Blackpool Council

7 April 2017

To: All Members of the Health and Wellbeing Board

The above members are requested to attend the:

HEALTH AND WELLBEING BOARD

Wednesday, 19 April 2017 at 2.00 pm
in Committee Room A, Town Hall, Blackpool

A G E N D A

1 DECLARATIONS OF INTEREST

Members are asked to declare any interests in the items under consideration and in doing so state:

(1) the type of interest concerned; and

(2) the nature of the interest concerned

If any member requires advice on declarations of interests, they are advised to contact the Head of Democratic Governance in advance of the meeting.

2 MINUTES OF THE LAST MEETING HELD ON 18 JANUARY 2017 (Pages 1 - 6)

To agree the minutes of the last meeting held on 18 January 2017 as a true and correct record.

3 STRATEGIC COMMISSIONING GROUP UPDATE (Pages 7 - 14)

To update the Board on the activity of the Strategic Commissioning Group since the last meeting.

4 HEALTH PROTECTION FORUM REPORT (Pages 15 - 18)

To receive the bi-annual report of the Health Protection Forum and consider any issues raised by that Forum.

5 INTERMEDIATE CARE UPDATE (Pages 19 - 24)

To update the board on the progress of Intermediate Care Services in Blackpool.

6 NEW MODELS OF CARE- VANGUARD UPDATE (Pages 25 - 28)

To update the Board on progress in delivering the New Models of Care Programme.

7 HEALTH AND WELLBEING STRATEGY UPDATE (Pages 29 - 46)

To update the Board on progress in delivering the actions in the Health and Wellbeing Strategy and to provide an update on the performance indicators.

8 BLACKPOOL BETTER CARE FUND UPDATE (Pages 47 - 84)

To provide the Board with an update on activity to meet NHS England (NHSE) requirements for the Better Care Fund 2017-19.

9 BLACKPOOL SEXUAL HEALTH STRATEGY AND ACTION PLAN 2017-20 (Pages 85 - 140)

To consider the Sexual Health Strategy and Action Plan 2017-20.

10 PUBLIC MENTAL HEALTH ACTION PLAN 2016-19 (Pages 141 - 172)

To present the Public Mental Health Action Plan 2016-19 for approval.

11 NOTIFICATION OF CHANGE IN LEGISLATION IN RELATION TO REQUIREMENT TO PROVIDE SUPPLEMENTARY STATEMENTS TO THE PHARMACEUTICAL NEEDS ASSESSMENT (Pages 173 - 176)

To highlight the key issues as a result of the changes to legislation which requires the Health and Wellbeing Board to comment upon Pharmaceutical Applications and thereafter the requirement to produce a supplementary statement to the Pharmaceutical Needs Assessment.

Venue information:

First floor meeting room (lift available), accessible toilets (ground floor), no-smoking building.

Other information:

For queries regarding this agenda please contact Lennox Beattie, Executive and Regulatory Manager, Tel: 01253 477157, e-mail lennox.beattie@blackpool.gov.uk

Copies of agendas and minutes of Council and committee meetings are available on the Council's website at www.blackpool.gov.uk.

MINUTES OF HEALTH AND WELLBEING BOARD MEETING - WEDNESDAY, 18 JANUARY 2017

Present:

Councillor Clapham, Opposition Group Member, Blackpool Council
Councillors Collett, Critchley and Ryan, Blackpool Council
Roy Fisher, Chairman, Blackpool Clinical Commissioning Group
Eddy Jackson, Blackpool Healthwatch Interim Chairman
Phil Jones, Area Group Manager, Lancashire Fire and Rescue Service
Greg Molyneux, Blackpool Healthwatch representative

In Attendance:
Venessa Beckett, Corporate Development and Policy Officer, Blackpool Council
Lennox Beattie, Executive and Regulatory Manager, Blackpool Council
Jayne Bentley, Care Bill Implementation and Better Care Fund Project Lead, Blackpool Council
Matthew Burrow, Head of Corporate Assurance, Blackpool, Fylde and Wyre Hospital Trust
Lynn Donkin, Public Health Specialist, Blackpool Council
Steve Freeman, Office of the Police and Crime Commissioner for Lancashire
Paul Greenwood, Interim Chief Executive, Blackpool Council for Voluntary Services
Tracey Handley, Clinical Specialist, Lancashire Care Foundation Trust
Neil Jack, Chief Executive, Blackpool Council
Helen Lammond-Smith, Chief Clinical Officer, Blackpool Clinical Commissioning Group
Gary Raphael, Chief Financial Officer, Blackpool Clinical Commissioning Group
Donna Taylor, Public Health Practitioner, Blackpool Council
Janet Watson, Better Care Fund Accountant, Blackpool Council

Apologies:
David Bonson, Chief Executive Officer, Blackpool Clinical Commissioning Group
Councillor Cain, Cabinet Secretary (Resilient Communities), Blackpool Council
Councillor D Coleman, Blackpool Council
Delyth Curtis, Director of People, Blackpool Council
Dr Amanda Doyle, Chief Clinical Officer, Blackpool Clinical Commissioning
Jane Higgs, Director of Operations and Delivery, NHS England
Sue Moore, Chief Operating Officer, Lancashire Care NHS Foundation Trust
Karen Smith, Deputy Director of People (Adult Services), Blackpool Council

1 APPOINTMENT OF CHAIRMAN

In the absence of the Chairman and Vice-Chairman, the Board considered the appointment of a Chairman for the meeting.

Resolved:

That Mr Roy Fisher be appointed Chairman for the meeting.

2 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

3 MINUTES OF THE LAST MEETING HELD ON 19 OCTOBER 2016

The Board considered the minutes of the last meeting held on 19 October 2016.

Resolved:

That the minutes of the last meeting held on 19 October 2016 be approved and signed by the Chairman as a correct record.

4 STRATEGIC COMMISSIONING GROUP (SCG) UPDATE

The Board received an update on the last meeting of the Strategic Commissioning Group from Mrs Helen Lammond-Smith, Blackpool Clinical Commissioning Group.

The Board received the final minutes of the meeting held on 20 October 2016 on which a verbal update had been given at the last meeting of the Health and Wellbeing Board.

Mrs Lammond-Smith provided the Board with a verbal update on the meeting of the Strategic Commissioning Group held on 4 January 2017. She explained that the Better Care Fund 6 Month Update formed part of the agenda of this meeting of the Health and Wellbeing Board and that both the Mental Health and Sexual Health Action Plans would be brought for approval to the March Health and Wellbeing Board meeting. Mrs Lammond-Smith also highlighted the report on the redesign of Community Therapy noting that the redesign would work as part of the new models of care to deliver better health based outcomes. The Board noted that the Group had also considered an update on the changes to Reablement services delivered through the ARC centre and the start of the commissioning review of the Hub/Wish service.

Resolved:

1. To note the verbal update from the meeting on 4 January 2017.

2. To note the main actions arising from the work of the group.

3. To note the minutes of the last meeting on 20 October 2016 attached to the agenda at Appendix 3a, on which a verbal update had been given at the previous Health and Wellbeing Board.

5 BETTER CARE FUND SIX MONTH UPDATE

Mrs Jayne Bentley,Care Bill Implementation and Better Care Fund Project Lead, and Mrs Janet Watson,Better Care Fund Accountant, Blackpool Council provided the Board with the mid-year update on the Better Care Fund and outlined the requirements for the future development of the fund.

Mrs Bentley started her presentation by providing a brief recap of the development of the Better Care Fund and the development of pooled budgets between the Clinical Commissioning Group and the Council's Social Care under Section 75. She then outlined how the plan had met its objectives so far during the plan and that as required NHS England had received quarterly updates on the plan. In terms of future developments for the fund, the Board was informed that the 2017/2019 proposals were currently under development and would be brought to a future board meeting for approval and this would include further information on the use of the additional funding available through the government's recently announced Improved Better Care Fund.

Resolved:

To note the update on the Better Care Fund.

6 PAN-LANCASHIRE HEALTH AND WELLBEING GOVERNANCE ARRANGEMENTS

Mr Lennox Beattie, Executive and Regulatory Manager, Blackpool Council gave a presentation to the Board on the transition towards a Health and Wellbeing Board on larger footprint over Lancashire, Blackpool and Blackburn with Darwen. Mr Beattie explained that as previously presented to the Board the Lancashire Leaders had agreed to work to towards the creation of a joint Health and Wellbeing Board supported by five more local Health and Wellbeing partnerships. The approach had then been subsequently endorsed a summit held in July 2016 in Preston.

Mr Beattie explained that more detailed proposals had now been approved by the three Councils' Executives and it had been agreed that the new pan-Lancashire model would operate in a shadow form before final approval of the operating structure in May 2017.

Resolved:

1. To note the proposals for a new pan-Lancashire model for Health and Wellbeing Board governance set out in this report.

2. To note the draft terms of reference for the proposed Pan Lancashire Health and Wellbeing Board and Local Health and Wellbeing Partnerships, (Appendices 6(a) and 6(b) to the Agenda) , which will be finalised during the shadow operation period and presented to the annual meeting of the Council for formal adoption

3. To note that the new pan-Lancashire model will operate in shadow form between January and March 2017 in accordance with the draft terms of reference

4. To support the principles for the new pan-Lancashire model for Health and Wellbeing

Board governance arrangements for adoption and implementation from May 2017.

7 LANCASHIRE AND SOUTH CUMBRIA CHANGE PROGRAMME AND SUSTAINABILITY AND TRANSFORMATION PROGRAMME UPDATE

Mr Gary Raphael, Finance Lead, Healthier Lancashire Programme provided an update to the Health and Wellbeing Board on the Lancashire and South Cumbria. He reminded members that the Sustainability and Transformation Plan had been previously approved by a Joint meeting of the Blackpool, Blackburn with Darwen and Lancashire Health and Wellbeing Boards on 19 October 2016 and then submitted to NHS England.

Mr Raphael highlighted to members that the plan consisted of a technical document addressing the need to work together across Clinical Commissioning Group to address future demographic pressure to address the funding gap. Mr Raphael explained how the plan was to be developed going forward with the addressing of areas of interest where economies of scale could be developed across Lancashire and further alignment of health and social care.

Members of the Board while continuing to endorse the aspirations of the plan expressed concern as to how the implementation would work in practice and asked for further updates on progress to be brought to future meetings of the Health and Wellbeing Board. Particular concern was expressed as whether the economies of scale outlined could be realised and the implications for Blackpool if the plan outcomes were not achieved.

Resolved:

To note the content of the update report.

8 REVIEW OF PARTNERSHIPS AND FORUMS

The Board received a report on the Review of Partnerships and Forums of the Council which included proposals for rationalising the governance and meeting arrangements of the Council's partnerships and other statutory boards. The review had been undertaken to consider the membership, purpose and activity of the various boards and sub-groups to identify any crossover, duplication or further potential areas for alignment. The review had now taken place and the key outcomes were highlighted in the report namely a rationalisation of meetings, the development of linkages in data analysis and the creation of quality assurance workshops.

Members of the Board endorsed the outcome of the review and considered that it beneficial to reduce duplication between meetings and clearly align the different responsibilities of different partnership meetings.

Resolved:

To note the report and support the proposals for new ways of working to be developed, to include consideration of partnership arrangements where possible and appropriate.

9 UPDATE ON 0-5 CHILDREN'S PUBLIC HEALTH SERVICES (ENHANCED HEALTH VISITING MODEL) 2017-2018

The Board received an update from Ms Lynn Donkin and Ms Donna Taylor, Blackpool Council, on the development of the Enhanced Health Visiting Model for children from zero to five.

Ms Donkin reminded members that the new Enhanced Health Visiting Model had been developed to transform this vital stage in the delivery of Public Health. The model had been agreed through the Better Start Partnership with its four levels of intervention (Universal, Universal Plus, Universal Partnership plus and Safeguarding) which would be supported by an increased offer to all parents. The universal level the model consisted of eight home visits to all families, six within the first year of life plus two additional health reviews, including a school readiness child health review. The enhanced health visiting model had been developed from consultation with a wide range of stakeholders as part of the Health Visitor review over the summer led by Public Health in partnership with a Better Start.

The Board considered it particularly beneficial that the Better Start partners had been involved in the development of the new model but emphasised their view that it would be vitally important to ensure that the implementation phase was properly monitored against desired outcomes.

Resolved:

To note the update on the development of the Enhanced Health Visiting Model for children from zero to five.

10 CHILDREN AND YOUNG PEOPLE'S EMOTIONAL HEALTH AND WELLBEING TRANSFORMATION PLAN

The Board received an update on the Children and Young People's Emotional Health and Wellbeing Transformation Plan from Mrs Helen Lammond-Smith, Blackpool Clinical Commissioning Group. She reminded board members that the eight Clinical Commissioning Groups across Lancashire had submitted to NHS England a joint Transformation Plan designed to address and take ownership of children and young people's emotional health and wellbeing.

Mrs Lammond-Smith highlighted the development of five key workstreams: Promoting resilience, Prevention and Early Intervention, Improving access to effective support, Care for the most vulnerable, Accountability and Transparency and Developing the Workforce. This pan-Lancashire plan had been translated into an robust action plan for Blackpool and the Fylde area with contributions from Better Start, Head Start, council services e.g. Youth Offending, and emotional health and wellbeing services (CASHER, Connect and CAMHS).

Mrs Lammond-Smith then highlighted the key achievements so far of the plan including the co-designed community eating disorder service, the creation of a full 0-19 CAMHS service including opening until 7pm and reductions in waiting times, and the ongoing development of safe places for children and young people in crisis. Ms Lammond-Smith

also explained about the work of the CASHER team for those presenting at Accident and Emergency in mental health crisis and its further development.

Resolved:

To endorse the progress made in delivering the Transformational Plan for Children and Young People's emotional wellbeing.

11 FORWARD PLAN

The Board considered the draft forward plan for forthcoming agendas, which would enable the Board to strategically plan its future agendas and ensure that items were relevant to the Board's priorities.

Resolved:

To approve the Health and Wellbeing Board Forward Plan as set out in Appendix 10a, to the agenda.

12 DATE OF FUTURE MEETINGS

To note the dates of future meetings as follows:

1 March 2017
19 April 2017

Chairman

(The meeting ended at 4.50pm)

Any queries regarding these minutes, please contact:
Lennox Beattie Executive and Regulatory Manager
Tel: 01253 477157
E-mail: lennox.beattie@blackpool.gov.uk

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Arif Rajpura, Director of Public Health
Relevant Cabinet Member:	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting:	19 April 2017

STRATEGIC COMMISSIONING GROUP (SCG) UPDATE

1.0 Purpose of the report:

1.1 To update the Board on the activity of the Strategic Commissioning Group since the last meeting.

2.0 Recommendation(s):

2.1 To note the minutes of the last meeting on 4 January 2017 as attached at Appendix 3a.

2.2 To receive a verbal update from the meeting on 6 April 2017.

2.3 To note the main actions arising from the work of the group.

3.0 Reasons for recommendation(s):

3.1 The Strategic Commissioning Group is a sub-group of the Board, which is responsible for overseeing the integration and alignment of commissioning across the Clinical Commissioning Group and Council. It has a duty to update the Health and Wellbeing Board on activity against its work programme and future planned activity.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

No alternative options.

4.0 Council Priority:

4.1 The relevant Council priority is:

"Communities: Creating stronger communities and increasing resilience"

5.0 Background Information

5.1 Items on the agenda for discussion at the meeting on 6 April 2017 include:

- Hub/Wish Commissioning Review Community Therapy evaluation -
- Better Care Fund update
- Integrating statutory and big lottery early intervention projects
- Third sector, voluntary and faith sector engagement
- Integrating evaluation
- Integrated Commissioning Board

5.2 As the minutes for this meeting are not yet available a verbal update will be given to the Board as to matters

5.3 The Board at its meeting on the 18 January 2017 received a verbal update on the meeting of the Strategic Commissioning Group, the minutes have been approved and are attached at Appendix 3a for information.

5.4 Does the information submitted include any exempt information? No

5.5 **List of Appendices:**

Appendix 3a – Notes from Strategic Commissioning Group meeting on 4 January 2017

6.0 Legal considerations:

6.1 None.

7.0 Human Resources considerations:

7.1 None.

8.0 Equalities considerations:

8.1 None.

9.0 Financial considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Ethical considerations:

11.1 None.

12.0 Internal/ External Consultation undertaken:

12.1 None.

13.0 Background papers:

13.1 None.

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Appendix 3a: Strategic Commissioning Group
Notes and Actions
4 January 2017, 9.30 – 11.30am
Conference Room 3A, Bickerstaffe House

Present	Delyth Curtis, Director of People (Director of Children's Services), Blackpool Council David Bonson, Chief Operating Officer, Blackpool CCG Val Raynor, Head of Commissioning, Blackpool Council John Gaskins, Fylde and Wyre CCG Steve Thompson, Director of Resources, Blackpool Council Nikki Evans, Superintendent, Lancs Constabulary Karen Smith, Director of Adult Services, Blackpool Council Judith Mills, Public Health Specialist, Blackpool Council
Also present	Venessa Beckett, Corporate Development Officer, Blackpool Council Moya Foster, Senior Service Manager Early Help, Blackpool Council Kate Aldridge, Priority Lead, Corporate Delivery Unit, Blackpool Council Jayne Bentley, Care Bill Implementation and Better Care Fund Project Lead, Blackpool Council Jeannie Harrop, Commissioning Manager, BCCG
Apologies	Pauline Wigglesworth, HeadStart Programme Lead, Blackpool Council Lynn Donkin, Public Health Specialist, Blackpool Council Liz Petch, Public Health Specialist, Blackpool Council Dr Arif Rajpura, Director of Public Health, Blackpool Council Merle Davies, Director Better Start, NSPCC Helen Lammond-Smith, Head of Commissioning, Blackpool CCG

1.	**Welcome, introductions and apologies.** Del welcomed everyone to the meeting and apologies were noted.
2.	**Notes and actions from last meeting (October)** **8. Delayed transfers of care** David Bonson advised that work is ongoing regarding delayed transfers of care and further work is also taking place to relief pressures in the system. Discharge processes across the whole system would be examined and work with the emergency care network would look at homes of choice and assessment processes, with the intention to agree a common approach to be implemented locally rather than one size fits all. Val Raynor advised that our intermediate care model is more advanced than in other areas and while the choice of home policy could be agreed across all areas, models of delivery could be different.

3.	**Better Care Fund** Jayne Bentley advised that the quarter two report had been submitted to NHS England and that we were hoping to have had the framework for 2017-19 but NHSE had not yet published the documents. A recent webinar confirmed that there will only be three national conditions to be met but the performance metrics will remain the same. Del Curtis queried where the bigger piece of work was up to and was advised that there was limited information regarding the STP and the work was running in parallel because BCF had been set up at a particular point in time and the STP was subsequent to it. Jayne added that the Vanguard added complications due to different geographical footprints. There was further discussion about the proposed improved better care fund and the view was expressed that it may be a vehicle to support the funding of integration. It was queried whether this would bring new money however future costs outweigh the funding due to the national living wage.
4.	**Community therapy redesign** Jeannie Harrop presented the item advising that community therapy services had been reviewed as part of enhanced primary care and it had been agreed that an integrated rehabilitation service would be commissioned rather than the existing Community OT and Community Physiotherapy along with the exploration of options for creating a Complex Equipment and Adaptations Team with Blackpool Council. There was some discussion around whether an occupational therapist would still be required in addition to the Community Therapy service and it was recognised that the processes and pathways would need to change within neighbourhoods. **Action: An evaluation of the service redesign would be brought to the next meeting (Kate Jackson).**
5.	**Intermediate Care Service update** Kate Aldridge attended to present an update on reablement and enablement services in Blackpool that were remodelled following the Intermediate Care Review in 2016 which saw disinvestment in the Nurse Led service in Blackpool to focus on delivering a more intensive service from one site and directly routing more people home from hospital to receive support; there was a reduction in bed based services from 53 to 33. Kate advised that the new service continues to bed in and there is positive use of clinically enhanced beds, which can be adapted to accommodate additional demand when needed – accommodating need rather than number of beds. Data initially shows that there has been an increase in the number of people coming from hospital through the discharge to assess model, but they going home quicker than previously, the length of stay is consistent; the longest stay is with people who are making choice of next home for life at around 30 days, and around 70% are returning

	home. Discussion followed which highlighted concerns regarding the anticipated ending of additional funding in September as a result of good performance in this area. It was advised that this had been raised at the A & E Delivery Board where it had been made clear that the additional funding was to support the system not a specific area. Some minor issues remain with regards to governance arrangements and some inconsistencies but these are being managed by the Board. Next steps will involve further embedding and recruiting, and from an integration perspective, introducing more generic working to have HCA supporting RSW, with mentoring and stepping up, and a certification process The group praised the Service Manager and acknowledged the remarkable performance in returning 70 per cent of people home. Patient feedback has been positive and the new service has modernised the whole process, with good lessons to be learnt regarding training and generic working.
6.	**Hub and Wish commissioning review** Nicky Dennison presented a report outlining the service and purpose of the review, which was undertaken to review the different elements of the Young Person's Harm Reduction and Risk Taking Behaviour contract since it was re-designed in 2013/14. The review was carried out to explore the outcomes achieved to date, understand if the current model was fit for purpose and how it could be best shaped within the changing environment, in terms of linking into the Vulnerable Adolescent Hub and achieving financial efficiencies. The main recommendation of the review is that the Hub: Wish service would be structured as a specialist 'hub and spoke' model that links into each pod of the Vulnerable Adolescent Hub. This model will have a significant focus on early intervention and prevention in schools. However, this structure is not in accordance with the Vulnerable Adolescent Hub proposals which have been based upon fully integrating the Hub: Wish workers within the Hub. Following discussion it was agreed that further conversations were required regarding the proposed model and the item would come back to the next meeting. **Action: Revised proposal to be brought to the next meeting (Nicky Dennison)**
7.	**Mental Health Action Plan** Judith Mills presented the draft document, advising that it had been refreshed and where previously there had been a focus on treatment, there was now a focus on prevention and treatment. The plan will be monitored by the Mental Health Partnership Board and will be presented to both safeguarding boards and will pick up any recommendations from

	serious case reviews that might pick up on public health messages. The plan will be taken to the next HWB in April.
8.	**Sexual health strategy** The Sexual Health Strategy has been refreshed and incorporates links to the new Pause project. In terms of sexual health, Blackpool has been successful on many indicators apart from repeat terminations. We are also looking at alternatives to LARC as an audit has shown that removal rates were high and women were not liking the implant. The strategy will be presented to the next HWB
	Next meeting: Tbc

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Arif Rajpura, Director of Public Health
Relevant Cabinet Member:	Councillor Amy Cross, Cabinet Member for Adult Services and Public Health
Date of Meeting:	19 April 2017

HEALTH PROTECTION FORUM REPORT

1.0 Purpose of the report:

1.1 To receive the bi-annual report of the Health Protection Forum and consider any issues raised by that Forum for escalation.

2.0 Recommendation(s):

2.1 To receive the Health Protection Report for the period September 2016- 31 March 2017.

2.2 To consider further the issues outlined at Paragraph 5.2 and agree where necessary further action.

3.0 Reasons for recommendation(s):

3.1 To report on the work of the Health Protection Forum and consider any issues raised by the Forum.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered:

None

4.0 Council Priority:

4.1 The relevant Council Priority is:

"Communities: Creating stronger communities and increasing resilience"

5.0 Background Information

5.1 The Health Protection Forum was established to provide a mechanism for warning and informing on local health protection arrangements within Blackpool to the Health and Wellbeing Board; providing information and advice on arrangements and plans in place to protect the health of the population of Blackpool. The Director of Public Health (DPH) is responsible for the local authority's contribution to health protection matters, including the local authority's roles in planning for and responding to incidents that present a threat to the public's health.

5.2 The following items have been identified for highlighting to the Board:

1. **Infectious diseases, outbreaks and incidents:** On the whole these are in line with seasonal norms
2. **Group A Streptococcus**
   Blackpool experienced high levels of Group A Streptococcal infection (Scarlet Fever) in comparison with other areas of Lancashire in 2016, and numbers remain elevated in 2017. Whilst Scarlet Fever used to be a serious disease, nowadays most cases tend to be mild and it can be easily treated with antibiotics. Information along with Guidelines on infection control has been circulated to schools.
3. **Seasonal Flu Vaccination Uptake**
   - NHS England report an increase in vaccine uptake across all flu risk groups overall in 2016/17.
   - Improved flu vaccine uptake in Blackpool in pregnant women – as vaccinations in pregnancy become more normalised and acceptable.
   - Flu immunization for Reception age school children class to be introduced to the national programme from Autumn 2017.
   - **Flu vaccine uptake in Health and Social Care:** Blackpool Hospital continues to has achieved good uptake amongst healthcare workers (78%)
   - Blackpool Council: Although increased uptake of flu vaccine in council staff from previous years; uptake is predominantly from office based staff. Uptake is lower uptake in front line staff.

4. **Healthcare acquired infections**
   - **E-Coli Blood stream infection rates in Blackpool** -Enhanced surveillance of *E. coli* blood stream infection has been mandatory for NHS acute trusts

since June 2011. Patient data of any *E. coli* blood stream infection are reported monthly to Public Health England. These are Trust identified, and attributed to Clinical Commissioning Group area. There is a trend towards increasing incidences of the incidence of E. coli blood stream infection observed nationally.

- The Health Protection Forum is aware that Blackpool rates have also been increasing in line with these national trends. Blackpool Clinical Commissioning Group and Blackpool Teaching Hospitals Trust, supported by Public Health England are meeting to review and discuss actions to reduce E.coli blood stream infections.

5. Flu Pandemic Exercise 14 March 2017

- Public Health England hosted Flu Pandemic Preparation Exercise; this was well attended by organisations across Health and Social Care in Lancashire. Blackpool Council representation from Public Health and Director of Adult Social Care.

5.3 Does the information submitted include any exempt information? No

5.4 **List of Appendices:**

None.

6.0 Legal considerations:

6.1 None.

7.0 Human Resources considerations:

7.1 None.

8.0 Equalities considerations:

8.1 None.

9.0 Financial considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Ethical considerations:

11.1 None.

12.0 Internal/ External Consultation undertaken:

12.1 None.

13.0 Background papers:

13.1 None.

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Karen Smith, Director of Adult Services
Relevant Cabinet Member:	Councillor Amy Cross, Cabinet Member for Adult Services and Health
Date of Meeting:	19 April 2017

INTERMEDIATE CARE UPDATE

1.0 Purpose of the report:

1.1 To update the board on the progress of Intermediate Care Services in Blackpool.

2.0 Recommendation(s):

2.1 To note the contents of the report.

3.0 Reasons for recommendation(s):

3.1 To ensure that the Board have information about the implementation of a revised Intermediate Care Service in Blackpool.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered:

None.

4.0 Council Priority:

4.1 The relevant Council Priority is:

"Communities: Creating stronger communities and increasing resilience"

5.0 Background Information

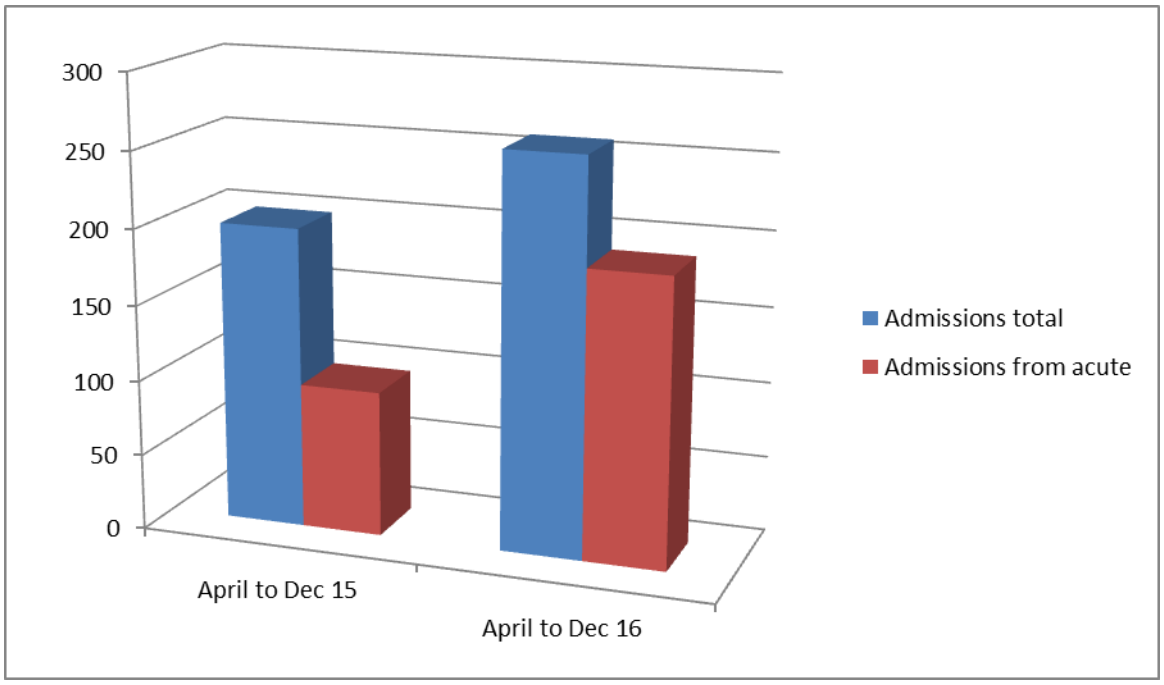
5.1 Intermediate care services are designed to help people adapt to a recent illness or disability by learning or relearning the skills necessary for independent daily living at home, and to ensure that people are supported to have assessments for long term services in an environment which is supportive and enabling. Intermediate care services are delivered by professionals in health and social care working together to support people to achieve their goals.

In Blackpool the main community Intermediate Care Services are the reablement service which supports people in their own home and the Assessment and Rehabilitation (ARC) service which supports people in a residential environment to facilitate a hospital discharge or prevent an admission. There is an increasing focus nationally and locally on delivering reablement services as close to home as possible, and this is supported by initiatives with the neighbourhood teams, rapid response and early supported discharge in health.

In April 2016, Blackpool Clinical Commissioning Group (BCCG), Blackpool Council and Blackpool Fylde and Wyre Teaching Hospitals (BFWTH) refocussed investment in Blackpool to focus on delivering a more intensive service from one site and directly routing more people directly home from hospital to receive support. In recognition of the change to delivering more services at home, there was a reduction in bed based services from 53 to 33. The ARC service is now an integrated Health and Social Care service, supported by staff from the Council and the Blackpool Fylde and Wyre Teaching Hospitals with the Council holding the Care Quality Commission registration.

Residential Rehabilitation – ARC

In April – December of 2015, **96** people were admitted to ARC following a stay in Hospital,with a total of **199** admissions. In the same period in 2016, **189** people have been admitted to the ARC following a stay in Hospital, with a total of **259** admissions.



The overall number of admissions to ARC has increased by **30%,** with **97%** increase on the number directly from hospital.

With new, more focussed services in place and continuing to develop, **increased capacity has been achieved through reducing length of stay**. A new referral pathway has been put in to support referrals from community health services, these are now routed through the Rapid Response team. This team explore all options for the person to stay in their own home and receive support.

There are consistently vacancies available in residential rehabilitation, so the team can be confident that although there has been a reduction in residential resource, there are not referrals routinely being declined due to service availability. It is the case, however, that there has been a higher demand for the 10 beds which are "clinically led" with GP oversight and 24 hour nursing support, though this has been infrequent and with focus on timely discharges, capacity is freed up promptly to support new admissions. On one occasion to date there was a delay in admission of intensive stroke patients due to therapy availability, though admissions were arranged for these patients as soon as possible and alternative care was not required.

Length of stay has decreased from an average of 42 days per person prior to April 2016 to 29 days, with far fewer people staying more than 6 weeks. In this period last year 61 people stayed over 42 days, this year it has been 33.

The main reasons for delays in discharge has been the delivery of a complex 2 carer package of care, significant change in accommodation not foreseen on referral and finding a care home “for life” following a thorough assessment.

