Nottinghamshire County Council

Health Scrutiny Committee

Tuesday, 09 January 2018 at 10:30

County Hall, **West Bridgford, Nottingham, NG2 7QP**

AGENDA

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact David Ebbage (Tel. 0115 977 3141) or a colleague in Democratic Services prior to the meeting.

(4) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE

Tuesday 21 November 2017 at 10.30am

Membership

Councillors

Keith Girling (Chair)
Richard Butler
Dr John Doddy
Kevin Greaves
David Martin
Liz Plant
Mike Pringle
Kevin Rostance
Andy Sissons
Steve Vickers
Muriel Weisz

Officers

David Ebbage	Nottinghamshire County Council
Martin Gately	Nottinghamshire County Council

Also in attendance

Michelle Livingston Healthwatch Nottinghamshire

MINUTES

The minutes of the last meeting held on 10 October 2017, having been circulated to all Members, were taken as read and were signed by the Chair.

APOLOGIES

Councillor Pringle replaced Councillor Payne for this meeting only.

DECLARATIONS OF INTEREST

None

BASSETLAW HOSPITAL'S WINTER PLAN

David Purdue, Acting Chief Operating Offiver and Laura Diciacca, Discharge Lead Manager from Doncaster and Bassetlaw Hospital gave a short presentation on the hospital's winter plan.

The following points were raised within the presentation:-

- The Trust-wide bed plan has been reviewed and updated. There is a focus on length of stay in rehabilitation and trauma, patient flows for elective care have been mapped to maximise the use of elective beds on the Bassetlaw site. Escalation beds will be used during surges in activity, Daily predictor tool will be used to ensure correct bed capacity

- Elective work will stop for the first 10 days in January with the exception of clinically urgent, cancer and day-case activity, Elective capacity will be ring fenced to maintain patient pathways.

- Local ED improvement pathway work undertaken to optimise flow and efficiency

- Dedicated liaison manager now identified to support at times of surge with ambulance handovers.

- To support staffing of additional beds, education team staff plan developed to be released to work clinically and nurse specialist/ out-patient nurses availability reviewed to allow additional support to wards.

During discussions the following points were raised:

- The ambulance liaison officer comes into force when areas of surge start to build and handover times are taking longer than 30 minutes to turnaround.

- In regards to the first 10 days in January where elective work will stop, it is quite flexible but the hospital have to make sure by 23rd December 20% of beds are empty. Neuro virus and flu are a real issue at the moment, two wards in Doncaster are closed due to flu. Bassetlaw and Doncaster are one of the first Trusts to get over 75% of staff vaccinated.

- With the transfer to access model, short term nursing care beds are available but the maximum stay is 28 days and then communication with the family of that patient to decide the care that would best suit their loved one.

- Attendance and admissions increased a significant amount on a Friday in Bassetlaw, 22% extra admissions, whereas over the weekend, an 11% increase in Doncaster and just 2.6% at Bassetlaw.

- In the ED department, there has been success in appointing consultants, which is a joint post over the two hospitals.

The Chair thanked them both for their attendance and asked for them to come back next year to let the Committee know how they get on.

PRIMARY CARE 24

Amanda Sullivan introduced a briefing on the operation and performance of the Primary Care 24 service, she highlighted the following points:

- PC24 is co-located with the Emergency Department (ED) at King's Mill Hospital, and as such benefits from access to a variety of on-site diagnostics and wider services, something which is not routinely available to Primary Care services in other healthcare systems.

- In and out of hours, patients are assessed (triaged by a nurse in ED) and if deemed to have a primary care problem then streamed to NEMS at PC24. This streaming improves the flow of patients through the department and ensures that patients are seen by the right person in the right place at the right time.

- During OOH periods, patients are booked into appointment slots at PC24 via 111, where the 111 algorithm provides the relevant disposition (this is a protocol that tells the call handler where the person needs to be seen). If 111 require more clinical advice they contact NEMS who call the patient back and book an appointment.

- There are currently a number of improvement initiatives taking place at the front door of ED which are resulting in additional activity being provided by NEMS at PC24. The development of Ambulatory Care pathways resulting in more patients being streamed to PC24 as opposed to being treated within another unit in hospital.

- NEMS are currently also delivering (from the base at PC24) a service to call patients whom 111 may have traditionally sent to ED.

During discussions the following points were raised:

- In regards to allocating appointments, the Nottingham model, patients come through the out of hour's service and then assessed by a clinician through the 111 service.

- A number of campaigns have been launched and well received to get the word across to the public about the service.

- If the service receives any complaints, these get sent on and dealt with through the CCG's.

- Building up ambulatory pathways which are developed by clinicians alongside NEMS, continuing to add to them.

The Chairman thanked Amanda and her colleagues for their attendance.

CHATSWORTH WARD, MANSFIELD COMMUNITY HOSPITAL (NEURO-REHABILITATION

Lucy Dadge, Chief Commissioning Officer and representatives from Mansfield & Ashfield/Newark & Sherwood CCG's gave members a further briefing and progress report on changes to the delivery of services at the Chatsworth Ward at Mansfield Community Hospital. The following points were raised:-

- The CCG has been collecting information about current provision, exploring other models working elsewhere and engaging with patients, family members, staff and other partners to canvas views.

- There is no community-based specific rehabilitation service available in Mid-Nottinghamshire to patients with neurological injury and disease.

- Some patients using Chatsworth Ward have a diagnosis of a neurological nature but others do not. Criteria and thresholds could be clearer.

- People are typically waiting 10-11 weeks for a first outpatient appointment, which is not optimal for patients with a new event stroke, head injury or MS relapse.

- The average length of stay on Chatsworth ward is longer than other equivalent rehabilitation services, which is a concern.

- Therapy is only available on Chatsworth Ward Monday to Friday. This inhibits progress with rehabilitation.

- Some patients, families and staff naturally feel very loyal to the Chatsworth Ward service.

- Further data is required to reach definitive conclusions about demand and needs of the population.

During discussions, the following points were made:-

- 81 people attended, including 21 service users, carers and members of the public, 34 hospital therapists and nurses, and 26 others (from charities, support groups and other partners such as Adult Social Care and Community Health).

- As well as having access to routine support and reviews to help people maintain their life at home, people need urgent access to services that can prevent admission to hospital, as well as access high quality acute care, where appropriate. Pathways will be there for patients when needed.

- Chatsworth Ward will remain open over the winter period, staffing is not at crisis point, nurse staffing and therapy nurses are stable. Would look to maintain as man skilled staff as possible.

- Going forward for the needs of patients, they will receive the correct care in the correct setting.

The Chair requested to stay in close contact with the transition stage of the process and to come back to the Committee before they implement the next steps.

NEWARK HOSPITAL URGENT TREATMENT CENTRE

Representatives from Mansfield and Ashfield and Newark and Sherwood CCG attended to brief Members on issues associated with Newark Hospital Urgent Treatment Centre.

During their briefing, the following points were raised:

- We propose that the Newark Urgent Care Centre will become an Urgent Treatment Centre (UTC) which complies with the national standards from early 2018.

- The Newark UTC will be open 24 hours a day, staffed by a mix of GPs and other clinicians between 8am and midnight with a GP led service available between midnight and 8am via NHS 111, providing a more consistent presence at Newark.

- The Vision and Strategic Direction seeks for Newark Hospital to be a centre of excellence for a broad range of diagnostics and provide an urgent care service, have rapid assessments and diagnosis through the Urgent Care Centre (UCC) and have GPs working alongside clinicians in the UCC during evenings, holidays and weekends

- Commissioners are currently working closely with local General Practitioners and current urgent care providers (particularly Sherwood Forest Hospitals NHS Foundation Trusts and NEMS) to develop a model, agree, and plan to mobilise the service in early 2018 to the population of Newark, that directly matches the agreed Vision and Strategic Direction for Newark..

During discussions the following points were raised:

- Diagnostic services are already present at the hospital, so no additional costs needed and also new patient testing will be available at the Centre.

- Important to let the local people know what services will be available. Make sure the centre is known to the people of Newark and the surrounding areas.

WORK PROGRAMME

The work programme was noted

The meeting closed at 1.10pm

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

9 January 2018

Agenda Item: 4

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

LOCAL PHARMACEUTICAL COMMITTEE

Purpose of the Report

1. To introduce an initial briefing on the work of the Local Pharmaceutical Committee.

Information and Advice

2. The purpose of the Local Pharmaceutical Committee (LPC) is to promote the work of the pharmacy profession across the area. The Nottinghamshire LPC is a committee made up for 14 members. The LPC is formally recognised by NHS England to represent contractors in the area.

3. Nick Hunter is the Chief Officer for the Local Pharmaceutical Committee and he will attend this meeting of the Health Scrutiny Committee to provide a briefing and answer questions as necessary.

RECOMMENDATION

That the Health Scrutiny Committee considers and comments on the information provided.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Pharmacy Quality Scheme

NHS England introduced a Quality Scheme for pharmacies in 2017

This infographic shows the declaration data for April 2017.

11,094

that's over 90%, of NHS pharmacies in England took part in the scheme

Patient safety/clinical effectiveness

***11,031**

provide support for:

- Taking medicines correctly
- Starting new medicines
- Obtaining urgent supplies

10,434

have 80% of pharmacy professionals (pharmacists and pharmacy technicians) trained to Level 2 Safeguarding - that's approx. 20,000 pharmacy professionals

6,036

produced a reflective safety report specific to that pharmacy. Reporting from pharmacy to the National Reporting and Learning System has significantly increased

10,415

identified an estimated 12,500 high risk asthma patients and referred for review

Patient experience

***11,064**

updated their NHS Choices profiles to include information about their opening times, services and facilities

9,271

have uploaded their latest patient survey onto NHS Choices

1,792

are accredited Level 1 Healthy Living Pharmacies providing expert proactive support for healthy living to local communities

10,691

have 80% of patient-facing staff - that's over 70,000 people - who are Dementia Friends

Digital enablers

***11,075**

applied for NHSMail accounts. Over 30,000 NHSMail accounts have now been rolled out to support communication of patient information and integrate pharmacy into the NHS primary care team

10,201

increased their use of the Summary Care Record to support clinical care. Over 95% of pharmacies now have access to SCR

***11,091**

are enabled to receive and dispense prescriptions via the Electronic Prescription Service

10,882

updated their NHS 111 Directory of Services profile to enable real time referral to community pharmacy to support urgent and self-care

*Gateway criteria required to take part in the scheme

There is a second review date on 24 November 2017. The scheme will be evaluated.

Community pharmacy: providing great value for communities

Community pharmacies are vital parts of local communities, offering a range of services to support people's health and wellbeing. Research from PricewaterhouseCoopers (PwC) has shown just how important some of these services are to public spending.

The research

The research analysed 12 community pharmacy services acoss:

Public health

Medicines support

Support for self-care

The savings

The 12 services in 2015 delivered £3bn worth of net benefit to the NHS, public sector, patients and wider society.

This included:

£1.1bn NHS cash savings

£600m benefits to patients

£1bn benefits to the public sector and wider economy

£242m avoided NHS treatment costs

The benefits

Avoided NHS treatment costs

Avoided GP appointments

Cost efficiencies

Avoided social care costs

Reduced travel time

Increased economic output

Find out more at: psnc.org.uk/valueofpharmacy

Support the campaign for community pharmacy: supportyourlocalpharmacy.org

PHARMACY the Heart of our Community

PSNC

Briefing paper for Nottinghamshire County Health Scrutiny Committee

09 January 2018

Local Pharmaceutical Committee, Local Professional Network and Community Pharmacy

Authors – Nick Hunter, LPC Chief Officer and Samantha Travis, LPN Chair

How Pharmacies are commissioned

From 1 April 2013, NHS England became responsible for the commissioning of NHS pharmaceutical services in England, and the development of Pharmaceutical Needs Assessments (PNA's) became the responsibility of local authority Health and Well-being Boards (HWB's). PNA's became the future commissioning tool to identify the pharmaceutical needs of its population, support the decision-making process for pharmacy applications (subject to Regulation) and support the commissioning decisions in relation to pharmacy services.

New pharmacy applications are considered in line with The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Applications are submitted to the Pharmaceutical Services Regulations Committee (PSRC) and each application is considered against the appropriate test as outlined in the Regulations. Applicants and certain interested parties are permitted to appeal any of NHS England's decisions by submitting a formal appeal to the NHS Litigation Authority (NHSLA).

We have recently worked closely with local authority colleagues to co-produce a new Pharmaceutical Needs Assessment, which is currently out for public consultation.

NHS England, North Midlands commissions 150 community pharmacy contracts in Nottinghamshire County Local Authorities geography and a further 68 contracts within Nottingham City Councils boundary.

