



# **Improving Young Peoples' Sexual Health and Wellbeing**

**Plymouth's Joint Commissioning Strategy  
2009-2012**

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# **i. Foreword**

**TO BE COMPLETED**

## **ii. Executive Summary**

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# 1. Introduction

Sexual health is a basic human need. It is central to the joy and development of some of the most important and lasting relationships in our lives.

Positive sexual health is about every person having the choice and skills to develop positive emotional and physical relationships which are enjoyable and fulfilling. Poor sexual health can have a detrimental effect on our physical and mental wellbeing, with outcomes such as unintended or unwanted pregnancies, sexually transmitted infections and the effects of sexual exploitation and abusive relationships.

Young people are at the beginning of their sexual and reproductive lives. How they are prepared for this journey has tremendous implications for their own lives and that of the future generation.

## 1.1 Purpose and Scope of the Commissioning Strategy

The purpose of this strategy is to provide a coherent strategic approach for how the City will meet the sexual health and wellbeing needs of young people living in Plymouth. Within this strategy, 'sexual health and wellbeing' is understood in the context of a young person's physical, emotional, mental and social well-being in relation to their sexuality. A more detailed definition can be found in Section 1.2.

It is well documented that sexual health and wellbeing cannot be tackled in isolation. Problems in sexual health can affect all aspects of young people's lives, including their physical health, emotional and mental health, social and spiritual health. Additionally, any issues for young people in any of these areas can also impact detrimentally on their own sexual health. For example, high teenage conception rates present a serious social problem - having children at a young age can damage young women's health and well-being and limit their education and career prospects. Evidence also shows that children born to teenagers are much more likely to experience a range of negative outcomes in later life.

This strategy acknowledges that sexual health improvement is not only about those young people who are already sexually active, and therefore takes into account the progressive, longer term needs of young people at each stage of their lives, both before and after they become sexual active, leading up to and including their move from childhood into adulthood. In addition, this strategy strongly emphasises that the welfare of any child or young person is paramount, with safeguarding being integral within the delivery of all sexual health and wellbeing services.

*'We want all our children to live, grow, achieve and exceed in their hopes for the future'* - this vision, adopted by the Plymouth Children and Young People's Trust, is grounded in listening and responding to what young people and their families are saying, and reflects the national drive for agencies and services to work closer together to meet needs.

Successful delivery of this joint commissioning strategy can only happen with the active involvement of young people and their families, combined with real partnership working. While Plymouth has pockets of excellent practice around sexual health and wellbeing, there remains scope for improvement.

This strategy provides the holistic framework to inform and direct delivery of an inclusive, co-ordinated and comprehensive approach to young people's sexual health and wellbeing. It offers a real opportunity to do things differently – to learn from past mistakes and build on our collective strengths and best practice to move forward together in a way that improve outcomes for young people. We must embrace this wholeheartedly if we are to achieve our vision.

### **Vision**

**Young people can enjoy positive sexual health and wellbeing free from prejudice or harm**

## 1.2 Language & Terminology

Terms such as ‘teenage pregnancy’, ‘sexual behaviour’ and ‘sexuality’ are often used interchangeably in our day to day language when we talk about young people’s sexual health, and as a result there is often some confusion about what they actually mean.

For the purpose of this strategy, it is necessary to reach a consensus about the terms we will collectively use that will enable us to understand and respond to young people’s sexual health needs and choices.

### ***Sexual Health & Wellbeing***

Being healthy is about feeling good physically, mentally and emotionally. Good sexual health is an important and integral part of overall health.

Sexual health involves the consideration of a young person’s physical, emotional, mental and social well-being in relation to their sexuality; it is not merely the absence of disease. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For a young person’s sexual health to be attained and maintained, the sexual rights of all young people must be respected, protected and fulfilled<sup>1</sup>.

Sexual health is influenced by a complex web of factors ranging from individual and social sexual behaviour and attitudes and wider societal factors, to biological risk and genetic predisposition. It encompasses the problems of HIV and Sexually Transmitted Infections (STIs) / Reproductive Tract Infections (RTIs), unintended pregnancy and abortion, infertility and cancer resulting from STIs, and sexual dysfunction. Sexual health can also be influenced by a young person’s or their family’s mental health or acute and chronic illnesses, and any exposure they may have to violence.

### **Additional Terminology**

#### ***Reproductive Health***

“Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Reproductive health deals with the reproductive processes, functions and system at all stages of life<sup>2</sup>.”

The International Conference on Population and Development Programme of Action states that “reproductive health ... implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

Implicit in this last condition are the right of (young) men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

Reproductive health includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.”

#### ***Teenage Pregnancy / Teenage Parent***

For the purposes of this strategy, a teen pregnancy is a pregnancy experienced by a young woman or couple in their teenage years up to their 20<sup>th</sup> birthday. For statistical purposes there may be a division made between the pregnancies of under-16 year olds and under-19 years old, and

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<sup>1</sup> Adapted from WHO-convened international technical consultation on sexual health, January 2002

<sup>2</sup> United Nations Population Fund

sometimes pregnancies experienced by those as young as 11 year olds are considered teenage pregnancies.

The term 'teenage parent' refers to any young woman or young man under the age of 20<sup>3</sup> who is a parent or carer of a child.

## **Sexuality**

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

## **Sexual rights**

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- seek, receive and impart information related to sexuality;
- sexuality education;
- respect for bodily integrity;
- choose their partner;
- decide to be sexually active or not;
- consensual sexual relations;
- consensual marriage;
- decide whether or not, and when, to have children; and
- pursue a satisfying, safe and pleasurable sexual life.

The responsible exercise of human rights requires that all persons respect the rights of others.

## **1.3 Safeguarding**

### **1.3.1 Sexual abuse and exploitation**

While the vision of this strategy is for young people to enjoy positive sexual health and wellbeing free from prejudice or harm, it is recognised that some children and young people can find themselves at risk of abuse or exploitation. *Working Together to Safeguard Children*<sup>4</sup> (2006) defines sexual abuse as follows:

*'Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, sexual online images, watching sexual activities or encouraging children to behave in sexually inappropriate ways.'*

The sexual exploitation of children and young people is a form of sexual abuse. While there is no universally agreed definition of sexual exploitation, this strategy uses the following definition;

*Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain.*

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<sup>3</sup> Up to and inclusive of 19 years and 364 days. In some circumstances, legislative requires that services and support may be offered up to 25 yrs (e.g. care leavers, chlamydia screening, disability).

<sup>4</sup> Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children (HM Government 2006), paragraph 1.32.

*In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability<sup>5</sup>.*

Sexual exploitation results in children and young people suffering harm. The extent of the harm can range from situations where the exploitation is short lived and the young person is effectively supported to recover, to situations which lead to serious life-long impact and on occasions to the death of the young person, including through suicide and murder. Safeguarding and promoting the welfare of children, including keeping children safe from sexual exploitation, is a key part of the Government's drive to improve outcomes for children and young people<sup>6</sup>, and as such is a cornerstone for this strategy.

### **1.3.2 Age appropriateness**

Children and young people should be seen as human beings on a journey of development towards adulthood. The journey moves through clear stages of physical, emotional, intellectual and social development, all of which are entwined, influencing and affecting one another. Sexual development is part of this journey, affecting the child as a complete person. The period through puberty, some five years between the ages of 10 and 16, represents a dramatic transformation of physical and emotional characteristics. New chemical, hormonal processes, and substantial physical changes represent a fundamental change from childhood to sexual maturity.

There should be no direct comparison between childhood sexuality and adult sexuality. Before puberty, whilst there is a growing recognition of physical body and feelings, children are not able to understand adult sexual behaviours. Even through the period of puberty and after, the young person's physical, emotional, intellectual and social development move at different speeds, often creating tensions between the mature physical drive and less developed and vulnerable emotions.

At all times, adults have a responsibility to ensure children can recognise and safeguard themselves from sexually inappropriate and harmful activities. Providing basic information at a younger age provides the foundation on which more complex knowledge is built up over time. The precise age at which information should be provided will depend on the physical, emotional and intellectual development of the young person as well as their level of understanding. A key consideration within this is that talking about sex and relationships becomes normalised from the beginning of a child's education. There is no evidence that providing information about sex and sexuality arouses curiosity and leads to sexual experimentation.

This approach has been shown to be effective in European countries such as France, Germany and the Netherlands, where schools, communities and families regard it as an important responsibility to talk openly with young people about sex, sexuality and relationships, and contributes to greater cultural openness about sex and sexuality and improved sexual health among young people.

The Key Stage outcomes outlined within the statutory PSHE education framework will be utilised across agencies and services in the provision of sexual health information, education and advice.

#### Key stage 1: 5–7 years old

Example: Be able to understand the main external parts of the body; understand differences between male and female; identify and share their feelings with others; recognise safe and unsafe situations; be aware that their feelings and actions have an impact on others.

#### Key stage 2: 7–11 years old

Example: Be able to express opinions, for example, about relationships and bullying; recognize their changing emotions with friends and family and be able to express their feelings positively; recognize their own worth and identify positive things about themselves; understand the main stages of the human life cycle; keeping themselves safe when involved with risky activities.