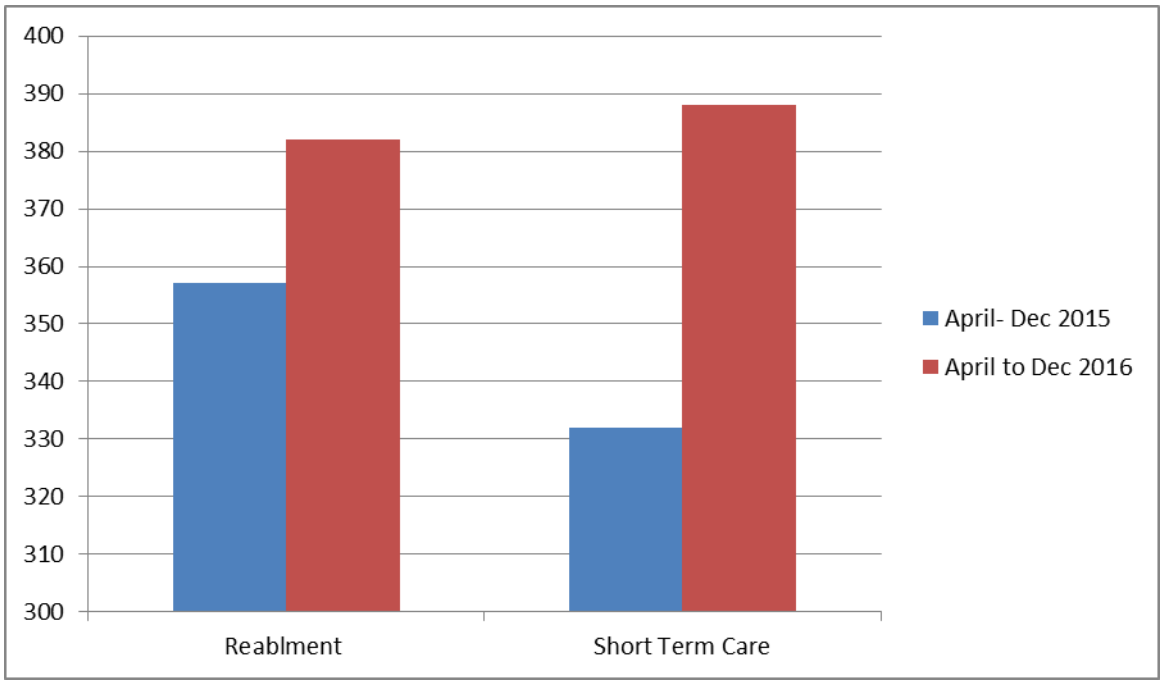
Last year, the 74% of people discharged were able to return home. Despite a significant increase in acuity with the introduction of clinically enhanced beds, over 70% of the people discharged in the first 9 months of the service have been able to return home.

Where people have been discharged home from the ARC, a system follow up check is completed after 91 days. In this check for discharges in 96% of people discharged were still at home.

Reablement at Home

The in house Home Care teams work with other professionals in the community to support timely discharges from, and prevent avoidable admissions to, hospital. The reablement at home function is commissioned from the team where the person has identified rehabilitation potential and will be working toward a reduced dependence on care services. The team also support timely discharges through the provision of short term care where a service provider is being identified, and will support people be as independent as possible during this period.

In 2015, the team supported 689 people between April and December. In 2016, the number has been 770. Overall there has been an 11.8% increase in demand for these services, with an increase of 7% in reablement services and 20.5% increase for short term care.



Most demand can be met with the resources available for Care at Home, however, where there is delay due to availability the themes are the availability of specific time slots or packages which require 2 carers. Additional resource has been secured until September 2017 to ensure that demand to meet hospital discharges can be met and discussions are ongoing with health colleagues to ensure that discharges are manageable next Winter.

The service is developing strong links with the developing neighbourhood services to maximise the potential for independence for individuals who have had a significant change to support them to access the right support and guidance, particularly where there is new medication, or where they have a new condition which they need to learn to manage.

In the last quarter of this year, the team worked with service users to reduce their dependence on formal care services and increase their control over their daily lives. Just under 400 hours per week were reduced from care packages through a successful reablement programme. 63% of people successfully completed the programme, with 66% of these requiring no ongoing formal care services on discharge.

Follow up system checks 91 days after discharge show that 87% of the people supported are still at home 3 months after their reablement period

5.2 Does the information submitted include any exempt information? No

53 **List of Appendices:**

None.

6.0 Legal considerations:

6.1 None.

7.0 Human Resources considerations:

7.1 None.

8.0 Equalities considerations:

8.1 None.

9.0 Financial considerations:

9.1 **None.**

10.0 Risk management considerations:

10.1 None.

11.0 Ethical considerations:

11.1 None.

12.0 Internal/ External Consultation undertaken:

12.1 None.

13.0 Background papers:

13.1 None.

Report to:	**Health and Wellbeing Board**
Relevant Officer:	David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group
Relevant Cabinet Member	Councillor Graham Cain, Cabinet Secretary- Resilient Communities
Date of Meeting:	19 April 2017

NEW MODELS OF CARE- VANGUARD UPDATE

1.0 Purpose of the report:

1.1 To update the Board on progress in delivering the New Models of Care Programme.

2.0 Recommendation(s):

2.1 To note the presentation on the New Models of Care Programme.

3.0 Reasons for recommendation(s):

3.1 The New Models of Care Programme aims to commission an integrated care system to improve the health and wellbeing of the population, ensuring people are empowered to make informed decisions about their health and care.

The programme is transforming the way care is delivered through a targeted and highly coordinated integrated model of delivery, bringing health, social and third sector services together based within neighbourhoods with a focus on prevention, early intervention, shared decision making and self-care.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered:

None.

4.0 Council Priority:

4.1 The relevant Council Priority is:

"Communities: Creating stronger communities and increasing resilience"

5.0 Background Information

5.1 The key principles underpinning Blackpool's New Models of Care Programme are to provide targeted support to those who require services, to ensure a focus on prevention and early identification in the wider population and access to appropriate support where necessary, across the continuum of need.

5.2 There are two components of the model being implemented under the Vanguard programme; Enhanced Primary Care (EPC) and Extensive Care, which together will deliver a seamless out of hospital service. The two components of the model offer the same or very similar benefits but are targeted at different cohorts of patients. Extensive Care is focused initially on patients over 60 years of age with two or more long term conditions. Enhanced Primary Care is focused on patients with one or more long term conditions. Both components work seamlessly together to provide targeted out of hospital care.

5.3 The model is founded on patients, who are supported by fully integrated health and social care teams. One of the key components of the care model is clear patient accountability. All care decisions are taken by the patient and/or their Carers, supported by the lead professional and their care team. This care team has holistic responsibility for the patient's care, acting as the coordinating point across the local health and social care system, holding other individuals and organisations to account with respect to their patients. This is consistent with the public health approach of community-oriented primary care, basing interventions on community need. The Board has received updates at a number of previous meeting on the development of the Vanguard programme and will again receive an update on the implementation of this project.

5.4 Does the information submitted include any exempt information? No

5.5 **List of Appendices:**

None.

6.0 Legal considerations:

6.1 None.

7.0 Human Resources considerations:

7.1 None.

8.0 Equalities considerations:

8.1 None.

9.0 Financial considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Ethical considerations:

11.1 None.

12.0 Internal/ External Consultation undertaken:

12.1 None.

13.0 Background papers:

13.1 None.

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Arif Rajpura, Director of Public Health
Relevant Cabinet Member:	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting:	19 April 2017

HEALTH AND WELLBEING STRATEGY SIX MONTHLY UPDATE

1.0 Purpose of the report:

1.1 To update the Board on progress in delivering the actions in the Health and Wellbeing Strategy and to provide an update on the performance indicators.

2.0 Recommendation(s):

2.1 To note the six monthly update on the Health and Wellbeing Strategy

3.0 Reasons for recommendation(s):

3.1 The Council adopted the Health and Wellbeing Strategy in September 2016 and it was agreed that six monthly updates would be provided on the actions, (Appendix 7a) and twelve monthly updates on the performance indicators. This update is timely in setting out the current position as the Board moves towards its new governance arrangements.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered:

None, the Board has a duty to produce a strategy

4.0 Council Priority:

4.1 The relevant Council Priority is:

"Communities: Creating stronger communities and increasing resilience"

5.0 Background Information

5.1 The Health and Wellbeing Strategy 2016-2020 was approved in 2016 with four key priorities identified as the main areas where the Board would need to focus its efforts in order to reduce health inequalities and improve health and wellbeing in Blackpool. The priorities are:

- Housing
- Substance misuse including alcohol and tobacco
- Reducing social isolation and building community resilience and
- Early intervention

5.2 Plans are underway as part of the South Cumbria and Lancashire Sustainability and Transformation Plan to create a governance structure that will be accountable and to develop of a pan Lancashire Health and Wellbeing Board, with five local Health and Wellbeing Partnerships as part of that structure.

5.3 It is therefore appropriate to present this report as a current position statement on Blackpool's current strategy and performance indicators with a view to the Board giving further consideration to how these priorities will be taken account of in the new Fylde Coast Health and Wellbeing Partnership structure. An overview of the performance indicators will be presented at the meeting.

5.4 Does the information submitted include any exempt information? No

5.5 **List of Appendices:**

Appendix 7a – update of actions

6.0 Legal considerations:

6.1 None.

7.0 Human Resources considerations:

7.1 None..

8.0 Equalities considerations:

8.1 None.

9.0 Financial considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Ethical considerations:

11.1 None.

12.0 Internal/ External Consultation undertaken:

12.1 None.

13.0 Background papers:

13.1 Blackpool's Health and Wellbeing Strategy

file:///Q:/Health%20and%20Wellbeing/Blackpool%20HWB/JHWS%202016/HWB%20Strategy%202016-19%20final.pdf

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Health and Wellbeing Strategy Action Plan: Update April 2017

Priority One: Housing	
Action	**Progress**
Reduce the number of HMO's	Currently planning policies enable a managed transition from guest houses to better quality residential uses and these are currently being further refined. However sustained enforcement activity through inspections programmes targeted at the worst properties is the only tool that can force change in established HMO's. Blackpool Housing Company is now delivering 80 new homes per annum through conversion and refurbishment from commercial uses and existing houses/HMO's and forty properties have been demolished as part of Foxhall Village development. Approaches to Government to allow local changes to Housing Benefit rules that would incentivise better quality haven't yet progressed – the new Government has halted discussions on devolution deals.
Redevelop Queen's Park estate, creating 191 new homes	Developers are on site and Phase 2 construction is underway, and on target to complete all new homes by March 2018. This will be a mixture of low rise apartments and new houses to create a more desirable community in this area
Build over 400 new homes in Bloomfield	There have been 150 completions to date at Foxhall Village and are currently building further units at a rate of around 50 a year (as per sales), which suggests completion by 2024. There is a target to increase sales and complete the scheme by 2022. The Council is reviewing the potential for further homes at the adjacent Transport Depot to significantly exceed 400 in total.
Continue to implement Selective Licensing	A new Additional Licensing scheme in Central area went live July 2016, and further Selective Licensing in the Central area was approved by the Council in Feb 2017. Implementation of the new scheme is planned for September 2017 subject to Government approval.

	The South Beach Selective Licensing scheme ends March 2017 and we are currently considering options to maintain the improvement.
Continue to implement Cosy Homes in Lancashire	This pan Lancashire approach to tackling fuel poverty and cold related illness is seen as a very attractive proposition to Energy Companies and government initiatives due to the potential market size and high levels of households in the Affordable Warmth Group and the mix of urban and rural areas. In 2016 CHiL won a prestigious National Ashden Award in the sustainable homes category. The award came with prize money of £10,000 which is being used to extend the scope of the hospital in-reach initiative and Take Home and Settle into Blackpool Victoria Hospital from March 2017, through Blackpool Council Housing Strategy Team and Age UK Lancashire, for 6 months pending future funding decisions. CHiL also secured **£50,000** of funding from the DECC Health & Fuel Poverty Booster Fund. This funding allowed heating upgrades to be carried out in the homes of 70 residents suffering from long term health conditions that had either just being discharged from hospital or were in danger of being admitted again. CHiL also received **£2.241m** from the DECC Central Heating Fund. At least **570** Lancashire residents will receive 1st time central heating by May 1st 2017 protecting some of our most vulnerable residents from the health impacts of living in a cold damp home. This fund has facilitated a dedicated CHiL website www.chil.uk.com, funded by the CHF until July 2017 that educates, informs and offers an increasingly important route to accessing measures for vulnerable residents. To date CHiL has installed in excess of **2800** measures representing over **£5.1m** of investment in some of the oldest and worse housing stock in the county. This figure represents 9.2% of all measures carried out in Lancashire over the same period of time. Residents assisted through CHiL are particularly vulnerable and at high risk of being badly affected by living in a cold damp home. Often the measures required are difficult and expensive to install. Without CHiL and the financial support it has allowed these residents to access many

would have been at risk of hospital readmission or even death.

CHiL recognises the need to bring added value to any initiative it supports and therefore uses local contractors employing local people and has been particularly successful in the regard with the Central Heating Fund, where all the man power has been locally based. CHiL is recognised by the Energy Sector, BEIS (formerly DECC) and Ofgem as an example of good practice.

The next phase of CHiL will present challenges as the inconsistent nature of funding means there are periods of time when no measures are offered leaving Lancashire residents vulnerable to the effects of the cold. The Operational Group are pursuing a number of avenues to access funding streams outside of the Energy Company Obligation (ECO) including:-

- Warm Homes Discount Funding - CHiL currently has 3 proposals it is seeking funding for from the Energy Companies.
- Voluntary Redress Payments (government fines on energy companies who are found guilty of breaking industry rules) – Preston have already had funding through this to correct an external wall insulation scheme.
- ECO – Flexible Eligibility – This is an increasingly important funding stream as central government move the emphasis for measures to the most vulnerable away from general access. CHiL operational group is in talks with several energy companies to try and secure funding for Lancashire where eligibility will be determined by the local authority.
- ECO – Continues to be problematic as funding levels are low and replacement boilers require additional funding to subsidise them. This situation looks unlikely to change in the foreseeable future making the other sources of funds even more critical.

Since the introduction of the Energy Company Obligation, Blackpool Council, through supporting CHiL, has helped residents access more measures than anywhere else in the UK, ** Reducing the amount of energy needed to keep homes warm, cutting down on carbon emissions as well as reducing monthly energy bills. The town has reduced its carbon emissions by 35% * over the last 10 years, the biggest reduction across the UK;

Blackpool Council will publish a revised HECA (Home Energy Conservation Act) return on March 31st 2017 outlining its ambitions for the next 2 years as well as it's achievements to date in

	respect of improving the energy efficiency of its housing stock and reducing carbon emissions. *https://www.gov.uk/government/statistics/uk-local-authority-and-regional-carbon-dioxide-emissions-national-statistics-2005-2014 **https://www.gov.uk/government/statistics/household-energy-efficiency-national-statistics-headline-release-february-2017
Continue to support people with complex needs and chaotic lifestyles with their housing needs	Successful bid for Homelessness Prevention Trailblazer funding will enable additional support from April 2017. Fulfilling Lives have agreed to fund a Housing First pilot, to start in May 2017. This is a new scheme based on evidence from the US and supported by the Centre for Social Justice; it supports people with multiple and complex needs into secure tenancies and provides wrap around support to maintain the tenancy whilst addressing the individual's other presenting issues such as health needs or substance misuse. Council cuts are likely to mean reduced availability of hostel accommodation in 17/18, but we're planning new dispersed accommodation with support.
Deliver the Health Works hub to support people with health problems into work	The Healthworks building is now open and operational, co-locating a number of services in order to provide a more holistic approach to clients requiring support to gain employment and deal with the health issues which may be a barrier to employment. The services support those furthest from the job market such as the long term unemployed, those with mental health issues, substance issues etc. The health services include: **Supporting Minds - Mental Health and Employment Trailblazer -** Blackpool is one of four areas in England piloting a randomised control trial of the impact of more integrated employment coaching and health therapies to improve the work and health outcomes of jobseekers assessed as having common mental health disorders. **Healthy Lifestyles Service (formerly the Wellness Service) –** the use of Health Trainers and

	Health Buddies to support lifestyle change over a defined period of up to 6 months. A Public Health Nutritionist will provide nutritional advice, support and training to the service and hold a key role within the Blackpool Healthier Catering Award scheme. **Specialist Weight Management Service -** a multi-disciplinary team (MDT) comprising dietetics, occupational therapy, physiotherapy, psychology and endocrinology. These posts will be employed by Blackpool Teaching Hospitals NHS Foundation Trust on behalf of Blackpool CCG.

Priority Two: Tackle substance misuse (alcohol, drugs and tobacco)	
Action	**Progress**
Review and recommission drug and alcohol treatment services by 2017	A decision was made to re-tender the service as a prime provider model in order to achieve transformational change throughout the system. A procurement process took place in December 2016 and the successful bidder was Delphi Medical Consultants Ltd. The contract start date is 1st April 2017 and the new Horizon service model is outlined below: • Integrated clinical and adult recovery service for drugs and alcohol • A specialist alcohol service and workforce • De-commission the enhanced arrest referral service • More flexible opening hours based on client need with movement away from traditional 9am – 5pm service • Deliver a 'hub and spoke' style community based treatment model with services delivered in the GP neighbourhood teams and other community hubs • Good standard buildings utilized • Mental health support built into the service model to ensure dual diagnosis needs of clients are met • Continue with employment, education and meaningful activity integration • Develop peer and volunteer model The model will also take into consideration the wider determinants of health and ensure that provision becomes integrated with other health and social care services. The provision will be focused on delivering outcomes that support improved economic value, family outcomes and safeguarding. The new service offers an exciting opportunity to deliver improved outcomes through a whole systems approach, new culture, building and initiatives and will still operate under the Horizon branding that has become established to clients and professionals across Blackpool. The new

	contract will also achieve annual financial savings of £200,000.
Continue to lobby central government for a minimum unit price for alcohol	The Director for Public Health sits on a North West regional group chaired by Margaret Carney which is taking forward this piece of work.
Introduce smoke-free outdoor public places	Blackpool Zoo agreed to be ambassadors of the scheme – hope to launch smoke-free Zoo in Easter 2017. Marketing materials have been developed to encourage other businesses to sign up to smoke-free scheme and a handbook has been produced to support businesses in implementation.
Continue to develop Specialist Services to help people to stop smoking	A review of these services is currently underway which will determine how effective they have been and whether the service offer needs to change to reflect the needs of service users.
Utilise insights with pregnant women to develop effective interventions to reduce smoking during pregnancy	Risk Perception interventions now live. Tommy's research project currently testing intervention developed from outcome of insight work.

Priority Three: Building community resilience and reducing social isolation	
Action	**Progress**
Develop a Self-Care Strategy for Blackpool	This work is currently underway and was launched with a stakeholder engagement event in November 2016 followed by extensive consultation with patients and carers during January – March 2017. A draft Strategy will be presented to the Task and Finish Group for discussion and agreement in May 2017.
Piloting Community Orientated Primary Care in a Vanguard Neighbourhood	COPC has been successfully piloted in the Central West Neighbourhood with the regular engagement of between 16 – 20 residents. A launch event with the resident's findings and recommendations is planned for 4th May and the next phase of the work is currently being prepared.
Deliver the CYP Emotional Health, Wellbeing and Resilience Transformation Plan	A number of key achievements have been made to date. - national trajectories for access have been set by NHSE to increase access of children and young people with a diagnosable Mental Health Condition from 25% (baseline) to 35% in 2020/21 (70,000 children and young people nationally). From a baseline in 2015/16, incremental year on year increases have been identified to reach the target of 35% for 2020/21 – the target for 2016/17 is 28%; Blackpool CAMHS/Connect Counselling services are currently achieving 33.6% (Q's 1 and 2 2016). - as a result of additional funding being released by NHSE, commissioners and providers have been able to develop robust plans to reduce waiting times for Blackpool CAMHS/Child Psychology by 20% by end of Q4 - duty hours (for the provision of emergency paediatric psychosocial assessments) within CAMHS have been extended until 4:00pm – Child and Adolescent Self Harm Emergency Response Team (CASHER) are on duty at 5:00pm - CAMHS have extended their opening hours until 7pm twice a week; Connect Counselling are now opening and offering appointments 3 evenings a week with a twilight drop in starting in January 2017 - CAMHS 'Choice' appointments will be offered in both North and South Shore Medical Centre and at Youth Offending Team offices from January 2017 - a clinical psychologist for Looked After Children has been recruited to offer

	consultation and support to social workers working with our children who are experiencing emotional or mental health difficulties. A second post, currently out for recruitment, will offer direct support for our children and young people - Connect Counselling CLA post - Connect Counselling are now offering counselling support to the children's diabetic clinic - two CAMHS Transformation Champions have been identified within our CAMHS service and have completed two days training funded by Health Education England - two Primary Mental Health Workers are in post with Blackpool CAMHS. This role acts as a named contact in CAMHS for all schools and GPs and supports professionals to identify a child's mental health needs and consider appropriate ways of meeting their needs. They will work with staff in universal services and directly intervene when a child has not responded to the measures undertaken by the staff, if the intervention is likely to be short term and the level of need does not warrant intervention by specialist CAMHS. The PMHW will work alongside colleagues in Headstart to provide training programmes for professionals working with children to increase and build on their understanding of mental health issues. - a CAMHS patient experience survey has been completed – 77% of respondents said that they were very satisfied/satisfied with the care delivered by the service - engagement events are being held on a regular basis with 'Breaking the Cycle' (anti bullying group) - CASHER self-harm support follow up will commence in Spring 2017
Strengthen our approach to volunteering for public sector services	Work is underway with the Police and other statutory sector partners to establish a centralised volunteer database.

Priority Four: Early intervention	
Action	**Progress**
Deliver a Better Start for 0-3 year olds and their families	Better Start's work is focused around our four cornerstones, Public Health, Evidence Based Interventions, Reframing and Systems Transformation and Centre for Early Child Development. Around Cornerstone One, Public Health, Better Start has undertaken research and consultation with our communities in a number of areas namely Alcohol Exposed Pregnancies, Parks and Open spaces around the redevelopment of green spaces in Revoe, Claremont, Mereside and Grange Park and Oral Health. Early Years Park Rangers have been employed to run activities in green spaces with an early years focus, grow community cohesion and enable communities to take pride in the green spaces available to them. Our Dads Engagement Group have been working to redevelop the early years reading spaces in libraries and through this we have launched our Fathers Reading Every Day programme to encourage fathers engagement within their children's early literacy skills. Our second Cornerstone seeks to expand evidence based interventions across the town, working with our Public Health colleagues as part of the transformation of the Healthy Child Pathway we are expanding our Antenatal Baby Steps programme universally to every pregnant woman in Blackpool. Blackpool will be the first place in the UK to offer an evidence based programme to all pregnant women. Other evidence based programmes which have been implemented by the NSPCC Service Delivery team include Video Interactive Guidance, Parents Under Pressure, SafeCare and Survivor Mums. These programmes are receiving good numbers of referrals from partners and are being delivered at capacity and early indications show that these programmes are having a positive impact with those families that they are working with. We are working with a multidisciplinary team on MABIM (Mothers and Babies in Mind) looking at our pathways in perinatal mental ill health to ensure that our offer gives the support required when required. We are working with NATSEN with the other five Better Start sites on early years workforce development, Linda Dutton is leading on this across the Better Start partnership to ensure that the early years workforce have the skills which they require to deliver the best services to

	children and families. Our training offer will be expanded to offer ensure that the latest research and development is cascaded through our workforce including the ground breaking work with Frameworks on reframing communication in early child development. This work pulls together cornerstone three. The Centre for Early Child Development has joined with partners to look at service offers, the Speech and Language Review recently undertaken highlighted areas of best practice and proposals for how these can be maximised to improve outcomes for our youngest children.
Implement HeadStart for 10-16 year olds	The first 6 months of the phase 3 programme has proved to be an exciting but also demanding time. The response from all programme partners has been extremely positive, it was expected that a period of promoting and influencing would be needed to encourage wider partners to get involved and see the benefits of a new way of working, however we are now focusing more on managing expectations, which is a more positive place to be. Implementation continues to be demanding, all partners are on a steep learning curve as we experience what it is like to be part of embedding a large, complex, town wide strategic programme. However, with delivery now taking hold and emerging green shoots of learning being seen, our enthusiasm and passion to make a success of this investment is as strong as ever. Strong links with A Better Start are continuing to being forged. A clear joint strategy on community development and engagement work is emerging with discussions regarding co working and co commissioning taking place and plans to bring together key strands of research and evaluation are being developed. Both programmes have key aims to build capacity within our VCS sector and the commitment to maximising the impact of the investment across the two programmes is strong. Young people continue to drive forward our work, it is a privilege to see their continued drive and commitment and witness the difference they are making to the development of the programme. Co-production is meaningful and purposeful, through a robust training and support programme; young people are already directly influencing commissioning, delivery and research/evaluation. This model is currently being developed for our engagement with parents and carers.

	The learning from this initial 6 months is significant (we have a small research project in place, focused on evidencing this learning) which has positioned the programme ready to embrace the next 12 months with informed practice and renewed vigour.
Prevention and Wellbeing visits	A pilot initiative is underway to trial the safe and well visits
Implement the Healthy Weight Strategy and Local Authority Declaration on Healthy Weight	An update on progress with the actions arising from the strategy was presented to the Health and Wellbeing Board in October 2016. Progress to date in implementing the strategy: • In January 2016, Blackpool Council became the first council in the country to sign a Local Authority Declaration on Healthy Weight and made a commitment to support employees and the residents of Blackpool to tackle the issue of obesity by encouraging individuals to make healthy choices. Good progress is being made with the Local Authority Declaration and a number of the priorities are progressing well. • Blackpool's first Healthy Weight Summit took place on 2nd February 2017 and saw 20 organisations pledge to follow the Council's lead and adopt their own declaration on healthy weight. • Give up loving pop (GULP) campaign in secondary schools and colleges in November 2015 and March 2017. Work is underway to incorporate the GULP messages in the Fit2go programme that is delivered across all Year 4 children and we are exploring the development of a GULP science lesson plan which will be targeted at Years 5/6 children. • Work to promoting healthier lunchboxes is underway at present and on track to launch Spring/Summer 2017. • Healthier vending guidelines implemented and audited. • Making Changes, the redesigned weight management service for children and families launched in September 2016. • The Healthy Choices Award is now operational and a number of takeaways and sandwich shops have already received the award. • There has been good partnership work with the Corporate Procurement team reviewing how we influence and shape contracts in the future to reflect the priorities of the declaration. • Public Health and Public Protection/Enforcement are working together to develop a Street Trader Policy with particular reference to Ice Cream Vans and Street Food providing healthier choices.

	• Holiday breakfast scheme in local authority children's centres. • Living Streets 'Walk to School' project extended.

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Jayne Bentley, Care Bill Implementation and Better Care Fund Project Lead
Relevant Cabinet Member	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting	19 April 2017

BLACKPOOL BETTER CARE FUND

1.0 Purpose of the report:

1.1 To provide the Board with an update on activity to meet NHS England (NHSE) requirements for the Better Care Fund 2017-19 (full details are not available at the time of preparing this report and will be presented via PowerPoint at the meeting).

2.0 Recommendation(s):

2.1 That the contents of this report are noted.

3.0 Reasons for recommendation(s):

3.1 The Better Care Fund pooled budget is a statutory requirement under the amended NHS Act 2006.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

The Better Care Fund pooled budget is a statutory requirement under the amended NHS Act 2006.

4.0 Council Priority:

4.1 The relevant Council Priority is:

"Communities: Creating stronger communities and increasing resilience"

5.0 Background Information

5.1 There has been a considerable delay in the publication of the Policy Framework and Planning Guidance for the Better Care Fund 2017-19 (Appendix 8a), and at the time of writing only partial details of what is required is known:

- Two year planning cycle 2017-2019;
- Focus on the 'bigger integration picture' – Better Care Fund plans will need to align with the Sustainable Transformation Plan etc.;
- Reduction in number of national conditions from eight to four, which will be:
    - Plans to be jointly agreed;
    - Maintain provision of social care services;
    - Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;
    - Managing transfers of care to ensure smooth transfers between all settings.
- Performance metrics which will continue to be reported quarterly to NHS England will remain the same:
    - Non-elective admissions (Acute Specific previously General and Acute);
    - Delayed transfers of care from hospital per 100,000 population.
    - Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population.
    - Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.
- Timescales for submission and assurance are not yet known. Information will be provided to the Health and Wellbeing Board as it becomes available.

5.2 Additional funding announced in the Spring Budget will be paid as a Local Authority grant and is subject to the following conditions:

- It must be used to meet unmet social care needs;
- It will focus on the unmet needs of the older adult population;
- It should be used to help implement the high impact changes needed to reduce Delayed Transfers of Care.

5.3 The Monitoring Group is working with Commissioning Managers to develop a quality and activity monitoring framework. The following outcomes have been agreed as a starting point:

- Increased integration of health and social care services;
- Freeing up Accident and Emergency capacity;
- Put partners on more sustainable financial footing;
- Individuals maintaining independence in their own homes;
- Improved health and wellbeing of Blackpool residents.

5.4 Contract Monitoring and Commissioners are looking at what key performance indicators are currently collected on the Better Care Fund schemes, and considering if these need to be amended to bring them into line with the Better Care Fundmetrics at contract review dates.

5,5 Does the information submitted include any exempt information? No

5.6 **List of Appendices:**

Appendix 8a – 2017-19 Integration and Better Care Fund Policy Framework

6.0 Legal considerations:

6.1 The legal framework for the Better Care Fund derives from the NHS Act 2006 (amended by the Care Act 2014), which requires that in each area the Better Care Fundis transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with Department of Health (DH) and Department of Communities and Local Government (DCLG). The Act also gives NHS England powers to attach additional conditions to the payment of the BCF to ensure that the policy framework is delivered through local plans.

7.0 Human Resources considerations:

7.1 None.

8.0 Equalities considerations:

8.1 None.

9.0 Financial considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Ethical considerations:

11.1 None.

12.0 Internal/ External Consultation undertaken:

12.1 None.

13.0 Background papers:

13.1 None.

Department of Health

Department for Communities and Local Government

Appendix 8a

2017-19 Integration and Better Care Fund

Policy Framework

March 2017

Title: Integration and Better Care Fund Policy Framework 2017-19
Author: Social Care, Ageing and Disability / Integration, Local Devolution and Policy Improvement / 11120
Document Purpose: Policy
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2017-19 Integration and Better Care Fund

Policy Framework

Prepared by the Department of Health and the Department for Communities and Local Government

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Executive Summary

Why Integrate?

People need health, social care, housing and other public services to work seamlessly together to deliver better quality care. More joined up services help improve the health and care of local populations and may make more efficient use of available resources.

How is Integration being done?

There is no single way to integrate health and care. Some areas are looking to scale-up existing initiatives such as the New Care Models programme and the Integration Pioneers. Others are using local devolution or Sustainability and Transformation Plans as the impetus for their integration efforts.

One part of the solution – the Better Care Fund

The Better Care Fund is the only mandatory policy to facilitate integration. It brings together health and social care funding, with a major injection of social care money announced at Spring Budget 2017. This policy framework for the Fund covers two financial years to align with NHS planning timetables and to give areas the opportunity to plan more strategically. Details of the financial breakdown are below:

Better Care Fund funding contribution (£bn)	2017-18	2018-19
Minimum NHS (clinical commissioning groups) contribution	£3.582	£3.65
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.431	£0.468
New grant allocation for adult social care (Improved Better Care Fund)*	£1.115	£1.499
Total	£5.128 billion	£5.617 billion

*Combined amounts announced at Spending Review 2015 and Spring Budget 2017

Many areas choose to pool more than is required. For 2017-19, there are four national conditions, rather than the previous eight:

1. **Plans to be jointly agreed**
2. **NHS contribution to adult social care is maintained in line with inflation**
3. **Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care**

4. **Managing Transfers of Care** (a new condition to ensure people's care transfers smoothly between services and settings).

Beyond this, areas have flexibility in how the Fund is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance in the following four metrics: **Delayed transfers of care; Non-elective admissions (General and Acute); Admissions to residential and care homes; and Effectiveness of reablement.**

Going beyond the Better Care Fund through Graduation

The Better Care Fund is intended to encourage further integration and 90% of areas say it has already had a positive impact on integration locally. For the most integrated areas, there will be benefits in graduating from the Fund to reduce the reporting and oversight to which they are subjected. We are planning to test the graduation process with a small number of advanced areas (6 to 10) in a 'first wave', in order to develop our criteria for graduation for all areas. We are therefore inviting 'Expressions of Interest' from areas that think they are exemplars of integration, by 28th April 2017.

Agreeing a local vision of integration

As part of Better Care Fund planning, we are asking areas to set out how they are going to achieve further integration by 2020. We would encourage areas to align their approach to health and care integration with Sustainability and Transformation Plan geographies, where appropriate. This may be an exact match (e.g. Greater Manchester) or it may be smaller units within Sustainability and Transformation Plans. The focus may also be on commissioning integration (e.g. North East Lincolnshire) or through Accountable Care Systems or Organisations that bring together provision (e.g. Northumberland). What matters is that there is locally agreed clarity on the approach and the geographical footprint which will be the focus for integration.

Measuring progress on integration

To help areas understand whether they are meeting our integration ambition, we are seeking to rapidly develop integration metrics for assessing progress, particularly at the interface where health and social care interact. These will combine outcome metrics, user experience and process measures. Following the development of the metrics and an assessment of local areas, we will ask the Care Quality Commission to carry out targeted reviews in a small number of areas, starting as soon as is practical from May 2017. These reviews will be focused on the interface of health and social care.

Need more detail?

Further information on everything here can be found in the full Integration and Better Care Fund Policy Framework 2017-19.

