TORBAY Health & Wellbeing BOARD

Working together for a healthier Torbay

Wednesday, 11 September 2013

Meeting of the Health and Wellbeing Board

Thursday, 19 September 2013

3.00 pm

Meadfoot Room, Town Hall, Castle Circus, Torquay, TQ1 3DR

Members of the Board

Caroline Taylor, Torbay Council
Debbie Stark, Torbay Council
Sam Barrell, South Devon and Torbay Clinical Commissioning Group
Richard Williams, Torbay Council
Steve Moore, NHS England
Pat Harris, Healthwatch Torbay

Councillor Lewis
Councillor Scouler
Councillor Pritchard
Councillor Davies
Councillor Morey

For information relating to this meeting or to request a copy in another format or language please contact:

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TORBAY COUNCIL

NHS

HEALTH AND WELLBEING BOARD
AGENDA

1. Apologies
To receive any apologies for absence, including notifications of any changes to the membership of the Committee.

2. Minutes (Pages 1 - 4)
To confirm as a correct record the Minutes of the Health and Wellbeing Board held on 17 July 2013.

3. Declaration of interest

3(a) To receive declarations of non pecuniary interests in respect of items on this agenda

For reference: Having declared their non pecuniary interest Members may remain in the meeting and speak and, vote on the matter in question. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

3(b) To receive declarations of disclosable pecuniary interests in respect of items on this agenda

For reference: Where a Member has a disclosable pecuniary interest he/she must leave the meeting during consideration of the item. However, the Member may remain in the meeting to make representations, answer questions or give evidence if the public have a right to do so, but having done so the Member must then immediately leave the meeting, may not vote and must not improperly seek to influence the outcome of the matter. A completed disclosure of interests form should be returned to the Clerk before the conclusion of the meeting.

(**Please Note:** If Members and Officers wish to seek advice on any potential interests they may have, they should contact Governance Support or Legal Services prior to the meeting.)

4. Urgent items
To consider any other items that the Chairman/woman decides are urgent.

5. Update Report - Adult Social Services (Pages 5 - 8)
To receive an update on the current position of Adult Social Services.

6. Update Report - Clinical Commissioning Group (Pages 9 - 22)
To receive an update on the current position of the Clinical Commissioning Group.

7. Update Report - Public Health (Pages 23 - 25)
To receive an update on the current position of Public Health.

8. **Update Report - Healthwatch** (Pages 26 - 89)
To receive an update on the current position of Healthwatch.

9. **Update Report - Children's Services** (Pages 90 - 94)
To receive an update on the current position of Children's Services.

10. **Children and Young People Update - Health** (Pages 95 - 104)
To consider an update on progress being made in relation to the jointly agreed priority areas for children and young people.

11. **Collaboration without Duplication** (Pages 105 - 106)
To consider a report on the above.

12. **Winterbourne View Action Plan** (Pages 107 - 109)
To receive an update on progress being made in relation to the jointly agreed action plan for Winterbourne View.

13. **Joint Health and Wellbeing Strategy Priority 9 - Increase Sexual Health Screening** (Pages 110 - 161)
To discuss how the Health and Wellbeing Board can broaden and lengthen the whole community approach to aid an increase in sexual health screening.

14. **Joint Health and Wellbeing Strategy Priority 3 - Reduce Teenage Pregnancy** (Pages 162 - 169)
To discuss how the Health and Wellbeing Board can broaden and lengthen the whole community approach to the reduction of teenage pregnancy.

TORBAY Health & Wellbeing BOARD

Working together for a healthier Torbay

Minutes of the Health and Wellbeing Board

17 July 2013

-: Present :-

Councillor Chris Lewis (Chairman)

Debbie Stark, Richard Williams, Councillor Ken Pritchard, Councillor Bobbie Davies, Councillor Mike Morey, Pat Harris, Julie Foster and Steve Wallwork

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18. Apologies

Apologies for absence were received from Councillor Scouler, Steve Moore (NHS England), Caroline Taylor who was represented by Julie Foster, and Sam Barrell who was represented by Steve Wallwork.

19. Minutes

The Minutes of the meeting of the Health and Wellbeing Board held on 23 May 2013 were confirmed as a correct record subject to Councillor Davies attendance being recorded.

20. Urgent items

The Board considered the item in Minute 29, and not included on the agenda, the Chairman being of the opinion that the item was urgent by reason of special circumstances i.e. the matter having arisen since the agenda was prepared and it was unreasonable to delay a decision until the next meeting.

21. Update Report - Adult Social Services

The Board noted the update on Adult Services.

22. Update Report - Clinical Commissioning Group

Members noted the update from the Clinical Commissioning Group and were advised that the project to connect clinicians with e-Prescribing had received funding in the region of £3.1 million. Work on the project was already underway and would be concluded in two years.

23. Update Report - Public Health

The Board noted the update on Public Health and were advised that following the consideration of the Joint Health and Wellbeing Strategy – Priority 15 Improve Care for People Living with Dementia and their Carers an application was made to Public Health England for support from their System Leadership – Local Vision Programme in order to progress work around a 'Dementia Aware Torbay'. Over the summer officers will be working with Public Health England, Clinical Commissioning Group, Torbay Healthwatch and local people to develop a project plan.

24. Update Report - Healthwatch

Members noted the update from Healthwatch. Members attention was drawn to the need for better communication between partners as there was already evidence of duplication between stakeholders.

By consensus, Members agreed for Debbie Stark to raise with the Senior Leadership Team the issue of communication and duplication with stakeholders.

25. Update Report - Children's Services

The Board noted the update on Children's Services and the spike in referral activity. Members were advised that Torbay was not alone in an increase of referral activity with partners experiencing a similar issue.

Members were informed of work that had been undertaken to refocus and restructure the Children's Partnership Improvement Plan with emphasis being removed from early intervention to a more targeted approach.

26. The Preventative Community Project (Community HUB)

Members received an overview of the activities being undertaken by the Preventative Project/Community HUB pilot in the Hele and Watcombe communities. Members were advised that the original vision of Preventative Community Project was based upon the idea of a community preventative multi-agency team.

With the planned increase in health visiting numbers in Torbay the opportunity had arisen to develop a preventative community model in partnership with Children's Services that helps increase community capacity and social capital to ensure sustainable support from the community.

Resolved:

That the activities being undertaken by the Preventative Community Project/Community HUB pilot in the Hele and Watcombe communities be noted.

27. Adult Learning Disability Services (including Winterbourne View Action Plan)

The Board were provided with an update in respect of the implementation of the Winterbourne Action Plan. Following the Winterbourne View Hospital Serious Case Review the Department of Health published 'Concordat: Programme for Action'. The document was signed by many Health and Social Care agencies, committing to a programme of change to transform health and care services and to improve the quality of care offered to children, young people and adults with learning disabilities or autism, to ensure better outcomes for them.

Members were advised that the local Winterbourne View task and finish group met on 12 April 2013 following the publication of the Concordat, the group discussed the existing Winterbourne View action plan which was based upon interpretation of the Serious Case Review when it was first published, the action plan was refreshed to ensure that there was a real focus on the major issues outlined in the Concordat.

The Board noted that all Torbay clients currently placed in in-patient facilities have had their personalised care plan reviewed.

Resolved:

(i) That the report and recommendations for on-going monitoring and review be noted; and

(ii) that a further report regarding the assessment as to whether pooled budgets would support the pace of progress be presented to the Health and Wellbeing Board on 19 September 2013.

28. Joint Health and Wellbeing Strategy Priority 8 - Reduce Alcohol Consumption

As part of its agreed approach, the Board gave consideration to one of its priorities within the Joint Health and Wellbeing Strategy, namely Priority 8: Reduce Alcohol Consumption. Representatives from the Public Health Team and Healthwatch presented statistical analysis, research and details of work that was currently underway to address alcohol misuse.

Members of the Board then discussed how the Health and Wellbeing Board could "broaden and lengthen" the whole-community approach to the reduction of alcohol consumption. In particular, members were asked to pay particular attention to whether the actions within the Joint Health and Wellbeing Strategy were the right ones, what needed to change locally to meet the outcomes required by the Board, and what could the Board do to promote integrated working to support this priority.

Members were advised that there was an upward trend for alcohol consumption with alcohol being cheaper to purchase than in 1980 and the location of consumption of alcohol changing from licensed premises to people's homes. It is believed that the shift from consumption of alcohol in licensed premises to the home is the likely driver of the marked increase in alcohol morbidity and mortality amongst 'sensible' drinkers.

The measurement for alcohol reliance is subjective therefore statistical data is reliant upon hospital admittance. Over a period of three years Torbay registered 3,800 alcohol related admissions, 1,200 of these were alcohol specific admissions with 2,600 being alcohol related admissions such as trips and falls. Irresponsible drinkers are stereotypically portrayed as young people however analysis has shown that middle aged professionals who think they drink responsibly are the most irresponsible drinkers.

Members were advised that the Clinical Commissioning Group had developed a screening programme of healthchecks. A number of different organisations were trained to undertake the healthchecks including street wardens, street pastors and Job Centre Plus. Members suggested that the healthchecks target two particular wards, a deprived ward and an affluent ward to see if there is a correlation between alcohol consumption and deprivation.

Doug Anderson, ambassador for Healthwatch informed members of a new group called 'Torbay Recovery Information Project' (TRIP). TRIP was established by people in recovery who want to help others. Debbie Stark offered assistance and support from the Public Health Team.

The Board were advised that Health and Wellbeing Boards across the peninsula had the reduction of alcohol consumption as one of their priorities. Therefore it was suggested that a peninsula alliance be formed that would share work to address alcohol consumption across the peninsula. Members were requested to involve service users whenever possible.

29. Section 256 Social Care Funding for Health Benefit - Allocation and Monitoring

Members considered a report that sought the approval of the Health and Wellbeing Board on the allocation of Section 256 funding for projects within the financial year 2013/14.

Members were advised that under Section 256 of the NHS Act 2006, the Department of Health makes available, through NHS England, funding to support adult social care which also has a health benefit. NHS England provides flexibility for local areas to determine how this investment in social care services is best used.

Resolved:

That, taking account of Torbay's Joint Strategic Needs Assessment, the funding allocations, outcomes and monitoring arrangements in relation to Section 256 monies be agreed.

30. Information Pack

The information pack was noted.

Chairman

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Update Report Adult Services
Wards Affected:	All
To:	Health and Wellbeing Board **On:** 19 September 2013
Contact:	Caroline Taylor, Director Adult Social Services
Telephone:	01803 207116
Email:	caroline.taylor@torbay.gov.uk

1. Achievements since last meeting

1.1 The first quarter of the financial has indicated that the commissioning of adults services from TSDHCT has been progressing in line with the ASA. This continues to be a positive achievement given the demand pressures on the services for adults.

- Dialogue with care homes as providers of services continues to develop and a further development of the fees model in conjunction with the CCG is in process. Supporting People services will be reduced and there will be a provider meeting in early October for dialogue as to how local suppliers can re-shape their services and businesses as there will be reduced public money available over the next few years. Early consultation is taking place on the commissioning of domestic abuse services.

- The process of acquisition of TSDHCT continues with recommendations of the final business case following formal evaluation in June agreed at council on 18th July 2013, followed by NHS processes including TDA (Trust Development Agency)for final decision and determination.

- Shortlisted for lottery support to combat social isolation by working with voluntary sector- other bids for homelessness, rogue landlords and housing related support being pursued which if successful will support vulnerable adults.

- Potential development of health and care spin off businesses with NHS partners, academic science network and TDA(economic development)

- Community Services Engagement-joint work with CCG on rethinking future of community services in Torbay and South Devon. It will include adult social

care. Councillors will support the dialogue with the public in the Torbay local authority area.

- The pioneer bid to government to help support the transformation of health and social care for local people was submitted on time and has been shortlisted. This will be assessed in more detail in September with any likely announcement now being likely in October.

- Government set out its funding intentions in June for CSR. This means overall funding for local government will fall by £2.1 billion in 2015/16. The council will be reducing support for services and will be consulting key service users and stakeholders about its options for Mayor and Cllrs decisions.

- The £3.8 billion pooled budget for health and adult social care is being developed in more detail. The money will be called the 'Integration Transformation Fund' (ITF). It is expected that plans will develop this autumn with the CCG using the additional £200m 256 monies. There will need to be 2 years plans for 2014/15 and 2015/16 which must be in place by 2014.There is also an additional £200m to support the transformation process. Clarity is still being sought but the ITF fund will come from existing 256, carers break funding, CCG reablement funding, capital including DFG (disabled facilities grant) and transfer from health to social care. It is expected that £1bn will be performance related and ITF will have conditions which have yet to be agreed. HWBB Boards will sign off the plans.

- Adult social care services will need to develop its approach to Dilnot and self-funders which will drive new organisational demands and new processes for assessments will be required. Some of the new monies in the government announcements it is understood are for the costs of Dilnot year 1. Locally we will be modelling what this means to us from September. The London Authorities have undertaken some modelling and it indicates this may be a further cost pressure with the costs of the new system not being covered by new government monies.

- The reporting of adult care performance is being changed by government. The PIs are more helpful to what we wish to achieve locally. However it is a big system change including ICT changes. Government have provided some one off monies to support this.

- There is a requirement of a second self assessment exercise for the implementation of the adult autism strategy. This is being completed in collaboration with the CCG for the return date of 30 September 2013. The governance of the local autism board has yet to be determined.

- Jon Rouse the Director General for Social Care, Local government and Care Partnerships in the Dept of Health has asked to visit Torbay on 6 December 2013- arrangements will be put in place.

2. Challenges for the next three months

2.1 The need to focus on delivery whilst the acquisition process goes through its determination is a continued risk to our local system. This is mitigated through good local working relations across the health and care system and an emphasis on the focus on 'Mrs Smith' with shared vision and values.

- The action plan to improve our mental health services to CQC is still being implemented. Progress has been achieved through temporary posts which are in the process of permanent recruitment. Background work is being done to understand the implications of transferring the employment of Approved Mental Health Practitioners from Council to TSDHCT.

- The number of Safeguarding Adults referrals have increased again during July placing pressure on resources. A review of services will be carried out during September to develop options for sustainability if the increase continues.

- It has been proposed that a protocol between Torbay Safeguarding Adult Board and the Health and Wellbeing Board will be drafted in line with that produced for the Torbay Local Children Safeguarding Board for October 2013.

- It appears that winter pressures monies will be determined centrally with Torbay not receiving money to cope with its pressures. This is disappointing.

- Work to develop the pioneer bid and ensure whether successful or not we implement the changes we need locally and have a single set of plans and proposals

- Develop joint plans for the use of the ITF fund with CCG in readiness for April 2014 sign off

- Formal agreement of risk share with CCG and acquiring organisation as acquisition program

- Consulting services users and partners as we decommission or recommission some services

- Ensure the development of holistic review of accommodation based care and support, including care homes, Dom care, supported living, extra care housing is complete and procure new care and support provision based outcomes.

3. Action required by partners

3.1 Support to develop work for pioneer of health and care system as per Norman Lamb pilot within a single work programme for local government, CCG and providers reporting to HWBB and DCC Governance.

- Continued engagement of role of voluntary and community sector for joined up role of health and care in financially sustainable way. Specific work on lottery bid to combat social isolation

- Joint work on dialogue on the future of community services this autumn to shape our future configuration of services

- Develop joint plans for the use of the ITF fund with CCG in readiness for April 2014 sign off

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Update Report –South Devon and Torbay Clinical Commissioning Group
Wards Affected:	All
To:	Health and Wellbeing Board **On:** 19 September 2013
Contact:	Dr Sam Barrell, Chief Clinical Officer
Telephone:	01803 652 451
Email:	mollybishop@nhs.net (PA)

1. Achievements since last meeting

1.1 The CCG led a bid on the part of the whole South Devon and Torbay health and care community to become a Pioneer site for integration, under the scheme announced by Norman Lamb, Minister of State for Care and Support. From 111 submissions, South Devon and Torbay has now been shortlisted, and – at the time of writing – was due to take part in the second and final part of the process during September. Selection as a pioneer site would give us invaluable external support in further joining up the system to the benefit of our population.

1.2 In partnership with Devon Partnership NHS Trust, the CCG has been holding a series of engagement events on improving mental health services – a high priority in the CCG integrated plan. The latest listening and discussion event was held in Newton Abbot, building on the ideas put forward at earlier meetings. Early actions resulting from the engagement include plans for a Crisis House to be piloted in Torbay as an alternative to inpatient admission. Feedback from participants to these events has been extremely positive, and has helped us understand more about what people with experience of mental health problems are looking for in the way of better support.

1.3 From this month, we are starting a widespread engagement with communities across the CCG about the future of community services. This will be carried out at the level of the five localities into which the CCG is divided in order to keep commissioning of services really local and responsive to the particular needs of our different communities. We see this as an important opportunity to listen to people's concerns, expectations and priorities. The insights we gain will help us build an overarching strategy for community services in the years ahead. The engagement is being held, at least partly, in the context of the NHS Call to Action, which sets out the need for change in the NHS if a worrying shortfall in resource versus demand is to be avoided in the coming years.

2. Challenges for the next three months

2.1 Whether or not the South Devon and Torbay health and care community is successful in its bid for Pioneer status, there are important challenges as we work to integrate more fully. We will need to alleviate pressure experienced by all GP practices, as a first step towards integrating primary care with the wider community services, including mental health services. There is also much to be done in moving towards seven-day working in the parts of the system that need to meet demand outside the normal Monday to Friday hours.

2.2 Finance continues to present a challenge for the CCG, along with the rest of the public sector. In particular, we have been required to allocate an additional £4 million of our funding to specialised commissioning. This means the CCG is continuing to take a cautious approach to investment, at a time when it would otherwise aspire to set many new schemes in motion for improving services and ensuring equity of service and access for all in our CCG area.

3. Action required by partners

3.1 To note the contents of this update

Appendices: South Devon and Torbay – a bid for Pioneer status (attached)

Background Papers: None

Integrated care and support: a bid for pioneer status

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

National Voices
People shaping health and social care

South Devon and Torbay Clinical Commissioning Group
South Devon Healthcare NHS Foundation Trust
Torbay and Southern Devon Health and Care NHS Trust
Torbay Council
Devon Partnership NHS Trust

Supported by:

Devon Health and Wellbeing Board
Torbay Health and Wellbeing Board
Devon County Council
Rowcroft Hospice
South Devon and Torbay Strategic Public Involvement Group
Northern, Eastern and Western Devon Clinical Commissioning Group

This bid is submitted with the backing of our neighbouring Northern, Eastern and Western (NEW) Devon CCG.
As a pioneer, we would work closely with NEW Devon and our joint partners to extend the learning across a combined population of more than 1.2 million people, rapidly sharing and exchanging best practice and innovation to achieve integration at pace and scale.

TORBAY COUNCIL

NHS

> "With our local communities, we are resolved to make a major difference to the quality of life of our population, to break – permanently – the cycle of disadvantage which curtails the opportunities of one generation after another, to support people to be as well and independent and fulfilled as they can be, and to care with compassion when they cannot. To do this, we need to join up with each other to make our care seamless and put more power in the hands of those who need our care and support."

Introduction

We have a strong track record of collaboration across our whole area. The model of integrated health and social care in Torbay has won national and international recognition and brought many to our door seeking to learn from us. For several years, care has been viewed from the perspective of how it will be experienced by "Mrs Smith" and her family and carers. But we have only just begun, and our ambition for coordinated care is huge.

In the Torbay of the future, Mrs Smith or her daughter will make a single call for any health or care service. Her GP will be integrated into a community hub, where she can find not just health and social care but personalised support for her mental health and general wellbeing needs, too, all organised with her single named care coordinator. Thanks to information-sharing across all parts of the system, whenever Mrs Smith receives care for one condition it automatically and electronically triggers others that are needed, for support or prevention. Acute hospital interventions are included, but it's a long time since Mrs Smith has been to hospital; hand-held diagnostics come to her in her home, her GP can monitor her vital signs remotely and the last time she did need intravenous treatment she preferred to have it in her own bed. Together with her family and key health worker, Mrs Smith has planned her end of life care, and has chosen hospice care in her own home. For now, volunteers from the 'neighbourhood connector' scheme have made sure handrails are fitted in her home, and they help her with her much-loved garden.

But the Mrs Smith we know so well now has a grandson, Robert, who at 15 is living with his mother in a deprived ward in the market town of Newton Abbot. Robert has been struggling with his mental health, drinking alcohol and taking drugs at times, getting in trouble with the police and "failing" at school. He has been receiving support from the Child and Adolescent Mental Health Services but soon he will be 16, when normally he would lose all his familiar professional contacts as he moves into adult services. Robert isn't planning to stay at school but his work prospects aren't good. Recently, he has been self-harming. We will return to Robert in a moment…

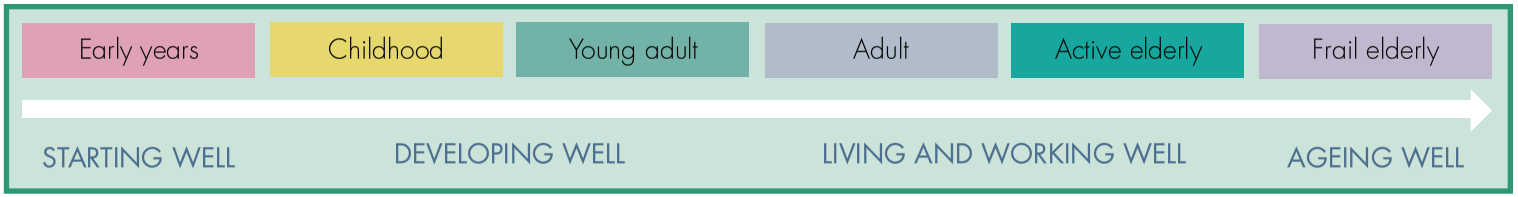
It is well known across England, and across South Devon, that the population is ageing. Today, nationally, 2.2% of the population is 85 or over. Torbay reached this 31 years ago. By 2021, the rate for England will be 2.9%, but 4.9% here.[1] For Mrs Smith, integrated health and care has delivered. Waits for physiotherapy have dropped from 8 weeks to 48 hours. Waits for occupational therapy have fallen from 2 weeks to 2 days, for urgent equipment from 4 weeks to 4 hours. Multiple calls were once needed to reach a social worker, district nurse, physio or OT; now it takes just one. Torbay Hospital has one of the lowest lengths of stay in the country, enabling acute hospital beds to be reduced from 750 to under 500. It has the lowest rate of emergency admissions in the South West.

But there are important challenges surrounding young people and families too. Numbers of children on protection plans or in 'looked-after' care in Torbay are among the highest in the country. Inequalities mean a 7-year life expectancy gap, 17 years more for some of expected ill-health, and a cost to our system of £150+ million. On Dartmoor we see rural isolation, with poor transport links and more difficult access to services. Suicide rates are falling in Torbay but those of self-harm are not. Housing problems for many are acute. There is much to do to reduce alcohol misuse.[2]

The challenge is this: the principles that enabled our integrated health and social care for adults to flourish must now be extended across the whole community. The seamless, multi-disciplinary working, the strong relationships, the culture of holistic care, the care coordinator, must all be offered too – across two local authorities – to our families with troubles and to our young people. To Robert.

In future, Robert won't lose his CAMHS support at his next birthday; his named key worker will be on hand and work closely with the community-hub-based GP and adult mental health services so that he can transfer smoothly. Robert will take control of planning his care, in a way that works for him. He now benefits from peer support, so he is learning ways to manage his emotions, complementing his psychological therapy from the all-age depression and anxiety service. Carer support for his mother is automatically triggered; this means help with her housing difficulties, too. Moreover, Robert is getting support to find a vocational course that he now thinks might interest him.

We are proud of our progress so far but we now need support as we tackle the rapid, whole-system transformation required to make our vision a reality. Pioneer status would give us vital expertise in change management, open access to international learning to guide a major system redesign, national support for pushing at the boundaries and for flexibility where that would ease the path for integration, and leverage for tackling very difficult issues head on. In return, we make a firm commitment to share our gains to help integration flourish across the country.



Introduction continued...

We believe in integration in South Devon and Torbay and will use it to make that "major difference" for our population, with excellent, joined-up care, now and in the future.

As a joined-up health and care community, South Devon and Torbay has left behind the disease-based and reactive model, with an agreed vision to focus on wellbeing, prevention, self-care and reablement, always striving for maximum independence – so that over their life course the people of South Devon and Torbay can start well, develop well, live and work well, age well and die well.

We see a reformed and vibrant primary care model integrated with the community in the widest sense – with the whole spectrum of health and care but also with the voluntary and community sector which can do so much to offer support for self-care and peer support and help get services right. At the centre is a smaller acute hospital offering leading-edge, highly specialist care – not when all else fails, but only when all else could never have succeeded.

To achieve this, we have innovative schemes running across the spectrum of this life course. You will find them at the village hall and in the district hospital, in the nursery and the care home. They are parts of the jigsaw we are putting together to create one picture – of seamless, joined-up care in which people won't fall through the gaps because the gaps will have been closed.

Shared values are the starting point for this. In January 2012, leaders of the whole health and care community launched the Joined Up Health and Care Cabinet, with the agreed commitment to deliver "High-quality, reliable and joined-up health and care which puts people first". Professional bonds are strong, a culture of drive and collaboration well established and common goals approved.

This will be where we drive the shift in emphasis and resources towards our young people and families, so that the patterns of lifelong reliance on care can be broken, wherever that's possible. This is a long-term plan; it is a sustainable service model leading to active and resilient communities being better able to support their older people.

The Cabinet itself is being re-shaped, with a voice for people using services. It is establishing a programme board and recruiting a project lead for delivering the transformation that Cabinet leaders have already mapped for years one to five, following the life course.

Starting well: early years

At the Joined Up Health and Care Cabinet we are lengthening and broadening our care pathways, to formalise prevention and early intervention and address inequalities through the 'Proportionate Universalism'[3] approach, with evidence-based action across all the social determinants. As disadvantage starts at birth and accumulates through life, the focus for integrated work in the early years is therefore on those with significant needs.

"We will drive the shift in emphasis towards our young people and families so that the patterns of life-long reliance on care can be broken."

Poor family skills lead to poor outcomes for children. Within the universal health visitor service in Torbay, the Family Health Partnership team delivers an intensive, evidence-based support programme to some of our most disadvantaged and vulnerable first-time young parents. Currently, 50-75 families are targeted; this needs to be extended.

With budgets taut and certain to remain so, we need to work to maximum effect with our communities, using an assets-based approach. The Watcombe/Hele Project aims to support the community to better meet its own needs, using its own strengths – guided by the Munro principle that "preventive services can do more to reduce abuse and neglect than reactive services."[4] Here, the 0-19 specialist community public health nursing team works alongside street wardens, community policing, education and the community group Hele's Angels in one of the most deprived areas of Torquay. Together, they address the issues the community itself identifies as priorities. Families with problems are identified earlier, safeguarding issues are spotted and flagged, and carers identified for support. Vital links with schools and housing providers have been strengthened. The pilot is already building community capacity – a mother starting a network group for families has asked that a health visitor offer regular support at drop-in sessions. If outcomes are good, we will build on this by rolling out the Watcombe/Hele Project to targeted communities across the whole area.

"The people helping me have been my lifesavers. I shall never, ever forget them."

Patient, alcohol service

Developing well: childhood and the young adult

To drive overall improvement in our children's services, we have reviewed our Child and Adolescent Mental Health Services (CAMHS) in Torbay and have agreed the outcomes we believe are needed to better meet the needs of children, young people and their families. We will now check these with people using the services. We want young people to get the support at their GP practice, which will have specialist oversight, training and professional leadership. Each cluster of GP practices and schools will have a dedicated primary care mental health worker, together with targeted screening, a seemless transition for young people to adult services, and a fast-track to the specialist service where needed, with a return to primary care after a time-limited intervention. Appropriate preventive programmes can be delivered in the classroom.

We will consider CAMHS provision in South Devon, to build on improving access, including to psychological therapies, providing excellent support for children in the care of the local authority and others with more complex needs. We also plan an all-age learning disability service in Torbay with lifelong support.

Self-harm is still largely a hidden problem. In Torbay we see a significantly high standardised rate for emergency admissions[5] for self-harm, but there are more who attend A&E but are not admitted – and likely to be more still who do not go to A&E. This comes at a significant cost to young people, families, employment, and health and social care – with an annual repetition rate of 15% and the risk of suicide 30-50% higher than in the general population. Our integrated public health response is improving public and professional awareness of the support available. We are developing consultation models for other frontline staff such as teachers, and putting in place peer support, time-limited intervention and care planning for young people like Robert, together with better access to psychological therapies.

KPIs:

- Reduce self-harm attendances by 10% a year
- Improve experience of people using the service by: to be agreed with service users.[6]

Excessive drinking and the associated rise in crime and violence has an impact across communities, within families, and on individuals. On national measures for alcohol admissions, Torbay scores significantly worse than average, including among the under 18s.[7] We have newly-redesigned integrated alcohol services, but

"We are extending our holistic alcohol service from Torbay into South Devon."

alongside these we invested in an intensive, holistic alcohol service for those with alcohol dependence and particularly high attendance at hospital, who often present with poor physical and/or mental health.

A targeted case worker works intensively with a small cohort, delivering a wide range of interventions including detox, referral to mental health or GP services, talking therapies and practical help with benefits or housing. This initiative was nominated for a national award for best service redesign with the best outcomes. The investment of just £40,000 was recouped in year one.

KPIs:

- Rate of increase of alcohol related hospital admissions: 0%
- Attainment of personal goals set with individuals for the outcomes they want
- Experience against National Voices measures

Many young people have disabled or ill adults relying on them for care. The Census 2011 indicates about 900 self-identified young carers in South Devon and Torbay but greater numbers are likely to be shouldering this responsibility.

Health and wellbeing checks for young carers are being further developed. In South Devon, they run alongside the current Common Assessment Framework for children. A model policy for closer working with schools is being tested so that more young carers are identified. In Torbay, a joint strategy for young carers under 25 (2012), developed with carers, represents a bold approach to developing joined-up support services for young carers and their families.

Our local authorities are also exploring the potential of 'social investment bonds' for early intervention for children. These are based on the commitment from Government to use a proportion of the savings from improved social outcomes to 'repay' the non-Government investors which fund these early intervention activities. An evidence-based financial model is being researched.

> "Quite a week for diabetes! It really feels like we have huge support at a senior management level to sort out diabetes in a way that we've talked about for ten years. Really exciting."
>
> Dr Robert Dyer, consultant in diabetes mellitus, Torbay Hospital, 2011

Living and working well – adults and the active elderly

The economy and opportunities for work are clearly critical, and we are all, as organisations, conscious of our duties as major employers to offer apprenticeships, work experience and training. We recognise, though, that economic hardships have an impact on health and wellbeing, which makes active support essential in these middle and later years.

Integration will be vital in actively managing long-term conditions. Our diabetes service is the model for our vision: an approach that identifies problems early in primary care and intervenes when there's the best possible chance of keeping people well, before they end up at the hospital door. It brings together consultants, specialist nurses and primary care in a community-based model founded on education.

The number of people with diabetes is increasing year on year in Southern Devon.[8] These patients are living longer, with more complications – factors that were leading to increasing referrals to secondary care. In our outreach model, primary care is seen as the base for all patients, with specialist services being made accessible as needed. Comprehensive guidelines are written by and for primary care staff. There is a strong joint formulary, and simple but cost-effective guidance on insulin prescribing.

Outcomes include a reduction in major amputations from 10.2/10,000 to 4.3, reduction in admissions for hypoglycemic emergency, low rates of diabetic retinopathy, a 50% reduction in admissions for heart attack and a rate of admissions for acute coronary syndromes now below the national average.

We will further integrate with end of life care, as this work has highlighted a one-year mortality in patients with high blood-sugar levels who have multiple hospital admissions.

This preventive/early intervention model will be extended next to chronic obstructive pulmonary disease, and then for each long-term condition area as appropriate.

An important factor in long-term conditions is the effect they may have on mental wellbeing. The close link between physical and emotional health is well established. As well as depression, medically unexplained symptoms (MUS) may be seen.[9]

We are developing more integrated primary, secondary, psychiatric, health psychology and psychological therapy service care pathways, so that people with MUS and significant psychiatric comorbidity are more likely to be identified and given appropriate psychological interventions and support.

KPIs:

- Reduce the numbers of frequent attenders to secondary care with MUS by >10%
- Experience against National Voices measures

Social care reablement in Devon has been highly successful in promoting independence for people who may otherwise have needed longer-term personal care at home. As at April 2013, results from the six-week interventions show:

- 79% needing no further assistance from the council in terms of care provision, with 71% of these still remaining unaided 18 months later
- 12% having ongoing personal care at home at a reduced level from the standard service level
- 9% needing ongoing personal care at home beyond the standard service level

We will develop enhanced services on this model in our South Devon area, and – working with the County Council – take the learning to our Torbay area.

In 2009 Devon County Council became a demonstrator site for health and wellbeing checks for carers, and has been blazing a trail ever since with its integrated approach with primary care, social care and the voluntary sector. The check is a carer-led consultation, covering all-important outcome areas such as safety and warmth at home, work, education, leisure and support needs and incorporating the carer assessment, formally delegated by the council to primary care. A modified form of this check has been adopted for use in the voluntary sector.

Devon Carers, the jointly-funded, jointly-commissioned carers' support service, was designed with carers and has won national recognition as providing quality services. Self-care is a priority in the CCG Integrated Plan. To build on our Co-Creating Health work, we are procuring an evidence-based self-care service that supports people to achieve their own goals.

"As a former PCT Board member in a different area I have been really struck by the considerably higher priority that is being given to mental health at the Governing Body of the CCG. I think this reflects the impact of having senior GPs at the table when commissioning decisions are made."

Nick Ball, non-executive director, South Devon and Torbay Clinical Commissioning Group

Ageing well and dying well – keeping frail, elderly people at home

If we are to help people stay in their own homes – wherever possible, for as long as possible and as far as possible until they die – then we need, among other things, to marshal and mobilise the support of the voluntary sector. We need to work more closely with the voluntary sector and with local communities themselves to develop further capacity to complement that of public sector services and to promote self-help and independence for people living at home.

In South Devon, 'village agents' and Neighbourhood Health Watch schemes are spreading, and in Torbay we are developing the concept of neighbourhood connectors, to work in every neighbourhood. They will help combat social isolation – the blight of old age – and enable older people (and families with particular vulnerabilities) to engage in a wide range of activities. The connectors will act as a bridge to any other services required. Torbay Council has recently endorsed and supported the creation of a Community Development Trust, bringing together community leadership and voluntary organisations to tackle some of the wider issues that local communities themselves identify. There is now an opportunity to add clinical leadership and support to this structure, both strategically, by commissioners, and operationally, by NHS providers working on a locality basis.

The corporate social responsibility resource of our local business and professional organisations also remains largely untapped.

The virtual ward helps keep people in their own homes through a holistic approach. Every GP practice in South Devon joins up with the inter-disciplinary health and care teams, and uses predictive modelling to identify patients at risk of admission. As they are actively case managed to reduce that risk, the wider support each person has available is also considered – be that family, neighbours, religious or spiritual support. If we don't know, we find out. Each patient has a dedicated case manager, an active care plan and details of these are visible on the out-of-hours system. Full data for virtual ward patients in 2011/12 showed a sizeable reduction in admissions for that cohort of patients – down by 25%.

"Our case manager is marvellous, caring, kind and helpful. She is knowledgeable and I am able to talk to her about any concerns. If I didn't have Angela, I would have no-one else to turn to."

We have been chosen by The King's Fund as a demonstrator site to study further the care coordination of people with complex needs. The virtual ward has changed the culture: an emergency admission for a person with a known long-term condition is seen as a failure.

Scale: For 2013/14 the CCG has increased its investment. The approach will be extended to a broader cohort of patients (the 5% most at risk, from the 0.5%), introducing integrated specialist input, for example through the use of virtual clinics.

In East Devon, Section 256 monies used by Devon County Council have brought about a successful hospital at home scheme, and we want to extend this to South Devon. Patients needing stepped up medical care can be admitted directly by their GP, or are discharged to their own home from community hospitals or the acute hospital, with continuing oversight from the care of the elderly consultant where appropriate. Hospital lengths of stay have been reduced, care is personalised and patient experience is exceptionally good. Doctors and families particularly welcome the scheme for people with dementia.

The overwhelming impact of dementia is not medical, but on a person's ability to function independently within their family, community and society. We are, therefore, supporting the spread of dementia-friendly communities as the absolute cornerstone of our response, signing up local businesses and others with the help of our volunteer dementia champions.

Working with people who use services, the two Devon CCGs and Devon County Council have developed a dementia care pathway which defines the supports available from pre-diagnosis to end of life. No-one in future will feel abandoned after diagnosis. Commissioned services are also undergoing dramatic redesign. In Torbay, the local memory clinic has been relocated to Torbay Hospital to serve as a 'one stop shop' for both diagnosis and post-diagnosis interventions, such as group therapy and the legal advice that's often much needed. Acute hospital psychiatric liaison services are being developed on the West Midlands RAID model to reduce inappropriate admission and reduce bed stay durations. GPs are now facilitating access to anti-dementia drugs, and people with dementia and their carers will get active community support through a newly-commissioned dementia advisor/support worker service.

> "I was working with the GP but we couldn't get my mother to agree to access services. Through the case manager, we were able to get a benefits check, get voluntary sector services involved and a care package in place. Dealing with one person increased my mother's confidence and she finally agreed to have essential medical tests."
>
> Carer

Ageing well and dying well – keeping frail, elderly people at home continued...

The next step is a pilot to integrate and extend out-of-hours support to match peak demand, with community psychiatric and district nursing, social care and medical services working together. The goal is to improve quality of life. Torbay has the second highest percentage of people with dementia in England but our rates of admission to psychiatric care and of antipsychotic prescribing are now among the lowest in the country.[10]

KPIs:

- Reduce hospital admissions by 10% a year
- Improve experience of person with dementia/families by: measures to be determined at engagement
- Experience of individual, families and carers against National Voices measures

With providers and the community, Torbay is developing an integrated housing strategy, including best use of equipment, home improvements, disabled facilities grants, but also support and care within people's own homes, particularly for frail, elderly people. Intermediate care in Torbay has helped bring social-care use of care homes, age standardised, to within the best 10% in the country. The number of publicly-funded residents in South Devon is still comparatively high for the county and we need to expand services in the community.

We are keen to support a Devon County Council initiative to develop extra-care housing to promote person-centred care and support, and accommodation for rent and sale. At Newton Abbot, 50-60 flats are being built. Centrally located and used as a 'hub,' they will provide an oasis where the older and more vulnerable members of the community can meet, interact socially and be assured of care and support, round the clock. We support extending this model to other towns with poorer transport links.

We have 222 care homes in South Devon and Torbay and they are home to 3,892 older people. Care can be excellent, but is not uniformly so. We see about 1,500 unplanned hospital admissions from care homes every year, with around 400 ambulance 999 calls a month. Of these, one in six is discharged the same day, and one in five has a one-day length of stay. All of this indicates that many residents could be treated instead in their home, without the unwelcome disruption of an unplanned trip to hospital.

We launched a jointly-funded secondary care outreach pilot in December 2012. Nurses from the hospital Medical Admissions team provide an integrated approach between hospital and care home. They offer an acute nursing service, with advice, guidance and nursing support, and some acute nursing treatments such as intravenous treatments and blood transfusions.

After an all-stakeholder event, our five locality commissioning groups agreed integrated plans with pharmacy and mental health to avoid unplanned admissions, avoid over (or under) medication, improve end of life care, and support the homes with improved education and clinical skills. Each home will be linked with a named GP practice, to improve care planning and people's continuity of care, if they want this. Medicines will be reviewed to maximise safety and minimise safeguarding worries.

Emergency admissions from care homes cost the CCG around £4 million a year. Preventing 474 admissions in year one by bringing the admission rate from the top 20 homes in line with the average will save £1.254 million.

Improving integrated end of life care is a goal for all, not just for those in our care homes. Nationally, 70% of people do not die where they choose – in South Devon and Torbay that figure averages 48%. However, there is still work to be done.[11]

In line with the 2013 Cochrane Review[12], the CCG has supported a 24/7 hospice at home service. Our valued provider, Rowcroft Hospice, delivers this through a team of specialist nurses and senior healthcare assistants, with a rapid response service and dedicated night drivers.

In the first year, the Rowcroft at Home service cared for over 400 patients, 84% of whom died at home, with 7% supported to stay at home until they could be admitted to their preferred place of care to die. 69% of referrers advised that referral had prevented admission to hospital. Carers have reported a reduction in the burden and anxiety of caring; patients have reported improved quality of life, dignity and self-worth. We are now exploring with Rowcroft ways of extending the numbers of people supported, and palliative care teams across the system will join up – from hospice to hospital to community.

KPIs:

- Increase the number of people supported to die at home if that is their wish
- Support the reduction in hospital deaths by 10% per year
- Support a 25% reduction in the average length of stay in hospital for patients in the last two weeks of life

> "Never in my wildest nightmare did I imagine that I would be trapped in a paralysed body unable to speak. First and foremost I wanted to maintain my independence and I have every intention of enjoying the rest of my life. Integrated care in the community gives me my last piece of freedom. Priceless!"
>
> Bob Brewis, diagnosed with motor neurone disease

Recreating the system

Bringing about lasting improvements in the life chances and wellbeing of our population will entail far-reaching and urgent change. Strategic leadership for our integration plans will be through the South Devon and Torbay Joined Up Health and Care Cabinet, and through Devon's Joint Strategic Commissioning Group, which includes Northern, Eastern and Western Devon CCG. The Health and Wellbeing Boards will be regularly updated, and provide system-wide leadership for addressing inequalities and the wider determinants of health.

We will take an assets-based approach, drawing on the existing strengths of our communities to build their resilience and capacity. At the same time, we need to mould the system to the people using our services, so they can move through it seamlessly and in a way that they themselves can control.

All this has great implications for our highly-valued workforce. Redesigning this is a task we have just begun, and with which we will need external support. Our professional staff will need to work and co-create in an entirely innovative way. We are thinking about how to change, merge, blend and redesign the traditional roles of nurses and allied healthcare professionals around the needs of Mrs Smith, her daughter and her grandson as they access health and care throughout their lives. Our recent contribution to the first draft of the Centre for Workforce Intelligence integrated workforce paper (2013) will enable us to think through a methodology for bringing together the future workforce around the needs of people using services. We'll be using analysis, policy review, workforce modelling (with accurate information on current structures) and scenario planning, all with the detailed involvement and engagement of our staff.

> "Our valued staff will need to work and co-create in an entirely innovative way."

New ways of measuring performance – no longer by activity – will require new ways of collecting and evaluating data. We are working with the University of Exeter on solutions to this complex task.

In readiness for the new system, the Joined Up Cabinet will stretch an ambitious joined up IT programme over Torbay's whole Joined Up endeavour. Incorporating the principles of Patient Knows Best, this will see leading-edge systems spanning the whole healthcare community, linking health and social care, primary care, mental health care, hospital care and residential care, with meticulous governance and consents.

We see this as streamlining processes, adding assurance about patient safety, improving patient care and ultimately helping avoid unnecessary admissions to hospital. There are three strands:

E-prescribing: a patient's prescribing and medication record visible not just in the hospital but across the whole community including mental health, hospice providers, pharmacy, and ambulance service – increasing patient safety. We have won a £3.7 million Government grant for this; the only area to bid jointly as an entire healthcare community.