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<sup>5</sup> Proposed in the consultation draft of the guidance on Safeguarding Children and Young People from Sexual Exploitation, 18th July 2008. This definition arises from joint work between project members of the National Working Group for Sexually Exploited Children and Young People (NWG) 2008

<sup>6</sup> Consultation draft of the guidance on Safeguarding Children and Young People from Sexual Exploitation, 18th July 2008.

### Key stage 3: 11–14 years old

Example: Be able to manage changing relationships; recognise risk of personal safety in sexual behaviour and be able to make safe decisions; understand the physical and emotional changes that take place during adolescence; understand the human reproductive system, including the menstrual cycle and fertilization; understand the law relating to sexual behaviour of young people, and sources of advice and support.

### Key stage 4: 14–16<sup>7</sup> years old

Example: Be able to recognise the influences and pressures around sexual behaviour and respond appropriately and confidently seek professional health advice; manage emotions associated with changing relationships with parents and friends; make informed choices about the pattern of their lifestyle which promote well-being; understand the risks of early sexual activity and the link with the use of alcohol and other drugs.

### **1.3.3 Confidentiality**

The assessment of a young person's sexual health needs is a skilled process that relies on experienced judgement and sensitivity. Many young people guard their privacy closely, or feel anxious when discussing their sexuality. It is important that services do what they can to reassure young people that the information they share about their sexual health will be handled sensitively and confidentially.

Guidance issued by the Department of health in July 2004, concerning sexual and contraceptive advice to those aged under 16 years, underlined the duty of confidentiality enshrined in professional codes of conduct, and made it clear that those under 16 have the same right to confidentiality as adults<sup>8</sup>.

Any practitioner working with young people is not legally obliged to inform anyone if they learn of or suspect sexual activity in a young person under the age of consent (16 in the UK) **if there is no evidence of abuse or exploitation**. Based on this, practitioners working across the Plymouth Children and Young People's Trust, including those working within sexual health settings need to have relevant child protection competencies, or have access to other professionals who have such competencies.

**All practitioners should regard highly their duty to safeguard children and young people's health and well being, including being alert to any potential abuse or potential harm.**

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<sup>7</sup> Information relevant to 14-16yr olds would also be extended to young people aged 17yrs up their 20th birthday

<sup>8</sup> 'Best Practice Guidance for Doctors & Other Health Professionals on the provision of advice & treatment to young people under 16 on contraception, sexual and reproductive health'  
DoH 2004

## 2. Policy Guidance Overview

This joint commissioning strategy responds to and builds upon both international and national policy and guidance, alongside key strategic drivers within the City.

### 2.1 International Drivers

#### ***United Nations Convention on the Rights of the Child (1989)***

The Convention on the Rights of the Child brings together children's human rights articulated in other international instruments. This compilation and clarification of children's human rights sets out the necessary environment and means to enable every human being to develop to their full potential. The convention includes general principles, including the right to life, survival and development, the right to non-discrimination, respect for the views of children and to give consideration to a child's best interests, and the requirement to give primary consideration to the child's best interests in all matters affecting them.

#### ***International Conference on Population and Development (ICPD), Cairo 1994***

At this conference, 179 countries agreed that population and development are inextricably linked, and that empowering women and meeting people's needs for education and health, including reproductive health, are necessary for both individual advancement and balanced development. Advancing gender equality, eliminating violence against women and ensuring women's ability to control their own fertility are acknowledged as corner-stones of population and development policies. Concrete goals centre on providing universal education and reproductive health care, including family planning; and reducing infant, child and maternal mortality.

#### ***Fourth World Conference on Women, Beijing 1995***

The UK agreed to the outcomes of the 1995 Fourth World Conference on Women, which includes an important affirmation of the right of women to have control over their sexuality.

"The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences" (*Fourth World Conference on Women, paragraph 96*).

### 2.2 National Drivers

***The Children Act (2004)***: Section 10 of the Children Act places a duty on agencies to cooperate to improve the well being of children and young people. The requirement to develop a Children's Trust provides the opportunity to integrate the planning and commissioning of services and where appropriate the provision of services for children and young people. Under Section 31 of the Health Act (1999) and now under Section 10 (6) (7) of the Children Act (2004), agencies can pool resources to improve joint commissioning, service delivery and enable partnership working.

***The Education Act (1996)*** reaffirmed earlier legislation obliging all secondary schools to provide sex education. It stated that the term 'sex education' included education about HIV/AIDS and other sexually transmitted infections. Key points related to SRE are:

- The sex education elements of the National Curriculum Science Order are mandatory for all pupils of primary and secondary school age. These cover anatomy, puberty, biological aspects of sexual reproduction and use of hormones to control and promote fertility.
- Secondary schools are required to provide an SRE programme which includes (as a minimum) information about sexually transmitted infections (STIs) and HIV/AIDS.
- Other elements of personal, social and health education (PSHE), including SRE, are non-statutory.
- All schools must provide, and make available for inspection, an up-to-date policy describing the content and organisation of SRE outside of national curriculum science. This is the school governors' responsibility.

- Primary schools should have a policy statement that describes the SRE provided or gives a statement of the decision not to provide SRE

**The Learning and Skills Act** (2000) requires that:

- Young people learn about the nature of marriage and its importance for family life and bringing up children.
- Young people are protected from teaching and materials which are inappropriate, having regard to the age and the religious and cultural background of the pupils concerned.
- School governing bodies have regard for the guidance.
- Parents have the right to withdraw their child from all/ or part of SRE provided outside national curriculum science.

Following a review, the Government announced in October 2008 that comprehensive SRE will be made compulsory as a part of a statutory PSHE curriculum.

**Healthy Lives, Brighter Futures** (Department of Health, 2009): The report focuses on three age groups: pregnancy and up to five; school age; and young people. It then outlines new proposals for universal, targeted, and specialist services for each age group. There is a strong emphasis on the need for better support for young people around mental health and emotional wellbeing, and recognition that emotional issues often underlie risky behaviours around sexual health, alcohol and drugs and eating. In addition, there is a requirement to undertake joint needs assessments and to jointly commission contraception and sexual health services in the health, school/college and community youth settings that meet the needs of their teenage population.

**The National Service Framework for Children, Young People and Maternity Services**

(Department of Health, 2004): This is the Government's 10-year programme to stimulate long-term and sustained improvement in children's health, by setting standards for high quality integrated health and social care for children from before birth right through to adulthood. Standards 1, 2 and 4 cover young people's sexual health and teenage pregnancy through health promotion, parenting support and access to age appropriate sexual health services.

**Choosing Health: Making Healthy Choices Easier** (Department of Health, 2004): sets out comprehensive measures for improving sexual health, and introduces sexual health into local delivery plans (LDPs) for the first time. In their LDPs, PCTs and strategic health authorities (SHAs) are required to detail proposed action to ensure delivery of this target and demonstrate an integrated approach to their broader strategy for improving sexual health. The specific activity indicators to be included in LDPs are, in summary:

- the percentage of patients attending genitourinary medicine (GUM) clinics who are offered an appointment to be seen within 48 hours of contacting a service, aiming to reach 100 per cent by 2008,
- the number of new diagnosis of gonorrhoea per 100,000 population,
- the percentage of the sexually active population aged 15-24 accepting screening for chlamydia,
- the under-18 conception rate defined as the number of conceptions to under-18 year olds in a calendar year per thousand females aged 15 to 17.

**National standards, local action: health and social care standards and planning framework**

(2005-2008): clearly reflects the importance of sexual health. This document includes the national target, set out in the Department of Health's Public Service Agreement (PSA) 'to reduce the under-18 conception rate by 50 per cent by 2010 as part of a broader strategy to improve sexual health'.

**Children's Plan: Building Brighter Futures** (Department for Children, Schools and Families, 2007): the Government ten-year vision for children's and young people's health, building on the National Service Framework for Children, Young People and Maternity services is that young people show lower levels of risky adolescent health behaviour, evidenced in reduced drinking and sustained reduction in under-18 conception rates and sexually transmitted diseases (addressed in Chapter 6).

***Every Child Matters: Change for Children*** (Department for Education and Skills: 2004): identifies five key outcomes that services should be working towards for all children – being healthy, staying safe, enjoying and achieving, making a positive contribution and achieving economic well being. Reducing conception rates and promoting good sexual health is part of the ‘Be Healthy’ outcome.

### 2.2.1 Safeguarding

***Working Together to Safeguard Children*** (Department for Education and Skills: 2006): sets out how individuals and organisations should work together to safeguard and promote the welfare of children.

#### ***The Sexual Offences Act*** (2003)

Aims to protect the rights and interests of young people, and make it easier to prosecute people who pressure or force others into having sex they don't want. In England and Wales and Northern Ireland the same laws apply to heterosexual and homosexual activity and offences can be committed by anyone, male or female, over the age of 10, which is the age of criminal responsibility. It is an offence to intentionally engage in sexual touching with a young person aged 13, 14 or 15. ‘Touching’ covers all physical contact, including touching with any part of the body, with anything else and through anything, for example, through clothing. It includes penetration. Although the age of consent remains at 16, the law is not intended to prosecute mutually agreed teenage sexual activity between two young people of a similar age, unless it involves abuse or exploitation. Under the Sexual Offences Act young people still have the right to confidential advice on contraception, condoms, pregnancy and abortion, even if they are under 16.

