Blackpool Council

27 November 2018

To: All Members of the Health and Wellbeing Board

The above members are requested to attend the:

HEALTH AND WELLBEING BOARD

Wednesday, 5 December 2018 at 3.00 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 either a

(a) personal interest
(b) prejudicial interest
(c) disclosable pecuniary interest (DPI)

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 10 OCTOBER 2018 (Pages 1 - 6)

To agree the minutes of the last meeting held on 10 October 2018 as a true and correct record.

3 BLACKPOOL BETTER CARE FUND (Pages 7 - 12)

To provide the board with a mid-year update for the Better Care Fund (BCF) 2018/19.

4 SEXUAL HEALTH STRATEGY UPDATE (Pages 13 - 66)

To provide an update on the implementation of the Sexual Health Strategy and Action Plan objectives to improve poor sexual health in Blackpool and reduce sexual health inequalities.

5 PUBLIC MENTAL HEALTH ACTION PLAN 2016-19 UPDATE (Pages 67 - 96)

To provide an update on the progress made on delivering the actions of the Public Mental Health Action Plan 2016-19.

6 DATE OF NEXT MEETING

To note the date of next meeting as the 6 February 2019.

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 10 OCTOBER 2018

Present:

Councillor Cain, Cabinet Secretary (Resilient Communities) (in the Chair)
Councillor Cross, Cabinet Member for Adult Services and Health
Councillor Clapham, Conservative Group Member

Roy Fisher, Chairman, Blackpool Clinical Commissioning Group
David Bonson, Chief Executive Officer, Blackpool Clinical Commissioning Group

Wendy Swift, Chief Executive, Blackpool Teaching Hospitals NHS Foundation Trust

Dr Arif Rajpura, Director of Public Health, Blackpool Council
Karen Smith, Director of Adult Services, Blackpool Council

In Attendance:

Nicky Dennison, Senior Public Health Practitioner, Blackpool Council
John Hawkin, Chief Operating Officer, Blackpool Council
Bernadette Jarvis, Senior Democratic Governance Adviser
Darren Maddocks, Senior Accountant, Blackpool Council
Judith Mills, Consultant in Public Health, Blackpool Council

Apologies:

Dr Amanda Doyle, Chief Clinical Officer, Blackpool Clinical Commissioning Group
Diane Booth, Director of Children's Services, Blackpool Council
Dr Leanne Rudnick, GP Member, Blackpool Clinical Commissioning Group
Neil Jack, Chief Executive, Blackpool Council
Jayne Bentley, Better Care Fund Lead, Blackpool Council

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 MINUTES OF THE LAST MEETING HELD ON 20 JUNE 2018

The Board considered the minutes of the last meeting held on the 20 June 2018.

Resolved:

That the minutes of the meeting held on 20 June 2018 be approved and signed by the Chairman as a correct record.

3 BLACKPOOL BETTER CARE FUND UPDATE

Mr Maddocks, Senior Accountant, Blackpool Council presented the Board with an update on progress on the Better Care Fund 2018-19.

The Board noted that the Section 75 agreement between Blackpool Council and Blackpool Clinical Commissioning Group, had been refreshed in accordance with Better Care Fund requirements. The refreshed agreement had been considered by the Council's Legal Services and was currently awaiting final approval. Mr Maddocks referred the Board to the Integration and Better Care Fund Operating Guidance for 2017-19 and the Q1 Better Care Fund Reporting Template that had been attached as appendices to the report. The Board was also referred to the detailed Delayed Transfer of Care (DToC) information report and in particular the performance for the period April 2018 – July 2018, during which NHS had achieved target for three months out of four during the period and the Local Authority had moved significantly closer to achieving its target than in previous years.

The Board noted the increase in the pooled budget for 2018-19. It also noted that the Local Authority's contribution to the pooled budget was made up in part from the improved Better Care Fund (iBCF) which would end in 2019-20, thereby creating a budget pressure for 2020-21. The Board acknowledged the need to take a broader view across the Fylde Coast of the impact on service provision from the future loss of iBCF funding.

Resolved:

1. To note the update on the Blackpool Better Care Fund 2018-19.

2. To agree to receive a further update report on Blackpool Better Care Fund at the next meeting of the Health and Wellbeing Board.

4 PUBLIC HEALTH ANNUAL REPORT 2017

Prior to consideration of this item, the Chairman circulated to the Board a press release from the Council that provided details on the launch of a new mental health campaign, 'Get Vocal' that focussed on promoting ways in which individuals could improve their mental wellbeing. He emphasised the campaign's link to the issues outlined within the Public Health Annual Report 2017. The launch date had coincided with World Mental Health Day.

Dr Rajpura, Director of Public Health, Blackpool Council, presented the Public Health Annual Report 2017. He reported on the improvements in a number of key health indicators in the last 10 years which included a reduction in early deaths from heart disease, cancer, suicide and teenage pregnancies rates. He highlighted emerging challenges in relation to self-harm and drug and alcohol abuse. There had been an increase in drug related deaths over recent years and Dr Rajpura advised the Board on a number of initiatives being undertaken to reverse the current trend.

The Board was referred to Section 2 of the Report that provided a detailed analysis of the impact of housing on health indicators. The emerging picture from the analysis showed

that low cost housing accommodation was driving inward migration of less healthy and less educated members of the population and outward migration of healthier people. Dr Rajpura welcomed the Council's future Housing Strategy which would included a restructure of the current housing stock.

Following Dr Rajpura's report, the Board held a lengthy discussion on mental health provision and noted the rising rate of self-harm and suicides which was significantly above the national average. It also noted the new 'Get Vocal' campaign and acknowledged the need for the campaign message to be spread as widely as possible throughout the local community. The Board considered the issue timely and linked to the Public Health Annual Report 2017.

The Board acknowledged the need for further interventions in the local community to address mental health issues prior to crisis point and noted the increased pressure on partner organisations as a result of the current mental health service provision. Further pressures included the increased demands for mental health services from an ageing population. Board Members further discussed the need to fully understand the scale of the problem and the need to develop a comprehensive mental health pathway.

The Board also discussed the engagement of Lancashire Care Foundation Trust at a strategic level and in particular the attendance of its representatives at Health and Wellbeing Board meetings. It also noted the recent appointment of a Minister for Suicide Prevention. It agreed that a special meeting of the Health and Wellbeing Board would be arranged to discuss mental health provision, with a need to ensure representation from all partner organisations and in particular Lancashire Care Foundation Trust. It was also agreed that an invitation to the meeting would be forwarded to the Minister for Suicide Prevention.

