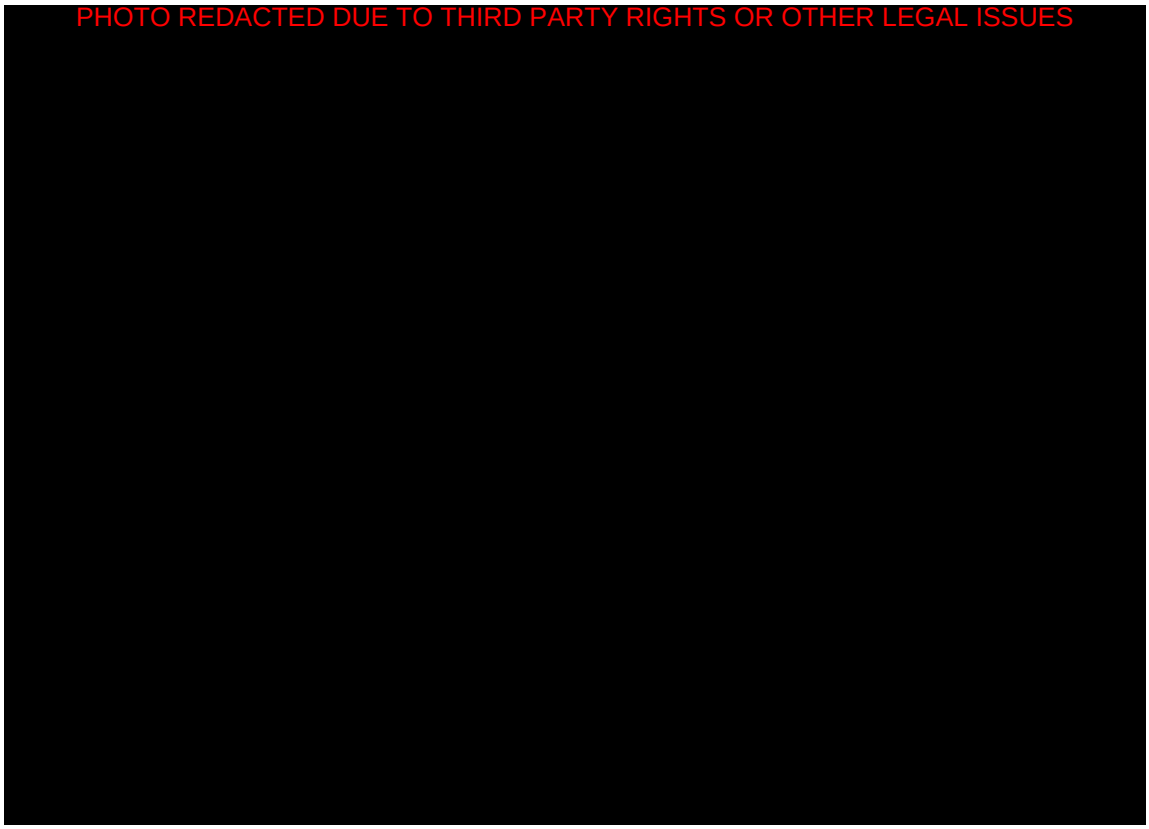
Teenage Pregnancy Next Steps: Guidance for Local Authorities and Primary Care Trusts on Effective Delivery of Local Strategies



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Change For Children

NON-STATUTORY GUIDANCE

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Contents

1. Executive Summary

1.1 Since the launch of the Teenage Pregnancy Strategy in 1999, steady progress has been made overall on reducing under-18 and under-16 conception rates, to the point where both are now at their lowest level for 20 years. But UK rates are still much higher than comparable EU countries, and we need to accelerate progress if we are to achieve the challenging target to halve the under-18 conception rate by 2010.

1.2 The progress achieved nationally, however, masks significant variation in local area performance. Those areas which effectively implemented their strategies with a prompt start are seeing significant reductions. But in other areas, Teenage Pregnancy has not been given sufficient priority either within the area as a whole or among key parts of the delivery chain. If all areas were performing as well as the top quartile, the national reduction would be 23% – more than double the 11.1% reduction that has actually been achieved.

1.3 This document states the rationale for the teenage pregnancy strategy, highlighting the short and long-term consequences of early parenthood in terms of poorer health and education outcomes for teenage mothers and their children. It makes the financial case for investing in measures to prevent early pregnancy and presents evidence on which young women get pregnant early and the underlying factors that affect both young people's sexual behaviour and the outcomes that result from it. While confirming the strong link to deprivation, it demonstrates that a range of other factors – in particular poor educational attainment and low aspiration – have an impact over and above deprivation levels.

1.4 It sets out in detail what we know about what has worked in areas with declining rates, based on findings from in-depth reviews in a number of areas with both good and poor performance in reducing teenage pregnancies. These 'deep dive' reviews, carried out by the Teenage Pregnancy Unit and members of the Independent Advisory Group on Teenage Pregnancy, looked at the key features of local strategies in areas where rates have reduced significantly and compared and contrasted their experience with what was

happening in statistically similar areas, where rates were static or increasing. The key factors contributing to success are set out in chapter 5.

1.5 In summary, successful local areas were characterised by the following factors, which confirm the evidence base for the strategy:

- Active engagement of all of the key mainstream delivery partners who have a role in reducing teenage pregnancies – Health, education, Social Services and Youth Support Services – and the voluntary sector;
- A strong senior champion who was accountable for and took the lead in driving the local strategy;
- The availability of a well publicised young people-centred contraceptive and sexual health advice service, with a strong remit to undertake health promotion work, as well as delivering reactive services;
- A high priority given to PSHE in schools, with support from the local authority to develop comprehensive programmes of sex and relationships education (SRE) in all schools;
- A strong focus on targeted interventions with young people at greatest risk of teenage pregnancy, in particular with Looked After Children;
- The availability (and consistent take-up) of SRE training for professionals in partner organisations (such as Connexions Personal Advisers, Youth Workers and Social Workers) working with the most vulnerable young people; and
- A well resourced Youth Service, providing things to do and places to go for young people, with a clear focus on addressing key social issues affecting young people, such as sexual health and substance misuse.

1.6 In order to make a lasting and positive impact on teenage pregnancy rates, all areas need to ensure all of the above measures are being implemented fully, and mainstreamed within their Children & Young People Plans. The key purpose of this document, therefore, is *to seek each area's commitment* to review their local strategies against the deep dive findings. Chapter 6 of this document sets out what arrangements we expect to be in place in each area and sets out what support we will be providing nationally to help areas to reach this position. A detailed self-assessment tool will be issued in October to help areas review their strategies ahead of this autumn's round of Priorities Conversations. In chapter 7, we set out how we will support and challenge local areas, with a focus on turning around performance in areas with high and increasing rates.

1.7 But as the analysis in chapter 4 makes clear, while effective delivery of local strategies is essential in making further progress, it is not the whole answer to reducing teenage pregnancy rates down to the levels of our Western European neighbours. The analysis demonstrates that as well as having the *means* to avoid early pregnancy – knowledge

and skills in relation to sex and relationships, easy access to contraceptive and sexual health advice and support etc – some young people also need the *motivation* to pursue further learning or a career, rather than to choose or accept early parenthood as the only passport to adulthood.

1.8 The analysis in chapter 4 provides compelling evidence that a range of underlying factors impact on the likelihood of early pregnancy. It demonstrates the well known link between deprivation and teenage pregnancy, but goes on to show that deprivation is not the only factor. In particular, it shows the strong links between leaving school at 16 with no qualifications, and early and risky sexual behaviour – which in turn impacts on the likelihood of early pregnancy. Chapter 4 also provides detailed analysis on other significant underlying risk factors.

1.9 This analysis of underlying risk factors is designed to help local areas to target their teenage pregnancies on young people most at risk. But it also demonstrates that action to tackle the root causes of teenage pregnancy needs further consideration. This document does not set out new measures to improve attainment, attendance at school and post-16 participation. We will, however, be returning to these issues later this year when we publish a broader strategy document setting out what action we will be taking to improve the life chances of those at risk of teenage pregnancy.

2. Introduction

2.1 The Government's Teenage Pregnancy Strategy, launched by the Prime Minister in 1999, required all local authorities to have measures in place to meet local reduction targets. The strategy is working – the England under-18 conception rate has fallen steadily, resulting in an 11.1% decline between 1998 and 2004. But individual areas have had contrasting success in reducing rates – some have seen impressive reductions of over 40%, while in other areas rates have increased, in some cases significantly. If all areas had performed as well as the top quartile, the England rate would have fallen by 23% – more than double the current rate of decline and well above the trajectory needed to achieve the PSA target. A table showing changes in conception rates between 1998 and 2004, for each top-tier local authority, are provided at annex 1.

2.2 While the strategy has made significant progress – both under-18 and under-16 conception rates are now at their lowest levels since the mid-1980s – we need to accelerate it if we are to achieve the ambitious target to halve the under-18 conception rate by 2010. While the interim target of a 15% reduction in conception rates by 2004 was achieved for under-16s, it was not met for under-18s.

2.3 During the first 6 years of the strategy, we have learnt a great deal about what approaches are effective in reducing teenage pregnancy. We also have a much better understanding about the wider social and cultural problems associated with teenage pregnancy and about the location and character of teenage pregnancy "hotspots".

2.4 This document sets out the lessons we have learnt since the strategy began, in particular, the findings from in-depth reviews carried out by the Teenage Pregnancy Unit in 2005. These reviews identified the key things that are happening in successful areas, which were absent or being delivered less intensively in the (statistically similar) comparison areas. It demonstrates the importance of focused and sustained delivery of all aspects of the strategy and engagement of all key partners.

2.5 It also provides new analysis on the underlying causes of teenage pregnancy, so that areas can – in an increasingly sophisticated way – target their strategies on those young people who are at greatest risk. It re-affirms the Government's commitment to the teenage pregnancy strategy and sets out how we will develop it further in the light of the findings from the in-depth reviews, new research and analysis.

2.6 This document focuses specifically on the action needed by LAs and PCTs to achieve the 50% conception rate reduction target. However, support to improve outcomes for teenage parents and their children will continue to be an essential part of the wider teenage pregnancy strategy. We will set out later in the year how we will build on the current approach to supporting teenage parents, through Children's Centres and targeted youth support, and how we will further develop the teenage pregnancy strategy.

3. Why teenage pregnancy matters

Summary

This chapter sets out the rationale for the teenage pregnancy strategy.

Local areas need to:

note the poor outcomes experienced by young mothers and their children;

ensure that senior managers through to front line professionals understand that reducing teenage pregnancy is a priority; and

recognise that actions to reduce teenage pregnancy represent an important 'invest to save' measure.

3.1 Teenage pregnancy is a serious social problem. Having children at a young age can damage young women's health and well-being and severely limit their education and career prospects. While individual young people can be competent parents, all the evidence shows that children born to teenagers are much more likely to experience a range of negative outcomes in later life. Children born to teenage parents are also much more likely, in time, to become teenage parents themselves. While the negative consequences of teenage pregnancy are felt most by young women and their children, it is important that strategies to reduce teenage pregnancy also impact on young men's attitudes and behaviour.

3.2 Each year, around 39,000 girls under-18 become pregnant in England. These pregnancies occur throughout the country – although they are much more likely to occur in deprived neighbourhoods. Nearly every local authority has at least one "hotspot" neighbourhood, where more than 6% of girls aged 15-17 become pregnant every year. The overwhelming majority of under-18 conceptions are unintended and around half lead to an abortion.

3.3 The facts are stark:

- Teenage mothers are less likely to finish their education, and more likely to bring up their child alone and in poverty;
- The infant mortality rate for babies born to teenage mothers is 60 per cent higher than for babies born to older mothers;
- Teenage mothers are more likely to smoke during pregnancy and are less likely to breastfeed, both of which have negative health consequences for the child;
- Teenage mothers have 3 times the rate of post-natal depression of older mothers and a higher risk of poor mental health for 3 years after the birth;
- Children of teenage mothers are generally at increased risk of poverty, low educational attainment, poor housing and poor health, and have lower rates of economic activity in adult life.
- Rates of teenage pregnancy are highest among deprived communities, so the negative consequences of teenage pregnancy are disproportionately concentrated among those who are already disadvantaged;

3.4 Teenage pregnancy is, therefore, a key inequality and social exclusion issue. But there is also a strong economic argument in investing in measures to reduce teenage pregnancy, which 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.
- Benefit payments to a teenage mother who does not enter employment in the three years following birth can total between £19,000 and £25,000 over three years.
- Teenage mothers will be much more likely than older mothers to require targeted support from a range of local services, for example to help them access supported housing and/or re-engage in education, employment and training.

3.5 Broad estimates suggest that every pound spent on the Strategy saves approximately £4 to the public purse, when assessed over a period of 5 years.

4. Who gets pregnant and why?

Summary

This chapter presents new analysis on the characteristics of young people who are at higher risk of becoming a teenage parent and the factors that contribute to that increased risk.

Local areas need to:

use the analysis to identify young people most at risk of early pregnancy and target delivery of their local strategy more intensively on these groups;

recognise the overlapping risk factors and use this information to inform the targeted support elements within their Children and Young People Plans; and

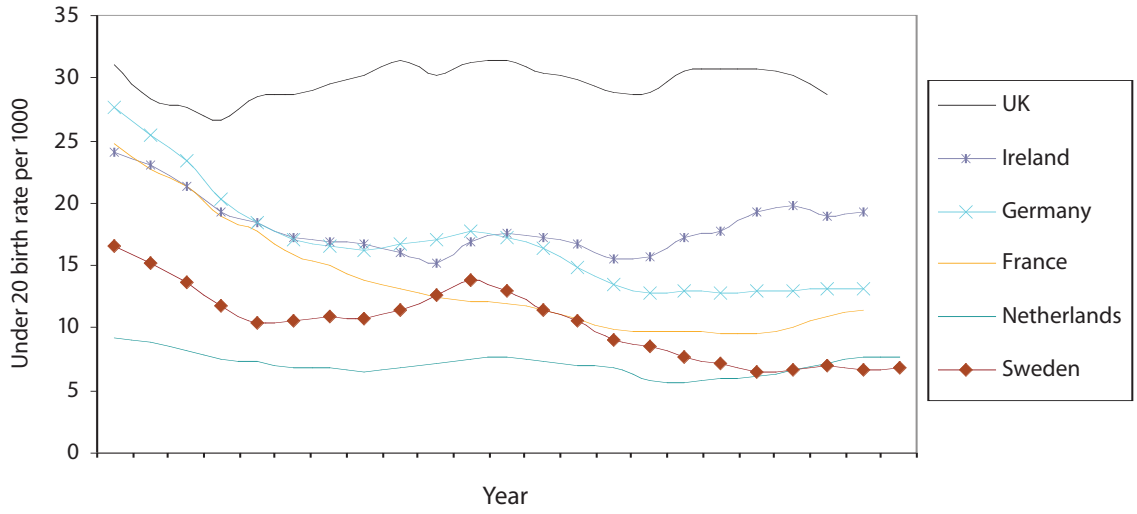
consider how they can ensure that improvements in performance on these key underlying risk factors have maximum impact on those most at risk of teenage pregnancy.