E-booking: that will allow the clinician to input directly into an electronic system that knows the pathways and will make all the associated bookings, eg for diagnostics, pre-admission and surgery. If, for instance, blood test results make scheduled surgery inappropriate, it will be rescheduled, with no administrative interface. Moreover, the patients themselves will be able to make changes from home; they can alter a pre-admission outpatient appointment without, as now, throwing out the schedule for surgery, and they will be able to track their own progress through the pathway.

VitalPAC: the vital signs recording and monitoring system already allows clinicians to record observations on a hand-held device at the bedside, with built in reminders and alerts. We will extend this across primary care, health and social care and into care homes, so that clinicians can monitor their patients remotely, and vice-versa. Specialist oversight will support increasingly sophisticated decision making, including about admissions from care homes. All will be visible to patients.

Integration of organisations is not the goal – but can be an enabler. Currently South Devon Healthcare NHS Foundation Trust is the sole bidder for the community services run by Torbay and Southern Devon Health and Care NHS Trust. It has put forward, in its acquisition bid, the case for creating a single Integrated Care Organisation, underpinned by a highly-detailed Integrated Business Plan detailing a reduction of workforce and efficiency savings. A key commissioner requirement of this process was that it should deliver more for less. That principle remains across our system.

> "In particular I wanted to thank the A&E consultant who handled the situation quickly and skilfully. Also the senior house officers, healthcare assistants, nurses and domestics all did a fantastic job looking after her. Everything happened smoothly and promptly and I was kept informed throughout by the team."
>
> Husband of a patient cared for at Torbay Hospital

Recreating the system continued...

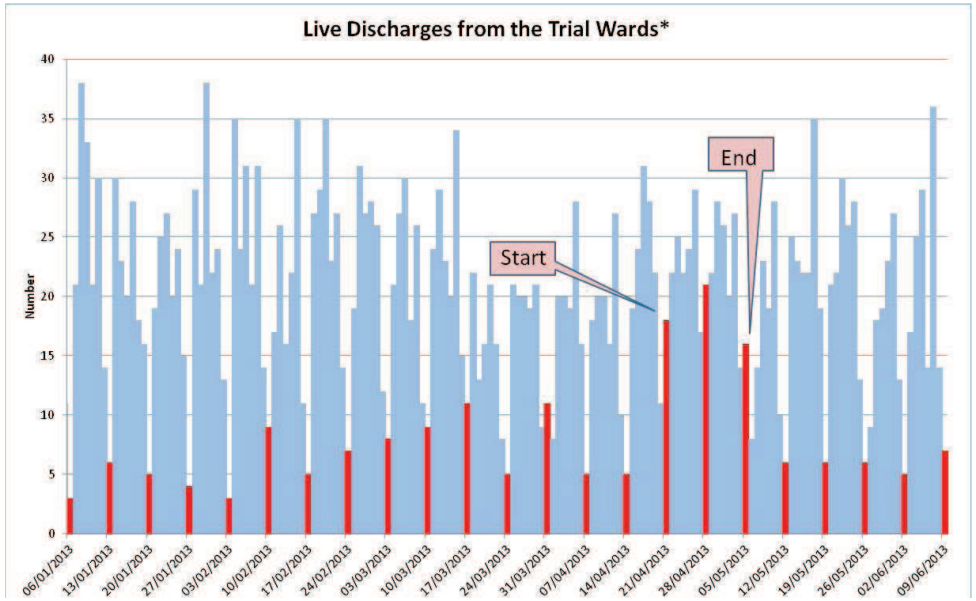
On finance, we already have, locally, a good record of not getting in the way of excellent ideas for service change: we collectively agree approaches to payment for services that promote high quality, innovative care while maintaining financial stability for all organisations. While we do work with national payment systems, we have worked with them flexibly, never allowing tariff alone to drive our working together. In future, we need even more flexibility to pool budgets so that together, across the integrated system, we can design, commission and provide the very best services for our population. As a pioneer site, we would pursue this with the benefit of the external support offered. And whether or not this acquisition takes place (outcome July) the key benefits outlined must be retained. Among them is the vast scope for improving patient flow – the key not only to safe, effective and efficient care, but directly linked to people's outcomes and their experience.

Real quality of care will require our integrated system to be responsive seven days a week – in the acute hospital, community hospitals and across all the relevant components of the multi-disciplinary teams in the community. The challenge is vast, but without it, patients end up in the wrong parts of the system – producing outliers on wards, patients being admitted to the acute hospital when they could have been cared for in the community and, ultimately, delays in patients getting where they need to be – back home.

Torbay Hospital already sees excellent patient flow – getting the front door right and transferring people onwards or home safely. Its occupancy rates, at 89.5%, are among the best in the country. Its seven day services include radiology, physicians, surgery and physiotherapy, but it still sees significant variation in performance over the seven day period.[13] Click to see charts.

This spring a pilot of Sunday working was run for three consecutive weekends on five wards (conducting 'business as usual' rather than a weekend service). It extended the working of general physicians with special interest in the fields of care of the elderly, respiratory medicine and gastroenterology, trainee doctors, therapists, ward clerks, patient transport services and discharge coordinators. After each weekend, emergency beds were available on the Monday, and there was "an atmosphere of calm" in the hospital. There were significant qualitative and quantitative improvements in system performance over the whole week.

Test of change – Sunday working



Notably, in a period when soaring demand on A&E made national headlines, Torbay Hospital continued to meet its 4-hour wait requirement, staying at >95% despite the pressure.

> "The professionals involved with my care talk to each other. We all work as a team."

In health and care, the multi-disciplinary approach is well established. In Torbay this sees teams in designated 'zones' bringing together community nursing, adult social care and intermediate care, including community pharmacy, occupational therapy and physiotherapy, with a clinical active case coordinator (or community matron) and an integrated health and social care coordinator. People needing services have a single point of access – one phone call

…pleasantly surprised by 'come and meet CCG' meeting in Torquay tonight. Others could learn from the positivity & transparency…

…having once worked in a PCT, actually now believe that CCGs can make a far improved difference. Tonight my faith is restored in the NHS…

Recreating the system continued…

is all that's needed. Seven day services include district nursing, out of hours emergency duty service, crisis/rapid response domiciliary care, with, in Torbay, intermediate care, discharge coordinators in A&E, intensive home support service, and, in South Devon, reablement. This needs extending.

The metrics for seven day working have been identified as: experience as against National Voices measures; patient survey; the SHMI mortality indicator; readmissions; average length of stay, including combined acute and community stays; staff survey; pathway cost; and recruitment to organisations. KPIs are still to be developed.

Central to our model for joined up care is the community hub. We are now extending its scope, integrating the learning disability service this year, along with a community psychiatric nurse and dementia support worker. We will consider with Devon County Council the further development of a new community hub in Newton Abbot in South Devon, using the single point of access via Care Direct Plus, and seeing closer integration with primary care. This hub model would, in common with that in Torbay, have direct mental health service support and a key focus on dementia friendly initiatives. A frailty service and an urgent care centre integrated with primary care and the out of hours service are also being considered for Newton Abbot community hospital – Devon's newest and best equipped. Key planned outcomes: fewer hospital admissions, increased early diagnosis of dementia and support for carers of people with dementia.

We have, too, been exploring ways of integrating working between primary care and the multi-disciplinary health and social care team. GPs and the community team are helping the same people, the same patients. Rising demand on primary care risks poorer service and experience for patients. There are obvious benefits if resources are shared, in terms of time, efficiency and quality of care. GPs greatly value the single point of contact and health and care coordination in the zones, but it is clear that there are gaps – school nursing, Child and Adolescent Mental Health Services, and health visitors are more difficult to access.

We have agreed, so far, the need for single clinical leadership and a single management structure across the local primary care and community services. This could include pooled and flexible use of resources running alongside clinical integration; for the patient this would mean being seen by the most appropriate person – not necessarily their GP – at the right time. This approach would help in managing long-term conditions. For primary care, there is the advantage of having contingencies at times of high demand or emergencies. A key enabler has also emerged for this model: prompt access for GPs to diagnostics.

"GP practices are developing provider networks so they can work effectively to improve health."

As the principal point of contact with health services for most people, primary care is an essential part of the jigsaw in whole system, person centred integration. To keep commissioning local, South Devon and Torbay CCG has five locality commissioning groups (LCGs) with coherent boundaries reflecting the common characteristics of the population served. The LCGs monitor and manage practices' commissioning performance (referrals, A&E attendances, urgent admissions) but everyone acknowledges that the practices' ability to perform well is directly related to the quality of provider services available. The 37 practices are therefore now developing GP provider networks so that they can work collaboratively to deliver patient care and share more specialist skills and resources. With greater scale, these networks – or federated practices – can work together more effectively to improve whole population health.

We know there's a lack of capacity for the increasing demand in general practice, evidenced locally[14] and nationally[15]. The age profile of our GPs means recruitment is not keeping pace with the retirement of the existing workforce. Action is needed, and our innovative solutions are developing. We have commissioned the University of Exeter to model capacity and demand in primary care and will use the results to develop a primary care strategy in conjunction with the NHS England Area Team.

We have also supported 22 of our 37 practices so far to adopt the Dr First or Productive Primary Care schemes that streamline and improve access for patients; early feedback tells us is greatly welcomed.

> "First comes thought; then organisation of that thought, into ideas and plans; then transformation of those plans into reality. The beginning, as you will observe, is in your imagination."
>
> Napoleon Hill, 1883-1970

Recreating the system continued...

Feedback has also been overwhelmingly positive for the National Voices narrative which we have used at all our recent Meet the CCG engagement events. We recognise that while we can claim to meet some of the "I" statements on what coordinated care looks like, we are nowhere near offering, consistently and across the board, the kind of inclusive, joined up care that puts those using services in control. The narrative will now form the basis of all our engagement; we will evaluate the response and use it, with National Voices' guidance, to develop criteria for our commissioning, building these requirements into our service specifications and performance monitoring. Providers have an excellent record on involvement and engagement and they, too, will be determining KPIs on the validated measures expected later this year.

We have already taken an entirely new approach to engagement, with our CCG Strategic Public Involvement Group (SPIG). Working with networks in the community, we went on a journey with partners in the voluntary sector, involvement networks and the-then LINks, to discover such a body should look like. Importantly, SPIG self-nominated, selected their own members from within their networks, and selected and elected their own Chair and Vice-Chair. As a result, we have wide networks back into the community. SPIG is working with us to ensure they influence commissioning at the most strategic levels. We think we've broken the mould in enabling our community to tell us how they want us to engage, and will, therefore, put SPIG and our two Healthwatch organisations in the driving seat in taking forward the work on the National Voices narrative.

We invite provocative, insightful and field-leading speakers to Torbay and South Devon to take part in seminars we call the 'Excite, Ignite, Imagine' series. But the words have wider resonance across our system, encapsulating our search for innovation and better, different ways of improving health and care for our communities. We are using the learning from other high performing systems such as Jönköping in Sweden to develop our own 'Qulturum' where innovation, improvement, education and research come together to support the delivery of an integrated care system. In our state-of-the-art innovation, education and research facility we are actively working with our academic partners, University of Exeter and research institute PenCLAHRC, to undertake operational research – using techniques such as simulation with clinical teams,

patients, families and carers to redesign care pathways. We are making our innovation processes open and accessible, crowd-sourcing opinion from across our care community via multiple platforms. Our groups such as Catalyst and iTorch gather staff inspiration and help instigate change.

The hospital's Hiblio is a pioneering digital TV service for healthcare, promoting concise health information and education to the public and clinicians alike. We are extending it with training DVDs for carers on topics such as preventing pressure ulcers. It also includes a medical education channel with transferrable mandatory training, and specialty-specific information for clinicians.

We search out ideas from all parts of the country and the world, working closely with the Association of British Healthcare

Industries, British In-Vitro Diagnostics Association and others. Our default setting is to share our own ideas and learning, too. As a pioneer site, we would use all our networks; our natural starting point would be the large geography and population of NEW Devon CCG, where integration is already a priority and where we both want to see system level partnership working across the Devon County Council footprint. We already arrange learning exchange visits with other care communities, and would formalise this programme. We are also active in NHS Clinical Commissioners and our Academic Health Science Network, have links with the International Foundation for Integrated Care and highly-valued ties with The King's Fund and The Nuffield Trust.

With the support of the pioneer programme and the external expertise it offers, we are confident we can achieve the transformation of our health and care system we are aiming for. We do not believe that making our existing system 'better' can be the answer – the system itself needs to change. None of us underestimates the challenge but we are ready for it. South Devon and Torbay is committed to making a lasting difference to the care and support of our local population.

References

[1] Office of National Statistics, Interim Subnational Projections, 2011

[2] Haines, D., (2013) Joint Strategic Needs Assessment, South Devon and Torbay

[3] Marmot, Professor Sir M., (2010) Fair Society, Healthy Lives, Institute of Health Equity

[4] Munro, Professor E., (2011) Munro Review of Child Protection, Department of Education

[5] In adults of 341/100,000 (national average 207) and for under 18s of 239/100,000 (national average 123)

[6] All Devon Partnership NHS Trust mental health projects integrate mental and physical healthcare and are designed around the NHS Change model of co-production involving patients, carers and stakeholders.

They align with the Peninsula Academic Health Science Network and CLAHRC priorities and will be subject to bids to these groups for full evaluation of patient experience, outcomes and against best practice guidelines.

[7] Local Alcohol Profiles for England (LAPE), North West Public Health Observatory

[8] Yorkshire and Humber Public Health Observatory, 2012

[9] Data analysis in Devon in 2010 showed that of 300 consecutive patients referred to a neurology clinic, 60% had MUS, 15% had a psychiatric disorder, 16% (48) attended A&E from 1 to 12 times a year with their complaint and of those 54% (26) were admitted.

[10] North West Public Health Observatory, Community Mental Health Profiles 2013

[11] End of Life Clinical Pathway Group, South Devon and Torbay Clinical Commissioning Group, performance data

[12] Gomes, B., Calanzani, N., Curiale, V., McCrone, P., Higginson, I.J., Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers. Cochrane Database of Systematic Reviews 2013, Issue 6. Art. No.: CD007760. DOI: 10.1002/14651858.CD007760.pub2

[13] In Torbay, there is no "Friday effect" on mortality rates as reported in June 2013 by the Imperial Group. Analysis of all elective procedures, a basket of intermediate to major elective operations, elective colorectal resections and elective major joint replacements shows no significant day-of-operation effect on mortality in the last five years, and a possible effect in the five preceding years.

[14] Oxenbury, Dr J., (2013). Practice Managers Survey Results: workforce information for South Devon & Torbay.

[15] Lueddeke, G.R., (2012). Transforming Medical Education for the 21st Century: megatrends, priorities and change. Radcliffe Publishing Ltd: London; Howard, Professor, J., (2013). General practice and primary care task force review. East of England Multi-Professional Deanery.

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Title:	Update Report –Public Health
Wards Affected:	All
To:	Health and Wellbeing Board **On:** 19 September 2013
Contact:	Debbie Stark, Director of Public Health
Telephone:	01803 207336
Email:	debbie.stark@torbay.gov.uk

1. Achievements since last meeting

1.1 Following the discussion on alcohol at the last Board meeting, Torbay hosted a forum for Chairs and Vice Chairs for Boards across Somerset, Devon and Cornwall.

The agenda included sharing of best practice, the opportunities for shared campaigns and a discussion about the creation of an alcohol alliance.

The examples of best practice shared by other areas included a number of schemes we are also developing in Torbay:

- Public Health professionals within acute hospital site
- Peer support for recovery
- Screening and brief intervention by other agencies

We showcased the targeted alcohol worker we have developed between the CCG and Public Health. This post has been actively working with high users of GP and hospital health services. Early results are very promising.

We were interested in some of the web-based content other areas were using, in particular Somerset, and will be looking at this over the coming months.

Torbay also provided copies of the poster campaign on parental responsibility and drinking which was developed in response to a local serious case review. The posters point out the dangers to children in terms of immediate safety and learned behaviour.

The members of the forum agreed to set up an Alcohol Alliance to oversee shared work and lobby collectively. It was felt by the group that a high profile campaigner on alcohol issues would give the Alliance greater credibility. We will be approaching a local MP with an invitation to chair this Alliance.

1.2 Following the report to the last Health and Wellbeing Board, the most recent figures for Teenage Conception have been updated and show a decrease for Torbay, in line with our more average position. The report to the previous Board meeting had shown a sharp increase and a project to review services for teenagers was proposed. Despite the better performance in the most recent quarter, Torbay still has high rates compared to other Councils nationally and this project has now commenced. Details are included in this agenda under the item for Sexual Health.

1.3 The Board has previously received presentations that have highlighted the Government programme for additional capacity in Health Visiting. The original capacity of 20 posts has increased to 38 from this September and will be 54 by 2015.

1.4 It has been announced that the Public Health grant to Councils will remain ring-fence for a third year (2015-16). The value for the third year has not been announced.

1.5 The performance figures for Health Checks have been published for quarter 1. Torbay is doing well on the number of checks it is able to offer with 5.3% of the eligible population compared to only 4.2% nationally and 1.9% for Devon, Cornwall and Somerset overall. Take up of offers is lower in Torbay however, at 1.8% compared to 2.0% nationally and reasons for this are being explored.

Challenges for the next three months

2.1 The Public Health commissioning team has now moved from St. Edmunds into the Town Hall. This team, financed from the ring fenced grant, commissions front line services, provides public health leadership to the Council and statutory support to the CCG. Like many Public Health teams across the country, the redesign of the NHS has led to a number of changes. Around 50% of the original team have left in the last 18 months and there are currently a number of vacant posts, some of which are being filled with secondments.

The Director of Public Health (DPH) in Torbay will be leaving in November. Across the five councils in Devon, Cornwall and Somerset (County) there will only be two DsPH in permanent posts.

The post of DPH is a statutory appointment and an update on appointing to/covering this and the other vacancies will be reported at the Board meeting.

3. Action required by partners

3.1 As we move into the winter season the annual influenza campaign starts. Vaccination is offered to the following at risk groups:

- Anyone aged 65 and over
- Those with specific long term conditions (all ages from 6 months)
- Those living in a long-term care home
- Health and social care workers who are in direct contact with patients and carers
- Carers in receipt of Carers Allowance or who are a main carer
- Pregnant women
- Children aged 2 and 3 (NEW FOR 2013)

In addition, vaccination against shingles is being offered to those who are aged 70 and 79. It is the intention to roll vaccination out to everyone aged 70-79 over coming years as national stocks allow.

Partners have been instrumental in promoting influenza uptake in previous years. The Care trust continues to have a popular District Nurse team (Flu'sEase) who vaccinate care homes and housebound elderly. The Maternity Unit at the hospital have been instrumental in improving our uptake rate for pregnant women from 31% to 48% (one of the best in South West). Healthwatch led a publicity campaign last year and will be including shingles in their programme for this winter.

We would ask all partners to continue this support. Councillors are invited to attend a training session in the Town Hall on 27th November.

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Update Report –Healthwatch		
Wards Affected:	All		
To:	Health and Wellbeing Board	**On**	10 September 2013

Contact: Pat Harris
Telephone: 01803 402751
Email: pat.harris@healthwatchtorbay.org.uk; www.healthwatchtorbay.org.uk

1. Achievements since last meeting

1.1 This month, Healthwatch Torbay released a report on the health and wellbeing of one of the most notoriously deprived areas of Torbay. The report - endorsed by a number of local VIPs - was commissioned after the Torbay Joint Strategic Needs Assessment (JSNA) revealed that people die 8 years younger in the Tormohun Ward area of Torquay – which has over 10,000 residents. The report – entitled 'Making Melville Marvellous' (MMM) - used data collected from a recent work with the Melville Hill and Warren Road community, which incorporates Abbey Road, St Lukes Road and Waldon Hill.

Issues highlighted in the MMM report that affect health & wellbeing in the area included: GP Appointment Systems; residents parking; dog fouling; the need for a children's play park; more police presence; street cleanliness; tackling rogue landlords and developing community facilities. Tormohun Ward Councillor Darren Cowell has since promised to begin the creation of a focus task group - including Public Health, Torbay Development Agency, Tor2, Constabularies, and key community organisations - to discuss and take away actions to implement the report's recommendations. The report is available to view on our website and in the attached appendix.

1.2 We have been working with Healthwatch Devon to give the public the chance to provide feedback on the '2014-17 Joint Commissioning Strategy for Health & Social Care Advocacy Services in Devon and Torbay'. The document is available to view online with a special online survey created to allow people the chance to feedback any issues or concerns regarding the document. We are also working with Healthwatch Devon to produce a joint memorandum of understanding and joint working protocol.

1.3 Healthwatch Torbay has been chosen as the detailed case study in national body Healthwatch England's upcoming Annual Report. We are expected to be cited as an example of good practice by the organisation due to a national

NHS conference describing our work with the South Devon and Torbay Clinical Commissioning Group (CCG) as the “jewel in the crown of partnership working in the South West”.

1.4 Healthwatch Torbay are holding our first ever Annual General Meeting at Paignton Library on Wednesday 18 September from 6pm to 8pm (please call should you wish to attend). Their inaugural AGM – open to all members of the public – will see a new Board of Directors appointed, including a Chair, Vice-Chair and Treasurer. An online profile page has been created showing profiles of our current interim Board – all of whom are up for nomination at the AGM.

1.5 Healthwatch Torbay have taken to the streets this in a bid to find out what the public think about the health & social care services in Torbay. They have visited Torbay’s three town centres with their ‘Consultation Caravan’ to discuss experiences with health & social care services in the Bay and have been very well-received. Healthcare professionals, including the CCG, have accompanied them as special guests to talk to the public. A report will be produced on the findings.

1.6 Our Youth Coordinator Bekki Redshaw is currently working on releasing a report into to Health and Wellbeing of young people in Torbay. This extensive report is the product of months of hard work and consultations with young people, and will be available to view online next month, complete with recommendations for local services. The final draft of the report can be found in the appendix, detailing how there appears to be a need for more in-depth research to support young people, parent/carers/professionals and commissioners, to ensure that appropriate and effective support services are provided.

1.7 Healthwatch Torbay has attended a variety of events recently, including a talk at Brixham Methodist Church on Fore Street, a special day on Torre Abbey Meadows for young people with learning disabilities, and a well-attended playday at Melville Hill carpark to officially launch our Making Melville Marvellous Report.

1.8 Public feedback gathered from external events prompted us – in partnership with Torbay Council, the CCG and both the TSDHCT and SDHFT - to produce an easy-to-read diagram on how the changes to the NHS in England will affect Torbay. It has already featured in the Herald Express and we will be distributing printed versions to providers should they wish to use them.

1.9 We are also currently working on producing a new community section of our website where we visit community groups and organisations and gather case studies on who they are and what they do. Our first features have been the 'SharedLives Scheme’ and also ROC (Robert Owen Communities).

2. Challenges for the next three months

2.1 We expect to appoint a dynamic new board to officially launch at our inaugural Annual General Meeting on Wednesday 18 September (6pm - 8pm) at Paignton Library.

2.2 To ensure all the feedback we capture is utilised in the correct way, we are currently in the process of populating our new information database system, to allow us to quickly and easily collate and analyse all the user feedback we receive – which is growing exponentially. We will then be able to produce more extensive reports and recommendations at a much faster rate. The system also allows us to signpost users to the correct services and deal with enquiries very efficiently.

2.3 To encourage the gathering and sharing of feedback and information for our new database, we will need to engage more with users. A communications plan will be adapted for the next 6 months to best maximise this.

3. Action required by partners

3.1 We still need our partners to continue to continue helping to publicise and support the development of Healthwatch Torbay in any dealings that they have with the public and the media. We are receiving more and more regular patient feedback which we expect to grow further – any help to achieve this would be greatly appreciated.

3.2 Communication as a whole is improving through meetings with key partners and organisations. However partners continuing to share their own information and feedback with us would help provide a greater understanding of patient issues. This would help us to make the correct recommendations for improvements and/or signposting and, in turn, help all of us provide greater user satisfaction.

4. **Appendix** (attached)

4.1 Our Making Melville Marvellous (MMM) report into the health and wellbeing of the Tormohun Ward area of Torquay.

4.2 Our report into Torbay Young People's Emotional Health and Wellbeing.

healthwatch Torbay

Torbay Young People's Emotional Health & Wellbeing Report

July 2013

Tell us your story ...
Your voice counts

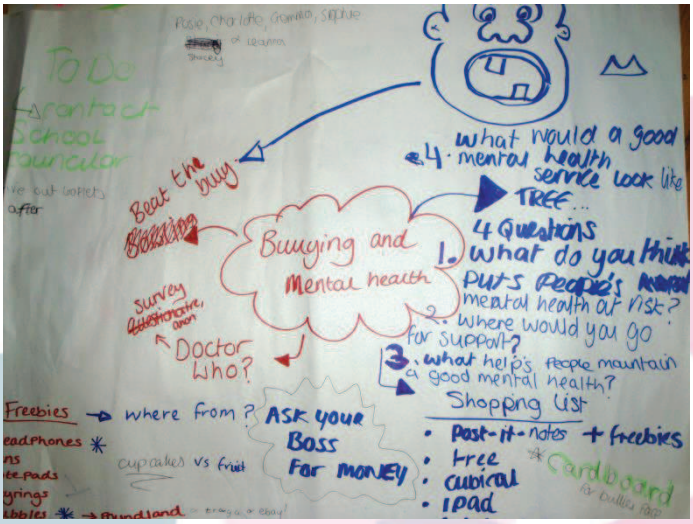
www.healthwatchtorbay.org.uk - 08000 520 029

Index

Executive Summary

This report covers young people's views, experiences and ideas for development on services to support their emotional wellbeing and mental health. Over 250 young people from Torbay gave their feedback, via a variety of methods of engagement, from one-to-one work, group and peer consultations, and online surveys.

The focus of this work developed from baseline assessment consultation with a variety of groups of young people delivered by Healthwatch Torbay Youth Coordinator Bekki Redshaw. These consultation activities covered all aspects of health to identify young people's priority areas and issues. It soon became apparent that emotional wellbeing received the strongest and most in-depth responses. Due to this high response more focussed work was devised and delivered with young people to gain a better understanding of their experiences, how they felt about services, and their recommendations for any improvements.



At the same time, various different pieces of work - delivered by Healthwatch Torbay - gathered feedback from parents, carers, and professionals working with young people. These raised independent adult-identified issues and concerns about the support for young people struggling with their mental health.

Specific consultation activities were then developed on emotional wellbeing and mental health to gather more focussed information, particularly feedback on existing services. Young people's thoughts on what their ideal services would look like and their suggested solutions to issues were also gathered.

NB. Any young people quotes included in this report have been copied and pasted precisely as was written to maintain authenticity.

The work was delivered to:

General groups of young people

- Torbay Youth Power (TYP) – Healthwatch Torbay's young people's forum
- Torbay Youth Power Facebook membership
- Students South Devon College – Level 1 & 2 Health & Social Care students, plus students from other courses who attended the TYP Launch.
- National Citizen Service (NCS)
- NCS Peer Consultation on Paignton Streets/Parkfield Young People's Centre
- Torquay Boys Grammar School

Targeted groups of young people

- Torbay Young Carers
- Torbay Adult Carers
- Torbay Pride Lesbian, Gay, Bisexual, Trans, Intersex youth project.

A wide range of experiences were gathered including from those who had accessed services and those who had not.

Those who had not accessed services were asked about their knowledge of services, how well services promoted themselves and what they did, and what young people would want if they felt they needed emotional support.

Many young people disclosed personal experiences of accessing support services, giving in-depth experiential feedback. Young people were not asked to disclose which service they used specifically, as this research was to give an overview of services, not to evaluate specific services.

Young people talked about services such as Counselling, School Counselling, and Drug & Alcohol Services. No young person said they had received a service directly from the Child and Adolescent Health Service.

National Picture

1 in 10 children and young people aged 5 - 16 suffer from a diagnosable mental health disorder - that is around three children in every class.

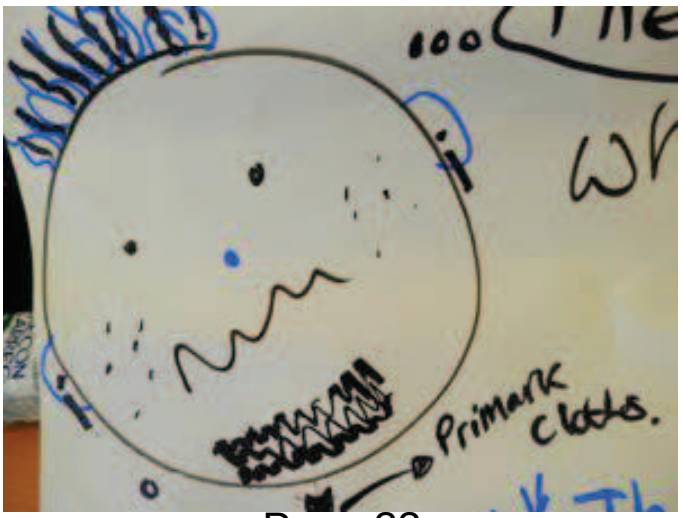
- Nearly 80,000 children and young people suffer from severe depression; and over 8,000 of these are aged under 10 years old.
- Between 1 in every 12 and 1 in 15 children and young people deliberately self-harm.
- There has been a big increase in the number of young people being admitted to hospital because of self-harm. Over the last ten years this figure has increased by 68%.
- More than half of all adults with mental health problems were diagnosed in childhood. Less than half were treated appropriately at the time.
- The number of young people aged 15-16 with depression nearly doubled between the 1980s and the year 2000.
- Almost a third of children have considered or attempted suicide by the time they turn 16.
- 29% had self-harmed because they felt "down".
- Almost half of those suffering from depression failed to get the support they needed.

MindFull YouGov (poll of over 2,000 young people)

Mentally healthy children should have the ability to:

- Develop emotionally, creatively and intellectually
- Develop and maintain good relationships with other people
- Play and learn
- Understand ‘right’ from ‘wrong’
- Face problems, setbacks and learn from them.

(The Mental Health Foundation 1999)



Torbay Picture

The direct standardised rate for emergency hospital admissions for self-harm and hospital admissions caused by intentional and deliberate injuries in under 18s in Torbay is higher than the national average across England, and also higher than the rest of the South West (The Network of Public Health Observatory, 2013; 32-34).

However, direct standardised rate for hospital admissions for mental health, 2009/10 to 2011/12, were not significantly different to England; and direct standardised rate for hospital admissions for unipolar depressive disorders, 2009/10 to 2011/12, were better than England (The Network of Public Health Observatory, 2013; 20-21).

The rate of improving access to psychological therapies was not significantly different to England (Public Health Observatory, 2013; 35).

Terminology used when working with young people

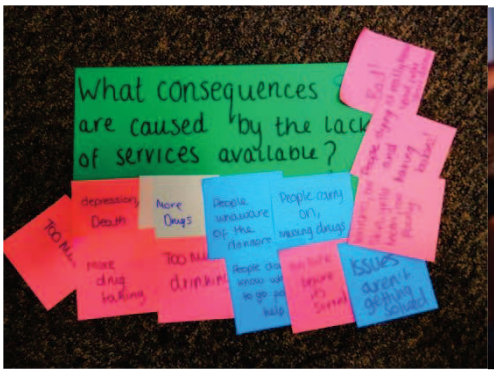
"Mental Health"

Mental health describes our ability to cope with life's problems and make the most of life's opportunities; it is about feeling good and functioning well, as individuals and collectively, or when socialising with friends.

"Mental Illness"

Mental illness is a term used by some people to describe serious, long term mental health problems such as bipolar disorder, schizophrenia or severe depression. People experiencing these problems often require treatment from specialist mental health services.

Results & recommendations from young people about emotional well-being experiences and services



Young people say

- Emotional well-being as an issue is extremely important to young people.

Support Services

- There is not enough support and what is in place does not work for many young people.

"The majority of the young people who had accessed statutory mental health services stated that they would not agree to be re-referred to that agency, which were for a variety of reasons such as: not trusting workers; lack of choice in regards to gender and age of worker; lack of choice around type of intervention offered (for example being offered family therapy but not wanting parent presents or involved); only being able to access service with parents' consent (which young people felt infringed their confidentiality); and specific complaints around worker's interventions."

Worker

- Services are not young people friendly.
- Lack of support results in other ways to deal with feeling down - drinking, drugs, self-harming. Isolating self from people.
- Young people get support from friends and family.
- Friendships/social interactions are seen by young people as the best way to support their emotional wellbeing.

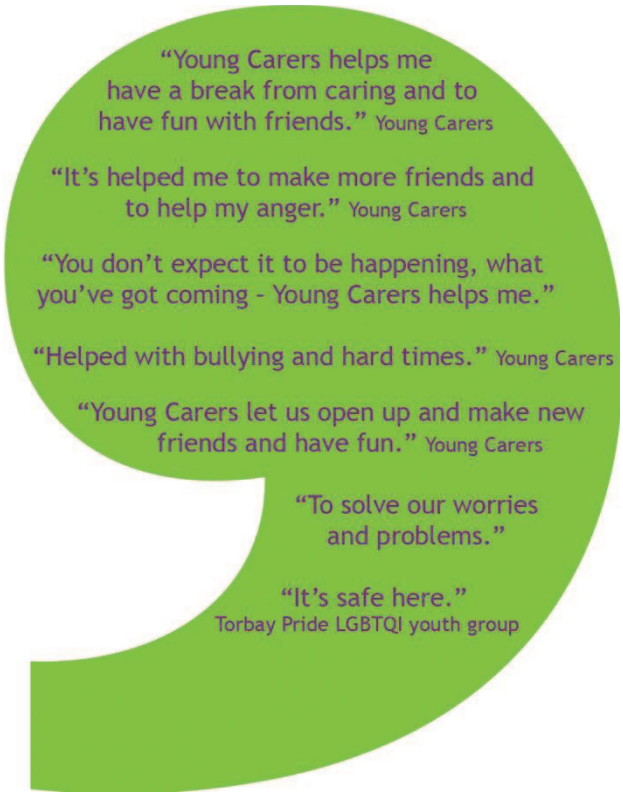
"You can only get help if you are really ill, but not if you are very ill."

Groupwork

- Young people think that as well as friends and family, youth workers are best to placed keep an eye out for young people's mental health, followed by Family Doctors. (NCS Peer Consultation)

Support Services: Young people's recommendations

- Provide young people friendly services.
- There is a need to continue to support early intervention projects, especially issue-based support groups such as Young Carers, Torbay Pride LGBTQI youth project, etc.
- Also valued were projects that offered social opportunities i.e. NCS which focussed on bringing groups of young people together who would not necessarily mix -breaking down isolation and challenging prejudices.
- There is confusion to what services are available to whom.



NCS Survey Monkey: In your local area, it is easy to gain access to help regarding mental health issues/support, for young people?

Disagree 20% Strongly disagree 50%

- There is not enough information on mental health, what it means and how to keep yourself mentally healthy.

NCS Survey Monkey: Young people are made aware enough of potential Mental Health/Emotional Wellbeing problems.

Disagree 30% Strongly disagree 50%

Information

- There is a lack of information on where to get help and what services are available.

NCS Survey Monkey: There is enough support given to young people suffering from Mental Health/Emotional Wellbeing problems.

Disagree 30% Strongly disagree 50%

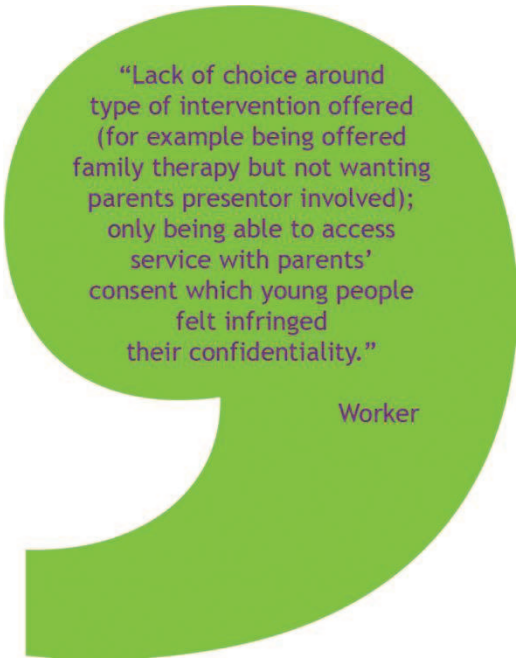
Information: Young people's recommendations

- Inform young people, parents/carers and young people's service providers of what services and help is available, from early intervention to CAHMS, through a variety of mediums.
- Create an accessible, easy-to-read website with local information, saying what services are available, having sections that introduce workers with who they are and what they do (see young people's Endorsed sites).
- Ensure all information given to young people is young people friendly/accessible, including easy-to-read information for young people with a learning disability.
- Ensure young people are informed about how a service runs i.e. confidentiality policy, their rights, access to files, complaint systems etc.
- Clearer information for young people and carers about all services, including clear criteria for all services (including Children & Adolescent Mental Health Service - CAMHS).
- Clearer information to frontline staff from all services, including clear criteria for all services (including CAMHS).

Confidentiality

- Lack of clarity of confidentiality protocols of services impact on young people's trust and wish to engage with services.

- Negative experiences of services insisting on telling families hinder young people's engagement with services.



Confidentiality: Young people's recommendations

- Be clear about your confidentiality.
- Let us know who you can/will tell.
- Listen to us when we say we don't want information shared.
- Let us know as soon as we start working with you or have it on a website before we start working with you.

Stigma

- There is huge stigma attached to having poor mental health.
- Stigma stopped young people talking about struggling with poor mental health/accessing services.
- Young people have to develop trust before they want to engage with services/workers.

Stigma: Young people's recommendations

- Mental health needs to be talked about in schools educating/informing/addressing stigma – PSHE.
- There is a need for training for teachers, youth workers, social workers and other young people's workers to understand mental health of young people including the experiences of Torbay young people.

Counselling/support services

"They just said we are referring you to someone else - but don't know who." *Facebook*

"you just get told to go there or there or there - no one asks you." *Groupwork*

"Counsellor made me bring up stuff that I didn't want to."

"...not getting referred to everyone a having to go over everything constantly, ...everything has been brought up." *One-to-one*

- Lack of choice of what services are on offer.
- Lack of choice of what services young people want to engage in.
- Young people were not asked if they actually wanted to engage with services or given a choice of which service to access.
- Counselling services not meeting young people's needs.
- Referral processes can be intrusive, repetitive, stressful and confusing.
- Young people do not feel listened too and therefore are not engaged in process impacting on success of work.
- Not offered choice of Counsellor/worker.
- Young people were not asked if counselling was having an impact.
- Quality of services was questionable.
- Young people were not asked if they were happy to end counselling.
- Young people felt that adults made the decision this is what they need and that they have no choice.

"One young person stated that she found the counselling 'too intense' and another stated that she found it difficult to build a relationship with her counsellor, although she said that she continues to access the sessions on an on-going basis." *worker*

"They put an empty chair in front of her and told her to talk to it. She said she felt stupid and thought they were mad." *worker*

- LGBTQI are not confident services will not be homophobic – this prevents them from accessing them.

"After about 45mins of answering questions I was tired, let alone by the end of it! It was very tiring and intense and felt stupid half time... didn't really tell me what they did, they did the first assessment they have to do, and next time they have to do another assessment." *one-to-one*

"So I've spoken to 6 different people today, and had 5 meetings - and 1 tomorrow." *Facebook*

"I just had another meeting for hour and half - I'm talked out!! It's confused the bleep out me!!!" *Facebook*

"They just don't listen so it's stressing me out." *Facebook*

"I had an assessment the first time like 2 weeks ago, then Thursday I had another assessment from the community mental health person, but kind just said like answers these questions they were firing at me but didn't really tell me what was going happen." *Facebook*

"Some of the questions were hard to answer, and I laugh sometimes cause it's how I get through and they were like you shouldn't laugh its serious." *Facebook*

"I know I need help but had so many meetings and talking to so many people. It's done my head in and I don't know if I'm coming or going." *One-to-one*

"They just don't seem to be listening to me. I just wish I never said anything to them in the first place.. Cause now I'm just talking to person after person and going back over it all :(" *Facebook*

"...She was not given a choice in regards to the gender of the worker, which led her to not speaking in sessions." *worker*

"No one asked if it was doing any good." *groupwork*

"Made me feel 1 step forward 2 steps back." *groupwork*

"So many questions I felt like I was on Mastermind. Went on & on." *groupwork*

"Once I had left the room I was left on my own." *groupwork*

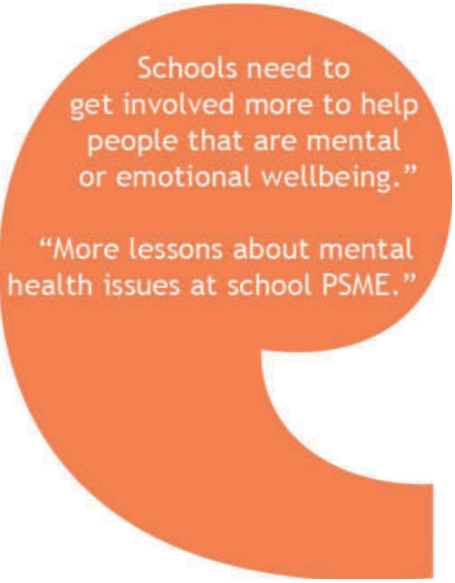
"... She met with various workers who she stated often spoke 'at' her rather than 'with' her." *Worker*

"Counsellor ended it as they said "my progress getting better." They didn't ask me how I felt." *groupwork*

Counselling/Support Services: Young people's recommendations

- Involve young people in decisions about attending counselling: where; by whom; choice of male or female; at what time; what method of counselling, etc.
- Inform young people of their rights.
- Offer young people different counsellors.
- Ensure all counsellors are trained in Additional Needs/ASD/Learning Disabilities.

Schools



- Schools were cited as the main place for addressing lack in services & accessing support.

- Improve what is delivered in schools already.

NCS Survey Monkey: Schools provide enough & good information regarding Mental Health/Emotional Wellbeing.

Disagree 30% Strongly disagree 70%

Schools provide enough & good information regarding Mental Health/Emotional Wellbeing.

	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
female	**2**	**7**	**1**	**0**	**0**
male	**2**	**4**	**1**	**1**	**0**
Trans/not say	**0**	**2**	**0**	**0**	**0**
total	**4**	**13**	**2**	**1**	**0**

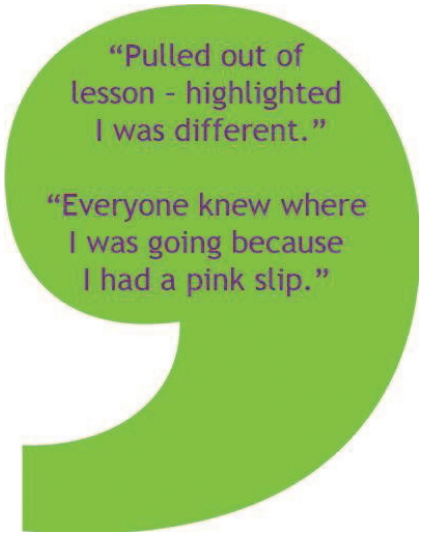
Schools: Young people's recommendations

- Mental Health awareness needs to be delivered in all schools, to include "What is mental health", indicators of mental ill-health, things to do to support good mental health and promotion of services available.
- Train teachers to deal with bullying, including homophobic bullying. Stop teachers being bullies.

School Counselling Services

- Most young people found accessing Counselling in schools challenging.
- Part of this is fear of breach of confidentiality.

- Confidentiality is compromised due to publicly known counselling rooms and their positioning in “general” areas of school.
- Confidentiality of using the service is often breeched by taking young people out of classes to attend counselling sessions and processes of doing so, e.g. pink card, teachers telling young people, being collected.
- Rooms in schools were unwelcoming, bare and functionally inept, which made young people feel uncomfortable. At worst they doubled up as store rooms.