Resolved:

1. To note the Public Health Annual Report 2017.

2. To endorse the report's headline statements namely:

    - To welcome the forthcoming Blackpool Housing Strategy and to note that the key to success would be to deliver all the actions identified within the strategy, at scale and pace.

    - To note that Blackpool Council had experienced amongst the highest budget cuts of authorities across the country and this had been especially challenging given the high levels of need and transience within the town. Although the Council had been very creative in managing these significant challenges, it was important now to recognise the need for future funding formulas to fully incorporate the high level of need and address the root causes of ill health locally.

3. To agree to hold a special meeting of the Health and Wellbeing Board to consider mental health provision and to invite the Minister for Suicide Prevention to the meeting.

5 GREEN AND BLUE INFRASTRUCTURE STRATEGY PRESENTATION

Mr Hawkin, Chief Operating Officer, Blackpool Council, presented the draft Green and Blue Infrastructure Strategy to the Board. He advised on the background for the development of the Strategy, its scope and key high level recommendations.

Mr Hawkin advised the Board that the scope of the Strategy included all green and blue open space both in public and private ownership and reported on the low tree canopy cover within Blackpool. Mr Hawkin reported on the health, environmental and economical benefits of improving the quality and provision of green and blue space and in encouraging the local community to utilise the space.

Ms Mills, Consultant in Public Health, Blackpool Council, presented the draft Action Plan for the Strategy. The intention was to deliver the Plan through a few flagship schemes and 1001 individual, neighbourhood and organisational actions. The Strategic Actions were presented which included the incorporation of green and blue infrastructure into the Town Strategy update and the Masterplans for the Leisure Quarter and Enterprise Zone. Ms Mills reported on several initiatives designed at encouraging residents and tourists to benefit from green and blue infrastructure and proposed actions for businesses and public sector organisations to encourage the adoption of innovative ways to introduce green and blue infrastructure into building developments and adopt part of the green and blue infrastructure public realm. In terms of street trees, Ms Mills highlighted the creation of a street tree planting plan to include key transport gateways to the town. Following the presentation the Board was asked to comment on the Strategy and Action Plan.

The Board noted Blackpool Council's duty to co-operate with other local authorities on housing developments that bordered both areas. The tension between the Council's Local Plan in terms of its requirement for housing supply was also acknowledged and Ms Mills reported on the intended actions to work alongside colleagues in the Council's planning department to incorporate green and blue infrastructure through planning processes. The Board acknowledged the importance of street tree planting and considered that the quality and the appropriateness of the trees used was key to success. The Board considered the importance of consultation with business leaders and schools and colleges. With regards to the 1001 actions in the draft strategy, it was suggested that consideration could be given to expanding the remit of the green team to include hospitals and mental health initiatives.

In terms of support from the Board for the emerging Strategy, Ms Mills highlighted the need to engage representatives from key organisations within the private and public sector and the Board suggested that it would be beneficial for further presentations to be delivered to partner organisations.

Resolved:

1. To request an update on progress on the draft Green and Blue Infrastructure Strategy 2018 to 2027 at its next meeting.

2. To recommend that partner organisations request a presentation on the draft

Green and Blue Infrastructure Strategy 2018 to 2027.

6 DATE OF THE NEXT MEETING

Resolved:

1. To note the date of the next meeting as 5 December 2018.

2. To note that it had been agreed to hold a special Board meeting to consider mental health service provision, with the date of the meeting to be confirmed.

Chairman

(The meeting ended at 4.45pm)

Any queries regarding these minutes, please contact:
Bernadette Jarvis, Senior Democratic Services Adviser
Tel: 01253 477212
E-mail: bernadette.jarvis@blackpool.gov.uk

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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	5 December 2018

BLACKPOOL BETTER CARE FUND

1.0 Purpose of the report:

1.1 To provide the board with a mid-year update for the Better Care Fund (BCF) 2018/19.

2.0 Recommendation(s):

2.1 To note the mid-year update contained in this report.

3.0 Reasons for recommendation(s):

3.1 The Better Care Fund pooled budget is a statutory requirement under the amended NHS Act 2006, including the requirement to submit quarterly reports in accordance with NHS England's policy framework.

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 Better Care Fund provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant (DFG) and funding paid directly to local government for adult social care services – the Improved Better Care Fund (IBCF).

5.2 The legal framework for the Fund derives from the amended NHS Act 2006 (s. 223GA), which requires that in each area the Clinical Commissioning Group(s) transfer minimum allocations into one or more pooled budgets, established under Section 75 of that Act.

5.3 The local Section 75 agreement between Blackpool Council and Blackpool Clinical Commissioning Group confirms that Blackpool Council is the Pooled Fund Manager and that the Pooled Fund Manager should prepare and submit to the Health and Wellbeing Board quarterly reports on income and expenditure relating to the Better Care Fund.

5.4 The schedule at Appendix 3a is a financial monitoring report of the Better Care Fund as at 30 September 2018 (i.e. quarter 2) that provides a forecast under and over spend position at an individual scheme level.

5.5 The Council has agreed to carry forward the forecast under spend of £249,000 into 2019-20 financial year so that the Better Care Fund schemes with time limited funding can be extended.

5.6 Of the total 16 Clinical Commissioning Group schemes, twelve are block contracts within the Blackpool Teaching Hospital community contract with no reported variance. Payment reform is high on the agenda so this will likely be reviewed in the not too distant future. From the remaining four schemes that are not block contracts the Clinical Commissioning Group is forecasting to be £17,000 overspent. This over performance relates to Richmond Fellowship. At the end of 2017-18 there were two patients at Windsor Road but there are now three patients. The Windsor Road part of the initial scheme total of £224,280 was based on a forecast of 2.5 patients for 2018/19.

5.7 By utilising the forecast under spend in 2018/19 alongside the recently announced additional funding for Adult Social Care[1] the Better Care Fund Schemes are fully funded to 31 March 2020.

1 https://www.gov.uk/government/publications/budget-2018-documents/budget-2018

5.8 There remains an underlying recurrent funding gap of around £4.2m as at 1 April 2020 if services are to be maintained at current levels.