Teenage pregnancy rates in context

4.1 The UK has historically high rates of teenage pregnancy. Figure 1 shows that since the early 1980s under 20 *birth* rates[1] in the UK have been consistently, and markedly, higher than rates in other European countries.

1 Due to differences in collecting and recording data on conceptions, under 20 birth rates are usually used for international comparisons

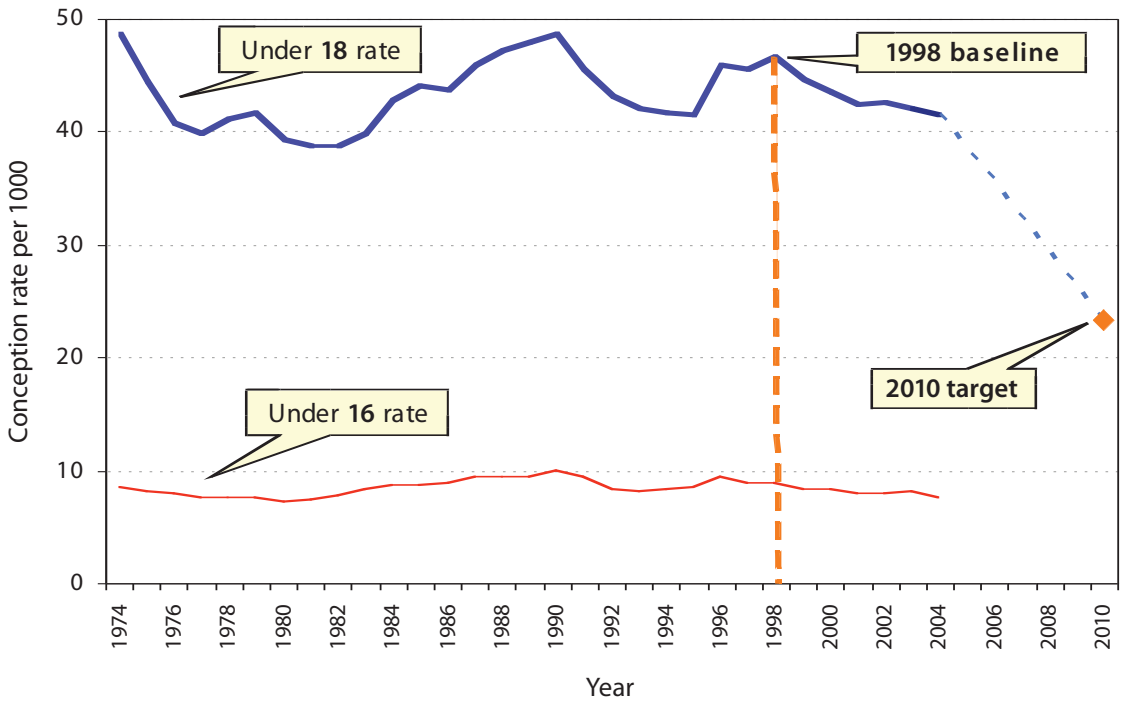
Figure1: Under 20 birth rate in selected European countries 1980-2002



Source: Eurostat

4.2 Figure 2 shows how teenage *conception* rates in England have moved over the last 30 years. The chart breaks the figures down between under-18 and under-16 pregnancies. (Conception rates are a measure of births and abortions combined – see fuller explanation on how conception statistics are compiled in Chapter 7.)

Figure 2: Under 18 and under 16 conception rates for England 1974-2004, and target projection



4.3 The graph shows that:

- high rates of teenage pregnancy are a long-established problem, with the rate of under-18 conceptions generally at more than 40 per 1000 for over 30 years;
- there has nevertheless been significant progress in reducing under-18 conception rates since the strategy began in 1998;
- the greatest progress has been in reducing conceptions among under 16s (15.2% decline);
- significant *further* progress is needed if the Government's target to reduce teenage conceptions by 50% by 2010 is to be achieved;
- under-16 pregnancies make up a relatively small proportion of all under 18 conceptions – 80% are to 16 and 17 year olds (although this fact should not detract from the importance of providing sex and relationships education to under-16s).

4.4 Teenage pregnancy is a complex issue, affected by young people's knowledge about sex and relationships and their access to advice and support; and influenced by aspirations, educational attainment, parental, cultural and peer influences and levels of emotional well-being.

4.5 Data analysis identifies strong associations between teenage pregnancy and certain risk factors and provides a compelling case for targeted action on young people who are exposed to these risk factors, while maintaining universal provision of PSHE and access to confidential advice for all young people.

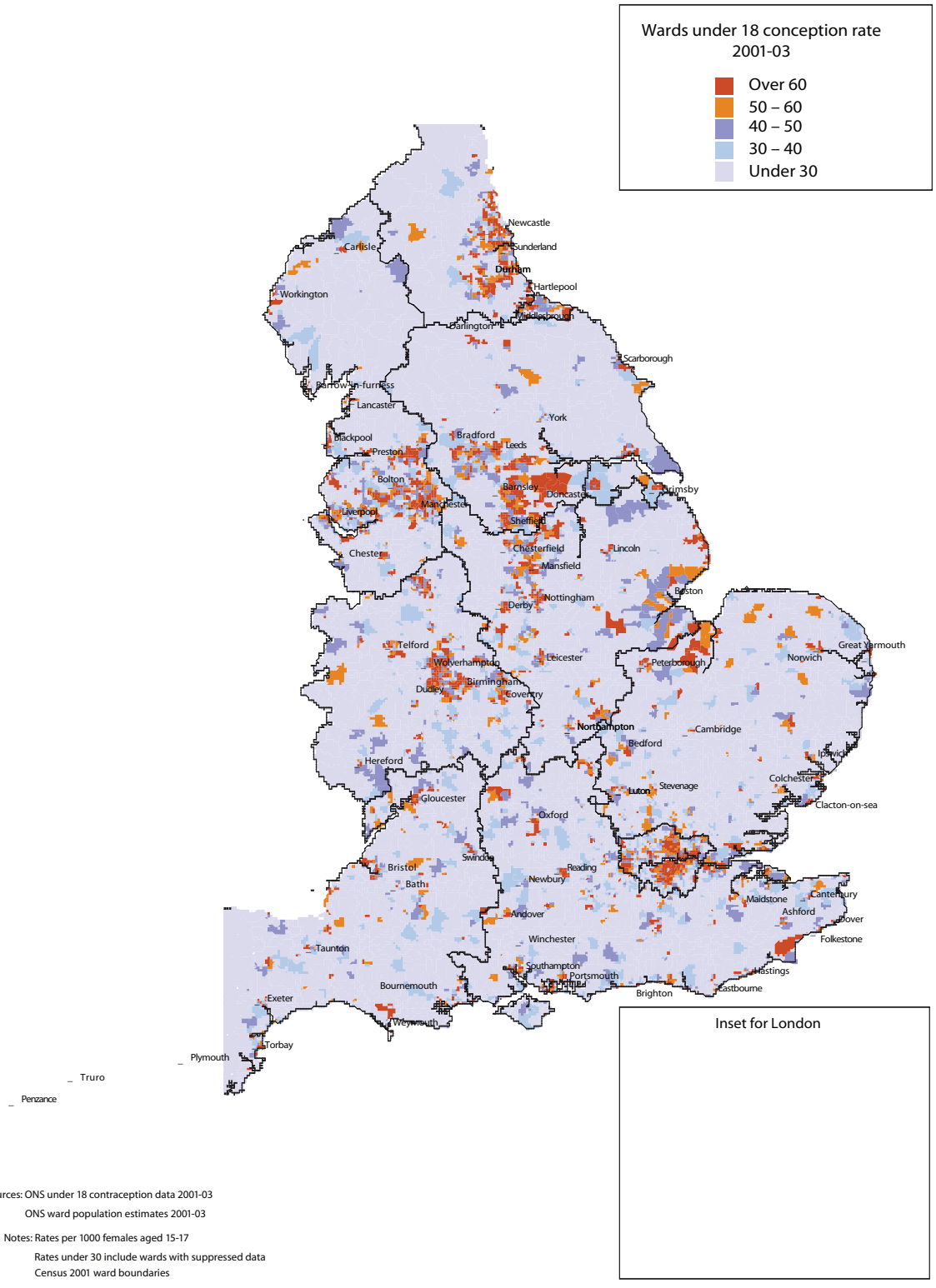
4.6 It is also clear that the wide range of personal, social, economic and environmental risk factors associated with teenage pregnancy are, ultimately, mediated through sexual activity and contraceptive use. Understanding differences in sexual activity rates and contraceptive usage among teenagers is, therefore, crucial to understanding how teenage pregnancy rates can be reduced.

Where you live matters

4.7 Variations in under-18 conception rates largely mirror the pattern of deprivation across England, with half of all conceptions under 18 occurring in the 20% most deprived wards. However, although teenage pregnancy is predominately concentrated in deprived urban areas, figure 3 shows that 'hotspots', with rates over 60 per 1000 girls aged 15-17, are found in virtually every local authority in England, including some rural areas.

Figure 3: Ward under 18 conception rates in England 2001-03

Under 18 conception rates for wards in England, 2001-03



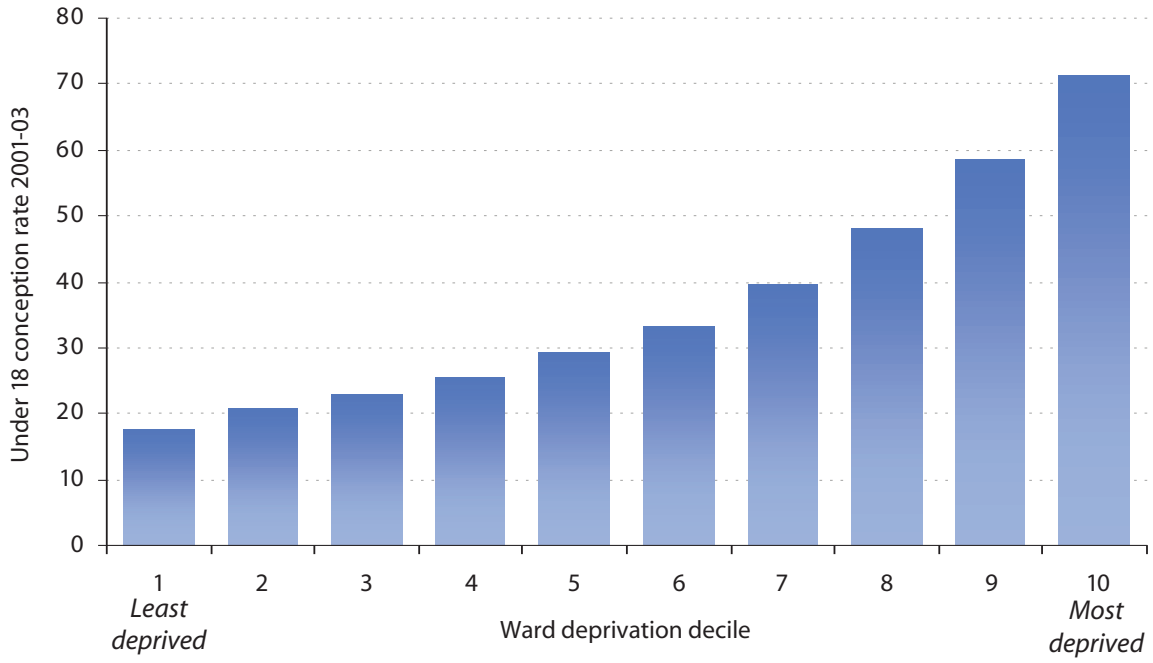
Sources: ONS under 18 contraception data 2001-03
ONS ward population estimates 2001-03

Notes: Rates per 1000 females aged 15-17
Rates under 30 include wards with suppressed data
Census 2001 ward boundaries

Produced by Teenage Pregnancy Unit, 2006

4.8 Nevertheless, high teenage pregnancy rates are much more likely to be found in deprived areas. Figure 4 shows the strong association between deprivation and teenage pregnancy with under 18 conception rates more than four times higher in the most deprived 10% of wards in England compared with the 10% least deprived.

