APPENDIX ONE

GOVERNMENT OFFICE FOR THE NORTH WEST

NHS North West

Cheshire & Merseyside NHS sexualhealthnetwork

Central and Eastern Cheshire

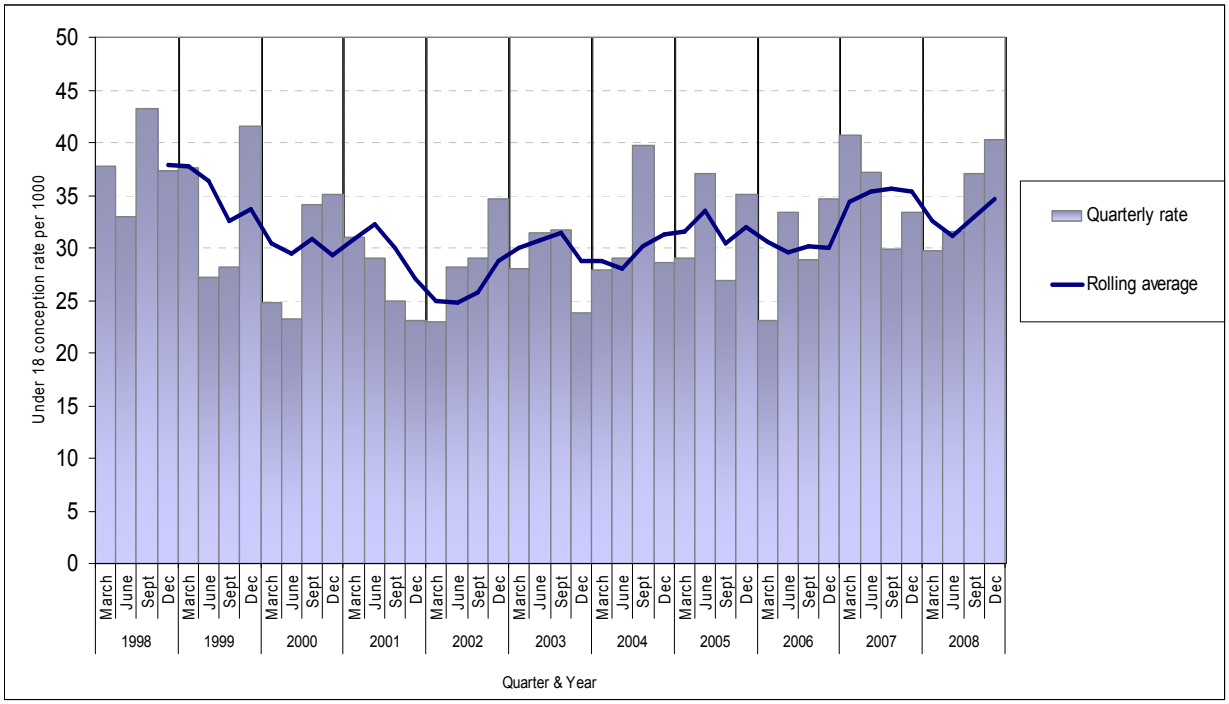
Contraceptive and sexual health services review findings and recommendations

Recently released (Feb 2010) ONS 2008 data for CEC shows a 9.1 decrease in under-18 conception rates since 1998 .Since the 1998 baseline the there has been a decrease in the areas of deprivation (-10%), however little progress in Macclesfield (-1.3%) and a sharp increase in conceptions in Congleton (20.8%). Worryingly, the rates in Congleton are one of the highest rates in the region. The termination rates have increased by approximately 10%, which are well above the national and regional averages.