5.9 Does the information submitted include any exempt information? No

5.10 **List of Appendices:**

Appendix 3a: Better Care Fund Budget Monitoring Report as at 30 September 2018

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 Fund is 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).

7.0 Human Resources considerations:

7.1 None.

8.0 Equalities considerations:

8.1 None.

9.0 Financial considerations:

9.1 As detailed in the report.

10.0 Risk management considerations:

10.1 None.

11.0 Ethical considerations:

11.1 None.

12.0 Internal/ External Consultation undertaken:

12.1 None.

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Appendix 3a – Better Care Fund Budget Monitoring Report as at 30 September 2018

Scheme no.	Scheme Name	Commissioner	2018/19 Budget (£)	2018-19 Forecast Expenidture	Variance to Budget (£)	Comments
1	Disabled Facilities Grant - Capital	Local Authority	2,135,766	2,135,766	0	
2	Phoenix Centre	Local Authority	437,267	441,167	3,900	Staffing - sickness/overtime
3	ARC - Incl Social Workers	Local Authority	1,596,288	1,615,788	19,500	Supplies & Services
4	Internal Homecare	Local Authority	2,681,287	2,598,487	(82,800)	Staff Vacancies
5	Vitaline (not 100%)	Local Authority	1,099,082	1,166,919	67,837	Telecare Equipment
6	Keats	Local Authority	228,743	229,643	900	
7	Extra Support	Local Authority	1,924,830	1,874,500	(50,330)	Staff Vacancies
8	Coopers Way	Local Authority	608,386	610,186	1,800	
9	Gloucester	Local Authority	244,518	261,418	16,900	Staffing - sickness/overtime
10	Primary MH Care	Local Authority	212,105	186,705	(25,400)	Staff Vacancies
11	Hospital Discharge Team	Local Authority	567,208	561,708	(5,500)	Staff Vacancies
12	MH Day services	Local Authority	226,498	220,598	(5,900)	Staff Vacancies
13	CHC Team	Local Authority	85,122	87,222	2,100	Staffing - sickness/overtime
14	Additional Social Workers - A&E,HDT, neighbourhoods	Local Authority	628,107	584,707	(43,400)	Staff Vacancies
15	6 Additional Social Work Posts	Local Authority	212,211	212,211	0	
16	Transitons	Local Authority	41,000	41,000	0	
17	Autism	Local Authority	97,000	97,000	0	
18	Homefirst Pilot	Local Authority	124,000	124,000	0	
19	Review of ASC	Local Authority	44,000	44,000	0	
20	Occupational Therapy	Local Authority	45,000	45,000	0	
21	Quality Assurance Team	Local Authority	308,875	249,375	(59,500)	Staff Vacancies
22	Contract Officer	Local Authority	70,000	70,000	0	
23	Adults Equipment	Local Authority	1,182,750	1,033,433	(149,317)	Partly Offsets Against Children's
24	Care & Repair Contract - BCH	Local Authority	169,524	169,524	0	
25	Spending Review Original iBCF	Local Authority	5,054,848	5,054,848	0	
26	Increase Rates -Additional iBCF - Spring 17 Budget	Local Authority	1,300,000	1,300,000	0	
27	Children's Equipment	Local Authority	101,900	161,937	60,037	Offsets Against Adults
28	Hub Manager	Local Authority	56,998	56,998	0	
29	Speech & language	Local Authority	45,598	45,598	0	
30	YOT	Local Authority	15,442	15,442	0	
31	Care Co-ordinator Manager	Local Authority	6,218	6,218	0	
32	Enhanced Primary Care and Care Homes	CCG	676,468	676,468	0	
33	Out of Hospital IV therapy service	CCG	257,968	257,968	0	
34	Frequent Callers	CCG	70,000	70,000	0	
35	Intermediate Care model	CCG	1,041,247	1,041,247	0	
36	Carers support workers/grants	CCG	125,000	125,000	0	
37	Rapid Response	CCG	473,805	473,805	0	
38	HD Team	CCG	133,179	133,179	0	
39	Hospital Aftercare service (existing)	CCG	38,000	38,000	(342)	A&E discharge
40	Extensive Care Service	CCG	1,200,000	1,200,000	0	
41	GP Plus NEL scheme	CCG	2,186,200	2,186,200	0	
42	Enhanced Support Discharge	CCG	346,774	346,774	0	
43	Speech & Language Therapy - BTH	CCG	458,751	458,751	0	
44	Richmond Fellowship	CCG	224,280	224,280	17,213	Payment for mental health at Hornby & Runcorn and Windsor Road.
45	Community End of Life Team	CCG	106,000	106,000	0	
46	Adult Beds	CCG	390,983	390,983	0	
47	Community Stroke and Neuro	CCG	83,000	83,000	0	
			29,362,225	**29,113,052**	**(232,302)**	

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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:	5 December 2018

SEXUAL HEALTH STRATEGY UPDATE

1.0 Purpose of the report:

1.1 To provide an update on the implementation of the Sexual Health Strategy and Action Plan objectives to improve poor sexual health in Blackpool and reduce sexual health inequalities.

2.0 Recommendation(s):

2.1 To note the update on the Sexual Health Strategy and Action Plan.

3.0 Reasons for recommendation(s):

3.1 The Sexual Health Strategy and Action Plan was approved by the Board on the 19 April 2017 and the purpose of the presentation is to update the Health and Wellbeing Board on the progress to date.

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 Council 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.

5.2 The Sexual Health Strategy and Action Plan 2017-20 approved on the 19 April 2017 (attached at Appendix 4a) aims to improve the sexual health of Blackpool's population by providing clear direction and focus for sexual health improvement. This was built on the recommendations of the sexual health needs assessment carried out in 2016 and follows national policy and guidance. The strategy 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

A presentation will be given to update the Board. The current strategy and action plan is also attached for information at Appendix 4a to this report.

5.3 Does the information submitted include any exempt information? No

5.4 List of Appendices

Appendix 4a: Sexual Health Action Plan (as approved on the 19 April 2017)

6.0 Legal considerations:

6.1 There are no legal considerations in relation to the implementation of the Sexual health strategy.

7.0 Human Resources considerations:

7.1 There are no Human Resources implications from the update.

8.0 Equalities considerations:

8.1 The aim of this strategy is to improve poor sexual health in Blackpool and reduce sexual health inequalities.

9.0 Financial considerations:

9.1 There are no financial considerations from the update.

10.0 Risk management considerations:

10.1 There are no risk management considerations.

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. Hence, the plan developed as part of this strategy was informed by a range of stakeholders to ensure that actions were taken to address the specific needs of the population.