Figure 4: Under 18 conception rates in England by deprivation decile, 2001-03



Sources: ONS, TPU, ODPM Deprivation Index 2004
Notes: Includes estimated rates for wards with suppressed data

But other factors matter too

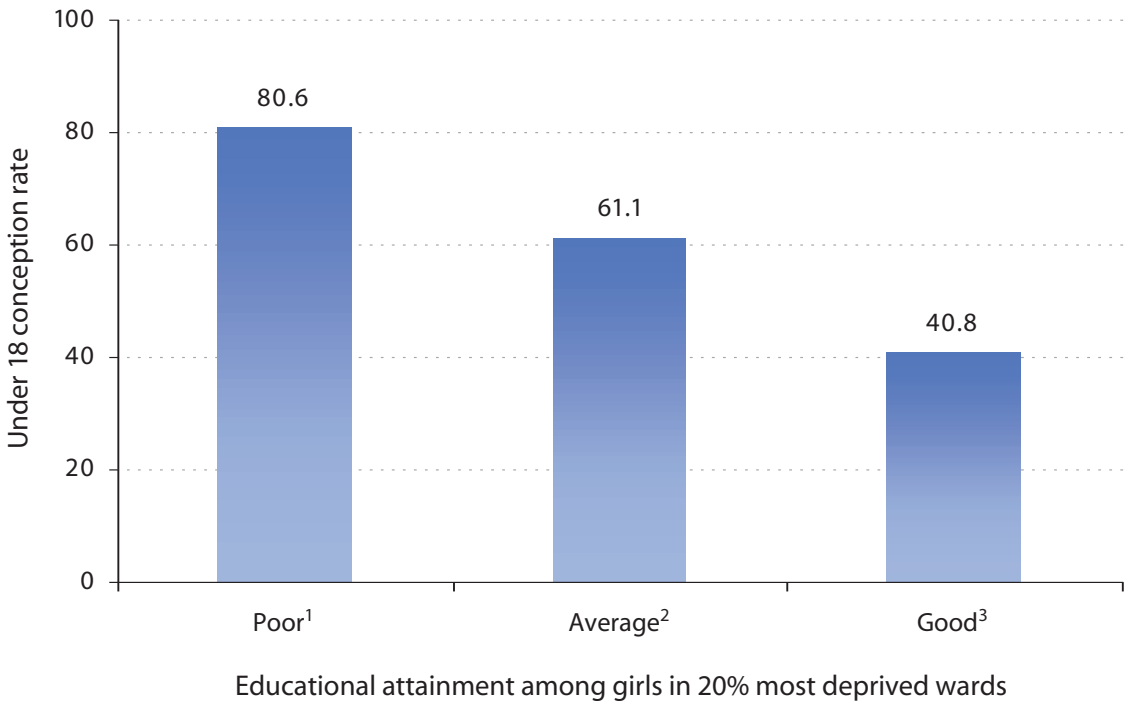
4.9 The relationship between teenage pregnancy and deprivation is not consistent across the country. Some local areas have rates markedly higher, or lower, than would be expected given their level of deprivation [Bradshaw paper 2005]. This variation demonstrates that deprivation is not the whole story, and that other factors have an important role to play in influencing under-18 conception rates – including educational attainment.

Educational Attainment

4.10 It is well understood that the likelihood of teenage pregnancy is far higher among those with poor educational attainment. Given that educational attainment is strongly associated with deprivation and socio-economic status this would be expected. However, analysis of new data clearly shows that low attainment is strongly associated with higher teenage conception rates even after accounting for the effects of deprivation and socio-

economic status.[2] On average, deprived wards with poor levels of educational attainment have under-18 conception rates twice as high as similarly deprived wards with better levels of educational attainment. (See figure 5.)

Figure 5: Under 18 conception rates and educational attainment in 20% most deprived wards

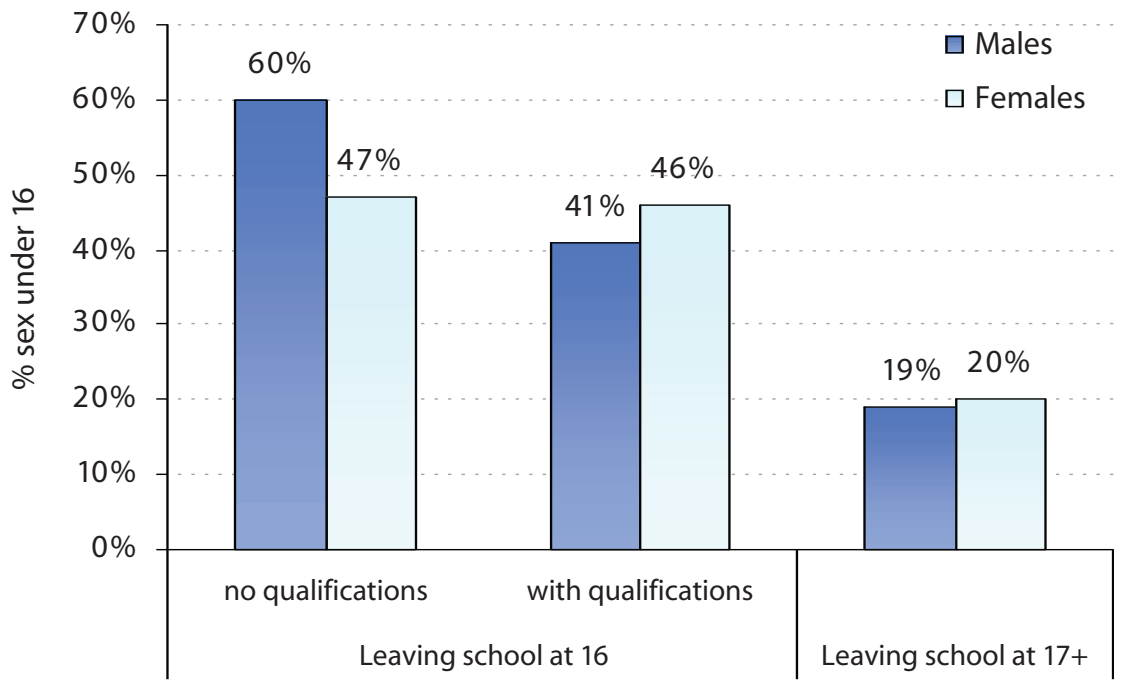


1 < 40% girls 5+ A-C GCSEs & > 10% no qualification
2 40-60% girls 5+ A-C GCSEs & 6-10% no qualification
3 > 60% girls 5+ A-C GCSEs & <6% no qualification

4.11 Educational outcomes also have a strong influence on the age at which young people first have sex. Sex under-16 is associated with higher levels of regret among young women, poorer contraceptive use and higher rates of teenage pregnancy. Young men also report that they regret putting pressure on their partners and that their experiences of sex at an early age are often negative [ref NATSAL]. Surveys estimate that between a quarter and a third of all young people have sex before they reach age 163, a proportion that has remained constant since the start of the Strategy.[3] But as figure 6 shows, around 60% of boys and 47% of girls leaving school at 16 with no qualifications had sex before 16. For those leaving school aged 17 or over with qualifications, the proportion having sex before 16 was around 20% for both males and females.

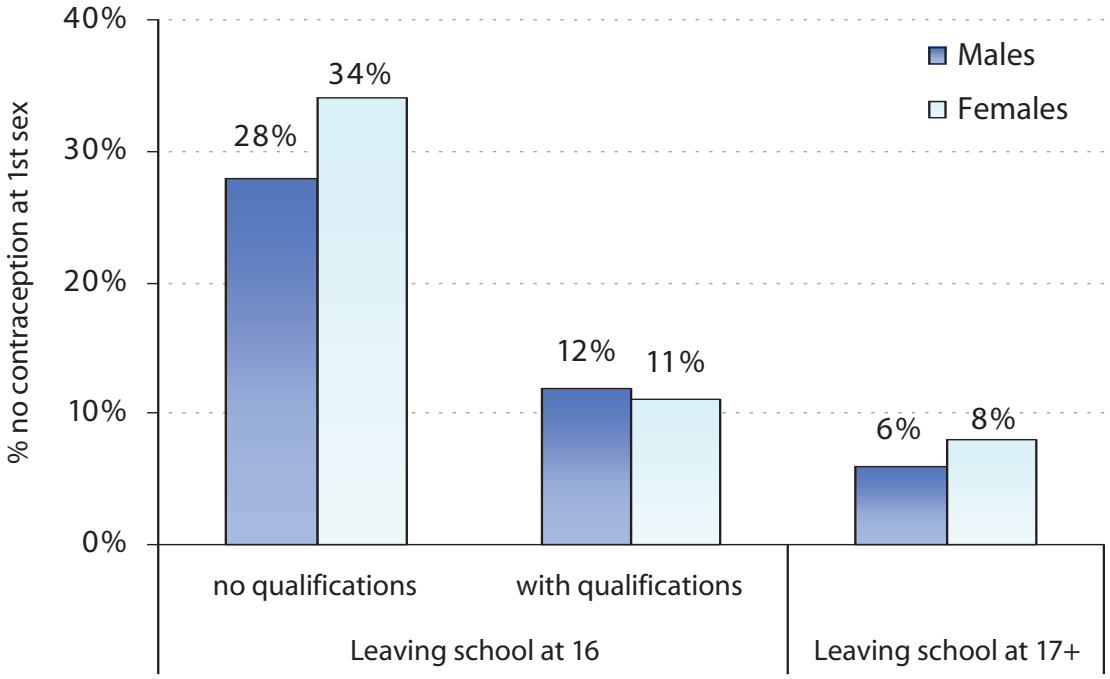
2 [Lancet NATSAL ref]
3 TP Tracking survey ref

Figure 6: Proportion having first sex under-16, by qualifications and school leaving age



4.12 Educational attainment also has a big impact on contraceptive use. Overall, reported use of condoms at first sex has increased significantly in recent years. In 2000, 83% of males and 80% of females aged 16-19 reported using condoms the first time they had sex. However, the likelihood of not using any contraception at first sex is higher in young people leaving school at 16 with no qualifications, as shown in Figure 7 below. 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. Overall, nearly 40% of teenage mothers leave school with no qualifications [insert Census ref?].

Figure 7: Rates of non-use of contraception, by qualifications and school leaving age



Other school-related factors

4.13 Poor attendance at school is also associated with higher teenage pregnancy rates. Among the most deprived 20% of local authorities, areas with higher rates of absenteeism have higher under-18 conception rates. Local authorities with fewer than 8% of half days missed averaged an under-18 conception rate of 33.6, compared with a rate of 47.7 in areas where more than 8% of half days were missed. Teenage Pregnancy Unit funded research shows that disengagement from education often occurred prior to pregnancy, with less than half of the young women interviewed attending school regularly at the point of conception.[4] Dislike of school was also shown to have a strong independent effect on the risk of teenage pregnancy.

Other factors that influence rates

4.14 Our analysis points to social deprivation, poor attainment and disengagement at school being the key underlying factors that affect conception rates. But a range of other factors affecting young people's lives are important too.

4 Ref for research ???

Ethnicity

4.15 There is evidence that suggests that young people from some ethnic groups are much more or less likely to experience teenage pregnancy than others, – even after taking account of the effects of deprivation. For example, teenage pregnancy rates vary dramatically between London boroughs with a similar level of deprivation, but a different ethnic composition. In some instances, a Borough's rate is double that of a similarly deprived Borough with a different ethnic make-up.

4.16 Establishing the precise impact of ethnicity is difficult because: ethnicity is not recorded at birth registration; BME groups are over-represented in deprived areas where high rates would be expected; and sexual behaviour, knowledge and attitudes may vary considerably *within* BME groups. Nevertheless, the available evidence does indicate that girls and young women from some ethnic groups are more likely to become pregnant under-18.

4.17 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 (Whilst Asian groups are under-represented among under-19 births, data on under-20 births show high rates of pregnancy among Asian groups, which suggests these groups have higher than average birth rates at age 19).

4.18 Girls and young women of Black and Black British ethnicity are also over-represented among abortions under 18. In 2004, Black[5] ethnic groups (which represent around 3% of all females aged 15-17) accounted for 9% of all abortions under 18, and in London, which has high rates of repeat abortion, 43% of all under 18 abortions following a previous pregnancy were for young women from Black ethnic groups.

4.19 Variations between ethnic groups in sexual activity and contraceptive use suggest the higher rates of teenage pregnancy among some ethnic groups are at least partly attributable to differences in behaviours and attitudes, and not simply a result of deprivation. A survey of adolescents in East London[6] 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, around 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. Survey data also demonstrate

5 Data quality and small numbers do not permit a more detailed disaggregation of 'Black' ethnicity

6 Research with East London Adolescents Community Health Survey (RELACHS), 2004, UCL, City University and Queen Mary, University of London

variations in contraceptive use by ethnicity. Among 16-18 year olds surveyed in London (ref), 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%).

4.20 Differences in sexual behaviour and risk of teenage pregnancy between ethnic groups demonstrate the need for local strategies to develop culturally appropriate approaches to reducing teenage pregnancy rates – especially in areas with large BME populations. These need to recognise, and address, differences in: norms around discussing sensitive issues within families; gender issues; religion; and accessing mainstream services.

Living in Care

4.21 Although the numbers are low, young people who are or have been looked after are at a significantly higher risk of teenage motherhood. Research has shown that by the age of 20 a quarter of children that had been in care were young parents, and four out of ten young women were mothers.[7] Statistics on Looked after Children released by DfES in November 2005 showed that 4.1% of 15-17 year old females in care were mothers – a proportion around three times higher than the prevalence among all girls under 18 in England.

Associated risk factors

4.22 The **daughter of a teenage mother** is at increased risk of becoming a teenage mother herself. Research findings from the 1970 British Birth Cohort dataset showed that being the daughter of a teenage mother was the strongest predictor of teenage motherhood.[8]

4.23 A number of studies have suggested a link between **mental health problems** and teenage pregnancy. A 1991 survey showed that a quarter of teenage parents involved in the study had a probable psychiatric disorder. One in ten 11-16 year olds have a clinically diagnosed mental health disorder, with the same proportion of 16-19s experiencing depressive disorders. A further study of young women with conduct disorders showed that a third became pregnant before the age of 17.

4.24 Studies have also shown an association between **sexual abuse** in childhood and teenage pregnancy, with experience of abuse twice as high among pregnant teenagers, compared to the general population. Researchers attribute this to low self esteem and a lack of confidence in resisting pressure to have sex, even years after the original abuse has taken place. [refs to be added]

7 Joseph Rowntree Foundation, March 2005

8 Berrington *et al* (2005) *Consequences of teenage parenthood: pathways which minimise the long term negative impacts of teenage childbearing* University of Southampton

4.25 **Sex before age 16 and non-use of contraception** were higher for those who did not live with both parents until age 16. The likelihood of not using any contraception at first sex is higher in young people who did not discuss sexual matters with their parents.

4.26 Factors such as **low aspiration, violence and bullying at school, poor parental support, domestic violence and a lack of things** to do and places to go for young people all impact upon the likelihood of teenage pregnancy.

4.27 There is also an association between **involvement in crime** and teenage parenthood. The 1958 UK birth cohort identifies that 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.