	1998 Number	**1998 Rate**	*1998 % leading to abortion*	**2008 Number**	**2008 Rate**	***2008 % leading to abortion***	***1998 - 2008 % change***
Cheshire East UA	230	37.9	-	233	34.5	*52*	**-9.1%**

Cheshire East UA	**-**	**-**		**674**	**33.2**	***53***	**-**
Congleton	104	21.8	*50*	137	26.3	*59*	***20.8%***
Crewe and Nantwich	288	49.2	*40*	297	44.3	*43*	***-10.0%***
Macclesfield	226	29.0	*53*	240	28.6	*61*	***-1.3%***

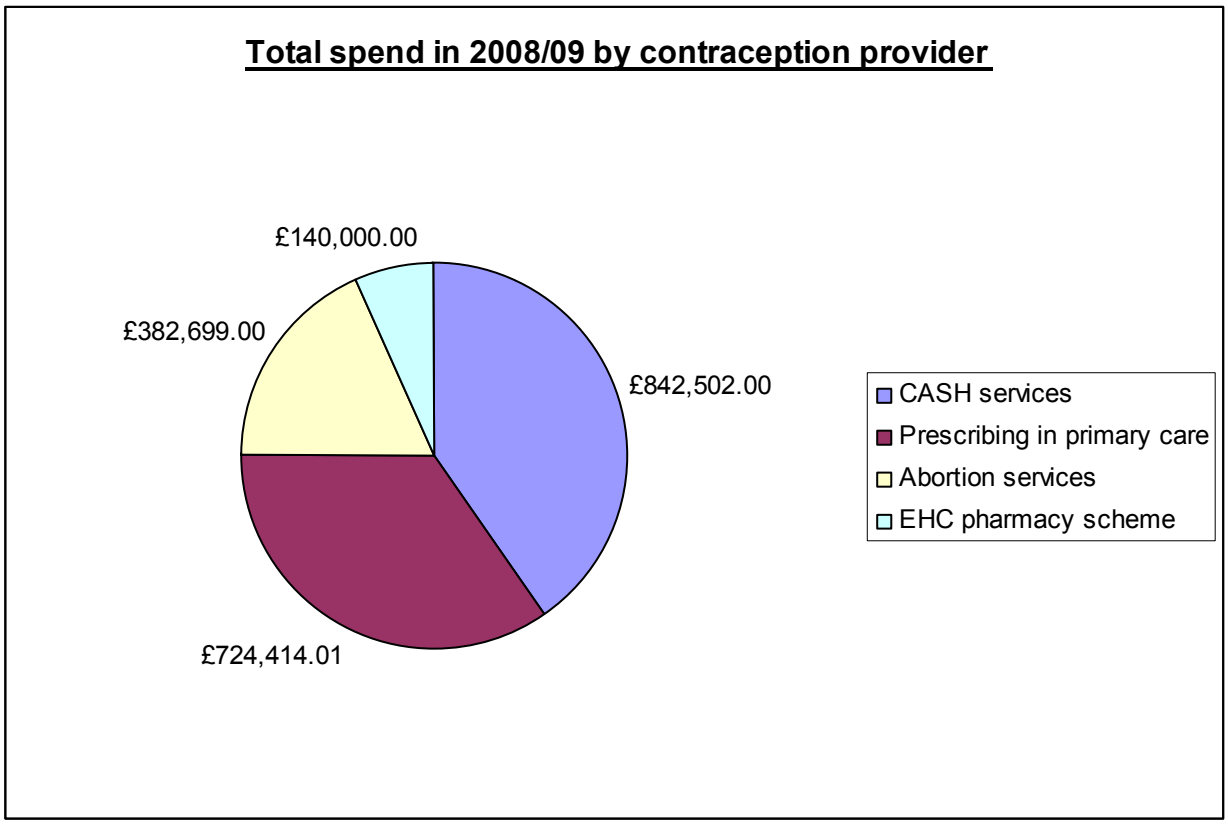
2008 Quarterly data



Contraceptive audit findings

The chart below reflects the breakdown in funding on contraceptive and abortion services in Central & Eastern Cheshire. The figures did not include the spend on contraception provided through GU services at Mid-Cheshire Hospitals Trust (see below).