***Safeguarding Children and Young People from Sexual Exploitation*** (Department for Children, Schools and Families: Consultation Draft July 2008): supplementary guidance to help local agencies to apply the core guidance in *Working Together* effectively in the context of sexual exploitation. It should help local agencies to:

- develop local prevention strategies
- identify those at risk of sexual exploitation
- take action to safeguard and promote the welfare of particular children and young people who may be sexually exploited, and
- take action against those intent on abusing and exploiting children and young people in this way.

This guidance replaces *Safeguarding Children Involved in Prostitution* (Department of Health, 2000).

***Fraser Guidelines*** (1985): This term refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. In recent times, the term has been widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

### 2.2.2 Sexual health

***Better Prevention, Better Services, Better Sexual Health: The National Strategy for Sexual Health and HIV*** (Department of Health, 2001): proposes a comprehensive model of sexual health service provision in the context of a broader framework of sexual health promotion, with an explicit focus on a small number of goals. The aims of the strategy include:

- reducing the transmission of HIV and STIs
- reducing the prevalence of undiagnosed HIV and STIs
- reducing the rates of unintended pregnancy
- reducing the stigma associated with HIV and STIs.

The strategy and its implementation action plan have been supported by a number of other publications including a commissioning toolkit, *Effective commissioning of sexual health and HIV services* and a health promotion toolkit, *Effective sexual health promotion: a toolkit for primary care trusts and others working in the field of promoting good sexual health and HIV prevention*. Both of these provide best practice guidance on how the sexual health strategy might be implemented locally. It complements the national teenage pregnancy strategy (see section overleaf) which set

targets to reduce teenage conception rates and increase the participation of teenage parents in education, training or work.

**Progress and priorities – working together for high quality sexual health: Review of the National Strategy for Sexual Health and HIV** (Department of Health, 2008): This review assesses the impact of the Strategy to date, highlights significant developments and recommends a wide-ranging set of actions required at national, regional and local level to respond to the new operating environment and drive further improvements. Action is identified in five key strategic areas including i) prioritising sexual health as a key public health issue, ii) building strategic partnerships, iii) holistic commissioning, iv) delivery of modern sexual health services, and v) investing more in prevention.

**Primary Care Service Framework: Management of Sexual Health in Primary Care** (2007): guidance that documents service objectives / intended health outcomes as well as outlining service provision such as, 'providers will be required to provide a robust outreach service within the local community to identify and support those in more vulnerable groups such as BME groups, deprived groups, lesbians and gay men'.

### 2.2.3 Teenage pregnancy

**Teenage Pregnancy Strategy** (Department for Children, Schools and Families, 1999): Launched by the Prime Minister, the strategy action plan included the setting of two clear goals:

- Halve the rate of conceptions among under 18 year olds in England by 2010; and set a firmly established downward trend in the conception rates for under 16s by 2010.
- Achieve a reduction in the risk of long term social exclusion for teenage parents and their children. This will be measured using the increase in sustained participation by teenage parents in education, employment or training as a key indicator

The actions for achieving these goals fell into four categories: A national campaign, Joined-up action, Better prevention and Better support.

**Teenage Pregnancy: Accelerating the Strategy to 2010** (Department for Children, Schools and Families, 2006): This document extends the teenage pregnancy strategy, and sets out how the strategy needs to develop to take account of the growing body of evidence of what is working in areas with sharply declining rates, and to reflect new analysis on who are at risk and what are the underlying causes of teenage pregnancy.

Known nationally as the Deep Dive findings, the key factors identified within successful areas are:

- Active engagement of all of the key mainstream delivery partners who have a role in reducing teenage pregnancies – Health, Children's Services and the voluntary and community sector;
- A strong senior champion who is accountable for and takes the lead in driving the local strategy;
- The availability of a well publicised young people-centred contraceptive and sexual health advice service, with a strong remit to undertake health promotion work, as well as delivering reactive services;
- A high priority given to PSHE in schools, with support from the local authority to develop comprehensive programmes of sex and relationships education (SRE) in all schools;
- A strong focus on targeted interventions with young people at greatest risk of teenage pregnancy, in particular with Looked After Children;
- The availability (and consistent take-up) of SRE training for professionals in partner organisations (such as Connexions Personal Advisers, Youth Workers and Social Workers) working with the most vulnerable young people; and
- A well resourced Youth Service, providing things to do and places to go for young people, with a clear focus on addressing key social issues affecting young people, such as sexual health and substance misuse.

## 2.2.4 Teenage parents

**Teenage parents: Who Cares? A guide to commissioning and delivering maternity services for young parents** (Department for Children, Schools and Families & Royal College of Midwives, 2008): This guide contains practical pointers as to how commissioning and delivery of maternity services for young parents can be achieved, with case studies of successful services. It places renewed emphasis on multi-agency working in the commissioning and delivery of services.

**Teenage Parents Next Steps: Guidance for Local Authorities and Primary Care Trusts** (Department for Children, Schools and Families, 2007): To complement guidance from 2006 for local areas on accelerating reductions in under-18 conceptions, DCSF launched a refreshed strategy designed to improve outcomes for teenage parents and their children in three broad areas:

- Child health outcomes, as children born to teenage mothers have 60% higher rates of infant mortality and are at increased risk of low birth weight
- Poor emotional health and well-being experienced by teenage mothers
- Teenage parents' poor economic well-being

Additional drivers include:

**Safe, Sensible, Social. The next steps in the National Alcohol Strategy** (Department of Health, 2007): This document reviews progress since the publication of the Alcohol Harm Reduction Strategy for England (2004) and outlines further national and local action to achieve long-term reductions in alcohol-related ill health and crime.

**Care Matters: Time for Change** (Department for Education and Skills: 2007): Outlines the specific challenges for children in care, who are more likely than other young people to become teenage parents. Key focus is on raising aspirations of young people in care, and training carers and social workers to support young people to avoid early sexual activity, provide advice on contraception and support their emotional development

**Youth Matters** (Department for Education and Skills: 2005): sets out the vision for empowering young people, giving them somewhere to go, something to do and someone to talk to. Youth Matters promotes a stronger focus on young people's physical and emotional health, including support to negotiate issues around sexual relationships, sexual health, and drug and alcohol use.

**Standards for Better Health** (Department of Health: 2004): sets out the level of quality that organisations providing NHS care will be expected to meet or aspire to.

**Our Choice, Our Care, Our Say** (Department of Health: 2006): sets out a vision to provide people with good quality social care and NHS services in the communities where they live.

## 2.3 Local Drivers

This joint commissioning strategy builds on Plymouth's ten year multi agency teenage pregnancy strategy, developed in 2000. The aim of that strategy was to improve access to information, advice, support and services for young people at locations and times best suited to their own sexual health and relationships needs. Its major areas of focus were – campaigns, better prevention, better contraception, advice and information services, and better support for teenage parents.

More recent strategies have been developed, such as the Plymouth Health & Well Being Strategy (2008-2020), which recognizes the high rates of teenage pregnancy within the City, and states the increasing concern about lifestyle issues, in particular those of young people, where risk taking behaviours such as binge drinking, drug use and unsafe sex is leading to alcohol related health issues, sexually transmitted infections and teenage pregnancy. Two of the strategy's five priorities directly seek to improve young people's sexual health. These include:

- *Priority 3: Health prevention and promotion* - to address lifestyle choices around risk taking behaviours, and;

- *Priority 4: Access and design of specific services* - to address access and uptake issues within sexual health services.

The challenge of addressing the risk taking behaviours of young people is also reflected in the Plymouth Children and Young People's Plan (2008-2011) (CYPP) where reducing risk-taking behaviours such as substance misuse, unprotected sex and criminal activities has been identified as a key priority. In addition, this strategy will need to link closely with other priorities around raising aspirations, improving opportunities for young people to make a positive contribution and improving young people's emotional wellbeing and mental health.

Implementation of the CYPP is overseen by the Plymouth Children and Young People's Trust which, underpinned by the Children Act 2004 duty to cooperate, brings together all services for children, young people and their families to deliver better outcomes. Delivery of CYPP priorities is supported by local strategies and strategic partnerships which have a contribution to make toward reducing risk taking behaviours and improving young people's sexual health and wellbeing.

Examples of such groups and strategies include:

- Teenage Pregnancy Commissioning Group
- Plymouth Area Sexual Health Commissioning Group
- Emotional Wellbeing and Mental Health Partnership  
- Improving the State of Our Minds: Joint Commissioning Strategy (2009-2014): Emotional Wellbeing and Mental Health of Children and Young People in Plymouth
- Plymouth Children and Young People's Trust Prevention Framework
- Parent and Family Support Strategic Group  
- Parent and Family Support Strategy (2007-2011)
- Early Years Strategic Partnership  
- Strategy for Early Years (2008-2011)
- Substance Misuse Commissioning Group  
- 'Minimise harm, prevent escalation' Substance Misuse Strategy (2008-2011)
- Plymouth Domestic Abuse Partnership  
Tackling Domestic Abuse Strategy
- Sexual Violence Working Group

## 3. Understanding Needs

### 3.1 Understanding risk and vulnerability<sup>9</sup>

Risk can be defined as any factor or combination of factors that increases the chance of an undesirable outcome affecting a person<sup>10</sup>. Vulnerability is a feature that makes a person more susceptible to a threat (risk). A vulnerable group is a collection of people that all share the same potential specific risks. Some young people have increased risk if they belong to certain groups and this risk increases if there is membership of more than one of these groups.