Contract Monitoring

The Community Pharmacy Contractual Framework (CPCF) is made up of three different tiers of service:

Essential Services – must be provided by all pharmacy contractors and consist of the following elements:

- Dispensing of medicines or appliances
- Management of repeat medication for up to one year in partnership with the patient and prescriber
- Disposal of unwanted medicines from households or individuals
- Promotion of healthy lifestyles
- Signposting to other health care providers, where appropriate
- Support for self-care to assist people to look after themselves or their families

- Compliance with clinical governance requirements

Advanced Services – these are undertaken voluntarily by some pharmacies and require accreditation of the pharmacy and pharmacist providing the service. Current Advanced Services are Medicines Use Reviews (MUR's), New Medicines Service (NMS), NHS Urgent Medicine Supply Advanced Service (NUMSAS) and Flu vaccination.

Local commissioned Services – these are services commissioned locally by either NHS England, the Local Authority or CCG's.

NHS England currently commissions the following services in Nottinghamshire:

- Pharmacy First minor ailments service (excluding Rushcliffe)
- Christmas Day and Easter Sunday bank holiday rota
- Palliative Care
- Emergency Supply Service
- Domiciliary Medicines Use Review

Community Pharmacy Assurance Framework (CPAF)

All pharmacies are subject to yearly contract monitoring via a national process agreed between NHS England and the Pharmaceutical Services Negotiating Committee (PSNC). Pharmacies complete screening questions and dependent on their responses may be requested to complete a comprehensive questionnaire or be selected for a contract review visit by NHS England. In addition, pharmacies may be identified for a contract review visit due to various other sources of information including complaints.

Where non-compliance is identified at a contract review, an action plan is developed with appropriate timescales. If a pharmacy fails to complete the actions, a referral is made to the PSRC who have the authority to issue breach or remedial notices against a pharmacy.

Regulation

Pharmacists and pharmacy technicians are registered healthcare professionals. The General Pharmaceutical Council is the regulatory body for all pharmacy professionals and pharmacy premises. The principle functions of the GPhC include:

- approving qualifications for pharmacists and pharmacy technicians and accrediting education and training providers;
- maintaining a register of pharmacists, pharmacy technicians and pharmacy premises;
- setting standards for conduct, ethics, proficiency, education and training, and continuing professional development (CPD);
- establishing and promoting standards for the safe and effective practice of pharmacy at registered pharmacies;
- establishing fitness to practise requirements, monitoring pharmacy professional's fitness to practise and dealing fairly and proportionately with complaints and concerns

Complaints

In comparison to other primary care contractor groups, only a small number of complaints relate to community pharmacy. There are two pathways for formal NHS complaints. Patients (or their representatives) can either complain to the contractor *or* the commissioner but not both. All complaints to the commissioner are processed via the NHS England Customer Contact Centre. The complaint is recorded, and attempts are made to resolve the complaint informally however if this is not possible, complaints are passed to the regional teams where the contractor is based.

Once consent is obtained, an investigation is undertaken and where appropriate contractors are asked to provide an apology and an outline of the measures they plan to put in place to achieve appropriate service improvements. Independent clinical review is also undertaken, and a formal response is sent to the complainant. If the clinical advisor considers it appropriate, the complaint would also be brought to the attention of the Fitness to Practise team for review by the Performance Advisory Group (PAG) within NHS England, North Midlands.

If the complainant has already complained to the contractor, NHS England are not permitted to re-investigate the complaint and complainants are advised to approach the Ombudsman should they wish an independent review of the investigation undertaken by the contractor. The Ombudsman is also the second stage for any complaints NHS England investigates.

Local Pharmaceutical Committee (LPC)

The local organisation for community pharmacy is the Local Pharmaceutical Committee (LPC). The LPC is the focus for all community pharmacists and community pharmacy owners and is an independent and representative group. The LPC works locally with NHS England Local Teams, CCGs, Local Authorities and other healthcare professionals to help plan healthcare services.

The LPC negotiates and discusses pharmacy services with commissioners and is available to give advice to community pharmacy contractors and others wanting to know more about local pharmacy. LPCs liaise closely with their medical equivalent the Local Medical Committee so that GPs and pharmacists can work together to deliver services to patients. LPCs also work closely with local dental committees and local optical committees. There are around 80 LPCs throughout England and Nottinghamshire LPC covers the 243 Nottinghamshire County and Nottingham City pharmacies.

Changes to pharmacy funding

On 20th October 2016 the Government imposed a two-year funding package on community pharmacy, with a £113 million reduction in funding in 2016/17.

This was a reduction of 4% compared with the previous year, but meant that contractors saw their funding for December 2016 to March 2017 fall by an average of 12% compared with previous levels. This was followed by further reductions in 2017/18 causing a number of applications to reduce opening hours and an increase in changes of ownerships.

So far we have only seen two closures as a direct result of cuts (Stapleford recently and Mansfield at end of January). Lloyds Pharmacy have announced nationally they will close 190 pharmacies, but have not yet identified the actual locations. We acknowledge we may see more closures in 2018 but are not able to predict where these might occur at the present time, because much of the decision for a contractor to close is based on cash flow rather than outright turnover – so big busy pharmacies are as vulnerable small quiet pharmacies. The LPC is supporting a number of pharmacy owners through some turbulent times and difficult decisions as they face extending their overdrafts, taking additional loans and in extreme cases re-mortgaging their homes.

It is clear to us that these measures are unsustainable and therefore ask the Health Scrutiny Committee to note the potential risk of a significant change to the community pharmacy network in Nottinghamshire in the next 12 months or so.

Recent developments

The seasonal flu vaccination was again commissioned in 2017/18 from pharmacies and the significant engagement and patient uptake demonstrates that community pharmacies can respond to a challenge despite very difficult trading environments – 98% of patients were very satisfied and 99% would recommend a friend or family in the patient evaluation from the 2016/17 season.

The local emergency supply service has provided service to over 8000 patients since April 2017 and although has some similarities to the national NHS Urgent Medicine Supply Advanced Service (NUMSAS) there is significant differences so essential both continue to be commissioned. The NUMSAS is developing links to NHS 111 and although sign up is low at around 15% of contractors it is a new service and both services together provide vital support to urgent care.

Medicines are a commodity market and consequently is part of the cause of drug shortages. However the way the Department of Health funds medicines means England benefits from some of the cheapest drug pricing in the developed world. Pharmacy teams spend several hours a day sourcing product dn although there is no current evidence of patients coming to harm as a result of the shortages the situation is inefficient and not sustainable.

NHS England nationally have this year from April set out a quality scheme for community pharmacies, which includes healthy living pharmacies, level 1 (HLP – see image below) and Making Every Contact Count (MECC). Part of the requirements is to have someone leadership trained and another member of staff training to level 2 in the Royal Society of Public Health, Health Champion programme. This was a considerable upskilling of staff and locally the LPC and LPN secured funding from Health Education England (HEE) to cover course and exam fees in order to deliver nearly 200 health champions trained in MECC and Dementia Friends alongside their Public Health qualification and nearly 200 healthy living leaders. This means that over three-quarters of Nottinghamshire pharmacies are now HLPs and present the local authority with a significant opportunity to capitalise on the 35,000 people a day who access community pharmacies in Nottinghamshire and add to the over 150,000 health interventions provided weekly to Nottinghamshire residents by community pharmacies. What better commissioning opportunity could a local authority want?

Public Health England

What is a Healthy Living Pharmacy?

Public Health England

The impact of Healthy Living Pharmacies

1. Healthy Living Pharmacies improve the public's health and drive improvements in service quality and innovation

2. People walking into a Healthy Living Pharmacy are twice as likely to set a quit date for smoking and then quit than if they walked into a non-Healthy Living Pharmacy

3. Healthy Living Pharmacies consistently deliver high-quality public health services – NHS Health Checks, weight management, sexual health, etc

4. Healthy Living Pharmacies reach out to local communities (universities, businesses, schools, community centres, etc) with health improvement advice and services

99% of people are comfortable and happy with the service provided by Healthy Living Pharmacies

98% of people would recommend Healthy Living Pharmacies to their families and friends

60% of people would make an appointment with their GPs if the health improvement service was not available at a Healthy Living Pharmacy

20% of people would not have gone to another provider (ie, they would have received no support for improving their health)

Over all the quality scheme has represented a significant change in community pharmacies with a steep learning curve and requiring investment at a difficult time. Pharmacies have risen to that challenge and delivered. The November declaration figures are yet to be released, so the most up to date are the ones from April, included in the attached infographic.

Also included is an infographic showing a Price Waterhouse Cooper report of the value of community pharmacy to the economy.

Community Pharmacy in Nottinghamshire

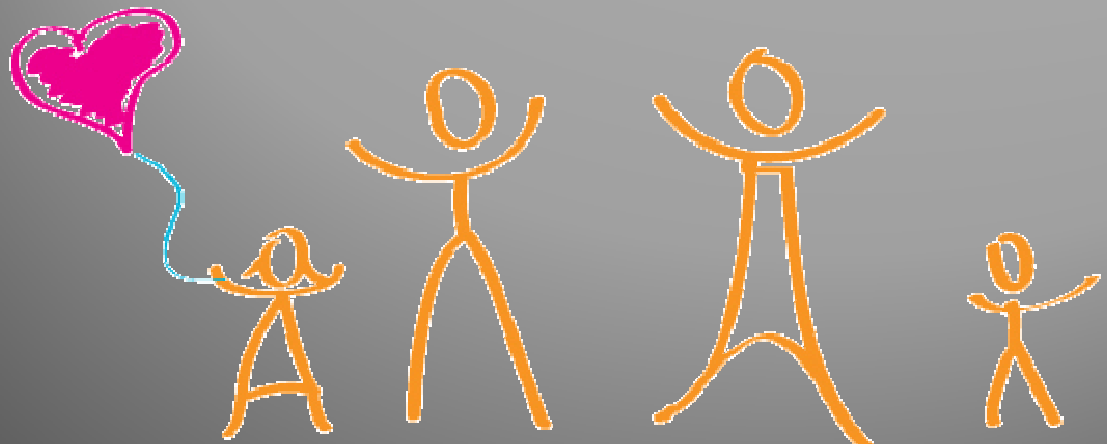
PHARMACY
the Heart of our Community

Nottinghamshire STP Advisory Board meeting
Nick Hunter – Nottinghamshire LPC
And Sam Travis – LPN Chair
07 Dec.2017

Introduction

- LPC and LPN
- Background to community pharmacy and link to the STP
- Quality scheme and HLP
- Pharmacy funding

A package of care, not just a packet of pills



PHARMACY

the Heart of our Community

Medicines

Medicines are the most common healthcare intervention, but:

- 30–50% not taken as intended
- 4–5% of hospital admissions due to preventable adverse effects of medicines

Role of the LPC

- Body recognised in statute to represent community pharmacies
- Committee of 13 members – nominated / elected according to local proportion of multiples / independents
- Works locally with NHSE, CCGs, Local Authorities and other healthcare professionals to help plan healthcare services

Role of the LPN

- Each NHSE team has three LPNs – pharmacy, dentistry and optometry
- Provide clinical input
- Focus for NHSE work on quality improvement
- Support implementation of national strategy and policy at local level
- Local clinical leadership
- Support LAs with development of the PNA
- Develop new programmes of work – self-care and long term conditions management
- Work with CCGs, LAs and others on PH, prevention and medicines optimisation initiatives

Our Vision: ***Sustainable, joined-up high quality health and social care services that maximise the health and wellbeing of the local population***

System Aims:

- People will be supported to develop the confidence and skills to be as independent as possible, both adults and children
- People will remain at home whenever possible. Hospital, residential and nursing homes will only be for people who appropriately need care there
- Resources will be shifted to preventative, proactive care closer to home
- Organisations will work seamlessly to ensure care is centred around individuals and carers
- Addressing mental and physical health and care needs of population collectively and making best use of the public purse

High Impact Areas:

1. **Promote Wellbeing, Prevention, Independence and Self-Care**: increase healthy life expectancy by 3 years by 2020/21 with a focus on decreasing the prevalence of smoking and reducing levels of obesity in the first 2 years. Enhance health and wellbeing to promote independence and expand levels of self-care
2. **Strengthen primary, community, social care and carer services**: ensure people stay healthier for longer by increasing access and resilience in general practice and improve the quality of life for people with long-term conditions and their carers
3. **Simplify Urgent and emergency care**: deliver the right advice or service at the right time including improving the urgent and emergency care pathway, and redesigning the system to enable reduction of 200 beds in acute hospitals in the first 2 years of this plan
4. **Deliver Technology enabled care**: help citizens stay healthy and manage their own care; help clinicians and other staff deliver more care more efficiently and use new technology to support independent living and care at home
5. **Ensure consistent and evidence based pathways in planned care**: standardise care pathways reducing unwarranted variation, improve the prevention, early diagnosis and recovery in cancer care

Measured through the following success criteria:

- All within the health and care economy achieving financial balance by 2021
- Delivery of the agreed outcomes and targets that reflect our system values and citizen satisfaction: Improve Healthy Life Expectancy by 3 years
- High quality providers through regulatory outcomes

Supporting workstreams and enablers:

1. **Strengthen acute services**: closer collaboration between Nottingham University Hospitals Trust and Sherwood Forest NHS Foundation Trust
2. **Drive system efficiency and effectiveness**: deliver provider Cost Improvement Programmes, additional efficiencies through Carter and reduce variation in top 10 area by value
3. **Improve housing and environment**: provide social and warm housing to reduce emergency department and non-elective attendances
4. **Future proof workforce and organisational development**: redesign our workforce to successfully deliver our transformation plan
5. **Maximise estates utilisation**: improve estate usage to release money and deliver our high impact changes
6. **Proactive communication and engagement**: engage citizens and staff to support us in the successful development and delivery of our plan

Clear delivery governance approach:

- One STP-level delivery architecture responsible for overall programme management, coordinates knowledge sharing and development of consistent standards, ensures capability building and organisation development, and implements footprint-wide initiatives and enablers
- Two delivery units with the vast majority of resources deployed that programme-manage locally implemented schemes, track performance and analytics, and allocates and deploys resources and teams
- Advisory Group, Clinical Reference Group and Delivery Group

Collaboration with Bassetlaw

1) Promote wellbeing, prevention, independence and self-care – pharmacy stats

- 243 in Nottingham/shire delivering over 25,000 health interventions a day
- Pharmacy environment offers anonymity that is more conducive to discussing health issues

Healthy Living Pharmacy

Public Health England

2) Strengthen primary, community, social care and carer services

- Pharmacist
- Medicines Counter Assistant
- Dispensing / pharmacy assistant
- Pharmacy technician
- Accredited checking technician
- RSPH Health Champion

3) Simplify urgent and emergency care – Accessibility

- Heart of communities where people live, work and shop
- Public's first point of contact – for some, their only contact with a healthcare professional
- 95% of people visit a pharmacy at least once per year

Locally commissioned services

- Since April 2017, 25600 Pharmacy First consultations have taken place
  - saving GP practice consultations
- 8300 patients have used the local community pharmacy emergency supply service
  - saving Out of hours GP appointments

4) Deliver technology enabled care

Quality scheme – gateway criteria

- Provision of one or more advanced service
- NHS Choices profile up to date
- Use NHSnet email
- Electronic Prescription Service use – eRD

Transfer of Care – discharge information is transferred electronically in real time for pharmacy of patients choice

5) Ensure consistent and evidenced based pathways in planned care

Quality scheme criteria

- Patient safety reports
- Safeguarding
- Patient satisfaction
- Health Living Pharmacy
- Summary Care Record use
- NHS111 DOS up-to-date
- Asthma / inhaler intervention and referral
- Dementia Friends

+ CPAF

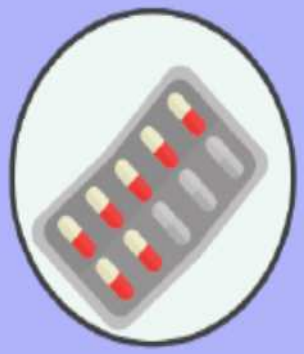
Community pharmacy: providing great value for communities

Community pharmacies are vital parts of local communities, offering a range of services to support people's health and wellbeing. New research from PricewaterhouseCoopers (PwC) has shown just how important some of these services are to public spending.

The research

The research analysed 12 community pharmacy services acoss:

Public health



Medicines support

Support for self-care

Funding for community pharmacies

- Local NHS services – 1%
- Private services – 1%
- OTC sales – 4%
- NHS services contract – 94%

Global sum and margin allowance

- Regulated and tightly controlled

Impact of cost saving prescribing policies and cuts

- Switching programmes
- 'Branded' generic or branded medicines prescribing policies
- Stock supply problems
- NCSO
- Multiple brands on the shelf
- Cash flow

http://www.pulsetoday.co.uk/clinical/prescribing/medicines-optimisation-schemes-simply-rob-peter-to-pay-paul-gps-should-boycott-them/20035359.article

Conclusion

- Community Pharmacy Teams have huge potential to support primary medical services and urgent care
- Need for commissioning structure to back up workforce development
- Need to navigate complex commissioning environment to support engagement
- Community pharmacists can and will deliver if given the opportunity –local IP project demonstrates this

Nottinghamshire County Council

Report to Health Scrutiny Committee

09 January 2018

Agenda Item: 5

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

OVERVIEW OF OBESITY PREVENTION AND WEIGHT MANAGEMENT SERVICES

Purpose of the Report

1. To provide information on the issue of obesity, and programmes and plans that contribute to obesity prevention, and weight management services.

Information and Advice

Excess weight

2. The terms overweight and obesity[1] (together referred to as excess weight) is when weight gain has reached a point which increases a person's risk of ill health. Unhealthy diets, physical inactivity and sedentary lifestyles have led to an increase in excess weight in recent years.

Why is excess weight an issue?

3. Obesity during pregnancy increases childhood obesity and infant death as well as impacting on the mother's immediate and future health. Overweight and obese children and young people have an increased risk of becoming overweight adults. Very overweight children face bullying, low self-esteem and school absence.

4. In adults, being overweight or obese is associated with an increased risk of many serious long term conditions including type 2 diabetes, fatty liver disease, cancer, heart disease and musculoskeletal conditions. The risk of poor health increases sharply with increasing weight. Severe obesity can result in physical and social difficulties and is costly on health and leads to increased demands on social care services. Obesity (Body Mass Index [BMI] 30+) reduces life expectancy by an average of 3 years whilst severe/morbid obesity (BMI 40+) reduces life expectancy by 8-10 years.

5. It is estimated that the NHS in England spent £5.1 billion on overweight and obesity related ill health in 2014/15. This is more than is spent each year on the police, fire service and judicial system combined and it does not cover the costs of wider economic and societal impacts including sickness absence, reduced productivity and welfare payments.

[1] Overweight and obesity is generally measured in body mass index (BMI) (weight (kg)/height (m^2).
Children: Overweight = BMI ≥ 91st centile for age & sex; Obese = BMI ≥ 98th centile for age & sex.
Adults: Overweight = BMI 25-29.9; Obese = BMI ≥30; Morbidly Obese = BMI ≥ 40

6. The percentage of adults who have excess weight in Nottinghamshire is significantly higher than the England average (table 1). Levels of overweight and obesity are highest in Bassetlaw and lowest in Rushcliffe.

Table 1 Prevalence of Excess Weight in Adults in Nottinghamshire (from the Public Health England Public Health Outcomes Framework)

2.12 - Percentage of adults (aged 18+) classified as overweight or obese - current method 2015/16 Proportion - %

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	61.3	61.1	61.5
Nottinghamshire	-	65.0	63.0	66.8
Ashfield	-	68.5	63.6	73.7
Bassetlaw	-	71.5	66.9	76.4
Broxtowe	-	56.9	52.6	61.5
Gedling	-	69.4	64.3	74.8
Mansfield	-	67.3	62.7	72.0
Newark and Sherwood	-	66.7	60.9	72.4
Rushcliffe	-	58.0	53.4	62.3

Source: Public Health England (based on Active Lives survey, Sport England)

7. The percentage of children in England who are obese, doubles between Reception age (age 4-5 years) and Year 6 (age 10-11 years). The percentage of Year 6 children who have excess weight in Nottinghamshire is lower than the England average (table 2). Levels of overweight and obesity are highest in Ashfield and lowest in Rushcliffe.

Table 2 Prevalence of Excess Weight in Children aged 10-11 years in Nottinghamshire (from the Public Health England Public Health Outcomes Framework)

Year 6: Prevalence of overweight (including obese) 2015/16 Proportion - %

Area	Count	Value	95% Lower CI	95% Upper CI
England	186,074	34.2	34.0	34.3
Nottinghamshire	2,229	30.6	29.5	31.6
Ashfield	415	34.8	32.1	37.5
Bassetlaw	333	32.2	29.5	35.1
Broxtowe	264	29.8	26.8	32.9
Gedling	326	30.7	28.0	33.5
Mansfield	311	32.6	29.7	35.6
Newark and Sherwood	345	32.1	29.4	35.0
Rushcliffe	235	21.5	19.2	24.1

Source: NHS Digital, National Child Measurement Programme

At risk groups

8. The burden of obesity is uneven across our communities, with certain groups being more at risk such as lower socio-economic and socially disadvantaged groups. Other groups at risk include those with physical disabilities (particularly in terms of mobility which makes exercise difficult), those with learning difficulties, people diagnosed with a severe and enduring mental illness, particularly schizophrenia or bipolar disease and older people.

How do we tackle excess weight?

9. Excess weight is a complex yet common issue however a whole system approach needs to be taken so that elements of the environment that are 'obesity promoting' are tackled as well as providing people with support to improve their diet and physical activity levels to enable them to be a healthy weight. The prevention of weight gain, beginning in childhood offers the most effective means of achieving healthy weight in the population.

10. Sustained collective leadership, taking a life course and place based approach, is needed to tackle the 'obesity promoting' environment. Coordinated action and integration is required across various council departments, services and partner organisations including: planning and the environment, environmental health, public health, leisure and fitness providers, transport, health and social care, parks and green space, education and learning early years, housing, the third sector, and business as emplyers and particularly the food industry.

11. For those individuals who are already overweight or obese the provision of treatment services that are accessible and appropriate are needed. These services are described in 4 tiers:

- **Tier 1 Preventative programmes:** Universal public health interventions aimed at prevention and reinforcement of healthy eating and physical activity messages across the life-course.
- **Tier 2 Weight management services:** Weight management, healthy eating, physical activity and behaviour change delivered in the community to children, young people, and adults.
- **Tier 3: Specialist weight management service:** Community or hospital based, potentially with outreach delivered by a team led by a specialist obesity physician including specialist dietetic, psychological and physical activity input.
- **Tier 4: Severe and complex obesity services (bariatric surgery and after care for 2 Years):** Specialist obesity medical and surgical multidisciplinary team. Referral by a Tier 3 service for those patients who have undergone an optimum level and duration of assessment and engagement with the tiered weight management service pathway so that referral for surgery is at the most appropriate time for the individual meeting NICE criteria. Surgical intervention is treatment of choice for adults with BMI greater than 50 and for adults with a BMI greater than 40 or 35 with serious co-morbidities that would be improved with weight loss. Obesity surgery is also recommended by NICE for patients with a BMI 30-35 with recently diagnosed diabetes mellitus.

Nottinghamshire Plans Programmes and Services

12. Nottinghamshire County Council's Public Health Division has a programme of work to tackle obesity. This involves working with relevant County Council Divisions, District and borough councils, the NHS and other Partner organisations. These Public Health programmes are:

- Strategic Leadership and Partnership Working to address the causes of obesity
- A commissioned Obesity Prevention and Weight management Service
- Healthier Option Take away scheme (HOT)
- National Child Measurement Programme
- Joint working between Public Health and Planning departments
- Breastfeeding support and Breastfeeding Friendly Nottinghamshire

Strategic Leadership and Partnership working to enable people to make healthy choices to reduce obesity

13. This work is led by County Council Public Health in partnership with district and borough councils and other partners. The 2018-2022 Health & Wellbeing Strategy now has workstreams to address the impact of the food environment on health & wellbeing; reduce physical inactivity amongst priority groups working with Active Notts (formerly Sport Nottinghamshire) and the Transport Strategy team; and influence how the Planning System can impact positively on health and wellbeing. These new workstreams will impact on how Nottinghamshire as a Place can influence obesity and other issues.

Commissioned Obesity Prevention and Weight Management Service

14. Public Health commission the obesity prevention and weight management service. This service is provided by Everyone Health, a division of SLM Ltd, for children and adults resident in Nottinghamshire providing increasing levels of service based on the need. The services comply with the latest National Institute of Health and Clinical Effectiveness (NICE) guidance.

15. Tier 1 of the service, is community health promotion activity aimed at women during the prenatal, pregnancy postnatal periods, children (0-4, 5-19 years) and families in areas of high child obesity prevalence, people with learning disabilities and with physical disability, adults with mental health problems, adults in the workplace, older adults at increased risk of falls. Examples of activity in 20171/8 include:

    - Group sessions on healthy eating and physical activity in residents with mental health problems.
    - Group sessions on healthy eating and physical activity with older people.
    - Engagement of local food businesses in the Healthy Options Takeaway Scheme working with ENvironement Health officers.
    - Groups sessions on breastfeeding, weaning and healthy eating for new mums.
    - Sessions on healthy eating and exercise with primar school children.
    - Promoting the “mile a day” initiative with Primary schools.
    - Supporting volunteers to promote physical activity and healthy eating.
    - Maintenance sessions for clients who had accessed the weight management programme to encourage and support them to continue to be physically active.
    - Woirking with volunteers to run walking groups.
    - Promoted the national Active 10 camapign linking in with local groups and large events such as the Tour of Britain.
    - Delivered brief intervention training to staff in other agencies to improve their skills in raising the issue of health weight.
    - Setting up an older peoples strength and stability physical acitivty programme across the county which will also support falls prevention working with Adult Social CXare and the NHS.

16. Tier 2 provides the Changepoint Weight Management services for those overweight or obese across the county. In 2016/17 408 adults and children used this service and were supported at 6 and 12 months to maintain weight loss. The proportion of service users who have lost weight as a result of the weight management intervention is 80.2% of measurements following the 12 week programme and 61.0% of measurements of those having the higher level service for morbidly obese.

