# BLACKPOOL HEALTH & WELLBEING BOARD

# BLACKPOOL SEXUAL HEALTH ACTION PLAN

# 2013 - 2015

**FINAL VERSION : FEBRUARY 2014**

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## FOREWORD FROM THE DIRECTOR OF PUBLIC HEALTH

The sexual health action plan outlines the strategic intentions of the Blackpool Health & Wellbeing Board as commissioners and providers of services for the residents of Blackpool.

The plan is targeted at promoting sexual health across the whole population but recognising that particular sub groups are at higher risk of poor sexual health and its consequences.

Blackpool has a population of 143,000 with a high transient population and booming newly rejuvenated tourist industry. National research has suggested that seaside resorts such as Blackpool face particular challenges from a "hedonistic and carnivalised environment", where locals, tourists and easy access to alcohol are combined to enhance risk taking behaviour.

There is a need, therefore, to ensure that local people understand the risks, have the knowledge to protect themselves, not just from unwanted pregnancy or sexually transmitted infections but also from abuse. Much of the work of the mental health action plan is to promote emotional resilience which supports the sexual health promotion agenda.

In addition, Blackpool has an ageing population. Sexual health services will need to ensure that they are able to understand and meet the particular needs of an ageing population.

No-one can be unaware of the current financial restrictions on public sector spending and therefore the work of local communities, voluntary organisations and the private sector must be maximised. We need to work with every asset we have.

There is an ongoing scrutiny of services, in how they are delivered, and at what cost, to ensure they are delivering value for money. This will continue in the future with a move to Payment by Results for all elements of clinical sexual health service activity.

Blackpool is now the 6$^{th}$ most disadvantaged local authority in England but in the face of increasing deprivation progress has been made and continues to be driven by partner organisations. A simple example of a successful outcome is that Blackpool now has one of the lowest late diagnostic rate of HIV in the North West and the whole of England, because of the emphasis of prevention and evidence based interventions such as increasing routine HIV testing in healthcare settings. This is just one of a number of successful outcomes from out previous work. This action plan, provides direction for the next three years, and aims to tackle some of the thorny issues such as repeat abortion rates.

**Dr Arif Rajpura**
**Director of Public Health**

## 1. Background

Sexual health has been a priority for Blackpool for over a decade. This is due to the levels of poor sexual health measured through teenage conception, termination of pregnancy rates, HIV diagnosis and the incidence of sexually transmitted infections. Though Blackpool remains significantly worse than the National average, improvements have been evident. These trends are summarised in the health needs assessment section of this plan.

The first Sexual Health Action Plan aiming to address these issues was produced in 2005, which was refreshed in 2008 and again in 2011. With the transfer of responsibility for Public Health to Blackpool Council and the development of NHS England and the Clinical Commissioning Group, a new action plan has been developed to provide direction for 2013 – 2015. This action plan takes account of the new national policy framework directive and good practice guidelines on the commissioning of sexual health services produced in 2013 by the Department of Health.

It is easy to forget how much progress has been made in Blackpool since 2005. A few key strategic changes are outlined below to describe the extent of improvement in preventative services, treatment and ongoing care.

**2005 – 2008**

- Waiting times for treatment of STI's drastically cut to less than 48 hours
- Appointment of an additional Consultant to extend the range of services provided
- Move from sessional nurses to doctor led but nurse delivered services with a full time, well trained nursing team
- GUM now offer HIV screening routinely in GUM with much improved uptake
- Distance learning packages for primary care nurses developed by the University of Cumbria to expand provision of sexual health clinical services in GP practices
- EHC offered in community pharmacies
- Development of the Blood Borne Virus (BBV)Team to support patients with all BBV's
- Development of preventative services to raise aspirations of young women to reduce teenage pregnancy
- Expansion of specialist sexual health treatment service delivery into evenings and Saturdays
- Screening rates for pregnant women continually increased to over 95% which means that it is rare for a child to be born with HIV

**2008 – 2012**

- Connect moved into newly refurbished larger ground floor premises
- Further development of services from Connect specialist young people's service, including the provision of Long Acting Reversible Contraception
- GUM and Contraceptive Services merged to deliver comprehensive sexual health services based at the purpose-built Whitegate Primary Care Centre
- Appointment of a Consultant Nurse in Sexual Health to support primary care and specialist clinicians
- A Chlamydia screening programme was established for 15 – 24 year olds to identify and treat undiagnosed Chlamydia
- Development of Sexual Health Hub website to guide people to the appropriate services
- Provision of local Early Medical Termination Services, including HIV screening, Chlamydia screening and Long Acting Reversible Contraception
- Enhanced wraparound care for people living with HIV to support a healthy and economically active life

- Development of rape and sexual assault services, including local counselling and advocacy
- Development of outreach support targeting higher risk groups, including sex workers, and selected high risk leisure venues, such as saunas
- Refinement and more targeted psychosexual counselling
- Development of GP based sexual health services which includes Long Acting Reversible Contraception with training and support from specialist services
- Pilot mystery shoppers to get real feedback about services

## 2. Aims & Objectives

### The Aims of the Plan

To:

- Ensure the enjoyment of sexual relations without exploitation, oppression or abuse
- Reduce the incidence of unwanted pregnancy
- Achieve the absence and avoidance of sexually transmitted diseases/infections

### Objectives

i. To raise awareness of sexual health
ii. To provide Information and Education for the whole population
iii. To develop sexual health services and stimulate the provider market
iv. To encourage uptake of services
v. To build skills and capacity in individuals and communities
vi. To reduce the stigma associated with HIV and reduce late diagnosis

This strategy should be read in conjunction with the Alcohol Harm Reduction Strategy, Teenage Pregnancy Strategy, Mental Health Action Plan and Children and Young People's Plan.

## 3. The New Commissioning Landscape

From April 2013, a number of different commissioning organisations are involved in commissioning various aspects of sexual health services. Local authorities are responsible for commissioning most sexual health services and interventions, but some elements of care will be commissioned by Clinical Commissioning Groups or by NHS England. The table at Annex A gives more information about commissioning responsibilities. All the commissioning bodies (including local authorities in the exercise of their public health functions), will be required by law to have regard to the NHS Constitution in their decisions and actions, including those in relation to sexual health services. (The Constitution also applies to providers of sexual health services, whether NHS trusts, Foundation Trusts, GPs or other primary care providers, or private providers).

Health and Wellbeing Boards have a duty to promote integrated working between commissioners of health and social care, and play a key role in ensuring that the sexual health services and care received by their communities is seamless. Through the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy (JHWS) of the Health and Wellbeing Board identifies the health and social care needs of the local community and agrees the joint priorities for local action. Sexual health needs have been considered as part of this process and the Blackpool Health & Wellbeing Board considers sexual health as one of its priorities.

Local authorities are now responsible for commissioning most sexual health interventions and services as part of their wider public health responsibilities, with costs met from the ring-fenced public health grant. While we will be able to make decisions about provision based on local need, there are also specific legal requirements ensuring the provision of certain services, which are set out in the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013.

The Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013 require Local Authorities to arrange for the provision of certain services. An extract from the regulations which cover the provision of sexual health services is attached at Annex B, and these require the provision of:

Open access sexual health services for everyone present in their area; covering

- Free sexually transmitted infections (STI) testing and treatment, and notifications of sexual partners of infected persons; and
- Free contraception, and reasonable access to all methods of contraception

The requirements are broadly the same as the requirements which the NHS previously had to fulfil. The rest of this section gives more detail about these requirements and how local authorities can go about fulfilling them.

The three upper tier Local Authorities in Lancashire and Cumbria County Council have organised a collaborative network to share good practice and ensure seamless provision across boundaries. This plan recognises the priorities across Lancashire in addition to local needs and groups.

In addition the Public Health Outcomes Framework contains three specific indicators for sexual health:

- Under 18 conceptions
- Chlamydia diagnoses in the 15 – 24 age group
- Late diagnosis of HIV

Therefore, in this time of significant change this plan aims to provide direction to local partners.

## 4. Why is Sexual Health Important?

The cost of poor sexual health can be measured in a number of ways, the cost of poor health to the individual in pain, impairment of functioning, loss of employment and stigma, from the wider community's perspective the impact on service and the nation as a whole can be measured in monetary terms. Some key facts are:

- Every year an additional 6300 people are diagnosed with HIV. It is thought that 96,000 people are living with HIV, a quarter of whom are not diagnosed
- 0.04% of pregnant women are HIV positive at time of delivery
- In 2011 47% of people diagnosed with HIV nationally were diagnosed late. Being diagnosed late is the equivalent of having had HIV for 5 years without knowing it
- An individual diagnosed late has a life expectancy 10 years shorter than someone who starts treatment early
- Each new HIV infection costs the NHS between £280K and £360K in treatment
- NICE estimates that by implementing its guidance on HIV testing 3,500 cases could be prevented, saving the NHS £18 million in treatment costs
- Reduced rates of late diagnosis will reduce the need for and costs of Local Authority provided social care
- Preventing unplanned pregnancies will save the NHS £2.5 billion per year
- Preventing Chlamydia will reduce the costs associated with pelvic inflammatory disease and preventable infertility (it causes ectopic pregnancy and tubal factor infertility) cost to the NHS currently £100 million (annually).