School Counselling Services: Young people’s recommendations

- Counselling services based in schools need to address confidentiality issues and build trust with young people.
- Check young people want to access a service in their school.
- Give clear information including confidentiality policy.
- Do not take young people out of classes.
- Private confidential and nice space.
- Do not use room for other purposes.
- Ensure young people are offered choice of counsellors as in adult counselling services model.

Torbay Hospital

There was one example of an experience of young person accessing Torbay Hospital, given by a worker.

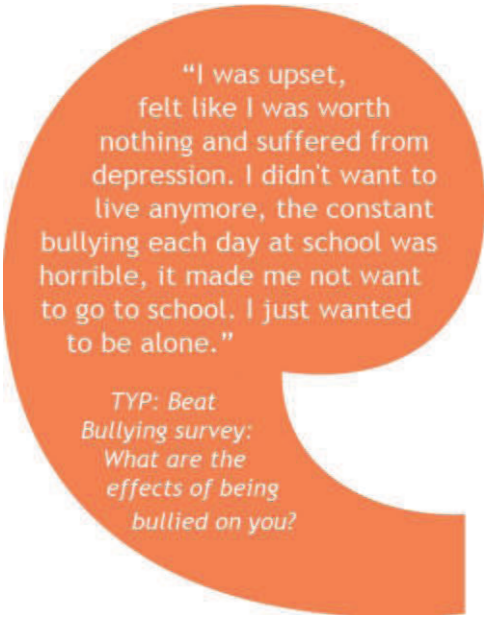
The worker was extremely concerned about the service received saying that although the young person was already distressed and agitated they had to wait in the general A&E waiting area for a considerable amount of time. When eventually seen in the treatment area it also took a long time to be seen by psychiatric services.

The young person was then taken to the Children’s Ward even though she was at times still distressed and agitated. This concerned the worker on behalf of the young person and other children and young people on the ward.

At one point the young person went to leave ward to have a cigarette and the nurse called security, although the young person was calm at the time. This only agitated the situation further.

She was discharged with no medication on the condition she engaged with mental health services.

Bullying

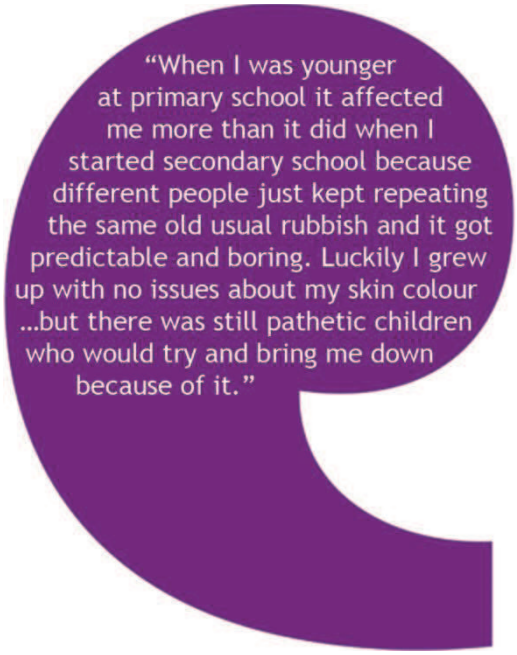


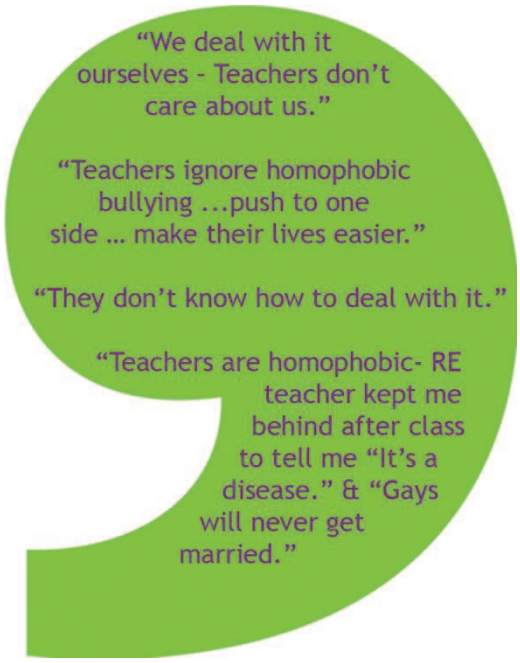
- There is a strong connection to bullying having a negative impact on young people's Emotional wellbeing/mental health.

- Responses to Beat Bullying/Beat Bullying Witness TYP online survey showed a wide range of negative impact on emotional wellbeing. (Apendix 2)

Eating disorders - Self harm - Depression - Anxiety - not being able to have a relationship: Beat Bullying survey "What are the effects of being bullied on you?"

They became detached from society, rebelled against everyone and were sometimes suicidal: Beat Bullying Witness survey "What were the effects of being bullied on them?"





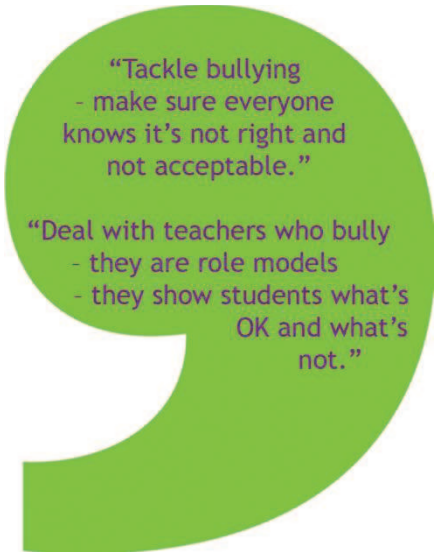
- Fear of being bullied also impacted on young people being open about having poor mental health. 40% (Beat Bullying Witness Survey) said they did not intervene when witnessing bullying, as they feared the bully turning on them. (Appendix 3)
- Schools do not deal with bullying well.
- LGBTQI young people are regularly bullied but do not access support as they see homophobic bullying as accepted in schools and have even received homophobia from teachers.
- Although no specific BME group engaged with Survey Monkey reported any incident/occurrence of racial abuse.

Bullying: Young people's recommendations

- No tolerance policy everywhere.

- Deliver diversity-friendly kite-marking system to support young people from minority groups of confidence in the services i.e. LGBTQ, BME, Disability etc.

- Train teachers on how to deal with bullying.

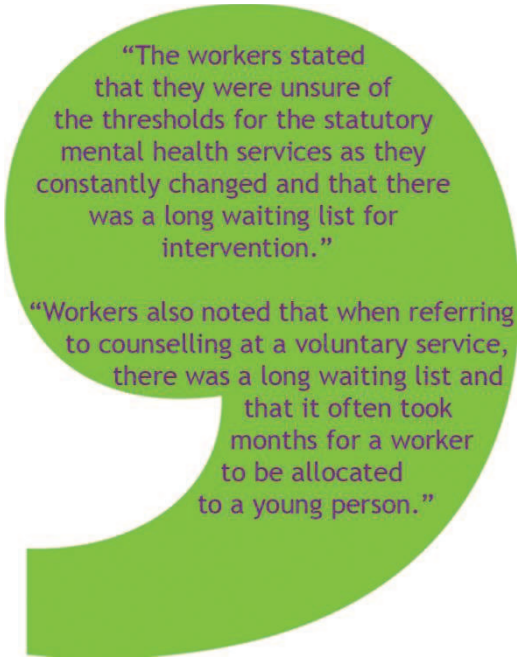


Direct work with parents

- Parents do not know enough about services.
- Frustrated at long referral processes.
- Feel they have to battle to get a service.
- Wide spread issues re getting support for children with LD Autism.
- Parents also value the support from early intervention services and the support and social interaction they provide.

Direct work with professionals

- Not enough information on what services are available, how to refer and criteria.
- Long waiting times for referral processes.
- Frustration at bouncing back and forth of referrals.



Further work/research required

- Work with young people, including those who access services, to identify their "ideal service." This will develop greater understanding to providers and commissioners about the type of service young people require to meet their needs.

- More in-depth evaluation of Counselling Services involving young people who have used the services, which include CAMHS, schools and Checkpoint. This should be an on-going process and preferably external to the delivery organisation.
- Collate feedback from other young people's targeted services who refer into support services i.e. Young Carers, LGBTQI, BME, Disability Council of the value and impact of early intervention on young people's emotional wellbeing.
- Engage with CLA & BME young people.

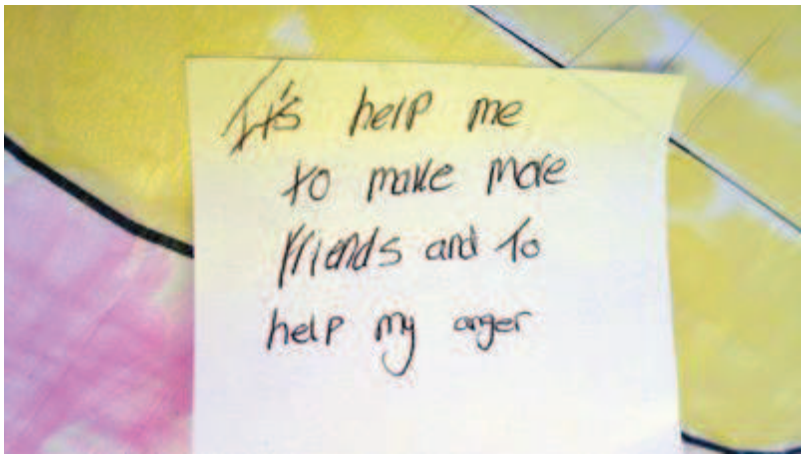
- Wider evaluation/consultations to include A&E, Young People's hospital wards, Young People's mental health units.

Online services young people endorsed

Surry CAMHS
http://www.surrey-camhs.org.uk/en/content/cms/cya/

My Health London
https://www.myhealth.london.nhs.uk/health-communities/young-people/blog/time-to-be-kind-big-white-wall

Young Minds
http://www.youngminds.org.uk/for_children_young_people/better_mental_health



What is Healthwatch

What is Healthwatch?

Healthwatch is the new consumer champion for both health and social care. It exists in two distinct forms – local Healthwatch, at local level, and Healthwatch England, at national level.

Local Healthwatch builds on the work that Local Involvement Networks (LINks) undertook to promote and support the involvement of people in the commissioning, provision and scrutiny of local health and care services, giving people the opportunity to comment on the quality and standard of services and whether they could or should be improved.

Local HealthWatch has retained all the LINk functions and powers and also provides or signposts people to advocacy services if they need help to complain about NHS services. It also provides or signposts people to information about services and how to access them, promoting choice.

HealthWatch England provides support and guidance to local HealthWatch and is able to use local evidence to influence national policy.

> *Healthwatch England is the new, independent consumer champion for health and social care in England. Our job is to argue for the consumer interest of all those who use health and social care service*

> *Healthwatch England's role, working with the Department of Health and the Local Government Association, will be to support local authorities to set up effective local Healthwatch. We will publish key tools and resources for local authorities and Healthwatch here when they become available.*

> *http://www.healthwatch.co.uk/*

What is Healthwatch Torbay?

Healthwatch Torbay is the local consumer watchdog for health and social care, influencing, responding, improving and monitoring services in Torbay. It provides local people, community and voluntary groups with a voice to influence the planning, purchasing and provision of these services. This independent, local consumer watchdog supports the public to promote better results in health and social care for all adults".

Healthwatch Torbay was launched in April 2013 and is based at:

Room 17
Paignton Library and Information Centre
Great Western Road
Paignton
TQ4 5AG
Freephone 08000520029
Direct Dial 01803 402751
Mobile 07717702123

www.healthwatchtorbay.org.uk

Email: admin@healthwatchtorbay.org.uk

HWTorbay Healthwatch Torbay

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How is Healthwatch Torbay engaging with young people?

Healthwatch Torbay is committed to reaching the most marginalised and seldom-heard groups within the community, including young people. To ensure this happens, Healthwatch Torbay has:

- A Youth Coordinator – Bekki Redshaw
- Torbay Youth Power (TYP): young people's group
- Run community engagement events
- Visits to young people's groups and schools
- http://www.healthwatchtorbay.org.uk/index.php?page=young-people

- Torbay Youth Power – Healthwatch
- HWTyouth
- Survey Monkey online questionnaires

These different formats ensure young people can feedback their experiences, views and wishes to Healthwatch Torbay and distributed to the relevant services.

Methodology

Young people

314 young people aged 14 – 19 were involved in a 6 month project.

The focus on this work developed from baseline assessment consultation with a variety of groups of young people delivered by Bekki Redshaw Youth Coordinator.

- Torbay Youth Power Core Group 36 young people
- Level 2 Health & Social Care students 28 young people
- Level 3 Health & Social Care students 23 young people
- Torquay Boys Grammar School 6 young people
- Torbay National Citizen Service 12 young people

Consultation activities covered all aspects of health. It soon became apparent that emotional wellbeing received the strongest and most in-depth responses. Due to the high response to these questions, more focussed work was devised and delivered to young people.

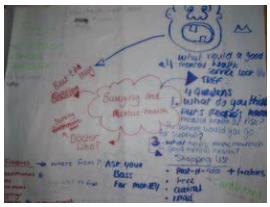
Through various different pieces of group and individual engagement work delivered by Healthwatch Torbay it became apparent issues around emotional wellbeing were a concern for parents and carers, and professionals who work with young people. This information has been added to this report to give an understanding of services for young people from all perspectives.

Focussed/targeted work

The work was then developed to deliver specific consultations on emotional wellbeing and mental health to gather more focussed information, and identify young people's solutions.

Young people were not asked to disclose which service they used specifically, as this research was to give an overview of services, not to evaluate specific services. Young people talked about services such as: Counselling, School Counselling, Drug & Alcohol Services.

Within conversations, many young people disclosed personal experiences of accessing support services, giving in-depth experiential feedback.



Direct work with Torbay Youth Power **36 young people**

- Identifying bullying as a major impact on emotional wellbeing.
- Devising Survey Monkey Bullying Questionnaire which looked at impact of bullying on young people's emotional wellbeing.

South Devon College **128 young people**

- Level 2 Health & Social Care students. 28 young people
  - Baseline assessment of issues that concern students identified bullying as a top issue for young people.
- Level 3 Health & Social Care students. 23 young people
  - Design & deliver of creative consultation activities at Healthwatch Torbay Young People's Launch (Appendix 1). 80 young people
  - Survey Monkey.

Torquay Boys Grammar School **6 young people**

- Baseline assessment of issues that concern students identified bullying as a top issue for young people.
- Survey Monkey.
- Planning peer support project – on-going.

Torbay Young Adult Carers **6 young people**

- Informal conversation.
- Question in YAC Evaluation interviews. **11 young people**

Torbay Young Carers **30 young people**

- Informal conversation at Young Carers Event.
- Evaluation responses.

National Citizen Service **37 young people**

- Consultation of NCS membership. **12 young people**
- NCS Peer Creative Consultation delivered to other young people. **25 young people**

Torbay Pride LGBTQIA youth group **3 young people**

- Generic consultation asking "How can we (adults) support young LGBTQIA people, where all conversation focussed on homophobic bullying.

Survey Monkey **78 young people**

- 3 X 10 question online surveys.
  - Beat Bullying. 38 young people
  - Beat Bullying Witness. 30 young people
  - Emotional Wellbeing. 10 young people

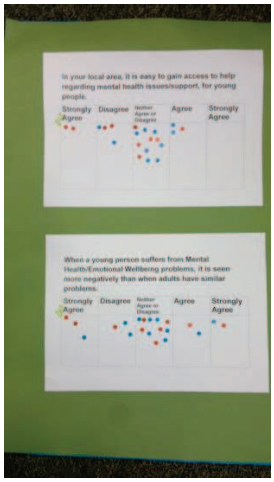
Facebook **4 young people**

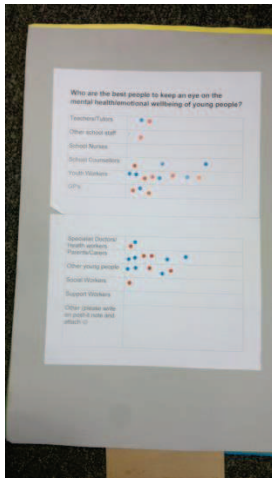
- Promotion of Survey Monkey and updates of bullying work prompted young people to contact Youth Coordinator with their personal experiences.

Research of online services

Some groups research online support and advice services to evaluate and find out other ways to support young people.

- Torbay Youth Power. 12 young people
- Level 3 Health & Social Care students. 25 young people
- Torbay National Citizen Service. 9 young people





Adults

Direct work with parents

- PPF consultation.
- Parent's feedback at Healthwatch Torbay events/consultations.

Direct work with professionals

- One to one conversations with staff from different organisations that had referred young people to services. Most of these conversations were initiated by professionals; highlighting issues were being identified by all parties involved, which informed the focus on this work.
- Evaluation delivered by worker on behalf of Report Author.

Gaps in Research

Children Looked After (CLA)

Nearly half of looked after children have a mental health disorder and two thirds have at least one physical health complaint. *DofE Outcomes for children looked after as at 31 March 2012*.

Three of the young people involved informed that they were CLA, however there was no research with CLA as a targeted group, therefore we were unable to explore with them the experiences and impact of being Looked After.

Black and Ethnic Minorities (BME)

Due to timescales no engagement was developed with All Different/All Equal or TIFFY (Torbay Inter Faith 4 Youth)

Conclusion

This work was delivered to general groups of young people, two targeted groups, and on Facebook via a Survey Monkey questionnaire. It therefore reached a broad range of young people, some who had used services and some who had not. However, all were experienced in knowing how well services promote themselves and inform young people of what they do.

The results show that the majority of these young people, parents and workers do not feel that there are sufficient effective young people friendly support services for young people.

Young people say

- They do not have enough information about services
- There is a need to develop early intervention services to ensure young people do not go into crisis
- They find it hard to access services
- Referral processes are too long, too intrusive and too complicated
- Young people are not actively involved in the processes of identifying need, identifying which service, engaging and ending of services
- When services are accessed they do not met young people's needs
- Early intervention is important to ensure good wellbeing by providing social engagement and access to youth workers who can give support before crisis sets in
- Schools need to provide good quality, young people friendly and appropriate information on how to keep well, indicators of ill health, how to support yourself and your friends, and what services are available
- Bullying is a huge unchallenged issue, with some teachers even seen as bullies themselves

There is a need for more in-depth research to support young people, parent/carers/professionals and commissioners, to ensure that the appropriate effective services are provided.

Acknowledgements

Torbay Youth Power would like to thank the following people for their input and support without which the project would have been impossible:

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South Devon College

Sally Freeman Health & Social Care Lecturer

Kelly Passmore Health & Social Care Lecturer

Anna Heath Head of Health & Social Care

Torbay Boys Grammar School

Mr Adam Last Teacher

Sharon Walker Pastoral Support Liaison Officer

Torbay Young Adult Carers

Cheryl McKinnon Young Adult Carer Development Worker

Lisa, Rob, Natalie and Lucy

Torbay Young Carers

Teresa Mikalauskas Senior Project Leader
Young Carers

National Citizen Service Community Action SW

Lucy Wood NCS Coordinator Torbay

Molly Williams NCS Worker

Geoff Carter NCS Worker

Young People

Torbay Pride

Emily Wilebore Sexual Health Outreach Young People's Worker

Karen Parker Senior Youth Worker

Young People from the group

Healthwatch Torbay

Sarah Bickley

Pat Harris CEO

Appendixes

Appendix 1

South Devon College
Creative consultation

What helps people have good mental health?

- Friends X 8
- Good family X 5
- Things to do

1. **Where do we go for support?**
    - Friends X 14
    - Family
    - PI

2. **What puts people mental health at risk?**
    - Bullying
    - Abuse
    - Bad experiences

3. **Where we would like to go if we needed extra help/what an ideal Mental Health Service look like??**

Appendix 2

Survey Monkey: Beat Bullying

38 young people

- I felt left out and lacking in enthusiasm.
- Feel like shit.
- It made me angry and felt like I didn't belong in the school. I was bullied by a teacher and asked everyone how they felt because I was 'keeping them behind' because I was talking. It made me feel small and that I was the hated one.
- Made me upset.
- Normally didn't bother me. Silly people.
- I felt that I couldn't be myself.
- When I was younger as in at primary school it affected me more than it did when I started secondary school because different people just kept repeating the same old usual rubbish and it got predictable and boring. Luckily I grew up with no issues about my skin colour and the way I was brought up without a Dad but there was still pathetic children who would try and bring me down because of it.
- made me feel bad about myself. Made me paranoid of the way I looked and I couldn't be myself around people.
- Eating disorders - Self harm - Depression - Anxiety - not being able to have a relationship.
- The bully often acts the VICTIM so TEACHERS believe them... Teachers need to OPEN their minds more.
- made me less confident and made me isolate myself.
- I just get annoyed why some people treat us unfairly.
- It made me feel alone and I didn’t want to go out, I didn’t tell anyone as I was embarrassed, it got to the point where I wanted to move to another country, but after a while it stopped and although I haven't forgot what it feels like I have moved on.
- Low self-esteem Feeling that you don't fit it Not feeling normal Feeling sad and destroyed emotionally Not knowing who to tell or who can help.
- I didn't want to who I was and faked being someone for years, I changed myself as a person and what I was like.
- I became very upset, self-conscious about my looks.

- I was upset, felt like I was worth nothing and suffered from depression. I didn't want to live anymore, the constant bullying each day at school was horrible, it made me not want to go to school. I just wanted to be alone.
- Made me depressed and I didn’t feel like wanting to do anything.
- Seriously knocked my confidence.
- Made me feel less confident and have low self-esteem. Caused me to feel shy when meeting new people and I was more reluctant to speak up in class.

Appendix 3

Survey Monkey: Beat Bullying Witness

30 young people

- Looking sad or not really talking in lessons by staying away from people.
- Was on public transport , on the top deck bus only about 10 people on the bus she a person was shouting at her and calling her names she tried to defend herself but this person was over powering her with words. In the end my friend and I told the person that was bullying the other person to stop it. The person that was getting bullied got off the bus.
- they wouldn’t come into school, wouldn’t talk to anyone, lost all confidence.
- Feel like shit :(
- harming themselves.
- They became detached from society, rebelled against everyone and were sometimes suicidal.
- They became very shy and did not like to go out anywhere.
- Low self-esteem.
- feel horrible about themselves.
- They become upset and scared.
- They were very quiet and not confident, they did not open up to other people or want to make new friends in case of more bullying. They wouldn't talk to anyone about the problem as they thought it would make things worse.
- they looked sad as if they have had enough.
- Low self-esteem, Low self-confidence, Staying away from public places, Suicidal thoughts.
- Made them depressed and upset.

Appendix 4

NCS young people consultation

General feedback:

- Girls get more recognition for health/mental health issues.
- Bigger force on boys.
- Both sexes have huge pressures re image.
- Boy's role models are either David Beckham or Shrek.

Specific feedback from YP who have accessed counselling:

- **Experiences:**

One young person experienced counselling at primary school, all others at senior school. None had experiences outside of school.

- Primary school – "Going to have special time" Played with animals. Felt judged.
- Mum wanted me to speak to some so she contacted the school.
- Pulled out of lesson –highlighted I was different. Everyone knew where I was going. Pink slips.
- Counsellor made me bring up stuff that I didn't want to.
- What is she going to do about it – makes no difference.
- I felt pre-judged – they watch you constantly.
- Everything I said wrote down – never shared what they wrote.
- So many questions I felt like I was on Mastermind. Went on & on.
- I didn't feel I connected with my counsellor.
- Sticking their nose in.
- Don't help you find.
- No one asked if it was doing any good.
- Made me feel 1 step forward 2 steps back.
- Once I had left the room I was left on my own.
- Counsellor ended it "my progress getting better." Didn't ask me how I felt
- (after questioning by facilitator) don't get told if we don't get on with counsellor we should be able to choose another – as in adult services.
- I didn't like them so I didn't go.
- Room was bare – desk chair & chair.

- **Recommendations:**

- Should be asked do we want to do counselling.
- Should be told what it's about.
- (after questioning by facilitator) should be told we can have different counsellor if we don't connect with first.
- Should chose time when meeting – don't pull us out of class.
- Should be able to choose where want to meet.
- Bigger space – make it feel it's not a prison.

NCS Community Consultation July 13

When a young person suffers from Mental Health/Emotional Wellbeing problems, it is seen more negatively than when adults have similar problems.

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Female	2	1	6	1	1
Male	1	2	6	1	1
Total	3	3	12	2	2

Young people are made aware enough of potential Mental Health/Emotional Wellbeing problems.

	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
Female	3	4	0	2	0
Male	1	5	1	0	0
Total	4	9	1	2	0

There is enough support given to young people suffering from Mental Health/Emotional Wellbeing problems.

	Strongly Agree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
female	1	4	5	0	0
male	2	2	2	0	0
	0	1	1	0	0
total	3	7	8	0	0

Schools provide enough & good information regarding Mental Health/Emotional Wellbeing.

	Strongly disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
female	2	7	1	0	0
male	2	4	1	1	0
Trans/not say	0	2	0	0	0
total	4	13	2	1	0

In your local area, it is easy to gain access to help regarding mental health issues/support, for young people.

	Strongly Agree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree

Female	**2**	**2**	**5**	**1**	**1**
Male	**0**	**2**	**7**	**2**	**0**
Total	**2**	**4**	**12**	**3**	**1**

Who are the best people to keep an eye on the mental health/emotional wellbeing of young people?

	Females	**Male**	**Total**
Teachers/Tutors	2	1	3
Other school staff	2	0	2
School Nurses	1	0	1
School Counsellors	0	0	0
Youth Workers	5	4	9
GP's	4	1	5
Specialist Doctors/ Health workers	1	1	2
Parents/Carers	3	4	7
Other young people	3	3	6
Social Workers	1	0	0
Support Workers	1	0	1
Other (please write on post-it note and attach ☺	Family School pastors		

What, for you, would be the most ideal way to provide support and advice for young people regarding mental health/emotional wellbeing?

- Have support at youth clubs discussing how they are feeling.
- Be there do something fun.
- Doing an engaging fun activity that involves people whilst providing awareness.
- Provide meetings as youth clubs.
- Through school counsellors etc.
- More friend in school.
- So be talkative & help other with their problems.
- Schools to get involved more to help people that are mental or emotional wellbeing.
- SE lessons.
- Have lessons at school.
- More lessons about mental health issues at school PSME.
- Unicorns and quadrophonic rhinos.
- Making it easier to access in a private and personal way.
- To approach people about any problems (16).

Appendix 6

Survey Monkey: Emotional wellbeing

10 young people

Q2 Which area are you from?

Answer Choices	Responses
Torquay	20% 2
Paignton	40% 4
Brixham	10% 1
Newton Abbot	10% 1
Teignmouth	0% 0
Dawlish	10% 1
Other (please specify) Responses	10% 1
Total	10

Q3 What is your gender?

Answer Choices	Responses
Male	40% 4
Female	60% 6
Trans	0% 0
Intersex	0% 0
Prefer not to say	0% 0
Total	10

Q4 When a young person suffers from Mental Health/Emotional Wellbeing problems, it is seen more negatively than when adults have similar problems.

Answer Choices	Responses
1 - Strongly Agree	30% 3
2	30% 3
3	20% 2
4	10% 1
5 - Strongly Disagree	10% 1
Total	10

Q5 Young people are made aware enough of potential Mental Health/Emotional Wellbeing problems.

Answer Choices	Responses
1 - Strongly Agree	10% 1
2	0% 0
3	10% 1
4	30% 3
5 - Strongly Disagree	50% 5
Total	10

Q6 There is enough support given to young people suffering from Mental Health/Emotional Wellbeing problems.

Answer Choices	Responses
1 - Strongly Agree	0% 0
2	0% 0
3	20% 2
4	30% 3
5 - Strongly Disagree	50% 5
Total	10

Q7 Schools provide enough & good information regarding Mental Health/Emotional Wellbeing.

Answer Choices	Responses
1 - Strongly Agree	0% 0
2	0% 0
3	0% 0
4	30% 3
5 - Strongly Disagree	70% 7
Total	10

In your local area, it is easy to gain access to help regarding mental health issues/support, for young people.

Answer Choices	Responses
1 - Strongly Agree	0% 0
2	10% 1
3	20% 2
4	20% 2
5 - Strongly Disagree	50% 5
Total	10

Who are the best people to keep an eye on the mental health/emotional wellbeing of young people?

Answer Choices	Responses
Parents/Carers	70% 7
Teachers/Tutors	70% 7
Other school staff	30% 3
School Nurses	50% 5
GP's	30% 3
Specialist Doctors/Health workers	40% 4
Other young people	60% 6
Youth Workers	80% 8
Counsellors	20% 2
Support Workers	40% 4
Social Workers	40% 4

Total Respondents: 10
Comments(0)

Q10 What, for you, would be the most ideal way to provide support and advice for young people regarding mental health/emotional wellbeing?

Youth workers as one has helped me with everything
Get the word out about mental health
Anonymous text line
Leaflets
chats at school in PSHE
Being told in early teens that its normal to have mental health problems and different types, also where you can get help from before it goes too far.
online and private meetings

Appendix 7

Consultation with Torbay Pride LGBTQI youth group

"What is it like to be a LGBTQIA young person in Torbay?"

The question was deliberately broad so young people identify their own focus, issues and experiences.

Experiences

- Homophobic teachers & students.
- More with girls.
- We deal with it ourselves – no teacher interventions.
- Teachers don't care about us.
- Teachers ignore homophobic bullying "push to one side … make their lives easier."

- “don’t know how to deal with it.”
- Teachers homophobic.
  - RE teacher – kept me behind after class to tell me “It’s a disease” & “Gays will never get married.”
  - “You can’t help the colour of your skin but you can chose your sexuality.”
  - “Shouldn’t know at your age.”
- Victim blame.
  - One young person constantly bullied, ignored by teachers, gets angry and “kicks off” “annoys me .. end up lashing out” so is constantly put on card, sent to unit - getting reputation as a problem. NOONE asks why she gets angry.
  - One young person had to move groups because of the amount of homophobic bullying aimed at her. Bullies not moved or dealt with.
  - Not believed – Ganged up on.
  - “Teachers believe more voices rather than true voices.”

Where does homophobia in school come from?

- Learn it from other students.
  - See young people get bullied.
  - See homophobic bullying not dealt with = OK to do it.
  - Don’t have an opinion so copy.
  - Influenced by homophobia at home.
- Learnt in primary school – not challenged there.
- Religion.
- Teachers don’t challenge/collude/are homophobic.
- Young homophobic people.
  - Don’t care about impact on bullied person.
  - Do it to look cool.
  - May not start but shift alliance as…
  - Homophobia is the norm – people accept it.

Complaints

- Don’t cos it won’t change anything.
- Complaint made by my mum cos I was put in unit cos I went mental cos I was getting from my whole year.

Coming out

- Safety in numbers.
- Large friendship groups coming out.
- Young people come out in groups/couples NOT as individuals.
- Outed by others as assumed LGBTQIA.

Support

- **Teachers -** No! they are either homophobic or don’t care or don’t know how to deal with it.
- **School nurse -** No! She’s hardly ever there, don’t know when she will be there, school uses first aiders.
- **Tic Tac -** doesn’t like me.
- **Parkfield -** assaulted but told youth worker (Becky) who dealt with it. Spoke to young people and didn’t tell LGBTQIA young person’s parents as they wouldn’t be supportive – they checked with young person.
- **Police -** If assaulted yes.
- **PC in school** – “No! Big, Tall and Scary! Not approachable.” “No because last time I was in trouble.”

Relationship support

- Sister.
- Dad.
- In all other consultations friends has come out as one of most popular – this group no young person said friend.

"How can we support LGBTQIA young people?"

- SUPPORT.
- Not judge the children/YP.
- Support for people who are out or questioning how to know.
- Not make inappropriate comments.
- Teachers need to do something.
- LGBTQIA needs to be addressed (education) to younger students.
- Train teachers how to deal with it – teachers need training.
- Get people – specialists in (school to deliver training).
- What action taken should take into consideration what LGBTQIA young person wants.
- Sex Ed needs to cover everything.
- Will put effort into supporting questioning/gay people.
- Will actually acknowledge sexuality instead of shrugging it off.
- Won't subject people because of sexuality and will support people and treat as equals.
- Posters.
- Websites (private).

healthwatch Torbay

Making Melville Marvellous Community Engagement Project Report

Tell us your story ...
Your voice counts

"I welcome this report and the community spirit behind it to 'Make Melville Marvellous'. We look forward to continuing to work in partnership to improve the lives of people in this area."

Mayor of Torbay, Gordon Oliver

"We look forward to working together with Healthwatch Torbay and other organisations to see the recommendations implemented and to significantly improve the health and wellbeing of Melville's residents, both present and future."

Torbay Council Executive Lead for Health and wellbeing , Cllr Chris Lewis

"This report shows the vital role Healthwatch will play in the new NHS system. Firstly the health service can always benefit from constructive criticism and the report's recommendations on the GP appointment booking system will hopefully start to resolve an issue that has concerned the public for some time.

Secondly there is now a drive to identify wide ranging issues that cut across local service boundaries and suggest long term, pro-active solutions that are very much needed. It's sadly long been the case that the Melville Hill area has suffered from some social problems and while things have improved in recent years, much more can be done. It's absolutely vital that decision makers recognise that things like housing conditions, street cleanliness and the provision of community assets all link together to improve wellbeing and are an essential part of a good public health strategy.

By being pro-active about this, as the report urges, we will see a happier and healthier quality of life for residents. This is excellent in itself but also has the added benefit of reducing the burden on hard-pressed local health services."

Adrian Sanders, Member of Parliament for Torbay

"This report offers a really valuable insight and understanding of the core health and wellbeing issues in the Melville area, which has much higher levels of deprivation and health inequalities than the Torbay average. It's realistic and targeted recommendations will enable all partners to work with the community to deliver more targeted work to improve the lives of residents in the area."

Torbay Director of Public Health, Debbie Stark

Making Melville Marvelous Community Engagement Project Report

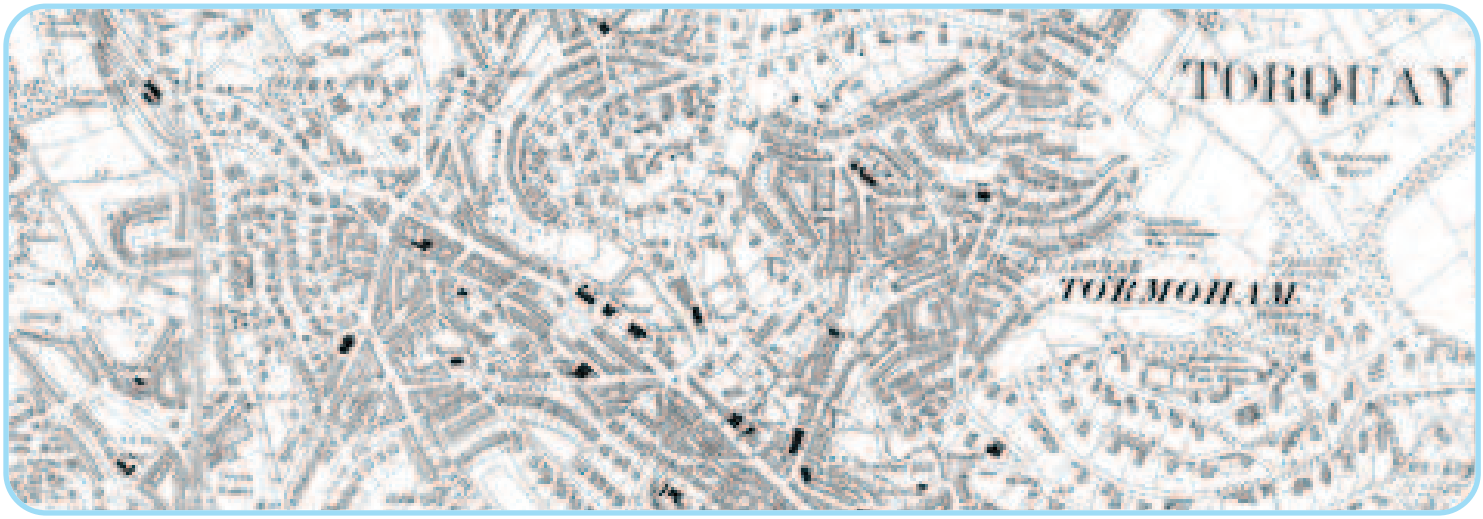
In March 2013 we worked with the community of Melville Hill and Warren Road to gather thoughts, comments and suggestions about how it is to live, work and play in their community as a commissioned project for healthwatch Torbay

healthwatch

Making Melville Marvelous

Melville Hill Community Group
Facebook Melville Hill

Context



The History

The Melville Hill neighbourhood sits above Rock walk overlooking Princess Theatre and is older than Torquay, which was established in 1850. Melville Street, Warren Road and Abbey Road have been described as making up a fine nineteenth century townscape.

As a Conservation Area the community has 44 listed buildings. During the 1820s some houses were built on Waldon Hill, and in the 1840s Warren Road, Abbey Road and Melville Street were constructed. A great community resource is the Clipper Inn, which used to be the Melville Inn.

It's reputed to be haunted. In the early 1960s the Clipper was home to Torquay's Beatniks, who used the pub to perform poetry and music. One of those Beatniks was Donovan who produced a series of hit albums and singles between 1965 and 1970.

Donovan was one of the few artists to collaborate on songs with the Beatles and he influenced both John Lennon and Paul McCartney when he taught them his finger-picking guitar style in 1968. In 1964 Donovan spent the summer in Torquay, living in a bedsit in Abbey Road, where he wrote his first hit, 'Catch the wind".

A map of 1861 shows that schools and church buildings were already in place. These included the Catholic Church on Abbey Road and the Quakers Meeting House, which is now the Samaritans.

K.Dixon (2013) THe History (Unpublished)

Context

In 2010, Sir Michael Marmot undertook an independent review (Fair Society Healthy Lives) of the causes of and most effective evidenced based strategies to reduce health inequalities. This review re-enforced the links between social conditions and health and the need to create and develop healthy and sustainable communities in order to reduce health inequalities. He concluded that reducing inequalities will only be achieved through the collaboration of services and communities to create flourishing, connected communities.

Flourishing communities are those where everyone has someone to talk to, neighbours look out for each other, people have pride and satisfaction with where they live and feel able to influence decisions about their area. Residents are able to access green and open space, feel safe going out and there are places and opportunities that bring people together.

One of the Review's key messages on challenging health inequalities is that:

"Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities". The asset asset based approach to community development (ABCD) provides an ideal way for councils and their partners to respond to this challenge.

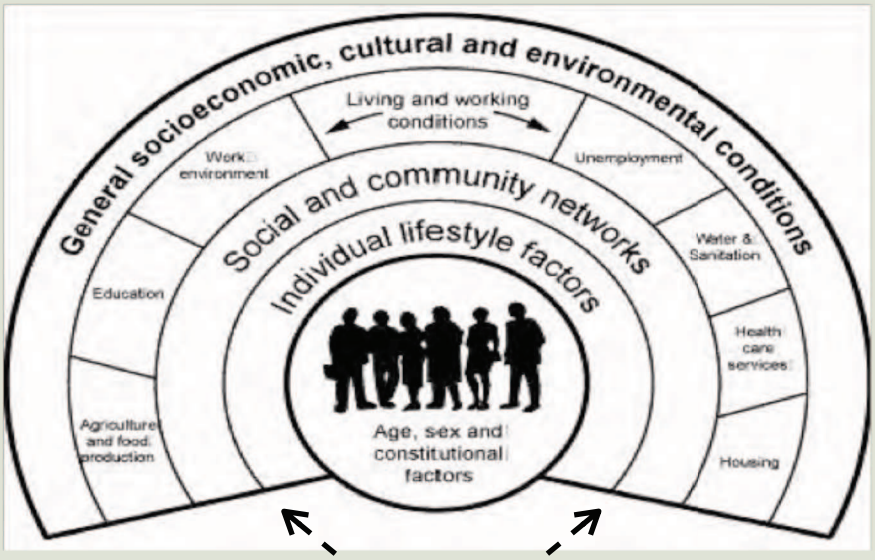
The emphasis of community-based working has been changing. Among other aims, asset based working promotes well-being by building social capital, promoting face-to-face community networks, encouraging civic participation and citizen power. High levels of social capital are correlated with positive health outcomes, well-being and resilience. (UCL,2010).

This report looks at one of the neighbourhoods within the Tormuhoun ward of Torquay, that has higher levels of deprivation and health inequalities. The Melville Hill area, where a perceived lack of community engagement and multi agency focus has led to poor health and well-being.

Specifically we have set out to;

- Explore the health and well-being needs and the community assets within Melville using a community engagement approach through the use of questionnaires, focus groups and other creative approaches.
- Identify issues that can be addressed in the short-term.
- Explore way to build community cohesion using an assets based approach.

To inform our work on the determinants of health and well-being, we have used the Dalgren and Whitehead model. Dahlgren and Whitehead model (1991) in conjunction with 'A Glass Half Full - how an asset approach can improve community health and wellbeing', a paper produced by IDeA in March 2010.



The asset approach values the capacity, skills, knowledge, connections and potential in a community. In an asset approach, the glass is half-full rather than half-empty.

The more familiar 'deficit' approach focuses on the problems, needs and deficiencies in a community. It designs services to fill the gaps and fix the problems. As a result, a community can feel disempowered and dependent; people can become passive recipients of expensive services rather than active agents in their own and their families' lives.

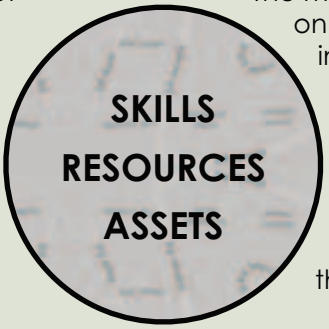


Image credit: Dalgren and Whitehead model

Fundamentally, the shift from using a deficit-based approach to an asset-based one requires a change in attitudes and values.

- Professional staff and Councillors have to be willing to share power; instead of doing things for people, they have to help a community to do things for itself.
- Working in this way is community-led, long-term and open ended. A mobilised and empowered community will not necessarily choose to act on the same issues that health services or councils see as the priorities.
- Place-based partnership working takes on added importance with the asset approach. Silos and agency boundaries get in the way of people-centred outcomes and community building.
- The asset approach does not replace investment in improving services or tackling the structural causes of health inequality. The aim is to achieve a better balance between service delivery and community building.
- One of the key challenges for places and organizations that are using an asset approach is to develop a basis for commissioning that supports community development and community building – not just how activities are commissioned but what activities are commissioned.
- The values and principles of asset working are clearly replicable. Leadership and knowledge transfer are key to embedding these ideas in the mainstream of public services.
- Specific local solutions that come out of this approach may not be transferable without change. They rely on community knowledge, engagement and commitment, which are rooted in very specific local circumstances.