Introduction

This document sets out the story of integration of health, social care and other public services. It provides an overview of related policy initiatives and legislation. It includes the policy framework for the implementation of the statutory Better Care Fund (BCF) in 2017-19, which was first announced in the Government's Spending Review of 2013 and established in the Care Act 2014. And it sets out our proposals for going beyond the BCF towards further integration by 2020. Whilst there will now be no separate process for integration plans, we will provide a set of resources, integration models and indicators for integration to help local areas towards our shared goal of person-centred, coordinated care.

This Policy Framework has been developed by the Department of Health (DH), Department for Communities and Local Government (DCLG), Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), and NHS England.

The case for integrated health and care services

Today, people are living much longer, often with highly complex needs and multiple conditions. These needs require ongoing management from both health and care services, which combine both the medical and social models of care. As our population ages and the financial pressures on the health and care system increase, we need to be better at providing proactive, preventative care in community settings, so that people can be supported to live at home for longer and avoid the need for commissioned health and care services.

More joined up and sustainable services help improve the health and care of local populations and may make more efficient use of available resources (i.e. by reducing avoidable hospital admissions, facilitating timely discharge, and improving people's experiences of care). Integration needs to reflect the different strengths that the NHS and social care bring to an integrated response, including the role of social services of promoting and supporting independence, inclusion and rights as far as possible, invigorating wider community services and supporting informal carers.

People want services to work together to provide them with person-centred coordinated care. National Voices set out a narrative for person-centred care, which sums up what we are working to achieve: "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."[1] This translates into positive interactions with health and care services, and better experiences for individuals as illustrated by Figure 1.

[1] http://www.nationalvoices.org.uk/publications/our-publications/narrative-person-centred-coordinated-care

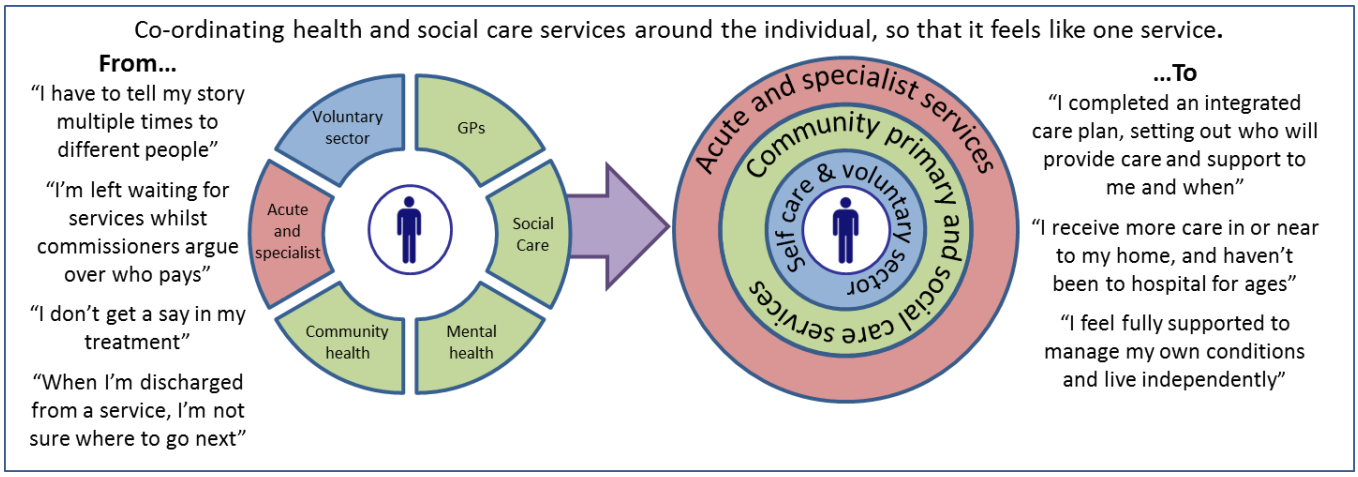


Figure 1: Co-ordinating health and care services around the individual

1. Integration to date

Integration is not a new goal and there have been initiatives over a number of years (see Figure 2).

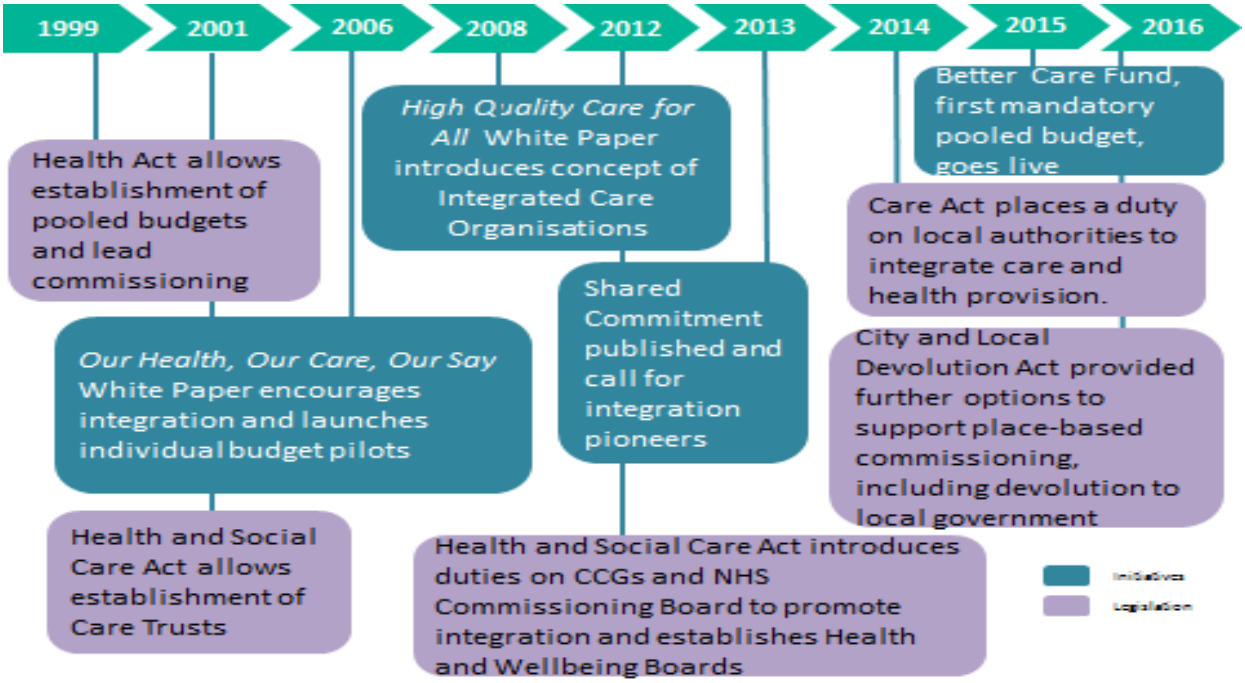


Figure 2: Key integration initiatives and enabling legislation

The Coalition Government and partners set out collective intentions on integration in Integrated Care and Support: Our Shared Commitment in 2013.[2] This showed how local areas can use existing structures such as **Health and Wellbeing Boards** to bring together local authorities, the NHS, care and support providers, education, housing services, public health and others to make further steps towards integration.

This collaboration with 12 national partners was backed by a call for areas wanting to lead the way to apply to become an 'Integrated Care Pioneer'. We identified excellent examples of joined-up care happening in different ways up and down the country and the **Integrated Care Pioneers Programme** was launched to learn from the most innovative areas and to encourage change from the bottom up. The second annual report[3] of the Pioneers summarises some of the recent learning and experiences, and the Pioneers' resource centre[4] contains a collection of tools, information and useful links.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf
[3] https://www.england.nhs.uk/pioneers/wp-content/uploads/sites/30/2016/01/pioneer-programme-year2-report.pdf
[4] https://www.england.nhs.uk/pioneers/resource-centre/

More recently, the LGA, ADASS, NHS Confederation and NHS Clinical Commissioners have developed a shared vision document, Stepping up to the place[5] for a fully integrated system based on existing evidence. This framework describes the essential characteristics of an integrated system to improve the health and wellbeing of local populations, and paves the way for integration to happen faster and to go further, so that integrated, preventative, person-centred care becomes the norm.

There is also a growing recognition of the important contribution of housing to integration. A national Memorandum of Understanding to Support Joint Action on Improving Health through the Home[6] has been signed by a spectrum of organisations including: DH, DCLG, NHS England, ADASS and the LGA, along with members of the wider housing sector. The proposals set out in the Housing White Paper – Fixing our Broken Housing Market[7] – also underline the Government's commitment to do more to provide the homes we need for all in our society, including older people and those with care and support needs.

[5] http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Stepping%20up%20to%20the%20place_Br1413_WEB.pdf
[6] https://www.adass.org.uk/media/3957/health-and-housing-mou-final-dec-14.pdf
[7] https://www.gov.uk/government/collections/housing-white-paper

2. Integration now and the wider policy context

Just as progress has already been made on integration, there are a number of current initiatives across the health and care system that contribute towards this goal.

Announced in June 2013, the **Better Care Fund (BCF)** brings together health and social care budgets to support more person-centred, coordinated care. In the first two years of the BCF, the total amount pooled has been £5.3bn in 2015-16 and £5.8bn in 2016-17.

The BCF offers a good opportunity to have shared conversations, and to consider issues from different perspectives, particularly how BCF plans can support the delivery of wider objectives and strategies around health and social care. In particular, every health and care system in England has produced a **Sustainability and Transformation Plan (STP),** providing the system-level framework within which organisations in local health and care economies can plan effectively and deliver a sustainable, transformed and integrated health and care service. Local areas should ensure the financial planning and overall direction of travel within BCF plans and the local STP(s) are fully aligned.

The **vanguards**, which are part of NHS England's new care models programme[8], have clear plans for managing demand more effectively across the local health and care system and reducing costs, at the same time as improving outcomes for patients and users. The vanguards programme has published two frameworks that cover population-based integrated models – the **Multi-speciality Community Providers (MCPs) and the Primary and Acute Care Systems (PACs)**.[9] Many of these two types of vanguards include social care as well as pursuing integration within health services. All areas are encouraged to take action against the core elements described in the models where these support local objectives around the integration of health and care services. Scaling up of PACS and MCPs in a small number of STP areas will create Accountable Care Organisations, with further details in the Next Steps on the NHS Five Year Forward View.

Local devolution deals can add impetus to all of these initiatives, offering local areas the opportunity to go beyond the integration of health and social care and drawing in other local government services such as housing, planning, skills, justice, and transport. This provides opportunities for local areas to further tailor public services around individual needs and also to tackle the wider determinants of health. Figure 3 shows how multiple integration initiatives interact, for example, within Greater Manchester.

[8] https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf
[9] https://www.england.nhs.uk/wp-content/uploads/2016/09/pacs-framework.pdf and https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf

Figure 3 – Integration initiatives in Greater Manchester

There is a growing evidence base on the contribution that **housing** can make to good health and wellbeing. At a system level, poor housing costs the NHS at least £1.4bn per annum. And there are also costs to local government and social care. On an individual level, suitable housing can help people remain healthier, happier and independent for longer, and support them to perform the activities of daily living that are important to them – washing and dressing, preparing meals, staying in contact with friends and family.

The increase in funding for the **Disabled Facilities Grant (DFG)** – and the decision to move it into the BCF in 2015-16 – is recognised as an important step in the right direction. Further action to support people into more suitable accommodation, and to adapt existing stock, is also to be welcomed.

The Department of Health is also currently working with NHS England, Local Government and others to improve the support available to informal **carers**. Supporting informal carers also supports those they care for: improving outcomes for both parties, enabling people to live independently in the community for longer and reducing impact on commissioned services. All areas are therefore encouraged to consider how BCF plans can improve the support for carers. In doing so, they may wish to make use of *'An Integrated Approach to Identifying and Assessing Carer Health & Wellbeing'*[10], an NHS England resource that promotes and supports joint working between adult social care services, NHS commissioners and providers, and voluntary organisations.

Within an area, a number of initiatives can also contribute towards overall system integration. These are not sufficient to full integration of health and social care, but can offer important contributions to key cohorts of patients and service users. For example:

[10] https://www.england.nhs.uk/wp-content/uploads/2016/05/identifying-assessing-carer-hlth-wellbeing.pdf

- Some local areas are also taking action on **'Integrated Personal Commissioning'** (IPC), whereby individuals experience holistic, personalised care and support planning, and an option for them to commission their own care using a personal budget or direct payment arrangements that combine funding from health, social care and education. IPC is being progressed by nine demonstrator areas (covering 20 CCGs and 12 local authorities) that are leading the way in developing a practical operating framework to enable wider replication, with a further 10 early adopters set to join the programme by March 2017.[11]

  NHS England expects that IPC will become a mainstream model of care for around 5 per cent of the population, enabling the expansion of personal health budgets and integrated personal budgets at scale. IPC is expected to be operational in 50% of STP footprints by 2019. Some Demonstrator sites (i.e. Luton and Stockton on Tees) are incorporating their work on IPC into BCF plans, using personal health budgets and integrated personal budgets to create more stable, coordinated care at home and in the community for high risk groups. Others parts of the country are also encouraged to consider this approach.

- Learning from the six **Enhanced Health in Care Homes** (EHCH) vanguard sites suggests that action to provide joined up primary, community and secondary health and social care to residents of care and nursing homes, as well as those living in the wider community, can have significant benefits. These include transforming the quality of care, reducing costs and activity levels, and supporting relationship-building at local level. Some parts of the country (i.e. East and North Hertfordshire and others) are already building in work around EHCH into their BCF plans and other parts of the country are encouraged to do the same. For more details, please see the 'Enhanced Health in Care Homes Framework'.[12]

[11] https://www.england.nhs.uk/commissioning/ipc/sites
[12] https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf

3. Integration now and the Better Care Fund 2017-19

This Policy Framework for the Better Care Fund (BCF) covers two financial years (2017-19) to align with NHS planning timetables and to give areas the opportunity to plan more strategically. In 2017-18, the BCF will be increased to a mandated minimum of £5.128 billion and £5.617 billion in 2018-19.[13] The local flexibility to pool more than the mandatory amount will remain. Further details of the financial breakdown are set out in Table 1 below.

The main change to the Framework from last year is inclusion of significant amounts of local authority social care grant funding. Some of this was announced at the 2015 Spending Review, with an additional £2 billion over three years announced at Spring Budget 2017. There will be grant conditions on this new money to ensure it has the expected impact at the care front line.

In developing this framework, we have listened to feedback from local areas about the need to further streamline the processes around planning, assurance and performance reporting. There is also a halving of the number of national conditions that areas are required to meet through their BCF plans - reduced from eight to four. We have also set out more clearly, the requirements around the social care national condition.

The national conditions that areas will need to meet in their plans for 2017-18 and 2018-19 are: **plans to be jointly agreed; NHS contribution to adult social care is maintained in line with inflation; agreement to invest in NHS commissioned out of hospital services; and managing transfers of care**. The detailed requirements for each condition are set out in **Annex A**.

The removal of some national conditions from 2016-17 does not reflect a downgrading of the importance of these policies and we expect them to underpin local BCF plans. For example, all areas should be working to embed 7-day services across the health and care system. Shared information, interoperable IT and joint care assessments are critical enablers to deliver integrated services - therefore, we expect every area to continue taking action to build on the progress made in the last two years. In **Annex B** we have set out what you can do to keep up the momentum.

Statutory and Financial Basis of the Better Care Fund

The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the BCF. It allows for the Mandate to NHS England to include specific requirements to instruct NHS England over the BCF, and NHS England to direct Clinical Commissioning Groups to pool the necessary funding.

[13] These are indicative figures only.

Better Care Fund in 2017-18

The Mandate to NHS England for 2017-18 requires NHS England to ring-fence £3.582 billion within its overall allocation to Clinical Commissioning Groups to establish the BCF in 2017-18. The Mandate was published on 20th March 2017.[14]

The remainder of the £5.128bn BCF in 2017-18 will be made up of the £431m Disabled Facilities Grant (DFG) and £1.115bn new grant allocation to local authorities to fund adult social care, as announced in the 2015 Spending Review and Spring Budget 2017. Both grants are paid directly from the Government to local authorities.

As in the previous two years, the NHS contribution to the BCF includes funding to support the implementation of the Care Act 2014. Funding previously earmarked for reablement (£300m) and for the provision of carers' breaks (£130m) also remains in the NHS allocation.

Better Care Fund in 2018-19

The Mandate to NHS England for 2017-18 also denotes an indicative ring-fence of £3.65bn from allocations to Clinical Commissioning Groups for the establishment of the BCF in 2018-19. The actual amount will be confirmed via the Mandate for 2018-19, which will be published in winter 2017-18.

The remainder of the £5.617bn BCF in 2018-19 will be made up of the £468m DFG and an indicative amount of £1.499bn new grant allocation to local authorities to fund adult social care, both of which will be paid directly from the Government to local authorities.

As in 2017-18, funding previously earmarked for reablement (£300m) and for the provision of carers' breaks (£130m) remains in the NHS contribution.

Table 1: BCF funding contributions in 2017-19

Better Care Fund funding contribution (£bn)	2017-18	2018-19
Minimum NHS (clinical commissioning groups) contribution	£3.582	£3.65
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.431	£0.468
New grant allocation for adult social care (Improved Better Care Fund)	£1.115	£1.499
Total	£5.128 billion	£5.617 billion

[14] https://www.gov.uk/government/publications/nhs-mandate-2017-to-2018

Conditions of access to the Better Care Fund

The amended NHS Act 2006 gives NHS England the powers to attach conditions to the amount that is part of Clinical Commissioning Group allocations (as discussed earlier, these are £3.582bn in 17-18, and an indicative amount of £3.65bn in 18-19). These powers do not apply to the amounts paid directly from Government to local authorities.

For the DFG, the conditions of usage are set out in a Grant Determination Letter, due to be issued by DCLG in April. This references the statutory duty on local housing authorities to provide adaptations to those disabled people who qualify, and sets out other relevant conditions.

For the new grant allocation to local authorities to fund adult social care, the conditions of usage will also be set out in a Grant Determination Letter. This will also be issued by DCLG in April, though a draft version of the conditions has been shared in March, for information.

National Conditions for 2017-19

In 2017-19, NHS England will require that BCF plans demonstrate how the area will meet the following national conditions:

- **Plans to be jointly agreed;**
- **NHS contribution to adult social care is maintained in line with inflation;**
- **Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care; and**
- **Managing Transfers of Care**

The refreshed definitions of these national conditions are set out at **Annex A.**

NHS England will also set the following requirements, which local areas will need to meet to access the CCG elements of the funding:

- A requirement that the BCF is transferred into one or more pooled funds established under section 75 of the NHS Act 2006; and
- A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s).

Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of CCG funding where conditions attached to the BCF are not met, except, as mentioned above, for those amounts paid directly to local government. The Act makes provision

at section 223GA(7) for the mandate to NHS England to include a requirement that NHS England consult Ministers before exercising these powers. The 2017-18 Mandate to NHS England confirms that NHS England will be required to consult the Department of Health and the Department for Communities and Local Government before using these powers.

Disabled Facilities Grant

In two-tier areas decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government should be passed down by the county to the districts (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans; as set out in the DFG Grant Determination Letter due to be issued by DCLG in April 2017.

New grant for adult social care (announced in the 2015 Spending Review and Spring Budget 2017 as 'Improved Better Care Fund' (iBCF) funding)

The Government's Spending Review in 2015 announced new money for the BCF of £105m for 2017-18, £825m for 2018-19 and £1.5bn for 2019-20. The Spring Budget 2017 subsequently increased this to £1.115bn for 2017-18, £1.499bn for 2018-19 and £1.837bn for 2019-20. The Government will require that this additional Improved Better Care Fund (iBCF) funding for adult social care in 2017-19 will be pooled into the local BCF. This funding does not replace, and must not be offset against the NHS minimum contribution to adult social care.

The new iBCF grant will be paid directly to local authorities via a Section 31 grant from the Department for Communities and Local Government. The Government will attach a set of conditions to the Section 31 grant, to ensure it is included in the BCF at local level and will be spent on adult social care. The final conditions will be issued in April. However, a draft has been shared with areas in March. The draft conditions of use of the Grant can be summarised as:

1. Grant paid to a local authority under this determination may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.

2. A recipient local authority must:

    a) pool the grant funding into the local BCF, unless an area has written Ministerial exemption;

    b) work with the relevant Clinical Commissioning Group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and

c) provide quarterly reports as required by the Secretary of State.

3. The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans have been locally agreed.

In terms of the wider context, the funding is also intended to support councils to continue to focus on core services, including to help cover the costs of the National Living Wage, which is expected to benefit up to 900,000 care workers. This includes maintaining adult social care services, which could not otherwise be maintained, as well as investing in new services, such as those which support best practice in managing transfers of care.

Local authorities will be required to confirm that spending of the BCF money provided at Spending Review 2015 and Spring Budget 2017 will be additional to prior plans for social care spending, via a Section 151 Officer letter.

The assurance and approval of local Better Care Fund plans

As in 2016-17, plans will be developed locally in each Health and Wellbeing Board area by the relevant local authority and Clinical Commissioning Group(s). Plans will be assured and moderated regionally in line with the operational planning assurance process set out in the Integration and Better Care Fund Planning Requirements, published by NHS England and the Local Government Association.

Recommendations for approval of overall BCF plans will be made following moderation of regional assurance outcomes by NHS England and local government. Plans will be approved and permission to spend the CCG minimum contribution to the BCF will be given once NHS England and the Integration Partnership Board have agreed that the conditions attached to that funding have been met.

Local authorities are legally obliged to comply with grant conditions. The NHS Act 2006 (as amended by the Care Act 2014) allows NHS England to direct the use of the CCG elements of the fund where an area fails to meet one (or more) of the BCF conditions. This includes the requirement to develop an approved plan. If a local plan cannot be agreed or other National Conditions are not met, any proposal to direct use of the CCG elements of the Fund will be discussed with the Integration Partnership Board.

National performance metrics

As in 2015-16 and 2016-17, local areas are asked to agree and report metrics in the following four areas:

- Delayed transfers of care;
- Non-elective admissions (General and Acute);
- Admissions to residential and care homes; and
- Effectiveness of reablement

The detailed definitions of these metrics will be set out in the Integration and Better Care Fund Planning Requirements.

We are no longer requiring the national collection of a locally proposed metric.

Better Care Fund support offer in 2017-19

In implementing the BCF from 2017-18 to 2018-19, the joint Better Care Support team hosted by NHS England will continue to:

- Provide support to local areas to ensure effective implementation of agreed plans;
- Build an intelligence base to understand the real impact of the BCF on delivering integration;
- Support local systems to enable the successful delivery of integrated care in 2017-19 by capturing and sharing learning, building and facilitating networks to identify solutions;
- Promote and communicate the benefits of health and social care integration;
- Monitor the ongoing delivery of the BCF – including quarterly reporting on national metrics and spending; and
- Support areas that are proposing to graduate or have graduated from the BCF.

4. Integration now - Graduating from the Better Care Fund

Overview

The Government's Spending Review 2015 set out that "areas will be able to graduate from the existing Better Care Fund (BCF) programme management once they can demonstrate that they have moved beyond its requirements, meeting the government's key criteria for devolution."

It is the Government's ambition that all areas will be able to work towards graduation from the BCF to be more fully integrated by 2020, with areas approved in waves as they demonstrate maturity and progress towards greater integration. The best areas are showing that greater levels of integration bring positive benefits in terms of improving people's health, wellbeing and experience of care, particularly in wrapping services around people's needs and shifting the focus to keeping people well and happy at home, with reduced demand for hospital and other health and care services.

These areas can apply for 'earned autonomy' from the BCF programme management. Graduation will mean that we will have a different relationship with these local areas; with reduced planning and reporting requirements and greater local freedoms to develop agreements appropriate to a more mature system of health and social care integration. This will include a bespoke support offer for areas that graduate, in addition to them no longer being required to submit BCF plans and quarterly reports.

We are planning to test the graduation process with a small number of areas (6 to 10) in the first instance. We are inviting areas that believe they can demonstrate that they meet the criteria for graduation now to put themselves forward prior to the deadline for submission of first plans, with a view to graduating from the BCF in this first wave.

Subsequent waves of areas will have the opportunity to graduate over the course of this spending review period. Departments, the LGA and NHS England will work with graduated areas to role-model how integration can support better outcomes for populations across health, social care and housing.

A "first wave" of Better Care Fund graduation

We have no set targets for the numbers of areas that graduate from the existing BCF programme management in each year. In the first round, we are planning to test graduation with a small number of areas (between 6 and 10), and will use this learning to refine the criteria and process going forward.

Graduation proposals should be made, at minimum, across an entire Health and Wellbeing Board geography, but could be aligned to Sustainability and Transformation Plan (STP)

footprints or devolution deal sites, as long as all relevant Health and Wellbeing Boards included in the proposal are supportive.

The eligibility criteria are set out below. Areas interested in participating in the first wave of graduates should benchmark themselves against these criteria and discuss their interest with their Better Care Manager.

The process of graduation will utilise sector-led improvement principles, supporting areas through peer review and development. This will culminate in a "graduation panel", which will provide face-to-face support and challenge to local areas to agree the conditions for graduation.

Eligibility criteria for Better Care Fund graduation

To keep the application process simple, all partners in an area wishing to apply for graduation will need to complete an Expression of Interest and demonstrate that they:

a) **Have in place a sufficiently mature system of health and social care with evidence of:**
   - Strong shared local political, professional, commissioner and community leadership;
   - An agreed system-wide strategy for improving health and wellbeing through health and social care integration to 2020. The government supports a range of models of health and social care integration, as set out in Chapter 5. You should reference your choice of model in your integration strategy or action plans and their links to wider health and local government strategies; and
   - A robust approach to managing risk, including adequate financial risk management arrangements proportionate to the level of risk in the system, for example, if any CCG is subject to financial directions, a clear appraisal of any additional risk and approach to managing it.

b) **Can demonstrate the application is approved by all signatories required by BCF planning**

c) **Provide evidence of improvement and/or approach to improving performance on BCF national performance metrics and how graduation will enable the area to accelerate improvement on these metrics. This should include current performance data and stretch targets.**

d) **Set out plans to pool an agreed amount greater than the minimum levels of the BCF or align the commissioning of an equivalent or greater scope of services. Set out plans to maintain joint investment in integrated services, including:**
   - Maintaining the NHS contribution to social care and NHS commissioned services in line with inflation;
   - Maintaining additional contributions from CCGs and local authorities to the pooled fund, in addition to the 'improved Better Care Fund' grant funding to local government; and

- Continuing to meet grant conditions attached to the newly allocated funding within the Improved Better Care Fund.

e) Are committed to a 'sector-led improvement' approach in which they are willing to act as peer leaders, working with national partners to support other areas looking to graduate.

Selection criteria

As the first wave is testing the process, we will use the Expressions of Interest and other available information, including the following additional criteria, to select a small pool of 6-10 applicants, as follows:

a) The applicants commit and have the capacity to participate in the selection process which is set out below, participate in the pilot evaluation and share learning with peers and with national organisations supporting integration work.

b) The applicants have discussed their proposal with their local Better Care Manager.

c) The pilot cohort covers a range of different care model types as set out in Chapter 5.

d) The pilot cohort covers a spread of geographical locations and local authority type.

The selection process will include graduation workshops to help local leaders identify the steps necessary to graduate from the BCF and progress integration, in line with the 2015 Spending Review commitments. The workshops are based on the existing LGA sector-led improvement model, and will involve a half-day session for senior local health and local government leaders; these workshops will run in May and June, in order to complete the pilot in the agreed timeframe. The process will culminate in graduation panels (in early-to-mid July) with representatives from Department of Health, Department for Communities and Local Government, NHS England, Local Government Association, and Association of Directors of Adult Social Services, and will agree with local leaders, clear, measurable and transparent objectives and milestones for integration locally to 2020. We also intend to develop a dedicated package of support, building on the learning and experience of sites which have graduated from the pilot.

We are seeking areas which have made the most progress in moving beyond the requirements of the BCF. We recognise that the restricted number of pilot areas is likely to mean some areas are unsuccessful. We do understand that this will be disappointing for those areas not selected, but subsequent graduation waves will not be restricted in numbers in the same way. In addition those areas which are not selected for the pilot can continue to prepare for subsequent waves.

Expression of Interest process and timelines

- Applicants should submit to England.bettercaresupport@nhs.net an Expression of Interest, which demonstrates how local organisations meet the eligibility criteria a) to e) above by 5pm on 28th April 2017; this should include an indication of the discussion with their local Better Care Manager, which should take place before 19th April 2017.
- All applications will be assessed by the selection panel, with results communicated by 10th May 2017.
- Graduation workshops will run in May and June, with graduation panels taking place in early-to-mid July.

Guidance on submitting an Expression of Interest

The form should specifically address the eligibility criteria outlined in a) to e) above. Any submitted documents, including any covering letters, must not be longer than 6 pages, and have no embedded or attached appendices. Any attached or embedded documents will not be considered by the selection panel.

The Expressions of Interest will be assessed by a panel of representatives from the Department of Health, Department for Communities and Local Government, NHS England, Local Government Association, and Association of Directors of Adult Social Services. Its decision will be based on the evidence provided against eligibility criteria a) to e), with adjustments made to ensure a fair selection of pilots across geography, care model and local authority type in order to maximise the potential for learning from the pilots.

The support offer

We will put in place an ongoing support offer for areas, before, during and after the process of graduation. This will include:

- **Before –** Seminars, workshops or individual support for areas preparing for graduation (second and subsequent waves), including peer support from areas that have graduated;
- **During -** Advice and support for areas shortlisted for graduation to develop the core essential characteristics for integration including those required as evidence for graduation;
- **After -** Support for a peer network of graduated areas to share experience and evidence of what is working;

Once an area has been selected for graduation, we will aim to support them to achieve and/or maintain their integration vision. Areas that have 'graduated' from the BCF will continue to be subject to the normal local authority and CCG reporting requirements on finance and performance. We will develop with the first wave the format and process for providing a self-certifying annual report. In the unforeseen circumstances of serious financial or performance

issues or a breakdown in local partnership's ability to realise their integration plan, it may be necessary to reinstate some or all of the BCF programme management. This would be considered a last resort to support local leaders. Local areas would be given adequate advance notice, before any assurance or reporting requirements are reinstated.

BCF graduates will be at the forefront of demonstrating how integration of health and care is becoming a reality by 2020 and we expect that early graduates will work with national partners to share learning with others and provide leadership in delivering fuller integration by 2020.

5. Integration future - Integration to 2020

Overview

At the Spending Review 2015, the Government announced its ambition to integrate health and social care by 2020 so that it feels like one service. As noted by the Nuffield Trust there "is no one model of integrated care that is suited to all contexts, settings and circumstances".[15]

The ways local areas integrate will be different, and some parts of the country are already demonstrating different approaches, which reflect models the government supports. For example:

- **Greater Manchester –** a devolution area pooling health and social care budgets within 10 HWB localities. Where there are clear benefits, services will be commissioned across the footprint through the joint commissioning board (comprising the CCGs, local authorities and NHS England). Each locality has its own individual plan for integrating services which feeds into the overarching health and social care strategy.
- **North East Lincolnshire –** a lead commissioner model, in which the CCG exercises the Adult Social Care functions on behalf of the local authority;
- **Northumberland –** a single Accountable Care Organisation (ACO), taking on responsibility for general practice, primary care, hospital and community services, adult social care and mental health services.[16]

	Joint commissioning	Lead commissioning	Accountable Care Organisation (ACO)[17]
Characteristics	Some or all CCG/LA commissioning decisions made jointly. Budgets (and other resources) pooled or aligned in line with extent of joint commissioning.	One body exercises some or all functions of both the CCG and the LA, with the relevant resources delegated accordingly.	CCG and LA pay a set figure (possibly determined by capitation) to an Accountable Care Organisation to deliver an agreed set of outcomes for all health and care activity for the whole population, using a multi-year contract. The ACO decides what services to purchase to deliver those outcomes. MCPs and PACs are types of ACOs.

[15] Nuffield Trust, An overview of integrated care in the NHS. What is integrated care? (London: Nuffield Trust, 2011), 20.
[16] Northumberland is a PACs vanguard site, but the ACO goes well beyond simply combining primary and secondary acute care.
[17] M McClellan et al., Implementing Accountable Care to achieve Better Health at a Lower Cost, WISH 2016 http://www.wish-qatar.org/wish-2016/forum-reports

An integrated health and social care service should have full geographical coverage, with clear governance and accountability arrangements. As part of this, we would encourage areas to align their approach to health and care integration with STP geographies, where appropriate. This may be supplemented by initiatives for particular groups, such as Enhanced Health in Care Homes and Integrated Personal Commissioning.