Broadly speaking, the risk of an STI or an unintended pregnancy is associated with unprotected sexual activity, which in the case of STI's is heightened by high numbers of partners, including concurrent multiple partners, as well as high rates of partner change.

High risk sexual behaviours may be influenced by a number of factors, including<sup>11</sup>:

- low self-esteem
- lack of skills (for example, in using condoms)
- lack of negotiation skills (for example, to say 'no' to sex without condoms)
- lack of knowledge about the risks of different sexual behaviours
- availability of resources, such as condoms or sexual health services
- peer pressure
- alcohol and drugs
- attitudes (and prejudices) of society which may affect access to services.

Sexual health matters for everyone, but we also know that sexual health needs vary from one person to another and from one community to another, as well as evolving throughout life. Sexual ill health also disproportionately affects groups already experiencing high levels of social exclusion and health inequality.

Specific action<sup>12</sup> should recognise and meet the needs of particular groups of people, such as:

- **young people** who are, or are contemplating becoming, sexually active: teenage conception and abortion rates are consistently high, and numbers of new STIs among those in their teens and early twenties continue to rise.
- **men who have sex with men**: after early achievements in limiting the spread of HIV, more recent data indicate increases in new infections, and that a significant number of those with HIV are unaware they are infected. High rates of STIs are also diagnosed, especially gonorrhoea and syphilis, compared with other population groups.
- **black and minority ethnic communities**: surveillance data demonstrate a disproportionate burden of STIs, including HIV, in some black and minority ethnic communities in England.
- other individuals and groups within local populations who may have higher levels of sexual health need or who may be less likely, or unable, to access mainstream services: these might include refugees and asylum seekers, homeless people, sex workers, people in custodial settings, looked after young people and those leaving care.

Further detail about risk factors for teenage conceptions and STIs can be seen below:

<sup>9</sup> Information taken from Teenage Pregnancy Strategy – Accelerating to 2010

<sup>10</sup> Literature Review: Resilience in CYP, NCH 2007

<sup>11</sup> Ellis et al. 2003 NICE Guidelines

<sup>12</sup> MedFASH 2005

### 3.1.1 Teenage conceptions

Risk factors for teenage conceptions are well recognised and provide a compelling case for targeted action on young people who are exposed to these risks. Young people experiencing risk factors for teenage conceptions are often highly concentrated within particular areas and among vulnerable groups. To effectively target those most at risk requires both a geographical focus on high risk neighbourhoods and the identification of the vulnerable groups at high risk of teenage conceptions.

The national 'teenage pregnancy strategy' highlights the following risk factors which increase the likelihood of teenage conceptions<sup>13</sup>.

#### a. Risky behaviours. These include:

- early onset of sexual activity
- poor contraceptive use
- a mental health problem, a conduct disorder and/or involvement in crime
- alcohol and substance misuse
- already a teenage mother or had an abortion.

#### b. Education-related factors:

- low education attainment or no qualifications
- disengagement from school.

#### c. Family/background:

- living in care
- daughter of a teenage mother
- daughter of a mother who has low educational aspirations for them
- belonging to a particular ethnic group (in the 2001 census, 'mixed white', 'black Caribbean', 'other black' and 'white British' were over-represented among teenage mothers).

Localised and more detailed information for some of these groups can be found within the full needs analysis ([hyperlink](#)).

### 3.1.2 Sexually transmitted infections

Behaviours that increase the risk of STIs include:

- early onset of sexual activity
- use of alcohol and/or substances
- unprotected sex, and
- frequent change of and/or concurrent multiple sexual partners.

In addition to young people aged 15-24yrs who are, or are contemplating becoming, sexually active, key groups at risk of STIs, as identified by the National Institute for Clinical Excellence (NICE) include:

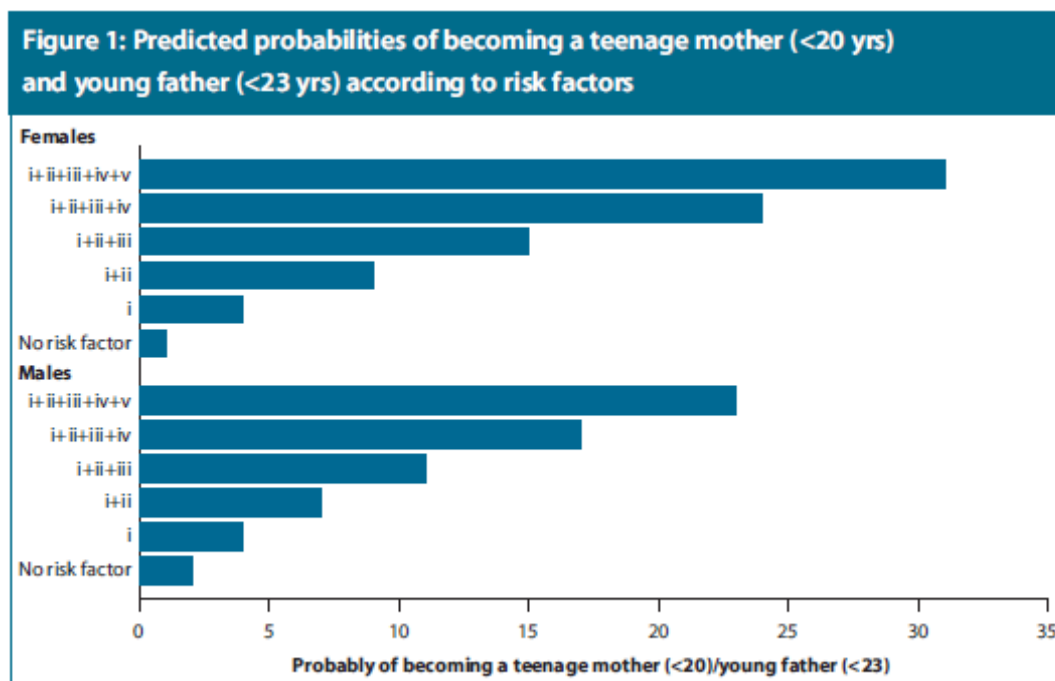
- men who have sex with men
- black and minority ethnic communities, and
- people who have come from or who have visited areas of high HIV prevalence.

### 3.1.3 Teenage conceptions: experiencing multiple risk factors

Risk factors function in a cumulative fashion; that is, the greater the number of risk factors, the greater the likelihood that young person will engage in risky behaviour.

Where young people experience multiple risk factors, their likelihood of becoming a teenage parent increases significantly. Figure 1 shows that young women experiencing five risk factors (daughter of a teenage mother; father's social class IV & V; conduct disorder; social housing at 10 and poor reading ability at 10) have a 31% probability of becoming a mother under 20, compared with a 1% probability for someone experiencing none of these risk factors.

Similarly, young men experiencing the same five risk factors had a 23% probability of becoming a young father (under age 23), compared to 2% for those not experiencing any of these risk factors.



Source: Analysis of 1970 British Cohort Study data in Berrington A, et al (2005)<sup>14</sup>

### 3.2 Protective factors

Many of the **risk factors** that make it likely that a young person **will** engage in risky sexual behaviours are the opposite of the **protective factors** that make it likely that a young person **will not** engage in such behaviours.

Protective factors operate in three ways:

- First** - may serve to buffer risk factors, providing a cushion against negative effects.
- Second** - may interrupt the processes through which risk factors operate.
- Third** - may provide protective factors may prevent the initial occurrence of a risk factor.

Exposure to risk factors in the relative absence of protective factors dramatically increases the likelihood that a young person will engage in risky behaviours. The most effective approach for improving young people's lives is to reduce risk factors while increasing protective factors in all of the areas that touch their lives.

#### ***Protective factors that may affect young people's sexual behaviour<sup>14</sup>***

<b>Family level</b>	<b>Individual level</b>	<b>Peer level</b>
<ul style="list-style-type: none"> <li>▪ Higher parental education</li> <li>▪ Greater parental supervision</li> <li>▪ Higher quality family interactions &amp; connectedness</li> <li>▪ Greater parent/child communication about sex</li> <li>▪ Parental support of contraception if sexually active</li> </ul>	<ul style="list-style-type: none"> <li>▪ Greater connectedness to school</li> <li>▪ Older age of physical maturity</li> <li>▪ Higher academic performance</li> <li>▪ More positive attitudes, greater self efficacy &amp; greater motivation to use contraception</li> <li>▪ Discussing pregnancy &amp; STI prevention with partner</li> <li>▪ Greater motivation to avoid pregnancy, HIV and other STIs</li> </ul>	<ul style="list-style-type: none"> <li>▪ Peer use of condoms</li> <li>▪ Peer support for condoms or contraceptive use</li> </ul>

<sup>14</sup> Kirby D. et al. 'Sexual Risk and Protective Factors' 2005

### 3.3 Summary of needs in Plymouth

This section provides a brief introduction to the sexual health needs of young people living in Plymouth. For more detailed information, including further data about particular issues or the sexual health needs of specific groups of young people, please refer to the full needs analysis report.