13.0 Background papers:

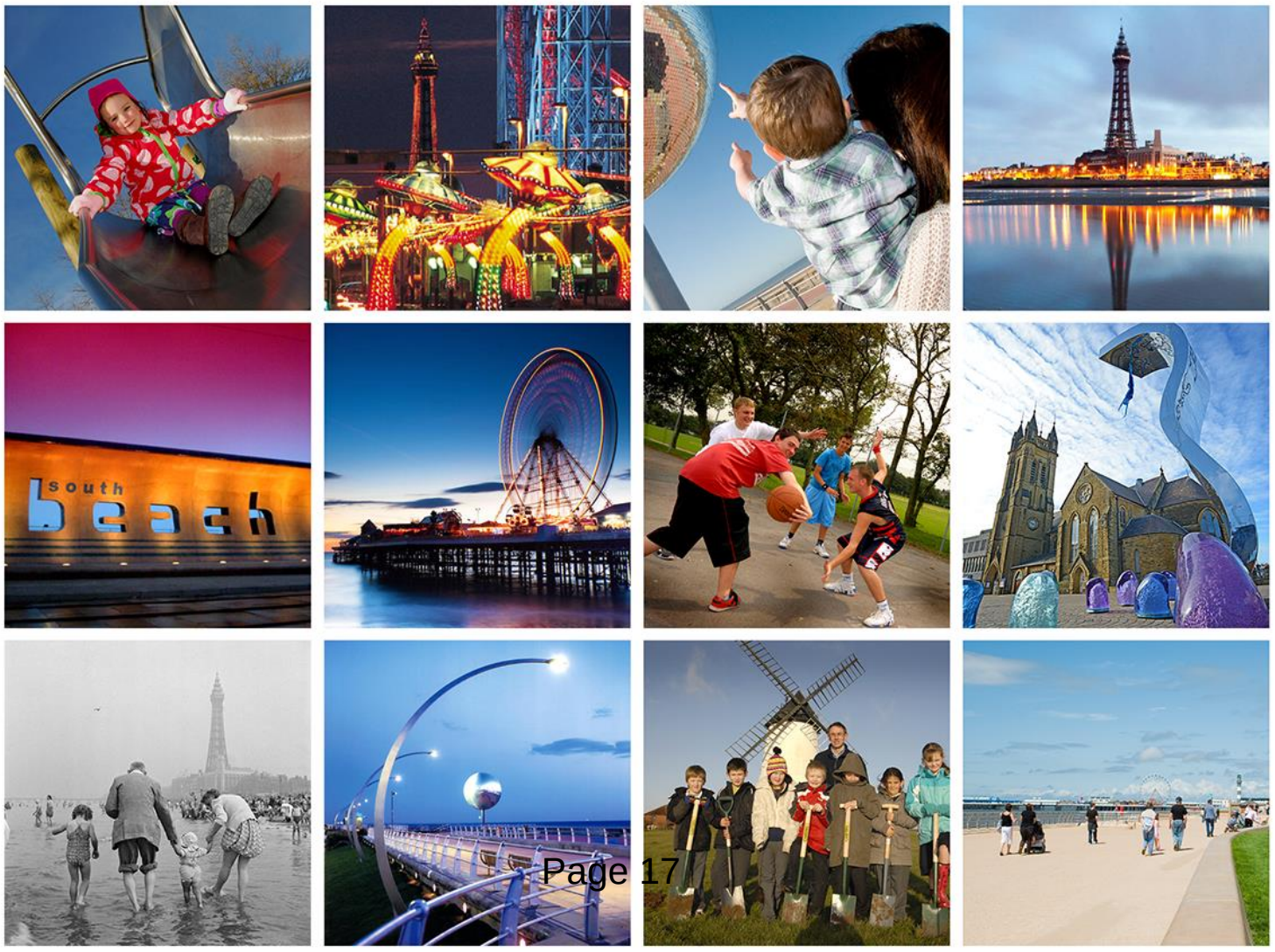
13.1 The Government set out its ambitions for improving sexual health in its publication, 'A Framework for Sexual Health Improvement in England'**. (Department of Health (2013). A Framework for Sexual Health Improvement in England. http://www.dh.gov.uk/health/2013/03/sex-health-framework/)**

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 guidance 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 4a

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

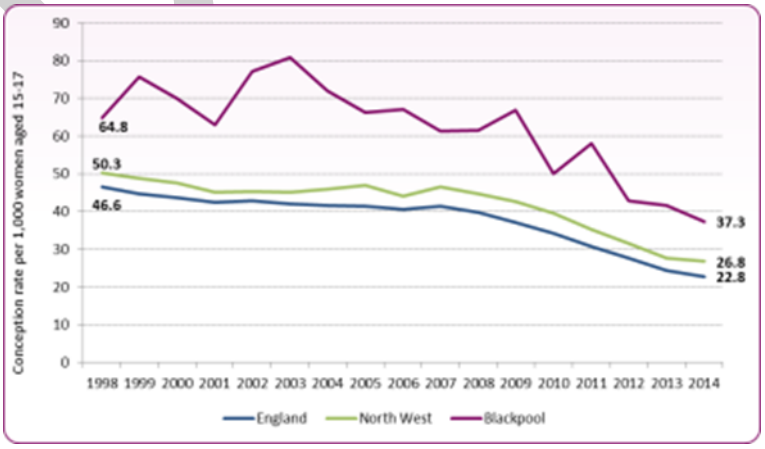
The following summary of need in Blackpool is taken from the Sexual Health Needs Assessment 2016. A more comprehensive breakdown on the data analysis can be accessed through Blackpool JSNA.

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.