4.28 Research points to **the use of alcohol and substance misuse** as being a significant factor in young people's sexual behaviour. Research among south London teenagers found regular smoking, regular drinking and experimenting with drugs increased the risk of starting sex under 16 for both young men and women. A study conducted by the local Teenage Pregnancy Strategy in Rochdale reports that 'feeling in control about negotiating consent to sex is seen as very difficult, and made harder by the effects of alcohol'. Findings from the study show that one in five white young women report going further sexually than intended because they were drunk. 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. (Ref: *Alcohol & Teenage Pregnancy:* Alcohol Concern, 2002).

4.29 Where young women experience multiple risk factors, their likelihood of teenage parenthood increases exponentially – The 1999 SEU report on teenage pregnancy analysed the 1958 UK birth cohort and found evidence that young women who experienced multiple risk factors (including having a mother who was a teenage parent, having emotional problems at age 7 and age 16 and low educational attainment at 16) had a *56%* chance of becoming a teenage mother, compared with a *3%* chance for young women experiencing none of these factors. A similar and subsequent analysis of the 1970 British Cohort Study found young women experiencing five selected 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) increased the likelihood of becoming a mother under 20 by 31%.

4.30 Much of the above analysis refers to the characteristics of young women who are more likely to conceive before age 18. Very little routine data exists on the characteristics of the young men who are the partners of these young women, although analysis of the 1970 British Cohort Study found young men experiencing the five selected risk factors mentioned above were 23% more likely to become a young father (under age 23) than

those not experiencing any of the risk factors.[8] Clearly it is important to ensure that boys and young men also receive the information and skills to enable them to understand the benefits of delay and use contraception when they become sexually active, as well as receiving support to help them in their role as young fathers, where appropriate. 'Motivation and means', therefore, applies to young men as well as young women.

What does the analysis tell us about problems and solutions?

4.31 The analysis points to a number of problems that we need to address in order to accelerate progress on reducing teenage pregnancies:

1) **Poor knowledge and skills among young people in relation to sex, relationships and sexual health risks;**
2) **Poor and inconsistent contraceptive use among young people;**
3) **Lack of support for parents and professionals on how to engage with young people on relationships, sex, and sexual health issues.**
4) **Disengagement from/dislike of school among those most at risk;**
5) **Low attendance/attainment at school;**
6) **Lack of aspiration among young people in the most disadvantaged communities.**

4.32 Chapter 5 of this document sets out what we know about what works in addressing the first 3 of these problems and chapter 6 describes what action areas need to take as a result. In broad terms, these focus on giving young people the 'means' to avoid unintended pregnancies and are the core business of local teenage pregnancy strategies.

4.33 But it is clear that in order to impact on *all of the factors* that increase the risk of teenage pregnancy, wider action to address the underlying causes of teenage pregnancy is also needed. Tackling these remaining problems will give young people at risk of early pregnancy the choice and motivation to aspire to further education and rewarding careers, leaving the decision to have children until later when they are better equipped to deal with the demands of parenthood.

4.34 Local areas can use the above analysis to help target their strategies on those most at risk of early parenthood – both boys and girls. In order to put these broad associations between teenage pregnancy and underlying risk factors into the context of assessments of individual young people's personal risk of early parenthood, a range of assessment tools exist. These range from more generic tools for assessing risk, such as the Common

8 Berrington *et al* (2005) *Consequences of teenage parenthood: pathways which minimise the long term negative impacts of teenage childbearing* University of Southampton

Assessment framework, to the sort of assessment tools used by projects such as Teens & Toddlers, which identify young people at specific risk of teenage parenthood. A copy of the assessment tool used by Teens & Toddlers is included at annex 3 [**Check T&T are content**].

4.35 We will produce a broader strategy document later this year. In the meantime, this document focuses on the actions that we would expect Local Authorities and PCTs to take to improve their delivery of local strategies based on the evidence of what works in Chapter 5. The support we will be providing nationally is set out in Chapter 6.

5. What works in reducing Teenage Pregnancy?

Summary

This chapter sets out the key findings from the 'deep dive' reviews carried out by the Teenage Pregnancy Unit to identify factors that were responsible for the significant variation in performance between local areas, including between areas that are statistically similar.

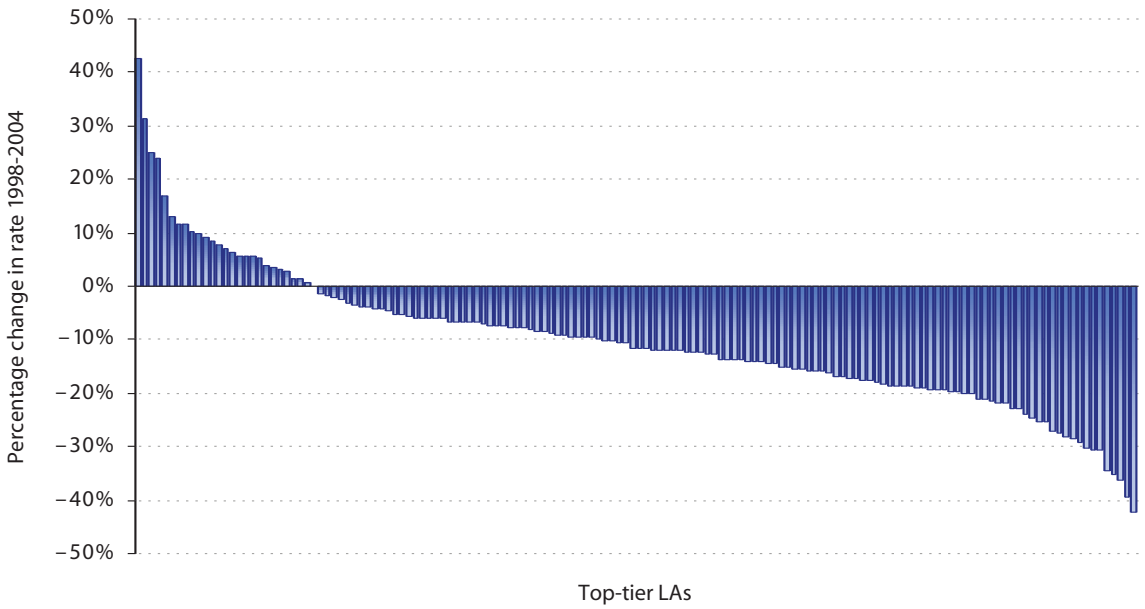
All areas must:

Ensure that all stakeholders are aware of the deep dive findings

Review their Strategies and Children and Young People's Plans against the 'deep dive' findings.

5.1 The wide variation in local performance – even when comparing areas with similar characteristics – provides strong evidence that the *delivery* of local strategies is critically important. In addition, the evaluation of the first four years of the strategy shows that the rate of decline has been steeper in areas that have received more funding. This positive link between funding and results indicates that effective delivery of local strategies – rather than unrelated factors – are driving under-18 conception rate reductions. Figure 8 shows the extent of this variation in performance, with at one end of the spectrum rates falling by 42%, while at the other rates increasing by 43%.

Figure 8: Percentage change in under 18 conception rates for top-tier Local Authorities, 1998-2004



5.2 In-depth reviews carried out by the Teenage Pregnancy Unit in 2005 (in 3 high performing local authorities and 3 'statistical neighbours' with static or increasing rates), sought to explain this variation by identifying factors that were evident in successful areas, but absent in those where rates were increasing. The key factors identified in the 'Deep Dive' review were:

- *Senior local sponsorship and engagement of all key partners.* In high-performing areas the seniority and personal commitment of key post-holders such as the chair of the Teenage Pregnancy Partnership Board, local Teenage Pregnancy Co-ordinator and senior personnel within key partner agencies, were seen as of critical importance. Conversely, in comparison areas, a lack of commitment by key players was seen as one of the main factors that explained the area's lack of success. This 'lack of commitment' might, for example, manifest itself in the form of acceptance that early parenthood in some communities was impossible to influence. There was further evidence that progress was greatest in areas where *all aspects of the strategy* were being delivered effectively. In particular, there needed to be engagement of the 4 key mainstream agencies involved in delivering the strategy – PCT, Education, Social Services and Youth Services/Connexions – and the voluntary sector.

Case Study Thurrock: Senior local sponsorship and engagement of all key partners

Thurrock's teenage pregnancy rate has fallen by 30.7% between1998 to 2004.

Thurrock Teenage Pregnancy Partnership Board and its relationship with the Children and Young People's Strategic Partnership (CYPSP) has changed over recent years with the advent of the first Children and Young People's plan and the reconfiguration of the local CYPSP. As a unitary authority there is a single Director of Children's Services and an amalgamated Directorate of Children's, Education and Families (CEF) that takes account of the previous separate directorates of education and social care. The CYPSP currently works with the coterminous Primary Care Trust (PCT) to effect planning and implementation for children and young people's services.

The local Teenage Pregnancy Coordinator is employed and hosted through the PCT and directly reports through the public health team, with dual reporting to the Strategic Lead for Targeted Services within CEF. This arrangement ensures that both key statutory partners are fully involved in the planning process and ownership of the strategy. The CYPSP had adopted an age-based framework for channelling all areas of planning and commissioning. This meant that the Teenage Pregnancy Action Plans and monitoring process were reported through the 13-19 Executive Board of the CYPSP. Whilst this did not account for all the activity within the plans, it made for a substantial home for the teenage pregnancy agenda over the last five years. However this changed in June 2006 to take account of the Every Child Matters Five Outcomes Framework approach.

For the future, the issues of teenage pregnancy and young people's substance misuse will have much greater union and common themes within each of these areas will be jointly addressed. This should lead to a greater emphasis on prevention and education and a sharing of resources. These will be addressed through a 'high risk behaviour' interest group, taking on board some of the previous functions and planning of the Teenage Pregnancy Partnership Board, with the commissioning functions fulfilled by the 'Be Healthy' – CYPSP Executive Board.

For further information contact Melody Williams on 01375 406437 or melody.williams@thurrock-pct.nhs.uk

- *Provision of young people focused contraception/sexual health services, trusted by teenagers and well known by professionals working with them.* This was the factor most commonly cited as having the biggest impact on conception rate reductions in the high performing areas. Features of successful services reflected the *Best practice guidance on the provision of effective contraception and advice services for young people*, issued by the Teenage Pregnancy Unit in 2000: easy accessibility in the right location with opening hours convenient to young people; provision of the full range of contraceptive methods, including long acting methods; a strong focus on sexual health promotion (as well as reactive 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.

Case Study Liverpool: Brook/Abacus + So to Speak outreach

Liverpool's teenage pregnancy rate has fallen by 24.7% between1998 to 2004.

Liverpool provides strong services through two discrete, highly visible, and young people friendly sexual health/contraceptive advice services in the city centre – Brook and Abacus. These services are highly accessible and trusted by young people. The services are supported by strong outreach work provided by *So To Speak*, a project which is supported by funding from the Liverpool and Sefton Teenage Pregnancy Partnerships. *So to Speak* train professionals to improve their ability to engage with young people on sexual health issues as well as equip young people with information to make informed choices about their sexual health.

Liverpool Brook has been providing contraceptive services for young people for over 30 years. It has been located in the city centre for the last 20 years and, following relocation to larger more visible premises in 2002, has been offering a 'drop in' service, which is open every weekday from 10am to 6pm and on Saturdays from 10am till 2pm. The service is commissioned by Liverpool PCTs, and provides all the main methods of contraception, emergency contraception, pregnancy testing, referral for abortion, chlamydia screening and sexual health advice. The centre also provides a twice weekly full STI testing service run in partnership with the Royal Liverpool University Hospital GUM department and 2 Chlamydia Treatment Sessions.

Appointments can be made to see the Brook Counsellor who is available one day a week and there is a Male Information Worker at the centre 5 days a week to provide sexual health and contraceptive advice to male clients. Although Liverpool Brook does not have an Outreach Team, it is one of the partners in a Healthy Living Centre "Healthy Arts Project" which aims to address health issues and problems which affect young people, through the use of arts and media. As part of this project, for the last 3 years, "Brook Advisors" have taken part in a Theatre in Education Project touring local schools with plays highlighting a different sexual health theme each year, and has contributed to various other Healthy Arts activities including magazines and videos.

Abacus clinics for Contraception and Reproductive Healthcare are a mainstream NHS service which provides open access to all methods of reversible contraception, including Long Acting Reversible Contraception (LARC), emergency contraception, pregnancy testing, referral for abortion, Chlamydia screening, and sexual health advice. The service provides 60 sessions per week, over 6 days per week, across Liverpool and South Sefton. There are 9 dedicated young-persons sessions across the area, although all sessions are attended by clients of all ages. The service also includes a base in Liverpool city-centre which is open 6 days per week, in an easily accessible, non-NHS building.

Provision of contraception following an abortion is also a high priority. Women attending for a termination at the Bedford Clinic, Liverpool Women's Hospital, have immediate access to post-abortion contraception via an Abacus contraceptive nurse or doctor, who attends the clinic on a daily basis. All clients are actively encouraged to access contraception prior to leaving the service. LARC is also actively promoted within the clinic. Women who attend for a termination at Merseyside BPAS also have the opportunity to obtain contraception on-site. For those who want to discuss contraception at a later date, information is provided about the Merseyside and Wirral Brook Advisory Centres.

Liverpool adopts a strong targeted approach to working with at risk groups of young people, and to providing workforce training on sex and relationship issues within mainstream partner agencies through *So To Speak* – a sexual health education outreach team, funded through the Liverpool and Sefton Teenage Pregnancy strategies. The aim of the project is to equip young people with the information required to make informed choices about their sexual health; to promote a greater understanding of the broader issues that impact upon sexual health; and to support agencies that work with young people to appreciate their role in tackling those issues and thereby enabling good sexual health. The team employs a number of different methods of delivery including face-to-face work with small groups of young people and parents; outreach; and promotional campaigns. In order to ensure sustainability of this work the team also delivers staff training and support to agencies that work with vulnerable young people and help to tackle inequalities in health through community development in targeted wards.