#### 3.3.1 Demographic and deprivation data

- Children and young people make up just over 1/5 of the population of Plymouth;
- Children and young people are not spread evenly within the city, with a greater proportion of the children and young people population being found in the most deprived neighbourhood grouping;
- Between a third and 2/5<sup>ths</sup> of all children and young people live in the most deprived areas of Plymouth – South West, North West and South East;
- Whilst population projections suggest that the number of children and young people may fall over the coming years, immigration, possible increases in total fertility rates and local development plans may act in opposition to this;
- BME groups make up 1.6% of the Plymouth population, and 6.5% of the school population<sup>15</sup>.

#### 3.3.2 Sexually transmitted infections

Sexually transmitted infections (STIs) are, as the title suggests, infections that are spread during sexual activity. HIV is considered an STI, even though it can be transmitted in several ways, including sex. Statistics produced by the Health Protection Agency show that Plymouth has among the highest prevalence of sexually transmitted infections (STIs) in the South West region across all ages.

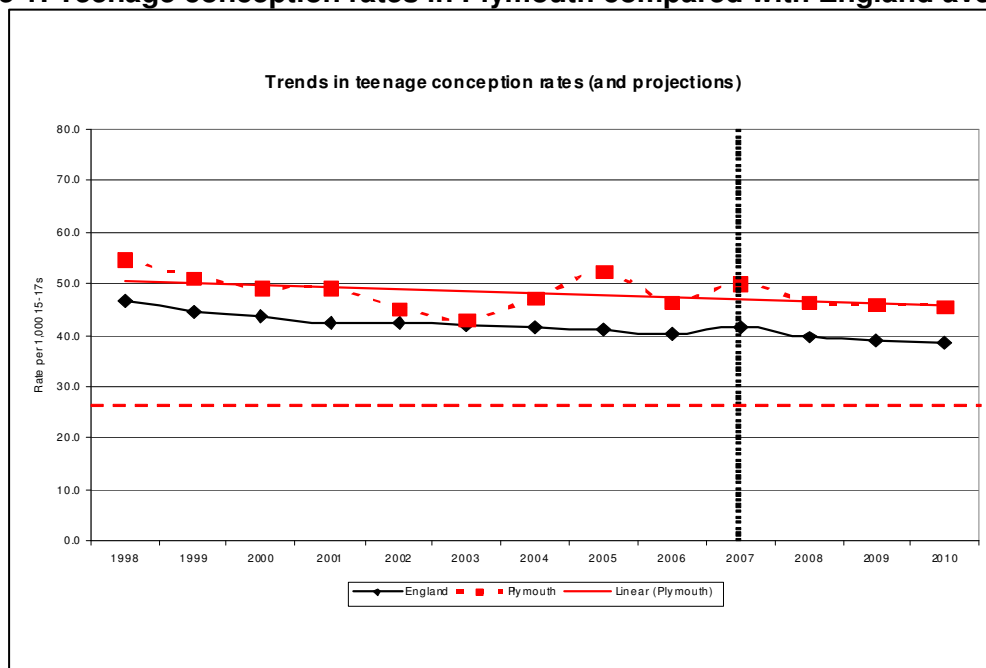
The most prevalent STI's among young people are Chlamydia<sup>15</sup> and Genital Warts. In recent years there has been a steep increase in Chlamydia detection rates, which has been enhanced with the roll out of the national Chlamydia Screening Programme.

Plymouth has relatively high rates of new HIV cases among the general population compared with other areas in the South West. In 2008, the Health Protection Agency reported that while new HIV cases in the UK amongst young people remained low compared to other age groups, the number of new cases is rising, with the number of new HIV cases among young people in 2007 three times higher than it was in 1998.

#### 3.3.3 Teenage conception rates

The under-18 conception rate is significantly higher in Plymouth than the England average and the South West average, a trend which has continued<sup>14</sup>

**Figure 1: Teenage conception rates in Plymouth compared with England average**



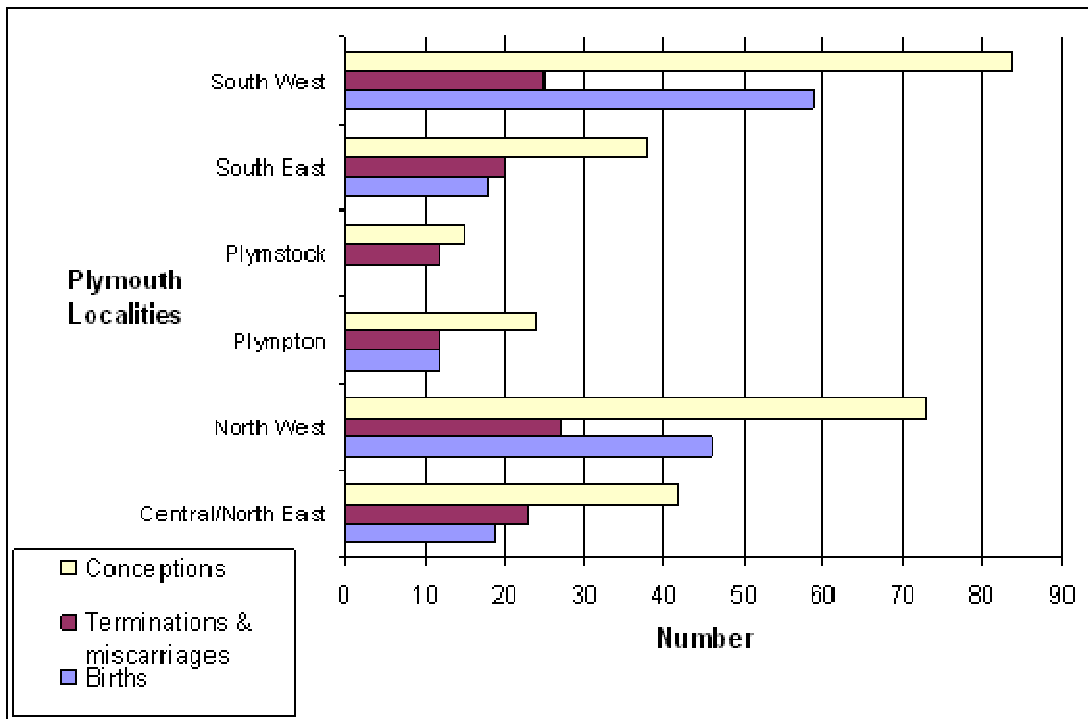
Source:  
PDHU  
2008

Not all

<sup>15</sup> Chlamydia is an STI which infects the genital tract

conceptions lead to births, and rates of both vary across the city geographically, between age groups and between ethnic groups. Anecdotal information from service providers suggests that there is no significant gap in ages between young mothers and young fathers.

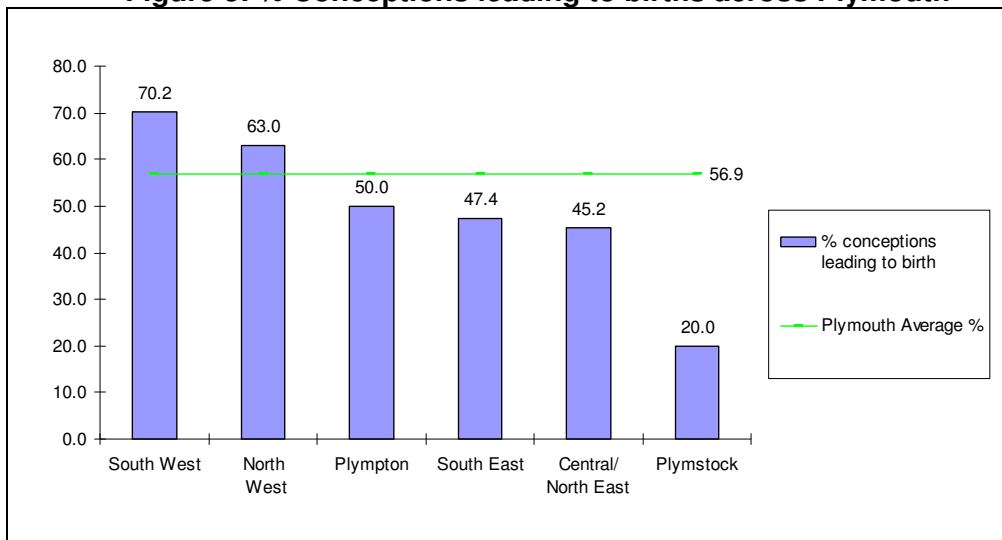
**Figure 2: Births, Terminations & Miscarriages and Conceptions by Plymouth Locality 2006**



Source: PHDU 2006

Figure 3 below shows that the South West and North West localities have above average proportion of conceptions leading to births.

**Figure 3: % Conceptions leading to births across Plymouth**



Source: PHDU 2006

In Plymouth in 2007 and 2008 the highest number of births occurs with 17-18 year olds.

The main ethnic group in Plymouth is White British and is also the highest proportion of teenage pregnancies<sup>15</sup>

### 3.3.4 Teenage parents

#### *i. Teenage Mothers*

As outlined in the DCSF guidance 'Accelerating the Strategy to 2010', the national figures around teenage conceptions are stark:

- At age 30, teenage mothers are 22% more likely to be living in poverty than mothers giving birth aged 24 or over, and are much less likely to be employed or living with a partner.
- Teenage mothers are 20% more likely to have no qualification at age 30 than mothers giving birth aged 24 or over.
- Teenage mothers are more likely to partner with men who are poorly qualified and more likely to experience unemployment.
- Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth;
- The infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers;
- Teenage mothers are three times more likely to smoke throughout their pregnancy, and 50% less likely to breastfeed, than older mothers – both of which have negative health consequences for the child;
- Children of teenage mothers have a 63% increased risk of being born into poverty compared to babies born to mothers in their twenties, have higher mortality rates under 8, and are more likely to have accidents and behavioural problems.
- Among the most vulnerable young women, the risk of becoming a teenage mother before the age of 20 is nearly one in three.