## 5. The New National Framework for Sexual Health Improvement Published by the Department of Health in March 2013

The national sexual health framework includes the following priorities:

| **1. Build knowledge and resilience among young people** | **2. Improve sexual health outcomes for young adults** | **3. All adults have access to high quality services and information** | **4. People remain healthy as they age** | **5. Prioritise prevention** | **6. Reduce rates of sexually transmitted infections (STI's) among people of all ages** | **7. Reduce onward transmission of and avoidable deaths from HIV** | **8. Reduce unwanted pregnancies among all women of fertile age** | **9. Abortion counselling** | **10. Continue to reduce the rate of under 16 and under 18 conceptions** |
|---|---|---|---|---|---|---|---|---|---|
| Sexual health up to age 16<br><br>• All children and young people receive good quality sex and relationship education at home, at school and in the community<br>• All children and young people know how to ask for help, and are able to access confidential advice and support about wellbeing, relationships and sexual health<br>• All children and young people understand consent, sexual consent, and issues around abusive relationships<br>• Young people have the confidence and emotional resilience to understand the benefits of loving, healthy relationships and delaying sex | Young people aged 16 – 24<br><br>• All young people are able to make informed and responsible decisions, understand issues around consent and the benefits of stable relationships, and are aware of the risks of unprotected sex<br>• All young people have rapid and easy access to appropriate sexual and reproductive health services<br>• All young people's sexual health needs – whatever their sexuality – are comprehensively met | People aged 25 – 49<br><br>• Individuals understand the range of choices of contraception and where to access them<br>• Individuals with children know where to access information and guidance on how to talk to their children about relationships and sex<br>• Individuals with additional needs are identified and supported<br>• Individuals and communities have information and support to access testing and earlier diagnosis and prevent the transmission of HIV and STI's | Older people aged over 50<br><br>• People of all ages understand the risks they face and how to protect themselves<br>• Older people with diagnosed HIV can access any additional health and social care services they need<br>• People with other physical health problem that affect their sexual health can get the support they need for sexual health problems | • Build a sexual health culture that prioritises prevention and supports behaviour change<br>• Ensure that people are motivated to practise safer sex, including using contraception and condoms<br>• Increased availability and uptake of testing to reduce transmission<br>• Increase awareness of sexual health among local healthcare professionals and relevant non-health practitioners, particularly those working with vulnerable groups | • Individuals understand the different STI's and associated potential consequences<br>• Individuals understand how to reduce the risk of transmission<br>• Individuals understand where to get access to prompt, confidential STI testing and provision allows for prompt access to appropriate, high quality services, including the notification of partners<br>• Individuals attending for STI testing are also offered testing for HIV | • Individuals understand what HIV is and how to reduce the risk of transmission<br>• Individuals understand how HIV is prevented<br>• Individuals understand where to get prompt access to confidential HIV testing<br>• Individuals diagnosed with HIV receive prompt referral into care and high quality care services are maintained<br>• Individuals diagnosed with HIV receive early diagnosis and treatment of STI's | • Increase knowledge and awareness of all methods of contraception among all groups in the local population<br>• Increase access to all methods of contraception including Long Acting Reversible Contraception (LARC) methods and Emergency Hormonal Contraception for women of all ages and their partners<br>• Reduce repeat abortion and unwanted pregnancy after childbirth | • All women requesting an abortion should be offered the opportunity to discuss their options and choices with a trained counsellor<br>• Post abortion support and counselling | • All young people receive appropriate information and education to enable them to make informed decisions<br>• All young people have access to the full range of contraceptive methods and here to access them |

## 6. Commissioning Sexual Health Services Best Practice Guidance for Local Authority March 2013 and National Framework Priorities

In addition to the National Framework, Commissioning Best Practice Guidance has been produced. The following table highlights what is included in the Best Practice Guidance and what we already have in place in Blackpool. In addition, it highlights key actions that have been identified as a priority by the wider Lancashire and Cumbria Sexual Health Network for collaborative work.

| National Recommendations | Already Provided in Blackpool | Lancs & Cumbria wide priority |
|---|---|---|
| Highlight those at high risk of teenage conception and put in place early intervention to promote behaviour change | √ | √ |
| Develop consistent high quality sexual health promotion and relationship education in schools, colleges and universities | | √ |
| Target sex and relationships education to at risk groups including NEET, those leaving care and those excluded from school | √ | √ |
| Commission open access sexual health treatment / clinical services including access to all types of contraception | √ | √ |
| Young people's sexual health treatment | √ | √ |
| Specialist services should be provided for:<br>– LGB+T<br>– Sex workers<br>– People with learning disabilities | <br>√<br>√ | √ |
| Cross charging for out of area. Access to treatment / clinical services | √ | √ |
| Good access to Chlamydia testing, including tests as part of routine primary care consultations | √ | |
| Implementation of NICE guidance on HIV testing to high risk groups | √ | |
| Partner notification | √ | |
| FSRH guidance (contraception)<br>BASHH guidance (STI testing) | √<br>√ | |
| Implementation of NICE guidance on Long Acting Reversible Contraception | √ | √ |
| EHC available widely | √<br>limited | |
| Condom distribution for all ages, targeting highest risk | √ | √ |
| Marketing – advertising of services to all ages including web based applications and apps – including texting | | √ |
| People over 50 understand the risk they face and how to protect themselves | | |
| Information and Education available in a range of formats | | √ |
| PEPSE prescribing in place | √ | |
| Provide easily accessible HIV testing and promote uptake | √ | |
| Older people with HIV can access any additional health and social care they need | | |
| Standardise clinical training to support the delivery of sexual health services in primary care | √ | √ |
| Provide sexual health awareness and training in behaviour change techniques to health care and non health care frontline workers | √ | |
| GP service provision to include the full range of sexual health interventions | √ | |
| Expand role of pharmacy in sexual health to oral contraception | | |
| Abortion services to include LARC, HIV and STI testing | √ | |
| Abortion services linked to sexual health services to reduce repeat terminations. Targeting high prevalence areas | √ | √ |
| All women who are considering an abortion have the opportunity to discuss options and choices | √ | |
| Provision of post abortion counselling service | √ | |
| Support national services providing abortion services to access training in Long Acting Reversible Contraception | √ | √ |
| Develop Patient Group Directives for nurses to prescribe and fit Long Acting Reversible Contraception | √ | √ |
| Implementation of the new national HIV treatment services specification | | |
| Referral pathways with Sexual Assessment and Referral Centres | √ | |
| Sexual health in the JSNA and PNA including teenage conception | √ | √ |
| Health & Wellbeing Boards prioritise sexual health | √ | √ |

## 7. What the Evidence Says Works

Based on previous best practice guidelines, Medfash, BASHH, BHIVA clinical guidance, Cochrane reviews and the recommendations of the National Institute for Health and Care Excellence. The following sexual health interventions are proven to be cost effective or cost saving.

### 7.1 Contraceptive and Abortion Services

Contraceptive services are cost-saving. Cost-saving measures include:

- Increasing uptake of LARC.
- Access to services that provide full information and choice about the range of Contraceptive methods.
- Reducing delays in obtaining abortion are cost saving.

### 7.2 Screening

Screening strategies targeting high-risk populations such as pregnant women for HIV, and young women for chlamydia are cost saving, leading to early treatment, averting costs of complications (such as infertility) and onward transmission.

Cost saving measures include:

- Antenatal screening for HIV in high-risk women.
- Antenatal syphilis screening.
- Chlamydia screening for young women and groups at high risk.

### 7.3 Treatment interventions and service organisation/delivery for STI's and HIV

Comprehensive and accessible STI treatment services are cost saving, and partner notification and highly active antiretroviral therapy (HAART) are also cost effective.

Measures include:

- STI treatment services in groups at high risk.
- Temporary increases in the capacity of services to gain control of infection.
- Partner notification.
- Access to services with very short or no waiting times.
- Antiretroviral treatment for HIV.
- Routine HIV testing for STI clinic attendees (and in AMU/ A & E in high prevalence areas)

### 7.4 Health Promotion and disease prevention

A range of interventions aimed at preventing HIV and promoting sexual health are cost saving and are most cost effective when targeted at high-risk groups.

Measures include:

- Free condom provision for medium and high-risk groups.
- Outreach programmes for high-risk, hard to reach groups.
- Provision of HIV risk-reduction messages in gay bars.
- Safer-sex skills training session/cognitive behavioural intervention for men who have sex with men (MSM).
- Peer leader interventions for MSM.
- Needle exchange provision for injecting drug users.
- High quality integrated SRE.

This evidence gained from meta analysed randomised controlled trials, cohort studies, and case control studies has been used to inform the development in sexual health services in Blackpool to date.

## 8. Sexual Health Needs Assessment

So far we have described how services have improved and what the national priorities are, in addition to the evidence base for cost effective interventions. The following identifies Blackpool population's sexual health needs that should be addressed in the action plan.

### 8.1 The following summarises the detailed sexual health needs assessment included in full in Annex D:

#### a) Demography

Population projections indicate that Blackpool can expect to see increases particularly in the 60+ age ranges. Blackpool has a high level of internal population movement (people who live within the borough moving within the borough). More transient populations may not be engaged with traditional health services and may be less likely to be registered with a GP. Blackpool displays a higher proportion of resident working age people claiming key out of work benefits, job seekers allowance, employment support allowance and incapacity benefits than the North West and England comparators.

#### b) Risk Factors

Blackpool has a far higher number of 'children looked after' than both the average for England and 'statistical neighbour' local authorities (150 per 10,000 population against 76 and 59 respectively). The rate for Blackpool has risen every year since 2008. 22% of 'children looked after', as at 31 March 2012, were placed within Blackpool by another Local Authority. These children are likely to have little or no knowledge of local services. Child Sexual Exploitation in Lancashire is an operational priority that represents a county wide threat. Referral rates in the Blackpool division have fallen between 2010/11 and 2012/13. However, in the Oct '12 – Mar '13 period, Claremont Ward had the highest number of referrals in Lancashire. Bloomfield ward was fourth highest and Greenlands was eighth.

Blackpool has a number of sex workers operating on the street, as well as in massage parlours and saunas. An outreach worker is employed to work with male, female and transgender sex workers in Blackpool. Blackpool has a large population of lesbian, gay, bisexual and transgender (LGB+T) people. The sexual health needs of LGB+T people are not homogenous. An outreach worker is employed to support the needs of this population. Alcohol consumption in Blackpool is significantly higher than the England average in many wards. Increased alcohol consumption is likely to lead to increased risk taking behaviour in terms of sexual health. Blackpool had a crude rate of 21 per 1,000 alcohol-related sexual offences in 2011/12.

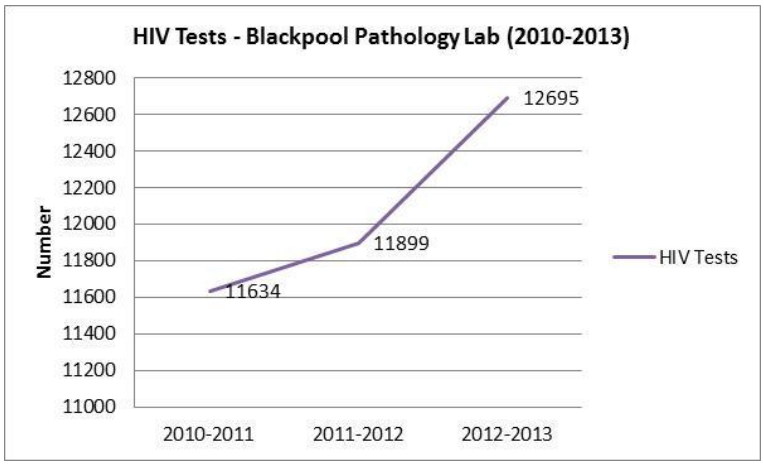
Links between alcohol use and poor sexual health outcomes have long been recognised and recent evidence suggests holistically addressing alcohol and sexual risk simultaneously in sexual health settings.

#### c) HIV

Blackpool continues to have amongst the highest prevalence of HIV in the North West. The population prevalence of HIV in Blackpool in 2011 was 360 per 100,000, compared to 149 and 150 for the North West and UK respectively. There was a 43% reduction in new HIV infections (from 42 to 24) between 2006 and 2011. 79.3% of total infections in Blackpool were through men who had sex with men, which is significantly higher than the North West (43.7%) and national average (43.4%).