For further information on Liverpool Brook contact Sue Ryrie or Jackie Spence on 0151 207 4000 or at sryrie@merseybrook.co.uk

For further information on Abacus contact Sue McVicker, Service Manager/Lead Nurse on 0151 284 2500 or at sue.mcvicker@pct.northliverpool.nhs.uk

For further information on So to Speak contact So to Speak on 01512271481 or at info@sotospeak.nwest.nhs.uk

- *Strong delivery of SRE/PSHE by schools*. Key features included: systematic delivery of SRE/PSHE in secondary and primary schools, driven by the LEA; a strong focus on achieving 'healthy schools' status; use of the DfES SRE guidance (issued in 2000) as a driver for training and support for schools, including planned programmes of training for Governors; LEA support to improve schools' PSHE delivery, including the development of exemplar lesson plans, investment in SRE resources and consultancy support for targeted schools.

Quote: "The lessons really helped us talk about things in a way we just don't do when we're hanging around together. I learned that relationships are not all about looks and sex. You need to look on the inside not just on the outside"

Boy, 15

Case Study Hackney: Pulling it Together (Secondary) Christopher Winter Programme (Primary)

Hackney's teenage pregnancy rates have fallen by 10% between 1998 to 2004.

An audit of schools in Hackney, as part of the Hackney Healthy Schools Programme, drew attention to the need for more consistency in the delivery of PSHE and Citizenship in schools and for support to further raise the quality of provision in this area. Therefore in 2000 all Hackney schools agreed to combine funding from their Standards Fund budgets to develop PSHE and Citizenship. Schools received advisory support and guidance known as 'Pulling it Together', which was informed by the DfES guidance on SRE, including a scheme of work and lesson plans that had been shared and agreed. This has been further developed by The Learning Trust and republished in 2001 with support from teachers. The Learning Trust's guidelines on PSHE and Citizenship can be found at http://www.learninglive.co.uk/. This contributes to the achievement of key targets in the Teenage Pregnancy Strategy for Hackney. For further information, contact Nicola Baboneau, Chair of Hackney & The City's Teenage Pregnancy Partnership – Nicola.baboneau@learningtrust.co.uk.

Former Hackney Education, now the Learning Trust and City & Hackney Teaching Primary Care Trust have funded The Christopher Winter Project since 2001. The project delivers primary school SRE Modelling for teachers. It was devised to complement strategies taken in line with the key themes of the National Teenage Pregnancy Strategy. The project demonstrates one of the key themes in the recent OFSTED report on SRE, which is to improve the quality of teaching and learning and is part of the teacher training strategy to provide good continuing professional development (CPD) in SRE. The project offers teachers professional support in their own classroom working with their own pupils. Assistance is given with lesson planning and delivery, policy development, parents and governors meetings. Parents are encouraged in writing to review the programme and have been mostly very supportive with relatively small numbers of parents withdrawing their children from SRE.

The project aims to increase teacher confidence in the delivery of SRE. Its objectives are to:

- Provide model lessons based on schemes of work from The Learning Trust's PSHE Guidance 'Pulling It Together';
- Model methods of delivery which are appropriate to SRE; and
- Provide team teaching and support to classroom teachers.

Initially ten Healthy Schools were invited to take part in the pilot and later this was offered to all Hackney schools. Schools with up-to-date SRE policies and programmes in place were allocated training places. This system is still in place and the project works regularly with 36 primary schools.

All teachers complete a pre and post-evaluation form. The data shows that the in-class training and planning support offered by CWP has resulted increased confidence in 90% of participating teachers.

CWP were filmed with pupils and teachers at Baden Powell School for a national training video on SRE for school governors (financed by the Department of Health). The video has been sent to all schools in England. CWP are currently making a teacher training DVD filmed in Hackney.

In 2004 CWP won the FPA Pamela Sheridan Award for SRE. They now run a similar modelling project with secondary schools in Hackney.

For further information contact Paula Power on power.coleman@virgin.net

- *Targeted work with at risk groups of young people, in particular Looked After Children.* All 3 high performing areas had examples of Social Services having a strong focus on sexual health issues – in one area Social Services had a local performance target that all Looked After Children (LAC) had access to advice on contraception and sexual health. In the same area, there was also mandatory SRE training for all social work managers, family support workers, foster carers and relevant social workers. And in another, Social Services delivered SRE programmes for young people in care and the LAC Nurse ran a sexual health clinic for LAC.

Case Study Bradford: Working with Looked After Children

Bradford's teenage pregnancy rates have fallen by 22.9% between1998 to 2004.

In 1997 the former Bradford District Health Promotion Service began work with Social Services and other agencies to develop sexual health promotion with looked after children. This group therefore had already been identified as a priority prior to the development of the Teenage Pregnancy Strategy. Good practice guidance on working on sexual health issues with young people was developed.

The health assessment team for looked after children work with the care leavers nurse to ensure that the young people are seen by their public health nurse for a health assessment on a six monthly or yearly basis. All the public health nurses undertaking health assessments are either school nurses or health visitors. Packages of care are developed and negotiated between young people and carers and the clinical team. As part of the assessment health education is provided on sexual health and teenage pregnancy. Information around local sexual health and contraception services is passed on to young people.

The leaving care nurse targets young people aged 16 to 17 who are in the process of pathway planning or who have already left care for independent living. As well as giving sexual health advice she has recently facilitated an eight week parenting group. This included sexual health advice as well as including other health subject's relevant to young parents, such as links into a local Sure Start, a local teen parents group, or to the group run by Social Services to support teenage parents. The leaving care nurse will also link in to other relevant services to ensure young people's housing, benefits and other needs are met.

The health assessment team are involved in an annual fun day which is arranged for all looked after children, carers and siblings, with stalls providing advice on various health issues, which includes sexual health information.

Training is also provided to staff in children's residential homes and for foster carers, to ensure they have an understanding of the sexual health needs of this group. It also aims to build on skills and confidence of staff and foster carers to enable them to talk about sexual health issues with young people.

For any professional working directly with young people there is a well established network group. The group provides professionals with the opportunity to network with others across a wide range of services and projects. The aims are to share good practice, to offer training (and share information on training both locally and nationally), to share information on new and existing initiatives, to provide workers with support, and to link operational work into the district wide strategy. As well as holding quarterly meetings the network group also receives information via email from the strategy and from each other. Information and opportunities to access training are shared in this way.

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- *Workforce training on sex and relationship issues within mainstream partner agencies.* An indicator of mainstream partners' engagement in the strategy was the extent to which the professionals working within the partner agency had received training on SRE issues. Many professionals – such as Youth Workers, Connexions PAs, Social Workers – will be working intensively with young people at risk of early pregnancy, as well as other negative outcomes. This relationship offers the potential to do early preventative work to help young people delay early sex and access early advice. The most systematic approaches were: 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.

Case Study Liverpool: Workforce Training on Sex and Relationship Issues within Mainstream Partner Agencies

Liverpool's teenage pregnancy rates have fallen by 24.7% between1998 to 2004.

So to Speak, Liverpool and Sefton's Young Person's Sexual Health Education Outreach team has delivered training to 357 professionals across Liverpool during 2005-06, including youth workers, social workers, teachers, foster carers, school nurses, E2E tutors and PCT staff. Level 1 training aims to provide professionals who work with young people with the opportunity to develop their awareness of, and confidence in discussing, sexual health with young people. This includes basic awareness of sexually transmitted infections and methods of contraception; exploring and addressing the issues concerned with working with young people around sexual health; and providing information for signposting young people to sexual health services. Level 2 aims to enable professionals who work with young people with the skills and knowledge to facilitate SRE sessions with groups of young people. Learning from the 'Delay training' initiative will also be incorporated into all future So to Speak training deliveries.

In the last year, delivery programmes have included Level 1 and Level 2 training for secondary school PSHE Co-ordinators, with the offer of on-going support when required; Level 1 training to school health practitioners, with a Level 2 session scheduled for later this year; and Level 1 and 2 training for a select group of workers from the Youth Offending Team, with the offer of on-going support when required. It is intended that Level 1 training will be rolled out to all YOT staff and volunteer mentors over the next twelve months. So to Speak are also working with the Foster Carer Training Co-ordinator to develop a training programme for foster carers and foster-care social workers. The module will be run up to 4 times a year, based on need.

In addition to this, So to Speak have worked with Healthline, Merseyside Youth Association, to deliver sexual health and relationships training to youth workers. In the last year this included a two-day training programme on delivering group work with young people and signposting young people on to relevant sexual health services. A rolling programme is planned for the coming 12 months to ensure all youth workers have the opportunity to develop their awareness of, and confidence in discussing, sexual health with young people, or to facilitate sessions with groups of young people. Ongoing support will be offered to ensure the sustainability of the work.

Training for Liverpool Community College Tutors is also a crucial element of Liverpool Community College's strategy since the recruitment of a PSHE Advisor. Few personal tutors feel confident to deliver SRE. However, through the work of the PSHE Advisor, there is a much greater awareness of the issues connected with SRE and of referral arrangements both within the college and externally.

For further information contact Karen Lawrenson on 0151 296 7643 or karen.lawrenson@northliverpoolpct.nhs.uk

- *A well resourced Youth Service, with a clear remit to tackle big social issues, such as teenage pregnancy and young people's sexual health.* Where Youth Services were well resourced, provision of positive activities for young people was strong. In addition, in high performing areas, Youth Workers had been equipped with the skills and knowledge to support young people on sex and relationship issues, and there was evidence of strategic leadership within the Youth Service, with a focus on the big social issues affecting young people, such as drugs, alcohol and sexual health.

Case Study Gateshead: Effective Youth Service Contribution

Gateshead's teenage pregnancy rates have fallen by 22% between1998 to 2004.

Gateshead has benefited from a Youth Service that is long established and relatively well resourced. Work with young women has been high on the agenda for a number of years and more recently work with young men has been identified as a priority. The Youth Service has contributed to the Gateshead Teenage Pregnancy Strategy through:

- Youth and Community Learning staff have helped to deliver SRE programmes within schools.
- Youth and Community Learning staff 'meet and greet' young people at young people's contraceptive and sexual health clinics, which are called *Sorted* in Gateshead.
- The Youth Service has 12 members of staff who have gained a level 3 Accredited Sexual Health. This is a five day course which is assessed by portfolio submission and includes delivery of a SRE session to young people.
- The Introduction to Community Education (ICE) course includes a session on why teenage pregnancy is an issue, promoting good sexual health and signposting to services. This course is aimed at unqualified part time youth workers and volunteers who are new to youth work.
- More recently the Youth and Community Learning Service has become a major contributor of outlets for the C-Card scheme.

There has also been a move towards multi-agency work that aims to equip young people with the knowledge, skills and ability to help them manage risks. Raising confidence and self-esteem are core elements of the programmes. Examples of this work are outlined below.

Urban Bush craft

This is a programme for young men to encourage them to reflect on their roles and behaviours within their community and in particular to look at issues around developing masculinity in a positive and supportive environment; exploring triggers and consequences of male violence and the feelings men hide and the consequence of such feelings; and how young men cope with expectations placed on them and the costs of conforming to traditionally held values of masculinity.

Participants from a young men's group, recently established at Pelaw Youth Centre as part of a Youth and Community Learning Service, attended three 'twilight sessions', held in the early evening when these young men would otherwise be hanging around the streets. A weekend residential was also held where they engaged in survival activities.

The young men were involved in the planning of the residential weekend. Group sessions enabled them to talk to each other. Most said it was the first time they had talked openly about relationships and sexual health and were surprised to find it enjoyable. They found activity based discussions useful in helping them to think beyond their own immediate experiences. The young men have identified other issues they wished to discuss in future.

Up 2 U

This was an outreach project in one of the 'hot spot' areas of drug and alcohol misuse. The project aimed to provide information, advice and education to young people who are hard to reach and not engaging in services. A number of agencies were involved. These included: North East Council on Addictions (NECA), Sexual Health, Youth and Community Learning, Sure Start, Substance Misuse Awareness Raising Team, Youth Offending Team, the Police and Community Wardens.

Young people were engaged in unsupervised outdoor locations. The issues worked on included developing positive relationships, substance awareness, diversionary activities to promote healthy lifestyles, 'natural highs', and respect for each other and for communities. Once a good relationship was formed they were asked to identify programmes of activities which were community centre based, such as hip hop. The project culminated in a 'blind date' event, which was also attended by young people from other areas identified as at risk.

As a result of the project young people understood their risk taking and the possible consequences of substance misuse and sexual heath issues. Young people, many of whom had previously been banned from youth clubs, engaged in structured activities. They started to use services in their own communities and formed relationships that supported each other. The young women want to continue to meet and all the young women were registered for the C-card.

Workers from NECA had completed the Sexual Health course, workers from Sure Start completed the FPA Speakeasy Course and the Sexual Health course.

Sexual Health Residential

The Youth Service's Young Women's Development Group identified that the young women they were working with experienced life only at a very local level, had low self-esteem and had very little knowledge of sexual health. A residential project aimed to increase their confidence and self-esteem, knowledge of sexual health, and raise awareness of life experiences of other young women in Gateshead. Young women were identified from four projects whose workers were part of the Young Women's Development Group. Some of these women had already experienced teenage pregnancy, some were from areas with high teenage pregnancy rates, and some were from backgrounds where they received very little SRE (and sensitive negotiations had to be held to allow them to participate in the residential).

Youth workers identified that young people gained most from residentials where they were engaged in a variety of tasks that have a common theme. Prior to the residential some projects had held preparation sessions and the young women were involved in the design of the residential.

The residential allowed young women from different backgrounds to develop interpersonal and relationship skills. The feedback from them was very positive. Young women enjoyed focused attention and those that had not received or had missed SRE at school appreciated the opportunity to discuss issues and have questions answered. Many had not previously appreciated the range of contraception available, or the range of sexually transmitted infections. One young woman said, "Now I know why condoms are the best form of contraception". Another young woman who was under pressure from her boyfriend to have sex found that the weekend had given her confidence to make the right decision for herself. The young women helped to design an e-card to use for emergency contraception as one of the tasks.

Two of the youth workers on the projected had completed Sexual Health Accredited Training and one was attending the course.