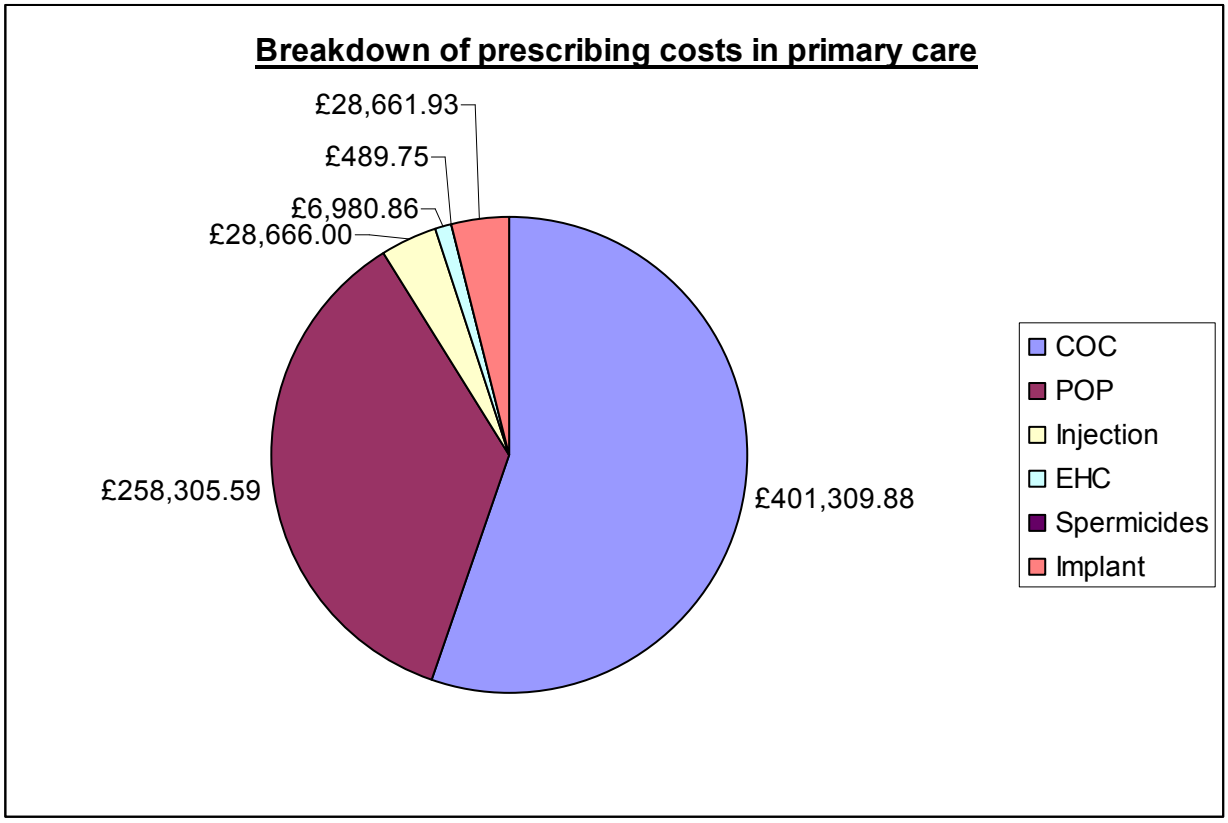
It is also noted from the audit that there is no identified budget for sexual health promotion.



Breaking this cost down further, staff costs in CaSH represent £632,002 of the total (over 75%). However, the point to be made here is that this is for a whole time equivalent of 15.85, split between 80 posts. 37 of these are band 6 nurses, adding up to a whole time equivalent of 3.92. This is a far from unusual pattern for traditional community contraceptive services, but is a key factor in the structural difficulties encountered in operational management, service and staff development, quality assurance, consistency of delivery and governance. Many areas are moving away from this model as part of service modernisation and reconfiguration.