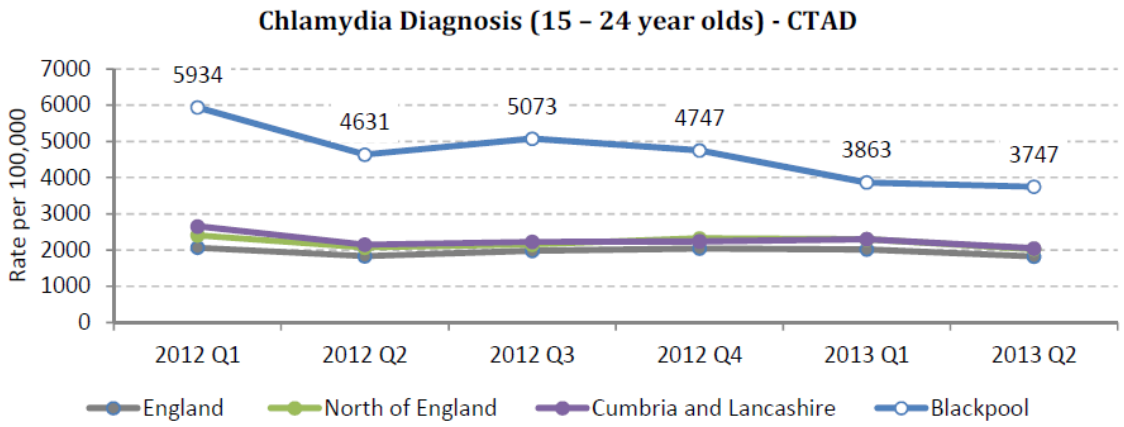
Routine HIV screens undertaken in Blackpool Victoria Hospital Path Lab have increased by 17% between 2010/11 and 2012/13. The number of people being offered and accepting HIV testing in Blackpool GUM have both increased by 7.2% between 2010/11 and 2012/13. Late diagnosis figures for HIV in Blackpool for 2009-11 were 29.4%, compared to 54.6% in the North West and 49.7% in the UK for the same period.

**HIV testing figures for Blackpool Pathology Lab (2010/11 - 2012/13)**



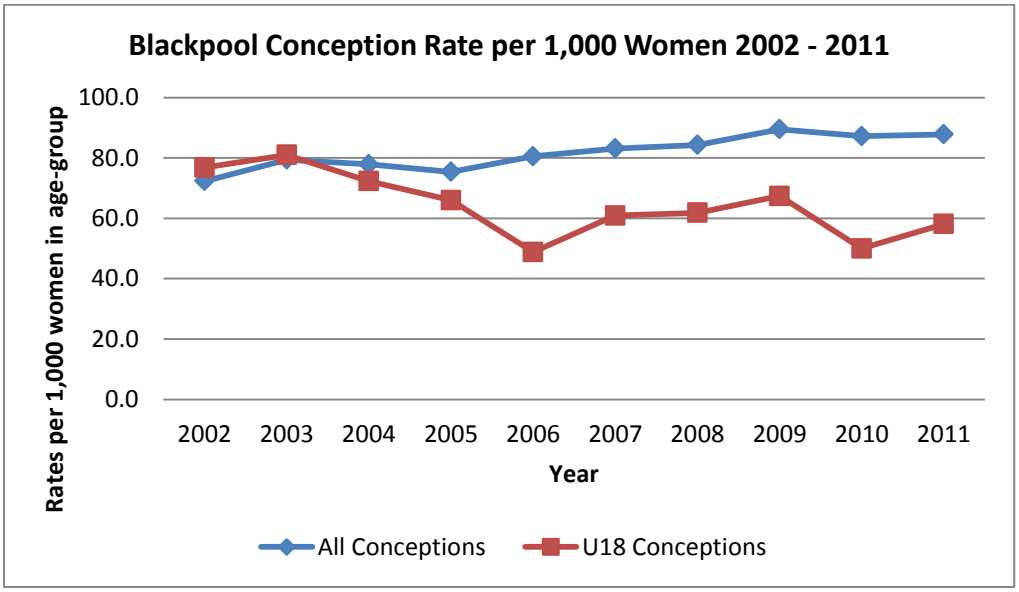

**d) STI's**

Diagnosis rates per 100,000 population of other STI's (gonorrhoea, herpes, syphilis and warts) at Blackpool GUM have been the highest in Cumbria and Lancashire for the period 2009-2012. However, rates for gonorrhoea and warts have fallen in the same period. Blackpool has a Chlamydia diagnostic rate which is significantly higher than the North of England and England rates of 2,317 and 1,979 respectively, and the diagnostic rate is falling. Positive results were 10.9% for Blackpool, compared to 8.5% for Cumbria and Lancashire and 7.7% for England over the same period. Overall the number of newly diagnosed STI's is falling.



### e) Teenage Pregnancy

Blackpool has one of the highest teenage pregnancy rates in the UK. The U18 conception rate in 2011 was 58.1 per 1,000 women in the age group, compared to 35.3 and 30.7 for the North West and England respectively. Bloomfield, Brunswick, Claremont, Clifton, Hawes Side, Park and Talbot wards all have rates significantly higher than the England average. The U16 conception rate for Blackpool for the period 2009-2011 was 10.3 per 1,000 women in the age group. This is higher than the rates for the North West and England of 8 and 6.7 per 1,000 respectively. 52.6% of these conceptions led to abortions, compared to 61.5% and 61.1% for the North West and England respectively. This was an increase from 38.7% for the period 2008-2010 for Blackpool. Increasing deprivation is associated with increasing birth rate. The following graph demonstrates the increase in conception rate in Blackpool for all ages compared to the under 18's.




### f) Termination of Pregnancy

Blackpool has seen no significant change in the overall rate of termination of pregnancy (all ages) since 2006. The rate remains slightly higher than those for both the North West and England. However U18 rates have fallen since 2008, from 27 per 1,000 to 18 per 1,000. Rates for the 18-19 age group, however, have increased since 2006 and are higher than North West and national rates. Repeat terminations in women aged under-25 for Blackpool increased to 28% in 2012, compared to 25% and 27.1% for the North West and England respectively.

### g) Provider Activity

Attendances at 'Connect' have declined from around 11,400 in 2010/11 to 7,200 in 2012/13. Reasons may include rectification of data quality issues and the service no longer running the condom distribution scheme for young people. 42% of Year 10 pupils were aware of the specialist contraception and advice service for young people in the 2012 SHEU Survey.

During 2009 and 2012 there was a 19% increase in the number of Blackpool residents using the GUM service. 60% of total attendees were Blackpool residents. There has been a 15% increase in males receiving sexual health screens since 2009. Greater numbers are seen in the 20-34 age ranges for males and 16-35 range for females. During April - June 2013 the five Tier 2 GP practices undertook 96 STI screens and 17 follow-up appointments.

There were 10,700 first contacts with contraceptive services in Blackpool in 2011/12 (9,900 female and 800 male). This compares to 12,000 in 2009/10 (9,900 female and 2,100 male). Emergency contraceptive contacts were 1,400 in 2011/12, compared to 2,000 in 2010/11 and 1,700in 2009/10. 44% (n=2,850) of patients accessing Connect and contraceptive services in 2012/13 related to LARC. 38.5% (n=984) of U18 contacts related to LARC for 2012/13. In 2012/13 16 GP practices provided 463 implants and 6 practices provided 122 IUD's. Approximately 4.5% (n=15) of those eligible clients within Horizon (Drug and Alcohol Integrated Treatment System) were referred for LARC during the period April 2012 – March 2103.

The Wellbeing in Sexual Health Services (WISH Team) undertook 295 group sessions with 1,044 young people in schools and colleges during 2012/13. The Wellbeing in Sexual Health Services (wish Team) undertook 1-1 sessions with 133 young women during 2012/13. 99% of 130 young women did not become pregnant during the course of the intervention. 77% of those sexually active young women accessed LARC. 1,624 young people accessed the Buzz Bus during 2012/13.

Renaissance at Drugline-Lancashire undertook 193 contacts with sex workers during 2012/13. Renaissance at Drugline-Lancashire undertook 3,096 public sex environment contacts during 2012/13. 3,006 individuals accepted information and there were 87 significant contacts (10 minutes or more spent with the individual).

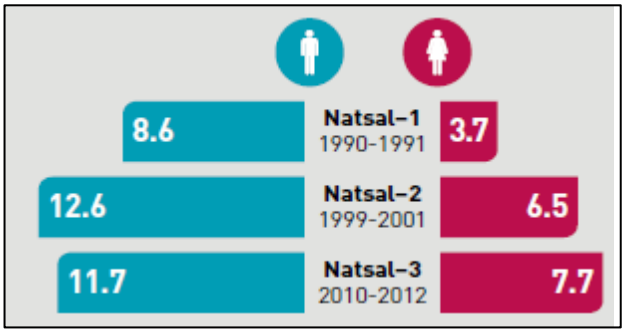
### 8.2 Attitudes to Sexual Health

Limited work has been undertaken locally to determine the trends in attitudes to sexual health because of the complexity and cost of such studies. Therefore, information is drawn from national studies. The National Sexual Attitude and Lifestyle study 2013 has recently been published.

The researchers interviewed 15,162 men and women aged 26 – 74 between September 2010 and August 2012.

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 key findings are as follows:

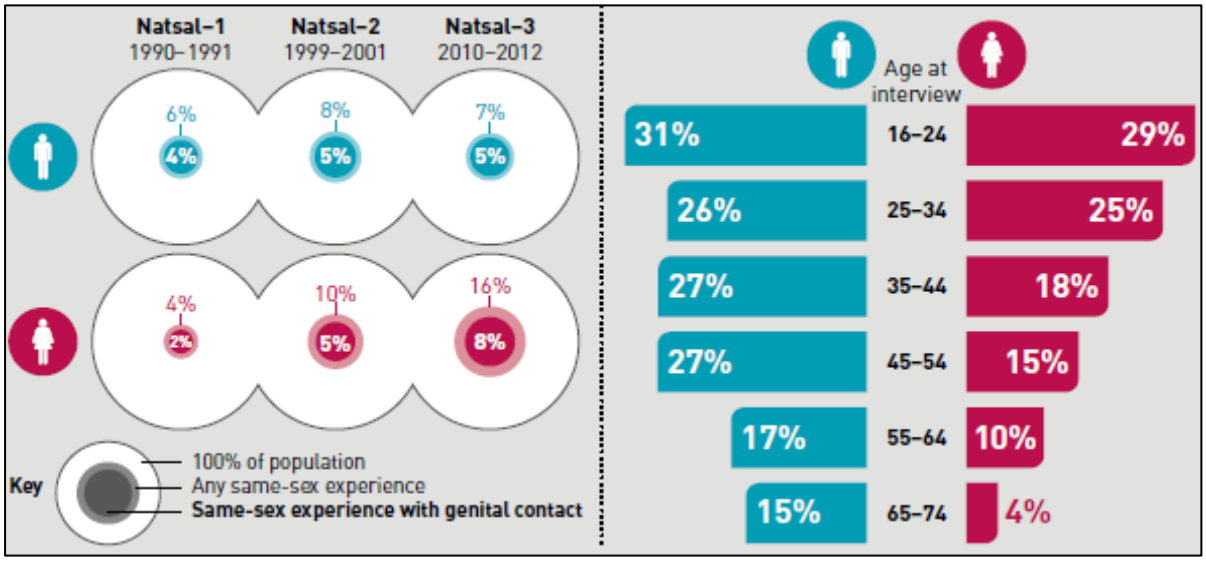
Average (mean) number of opposite sex partners, lifetime




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, with approximately 1 in 3 young people having sex before the age of 16.