17. From May 2017 the service has sub-contracted Slimming World and Weight Watchers. In quarter 2 2017/18, 339 service users accessed these options.

18. Tier 3 weight loss programmes are for those who are morbidly obese and require a more complex intervention involving members of a multi-disciplinary team. In 2016/17, 602 adults and 59 children were supported through this service. The commissioned services also work with obese women who are pregnant and adults after they have had weight loss (bariatric) surgery. So far the service has supported 26 women and 60 post bariatric patients. From 1st

April 2018, the commissioning of Tier 3 will transfer to NHS Clinical Commissioning Groups in line with national guidance.

19. The commissioning of bariatric surgery for patients in Nottinghamshire is the responsibility of the Clinical Commissioning Groups and provided by the NHS.

Healthier Option Take Away Scheme (HOT)

20. The HOT Schemewas launched in 2015. County Council and Environmental Health Officers (EHO) at District councils work together to support healthier eating by increasing the accessibility and awareness of healthier options in any food establishment offering hot food takeaways. Such premises are awarded a certificate and promotional material to display in premises. Other benefits include: increasing customer choice, increasing customer satisfaction and sales, enhancing the reputation of the business and it educates customers on healthier options. Such options can be created by making small changes to what is offered or how food is prepared, cooked or served to offer healthier choices to customers. So far 141 businesses across the whole of the County have been awarded the merit. Further Information can be accessed here: http://www.nottinghamshire.gov.uk/care/health-and-wellbeing/healthier-options-takeaways

National Child Measurement Programme (NCMP)

21. Nottinghamshire County Council has the statutory responsibility for NCMP, which is run annually. Findings from the programme are used to inform local planning and delivery of services for children and gather population-level surveillance data to allow detailed analysis of prevalence and trends in weight. The weighing and measuring of children takes place in school and is part of the Integrated 0-19 Years Public Health Nursing Contract by the Healthy Families Team (HFT). Parents and carers are informed of the programme in advance and have the option to opt out. The programme records the height and weight measurements of children in state-maintained schools in Reception (aged 4-5 years) and year 6 (aged 10-11 years) across England. These result are used to calculate the body mass index (BMI) of children. Through provision of a child's result to their parents, the NCMP provides the opportunity to raise parents' awareness of their own child's weight status and potential health impacts and provide an opportunity to provide further support to families to make healthy lifestyle changes. The NCMP ran across Nottinghamshire in 2015/16 with 100% of schools participating in the programme.

Joint Working between Public Health and Planning Departments

22. Public Health are also involved with our Planning departments at county and district level. Nottinghamshire County Council Public Health and Planning teams have developed a Health and Wellbeing Engagement Protocol for Planners and the NHS to use; with sets out the functions and powers of each agency and how they can work together to benefit health and wellbeing. The Protocol also contains a health and wellbeing checklist to consider as part of developing planning policy for an area. This includes consideration of factors which influence obesity such as the nature and amount of green and open space, promoting walking and cycling, access to fast food and areas to grow food; as well as wider issues such as housing and air quality. Nottinghamshire are proud to be a pilot site for the Town and County Planning Association, the Berry Hill site in Mansfield is a leading area showing how developments can consider the health of the population.

23. Some districts are proposing policies to limit planning permission for new fast food outlets under certain conditions, as there is strong evidence that the number of outlets has increased

overtime and there are more in more disadvantaged areas. They may include having a policy whereby they ensure that hot food takeaways are not within a certain proximity to schools.

24. Further information from here: https://www.tcpa.org.uk/developers-wellbeing, planning document on Nottinghamshire County Council website, Engagement protocol for wellbeing and planning.

Breastfeeding support and breastfeeding friendly Nottinghamshire

25. The World Health Organisation, UNICEF and the UK Government recommend that babies should be exclusively breastfed for their first six months of life to achieve optimal growth, development and health. There is evidence that babies who are not breastfed are more likely to become obese in later childhood[1]. A multi-agency breastfeeding framework for action, led by Public Health, drives efforts to increase the initiation and continuation of breastfeeding across Nottinghamshire.

26. All Nottinghamshire maternity, health visiting and children's centre providers are accredited to UNICEF Baby Friendly Initiative standards, meaning that the best practice advice, care and support around infant feeding is given routinely to all women. A range of support for breastfeeding women is commissioned: care from maternity services, the Healthy Families Programme, and from children's centre breastfeeding groups supported by volunteer peer supporters.

27. Breastfed babies feed frequently and need to be able to feed whenever required; mothers, particularly younger mothers, cite fear of breastfeeding in public as a barrier to continuing to breastfeed. It is important that women feel comfortable and welcome to breastfeed wherever they choose. Breastfeeding friendly Nottinghamshire, a partnership between Nottinghamshire County Council, Nottinghamshire Healthcare Trust, and all district and borough councils, aims to address this by encouraging business and venues to provide more welcoming environments for breastfeeding mums by signing up to being 'breastfeeding friendly'.

Other Options Considered

28. No other options were considered in compiling this descriptive report.

Reason for Recommendation

29. This report provides information on obesity prevention and weight management services as requested by the Committee.

Statutory and Policy Implications

30. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

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[1] https://www.nice.org.uk/guidance/ph11

Financial Implications

31. There are no financial implications resulting from the recommendations of this report. The obesity prevention and weight management service commissioned by the Public Health Division is funded by the Public Health Grant and has an annual budget of £1.4M. The contract with the current provider expires in March 2019. The National Child Measurement Programme (NCMP) forms part of the Integrated 0-19 Years Public Health Nursing Contract commissioned by the Public Health Division.

RECOMMENDATION/S

That the Health Scrutiny Committee:

1) Receives this report outlining obesity prevention and weight management services and asks questions, as necessary.

2) Indicates requirements for further information, as required

Barbara Brady
Director of Public Health

For any enquiries about this report please contact:
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Constitutional Comments (LMC 14.12.2017)

32. The Health Scrutiny Committee is the appropriate body to consider the contents of the report.

Financial Comments (DG 13.12.2017)

33. The financial implications are contained within paragraph 31 of this report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- 'None' or start list here

Electoral Division(s) and Member(s) Affected

- 'All'.

Nottinghamshire County Council

Report to Health Scrutiny Committee

09 January 2018

Agenda Item:

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

OVERVIEW OF ARRANGEMENTS FOR SUICIDE PREVENTION

Purpose of the Report

1. To outline arrangements for preventing suicides in Nottinghamshire County.

Information and Advice

2. For the period 2014 -16, the age-standardised incidence rate of suicide in Nottinghamshire County was 8.2 per 100,000 population, which is slightly lower than the average for England (9.9 per 100,000). This equates to approximately 58 suicide deaths per annum of which about three quarters occurred in men aged between 21 and 49 years.

   Further information on the Nottinghamshire suicide rates, trends and risk factors refer to Appendix 1.

3. Effective prevention of suicide requires a whole system approach involving Nottinghamshire County Council, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide.

4. The House of Commons Health Committee Suicide Prevention report[1] recommends that local suicide plans should be developed and implemented in line with the Public Health England's (PHE) suicide prevention planning guidance for local authorities (2016). The structure of this report broadly reflects that of the PHE planning guidance and includes
   - Applying the national policy context to the local Suicide Prevention Framework for Action and action plan
   - Multi-agency suicide prevention partnership
   - Use of suicide data sources
   - Evidence-based multiagency suicide prevention strategy and action plan

National policy context and Nottinghamshire multi-agency suicide prevention steering group

5. The Nottinghamshire (combined with Nottingham City) Suicide Prevention Steering Group was reformed in 2013. The main responsibility of the group was the development of a multi-agency

[1] House of Commons Health Committee Suicide Prevention report (March2017)

Suicide Prevention Framework for Action Nottinghamshire (2015-2018) and the implementation of the accompanying action plan (attached in Appendix 2).

6. The group comprises stakeholders from the following organisations;
    - Public Health (Chair and meeting facilitator)
    - Nottingham City Coroner's Office
    - Nottinghamshire Police
    - NHS Mental Health services (Children, Young People and Adults)
    - CCG Mental Health Commissioners (Children, Young People and Adult)
    - Substance Misuse service providers
    - Quality and safety leads (CCG and NHCT)
    - Primary Care GP mental health leads
    - Network Rail
    - British Transport Police
    - East Midlands Ambulance Service
    - University of Nottingham (Researchers)
    - Student Counsellors (University of Nottingham and Trent University)
    - Third Sector Organisation, such as; Samaritans offering bereavement support and Harmless offering support for people who self-harm

7. The Framework for Action is aligned to national guidance and current best practice for mental health and suicide prevention guidance and clinical evidence[2]. The key suicide prevention priorities and actions includes;

    Priority 1: Identify early those groups at high risk of suicide and self-harm and support effective interventions

    Actions Completed:
    - In 2015, Public Health undertook the Nottinghamshire Coroners Suicide Audit to review all Nottinghamshire suicide deaths in 2013 and 2014. The audit findings showed that the majority of suicides deaths were in men aged 49 years and younger, which is similar nationally. To reduce the number of suicide deaths in this group, the Nottinghamshire Suicide Prevention Steering group agreed to target this high risk group in 2017/18. (Refer to appendix 3 for the 2017/18 action plan).
    - Awareness campaigns targeting men have included;

- [2] **Preventing suicide in England: a cross government outcomes strategy to save lives (2012)** details the national objectives and actions are outlined in preventing suicide in England by;
- **No health without mental health: A cross-government outcomes strategy for people of all ages (2011)** is key in supporting reductions in suicide amongst the general population by improving access to effective mental health services
- **Five Year Forward View (2016)** to address gaps in mental health services
- **Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis** was published by the government in February 2014. The concordat outlines a vision for health, social care and emergency services work together to deliver a high quality response when people of all ages with mental health problems including suicidal behaviour, urgently need help.
- **Future in Mind (2015) targeting children and young people in** promoting resilience, prevention and early intervention and improving access to mental health effective support
- **Mental Health Crisis Concordat (2014)** outlines a vision for health, social care and emergency services work together to deliver a high quality response when people of all ages with mental health problems including suicidal behaviour, urgently need help.
- **National Institute for Health and Care Excellence (NICE) guidelines**
    - Depression in adults. The treatment and management of depression in adults (2009) NICE clinical guideline 90
    - Depression in adults with a chronic physical health problem: recognition and management. (2009) NICE clinical guideline 91.
    - Depression in children and young people: identification and management (2005) NICE clinical guidelines 28.
    - Self-harm in over 8s: long-term management (2011). NICE clinical guidelines 133

- Campaign Against Living Miserably (CALM) awareness
- National Suicide Prevention awareness campaigns such as 'It's okay to Talk'. Public Health have developed a local pamphlet to support this campaign which aims to develop a culture where people are feel comfortable talking about suicide and are able to have a difficult conversation with someone they are worried about

- Public health mental health awareness delivered through the Workplace Health schemes supports employers and employees in promoting good mental wellbeing which has positive impact on reducing mental health problems and preventing suicides
- Improved access to support for young people in mental health crisis through the establishment of a CAMHS Crisis Resolution and Home Treatment Service providing mental health support in the community, and in acute hospitals, with a liaison function in A and E being rolled out at QMC and King's Mill.
- Improved access to Adult Mental Health crisis services through the commissioning of Rapid Response Liaison Psychiatry (RRLP) service in acute hospital and the Police Mental Health Triage service

Actions Ongoing (2018/19):

- In 2016, there were ten suspected suicides on Nottinghamshire railways. Public Health in partnership with Network Rail, British Transport Police and the Samaritans are working to prevent any further suicides. The local Samaritans target those rail hotspot areas with suicide awareness signage and awareness raising that encourages passengers to notice what may be suicide warning signs. In 2017, there has been a 20% reduction Nottinghamshire Network Rail suicide deaths

Priority 2: Review of timely suicide and self-harm data and be informed by national and local evidence based research and practice in order to better understand the local needs

Public Health undertakes reviews of national and local suicide trends so that at risk groups are identified early and evaluates the effectiveness of suicide prevention interventions.

Actions Completed:

Suicide Prevention Joint Strategic Needs Assessment (2016)
Self-harm Joint Strategic Needs Assessment (due to be published December 2017).

Actions Ongoing (2018/19):

- Coroner's Office suicide verdict data
- Public Health Suicide Profile data
- Hospital Episode Statistic data
- Office of National Statistics annual suicide data
- Review of British Transport Police Network Rail suspected suicide daily incidents

Priority 3: Access effective support for those bereaved or affected by suicide

Actions Completed:

- At the time of a suicide death, Nottinghamshire Police give the families of the deceased person the Samaritans 'Help is at Hand'[3] that offers advice and where to get support

[3] Samaritans 'Help is at Hand' (2015) https://www.gov.uk/government/news/you-are-not-alone-help-is-at-hand-for-anyone-bereaved-by-suicide

- Coroner's office also provide relatives with the Samaritans 'Help is at Hand' at the coroner's inquest
- A research grant-funded 2 year pilot is in place and delivered by a third sector provider (Harmless). The pilot is assessing the impact of offering families affected by a suicide early access to bereavement counselling in reducing depression. This project ends the October 2018. Continuation of the project depends on ongoing CCG funding.
- Network Rail offer suicide prevention awareness and training to all rail staff. The training offers skills in ways of detecting those at risk of suicide and intervening to support the person to access mental health interventions

Actions Ongoing (2018/19):

- Samaritans target railway stations where a suicide death on the railway has occurred. Samaritan counsellors offer advice and support to those that have witnessed a railway suicide.