Co-production

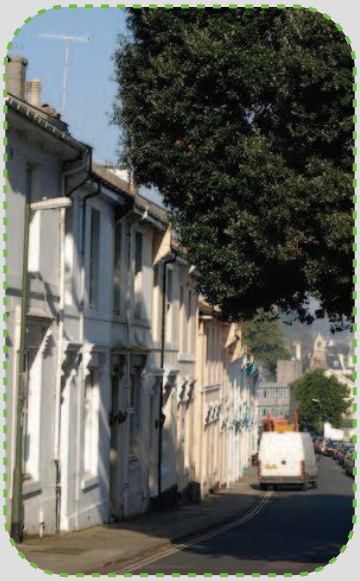
"Services do not produce outcomes, people do"

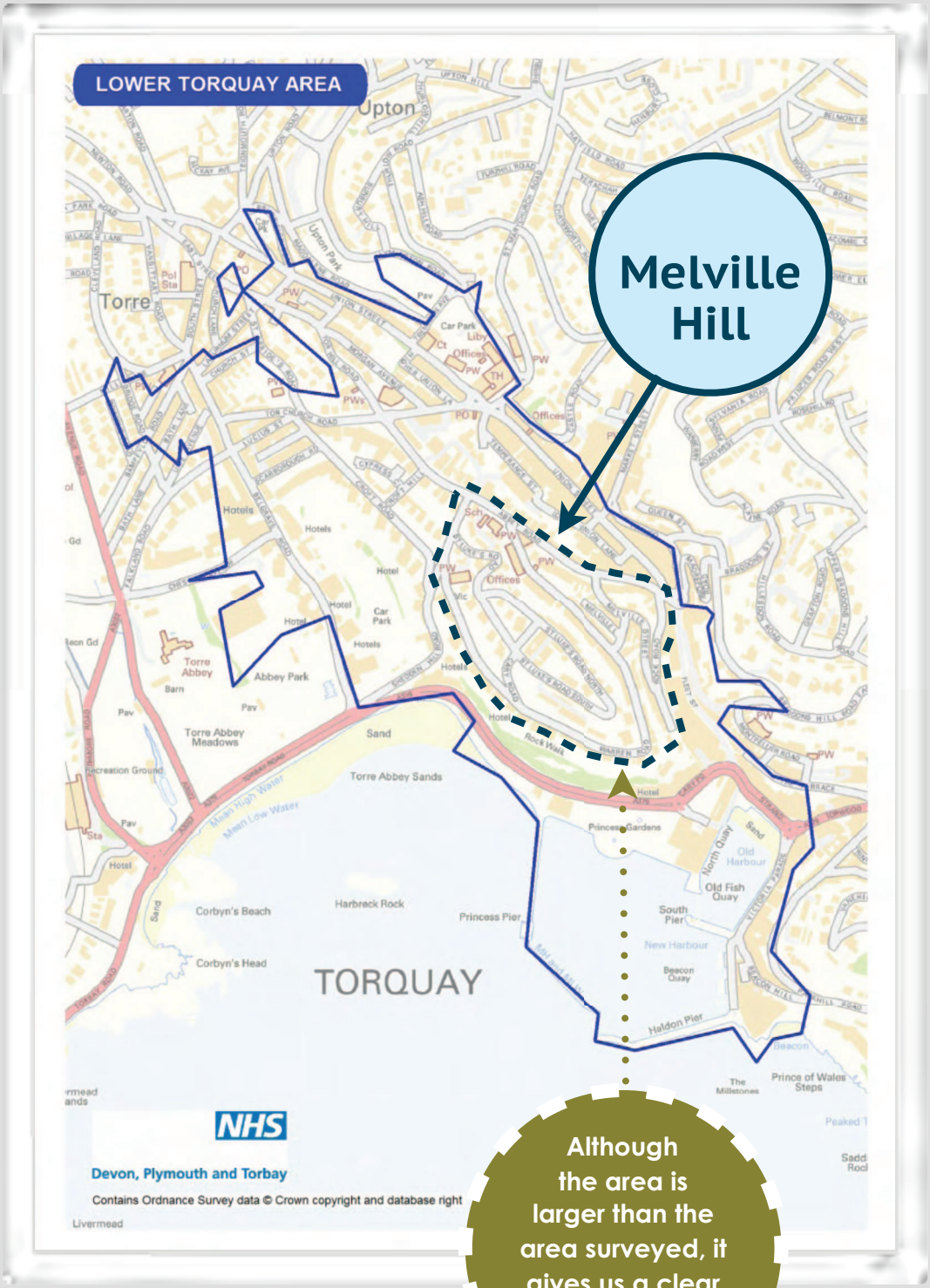
CUMMINS AND MILLER (2007)

"Individuals who are socially isolated are between two and five times more likely than those who have strong social ties to die prematurely. Social networks have a larger impact on the risk of mortality than on the risk of developing disease, that is, it is not so much that social networks stop you from getting ill, but that they help you to recover when you do get ill."

Marmot (2010) Fair Society Healthy Lives Final Report.

Context





Although the area is larger than the area surveyed, it gives us a clear indication of trends

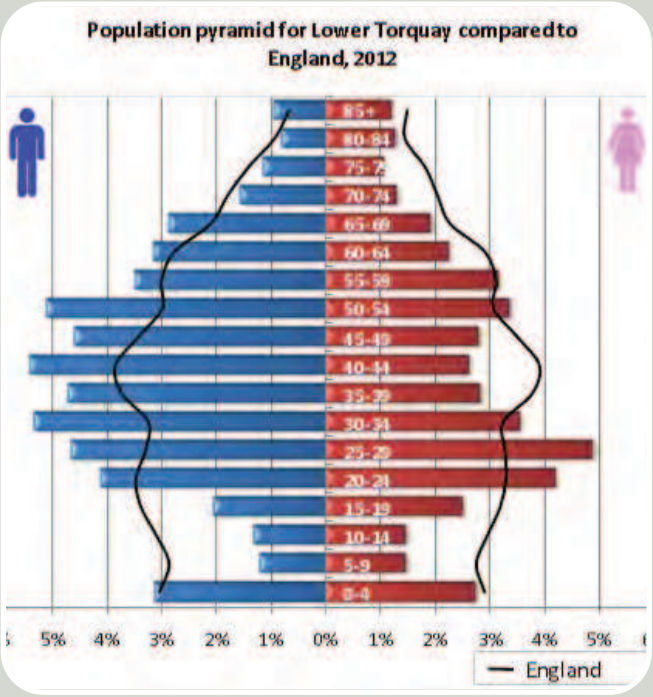
The statistics overleaf are sourced from the Office of National Statistics for the Lower Torquay Super Output area as shown on the map above. A large percentage of the blue line is retail and commercial business.

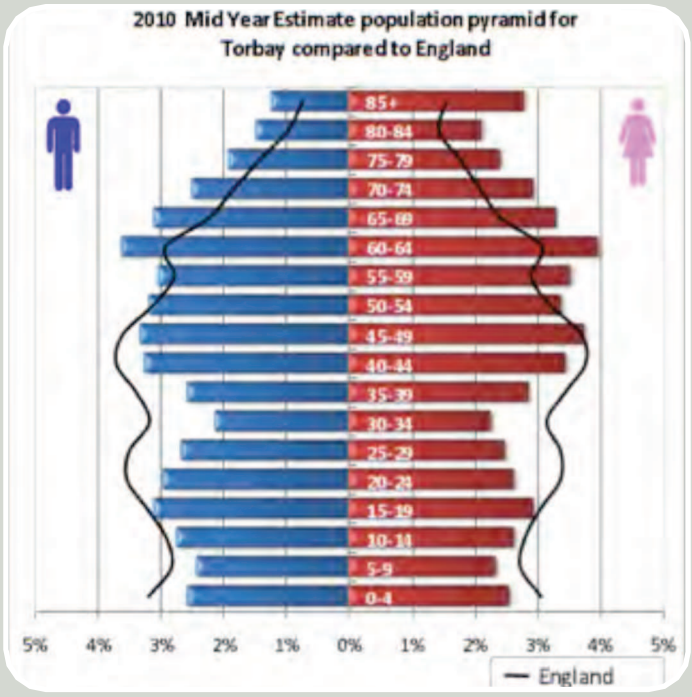
(ONS, 2011)

Demographics

Demographic charts above show a very different pattern to the wider Torbay area, with around 56% males, and a 'bulge' in the male population aged 20 through to 54.

The statistics below are sourced from the Office of National Statistics for the Lower Torquay Super Output area as shown on the map on page 5.





Worklessness and benefit are high with a large proportion of predominantly single men of working age claiming benefits. Overall, the analysis suggests that we would expect both Abbey Road and Croft Hall GP surgeries to have significantly higher rates of out of work benefit claimants than the Torbay average. Levels of incapacity and severe disablement and also duration of claim appear to be highest in Abbey and Croft. Also:

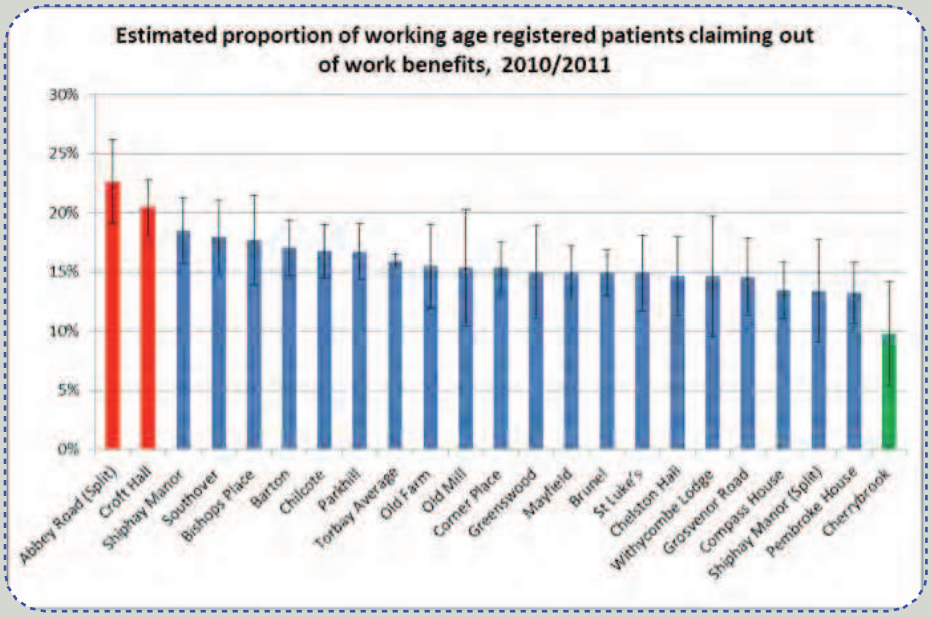
- 10.6% of the working age population are claiming Job Seekers Allowance (3.6% England & 4.3% Torbay).
- the proportion of the working age population claiming a key benefit is 34%, 2/3 of whom are men compared to 20% overall in Torbay.
- Of this, 19% is incapacity benefit.
- This area has a higher proportion of single households at 58% compared to 42% for Torbay.

Worklessness and Health

We would expect to see increased demand for GPs to sign sickness forms to support incapacity benefits. Additionally, there could be increased demand on GP time due to links between unemployment and increased chance of being ill.(Dorling, 2009)

In the following graph the position of Abbey Road and Croft Hall can be compared to the Torbay average for out of work benefits. Colours within the following graphs illustrate whether there is a significant difference, or not, to the Torbay mean. Red indicates a significantly higher values for that practice, green a significantly lower and blue suggests no significance.

Office of National Statistics (2013) Lower Torquay Super Output area [Online]. Available at http:www.statistics.gov.uk



(Source: Haines, 2011)

Housing Tenure

There are a high proportion of Houses in multiple occupation, with a density of 44 people per hectare, compared to 21 for the Torbay area: 67% of households live in rented accommodation versus 23% for the Torbay area, of which only 5% is social rented accommodation (ONS, Mar 2011). 81% of households live in flats. Several studies have shown a relationship between housing tenure and health, where housing tenure might influence health. Dampness and mould, which are related to respiratory and chronic illness and psychological distress [7]. Similarly there is a link between the high proportion of small private rented homes, the relatively high levels of benefit dependency and levels of unemployment and population profile. A more balanced housing picture with more family housing, greater levels of home ownership and less HMO's would impact positively on the feel of the area and the levels of worklessness and health inequalities.

MELVILLE HILL

Melville street (top), home to The Clipper, which Dave has painstakingly restored to a traditional community pub, banning over 60 people to ensure it is a friendly place to go!

The Alley opposite is a real piece of heritage, but subject to safety issues and anti social behaviour.

The Tree, a really positive symbol of the neighbourhood.

Whats it like in Melville

Community Activism

The Melville Hill Community Group is very active, making a real positive difference to the lives of residents in the area. Including being instrumental in lobbying the Mayor to take action against rogue landlords and to help clean up the area. As with many such groups, a small number of members are active, and the group's focus is only a part of the neighbourhood surveyed as part of the project. Making Melville Marvelous has helped the group reach out to more residents and acted as a catalyst for further activism and greater involvement.
Facebook: Melville Hill

COMMENTS FROM RESIDENTS ABOUT WHAT IT IS LIKE TO LIVE IN MELVILLE

- FANTASTIC VIEWS AND HERITAGE
- PEOPLE REALLY WANT TO CONNECT MORE, BUT HOW?
- TRANSIENT POPULATION
- TOO MUCH DOG MESS
- CLOSE TO SHOPS & TOWN
- LEGACY OF POOR REPUTATION DUE TO ANTI SOCIAL BEHAVIOUR, & DRUG RELATED ACTIVITY
- PEOPLE REALLY VALUE OTHER PEOPLE LIVING IN THE NEIGHBOURHOOD
- PARKING ISSUES

Making Melville Marvelous

Activities/methodology

Project commissioned by Healthwatch Torbay on the basis that the Melville Hill community is a neighbourhood exhibiting a number of social, health and economic issues reflected across the bay.

Methodology

The project steering group:

Kevin Dixon, Healthwatch Torbay (chair) Nick Burleigh, Melville Hill Community Group (chair) Darren Cowell (Ward Councillor)

The steering group commissioned Torbay Social Enterprise Network to conduct an engagement project

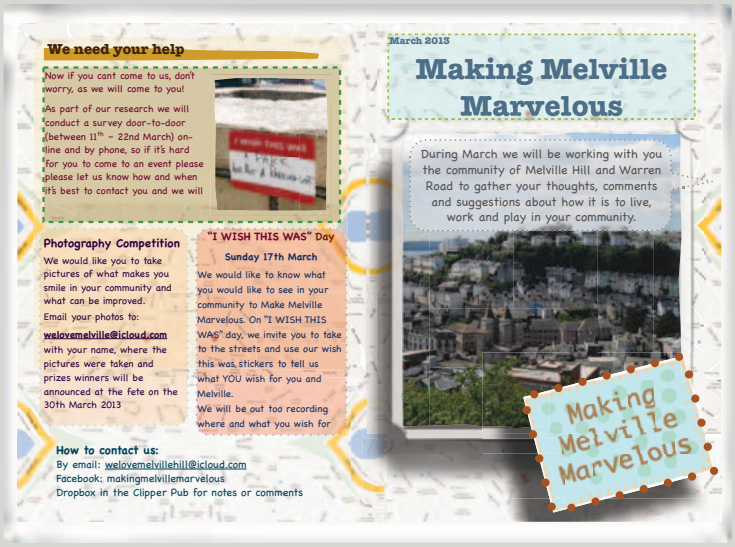
1. To gather statistical information on the area
2. To gather the views of members of the community by a variety of methods
3. To explore ways of working with the community to identify needs and to suggest ways of meeting such needs
4. To specifically consult those members of the community who may have difficulty in expressing their views
5. Ensure the approach is engaging and acts as a catalyst for community activism
6. Ensure the project covers current issues, such as ASB, poor housing stock and taps into positives, such as the heritage and history of the area

The team was lead by Simon Sherbersky, Chair, Torbay Social Enterprise Network and Patricia Dixon from Shiny Productions, an experienced creative engagement practitioner. They were supported by QUEST, which is a user led collaboration set up in Torbay to review and comment on services to vulnerable people, in order to better reach those unlikely to engage.

The project used an asset based approach to engaging the local community and designed a series of activities detailed below and a questionnaire which was taken door to door to capture people's passion and enthusiasm, to inform this report and its recommendations. In order to better appreciate the asset based approach it is worth reviewing the questionnaire in Appendix 1. Due to the limited timescale of the project a full asset mapping exercise was not conducted, but it is recommended that this is picked up by the community connector, who will be working in Torquay town centre from September.

"I WISH THIS WAS " DAY	WORKSHOPS	FOCUS GROUPS	CONSULTATION	VILLAGE FETE
	Creative workshops where the community could create their ideal neighbourhood	Opportunity to draw out further information about elements highlighted in the questionnaires	Targeting the harder to reach groups to ensure their voices were heard - door to door - on the street surveying	A community celebration to share what we learnt and to share local skills

Activities

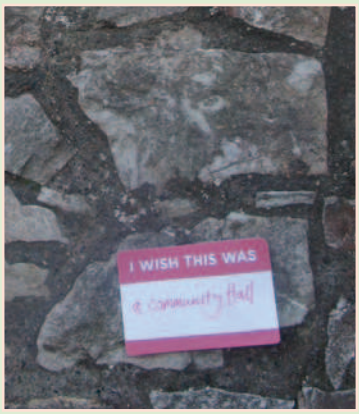


A project information leaflet was distributed to all households in the area, outlining the Making Melville Marvelous programme for March 2013. The introductory consultation session was well attended by over 40 people, which helped inform the development of a more detailed questionnaire, which is attached as Appendix 1.

In line with the brief, the questionnaire focused on trying to build community involvement. The summary survey findings are detailed below, with the full analysis in Appendix 2. 140 people completed the questionnaire.

The survey was conducted at varying times of day and evening, on weekdays and at the weekend. Both door to door and at other locations, such as the Clipper Pub and Carters convenience store to try to capture as wide a range of residents as possible. We would like to thank QUEST members for assisting us with the survey.

I WISH THIS WAS



I wish this was stickers were used by residents to place around the neighbourhood :

I wish Rock Road Laundry site was a community space; I wish they let me build my home on it

I wish the streets were cleaner and Coburg Place was re surfaced

I wish the Scout Hall was a community Centre

The best thing about this area is…

- There used to be a Guy Fawkes bonfire in the Melville Lane car park
- It's history – it's the oldest part of Torquay
- The views
- Local residents
- Friendly
- Central location – easy to get to town
- The architecture
- Samaritans drop in
- St Lukes church
- Coburg Place
- The buses

We must remember to include…

- Residents parking - Warren Rd
- Coburg Place
- Working residents
- The over 60's

Do you know your neighbours?

- Yes
- To nod to
- No
- People moving on quickly

We must remember to include…

- Somewhere for teenagers to hang out
- Residents' parking
- Young mothers
- Farnborough House
- Everyone!
- All our residents – no matter if they have social problems

The best way to talk to people about our community is…

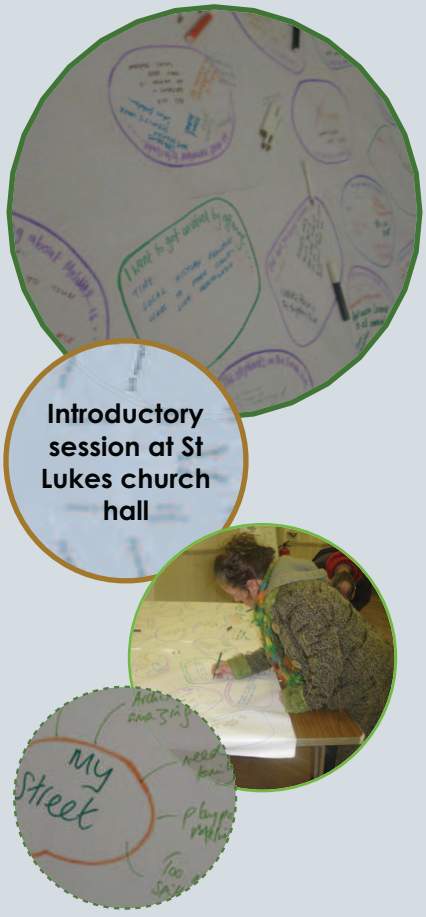
- Face to face
- The Clipper Pub
- Community Noticeboard
- Through our local faith leaders

I would really like to change…

- Dog fouling x3
- What people think about the area – aspirations
- The attitude of the dustmen, who make such a mess on collection days x3
- How we light our streets in the winter

Our biggest challenge is….

- Parking in Warren Rd x2
- Dodging the dog fouling
- Transient population
- Bad publicity
- Motivating, inspiring, encouraging those that feel disinterested / alienated



Introductory session at St Lukes church hall

Social Findings

- Over half (56.9%) of the residents of Melville have lived in the area for 5 years or less, with nearly a quarter (22.86%) being for less than 12 months indicating that the area is home to a fairly transient community which in itself presents many issues in connection to social cohesion, local crime rates and health related outcomes (Grover, 2008).
- However, a small proportion did comment that there was nothing that they liked, particularly young people and those with young families.

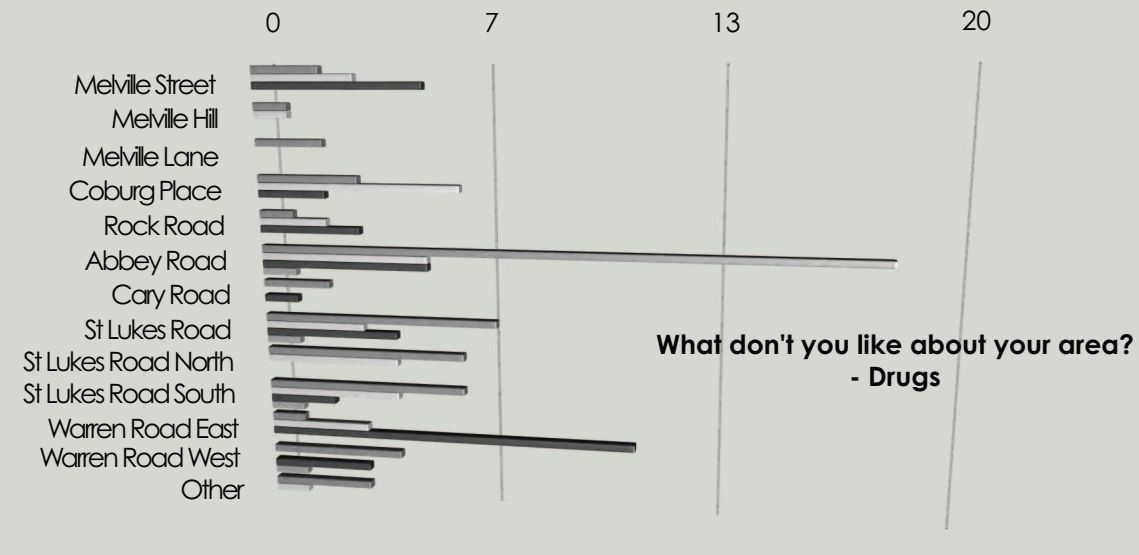
Social and Community Networks

Many respondents did state that the drug problem is nowhere near as bad as it was before and all of those who agreed with this statement had lived in the area for 5 years or more, some for over 30 years. In relation to the 'druggy / junkie' comments, many who said they were a problem then stated in the same question that drugs were not a problem in their area - leaving some ambiguity over these findings.

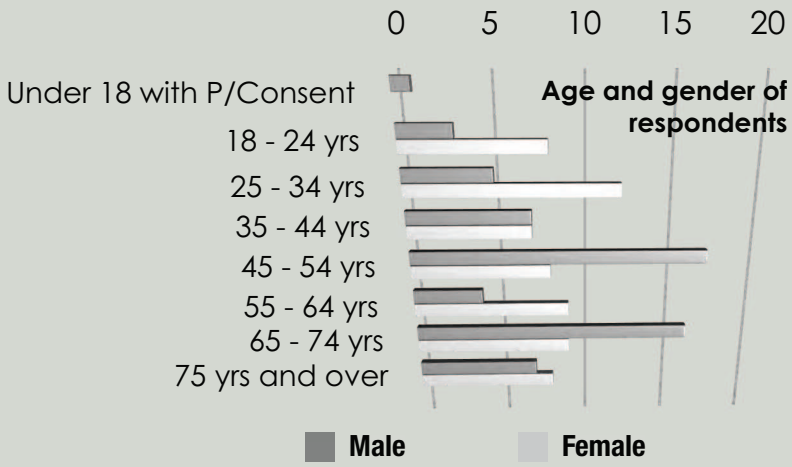
45.7% of respondents were female and 42.9% men

Indeed, and from analysing all of the comments found in this survey, it does appear that a small minority of drug users in the area today continue to promote and uphold the long-term reputation that the area had in previous years – one of heavy drug use, many drug dens and intensive drug dealing. A common theme found within communities that display evidence of a number of social issues (Croall, 1998).

Anti social behaviour was a specific issue which was not highlighted as a major concern, which is credit to recent collaborative activity between the community and relevant agencies.



What don't you like about your area? - Drugs



As you can see from the chart, it did prove problematic to reach the younger males within the area despite many attempts. This is not unusual with typically hard to reach populations – of which younger males are one. Grover (2008) notes the particular issues that specifically face this group and how not being education, employment or training (NEET), long-term unemployment, a propensity towards crime and other health inequalities all can affect young men – particularly those from lower class backgrounds. Given that this group were underrepresented in this survey indicates that there is a need to engage with this group on a more direct level, using techniques specifically tailored around their lifestyles and typical actions.

Regarding the household make up of the population surveyed, well over a quarter (36.4%) lived alone. Furthermore, three quarters (75%) of households in the area are adults only, indicating a possible lack of younger families in the area. 10% of households were single parent families (N = 132, 8 missing).

With regard to the employment status of those surveyed, 2 were students, 23 were in full time employment, 13 were in part time employment, 14 were self employed and 46 were retired. 23 respondents stated that they had been long-term unemployed whilst 9 had been unemployed for under 12 months. As seen in the charts below, unemployment spans both genders and all of the relevant age groups (N = 130, 10 missing).

Social and Community Networks

The main things that respondents wanted to keep in the area were the people, the Clipper pub, the community spirit, the views, green spaces and the big tree.

88 respondents reported that they could offer the following to Make Melville Marvelous – (N=88, 52 missing [62.9%])

Time = 24 people

Connections = 2 people

Resources = 1 person

Experience = 7 people

Passion = 5 people

Skills = 4 people

Most importantly however, 45 people stated that they could offer a combination of some or all and this was found across all age groups.

Environment Findings

When asked what the community most liked about the area, the fact that it is close to the town, beach, buses, and work were most commonly cited. Importantly, the people and the views were also the most liked within the area – strongly indicating that community spirit is found within the area and can be built upon. Being a quiet and peaceful area was also routinely mentioned. Quotes included:

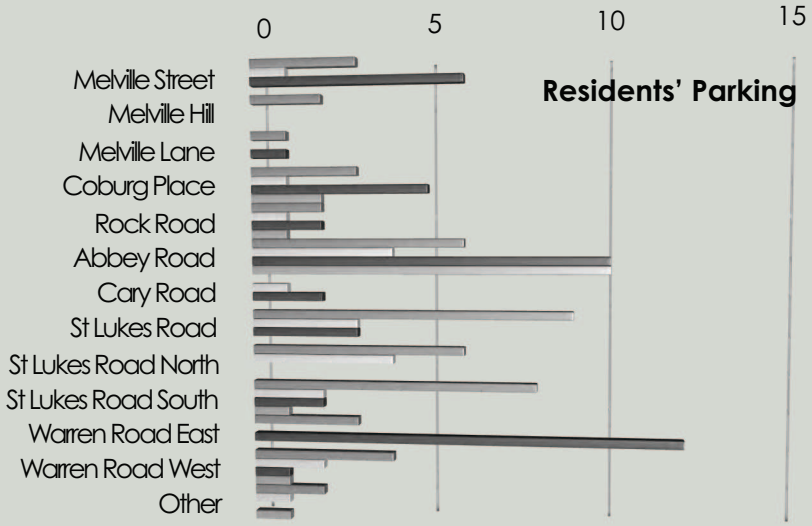
"Views, It's like Monte Carlo looking at the harbour"

"Lovely, it's pleasant and convenient for town"

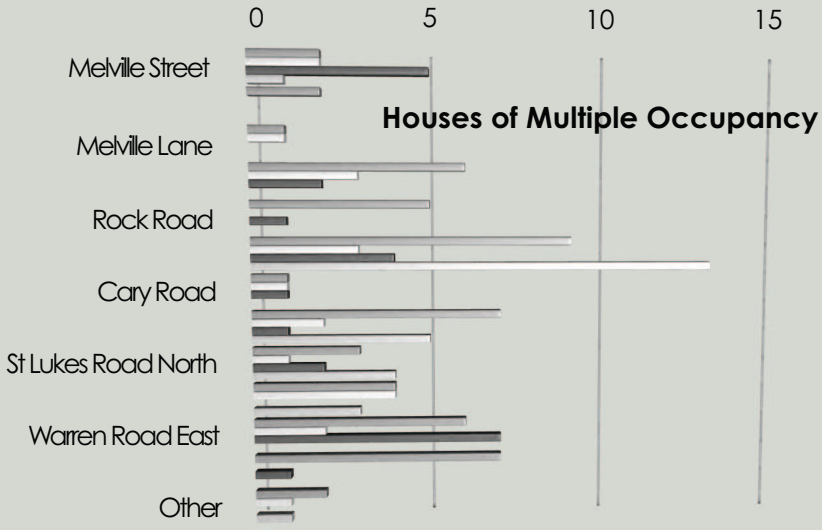
"Convenient for the shops and amenities"

"Quiet, lovely, supportive neighbours"

We asked people where they lived and therefore can pinpoint responses to specific streets or part streets (details in Appendix 2). We asked people what they didn't like and to rate the seriousness of the issue and the 3 key issues that people mentioned are shown graphically below:



Not a problem **Minor problem** **Serious problem** **Don't know**



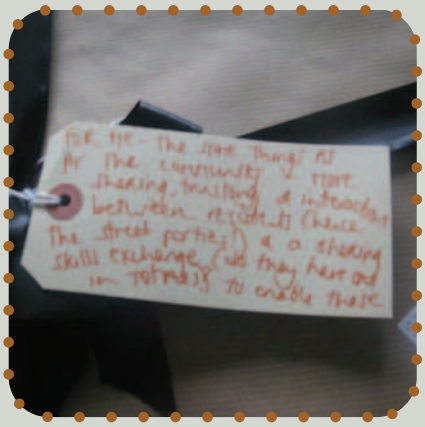
In the (please describe) section of what don't you like question (5), getting rid of the dog mess was by far the most commented upon with removal of the 'druggies' also strongly favoured.

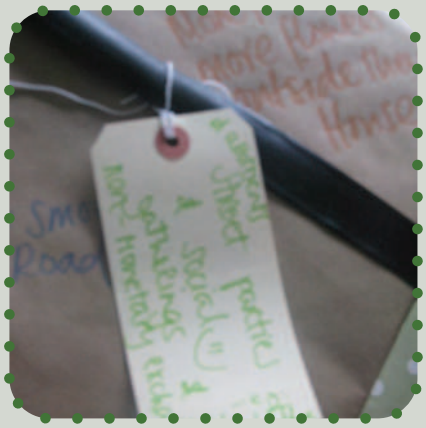
Environment findings

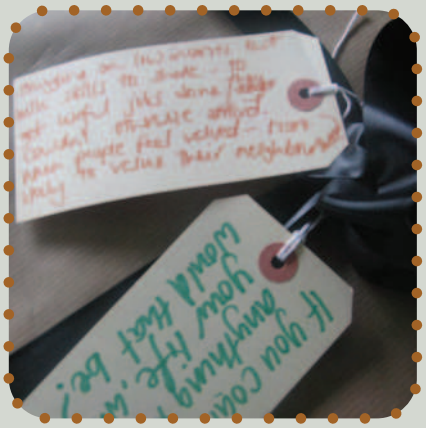
N = 129, 11 MISSING = 92.1%

NB Also highlighted by a number of respondents was the issue of the cleanliness of the streets after the rubbish had been collected, which was worse.

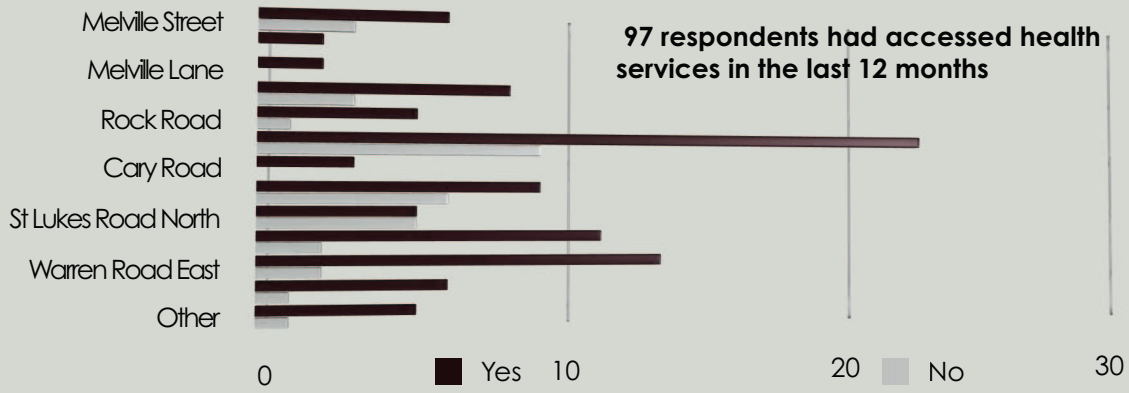
If respondents could give a gift to Making Melville Marvelous, a play park for children was the clear overall favourite with improved residents' parking, a cleaner / smarter area and more police presence being the other most commonly quoted responses.







Health Findings



97 respondents had accessed health services in the last 12 months

33.1% of those who accessed health services in the last 12 months visited their GP whilst a further 22.8% using more than one service. Interestingly, only one respondent openly stated that they had used a mental health service. Out of the above, 39.9% were very satisfied, 18.8% were satisfied, 8.7% were somewhat satisfied and 7.1% were not satisfied at all. For the respondents who did not use any services [25%] this question was not applicable.

(N = 138, 2 missing [98.6%])

Health Services

The main improvement to health services wanted was GP appointments. Many commented on the problems related to having to call first thing on the day to get an appointment, to not being able to book in advance (especially problematic when related to work, time planning etc) and the lack of quality concerning the service they received. All surgeries were both praised and criticised. Specific comments included:

"GP – being able to book in advance"

"Being able to book appointments as it's not easy having to ring on the day and hope you can get an appointment"

"Long wait to see consultant (3 months) and too long also to see GP"

"Hospital Parking"

There were many varied suggestions as to how the respondents lives could be improved. However, better health, standard of homes, job opportunities, improved green areas to sit in and access to others in similar lifestyle situations (such as families and the older age group) were the most commonly cited. Specific comments included:

"Good Health"

"To get my new hip working"

"A flat without steps"

"Better heating in my flat"

"Getting in to college"

"A job"

"Being able to walk out of my flat in to a clean street"

"A lunch club within walking distance like we had in Tor Hill Road"

"Clean up Abbey Road near Tor Haven"

"Avoiding parking on St Lukes Road (north and south) should be double yellow lines on narrow bits as bus and fire engines couldn't get through"

"A better bus service"

"Cheaper parking"

"More green spaces"

Whats Important

A lot of residents – of all age groups – live alone but strongly wish to meet up and work with other like-minded people in their area.

There is a a high level of unemployment within the younger and mid-age population, which is supported by available statistics.

There is also a high level of retirees, who have stated their desire to help but, given their age and / or health issues feel unable to commit to anything at this time.

People from all streets and ages have offered their time, resources, experience or other skills.

Therefore, it seems there is much that can be done to help residents connect, to improve their sense of health and well-being and to collectively Make Melville Marvelous!

Key to moving forward for residents is having community spaces to meet and interact and an outreach worker to work with groups to capacity build and reach more of the community.

Making Melville Marvelous

Recommendations

Melville Hill Community Group currently supports a part of the area, which has the higher proportion of rented and smaller properties (Rock Rd, Coburg Place, Melville St and Lane and Warren Rd East).

The area has a historic reputation as a dumping ground for transient, out of work single people with chaotic lifestyles. Although there are still issues, they are not as predominant as they were 5 years ago. However the area still has this association, despite the fact that the majority of residents feel it is a friendly area and what they value highly is the other people living there. This supports the need for ongoing community development that celebrates the area and builds on the area's positives, such as an asset based approach (ABCD), which was promoted in 'A Glass half full - how an asset approach can improve community health and well-being', a paper produced by IDeA in March 2010. (IDeA, 2010).

There are two examples of this already underway since the project started:

1. Residents Parking – a key priority for Warren Rd particularly. The Melville Hill Community Group has initiated a project to apply for Warren Rd east. There were a number of residents in Warren Rd west who also felt strongly about this and if involved would strengthen the case to the Local Authority.

   Recommendation 1(a): to combine resources and submit one application for the whole area concerned

   Recommendation 1(b): Given the number of people who expressed a desire to get more involved, consideration should be given to broadening the community group to encompass the whole area and try to enable people to connect more through shared activities, particularly younger and older residents

2. Tackling rogue landlords – a key political priority for Torbay's Mayor. A group of residents has formed to address this issue and have been very active in raising support through a residents' petition and social action

   Recommendation 2(a): For the Council to work with the group to support improved private landlord practice under the umbrella of the Mayor's existing initiative

3. Health – Recommendation (3a) GP appointment system is not user friendly and should be revised to make it easier for people to book in advance, around their other commitments.
Given the higher incidence of poverty and associated health issues, it is suggested that further work is undertaken with Abbey Road and Croft Hall surgeries, public health and the local community to assess potential new ways of reducing health inequalities and encouraging greater community involvement.
At the time the project took place Public Health were in the process of transferring to the Local Authority and therefore had limited capacity to engage.

Recommendation (3b): Further analysis of health issues and collaboration with GPs and CCG should be led by newly appointed Public Health Consultant, with a remit to work with community and CCG to support co produced solutions to health inequalities.

4. Play area – overwhelmingly the top priority for all age groups – set up a residents group to look at options and work with Council and Play Torbay to secure a facility or activities, either permanently or in holiday periods – this is key to changing the negative perception of younger people living in the area.

5. Develop The Clipper into more of a community resource, to ensure it is more viable and better used by more of the community

6. Community Facilities – Recommendation 6 (a) Work with the local churches to utilize existing buildings with capacity for additional community activities
Recommendation 6 b) Scout Hall – A potential community resource, unused and falling into disrepair - explore potential for re instating its use as a community facility
Recommendation 6 c) Explore potential for community space within proposed re located GP surgery in Roebuck House

7. Rock Road laundry site – owned by the Council, being marketed for sale. Major concern of residents as symbolic of an area that is not cared for by the authority and that it will be bought and land banked for later development, i.e. will remain an eyesore. Cllr Darren Cowell has made representations to Council that it will be a condition of sale to prevent this.
Recommendation: If unsuccessful, consider supporting the community to convert it into a green space, which is much needed in this neighbourhood

8. Street cleanliness – Work with TOR2 to improve the area and support development of longer term sustainable solution for Waste & Recycling and Street Cleansing services

9. Road maintenance – road surfacing on Coburg Place should be prioritized by Torbay Council

10. Dog Fouling – This was raised by the majority of people surveyed and efforts need to be continued to successfully prosecute the offending owners, galvanizing residents to take a more active role in getting admissible court evidence.

1. Longer term work:
    a. More targeted work with single working age people out of work – link to c below
    b. Street party / other community events to help build more active sense of community
    c. Make use of newly funded Community Connector to be focused on Torquay town centre from September 2013 as part of the successful Coastal Communities fund, Riviera Renaissance Asset Based Community Development project (ABCD), which is focused on working positively with those furthest from the labour market (to include asset mapping, tools to assist in mapping assets are available at http://www.abcdinstitute.org/resources/)

2. There is funding available to assist the community with their priorities:

    a. Community First – funding up to £2500 (requires matching in time / resources) - priorities are:
        i. To empower the community of Tormohun and increase the aspirations of residents
        ii. To improve the environment of Tormohun
        iii. To reduce anti-social behaviour in Tormohun
        iv. To reduce health inequalities in Tormohun
        v. To bridge the gap between older and younger people in Tormohun and improve facilites for young people

    b. Awards for All – Big Lottery up to £10,000

References

Croall, H. (1998) *Crime and Society in Britain*. Longman, Harlow. p.261-262

Cummins, J. and Miller, C. (2007) An OPM Briefing Paper: Co-production, social capital and service effectiveness [Online] Available at: http://www.commissioningsupport.org.uk/idocdec4.pdf?docid=b338a315-b38c-4c8e-b7e5-c414c8d5e4f5&version=-1

Dahlgren,G. and Whitehead,M. (1991) *Determinants of Health Model* [Online] Available at: http://www.nap.edu/books/030908704X/xhtml/images/p20008090g404002.jpg

Dixon, K. (2013) *The History* (Unpublished)

Dorling, D (2009) Unemployment and Health. *British Medical Journal*, 338:b829 [Online] Available at: http://www.bmj.com/content/338/bmj.b829

Grover, C. (2008) '*Young Men'* in Crime and Inequality. Willan Publishing, Cullompton

Haines, D. (2011) *Wider social determinants per GP practice in Torbay (Sources: Nomisweb official labour market statistics and 2010 GP practice list, The Practitioner and Patient Services Agency (PPSA)* [Online] Available at: http://www.nomisweb.co.uk/)

Ellaway A and Macintyre S (1998) Does housing tenure predict health in the UK because it exposes people to different levels of housing related hazards in the home or its surroundings? *Health and Place*, 4 (2), pp. 141-150 [Online] Available at: http://www.ncbi.nlm.nih.gov/pubmed/10671018

Improvement and Development Agency [IDeA] (2010) *A Glass Half Full - how an asset approach can improve community health and wellbeing* [Online] Available at: http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3511449/ARTICLE-TEMPLATE

Office of National Statistics [ONS] (2011) *Neighbourhood Statistics* [Online] Available at: http://neighbourhood.statistics.gov.uk/dissemination/datasetList.do?$ph=60&updateRequired=true&step=1&CurrentTreeIndex=-1&Expand13=1#13

UCL Institute of Health Equity [UCL] (2010) *Fair Society Healthy Lives: The Marmot Review – Strategic Review of Health Inequalities in England post-2010* [Online] Available at: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

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Shiny Productions

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TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title: Update Report – Children's Services

Wards Affected: ALL

To: Health and Wellbeing Board **On: 19th September 2013**

Contact: Richard Williams
Telephone: 208401
Email: Richard.williams@torbay.gov.uk

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1. I have utilised a copy of a report to the Torbay Safeguarding Children's Board to provide the Health and Wellbeing Board with an update for Children's Services.

Purpose

1.1 To outline to Members the continuing improvement journey for the Local Authority Children's Service

1.2 To provide Members with an outline of the financial challenges for the Local Authority Children's Services

2. Summary

2.1 Children's Services is continuing on its improvement journey and is positive about being formally removed from Intervention in December 2013.

2.2 The financial challenges facing the Local Authority over the next two years will call for ever clearer partnership response to both reduce demand and respond appropriately to our collective statutory duties.

3. Report

3.1 Following the Ofsted Inspection of Safeguarding in February/March 2013 the Local Authority began discussions with the DfE to formally remove our intervention status. This has not happened immediately for a number of reasons, but essentially there was a need to establish a level of confidence that the changes that had been initiated and recognised by Ofsted could be sustained.

3.2 To achieve this Professor Ray Jones would continue to visit over the next three months and provide reports to the DfE on our progress. The conditions of the Intervention Notice will then be considered at a formal review meeting in early December and I am confident that at this stage the Intervention Notice should be removed.

3.3 My level of confidence in this emanates from a number of developments that have taken place since the Inspection

1. A new Lead Member for Children's Services (Cllr Ken Pritchard) has settled into the role and provides an ongoing support and challenge role both to Officers, Members and Partners. A new Executive Head of Finance and Operations (Chief Executive, Steve Parrock) has been appointed to Torbay Council that will stabilise the organisation and provide leadership (alongside the Mayor) for the future. Finally, the appointment of the new Chair of the Safeguarding Board will bring a wealth of experience to bear on our continuing improvement journey.