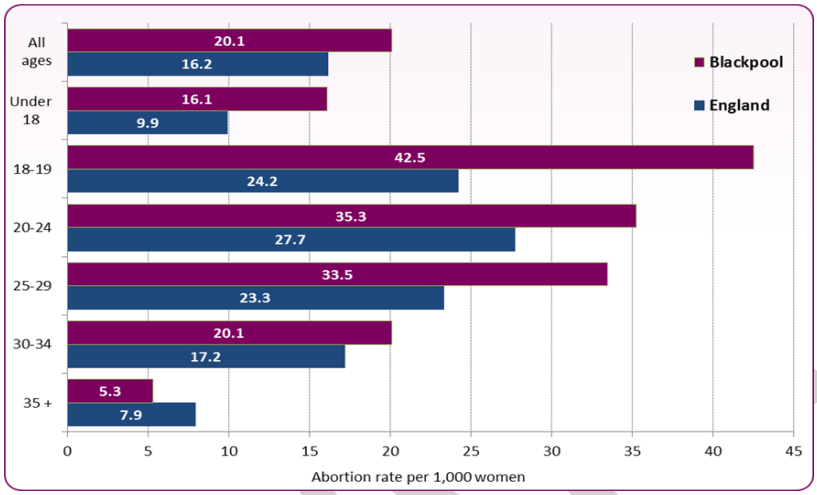
Figure 1: Trend in under 18 conceptions rate, 1998 to 2014



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:

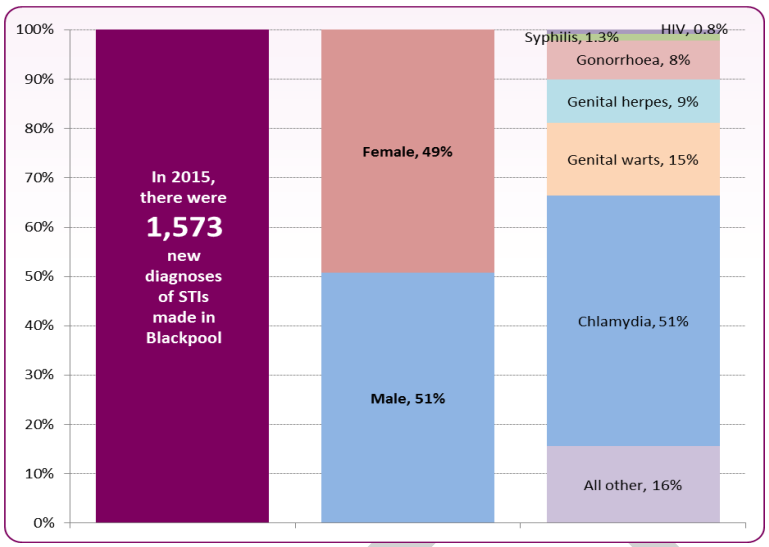
- Burden of ill health is predominantly in under 25s, so this is the focus for intervention;
- Overall, diagnoses of all new STIs have fallen slightly from 2014. The number of people diagnosed in Blackpool has fallen from 1,607 in 2014 to 1,573 in 2015 and the diagnosis rate has fallen from 1144 per 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

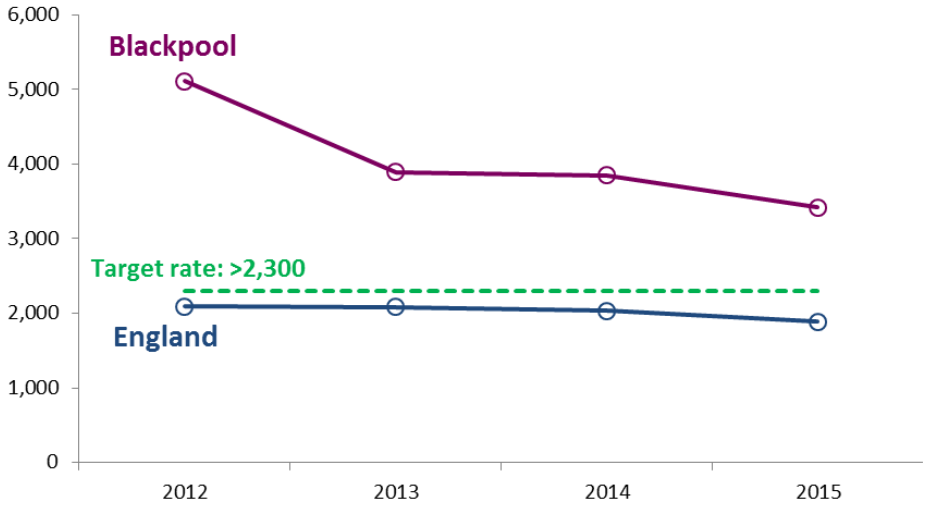
4.3 National Chlamydia Screening Programme (NCMP) ages 15-24

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.

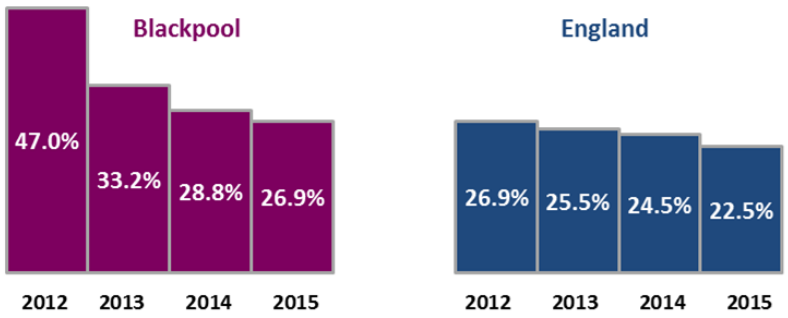
Figure 4: Chlamydia detection rates 2012 -2015



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

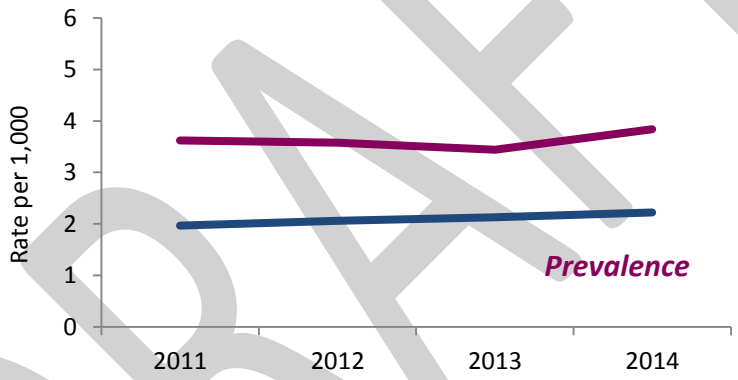
What we found:

- 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

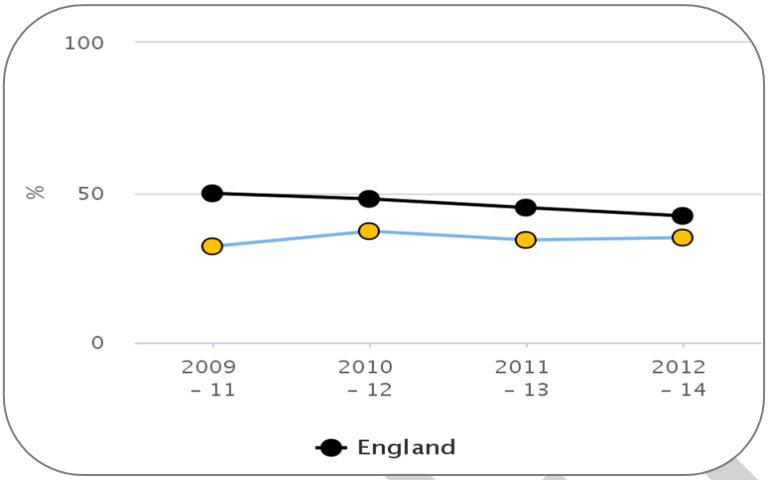
In the UK, a number of people are diagnosed at a late stage of HIV infection - this is defined as having a CD4 count under 350 within three months of a diagnosis. People living with HIV can expect a near-normal life span if they are diagnosed promptly. People diagnosed with HIV late continue to have 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.

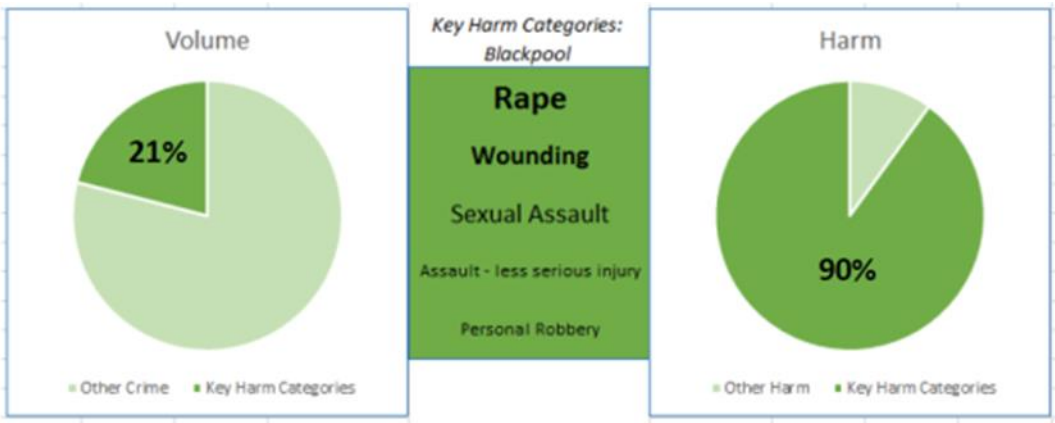
Overall, there is a correlation between sexual health and other key determinants of health and wellbeing, such as alcohol and drug misuse, mental health and violence (particularly violence against women and girls), contributing to a reduction in health inequalities.

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

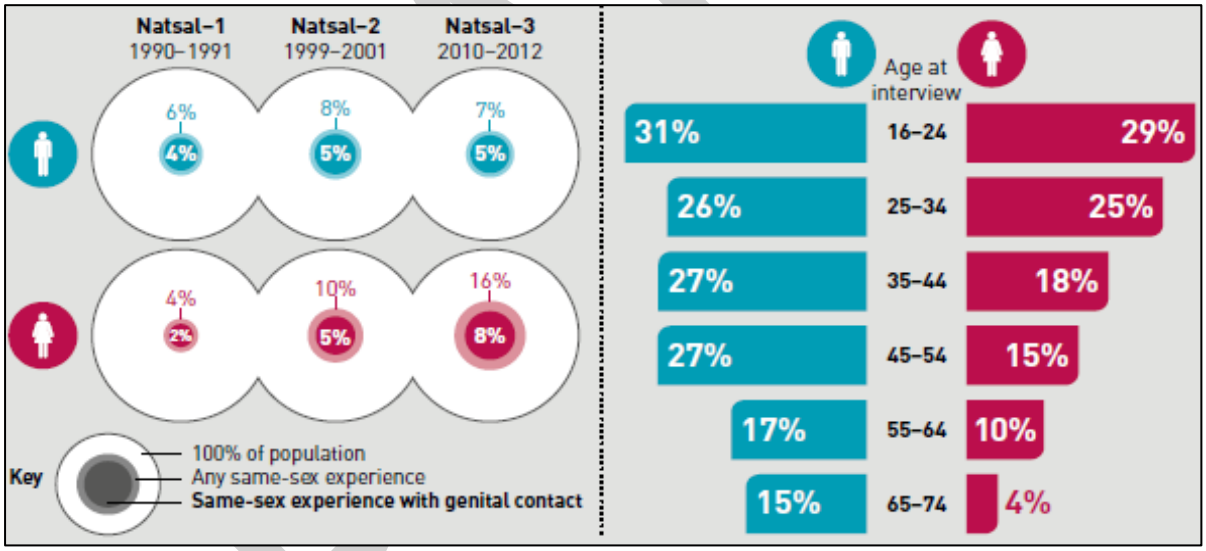
1990-1991 and the second survey in 1999-2001. The researchers interviewed 15,162 men and women aged 26–74 between September 2010 and August 2012.

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

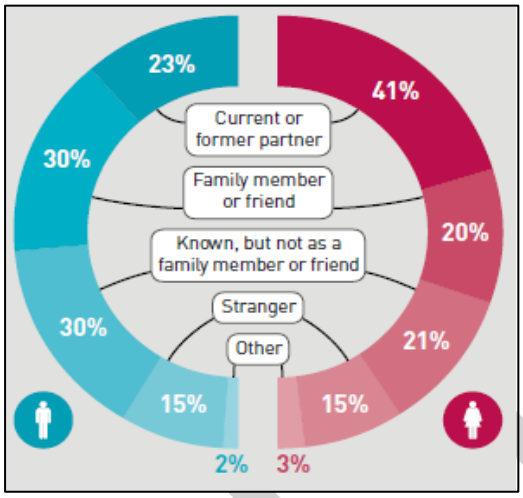
Percentage of the population who have ever had same-sex experience (people

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;