Percentage of the population who have ever had same-sex experience (people aged 16–44)

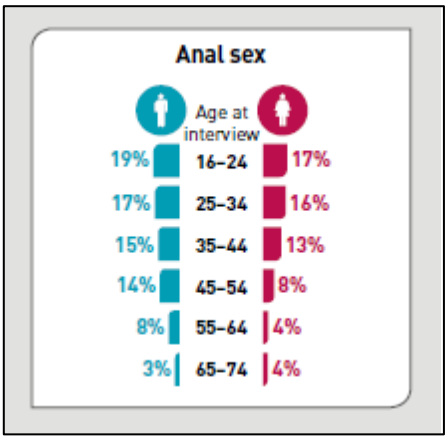
Percentage who had sexual intercourse with someone of the opposite sex before age 16




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.

People continue to have sex at all ages, but the frequency and range of sexual practices decrease with age. 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.

Percentage of people reporting different types of sex with people of the opposite sex



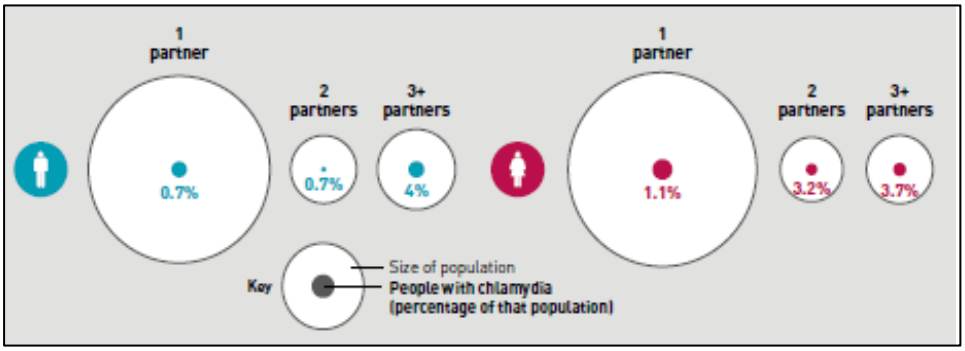

The researchers collected urine from a sample of men and women aged 16-44 which was tested anonymously for sexually transmitted infections (STI's), including Chlamydia, gonorrhoea, human papillomavirus (HPV), and HIV. These findings are for men and women who have ever had sex.

HPV was the most common STI, followed by Chlamydia. HIV and gonorrhoea were found in around one in a thousand people.

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.

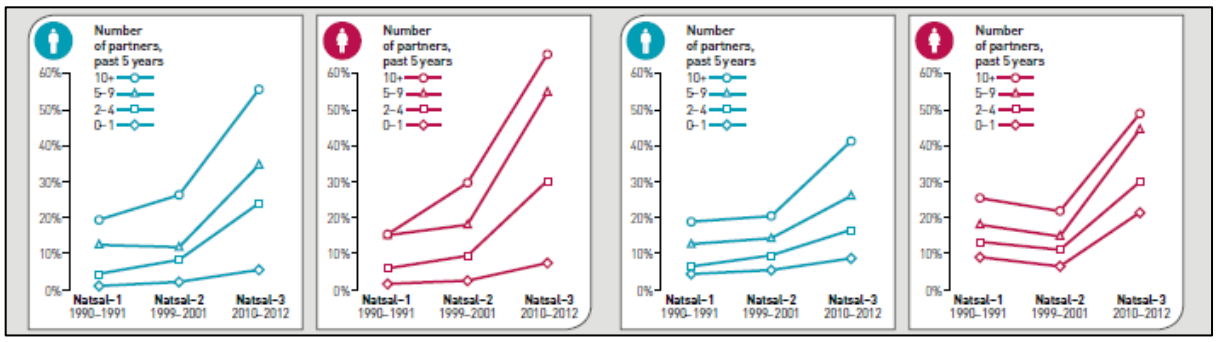
Percentage of people in the population with Chlamydia



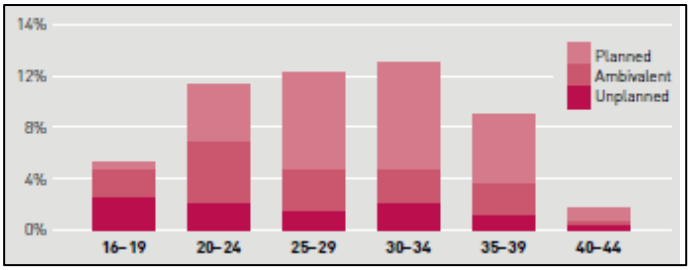

Over the past decade, national sexual health strategies in Britain have aimed to increase access to sexual health services and STI / HIV testing. Compared with the previous survey (1999-2001), more people reported having an HIV test or going to a sexual health clinic in the past 5 years. It is encouraging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

Sexual health clinic attendance, past 5 years (people aged 16–44)

HIV testing, past 5 years (people aged 16–44)




10% of women aged 16-44 had been pregnant in the past year (given birth, miscarried, or had an abortion in the past year). An estimated one in six of these pregnancies were unplanned, two in six were ambivalent and three in six were planned.




Although pregnancies among 16-19 year old women were more likely to be unplanned than those among older women, most unplanned pregnancies were in women aged 20-34, simply because that is when most women become pregnant.

Age profile of unplanned pregnancies

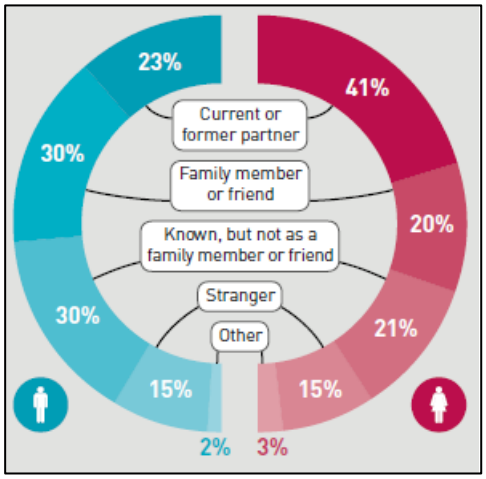
| 16 – 19 | 20 – 24 | 25 – 29 | 30 – 34 | 35 – 39 | 40 – 44 |
|---|---|---|---|---|---|
| 21% | 23% | 16% | 23% | 12% | 5% |

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.

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.

One in 10 women and 1 in 71 men said they had experienced non volitional sex since the age of 13. The median age for the most recent occurrence of non volitional sex was 16 for men and 18 for women.

Person responsible at most recent occurrence




In most cases the person responsible was someone known to the individual

People who reported non volitional sex were more likely to report potentially harmful health behaviours and poorer physical, mental and sexual health including treatment for depression.

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

The key issues raised by the NATSAL survey that need to be addressed by this action plan are:

- The most common STI remains HPV, and that Chlamydia prevalence remains high
- The narrowing of the gender gap in relation to the lifetime number of partners
- The increase in reporting of same sex experience
- The increase in the range of sexual practices between people of the opposite sex, ensuring that people protect themselves from HIV
- The increase in access to sexual health clinics. HIV test, use of condoms, use of contraception was positive.
- The need to respond effectively to non volitional sex by increasing self-esteem, addressing cultural issues, and ensuring that victims are appropriately supported
- The need to work with sex workers to prevent the transmission of STI's
- The need to ensure consistent sexual health education through schools, including HIV risk

## 8.3 The widening of the age range of people at risk of poor sexual health - Changes in the Onset Puberty and Impact of an Ageing Population

In 2013 the average age at which children, especially girls, reach puberty is lower compared to the 19th century, when it was 15 for girls and 16 for boys This can be due to any number of factors, including improved nutrition resulting in rapid body growth, increased weight and fat deposition, or exposure to endocrine disruptors such as xenoestrogens, which can at times be due to food consumption or other environmental factor.

The age at which puberty begins varies between individuals; usually, puberty begins between 10 and 13 years of age. The age at which puberty begins is affected by both genetic factors and by environmental factors such as nutritional state and social circumstance. An example of social circumstances is the Vandenberg effect; a juvenile female who has significant interaction with adult males will enter puberty earlier than juvenile females who are not socially overexposed to adult male. Research in the USA has also shown an association between family breakdown and earlier puberty.

Therefore, education and preventative services need to ensure they are age appropriate reflecting the trend in earlier puberty.

The rate of sexually transmitted infections has more than doubled among middle-aged adults and the elderly over the last decade, although numbers remain low in absolute terms.

There are a number of possible reasons. The increased popularity of erectile dysfunction drugs that have made sex possible for millions of aging men. The determination of baby boomers, who ushered in the sexual revolution, to stay sexually active as they age. The low rate of condom use among older couples, who no longer worry about pregnancy and may not think they are at risk for STI's.

The contribution of any or all of these factors to the rising STI rate in this age group is not clear, as to date little research has been conducted.

In its 2010 report "Sex, Romance, and Relationships," the AARP surveyed a nationally representative sample of middle-aged and older people about their sex lives in the USA.

Among the major findings:

- Close to 3 out of 10 respondents (28%) said they had sex at least once a week, including almost half of those who were single but dating or engaged, and 36% of those who were married.
- Eighty-five percent of men and 61% of women said sex was important to their quality of life.
- Just 12% of single men who were dating and 32% of single women who were dating reported always using condoms during sex.

The dramatic increase in the use of ED drugs since their introduction in 1998 has coincided with the rise in STI's among older people. Most research to date evaluating the association between ED drugs and STI's has focused on non-prescription / recreational use and has shown increased sexual risk taking and STI rates.

In a 2010 study, Anupam B. Jena, MD, PhD, and colleagues from Massachusetts General Hospital and Harvard Medical School examined the impact of prescribing erectile dysfunction (ED) drugs on the rising STI rate in the elderly. This study found that those receiving ED drugs are more likely to have an STI than those who do not use ED drugs.

Thus education, awareness and treatment services must recognise and respond to the increasing risk to both the young and old of the impact of poor sexual health, including those on erectile dysfunction drugs either prescribed or recreational.