2. A new Improvement Executive has been set up and meets for the first time early September. The Terms of Reference for the Executive are:

AIM

- To lead the delivery of the Children's Partnership Improvement process, securing excellent outcomes for children via the highest quality professional practice, leadership, management and partnership working

OBJECTIVES

- To monitor and direct the implementation of all the recommendations identified by Ofsted, peer reviews and address the actions arising from serious incidents

- To evaluate, support and challenge the progress being made across the partnership in improving safeguarding services and support for children

- To manage and oversee the mitigation of risks and issues arising from the improvement process and where necessary remove the barriers to improvement

- To provide added reassurance to the Department of Education that the appropriate pace and scope of improvement across children's safeguarding is being achieved.

- To receive, circulate and ensure the improvement plan addresses the outcomes from external reviews.

GOVERNANCE

The Children's Improvement Executive will be chaired by the Director of Children' Services, who will report directly to the Chair of the Local Safeguarding Children's Board and the Executive Director of Operations and Finance at Torbay Council.

The Membership of the Executive is:-

Chair: Richard Williams, Director Children's Services

Members

Cllr Ken Pritchard	Executive Lead for Children, Schools and Families, Torbay Council
Mike Lock	Headteacher Combe Pafford School
Paul Northcott	Detective Superintendant, Devon and Cornwall Police
Ms Jane Viner	Director of Nursing Professional Practice and People's Experience, SDHT
To be nominated	Torbay Community Development Trust
Gill Gant	Director of Quality Governance South Devon and Torbay Clinical Commissioning
Dr Bob Brown	Director of Nursing and Professional Practice, TSDHT
David Taylor	Chair, TSCB

The Executive will exist in its current role until the Improvement Notice is removed and will allow time for the LSCB to be reviewed and a possible revised structure to be implemented. The real challenge for the Executive will be to monitor ongoing improvements but also to pro-actively provide the executive leadership to a real multi-agency response to Safeguarding in Torbay.

3. The Children's Partnership Improvement Plan was recognised by Ofsted as an effective vehicle for change in Torbay. We have revisited the Plan and revised the projects to reflect the current situation. As previously many of the projects have 'multi-agency' working running through the middle of them and learning from the past we need to make sure that where appropriate this is reflected in the project groups that support the work.

   The key aspect of the CPIP was the discipline that was developed through the project management process and this resource has been retained to support ongoing improvements.

   The Improvement Executive will on behalf of the LSCB oversee the closure of the previous plan and the ongoing implementation of the new plan.

4. A review has taken place for Children's Services to ensure that it takes on board the learning from the previous two years, is fit for purpose and is

sustainable. Operational management of the full safeguarding process is therefore being streamlined under one Executive Head and a new commissioning team is being created jointly with adults, health and housing to ensure we maximise opportunities in the future. These changes along with other integrated approaches are currently being worked through for full implementation from April 2014.

5**.** In my eighteen months as Director of Children's Services in Torbay I have seen a significant cultural change both internally within Children's Services and externally with partners. Internally the service would often, in the past, dance around a problem, dealing with the symptoms and missing the underlying cause. Staff almost appeared afraid of raising issues and would therefore keep their heads down and carry on working a system that often worked against them. This has fundamentally changed and although there is always room for improvement we are now effective in resolving some of the long term issues that have underpinned poor performance in the past.

The relationship with partners has slowly improved during the improvement process and I now perceive willingness and indeed an enthusiasm to work together and share responsibility. This has been gathering momentum with a number of new developments and we are at a critical point where it needs to move from strategic/management discussions to influence day to day operational processes for frontline practitioners and middle managers.

3.4 The developments I have outlined provide me with a level of confidence in the continuing improvement process. However, I do retain a clear understanding of some of the challenges and realities that we will face. I have highlighted four of these to illustrate this:-

- **Budget:** The financial pressures on Local Authorities are increasing with the demands being drawn down from central Government. The targets for the Local Authority will potentially exceed £22m over the next two years and this will inevitably impact on Children's Services. As this process has now been ongoing for the past two years the majority of discretionary services have already gone and the inevitable impact will fall on early intervention/targeted support.

- **Organisation:** I am not sure that within my thinking and years in Children's Services I have ever experienced a time without change. However at this time all organisations seem to be turning themselves inside out. A characteristic of organisational change and of staff involved in the process is to look inwards and seek security through the comfort of the known. An organisation that is changing and in parallel implementing budget reductions, is only likely to exasperate this situation.

- **Demand:** The changes that are being driven at a national level and ironically the increased levels of confidence in the safeguarding services are driving up the number of contacts and referrals to the Safeguarding Service. The result

of this, in recent months, has been a steady increase in pressure within the system and parallel pressures on individual Social Workers.

- **Perception:** The increasing interest from the Media on issues relating to safeguarding and in particular the 'blame culture' associated with this places additional pressure on all levels of staff. The constant need to look for the negative overrides the consistent high quality of work undertaken by the majority of staff.

Each of these issues brings with it an additional challenge that rolled in together only serve to increase the pressures on individual organisations. As noted in the paper the natural reaction in these circumstances is to turn inwards, but the solution is often within our ability to work more effectively together and share both responsibility and accountability for safeguarding children.

4. Recommendations

4.1 It is recommended that Partners:-

Note the report
Welcome the continuing improvement journey
Pro-actively commit to the ongoing partnership approach in Torbay to secure removal from intervention
Pro-actively seek opportunities to further enhance the approach to reducing demand, statutory intervention and the ongoing improvement process

TORBAY Health & Wellbeing BOARD

Working together for a healthier Torbay

Title:	Children and Young People Update - Health
Wards Affected:	All
To:	Health and Wellbeing Board
Contact:	Siobhan Grady – South Devon and Torbay Clinical Commissioning Group
Telephone:	01803 652533
Email:	Siobhan.grady@nhs.net

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1. Purpose

1.1 To provide the Health and Wellbeing Board with an update on progress being made in relation to the jointly agreed priority areas for Children and Young People.

1.2 It is intended by April 2014 to have a single set of outcomes for the Health and Wellbeing Board which will reflect partner priorities and can be used as a performance management tool to track progress and trigger collective response. In regard to children, this work will form part of the Children's Improvement Plan.

Priorities:

- Child & Adolescent Mental Health Services
- Early Intervention (incl. Call to Action Heath Visiting)
- Disability Services
- Safeguarding

2. Recommendation

2.1 That the report be noted

2.2 That the Health and Wellbeing Board accept and sign up to the "**Better health outcomes for children and young people pledge**."

3. Children and Young Person Redesign Board

3.1 The Children and Young Person Redesign Board has been established and has currently met twice. Its Terms of Reference are as follows:

- To collaborate and co-operate to work towards ensuring that the commissioning ambitions and intentions of each of the partners are met, learning from each other and from best practice of other commissioning organisations.

- To collaborate and co-operate to ensure a focus on quality, children & families care and experience is maintained.

- Respond collaboratively to national and regional initiatives and developments

- Manage internal and external stakeholders and relationships effectively

- Work towards a reduction in health inequality and improvement in health and well-being

- Enable the benefit of working together on achieving best value for money and optimising productivity and efficiency

3.2 The membership of the group brings together both commissioners and providers as well as pubic involvement:

South Devon and Torbay Clinical Commissioning Group.
Torbay Council
NEW Devon Clinical Commissioning Group/ Devon County Council
South Devon Healthcare Foundation Trust
Torbay & Southern Devon Health and Care NHS Trust
Virgin Care
Strategic Public Involvement Group – South Devon representative
Strategic Public Involvement Group – Torbay representative Redesign Board.

4. Child and Adolescent Mental Health Services (Torbay)

4.1 Increased pressure on local CAMHS service continues with the complexity of need among children and young people presenting as well as the rise in numbers of referrals.

4.2 This is in addition to the on going staffing vacancies within the team. Interviews for Consultant Psychiatrist are due in September along with a number of other posts.

4.3 With each vacancy the opportunity to relook at skill mix of team has been taken, for instance 2 x Family therapists have been appointed, one to work in the generic team but with a focus on social care and safeguarding and another which has been joint funded with the local authority to provide a service to the Youth Offending Service and Family Intervention Service.

4.4 The service performance measures are as follows:

Measure	Apr-13 Actual	May-13 Actual	Jun-13 Actual	Jul-13 Actual	YTD Actual
CAMHS - Urgent referrals seen within 1 week (%)	33%	100%	100%	83%	81%
CAMHS - No. waiting > 18 wks for treatment	2	0	1	0	3

Wait times remain an issue as well as the flexibility to respond proactively to early intervention and preventative work at a Tier 2 level. Following an internal review of the Tier 2 service the provider has been required to submit a Management Improvement Plan.

4.2 Tier 4 – Inpatient.

Access to specialist in-patient beds has been escalated as a risk by Devon and there is cross CCG and specialist commissioning work in addressing this issue. Action to address this includes: business case to reopen Taunton beds and a business case being led by the Devon service supported by Devon Commissioners to develop an assertive outreach sat within Tier 3 operating at a 3/ 3 $^{1/2}$, in depth analysis of services and activity for eating disorder placements. Wider consideration needs to be given to extend this business case to include Torbay.

4.3 Needs Assessment

A joint mental health needs assessment (adult and children) has been completed by Devon Public Health team which covers Devon, Plymouth and Torbay. It provides some useful information based on national prevalence although is limited in presenting local service activity data. The relevant recommendations to children and Torbay are as follows:

- Service review of activity recording and data quality as part of plans for improvement.
- Carry out further analysis of self-harm activity data to gain a better understanding of the variation shown to inform future service provision
- Review current service provision for eating disorders and agree an appropriate care pathway based on the latest NIC guidance.
- Improve access to prescribing data by age group via the primary care data warehouse to support life course analysis.
- Review existing local suicide prevention strategies and consider the opportunity to refresh in light of the national strategy, o a peninsula wide basis to ensure an alignment of objectives and promote consistent preventive action.

- Undertake an improved audit and mapping exercise of the access to both commissioned mental health services and wider community based mental health support services.

5. Government Pledge

5.1 A letter went to all Health and Wellbeing Board Chairs on the 20th July 2013 from Dan Poulter, Department of Health Children's Health Minister and other experts, asking local authorities to sign up to the Government's "**Better health outcomes for children and young people pledge"**. The pledge is a part of the February 2013 system wide response, to the Children and Young People's Health Outcomes Forum Report (2012).

5.2 A copy of the pledge is attached as Appendix 1.

5.3 The Pledge focuses on addressing the variation in health outcomes for British children compared to those from other countries as well as improvements in specific areas. The Pledge asks us to focus on system wide change to work in partnership to deliver five ambitions:

1	Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.
2	Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce
3	Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.
4	Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life
5	There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

5.4 The pledge asks for joint commitment to:

- Reduce child deaths.
- Prevent ill health and improve opportunities for better long term health.
- Improve the mental health of children/ young people.
- Support and protect the most vulnerable.
- Provide better care for children and young people.

5.5 The majority of the Pledge's ambitions and joint commitments are specifically set out already in South Devon and Torbay CCG's Children's Work Plan and the Health and Wellbeing Strategy. The Pledge's joint working approach is particularly relevant to SDT CCG where services are commissioned for children crossing local authority boundaries.

5.6 The Health and Wellbeing Board is asked to officially become signatories to the Pledge.

6. Disability Services

6.1 SEND

In delivering against the Children and Families Bill, Torbay Council and SDT CCG have been working together to understand the local implications of the Special Educational Needs and Disabilities element. The changes being:

- Statements of Special Educational Needs (SEN), will be replaced by new birth to 25 Education Health and Care plans (EHC), extended to age 25 where a person stays in education,
- Personal budgets will be introduced for EH+C plans.
- Greater involvement of parents and experience in the EH+C plan.
- An increased contribution from health care professionals to MDT meetings and reports.

4% of young people aged 0 -19 are statemented for Special Educational Needs in Torbay, (900), which is considered high. There are additional numbers of those aged 19-25. 3.65% of Devon's total 0-19 population also has a statement.

A working group has been established with provider, commissioner and local authority representation and an event is planned on the 10th September, to be headed by Andre Imich from the DfE and the Southampton pathfinder authority, to whom Torbay is aligned. The event will provide an overview and help us consider the challenges we face and the solutions successful pathfinders have implemented. An action plan will be developed following this event and progress will be reported through the Paediatrics CPG and the Children's Redesign Board.

Devon have been a pathfinder for 18 months and have already developed the Devon Assessment Framework, (DAF) which they will start to roll out in their Southern Locality in late 2013/ early 2014.

6.2 Children with Complex Care Needs/Disabilities

Torbay Council has instigated a new Children's Access to Resources, Disability Panel, ensuring that specialised commissioned placements for children with disabilities and complex health needs are considered within a multi-agency forum, this is of particular relevance to jointly funded placements. The Panel provides greater assurance that children are placed appropriate to their needs and involves specialist expertise in how best to support them and their families. This Panel will also discuss IPP cases for those children who were placed under the block contract for respite care, which Torbay Council's CIS team had managed on behalf of SDT CCG. This Panel is meeting monthly.

A multi-agency group met in mid-September to review the Children's Integrated Service for Disabilities in Torbay. The meeting concluded that the team make up was appropriate to deliver the required service and that

referrals are now successfully going through the Council's Children's Hub. Further work is planned to consider the better integration of the team, the OT organisational split and utilisation of any savings.

SDT CCG has been working with the CQC in preparation for a potential inspection focusing on young people who are about to, or have recently transitioned to adults services. SDT CCG has been working with SDHFT and TSDHCT, with input from VCL, to review cases for young people 14-25, with complex health needs. SDT CCG would expect to be notified of any confirmed inspection towards the end of September.

7. Autism Pathway Review

Work is being undertaken to review the referral and diagnostic pathway for Autism, based on the model being used in Devon, where children are assessed by a Multi Disciplinary Team. It is anticipated that a business case will be brought to SDT CCG for discussion in September following commitment to redesign from all relevant providers and commissioners.

8. Engagement

The Children's Redesign Board has directed that a Children's Engagement Task and Finish Group be established to ensure the CCG learns, at every opportunity, the views of service users, parents and carers across South Devon and Torbay. Membership will include Healthwatch and Strategic Public Involvement Group (SPIG) to avoid duplication and to enable access to thoughts already captured. The engagement action plan will be monitored by the Paediatric Clinical Pathway Group, with updates provided to the Children's Redesign Board. Engagement has already taken place with consultation at the Fair Access to the Fair Day, for children with disabilities and through the Equality Delivery System Review Event.

Better health outcomes for children and young people

Our pledge

> “The foundations for virtually every aspect of human development – physical, intellectual, and emotional – are laid in early childhood.”
>
> **(Marmot)**

Children and young people growing up in England today are healthier than they ever have been before. Health care and social changes have had dramatic impacts. Previously common killer diseases are now rare. More children with serious illnesses and disabilities are surviving into adulthood and the infant mortality rate has fallen to less than a quarter of what it was at the beginning of the 1960s.

But international comparisons and worrying long-term trends demonstrate there is room for improvement, with poor health outcomes for too many children and young people compared with other countries. A smaller group of more vulnerable children – such as looked after children – suffer much worse outcomes. The variation in outcomes and quality of healthcare for children and young people is unacceptable. The clear evidence that pregnancy and the earliest years are critical to the future health and wellbeing of children and adults and that evidence-based early interventions can have significant positive impacts does not always inform how services are commissioned.

The need for improvement is not new; numerous reports have highlighted the issues. Individual initiatives have led to improvements in specific areas, but have not resulted in the system wide changes required to improve outcomes. What is new is the opportunity to ensure the focus on outcomes in the new health and care system includes children and young people clearly and explicitly, from conception through to adulthood.

We are committed to improving the health outcomes of our children and young people so that they become amongst the best in the world.

System-wide change is required to achieve this and each part of the system, at each level, has a vital contribution to make. To this end we pledge to work in partnership, both locally and nationally, with children, young people and their families.

Our shared ambitions are that:

1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.
2. Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.
3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.
4. Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.
5. There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

We all have a part to play in promoting the importance of the health of our children and young people.

Through our joint commitment and efforts we are determined to:

- **reduce child deaths** through evidence based public health measures and by providing the right care at the right time;
- **prevent ill health for children and young people and improve their opportunities for better long-term health** by supporting families to look after their children, when they need it, and helping children and young people and their families to prioritise healthy behaviour;
- **improve the mental health of our children and young people** by promoting resilience and mental wellbeing and providing early and effective evidence based treatment for those who need it;
- **support and protect the most vulnerable** by focusing on the social determinants of health and providing better support to the groups that have the worst health **outcomes**;
- **provide better care for children and young people with long term conditions and disability** and increase life expectancy of those with life limiting conditions.

Because

- **the all-cause mortality rate for children aged 0 – 14 years has moved from the average to amongst the worst in Europe**[1]
- **26% of children's deaths showed 'identifiable failure in the child's direct care'**[2]
- **more than 8 out of 10 adults who have ever smoked regularly started before 19**[3]
- **more than 30% of 2 to 15 year olds are overweight or obese**[4]
- **half of life time mental illness starts by the age of 14**[5]
- **nearly half of looked after children have a mental health disorder and two thirds have at least one physical health complaint**[6]
- **about 75% of hospital admissions of children with asthma could have been prevented in primary care**[7]

Building momentum

At national level a new **Children and Young People's Health Outcomes Board**, led by the Chief Medical Officer, will bring together key system leaders in child health to provide a sustained focus and scrutiny on improving outcomes across the whole child health system.

A new **Children and Young People's Health Outcomes Forum** will provide both ongoing expertise in child health and offer constructive challenge to the next phase of this work. The Forum will hold an annual summit involving the CMO to monitor progress on child health outcomes and make recommendations for their improvement.

The Children and Young People's Health Outcomes Forum report and system response can be found at **http://www.dh.gov.uk/health/2012/07/cyp-report/**

For the very first time, everyone across the health and care system is determined to play their part in improving health outcomes for children and young people.

1 Wolfe I, Cass H,Thompson MJ et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reforms. BMJ 2011; 342:d1277
2 CEMACH report 2008
3 Healthy Lives, Healthy People – our strategy for public health in England. Department of Health (2010)
4 Health Survey for England 2010
5 Kessler R, Angermeyer M, Anthony J et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry 2007 Oct; 6(3):168-76
6 DfE Outcomes for children looked after as at 31 March 2012
7 Asthma UK. Wish you were here – England (2008).

TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Collaboration without Duplication		
Wards Affected:	All		
To:	Health and Wellbeing Board	**On:**	19 September 2013

Contact: Gerry Cadogan
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Email: gerry.cadogan@torbay.gov.uk

1. Purpose

1.1 Torbay regularly achieves national recognition for being innovative and leading the way in terms of health and social care. In a time where there are financial constraints, and staff are already working to full capacity, instead of creating new groups and starting new processes to address issues identified above, there is an opportunity to collaborate and co-operate to ensure that there is:

- Clarity about the finances available for consultation, advice and information;
- One process, agreed and signed up to by all the funding organisations in the Bay, which identifies **who** will co-ordinate, **how** the process is best delivered to ensure that is both current, and accessible to all, **when** consultations occur, and is **monitored** by the people and organisations of the Bay.
- How is independence and credibility maintained- can organisations providing services effectively evaluate and monitor their impact on the users and carers?.

2. Recommendation

2.1 It is recommended that the Board discuss this paper and identify the most cost-effective way forward which ensures the most comprehensive service. The process can be managed as a project which will report regularly to the Health and Wellbeing Board which is the overarching group that oversees the Health and Wellbeing Strategy for the people of Torbay.

3. Supporting Information

3.1 At a previous meeting of the Health and Wellbeing Board there was a discussion about the fact that there needed to be some clarity around the co-ordination of information, advice and consultation with the general public and with patients, clients and carers around health and social care issues.

3.2 Currently the following organisations covering the Torbay area are providing these services as part of their role:

- The Clinical Commissioning Group (undertakes Advice and Liaison in the community, except in relation to primary care services which is covered by NHS England);
- Healthwatch Torbay, which covers health and social care issues in Torbay;
- Local Authority, which undertakes consultation exercises on a variety of issues;
- Torbay and Southern Devon Health and Care NHS Trust, who deliver information services in terms of health and social care, and undertake consultation;
- The variety of other health and care voluntary and community sector organisations that provide information and advice to people in the Bay.

3.3 As a result of the work currently being undertaken by the above, the following issues have arisen:

1. There is a substantial amount of **finance** involved in developing, implementing and maintaining the above services. This relates to actual funding allocations within the various organisations themselves, and/or funding available for the Torbay area. There is no understanding of the total amount of finances currently (or potentially) being used for the purposes identified in paragraph one above. Each organisation that holds the finances tends to prefer to lead on its allocation.

2. Consultation, information and advice services require **ongoing time commitment and staffing** in order to remain current. Currently there are processes in place which took time to develop but are not regularly maintained (Torbay Directory), separate consultation processes, separate advice, information and complaints procedures, yet all relating to the same group of people, that is, the population of Torbay, but all managed by different organisation. Services are often impatient that for effective consultation to occur, there needs to be time set aside for this.

3.4 The points identified in 1 and 2 above, lead inevitably to the fact that there is constant **duplication** of information, advice and consultation processes. These elements need to be planned, undertaken comprehensively yet swiftly, stand up to scrutiny, and deliver meaningful outcomes which are supported by the organisations in Torbay.

4. Relationship to Joint Strategic Needs Assessment

4.1 To ensure that the needs within the JSNA are met in the most cost effective and efficient way.

5. Relationship to Joint Health and Wellbeing Strategy

5.1 To ensure that the outcomes within the JHWS are delivered in the most cost effective and efficient way.

TORBAY Health & Wellbeing BOARD

Working together for a healthier Torbay

Title:	Winterbourne View Action Plan		
Wards Affected:	All	**On:**	19 September 2013
To:	Health and Wellbeing Board		
Contact:	Siobhan Grady – South Devon and Torbay Clinical Commissioning Group Julie Foster – Torbay and Southern Devon Health and Care NHS Trust		
Telephone:	01803 652533/01803 881332		
Email:	Siobhan.grady@nhs.net/ Julie.foster8@nhs.net		

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1. Purpose

1.1 To provide the Health and Wellbeing Board with an update on progress being made in relation to the jointly agreed action plan for Winterbourne View.

1.2 There is a master copy of actions which have been agreed by each of the organisations involved: Torbay Council, South Devon & Torbay CCG; Torbay & Southern Devon Health & Care Trust. A Winterbourne View Steering Group meets quarterly to review this plan (which also includes the Joint Commissioner for Devon County Council and NEW Devon CCG) with individual organisation responsible for progressing their own actions and in-house governance on a more regular basis.

2. Recommendation

2.1 That the report be noted as update in relation to implementing the recommendations coming from the Winterbourne View concordat.

3. Themes

3.1 The key themes and planned actions have been summarised below

Commissioner:

1. Care market which meets the complex needs of individuals; in terms of their housing need, support and care.
2. Rapid response and crisis services which can respond and access to specialist expertise in to continue to support people in more appropriate community settings.

3. Strengthen links between acute and primary care to reduce inequalities in healthcare access.
4. Specifications will be reviewed and provider performance monitored to ensure improvements in provision is maintained and evidence of quality of reviews.
5. Overarching Learning Disability Strategy with local implementation plan to address gaps in delivery identified through the self assessment process and inform the Market Position statement.
6. Review of Learning Disability Partnership Board with establishment of a health subgroup.
7. Commissioning protocols for dealing with Ordinary Residence issues and rebasing exercise for movement of specialist commissioning funded placements.

Providers:

1. Actively review and make regular contact with individuals to plan for their repatriation to their home area or to the least restrictive environment as appropriate to meet their specific needs.
2. Care management processes and specialist health services are equipped to manage and plan for individuals returning from out of area and to avoid whenever possible any more people being placed outside of their home area.
3. Workforce skills assessment and development
4. Initiate transitional working early so that adult and children services are planning together for future needs, in particular those with complex needs and challenge behaviours.
5. Take positive steps in making Torbay a safer place to live by working closely with partners especially the Police
6. Improve the experience of the service user and their family throughout safeguarding adult procedures, with a focus on candour and transparency and enabling full participation.
7. Quality of provision

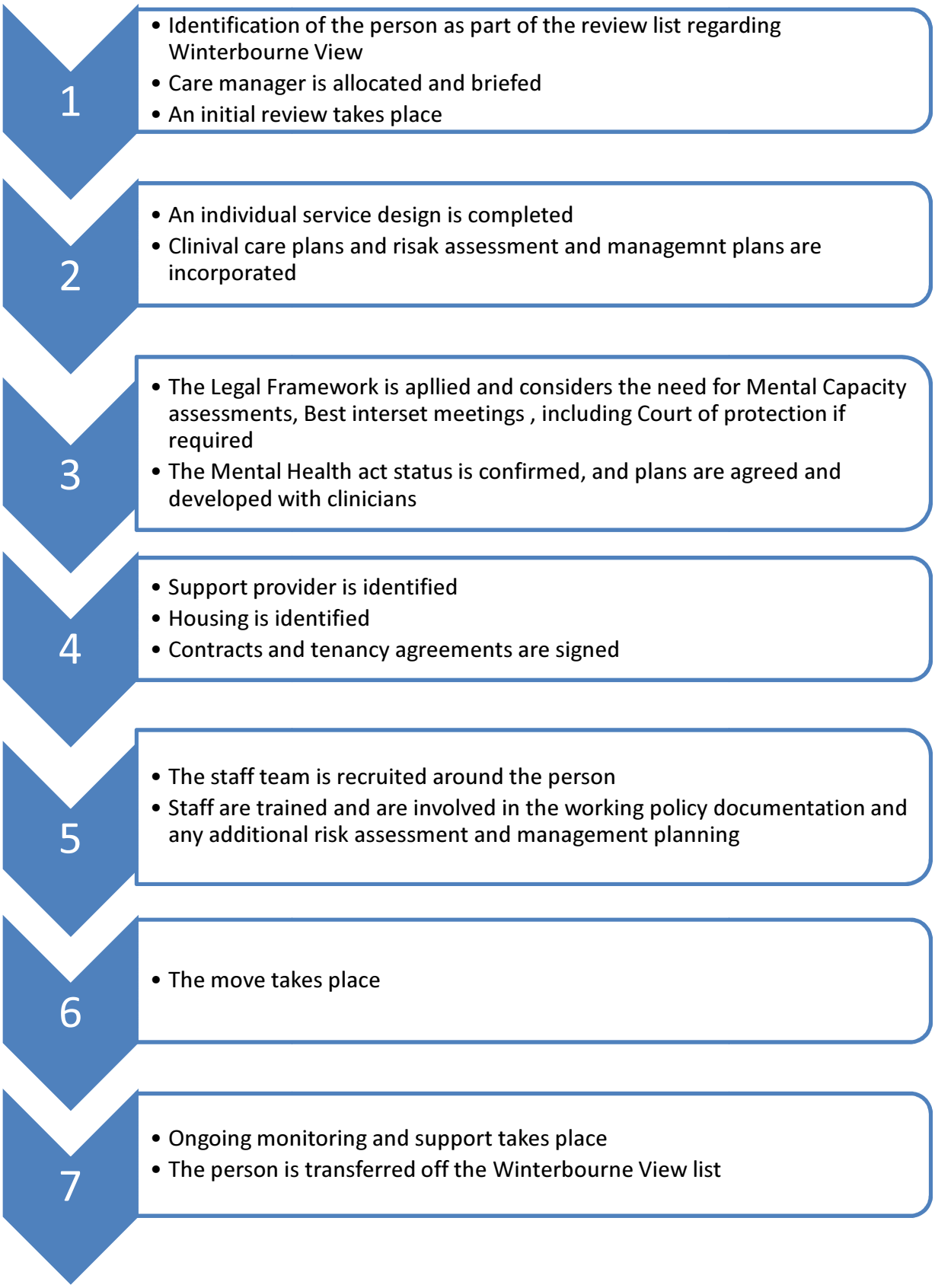
4. Monitoring Our Position

4.1 We have agreed to implement the pathway approach and use of the 'Seven Step' model' created by NEW Devon CCG (Appendix 1) which will be used by care managers and commissioner to help progress the person from institutional care and monitor the performance of services responsible and provide an understanding of our position.

4.2 Each month we are monitoring the people on our register to see how we have progressed against the pathway.

Winterbourne View Action Plan

'Seven Step' model' created by NEW Devon CCG



TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Public Health: Sexual Health Services Update
Wards Affected:	All
To:	Health & Wellbeing Board **On:** 19 September 2013

Contact:	Nanette Amos
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Email:	nanette.amos@torbay.gcsx.gov.uk

1. Context

1.1 On 1 April 2013, the Public Health Commissioning function returned to local government, after 40 years with the NHS. The DH (2013) states that, *local authorities are well placed to understand all the needs of their population and to provide joined-up services which meet those needs*. Sexual health services are part of the public health function.

1.2 In addition to the Local Authority Public Health Commissioning team, certain sexual health services are also commissioned by the Clinical Commissioning Group (CCG) and NHS England (Appendix 2) and *Health and Wellbeing Boards have a duty to promote integrated working between commissioners of health and social care and will play a key role in ensuring that the sexual health services and care received by their communities is seemless* (DH, 2013).

1.3 Public Health teams reports nationally on three indicators:

- Under 18 conceptions
- Chlamydia diagnoses for 15-24 year olds
- People diagnosed with HIV at a late stage of infection.

There are also national mandatory data collections for sexual health, including:

- Genitourinary Medicine Clinical Activity Dataset (GUMCAD) for STIs
- Chlamydia Testing Activity Dataset (CTAD)
- HIV and AIDS Reporting System (HARS).

Local Sexual Health outcomes are produced in Quarterly Indicator Reports, and Torbay's report is attached at Appendix 1.

1.4 This report fits with Torbay Joint Health and Wellbeing Strategy, specifically:

- Outcome 1, Priority 3: *Reduce Teenage Pregnancy*
- Outcome 2, Priority 9: *Increase Sexual Health Screening.*

1.5 This report acknowledges that in the outlining of sexual health services for Members, some services were, and always have been, in the hands of the Local Authority.

2. Local Background

2.1 Operation Mansfield, a multi-agency operation in 2011, uncovered the sexual abuse/exploitation of a number of girls in Torbay. The subsequent Serious Case Review identified the unorganised and opportunistic abuse of vulnerable girls linked to the supply and misuse of drugs and alcohol.

2.2 The sexual health budget for Torbay was disaggregated on 1 April 2013 to different commissioning organisations (Appendix 2) as commissioning responsibilities were shared between Torbay Council Public Health team, NHS England and the CCG. The Torbay Council budget for 2013/14 for public health amounts to approximately £1.887m. This is broken down broadly as follows:

- STI Screening – including HIV prevention, awareness and testing, Chlamydia testing, Genitourinary Medicine Services (in and out of area), screening in pharmacies and GP surgeries - £1.162m
- Contraception – including the provision of long acting reversible contraception methods, emergency hormonal contraception (morning-after pill), the Boys and Young Men's worker and clinics - £0.725m.

3. Purpose of this Report

- To provide an overview of the elements of sexual health services commissioned in Torbay.
- To provide an update on national and local Sexual Health initiatives for September 2013.
- To describe the challenges for sexual health commissioning, going forward.

4 Introduction

'Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity' (WHO, 1948).

Sexual health services are defined as the provision of treatment and advice around contraception, screening for sexually transmitted infections (STIs) including HIV and Chlamydia, relationships, partner notification and abortion (DH 2013). National direction of travel is towards the commissioning of services that are integrated, and can offer a 'one stop shop' for service users, covering all elements of sexual health, in one appointment where possible.

The Department of Health (2013) makes the point that whilst sexual relationships are essentially a private matter, good sexual health is important to individuals and to society. Most people in the UK are sexually activity and it is a stated government objective to improve the sexual health of the population (DH, 2013).

To accomplish this, Torbay Public Health team recognises that it must work with partners to reduce inequalities that exist in the Bay, by taking action to:

- build an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex
- continue to tackle stigma, discrimination and prejudice
- continue to work to reduce the rate of sexually transmitted infections
- reduce unwanted pregnancies by ensuring people have access to the full range of contraception in a timely manner
- support women with unwanted pregnancies to make decisions about their options as early as possible
- continue to tackle HIV through prevention and increased access to testing
- promote integration, quality, value for money and innovation in services

(DH, 2013).

5 Description of Sexual Health Commissioned Services in Torbay

Sexual health services are commissioned and designed to meet the needs of the population.

Additionally, there are specific groups within the population that have increased levels of risk and require specific services. The Department of Health (2013) defines groups requiring the provision of specialised services as including gay and bisexual men ("MSM"), young people, people with learning disabilities and sex workers. However, the overall service offered must be 'open access' and everyone able to access the service, irrespective of age, gender or sexual orientation.

Sexual health services commissioned in Torbay are as follows:

5.1 Torbay Sexual Medicines Services (TSMS)

TSMS (part of South Devon Healthcare Foundation Trust) is the provider of Torbay's sexual health service, and is based at Castle Circus Health Centre. The aims and objectives of the service are to provide an open access (self-referral), comprehensive, integrated contraception and sexual health service.

Sexual health services are offered from Castle Circus Health Centre and also take place in satellite clinics across Torbay. They are delivered by sexual health nursing staff and health advisors, who are able to refer people onto the consultant-led service if necessary.

The consultant-led service is the specialist service and provides genitourinary (GU) and reproductive health care under the leadership of a senior clinician, Dr Phil Kell. Dr Kell also provides clinical leadership and governance to the outreach services and satellite clinics, and to external services such as those GPs and Pharmacists who provide screening, contraceptive and signposting services.

Sexual health services have traditionally been divided into two elements: STI screening and contraception. However, the national direction of travel is to integrate services and train/recruit dual trained staff, because of the benefit to patients/service users of a 'one stop shop', as well as the potential for financial savings. Work is

underway regionally to provide an Integrated Sexual Health Nurse Training Course, to support this commissioning direction.

5.2 Outreach Team

As part of TSMS, a team works across schools and colleges in Torbay to provide an sexual health outreach service for young people. The outreach service is generally nurse-led and includes:

- discussion and counselling on 'delay', safer relationships and safer sexual health
- counselling for all types of contraception
- pregnancy testing – with referral to maternity services or TOPAS as requested by the service user
- Emergency hormonal contraception – counselling for, and provision of, prescribed medication
- Registration to the C-Card and supply of condoms
- Issue of first and subsequent oral contraceptive pill and EVRA contraceptive patch
- Counselling – pre-work and appointments made (if requested) at nearest suitable clinic for Implanon (sub-dermal hormonal implant), Depo (hormonal injection) and Intrauterine System (IUS – 'coil')
- Chlamydia screening (male and female)
- Treatment following a positive Chlamydia screen (antibiotics)

Outreach services in schools and colleges are run on a drop-in basis, and available to young people at times which are convenient to them.

The outreach team is largely comprised of staff who hold a nursing registration and this allows them to deliver contraception and nursing advice. In additional to this, there are a further two roles integrated within the outreach team, the post holders of which have a social work background, allowing the team to provide a holistic service to young people:

- The first is a role is employed by Children's Services and the post holder works primarily with young people who are deemed at risk of pregnancy, experiencing relationship abuse from their partner, have low self-esteem or confidence to access services, and young people who are questioning their sexual orientation.
- The second role is the Boys and Young Men's Worker, and the post holder works primarily with boys and young men and co-ordinates the C-Card scheme.

5.3 STI Screening

The government (2013) reported nearly half a million new sexual infections nationally in 2012. Part of this rise can be explained by better sexual health reporting systems, nevertheless, it is suggested that too many people are putting themselves at risk, through unprotected sex.

The message from Public Health England continues to be that use of condoms and regular STI testing remains of the highest importance. STIs have serious consequences for the public's health, including infertility.

- Chlamydia is the most common STI in young people under 25 which, if left untreated, can lead to pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility. However, 'Chlamydia is easily diagnosed and easily treated' (Public Health England, 2013). Young people can either be tested in clinic, or by post with a 'freetestme' kit available in 'grab bins' in GP surgeries and Pharamcies, or via the Sexwize website. Individuals can choose how to receive their results, either by post, text, email or letter and treatment is a course of antibiotics.
- Gonorrhoea and syphilis are often singled out for reports from other STIs because they are important bacterial infections which need to be managed in genitourinary clinics. New diagnoses of gonorrhoea rose by 21% in 2012, which is of concern because of the growing resistance of antibiotics to this bacteria. Further, the group most at risk of acquiring this infection is MSM, for whom there was a 37% increase in diagnoses last year. Ensuring resistant strains do not persist and spread remains a Public Health England priority (Gov.UK 2013).

5.4 C-Card Scheme

The C-Card Scheme is a scheme co-ordinated by TSMS where young people aged under 25 can register and access free condoms at approximately 70 outlets across Torbay, including youth centres, GP surgeries and schools. In addition, young people can also access condoms from a vending machine, free of charge under the C-Card scheme, at South Devon College.

Over the last years, an average of 7,600 condoms are supplied to young people aged 13-17 years, free of charge, each year. Proportionately more condoms are supplied, through the C-Card scheme, to service users registered at addresses in the more deprived communities than other areas. There are known links between the more deprived communities and prevalence of teenage conceptions.

C-Card is being re-launched in Torbay during September 2013, in line with item 6.2 below.

5.5 Sexwize

Sexwize is the brand under which sexual health services for young people are delivered in Torbay. The website is known as Sexwize and is available at http://www.s-wize.co.uk/sexwize.htm. The site is currently being updated and refreshed, with multi media clips, photographs and 'Top Tips' for good sexual health and condom use.

The site is now hosted by Torbay Council and has been made compatible with smart phones. It provides up to date information in relation to clinic times and venues, as well as offering FAQs and advice for emergency sexual health situations.

5.6 Sexual Health Training for Professionals

Eddystone Trust is commissioned to provide sexual health training for professionals in Torbay. A number of courses and dates are available on http://insight/shtraining.pdf.

Courses include how to conduct sexual health interventions with young people, working with boys and young men, 'delay' courses, HIV and Sexual Health

Awareness, pregnancy testing etc, and support the C-Card distribution scheme being re-launch, September 2013.

Members of the Health and Wellbeing Board are welcome to attend these courses.

5.7 Young People Services

- Young People friendly accreditation – the criteria for this accreditation is from the Department of Health and ten topic areas are assessed for compliance. Topic areas include staff training, skills, attitudes and values, clinic environment and publicity, and confidentiality. In Torbay, we have 7 YPF accredited sexual health clinics, including 4 GP Practices in Torquay and Paignton (Parkhill Surgery, Chilcote Surgery, Sherwell Valley Medical Practice, Corner Place Surgery), TIC TAC at Paignton Community College (Borough Road site and Waterleat Road site) and Castle Circus Health Centre. Torbay had the first accredited YPF service in the south west, however, reduction in capacity and changes in personnel has made it difficult to take a more proactive role in recruiting more services and supporting them to achieve this accreditation.
- Relationships and Sex Education ("RSE") in schools – high quality RSE, particularly where it starts in primary school, can ensure children and young people are equipped to cope with the many pressures and challenges of modern day living, and to protect them from sexual exploitation and abuse (RSE Hub, 2013). Polly Neate, Chief Executive of the charity, Women's Aid, said on BBC News (2013) that, *all UK children should have high quality education about sex and relationships to help counter attitudes that foster domestic violence'.* To ensure that children and young people across Torbay have access to high quality RSE that is carefully planned and implemented from primary through to secondary education, we will be reviewing current practice and working with the Torbay Teaching School and curriculum networks locally to develop and continue to improve education about sex and relationships.
- A secondment position with Torbay Council has been recruited to, to review all public health services for teenagers, identifying gaps and opportunities and auditing services against best practice guidance. It is felt that the outcome of this work will lead to improvements in commissioning, measured by public health outcomes relating to young people (including the under 18 conception rate and the under 25 STI new diagnosis rate).

5.8 Long Acting Reversible Contraception (LARC)

LARC methods of contraception, namely sub-dermal implants and interauterine devices (the 'coil'), are more cost effective than oral contraceptive methods (the pill), and usage of LARC methods has been estimated to offer potential savings in excess of £200,000 per 100,000 women (NICE, 2005).

Torbay has 90% coverage of GP surgeries that are trained and able to counsel, fit and remove LARC.

Further, £10,000 has been made available from the Network and Office of Sexual Health South West for Torbay, so that TSMS can train and accredit more primary health care professionals to fit LARC in the community.

LARC methods of contraception are recommended for young people who might otherwise be felt to be at high risk of an under 18 conception (DH, 2013). There are financial savings to be made to public health if more women use LARC methods of

contraception because once fitted, it will provide effective, consistent contraceptive cover without further action needed on the part of the woman (NICE, 2005).

5.9 The role of Pharamacies in sexual health provision

Pharmacies provide confidential sexual health services, on a drop-in basis, including the provision of emergency hormonal contraception, Chlamydia consultations, Chlamydia screening and signposting to other sexual health services.

- Emergency hormonal contraception (morning-after pill) is supplied by 32 out of 39 pharmacies in Torbay. The pharmacist undertakes a brief consultation with the woman and supply of the drug is confidential (and free of charge to women under 25 years of age).
- Chlamydia screening is also available to young people under 25 years of age, using the postal testing kits, situated in 'grab bins' in 10 out of the 39 pharmacies. Commissioned pharmacies also hold Chlamydia consultations on a drop-in basis, and as part of this consultation, young people are signposted to appropriate sexual health services (ie) C-Card Scheme etc.

5.10 Sexual Assault Referral Centres (SARC)

Post 1 April 2013, SARCs are commissioned by NHS England, rather than the Torbay Public Health Team, however, they remain an integral part of sexual health services for the people of Torbay (Appendix 2).

People who have been subject to a sexual assault in Torbay are referred to the SARC (located in Exeter) for care. The SARC offers a holistic service to the individual and also acts as advocate for the individual and co-ordinator in the legal process going forward.

People referred into SARC may be one of the following categories:

- men or women who have been the subject of a recent sexual assault and are still within the 'forensic window'. The individual is seen by a forensic medical examiner with a view to the collection of evidence for a police prosecution. They go on to receive care and emotional support for the duration of the police process from a team of specialists which may involve counselling.
- men or women who have been the subject of a historic sexual assault. The individual receives support and counselling and may – or may not – decide to give a statement to the police. However, this doesn't prejudice the care they receive under SARC.

Children who have been the subject of a sexual assault are seen by specialist paediatric medical examiners, in the same way as above.

Torbay usage of SARC services (figures apply to adults only):

Measurement of Activity – 2013		**April**	**May**	**June**	**July**	**August**
Number of referrals		10	22	24	22	19
of which..	Male		1	2	2	2
	Female	10	21	22	20	17
of which..	Eastern	1	11	8	6	8
	Southern	2	0	1	2	2
	North Devon	3	2	1	4	4
	Torbay	2	6	10	7	4
	Mid Devon	2	1	3	3	1
	Out of area	0	2	1	0	0

5.11 Abortion Services

Responsibility for commissioning abortion services for Torbay lies with the CCG, although links are maintained between the CCG and the Public Health team. This is because abortion provider services can play a key role in helping to reduce the risk of further unwanted pregnancy. The DH (2013) recommends that Public Health teams work with their CCG to ensure that the local abortion service provider is fully linked into wider sexual health services, so that contraception services are provided at point of termination. This is shown to prevent repeat procedures.

Just over half of all teenage conceptions in Torbay end with an abortion.

Whilst live births (to teenage conceptions) are highest in the more deprived communities, abortions are more evenly distributed across the population. The gap in the rate of abortions between the most and least deprived communities is less than that for live births.