Priority 4: Engage with media personnel to agree on sensitive approaches to reporting suicide and suicidal behaviour

Actions Completed:

- Nottinghamshire County Council Communication team has implemented the Samaritans guidance for the media on the reporting of suicide: www.samaritans.org/media_centre/media_guidelines.aspx
- This local suicide prevention communication plan promotes responsible reporting of suicide in the media and ensures effective local responses to the aftermath of a suicide

Actions Ongoing (2018/19):

- Where there have been incidences of irresponsible media reporting, the communications team of Nottinghamshire County Council has supported the local media to improve their reporting, using the Samaritans media guidance
- Where there has been irresponsible reporting, Public Health alerts local stakeholders and services of the possibility of raised levels of suicidal behaviour

Priority 5: Improve the understanding and care for people at risk of suicide and self-harm through training of frontline staff to deal with those at risk of suicide and self-harm behaviour

Actions completed:

- 2016 - Public Health Division committed £92k for the delivery of Mental Health and Suicide Prevention awareness and training, to equip frontline staff in the NHS, Police, Emergency Services and Third Sector with skills to detect those at risk of suicide and prevent suicides. The 18-month contract ended in March 2017.
- Rushcliffe CCG are running Suicide Response Training for GPs in Primary Care. The training equips GPs the skills to ask patients about their suicidal thoughts that equips GPs in putting in a safety plan to reduce the risk of suicide.
- A training programme for secondary schools has been jointly developed by CAMHS, Educational Psychology and the Healthy Families Team, and will be delivered through 8 sessions in the Spring term.
- The Primary Mental Health Team has been commissioned as part of CAMHS to provide training and case consultation to universal practitioners working with young people who express emotional health needs. Additionally, Nottinghamshire has become part of a pilot

project through the Anna Freud Foundation, aimed at strengthening the links between schools and CAMHS.

8. Implementation (Quality and Governance)

Progress and updates against the suicide prevention action plan are reported to:

- Nottinghamshire Health and Wellbeing Board (2016)
- Nottinghamshire Integrated Mental Health Commissioning Group
- CCG Quality and Safety Committees
- Nottinghamshire Healthcare NHS Trust (local Mental Health Trust) conducts a monthly suicide prevention audit. This audit is part of the "Monthly Audit Tool" taking place across all Adult Inpatient Services. Each month all in patient areas undertake a self-audit on their records. Part of the audit considers a series of standards based on the National Audit for Suicide Prevention: Ward Audit.
- In 2015 Nottinghamshire Health NHS Trust produced a 3 – year 'Signup to Safety Plan'. The plan aims to ensure processes are in place so that the target of no incidents of suicide (or suspected suicide) among people with recent clinical contact and a 50% reduction in overall severity of self-harm incidents by 2018 is reached.
- Substance misuse services have governance and quality procedures in place to review all cases of patient/service users suicides and make recommendations on actions to prevent any further suicide deaths.
- The Nottinghamshire Suicide Prevention Steering group meet quarterly and review progress against the suicide prevention action plan.

9. Funding

- CCGs have funded suicide prevention. Public health and CCGs together have invested in mental resilience programmes in schools to prevent and improve children and young people's mental health problems. Additionally CCGs have invested in the CAMHS Crisis Resolution and Home Treatment Service.
- The provision of government funding to the NHS for suicide prevention that is guaranteed for 2018/19-2020/21 is still to be allocated.
- The Council invested £92K of the public health ring-fenced grant to fund Suicide Prevention awareness and training between October 2015 to March 2017. The expiration of this contract and lack of funding leaves a significant gap in the training of frontline health, social care and emergency services in early identification and support for people at high risk of suicide and in the management of mental health crisis.
- On the 11th of December 2017, the ASCH and PP Committee agreed £50k from the Public Health grant to be allocated to Mental Health and Suicide Prevention awareness and training.

Statutory and Policy Implications

10. This report has been compiled after consideration of implications in respect of crime and disorder, data protection and information governance, finance, human resources, human rights, the NHS Constitution (public health services), the public sector equality duty, safeguarding of children and adults at risk, service users, smarter working, sustainability and the environment and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications
11. No financial implications

RECOMMENDATION/S

1) That members to comment on the information provided and to consider whether there are any actions they require in relation to the issues contained in the report.

Barbara Brady
Director of Public Health

For any enquiries about this report please contact:
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Constitutional Comments (LMC 14.12.2017)

12. The Health Scrutiny Committee is the appropriate body to consider the contents of the report and for members to consider whether there are any actions they require in relation to the issues contained within the report.
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Financial Comments (DG 13.12.2017)

13. The financial implications are contained within paragraph 11 of this report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

- 'None' or start list here

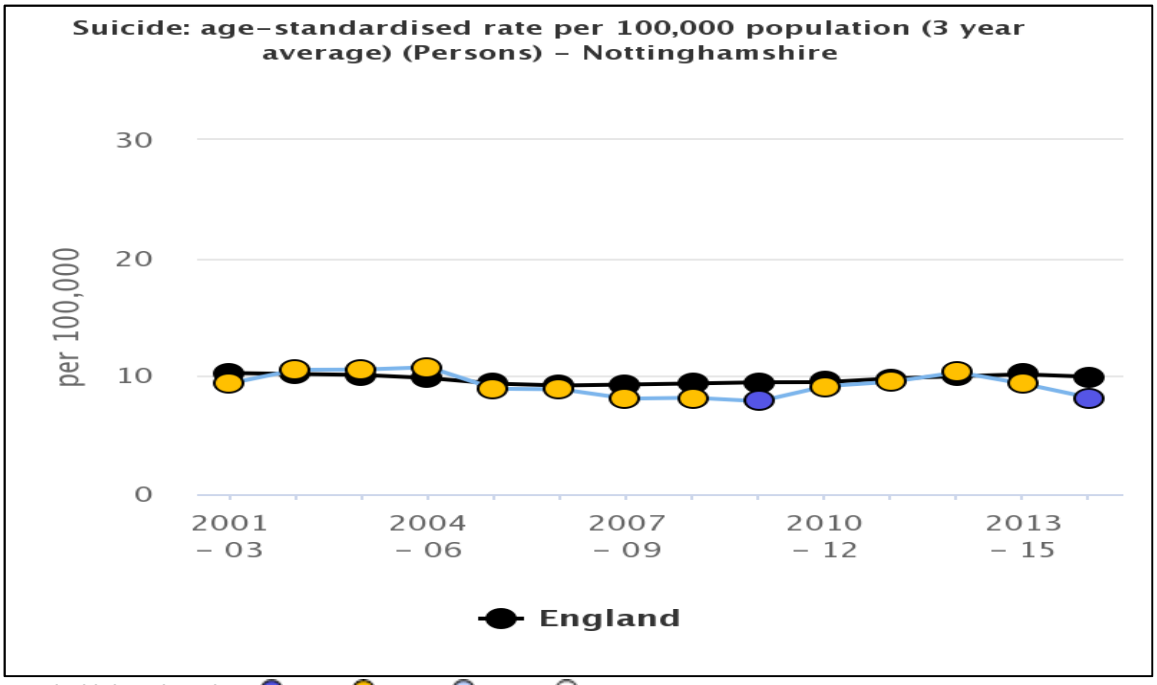
Electoral Division(s) and Member(s) Affected

- ’All’ or start list here

Appendix 1: Nottinghamshire Suicide Prevalence Rate and Risk Factors

Figure 1 below illustrates that since 2001, Nottinghamshire rate of suicide deaths are similar to national average. With the exception in 2009/11 and 2014/16, Nottinghamshire was lower than the national average.

Figure 1:



Compared with benchmark Lower Similar Higher Not Compared

In 2014/16, there was 176 suicide deaths which equates to approximately 59 deaths per year during that period (see Table 1)

Table 1: Suicide: age-standardised rate per 100,000 population and number (3-year average) (Persons) - Nottinghamshire

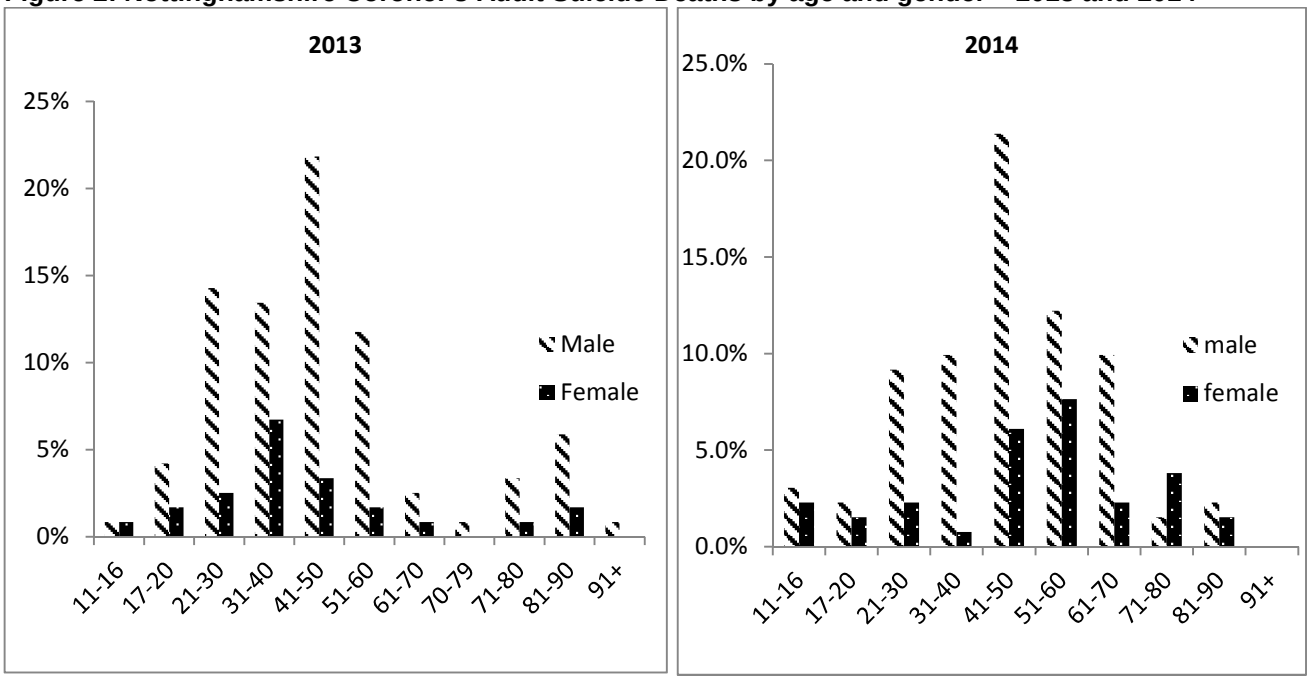
Period		Count	Standardised rate per 100,000 population	East Midlands	England
2001 - 03		184	9.4	10.2	10.3
2002 - 04		206	10.5	10.1	10.2
2003 - 05		209	10.6	10.0	10.1
2004 - 06		218	10.8	9.7	9.8
2005 - 07		184	8.9	9.2	9.4
2006 - 08		183	8.9	8.9	9.2
2007 - 09		166	8.1	8.9	9.3
2008 - 10		169	8.2	8.7	9.4
2009 - 11		164	7.9	8.9	9.5
2010 - 12		191	9.1	8.9	9.5
2011 - 13		200	9.5	9.4	9.8
2012 - 14		219	10.3	9.8	10.0
2013 - 15		200	9.3	9.9	10.1
2014 - 16		176	8.2	9.5	9.9

Source: Public Health England (based on ONS source data)

Nottinghamshire Coroner's Suicide Audit results

In 2015, Public Health undertook a Nottinghamshire Coroners Suicide Audit to review all Nottinghamshire suicide deaths in 2013 and 2014. As shown in figure 2 the majority of suicides deaths were in men aged 49 years and younger, which is similar nationally, whereby three in four deaths by suicide are by men.