### 8.4 Sexual Violence

A full sexual violence needs assessment was published in 2012 and informed priorities for community safety and the commissioning of sexual assault health services. Significant work has been undertaken in encouraging reporting of sexual assaults in Blackpool, particularly on males.

Police include sexual activity involving children under 16, sexual assaults, rapes, exposure, voyeurism and grooming as sexual offences. They record this by Division, which is wider than Blackpool. The SARC records forensic requests by old PCT area. Key changes in need since the 2012 assessment was published include:

- The significant increase in the number of reported rapes, with a 22% increase in Western Division for the period April to September 2013, compared to the previous year. The increased numbers have been monitored over the last three years and are statistically significant. Sexual offences as a whole increased by 21.4%.
- Part of this increase is due to historic reporting (before 1990). This represents only 1.4% of the total.
- 48.2% of victims of sexual offences in Western Division are under 16 yrs.
- 8.2% have been recorded as domestic violence related.
- 21.8% are recorded as alcohol related (this is a reduction for 12 / 13 when the proportion stood at 26%)
- 10% of sexual assaults / rapes resulting in forensic examination by the Sexual Assault Referral Centre (SARC) based at Preston are for men.
- The number of forensic referrals to the SARC has not reflected the increase in the number of assaults reported by the Police.

Therefore, though significant work on awareness, pathways and prosecution for sexual assaults has been made, more needs to be done because of the long term impact of sexual violence on victims and their families. More analysis is required of the breakdown of sexual offences by area.

Blackpool does not have a prison within its boundary but does have a significant proportion of its population who have been in prison.

Sex (both coercive and consensual) is not allowed in prison but former prisoners and reform groups say it is widespread and mostly unprotected. The World Health Organization (WHO) says HIV and AIDS are serious problems for jail populations across Europe.

A 2006 joint report by the Penal Reform Trust and the National AIDS Trust said there was evidence that significant levels of HIV had been going undiagnosed in prisons. Therefore, the Howard League for prison reform has commissioned a 2 year study on the prevalence of sex in prison. The results from this research will provide the basis for further work on a Lancashire wide basis to promote good sexual health and reduce sexual violence in prisons.

### 8.5 Summary of Recommendations from the Needs Assessment

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

- Improve HIV testing in general settings, including testing for all medical admissions and all new registrations in general practice.
- Continue to work with the Medical Assessment Unit to increase HIV screening rates.
- Extend targeted testing to other groups vulnerable to higher-risk sexual behaviours i.e. substance users, sex workers and swingers.
- Ensure sexual health services understand and are able to meet the sexual health needs of older people.
- Ensure all services are aware of the particular needs of people from BME and people with a learning disability in terms of sexual health.
- Ensure services are accessible to a highly transient and deprived population – making use of advice lines, peripatetic services, outreach, social media and proactive marketing.
- Ensure that sexual health services are accessible via public transport.
- Provide comprehensive outreach to looked-after young people and to care homes etc.
- Review and promote policy on sexual health needs of children and young people looked after.
- Include information on local sexual health services in reviews of children and young people looked after as a matter of course
- Ensure health and sexual health needs of sex workers are given a high priority in developing sex workers strategy for Blackpool.
- Continue to use sexual health advice materials which are suitable for LGB+T young people and Blackpool specific.
- All sexual health services should consider routinely monitoring sexuality of clients in order to ensure services are meeting the needs of LGB+T.
- Staff in sexual health services to consider being trained or refreshed in OBI for alcohol.
- Sexual health to be included as an element of future alcohol related social marketing.
- Increase the number of eligible clients within the Drug and Alcohol Integrated Treatment System being referred for LARC.
- Target social marketing and outreach by all sexual health services to precede seasonal peaks in GUM attendance.
- Improve use of Blackpool sexual health hub website to market services.
- Improve the awareness of school-age children around locally available specialist contraception and advice services for young people.
- Review the pathway for support for people affected by sexual violence.

## 9. Summary of Commissioned Services

### 9.1 Details of Services

All commissioned services are within formal legal contracts or within service level agreements with Council directorates. These contracts include activity levels, finance, key performance indicators and quality indicators.

The main commissioned services are as follows:

**a) Specialist Clinical Services**

Specialist Sexual Health Treatment Services (Open Access Services)

- GUM / contraceptive services based at Whitegate Primary Care Centre
- Connect young people's service based on Talbot Road
- Blood borne virus team based at Whitegate Primary Care Centre
- Psychosexual counselling based at Whitegate Primary Care Centre

Specialist GP Services (Open Access – Implants, IUD's, STI screening)

- Waterloo (Central South)
- Gorton Street (Central North)
- North Shore (North)
- Stonyhill (South)
- Harris Medical Centre (Mereside)
- Adelaide Street (Central)

Termination of Pregnancy Providers

- Marie Stopes
- South Manchester Private Clinic

Vasectomy Services

- Specialist sexual health services at Whitegate
- Arnold Medical Centre

**b) Primary Care Services**

- 18 out of 21 GP practices providing IUD
- 15 out of 21 GP practices providing contraceptive implants
- 32 out of 43 Pharmacies providing Emergency Hormonal Contraception

**c) Non Clinical Outreach, Awareness and Behaviour Change Services**

- Renaissance Shiver (Adults)
  - Sex worker outreach
  - Venue assertive outreach
  - Counselling / CBT
  - Condom distribution (adults)
  - LGB+T community development work
  - HIV support services
  - Brief intervention training for frontline staff
  - Sexual violence advocates

- WISH (Children and Young People)
  - Assertive outreach
  - Condom distribution
  - Targeted PSHE / Aspiration courses in schools
  - Brief intervention training for frontline staff
  - 1 to 1 intervention programmes / CBT

**9.2 Performance Trends**

The majority of key performance indicators are being met, or exceeded, but the following trends are being seen:

**a) Specialist Clinical Services**

Since the integration of services at Whitegate Primary Care Centre non PbR contraception / BBV activity, funded through a block contract, is reducing in specialist services. PbR activity is increasing.

This has resulted in an increasing cost to the commissioner. The commissioners preferred response to the trend is to move to a tariff based system for all activity, i.e. provider is paid for what they deliver rather than continue with a mixed block and PbR contract. Work has been undertaken nationally to produce a set of 10 grouped tariffs and Blackpool is currently submitting the data in shadow form to understand the financial implications.

**GP Specialist Services**

These services are relatively new and it was anticipated that they would take time for word of mouth to encourage use of these services. These services are paid approximately 75% of the tariff for specialist sexual services, reflecting their target of screening lower risk people, less likely to access services at Whitegate.

The need to continually market these services is a joint responsibility of the commissioner and provider. These are a key element in the fight to reduce late diagnosis of HIV by normalising screening.

These services have been moved on to a tariff from a block contract.

**Termination of Pregnancy Providers**

These services are now well embedded in Blackpool and the emphasis is now on increasing rates of women receiving Chlamydia screening, HIV screening and Long Acting Reversible Contraception to reduce repeat terminations.

**Vasectomy Services**

Community based services are more cost effective than hospital procedures. The number of procedures across both community and hospital has fallen.

**b) Primary Care Services**

The emphasis over the past five years has been on training primary care practitioners to provide IUD's, contraceptive implants and pharmacy EHC. Provision is now moving towards universal coverage. This ensures choice, accessibility and best use of specialist services to support those with the most complex needs.

**c) Non Clinical Sexual Health Services**

It is difficult to prove cause and effect in non clinical services**,** but these services are based on evidence of effectiveness from international research. These are the core preventative sexual health

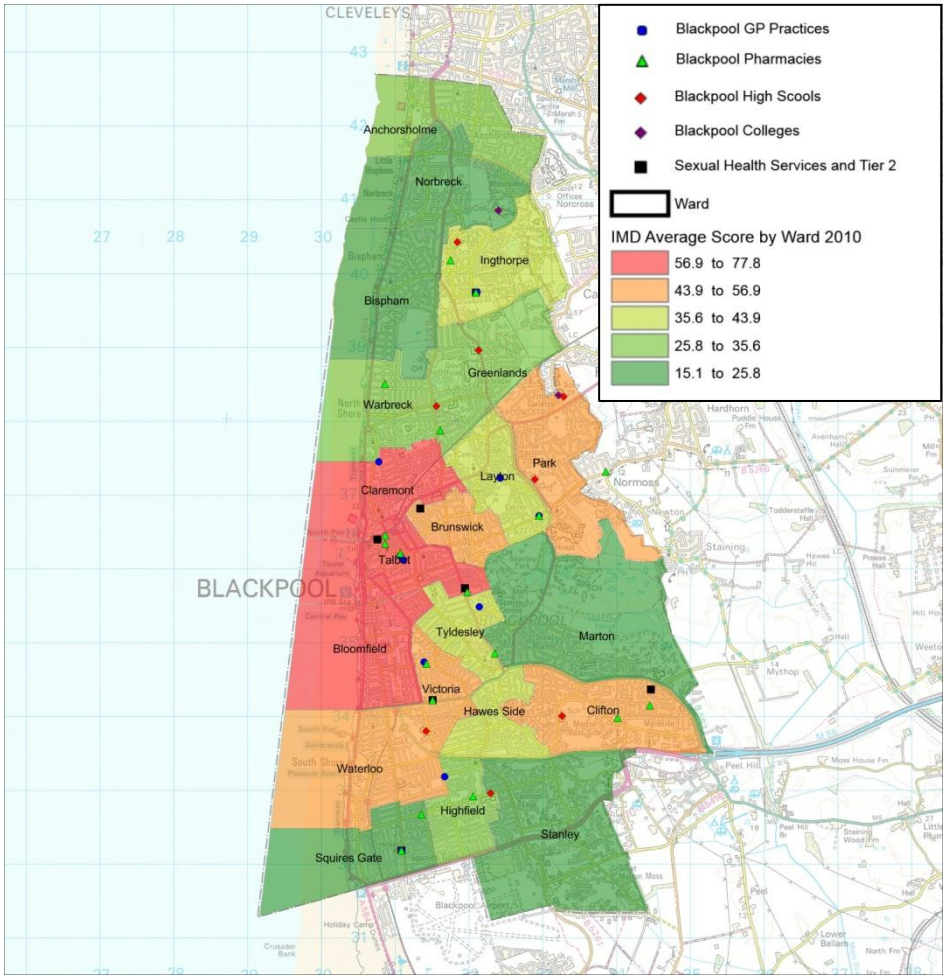
promotion services, targeting groups at highest risk of poor sexual health. Investment in this key area needs to increase over time funded from savings in clinical treatment services.

Procurement rules mean that the services should be re-tendered every three years to ensure best value. It is planned to tender specialist sexual health treatment in 2015 / 16, together with Lancashire County Council, Blackburn with Darwen Council and NHS England Specialist Commissioning.