Nationally, abortion rates for women under 30 years of age are rising (ONS, 2012). There is a link between good, accessible and comprehensive contraception advice for women of all ages, and abortion data.

In 2012, 34.6% of abortion procedures in Torbay and Southern Devon were repeat abortions (Appendix 1, p.22). Nationally, this figure is 36%, and Torbay and Southern Devon is the fourth highest of South West CCG areas for repeat procedures. Commissioners are working to reduce repeat procedures via LARC counselling and fitting at the point at which a woman is referred into the abortion service.

In Torbay, local abortion services are provided by TOPAS (Termination of Pregnancy Advisory Service).

5.12 Treatment of HIV

There are 3,500 new diagnoses of UK-acquired HIV per annum. When an individual is diagnosed as having HIV, the treatment is anti-retroviral drugs, and treatment is more effective when the virus is diagnosed early.

People diagnosed with HIV should have a near normal lifespan, as long as they have access to the appropriate healthcare at the appropriate clinical time (BBC, 2013), however the virus remains a burden for the infected individual and a major cost to the system (BHIVA, 2012).

The mean lifetime healthcare cost (based on a predicted median age at death of 75 years) for an individual with HIV has been estimated at approximately £360,000 (BHIVA, 2012).

Whilst the commissioning responsibility for HIV prevention, awareness and screening sits with the Local Authority, anti-retroviral drugs are paid for by NHS England.

Individuals who start to take anti-retroviral drugs at the appropriate clinical time, reducing the *viral load* in their blood, are shown to reduce the risk of infectiousness to sexual partners (Avert, 2013).

For those individuals who feel they may have been exposed to HIV perhaps through unprotected sex or occupational risk, treatment is available which aims to prevent the infection taking hold. This is called Post Exposure Prophylaxis (PEP) and although is prescribed via Torbay Sexual Medicines Service, is paid for by NHS England.

Most people in the UK acquire HIV through unprotected sex. 'HIV really is an infection where prevention is much easier than cure' (BBC, 2013).

6 Network and Office for Sexual Health South West

6.1 The Office for Sexual Health is a Directors of Public Health led network across the south west. Torbay Council hosts this network and is considered to be an example of best practice nationally.

6.2 The network has direct links with national leaders across Public Health England, Department of Health, NHS England, academia in general and several professional and medical journals.

6.3 The objective of the network is to facilitate improvements in sexual health services by:

- networking with south west sexual health commissioners and facilitating relationships to share best practice and learning
- supporting research that will culminate in recommendations for improvements in services
- sharing clinical best practice nationally via journals and internet articles
- fostering working relationships between local, regional and national organisations with a sexual health remit
- driving innovation, by providing opportunities for organisational development.

6.4 The network is supported by an overarching Programme Board, who sit quarterly to oversee progress and funding of the various projects and work streams. Membership of the Board includes Directors of Public Health, Department of Health epidemiologists, senior sexual health clinicians, Public Health England nurse managers, strategic managers, business managers and sexual health consultants.

6.5 Network work streams and projects currently include:

- Research project into incidence of late diagnosis of HIV – senior clinicians, strategic managers and commissioners working in two high prevalence areas in the south west, to understand why people might be diagnosed late with HIV and thereby miss the window for effective anti-retroviral treatment. For individuals, late diagnosis of HIV is perhaps the most important factor associated with HIV related morbidity and mortality in the UK. In addition, people diagnosed late have a much higher risk of onward transmission of the infection.
- Long Acting Reversible Contraception (LARC) training – co-ordination of the Department of Health budget for Improving Access to Contraception across the region, with a particular emphasis on funding training for clinicians and nurses in primary care. Torbay has 90% coverage of professionals accredited to fit LARC across GP Practices, which is the fourth highest in the region. Torbay has been allocated £10,000 from this budget for 2013/14 to cover further training which will be carried out by TSMS and start Autumn 2013
- Relationships and Sex Education Hub (RSE Hub) – an online resource for teachers, health professionals and pastoral workers, designed to facilitate high quality delivery of RSE in schools and educational establishments. The RSE Hub's objectives are to contribute to a reduction in under 18 conceptions, abortions and repeat abortion rates, incidences of STI diagnosis, sexual exploitation and bullying, particularly in relation to homophobia. The RSE Hub publishes guidance documents and other resources and has recently provided a briefing for councillors available on http://www.rsehub.org.uk/media/7781/relationships_and_sex_education_-_a_briefing_for_councillors.pdf.
- Integrated Sexual Health Nurse Training – a course of training amounting to 60 credits at level 3 (at degree level) in integrated sexual health nursing competencies. Learning takes place on the job, as well as face to face at university and local seminars. Places have been provided free of charge to students and their organisations. Work is currently underway to develop nurse mentor support networks and to attract and enrol students for modules commencing October 2013.
- Abortion Services Quality Assurance – work is underway with CCGs, providers and public health commissioners to facilitate a peer review exercise of abortion services across the south west, with peers identifying and recommending improvements for one another.
- Research into re-testing of people previously testing positive for Chlamydia (and other STI screens), with four pilot areas including Torbay, under Dr Kell. National Chlamydia Screening Programme will publish guidance on re-testing is shortly, with regional research feeding into national guidance.

7 Current initiatives

7.1 National Sexual Health Week

National Family Planning Association Sexual Health Week is 16 – 22 September 2013, entitled, "Yes, We Can't Go Backwards". The focus this year will be on the

protection and promotion of contraception and other sexual health services http://www.fpa.org.uk/campaigns/sexual-health-week.

7.2 Local Sexual Health Week

A local Sexual Health campaign for young people will be run alongside the national week, to promote services particularly for the under 24 population. This is planned to include:

- Refresh, update and relaunch of Sexwize, website for young people http://www.s-wize.co.uk/
- Media promotions (ie) Heart Radio adverts, Facebook and Twitter accounts
- Multi agency promotion of sexual health services for young people
- Media coverage on local news
- Sending of literature to parents.

Objectives of the local campaign include:

- Introducing students to Outreach and Clinic staff, at the beginning of the new academic year
- Raising awareness of the Sexwize website and TSMS service, as a centre of information for young people
- Re-launch of the C-Card Scheme
- Make in-roads into national reporting datasets, including Chlamydia testing and positivity rates, and reducing teenage conceptions
- Encourage health and social care professionals to enrol on training re the young people's sexual health agenda.

8 Conclusion

Achieving good sexual health is complex. In Torbay, we have a number of providers of services across Social Care, the NHS and the third sector who work collaboratively to achieve desired outcomes.

The challenges around the changed commissioning landscape of the system of 1 April 2013 mean that strong leadership between the Local Authority and its commissioning partners is essential. Partnership working has never been more important in the Public Health arena. The Local Government Association, Public Health England and the Department of Health continue, at a national and regional level, to network with Local Authorities to support them to work collaboratively with partners.

In Torbay, clinicians, consultants, commissioners and managers meet in a forum called Torbay Clinical Pathway Group. The purpose of this group is to ensure that pathways in and out of sexual health services across the Bay are robust, effectively managed and seemless. The Department of Health (2013) stipulates that although commissioning arrangements for sexual health services may have been disaggregated in the transition of 1 April, the provision of such services must appear to service users to be seemless. The Clinical Pathway Group takes a lead role in the system to ensure that this is indeed the case.

In addition, the Network and Office for Sexual Health South West works to support commissioners and organisations across the region, to ensure that local commissioning is not disadvantaged by the new commissioning arrangements.

The network works closely with Public Health England, whose remit is to facilitate local, regional and national relationships across commissioning structures, and to feed back nationally, outlining where guidance in the system is needed.

Debbie Stark (Torbay Council, 2013) stated, "Improving the health of the local population requires co-ordinated effort from everyone; the voluntary sector, the NHS and partners, and I very much feel that the right structures and positive relationships are in place in the Bay to ensure that the whole community benefits."

Joined up working between providers and their commissioners characterises sexual health services across Torbay, and must continue to do so, in order to improve outcomes for individuals.

Appendices:

Appendix 1	Torbay Sexual Health Quarterly Outcome Indicator Report – Quarter 4: 2012/13
Appendix 2	Table of Commissioning Functions

Background Papers:

Avert, 2013, http://www.avert.org/hiv-treatment-as-prevention.htm [accessed online 05 09 13]

BBC News, 2013, 4 March, *Analysis: A cure for HIV?* http://www.bbc.co.uk/news/health-21653463 [accessed online 05 09 13]

British HIV Association, *Projected lifetime healthcare costs associated with HIV infection,* (2012)http://www.bhiva.org/documents/Conferences/2012Birmingham/Presentations/Posters/Epidemiology-and-Surveillance/P178.pdf [accessed online 05 09 13]

Department of Health, *A Framework for Sexual Health Improvement in England*, 2013 https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england [accessed online 30 08 13]

Department of Health, *Commissioning Sexual Health services and interventions: Best practice guidance for local authorities,* 2013 https://www.gov.uk/government/publications/commissioning-sexual-health-services-and-interventions-best-practice-guidance-for-local-authorities [accessed on line 04 09 13]

Department of Health, *Quality Criteria for young people friendly health services,* 2011 https://www.gov.uk/government/publications/quality-criteria-for-young-people-friendly-health-services [accessed online 30 08 13]

Local Government Association and Public Health England, *Sexual Health Commissioning Frequently Asked Questions,* 2013

http://www.local.gov.uk/c/document_library/get_file?uuid=4905f0d4-8fad-4c3a-b53c-b49478b42a49&groupId=10171 [accessed online 30 08 13]

National AIDS Trust, *HIV: A Strategy for Success,* 2012 http://www.nat.org.uk/media/Files/Publications/Oct-2012-HIV-a-strategy-for-success.pdf [accessed online 04 09 13]

NICE guidance on long acting reversible contraception, 2005 http://www.nice.org.uk/cg030 [accessed online 04 09 13]

World Health Organization, 1948, *Preamble to the Constitution of the World Health Organization* as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948 [accessed online 04 09 13]

Websites

BBC News, *Theresa May to demand Police improve domestic violence handling,* 29 August 2013, http://www.bbc.co.uk/news/uk-23875557 [accessed online 29 08 13]

Gov.UK, https://www.gov.uk/government/news/nearly-half-a-million-new-sexual-infections-in-2012 [accessed online 05 09 13]

Gov.UK,https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216423/dh_132114.pdf [accessed online 06 09 13]

Office of National Statistics, http://www.ons.gov.uk [accessed online 04 09 13]

RSE Hub, http://www.rsehub.org.uk/ [accessed online 04 09 13]

Sexwize, http://www.s-wize.co.uk/ [accessed online 04 09 13]

Public Health England

DsPH Network and Office for sexualhealth South West

Sexual Health Quarterly Outcome Indicator Report

Torbay

Report for quarter 4 2012/13

DsPH Network and Office for sexualhealth South West

Introduction

This indicator report was set up by the South West Office for Sexual Health to provide Directors of Public Health, local commissioners, providers and clinicians with timely and relevant comparative information about the full range of sexual health indicators in order to support them in continuing to improve sexual health outcomes. It is produced by the Field Epidemiology Team, Health Protection Directorate, Bristol and has now been updated to include additional information. Work is underway to explore developing it as a national tool.

The Office for Sexual Health was established in January 2010 to provide leadership on all aspects of sexual health and seeks to avoid fragmentation by linking up the different policy areas including reducing sexually transmitted infections, chlamydia screening, reducing teenage pregnancy, improving access to contraception. Its work is being incorporated within Public Health England.

Knowledge and intelligence and the use of effective interventions to improve sexual health will be at the heart of the work of Public Health England. The South West Public Health Observatory, which has become part of Public Health England's Knowledge and Intelligence directorate already produces the Sexual Health Balanced Scorecard for England (http://www.apho.org.uk).

Information on sources of data are provided on the next page. Guidance on undertaking a sexual health needs assessment is available from Sexual Health Needs Assessment: A How To Guide (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109070).

The Public Health Outcomes Framework (http://www.dh.gov.uk/health/2012/11/phof-technical-refresh/) has six indicators relevant to sexual health:

Improving the wider determinants of health

- 16-18 year olds not in education, employment or training;
- Violent crime (including sexual violence);

Health improvement

- Under 18 conceptions;

Health protection

- Chlamydia diagnoses 15-24 year olds;
- People presenting with HIV at a late stage of infection;
- HPV vaccination coverage (females 12-17 year old).

Public Health England will continue to produce this quarterly outcome indicator set for sexual health for each locality to enable them to review their own performance in 21 areas of sexual health and to build on information from the quality assurance peer review visits of the sexual health systems in each locality undertaken by the Office for Sexual Health.

This report is divided into four sections:

- interventions to address harmful behaviours;
- sexual and reproductive health;
- access;
- sexually transmitted infections and HIV.

The report RAG rates in relation to public health outcomes framework indicators and relevant national ambitions. The rationale for each indicator and its significance is provided as well as signposting to relevant evidence or policy.

The quarter 4 report each year includes a summary tracking the South West position against each indicator to illustrate change over the financial year.

The report should be used in conjunction with the Field Epidemiology Team's surveillance and epidemiology reports; these reports provide background information to several of the indicators in this report. Please contact jo.jacomelli@phe.gov.uk if you would like advice on these reports.

Good use of data and evidence is central to effective commissioning of sexual health services. Public Health England will provide support tools such as this indicator report. Organisations can also use the Sexual Health Outcomes and Research Evaluation project (SHORE) commissioned by NHS South of England in 2011.

Public Health England will provide a range of services in relation to sexual health building on the work of the Health Protection Agency and other organisations that have moved into PHE. This includes support for young people's sexual health, particularly the National Chlamydia Screening Programme. The Office has previously undertaken a range of work in relation to young people and sexual health and has set up the relationship and sex education hub (http://www.rsehub.org.uk/).

Public Health England will provide a strong focus on multiple risk factors for poor sexual health including health inequalities and drug and alcohol misuse. The Office for Sexual Health has a useful publication about alcohol and sexual health setting out the importance of sexual health services using alcohol intervention and brief advice. This indicator report will be collecting data from the Sexual and Reproductive Health Activity Dataset (SRHAD) under SRH Care Activity Code 30, where health professionals can record every attendance where the service provides the patient with a brief alcohol intervention. This is to reflect NICE public health guidance on preventing harmful drinking, including for people attending GUM clinics or accessing emergency contraception. Data collection for SHRAD is not yet complete and is expected to be available in 2013.

A locally-led collaborative sexual health network led by South West Directors of Public Health is taking forward elements of work in the new system including:

- the South West-wide long acting reversible contraception training programme;
- the South West relationship and sex education hub;
- a project in three areas of the South West increasing access to partner notification for chlamydia;
- a project to coordinate peer-led review of abortion services and management of community of interest in good access to high-quality abortion services;
- an audit of HIV very late diagnosis in areas of low prevalence;
- providing peer-to-peer support on commissioning sexual health services.

From 1 April 2013 commissioning responsibilities for sexual health are as follows:

- NHSCB responsible for commissioning HIV, sexual assault referral centres and GP contract elements of contraception;
- Local authorities responsible for promoting health and preventing ill-health, commissioning specialist services both GUM and sexual and reproductive health and some contraception from GPs (ie enhanced services such as long acting reversible contraception);
- CCGs responsible for abortion services and sterilisation and vasectomy services.

All information about the Office for Sexual Health's work which is moving to PHE can be found at: http://www.hpa.org.uk/AboutTheHPA/WhatTheHealthProtectionAgencyDoes/LocalServices/SouthWest/OfficeForSexualHealthSW/.

Comparison of different sexual health outputs

Output:	Outcome Indicator Report	Local SH Profile (under review)	SH Profiles	SH Balance Scorecard	Performance Monitoring Report	Data Source
Produced by:	HPA SW	HPA SW	HPA	SWPHO	SHA	
Geographic level:	PCT (SW)	Lab/GUM/PCT (SW)	PCT (National)	PCT (National)	Regional (SW)	
Frequency:	Quarterly	Under review	Ongoing basis	Ongoing basis	Ad hoc	
Distribution:	DPHs, Sexual Health Leads	DPHs, CCDCs, GUM Microbiologists	Available via HPA website	Available via SWPHO website	Report produced for RDPH	
STIs						
New diagnoses of gonorrhoea and syphilis (combined)	✓					GUMCAD
New diagnoses of gonorrhoea		✓	✓	✓		GUMCAD
New diagnoses of syphilis		✓	✓	✓		GUMCAD
New diagnoses of Chlamydia		✓				CoSurv (Laboratory data) and GUMCAD
New diagnoses of Chlamydia (all settings)			✓	✓		NCSP, GUMCAD, HPA
Genital wart diagnoses (first episode)			✓			GUMCAD
Total STI diagnoses in under 25s	✓					GUMCAD
Pelvic Inflammatory Disease admissions				✓		HES data/ NHS information centre
Chlamydia screening						
Coverage (and positivity) NCSP and/or non-NCPS/non-GUM	✓	✓		✓	✓	NCSP
Coverage in all settings			✓	✓		NCSP and GUMCAD
Diagnostic rate in all settings	✓					
Tested in core services	✓					NCSP
HIV						
New diagnoses of HIV		✓				CfI
Mode of transmission		✓				CfI
Diagnosed HIV-infected patients seen for care	✓	✓	✓	✓		SOPHID
Recently acquired infection						RITA
Late/very late diagnoses (CD4 cell count <350/ <200)	✓		✓	✓		SOPHID, HANDD and CD4 surveillance
HIV individuals diagnosed with a concurrent STI			✓			GUMCAD
Uptake of HIV testing in GUM clinics			✓	✓		GUMCAD
GUM access						
Appointments offered and/or seen within 48 hrs	✓	✓	✓	✓	✓	GUMAMM (Dept. Of Health)
GUM clinic opening times (out of hours access)	✓					PCT quarterly reports
Attendees seen after 10 working days				✓		GUMAMM (Dept. Of Health)
Attendees who did not attend first appointment				✓		GUMAMM (Dept. Of Health)
Abortions						
Repeat abortions all ages	✓					Dept. Of Health
Abortions <10 weeks	✓			✓ (<18 & <16)		
Abortions medical vs surgical	✓					
Under 19 conceptions leading to abortion				✓		TPU and ONS
All abortions				✓		Dept. Of Health

Output:	Outcome Indicator Report	Local SH Profile (under review)	SH Profiles	SH Balance Scorecard	Performance Monitoring Report	Data source
Teenage conceptions						
Rate of teenage conceptions	✓			✓		Teenage Pregnancy Unit
Teenagers obtaining 5+ GCSEs				✓		Dept. For Children, Schools and Families
Teenagers not in education, employment of training (NEET)						
Schools with on-site sexual health services				✓		Sex Education Forum
Teenage mothers in educationd, employment or training (EET)				✓		TPU
Teenage mothers not know to Connexions service				✓		Connexions and ONS (provided by TPU)
Contraception						
LARC prescription rate	✓			✓		NHS Information Centre (Prescription Services)
Cost of prescribed LARC				✓		NHS Prescription Services
LARC GP practices	✓					Data provided by PCTs
Under 18s/16s choosing LARC at CSRH services				✓		NHS Information Centre
Sexual Assult Referral Centres (SARCs)						
Establishments of SARCs	✓					Data provided by SARCs
Percentage of those reporting sexual assault seen at SARCs				✓ (planned)		
Rate of police recorded rape of women				✓		Home Office
Percentage of sexual assaults in women (regional data)				✓		Home Office
Young People Friendly						
Services meeting criteria	✓					Dept. Of Health
Antenatal screening						
Women booked for antenatal care		✓				Antenatal screening surveillance
Uptake of antenatal testing for HIV		✓		✓ (planned)		
Hep B, HIV, syphilis and rubella testing		✓				
HPV						
Uptake of HPV (12-13 years)	✓		✓	✓		Dept. Of Health
Other						
Sex and relationships advce needs improving (12-15 years)				✓		Ofsted
10-15 year olds misusing alcohol, drugs etcs				✓		Dept. For Children, Schools and Families
Index of Multiple Deprivation average score				✓		Dept. Of Communities and Local Govt.

Key: GUMCAD=GenitoUrinary Medicine Clinic Activity Dataset; HES=Hospital Episode Statistics; NCSP=National Chlamydia Screening Programme; CfI=Centre for Infections; SOPHID=Survey of Prevalent HIV Infections Diagnosed; RITA=Recent Infection Testing Algorithm; HANDD=HIV and AIDs New; Diagnosis Database; GUMAMM=Genitourinary Medicine Access Monthly Monitoring; ONS=Office for National Statisticsl; CSRH=Community Sexual and Reproductive Health

Potential data sources to be used in a Sexual Health Needs Assessment

In the first instance, please refer to the **Sexual Health Outcome Indicator Reports, Sexual Health Balanced Scorecard** (http://www.apho.org.uk/sexualhealthbalancedscorecard) and the **Sexual Health Profiles** (http://www.hpa.org.uk/web/HPAweb&Page&HPAwebAutoListName/Page/1237277176628).

For further information, please see below:

Data	Source	Where the data can be found
HIV data		
New HIV diagnoses	HIV and AIDS New Diagnoses Database (HANDD), HPA	**National and regional data (including AIDs diagnoses and deaths):** http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/NewHIVDiagnoses/
		Local data: request from HPA South West regional office jo.jacomelli@hpa.org.uk
Prevalence of diagnosed HIV infection (persons accessing HIV related care)	Survey of Prevalent HIV Infections Diagnosed (SOPHID), HPA	**Regional and Local Authority level data:** HIV prevalence by LA (PDF) http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1203496957984
		For PCT level data or further information: request from HPA South West regional office jo.jacomelli@hpa.org.uk
		MSM, black Africans and black Caribbeans, young adults and injecting drug users by region: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/AccessingHIVCare/
Late and very late HIV diagnoses (proportion of those newly diagnosed with HIV who had a CD4 cell count <350 (late)	CD4 surveillance, HPA	**Overview:** http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/CD4TcellData/
		LA level data: http://profiles.hpa.org.uk/IAS/dataviews/report/fullpage?viewId=42&reportId=40&indicator=i426&date=2008-
Proportion of HIV infected individuals seen for care by level of anti-retroviral therapy	Survey of Prevalent HIV Infections Diagnosed (SOPHID), HPA	**Local data:** request from HPA South West regional office jo.jacomelli@hpa.org.uk
Uptake of HIV testing in GUM clinics	National Chlamydia Screening Programme	**National, regional and LA level:**http://www.apho.org.uk/addons/_118373/atlas.html
		By sexual orientation: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/SexualHealthProfilesAndIndex/SexualHealthProfilesPerformance/
Sexually transmitted infections (excluding HIV)		
Rate of chlamydia diagnoses	GUMCAD, HPA and National Chlamydia Screening Programme (NCSP)	**National, regional and LA level data (including NCSP and non NCSP non GUM):** Table 2 & 7: http://www.hpa.org.uk/web/HPAweb&Page&HPAwebAutoListName/Page/1201094610372 **Quarterly data on NCSP website** http://www.chlamydiascreening.nhs.uk/ps/data.asp
Chlamydia testing: coverage and positivity NCSP and non NCSP/ non GUM	National Chlamydia Screening Programme	**National, regional, PCT and LA level data:** http://www.chlamydiascreening.nhs.uk/ps/data.asp
Hospital admissons for pelvic inflammatory disease	HES data compiled by the NHS Information Centre	Data extracted and analysed by the South West Public Health Observatory http://www.apho.org.uk/resource/item.aspx?RID=74114
New diagnoses of syphilis	GUMCAD, HPA	National, regional and LA level data: STI annual data table, (tables 2 and 10): http://www.hpa.org.uk/web/HPAweb&Page&HPAwebAutoListName/Page/1201094610372
New diagnoses of gonorrhoea	GUMCAD, HPA	National, regional and LA level data: STI annual data table, (tables 2 and 8): http://www.hpa.org.uk/web/HPAweb&Page&HPAwebAutoListName/Page/1201094610372
New diagnoses of anogenital herpes simplex virus	GUMCAD, HPA	National, regional and LA level data: STI annual data table, (tables 2 and 9): http://www.hpa.org.uk/web/HPAweb&Page&HPAwebAutoListName/Page/1201094610372
New diagnoses of anogenital warts	GUMCAD, HPA	National, regional and LA level data: STI annual data table, (tables 2 and 11): http://www.hpa.org.uk/web/HPAweb&Page&HPAwebAutoListName/Page/1201094610372

Data	Source	Where the data can be found
Contraception		
First contacts with women at NHS community contraceptive clinics by primary method of contraception and age	NHS Information Centre	**National, regional and PCT level data:** http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/contraception
Community contraceptive clinic attendances by provider	NHS Information Centre	**National, regional and PCT level data:** http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/contraception
NHS provision of emergency contraception	NHS Information Centre	**National, regional and PCT level data:** http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/contraception
Maternity		
Live births per 1,000 women aged 15-44 (General Fertility Rate)	ONS	**National, regional and LA level data:** http://www.ons.gov.uk/ons/rel/vsob1/birth-summary-tables--england-and-wales/index.html
Ectopic pregnancies per 100 deliveries	NHS Information Centre (HES data)	**National data:** http://www.hesonline.nhs.uk/Ease/servlet/ContentServer?siteID=1937&categoryID=1815 **Regional and PCT level data:** try contacting the responsible statistician (named on the National dataset spreadsheet) at enquiries@ic.nhs.uk.
Number of IVF cycles (NHS and private) and number of live births per treatment	Human Fertilisation and Embryology Authority	**National data:** http://www.hfea.gov.uk/104.html **Clinic data:** http://guide.hfea.gov.uk/guide/AdvancedSearch.aspx
Abortions		
Abortion rate per 1,000 female population aged 15-44, by age and week of gestation	Department of Health	**National, regional and PCT level data:** http://transparency.dh.gov.uk/2012/05/29/abortion-statistics-2011/
Proportion of repeat abortions in women aged under 25	Department of Health	**National, regional and PCT level data:** http://transparency.dh.gov.uk/2012/05/29/abortion-statistics-2011/
Cervical cancer and screening		
Percentage of all cervical smear tests taken in clinics and GP practice settings	NHS Information Centre	**National, regional and PCT level data:** http://www.ic.nhs.uk/statistics-and-data-collections/screening/cervical-screening
New registrations of cervical cancer in adult female population	UK Cancer Information Service (UKCIS)	**Regional and PCT level data:** http://www.ncin.org.uk/cancer_type_and_topic_specific_work/cancer_type_specific_work/gynaecological_cancer/gynaecological_cancer_hub/profiles.aspx
Uptake of HPV vaccine	Department of Health	**National, regional and PCT level data:** http://immunisation.dh.gov.uk/category/data-and-statistics/
Young people		
Rate of teenage conception in under 18 year olds and under 16 year olds, by outcome	ONS and Department for Education	**National, regional and LA level data:** http://www.education.gov.uk/childrenandyoungpeople/healthandwellbeing/teenagepregnancy/a0064898/under-18-and-under-16-conception-statistics

Key: GUMCAD = GenitoUrinary Medicine Clinic Activity Dataset; SOPHID = Survey of Prevalent HIV Infections Diagnosed; HANDD = HIV and AIDS New Diagnoses and Deaths Database; GUMAMM = Genitourinary Medicine Access Monthly Monitoring; NCSP = National Chlamydia Screening Programme

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Contents

Rationale

1. Interventions to address harmful behaviours

1a. Establishment of SARCs in each area that accept self referrals

Rape and sexual assault can have long term effects on the lives of victims. Sexual assault referral centres (SARCs) exemplify how organisations can work in partnership to coordinate and simplify the pathway for victims to access wider healthcare, social care and criminal justice processes to improve individual health and well-being, as well as criminal justice outcomes. There are also significant benefits to the NHS, especially when considered in the context of sustainable quality, innovation, productivity and prevention (QIPP). DH published A Resource for Developing Sexual Assault Referral Centres in 2009. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107570.

1b. Rate of police recorded rape of women

The importance of sexual assault and its adverse effects on health has been highlighted through the inclusion of an indicator on violent crime including sexual violence in the Public Health Outcomes Framework. This indicator has been included to provide contextual information.

1c. Percentage of those reporting sexual assault seen at SARCs

Whilst the provision of specialist services at SARCs has been improving it is important that key agencies such as the Police refer every victim of serious sexual assaults. This indicator has been included to provide contextual information.

1d. Percentage of completed brief alcohol intervention questionnaires

There is strong evidence between alcohol misuse and risky sexual behaviours. The delivery of a brief alcohol intervention in sexual health settings provides an opportunity to reduce multiple risk taking behaviours. The Office for Sexual Health recommends Integrated Sexual Health Service Specifications should include commissioning of alcohol brief intervention and methods to allow commissioners to formally evaluate alcohol IBA. This is on the basis of NICE public health guidance on preventing harmful drinking, which recommends that: "NHS professionals should routinely carry out alcohol screening as an integral part of practice....These discussions should also take place when promoting sexual health....Where screening everyone is not feasible or practicable, NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition. This includes people who regularly attend GUM clinics or repeatedly seek emergency contraception...".

2. Sexual and reproductive health

2a. LARC prescription rate per 1,000 women, GP services

Long Acting Reversible Contraception is defined in the guideline as contraceptive methods that require administration less than once per cycle or month. NICE recommendations on LARC (October 2005) state these methods are more reliable than the oral contraception pill, where user error often results in unplanned pregnancy. The additional cost of providing these methods is more than offset by the cost savings related to abortion and births. All currently available LARC methods are more cost effective than the combined oral contraceptive pill, even at 1 year of use. NICE estimates LARC usage could save in excess of £200,000 per 100,000 women. This is aggregated data for all LARC methods. The NICE Public Health Guidance, *Prevention of Sexually Transmitted Infections and Under 18 Conceptions* recommends the increased use of LARC, greater awareness of LARC methods and improved one to one interventions. The South West has a region-wide training programme to increase uptake of LARC methods through implementation of the NICE LARC Guidance and create region-wide equity and consistency of LARC provision by increasing the number of fitters of all LARC methods for all healthcare professionals (HCPs) across the Local Authorities (both those that hold the DFSRH/RCN equivalent and those who do not).

2b. Percentage of GP practices offering LARC

Improved uptake of effective contraception has the greatest impact of reducing conception rates and therefore is a priority in strategies to reduce under 18 conception rates. 75% of all women visit their GP in the first instance for contraception advice. LARC practices indicates a practice that can offer all contraception methods (Implant, IUD/IUS and injection). Currently there is low LARC delivery in primary care. Information on percentage of practices offering LARC has been included for background information. The South West LARC training programme has had a specific focus on training nurses and doctors working in primary care.

2c. Percentage of repeat abortions in <25 year olds and >35 year olds

Repeat abortions represent unplanned conceptions, which can be seen as a failure of contraception service provision either in terms of access or availability of the most appropriate method for individual women at the time. Supply and fitting of LARC methods should be available at point of abortion procedure.

2d. Percentage of abortions within 9 weeks

Reducing the delay in obtaining abortion saves the NHS between £645,000—£30 million per year[2]. The earlier an abortion takes place the lower the risk of complications and the more cost effective it will be.

2e. Abortions by method (medical/ surgical)

The medical versus surgical procedures indicator is not able to distinguish between local anaesthetic outpatient based surgical procedures (manual vacuum aspiration) and theatre based surgical procedures. Manual vacuum aspiration allows for all forms of long acting reversible contraception to be fitted at the time of procedure as oppose to 4 weeks after early medical abortion. Local areas should review their services to ensure services are offering the best care to women that meet their needs and are clinically and cost effective.

2f. Rolling average rate of conceptions in under 18 year olds

Reducing teenage conceptions and improving outcomes for teenage parents reduces health inequalities and child poverty. Between 1998-2011 England has seen a 34.1% decline in the under 18 conception rate to 30.7 per 1,000, the lowest level for 20 years. However rates remain high compared to other Western European countries. In the South West rates have declined by 30.7% to a rate of 27.3 per 1,000 in 2011. For teenage pregnancy resources see: http://www.apho.org.uk/resource/view.aspx?RID=116355.

3. Access

3a. Access to appointments at GUM services over the weekend

To improve access to services so that infections are diagnosed and treated efficiently service users seeking access to genitourinary medicine services should be offered an appointment within 48 hours. In order to achieve this genitourinary medicine services should provide a weekend service with booked appointments. Public Health Teams will provide the Office with information relating to GUM service availability at weekends. The Office will then allocate a RAG rating.

3b. Percentage of services (inc sexual health) accredited as young people friendly.

The *You're Welcome* criteria aims to improve acceptability, accessibility and quality of services for young people. In July 2010, the Coalition Government confirmed that the 'You're Welcome' quality criteria for young people friendly health services will continue as Department of Health sponsored guidance for helping local health services put young people's needs at the centre of what they do. Service improvement and redesign is an ongoing process.

The Department of Health anticipates services reviewing their commitment to providing young people friendly services and checking that young people's experience of their service is as they would wish. The South West has developed a young people friendly badging scheme based on verification of You're Welcome Standards being met. Details are available on the South West Relationship and Sex Education Hub. Only services that have been verified and moderated through a locally determined process as achieving *You're Welcome* (or an equivalent local badging scheme criteria) are captured as part of this monitoring report.

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4. Sexually transmitted infections and HIV

4a. Combined rate of syphilis and gonorrhoea

This indicator supports local monitoring of sexually transmitted infections. The combined rate of new diagnoses of gonorrhoea and syphilis in GUM has been chosen because these are important bacterial infections which in most cases are managed in GUM therefore the data for comparative purposes are robust. The rate in men who have sex with men have also been included as they are a high risk group for acquiring these infections.

4b. Rate of new acute STIs in 15 - 24 year olds

The distribution of sexually transmitted infections varies by age and other demographic factors. The burden of sexually transmitted infections is greatest in young people and therefore services should meet the needs of young people as well as other groups. This indicator has been chosen to monitor the trends in sexually transmitted infections among young people. As rates may reflect testing practices the percentage of people aged 15-24 tested for a sexually transmitted infection has also been included.

4c. Percentage coverage and positivity of chlamydia screening in all settings

Chlamydia is the most commonly diagnosed STI in under 25s, which if left untreated can lead to pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility. Chlamydia is easily diagnosed and easily treated. The screening programme needs to target those 15-24 year olds in settings where positivity rates are known to be highest or will miss the aim of the national programme to reduce chlamydia prevalence.

4d. Partner treatment rate for chlamydia in GUM

Testing and treatment of chlamydia will only have a limited impact on the burden of disease if sexual contacts are not also tested and treated as the index case may quickly become reinfected. Treatment and partner notification can reduce complications estimated to cost the NHS at least £100m per year.

4e. Rate of chlamydia diagnoses in all settings

This is a new outcome measure in the Public Health Outcomes Framework and reflects both coverage and positivity of chlamydia tests from all sites, linked to reducing prevalence. Local Authorities have been advised to proactively review and monitor their diagnostic rate and prepare for the likely level by aiming to achieve (or maintain) rates in the range 2,400/100,000 – 3,000/100,000 or higher in 2012/13.

4f. Percentage uptake of the HPV vaccine

The following information is taken from the Health Protection Agency website (http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/GenitalWarts).

There are more than 100 types of HPV (human papillomavirus), including 40 which can infect the genital tract and are sexually acquired. Genital HPV infections are frequently asymptomatic and resolve without causing disease. However, certain HPV infections can cause cervical cancer, other cancers and genital warts. 13 types of HPV have been recognised by the WHO International Agency for Research on Cancer as being associated with cancer. HPV infections are extremely common in the sexually active population and are particularly common in the first few years after onset of sexual activity.

In the UK, a national HPV immunisation programme was introduced for all girls aged 12-13 years (school year 8) in Autumn 2008. From 2008 to August 2012 the immunisation programme used the bivalent HPV vaccine (CervarixTM, GlaxoSmithKline). From September 2012, 12-13 year old girls will be offered the quadrivalent vaccine (Gardasil, Sanofi Pasteur MSD) which protects against types 16 and 18 and also against types 6 and 11 (associated with the majority of genital warts).

4g. Percentage of sexual health service attendees accepting an HIV test

It is estimated that approximately 24% of persons with HIV are unaware of their infection. Individuals unaware of their infection are at risk of transmitting the infection and are also at risk of poorer outcomes as a result of starting treatment late or not at all. Provision of HIV testing in GUM clinics has been recommend since 2001 and the significant proportion of testing occurs in this setting. Through the expansion of the GUMCAD surveillance system to level 2 sexual health services it will be possible to also assess the levels of HIV testing and acceptance in community services.

4h. Rate of persons accessing HIV related care

The number of persons living with HIV and accessing care in England and the South West has increased continually since 2001 due to a variety of factors including better treatment and increased testing. HIV is an important public health issue and rates of persons accessing care alone are of limited value but used together with other indicators will be useful to monitor the impact of local strategies on the prevalence of HIV. One of the recommendations of the HPA's Time to Test for HIV report is that HIV testing in primary care and general medical admissions must be prioritized in areas with a high diagnosed HIV prevalence (more than 2 per 1,000 15-59 year olds) and among most at-risk populations in order to reduce late diagnoses and the proportion undiagnosed.

4i. Percentage of HIV diagnoses that were late

HIV infections that are diagnosed earlier lead to better outcomes and lower costs to the NHS. At the moment there is a high percentage of HIV infections that are diagnosed 'late' (taken as a CD4 cell count of below 350) and 'very late' (taken as a CD4 cell count of below 200). The Chief Medical Officer promotes increasing opportunistic testing in a wide range of settings. There are large variations in time of diagnosis by population groups, understanding these data is important for local service provision. The values should be interpreted with caution as the number of new diagnoses across the region is generally low and so a small change in the number of late diagnoses can have a large impact on the percentage.

DoPH Network and Office for sexualhealth South West

Timescales of data

1. Interventions to address harmful behaviours

1a. Data available quarterly
1b. Data available annually
1c. Data not currently available
1d. Data not currently available

2. Sexual and reproductive health

2a. Data available annually
2b. Data available quarterly, based on intelligence collected
2c. Data are available approximately 6 months after the end of the complete year
2d. Data are available approximately 6 months after the end of the complete year
2e. Data are available approximately 6 months after the end of the complete year
2f. Data are available approximately every February a year in arrears

3. Access

3a. Data available quarterly
3b. Data available quarterly

4. Sexually transmitted infections and HIV

4a. Data available 10 weeks after the end of each quarter
4b. Data available 10 weeks after the end of each quarter
4c. Data available from NCSP, approximately 6 weeks after the end of each quarter
4d. Data available from NCSP, approximately 6 weeks after the end of each quarter
4e. Data available from NCSP, approximately 6 weeks after the end of each quarter
4f. Data available monthly from DH, 6 weeks after the end of each month
4g. Data available 10 weeks after the end of each quarter
4h. Data available approximately a year after the end of the year
4i. Data available approximately a year after the end of the year

DsPH Network and Office for sexualhealth South West

Red Amber Green (RAG) rating

1. Interventions to address harmful behaviours

1a. Establishment of SARCs in each area that accept self referrals

No. 1

R = No access
A = Do not accept self-referrals outside of office hours or only open office hours but offer out of hours police call out
G = 24 hour access provided

No. 4

R = No forensic physicians or no SARC
A = Forensic physicians available but have delays to call out for some services or gender specified doctors
G = 24 hour access provided

No. 6

R = No service available
A = Service not available on current site or is available nearby
G = Service available

No. 8

R = No arrangements in place
A = Planning underway
G = Arrangements in place

1b. Rate of police recorded rape of women

No RAG rating

1c. Percentage of those reporting sexual assault seen at SARCs

No RAG rating

1d. Percentage of completed brief alcohol intervention questionnaires

No RAG rating

2. Sexual and reproductive health

2a. LARC prescription rate per 1,000 women, GP services

Percentage change from 2007-2008 given

2b. Percentage of GP practices offering LARC

No RAG rating

2c. Percentage of repeat abortions in <25 year olds and >40 year olds

No RAG rating

2d. Percentage of abortions within 9 weeks

No RAG rating

2e. Abortions by method (medical/ surgical)

No RAG rating

2f. Rolling average rate of conceptions in under 18 year olds

No RAG rating

3. Access

3a. Access to appointments at GUM services over the weekend

R = No weekend service provision *(unable to meet regional target)*
A = Weekend service provision, no appointments *(potential to meet regional target)*
G = Weekend service provision with appointments *(meets regional target)*

3b. Percentage of services (including Sexual Health) accredited as young people friendly

No RAG rating

4. Sexually transmitted infections and HIV

4a. Combined rate of syphilis and gonorrhoea

No RAG rating

4b. Rate of acute STIs in under 25 year olds

No RAG rating

4c. Percentage coverage and positivity of chlamydia screening in all settings in 15-24 year olds

RAG for 2012/13 Q1-2 (NCSP 2010/11 internal trajectory rolled over to 2012/13 to support the roll-over of the 2010/11 35% coverage target)

R = <10% *(Far short of NCSP internal trajectory)*
A = 10-<14% *(Under NCSP internal trajectory)*
G = ≥14% *(On or above NCSP internal trajectory)*

4d. Percentage of partners notified in GUM

No RAG rating

4e. Rate of chlamydia diagnoses in all settings in 15-24 year olds

No RAG rating but target rate between 2,400 - 3,000 per 100,000 15 - 24 year olds.

4f. Percentage uptake of the HPV vaccine

No RAG rating

4g. Rate of persons accessing HIV related care

No RAG rating

4h. Percentage of HIV diagnoses that were late

No RAG rating

4i. Percentage of sexual health service attendees accepting an HIV test

No RAG rating

1. Interventions to address harmful behaviours

1a. Establishments of SARCs in each area that accept self referrals

Indicator

Key elements nos 1, 4, 6 & 8, from: A Resource for Developing Sexual Assault Referral Centres (SARCs). Published 21 Oct 2009 jointly by the Department of Health, Home Office and the Association of Chief Police Officers, highlighting the minimum elements essential for providing high-quality SARCs for victims of sexual violence and sexual abuse, including forensic medical examination.

No. 1 Twenty-four hour access, including arrangements for self-referrals, to crisis support, first aid, safeguarding, specialist clinical and forensic care in a secure unit.

No. 4 Access to forensic physicians and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for adults and children.

No. 6 The medical consultation includes a **risk assessment** of harm/self harm, together with an assessment of vulnerability and sexual health; **immediate access to emergency contraception**, post exposure prophylaxis (PEP) or other acute, mental health or sexual health services and follow-up as needed.

No. 8 Well co-ordinated interagency arrangements are in place, involving local third sector service organisations supporting victims and survivors, and are reviewed regularly to support the SARC in delivering to agreed care pathways and standards of care.

SARC	Areas covered by SARC	RAG			
		No. 1	No. 4	No. 6	No. 8
Avon & Somerset	BANES, Bristol, North Somerset, Somerset, South Gloucestershire	G	G	G	G
Gloucestershire	Gloucestershire	G	G	G	G
Swindon & Wiltshire	Swindon, Wiltshire	G	G	G	G
Dorset	Bournemouth & Poole, Dorset	A	A	G	G
Devon & Torbay*	**Devon, Torbay**	**A**	**G**	**G**	**G**
Plymouth*	Plymouth	G	G	G	A
Cornwall*	Cornwall	G	G	G	G

Summary

Torbay is covered by the Devon & Torbay SARC. The SARC provides a 24 hour service for police referrals. They have access to forensic physicians as part of the medical management. Emergency contraception is also part of the routine aftercare for victims. The SARC also has co-ordinated interagency arrangements in place.

*Cornwall, Plymouth and Devon and Torbay SARCs share a Peninsula SARC Strategy Forum and have one Clinical Director to standardise procedures and make best use of limited funding. This is considered good practice.

DsPH Network and Office for sexualhealth South West

1. Interventions to address harmful behaviours

1b. Rate of police recorded rape of women

Indicator

Rate of police recorded rape per 100,000 female population all ages, 2009/10 to 2011/12. It should be noted that rape is under reported to the police and the figures may be higher than presented.