For further information contact Barbara Convery on 0191 478 5976
or barbaraconvery@gateshead.gov.uk

5.3 In contrast, these factors were largely absent or being delivered less effectively in the comparison areas. There was also evidence that in areas where rates were static or increasing, there was a long-standing culture of early pregnancy and low expectations of young women's aspirations, which local stakeholders felt could not be challenged. This acceptance of teenage pregnancy as a norm had resulted in a stronger focus on supporting teenage parents, rather than prevention measures. This lack of belief that things could change, combined with ineffective delivery of key aspects of local strategies, accounted for the different levels of performance in otherwise similar areas.

5.4 We expect all local areas to now review their strategies against these Deep Dive findings and to ensure that they are being implemented locally and captured within their high-level Children and Young People Plans.

6. Accelerating progress to 2010

Summary

This chapter sets out – in the light of the deep dive findings in the previous chapter – what areas need to do to address the problems presented by the analysis in chapter 4. It also sets out what support will be provided nationally to assist local delivery.

Areas should ensure that:

All stakeholders understand the actions required – from senior managers to front line professionals

A senior official in each stakeholder is accountable for delivery

Areas for development are Identified and addressed as part of the Strategy and Children and Young People's Plan

Local provision matches the descriptions of effective practice highlighted in the chapter

Best practice continues to be identified and shared

6.1 We have good evidence from the in-depth reviews about what works. The challenge is to ensure that **all areas** are tackling these problems as intensively as the best performing areas.

Improving Delivery

Problem: Poor knowledge and skills among young people in relation to sex, relationships and sexual health risks

> *Quote: "The sex ed lesson was about relationships really. It made me think about my feelings and relationships differently and more deeply. Different things matter to different people and you don't have to do something just because your friends do it."*
>
> *Girl, 14*

6.2 A number of measures have already been put in place to improve SRE delivery and are beginning to have a positive impact. These include: the issuing of SRE guidance by DfES in 2000 and PSHE assessment guidance by the Qualifications and Curriculum Authority in 2005; and the continued roll-out of the PSHE certification programme for teachers and community nurses who contribute to PSHE. The Healthy Schools programme – with its tighter focus on driving up standards in PSHE, including SRE, in all schools by 2009 and the new emphasis on schools' contribution to helping young people achieve the five Every Child Matters outcomes – strengthen efforts to improve school-based PSHE, including SRE. But OfSTED continue to report weaknesses in SRE in schools

6.3 Effective SRE delivery is critical – the national evaluation of the first 4 years of the teenage pregnancy strategy affirmed the importance of school SRE as a source of learning about sex for young people. This was especially the case for young men, whose primary source of information was through school. The evaluation found that, taking account of other factors, areas where a higher proportion of young people said the SRE they received had met their needs, had lower under-18 conception rates. It was also clear from the in-depth reviews carried out by TPU that the provision of SRE, within PSHE, was demonstrably better in the high-performing areas.

6.4 It is also clear from the evidence that early sex is associated with high levels of regret, poor use of contraception and pregnancy before 18. What is striking though is the consensus between young people and parents that sex under 16 is too young [**Add reference**]. Building on this consensus, promotion of the benefits of delaying early sex will be an integral part of providing information and SRE, alongside the knowledge and skills to prevent pregnancy and STIs when sexual activity begins.

Where we want to be

We want all young people – both boys and girls – to have access to high quality information about sex and relationships and support to develop the skills, confidence and appropriate values framework they need to make and carry through positive choices.

6.5 **Locally:** areas should ensure that:

- all schools have an SRE policy and are delivering a comprehensive programme of SRE, within PSHE, which reflects the *Sex and Relationships Guidance* (2000), meets the needs of boys as well as girls, and has a stronger focus on PSHE in primary schools;
- all schools plan and evaluate their programmes against the QCA end of key stage statements published in 2005.
- PSHE is delivered by specialist teams, made up of trained teachers, school and community nurses, the voluntary sector and other professionals, such as drug and alcohol education advisers;
- PSHE training, support and supervision for staff and development of specialist teams should be prioritised for schools which have under-18 conception hotspot wards in their catchment area and Pupil Referral Units
- They commission evaluated targeted intervention programmes – such as *Teens and Toddlers* – to provide intensive support to young people most at risk.

6.6 Schools' actions to improve PSHE delivery should be within the broader context of working towards achieving Healthy School status and helping young people to achieve the five *Every Child Matters* outcomes.

6.7 **Nationally:** we will:

- provide support for PSHE teachers through the introduction of a PSHE subject association;
- continue to develop and fund the PSHE certification programmes for teachers and community nurses;
- use the 'Healthy Schools' programme as a key lever for driving up quality of PSHE and pastoral support; and
- monitor the impact of the new schools inspection framework and QCA assessment guidance on delivery.
- with DH, continue to run a communications campaign to ensure young people have access to accurate information and advice to make safe choices;
- publish a Teenage Pregnancy Campaign toolkit for local areas, to help disseminate materials to young people and parents in a wide range of community settings.

6.8 The increased focus on promoting the benefits of delay within SRE programmes will be replicated in the national media campaign, alongside the other key messages on pregnancy and STI prevention and supported by the Sexwise helpline advisers. We will also ensure that Parentline Plus advisers help parents develop the confidence to talk about the benefits of delay when discussing sex and relationship issues with their children. We will continue to promote training on delay, for key professionals working with vulnerable young people. The impact of the training on professionals' skills and confidence will be evaluated as part of the Young People Development Programme (YPDP).

6.9 We will also do further work to assess the best ways of reaching boys and young men. Only 48% of boys report having been told 'a lot' or 'quite a lot' about sex and relationships by their parents; boys are also less likely than girls to obtain information from friends (43% boys versus 56% girls) and magazines/newspapers/books/posters (26% boys v. 52% girls). Boys and young men influence their partners' choice and use of contraception, yet their knowledge levels are poor. They are less likely than girls to know of a local clinic or advice service (65% v 77%), and only 54% of boys know that contraception can be obtained free of charge – dropping to 40% for boys under 16. Boy's awareness of the range of contraceptive methods is also low: only 36% are aware of long acting methods such as the implant and injection.

Quote: "I called the Helpline because all my friends said they were having sex and people were calling me names because they knew I hadn't. I felt under loads of pressure just to get a girlfriend and do it. The adviser was really good. He told me that most people don't have sex until they're at least 16, whatever they say, and it was important not to do something I didn't want to do. He suggested I talked to my dad or my brother but just talking to the adviser has helped."

Boy, 15

Problem: Poor contraceptive use among young people

Quote: "I was having sex with my boyfriend but we weren't always using condoms. I was worried I'd be judged or told off but the nurse was really kind and helped me think everything through and sort out our contraception. I had been scared to talk to my parents, but she gave me ideas of how to tell my mum. When I did, she was relieved I was being responsible. If the clinic hadn't been there, I would have just kept my fingers crossed and hoped I'd be safe. All teenagers need clinics like this where they can go for advice."

Girl, 16

6.10 We have made significant improvements in making access to services easier for young people, who remain the group least likely to seek advice. In the recent DH contraceptive service audit, 85% of PCTs report that they have commissioned new youth focused contraceptive services since the start of the Strategy and support is increasingly available in places where young people spend their time – in schools, FE colleges and other youth settings, often in partnership with the voluntary sector. This is particularly important for boys and young men, who are less likely to access advice and services in traditional settings.

6.11 At the same time, services which are delivered in traditional settings, including General Practice, are increasingly focused on young people, with more and more areas delivering dedicated services for young people. The Department of Health *'You're Welcome'* quality criteria, published in 2005, provide a clear commissioning framework for such services.

6.12 But we need to do much more. While the national evaluation shows that young people who had first sex before 16 and/or are living in deprived areas were more likely to use designated young people's contraceptive and sexual health advice services, overall the proportion of young people who do not access advice and support prior to first sex remains high. Dedicated services for young people – which were being provided in the high-performing areas visited by TPU – provide the opportunity to increase young people's use of services. This access to advice from sexual health professionals promotes both more consistent and more effective use of contraception. The national evaluation also shows more young people (especially boys) accessing school-based services.

6.13 Since the start of the Strategy, the proportion of boys and young men using contraceptive clinics and GPs has significantly increased from 9% to 29%, but the proportion remains considerably lower than for girls. Boys' use of services is influenced by travelling distance. They are significantly more likely to access advice if the service is within 1km of where they live. This is particularly so in deprived areas.

Quote: "Having the sexual health worker at the project was good. We were all there anyway, playing pool, so it was easy to ask a question without making a big deal about going to a clinic. Having free condoms is good because lots of people don't bother to buy them, but you can talk about anything really."

Boy, 17

Where we want to be

We want all young people to know where to access contraceptive and sexual health advice and to feel confident to do so.

6.14 **Locally:** all areas should ensure that:

- young people know about and have easy access to services which reflect the TPU *Best practice guidance on the provision of effective contraception and advice services* and meet the DH *You're Welcome Quality Criteria* for young people friendly services
- services include health promotion outreach work to reach young people most at risk of early pregnancy and engagement with non-health professionals so that they are clear about where to refer young people who need advice and support
- services are tailored to meet the needs of boys and young men with arrangements for condom distribution to reach those least likely to access mainstream services
- young people in school, as part of PSHE, are provided with precise details of local services, and that up-to-date details of local services are on the database held by the ruthinking website and helpline, to allow speedy referrals to local advice;
- young women who are pregnant have access to impartial advice and counselling services that help them make an informed choice about whether to continue with the pregnancy;
- the provision of young people focused contraceptive and sexual health services is explicitly included in local commissioning arrangements;
- in line with the principles in the recent 'Our Care, Our Health, Our Say' Health White Paper, areas develop strong relationships between GPs, PCTs and local authorities, so commissioning arrangements secure trusted and confidential advice for young people in the right places, with seamless links between services.

6.15 **Nationally:** we will:

- help primary care trusts to identify gaps in local services by sharing the findings of the national audit of contraceptive services and by publishing best practice commissioning guidance for PCTs on contraception/reproductive health services;
- continue to run *'You're Welcome'* dissemination events to encourage the commissioning of young people friendly services in a range of community settings, in line with recommendations in Our Health, Our Care, Our Say;
- with young people, devise a 'Quality Mark' to identify designated *'You're Welcome'* health services in line with the quality criteria identified in that document;
- use the lessons from the four DH Adolescent Health Demonstration sites to drive forward service improvements, including establishing transition champions in all areas;

- continue to provide support for consultants working locally to implement the Extended Schools programme, so they are better able to support schools who wish to develop on-site health advice services;
- publish a 'Know How' leaflet for schools on developing on-site services as part of their extended provision, to help them overcome common barriers and concerns;
- In line with the *Choosing Health* commitment, provide new funding so that by 2010 every PCT will be resourced to have at least one full-time, year round, qualified school nurse working with each cluster or group of primary schools and their linked secondary school;
- produce guidance to support the establishment of health and pastoral advice services in FE colleges, supported by an e-mail network for FE colleges to promote best practice – work in FE will also help address the needs of 14-16 year olds who are increasingly in college-based learning;
- develop national standards for Local Authorities on the quality of Information, Advice and Guidance provided to young people on the full range of issues that affect their lives;
- ensure that professionals providing targeted support for young people at risk – including those outside mainstream education – can signpost young people to sexual health services, where appropriate;
- issue revised guidance on effective ways of encouraging more boys and young men to access health advice in a range of settings, including condom distribution schemes and innovations such as texting services;
- work in partnership with industry to help improve access to condoms for vulnerable and hard to reach groups, including young people;
- In line with the *Choosing Health* commitment, roll out the Chlamydia Screening Programme nationally by 2007, which will also offer broader signposting to sexual health services locally for young people; and
- publish findings from the DH one-stop shop sexual health services evaluation and disseminate messages on service development and integration that meet the needs of service users including young people.

6.16 Around 20% of births conceived to under-18s are to young women who are already teenage mothers; around 7.5% of abortions under-18 are to young women who have had a previous abortion. We will reduce the risk of repeat unplanned conceptions through:

- clear messages to teenage parents on the risk of pregnancy after childbirth;
- Identifying and sharing effective practice on preventing repeat unplanned conceptions through the ECM website and the National Service Framework's 'emerging practice database';

- Disseminating information about training courses on contraception through relevant maternity and health visitor networks;
- liaising with relevant professional bodies for midwives and health visitors, including the Royal Colleges, to build in training on contraception into pre-registration and CPD programmes;
- testing different ways of supporting young people who have had an abortion, and teenage parents, in their use of contraception – in the four DH Adolescent Health Demonstration pilots;
- including the need to provide comprehensive abortion care packages (including information on contraception and counselling) in the forthcoming DH best practice commissioning guidance on contraception/reproductive health for PCTs, commissioners and service providers;
- ensuring that promotion of contraception always includes long-acting reversible contraceptive (LARC) methods, in line with the recently published NICE guidance and value for money principles;
- communicating the importance of ensuring young women who have had a prior pregnancy are advised about contraception to a range of professionals, including health visitors, staff working in Children's Centres and Teenage Pregnancy Re-integration Officers.

Problem: Lack of support for parents/carers and professionals on how to engage with young people on relationships, sex and sexual health

6.17 Many of the young people at greatest risk of teenage pregnancy will be in touch with professionals (such as Connexions Personal Advisers and Learning Mentors) on other issues, such as poor attendance/attainment at school and behavioural problems. But the opportunity this trusted relationship provides to address their sexual health needs is often missed because professionals lack the skills and confidence to deal with these issues.

6.18 The national evaluation reports that many young people still find it difficult to talk to their parents/carers about sex and relationships, and calls for more innovative approaches to improving communications between parents/carers and children. We therefore want local areas to improve the support available for parents/carers, so they feel better able to talk to their children about these issues, in particular helping fathers to talk to their sons.

Where we want to be

We want professionals and parents/carers to feel confident to discuss sex and relationship issues so that they can better support young people in making positive choices.

Workforce

6.19 **Locally:** all local areas should ensure that:

- all delivery partners provide training so that key professionals are more confident to: engage with young people on sexual health issues (including those working with boys and young men); promote messages on delay and – for the sexually active – use of contraception and condoms; and make supported referrals to contraceptive and sexual health services
- training for professionals on SRE should be provided in the induction and in-service programmes delivered by mainstream partners and be included as part of the corporate workforce plans. This needs to re-inforced through ongoing support and supervision.