**9.3 Distribution of Services**

The majority of women and a large proportion of men will need to access sexual health services at some point in their life. There is a direct correlation between disadvantage and poor sexual health indicators. The following identifies the major service delivery points for sexual health clinical interventions in Blackpool mapped against deprivation as an indicator of need. Local schools have also been mapped.

**Clinical Sexual Health Delivery Points in Blackpool Mapped against Deprivation**




From this map, Blackpool now has good provision of clinical treatment services. The areas with high need and lower access are South Beach and Grange Park.

Services have been delivered in these areas historically but uptake was poor. Therefore, there is need to continue to consider innovative ways to target these areas.

## 10. Gaps Analysis

Consultation has taken place since the publication of the last action plan with young people, LGB+T groups, doctors and nurses, other professionals, volunteers, community representatives and Healthwatch. This is a list of their views on current provision.

| **Stop** |
|---|
| • Ongoing group support, need more on enabling strategies<br>• Stop the teachers referring, be able to self-refer to young people's services<br>• Sending out letter to parents regarding support (school policy for group work)<br>• Giving out the Realcare baby |
| **Start** |
| • Define the role of school nurses/practitioners and targeted youth workers in delivery of PSHE/SRE<br>• Undertake HIV screening as part of GP new patient checks<br>• Homeless health clinic to screen for HIV/Hep C<br>• Providing specialist support to support long term unemployed people living with HIV back into training and the workplace<br>• Counselling for self-esteem and trained CBT therapists<br>• Use of community pharmacy for BBV testing and Emergency Hormonal Contraception<br>• Actively market pharmacy services<br>• Train health visitors in post natal contraception<br>• Hep C testing for sex workers<br>• Evaluate sex education in schools, ensure lesson delivery and 1:1 work<br>• Ask the doctor sessions in LGB+T and straight venues<br>• Peer mentors in colleges and use of A level media students to better market websites<br>• Promotion of school nurses and their potential role in sexual health to young people<br>• Incentive scheme for LARC for high risk young women<br>• Establish a single point of access for support for those who have been affected by sexual violence |
| **Do More** |
| • Better links with benefits / welfare advice services for disability appeals<br>• Greater awareness of testing required for the general population<br>• Communication between outreach workers and mainstream sexual health workers needs to be improved<br>• Address sexual exploitation via education and frontline working<br>• More use of GP's for non-specialist work including HIV screening<br>• Examine street sex work and outreach to home sex workers<br>• Utilise volunteers to their full potential<br>• More education in schools including STI's and HIV<br>• More services and venue outreach testing including straight venues, libraries and job centres<br>• Sexual health screening in colleges<br>• Raffle / draw prizes for testing<br>• Improved links to children's centres, youthability hub, streetlife and hostels to promote sexual health<br>• Re-visit use of domiciliary contraceptive services to target those in greatest need<br>• Train frontline staff to 'sell' LARC and dispel myths<br>• Market targeted youth services and re-visit role and function to effectively intervene to reduce risk taking behaviour<br>• **Confidentiality of the support** |
| **Do Differently** |
| • Friends should be allowed into the young people's sessions<br>• Sessions should occur out of school environment<br>• Offer a drop-in after a young people's group session<br>• Use a computer for resources |

## 11. Sexual Health Action Plan

From the national framework, the Lancashire Sexual Health Network the local gaps analysis and patient feedback the following actions were identified as a priority for implementation by March 2015.

| Objectives | Action | Lead | Milestones Outcome | Milestones Date |
|---|---|---|---|---|
| **1. Build knowledge and resilience among young people** | | | | |
| Establish consistent PSHE/SRE in secondary schools and FE colleges | Agree the evidence for a consistent approach and incentivise it with schools | Claire Grant | Appointment of postholder | 31/03/14 |
| Ensure the needs of looked after children are a priority to promote their sexual health | Implement Healthy Care Home self-assessment toolkit in all care homes and promote training | Claire Grant | Establish minimum health entitlement and include it as a KPI in the contract | 30/09/14 |
| Ensure the needs of looked after children are a priority to promote their sexual health | Work with LAC nurse to improve uptake of LARC in young women who are sexually active | Claire Grant | Agree approach with LAC nurse | 31/07/14 |
| Ensure key professionals are appropriately trained and delivering agreed interventions | Identify core sexual health promotion delivered by youth workers and school nurses as part of the co-ordinated PSHE programme including group work. Ensure it is consistently delivered through monitoring | Donna Taylor / Pauline Wigglesworth | PSHE post is currently in the recruitment process.<br>Meeting booked with DT and SB to discuss the role of SNP's. Core programme agreed.<br>Identify any training needs for school nurses to deliver agreed PHSE message | 01/09/14 |
| Increase effectiveness of school nursing service and nurses to PRU | Identify, describe and performance manage the role of school nurses and health practitioners in relation to sexual health, substance misuse and self esteem | Donna Taylor | Pan Lancashire school nursing services currently in review to ensure delivery of the Universal core offer for school nursing regardless of settings for all children; mapping work to identify what level of offer addresses these issues (possible Universal PLUS) | 31/01/14 |

| Objectives | Action | Lead | Milestones Outcome | Milestones Date |
|---|---|---|---|---|
| Encourage healthy relationships | As part of PSHE, develop a programme to address pornography and to impact on young people | Pauline Wigglesworth | This has now been implemented into the RBT training programme and will be a core part of the PSHE programme to be developed | 01/09/14 |
| Implement Royal College of Physicians guidance | Ensure sexual health and alcohol harm reduction are jointly addressed | Judith Mills | Integration of harm reduction service specification as part of re-tendering | 31/03/14 |
| **2. Improve sexual health outcomes for young adults** | | | | |
| Ensure young people with a learning disability have positive sexual health awareness | Develop follow-on support for young people with moderate learning disabilities entering into college from special schools | Pauline Wigglesworth | Buzz bus attends college regularly and the transition post is now trained to advise and works closely with the Wish team. Complete | 30/09/13 |
| Ensure young people receive evidence based interventions | Review role of Hub/Wish/targeted youth work to ensure risk taking behaviour is reduced including outreach, lessons/group work in schools and 1:1 interventions | Pauline Wigglesworth | Develop an integrated delivery model with all staff trained across the team. Develop a set of PSHE KPI's that will record the number of interventions offered across the team | 31/03/14 |
| Ensure young people with a learning disability have positive sexual health awareness | Review sexual health literature to ensure it is accessible to young people with learning disabilities | Vicky Buddo | Nurse identified to lead upon collation and review of sexual health literature in relation to young people with learning disabilities. | 31/03/14 |
| Ensure young people receive evidence based interventions, including CBT | Undertake training needs analysis of Hub/Wish staff to ensure delivery of evidence based interventions | Pauline Wigglesworth / Zohra Dempsey / Claire Grant | Identify the most appropriate CBT qualification that will be offered to all staff | 31/03/14 |
| **3. All adults have access to high quality services and information** | | | | |
| Ensure value for money of service provision | PIN and tender specialist sexual health services | Judith Mills | Tender process complete | 31/03/15 |

| Objectives | Action | Lead | Milestones Outcome | Milestones Date |
|---|---|---|---|---|
| Ensure comprehensive availability of free EHC in all suitable pharmacies | Review access to the pharmacy EHC scheme by individual pharmacy and ensure training is available to deliver comprehensive coverage. Market the service | Helen Hindle / Zohra Dempsey | EHC training delivered to approx. 50 Pharmacists Sept 2013 and encouraged to deliver service. | 31/07/14 |
| Ensure EHC delivery is high quality | Establish a self-assessment and accredited process for community pharmacies delivering EHC | Zohra Dempsey | Self-assessment framework established and 'Declaration of Competence' can be provided by all community pharmacists delivering EHC | 31/03/14 |
| Ensure open access to sexual health clinical services | Implement full tariff for sexual health service clinical services | Judith Mills | Obtain Treasurers' approval across Lancashire to move to full tariff | 31/03/15 |
| Effectively market services | Ensure joined up use of technology including mobile channels, apps and texting, and digital channels, Facebook, Twitter and Google | Amy Ratcliffe | Service users are aware of and can access information through a variety of digital and mobile channels. Services communicate messages with each other to ensure joined up use of channels | Ongoing as technology develops |
| Effectively market services | Explore opportunities to use texting for parents of children starting SRE and through GP's to patients 18 - 24 yrs | Claire Grant / Zohra Dempsey | Pilot and adopt effective marketing techniques. | 31/03/15 |
| Based on needs assessment consider provision in areas with high need and low access | Review equity audit information from specialist sexual health services and geographical map to decide where outreach clinics may be provided | Vicky Buddo | Work taking place with the Consultant nurse regarding review of outreach provision | 31/03/14 |
| Increase proportion of LARC provided through GP practices | Ensure training in place, target those practices not currently delivering and performance manage | Judith Mills | Review uptake as part of practice contract review meetings | 31/03/14 |
| Improve access to clinical services | Explore use of domiciliary contraceptive services for high risk groups | Judith Mills / Vicky Buddo | Service specification to include domiciliary input | 31/03/14 |

| Objectives | Action | Lead | Milestones Outcome | Milestones Date |
|---|---|---|---|---|
| Improved awareness of practitioners | Improve communication and awareness between agencies through twice yearly events, to include children's centres | Zohra Dempsey | Well attended and positively evaluated events delivered. | 31/03/15 |
| **4. People remain healthy as they age** | | | | |
| Reduce social isolation of the ageing population living with HIV | Consider jointly funding a piece of research to determine current support methods and ways of improving them | Judith Mills / Val Raynor | Review commissioned | 31/03/14 |
| Support people living with HIV back into the workplace | Establish a pilot programme to support people living with HIV into secure employment | Vanda de Freitas/Nicky Dennison | Programme established.<br>Review uptake of the programme at quarterly contract review meetings<br>Review programme outcomes<br>Review numbers gaining employment<br>Review numbers in voluntary work<br>Review numbers accessing training/education | 31/03/14 |
| Ensure people living with HIV are not disadvantaged through disability appeals | Support people living with HIV where needed in the appeals process | Kath Talboys | Ensure supporting staff are appropriately welfare benefits trained.<br>Ensure beneficiaries in need are offered appropriate support from within the service and external resources.<br>Utilise dedicated HIV back to work support for those deemed able.<br>Promote HIV awareness training for decision makers | 31/03/14 |