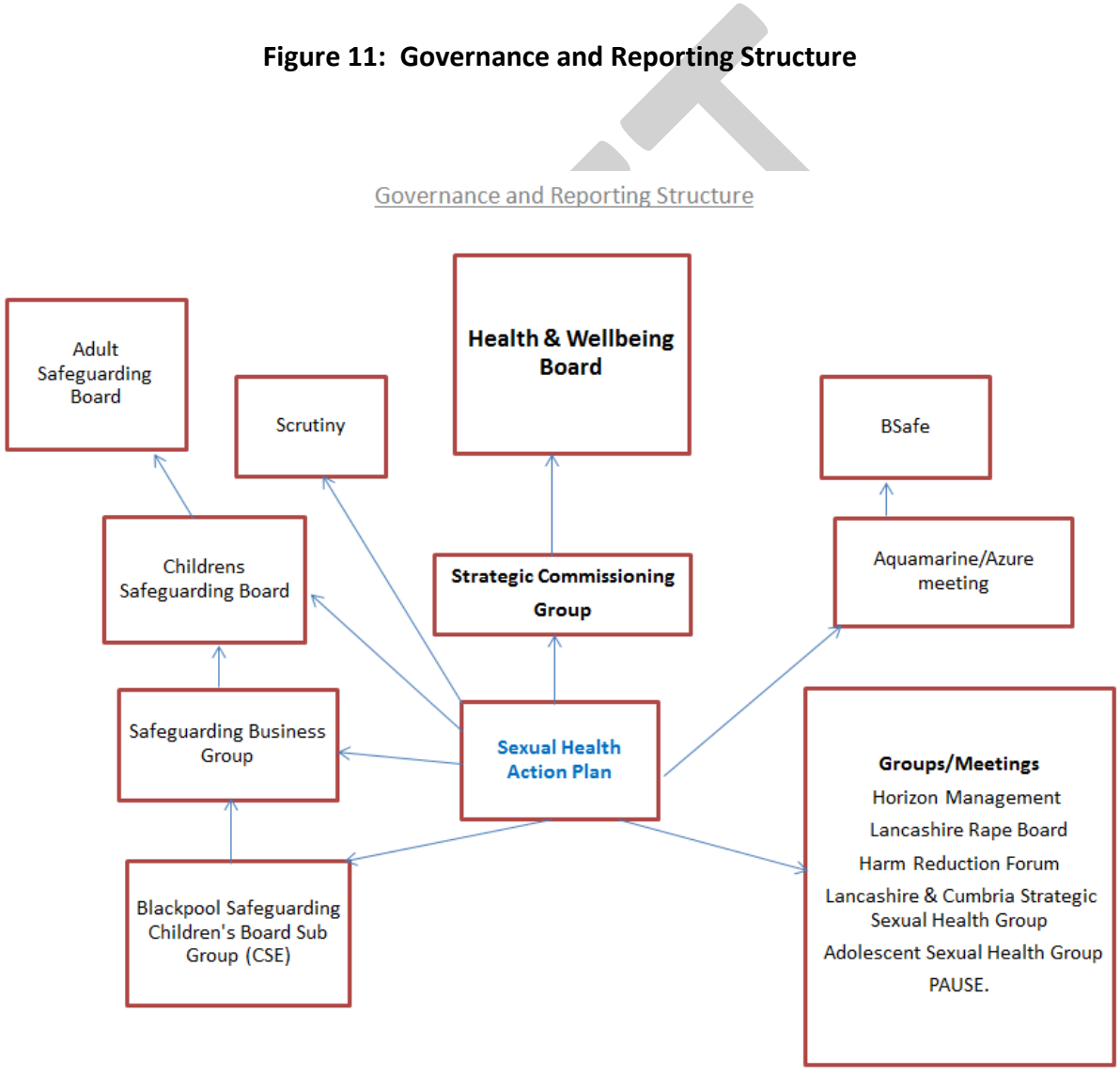
- Revisit SHEU survey to see what an impact this has had on young people's attitudes and knowledge of sexual health and services available;
- Audit of LARC methods still fitted at 12 months will be used as a baseline to monitor an increase in the number of women who maintain this method of contraception.

[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:	5 December 2018

PUBLIC MENTAL HEALTH ACTION PLAN 2016-19 UPDATE

1.0 Purpose of the report:

1.1 To provide an update on the progress made on delivering the actions of the Public Mental Health Action Plan 2016-19.

2.0 Recommendation(s):

2.1 To note the update on the Public Mental Health Action Plan.

2.2 To discuss future actions for mental health with a view to, if necessary, reporting back to the next Board meeting.

3.0 Reasons for recommendation(s):

3.1 The Public Mental Health Action Plan is due to expire in March 2019. An update on the actions is timely along with a discussion on the strategic direction of public mental health post-March 2019.

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 Public Mental Health Action Plan was approved by the Health and Wellbeing Board on 19 April 2017 and is attached at Appendix 5a. Promoting mental health and wellbeing is integral to any strategies to improve health and reduce health inequalities.The plan was underpinned by national policy and guidance. The actions were developed using data on local needs and evidence of what works to improve mental wellbeing. Four key priorities were therefore identified:

- 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.

A presentation will be given to update the board as to progress made. The current action plan is also attached for information at Appendix 5a to this report.