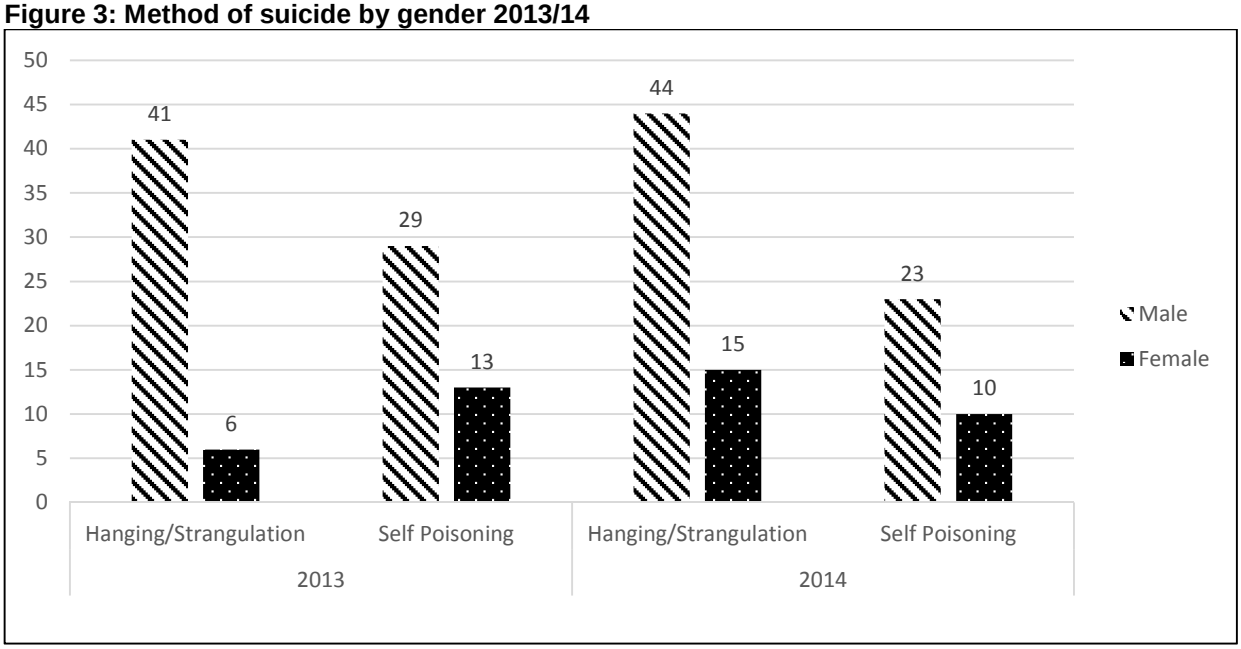
Figure 2: Nottinghamshire Coroner's Audit Suicide Deaths by age and gender – 2013 and 2014



Source: Nottinghamshire Coroner's Audit

In Nottinghamshire, hanging and strangulation rated as the highest method of suicide of men in 2013/14 and women in 2014 as shown in figure 3.

Figure 3: Method of suicide by gender 2013/14

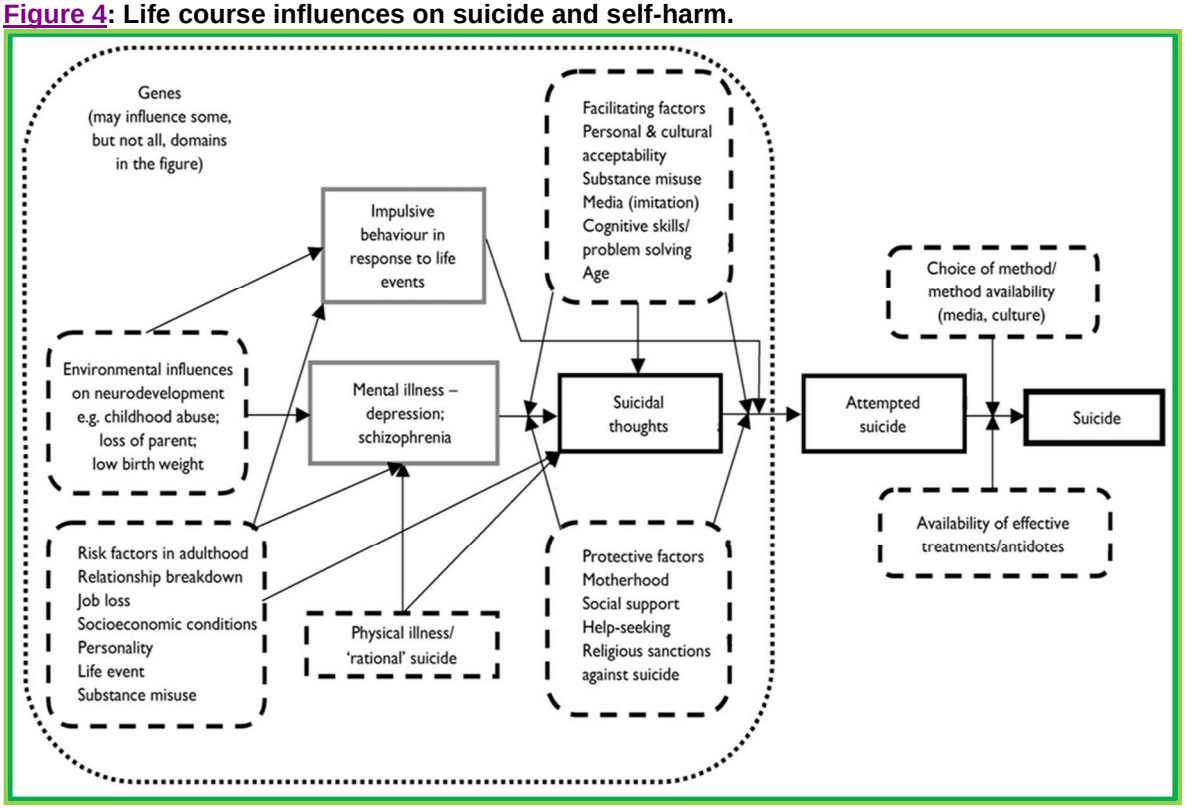


Source: Nottinghamshire Coroner's Audit

Suicide Risk Factors

There are a wide variety of factors that can contribute to suicide and self-harm as shown in **figure 4**, below. These include distal factors (e.g. genetic influences, family history and early trauma) and proximal factors (e.g. psychiatric disorder, physical illness, relationship breakdown and other life events). Changes in socio-economic environment are important, as is exposure to suicidal behaviour by others, including through the media. Availability of suicide methods can contribute to risk, and the danger of the method will partly determine whether an act is fatal or non-fatal.

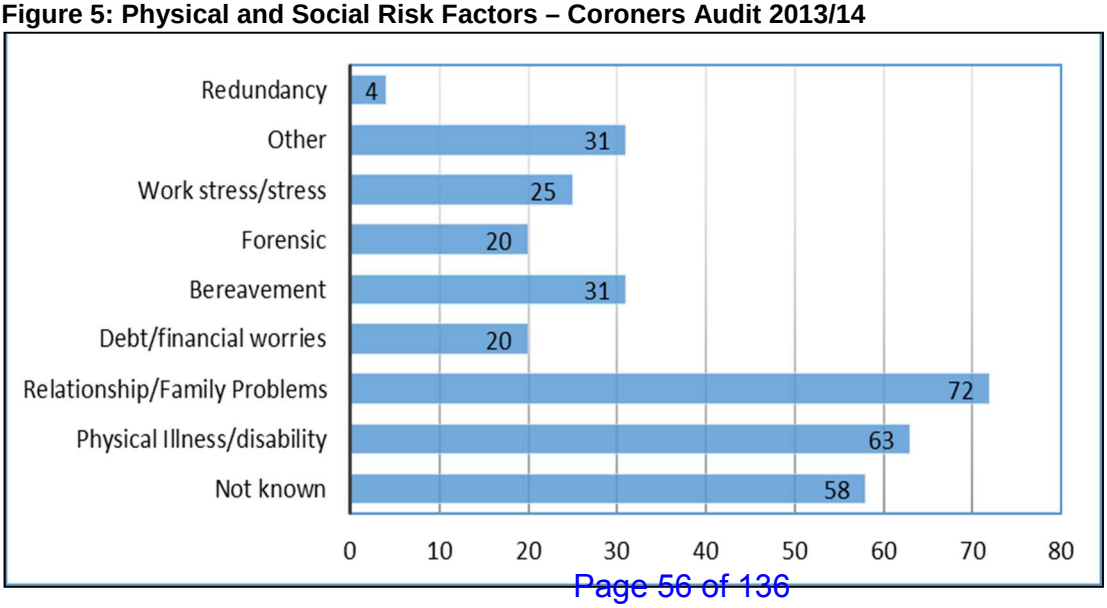
Figure 4: Life course influences on suicide and self-harm.



Source: Gunnell D, Lewis G. Studying suicide from the life course

The 2013/14 Coroners Suicide Audit indicated that relationship/family problems and physical illness/disability rated the highest risk factors for suicide deaths in Nottinghamshire, as shown if figure 5.

Figure 5: Physical and Social Risk Factors – Coroners Audit 2013/14



Nottinghamshire County Council

Nottinghamshire Suicide Prevention Framework for Action

2015-2018

Produced by Nottinghamshire County Public Health, in partnership with Nottinghamshire and Nottingham City Suicide Prevention Steering Group. December 2014.

THIS SUICIDE PREVENTION FRAMEWORK FOR ACTION IS AN UPDATE OF THE NOTTINGHAMSHIRE AND NOTTINGHAM CITY SUICIDE PREVENTION STRATEGY 2009-2012. THIS FRAMEWORK FOR ACTION WAS DEVELOPED IN PARTERSHIP BY THE NOTTINGHAMSHIRE AND NOTTINGHAM CITY SUICIDE PREVENTION STEERING GROUP. CONTRIBUTORS INCLUDE:

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CONTENTS

WELCOME TO THE NOTTINGHAMSHIRE SUICIDE PREVENTION FRAMEWORK FOR ACTION - 2015-2018

FOREWORD

Every suicide is a tragedy that has a far reaching impact on family, friends and the community long after a person has died. This Framework for Action (FfA) sets out our ambition to meet the aims of the national Suicide Prevention strategy.

We know that many people who die by suicide have a history of self-harm, but the relationship between suicides and self-harm are complex. Therefore, we want this FfA to deliver better outcomes to the people of Nottinghamshire who have suicidal thoughts and a history of self-harm who come to services, to their families and carers, or for those not in contact with services. We also need to improve our knowledge of what works in this field to ensure people get the support and help they need early.

We acknowledge that there is a broader focus of activities not directly related to suicide prevention but which, if taken forward effectively, contributes to reducing the overall rate of suicide and self-harm. Activities within this broader focus include building mental resilience and emotional wellbeing and mental health in schools and in the general population; work to reduce discrimination and stigma around mental health problems; the promotion of good early years services; and improved access to early interventions and recovery from mental health problems. All of this work is undertaken in a context of being vigilant about improving mental wellbeing, about supporting people who experience mental illness and about preventing suicide and self-harm.

We would like to take this opportunity to thank all of the organisations that have contributed to the development of this FfA. Our partnership approach will help us to drive forward improvements in preventing suicide and self-harm.

Councillor Joyce Bosnjak
Chair of the Nottinghamshire Health and Wellbeing Board

FOREWORD

Suicide is a major issue for society and a leading cause of years of life lost**.** Important factors are linked to suicide and self-harm such as mental ill-health, significant adverse life events and access to means.

Although the average rate of suicide in Nottinghamshire is not high in comparison with other areas, suicide is often preventable and is most effective when it is addressed across the life course. This means we will focus on the needs of children and young people, adults and older people in Nottinghamshire, and particularly those who are most at risk of suicide and self-harm.

This FfA outlines the ways in which Nottinghamshire County Public Health will work with our local health, social care commissioners and providers, Police and the Criminal Justice System, emergency services, transport and the voluntary sector alongside community partners towards a reduction in suicides and self- harm amongst our populations.

Dr Chris Kenny – Public Health
Director of Nottinghamshire County and Nottingham City Public Health

Advice when reading this document:

If by reading and reviewing this FfA you become concerned about your own or someone else's suicidal and self-harm thoughts or behaviour we advise that you speak to a trained health care professional by either:

- ***Making an appoint with your GP***
- ***Telephoning the Samaritans on 08457 90 90 90***
- ***Cruse Bereavement Care on 0844 477 9400***

1.0: EXECUTIVE SUMMARY

In England, approximately one person dies every two hours as a result of suicide[1]. Suicide is a major issue for society and a serious but often preventable public health problem. Suicide can have lasting harmful impact- economically, psychologically and spiritually on individuals, families, and communities. While its causes are complex and no strategy can be expected to completely remove the tragedy of suicide, there is much that can be done to ensure that we reduce the likelihood of suicide and to ensure support is available for those at their most vulnerable.

There has been a slight increase in the Nottinghamshire average rate of death by suicide or injury of undetermined intention. For the period 2008-10 Nottinghamshire rate of 6.9 per 100,000 population increased to 8.2 per 100,000 population in 2010-12, which is slightly below the England average of 8.5 per 100,000 population.

Nationally more men die of suicide than women, the ratio of male to female suicide deaths is 3:1. For Nottinghamshire the gender split in the suicide rate is in line with national suicide rates with men accounting for around three quarters of suicides.