| Objectives | Action | Lead | Milestones Outcome | Milestones Date |
|---|---|---|---|---|
| Increase uptake of vasectomy as an alternative to long term use of hormonal contraception | Review uptake of vasectomy services to inform marketing strategies or need to de-commission our provision | Judith Mills | Uptake reviewed and decision to market or de-commission | 31/03/14 |
| **5. Prioritise prevention** | | | | |
| Monitor impact of preventative initiatives | Repeat SHEU survey to monitor change in attitudes of young people | Zohra Dempsey | Results of survey used to monitor impact and inform future interventions. | 31/03/15 |
| Continue to review evidence to inform interventions | Review NATSAL research findings to monitor trends in sexual attitudes | Alan Shaw / Judith Mills | Attitude survey research findings reviewed | 31/12/13 |
| Target prevention at key groups to reduce the number of children in care | Ensure female partners of drug and alcohol treatment services receive LARC | Zohra Dempsey / Nicky Dennison | Robust mechanisms for LARC access developed and utilised.<br>Review KPI data and monitor number of clients offered LARC through contract review meetings.<br>Review number of clients in specialist pregnancy clinic and identify if clients were in treatment when they became pregnant | 31/07/14 |
| Target prevention at key groups | Consider an incentive scheme to promote LARC in chaotic drug and alcohol users | Zohra Dempsey | Incentive scheme investigated and if feasible, scheme developed and piloted. | 31/03/15 |
| Target prevention at key groups | Work with Children's Social Care to monitor the impact on the rate of children going into care | Zohra Dempsey | Baseline established and monitoring ongoing. | 31/03/14 |
| Reduce sexual violence by raising awareness | Establish a system for reporting anonymously incidents of sexual violence | Vicky Buddo / Kath Talboys | Aquamarine agreed reporting of intelligence. Work ongoing regarding a generic anonymous reporting form, discussed at the police force rape forum on 10/10/13; SAFE centre's form identified to be rolled out but awaiting merger of the police force divisions in April 2014 | 30/09/13 |

| Objectives | Action | Lead | Milestones Outcome | Milestones Date |
|---|---|---|---|---|
| Reduce unplanned second pregnancies | Train health visitors in post natal contraception | Cath Shelley | Training needs identified and training provided | 31/03/14 |
| Reduce poor sexual health outcomes related to alcohol misuse | Integrated provision of alcohol IBA within mainstream sexual health services | Zohra Dempsey | Relevant staff trained and alcohol IBA embedded within service provision. | 31/03/15 |
| Ensure coverage of clinical treatment services | Consider ways to successfully outreach in South Beach and Grange Park for the delivery of services | Vicky Buddo | Work taking place with the Consultant Nurse regarding review of outreach provision | 31/03/14 |
| **6. Reduce rates of sexually transmitted infections (STI's) among people of all ages** | | | | |
| Review evidence of need | Review the rise in STI's by age band | Zohra Dempsey | Data reviewed and target age groups identified. | 31/01/14 |
| Raise awareness | Develop a marketing plan to raise the awareness of safer sex in key age groups, particularly older people | Zohra Dempsey / Amy Ratcliffe | Marketing plan is complete with clear and measureable objectives and outcomes | 31/03/14 |
| Surveillance of STI incidence prevalence | Ensure all level 2 treatment services submit GUMCAD2 data to Public Health England | Zohra Dempsey | Ensure through contract review meetings | 31/03/14 |
| Screening for Chlamydia | Continue to performance manage screening within contracts | Judith Mills | Contract review meetings | Quarterly |
| Ensure accessibility of services | Ensure the delivery of STI screening in Connect and target localities | Zohra Dempsey / Vicky Buddo | STI screening delivered routinely. | 31/03/14 |
| Use social media to market safer sex messages | Use social media to promote early interventions, i.e. chat rooms | Kath Talboys | A minimum of weekly updates are provided to Twitter and Facebook.<br>All designated staff receive modern media training, inclusive of chat rooms / net reach approach.<br>A portfolio of modern media support is launched following the training | 30/09/13 |

| Objectives | Action | Lead | Milestones Outcome | Milestones Date |
|---|---|---|---|---|
| Market services and raise awareness | Consider novel approaches such as ask the Doctor outreach sessions in venues | Vicky Buddo | To be discussed with medical colleagues – scope when the website is revamped for virtual questions | 31/03/14 |
| Raise self-esteem in high risk groups | Ensure CBT is available for people with significant risk taking history | Kath Talboys / Vicky Buddo | Appropriate training is identified for designated staff.<br>Staff training in CBT is completed<br>CBT interventions are live in group and one to one settings across centre and outreach working | 31/03/14 |
| Ensure at risk groups have access to cost effective interventions | Monitor the increase in the number of sex workers in Blackpool. Expand targeted outreach to street sex workers and same sex clubs to promote safety | Kath Talboys | Assess demand for Assertive Outreach.<br>Affirm application of Sex Worker CJIT and Challenge of Change with Horizon Substance Misuse and Criminal Justice services.<br>Consider UKNSWP Sex Worker. | 31/03/15 |
| Ensure at risk groups have access to cost effective interventions | Develop Horizon key worker response to sex workers with 'street working' awareness / implications and exit strategies support | Kath Talboys | Key worker training in place | 30/09/14 |
| Reduce street sex work | Establish a behaviour change course for kerb crawlers to reduce repeat offenders "change course" | Dominic Blackburn | Pilot programme in place | 31/03/14 |
| **7. Reduce onward transmission of and avoidable deaths from HIV** | | | | |
| Reduce late diagnosis of HIV | Fully implement HIV testing in Acute Medical Unit of BTH | Dr Peter Flegg | Scheme re-launched. Roll out of HIV screening on AMU supported by the HIV specialist nurse | 30/09/13 |
| Increase screening for HIV in all groups | Performance manage HIV screening in GUM, TOP (abortion) services, AMU and tier 2 practices | Zohra Dempsey / Emily Grundy | Performance managing schedule in place with routine HIV screening delivered. | 31/03/14 |

| Objectives | Action | Lead | Milestones Outcome | Milestones Date |
|---|---|---|---|---|
| Standardise HIV care nationally | Implement the new national service specification and payment by results tariff | Roz Jones | New specification / PbR implemented | 31/03/15 |
| Increase HIV screening for high risk groups | Increase HIV screening and update the protocol of the homeless health team | Emily Grundy | Increased uptake of HIV screening within vulnerable groups including homeless | 30/06/14 |
| Work with NHS England to increase HIV screening in general practice | Reconsider HIV testing as part of new patients for GP's | Judith Mills | Review national research to inform re-consideration | 30/09/14 |
| Ensure access to mainstream health and social care | Develop health and social care pathways for HIV generic services including development of champions in social work and community matrons | Helen Hindle | Community Matron identified – waiting on organisational changes before Social Worker Champions can be identified. Pathway work commenced. KT to deliver training. | 31/03/14 |
| Normalise HIV screening | Based on the audit of the service, target POC / outreach testing at high risk venues, including swingers clubs | Kath Talboys / Vicky Buddo | Increase resource of 'insti' testing packs.<br>Refresh HIV testing focused materials (posters and drop cards).<br>Launch Blackpool specific Testing posters (RISK and DQ).<br>Extend testing to at least 3 new venues.<br>Sexual Health Services provide a complete service once a month for ¾ of the Sauna's Collaborative work between Sexual Health Services and Renaissance to undertake screening at high risk venues.<br>Roll out of HIV screening on AMU supported by the HIV specialist nurse | 31/03/14 |

| Objectives | Action | Lead | Milestones Outcome | Milestones Date |
|---|---|---|---|---|
| **8. Reduce unwanted pregnancies among all women of fertile age** | | | | |
| Encourage uptake of Long Acting Reversible Contraception | Lobby for national advertising of Nexplanon to increase its appeal | Judith Mills | Meet with marketing lead for pharmaceutical industry | 30/09/13 |
| Ensure low incidence of early removal of LARC | Audit early removal of implants in GP practices | Zohra Dempsey | Audit completed and data used to develop action plan to reduce the number of early removals if required | 31/03/14 |
| Ensure SHS providers are promoting Long Acting Reversible Contraception | Continue to performance manage uptake of LARC as preferred method of contraception through contracting processes | Judith Mills | Quarterly monitoring meeting | Quarterly |
| Support primary care to reduce unwanted pregnancies | Standardise reporting of sexual health interventions in primary care through computer templates | Zohra Dempsey | Clear reporting mechanisms in place | 30/09/14 |
| **9. Abortion** | | | | |
| Learn from serious incidents and complaints | Review problem referrals to identify any particular pathways that need to be put in place | Claire Grant | Each incident investigated and action plan agreed | 31/03/15 |
| Re-visit service specifications for abortion/TOP ready for 14/15 | Review impact of HIV screening | Claire Grant / Judith Mills | Review complete | 31/03/14 |
| Identify women / girls at risk of sexual exploitation | Ensure repeat abortions in young people and vulnerable adults are flagged for safeguarding consideration | Claire Grant | Audit complete. Flag with provider. Will be re-audited | 31/10/13 |
| Reduce rate of repeat abortions | Monitor repeat abortion rates and work with provider to identify risk factors to inform future targeting interventions | Claire Grant / Judith Mills | Risk factors identified by providers | 31/03/15 |
| **10. Continue to reduce the rate of under 16 and under 18 conceptions** | | | | |

| Objectives | Action | Lead | Milestones Outcome | Milestones Date |
|---|---|---|---|---|
| Improve targeted work | Review opportunity to better link Connect with the Hub and Wish to better target vulnerable young people | Pauline Wigglesworth / Vicky Buddo | Training has now been delivered to Connect staff with clear referral pathways in place. Ongoing referral data will be provided. KPI developed | 31/01/14 |
| Implement Teenage Pregnancy Strategy | TP Steering Group fully implements action plan | Claire Grant | Complete production of the new teenage pregnancy strategy | 31/03/14 |
| Reducing second pregnancies | Through the Family Nurse Partnership programme to address sexual health needs of young mothers to reduce subsequent teenage pregnancies | Carol Ann McElhone | To monitor uptake of Long Acting Reversible Contraception and reduction in second pregnancies within 12 months of young women on the Family Nurse Partnership programme | 31/03/15 |
| Improve targeted work | Consider using contraceptive patches for defined at risk girls / young women. Agree protocol and evaluate | Pauline Wigglesworth / Vicky Buddo | Consideration by all parties | 31/12/13 |
| Reduce the risks of sexual exploitation and violence | Education of frontline workers to raise awareness | Pauline Wigglesworth / Kath Talboys | SV information sessions to run quarterly.<br>Safe Space targeting LGBT SV to offer intelligence for better WF responding to the community.<br>CSE awareness training for YP in all group work and 1-1's. CSE training in place for the wider workforce.<br>Work on evidence based programme for low level sexually harmful behaviour being explored.<br>Conference to be planned and delivered | 31/10/14 |

| Objectives | Action | Lead | Milestones Outcome | Milestones Date |
|---|---|---|---|---|
| **11. Sexual Violence** | | | | |
| Reduce the incidence of sexual violence | As part of Respect and Enjoy, ensure awareness of staying safe in the night-time economy is highlighted | Judith Mills | Launch Respect & Enjoy | 29/11/13 |
| Ensure victims are supported to reduce long term impact | Review the pathway from Police / SARC to sexual violence support services including under 16's | Judith Mills / Nina Carter | Review complete with recommendations and bid to NHS E | 30/06/14 |
| Improve sexual health in prisons | Work with NHS England to consider how prisons can support people to promote sexual health and to remain safe | Judith Mills / Abby Jones | Publication of national research. Consideration of recommendations and findings | 31/03/15 |
| Improve the culture in relation to interpersonal relationships | Identify shortfall in knowledge of young people in relation to interpersonal relationships through a school quiz | Dominic Blackburn | Knowledge gaps identified | 30/09/14 |
| Improve the culture in relation to interpersonal relationships | Establish an educational campaign across all schools, including consent | Dominic Blackburn | Educational campaign agreed | 31/03/15 |
| Ensure people remain safe | Enhance current pilot systems for getting vulnerable people home within the night-time economy | Dominic Blackburn | Pathway in place, including door staff and safe haven bus | 31/03/15 |
| Effective services for children who may have been subjected to sexual violence | To mainstream the paediatric function within BTH examination service | Louisa Sharples | Include in mainstream contract | 30/11/14 |

## 12. Outcomes – How will we Measure Success?

Progress against a range of indicators has been described within the needs assessment.