The Government recognises the integration efforts that are already happening, including through the Better Care Fund (BCF), STPs and local devolution. There will be no separate process for integration plans. **Instead, we will simply require local areas to set out how they expect to progress to further integration by 2020 in their BCF 17-19 returns.**

Next Steps

To help areas understand whether they are meeting our integration ambition, we will develop integration metrics for assessing progress, particularly at the interface where health and social care interact. This will combine outcome metrics, user experience and process measures. The metrics will build on work already carried out on behalf of Government (see Annex C) and the Integration Standard tested on the Government's behalf by the Social Care Institute for Excellence (SCIE) found at Annex D. SCIE found that the standard identified helpful integration activities such as risk stratification and multi-disciplinary community teams, but was process-focussed and did not tell the whole integration story. We therefore want to bring elements of the standard into the wider integration scorecard. SCIE's full report is available here: www.scie.org.uk/integrated-health-social-care/integration-2020/research

Further work involving SCIE and key stakeholders will develop these integration metrics. If you have any thoughts on what to include in these, please email: Bettercarefund@dh.gsi.gov.uk

Following the development of the metrics we will ask the Care Quality Commission (CQC) to carry out targeted reviews in a small number of areas, starting as soon as is practical from May 2017. These reviews will be focused on the interface of health and social care and will not cover wider council social care commissioning. This should lead to a tailored response to ensure those areas facing the greatest challenges can improve rapidly.

Other actions will include:

a) Consideration of Section 75 arrangements

The Department of Health, working with NHS England, is now considering what further changes could be made to secondary legislation to support more integrated, place-based approaches to health and social care, for example:

- The commissioning functions that can be included in scope
- The governance and partnership working arrangements that are permissible, for example Joint Committees

Before NHS England can make arrangements involving combined authorities and local authorities for example, regulations would need to be made prescribing those bodies for the purposes of such arrangements. The Department is also considering whether further amendments to the section 75 partnership regulations would support local areas to extend the benefits of partnership working as they take forward their integration vision.

b) Developing our evidence base on integration, through independent evaluation and sector-led engagement

We will build on our evidence base on what good integration looks like through:

- **The final report of the system-level evaluation of the Better Care Fund will be ready in winter 2017-18.** An interim report is expected in spring 2017, including a typology analysis of integration activities, initial findings from the comparative evaluation, and a BCF policy background paper (a documentary analysis of official BCF literature).

- **Learning from LGA's sector-led support using the Integration 'self-assessment' tool**[18] developed by LGA, ADASS, NHS Confederation and NHS Clinical Commissioners. The peer-led tool assesses local leaders' readiness, capacity and capability to integrate. We will build on this to facilitate graduation panels.

- **NHS England and NHS Improvement evaluation of the New Care Models Programme.** There is a wide range of national, local and independent evaluation of the NCM. Evaluations are progressing at pace.

- **DH and CQC testing the feasibility of a national survey of people's experience of integrated care.** This will be piloted in 2017-18 with a view to national roll out in the future.

Resources:

The LGA has developed a library of resources, signposting local areas to evidence, case studies, tools and resources which will support the development of integration ambitions locally.[19] The resource is organised around the essential integration characteristics, such as leadership, governance, prevention, housing and planning, co-production, care models and workforce. Organisations may also find the slides on Integration, produced by consulting firm Oliver Wyman, a useful resource.[20]

[18] http://www.local.gov.uk/documents/10180/7632544/1.10+Stepping+up+to+the+place+-+integration+self-assesment+tool+WEB.pdf/017681db-bec4-405d-b51d-4ff6f930227d
[19] http://www.local.gov.uk/integration-better-care-fund/-/journal_content/56/10180/8026967/ARTICLE
[20] http://www.oliverwyman.com/our-expertise/insights/2016/nov/global-health-strategy-hub.html

Annex A: Further information on the national conditions for 2017-19

NATIONAL CONDITION	DEFINITION
Condition 1: **Plans to be jointly agreed**	Local areas must ensure that their Better Care Fund (BCF) Plan covers the minimum of the pooled fund specified in the BCF allocations spreadsheet, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area. The plans should be signed off by the Health and Wellbeing Board itself, and by the constituent councils and Clinical Commissioning Groups. The Disabled Facilities Grant (DFG) will again be allocated through the BCF. As such, areas are required to involve local housing authority representatives in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing. In two-tier areas decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government should be passed down by the county to the districts (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans. During these discussions, it will be important to continue to meet local needs for aids and adaptations, whilst also considering how adaptation delivery systems can help meet wider objectives around integration. For both single tier and two tier authorities, areas are required to set out in their plans how the DFG funding will be used over the two years. In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with groups likely to be affected by the use of the fund (including health and social care providers) in order to achieve the best outcomes for local people.
Condition 2: **NHS contribution to adult social care is maintained in line with inflation**	For 2017/18 and 2018/19, the minimum contribution to adult social care will be calculated using the assured figures from 2016/17 as a baseline. This will apply except where a Health and Wellbeing Board secures the agreement of the Integration Partnership Board to an alternative baseline. The NHS contribution to adult social care at a local level must be increased by 1.79% and 1.9% (in line with the increases applied to the money CCGs must pool) in 2017-18 and in 2018-19 respectively. Local areas can opt to frontload the 2018-19 uplift in 2017-18 and then carry over the same level of contribution in 2018-19 as in 2017-18. The funding must be used to contribute to the maintenance of adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition, the Department of Health wants to provide flexibility for local areas to determine how this investment in adult social care

	services is best used. The additional funding for adult social services paid directly to local authorities by the government in each year (please refer to page 17) does not replace, and cannot not be offset against, the NHS minimum contribution to adult social care.
Condition 3: **Agreement to invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care**	Local areas should agree how they will use their share of the £1.018 billion in 2017/18 and £1.037 billion in 2018/19 that had previously been used to create the payment for performance fund (in the 2015-16 BCF). This should be achieved by funding NHS commissioned out-of-hospital services, which may include 7-day services and adult social care, as part of their agreed BCF plan. This can also include NHS investment in the high impact change model for managing transfers of care (linked to compliance with national condition 4), although CCGs can commission these services from funding outside of this ringfence. Local areas can choose to put an appropriate proportion of their share of the £1.018bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including 7-day services and adult social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 2016-17). Further guidance to support local areas on deciding whether to hold back a proportion of funds as part of a risk share agreement will be provided in the Integration and Better Care Fund Planning Requirements.
Condition 4: **Managing Transfers of Care**	All areas should implement the High Impact Change Model for Managing Transfer of Care[21] to support system-wide improvements in transfers of care. Narrative plans should set out how local partners will work together to fund and implement this and the schemes and services commissioned will be assured through the planning template. Areas should agree a joint approach to funding, implementing and monitoring the impact of these changes, ensuring that all partners are involved, including relevant Accident and Emergency Delivery Boards. Quarterly reports will be provided, as required by the Department of Health and the Department for Communities and Local Government.

[21] Including arrangements for a Trusted Assessor model, as per the following link: http://www.local.gov.uk/documents/10180/7058797/Impact+change+model+managing+transfers+of+care/3213644f-f382-4143-94c7-2dc5cd6e3c1a

Annex B: Maintaining progress on the 2016-17 national conditions

We have made changes to the national conditions and reduced the number of conditions to reflect wider changes in the policy and delivery landscape.

For the policy areas that are no longer national conditions of the Better Care Fund (BCF) in 17-19 (see table below), we encourage areas to continue taking action through their BCF plans or other local agreements to ensure these policy priorities and critical enablers for integration continue to feature in local planning and delivery.

National condition	Update for 2017-19 Better Care Fund planning
1. Plans to be jointly agreed	This is a condition for 2017-19 (see Annex A)
2. NHS contribution to adult social care is maintained in line with inflation.	This is a condition for 2017-19 (see Annex A)
Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admission to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Improving services through the implementation of the 7-day service clinical standards remains an important priority.[22] All areas should be working to make progress on implementing the 4 priority clinical standards, supported by NHS England and NHS Improvement, so that by April 2018, 50% of patients have access to these standards of care every day of the week with this rising to everyone by 2020. Sustainability and Transformation Plans are providing an opportunity for areas to come together to consider the delivery of 7-day services across geographical areas. Although not a requirement for accessing BCF funding in 2017-19, BCF areas should continue to make progress locally, building on the action taken in 2016-17, on implementing standard 9 of the 7- day hospital service clinical standards which concerns the transfer of patients to community, primary and social care. Standard 9 sets out that: 'Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken, 'Academy of Medical

[22] https://www.england.nhs.uk/ourwork/qual-clin-lead/seven-day-hospital-services/the-clinical-case/

	Royal Colleges (2012): Seven day consultant present care'. Without the timely transfer of patients across settings of care there can be detriment to both existing hospital patients and newly-arriving patients. All BCF areas should work together to avoid unnecessary delays in patient pathways, including taking the actions to reduce delayed transfers of care set out in the section on DTOC below.
Better data sharing between health and social care, based on the NHS number	Data sharing is no longer a condition of the BCF but it remains an important enabler to delivery of BCF or wider integration commitments. To enable effective information sharing for direct care, Parliament introduced the Safety and Quality Act in 2015 which now makes it a legal requirement to share information where it is likely to facilitate the provision of health or care services and is in the individuals' best interests. The Safety and Quality Act also now makes it a legal requirement to use a consistent identifier (such as the NHS number) to support local information sharing. There are examples of where leadership commitment is enabling information sharing at a local level. In addition, through Local Digital Roadmaps, local areas are outlining ambitions for the use of information sharing and technology to support the delivery of care. There are existing examples across the country of where local areas are joining up local systems to give a single health and care record to support the delivery of direct care. These approaches will enable improved coordination of care and support information sharing across health and care settings. The National Data Guardian has also published a review of data security, consent and opt outs across health and care. The report proposed a set of ten data security standards for the health and care system and made a series of recommendations to support information sharing. This includes a commitment to refresh the current Information Governance Toolkit, so that it becomes a portal to support organisations across health and social care to demonstrate increasing resilience and compliance with the standards. Local areas should consider how best to implement these recommendations in conjunction with national policy and services such as CareCERT. The review builds on the previous two Caldicott reports to emphasise the

	importance of building public trust in data security and information sharing, and encouraging public bodies to ensure they engage with citizens regarding how their information is shared.
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	This is no longer a condition of the BCF; however, BCF plans should have embedded within them, an integrated and proactive approach to planning and managing care with other health and care professionals.
Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans	This is no longer a condition of the BCF but areas should engage with groups likely to be affected by the use of the fund (including health and social care providers) in order to achieve the best outcomes for local people (as set out in condition 1 for 2017-19)
3. Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	This is a condition for 2017-19 (see Annex A)
Agreement on local action plans to reduce delayed transfers of care (DTOC)	There is an improved condition around Managing Transfers of Care (National Condition 4), which requires areas to implement the High Impact Change Model for Managing Transfers of Care. Areas should agree a joint approach to funding, implementing and monitoring the impact of these changes, including setting out the intended impact on reducing delayed transfers of care. This will also support the target of a reduction in total delayed transfers of care to 3.5% by September 2017 (recognising existing variation between areas), which is referenced in the Mandate to NHS England for 2017-18.

Annex C: Draft Interface Metrics

Proposed scorecard for measuring effectiveness of social and healthcare interfaces

A Main performance indicators

A1 NEL admissions (65+) per 1,000 65+

A2 NEL admissions (65+) with length of stay >30 days per 1,000 65+

A3 Emergency readmission (65+) per 1,000 emergency admissions 65+

A4 Institutionalisation bed days (65+) per 1,000 65+

A5 DTOC – overall and due to social care placement or package per 1,000 65+

B Supporting overarching indicator

B1 Index of 'User reported quality of life' and 'Proportion of people feeling supported to manage their LTC'

C Contextual indicator

C1 Index of multiple deprivation (IMD)

Additional contextual indicators to collect in the future:
- Public health and social care spend per capita for 65+
- Proportion of 65+ with shared care records in place which are accessible by all care manage teams

Annex D: Integration Standard

	Objective	Improvement to person's experience	System change needed to deliver this objective
1	**Digital inter-operability**	"I have access to a Digital Integrated Care Record that moves with me throughout the health and care system. All professionals involved in my care have access to this record (with the appropriate safeguards in place to protect my personal data)"	• Areas reach **digital maturity**, including universal use of the NHS number as the primary identifier and fully interoperable IT across providers and commissioners.
2	**Resource targeted at key cohorts to prevent crises and maintain wellbeing**	"If I am at risk of emergency hospital admission, I will receive the right care at the right time to help me to manage my condition and to keep me out of hospital." "If it would benefit me, I will be able to access a personal budget, giving me greater control over money spent on my care."	• Areas use health and social care data to **risk stratify** their populations, identifying those most at risk of unplanned admissions and allocating resources according to need. • Areas will allow greater access to **Integrated Personal Commissioning**, for identified groups who could benefit. • Areas use **capitated budgets** where appropriate
3	**Value for money**	"I receive the best possible level of care from the NHS and my Local Authority."	• Areas deliver against a **clear plan for making efficiencies** across health and care, through integration.
4	**Single assessment and care plans**	"If I have complex health and care needs, the NHS and social care work together to assess my care needs and agree a single plan to cover all aspects of my care."	• Areas use **multi-disciplinary integrated teams** and make use of professional networks to ensure high-quality joined-up care is delivered in the most appropriate place seven days a week.
5	**Integrated community care**	"My GP and my social worker or carer work with me to decide what level of care I need, and work with all of the appropriate professionals to make sure I receive it."	
6	**Timely and safe discharges**	"If I go into hospital, health and social care professionals work together to make sure I'm not there for any longer than I need to be."	
7	**Social care embedded in urgent and emergency care**	"If I have to make use of any part of the urgent and emergency care system, there are both health and social care professionals on hand when I need them".	

Report to:	**Health and Wellbeing Board**
Relevant Officer	Dr Arif Rajpura, Director of Public Health
Relevant Cabinet Member	Councillor Amy Cross, Cabinet Member for Adult Services and Health
Date of Meeting	19 April 2017

BLACKPOOL SEXUAL HEALTH STRATEGY AND ACTION PLAN 2017-20

1.0 Purpose of the report:

1.1 The Sexual Health Strategy and Action Plan responds to the local sexual health needs assessment conducted in 2016 and acts in response to the changing landscape and needs of the Blackpool population.

2.0 Recommendation(s):

2.1 To consider and approve the draft Blackpool Sexual Health Strategy and Action Plan.

3.0 Reasons for recommendation(s):

3.1 Sexual health clinical services and sexual health promotion activities are commissioned and provided by a range of organisations, from school delivered Personal, Social and Health Education to Clinical Commissioning Group and NHS England commissioned HIV treatment services. The aim of this strategy is to provide a framework to guide both our planning of services commissioned by the Health and Wellbeing Board partner organisations, and the operational delivery of public health interventions.

The sexual health needs assessment informed a programme of sector led improvement workshops with Lancashire County Council, Blackburn with Darwen Council, Cumbria County Council and Public Health England. Sector led improvement aims to scrutinise data and activities and learn from best practice.

In addition the health needs assessment was presented at a stakeholder event, where a deep dive process was used to identify key actions to address the current issues faced in Blackpool and to horizon scan for the future.

A literature review was also completed to identify the evidence base for tackling the

issues highlighted in the needs assessment.

This work was then assimilated into a single plan for Blackpool.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

None.

4.0 Council Priority:

4.1 The relevant Council Priority is :

"Communities: Creating stronger communities and increasing resilience"

5.0 Background Information

5.1 Since the first Sexual Health Strategy and Action Plan, produced in 2005, the last decade has seen significant progress in the improvement in sexual health across Blackpool. These improvements include:

- A significant reduction in teenage pregnancy
- A significant reduction in the incidence of sexually transmitted infections (STI) including chlamydia and genital warts
- A move to regular sexually transmitted infections testing by young people rather than accessing services when there is a problem
- A significant reduction in the incidence of HIV over a ten year period
- Through the national NATSAL all age survey, improvement in sexual health measured by contraception and condom use
- Through the SHEU survey of children, improvement in awareness, knowledge and understanding in sexual health and where to access contraceptive services and advice
- Large scale availability and uptake of Long Acting Reversible Contraception across all age groups, the most evidence based and cost effective way of reducing unplanned pregnancy.

Despite the progress that has been made, Blackpool continues to face a range of challenges and still has higher levels of need for sexual health services than other areas. Clear priorities have been identified from the needs assessment, and in consultation with stakeholders this has directed a strong focus on sexual health inequalities. This also resulted in a plan to ensure that there are robust care pathways between sexual health services and all other relevant services, particularly alcohol and drug misuse services, and services for the victims of sexual exploitation, violence and assault.

Blackpool continues to have amongst the highest prevalence of HIV in the North West and although the proportion of people diagnosed at a late stage is considerably lower than average; this is not showing a year on year reduction in line with the national picture. Similarly, teenage conceptions are down, but the downward trend needs to be maintained as the overall figure is still higher than the national average.

Abortion rates in the 18-19 year olds are almost twice the national average and a significantly higher proportion of 15-19 year olds are diagnosed with a new sexually transmitted infection (STI). Indeed, overall the burden of ill health is predominantly in under 25's, so this again is a focus for interventions.

5.2 Strategic Priorities

The strategy has identified six locally agreed strategic priorities to deliver on these outcomes, providing clear direction and focus for sexual health improvement in Blackpool going forward. These are:-

i. Reduce unplanned pregnancies among all women of fertile age
ii. Reduce the rate of sexually transmitted infections and re-infections
iii. Improve detection rate in chlamydia diagnosis in 15-24
iv. Reduce onward transmission and proportion of late diagnoses of HIV.
v. Reduce inequalities and improve sexual health outcomes
i. Tackling sexual violence

5.3 Action Plan

The action plan identifies 13 actions to reduce unplanned pregnancies, 7 actions to reduce sexually transmitted infections, 11 actions to improve chlamydia diagnosis, 16 actions to address transmission of HIV and in particular late diagnosis, 13 actions to tackle inequalities in health and 14 actions towards tackling sexual violence. All actions are agreed with the lead organisation's representative and have a responsible person assigned to the timescale outlined.

5.4 **Outcome measures**

There are a number of high level indicators that indicate good sexual health or at least avoidance of sexual ill health. Success will be measured by improvement on current position and a target set for 2016/19.

	15/16 Position (data available)	19/20 Target
Teenage pregnancy	37.3 per 1,000 women 15-17 yrs	27 per 1,000 women 15-17yrs
Chlamydia detection rate	3,416 per 100,000 15 - 24 yrs	3,300 per 100,000 women 15 - 24 yrs
Chlamydia detection rate in young men	2,219 per 100,000 aged 15-24 yrs	2,500 per 100,000 aged 15-24 yrs
TOP rate	21.2 per 1,000 women 15 - 44 yrs	20 per 1,000 women 15 - 44 yrs
SHS Prescribed LARC (excluding injections)	38.5 per 1,000 women	40 per 1,000 women
Chlamydia screening	26.9% proportion screened aged 15-24 yrs	30% proportion screened aged 15-24 yrs
HIV late diagnosis	35%	30%
Sexual Violence	Taking to BSafe for agreement on target	

5.5 Does the information submitted include any exempt information? No

5.6 **List of Appendices:**

Draft Sexual Health Strategy and Action Plan 2017-20

6.0 Legal considerations:

6.1 None.

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 Equality Analysis completed (embedded in the strategy).

9.0 Financial considerations:

9.1 In developing the action plan all parties were cognisant of financial constraints and reduction in staffing levels across all stakeholders. By improving sexual health, savings will be made in children's social care, Council commissioned sexually transmitted disease treatment services, Clinical Commissioning Group commissioned termination of pregnancy services and maternity services and NHS England commissioned HIV care.

10.0 Risk management considerations:

10.1 None.

11.0 Ethical considerations:

11.1 None.

12.0 Internal/ External Consultation undertaken:

12.1 To reduce and tackle the rate of sexually transmitted diseases (STIs) in those at higher risk it is important to work with strategic partners and stakeholders to implement targeted prevention measures.

12.2 The needs assessment used information from services, demographic data, information from the Joint Strategic Needs Assessment service reviews and stakeholder consultations before identifying key needs, gaps and priorities for sexual health improvement in Blackpool. The plan developed and included as part of this strategy has been informed by a range of stakeholders and will ensure that actions are taken to address these specific needs.

12.3 A stakeholder event was held in September 2016.

13.0 Background papers:

13.1 The Government has set out its ambitions for improving sexual health in its publication, 'A Framework for Sexual Health Improvement in England'**. (Department of Health (2013). A Framework for Sexual Health Improvement in England. http://www.dh.gov.uk/health/2013/03/sex-health-framework/)**

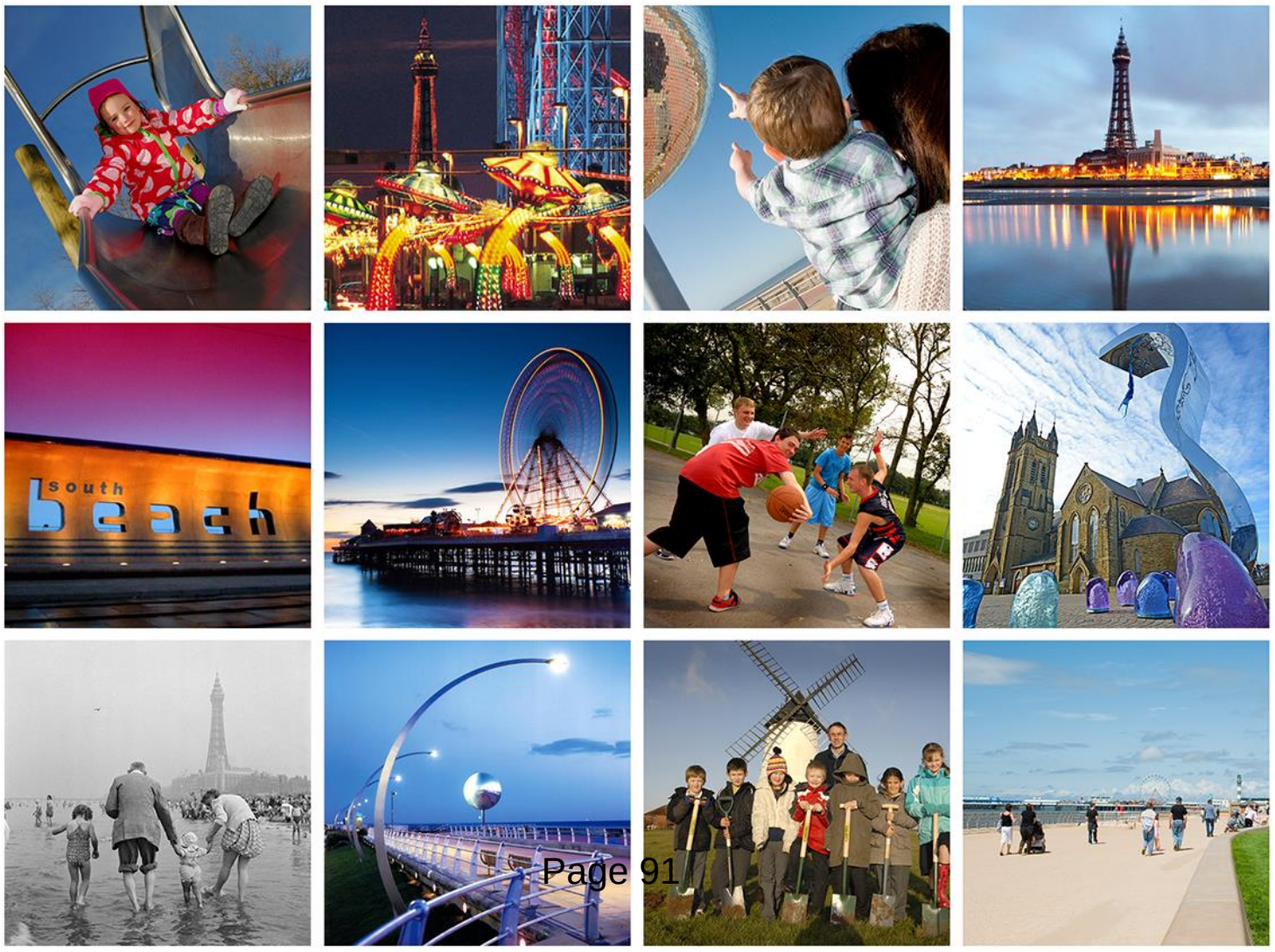
13.2 **Making it Work. A guide to whole system commissioning for sexual health, reproductive health and HIV (Public Health England, 2014).** This framework was published at the same time as changes in commissioning arrangements and provided a supporting framework for joined up service development. The guide recognises that responsibilities for the commissioning of services are divided across local

authorities, NHS England and clinical commissioning groups and is concomitant with the ambitions set out in the 'Framework for Sexual Health Improvement'. **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/313866/Guide_to_whole_system_sexual_and_reproductive_health_and_HIV_commissioning_FINAL_DRAFT_2.pdf**

Appendix 9a

Blackpool Sexual Health Strategy 2017-2020

Blackpool Council



Contents

1. Introduction

Sexual health is an important and integral part of overall health. This is captured in the working definition of sexual health developed by the World Health Organisation (WHO):

> 'Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be protected, respected and fulfilled'[1]

The local authority has a mandated responsibility to commission comprehensive, open access sexual and reproductive health services. Open access services are essential to control infection, prevent outbreaks and reduce unwanted pregnancies and means that non-residents are entitled to use the sexual health services provided in Blackpool. This includes;

- free testing and treatment for sexually transmitted infections (STI);
- free contraception, and reasonable access to all methods of contraception;
- Notification of sexual partners of infected persons.

Sexual ill health is not equally distributed among the population. Those at highest risk of poor sexual health are often from specific population groups with varying needs. These groups include; young people, men who have sex with men (MSM), people from African communities, people living with the human immunodeficiency virus (HIV), sex workers, victims of trafficking, victims of sexual and domestic violence and abuse and other marginalised or vulnerable groups.

This sexual health strategy has been designed to deliver on our objectives to improve poor sexual health in Blackpool and reduce sexual health inequalities. This builds on the recommendations of the 2016 sexual health needs assessment. The aim is to provide a strategic framework to shape the planning and delivery of services and interventions to support improved sexual health outcomes.

[1] WHO (2006) Defining sexual health: Report of a technical consultation on sexual health, 28-31 January 2002, Geneva, http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf

2. The Strategic Importance of Sexual Health

The Public Health White Paper 'Healthy Lives, Healthy People: Our Strategy for Public Health in England' highlights a commitment to work towards an integrated model of service delivery to allow easy access to confidential, non-judgmental sexual health services (including for sexually transmitted infections (STIs), contraception, abortion, health promotion and prevention).

The 'Framework for Sexual Health Improvement in England' sets out steps towards achieving a reduction in sexual health inequalities and aims to support the commissioning of sexual health services, setting priority areas for sexual health improvement. Prioritising prevention is one of the key principles outlined in the framework. Prevention includes early testing, raising awareness of risk factors to ill health, health education programmes and activities directed at protecting people from real or possible health threats and promoting healthy behaviour. Unlike other conditions affecting public health, STIs and HIV are transmissible, so the benefits of early testing and treatment extend beyond the individual. Good quality prevention work, prompt treatment, and sexual partner notification can reduce onward transmission and benefit the individual and the public. The framework states that we must:

- Reduce inequalities and improve sexual health outcomes
- Build an honest and open culture where everyone is able to make informed and responsible choice about relationships and sex; and
- Recognise that sexual ill health can affect all parts of society – often when it is least expected.

To achieve this, the following ambitions are identified by the framework:

- Build knowledge and resilience among young people
- Rapid access to high quality services
- People remain healthy as they age
- Prioritise prevention
- Reduce rates of STIs among people of all ages
- Reduce onward transmission of HIV and avoidable deaths from it
- Reduce unintended pregnancies among all women of fertile age
- Continue to reduce the rate of under 16 and under 18 conceptions

Public Health Outcome Framework (PHOF) Indicators

The following public health outcomes were established for local government in 2012 and are included in the PHOF for 2013–16 (Department of Health, 2013):

- A continuing fall in the rate of births to women under the age of 18
- An increase in chlamydia diagnoses among young people aged 15–24, to be achieved through testing
- A reduction in the proportion of people with HIV whose infection is diagnosed late.
- Related PHOF indicators include:
- Rate of sexual offences
- Population vaccination coverage of Human Papilloma Virus (HPV)

Making it Work (2014)[2] recognises that responsibilities for the commissioning of services are divided across local authorities, NHS England and clinical commissioning groups and is concomitant with the ambitions set out in the 'Framework for Sexual Health Improvement'. This framework was published at the same time as changes in commissioning arrangements and provides a supporting framework for joined up service development;

Local Authorities are responsible for commissioning comprehensive sexual health services, this includes;

- Contraception, including implants and intrauterine contraception (all prescribing costs);
- STI testing and treatment, chlamydia testing as part of the National Chlamydia Screening Programme and HIV testing.

NHS England commission related services including;

- HIV treatment and care, health services for prisoners, sexual assault referral centres, cervical screening;
- General practitioners are commissioned by NHS England to provide standard contraception services under the GP contract.

Clinical Commissioning Groups commission related services including;

- Community gynaecology, vasectomy, sterilisation and abortion services.

Public Health England's (PHE) Strategic action plan (2015) sets out an approach to improving the public's sexual and reproductive health and reversing the HIV epidemic. This approach focuses on;

- key population groups – targeting interventions towards those who are at risk of, or are particularly adversely affected by, poor sexual and reproductive health and HIV

[2] PHE, Making It Work–A guide to whole system commissioning for sexual health, reproductive health and HIV. (2014)

- key geographical areas – delivering appropriate and specific interventions and support to areas with poor sexual and reproductive health and with high levels of HIV infection
- key life stages – focusing preventative interventions on critical periods of risk in people's lives

PHE will use its strength in technical expertise, surveillance and data analysis, and local public health leadership to identify where interventions are needed, how they should be appropriately targeted. Health promotion priorities will include;

- Reduce onward HIV transmission, acquisition and avoidable deaths
- Reduce rates of sexually transmitted infections
- Reduce unplanned pregnancies
- Reduce rate of under 16 and under 18 conceptions

3. Achievement over the last 10 years

This strategy and action plan follows the direction set within the preceding strategy 2013 – 2015, which acknowledged the national policy framework directive and good practice guidelines on the commissioning of sexual health services (DH, 2013). One of the key developments over recent years is that of a fully integrated sexual health service. This model has improved sexual health outcomes in Blackpool by providing easy access to services through an open access 'one stop shop', where the majority of sexual health and contraceptive needs have been met at one site, usually by one health professional.

Blackpool is also one of the first local authorities to implement the integrated sexual health tariff, delivering a clear evidence based approach for sexual and reproductive health charging. The tariff is underpinned by clinical, technical and financial scrutiny and impact assessment from across England and we felt it was technically ready to be fully implemented locally in Blackpool in 2015/16. Tariff minimises perverse incentives and unnecessary follow up – treatment is one payment regardless of number of visits. The national integrated sexual health tariff system gave us the level of detail to ensure payment was based on activity, or care given to patients, whilst also showing a significant reduction in expenditure.

Blackpool sexual health services have been recommissioned this year with the provision of a fully integrated Specialist Sexual Health Service (all age) and Young People Service (<25), which includes the National Chlamydia Screening Programme. We were one of the first local

authorities to procure sexual health services using the national integrated sexual health tariff payment system.

We have introduced on-line HIV home sampling this year, initially targeting MSM and high risk groups, which increases access to testing, particularly for individuals not engaging with sexual health services.

Summary of progress made over the last ten years;

- Young People preventative services targeted at raising aspirations
- Doctor led, nurse delivered clinical services
- Expansion of Connect, including Long Acting Reversible Contraception (LARC)
- GUM and contraceptive services moved to Whitegate and are now truly integrating under a tariff payment system
- Chlamydia screening and HPV vaccination
- Local Early Medical Termination services
- Support for people living with HIV
- Development of rape and sexual assault services
- Outreach to high risk venues and target groups
- GP based specialist services
- Screening for HIV in Maternity and Acute Medical Unit (AMU)

There has been an increase in service provision over the last decade and activity data shows that there has been significantly improved access to contraceptive and sexual health services over this time. These improvements in access must now be built upon to ensure that all sections of society are supported in achieving and maintaining good sexual health. In order to do this, there must be improved access for;

- Vulnerable groups and segments of the population where there is evidence of poor sexual health.
- Men, both heterosexual and men who have sex with men
- Young people (particularly those aged under 25)
- African people at risk of HIV

Others vulnerable to poor sexual health include people who have experienced mental health problems, sexual exploitation or sexual violence. To reduce and tackle the rate of STIs in those at higher risk it is important to work with strategic partners and stakeholders to implement targeted prevention measures.