There is a socio-economic gradient in suicide risk. Those in the poorest socio-economic group are 10 times more at risk of suicide than those in the most affluent group living in the most affluent areas. Nottinghamshire has a similar pattern, although due to small numbers we need to be cautious in interpretation of our local data. In Nottinghamshire, for the period 2008-10 the highest rate of suicide occurred in the 35-64 age group, which is similar to the picture nationally. However, Nottinghamshire has a higher than the national rate in those aged 75 or over. These differences are not statistically significant due to the small numbers.

Suicide prevention goes hand in hand with addressing self- harm. People who self-harm are at increased risk of suicide. UK studies have estimated that in the year after an act of deliberate self-harm the risk of suicide is 30–50 times higher than in the general population. Non-fatal self-harm leading to hospital attendance is the strongest risk factor for completed suicide[2]. Self-harm is one of the top five causes of acute medical admission and those who self-harm have a 1 in 6 chance of repeat attendance at A&E within the year[3].

Nationally, the rates of self-harm are highest in girls and women with the highest incidence being among 15-19 year olds. In men, the highest rates are in 20-29 year olds.

For the period 2010-13, the Nottinghamshire rate of hospital admissions caused by unintentional and deliberate injuries in children (aged 0 -14years) was 85.2 per 100,000 population. For the age range of 15-24, the rate was 120.4 per 100,000 per population. Both rates are better than the national averages of 103.8 per 100,000 and 130.7 per 100,000 population, respectively.

This FfA outlines the ways in which Nottinghamshire County Public Health and local partners aim to work towards a reduction in suicides and self- harm amongst the

population of Nottinghamshire in line with the national suicide prevention strategy for England (2012)[1] and the national mental health strategy – No health without mental health (2011)[4].

Overall aim of this framework for action:

- ***To reduce the rate of suicide and self-harm in the Nottinghamshire population***

The following priorities have been identified as the local key areas for action in Nottinghamshire:

Priority 1: ***Identify early those groups at high risk of suicide and self-harm*** and support effective interventions

Priority 2: Review of ***timely suicide and self-harm data and be informed by national and local evidence based research and practice*** in order to better understand the local needs

Priority 3: Access effective support for those ***bereaved or affected by suicide***

Priority 4: ***Engage with media personnel*** to agree on sensitive approaches to reporting suicide and suicidal behaviour

Priority 5: Improve the understanding and care for people at risk of suicide and self-harm through ***training of frontline staff*** to deal with those at risk of suicide and self-harm behaviour

This FfA is aligned and supports the delivery of a number of other Health and Wellbeing local strategies, including:

- No health without mental health, Nottinghamshire's Mental Health Framework for Action 2014-17[5]
- Nottinghamshire Children and Young People (CYP) Mental Health and Emotional Wellbeing Strategy 2014-16.

All of the above strategies place an emphasis on evidenced-based research and practice in prevention, early identification and intervention to ensure that people of all ages have the opportunity to enjoy good mental health and wellbeing.

Prevention of suicide calls for working across sectors at local and national level. There is need to tackle all the factors which may increase the risk of suicide and self-harm in the communities where they occur if our efforts are to be effective. Suicide prevention is most effective when it is addressed across the life course and when combined with wider prevention strategies that address improving the mental health and wellbeing of the population and the wider determinants that impact on health, such as: employment, low income and housing.

2.0: INTRODUCTION

"On average, one person dies every two hours in England as a result of suicide. When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing the support and care will feel the impact."[1]

Suicide is a major issue for society. The number of people who take their own lives in England has reduced in recent years. However, in 2010 there were over 4,200 reported deaths from suicide. The impact of every suicide can be devastating – economically, psychologically and spiritually – for all affected[1.] The cost of a completed suicide for someone of working age in the UK exceeds £1.6 million[6]. Suicidal thoughts at some point in a person's life are relatively common: in 2007 16.7% had thought about suicide, 5.6% reported attempting suicide and 4.9% had harmed themselves without suicidal intent[7].

Preventing suicide is acknowledged to be a complex challenge. This FfA is intended to outline the local approach to suicide prevention and it recognises the contributions that can be made across all sectors of society. The FfA draws on local experience and expertise and national research evidence and guidance.

In 2002, the government made suicide prevention a health priority and set a target to reduce the death rate from suicide and injury (and poisoning) of undetermined intent by 20% by the year 2010[8]. The new national strategy, launched in 2012[1] emphasises local action and supports this by bringing together knowledge about groups at higher risk of suicide, identifying evidence of effective interventions and highlighting available resources.

In 2009, Nottinghamshire County, Bassetlaw and Nottingham City Primary Care Trusts (PCT) produced a joint suicide prevention strategy for the period 2009-2012[9]. This placed emphasis on achieving the Our Healthier Nation target of reducing suicide by one fifth by 2010[10]. This 2015-2018 FfA provides an update on the continuous prevention work which has been carried out in Nottinghamshire since 2009 and reflects the new national and local priorities and guidance.

This FfA includes five priority areas for action to reduce the incidence of suicide. The Nottinghamshire and Nottingham City Suicide Prevention Steering Group, oversees the implementation of the associated action plan. This multi-agency steering group includes representation from Nottinghamshire County and Nottingham City Public Health, Clinical Commissioning Groups (CCGs), Children and Adult Mental Health Services, Health and Social Care, HM Coroner's Service, Police, Fire and Ambulance, Network Rail and Third Sector organisations with a remit in suicide prevention. Progress against its objectives is presented annually to Nottinghamshire Health and Well-being Board.

This FfA applies to all ages from children to older people, with or without mental health problems.

The most recent published data and information used to inform this FfA is taken from the official statistical body, the Office of National Statistics (ONS) suicide data up to the 2012[11]. This data has been analysed according to the calendar year in which the death was registered (as opposed to when it occurred) which follows the coroner's inquest

verdict. Therefore, there will be a delay between the death occurring and being registered. Analysis is also based on the postcode of usual residence of the deceased (rather than where the death occurred).

Suicide rates have been age and sex-standardised unless otherwise stated to allow comparisons over time and between localities which may differ in the size and age structure of the population.

In the UK, a coroner is able to give a conclusion of suicide for those as young as 10 years. However, rates per 100,000 are provided by the ONS for only ages 15 years and over when the suicide bulletin is released. This is due to the known subjectivity between coroners with regards to classifying children's deaths as suicide, and because the number in those under 15 tends to be low and their inclusion may not give a true picture of the rates.

3.0: CONTEXT

3.1 National drivers

This FfA responds to the national suicide prevention strategy, **Preventing suicide in England: A cross-government outcomes strategy to save lives, HM Government 2012**[1].

The national strategy is an all-age suicide prevention strategy which builds on the national Suicide Prevention Strategy (2002)[8]. The strategy supports actions by bringing together knowledge about groups at higher risk of suicide, applying evidence of effective interventions and highlighting resources available. The national suicide prevention key objectives and action areas aim to define what the strategy as a whole is intended to achieve. The objectives and actions are outlined in Box 1 overleaf:

Box 1: National suicide prevention strategy key objectives and areas for action

Key Objectives

- ***Reduce the suicide rate*** in the general population of England
- Offer better ***support for those bereaved*** or those affected by suicide

Six key areas for action

In order to support the Suicide Prevention strategic objectives, six key areas for action have been identified ***(Appendix A: Preventing suicide in England)*** and includes;

Action area 1- Reduce the risk of suicide in key high-risk groups.
Action area 2 - Tailor approaches to improve mental health in specific groups**.**
Action area 3 - Reduce access to the means of suicide.
Action area 4 - Provide better information and support to those bereaved or affected by suicide.
Action area 5 - Support the media in delivering sensitive approaches to suicide and suicidal behaviour.
Action area 6 - Support research, data collection and monitoring

The **Preventing Suicide in England – One year on (2014)**[11] report, published by the Department of Health sets out the developments since the launch of the national 'Prevention suicide in England (2012) strategy' and highlighted the areas where things need to be done in 2014. The messages in this report are designed to help local areas focus on the most effective things that they can do to reduce suicide.

The **Public Health Outcomes Framework: Improving outcomes and supporting transparency, 2012**[12] sets out the overarching vision for public health. This strategy set out the outcomes to be achieved. The indicator in relation to suicide prevention is to reduce the numbers of people living with preventable ill health and people dying prematurely.

No health without mental health: A cross-government outcomes strategy for people of all ages (2011)[4] is key in supporting reductions in suicide amongst the general population as well as those under the care of mental health services. The first agreed objective of *No health without mental health* aims to ensure that more people will have good mental health.

Healthy Lives, Healthy People: Our strategy for public health in England (2011)[10] gives a new, enhanced role to local government and local partnerships in delivering improved public health outcomes. This document outlines that the local responsibility for coordinating and implementing strategic direction for suicide prevention from April, became an integral part of local authorities' new responsibilities for leading on local public health and health improvement. The prompts for local councillors on suicide prevention published alongside this FfA are designed as helpful pointers for how local work on suicide prevention can be taken forward**.**

National Institute for Health and Care Excellence (NICE) guidelines: Self-harm: short-term management, Self-harm: longer-term management and evidence

updates[13] - These are evidence-based clinical guidelines for professionals involved in the management of people who self-harm.

The Nation Confidential Inquiry into suicide and homicide by people with mental illness: Annual report for England, Northern Ireland, Scotland and Wales, University of Manchester 2014[14] report covers deaths by suicide for the period January 2001 to December 2012. Information on all general population suicides (i.e. deaths by intentional self-harm and deaths from undetermined intent) by individuals aged 10 and over is collected from the Office for National Statistics (ONS)[15]. Comparisons are made against identified as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. The report gives recommendations for mental health services to undertake in order to prevent suicide.

Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis[16] was published by the government in February 2014. The concordat outlines a vision for health, social care and emergency services work together to deliver a high quality response when people of all ages with mental health problems including suicidal behavior, urgently need help.

Annual Report of the Chief Medical Officer 2013 Public Mental Health Priorities: Investing in the Evidence[6] was published in September 2014. **T**his report includes a focus on the epidemiology of public mental health and the quality of the evidence base, 'horizon scanning' of innovation in science and technology, the economic case for good mental health and chapters outlining the importance of both treating mental health as equal to physical health and of focusing on the needs and safety of people with mental illness. The chapters also include authors' suggestions for improvement.

The report, **Why children die: death in infants, children, and young people in the UK**[17] was published in May 2014 by the Royal College of Paediatrics and Child Health, National Children's Bureau and the British Association for Child and Adolescent Public Health recommends national analysis to be completed on young people's suicides and a concerted and sustained policy response is need "to the problem of violence and self-harm among Britain's young people is needed urgently to address the lack of progress in reducing deaths and injuries from these causes."

3.2 Local drivers

The priorities within this FfA capture local concerns and link with other local strategies listed in box 2 below:

Box 2: Nottinghamshire Health and Wellbeing Mental Health strategies

- No health without mental health, Nottinghamshire's Mental Health Framework for Action 2014-2017[5]
- Nottinghamshire Children and Young People (CYP) Mental Health and Emotional Wellbeing Strategy 2014-16.

The above strategies place an emphasis on research and evidenced-based practice in prevention, early identification and intervention to ensure that people of all ages have the opportunity to enjoy good mental health and wellbeing.

All local strategies and plans linked to this FfA are detailed in Appendix B

4.0: OVERVIEW OF OUR AIMS AND PRIORTIES FOR THIS FRAMEWORK FOR ACTION

Suicide prevention is not the sole responsibility of any one sector of society, or of health services alone. Therefore, prevention largely necessitates a general population approach rather than service-related initiatives. For example, restriction of access to means for suicide, population approaches to prevention of depression, improved detection and management of psychiatric disorders in primary care, and voluntary agency and internet-based support[6].

The greatest impact is likely to result from a combination of preventative strategies directed at potential suicide determinants, which include;

- The factors which increase the risk of suicidal behaviour in a population; for example, availability of means, knowledge and attitudes concerning the prevalence, nature and treatability of mental disorders, and media portrayal of suicidal behaviour

- Recognised high risk groups - e.g. people with recurrent depressive disorders, previous suicide attempts, people who misuse alcohol, the unemployed, people with certain co-morbid mental and personality disorders [18] and people recently discharged from psychiatric in-patient care

Since the 2002 National Suicide Prevention Strategy[8] the emphasis has shifted from focusing on achieving suicide prevention through a reduction in suicide target, to that of viewing this target as

'…. a guiding beacon that can lead to the problem of suicidal behaviour being taken more seriously and galvanise more active planning of national policy to improve mental health and mental health care.'[19]

This suicide prevention FfA aims to reduce the suicide and self-harm rate in Nottinghamshire County. This FfA has been developed in line with the national Suicide Prevention Strategy for England (2012)[1] and builds on existing local work.

The overall strategic aim of this FfA is:

- ***To reduce the rate of suicide and self-harm in the Nottinghamshire population***

In order to reduce the local suicide and self-harm rate the suicide prevention FfA priorities are outlined in Box 3 below.

As well as targeting high-risk groups, another way to reduce suicide and self-harm is to improve the mental health of the population as a whole. Therefore, this FfA takes a life course approach which recognises that mental health problems often start in childhood, and that opportunities to promote and protect good mental health arise form pre conception through to old age.