In terms of the contraception provided by the CaSH service, LARC methods account for 17.6% of methods provided at first visit[1]. This is only slightly less than a national average of 18%. However, this is across all ages. LARC accounts for just over 9% of under 18s first visits. Under 18s represent 18% of first visits at CaSH; 29% 18-24s and 53% 25 and older.

[1] KT31 returns, 08/09



The chart above shows primary care prescribing costs of over £400k in 2008-09 on the combined oral contraceptive pill alone, across all ages. This equates to 46704 prescriptions. If an approximation is made based on the assumption that a woman would have four COC prescriptions a year, this roughly represents 11676 women. Real use failure rates in contraception[2] suggest 8% failure in COC (as opposed to less than 0.1% in all LARC methods). This would indicate around 934 conceptions arising from contraceptive failure. If half of these were to be terminated, at an approximate cost of £500 per procedure, this would cost the PCT a further £233,500.

Prescribing rates against national averages

	Rate per 1000 females 15-44	
	C&E Cheshire	England
All LARC methods	39	41.4
Implant	7.1	7.2
IUD/S	11.8	13.9
Depo	20.1	20.4

The table above shows that prescribing rates in Central & Eastern Cheshire are lower than national average; it would be useful to break these figures down further by age, which is not currently possible through data available at regional or national level. This could be done locally as part of further mapping of contraception uptake.

[2] Trussell, 2007

Key issues emerging from CASH review 2010:

- Leadership
- Performance improvements
- Co-ordination
- Communication
- Commissioning for Contraception and sexual health
- Contraceptive services / Sexual health (including screening)
- Young people friendly services
- Workforce development

Theme	Issues	Recommendations
Leadership and vision	• Clarification of roles for acountability and taking this piece of work forward • Delivering the vision	• Defining roles to deliver vision eg: strategic leadership / operational delivery / accountability • Ensuring actualisation of plans and aspirations • Emphasis on solution focussed approaches • Linking in Children's Trust arrangements • Communicating an agreed vision and translating the vision into reality with clear deliverables within an accountability framework
Performance improvement	• Difficult to assess in the absence of a progress report based upon an up to date self assessment (Requested by GONW March 2009 – still outstanding) • No clear plans evident • Improvement in data but increase terminations – higher than national and regional average	• Progress updates submitted in line with Regional requests • Completion of self assessment – annually (immediate action required in light of consultation on TP) – Progress Update to be submitted to GONW by end of March • Clear plan of action and key deliverables with monitoring systems within an accountability framework • Further detailed local analysis – in each practice to gather segmented data (age)

	• Data not being utilised -Only pct level data available for primary care	
Co-ordination	• Confusion over current arrangements between internal partners and external partners • Ownership and accountability unclear	• Effective co-ordination is acknowledged nationally as key component of an effective strategy • Recruitment of a local teenage pregnancy co-ordinator who has a clear remit for teenage pregnancy prevention and understands the cross cutting agendas • TPC has a role for raising the profile of TP at levels the appropriate organisations • A LTPC who interfaces regularly with regional tier
Communication	**Staff:** • Inconsistent understanding of Teenage pregnancy prevention and sexual health • Current vision statement does not appear to be fit for purpose and/or owned • Still using the term family planning on info re clinics etc **Young people:** • Information available to sign post young people is inaccurate and confusing *'I want it there and I want it fast' – (integrated delivery of sexual*	• Explicit and concise so all partners are clear about their role/involvement in delivery • Communicate the vision through all levels in the organisations • Identify champions for teenage pregnancy / Sexual health - we can work with CEC to provide training or guidance (including schools and elected members) • Clear messaging for the whole workforce – consistent messages and updates delivered through all levels in the organisations • Regular briefings / updates for all staff on TP prevention messages and priorities • Clear processes for engaging young people which are inclusive and representative of the whole population (including marginalised and hard to reach groups) • Better reach to targeted and non- targeted groups • Consistently and systematically engagement of parents and communication of key messages

