered.

During 2012 Warrington's Public Health Team led on a Social Marketing exercise, which saw a range of focus groups run in a co-ordinated fashion with youth groups across the town. Some of the key comments/findings were:

- In discussing reliability of sources, parents were considered reliable but embarrassment was cited as a barrier to information seeking or sharing. Friends were generally considered less reliable although value was placed on their advice if they were 'experienced';
- Varied levels of understanding were reported in relation to sex and relationships, STIs, contraception and drugs and alcohol, linked by participants to their experiences of the PSHE curriculum;
- Youth workers identified as acceptable sources for advice and support, perceived as non-judgemental and approachable;
- Clear rejection by many participants of GP as source of sexual health advice or support due to such concerns as embarrassment, confidentiality relating to surgery staff and privacy relating to other patients;

In relation specifically to PSHE & SRE delivery:

- The delivery and content of SRE lessons varied considerably however the majority of participants reported not having covered relationships in any PSHE classes;
- Perception amongst large number of focus group participants that teachers generally appeared awkward and uncomfortable delivering these lessons.

In relation to service type and location specifically:

- Clear message from participants that a one stop shop approach, whereby a variety of services would be provided in one place, would address issues of embarrassment and fear of being seen going in to sexual health specific service;
- Participants identified the need to be advised and supported by properly trained workers however there was a general agreement across focus groups that young people could feel most relaxed discussing issues with youth workers.

In relation to promotion of services and awareness:

- Raising awareness and understanding about how and where to access young people's services, general feeling that current services were not advertised widely enough;

- Need to 'advertise' the process i.e. what happens when you go to these places, who will you talk to, what will they do.

7) UNMET NEEDS AND SERVICE GAPS

There is a need to increase uptake of LARC and work needs to be undertaken to establish a baseline assessment, review of removal rates, training needs assessment and marketing campaign. See NICE Clinical Guideline CG30.

There is still currently, no Personal Social Health Education (PSHE) Continued Professional Development (CPD) training taking place in Warrington. However, work has begun as part of the strategy to provide training to teachers delivering PSHE, which will incorporate modules such as SRE as mentioned in the commissioning recommendations section.

Greater coordination of delivery of PSHE training for teachers and school staff is needed, to ensure that skills and knowledge remain up to date. Work is underway amongst professionals working on the young people risky behaviour agenda to coordinate the various training offers to schools and provide support where necessary.

There is a need to re-establish the service (sexual Health satellite session) delivered in Warrington Collegiate as they have been identified as a group in need in the recent needs analysis.

8) RECOMMENDATIONS FOR COMMISSIONING

Recommendations from the last JSNA chapter suggested that a task group of key commissioners be established and accepted as the formal reporting route for teenage pregnancy issues to the Children and Young People's Partnership (CYPP).

This group was established, formulated a brief action plan and co-ordinated a variety of issues relevant to this work area to ensure that issues relating to teenage pregnancy had somewhere to be discussed. As has been outlined in the previous section, this work has now transferred to the Better Prevention group.

Key recommendations moving forward are as follows (many of these are taken directly from the recent needs assessment findings and make up the priorities for action within the Warrington Young People Sexual Health Strategy (Warrington Borough Council, 2012)):

- In line with best practice, develop and pilot enhanced sexual health/risk taking behaviour drop-ins sessions in targeted secondary schools (starting with areas with highest teenage conception rates) to provide an all-round holistic service offer to young people;

- Review arrangements for sexual health services in relation to contraceptive access, teenage parenting and counselling/advisory services to ensure that young women are getting all round support along the pathway;
- Utilise the main findings from service provider post termination audits to further improve the pathway/service offered to young women in relation to post abortion support, counselling, referral and contraceptive choice;
- Evaluate the impact of work with young mums/families to understand where we are successful and not;
- Develop a bank of 'Youth Health Champions' in schools to ensure we promote vital agendas such as teenage pregnancy and good all round sexual health;
- Develop a wider network of trained staff across the C&YP workforce who can provide sound sexual health advice;
- Improve the quality and consistency of Sex & Relationships Education as part of PSHE in schools beginning with a secondary school PSHE leads upskill;
- Devise a robust sexual health and risk taking behaviour communications plan based on young people's feedback to ensure that we structure the way in which we communicate and raise awareness;
- Ensure the maintenance of access to Emergency Hormonal Contraception (EHC) and effectively promote where it is available for those not utilising longer-term methods;
- Reduce the need for young women to attend Youth Advice Shop or any other sexual health satellite for Emergency Hormonal Contraception (EHC) as they have chosen longer term safe methods;
- Actively promote the use of LARC (Long Acting Reversible Contraception) to enhance take up across the town;
- Review Warrington's C-Card scheme to ensure it is located in sites that are successful and that sound signposting advice is being given out;

In relation to governance structures and reporting frameworks:

- Report progress on the strategy and associated performance to the Healthy Child Sub-Group of the Children & Young People's Partnership, in order to maintain a clear relationship between the council as commissioners of these services and the providers delivering on the strategies and subsequent plans;
- Ensure that accountability for the Young People Sexual Health Strategy rests with the C&YP Partnership;
- Further development of the young people's sexual health dashboard to include wider indicators is required (eg. Add more outcome based and qualitative data capture as well as KPI's, Public Health Outcome Framework Outputs/datasets);

9) RECOMMENDATIONS FOR NEEDS ASSESSMENT WORK

There is still a need to undertake a contraception baseline assessment and a training needs assessment for primary care staff to ascertain workforce development needs.

Continued local qualitative research around young people's needs would help further develop understanding of issues in local areas with sustained high rates of conception. Increased knowledge and insight would help better inform targeted interventions with key groups at greatest risk of teenage pregnancy. This type of work would also greatly enhance our understanding of other wider issues affecting young people's ability to access services and hence have an impact upon not just teenage pregnancy but the prevalence of sexually transmitted infections (STI's) and other issues.

There are also cultural and ethnic differences in attitudes to teenage pregnancy. Warrington has a relatively small, but increasing, ethnic minority population. As numbers increase, further work may be needed to investigate any differences in attitudes between ethnic groups.

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