#### *ii. Teenage Fathers*

Society often regards teenage fathers as irresponsible individuals who get their girlfriends pregnant and then abandon them. Yet all the evidence shows that when young fathers are offered reliable and sympathetic support, the impact upon them, their children and their families can be profound.

Compared to their female counterparts, young fathers are almost invisible as group. However, while limited research has been undertaken around the impact of parenthood on young men, there is strong evidence that young fathers who are actively involved with raising a child are also at risk of serious educational and financial disadvantage.

#### **Plymouth data shows the following:**

*Repeat conceptions:* Plymouth maternity data shows that a significant number of teenage mothers have typically had at least one previous conception prior to giving birth to their first child. 7% of our teenage mothers already had one other child by the time they were 17yrs.

*Breastfeeding* prevalence among teenage mothers is comparatively low compared to older mothers, around a third less<sup>13</sup>. In Plymouth, the proportion of mothers initiating breastfeeding is lower than the national average.

*Smoking* rates through pregnancy are three times higher among young mothers than with older mothers, including older mothers from lower socio-economic groups.<sup>16</sup> Data from Derriford Hospital for 2007 & 2008 shows that young mothers who smoke at initial booking often still smoke at delivery.

*Not in Education Employment or Training (NEET):* Connexions report that Plymouth teenage mothers are the largest proportion of NEETS that are available for employment, education or training, due largely to limited and inflexible post 16 employment, education and training opportunities. Proportions of NEET groups vary across the city. The North West, South West and South East localities have the largest proportion of teenage parents who are NEETS.

### 3.4 Views of young people

A city wide consultation with young people undertaken by the Children's Fund in 2008 included several questions about Sexual Health and Risk Taking Behaviours. Of the 3047 young people

included within this consultation, 2091 were over the age of 13yrs. Of the 685 young people who were asked when they had their first sexual experience<sup>16</sup>, 63% stated that they were between the ages of 13-14yrs, with an additional 23% experiencing this aged 15-16yrs. 14% of those consulted had their first sexual experience at 12yrs or under.

In addition, 34% of those surveyed reported having had a sexual relationship, with 40% having had sex under the influence of alcohol. Nearly 40% stated that their parents did not know about their sexual activity.

The top five responses provided when young people were asked who they would like to get information from regarding sexual health include, in order of preference:

1. Parents / carers
2. Friends
3. School nurse
4. Teacher
5. Doctor

In 2006, the Plymouth Youth Parliament produced a report about Sex and Relationships Education (SRE), which provided several recommendations for future action. Evidence to inform the report was generated through interviews with key professionals and a survey completed by over 150 young people.

The report found that:

- Young people want a structured SRE syllabus.
- Over half of young people interviewed wanted more information on the relationship side of SRE – more emotional education.
- When asked how SRE could be improved, popular responses included;
  - Better teachers, who explained things more fully and were comfortable with the content of SRE;
  - Want to learn more about contraception – such as correct use of condoms;
  - More information about the emotional side of having sex;
  - Should be taught about homosexual relationships.

The report concluded that current SRE provision is far too inconsistent and lacking, and provided a number of proposals for change.

At the end of 2008, 37 young people were consulted citywide to inform the development of a new citywide strategy to improve young people's sexual health and wellbeing. Key messages from this consultation include:

- Schools are the most popular place for where services should be delivered;
  - ‘It should be in schools, because we are already there’**
- SRE delivered at 10-11yrs was the right age – before going to secondary school;
- Young people wanted to talk to their parents, but felt that their knowledge was out of date and they needed educating too;
- Young people want to see something ‘real’ about SRE, teenage pregnancy etc rather than just read or be ‘taught’;
- Young people want to be anonymous about SRE – to ask the ‘silly’ questions that their friends may laugh at them about. Teachers are ‘too familiar’ and young people want someone they don't know – confidential and anonymous;

**“It would be good to have someone who's impartial & not around every day in school”**

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<sup>16</sup> The term ‘sexual experience’ was not predefined and so young people responded to this question based on their own understanding of what constitutes sexual experience.

- Provision and quality of SRE is inconsistent within primary and secondary schools
- Key barriers to effective SRE inside and outside of school included i) embarrassment (asking silly questions, other people knowing), and ii) Intimidation from older young people.

### 3.5 What about parents?

Parents are key to teaching young people about sex and relationships, helping them cope with the emotional and physical aspects of growing up and preparing them for the challenges and responsibilities that sexual maturity brings.

Evidence shows that young people benefit immensely from being able to talk to adults close to them – *particularly their parents* – about sex and relationships. This can act as a strong and valuable means of support for young people, and gives them a credible source of information and advice to turn to<sup>17</sup>. Research shows that talking to young people about sex, delays first sex and reduces unplanned pregnancy and STIs<sup>18</sup>.

In light of this parents need up to date factual information, knowledge of services available in their local area and ways to address these subjects with their children. There are still barriers however to achieving this, which include;

**Values and beliefs** – British society today is much more open and tolerant about sex<sup>19</sup> than it was when many of today's parents of teenagers grew up. There are far fewer societal codes about what is and is not deemed to be an acceptable relationship, just as there is much greater acceptance of a wide diversity of family structures.

Many parents view discussing sex and relationships with their children as a 'taboo', difficult or just plain embarrassing subject area. This is further complicated by some cultures and religions that may have strict ideals about relationships, sex and sexuality. The reality however is that most young people will find out about sex from somewhere, be it the media, friends or gossip etc.

**Out of date information** – Unless they actively seek information out, many parents are simply unaware of what information to give to their children. Developments happen quickly, be it the emergence of a new STI (e.g. HIV/AIDS in the 1980's), new forms of contraception for young women and men (e.g. the female condom or hormonal injection), as well as the language used by young people around sexual health and wellbeing. Young people are faced with different problems and pressures to the ones you may have gone through at their age.

**Communication** – We know that it can be very difficult for parents to talk to their children about sex and relationships. Parents are worried about how to initiate conversations and are unsure about all the facts. There is still a certain level of embarrassment around this subject. An Ofsted report found that pupils felt some parents lacked the knowledge and skills to talk to them directly about sensitive issues<sup>20</sup>.

### 3.6 Other stakeholder messages

A one day data analysis workshop was conducted using data from a number of key services across the city. Review and analysis of this data was undertaken by stakeholders from across the city including, but not limited to; public health, community nursing, contraceptive services, voluntary and community sector, education, family nurse partnership and Connexions.

1. There are recognised links between deprivation, poverty and high rates of conception. This is reinforced by neighbourhood / locality needs assessment. Key geographical areas of need that were identified were North West, South West and South East Localities.

<sup>17</sup> Family Planning Association (2007) Are you ready? Young people's views of sex and relationships

<sup>18</sup> <http://www.swish.org.uk/?q=parents/talking>

<sup>19</sup> Family Planning Association (2005): Past, Present and Future

<sup>20</sup> <http://www.timesonline.co.uk/tol/news/uk/education/article1642771.ece>

2. There is growing concern, and to a certain extent anecdotal evidence<sup>21</sup> that some young women in Plymouth are getting pregnant because of their perception that they are unlikely to ever achieve anything as important or be good at something else during the course of their lives. Having a baby provides a focus for their lives. Factors such as low self esteem, low achievement, mental health concerns and a poor family environment are critical elements of a young person's decision to have a baby. Additional factors such as the use of alcohol and opportunistic sex, parental aspirations, intergenerational expectations and peer pressure must also be considered.
3. Low aspirations, confidence and self esteem are considered a central factor in Plymouth's current conception rates, particularly for those young people with higher levels of vulnerability. As such, their sexual health needs will be different from other young people.
4. Significant levels of need remain for young parents during pregnancy, birth and up to the child's fifth birthday.
5. There are significant educational needs of teenage parents, which do not fit within services currently available (post 18, CFE GCSEs, crèche facilities, timeframes for exams).
6. The needs of teenagers and teenage parents do not stop once they reach 18yrs. The data also acknowledges that many conceptions are occurring within the 18-19yrs age group
7. We know more about the mothers than the fathers. The sexual health needs of young men the needs of fathers have been disproportionately explored compared to their role within conceptions and raising children. Concerns about serial impregnators within Plymouth were raised, but more investigation is required to validate this.
8. Informal feedback from service providers indicates that a significant proportion of young mothers have had contact with a mental health service at some point in their lives.

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<sup>21</sup> Based on informal feedback from within the Family Nurse Partnership, March 2009

## 4. The Role of Commissioning

### 4.1 How will commissioning help to deliver this strategy?

Commissioning is a process which encompasses assessing population needs, assessing evidence of effectiveness, prioritising outcomes and identifying service gaps, identifying funding, buying in or 'procuring' products and services, and performance managing service providers.

As commissioning should be outcome focused, it has the needs of service users (such as children, young people and families) at its core rather than the needs of service providers.

Commissioning sets out a framework for deciding how best to deploy resources strategically and tactically in order to achieve objectives, making best use of the strengths of the statutory, voluntary and private sectors.