	health services) *'A welcoming, high quality young people led proactive service which meets the diverse needs of young people, including accessibility, confidentiality and consistency.'*	• Clear and consistent use of the term sexual health as oppose to Family Planning to reflect holistic integrated service delivery - both outward facing and internally throughout all levels in the PCT / LA • Review all publicity materials and identify clear branding plus a process for review and update websites / information, aligning any campaigns with seasonal peaks and regional / national campaigns. Young people need to be routinely included in this process
Commissioning for Contraception and sexual health	**Commissioning arrangements needs to reflect the integrated values of the vision.** • Young person led • Integrated delivery – not silos • Linked to accountability framework • Cost savings – over reliance on EHC/Abortion • CaSH services need to be commissioned to provide clinical governance support to wider workforce. **CaSH Provision:** • CaSH provision only sees small proportion of young people in CEC 6%. Therefore, contraception uptake and chlamydia screening performance is low. • CaSH operating out of too many locations, unable to	• Need to link into the QIPP and Transforming community services agenda • Joint commissioning with a key focus on preventative services • Current spend on reactive services such as abortion needs to be reconfigured to support proactive and preventative sexual health services for young people • Sustainable involvement/engagement of young people in commissioning and evaluation of sexual health services • Consistency of service delivery • Partnership working - sharing and adopting good practice (locally and regionally via existing Cheshire and Merseyside Sexual Health Network and Government Office North West) • Need to shift the balance and to be working up stream • Need age specific contraception data • Dedicated venues for provision of CaSH, including: o Schools (linked to good SRE) o FE/Colleges(linked to good SRE) o Integrated Youth Support Services (linked to good SRE)) o General Practice o Sexual Health Services in a dedicated 'One Stop Shop' in place of current fragmented sexual health provision. • Reduced numbers of locations in favour of more centralised model • Opening hours to suit client need

	display posters etc. Spread too thinly	
Young people friendly services	• Progress has been slow in terms of identifying a You're Welcome • Strategic Leadership and developing sustainable local processes. • Dedicated holistic/integrated young person friendly services in a variety of locations working towards the DH You're Welcome Quality Mark.	• The identification of a You're Welcome Strategic Lead by the start of the new financial year • A project plan for YW implementation with key milestones and targets to be in place for the duration of the leads post - by March 2010. • A long-term project plan to support the scale up and sustainability of You're Welcome in line with DH's 2020 aspiration. • A trained multi-agency verification panel embedded within the Children's Trust arrangements to be in place and ready to open its waves by May 2010 (including training of YP) • 3 Priority services to be identified and supported to complete the self • –assessment toolkit for submission to the May verification panel. (12 services by year end) • You're Welcome Self assessment toolkit to be cascaded to all sexual health services regularly seeing young people to allow them to start the assessment process – by August 2010. • You're Welcome to be used as a tool for commissioning sexual health services. • Young People to attend the regional verifier training in May in preparation for the May verification wave opening. • At least 12 services to have received the You're Welcome Quality Mark by the end of the year. • Systematic, comprehensive and truly representative engagement with young

		people
Workforce development	• Staffing structure of CaSH service does not lend itself to effective and cohesive delivery. 80 members of staff only constitute 15.85 wte posts. • Need to consider training needs for wider workforce including general practice and those working with young people.	• Review and revise staffing structure in line with new and effective ways of working • Development and implement a tiered workforce training programme re sexual health and teenage pregnancy • Clear policies on confidentiality, competence and consent should be implemented by all staff and communicated to service users to build trust in services • Kitbag training currently being co-ordinated – need to measure impact • Wider workforce is able to proactively communicate sexual health and other related teenage health issues with young people • Discussing sexual health issues/signposting with young people to be to be embedded into job descriptions and training plans for the wider workforce be available to ensure accurate information and signposting to services

Models for delivery

Achieved through:

- QIPP
- Reducing Abortion spend by 1/3 in year 1 and 2/3 by year 2