5.2 Does the information submitted include any exempt information? No

5.3 List of Appendices

Appendix 5a: Mental Health Action Plan (Approved by Health and Wellbeing Board 19 April 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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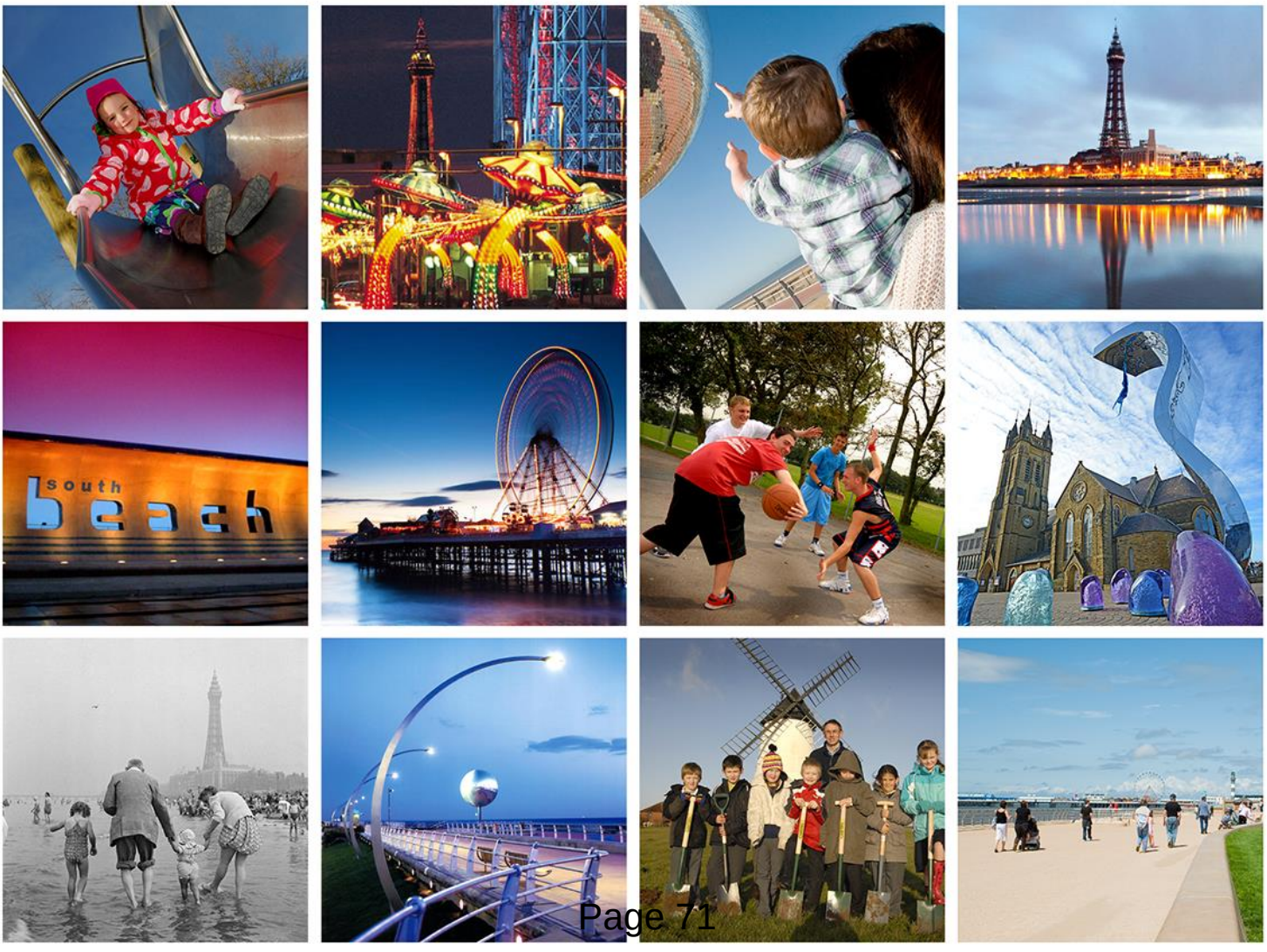
Appendix 5a

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.

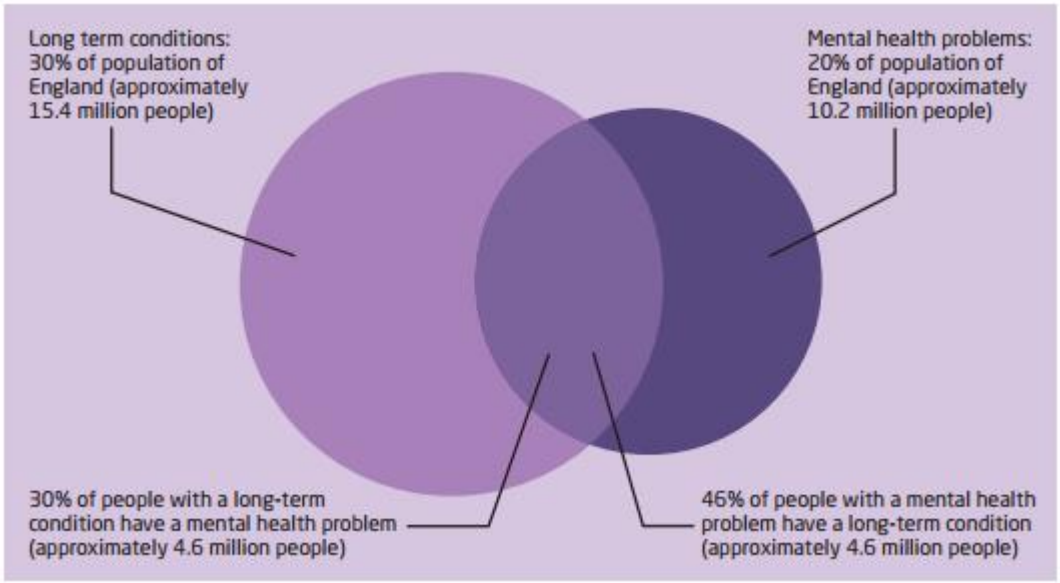
have found prevalence of around 60% in people with probable psychosis and up to 70% for people in psychiatric units.[26]

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]

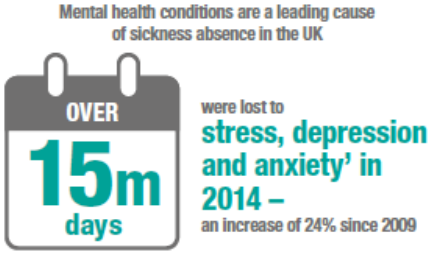
Lack of integration between mental health and physical health services can mean that the mental health of people living with long term conditions and the physical health of people living with a mental health condition are not adequately addressed.

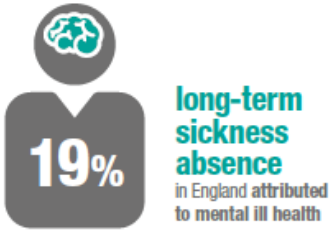
[31] Open Public Services Network (2015) https://www.ther sa.org/action-and-research/rsa-projects/public-services-and-communities-folder/mental-health/long-life.html

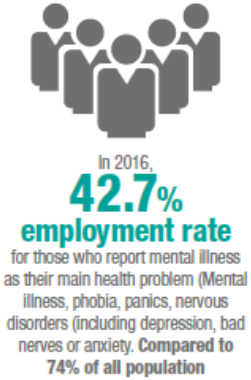
[32] World Health Organisation: Information Sheet: Premature death among people with severe mental disorders

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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