It embraces the following approaches and concepts:

- Learning from best practice and research
- Evidence based interventions
- Clinical governance
- Being clear about outcomes
- Performance management
- Re-aligning, and in some cases, redesigning services to meet strategic objectives
- Making best use of available resources, aligning them to agreed priorities and ensuring value for money

### 4.2 The commissioning process

Services to deliver this strategy will be commissioned using the Every Child Matters Commissioning Cycle (illustrated below) and aligned with core competencies outlined within the NHS World Class Commissioning Framework (see overleaf). The aim is to transform the way that sexual health services for young people are commissioned.



The **core competencies** of world class commissioning include, but are not limited to -

- Engaging with the public and service users
- Assessing need and prioritising investment
- Stimulating the market (providers)
- Promoting improvement and innovation
- Making sound financial investments.

Commissioners will work closely and develop a shared ambition with all key partners, including Third Sector organisations (also known as voluntary and community sector). The Third Sector plays an essential part within the Plymouth Children and Young People’s Trust, and a great deal of Third Sector activity within Plymouth is funded by the public sector and there is a growing record of partnership working between the sectors. The Third Sector VCS are also a key partner in the delivery of sexual health services within Plymouth.

### 4.3 Standards for sexual health services

The recommended standards<sup>22</sup> for sexual health services are presented as a means for service improvement to support more people to enjoy healthy and happy sex lives, receive effective and rapid treatment for sexually transmitted infections, and more people to have appropriate access to contraception and abortion when needed. Published in 2005 by the Medical Foundation for AIDS & Sexual Health (MedFASH) with DoH endorsement, they include;

<b>Standard One: Sexual Health Service Networks</b>	Young people should be able to access the full range of sexual health services across settings convenient to them receiving integrated care with clear information and direction or referral to other services when needed.
<b>Standard Two: Sexual Health Promotion</b>	Young people should have access to accurate and appropriate information and effective interventions to minimise sexual health risks with opportunities to develop personal and social skills to support them in decision making.
<b>Standard Three: Empowering Service Users</b>	Young people should receive services that are user centered and that encourage them in decision making, enable them to make informed choices and support them in taking responsibility for protecting their own (and others) sexual health.
<b>Standard Four: Identifying Needs</b>	Young people need access to services that utilise opportunities to identify their full range of sexual health needs through comprehensive and appropriate assessment.
<b>Standard Five: Access to Services</b>	Young people should have access to comprehensive information on local service provision with prompt access to available services within nationally agreed time-scales and have urgent access in times of emergency.
<b>Standard Six: Detecting and Managing Sexually Transmitted Infections</b>	Young people who may have been at risk of an STI or HIV should have prompt access to quality diagnostic and treatment services in line with clinical effectiveness guidance and be offered support to minimise risk of transmission or further infection and be encouraged to ensure partners access appropriate services.
<b>Standard Seven: Contraceptive Advice and Provision</b>	Young people should receive accurate information about, and prompt access, to the full range of contraceptive methods freely available to them and receive ongoing support in their use of their chosen method.
<b>Standard Eight: Pregnancy Testing and Support</b>	Young women who think they are pregnant should have free rapid access to confidential pregnancy testing with same day results and opportunity to receive unbiased information about the options available to them.
<b>Standard Nine: Termination Service Provision</b>	Young women considering termination should have direct access to unbiased assessment, support and counselling and be offered a timely and clinically appropriate termination of their choice with the option of screening for STI’s.
<b>Standard Ten: Protection</b>	Young people should expect information relevant to their sexual health to be treated as confidential and retained securely and only shared if necessary for their care and with their consent – unless there is serious risk of harm to themselves or others.

<sup>22</sup> Medfash 2005, and adapted to relate to young people

## 4.4 Strategy development and delivery

### 4.4.1 Governance

This joint commissioning strategy has been developed in partnership with the Children and Young People's Teenage Pregnancy Commissioning Group and Plymouth Area Sexual Health Commissioning Group<sup>23</sup>, both of which are made up of multi agency stakeholder representatives from across the city.

The Teenage Pregnancy Commissioning Group is accountable to the Risk Taking Behaviour Commissioning Group, a strategic multi agency group which reports directly to the Children and Young People's Trust. Both have a memorandum of understanding (MoU) with the Plymouth Area Sexual Health Commissioning Group, which is responsible for sexual and reproductive health services across all ages. The current MoU aims to ensure that both groups maximise their effectiveness for<sup>24</sup>:

- Reducing conception rates among under 18s;
- Supporting teenage parents;
- Improving general sexual health among under 18s;
- Increasing screening and treatment of STIs among under 18s.

The Teenage Pregnancy/Risk Taking Behaviour Commissioning Group currently shares responsibility for improving outcomes for pregnant teenagers and teenage parents, and with delegated authority from the Children and Young People's Trust, to deliver on the CYPP's priorities for teenage pregnancy.

The Plymouth Area Sexual Health Commissioning Group currently takes lead responsibility for ensuring that there is improved access to a comprehensive range of sexual, genito-urinary and reproductive health services for all people provided across a range of settings. This group acts with delegated authority from NHS Plymouth Board to deliver Sexual and Reproductive Health Strategic Plan priorities for work with all people including young people.

The MoU clearly states that both Commissioning Groups have 'clear joint interest' and shared responsibility in working toward achieving the current LAA target on reducing teenage conceptions. The current governance structure will be reviewed and aligned to support delivery of the joint commissioning strategy.

### 4.4.2 Strategy development process

The process for developing the joint commissioning strategy has closely followed Phase 1 of the Every Child Matters Commissioning Cycle. Activities have included:

- Needs analysis workshop;
- Consultation with young people, parents and other stakeholders;
- Stakeholder engagement in developing implementation plans.

The strategy development process has been led by the Children and Young People's Trust Policy and Planning Team in partnership with the Children and Young People's Teenage Pregnancy Commissioning Group and Plymouth Area Sexual Health Commissioning Group.

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<sup>23</sup> The Plymouth Area Sexual Health Commissioning Group covers all ages

<sup>24</sup> As stated within the current MoU (May 2009) In line with this strategy, these targets may change in relation to the agreed age range

# 5. Strategic Commissioning Priorities 2009-2012

## 5.1 Aim of the strategy

To create a positive and supportive environment within which young people up to age of 20yrs<sup>25</sup> are enabled to make informed choices about sex, relationships and reproduction, have access to high quality and timely services, and receive support and choice in response to their sexual health and wellbeing needs.

## 5.2 Underlying beliefs & principals of the strategy

- Sexual health is viewed positively as part of a fulfilling and healthy life;
- Self-esteem, confidence and communication skills are very important to healthy relationships;
- Young people should be respected and supported in relation to the choices and decisions that they make about their reproductive and sexual health, including the decision of if and when to have a baby;
- All sexualities have the right to be respected and accepted;
- Sexual behaviour should never result in exploitation, oppression, physical, emotional or psychological harm. Agencies and services across the Trust will work within local safeguarding parameters to ensure that any exploitation, oppression, physical, emotional or psychological harm arising from early sexual activity is responded to swiftly in order to protect a young person;
- Young people should have access to age-appropriate, accurate, high-quality, locally delivered and timely sexual health information, education and services;
- Sexual health and wellbeing services are inclusive, respectful, confidential and non judgemental;
- Sexual health and wellbeing services are delivered by an appropriately skilled workforce;
- Sexual health and wellbeing services will be shaped by and responsive to the needs of young people, including consideration of local delivery, choice and age appropriate environments, rather than being designed around professional boundaries and/or curricula;
- All agencies, including Third sector, collectively support the strategic framework for joint commissioning of services in order to ensure the most effective outcomes for young people;
- Regular user feedback and audit of services will be undertaken with the results incorporated into service change where required.
- Services will be planned and delivered using a whole person approach, in recognition of the way in which biological, psychological and social factors interact to determine young people's sexual health.

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<sup>25</sup> Inclusive of 19years and 364 days In specific situations, the age limit is extended to 25yrs

### 5.3 Strategic Outcomes and Priorities

Strategic Outcomes	Strategic Objectives (SO)
<b>1. Increased resilience<sup>26</sup> and raised aspirations of children, young people and their families to improve sexual health and wellbeing.</b>	<b>SO 1.1</b> Provision of positive activities for ALL children and young people to build their self esteem, confidence and self belief that they can be the best that they can.
	<b>SO 1.2</b> Targeted provision of positive activities for children and young people with multiple vulnerabilities <sup>27</sup> to build their self esteem, confidence and self belief that they can be the best that they can.
	<b>SO 1.3</b> Provision of targeted support for families of the young people identified as part of SO 1.2.
<b>2. Young people are enabled to engage with safe and responsible behaviours that promote sexual health and wellbeing</b>	<b>SO 2.1</b> Culture, practices and education within schools will strengthen the ability of young people to make age appropriate, safe and responsible decisions about sexual health and wellbeing.
	<b>SO 2.2</b> Culture, practices and informal education within neighbourhoods and the community will strengthen the ability of young people to make safe and responsible decisions about sexual health and wellbeing.
	<b>SO 2.3</b> Information, education and advice that is easily accessible, evidence based, age appropriate, timely and pro-active is provided to meet the emerging and holistic sexual health and wellbeing needs of <b>ALL</b> young people.
	<b>SO 2.4</b> Development and/or delivery of information, education and advice will be proactively provided to meet the emerging and holistic sexual health and wellbeing needs of specific groups of young people. Priority groups identified within this strategy include i) <b>teenage parents</b> , ii) <b>young people not in education, employment or training</b> , iii) <b>young people in care<sup>28</sup></b> , iv) <b>young people with multiple vulnerabilities<sup>29</sup></b> , v) <b>young offenders<sup>30</sup></b> , vi) <b>boys &amp; young men<sup>31</sup></b> , vii) <b>young people engaging in alcohol and/or drug misuse<sup>32</sup></b> , viii) <b>young people engaging in/at risk of sexual exploitation</b> , ix) <b>young people who identify as lesbian, gay, bisexual and/or transgender</b> x) <b>young people with culturally diverse backgrounds</b> , and xi) <b>young people with a disability<sup>33</sup></b> .
	<b>SO 2.5</b> Parents and carers will be enabled to respond to and support young people's needs, choices and decisions around sexual health and wellbeing.
	<b>SO 2.6</b> Creating an informed and supportive community environment that promotes good sexual health and wellbeing of young people.