6.20 **Nationally:** we will:

- develop training for the wider Children's Workforce, providing additional skills and competencies to address the health and emotional well-being of young people. The training will reflect each of the six areas of the Common Core of Skills and Knowledge – the common, basic set of skills required by everyone working with children, young people and families. Work to develop the training will be undertaken with the Children's Workforce Network, which includes the Children's Workforce Development Council – the organisation which is leading on work to build an integrated qualifications framework for the children's workforce. The framework will be the key means of embedding the Common Core into National Occupational Standards, from which qualifications are derived.

Supporting parents/carers

Quote: "I had never done anything like this before. I didn't know what to expect and I was quite nervous talking about sex and relationships with a load of strangers. But I didn't have to worry. The facilitator put us at ease straight away and it was very easy and actually a lot of fun. Now I have finished the programme, I feel I can talk more openly to my children about sex, body changes and relationships. It has given me the opportunity to understand my children better as they share their questions and worries with me."

Mother of son (10) and daughter (12) on Speakeasy programme

6.21 We have provided support for parents/carers through the 'Time to Talk' initiative delivered through Parentline Plus and targeted community-based parenting programmes. But we want to increase the reach of this essential aspect of the strategy.

6.22 **Locally:** all areas should ensure that:

- Parentline Plus *Time to Talk* materials are displayed in all relevant community settings with clear information about sources of local and national support
- Parents/carers are actively consulted and involved in SRE/PSHE programmes in schools
- targeted programmes, such as the fpa Speakeasy programme or Parentline Plus Time to Talk community projects, are commissioned to support parents/carers of young people most at risk of early sex and teenage pregnancy.

6.23 **Nationally:** we will:

- increase the universal reach of the Time to Talk initiative by disseminating materials to Children's Information Services, Children's Centres, General Practice, health centres and other community settings and encourage their use to help Healthy Schools and Extended Schools fulfil their commitment to involve and consult parents/carers on SRE;
- involve parents/carers in discussion about puberty, relationships and sexual health through Transition Information Sessions in secondary schools; and
- provide funding for roll out of the fpa Speakeasy programme, to create a new support and development network for professionals who have been trained to deliver Speakeasy, with an independent evaluation to monitor how children directly benefit when their parents/carers attend a Speakeasy course
- pilot the Time to Talk community pilots in some of the Respect Action Plan (January 2006) Parenting Early Intervention Pathfinder areas, to be announced later in 2006.

Quote: "You have to bite the bullet and be honest and open about your own experiences. Knowing local information and voicing it helps. Using TV programmes is good, for example 'oh, she's got chlamydia, she will need to go to a GUM clinic, she would have been better getting free condoms from the youth centre.'"

Parent on Speakeasy programme

London

6.24 London is the Region that has: made least progress; has the highest proportion of areas which have seen *increases* in their rates; and has the highest rate areas.

6.25 All of the measures in this document will apply to London. But in addition, the size of the challenge in London requires additional action to address issues specific to the Capital. This work will be led by Government Office for London and brought together under a 'London Teenage Pregnancy Strategy', which will be jointly agreed between a wide range of organisations. The Action Plan, as part of the Young London Matters Strategy and in

partnership with GOL and London Challenge, will include targeted work to raise aspirations and attainment among disengaged girls in secondary schools with the greatest challenges. The Action Plan will encourage better training for professionals in London working with young people most at risk of early pregnancy; an intensive drive to support all schools in becoming Healthy Schools; and better support for parents of teenagers to discuss sex and relationship issues. The Action Plan will also ensure all work to address teenage pregnancy meets the needs of a culturally diverse population and, in particular, the needs of different BME groups/different Faith perspectives.

7. Support and Challenge

Summary

This chapter sets out the arrangements for performance managing local areas' progress against local conception rate reduction targets.

7.1 The principle of differentiated levels of support and challenge, based on each area's progress against local conception rate targets, will apply. Using the traffic-light ratings used in annex 1 (which are updated annually), Government Offices will performance manage local areas, using the deep dive findings as the basis for assessing whether local strategies are being implemented effectively.

7.2 Under the direction of the new Directors of Children and Learners, Government Offices – working closely with Strategic Health Authorities and Regional Public Health teams – will identify the best performers in the system, and disseminate effective practice so that the best lead the rest to higher standards and better outcomes.

7.3 Concerns about areas which fail to address the key findings from the deep dive reviews will be addressed by Children's Services Advisers (CSAs) in local authority Priorities Conversations, and through School Improvement Partners' conversations with head teachers. Strategic Health Authorities will continue to performance manage PCTs' contribution to local strategies and the new National Support Team in DH will provide intensive support for areas failing to achieve conception rate reduction targets. Actions to reduce teenage pregnancy rates locally will be assessed through local authority annual performance assessments (APAs) and the combination of individual partners' efforts to reduce under-18 conception rates assessed through the Joint Area Reviews (JARs).

7.4 To ensure a consistent approach to performance management, we will issue audit guidance in October, which will provide a detailed checklist of an effective local strategy. This can be used as a self assessment tool by LAs and PCTs, and by CSAs and other

performance managers in the improvement cycle, to assess whether all key mainstream partners are fully engaged in local strategies.

7.5 A key feature of our efforts to improve delivery will be to continue to provide local teenage pregnancy strategies with the most accurate and up-to-date data and analysis, so that they can focus their efforts in high-rate neighbourhoods and on young people most at risk. From February 2005, we have provided all local areas with individual analytical reports, including trends in teenage birth and abortion rates and comparisons with statistical neighbours. An illustrative copy of the information provided to local areas is attached at annex 2. These reports will be updated and issued annually by TPU. Local areas are also sent ward level conception data which identifies 'hotspot' wards within local authority areas.

Conception Data Explained

ONS conception statistics are compiled from birth registrations and abortion notifications, and are the most accurate and robust data available to monitor trends in teenage pregnancy. Conception statistics measure the actual date of conception, and not the date of the birth or abortion resulting from a conception.

As conception statistics are partly compiled from birth registrations there is an inevitable time-lag in their release. Birth registration can be done up to six weeks after birth so information on conceptions leading to birth may not reach ONS until up to 11 months after the date of conception. ONS require a further three months to compile the statistics so data are released 14 months after the period to which they relate (e.g. data for 2004 were released in February 2006). To improve the timeliness of data to monitor the Teenage Pregnancy Strategy, ONS release quarterly under-18 conception data for top-tier local authorities.

7.6 At a national level, the focus will be on:

- communicating what the key ingredients of a successful local strategy are (drawing on what is working in successful areas), so that all those in the delivery chain are clear about the contribution they need to make; and
- providing a clear rationale for why tackling high rates of teenage pregnancy matters.

7.7 The Teenage Pregnancy Unit will produce detailed descriptions of the main features of successful local strategies – for example, on what constitutes 'strong PSHE delivery' – exemplifying the shorter descriptions of effective practice contained in Chapter 5. This will make clear who is accountable for delivering each aspect of local strategies. Each

description will include case studies, drawn from areas which are having most success in reducing conception rates.

7.8 To help areas decide which specific programmes/interventions to commission (for example, programmes that improve young people's knowledge and skills about sex and relationships, or build their aspirations), TPU will develop a menu of promising programmes, with evaluation evidence where it is available. This will help areas to invest in tailored, yet proven, resources that best suit the needs and circumstances of their individual cohorts of young people.

7.9 We will also develop a clear and strong statement about why reducing teenage pregnancy is a priority, so that all of the individual partners within the delivery chain can better understand how they contribute to local teenage pregnancy rates and why it matters to both individuals' future life outcomes and the wider community. This will be in a format that allows senior colleagues within Local Authorities and PCTs to communicate clear and consistent messages to frontline practitioners.

7.10 We will establish a group of analysts from across Government to look at the way in which alternative data sources and proxy indicators might provide local areas with more real-time assessments of the impact of new measures and initiatives that areas have taken to strengthen their delivery. For the purpose of measuring progress against the PSA target, however, existing ONS data will continue to be used.

7.11 Ministers and DfES officials in the Teenage Pregnancy Unit will review regularly the progress being reported by CSAs and others involved in performance management, with a particular focus on the 21 areas with high and increasing rates. Where performance remains a concern, TPU will carry out 'deep dive' visits to provide consultancy advice on how local strategies might be enhanced.

Annex 1: Under 18 Conception Rates for Top-Tier Local Authorities 1998 and 2004

Rates are per 1000 females aged 15-17

Region	LA Name	1998 rate	*Provisional* 2004 rate	% change 98-04	2004 Traffic light rating
London	Barnet LB	24.2	34.6	42.7	Red
London	Barking and Dagenham LB	54.6	71.8	31.5	Red
London	Redbridge LB	25.9	32.4	25.0	Red
London	Harrow LB	27.1	33.6	24.0	Red
South East	Windsor and Maidenhead UA	25.0	29.3	16.9	Red
South West	Torbay UA	44.2	49.9	13.0	Red
London	Brent LB	47.8	53.4	11.7	Red
North West	Blackpool UA	64.8	72.3	11.6	Red
London	Enfield LB	46.4	51.1	10.2	Red
London	Haringey LB	62.3	68.6	10.0	Red
South East	Oxfordshire	31.4	34.3	9.3	Red
North East	Newcastle upon Tyne MCD	52.8	57.4	8.6	Red
Yorkshire & Humber	Sheffield MCD	50.5	54.4	7.6	Red
West Midlands	Solihull MCD	40.3	43.2	7.2	Red
North West	Manchester MCD	61.3	65.2	6.3	Red
North West	Bolton MCD	50.3	53.2	5.8	Red
London	Hillingdon LB	43.9	46.4	5.7	Red
South West	Swindon UA	53.5	56.4	5.5	Red
London	Hounslow LB	49.6	52.2	5.3	Red
East England	Luton UA	43.1	44.7	3.8	Red
Yorkshire & Humber	York UA	34.0	35.1	3.5	Red
London	Greenwich LB	62.6	64.7	3.3	Red
London	Bexley LB	37.2	38.3	2.9	Red

Region	LA Name	1998 rate	*Provisional* 2004 rate	% change 98-04	2004 Traffic light rating
North East	Stockton-on-Tees UA	48.3	49.0	1.5	Red
West Midlands	Hereford, County of UA	37.2	37.8	1.4	Red
North West	Tameside MCD	53.6	53.9	0.6	Red
North East	Redcar and Cleveland UA	58.3	58.3	0.1	Red
London	Lambeth LB	85.3	84.0	–1.5	Red
West Midlands	Stoke-on-Trent UA	68.5	67.4	–1.6	Red
London	Southwark LB	87.2	85.2	–2.3	Amber/red
East Midlands	Nottingham UA	74.7	72.8	–2.5	Amber/red
East England	Norfolk	37.0	35.8	–3.2	Amber/red
North West	Trafford MCD	34.0	32.8	–3.6	Amber/red
London	Bromley LB	32.1	30.9	–3.8	Amber/red
London	Richmond upon Thames LB	23.1	22.2	–3.9	Amber/red
South West	Bath and North East Somerset UA	29.0	27.8	–4.1	Amber/red
North West	Wigan MCD	53.6	51.3	–4.3	Amber/red
Yorkshire & Humber	North Lincolnshire UA	53.9	51.5	–4.6	Amber/red
South East	Portsmouth UA	57.0	54.0	–5.3	Amber/red
South West	Devon County	32.9	31.2	–5.3	Amber/red
Yorkshire & Humber	North East Lincolnshire UA	69.8	65.9	–5.6	Amber/red
South East	East Sussex County	39.8	37.5	–5.8	Amber/red
South East	Reading UA	63.1	59.4	–5.9	Amber/red
East Midlands	Northamptonshire	45.9	43.1	–6.0	Amber/red
West Midlands	Worcestershire County	35.1	33.0	–6.0	Amber/red
North West	Sefton MCD	33.5	31.5	–6.1	Amber/red
Yorkshire & Humber	Kingston upon Hull UA	84.6	79.0	–6.5	Amber/red
London	Islington LB	58.3	54.5	–6.6	Amber/red
South West	South Gloucestershire UA	33.8	31.6	–6.6	Amber/red
East England	Peterborough UA	57.7	53.8	–6.7	Amber/red
London	Croydon LB	59.1	55.1	–6.8	Amber/red
North West	Halton UA	47.1	43.8	–7.0	Amber/red
North West	Salford MCD	61.5	57.0	–7.3	Amber/red
North East	Middlesbrough UA	66.5	61.6	–7.5	Amber/red
South East	Brighton & Hove UA	48.1	44.4	–7.6	Amber/red
South West	Dorset County	31.1	28.7	–7.6	Amber/red
South East	Southampton UA	60.9	56.1	–7.8	Amber/red
Yorkshire & Humber	Leeds MCD	50.4	46.5	–7.9	Amber/red
Yorkshire & Humber	Wakefield MCD	56.5	52.0	–8.0	Amber/red