4. Summary of Need

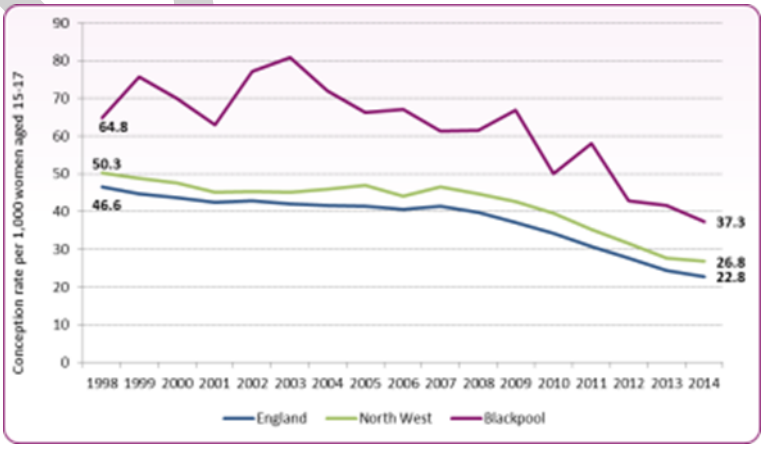
The following summary of need in Blackpool is taken from the Sexual Health Needs Assessment 2016. A more comprehensive breakdown on the data analysis can be accessed through Blackpool JSNA.

4.1 Teenage Conception, Abortions and Repeat Abortions

What we found:

- Teenage conceptions are significantly down, but we need to maintain a downward trend as we are still significantly higher than nationally (fig 1);
- Blackpool abortion rates are highest in women aged 18-19 (almost twice the national average), unlike the national picture which is highest in those aged 20-24 (fig 2);
- In 2015 , 90.4% of abortions were carried out at under 13 weeks gestation, 81.4% were carried out under 10 weeks compared to 77% in 2009 and 37% in 2004
- Repeat abortion rate in women under 25 is similar to the national average. Since 2005 the proportion of repeat abortions has stayed around 25% in under 25.
- A reduction in women under 25 who had an abortion after a previous birth. This is a reduction from 37.6% in 2014 and is now similar to the national average of 28.2%.
- High uptake of LARC, although we need to look at removal rates, versus where they are inserted and whether women are fully informed at time of insertion re side effects.

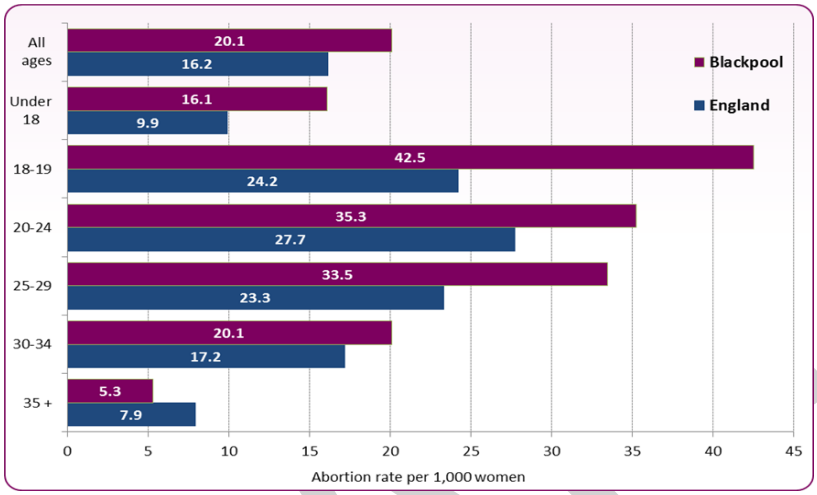
Figure 1: Trend in under 18 conceptions rate, 1998 to 2014



Source: ONS, Conceptions statistics tables, 2014

Compared to the national average, a greater proportion of attendances at contraception services are in the younger age groups, for example 32% are under 20 years of age, compared to only 24% nationally. Locally, regionally and nationally, the abortion rate among females under 18 has changed only slightly since 1998 so the decline in conceptions has been essentially among those resulting in a birth.

Figure 2: Age specific abortion rates, Blackpool and England, 2015



Source: Dept of Health, Abortions Statistics, England and Wales

Over a quarter of England abortions in the under 25's are repeat abortions. This is an indicator of access to (or lack of) good quality contraception services and advice as well as problems with individual use of contraceptive method. The proportion of women having an abortion after a birth is a guide to awareness of post-partum contraception need at local level and the possible need to develop more effective support around contraception for these women to help people manage reproductive lives and prevent further unplanned pregnancies.

It is important to point out that the time frame between each abortion could be up to 10 years; as women in general are delaying motherhood, giving them more years in which to have a 'mistake'[3]. The age they have their first child has widened so there is now a longer period in women's lives where efforts are needed to prevent unplanned pregnancy.

LARC methods are more effective at preventing pregnancy than other hormonal methods and condoms. There is also evidence LARC methods fitted by the abortion provider can reduce repeat abortions.

[3] NATSAL: The National Survey of Sexual Attitudes and Lifestyles, 2013

The number of LARCs (long-term) reported is not indicative of accordance as data on LARC removals are not available nationally. However, Blackpool sexual health service data shows that over the last 3 years a significant number of women in Blackpool have had the hormonal contraceptive implant removed compared to other LARC methods. Clinics can remove implants and coils that they haven't inserted, therefore it is possible that a clinic may remove more devices than they provide. However, compared to the North West and England, Blackpool had a higher percentage of implant removals in 2014, whereas removal of coils was similar to the proportion nationally.

4.2 Sexually transmitted infections and re-infections

What we found:

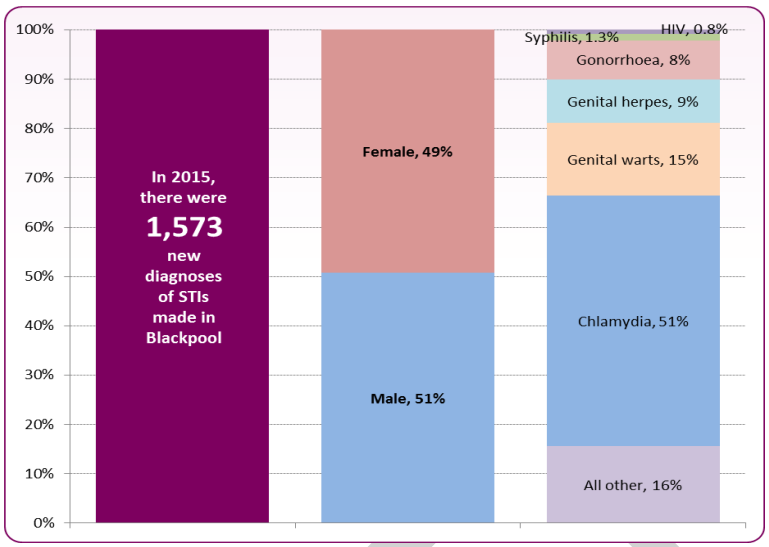
- Burden of ill health is predominantly in under 25s, so this is the focus for intervention;
- Overall, diagnoses of all new STIs have fallen slightly from 2014. The number of people diagnosed in Blackpool has fallen from 1,607 in 2014 to 1,573 in 2015 and the diagnosis rate has fallen from 1144 per 100,000 to 1120 per 100,000.
- Positivity rates are higher than England. Better detection rates and more risk taking behaviour;
- Reinfection rate is higher in Blackpool than nationally and is significantly higher in young people aged 15-19 years within a 12 month period;
- Reinfection is of concern, condoms important and we need to offer repeat screening.

In 2015, there were 434,456 new STI diagnoses made at Sexual Health Clinics in England. Of these, the most commonly diagnosed STIs were chlamydia (46%), genital warts (16%), non-specific genital infections (10%), and gonorrhoea (10%). The impact of STIs remains greatest in young heterosexuals under the age of 25 years and in men who have sex with men (MSM)[4]. Testing and partner notification are essential elements of STI management and control, protecting patients/partners from re-infection and long-term consequences from untreated infection, reducing the cost of complications and onward transmission.

In Blackpool, new STI diagnoses have continued to fall however when we exclude chlamydia diagnoses in the under 25s (NCSP age group) we see a slight rise in new STI diagnoses (Fig 3). However, when looking at new STI diagnoses excluding young people aged under 25 (the age group targeted by the National Chlamydia Screening Programme (NCSP), the number and rate has risen slightly from 2014 to 2015.

[4] PHE, Health Protection Report, Vol 10 Number 22. Sexually transmitted infections and chlamydia screening in England, 2015

Fig 3: New STI diagnoses in Blackpool, 2015



Source: PHE Sexual and Reproductive Health Profiles and PHE GUMCADv2 Report

There has been a general fall in genital wart infection and this is expected to continue as a positive effect from the national HPV vaccination programme for young women. MSM HPV vaccine could have an even greater influence if implemented.

An increase seen in gonorrhoea is in line with the national picture. Although improved test sensitivity and uptake may have contributed, increased gonorrhoea transmission is likely playing a major role. Reversing this trend is a public health priority given the spread of resistance to frontline antimicrobials used for treating gonorrhoea and the depletion of effective treatment options.

There has been a slight increase in syphilis following what was a downward trend. While the number of syphilis and gonorrhoea is low, these infections are predominantly in MSM (reflecting higher levels of risky sexual behaviour).

Nationally, an emerging trend of sexualised drug use has also been identified. 'Chemsex' occurs under the influence of (most commonly) stimulant drugs. It is reported to be changing the way some MSM socialise, including the arrangement of private parties online or via smartphone apps and sourcing sexual partners with the explicit intention to use drugs together[5].

[5] Substance Misuse Skills Consortium, 2013

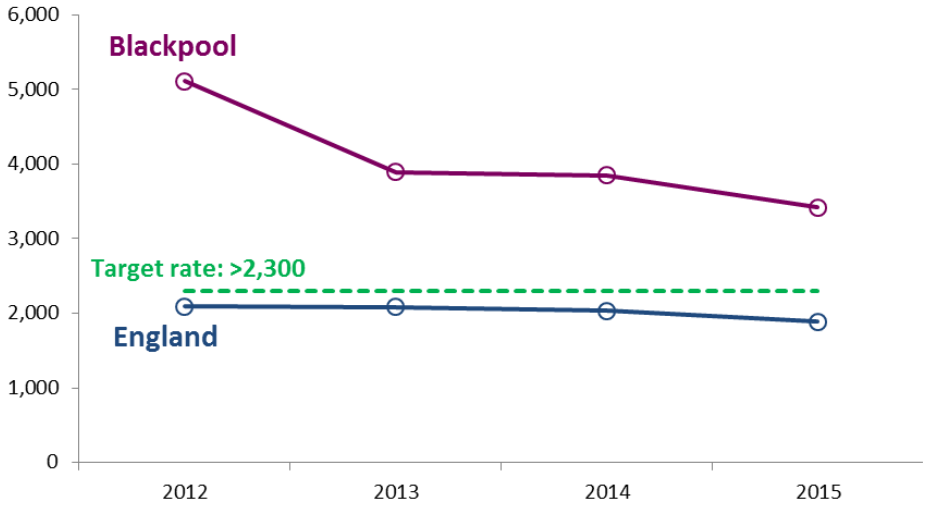
4.3 National Chlamydia Screening Programme (NCMP) ages 15-24

What we found:

- The chlamydia detection rate per 100,000 young people aged 15-24 years in Blackpool was 3,416 (compared to 1887.0 per 100,000 in England) in 2015.
- Higher detection rates in females across all areas, reflecting higher testing rates in females.
- Decline in chlamydia testing coverage nationally, with Blackpool showing a similar decline since 2012 (fig 5).
- Chlamydia positivity rates are shown to be higher than the England average (15-24), with male positivity rates higher in those aged 20-24 and in females 15-19. In 2015, Blackpool was higher than both the North West and England, with a positivity rate of 5.9 compared to 5.5 and 5.2 respectively. Better detection but also more risk taking behaviour taking place.

The National Chlamydia Screening Programme (NCSP) was established in 2003 in England to facilitate early detection and treatment of asymptomatic Chlamydia infection. Chlamydia is the most common bacterial STI diagnosed in England (accounting for 46.1% of all STIs diagnosed in 2015). Chlamydia is most often asymptomatic; hence a high diagnosis rate reflects success at identifying infections that, if left untreated, may lead to reproductive health complications. The chlamydia detection rate reflects both screening coverage levels and the proportion of tests that are positive at all testing sites, including primary care, sexual and reproductive health and genitourinary medicine services.

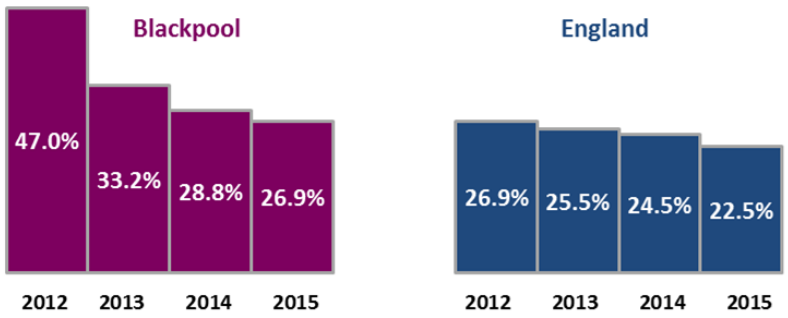
Figure 4: Chlamydia detection rates 2012 -2015



Source: PHE, Sexual and Reproductive Health Profiles

Overall, Blackpool has a higher detection rate than England (and the North West); despite the detection rate showing a decline in line with the national picture (Fig 4). There has also been a decline in chlamydia testing coverage nationally, with Blackpool showing a similar decline since 2012 (mostly attributable to fewer tests in non-specialist services and community venues).

Figure 5: Proportion of 15-24 year olds screened for chlamydia



A process of Sector Led Improvement across Lancashire and Cumbria, initially looking at Chlamydia was undertaken in 2016. The data analysis highlighted a number of areas for consideration and plans and ideas for improvement were collated against the key areas of young men, data, delays to treatment and partner notification. Actions identified from this work are included in the action plan going forward, and these will include the following elements monitored through key performance indicators;

- Increased scale up of opportunistic screening through NCSP
- Emphasise the need for repeat screening annually and on change of partner
- Re- testing after a positive diagnosis within 3 months of initial diagnosis
- Ensure treatment and partner notification standards are met

4.4 HIV and late diagnoses

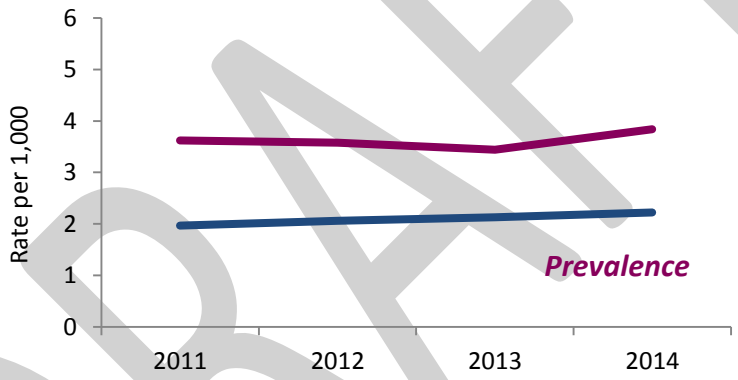
What we found:

- Despite late diagnosis rates being better than the England average, the rates have not shown the same gradual reduction as in the North West and England;
- The new diagnosis rate for residents aged 15-59 years in 2014 (10 per 100,000) is below that of England (12 per 100,000). Apart from a spike in 2013, rates have remained below England since 2011;
- HIV is predominantly in MSM and late diagnosis continues to be an issue;

- HIV testing coverage in Blackpool has been consistently higher than the North West average since 2009 and higher than the England average since 2013;
- An increase in HIV from heterosexual route seen in 2014 from a constant 15% over the last few years to 18%.

In 2014 there were 354 total cases of HIV and AIDS in Blackpool residents. Among these, 93.2% were white, 1.4% black African and 1.4% black Caribbean. The diagnosed HIV prevalence rate was 3.8 per 1,000 population aged 15-59 years, compared to 2.1 per 1,000 in England (Fig 6). This has increased from the 2013 rate of 3.4 per 1,000 population aged 15-59 years. Blackpool is the only authority in Lancashire above the threshold whereby testing is recommended in general settings including all medical admissions and all new registrations in general practice (i.e., 2 per 1,000 or 200 per 100,000).

Figure 6: HIV diagnosed prevalence rate 2011-2014



Source: PHE, Sexual and Reproductive Health Profiles

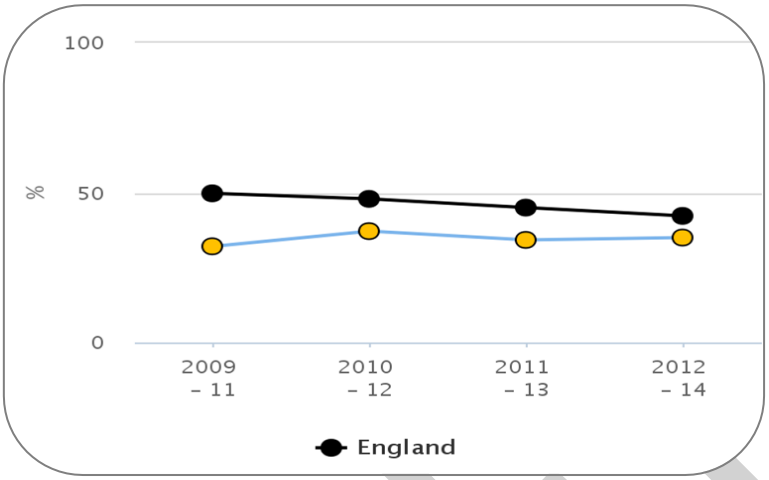
In the UK, a number of people are diagnosed at a late stage of HIV infection - this is defined as having a CD4 count under 350 within three months of a diagnosis. People living with HIV can expect a near-normal life span if they are diagnosed promptly. People diagnosed with HIV late continue to have a ten-fold increased risk of death in the year following diagnosis compared to those diagnosed early[6]. Not only does an early diagnosis and treatment for people with HIV being diagnosed reap health benefits, this also minimises the demand on NHS and social care services.

In Blackpool, between 2012 and 2014, 35% of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm³ within 3 months of diagnosis) compared to 42% in

[6] HIV in the United Kingdom: 2014 Report, PHE

England. Despite late diagnosis rates being slightly better than the England average, the rates have not shown the same gradual reduction as in the North West and England (fig 7).

Figure 7: HIV late diagnosis Blackpool 2009/11 – 2012/14



Source: PHE, Sexual and Reproductive Health Profiles

The transmission of HIV through injecting drug use is low and accounted for <1% of new diagnoses. However, according to the Gay Men's Survey findings in 2014, 31% of the men diagnosed in the last year indicated other drugs played a part in their acquiring HIV, suggesting that drugs (but not alcohol) are playing an increasing (but still not primary) role in the HIV epidemic[7].

Nationally, heterosexuals are more likely to be diagnosed late. According to the Gay Men's Survey carried out in 2014, men with a bisexual, straight or heterosexual identity were far less likely to have ever been tested. While gay men may have a sense of belonging and access to gay-oriented culture, other men who have sex with men often see themselves as bisexual or even heterosexual, are sometimes married, and may not be willing to be open about their same sex encounters.

Going forward we need to look at fully implementing BASHH testing guidance in primary care and increase awareness and uptake of HIV testing, ensuring HIV testing is accessible through secondary care, primary care, community settings, integrated sexual health services and on-line self-sampling.

[7]Hammond G, Hickson F, Reid D and Weatherburn P. State of Play: Findings from the England Gay Men's Survey 2014 http://sigmaresearch.org.uk/files/GMSS-2014-State-of-Play.pdf (accessed 12.09.16)

4.5 Sexual exploitation, violence and abuse (inequalities)

What we found:

- Abuse and neglect represent the biggest need areas for safeguarding children in Blackpool and proportions of children in need are higher than seen elsewhere;
- Early findings from the PAUSE project have indicated a significant number of women have had multiple children removed and taken into care. Early indications estimate approximately 140 women and 380 children are in the cohort identified. Although these figures may change as the scoping exercise develops.
- Although low in volume, rape has the greatest impact in terms of harm in Blackpool. The number of recorded rapes has been increasing during the last 3 years;
- Mental illness can impact on sexual behaviour, impairing judgement, especially for individuals dependent on alcohol and other substances;
- Self-report of STIs, termination of pregnancy and sexual assault are high in sex workers;
- Poor access to sexual health services for sections of our society who need it the most.

It is widely acknowledged reliable information on the volume of sexual offences is difficult to obtain because a high proportion of offences are not reported to the police. However, we need to ensure that sexual violence pathways are available to all agencies, and there is equity of provision. Rape is not a gender specific issue but evidence does suggest it disproportionately affects females. The Violence against Women and Girls Strategy (2016 - 2020) aims to increase awareness in children and young people of the respect and consent in relationships and that abusive behaviour is wrong – including abuse taking place on line.

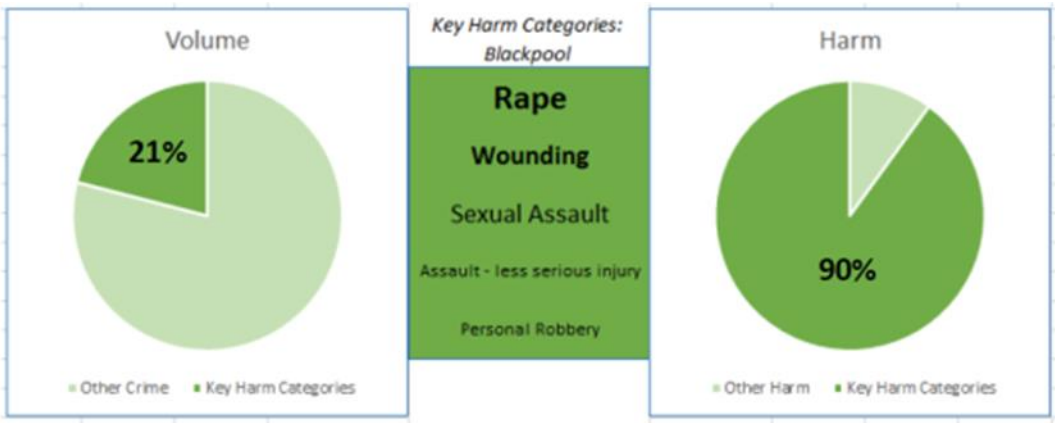
Overall, there is a correlation between sexual health and other key determinants of health and wellbeing, such as alcohol and drug misuse, mental health and violence (particularly violence against women and girls), contributing to a reduction in health inequalities.

Sexual assaults and rape offences are significantly higher than the Lancashire and National average. Although low in volume (average of 115 offences per year over the last three years), rape has the greatest impact in terms of harm in Blackpool, accounting for 39% of the total[8]. The number of recorded rapes has been increasing during the last 3 years (fig 8).

[8] Safer Lancashire Crime Report 2015

- Increasing trend over the last 4 years.
- Issues around young victims and inter-relationship offences.
- Increase in the number of historical offences being reported.
- 90% of victims are female
- 87% victims knew the offender

Figure 8: **Key Harm Categories for Blackpool**



Source: Safer Lancashire Strategic Assessment, 2015, Blackpool District Profile

Blackpool experiences considerable levels of disadvantage with many families who are from socially and economically deprived backgrounds, and who often have an array of complex needs that require additional support from a range of service providers. The proportion of 'looked after children' is high compared to many other authorities in England, and Blackpool has the 10th highest rate of 'children in need' in England. Abuse and neglect represent the biggest need areas for safeguarding children in Blackpool and proportions of children in need under these categories are higher than seen elsewhere[9].

Early findings from the Pause project in Blackpool have indicated a significant number of women have had multiple children removed and taken into care. Sexual health services will need to consult with service users to support effective marketing/promotion of LARC to complex women. A number of expectant mothers would be eligible for the Pause project in Blackpool, most of whom have had a number of children taken into care previously. Pause works with women who have experienced, or are at risk of, repeat removals of children from their care. It aims to break this cycle and give women the opportunity to develop new skills and responses that can help them create a more positive future.

[9] Blackpool JSNA http://www.blackpooljsna.org.uk/Developing-Well/Children-and-young-peoples-wellbeing/Child-Sexual-Exploitation.aspx

Child Sexual Exploitation (CSE) across Lancashire is an operational priority area that represents a county wide threat. An increasing number of victims are initially contacted via social media and there has been an increase in boys/young males being referred. The offender profile shows that perpetrators are 90% male and 93% white[10].

The Awaken Project is run jointly by Blackpool Children's Services and the police, based at Bonny Street Police Station. Its aim is to safeguard vulnerable children and young people under the age of 18 who are sexually exploited and to identify, target and prosecute associated offenders. Blackpool Safeguarding Children Board (BSCB) has a safeguarding policy in place to assist practitioners working with sexually active under 18s to identify and assess where relationships may be abusive and the young people may be in need of protection and/or additional services. Figures reported by Lancashire Constabulary show that there were 144 reports of crimes with a CSE element in Blackpool in 2015/16, a rate of 1.0 per 1,000 population and is significantly higher than the Lancashire average of 0.4 per 1,000[11].

Tackling child sexual exploitation must be a priority and sexual health services ensure that safeguarding policies and procedures are in place and comply with the Blackpool Safeguarding Adult and Children Board's guidelines. The service is also required to undertake the CSE Toolkit (developed by Brook) designed for health professionals to help them identify children who are at risk or have been sexually abused and refer to other agencies such as child protection as per safeguarding policies. The sexual health strategy and action plan will align with the Child Sexual Exploitation & Missing Children Operational Action Plan 2016-18.

Mental illness can impact on sexual behaviour, impairing judgement, especially for individuals dependent on alcohol and/or other substances. Engaging in certain sexual behaviour can put people at risk of poorer sexual health outcomes, coercion, exploitation, unplanned pregnancies, STIs and HIV. For example, some people may use sex work to fund their substance use. The Blackpool Harm Reduction Forum provides leadership and direction across the partnerships on harm reduction services, initiatives and pathways to actively promote and support Blackpool residents at high risk of harm.

[10] Safer Lancashire Strategic Assessment, 2015, Blackpool District Profile
[11] Safer Lancashire, MADE database, District Profile v15.1

4.6 Health Related Behaviour Survey (School Health Education Unit)

The Schools and Student Health Education Unit at Exeter University (SHEU) have been completing children and young people's health and wellbeing surveys since 1977. The survey is undertaken in order to support planning and evaluation of health focused initiatives. This enables Public Health to establish the extent of emerging behaviours or investigate those behaviours which are not yet quantified in other data sets such as the Public Health Outcomes Framework.

As a result of this work we have useful data to inform actions for improving the sexual health and wellbeing of pupils in schools.

Results from the 2015 SHEU Survey show 47% of Year 10 boys and 63% of Year 10 girls say they know how to access contraceptive and sexual health advice locally. Thirty six per cent of pupils said that school lessons were their main source of information about sex.

- 8% of Year 10 pupils said that they were currently in a sexual relationship.
- 15% said that they had a sexual relationship in the past and 4% said they were currently in a relationship and thinking about having sex.
- 47% of pupils said they have used an Internet chat room.
- 10% of pupils said they have received a chat message that scared them or made them upset.
- 45% of pupils said they have seen images aimed at adults
- 30% (63% Year 10 boys) of pupils said they had looked online for pornographic or violent images, games or films.

The PHSE pilot within Blackpool secondary schools aims to improve on this by raising greater awareness, knowledge and understanding. The SHEU survey will be revisited to see what an impact this has had. An important part of the programme offered is lessons on consent and healthy relationships. Results from this survey will also be used to shape young people sexual health services.

4.7 Attitudes to Sexual Health - National Survey of Sexual Attitudes and Lifestyles (NATSAL)

Due to the cost and complexity of such studies, limited work has been undertaken locally to determine the trends in attitudes to sexual health. Hence, information is drawn from national studies, such as the National Sexual Attitude and Lifestyle study 2013. This was the third NATSAL survey that has been carried out in Britain, the first survey was undertaken in

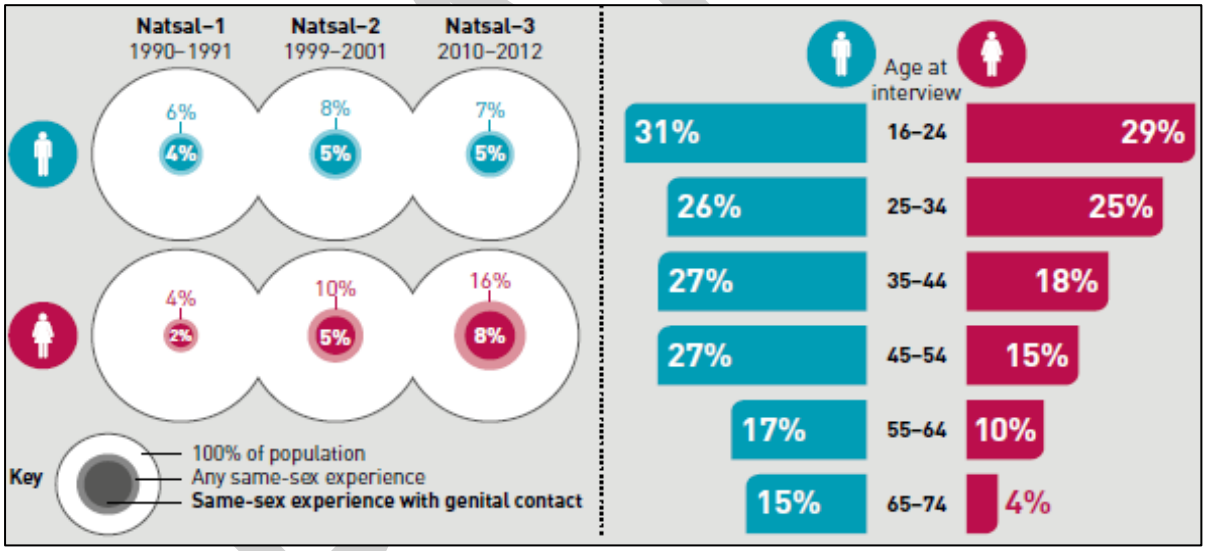
1990-1991 and the second survey in 1999-2001. The researchers interviewed 15,162 men and women aged 26–74 between September 2010 and August 2012.

Over the 1990's, there was an increase in the number of opposite sex partners people reported and more people reporting same sex experience. Over the last decade there have only been further increases for women, so the gender gap is narrowing. The percentage of people reporting sexual intercourse with someone of the opposite sex before the age of 16 has not increased substantially since the mid 1990's (figure 9), with approximately 1 in 3 young people reportedly having sex before the age of 16.

Figure 9: Percentage of the population who have ever had same sex experience and sexual intercourse with someone of the opposite sex

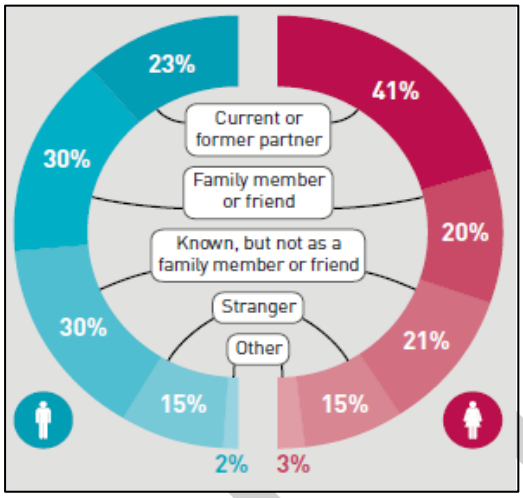
Percentage of the population who have ever had same-sex experience (people

Percentage of the population who had sexual intercourse with someone of the opposite **sex**



Data from the survey provides the first population prevalence estimates of non-volitional sex in Britain. Non volitional sex is a term which includes coercion, sexual assault and rape by friends, partners or strangers, i.e. sex against your will since the age of 13. In most cases the person responsible was someone known to the individual (figure 10). This was the first of the NATSAL surveys to include questions on sexual violence (outside the context of crime) and was strongly associated with a range of adverse health outcomes in both men and women.

Fig 10: Person responsible at most recent occurrence of sexual violence



Over the past decade, national sexual health strategies in Britain have aimed to increase access to sexual health services and STI/HIV testing. Compared with the previous survey (1999-2001), more people reported having an HIV test or going to a sexual health clinic in the past 5 years. It is encouraging to see that these increases were even larger in those at highest risk, such as people who reported multiple partners.

The researchers found that unplanned pregnancy was less common than has been found in studies done in some other high income countries such as the USA. This may in part reflect the fact that contraception is provided free of charge in Britain under the NHS.

The survey found that sexual lifestyles in Britain have changed substantially in the past 60 years, with changes in behaviour ostensibly more evident in women than men. The continuation of sexual activity into later life emphasises that consideration of sexual health and wellbeing is needed throughout the life course[12]

Condom use and the use of contraception had increased over the period of the three studies. The main source of sexual health education is now schools. In the 1990 survey most advice was sourced from friends.

[12] 1. Mercer C. H. Et al (2013) Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal) The Lancet 382(9907); 1781 – 1794

While most people have had vaginal sex in the past year, other practices are less common, especially anal sex. Anal sex was most frequently reported by young people. This is important in relation to communicating the risk of HIV in both the younger heterosexual population and men who have sex with men.