<sup>26</sup> Resilience concerns the ability to 'bounce back'. Involves doing well against the odds, coping, and recovering (Rutter, 1985; Stein, 2005)

<sup>27</sup> As characterised within section 3.1 – Understanding Need.

<sup>28</sup> Includes care leavers and young people on the fringes of care

<sup>29</sup> Refer to section 3 for definition of vulnerability

<sup>30</sup> Includes young people at risk of offending

<sup>31</sup> Includes men who have sex with men

<sup>32</sup> As defined by use that harms health or social functioning

<sup>33</sup> Includes physical and learning disability

Strategic Outcomes	Strategic Objectives
<p><b>3. Young people have access to and utilise high quality, locally delivered and timely support and services that respond to their sexual health and wellbeing needs and choices</b></p>	<p><b>SO 3.1</b> Ensure that <b>ALL</b> young people have access to high quality, locally delivered, evidence based and timely sexual health and wellbeing services. Priority areas identified within this strategy include i) <b>Contraception</b>, ii) <b>Chlamydia Screening</b>, and iii) <b>HIV Screening</b>.</p>
	<p><b>SO 3.2</b> Targeted and/or enhanced services will be delivered to meet the sexual health needs of specific groups of young people. Priority groups identified within this strategy include i) <b>teenage parents</b>, ii) <b>young people in care</b>, iii) <b>young offenders</b>, iv) <b>boys and young men</b>, v) <b>young people engaging in alcohol and/or drug misuse</b>, vi) <b>young people with a disability</b>, vii) <b>men who have sex with men</b>, and viii) <b>young people with culturally diverse backgrounds</b>.</p>
	<p><b>SO 3.3</b> Routine appraisal of the sexual health and wellbeing needs of young people with multiple vulnerabilities will be embedded within the common assessment framework (CAF), to be utilised by all agencies and services working with young people and families across the City.</p>
	<p><b>SO 3.4</b> Jointly agreed multi agency pathways will facilitate pro-active, easy, timely and coordinated referral and support to meet young people's sexual health and wellbeing needs and choice. Priority pathways identified within this strategy include (but not limited to) i) <b>post pregnancy test</b>, ii) <b>teenage parents</b>, iii) <b>identification of high risk sexual behaviours</b>.</p>
	<p><b>SO 3.5</b> Enhanced safeguarding processes and support will identify and respond to the needs of young people as a result of sexual abuse and/or exploitation.<sup>34</sup></p>
	<p><b>SO 3.6</b> Provision of a holistic package of support to reduce the risk of poor outcomes for teenage parents and their children</p>
	<p><b>SO 3.7</b> Ensure smooth transitions between young person friendly and adult focused sexual health services.</p>
<p><b>4. Systems will be in place that facilitate effective delivery of integrated sexual health advice, services and support to young people and their families</b></p>	<p><b>SO 4.1 Participation:</b> Commissioners and providers will develop active partnerships with young people and their families to identify needs, and engage in service planning and service review.</p>
	<p><b>SO 4.2 Governance:</b> Effective governance processes are in place – i) leadership and accountability, and ii) shared terminology and assessments, including governance in multi agency work.</p>
	<p><b>SO 4.3 Joint Commissioning<sup>35</sup>:</b> Determining the most effective method of commissioning, evidence based/best practice joint service planning, resource mapping, pooled resources, finance (including detailed costs), procurement, contracts, service level agreements, performance management (monitoring data, effectiveness and outcomes, evidence based resource base).</p>
	<p><b>SO 4.4 Workforce Development:</b> All staff working with young people will have sufficient knowledge, skills, training and support to promote positive sexual health and wellbeing, and to recognize when a child or young person needs more support. Includes workforce development framework consistent with development of the one children's workforce, cultural sensitivity, safeguarding and child protection, CAF and joint training opportunities.</p>
	<p><b>SO 4.5 Communication:</b> Development of city wide sexual health and wellbeing communications strategy, development and delivery of sexual health messages and supportive information materials for young people.</p>

<sup>34</sup> Extends to commercial sex work, sexual assault and violence, physical & emotional harm as a result of sexual exploitation and pornography.

<sup>35</sup> Joint commissioning is where objectives, plans, actions and decisions are developed in partnership by separate agencies working together.

## 6. Implementation of the Strategy

### 6.1 Implementation plan template

Detailed implementation plans for each strategic objective will be developed by small task and finish groups overseen by the Plymouth Teenage Pregnancy Commissioning Group and Plymouth Area Sexual Health Commissioning Group between June and October 2009, using the template seen below.

Implementation plans will be developed using evidence based/best practice data, and will consider what activities can be implemented without the need for additional resources (i.e. by realigning existing budgets or pooling budgets) as well as those that will need additional resources (i.e. grant funding etc). There is a clear expectation that any stakeholder will be able to engage with the development of the implementation plans dependant on their area of interest and/or skills. This will contribute to increased ownership to deliver the strategy across the Trust.

<b>Outcome / Objective</b>	<b>Best Practice</b> <i>(what works?)</i>	<b>Preferred Local Model of Delivery</b> <i>(what should we be doing in Plymouth?)</i>	<b>Local Actions</b> <i>(what will we do locally?)</i>	<b>Performance: Outcomes / Targets</b> <i>(how will we measure if we are successful?)</i>	<b>Lead / Timeframe</b> <i>(who will do it and when?)</i>

How we will monitor and performance manage delivery of the strategy will be determined during development of the implementation plans. This will enable the Trust to assess whether the strategy is achieving its strategic outcomes and objectives. The key performance indicators can be seen below.

The joint commissioning strategy will be reviewed and where necessary refreshed in March 2011.

### 6.2 Key performance indicators

<b>Performance measure</b>	<b>Details</b>	<b>Monitoring</b>	<b>Baseline</b>	<b>2008/09 performance</b>	<b>2008/09 Target</b>	<b>2009/10 Target</b>
<b>NI 112 (LAA)</b> Under 18 Conception Rate	<i>The change in the rate of under-18 conceptions per 1,000 girls aged 15-17yrs resident in the area for the current calendar year</i>	Quarterly	Yes	-8.62% (2007)		NI -50% LAA - 57%
<b>NI113 (VSB13)</b> Prevalence of Chlamydia in under 25 year olds (% of pop)	<i>Screening volumes in young people age 15-24yrs</i>	Quarterly	Yes	15.6%	17%	25%
<b>SHA Target</b> All first attendees at GUM clinics should be offered an appointment to be seen within 48 hours of contacting the service	<i>As an existing standard, GUM continues to be a Healthcare Commission indicator for both PCTs and Acute Trusts. There is also a supporting measure of the % of patients <b>seen</b> within 48 hours</i>	Monthly	Yes	99%	98%	98%

## 7. Glossary

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>BME</b>	Black and Minority Ethnic
<b>CAF</b>	Common Assessment Framework
<b>CYP</b>	Children and Young People
<b>CYPP</b>	Children and Young People's Plan
<b>DCSF</b>	Department of Children, Schools and Families
<b>DoH</b>	Department of Health
<b>GUM</b>	Genito Urinary Medicine
<b>HIV</b>	Human Immunodeficiency Virus
<b>LAA</b>	Local Area Agreement
<b>LARC</b>	Long Acting Reversible Contraceptive
<b>LGBT</b>	Lesbian, Gay, Bi-sexual and Transgender/Transsexual
<b>MoU</b>	Memorandum of Understanding
<b>NEETS</b>	Not currently engaged in Employment, Education or Training
<b>NI</b>	National Indicator
<b>PCT</b>	Primary Care Trust
<b>PSHE</b>	Personal, Social and Health Education
<b>RTI</b>	Reproductive Tract Infection
<b>SHA</b>	Strategic Health Authority
<b>SRE</b>	Sex and Relationships Education
<b>STI</b>	Sexually Transmitted Infection
<b>TP</b>	Teenage Pregnancy
<b>TPU</b>	Teenage Pregnancy Unit
<b>VCS</b>	Voluntary and Community Sector
<b>VS</b>	Vital Sign (NHS Indicator)
<b>YOS</b>	Youth Offending Service
<b>YP</b>	Young People

## 8. Bibliography

TO BE COMPLETED