Source: Data for 'Community Safety Partnerships (CSPs)' obtained from the Office for National Statistics (ONS) on request. Apr 09/Mar 10 - Apr 11/Mar 12

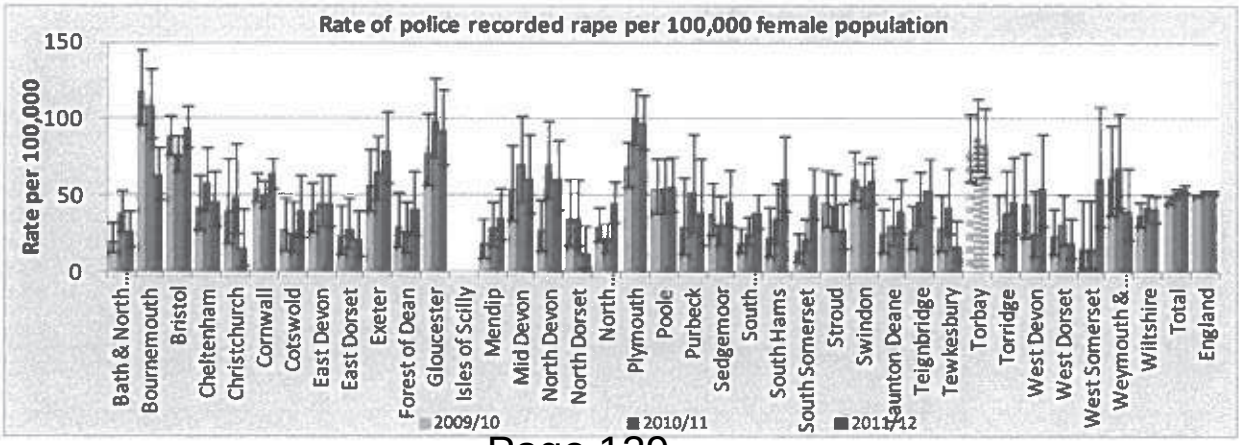
Further information and to refer to comparator areas see Balance Scorecard for Sexual Health:
http://www.apho.org.uk/addons/_118373/atlas.html

Summary

The rate of police recorded rape per 100,000 female population in Torbay was 82.6. This was higher than the Local Authority average rate (54.8 per 100,000) and England rate (52.1 per 100,000). This was also higher than the closest statistical neighbour, Isle of Wight, which had a rate of 53.7 per 100,000.

Over the past three years there has been no significant change in the rate of police recorded rape in Torbay. The rate rose from 79.5 per 1,000 in 2009/10 to 88.1 per 1,000 in 2010/11 before dropping again in 2011/12.

LA	2009/10	2010/11	2011/12
Bath & North East Somerset	21.1	38.6	26.7
Bournemouth	118.9	108.9	63.0
Bristol	88.6	76.4	94.3
Cheltenham	43.1	58.0	45.6
Christchurch	40.7	48.5	16.1
Cornwall	55.0	50.2	64.5
Cotswold	28.0	25.7	39.7
East Devon	40.6	45.0	44.9
East Dorset	24.1	28.4	22.1
Exeter	57.8	65.7	79.2
Forest of Dean	30.9	26.2	40.8
Gloucester	77.7	98.7	92.5
Isles of Scilly	0.0	0.0	0.0
Mendip	19.8	28.7	35.8
Mid Devon	54.4	70.1	60.5
North Devon	27.8	70.6	60.3
North Dorset	34.0	34.1	11.6
North Somerset	30.0	21.3	45.1
Plymouth	69.7	100.8	97.1
Poole	54.7	54.5	55.6
Purbeck	30.2	51.8	39.3
Sedgemoor	38.4	31.2	46.2
South Gloucestershire	19.8	25.7	38.5
South Hams	23.4	35.1	60.5
South Somerset	14.8	22.2	49.9
Stroud	46.0	44.0	27.9
Swindon	61.4	55.6	59.3
Taunton Deane	24.9	30.2	40.4
Teignbridge	27.4	45.7	53.0
Tewkesbury	29.1	43.0	16.7
Torbay	79.5	88.1	82.6
Torridge	27.1	38.8	45.9
West Devon	44.7	25.9	54.7
West Dorset	23.8	31.7	19.4
West Somerset	16.2	16.2	60.8
Weymouth & Portland	62.4	68.7	39.8
Wiltshire	37.6	42.1	41.0
Total	47.5	51.8	54.8
England	50.3	52.7	52.1



DsPH Network and Office for sexualhealth South West

1. Interventions to address harmful behaviours

1c. Percentage of those reporting sexual assault seen at SARCs

Indicator

Percentage of those reporting a sexual assault, as in indicator 1b, to the police who are referred to a sexual assault referral centre. Please note that other agencies will refer victims to SARCs, which is not captured here.

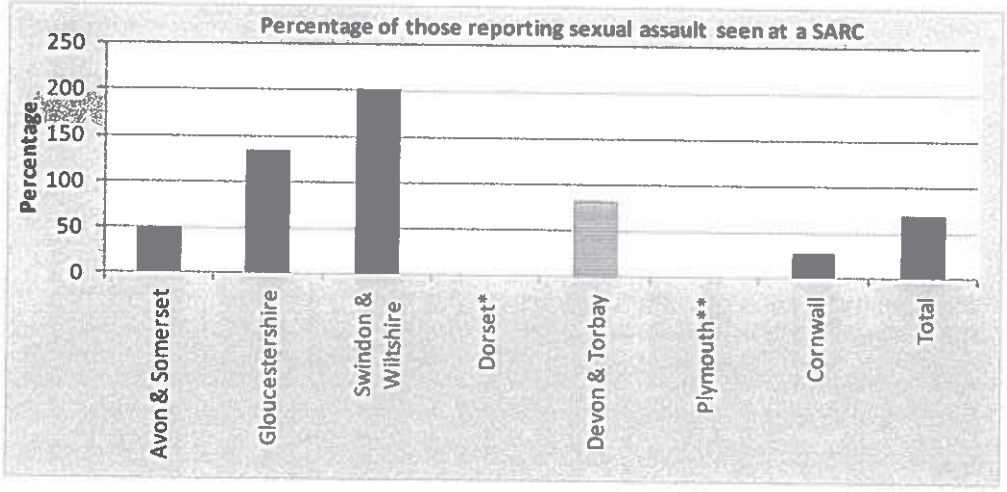
Numerator source: Sexual Assault Referral Centres
Denominator source: Data for 'Community Safety Partnerships (CSPs)' obtained from the Office for National Statistics (ONS) on request. April 2011 - March 2012.

SARC	Number of referrals	Number of assaults	Percentage referred
Avon & Somerset	219	447	49.0
Gloucestershire	189	141	134.0
Swindon & Wiltshire	322	160	201.3
Dorset*	-	150	-
Devon & Torbay	**232**	**278**	**83.5**
Plymouth**	-	126	-
Cornwall	47	177	26.6
Total	**1009**	**1479**	**68.2**

Summary

From April 2011 to March 2012 the Devon and Torbay SARC received 232 referrals from the Police service while the police recorded 278 sexual assaults against women. This represents a 83.5% referral rate from the Police to the SARC. Some cases may not be referred due to the case being historical and some victims will decline referral.

Please note that the Police may refer women to the SARC who require support but have not formally reported a sexual assault leading to a percentage higher than 100%. Referrals from other agencies are also not captured.



DsPH Network and Office for sexualhealth South West

1. Interventions to address harmful behaviours

1d. Percentage of completed brief alcohol intervention questionnaires

Indicator

Percentage of attendees of a sexual health service who have received a brief alcohol intervention.

Source: sexual and reproductive health activity dataset. Code: 30

Summary

Data are not currently available and it is estimated that all services will be reporting by April 2015.

This indicator is included in preparation and to facilitate local discussions about the NICE guidance and new studies on alcohol intervention and brief advice in sexual health settings.

DsPH Network and Office for sexualhealth South West

2. Sexual and reproductive health

2a. LARC prescription rate per 1000 women, GP services

Indicator

Rate of GP prescribed long-acting reversible contraception (LARC) per 1,000 registered female population aged 15-44, 2011/12. LARC includes Implant, IUD/IUS and injection.

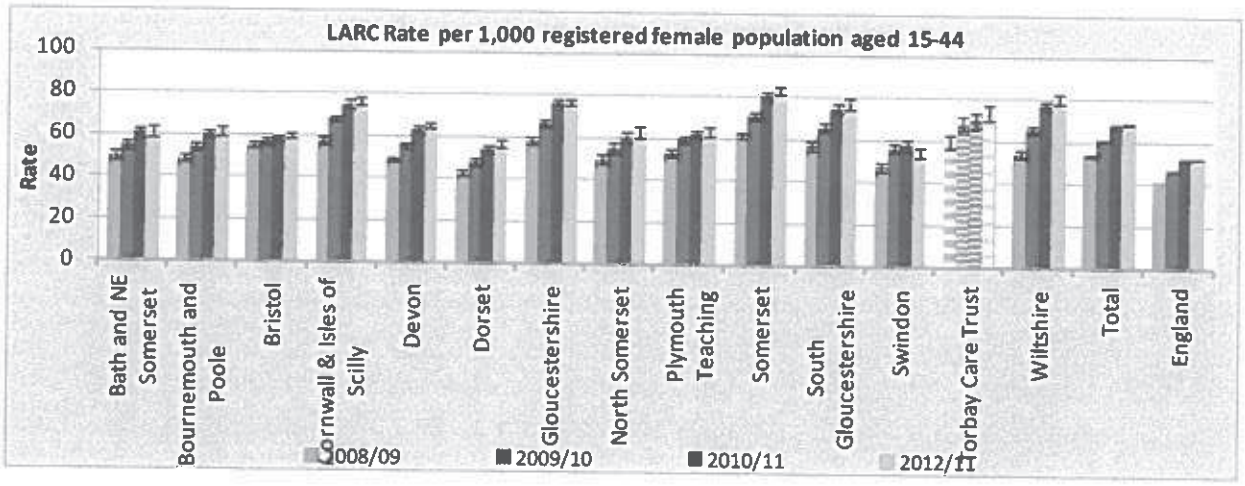
Source: NHS Information Centre for Health and Social Care Information.

PCT	Rate per 1,000 2011/12	% change 08/09 11/12
Bath and NE Somerset	61.1	22.6
Bournemouth and Poole	61.6	27.1
Bristol	59.5	8.0
Cornwall & Isles of Scilly	75.8	32.0
Devon	65.4	34.2
Dorset	56.4	31.9
Gloucestershire	76.7	31.3
North Somerset	62.0	24.4
Plymouth Teaching	63.4	19.9
Somerset	82.7	34.2
South Gloucestershire	77.1	34.7
Swindon	53.2	12.4
Torbay Care Trust	**73.1**	**21.9**
Wiltshire	80.3	48.5
Total	**68.8**	**28.3**
England	**52.4**	**26.3**

Summary

The rate of GP prescribed LARC per 1,000 registered female population aged 15-44 in Torbay has increased by 21.9% from 2008/09 (59.9 per 1,000) to 2011/12 (73.1 per 1,000), the fourth lowest increase in the region. The LARC prescription rate in Torbay was higher than the local authority average rate (68.8 per 1,000) and the national rate (52.4 per 1,000) for 2011/12.

All the areas in the region have primary care LARC prescribing rates above the England average (52.4 per 1,000).



DsPH Network and Office for sexualhealth South West

2. Sexual and reproductive health

2b. Percentage of LARC GP practices

Indicator

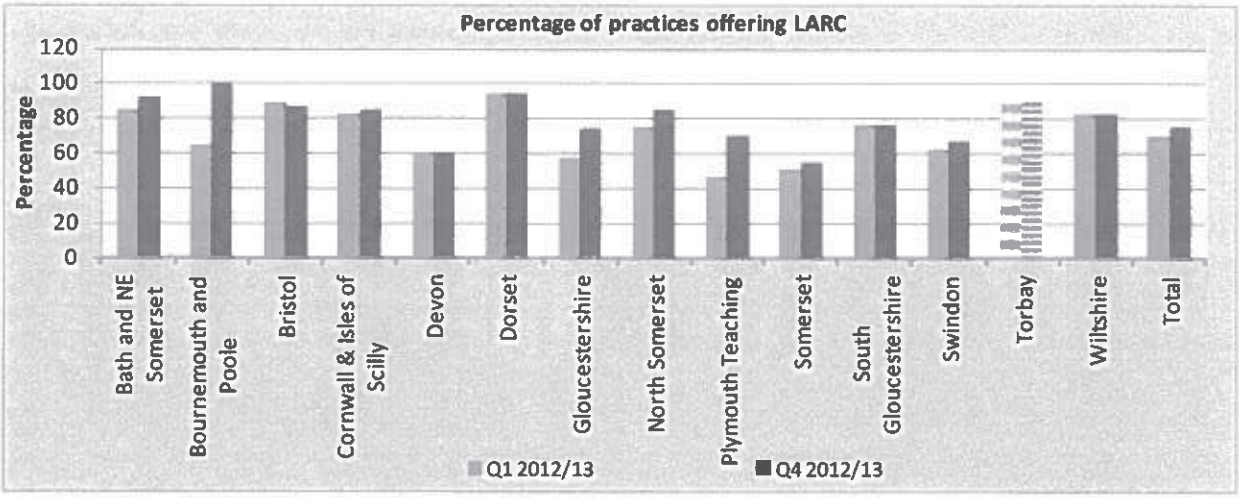
Percentage of practices that can offer all methods of LARC (Implant, IUD/IUS and injection). Information as of July 2013.

Source: Data provided by the Public Health teams.

PCT	% Practices offering LARC	
	Q1 2012/13	Q4 2012/13
Bath and NE Somerset	85.2	92.6
Bournemouth and Poole	65.1	100.0
Bristol	89.3	87.3
Cornwall & Isles of Scilly	82.9	85.5
Devon	60.4	60.4
Dorset	94.8	94.8
Gloucestershire	57.6	74.0
North Somerset	76.0	85.0
Plymouth Teaching	46.5	70.0
Somerset	51.3	55.3
South Gloucestershire	76.9	76.9
Swindon	63.0	66.7
Torbay	**90.0**	**90.0**
Wiltshire	82.5	82.5
Total	**70.5**	**75.1**
England	-	-

Summary

The percentage of GP practices offering all methods of LARC in quarter 4 2012/13 was 90.0%, which was higher than the Local Authority average (75.1%). This was the fourth highest in the region and but there was no change from the percentage of GP practices offering LARC in quarter 1 2012/13 (90.0%).



DsPH Network and Office for sexualhealth South West

2. Sexual and reproductive health

2c. Percentage repeat abortions all ages

Indicator

Percentage of abortions that are repeat abortions, 2009 - 2012.

Please note that in 2012 the data were presented by clinical commissioning group as opposed to PCT. PCTs align to all areas except Devon County which forms two CCGs and Dorset County which forms one.

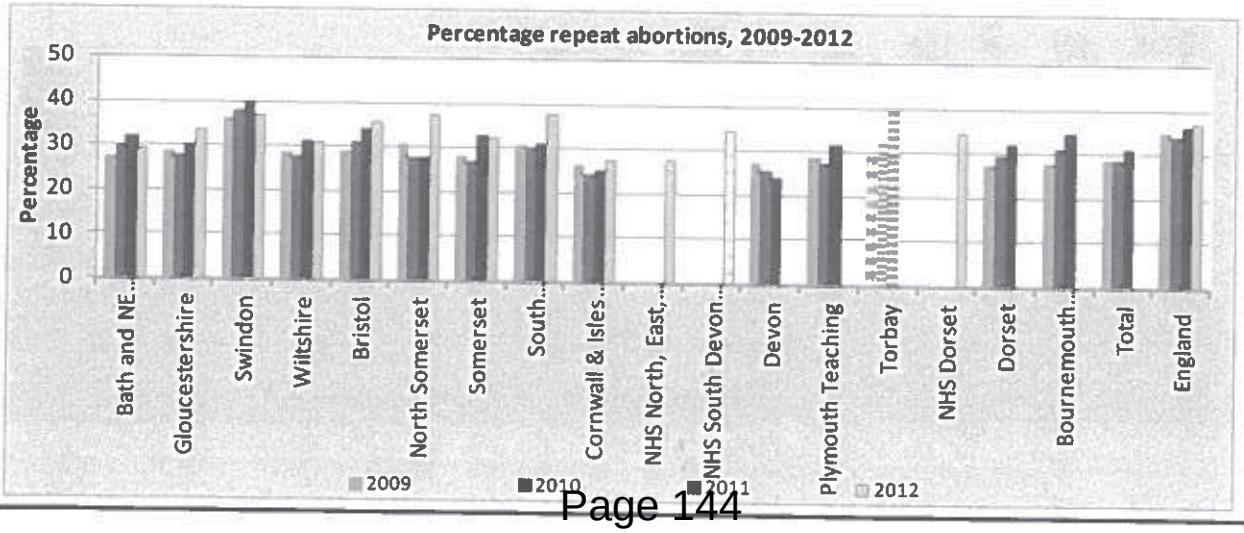
Source: Department of Health

PCT (2009-11)/ CCG (2012)	% repeat abortions				% change
	2009	2010	2011	2012	2009-2012
Bath and NE Somerset	27.4	29.9	31.9	29.4	7.4
Gloucestershire	28.7	27.9	30.4	33.4	16.3
Swindon	36.5	38.1	40.1	36.9	1.2
Wiltshire	28.5	27.6	31.0	31.0	9.1
Bristol	28.8	31.2	34.1	35.6	23.5
North Somerset	30.8	27.8	27.8	37.1	20.6
Somerset	28.4	27.0	33.1	32.2	13.3
South Gloucestershire	30.8	30.2	31.1	37.7	22.3
Cornwall & Isles of Scilly	26.4	24.4	25.4	27.6	4.5
NHS North, East, West Devon				27.5	
NHS South Devon and Torbay				**34.6**	
Devon	27.2	25.7	23.9		
Plymouth Teaching	28.5	27.2	31.7		
Torbay	**29.5**	**31.8**	**39.4**		
NHS Dorset				34.4	
Dorset	27.4	29.6	32.1		
Bournemouth and Poole	27.7	31.0	34.4		
Total	**28.7**	**28.8**	**31.3**		
England	**34.8**	**34.2**	**36.1**	**36.9**	**6.1**

Summary

In April 2012 commissioning responsibility for abortion services transferred to Clinical Commissioning Groups (CCGs), therefore the 2012 data are presented by CCG area. Although not directly responsible for these services Sexual Health Commissioners in Public Health may wish to continue monitoring abortion statistics due to impacts on other services such as contraception and the health of the wider population.

The percentage of repeat abortions for the NHS South Devon and Torbay CCG was 34.6% for 2012 which was lower than England average (36.9%). It was the fourth highest percentage of repeat abortions across the CCGs in 2012. Unfortunately it is not possible to directly compare the 2012 percentage with those of previous years due to a change in boundaries.



DsPH Network and Office for sexualhealth South West

2. Sexual and reproductive health

2d. Percentage abortions within 9 weeks

Indicator

Percentage of abortions carried out between 3 and 9 weeks of gestation (9 weeks is defined as 9 completed weeks plus up to 6 days), 2009 - 2012.

Please note that in 2012 the data were presented by clinical commissioning group as opposed to PCT. PCTs align to all areas except Devon County which forms two CCGs and Dorset County which forms one.

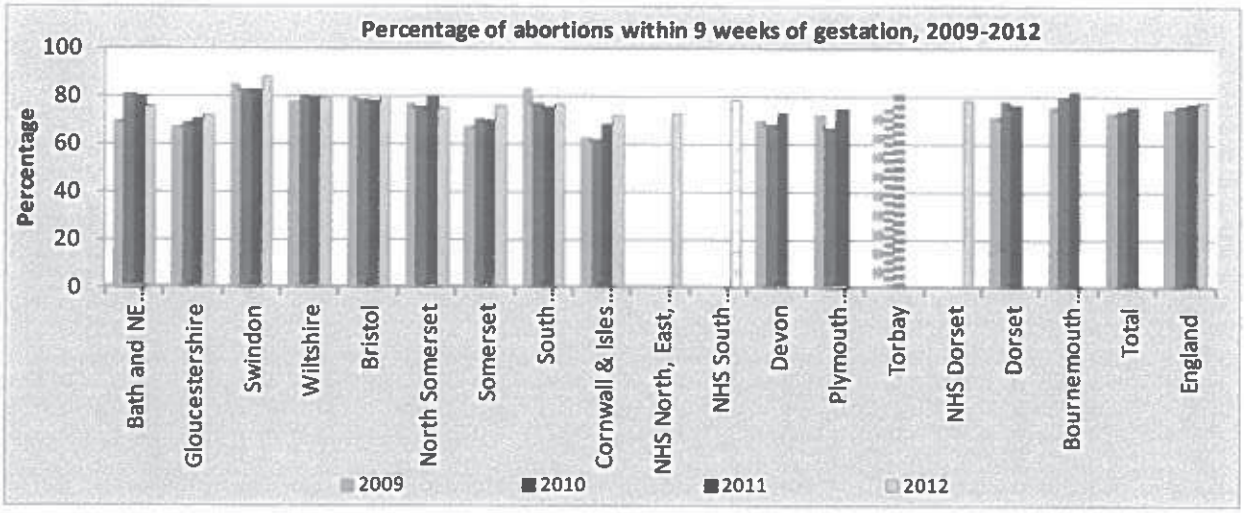
Source: Department of Health.

PCT (2009-11)/ CCG (2012)	% within 9 weeks				% change
	2009	2010	2011	2012	2009-2012
Bath and NE Somerset	69.8	81.0	80.5	76.3	9.3
Gloucestershire	67.9	69.6	70.6	72.5	6.8
Swindon	85.2	83.1	83.3	87.8	3.1
Wiltshire	78.1	80.9	80.1	79.1	1.2
Bristol	80.2	79.0	78.5	79.8	-0.6
North Somerset	77.3	75.9	80.6	75.3	-2.5
Somerset	67.5	70.9	70.3	76.4	13.2
South Gloucestershire	83.3	77.6	75.5	77.1	-7.5
Cornwall & Isles of Scilly	62.8	62.4	68.5	72.4	15.3
NHS North, East, West Devon				72.8	
NHS South Devon and Torbay				**78.6**	
Devon	70.3	68.4	73.6		
Plymouth Teaching	72.2	67.2	74.6		
Torbay	**73.8**	**75.7**	**81.2**		
NHS Dorset				78.4	
Dorset	71.6	77.8	76.7		
Bournemouth and Poole	75.9	79.8	82.3		
Total	**73.5**	**74.0**	**76.0**		
England	**75.1**	**76.9**	**77.7**	**77.8**	**3.6**

Summary

The percentage of abortions carried out within 9 weeks was 78.6% for NHS South Devon and Torbay in 2012. This was slightly higher than the England average (77.8%). It was the fourth highest percentage of abortions within 9 weeks in the region.

Unfortunately it is not possible to directly compare the 2012 percentage with those of previous years due to a change in boundaries. However, between 2009 and 2011 the percentage of abortions carried out within 9 weeks increased by 10%.



DsPH Network and Office for sexualhealth South West

2. Sexual and reproductive health

2e. Percentage abortions medical vs surgical

Indicator

Percentage of abortions carried out by medical and surgical procedures, 2009 - 2012.

Please note that in 2012 the data were presented by clinical commissioning group as opposed to PCT. PCTs align to all areas except Devon County which forms two CCGs and Dorset County which forms one.

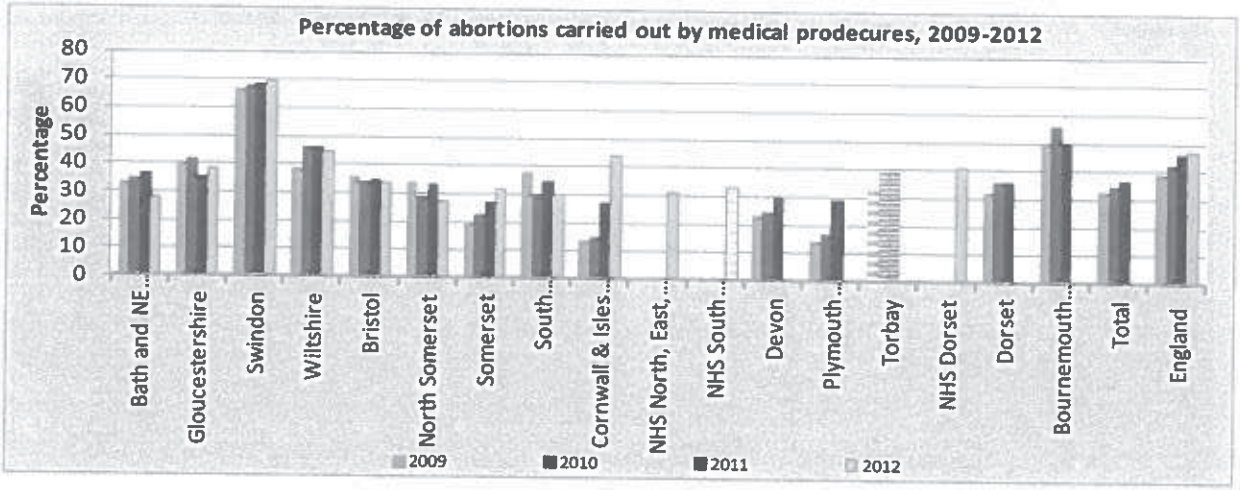
Source: Department of Health.

PCT (2009-11)/ CCG (2012)	% Medical				% change
	2009	2010	2011	2012	2009-2012
Bath and NE Somerset	33.2	35.0	36.4	27.9	-16.1
Gloucestershire	40.5	41.5	35.7	38.0	-6.0
Swindon	66.5	68.2	68.6	69.4	4.3
Wiltshire	38.5	46.0	46.1	44.4	15.2
Bristol	35.9	34.3	35.1	33.9	-5.4
North Somerset	34.4	29.1	33.3	27.4	-20.4
Somerset	20.0	22.4	27.2	31.8	58.7
South Gloucestershire	37.8	29.8	34.4	29.9	-20.8
Cornwall & Isles of Scilly	13.9	15.2	27.1	44.3	217.9
NHS North, East, West Devon				31.4	
NHS South Devon and Torbay				**33.6**	
Devon	23.5	24.7	29.6		
Plymouth Teaching	14.4	16.7	28.8		
Torbay	**33.5**	**39.1**	**39.0**		
NHS Dorset				41.0	
Dorset	32.0	35.8	36.3		
Bournemouth and Poole	49.6	55.9	50.1		
Total	**33.0**	**34.7**	**36.9**		
England	**39.0**	**42.2**	**46.4**	**47.4**	**21.6**

Summary

The percentage of abortions carried out by medical procedure was 33.6% for NHS South Devon and Torbay CCG in 2012. This was lower than the England average (47.4%).

Unfortunately it is not possible to directly compare the 2012 percentage with those of previous years due to a change in boundaries. The percentage of medical abortions had increased between 2009 (33.5%) and 2010 (39.1%) but there was no change in 2011 (39.0%). The lower percentage in the CCG may be due to the lower percentage of medical abortions carried out within the Devon area.



DsPH Network and Office for sexualhealth South West

2. Sexual and reproductive health

2f. Rate of under 18 year old conceptions

Indicator

Rolling average rate of conceptions per 1,000 15-17 year old females by Top Tier Local Authority, April 2011 to March 2012 (provisional data).

Source: ONS and Teenage Pregnancy Unit, Department for Education.

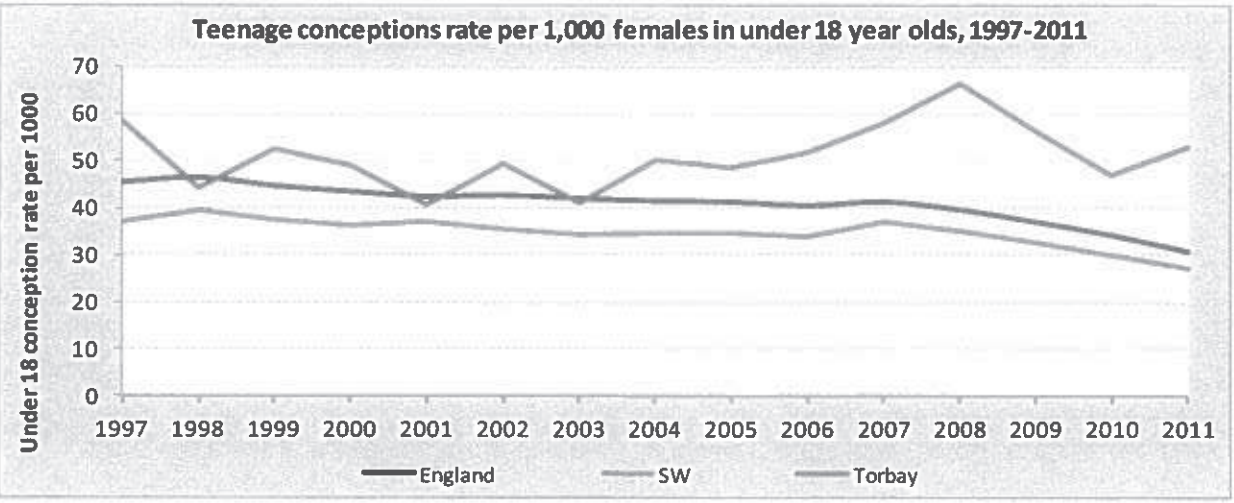
Denominator: the May 2013 revised mid year population estimates for 2002—2010 have been used to calculate the denominator for these years. All years prior to 2002 are based on the 2001 census mid year population estimates.

Local Authority	Average rate per 1,000 females Q2 '11 - Q1'12	% change of rate 1998 to 2011
Bath and NE Somerset	16.9	-44.1
Bournemouth	28.8	-38.6
Bristol	34.5	-34.9
Cornwall & Isles of Scilly	30.5	-23.9
Devon County	26.5	-21.0
Dorset County	23.5	-27.7
Gloucestershire	21.7	-48.3
North Somerset	24.3	-28.3
Plymouth	40.4	-20.3
Poole	29.3	-27.7
Somerset	28.5	-28.4
South Gloucestershire	19.5	-39.3
Swindon	28.8	-42.4
Torbay	**57.7**	**20.1**
Wiltshire County	23.8	-28.7
Total	**27.5**	**-30.7**
England	**30.7**	**-34.1**

Summary

The rate of conceptions in under 18 year olds in Torbay was 57.7 per 1,000 for Q2 2011 to Q1 2012. This was higher than the England rate (30.7 per 1,000) and was the highest rate in the region.

Torbay is the only area within the region to have seen an increase in the rate of under 18 year old conceptions between 1998 (58.5 per 1,000) and 2011 (53.1 per 1,000). While a decrease was seen between 1998 and 2003 there was a subsequent increase up to 2008, where the rate peaked at 66.4 per 1,000. Although the rate had been reducing again in the following two year there was a rise in 2011. Reducing teenage pregnancies remains a priority in Torbay.



3. Access

3a. Access to appointments at GUM services over the weekend

Indicator

Availability of weekend GUM service provision with appointments. This will be measured by quarterly reports from Public Health teams

Source: Public Health teams

Local area	RAG
Bath and NE Somerset	R
Bournemouth and Poole	A
Bristol	G
Cornwall & Isles of Scilly	G
Devon	G
Dorset	R
Gloucestershire	G
North Somerset	R
Plymouth Teaching	G
Somerset	A
South Gloucestershire	G
Swindon	G
Torbay	**R**
Wiltshire	R
Total	R
England	-

Summary

Torbay Care Trust does not currently provide a weekend GUM service and therefore only meets the criteria for the red RAG rating.

DsPH Network and Office for sexualhealth South West

3. Access

3a. Number of young people services in LA verified as meeting 'You're Welcome' standard

Indicator

Number of health services which have been accredited through a locally determined verification and moderation process which is aligned to the Department of Health *You're Welcome* quality criteria for assessing young people friendly services.

Source: Department of Health

Summary

Reduction in capacity and changes in personnel has made it difficult to take a more proactive role in recruiting more services and then supporting them. This has resulted in no further services being accredited as Young People Friendly in Torbay between quarter 1 and quarter 4 2012/13.

	Q1 2012/13 data		Q4 2012/13	
	Total no. of services verified as meeting YW (inc sexual health services)	No. of sexual health services verified as meeting YW	Total no. of services verified as meeting YW (inc sexual health services)	No. of sexual health services verified as meeting YW
Bath and NE Somerset	54	54	54	54
Bournemouth and Poole	5	5	5	5
Bristol	6	6	13	13
Cornwall & Isles of Scilly	23	4	23	4
Devon	9	4	9	4
Dorset	2	2	2	2
Gloucestershire	5	5	5	5
North Somerset	15	15	15	15
Plymouth Teaching	6	5	6	5
Somerset	13	12	19	19
South Gloucestershire	0	0	0	0
Swindon	3	3	3	3
Torbay	**11**	**7**	**11**	**7**
Wiltshire	11	11	17	16
Total	**163**	**131**	**182**	**152**

Please note, numbers correct as of 12/07/2013 and will not reflect services verified as meeting You're Welcome since this date

DsPH Network and Office for sexualhealth South West

4. Sexually Transmitted Infections

4a. Combined rate of new diagnoses of gonorrhoea and syphilis in GUM

Indicator
Combined rate of new diagnoses of gonorrhoea and syphilis in GUM based on Upper Tier LA of patient residence, October to December 2012.

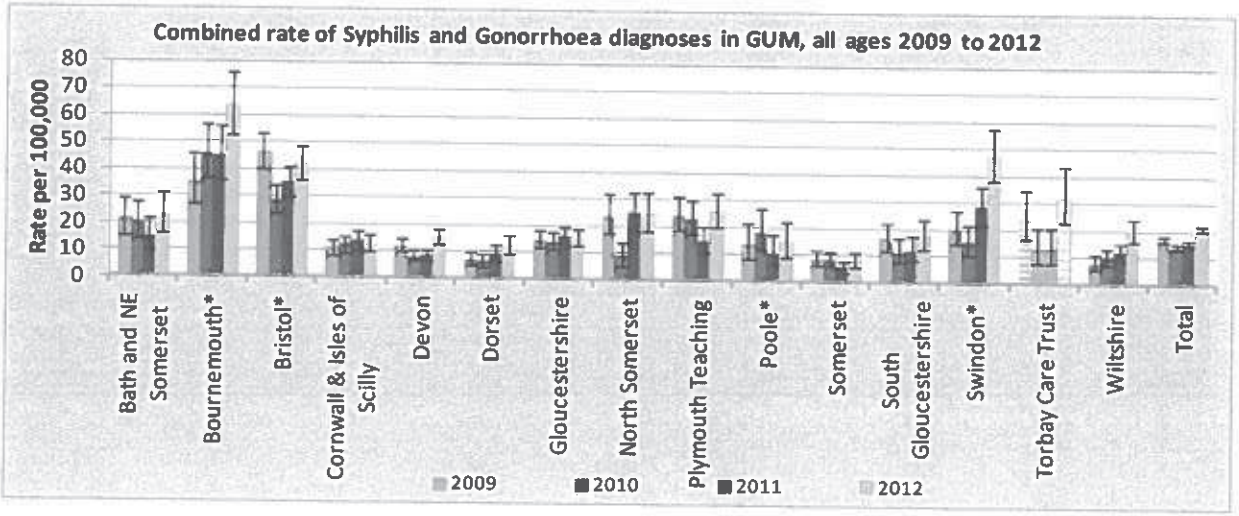
Numerator source: GUMCAD. Gonorrhoea codes: B1, B2, B5. Syphilis codes: A1, A2, A3.

Denominator source: ONS mid 2011 LA population estimates. Estimated MSM population: 2.8% of the male population over 15 years of age are estimated to be MSM outside of London3. Higher estimates are used for Bournemouth, Poole, Bristol and Swindon (3.4%, national average % of MSM).

UTLA	Rate in all persons per 100,000	% change 2009-2012	Rate in MSM† per 100,000	% change 2009-2012
Bath and NE Somerset	9.7	6.8	249.1	28.4
Bournemouth*	14.7	77.7	527.9	281.6
Bristol*	15.7	-8.7	870.0	861.7
Cornwall & Isles of Scilly	3.5	12.2	148.4	49.9
Devon	4.1	26.1	176.2	1005.3
Dorset	2.7	74.6	-	0.0
Gloucestershire	4.2	4.3	103.1	219.9
North Somerset	3.4	3.4	0.0	184.7
Plymouth Teaching	7.8	5.0	372.0	24.1
Poole*	4.1	8.0	0.0	0.0
Somerset	1.1	-7.4	-	119.5
South Gloucestershire	6.5	5.5	300.7	352.3
Swindon*	16.2	135.4	207.4	38.0
Torbay Care Trust	**8.4**	**31.7**	-	**300.0**
Wiltshire	4.8	147.3	243.2	607.6
Total	**6.1**	**24.8**	**248.5**	**230.8**

Summary
The combined rate of gonorrhoea and syphilis in Torbay was 8.4 per 100,000 for October to December 2012. This was higher than the Local Authority average rate (6.1 per 100,000) and the fifth highest rate in the region. There was a 31.7% increase in the rate of gonorrhoea and syphilis in Torbay from 2009 (24.3 per 100,000) to 2012 (32.0 per 100,000). This was the fifth highest increase in infection in the region.

The rate of gonorrhoea and syphilis in MSM for October to December 2012 had been masked as the number was less than five. Between 2009 and 2012 the rate of gonorrhoea and syphilis in MSM rose by 300% from 337.6 per 100,000 to 1,350.3 per 100,000. This was the fifth highest percentage increase in the region and the rate in 2012 was the third highest in the region.



DsPH Network and Office for sexualhealth South West

4. Sexually Transmitted Infections & HIV

4b. Rate of total STI diagnoses in people aged under 25 in GUM

Indicator

Rate of total STI diagnoses (chlamydia, gonorrhoea, syphilis, herpes and warts) per 10,000 people aged 15-24 years in GUM based on Upper Tier LA of patient residence, October to December 2012.

Numerator source: GUMCAD. Codes: A1, A2, A3, B, B1, B2, B5, C4, C4A, C4B, C4C, C4H, C4N, C5, C5A, C6A, C8, C9, C10A, C11A and C12.

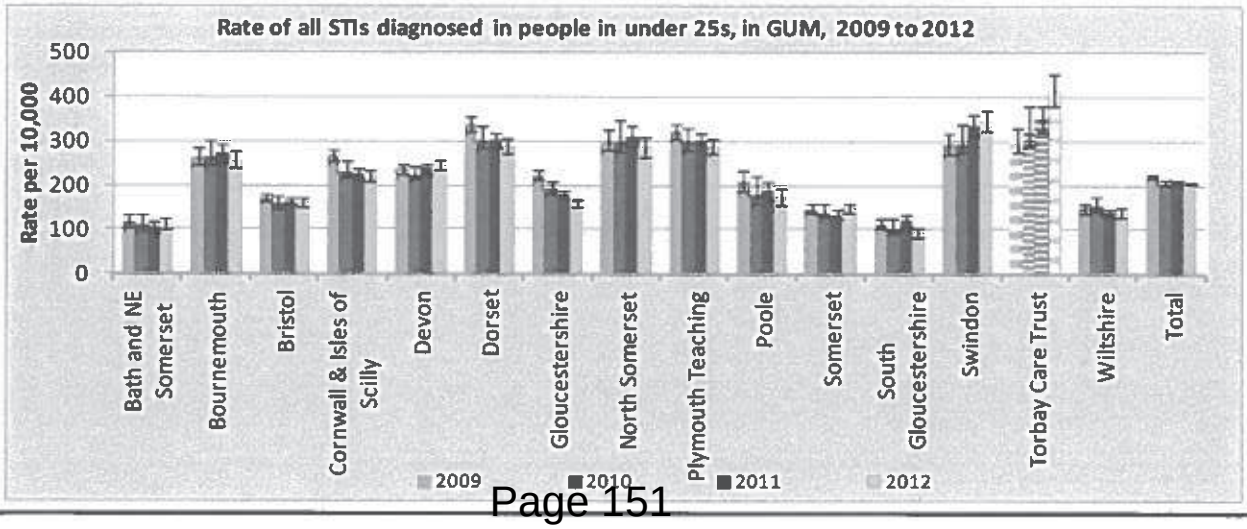
Denominator source: ONS mid year LA population estimates.

UTLA	Rate per 10,000	% change 2009-2012	% 15-24 year olds tested	% change 2009-2012
Bath and NE Somerset	28.5	-5.2	1.0	-8.3
Bournemouth	73.0	-3.6	2.3	-23.5
Bristol	39.1	-6.2	1.2	5.0
Cornwall & Isles of Scilly	49.7	-17.8	1.9	11.7
Devon	60.0	3.7	2.2	21.9
Dorset	69.7	-14.8	2.0	-2.2
Gloucestershire	38.4	-28.4	1.3	-10.8
North Somerset	55.7	-5.7	3.3	8.6
Plymouth Teaching	78.2	-10.7	2.8	3.9
Poole	48.8	-18.5	1.7	-15.9
Somerset	37.9	0.7	1.3	16.9
South Gloucestershire	20.2	-16.5	0.6	-0.7
Swindon	100.4	17.6	2.7	23.0
Torbay Care Trust	**105.6**	**37.4**	**2.7**	**22.2**
Wiltshire	31.6	-5.1	1.1	2.2
Total	**51.1**	**-7.3**	**1.7**	**5.2**

Summary

The rate of acute STIs in 15-24 year olds in Torbay was 105.6 per 10,000 for October to December 2012. This was the highest rate of acute STIs in the region. Between 2009 and 2012 there was a 37.4% increase from 302.8 per 10,000 to 416.1 per 10,000. This was the largest increase in acute STIs in young people in the region.

The percentage of 15-24 year olds tested for an acute STI in Torbay was 2.7% for October to December 2012. This was higher than the local authority average (1.7%) and was the third highest in the region. There was a 22.2% increase in the percentage of 15-24 year olds tested between 2009 (9.8%) and 2012 (12.0). This was the second largest increase in testing in the region.



DsPH Network and Office for sexualhealth South West

4. Sexually Transmitted Infections & HIV

4c. Percentage coverage and positivity of chlamydia in all settings

Indicator

Percentage coverage and positivity of tests from all settings submitted to CTAD (Chlamydia Testing Activity Dataset) January to December 2012.

Denominator source: 15-24 year old population estimates are the mid year LA population estimates.