According to the survey, overall, around one in a hundred people aged 16-44 had Chlamydia, although this varied by age, peaking at almost one in twenty women aged 18-19 and one in thirty men aged 20-24. Although people who reported more partners in the past year were more likely to have Chlamydia, Chlamydia was found in people who reported only one partner in the past year.

The percentage of men reporting the use of sex workers in the past five years was 4% with 0.1% of women (4 in 100 men and 1 in 1,000 women).

The key issues raised by the NATSAL survey will be addressed by this action plan, alongside the findings of the needs assessment. Importantly, we need to build on the improvements demonstrated in changing behaviour and work to reduce the range of adverse health outcomes as a result of sexual violence.

5. Summary of Recommendations

Based on the needs assessment, the following recommendations have been highlighted for consideration:

4.1 Teenage Conception, Abortions and Repeat Abortions
• Strengthen the provision of contraception, including LARC for all women of fertile age. • Develop follow up pathways between contraceptive/termination of pregnancy services. • Develop targeted approaches for 18-19 year old women at risk of unplanned pregnancy. • Utilise opportunities to promote LARC through collaborative working – targeting women with complex needs. • Increase the number of eligible clients within the Drug and Alcohol Integrated Treatment System being referred for LARC.

4.2 Sexually transmitted infections and re-infections
• Ensure GP's are undertaking partner notification where appropriate, offering training if needed. • Raise awareness of reinfection rates in young people under 25. • Ensure young people under 25 are aware of the services available to them. • Effectively manage Gonorrhoea treatment. • Extend targeted testing to other groups vulnerable to higher-risk sexual behaviours i.e. substance users, sex workers and swingers. • Work in collaboration with partner agencies to provide domiciliary outreach to young people not engaging with services, for example looked-after young people. • Development of digital access and self-management of asymptomatic patients. • Ensure information, including harm reduction messages about Chemsex are made available and promoted to high risk group

4.3 National Chlamydia Screening Programme (NCMP) ages 15-24
• Scale up of opportunistic screening through NCSP • Ensure treatment and partner notification standards are met • Improve follow up and contact tracing between TOP/SHS for chlamydia positive patients • Increase access and uptake of screening to SHS services for young men • Explore innovations to target young men in chlamydia screening • Ensure NCSP data collection process is in line with CTAD mandatory data set

4.4 HIV and late diagnoses
• Increase awareness and uptake of HIV testing, ensuring HIV testing is accessible through secondary care, primary care, community settings, integrated sexual health services and on-line self-sampling. • Investigate cases of late diagnoses to identify missed opportunities for testing in primary care. • Work with primary care, offering training and support, to increase HIV testing in line with the BASHH guidance. • Continue to work with AMU (Combined Assessment Unit) to increase HIV screening rates in secondary care. • Develop targeted services for MSM, including the pilot of a 'male only' clinic.

4.5 Sexual exploitation, violence and abuse (inequalities)
• Ensure that NICE recommendations on harmful sexual behaviour among children and young people are reflected in relevant plans (BCSB CSE operational plan). • Ensure that there are clear care pathways between sexual health services and all other relevant services, particularly alcohol and drug misuse services, and services for the victims of sexual exploitation, violence and assault. • Continue to improve measures to protect and support children and young people from exploitation, violence and abuse. • Reduce inequalities in sexual health by targeting vulnerable groups and communities with greater sexual health needs and tackling the stigma and discrimination associated with HIV and poor sexual health in partnership with other agencies. • Improve access to sexual health services for people with mental health/learning disability • Ensure all services are aware of the particular needs of black and minority ethnic groups and people with learning disabilities in terms of sexual health. • Ensure young people experience comprehensive relationship and sex education in schools. • Ensure there is a uniform offer of support to victims of rape and sexual violence. • Target problematic places and people of concern in terms of sexual assault, CSE and 'missing from home'. • Ensure provision of an Independent Sexual Violence Advisor (ISVA) for victims of sexual violence (including child ISVA).

6. Priority Outcomes for Blackpool

The Blackpool Sexual Health Strategy aims to improve the sexual health of Blackpool's population by providing clear direction and focus for sexual health improvement. The strategy has identified six locally agreed strategic priorities;

1. Reduce unplanned pregnancies among all women of fertile age
2. Reduce the rate of sexually transmitted infections and re-infections
3. Improve detection rate in chlamydia diagnosis in 15-24
4. Reduce onward transmission and proportion of late diagnoses of HIV.
5. Reduce inequalities and improve sexual health outcomes
6. Tackling sexual violence

7. Evidence base

Improving sexual health is important because of the impact on the delivery of broader local authority and NHS priorities, not least, the consequences and economic costs of poor sexual health.

The provision of integrated sexual health services is supported by current accredited training programmes and guidance from relevant professional bodies. Providers of sexual health services must ensure commissioned services are in accordance with this evidence base:

- The British Association for Sexual Health and HIV (BASHH) has published Standards for the Management of Sexually Transmitted Infections (BASHH, 2010).
- The Medical Foundation for HIV and Sexual Health (MEDFASH) developed Recommended Standards for Sexual Health Services (MEDFASH, 2005) and Recommended Standards for NHS HIV Services (MEDFASH, 2015).
- New Service Standards for Sexual and Reproductive Healthcare (Healthcare, 2015) have been published by the Faculty of Sexual and Reproductive Healthcare.
- The British HIV Association (BHIVA) issued UK Guidelines for the Management of Sexual and Reproductive Health of People Living with HIV Infection (BHIVA, 2008).

Appropriate investment in sexual health services can deliver healthcare savings through preventing unplanned pregnancies and reducing the transmission of STIs including HIV, preventing significant health and social care costs down the line. Evidence demonstrates that spending on sexual health interventions and services provides cost savings[13];

- For every £1 spent on contraception, £11 is saved in other healthcare costs[14].
- The provision of contraception saved the NHS £5.7 billion in healthcare costs that would have had to be paid if no contraception at all was provided.
- Condoms have been found to be effective in preventing HIV and STI's [15]

[13] A Framework for Sexual Health Improvement in England, Department of Health, 2013
[14] The Kings Fund,2014, Making the case for public health interventions
[15] Weller S, Davis-Beaty K (2002) Condom effectiveness in reducing heterosexual HIV transmission (Cochrane Review). The Cochrane Library

- National Institute for Health and Clinical Excellence (NICE) Clinical Guideline CG30 demonstrated that long-acting reversible contraceptives are more cost effective than condoms and the pill. If more women chose to use these methods there would be cost savings.
- Early testing and diagnosis of HIV reduces treatment costs by £12,600 per annum per patient compared with £23,442.
- Early access to HIV treatment significantly reduces the risk of onwards HIV transmission;
- Effective partner notification is an important way of improving the detection rate and treating undiagnosed infection[16]

There has been a significant economic research[17] into sexual health interventions since 2010, which supports current National Institute of Health and Care Excellence (NICE) sexual health guidance. Cost-effectiveness or cost savings were reported for:

- ulipristal acetate (UPA) as emergency contraception,
- long-acting reversible contraceptives (LARCs) for regular, post-natal and post-abortion contraception, and
- targeting to high risk groups;

Health promotion interventions for HIV or sexually transmitted infection outcomes were found to be cost-effective according to the NICE thresholds in the following[18]:

- nurse-led rapid testing and tailored counselling;
- condom negotiations skills training for female sex workers; and
- A teacher-led STI prevention and skills training intervention.

Research shows that young people who have taken part in a good quality Sex and Relationship Education (SRE) programme are more likely to use condoms and contraception when they first have sex[19]. So a broad, comprehensive programme of SRE that includes learning about contraception is essential.

[16] Opportunistic Chlamydia Screening of Young Adults in England. An Evidence Summary https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497371/Opportunistic_Chlamydia_Screening_Evidence_Summary_April_2014.pdf

[17] Brunton G, Michaels-Igbokwe C, Santos A, Caird J, Siapka M, Teixeira-Filha N, Burchett H, Thomas J (2016) Sexual health promotion and contraceptive services in local authorities: a systematic review of economic evaluations 2010-2015. London: EPPI-Centre, Social Science Research Unit, UCL Institute of Education, University College London

[18] Brunton G, Michaels-Igbokwe C, Santos A, Caird J, Siapka M, Teixeira-Filha N, Burchett H, Thomas J (2016) Sexual health promotion and contraceptive services in local authorities: a systematic review of economic evaluations 2010-2015. London: EPPI-Centre, Social Science Research Unit, UCL Institute of Education, University College London

[19] Kirby, D (2008) The impact of abstinence and comprehensive sex and STD/HIV education programmes on adolescent sexual behaviour, Sexuality Research and Social Policy, 5, 3, 18–27).

Evidence suggests that certain groups are disproportionally affected by HIV late diagnosis, namely older adults, heterosexuals and non-national populations, in particular black Africans.[20] With targeted interventions recommended with high risk groups.

Interventions to expand HIV testing beyond routine settings have been shown as both acceptable and feasible to patients and staff and have shown to be cost effective[21]. Pilots to expand testing in hospital and primary care settings have found varying levels of testing activity among clinicians suggesting that support and training for healthcare staff is necessary and effective in increasing testing.[22]

Randomised trials have found uptake for home-sampling to be equal to or higher than clinic-based services[23]. There is some evidence that online sexual health services increase access, for some groups[24] and that this approach may be less expensive than similar services delivered in clinic settings[25].

It is estimated that every £1 that is cut from sexual health spending could result in a £86 additional future public spending.[26] The impact of disinvestment in sexual health services is likely to increase incidents of poor sexual health leading to increased rates of unplanned pregnancy and STI transmission, leading to a demand on sexual health services.

Across England and Wales, crime figures showed an increase of 31% in all sexual offences for the year ending September 2014 compared with the previous year[27].

Recent NICE guidelines cover children and young people who display harmful sexual behaviour, including those on remand or serving community or custodial sentences. It aims to ensure these problems don't escalate and possibly lead to them being charged with a sexual offence. It also aims to ensure no-one is unnecessarily referred to specialist services[28].

[20] Public Health England (2013). HIV in the United Kingdom 2013. Colindale: PHE.
[21] Health Protection Agency (2011) Time to test for HIV: expanding HIV testing in healthcare and community services in England. Colindale: HPA
[22] Rayment M et al (2012). Testing in non-traditional settings – The HINTS study: A multi-centre observational study of feasibility and acceptability. PLoS ONE 7(6): e39530 (sited in Late diagnosis of HIV in the United Kingdom: An evidence review http://www.cph.org.uk/wp-content/uploads/2015/12/Late-HIV-diagnosis-rapid-evidence-review_final_covers.pdf (accessed 1.11.16)
[23] Fajardo-Bernal L, et al. Home-based versus clinic-based specimen collection in the management of Chlamydia trachomatis and Neisseria gonorrhoeae infections. Cochrane Database Syst Rev. 2015;9:CD011317 https://www.ncbi.nlm.nih.gov/labs/articles/26418128/ (accessed 12.10.16)
[24] Lorimer K, McDaid L. Young men's views toward the barriers and facilitators of Internet-based Chlamydia trachomatis screening: qualitative study. J Med Internet Res. 2013;15(12):e265 https://www.ncbi.nlm.nih.gov/pubmed/24300158 (accessed 12.10.16)
[25] Griffiths F, Lindenmeyer A, Powell J, Lowe P, Thorogood M. Why are health care interventions delivered over the internet? A systematic review of the published literature. J Med Internet Res. 2006;8(2):e10
[26] Lucas S (2013) Unprotected Nation: the financial and economic impacts of restricted contraceptive and sexual health services. http://www.fpa.org.uk/sites/default/files/unprotected-nation-sexual-health-full-report.pdf (accessed 1.11.16)
[27] ONS, 2013. Statistical Bulletin: Crime in England and Wales, Year Ending September 2013, s.l.: ONS.
[28] Harmful sexual behaviour among children and young people NICE guideline [NG55] https://www.nice.org.uk/guidance/indevelopment/gid-phg66 (accessed 1.11.16)

Emerging developments

Pre-exposure prophylaxis (PrEP) is a course of HIV drugs taken before sex to reduce the risk of getting HIV. The UK's PROUD study reported an 86 per cent reduction in HIV infections in gay men taking PrEP[29] NHS England is working in partnership with Public Health England to run a number of early implementer test sites to research how (PrEP) could be commissioned in the most clinically and cost effective way.

PHE is currently piloting the new human papillomavirus (HPV) vaccination programme in selected clinics across England. HPV is one of the most common sexually transmitted infections in the UK. Following review of all the epidemiological and economic evidence, as well as vaccine safety and efficacy, a targeted HPV vaccination programme for MSM is considered an effective way to reduce the number of preventable HPV infections and their onward transmission in the MSM population[30].

8. Process and consultation

Local Authorities are given the responsibility for the commissioning of sexual health services, ensuring that services meet local population needs and reduce health inequalities. Part of the commissioning process involves a sexual health needs assessment (SHNA) which informs the planning, commissioning and delivery of sexual health services across the borough.

The needs assessment used information from services, demographic data, and information from the JSNA, service reviews and stakeholder consultations before identifying key needs, gaps and priorities for sexual health improvement in Blackpool. The plan developed and included as part of this strategy has been informed by a range of stakeholders and will ensure that actions are taken to address these specific needs.

The sexual health needs for Blackpool will be addressed through the use and development of relevant services that are in line with national and local policies and targets. Health promotion and sexual health education will play a key role in increasing sexual health awareness and helping people to make informed and responsible choices for their own

[29] 1.Pre-exposure prophylaxis to prevent the acquisition of HIV-1 infection (PROUD): effectiveness results from the pilot phase of a pragmatic open-label randomised trial McCormack, Sheena et al.The Lancet , Volume 387 , Issue 10013 , 53 - 60 http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00056-2/abstract (accessed 5.11.16)
[30] PHE HPV vaccination pilot for men who have sex with men (MSM) 2016 Information for healthcare professionals

health. The service provision will be evidence based and delivered in a variety of clinical and community settings so that all individuals can have choice and access.

9. Local Strategies

A number of local strategies link to, and impact on, local actions to improving sexual health in Blackpool and have informed the strategy development, these include;

- Health and Wellbeing Strategy
- Blackpool Alcohol Strategy (2016-19)
- Child Sexual Exploitation and Missing Children Operational Action Plan (BSCB 2016-18).
- Blackpool Community Safety Plan (2012-2015) - Working together to make a difference
- Domestic abuse strategy
- Blackpool Drug Strategy (2016-2019)
- Blackpool Mental Health Action Plan 2016-18 (currently being developed)

10. Action Plan and Delivery of the Strategy

In order to deliver these objectives, Public Health in consultation with a wider stakeholder group, has developed an action plan. A wide variety of stakeholders were invited to a stakeholder event and presented with the key findings of the needs assessment with robust consultation on the contents of the plan (appendix 1).

The action plan identifies 17 actions to reduce unplanned pregnancies, 6 actions to reduce sexually transmitted infections, 11 actions to improve chlamydia diagnosis, 15 actions to address transmission of HIV and in particular late diagnosis, and 21 actions to tackle inequalities in health. All actions are agreed with the lead organisation's representative and has a responsible person assigned to support delivery of the desired outcomes.

11. Outcomes - How will We Measure Success?

Key performance indicators are available through the Public Health England Sexual and Reproductive Health Profiles.[31] There are a number of high level indicators that indicate good sexual health or at least avoidance of sexual ill health. Success will be measured by improvement on our current position and a target set for 2019/20.

The current position and a target for 2019/20 are outlined below:

	15/16 Position (data available)	**19/20 Target**
Teenage pregnancy	37.3 per 1,000 women 15-17 yrs.	27 per 1,000 women 15-17yrs
Chlamydia detection rate	3416 per 100,000 15 - 24 yrs.	3300 per 100,000 women 15 - 24 yrs.
Chlamydia detection rate in young men	2,219 per 100,000 aged 15-24 yrs.	2,800 per 100,000 aged 15-24 yrs.
Chlamydia screening	26.9% proportion of 15-24 yrs.	30% proportion of 15-24 yrs.
TOP rate	21.2 per 1,000 women 15 - 44 yrs.	20 per 1,000 women 15 - 44 yrs.
SHS Prescribed LARC (excluding injections)	38.5 per 1,000	40 per 1,000 women
STI re-infection rates	9.8% (all persons)	9% (all persons)
HIV testing coverage	72.8%	75%
HIV late diagnosis	35%	30%
Sexual violence	Taking to BSAFE meeting for agreement on target	

In addition to the above, success will also be measured through the following;

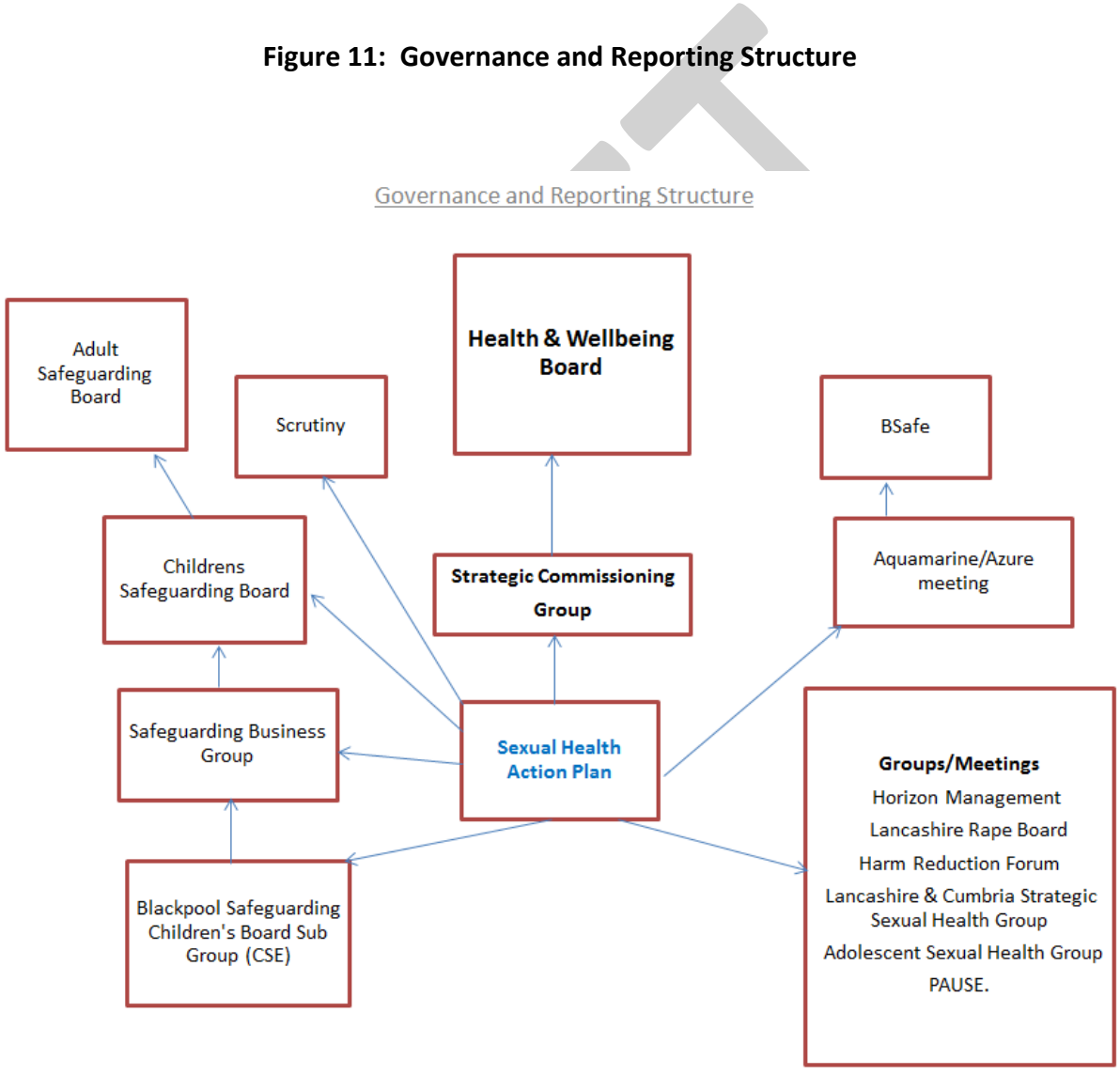
- Revisit SHEU survey to see what an impact this has had on young people's attitudes and knowledge of sexual health and services available;
- Audit of LARC methods still fitted at 12 months will be used as a baseline to monitor an increase in the number of women who maintain this method of contraception.

[31] Sexual Health Profiles - Available online at http://fingertips.phe.org.uk/profile/sexualhealth).

12. Governance and reporting

Performance will be monitored by the Strategic Commissioning Group who will support progress of key elements of the strategic approach to improving sexual health in Blackpool. This will include ensuring alignment with cross cutting strategies and actions plans, such as the Child Sexual Exploitation and Missing Children Operational Action Plan (BSCB 2016-18). It is not proposed to form a steering group as there is sufficient robustness in meetings already in the system (fig 11).

Figure 11: Governance and Reporting Structure



13. Action Plan

BLACKPOOL SEXUAL HEALTH ACTION PLAN

	Objectives	Action	Lead	Milestones Outcome Update	Milestones Date	BRAG
1. Reduce unplanned pregnancies among all women of fertile age • Reduce the overall abortion rates from 21.2 per 1,000 to 20 per 1,000 • Continue to increase access and uptake of LARC methods – increase SHS prescribed LARC (excluding injections rate) from 38.5 per 1,000 to 40 per 1,000 women aged 15-44 years • Increase in LARC still fitted at 12 months - create baseline after initial audit						
1.1	Improve access to LARC for young people	Specialist SHS and TOP providers to develop parallel clinics for termination and contraception services, including Jaydess and depo injection provision.	Helen Burford/Neil Lazarro	Plan developed to improve access to Jaydess on day of early medical termination	31.03.17	
1.2	Improve access to SHS for follow up from TOP	Revise consent form and follow-up processes for referral to specialist SHS following a termination.	Leigh Bennett/Louise Thompson	Report produced	31.03.17	
1.3	Develop targeted approaches for 18 -19 year old women at risk of unplanned pregnancy.	PHE to identify existing insight work conducted on 19 year olds going through TOP or to undertake insight work in Blackpool.	Dianne Draper	Insight work complete	31.03.18	
1.4	Improve LARC uptake in women attending substance misuse services.	Audit females attending Horizon to identify those currently not accessing LARC	Karen Mottram/Jackie Crooks	Audit complete	31.02.17	
1.5	Develop targeted messages to promote contraceptive use.	Use result of audit to more effectively target contraceptive messages	Karen Mottram/Jackie Crooks	Re-audit complete	31.03.17	

	Objectives	Action	Lead	Milestones Outcome Update	Milestones Date	BRAG
1.6	Increase access to all LARC methods in substance misuse services	Sexual health and substance misuse services to set internal target for LARC uptake	Gill West/Karen Mottram/Dr W Wasef	Target set and monitored through HR forum	31.03.17	
1.8	Ensure women leaving prison are given full SH provision and targeted for LARC	Audit SH provision in local prisons and opportunities to promote LARC to women leaving prison	Karen Mottram	Audit complete	31.03.18	
1.9	Ensure that women not in treatment are targeted for LARC	Utilise opportunities to promote LARC through Fulfilling Lives – targeting women not in treatment	Gill West	Training provided for Fulfilling Lives staff	31.03.18	
1.10	Engage and consult with service users to support effective marketing and promotion of LARC to women with complex needs	Develop a service user group to consult re: best ways to promote LARC to women with complex needs.	Sean Callaghan	Service user group in place	30.09.17	
1.11	Raise awareness of contraceptive choices	Produce a myth busting leaflet on contraceptive choices for frontline staff to distribute	Janet Duckworth/Zohra Dempsey	Leaflet produced	31.03.18	
1.12	Develop opportunities to provide contraceptive services in other settings	Explore how pharmacies can contribute to contraceptive services for women	Irfan Tariq/Janet Duckworth	Options paper complete	31.12.18	
1.13	Maximise opportunities for pharmacies to work with harm reduction services to promote LARC	Pharmacy services to link in with Horizon to promote LARC	Irfan Tariq/Sean Callaghan	Links made and promotion of LARC commenced.	31.03.18	

	Objectives	Action	Lead	Milestones Outcome Update	Milestones Date	BRAG
2. Reduce the rate of sexually transmitted infections and re-infections • Reduction of STIs in under 25's – increase proportion of 15-24 screened for chlamydia from 26.9% to 30% • Reduction in re-infection rates within 12 months – reduce reinfection rates from 9.8% (all persons) to 9% (National average is 8%)						
2.1	Raise awareness of reinfection rates in young people under 25	PHSE STI session to include being honest about transmission sites 'where you stick it, you can get it!' –	Kerry Burrows	Discussion with PHSE leads from all schools	01.01.17	
2.2	Make young people aware about the services available to them	Young people to develop a virtual tour of treatment DVD/YouTube	Andrew Scarborough-Barnes	DVD to be produced	31.03.18	
2.3	Improve harm reduction and treatment compliance	Compliance is discussed on issuing treatment for STIs as a standard.	Andrew Scarborough-Barnes	Check list to be produced for harm reduction and treatment compliance	31.3.17	
2.4	Improve recall in primary care	Ensure all GP practices undertaking Chlamydia testing undertake recall	Cath Shelley	To introduce the need for 3monthly recall at practice nurse forum	31.12.17	
2.5	Improve return rate for STI tests in high risk groups who initially fall outside the clinical window	Pathway to be developed to improve recall measures for patients who fall outside the clinical window (and fail to return).	Andrew Scarborough-Barnes/Ian Bolton	Pathways to be developed and agreed at the Harm Reduction Forum	31.03.17	
2.6	Improve patient care through utilisation of technology	SHS to implement digital access plan i.e. Consultancy, e booking of appointments, web based on line testing services for asymptomatic patients	Vicky Buddo	Digital access plan fully implemented	31.10.17	

	Objectives	Action	Lead	Milestones Outcome Update	Milestones Date	BRAG
2.7	Increased number of registration and distribution outlets for the C-Card Scheme	Work to engage key stakeholders as registration and distribution outlets	Donna Finer	Stakeholders engaged and compliant	31.1.18	
3. Improve detection rate in chlamydia diagnosis in 15-24 • Ensure the minimum Chlamydia detection rate of 3,300 from 3,416 per 100,000 15-24 year olds. • Increase the Chlamydia detection rate in young men aged 15-24 from 2,219 per 100,000 to 2,500 per 100,000						
3.1	Increased availability and uptake of Chlamydia testing to reduce transmission	Pharmacy to give out Chlamydia packs to all <25s who purchase pregnancy tests/EHC	Irfan Tariq/Janet Duckworth	To discuss and agree at LTC	31.10.17	
3.2	Improve Partner Notification and contact tracing	Clinical staff at Connect to use innovative methods to obtain partner notification and effectively contact trace	Andrew Scarborough-Barnes	To provide training on importance of partner notification and develop a checklist for all staff	31.03.17	
3.3	Ensure robust data flow from TOP services for Chlamydia screen	TOP providers and PHE to consider data flow to CTAD for Chlamydia screens	Leigh Bennett/Dianne Draper	Data flow analysed-report produced	30.06.17	
3.4	Improve follow up and contact tracing between TOP/SHS for chlamydia positive patients	Agree a pathway between Marie Stopes International and SHS for the follow up and contact tracing of Chlamydia positive patients	Helen Burford/Leigh Bennett/Louise Thompson	Pathway agreed	30.09.17	
3.5	Increase access and uptake of screening to SHS services for young men	Undertake focus groups with boys and young men to look at barriers to testing and ways to encourage uptake.	Andrew Scarborough-Barnes	Focus group undertaken and barriers identified.	31.03.17	

	Objectives	Action	Lead	Milestones Outcome Update	Milestones Date	BRAG
3.6	Market services to young men and raise awareness	Explore targeted outreach testing for young men 17+ and young men only clinic and explore innovations to engage young men, such as 'Ask Jordon' and SXT.org.uk	Andrew Scarborough-Barnes.	Outreach/clinic testing sites identified and agreed	31.03.17	
3.7	Improve community partner notification (PN)	Ensure all GPs practices undertaking Chlamydia testing are meeting the PN standards and offer training where necessary	Cath Shelley	Practices audited and training offered	01.10.17	
3.8	Ensure efficiency and effectiveness of current system for Partner Notification	Review current partner notification templates and ensure Lille compatible.	Cath Shelley/Laura Faulkener (wider team across Lancashire)	Partner notification system improvements	31.03.17	
3.9	Ensure a high standard of data quality in Partner Notification	Improve data quality, re undertaking the partner notification and treatment audits to monitor change.	Nicole Littlewood/Laura Faulkener/Dr W Wasef	Audit completed and data quality improved	31.12.17	
3.10	Ensure NCSP data collection process in line with CTAD mandatory data set	Update and standardise NCSP patient data collection forms to ensure collection of CTAD mandatory data set	Andrew Barnes/Helen Burford	Data collection forms updated and standardised	31.03.17	
3.11	Review process to identify any gaps	Map process for tests – GPs, TOP and internet to identify any data issues	Andrew Barnes/Helen Burford	Mapping process complete	01.02.17	

	Objectives	Action	Lead	Milestones Outcome Update	Milestones Date	BRAG
4. Reduce the onward transmission of, and late diagnoses of, HIV • Increase uptake of HIV testing outside sexual health services – Increase HIV testing coverage from 72.8% to 75% • Reduce missed opportunities to test for HIV and ensure the Blackpool rates fall in line with England reductions.						
4.1	Reduce late diagnosis through opt out testing in the admissions unit	Commence roll-out of opt-out HIV testing policy within the Combined Assessment and Treatment Unit.	Sue Potts/Shane Faulkner/Dr W Wasef	Develop and implement opt out HIV testing policy	31.03.17	
4.2		Implement opt -out HIV testing policy in AMU	Sue Potts/Shane Faulkner/Dr W Wasef	Policy ratified and HIV testing implemented.	31.03.17	
4.3	Ensure BBV team working closely with both primary and secondary care to improve pathways	Develop pathway with Pathology to ensure BBV team to be informed of all HIV positives in both primary and secondary care	Sue Potts/Dr J Sweeney	Flowchart to be developed and implemented	31.10.17	
4.4	Ensure that HIV training and support is offered to primary/secondary care health professionals	Innovate and deliver tailored education and training to health care professionals (primary and secondary care settings)	Sue Potts/Shane Faulkner/Cath Shelley/Dr W Wasef	Training plan in place and record of training delivered.	31.01.17	
4.5	Reduce missed opportunities and late diagnosis in primary care	Conduct an annual audit of late presenters in primary care (recording sexuality/sexual orientation and if new registrants)	Sue Potts	Ongoing collating of date for late presenters 2016	31/01/17 (each year)	
4.6		Complete a piece of service user research around late diagnosis/missed opportunities	Shelley Mullarkey	Presentation at December HIV event	8.01.17	

	Objectives	Action	Lead	Milestones Outcome Update	Milestones Date	BRAG
4.7	Normalise HIV testing in primary care	Work with GP practices, offering training and support, to increase testing in line with the national guidance	Sue Potts/Janet Duckworth/Dr J Sweeney	Increase HIV testing in GP practice	31.10.17	
4.8		Explore routine HIV testing in primary care informed by the outcomes of seroconversion research	Janet Duckworth	Seroconversion research complete and findings used to inform	31.12.18	
4.9	Develop targeted services for MSM	Pilot a 'male only' clinic at Whitegate Drive to improve access for MSM	Andrew Scarborough-Barnes/Dr W Wasef	Pilot commenced	31.10.17	
4.10	Target HIV prevention messages	Develop an innovative HIV testing campaign to raise awareness of HIV across all demographics.	Shelley Mullarkey/ Anthony West/ Sue Potts	HIV testing week campaign launch	1.12.17 (annual)	
4.11	Ensure robust pathways in place for people presenting with high risk behaviour	Ensure information on risk taking behaviour, including chemsex, is captured during sexual health assessment and pathways are in place for referral to other services, for example Horizon.	Helen Burford/Shelley Mullarkey	Audit data collection on risk taking behaviour Pathway agreed Patterns of risk to support harm reduction messages	31.12.17	
4.12	Ensure SHS workforce are 'Making every contact count '	Ensure staff in SHS are undertaking brief intervention for risk taking behaviour	Helen Burford/Andrew Scarborough-Barnes	Audit/training update completed.	31.03.17	