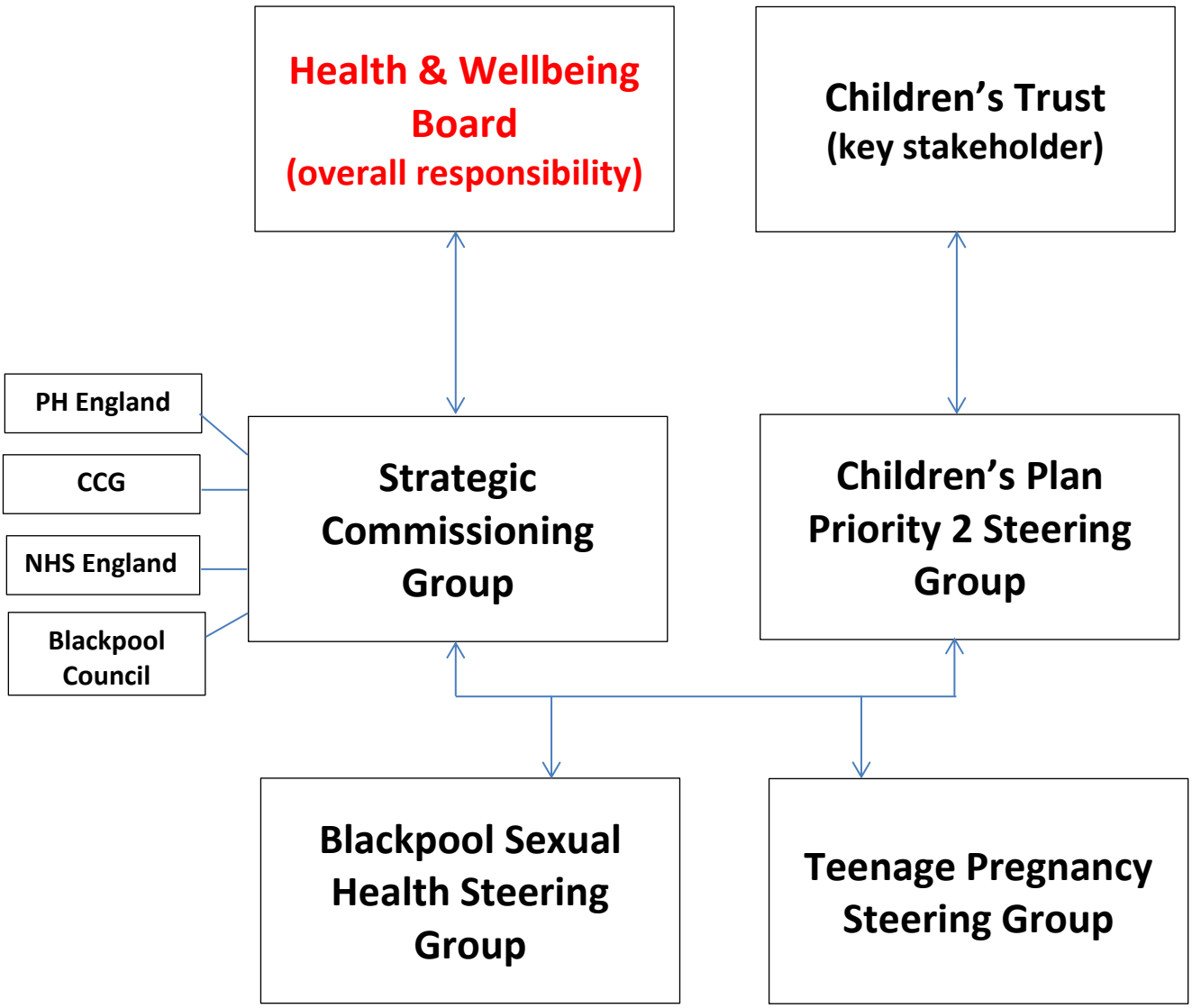
There are a number of high level indicators that summarise good sexual health or at least avoidance of sexual ill health.

The current position and a target for 2014/15 is outlined below:

| | **11 / 12 Current Position** | **14 / 15 Target** |
|---|---|---|
| HIV late diagnosis | 29.4% | 25% |
| Chlamydia diagnostic rate | 4147 per 100,000 women 15 - 24 yrs | 5096 per 100,000 women 15 - 24 yrs |
| TOP rate | 21.3 per 1,000 women 15 - 44 yrs | 18.5 per 1,000 women 15 - 44 yrs |
| Repeat TOP rate in under 25's | 24 per 1,000 women 15 – 24 yrs | 21 per 1,000 women 15 – 24 yrs |

## 13. Governance Arrangements

The following describes the governance structures for the implementation of the plan.




Sexual health is a priority for the Health and Wellbeing Board. The above outlines the governance arrangements for the implementation of the action plan. The Health and Wellbeing Board will hold overall responsibility, but the Children's Trust will be a key stakeholder.

Performance will be monitored strategically by the Health and Wellbeing Strategic Commissioning Group. Day to day monitoring will be through the Blackpool Sexual Health Steering Group with representation for all stakeholders.

**ANNEX A**

**Sexual Health Commissioning Responsibilities from April 2013**

| Local Authorities will | Clinical Commissioning | NHS England Commissioning |
|---|---|---|
| Comprehensive sexual health services, including:<br>• Contraception, including LES's (implants) and NES's (intrauterine contraception) including all prescribing costs – but excluding contraception provided as an additional service under the GP contract<br>• STI testing and treatment, Chlamydia testing as part of the National Chlamydia Screening Programme and HIV testing<br>• Sexual health aspects of psychosexual counselling<br>• Any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotional work, services in schools, colleges and pharmacies | Most abortion services (but there will be a further consultation about the best commissioning arrangements in the longer term)<br>sterilisation<br><br>Vasectomy<br><br>Non sexual health elements of psychosexual health services<br><br>Gynaecology, including any use of contraception for non-contraceptive purposes | Contraception provided as an additional service under the GP contract<br><br>HIV treatment and care, including post-exposure prophylaxis after sexual exposure<br><br>Promotion of opportunistic testing and treatment for STI's, and patient requested testing by GP's<br><br>Sexual Assault Referral Centres<br><br>Cervical screening<br><br>Specialist foetal medicine |

**ANNEX B**

**Extract from the regulations**

**Sexual health services**

**6.**—(1) Subject to paragraphs (4) and (5), each local authority shall provide, or shall make arrangements to secure the provision of, open access sexual health services in its area—

(a) by exercising the public health functions of the Secretary of State to make arrangements for contraceptive services under paragraph 8 of Schedule 1 to the Act (further provision about the Secretary of State and services); and

(b) by exercising the public health functions of local authorities pursuant to section 2B of the Act—

(i) for preventing the spread of sexually transmitted infections;

(ii) for treating, testing and caring for people with such infections; and

(iii) for notifying sexual partners of people with such infections.

(2) In paragraph (1), references to the provision of open access services shall be construed to mean services that are available for the benefit of all people present in the local authority's area.

(3) In exercising the functions in relation to the provision of contraceptive services under paragraph (1)(a), each local authority shall ensure that the following is made available—

(a) advice on, and reasonable access to, a broad range of contraceptive substances and appliances; and

(b) advice on preventing unintended pregnancy.

(4) The duty of the local authority under paragraph (1)(a) does not include a requirement to offer to any person services relating to a procedure for sterilisation or vasectomy, other than the giving of preliminary advice on the availability of those procedures as an appropriate method of contraception for the person concerned.

(5) The duty of the local authority under paragraph (1)(b) does not include a requirement to offer services for treating or caring for people infected with Human Immunodeficiency Virus.

**ANNEX C**

**Glossary of Terms**

| | |
|---|---|
| A & E | Accident & Emergency |
| AIDS | Acquired Immunodeficiency Syndrome |
| AMU | Acute Medical Unit |
| BASHH | British Association for Sexual Health and HIV |
| BBV | Blood Borne Virus |
| BHIVA | British HIV Association |
| CBT | Cognitive Behavioural Therapy |
| ED | Erectile Dysfunction |
| EHC | Emergency Hormonal Contraception |
| FE | Further Education |
| FSRH | Faculty of Sexual and Reproductive Healthcare |
| GUM | Genito Urinary Medicine |
| HAART | Highly Active Antiretroviral Therapy |
| HIV | Human Immunodeficiency Virus |
| IUD | Intrauterine Device |
| JSNA | Joint Strategic Needs Assessment |
| LAC | Looked After Children |
| LARC | Long Acting Reversible Contraception |
| LGB+T | Lesbian Gay Bisexual and Transgender |
| Medfash | Medical Foundation For HIV And Sexual Health |
| MSM | Men who have Sex with Men |
| NATSAL | National Survey of Sexual Attitudes and Lifestyles |
| NICE | National Institute for health and Care Excellence |
| OBI | Opportunistic Brief Interventions |
| PbR | Payment by Results |
| PEPSE | Post Exposure Prophylaxis for HIV following Sexual Exposure |
| PIN | Prior Information Notice |
| PNA | Pharmacy Needs Assessment |
| POC | Point Of Contact |
| PRU | Pupil Referral Unit |
| PSHE | Personal Social Health and Economic Education |
| SARC | Sexual Assault Referral Centre |
| 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 |
| TPSG | Teenage Pregnancy Steering Group |
| WHO | World Health Organisation |
| WISH | Wellbeing in Sexual Health |

**ANNEX D**

**Full Sexual Health Needs Assessment**

Sexual Health Rapid Needs Assesment 20:

**ANNEX E**

**Equality Analysis**

Equality Analysis
Record Form SH.doc