CTAD

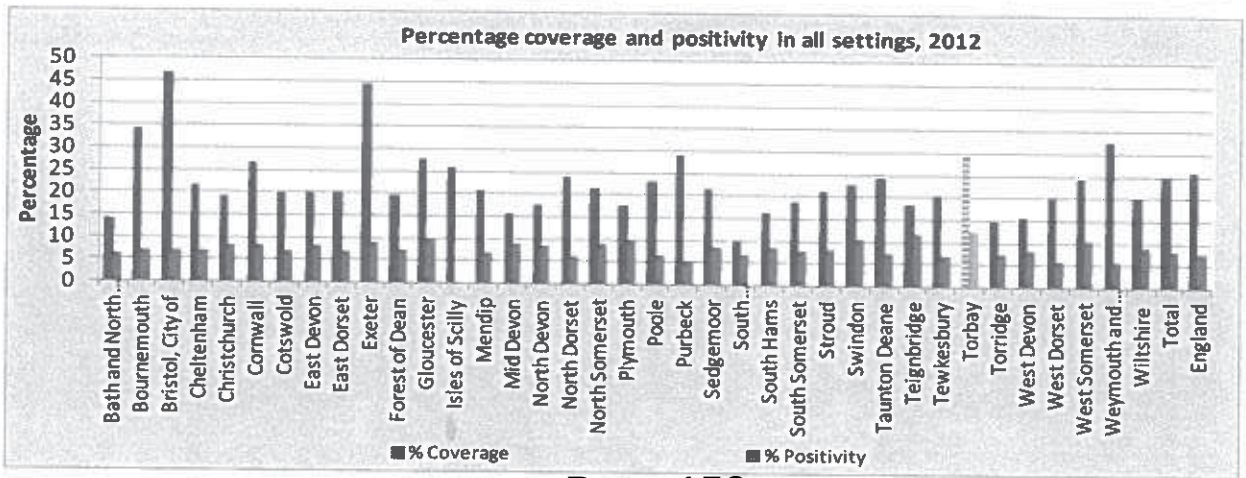
In 2012 CTAD replaced the NSCP, non-NCSP non GUM and GUM submissions of chlamydia screens. In the new system laboratories processing the specimens report the figures directly to PHE who collate the data. **Please note that the completeness of key fields such as postcode of residence in the 2012 is not as high as under NCSP and so records will have been assigned to LA based upon site of test or laboratory rather than residence**. Therefore the 2012 chlamydia figures should be interpreted with caution. Details of completion can be found on page 33.

Summary

The coverage of chlamydia screening in Torbay was 29.2% of 15—24 year olds. This was higher than the Local Authority average (24.8%) and national average (25.8%).

The percentage of persons testing positive was 12.5% in Torbay for 2012. This was higher than the national average (7.7%) and was the highest positivity in the region indicating appropriate targeting of screening.

LA	% Coverage	% Positivity
Bath and North East Somerset	14.0	6.2
Bournemouth	34.0	6.7
Bristol, City of	46.8	6.7
Cheltenham	21.4	6.9
Christchurch	19.3	7.9
Cornwall	26.7	8.2
Cotswold	20.0	7.0
East Devon	19.7	7.9
East Dorset	20.0	6.7
Exeter	44.5	8.8
Forest of Dean	19.6	7.3
Gloucester	27.9	9.5
Isles of Scilly	25.7	<5%
Mendip	20.9	6.8
Mid Devon	15.5	8.9
North Devon	17.4	8.3
North Dorset	24.0	5.9
North Somerset	21.4	8.7
Plymouth	17.6	9.6
Poole	23.1	6.3
Purbeck	29.1	5.2
Sedgemoor	21.3	8.4
South Gloucestershire	10.1	7.0
South Hams	16.4	8.3
South Somerset	18.6	7.8
Stroud	21.2	8.1
Swindon	22.8	10.6
Taunton Deane	24.1	7.4
Teignbridge	18.2	11.5
Tewkesbury	20.5	6.9
Torbay	**29.2**	**12.5**
Torridge	14.9	7.2
West Devon	15.4	8.2
West Dorset	19.9	5.8
West Somerset	24.4	10.2
Weymouth and Portland	32.5	5.6
Wiltshire	20.0	8.8
Total	**24.8**	**7.9**
England	**25.8**	**7.7**



DsPH Network and Office for sexualhealth South West

4. Sexually Transmitted Infections & HIV

4d. Partner treatment rate for chlamydia in GUM

Indicator

Proportion of partners attending a GUM clinic for chlamydia per index case diagnosed in a GUM clinic, 2011-2012. GUMCAD data only. Please note this data source does not include partner notification data from other settings i.e. GPs and pharmacies. Please contact your local provider for this data.

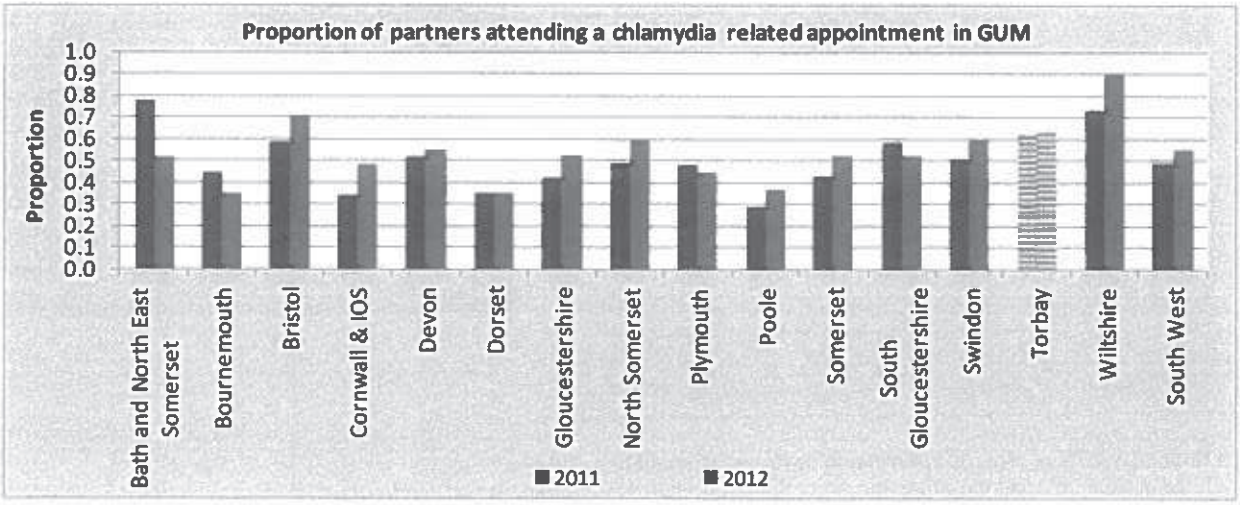
Source: Genitourinary medicine clinical activity dataset

Upper Tier Local Authority	2011	2012
Bath and North East Somerset	0.77	0.51
Bournemouth	0.45	0.35
Bristol	0.58	0.71
Cornwall & IOS	0.34	0.48
Devon	0.52	0.55
Dorset	0.35	0.35
Gloucestershire	0.42	0.52
North Somerset	0.49	0.59
Plymouth	0.48	0.45
Poole	0.29	0.37
Somerset	0.43	0.53
South Gloucestershire	0.58	0.53
Swindon	0.51	0.60
Torbay	**0.62**	**0.64**
Wiltshire	0.73	0.90
South West	**0.49**	**0.55**
England	-	-

Summary

The proportion of partners attending a chlamydia related appointment per index case diagnosed in GUM was 0.64 in Torbay for 2012. This was higher than the regional average (0.55) and was the third highest proportion in the region. However, there has only been a small increase in the proportion of partners attending from 2011 to 2012.

BASHH guidelines on partner notification state that male index cases with urethral symptoms should have all contacts in the four weeks prior to symptoms contacted. All other index cases should have all contacts in the six months prior to presentation contacted[4]. The performance standard for verified chlamydial partner notification is at least 0.4 contacts per index case for level 1, 2 and 3 sexual health services.



DsPH Network and Office for sexualhealth South West

4. Sexually Transmitted Infections & HIV

4e. Rate of chlamydia diagnoses in all settings including GUM

Indicator

Rate of chlamydia diagnoses per 100,000 15-24 year olds. This includes diagnoses from NCSP, non-NCSP/ non-GUM and GUM (Jan - Dec 2012) submitted to CTAD.

Numerator source: GUMCAD and NCSP data
Denominator source: 15-24 year old population estimates are the mid year LA population estimates

Summary

The rate of chlamydia diagnoses in Torbay was 3,644 per 100,000 for 2012. This was higher than the national average (1,979.1 per 100,000) and was the second highest rate in the region. It was also higher than the national diagnoses target of 2,300 per 100,000.

Torbay residents are likely to have their samples sent to the South Devon laboratory which had 52.4% of records with no NHS number and only 1.8% of non-GUM records had no postcode of residence. 98% of records submitted to the laboratory will therefore be assigned to the correct Local Authority of residence. Therefore the rate given will have a high degree of accuracy.

LA	Diagnoses rate per 100,000
Bath and North East Somerset	873.8
Bournemouth	2,290.1
Bristol, City of	3,142.3
Cheltenham	1,476.6
Christchurch	1,532.5
Cornwall	2,193.9
Cotswold	1,396.8
East Devon	1,567.9
East Dorset	1,335.1
Exeter	3,910.9
Forest of Dean	1,424.0
Gloucester	2,657.2
Isles of Scilly	1,197.6
Mendip	1,414.3
Mid Devon	1,379.6
North Devon	1,437.0
North Dorset	1,417.3
North Somerset	1,865.6
Plymouth	1,687.7
Poole	1,458.2
Purbeck	1,504.7
Sedgemoor	1,781.0
South Gloucestershire	702.8
South Hams	1,363.0
South Somerset	1,440.6
Stroud	1,713.6
Swindon	2,413.4
Taunton Deane	1,792.2
Teignbridge	2,094.7
Tewkesbury	1,418.2
Torbay	**3,644.0**
Torridge	1,075.8
West Devon	1,262.1
West Dorset	1,149.8
West Somerset	2,495.7
Weymouth and Portland	1,819.1
Wiltshire	1,766.2
Total	**1,953.0**
England	**1,979.1**

Percentage of tests with unknown or missing codes

Laboratory	Number of tests	NHS number	Postcode of residence (non-GUM tests)	Postcode of testing service	Testing service type
Cornwall	22,814	51.1	10.3	7.8	6.0
Dorset County	16,533	76.5	29.0	78.9	43.2
Exeter	10,950	58.9	52.7	60.4	74.3
Gloucester	29,677	38.3	6.3	25.7	0.0
Great Western	22,118	71.2	0.9	25.9	0.0
Northern Devon	8,415	62.3	3.1	0.2	0.2
PHE Bristol	104,515	61.5	62.1	0.1	0.2
Plymouth	10,898	59.9	19.2	2.7	0.0
Poole	30,733	55.0	16.9	0.0	0.0
Salisbury	5,718	51.0	9.2	6.8	4.9
South Devon	**11,590**	**52.4**	**1.8**	**100.0**	**0.0**
Taunton	26,691	40.1	5.7	6.0	0.5

Nationally 28% of records are missing postcode of residence.
Locally we would like to reduce the percentage of records with unknown postcode of residence to below 3% and postcode of testing service to less than 1%. Testing service type should be recorded for all tests.

DsPH Network and Office for sexualhealth South West

4. Sexually Transmitted Infections & HIV

4f. Percentage uptake of third dose HPV vaccine

Indicator

Percentage uptake of third dose vaccine uptake amongst 12-13 year old females. 2008/09—2011/12 annual data.

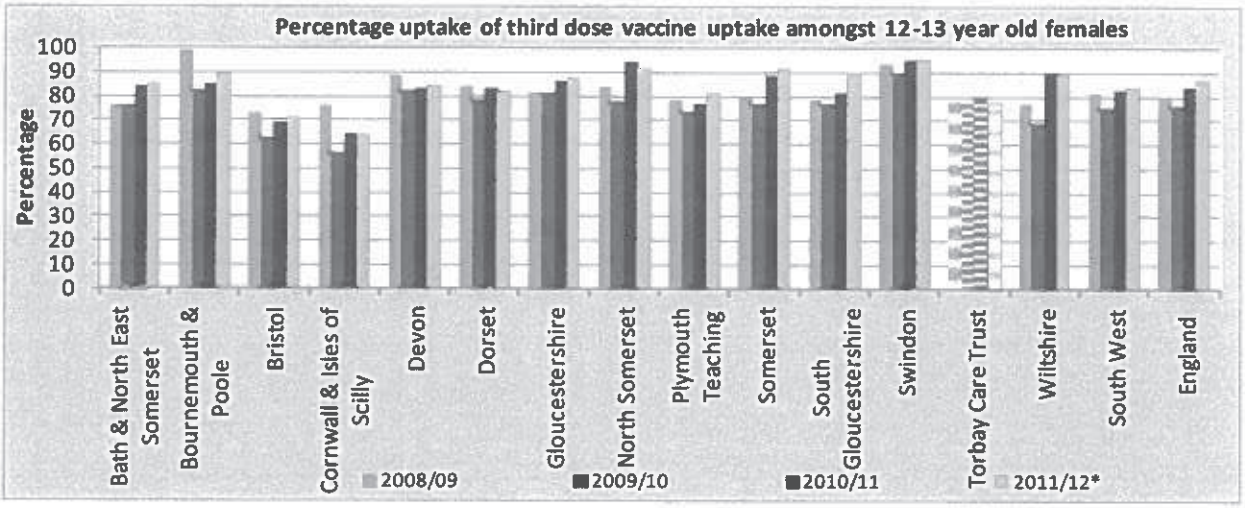
Source: Department of Health

*2011/12 provisional data

PCT	Percentage uptake				Direction of change 08/09-11/12
	2008/09	2009/10	2010/11	2011/12*	
Bath and NE Somerset	75.9	76.3	83.7	85.4	↑
Bournemouth and Poole	98.9	82.3	84.8	89.4	↓
Bristol	72.9	62.8	69.1	70.9	↓
Cornwall & Isles of Scilly	76.3	56.9	64.4	64.2	↓
Devon	88.8	82.8	83.5	84.3	↓
Dorset	84.1	78.3	83.1	82.3	↓
Gloucestershire	81.8	81.3	86.1	87.9	↑
North Somerset	84.2	78.1	94.4	91.7	↑
Plymouth Teaching	78.4	73.7	76.6	81.4	↑
Somerset	79.9	77.2	88.7	91.4	↑
South Gloucestershire	78.7	76.7	81.7	90.2	↑
Swindon	93.7	89.6	94.8	95.2	↑
Torbay	**79.6**	**77.9**	**80.2**	**77.9**	↓
Wiltshire	77.3	69.3	89.7	89.2	↑
Total	**81.9**	**75.2**	**82.3**	**83.8**	↑
England	**80.1**	**76.4**	**84.2**	**86.8**	↑

Summary

The percentage uptake of HPV vaccine (3rd dose) for 2011/12 was 77.9% for Torbay. This was lower than the Local Authority average (83.8%) and England average (86.8%) and was the third lowest in the region. Overall the percentage uptake of the third dose of the HPV vaccine has decreased from 79.6% in 2008/09 to 77.9% in 2011/12 however this is only a 2% change. Uptake has remained relatively stable of the four years of the programme.



DsPH Network and Office for sexualhealth South West

4. Sexually Transmitted Infections & HIV

4g. Percentage of sexual health service attendees offered and accepting an HIV test

Indicator

Percentage of persons attending a GUM clinic who have been offered and percentage who have accepted an HIV test, 2009—2012. Attendances by known HIV patients or where a test was not appropriate have been excluded.

Only % offered an HIV test shown.

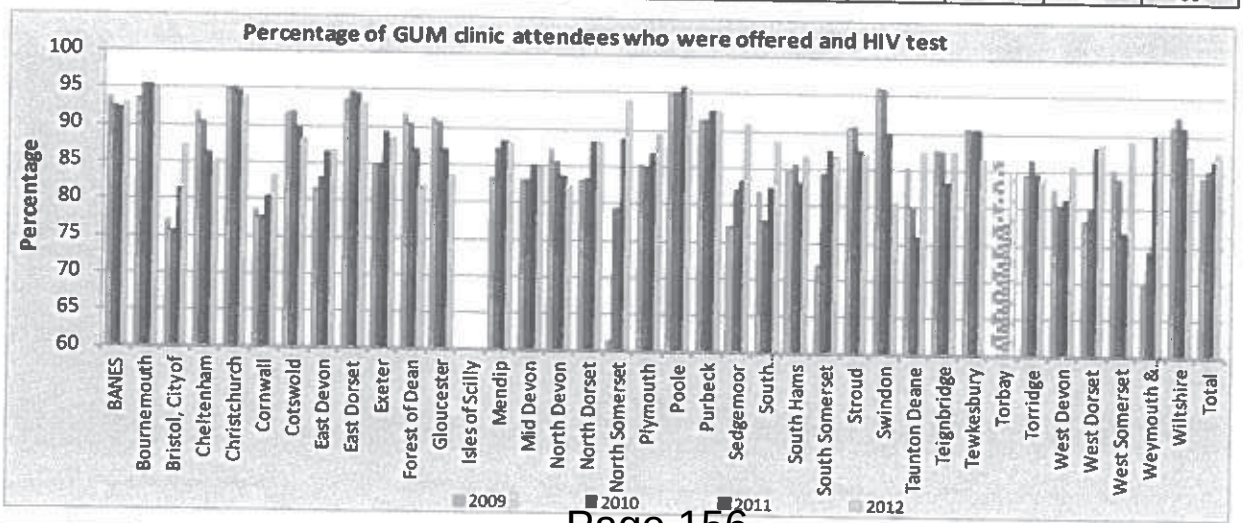
Source: GUMCAD (Genitourinary medicine clinical activity dataset).

Summary

In Torbay 85% of persons attending a GUM clinic were offered an HIV test. This was slightly lower than the Local Authority average (88%). However, it was similar to the rate in 2009 and 2010.

The percentage of persons attending GUM who accepted the HIV test was 59% for 2012. This was a decrease from 62% in 2009. Torbay had the second lowest percentage of person having an HIV test in the region in 2012.

Local Authority	% offered HIV test			
	2009	2010	2011	2012
BANES	94	92	92	93
Bournemouth	94	96	95	95
Bristol, City of	77	76	81	87
Cheltenham	92	90	86	85
Christchurch	95	95	95	94
Cornwall	79	78	80	83
Cotswold	92	92	90	88
East Devon	82	83	87	87
East Dorset	94	95	95	93
Exeter	85	85	89	88
Forest of Dean	92	90	87	82
Gloucester	91	91	87	84
Isles of Scilly	0	0	0	0
Mendip	83	87	88	88
Mid Devon	83	83	85	85
North Devon	87	86	84	82
North Dorset	83	83	88	88
North Somerset	62	80	89	94
Plymouth	85	85	87	89
Poole	95	95	96	96
Purbeck	91	92	93	93
Sedgemoor	77	82	83	91
South Gloucestershire	82	78	83	89
South Hams	85	86	83	87
South Somerset	72	85	88	87
Stroud	91	91	87	87
Swindon	96	96	90	81
Taunton Deane	85	80	76	87
Teignbridge	88	88	83	88
Tewkesbury	91	91	91	86
Torbay	**87**	**87**	**78**	**85**
Torridge	85	87	85	84
West Devon	83	80	81	86
West Dorset	79	80	88	89
West Somerset	85	84	77	89
Weymouth & Portland	70	74	90	90
Wiltshire	91	93	91	87
Total	**84**	**85**	**87**	**88**



DsPH Network and Office for sexualhealth South West

4. Sexually Transmitted Infections & HIV

4h. Rate of persons accessing HIV related care per 1,000 persons

Indicator

Rate of persons accessing HIV related care per 1,000 persons aged 15-59 years. Cases are assigned to LA based on postcodes of residence.

Numerator source: SOPHID (Survey of Prevalent HIV Infections Diagnosed).

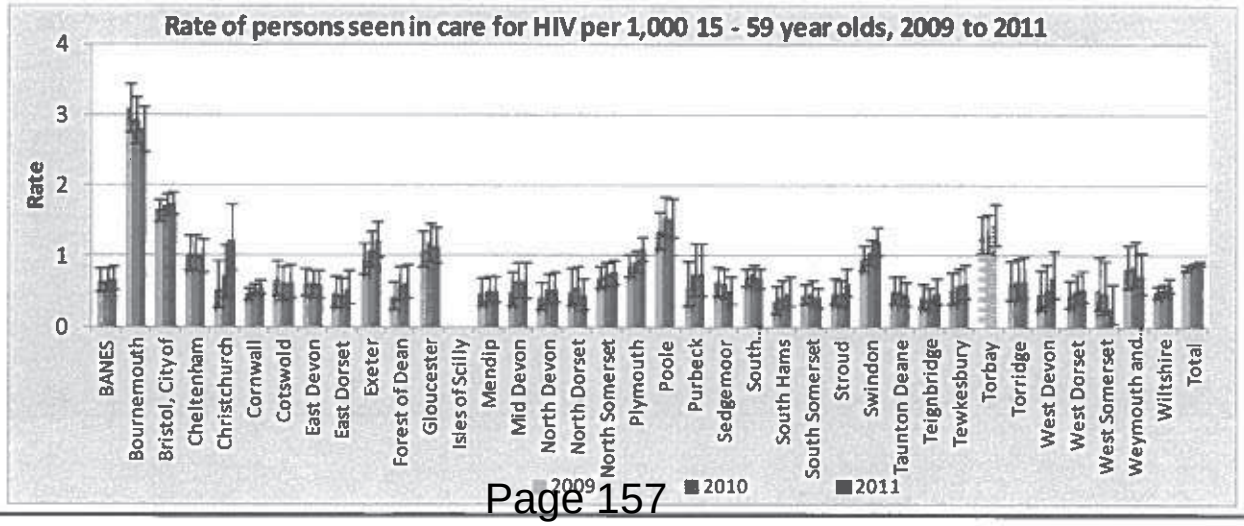
Denominator source: ONS mid year LA population estimates.

Summary

The rate of persons accessing HIV related care in Torbay was 1.43 per 1,000 15-59 year olds in 2011. This was higher than the Local Authority average rate (0.92 per 1,000). It was the fourth highest rate in the region for 2011.

Between 2009 and 2011 there has been a 10% increase in the rate of persons accessing HIV related care. This increase will be due to new diagnoses and persons living long due to antiretroviral therapy.

Local Authority	Rate per 1000			Trend 2009-2011
	2009	2010	2011	
BANES	0.65	0.65	0.67	↑
Bournemouth	3.10	2.92	2.80	↓
Bristol, City of	1.65	1.71	1.75	↑
Cheltenham	1.04	1.03	0.99	↓
Christchurch	0.53	0.71	1.21	↑
Cornwall	0.47	0.51	0.56	↑
Cotswold	0.66	0.60	0.62	↓
East Devon	0.61	0.60	0.59	↓
East Dorset	0.46	0.44	0.53	↑
Exeter	0.94	1.09	1.23	↑
Forest of Dean	0.41	0.59	0.61	↑
Gloucester	1.09	1.18	1.13	↑
Isles of Scilly	-	-	-	-
Mendip	0.48	0.51	0.51	↑
Mid Devon	0.50	0.63	0.63	↑
North Devon	0.41	0.51	0.53	↑
North Dorset	0.51	0.55	0.43	↓
North Somerset	0.70	0.74	0.77	↑
Plymouth	0.87	0.92	1.10	↑
Poole	1.36	1.55	1.53	↑
Purbeck	0.55	0.76	0.76	↑
Sedgemoor	0.63	0.60	0.50	↓
South Gloucestershire	0.70	0.73	0.88	↓
South Hams	0.35	0.42	0.48	↑
South Somerset	0.46	0.48	0.41	↓
Stroud	0.48	0.47	0.61	↑
Swindon	0.96	1.06	1.22	↑
Taunton Deane	0.51	0.51	0.45	↓
Teignbridge	0.43	0.38	0.48	↑
Tewkesbury	0.53	0.57	0.61	↑
Torbay	1.30	1.31	1.43	↑
Torridge	0.61	0.64	0.65	↑
West Devon	0.46	0.53	0.70	↑
West Dorset	0.44	0.51	0.54	↑
West Somerset	0.53	0.48	0.24	↓
Weymouth and Portland	0.82	0.86	0.71	↓
Wiltshire	0.49	0.53	0.59	↑
Total	0.84	0.89	0.92	↑



DsPH Network and Office for sexualhealth South West

4. Sexually Transmitted Infections & HIV

4i. Late diagnoses, percentage with CD4 cell count <350

Indicator

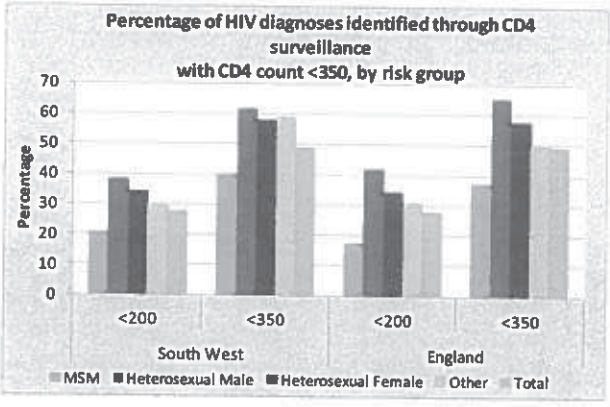
Percentage of new diagnoses of HIV with a CD4 cell count of less than 350 per mm^3 between 2009 and 2011.

Source: Integrated HIV surveillance data (Survey Of Prevalent HIV Infections Diagnosed (SOPHID), HIV and AIDS New Diagnoses Database (HANDD) and CD4 Surveillance).

Summary

In Torbay percentage of HIV new diagnoses identified through CD4 surveillance with a CD4 count of less than 350 between 2009 and 2011 was 69.2% which was higher than the regional average of 49.5%. This was the fourth highest percentage of late diagnoses in the region. The percentage of late diagnoses has also increased slightly from 66.7% in 2008/10.

62% of heterosexual male, 58% of heterosexual females and 40% of men who have sex with men in the South West had new diagnoses with a CD4 cell count less than 350/mm^3.



LA	2008-2010	2009-2011
BANES	51.6	50.0
Bournemouth	36.0	30.4
Bristol, City of	51.1	52.6
Cheltenham	72.2	42.9
Christchurch	-	50.0
Cornwall	70.6	63.2
Cotswold	50.0	57.1
East Devon	38.9	30.8
East Dorset	-	40.0
Exeter	63.6	57.1
Forest of Dean	40.0	42.9
Gloucester	48.5	65.0
Isles of Scilly	-	-
Mendip	55.6	70.0
Mid Devon	28.6	16.7
North Devon	83.3	60.0
North Dorset	-	-
North Somerset	75.0	65.0
Plymouth	54.2	45.1
Poole	65.7	48.7
Purbeck	66.7	40.0
Sedgemoor	41.7	25.0
South Gloucestershire	57.1	46.7
South Hams	-	-
South Somerset	60.0	60.0
Stroud	69.2	57.1
Swindon	51.3	55.6
Taunton Deane	75.0	70.0
Teignbridge	44.4	-
Tewkesbury	50.0	40.0
Torbay	**66.7**	**69.2**
Torridge	-	-
West Devon	-	-
West Dorset	20.0	-
West Somerset	-	-
Weymouth and Portland	72.7	80.0
Wiltshire	42.1	42.9
Total	**53.5**	**49.5**

DsPH Network and Office for sexualhealth South West

Reference List

1. Delivering Alcohol Identification and Brief Advice in Sexual Health Settings. Available from: http://www.alcohollearningcentre.org.uk/_library/Resources/ALC/SH.IBAFinal.pdf

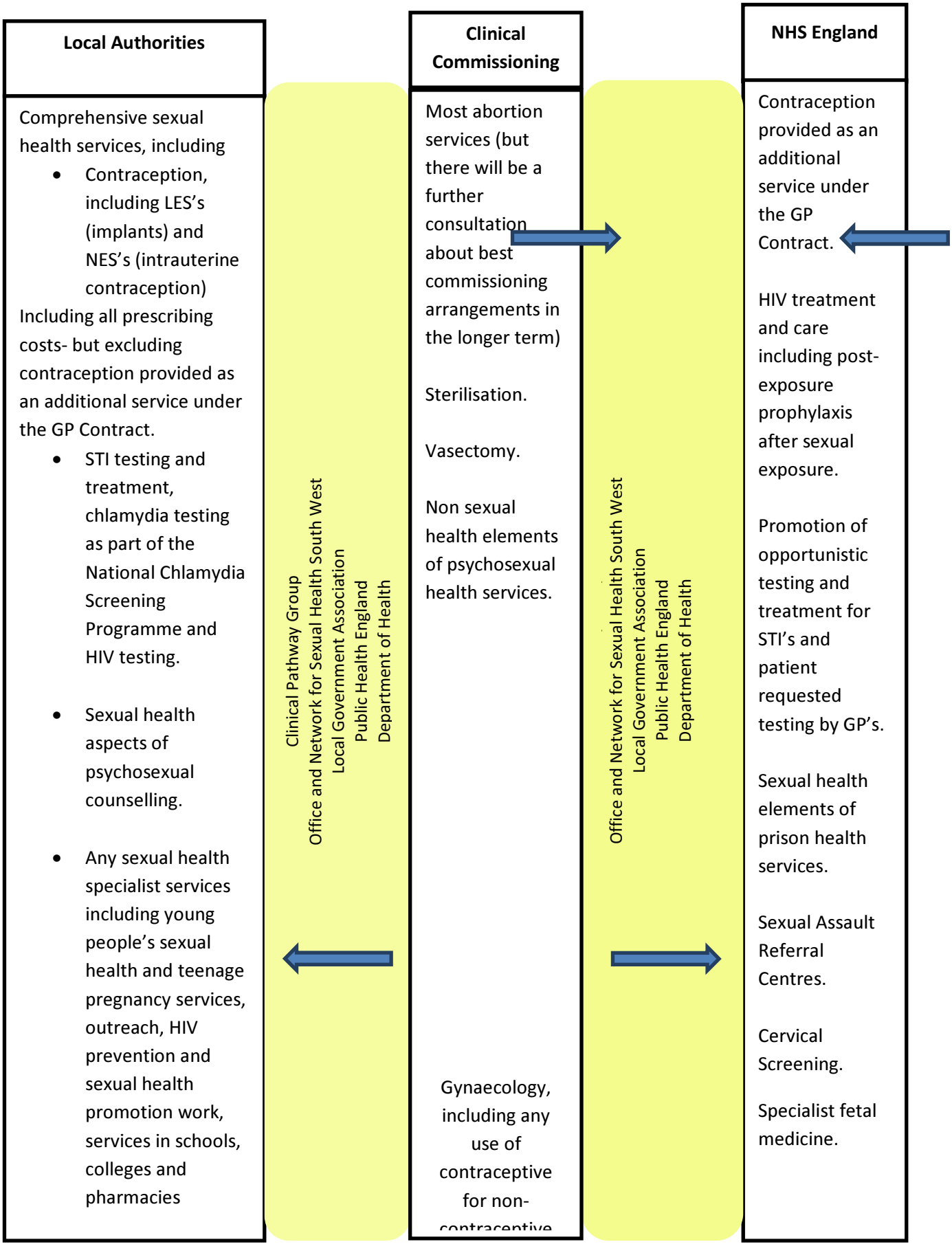
2. Department of Health (2005) Health Economics of Sexual Health: A Guide for Commissioning and Planning. Available from: http://webarchive.nationalarchives.gov.uk/20100811230802/webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publichealth/healthimprovement/sexualhealth/dh_4001942

3. UK guideline for the use of post-exposure prophylaxis for HIV following sexual exposure (2011). P Benn *et al.* Available from: http://www.bhiva.org/PEPSE.aspx

4. BASHH statement on partner notification, 2012. Available from: www.bashh.org/documents/4445.

Appendix 2

Sexual Health Commissioning Responsibilities and Relationships from April 2013



TORBAY Health & Wellbeing BOARD
Working together for a healthier Torbay

Title:	Priority 3 – Reduce Teenage Pregnancy / Public Health Work Programme		
Wards Affected:	All		
To:	Health & Wellbeing Board	**On:**	19 September 2013
Contact:	Sue Matthews		
Telephone:	208204		
Email:	sue.matthews@torbay.gov.uk		

1. Purpose

1.1 To brief the Board on the proposed work programme:

1.2 As a senior manager within community public health I have been seconded to the Local Authority Public Health department with a clear remit of 'Designing a young person's sub strand of the PH work programme…'.

1.3 Within this is the remit of 'reviewing existing services and best practice elsewhere' and in particular using teenage conception statistics and the sexual exploitation case as evidence.

1.4 I have also been asked to 'identify training requirements across all agencies around risk taking behaviour and aspiration'.

1.5 I also have a mandate for seeking opportunities to '…improve working together….' between the NHS and Children's Services.

2. Recommendation

2.1 The Board to accept the proposed work programme

3. Supporting Information

3.1 For today's report I will be focusing on two priorities of Torbay's Outcomes:

- Reduce teenage pregnancy
- Increase sexual health screening

3.2 You will have seen the statistics from Doug Haines and whilst there is a quarterly variable, over the last 10 years our overall annual rate has changed very little.

3.3 Whilst reviewing teenage pregnancy it is very important to see this as a symptom rather than the cause. Many young people are vulnerable to a range of risk taking behaviour and challenging outcomes, for example:

- Drug and alcohol misuse
- Self-harming
- Teenage conception
- Worklessness

Low self-esteem and aspiration, intergenerational poverty, poor parenting/role modelling all play their part in determining outcomes.

3.4 I propose to (please see Appendix A for full work programme and proposed time scales):

- Review sexual health training
- Identify best practice and identify gaps by auditing against national recommendations and best practice
- Review previous work undertaken to identify causes and interventions for teenage conceptions
- Consult with young people on provision of Public Health services
- Review current RSE provision
- Review job roles
- Identify training needs
- Review risk assessment currently undertaken by all agencies

3.5 Whilst I have focused on two priorities, my work programme will touch on many of the other priorities identified for Torbay and I will be working in partnership with the evolving Youth trust arrangements.

3.6 I will report regularly to the Board on progress.

4. Relationship to Joint Strategic Needs Assessment

4.1 Teenage conceptions is a key indicator for Public Health locally.

5. Relationship to Joint Health and Wellbeing Strategy

5.1 Priority 3 – Reduce Teenage Pregnancy

5.2 Priority 9 – Increase Sexual Health Screening

6. Implications for future iterations of the Joint Strategic Needs Assessment and/or Joint Health and Wellbeing Strategy

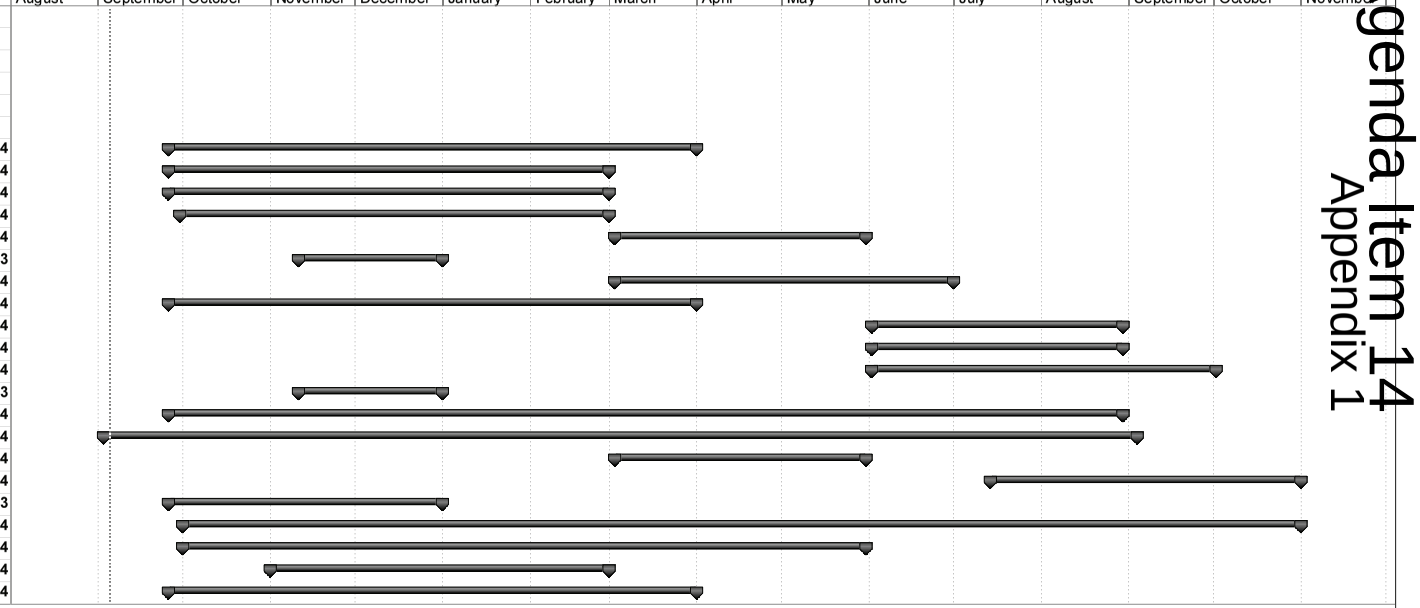
6.1 Remains a key strand.

Appendices

Appendix 1

Youth Public Health Services Review

ID	Task Name	Start	Finish
1			
2			
3			
4			
5			
6			
7	Review Sexual Health Training	Thu 26/09/13	Mon 31/03/14
15	Identify best practice by audit	Thu 26/09/13	Fri 28/02/14
25	Identify gaps in delivery by auditing against best pract	Thu 26/09/13	Fri 28/02/14
35	Review previous work undertaken to identify causes a	Mon 30/09/13	Fri 28/02/14
43	Review actual cases	Mon 03/03/14	Fri 30/05/14
46	Review lessons learnt from Sexual Exploitation case	Mon 11/11/13	Tue 31/12/13
53	Review agencies information sharing	Mon 03/03/14	Mon 30/06/14
58	Review current RSE provision	Thu 26/09/13	Mon 31/03/14
64	Identify opportunities for One Stop Shop	Mon 02/06/14	Fri 29/08/14
68	Review opportunities in Community Hub model	Mon 02/06/14	Fri 29/08/14
73	Review job roles	Mon 02/06/14	Wed 01/10/14
78	Review supervision arrangements	Mon 11/11/13	Tue 31/12/13
81	Identify training needs	Thu 26/09/13	Fri 29/08/14
85	Identify strengths and weaknesses of implementation	Tue 03/09/13	Wed 03/09/14
88	Identify the possibility of a Young Person At Risk tean	Mon 03/03/14	Fri 30/05/14
94	Review all aspects of PH work programme and audit a	Mon 14/07/14	Fri 31/10/14
100	Review disability and transition arrangements	Thu 26/09/13	Tue 31/12/13
102	Identify and develop multi agency pathways	Tue 01/10/13	Fri 31/10/14
105	Review risk assessment currently undertaken by all ag	Tue 01/10/13	Fri 30/05/14
109	Social norms	Fri 01/11/13	Fri 28/02/14
11[illegible]	Acquisition	Thu 26/09/13	Mon 31/03/14



Project: Sue Matthews Project Gantt r
Date: Thu 05/09/13

Task | Progress | Summary | External Tasks | Deadline
Split | Milestone | Project Summary | External Milestone

Report Period Quarter 1 April-June 2013	**Agency name and contact details** Torbay Public Health Team mark.richards@torbay.gov.uk	**RAG rating**

Description of the measure:
Teenage conceptions/teenage pregnancy refers to young women who conceived under the age of 18 and includes live births, still births and legal abortions. The rate equates to conceptions per 1000 women aged 15-17.

Latest Data (ONS):

- There were 19 conceptions in Torbay recorded in Q2 2012 - this equates to a rate of 34.2.
- This is a reduction from 32 conceptions recorded in Q1 2012 and a rate of 58.1.

Comparison Data:
Rate per 1000 15-17 year olds Q2 2012: England 28.3%, South West 25.3%, Torbay 34.2%

Discussion:
The quarterly data shows a positive direction of travel and a distinct change from Q1. However, Torbay continues to struggle against the 1998 national target to reduce U18 conceptions by 50% - giving Torbay a target of 22.1 per 1000.

Local priorities as agreed by a Joint Teenage Pregnancy Partnership Board and Teenage Pregnancy Strategy Executive in March:

- Ensuring contraceptive / sexual health services are young people focused, trusted by teenagers and well known by professionals working with them
- Ensuring a strong delivery of Sex and Relationships Education / Personal Social Health Education by schools
- Providing targeted work with young people who may be more at risk of becoming pregnant, in particular 'looked after children' and 'care leavers'.
- Working with parents and carers to prevent teenage conceptions.

These priorities must be set against some underpinning, wider issues:

- Ongoing safeguarding concerns – e.g. non-consensual sex, exploitation, abuse,
- Serious Case Review recommendations
- Child poverty and unemployment – both a contributory factor and an outcome.
- Health inequalities – areas of greater deprivation have higher rates of teenage conceptions.

Planned Work

- Establish governance arrangements for the teenage conceptions agenda within the Health and Wellbeing Board.

- Outcomes for some young adults are challenging in Torbay. This is despite investment of both time and additional services. Existing services and best practice elsewhere will be reviewed with an eye to:

- Designing a young adults sub strand of the Public Health work programme
- Identifying training requirements across all agencies around risk taking behaviour and aspiration. To include:
    - Sexual Health training
    - Previous work undertaken to identify causes and Interventions for teenage conceptions
    - Consultation with young people on Public Health provision of services
    - Review Current RSE provision
    - Identify Opportunities for a One-Stop Shop
    - Review Opportunities in Community Hub Model

Recommendations:

That the TSCB continues to receive quarterly reports and endorses the planned work outlined above.

LSCB Safeguarding Performance Report (DATE)

Under 18 Conception Data.		
Report compiled April 2013	**Report written by Kim Flemming, Torbay Council Children's Services.**	**RAG rating: RED**

No data update from previous report:

ONS quarterly U18 conception data is published May, August, November and February.
Q1 2012 will therefore be available May 2013.

ROOT CAUSE ANALYSIS

Kim Flemming interviewed five Young Mothers in January 2013. It was agreed that their information (without name, address, school and date of birth) could form part of a report that will be shared with professionals in meetings in order to gain greater understanding of the lives of local young mothers with the aim of improving services and practice. It is important to acknowledge that this study does not provide a generalised view of the experiences of teenage mothers, but rather it outlines the experiences and views of the small cohort who participated and provides us with a useful insight into their circumstances.

The interviews with young parents have been written up into 4 different documents, all using the same information but with a different focus.

1. Root Cause Analysis (RCA) – written up using RCA methodology.
2. Risk Factors – matching young parent's information against national risk factors.
3. Young Parents Stories – providing in-depth information on their circumstances
4. Appendices.

Senior Managers can access these on Torbay Council G drive, Children's services, Shared, Teenage Pregnancy, Consultation/Participation, RCA.

The following RCA recommendations are addressed in the updated Reducing Teenage Conceptions Plan.

DISCUSSION AND RECOMMENDATIONS.

1. One of the key requirements for reducing teenage conceptions is access to reliable contraception. Whilst the young mothers interviewed had all accessed contraception this was either not used correctly or they reported it did not work. Even if providers of oral contraception and condoms had provided information on how to use the contraception correctly and explained what would happen if not taken correctly, improper use may still have occurred. This could be due to the young woman misunderstanding the information or the belief that perhaps 'it won't happen to me'. The use of Longer Acting Reversible Contraception (LARC) would have most probably prevented these young women from becoming pregnant as LARC does not rely on patients having to use it correctly.

Recommendation: Actively promoting the use of LARC with young women not wishing to become pregnant.

2. Many of the young women were also disengaged from school and had not received adequate sex and relationship education. The young women would have benefitted from being identified by the school as more 'at risk' of teenage conceptions and would possibly have benefitted from being provided with additional input sex and relationships.

Recommendation: Schools to improve their identification of young women who would benefit from additional sex and relationships education.

3. None of the young women interviewed said they had experienced ongoing sex and relationships education in school; either it was a one off session or they could not remember it.

Recommendation: Improve the quality and effectiveness of SRE in schools in line with best practice with ongoing sessions throughout the school years.

4. Evidence shows that teenage pregnancy is both a contributory and an outcome of child poverty and follows intergenerational cycles. Teenage pregnancy also increases health inequalities and leads to poor long term outcomes for young parents and their children. It is worth noting that all the young women interviewed had lived and were living in areas of deprivation.

Recommendation: Ensure 'reducing teenage conceptions' is included in overarching strategy and delivery plans to reduce child poverty.