	Objectives	Action	Lead	Milestones Outcome Update	Milestones Date	BRAG
4.13	Continually improve equality monitoring information collected and recorded	Review and refine current equality categories and ensure equality monitoring information is collected and recorded accurately.	Helen Burford	Audit/staff training update completed	31.04.17	
4.14	Ensure communication of harm reduction messages are cross cutting	Information, including harm reduction messages about chemsex made accessible.	Shelley Mullarkey/ Anthony West/ Helen Burford	Resource developed	31.03.17	
4.15	Effectively manage Gonorrhoea	Work with primary care to ensure gonorrhoea is being treated in specialist services	Cath Shelley/Dr W Wasef	Audit completed	31.02.17	
4.16	Improve HIV awareness and promotion of harm reduction messages	Develop HIV awareness training package as part of the HR training programme	Shelley Mullarkey	HIV training package developed	30.07.17	
5. Reduce inequalities and improve sexual health outcomes. • The SHEU survey will be revisited to see what an impact this has had on young people's attitudes • A continued reduction in teenage pregnancy as a measure of inequality. A reduction to 27 per 1,000 from 37 per 1,000						
5.1	Contribute to raising awareness of CSE to the wider community to increase reporting of concerns to keep young people safe.	Participate in the pan-Lancashire CSE awareness week to ensure that the campaign is relevant to Blackpool needs and communities.	Janet Duckworth/ Andrew Scarborough-Barnes/Margot Roe	Greater community awareness of CSE. Increased reporting of CSE concerns by the general public, thereby keeping children safer	Annually November	

	Objectives	Action	Lead	Milestones Outcome Update	Milestones Date	BRAG
5.2	Enable the SHS workforce to be aware, and respond effectively to, all safeguarding concerns and emerging issues.	BCSB training and briefings cascaded to the wider team by attendees/ team leaders	Vicky Buddo/Helen Burford/Terri Crossland	Briefing cascaded at staff meetings and 7 minute monthly briefings.	31.07.17	
5.3	Participate in the development of a pan-Lancashire CSE strategy and action plan, providing assurance that it meets local need.	Attend the Safeguarding BCSB working group and contribute to the CSE Operational Action Plan.	Janet Duckworth/ /Dominic Blackburn	Compliance with the BSCB guidelines. Safeguarding policies, procedures and protocols in place.	Quarterly	
5.4	Ensure lesson plans around consent, sexual consent and issues around abusive relationships are included in PSHE	PH lead to ensure inclusion in lesson plans is maintained.	Alan Shaw	Lesson plans include consent, sexual violence, and media	30.09.17	
5.5	Ensure all Children and Young People receive good quality SRE through PSHE	Promote age-appropriate SRE, in all schools and in a range of settings	Alan Shaw	CYP receiving good quality PSHE	TBC	
5.6	Improve 'spotting the signs' process to include all vulnerable groups	Redesign the safeguarding template in line with Spotting the Signs to incorporate all vulnerable groups	Terri Crossland/Helen Burford	Template ratified	31.03.17	
5.7	Ensure that NICE guidance (NG55) recommendations on harmful sexual behaviour (HSB) among children and young people are reflected in relevant plans.	BSCB oversight of the implementation of the NICE guidance and review any issues that impact on delivery.	Paul Threlfall/ Janet Duckworth	Relevant plans identified and updated with actions in line with guidance .	**31.5.17**	

	Objectives	Action	Lead	Milestones Outcome Update	Milestones Date	BRAG
5.8	Ensure effective working pathways between substance misuse and sexual health services for women with complex needs	Horizon, sexual health staff and be involved with the development and delivery of the PAUSE programme.	Karen Mottram/Cath Shelley/Terri Crossland	Attendance at PAUSE meeting and feedback to Harm Reduction Forum	31.07.18	
5.9	Improve marketing and communications between services	Share consistent messages around SH for substance misuse and SH services.	Helen Burford/Andrew Scarborough-Barnes/Sean Callaghan	Included in Communications plan	31.01.17	
5.10	Identify need for outreach support for vulnerable women	Audit number of women attending soup kitchen and Salvation Army to determine potential need for outreach service	Karen Mottram	Audit complete	30.09.17	
5.11	Promote the sexual health of people experiencing a mental health condition	Enable mental health services workforce to promote the sexual health of their clients.	Gill West/Paula Cherry/Zohra Dempsey	Include in MECC training	31.09.17	
5.12	Ensure sexual and reproductive health of substance misusing women is included on the harm reduction agenda	Sexual health and contraception for women in substance misuse services to be included on the HR agenda as a standard item. Contraceptive services to be invited to HR forum.	Emily Davis	Quarterly meeting Clinical nurse specialist from SHS to invited to attend HR forum meetings.	31.01.17	
5.13	Improve access to SHS for people with a learning disability/ mental health condition	Sexual Health Service to work with Mental Health/Learning Disability team to develop domiciliary care pathways for vulnerable groups not accessing services	Gill West/Michelle Sowden	Domiciliary pathway agreed	31.02.17	

	Objectives	Action	Lead	Milestones Outcome Update	Milestones Date	BRAG
6 Tackling Sexual Violence • Sexual violence – BSafe for agreement on measure						
6.1	Ensure provision of an ISVA for victims of sexual violence	Map the ISVA provision for all age groups across the borough	Shelley Mullarkey Rachel A	Mapping exercise commencement for the borough. Provision map and overview of services to be communicated via the Blackpool ISVA service to all relevant stakeholder groups/boards/event	31.10.17	
6.2		Child ISVA service to deliver a child abuse awareness event and lead a local social media campaign	Shelley Mullarkey CISVA lead	April 2017 Prevent child abuse awareness month.	31.03.17	
6.3		Explore the use of ISVA resource within the hospital and police station	Robert Rushton	ISVA resource confirmed	30.04.17	
6.4	Prevent harm from unhealthy sexual relationships, sexual assault and rape	Harm reduction messages to promote #itsnotok campaign during sexual violence event/awareness week.	Shelley Mullarkey/ Anthony West	https://www.awarenessdays.co.uk/awareness-days-calendar/sexual-abuse-sexual-violence-awareness-week-2017-02-01/2017-02-06/	06.02.17	

	Objectives	Action	Lead	Milestones Outcome Update	Milestones Date	BRAG
6.5		Harm reduction messages to target MSM via LGBT Horizon service on Gay dating app's	Shelley Mullarkey/ Anthony West	Complete – adverts for support services, harm reduction messages and access to HIV testing are visible on Gay dating applications and websites.	31.10.17	
6.6		Harm reduction messages to sex workers via sex worker support service on national online sex sites and via national Ugly Mugs. Horizon to explore funding for netreach to target online support to those at risk of harm and exploitation.	Shelley Mullarkey/ Charlene K/ Anthony West	Adverts and harm reduction messages are now visible on the two most popular sex sites.	31.01.17	
6.7		Horizon Harm Reduction service to develop harm reduction information pack to be distributed in key venues, targeting high risk groups.	Shelley Mullarkey	Activity to take place throughout festive period.	31.01.17	
6.8	Ensure there is a uniform offer of support to victims of Rape & Sexual Violence	Multi-agency 'Pathfinder' working group to identify and implement	Chief Supt. Sue Clarke Dom Blackburn	Uniform offer agreed and implemented	TBC	
6.9	Target problematic places and people of concern in terms of sexual assault, CSE and MFH	Use tools and powers from ASB Crime & Poling Act 2014 to tackle places and people of concern	Dom Blackburn James Edmonds	Problematic places identified and targeted interventions place	TBC	

	Objectives	Action	Lead	Milestones Outcome Update	Milestones Date	BRAG
6.10	Ensure there is a fit for purpose educational campaign aimed at young people re online grooming, and the dangers of social media	Design a tailor made presentation to be delivered as part of PHSE	Dom Blackburn Judith Mills	Work with Kerry Burrow (link)	TBC	
6.11	Ensure provision of Safehouse for victims of Domestic Violence/Sexual Violence	Negotiate new terms with Great Places Housing Group	Dom Blackburn	Provision to be renewed in November 2016	TBC	
6.12	Ensure provision of Safer Taxi Scheme in Night Time Economy for vulnerable victims	Secure further funding to continue provision	Dom Blackburn	Provision of scheme confirmed and running.	TBC	
6.13	Reduce risk of SA and Rape in Night Time Economy	Conduct media campaigns at key times e.g. Christmas, Easter etc.	Dom Blackburn	Alcohol Changes You campaign outcomes	31.01.17	
6.14	Reduce the harm caused by Modern Day Slavery	Explore elements of modern day slavery and relationship with the sex trade	Dom Blackburn/ Danielle Hague	Targeted interventions in place	TBC	

BRAG rating	
Complete	
On target for completion	
Action falling behind target	
Not started / behind target	

14. Draft Sexual Health Needs Assessment 2016 and Equality Analysis Assessment

V3 Blackpool Sexual Health Needs Assesm

Equality Analysis Record Form Sexual H

15. Current Services

Blackpool Teaching Hospital Foundation Trust provides the 'all age' sexual health service which is a fully integrated offer, combining Genitourinary Medicine (GUM) and Contraception and Sexual Health services. This includes the provision of an open access Tier 1, 2 and 3 services which are open to anyone of any age, irrespective of where they live. Elements of a Tier 1 service include the provision of emergency oral contraception, sexual history taking and Chlamydia testing, with Tier 3 including management of complex contraceptive problems and specialised infections management.

- Coordinate the HIV screening programme, including increasing HIV testing in the Acute Medical Unit (AMU)
- Outreach, including domiciliary visits to enable those who are not engaging with services to access contraception and sexual health services.

Blackpool Teaching Hospital Foundation Trust provide the Connect Young People's Service offering integrated Level 2 open access clinical service for anyone aged under 25, which includes STI screening, delivery of long-acting reversible contraception (LARC), emergency hormonal contraception and other appropriate interventions.

As part of the National Chlamydia Screening Programme (NCSP) for 15-24 year olds, Connect Young People's Service co-ordinate and manage the testing, including postal tests and triage of results for Chlamydia and Gonorrhoea on behalf of Blackpool.

Tier 2 General Practitioner (GP) led Sexual Health Service was developed in 2007/08 to provide testing and treatment of sexually transmitted infections (STIs) in the community. Patients testing positive for more complex conditions such as HIV, Syphilis and Gonorrhoea are referred to the Level 3 service. The service is currently provided by the following GP practices:

- Harris Medical Centre (part of Adelaide St Surgery)
- Gorton Street Practice
- Waterloo Medical Centre
- Stonyhill Medical Centre

Renaissance at Drugline Lancashire provide a Harm Reduction service in non-clinical settings offering co-ordinated support for individuals who are living with/are affected by human immunodeficiency virus (HIV), Hepatitis C, affected by sexual violence including sex workers/male victims: the Lesbian, Gay, Bisexual and Transgender (LGBT) community; populations at high risk of poor sexual health for example sex workers and men who have sex with men (MSM).

Sexual health support is offered by way of outreach working, HIV/BBV and chlamydia screening, education, condom distribution, peer support programmes, support groups and harm minimisation. Independent counselling and advocacy service for those living with and affected by HIV and victims of sexual violence is also provided by the service and appropriate non-clinical support, in all areas e.g. benefits, housing.

Blackpool Council Young People's Harm Reduction Service (Wellbeing in sexual health – WISH) offers 1-1 and group support to young people under 18 regarding sexual health and relationship issues. The team offer sexual health and relationships education in schools and training to professionals on how to support young people who engage in risk taking behaviours.

Primary care staff are trained to fit and remove contraceptive implants, intrauterine systems/devices and local enhanced service agreements are in place with a number of GP practices in Blackpool for both their registered and non-registered patients. LARC (long acting reversible contraceptive) are more reliable than user-dependent methods like oral contraceptives and less likely to lead to unintended conceptions.

Personal Social and Health Education (PSHE), including SRE, is consistently being provided in school curriculums, with many schools delivering this since 2015.

Abortion service providers currently provide chlamydia screening, HIV testing, contraceptive advice and contraceptive methods, including LARC.

15. Stakeholders

Service	Organisation	Number in Attendance at Stakeholder Event
Children's Social Care	Blackpool Council	1
Equality Officer	Blackpool Council	1
HUB (Young People Substance Misuse)	Blackpool Council	1
WISH Team (Wellbeing in Sexual Health) Young People	Blackpool Council	2
Children & Families Vulnerable Young Persons worker	Blackpool Council	1
Specialist Sexual Health	Blackpool Teaching Hospitals	7
Primary Care	Blackpool GP Surgeries	3
Substance Misuse Services	Horizon	2
Pharmacy Network representative	Lancashire Pharmaceutical Network	1
Termination of Pregnancy	Marie Stopes	2
Sexual Health Lead	Public Health England	1
Harm Reduction Service	Renaissance	4
Public Health leads	Blackpool Council	7
Communications	BTH	1
Community Safety	Lancashire Constabulary/Blackpool Council	
Awaken Project	Blackpool Children's Service and Police	

Glossary of Terms

AIDS	Acquired Immunodeficiency Syndrome
AMU	Acute Medical Unit
BASHH	British Association for Sexual Health and HIV
BBV	Blood Borne Virus
BHIVA	British HIV Association
BSCB	Blackpool Safeguarding Children's Board
CSE	Child Sexual Exploitation
CAU	Combined Assessment Unit
FSRH	Faculty of Sexual and Reproductive Healthcare
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
ISVA	Independent Sexual Violence Advisor
JSNA	Joint Strategic Needs Assessment
LAC	Looked After Children
LARC	Long Acting Reversible Contraception
LGBT	Lesbian, Gay, Bisexual and Transgender
Medfash	Medical Foundation for HIV and Sexual Health
MSM	Men who have Sex with Men
NCSP	National chlamydia Screening Programme
NATSAL	National Survey of Sexual Attitudes and Lifestyles
NICE	National Institute for health and Care Excellence
PHE	Public Health England
PReP	Pre - exposure Prophylaxis
PSHE	Personal Social Health and Economic Education
PHOF	Public health Outcomes Framework
SHEU	Schools and Student Health Education Unit
SHS	Sexual Health Services
SRE	Sexual Relationship Education
STI	Sexually Transmitted Infection
TOP	Termination of Pregnancy or abortion
WHO	World Health Organisation

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Arif Rajpura, Director of Public Health
Relevant Cabinet Member:	Councillor Amy Cross, Cabinet Member for Adult Services and Health
Date of Meeting:	19 April 2017

PUBLIC MENTAL HEALTH ACTION PLAN 2016-19

1.0 Purpose of the report:

1.1 To present the Public Mental Health Action Plan 2016-19 for approval.

The Public Mental Health Action Plan uses a public health approach to promoting mental wellbeing in Blackpool and preventing mental health problems. The action plan incorporates interventions at both a universal level (to improve the mental wellbeing of our population) and targeted (targeting those communities most at risk of poor mental health).

2.0 Recommendation(s):

2.1 To approve the Public Mental Health Action Plan 2016-2019.

3.0 Reasons for recommendation(s):

3.1 The promotion of mental health is an integral part of any strategies to improve health and reduce health inequalities. Mental health is a significant issue in Blackpool. The rate of suicide is 17 per 100,000 (compared to a national average of 10 per 100,000) 74% of deaths by suicide in 2011-13 were male.

The rate of self-harm in Blackpool is the highest of any local authority in the country and is over three times the England average. The prevalence of depression, both identified by GPs and self-reported within the GP patient survey, is significantly higher than the England average. In total 19.1% of the Blackpool population reported moderate or extreme anxiety or depression compared to 12.0% of the population of England as a whole.

This plan is underpinned by national policy and guidance. The actions have been developed using data on local needs and evidence of what works to improve mental wellbeing.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

None.

4.0 Council Priority:

4.1 The relevant Council Priority is:

"Communities: Creating stronger communities and increasing resilience"

5.0 Background Information

5.1 The overall aim of this action plan is to provide a framework for the promotion of mental health and resilience in Blackpool, creating a supportive environment for individuals and communities to flourish. There are four areas of focus:

- Promoting good mental health and resilience across the population;
- Preventing mental ill health and suicide;
- Reducing the stigma and discrimination associated with mental illness;
- Improving the quality and length of life of people living with mental illness.

5.2 There are a number of current local strategies and work plans that address mental health, wellbeing and resilience. As a result, this Public Mental Health Action Plan does not include actions that are already being undertaken as part of existing work. For example, actions related to children and young people, which are outlined under the Lancashire and South Cumbria Sustainability and Transformation plans or perinatal mental health, which is addressed through Blackpool Better Start.

5.3 Does the information submitted include any exempt information? No

5.4 List of Appendices:

Appendix 10a: Public Mental Health Action Plan 2016-19

6.0 Legal considerations:

6.1 None.

7.0 Human Resources considerations:

7.1 None.

8.0 Equalities considerations:

8.1 An Equality Impact Analysis was completed and identified that there was no explicit mention of certain protected groups that are at higher risk of mental ill health - black and minority ethnic (BME) and lesbian, gay, bisexual and transgender communities in an earlier draft of the action plan. This has now been addressed in the action plan.

10.0 Financial considerations:

10.1 Some interventions will require external funding - for example, potential application for funding through Sport England for physical activity interventions aimed at vulnerable men.

10.2 Police and Crime Commissioner funding has been allocated for the crisis/mental health café and the innovative psychological therapies.

10.3 Applied Suicide Intervention Skills Training (ASIST) continues to be funded through the Public Health budget allocation.

11.0 Risk management considerations:

11.1 The development of a local suicide action plan is recommended by government and supports government strategy. This action plan incorporates the local suicide action plan for Blackpool.

12.0 Ethical considerations:

12.1 None.

13.0 Internal/ External Consultation undertaken:

13.1 Consultation has been undertaken individually with internal and external stakeholders and through presentation at groups such as the Adult Safeguarding Board and the Mental Health Partnership Board.

14.0 Background papers:

14.1 NHS England Mental Health Taskforce, '*The Five Year Forward View for Mental Health'*.[1] This report makes the case for transforming mental health care in England, with more of a focus towards prevention. The corresponding implementation plan outlines how this will be achieved with the main focus on NHS services.

14.2 *Better Mental Health for All: a public health approach to mental health improvement*[2] – this guidance from the Faculty of Public Health and the Mental Health Foundation outlines what can be done individually and collectively to enhance the mental health of individuals, families and communities by using a public health approach.

14.3 *Improving the Physical Health of People with Mental Health Problems: Actions for mental health nurses*[3] - this resource provides information on a more holistic approach to physical and mental health. The action areas identified are, support to quit smoking; tackling obesity; improving physical activity levels; reducing alcohol and substance misuse; sexual and reproductive health; medicine optimisation; dental and oral health and reducing falls.

14.4 *Building Resilient Communities: Making every contact count for public mental health*[4] - this report summarises information from literature in the area of resilience and personal experiences from interviews and focus groups. It identifies three factors that can affect resilience, activities that promote wellbeing, building social capitol and developing psychological coping strategies.

14.5 *Preventing suicide in England: Two years on*[5] outlines current trends in suicide, new messages from research and specific information on preventing male suicides. The report refers to the All-Party Parliamentary Group on Suicide and Self-harm, which considers that there are three main elements to the successful implementation of the national suicide prevention strategy. These are, carrying out a local suicide audit; developing a suicide action plan and establishing a multi-agency suicide prevention group.

14.6 *Local suicide Prevention Planning: A practice resource*[6]- This resource, supported by the National Suicide Prevention Alliance outlines how local authorities can in partnership with mental health and health care services, primary care, schools,

[1] The Mental Health Taskforce (2016) the five year forward view for mental health.
[2] Mental Health Foundation & Faculty of Public Health (2016) Better mental health for all: a public health approach to mental health improvement
[3] Nursing, Midwifery and Allied Health Professionals Policy Unit (2016)
[4] The Mental Health Strategic Partnership (2013) Building resilient communities: Making every contact count for mental health
[5] HM Government (2015) Preventing suicide in England: Two years on – second annual report on the cross-government outcomes strategy to save lives
[6] Public Health England (2016) Local suicide prevention planning: a practice resource

employers and other organisations to develop a local suicide prevention plan.

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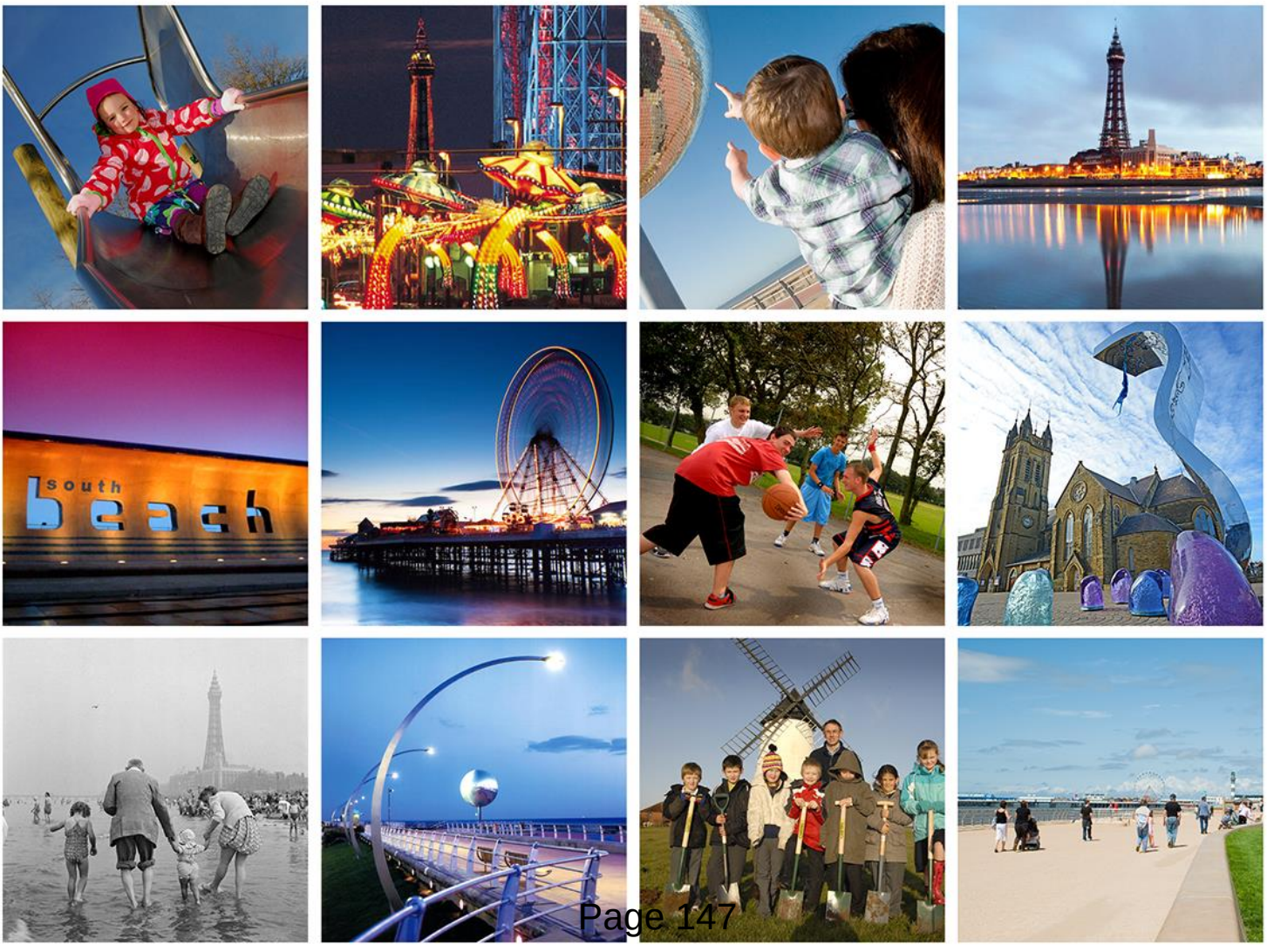
Appendix 10a

PUBLIC MENTAL HEALTH ACTION PLAN

2016-2019

Blackpool Council



Contents

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Introduction

We all have mental health and it can impact on all areas of our lives – how we feel about ourselves and others, our relationships and our psychological and emotional development. It is just as important as our physical health and the two are intrinsically linked. Poor mental health underlies many risk behaviours, including smoking, alcohol and drug misuse, higher-risk sexual behaviour, lack of exercise, unhealthy eating and obesity.[1]

Mental health not only refers to the absence of ill health - being mentally healthy helps us to realise our potential, gives us the strength to cope with change, overcome challenges and adversity and make a positive contribution to our community. [2]

Mental wellbeing, or emotional health and wellbeing are associated with better physical health, positive interpersonal relationships and socially healthier societies.[3] 'Wellbeing' itself comprises of two key elements, 'feeling good' and 'functioning well'[4].

The promotion of mental wellbeing is an integral part of any strategies to improve health and reduce health inequalities. The social, physical and environmental factors in which we are born, grow, live, work and age have important implications for mental health [5] and various circumstances can interact with each other, leading to a positive or negative affect on an individual's mental wellbeing.[6]

Public mental health refers to mental health in public health practice. It involves promotion, prevention, effective treatment, care and recovery.[7]

This strategy and action plan uses a public health approach to promoting mental wellbeing and preventing mental health problems. It incorporates interventions at both a universal level (to improve the mental health of our local population) and targeted (targeting those groups and communities most at risk of poor mental health).

Enhancing protective factors for mental health and wellbeing, building resilience and harnessing the assets of individuals and communities are all central to this strategy.

Mental Health – Some National Statistics

- At least 1 in 4 people will experience a mental health condition at some point in their life and 1 in 6 adults has a mental health condition at any one time[8]
- 1 in 10 children aged between 5 and 16 years experiences a mental health condition, and many continue to have a mental health condition into adulthood[9]
- Half of those with lifetime mental health conditions first experience symptoms by the age of 14, and three-quarters before their mid-20s[10]

[1] Royal College of Psychiatrists Position Statement PS4 (2010)

[2] World Health Organisation (2005) Promoting Mental Health; Concepts, emerging evidence and practice.

[3] Mental Health Foundation & Faculty of Public Health (2016) Better mental health for all: a public health approach to mental health improvement

[4] New Economics Foundation (2008) Five ways to wellbeing

[5] Mental Health Foundation & Faculty of Public Health (2016) Better mental health for all: a public health approach to mental health improvement

[6] World Health Organisation (2012) Risks to mental health: An overview of vulnerabilities and risk factors.

[7] Mental Health Foundation & Faculty of Public Health (2016) Better mental health for all: a public health approach to mental health improvement

[8] McManus s, Meltzer h, Brugha T et al. (2009) Adult Psychiatric Morbidity in England, 2007: Results of a household survey. Leeds: NHS Information centre for health and social care

[9] Green h, McGinnity A, Meltzer h et al. (2005) Mental Health of Children and Young People in Great Britain, 2004. Basingstoke: Palgrave Macmillan.

- Self-harming in young people is not uncommon (between 10 and 13% of 15-16 year olds have self-harmed)[11]
- Almost half of all adults will experience at least one episode of depression during their lifetime[12]
- 1 in 10 new mothers experiences postnatal depression[13]
- About 1 in 100 people has a severe mental health illness[14]
- Some 60% of adults living in hostels have a personality disorder[15]
- Some 90% of all prisoners are estimated to have a diagnosable mental health condition (including personality disorder) and/or a substance misuse problem[16]
- People with severe mental illness will die up to 20 years younger than their peers in the UK[17]
- People with mental health conditions consume 42% of all tobacco in England[18]
-

Risk Factors, Protective Factors and Emotional Resilience

Any one of us can experience poor mental health and mental illness, but some individuals and communities are particularly vulnerable. Risks to mental health can happen at all stages in life and a 'life-course' approach is helpful, as it provides a model to explain how biological and social factors experienced at different life stages, such as early life and adolescence can interact with each other and impact in adulthood and later life. There are also other factors that can impact on an individual at any age or stage in their life, depending on the sociocultural context in which they live. For example, experiencing homophobia and discrimination can lead to social exclusion and leave people vulnerable to stress, anxiety and other common mental health problems.

Risk factors can include:

- Adverse childhood experiences - ACEs (e.g. experiencing physical or emotional neglect or abuse, having a parent/carer with a mental health condition, domestic abuse)
- Demographics (being female- as women are more likely to be diagnosed with common mental health problems; belonging to particular ethnic groups; and lacking educational qualifications);
- Socio-economic context (living in social housing; on a low income; in debt; poor housing conditions; and lacking employment or in stressful working conditions);
- Social relationships (separation or divorce; living as a one-person family unit or as a lone parent; and experience of violence or abuse);
- Health, disability and health behaviours (low predicted IQ; impaired functioning; physical health conditions; nicotine, alcohol and illicit drug consumption).
  (from Stansfeld et al 2014)[19]

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[10] Kim-Cohen J, Caspi A, Moffitt T et al. (2003) Prior juvenile diagnoses in adults with mental disorder. Archives of General Psychiatry 60: 709–717; Kessler R, Berglund P, Demler o et al. (2005) lifetime prevalence and age-of-onset distributions of dsM-Iv disorders in the national comorbidity survey Replication. Archives of General Psychiatry 62: 593–602.

[11] Hawton k, Rodham k, Evans E and Weatherall R (2002) deliberate self-harm in adolescents: self-report survey in schools in England. British Medical Journal 325: 1207–1211

[12] Andrews G, Poulton R and Skoog I (2005) lifetime risk of depression: restricted to a minority or waiting for most? British Journal of Psychiatry 187: 495–496.

[13] Gavin n, Gaynes B, Lohr k et al. (2005) perinatal depression: a systematic review of prevalence and incidence. Obstetrics and Gynaecology 106: 1071–1083.

[14] Department of Health (2011) No Health without Mental Health; A Cross Government Mental Health Outcomes Strategy for People of All Ages.

[15] Rees s (2009) Mental Ill Health in the Adult Single Homeless Population: A review of the literature. London: crisis and Public health Resource unit.

[16] Department of Health (2011) No Health without Mental Health; A Cross Government Mental Health Outcomes Strategy for People of All Ages

[17] Chang C-K, Hayes RD, Perera G, Broadbent MTM, Fernandes AC, Lee WE, et al. (2011) Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Care Case Register in London. PLoS ONE 6(5): e19590. doi:10.1371/journal.pone.0019590

[18] McManus et al (2010) Cigarette smoking and mental health in England

A public mental health approach also involves consideration of protective factors for mental health. There is an imperative to enhance the resilience of individuals and communities, to help them cope with adversity and flourish. Some examples of protective factors are:[20] [21]

- Having a secure attachment experience in childhood;
- Having psychological coping skills / problem-solving skills;
- Having a supportive network / positive personal relationships;
- Good physical health;
- Having a belief in control;
- Faith or spirituality;
- Good communication skills.

Emotional resilience is a complex and personal concept; what is important for one person may not be helpful to another. Resilience is often described as the ability to cope with life's ups and downs, or the ability to bounce back when something difficult happens in your life. Resilient people can adapt when faced with challenging circumstances, whilst remaining mentally well.

In terms of developing resilient communities, three key factors have been identified:[22]

- Promoting wellbeing
- Building social capital
- Developing psychological coping strategies

Mental Health and Physical Health

There are a number of ways in which poor mental health is linked to physical health. High levels of wellbeing directly affect good health. It is estimated that high levels of subjective wellbeing can increase life by 4 to 10 years, compared with low levels of subjective wellbeing. Positive emotions have also been linked to living longer and negative emotions to mortality.[23]

People with long-term conditions commonly experience mental health problems such as depression and anxiety, or dementia in the case of older people. There is particularly strong evidence for a close association with cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorders. Overall, the evidence suggests that at least 30 per cent of all people with a long-term condition also have a mental health problem[24].

Thirty three percent of people with a mental health condition smoke compared to 18.7% of people in the general population [25] Studies which examine prevalence within individual mental conditions

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[19] Stansfeld et al (2014) Annual report of the Chief Medical Officer 2013, Public mental health priorities: Investing in evidence. Chapter 7, page 116.
[20] Mind (2015) Our communities, our mental health: Commissioning for better public mental health
[21] Department for Education (2016) Mental health and behaviour in schools
[22] The Mental Health Strategic Partnership (2013) Building resilient communities: Making every contact count for mental health
[23] Department of Health (2014) What works to improve wellbeing? A compendium of factsheets: wellbeing across the lifecourse.

24 The Kings Fund and Centre for Mental Health (2012) Long term conditions and mental health, the cost of co-morbidities.
25 Public Health England (2015) Smoking cessation in secure mental health settings – guidance for commissioners.