Region	LA Name	1998 rate	*Provisional* 2004 rate	% change 98-04	2004 Traffic light rating
West Midlands	Wolverhampton MCD	66.3	60.8	–8.3	Amber/red
South West	Bristol UA	51.0	46.7	–8.4	Amber/red
North West	Oldham MCD	66.1	60.3	–8.8	Amber/red
Yorkshire & Humber	East Riding of Yorkshire UA	34.7	31.5	–9.1	Amber/red
Yorkshire & Humber	Rotherham MCD	56.6	51.5	–9.1	Amber/red
North West	Knowsley MCD	54.8	49.7	–9.3	Amber/red
South East	Kent County	42.1	38.1	–9.4	Amber/red
East England	Suffolk	37.5	33.9	–9.6	Amber/red
South East	West Berkshire UA	31.0	28.1	–9.6	Amber/red
London	Hackney LB & City of London	77.1	69.4	–10.0	Amber/green
Yorkshire & Humber	Kirklees MCD	48.6	43.6	–10.3	Amber/green
West Midlands	Warwickshire	41.4	37.1	–10.3	Amber/green
North East	Northumberland	41.8	37.4	–10.4	Amber/green
North West	Blackburn with Darwen UA	58.2	52.1	–10.5	Amber/green
North West	Cheshire County	37.8	33.4	–11.5	Amber/green
North East	Durham County	54.4	48.1	–11.6	Amber/green
West Midlands	Birmingham MCD	58.3	51.5	–11.7	Amber/green
North West	Bury MCD	55.6	48.9	–11.9	Amber/green
South East	Medway Towns UA	46.2	40.7	–11.9	Amber/green
South East	Buckinghamshire County	24.8	21.9	–11.9	Amber/green
East Midlands	Derbyshire County	41.6	36.6	–12.1	Amber/green
West Midlands	Dudley MCD	54.7	48.1	–12.1	Amber/green
London	Lewisham LB	80.0	70.2	–12.3	Amber/green
North East	North Tyneside MCD	58.4	51.1	–12.4	Amber/green
North West	Wirral MCD	50.6	44.4	–12.4	Amber/green
North West	Rochdale MCD	61.9	54.1	–12.6	Amber/green
West Midlands	Coventry MCD	60.5	52.8	–12.8	Amber/green
South West	Cornwall and the Isles of Scilly	39.8	34.3	–13.6	Amber/green
North West	Lancashire County	48.5	41.9	–13.7	Amber/green
South West	Plymouth UA	54.7	47.2	–13.8	Amber/green
London	Havering LB	40.7	35.1	–13.9	Amber/green
North West	St Helens MCD	55.5	47.8	–14.0	Amber/green
North West	Cumbria	41.9	35.9	–14.2	Amber/green
East Midlands	Derby UA	63.8	54.7	–14.2	Amber/green
Yorkshire & Humber	Doncaster MCD	73.7	63.0	–14.5	Amber/green
East England	Hertfordshire	32.0	27.4	–14.5	Amber/green

Region	LA Name	1998 rate	*Provisional* 2004 rate	% change 98-04	2004 Traffic light rating
North West	Stockport MCD	43.2	36.8	–15.0	Green
North East	Hartlepool UA	75.6	64.1	–15.2	Green
London	Waltham Forest LB	56.0	47.3	–15.6	Green
Yorkshire & Humber	Barnsley MCD	60.2	50.8	–15.7	Green
South East	Hampshire County	35.9	30.2	–15.8	Green
London	Camden LB	49.3	41.4	–15.9	Green
East England	Southend-on-Sea UA	56.4	47.4	–16.0	Green
South West	Wiltshire County	32.1	26.9	–16.1	Green
East England	Essex County	36.9	30.6	–17.0	Green
London	Ealing LB	44.3	36.7	–17.1	Green
London	Kingston upon Thames LB	30.9	25.6	–17.1	Green
North West	Warrington UA	48.8	40.4	–17.3	Green
South West	Somerset	38.8	32.0	–17.6	Green
South West	Gloucestershire	41.6	34.3	–17.7	Green
West Midlands	Sandwell MCD	69.1	56.6	–18.1	Green
South East	Milton Keynes UA	51.2	41.9	–18.1	Green
London	Wandsworth LB	71.1	58.0	–18.5	Green
East England	Cambridgeshire County	31.4	25.6	–18.6	Green
North East	Sunderland MCD	63.1	51.3	–18.7	Green
South East	West Sussex	37.0	30.0	–18.8	Green
London	Newham LB	59.9	48.6	–18.9	Green
West Midlands	Telford and Wrekin UA	64.2	52.0	–19.1	Green
Yorkshire & Humber	Calderdale MCD	53.4	43.0	–19.3	Green
West Midlands	Shropshire County	34.0	27.4	–19.5	Green
London	Sutton LB	38.8	31.3	–19.5	Green
South East	Surrey	27.6	22.2	–19.6	Green
North East	South Tyneside MCD	64.9	52.1	–19.7	Green
West Midlands	Staffordshire County	43.2	34.6	–20.0	Green
East Midlands	Leicestershire County	38.0	30.3	–20.2	Green
East England	Bedfordshire County	41.0	32.3	–21.2	Green
South East	Isle of Wight UA	40.2	31.7	–21.2	Green
East Midlands	Nottinghamshire County	46.4	36.5	–21.4	Green
East Midlands	Lincolnshire	50.1	39.1	–21.8	Green
North East	Gateshead MCD	57.1	44.5	–22.0	Green
London	Merton LB	51.0	39.4	–22.7	Green
Yorkshire & Humber	Bradford MCD	57.2	44.1	–22.9	Green

Region	LA Name	1998 rate	*Provisional* 2004 rate	% change 98-04	2004 Traffic light rating
East Midlands	Leicester UA	64.6	49.2	–23.8	Green
North West	Liverpool MCD	57.9	43.6	–24.7	Green
North East	Darlington UA	64.0	47.8	–25.3	Green
London	Tower Hamlets LB	57.8	43.2	–25.3	Green
South East	Slough UA	56.5	41.2	–26.9	Green
West Midlands	Walsall MCD	67.2	48.7	–27.5	Green
South West	Bournemouth UA	51.6	37.1	–28.1	Green
South West	North Somerset UA	35.7	25.5	–28.7	Green
South East	Wokingham UA	27.8	19.6	–29.4	Green
Yorkshire & Humber	North Yorkshire County	36.6	25.5	–30.2	Green
East England	Thurrock UA	62.3	43.1	–30.7	Green
South East	Bracknell Forest UA	45.5	31.5	–30.7	Green
London	Westminster City of LB	40.8	26.7	–34.5	Green
East Midlands	Rutland UA	16.9	10.9	–35.3	Green
London	Hammersmith and Fulham LB	69.0	43.9	–36.4	Green
South West	Poole UA	43.3	26.3	–39.3	Green
London	Kensington and Chelsea LB	41.7	24.1	–42.2	Green

Sources: Office for National Statistics and Teenage Pregnancy Unit

Note: Criteria for traffic-lights

Traffic-light	*Change in rate 98-04*
Red	**Increase** *or static (<2% change) and rate over 60*
Amber/red	**0-10% decline**
Amber/green	**10-15% decline**
Green	**Over 15% decline**

Annex 2: Example of data analysis sent to local areas

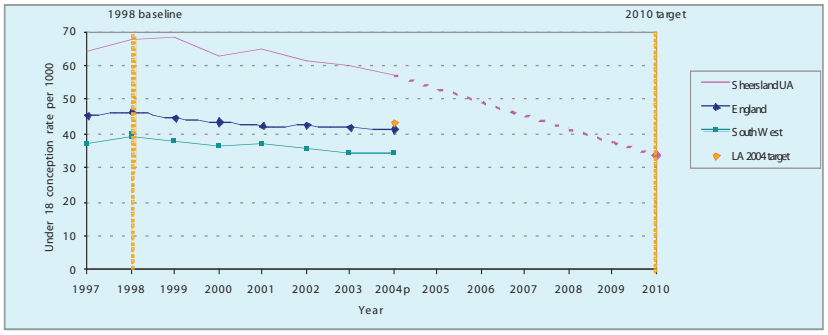
Sheet 1: Analysis of conception trends

PLEASE SELECT FROM DROP-DOWN LIST

Sheersland UA

Teenage Pregnancy Trends in Sheersland UA

	Under 18 conception rates								Trajectory required to meet 2004 & 2010 target					
	1997	1998	1999	2000	2001	2002	2003	2004p	2005	2006	2007	2008	2009	2010
Sheersland UA	64.4	67.3	68.1	62.9	64.8	61.0	60.1	57.2	53.3	49.4	45.4	41.5	37.6	33.7
% change in rate from baseline		*0*	*1.2*	*-6.5*	*-3.7*	*-9.4*	*-10.7*	*-15.0*	*-15.3*	*-22.3*	*-29.2*	*-36.1*	*-43.1*	***-50.0***
								43.3						
South West	37.1	39.4	37.5	36.3	37.1	35.4	34.1	34.4	-	-	-	-	-	-
England	45.5	46.6	44.8	43.6	42.5	42.6	42.1	41.5	38.5	35.4	32.4	29.4	26.3	**23.3**
% change in rate from baseline		*0*	*-4.1*	*-6.4*	*-8.9*	*-8.6*	*-9.8*	*-11.1*	*-17.5*	*-24.0*	*-30.5*	*-37.0*	*-43.5*	***-50.0***

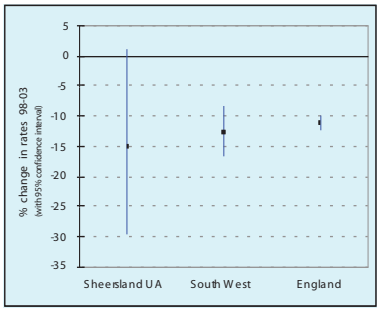


Change in under 18 conception rate 1998-04

	% change	*Upper limit*	*Lower limit*	% change
Sheersland UA	**-15.0**	*1.1*	*-29.7*	-15.0
South West	**-12.6**	*-8.3*	*-16.8*	-12.6
England	**-11.1**	-9.8	-12.3	-11.1

2004 conception rate with 95% confidence interval

	2004 rate	*Upper limit*	*Lower limit*	2004 rate	Difference from England rate
Sheersland UA	**57.2**	50.2	64.2	57.2	Significantly higher
South West	**34.4**	33.3	35.6	34.4	Significantly lower
England	**41.5**	41.1	41.9	41.5	n/a



Outcome of u18 conception 1997-99 and 2002-04

Sheersland UA	1997-99	2002-04	% change
Under 18 conceptions	66.6	59.4	-10.8
Abortion rate	31.2	33.2	6.4
Maternity rate	35.4	26.2	-26.0

Under 18 conception rate split by age group, 2001-03

	<16	16-17
Sheersland UA	17.3	44.7
South West	6.4	29.1
England	8.1	34.3

Last update: 08.03.06
Note: Data for 2004 are provisional

Note: Dummy data for illustrative puposes only

Sheet 2: Comparisons with 'statistical neighbours'

Please select LA:

Sheersland

Teenage Pregnancy in Sheersland

Table 1: Comparison of under 18 conception trends by corresponding local authorities

	Code	LA Name	Region	Deprivation Score	Under 18 conception rate 1997-99	2001-03	% change in rates
Selected LA	00DS	Sheersland UA	SW	32.6	66.6	62.0	-6.9
Most similar	00AH	Hadleyshire	SE	31.4	56.2	64.7	15.1
2nd most similar	23MB	Bell-on-the-Wold	SW	29.8	52.9	49.1	-7.2
3rd most similar	00RM	Robmacshire	NW	23.4	50.8	42.5	-16.3
4th most similar	-	-	-	-	-	-	-

Figure 1: Under 18 conception rates by corresponding local authorities

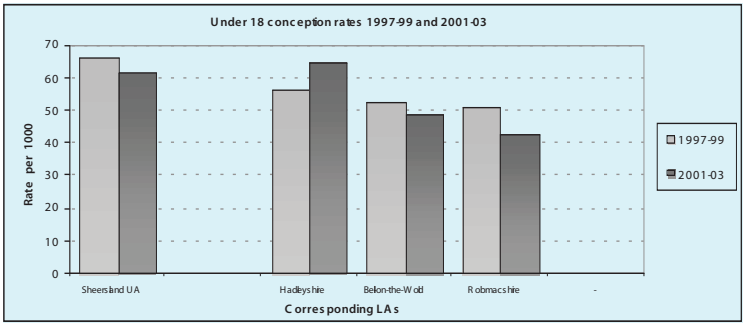


Figure 2: Deprivation score and under 18 conception rate for 2001-03 by local authority

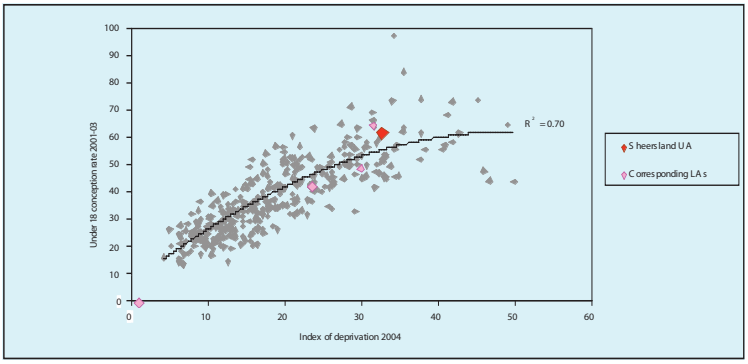


Table 2: GCSE attainment for boys and girls by local authority of residence, 2002

	Code	LA Name	% of boys 5+ GCSEs at A*to C	% of boys 5+ GCSEs at A*to G	% of boys no GCSE passes	% of girls 5+ GCSEs at A*to C	% of girls 5+ GCSEs at A*to G	% of girls no GCSE passes
Selected LA	00HB	Sheersland UA	45.5	83.4	12.0	46.7	88.6	11.2
Most similar	00AH	Hadleyshire	39.4	81.0	11.3	41.8	85.7	10.1
2nd most similar	23MB	Bell-on-the-Wold	55.8	91.2	8.2	61.7	92.9	5.9
3rd most similar	00RM	Robmacshire	59.2	91.0	5.6	63.8	93.0	4.4
4th most similar	-	-	-	-	-	-	-	-
		England	**43.7**	**86.6**	**7.1**	**54.6**	**90.6**	**5.1**

Table 3: Characteristics of mothers giving birth under 19 between 1999-2001

	Code	LA Name	% Lone Parent	% Married couple	% Cohabiting	% No qualifications*	% Level 1**	% White British
Selected LA	00HB	Sheersland UA	62.8	9.9	33.7	32.4	31.8	93.6
Most similar	00AH	Hadleyshire	88.0	3.4	6.5	39.8	29.7	77.0
2nd most similar	23MB	Bell-on-the-Wold	56.4	12.0	30.7	44.4	34.7	97.8
3rd most similar	00RM	Robmacshire	45.6	6.0	44.0	21.5	17.1	96.6
4th most similar	-	-	-	-	-	-	-	-
		England	**61.4**	**7.5**	**29.8**	**37.4**	**29.0**	**89.3**

Source: 2001 Census

*No qualifications: No academic; vocational or professional qualifications

**Level 1: 1-4 'O' levels/CSE/GCSE (any grade); NVQ level 1; Foundation GNVQ

Last update: 20.01.06

Note: Dummy data for illustrative puposes only

Annex 3: Assessment Tool used by Teens & Toddlers

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