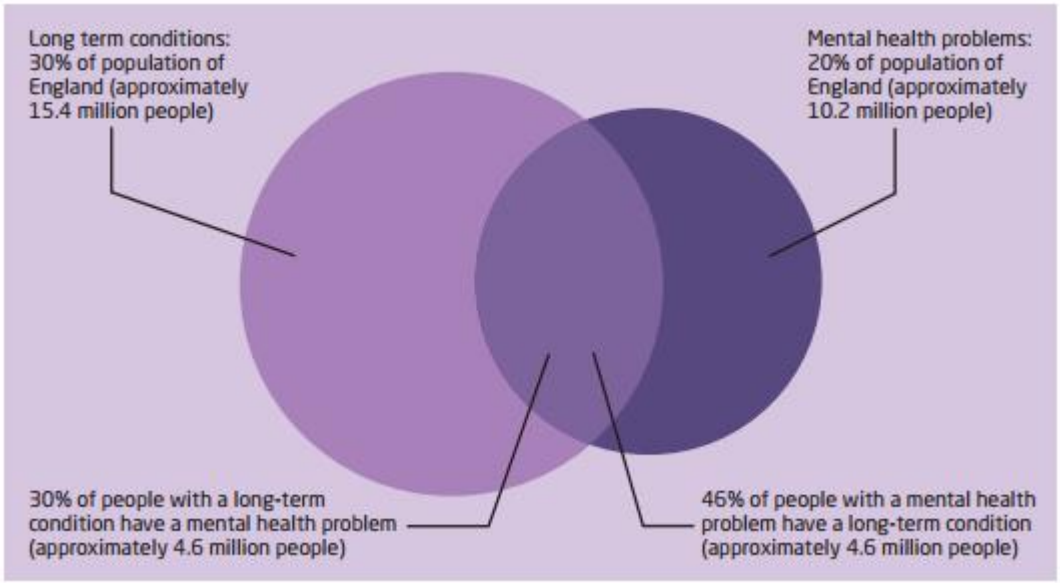
have found prevalence of around 60% in people with probable psychosis and up to 70% for people in psychiatric units.[26]

People with severe mental illness die on average 20 years younger than the general population, often from avoidable physical illness. The vast majority of these deaths are due to chronic physical medical conditions such as cardiovascular, respiratory and infectious diseases, diabetes and hypertension. Suicide is another important cause of death.[27] The medical conditions experienced by this group are associated with preventable risk factors, such as smoking, physical inactivity, obesity, and side effects of psychiatric medication.

Unhealthy behaviours such as tobacco use and inactivity are associated with depression, schizophrenia and bipolar disorder and can lead to the development of long term conditions. Once illness has developed, poor self-care associated with having a severe mental illness can lead to worse health outcomes and higher mortality rates.[28]

There are also strong links between adverse experiences in childhood and physical health outcomes in adults. Evidence shows that ACEs effect neurological, immunological and endocrine development, increasing stress on the body and a person's vulnerability to health-harming behaviours (e.g. tobacco use, substance misuse). This can lead to increased risk of poor health outcomes in adulthood.[29]

The following table shows the overlap between long-term conditions and mental health problems:[30]



[26] Action on Smoking and Health (2016) Factsheet: smoking and mental health
[27] World Health Organisation: Information Sheet: Premature death among people with severe mental disorders
[28] World Health Organisation: Information Sheet: Premature death among people with severe mental disorders
[29] C. McGee, K. Hughes, Z. Quigg, M. Bellis, W. Larkin & H/Lowey (2015) A Scoping Study of the Implementation of Routine Enquiry about Childhood Adversity (REACh) Centre for Public Health
[30] The Kings Fund and Centre for Mental Health (2012) Long term conditions and mental health, the cost of co-morbidities.

People in Blackpool are 0.4 times more likely to die before age 75 than the national average and this rises to 3.6 times for people with a serious mental health problem. This rate is significantly higher than the national average (2.4)[31]

Those living with any mental health condition are often at a disadvantage compared with the general population owing to factors such as unemployment, living in institutions, social isolation and exclusion, as well as socioeconomic status – all risk factors that can prevent recovery as well as lead to poor health and premature mortality.[32]

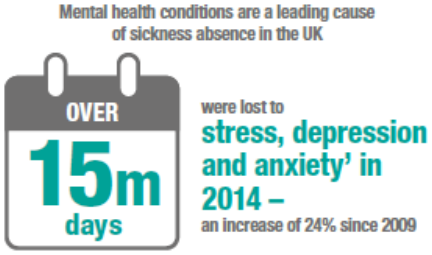
Lack of integration between mental health and physical health services can mean that the mental health of people living with long term conditions and the physical health of people living with a mental health condition are not adequately addressed.

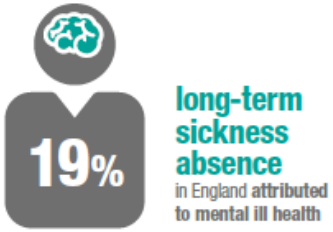
[31] Open Public Services Network (2015) https://www.ther sa.org/action-and-research/rsa-projects/public-services-and-communities-folder/mental-health/long-life.html

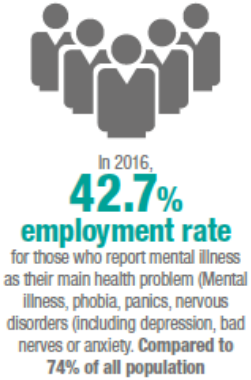
[32] World Health Organisation: Information Sheet: Premature death among people with severe mental disorders

The Business Case for Public Mental Health

Poor mental health has a personal, economic and societal cost. Globally, mental health problems form the largest single source of economic burden, with an estimated global cost of £1.6 trillion. People with mental health problems are more likely to have a disrupted education, be unemployed, take time off work, fall into poverty and be over-represented in the criminal justice system. [33] Mental ill health is the cause of 40% of new disability benefit claims each year in the UK.







The Work Foundation, Lancaster University (2016)

[33] Mental Health Foundation & Faculty of Public Health (2016) Better mental health for all: a public health approach to mental health improvement

The following table demonstrates how investing in prevention, promotion and early identification can lead to a significant return on investment.

Table 1: Total returns on investment: economic pay-offs per £1 expenditure)[34]

Economic pay-offs per £1 investment

Early identification and intervention as soon as mental disorder arises				
	NHS	**Other public sector**	**Non public sector**	**Total**
Early intervention for conduct disorder	1.08	1.78	5.03	7.80
Heath visitor interventions to reduce postnatal depression	0.40	-	0.40	0.80
Early intervention for depression in diabetes	0.19	0	0.14	0.80
Early intervention for medically unexplained symptoms	1.01	0	0.74	1.75
Early diagnosis and treatment of depression at work	0.51	-	4.52	5.03
Early detection of psychosis	2.62	0.79	6.85	10.27
Screening for alcohol misuse	2.24	0.93	8.57	11.75
Suicide training courses provided to all GPs	0.08	0.05	43.86	43.99
Suicide prevention through bridge safety barriers	1.75	1.31	51.39	54.45
Promotion of mental health and prevention of mental disorder				
	NHS	**Other public sector**	**Non public sector**	**Total**
Prevention of conduct disorder through social and emotional learning programmes	9.42	17.02	57.29	83.73
School-based interventions to reduce bullying	0	0	14.35	14.35
Workplace health promotion programmes	-	-	9.69	9.69

Current National Policy and Guidance

The following policy and guidance underpin the development of this action plan:

In 2016, the independent Mental Health Taskforce to the NHS in England, produced '*The Five Year Forward View for Mental Health*'.[35] This report makes the case for transforming mental health care

[34] London School of Economics and Political Science (2011) Mental health promotion and prevention: the economic case. Department of Health.

in England, with more of a focus towards prevention. The corresponding implementation plan outlines how this will be achieved with the main focus on NHS services.

Better Mental Health for All: a public health approach to mental health improvement[36] – this guidance from the Faculty of Public Health and the Mental Health Foundation outlines what can be done individually and collectively to enhance the mental health of individuals, families and communities by using a public health approach.

Improving the Physical Health of People with Mental Health Problems: Actions for mental health nurses[37] - this resource provides information on a more holistic approach to physical and mental health. The action areas identified are, support to quit smoking; tackling obesity; improving physical activity levels; reducing alcohol and substance misuse; sexual and reproductive health; medicine optimisation; dental and oral health and reducing falls.

Building Resilient Communities: Making every contact count for public mental health[38] - this report summarises information from literature in the area of resilience and personal experiences from interviews and focus groups. It identifies three factors that can affect resilience, activities that promote wellbeing, building social capitol and developing psychological coping strategies.

Preventing suicide in England: Two years on[39] outlines current trends in suicide, new messages from research and specific information on preventing male suicides. The report refers to the All-Party Parliamentary Group on Suicide and Self-harm, which considers that there are three main elements to the successful implementation of the national suicide prevention strategy. These are, carrying out a local suicide audit; developing a suicide action plan and establishing a multi-agency suicide prevention group.

Local suicide Prevention Planning: A practice resource[40]- This resource, supported by the National Suicide Prevention Alliance outlines how local authorities can in partnership with mental health and health care services, primary care, schools, employers and other organisations to develop a local suicide prevention plan.

What Works to Improve Wellbeing?

Wellbeing has a wide range of determinants. Interventions in a number of areas have been shown to improve wellbeing[41], for example,

- Improving physical health;
- Physical activity;
- Parenting and early years;
- Engaging in learning throughout the life course;
- Good quality employment and promoting employee mental health in the workplace;
- Improving housing;
- Taking part in social activities, having good relationships and strong social networks;
- Arts activities;
- Green spaces.

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[35] The Mental Health Taskforce (2016) The five year forward view for mental health.

[36] Mental Health Foundation & Faculty of Public Health (2016) Better mental health for all: a public health approach to mental health improvement

[37] Nursing, Midwifery and Allied Health Professionals Policy Unit (2016)

[38] The Mental Health Strategic Partnership (2013) Building resilient communities: Making every contact count for mental health

[39] HM Government (2015) Preventing suicide in England: Two years on – second annual report on the cross-government outcomes strategy to save lives

[40] Public Health England (2016) Local suicide prevention planning: a practice resource

[41] Department of Health (2014) A compendium of factsheets: Wellbeing across the lifecourse -What works to improve wellbeing?

The Five Ways to Wellbeing

The Foresight Project on Mental Capital and Wellbeing looked at how to achieve the best possible mental development and mental wellbeing for people in the future. From a broad evidence base, a long list of actions emerged, which were reduced to a set of five key messages on the evidence around social relationships, physical activity, awareness, learning and giving. [42]

These messages have been organised into five key actions, as detailed on the following page, each offering examples of more specific behaviours that enhance wellbeing. These are not just any one person's individual responsibility, but can be influenced by 'upstream' interventions; shaping existing services or providing new services in such a way that they encourage behaviours that promote the Five Ways to Wellbeing.[43]

For the purpose of this plan, the Five Ways to Wellbeing have helped to guide the development of specific actions to improve wellbeing. The Five Ways will also be used as a framework to communicate and promote public mental health to different stakeholders, including the general public.

[42] New Economics Foundation (2008) Five ways to wellbeing
[43] The Mental Health Strategic Partnership (2013) Building resilient communities: Making every contact count for mental health

Health and Wellbeing– The Local Picture [44]

The health of people in Blackpool is generally worse than the England average. Blackpool is one of the 20% most deprived districts/unitary authorities in England and about 30% (7,700) of children live in low income families. Life expectancy for both men and women is lower than the England average. Life expectancy is 11.8 years lower for men and 8.5 years lower for women in the most deprived areas of Blackpool than in the least deprived areas.

In Year 6, 22.0% (335) of children are classified as obese, worse than the average for England.

The rate of alcohol-specific hospital stays among those under 18 was 89.8, worse than the average for England. This represents 26 stays per year. Levels of teenage pregnancy, GCSE attainment, breastfeeding initiation and smoking at time of delivery are worse than the England average.

The rate of alcohol-related harm hospital stays is 1,223, worse than the average for England. This represents 1,702 stays per year. The rate of smoking related deaths is 423, worse than the average for England. This represents 365 deaths per year.

Estimated levels of adult excess weight, smoking and physical activity are worse than the England average. Rates of hip fractures and sexually transmitted infections are worse than average.

Mental health is a significant issue in Blackpool. Our suicide rate is 17 per 100,000 (compared to a national average of 10 per 100,000) 74% of deaths by suicide in 2011-13 were male.

The rate of self-harm in Blackpool is the highest of any local authority in the country and is over three times the England average. The rate of self-harm hospital stays is 629.9; this represents 861 stays per year.

The prevalence of depression, both identified by GPs and self-reported within the GP patient survey, is significantly higher than the England average. 19.1% of the Blackpool population reported moderate or extreme anxiety or depression compared to 12.0% of the population of England as a whole. The percentage of people with a high anxiety score is 21.4%, compared to 19.4% for England.[45]

Approximately 7% of Blackpool's population is Black and minority ethnic (BME). Different ethnic groups have different rates and experiences of mental health problems. BME communities in the UK are more likely to be diagnosed with mental health conditions, more likely to be admitted to hospital, more likely to experience a poor outcome from treatment and more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in mental health.[46]

Local data on sexual identity is not available but based on the number of businesses and venues; Blackpool has a thriving LGB&T population. Studies show that lesbian, gay and bisexual people show higher levels of anxiety, depression and suicidal feelings than heterosexual men and women. Poor levels of mental health among gay and bisexual people have often been linked to experiences of homophobic discrimination and bullying. Suicide risk in the Transgender population is high and this group face considerable social stigma and issues with access to services.[47]

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[44] Public Health England (2016) Blackpool Health Profile http://fingertipsreports.phe.org.uk/health-profiles/2016/e06000009.pdf
[45] Public Health Outcomes Framework (2016) https://fingertips.phe.org.uk/profile-group/mental-health
[46] Mental Health Foundation (2016) https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities
[47] Trans Mental Health Study (2012) https://www.gires.org.uk/assets/Medpro-Assets/trans_mh_study.pdf

(Visit http://www.blackpooljsna.org.uk/Home.aspx for more information from Blackpool's Joint Strategic Needs Assessment)

Improving Mental Health and Wellbeing: Related strategies

There are a number of current local strategies and work plans that address mental health, wellbeing and resilience, as outlined below. As a result, this Public Mental Health Action Plan does not include actions that are already being undertaken as part of existing work. For example, actions related to children and young people which are outlined under Lancashire and South Cumbria Sustainability and Transformation plans or perinatal mental health, which is addressed through Blackpool Better Start.

Blackpool Council Plan 2015 to 2020

The plan has two priorities, maximising growth and opportunities across Blackpool and creating stronger communities and increasing resilience.

Blackpool Council Workforce Strategy 2016 to 2020

Employee health and wellbeing is part of this strategy and it includes a commitment to activities that improve the mental health and wellbeing and resilience of council staff.

Joint Health and Wellbeing Strategy for Blackpool 2016 to 2019

This strategy outlines the priorities for Blackpool Health and Wellbeing Board which are, housing, tackling substance misuse, early intervention and building resilience and reducing social isolation.

Blackpool Better Start In 2014, Blackpool was chosen as one of only five locations in the UK to receive Big Lottery Funding to help give Blackpool babies a better start in life. Specialist services are being developed to support the most vulnerable families with babies across seven key wards in Blackpool, as well as delivering public health messages and improving public spaces for the benefit of all families in Blackpool. Better Start focuses on pregnancy to pre-school a sit is a crucial time for child development and a unique opportunity for prevention. Priorities for Better Start include:

- Giving babies the best start in relation to Diet and Nutrition, Language and Communication and Social and Emotional Development
- Tackling poor parental health and unhealthy gestation and birth
- Enabling youngest children to enter school ready and able to learn and reach their full potential
- Safeguarding and protecting the most vulnerable children and families
- Tackling poor mental health and well-being along with other parental risk factors
- Delivering quality services through a committed, professional and motivated workforce.
-

A number of initiatives have been developed through Better Start, as outlined in the strategy:

Blackpool HeadStart: Blackpool HeadStart is a Big Lottery funded programme designed to build the resilience of young people aged 10 to 16 to help prevent them from developing mental health problems as they get older. A number of interventions are currently being delivered or planned as part of the HeadStart programme, including 'Walk and Talk' therapy, equine and pet therapy and online counselling. HeadStart is working with number of schools, developing training for the children and young people workforce and developing campaigns to decrease stigma and discrimination related to mental ill health.

Blackpool Fulfilling Lives Blackpool is one of 12 areas in England that has received Big Lottery Funding to support people with multiple needs. Blackpool Fulfilling Lives is targeted at people living very chaotic lifestyles who do not currently engage with services. The programme engages with and supports adults living with a combination of issues – working with individuals that present with at least two of the four specified areas of multiple need (homelessness, reoffending, problematic substance misuse and mental ill health).

Lancashire and South Cumbria Sustainability and Transformation Plans In 2015, the NHS shared planning guidance outlined a new approach to help ensure that health and care services are built around the needs of local populations. To do this, every health and care system in England must produce a multi-year Sustainability and Transformation Plan (STP), showing how local services will evolve and become sustainable over the next five years – ultimately delivering the Five Year Forward View vision of better health, better patient care and improved NHS efficiency.

To deliver plans that are based on the needs of local populations, local health and care systems came together to form 44 STP 'footprints' and Blackpool is part of the Lancashire and South Cumbria STP 'footprint'. Plans for Lancashire and South Cumbria, include transformation of emotional health and wellbeing services for young people and promoting wellbeing.

The Children and Young People's Resilience, Emotional Wellbeing and Mental Health plan for Lancashire has been developed by the Children and Young People's Emotional Wellbeing and Mental Health System Board, which consists of key partners, including all eight CCGs, and has been informed by consultation with children, young people and families. It is based on comprehensive identification of needs and evidence based practice to promote good emotional wellbeing and prevention of mental ill-health through early intervention, care and recovery.

In order to promote build resilience in Lancashire, ambitions include actions to build resilient communities in all settings including home, school and wider community which promote, improve and maintain the emotional health, mental health and wellbeing of children, young people and their families, to encourage them to help themselves and improve public awareness and understanding of children and young people's wellbeing and mental health, including perinatal mental health, and work to reduce stigma and discrimination. These ambitions have been translated into a local transformation plan for Blackpool.

Aims and Objectives of the Plan

The overall aim of this action plan is to provide a framework for the promotion of mental health and resilience in Blackpool, creating a supportive environment for individuals and communities to flourish. This will be achieved by:

1. Promoting good mental health and resilience across the population
2. Preventing mental ill health and suicide
3. Reducing the stigma and discrimination associated with mental illness
4. Improving the quality and length of life of people living with mental illness

10. Public Mental Health Action Plan

As this is a Public Mental Health Action Plan, most actions are led by Public Health, with actions completed in partnership with other stakeholders.

Promote good mental health and resilience across the population				
Objective	**Actions**	**To be Achieved by**	**Lead/s**	**Outputs**
Support individual, community and population mental health and resilience.	Implement and evaluate a neighbourhood resilience programme in Claremont.	31.03.19	Liz Petch	Evaluation completed and learning outcomes disseminated.
	Develop and promote an online resilience programme incorporating the Five Ways to Wellbeing for residents.	30.09.17	Emily Davis	Resilience programme in place.
	Develop an e-learning tool for Blackpool Council frontline staff to raise awareness of the Five Ways to Wellbeing and how to promote them to service users.	30.06.17	Emily Davis / Rachel Swindells	Staff completion rates for e-learning tool.
	Develop and deliver a short face-to-face training session for non-office-based staff to raise awareness of the Five Ways to Wellbeing and how to promote them to service users.	31.03.18	Emily Davis / Rachel Swindells	Non-office based staff completion rates.
	Develop and deliver a campaign to promote the Five Ways to Wellbeing, with specific targeting for high risk groups (e.g. 'Happier Lancashire')	31.03.18	Emily Davis / Zohra Dempsey	Campaign delivered and evaluated.
	Raise the profile of evidence based interventions to improve mental health and wellbeing for residents and promote	31.03.17	Zohra Dempsey / Lynn Howarth	Marketing plan developed and delivered.

	access to mental health and resilience building courses.			
	Develop and promote a social prescribing offer for all residents, through Healthy Lifestyles at HealthWorks.	31.03.17	TBC	Number of residents accessing socially prescribed activities.
	Ensure mental wellbeing is incorporated into any tools developed for health impact assessments.	31.03.17	Alan Shaw	Blackpool Council Health impact assessment tool includes mental wellbeing.
Support the mental health and resilience of the Blackpool Council workforce.	Implement recommendations and best practice from the Centre for Mental Health as part of the Mental Health Challenge.	31.03.19	Zohra Dempsey	Implementation plan in place.
	Audit line managers' use of the Mindful Employer Resource, particularly for staff working in Health and Social Care, identify gaps and encourage better use.	31.03.17	TBC	Action plan in place.
	Develop courses for Blackpool Council staff focusing on building resilience, Mindfulness and promoting the use of evidence-based stress management techniques, including online support and resources.	31.12.17	Zohra Dempsey / Lynn Howarth	Number of Blackpool Council staff accessing workplace opportunities to build resilience.
Increase opportunities for Ecotherapy	Develop a green infrastructure strategy for Blackpool Council.	31.03.19	Judith Mills	Strategy developed.
	Develop a Blackpool-wide network of community growing projects that can be accessed through Healthy Lifestyles as a	31.03.18	Judith Mills	Number of people accessing growing opportunities through Health Lifestyles.

	vehicle for social prescribing.			
Improve access to arts and cultural activities to improve wellbeing.	Develop and implement an arts and health Strategy for Blackpool.	31.03.18	Zohra Dempsey / Carolyn Primett	Strategy and implementation plan in place.

Prevent mental ill health and suicide				
Objective	**Actions**	**To be Achieved by**	**Lead/s**	**Outcome Measure**
Develop a partnership approach to suicide prevention.	Establish a multi-agency suicide prevention group for Blackpool to ensure delivery of the suicide prevention plan.	31.03.17	Emily Davis	Formal group in place.
Ensure appropriate assessment and response for those presenting with deliberate self-harm.	Review and develop multi-agency care pathways for deliberate self-harm in adults, including appropriate psychosocial assessment and follow-up for those presenting at A&E	31.01.18	Zohra Dempsey	Care pathways in place.
Improve access to psychological therapies for people with common mental health conditions	Develop a list of free non-NHS counselling providers to be promoted with NHS, substance misuse and social care staff and ensure details are included in the new directory of services for Blackpool, Fylde and Wyre residents.	31.03.17	Zohra Dempsey	Details circulated to all staff teams.
	Pilot and evaluate the use of behavioural activation for depression to be delivered by mental health and non-mental health staff.	31.03.19	Zohra Dempsey / Helen Lammond-Smith	Number of people receiving behavioural activation as a treatment for depression.
	Pilot and evaluate innovative and alternative ways of delivering talking therapies that are more accessible for those patients that do not want to access traditional models of delivery.	31.12.17	Zohra Dempsey / Nicky Dennison	Number of people accessing psychological therapies.

	Ensure any weight management interventions for people who are overweight or obese include an assessment of mental health and wellbeing and appropriate support and referral.	31.03.17	Helen Lammond-Smith / Nicky Dennison	Number of people accessing weight management care pathways having their mental health and wellbeing assessed.
Develop more effective assessments and gender specific interventions for men at risk of poor mental health and suicide.	Pilot and evaluate innovative and alternative ways of delivering psychological therapies that are more acceptable to men.	31.12.17	Zohra Dempsey	Number of men accessing psychological therapies.
	Work with delivery partners to develop specific programmes of physical activity to attract inactive at-risk men.	31.03.19	Zohra Dempsey	Number of inactive men accessing specific programmes.
	Ensure mental health services are commissioned to meet the needs of at-risk men, including support services for vulnerable men.	31.03.19	Helen Lammond-Smith / Zohra Dempsey	Number of men accessing mental health services.
	Pilot ways of delivering relationship therapy and anger management programmes that are more appealing to men.	31.03.19	Zohra Dempsey	Outcomes from pilot used to inform future service provision.
	Work with partner organisations to ensure that vulnerable men are targeted for debt advice services.	31.12.17	Emily Davis / Zohra Dempsey	Debt advice care pathway in place and promoted with services.
	Investigate male-specific measures of depression for use in primary care and pilot use in a GP practice.	31.03.19	Zohra Dempsey	Protocols in place and evaluation completed
Ensure the mental health needs of people with substance misuse issues are	Providers of mental health and substance misuse services to develop and adopt joint working protocols.	31.03.18	Helen Lammond-Smith / Nina Carter	Joint working protocols in place and monitored through contracts.

addressed effectively.				
	Ensure key personnel in substance misuse services are trained in Applied Suicide Interventions Skills Training (ASIST).	31.12.17	Nina Carter / Emily Davis	Number of key personnel trained in ASIST.
	Assertive outreach teams in both mental health and substance misuse services to develop effective protocols to prevent loss of contact with vulnerable and high-risk clients.	31.03.18	Helen Lammond-Smith / Nina Carter	Protocols in place and monitored through contracts.
	All patients accessing primary or secondary care identified as having substance misuse issues to be screened for depression.	31.03.19	Rachel Swindells / Emily Davis	Number of patients with substance misuse issues being screened for depression in primary and secondary care.
Ensure identification of suicide risk, particularly for vulnerable groups (e.g. BME, LGB&T)	Work with service providers to develop appropriate postvention activities for people bereaved or affected by suicide.	31.03.19	Emily Davis	Care pathway in place for bereavement through suicide.
	Review the process for future Public Health audits to eliminate duplication and improve data collection.	31.12.18	Emily Davis	Review completed and new protocol established.
	Ensure that all those working with vulnerable groups, have been trained to deliver the Applied Suicide Interventions Skills Training (ASIST) model of suicide prevention.	31.03.19	Emily Davis	ASIST training audit shows uptake from those working with vulnerable groups.
	Develop a system within primary care for frequent attenders to identify frequent attenders at risk of suicide.	31.03.19	Emily Davis	System developed and adopted by all Blackpool GP practices.

	Pilot 'real time' surveillance of suicides.	31.03.19	Emily Davis	Pilot completed and evaluated.
Ensure responsible reporting of suicide and self-harm in the local media.	Develop locally agreed protocols with local media for reporting of suicide and suicidal behaviour.	31.12.18	Emily Davis / Communications	Protocols agreed.
Ensure Blackpool Council planning considerations include suicide risk.	Identify actual or potential suicide hotspots and work with partners to reduce risk and introduce signage.	31.03.19	Emily Davis	Appropriate signage introduced.
	Ensure suicide risk is incorporated into any tools developed for health impact assessments.	31.03.17	Alan Shaw	Health Impact Assessment tool developed and includes suicide risk.
Ensure safer prescribing of opiate analgesics and antidepressants.	Work with primary care and A&E to review prescribing arrangements.	31.12.17	TBC	Review completed and recommendations in place.
Help to alleviate loneliness and social isolation, particularly for older people, carers, those living with mental health and/or long term conditions, those at-risk of a mental health condition and those with substance misuse issues.	Ensure frontline local authority staff and NHS staff (e.g. district nurses) are trained to use the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) and a validated tool to measure social inclusion as part of their assessments and can promote practical steps on activities to improve social inclusion.	31.03.19	Zohra Dempsey / Rachel Swindells	Training delivered as part of Making Every Contact Count.
	Ensure at-risk groups are accessing socially prescribed activities through the Healthy Lifestyles service.	31.12.17	TBC	Equity audit report for Healthy Lifestyles service completed and action plan in place.
	Evaluate the 'Grow you own Happiness' programme.	30.06.17	Zohra Dempsey	Evaluation report completed and disseminated.
	Work with physical activity providers to promote access for at-risk groups.	31.12.17	Zohra Dempsey	Work plans in place.
	Develop a community café for Blackpool to	31.03.18	Nicky Dennison / Zohra	Café sustainability plan in

	provide out of hours support for vulnerable people.		Dempsey	place and out of hours support provided.

Reduce the stigma and discrimination associated with mental illness				
Objective	**Action**	**To be Achieved by**	**Lead/s**	**Outcome Measure**
Promote positive conversations around mental illness and encourage open discussions.	Create a Blackpool-wide network of Time to Change Champions.	31.03.19	Zohra Dempsey	Group established.
	Deliver multi-agency awareness raising activities for World Mental Health Day and Time to Talk Day.	31.03.19	Zohra Dempsey / Emily Davis	World Mental Health Day and Time to Talk Day events delivered.
	Work with local media to share best practice for responsible reporting of any incidents that involve mental health/mental illness.	31.03.19	Communications	Local protocols agreed.
	Develop a programme of Time to Change activities for Blackpool Council employees.	31.03.19	Zohra Dempsey / Karen White	Programme in place and activities delivered.

Improve the quality and length of life of people living with mental illness				
Objective	**Action**	**To be Achieved by**	**Lead/s**	**Outcome Measure**
Ensure the physical health needs of people living with mental health conditions are addressed.	Work with mental health services and primary care to look at ways of targeting adults with mental health conditions to promote access to NHS Health Checks.	31.03.18	Liz Petch	Number of people living with a mental health condition receiving an NHS Health Check.

	Ensure all those living with serious mental illness receive an annual physical health check, with appropriate signposting and support to access physical health improvement services.	31.03.19	Helen Lammond-Smith	Numbers of people living with a serious mental illness receiving an annual physical health check.
	Work with providers of mental health services and smoking cessation services to ensure people with a mental health condition are effectively supported to quit smoking, effective harm reduction strategies are put in place for those that are not ready to quit and that all inpatient and community mental health sites are smoke free by 2018.	31.03.19	Rachel Swindells	Plans in place for all providers.
	Ensure mental health services staff adopt a holistic approach to managing physical health and are able to 'Make Every Contact Count' and promote the Five Ways to Wellbeing as part of recovery.	31.03.19	Rachel Swindells	Making Every Contact Count training delivered.
	Produce guidance/script for mental health staff on all NHS population health screening programmes to raise awareness of them and how people who are eligible to access these programmes can be supported.	31.03.19	Zohra Dempsey / Lynn Donkin	Guidance distributed to all mental services health staff.
	Promote Mind's Get Set to Go programme.	31.03.17	Zohra Dempsey	Programme information disseminated.
	Develop and implement a self-care strategy for Blackpool, which addresses	31.03.19	Emily Davis / Liz Petch	Strategy completed.

	the needs of people experiencing a mental health condition.			
Offer people in crisis alternatives to acute inpatient mental health care.	Explore the further development of crisis support in Blackpool (for example, peer led crisis houses)	31.03.19	Zohra Dempsey	Options paper developed and funding streams identified.

11. Outcomes – How will we measure progress?

A number of outputs are described within the action plan above.

Additionally, there are a number of high level indicators from the Public Health Outcomes Framework that summarise good mental health or at least avoidance of mental ill health and will be used to measure impact.

These will include:

- Mortality from suicide and injury undetermined;
- Self-reported wellbeing scores;
- Recorded prevalence of depression and anxiety;
- Emergency admissions for self-harm;
- Premature mortality in adults with serious mental illness.

12. Governance Arrangements

The Health and Wellbeing Board will have overall responsibility for this action plan. Performance will be monitored strategically by the Health and Wellbeing Strategic Commissioning Group. Day to day monitoring will be through the Blackpool Mental Health Partnership Board, with representation from all stakeholders.

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Sheena Wood, NHS England
Relevant Cabinet Member:	Councillor Amy Cross, Cabinet Member for Adult Services and Health
Date of Meeting:	19 April 2017

NOTIFICATION OF CHANGE IN LEGISLATION IN RELATION TO REQUIREMENT TO PROVIDE SUPPLEMENTARY STATEMENTS TO THE PHARMACEUTICAL NEEDS ASSESSMENT

1.0 Purpose of the report:

1.1 To highlight the key issues as a result of the changes to legislation which requires the Health and Wellbeing Board to comment upon Pharmaceutical Applications and thereafter the requirement to produce a supplementary statement to the Pharmaceutical Needs Assessment.

2.0 Recommendation(s):

2.1 To note the process for reviewing Pharmaceutical Applications.

2.2 To note the requirement for the Health and Wellbeing Board to provide comment in relation to any Pharmaceutical Applications and to issue a supplementary statement to the Pharmaceutical Needs Assessment when required as per the legislation.

2.3 To note the request for NHS England to receive a copy of any such additional statements, ensuring that they are emailed to england.lancsat-pharmacy@nhs.net for reference purposes.

3.0 Reasons for recommendation(s):

3.1 To provide the Health and Wellbeing Board with an update on the changes in legislation regarding the Health and Wellbeing Board's role on Pharmaceutical Applications.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

None.

4.0 Council Priority:

4.1 The relevant Council Priority is:

"Communities: Creating stronger communities and increasing resilience"

5.0 Background Information

5.1 SI 1077 of 2016 introduced amendments to the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Primarily, the new legislation allows applications for consolidation of 2 or more pharmacy sites to be considered. The opinion of the Health and Wellbeing Board on this issue must be given when the application is notified locally and representations are sought. If the application is granted and pharmacy premises are removed from the relevant pharmaceutical list, if the Health and Wellbeing Board does not consider that a gap in service provision is created as a consequence, it must publish a supplementary statement to be published alongside its pharmaceutical needs assessment recording its view.

5.3	Does the information submitted include any exempt information?	No

5.4 List of Appendices:

None

6.0 Legal considerations:

6.1 None.

7.0 Human Resources considerations:

7.1 None.

8.0 Equalities considerations:

8.1 None.

10.0 Financial considerations:

10.1 None.

11.0 Risk management considerations:

11.1 None.

12.0 Ethical considerations:

12.1 None.

13.0 Internal/ External Consultation undertaken:

13.1 Discussions with Health and Wellbeing representatives at Pharmaceutical Needs Asessment meetings with NHS England.

14.0 Background papers:

14.1.1 *National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013*

14.2 *SI 1077 of 2016 – The National Health Service (Pharmaceutical Services, Charges and Prescribing) (Amendment) Regulations 2016*

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