Box 3: Nottinghamshire suicide and self-harm prevention framework for action priorities

Priority 1: ***Identify early those groups at high risk of suicide and self-harm*** and support effective interventions

Priority 2: Review of ***timely suicide and self-harm data and be informed by national and local evidence based research and practice*** in order to better understand the local needs

Priority 3: Access effective support for those ***bereaved or affected by suicide***

Priority 4: ***Engage with media personnel*** to agree on sensitive approaches to reporting suicide and suicidal behaviour

Priority 5: Improve the understanding and care for people at risk of suicide and self-harm through ***training of frontline staff*** to deal with at risk of suicide and self-harm behaviour

5.0: SUICIDE AND SELF-HARM DEFINED

5.1 What is suicide?

Suicide is defined by the Oxford Dictionary of Law as *'the act of killing oneself intentionally.'*[20] For a Coroner to reach a conclusion of suicide this would need to be proved beyond reasonable doubt.

There are difficulties in determining the exact intent of a person who dies thus measuring or estimating the true level of suicide can be complex. However, for the purpose of this FfA the 'suicide rate', will include deaths recorded as follows;

'..as deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent'[11]

In England and Wales, it has been customary to assume that most injuries and poisonings of undetermined intent are cases where the harm was self-inflicted but there was insufficient evidence to prove that the deceased deliberately intended to kill themselves.

Throughout this FfA suicide cases will be those cases where the Coroner has given a conclusion of suicide or where the injury was of undetermined intent and an open verdict has been given[6].

However, it should be noted that over the past decade, coroners have increasingly returned narrative verdicts. These record the circumstances of a death rather than providing a 'short form' verdict such as suicide, accident, or natural causes. Prior to 2011, some narrative verdicts were coded as accidental deaths where intent was not specified which may have led to an underestimation of suicide. However, in 2011 guidance was issued to coroners in England and Wales when returning narrative verdicts to provide clearer information on the intent of the deceased. This has led to improvements to the coding of narrative verdicts by the ONS coding team, and some cases which would previously be coded as accidental may now be coded as possible suicide. The impact of these changes, therefore, will potentially increase the number of estimated suicides in 2011, although the anticipated increase is likely to be small[15].

5.2 What is self-harm?

Self-harm is:

'.. self-poisoning or self-injury, irrespective of the apparent purpose of the act'.[11]

The self-harm focuses on those acts of self-harm that are an expression of personal distress and where the person directly intends to injure him/herself. It is important also to acknowledge that for some people, especially those who have been abused as children, acts of self-harm occur seemingly out of the person's control or even awareness, during 'trance-like', or dissociative, states. It therefore uses the term 'self-harm' rather than 'deliberate self-harm'[4].

6.0: WHY IS REDUCING THE RATE OF SUICIDE A PRIORITY?

6.1 National suicide rates and current trends

The report by the Department of Health (DH) Preventing Suicide in England - one year (2014)[11] outlines that;

- There were 4,524 suicides recorded in 2012, similar to the 2011 figure of 4,518. In the past decade, the national overall trend has seen a decrease in the suicide rate but with a small rise in the last 4 years.
- Suicide continues to be more than three times as common in males (12.4 per 100,000 for males in 2010-12, compared to 3.7 for females)
- The numbers and rates of suicide and undetermined deaths vary between age groups, with rates among males highest for those aged 35-54 years and among females, highest for those aged 40-59 years
- Suicide is rare under the age of 15 years, and its incidence in 15-19 year olds is around a quarter of that seen in 40-54-year-olds
- Hanging, strangulation and suffocation accounts for the largest number of suicides in males, (60%). In females hanging and drug related poisoning are the joint most frequent methods, (38%)

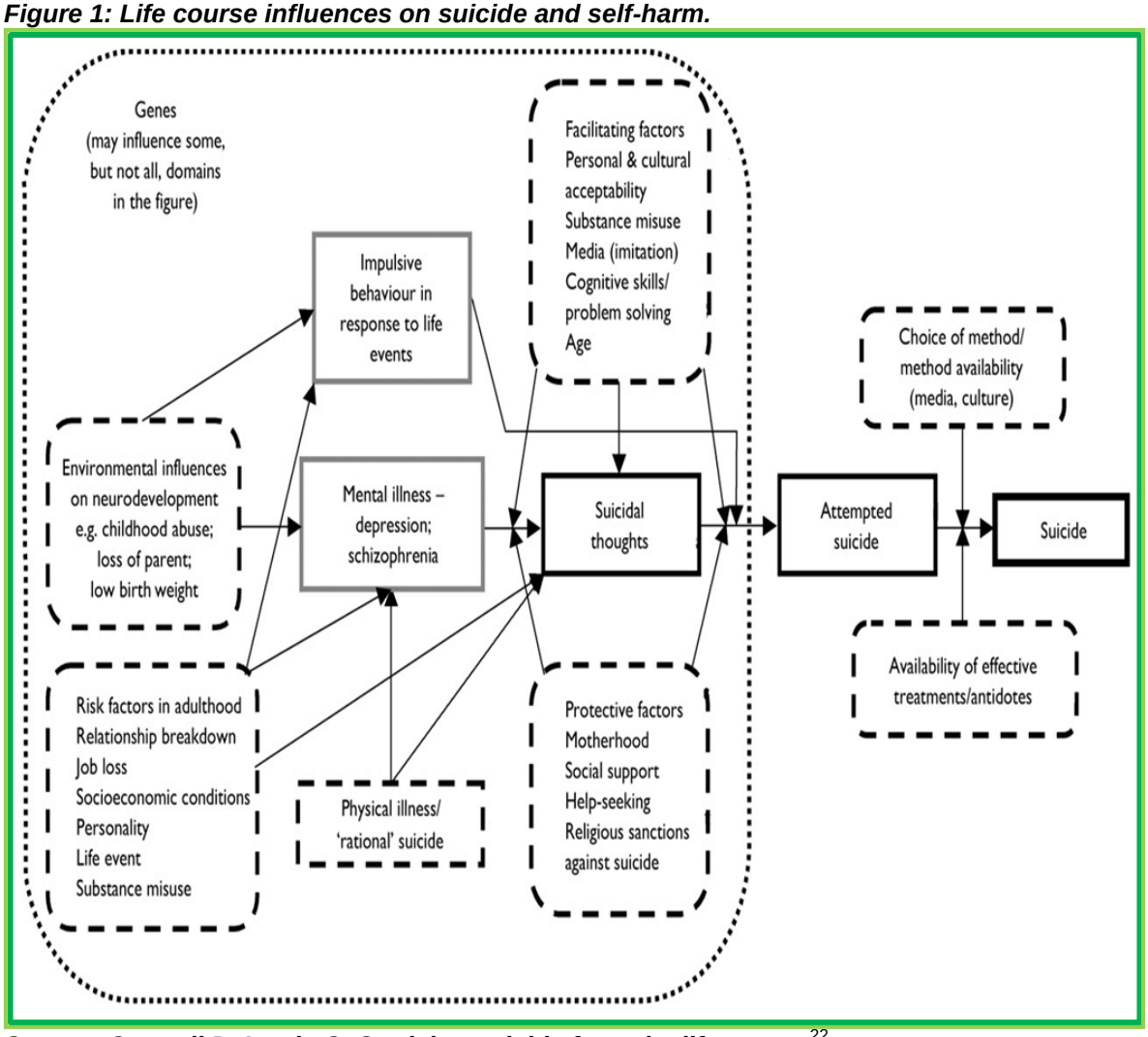
- There was a rapid rise in the number of deaths caused by helium poisoning, almost all of which, are likely suicide related. There were no recorded deaths in 2000 from helium. However since 2007 there has been a steady rise, with 51 deaths in England in 2012

- Suicide rates among older people in the UK are falling[21].

6.2 What are the suicide and self-harm risk factors?

There are a wide variety of factors that can contribute to suicide and self-harm[22,23,24] shown in **figure 1**, below. These include distal factors (e.g. genetic influences, family history and early trauma) and proximal factors (e.g. psychiatric disorder, physical illness, relationship breakdown and other life events). Changes in socio-economic environment are important, as is exposure to suicidal behaviour by others, including through the media. Availability of suicide methods can contribute to risk, and the danger of the method will partly determine whether an act is fatal or non-fatal.

Figure 1: Life course influences on suicide and self-harm.



Source: Gunnell D, Lewis G. Studying suicide from the life course[22]

Some groups of people are known to be at higher risk of suicide than the general population.

The groups at high risk of suicide[1] are;

- Men aged 35-54 years[25]
- People in the care of mental health services, including inpatients
- People with a history of self-harm, untreated, depression, misuse alcohol, are facing economic difficulties, are going through divorce or separation, or have long-term physical illnesses[1]
- People in contact with the criminal justice system (police, probation, the courts and prisons)
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers
- Young women from South Asian, Caribbean and African origin and older South Asian women[26,27]
- Children and Young People who have experience abuse and/or neglect
- Lesbian, Gay, Bisexual or Transgender people
- Older people aged 65+ experiencing social isolation and loneliness[28].

Table 1 below shows the estimated increased risk for the high risk of suicide group to that of the general population. The highest risk of suicide group are patients up to 4 weeks following discharge from a psychiatric hospital with an estimated increased risk of x110-200**.**

Table 1: Increased risk for groups at higher risk compared to the general population

High risk group	Estimated increased risk
Males compared to females	x 2-3
Current or ex-psychiatric patients	x 10
4 weeks following discharge from inpatient psychiatric hospital	x 100-200
First year after self-harm[29,30]	x 60-100
Alcohol misuse and dependency	x 5-20
Drug misusers	x 10-20
Family history of suicide	x 3-4
Serious physical illness/disability	Not known/under review [31]
Prisoners	x 9-10
Offenders serving non-custodial sentences	x 8-13
Doctors	x 2
Farmers	x 2
Unemployed people	x 2-3
Divorced people	x 2-5
People on low incomes (social class IV/V)	x 4

Source: Adapted from information on Mental Health Specialist Library website at www.library.nhs.uk/mentalhealth

6.3 Factors associated with suicide and self-harm

Suicide and self-harm is often precipitated by recent adverse events across the life course. These include relationship breakdowns, conflicts, legal problems, financial

concerns, interpersonal losses, traumatic events. There is also research into the links between suicide and terminal and/or chronic illness.

The following points are also important in terms of suicide prevention[18]. These are shown in Box 4 below.

Box 4: Factors associated with increased risk of suicide

- In up to half of all suicides there have previously been ***failed attempts***[8]
- Only a quarter of people (nationally) who die by suicide are ***under psychiatric care*** in the year before their death (i.e. 75% are not)[10]
- 5-10% of all suicides happen in the ***four weeks after discharge from psychiatric*** hospital, making this a time of high risk[10]
- Following a suicide attempt or completion, adolescents are at an ***increased risk of copycat suicides***[32]. Reports indicates that youth suicide can increase two to four times more following exposure to another individual's suicide than among older age groups[33]
- ***Repeated exposure to bullying and cyber-bullying*** may precipitate or aggravate depression, anxiety, psychosomatic symptoms, eating difficulties and self-harm, and is associated with suicide[34]. Exposure to bullying is also associated with elevated rates of anxiety, depression and self-harm in adulthood[35,36]
- A number of ***occupational groups*** - doctors, farmers, vets, dentists and pharmacists - are at increased risk of suicide, although deaths in these groups make up only 1-2% of all suicides. One important factor influencing the increased risk in these occupations is their access to lethal means of suicide[1]
- The risk of suicide in men aged 24 years and younger who have ***left the Armed Forces*** is approximately two to three times higher than the risk for the same age groups in the general and serving population[37]
- ***Victims of sexual or domestic violence in adulthood*** is associated with the onset and persistence of depression, anxiety and eating disorders, substance misuse, psychotic disorders and suicide attempts[6]
- ***Several physical disorders*** such as diabetes, epilepsy and asthma are associated with increased risk of self-harm and suicide[38,39]
- The risk of suicide is four times more likely in ***gay and bisexual men***[40] and higher rates of suicidal thoughts and self-harm in ***lesbian and bisexual women*** compared to women in general[41]
- Suicide in ***older people*** is strongly associated with depression[42]
- A follow-up study of patients at a general hospital, reported a 0.7% risk of adults dying by suicide in the year following self-harm, a 1.7% risk within five years and 2.4% at ten years. The ***risk was far higher in men than in women***[43]
- ***More men die from suicide than women***, but suicidal thoughts and self-harm are more common in women[44].

Groups who have more frequent thoughts of suicide are:

- Women
- Those aged 16 to 24
- Those not in a stable relationship
- Those with low levels of social support
- Those who are unemployed[45]

6.4 Mental health services and suicide

The most recent National Confidential Inquiry into Suicide and Homicide annual report (July 2013) shows a rise in overall patient suicide, probably reflecting the rise in suicide in the general population, which has been attributed to current economic difficulties. In-patient suicide continues to fall. There are twice as many suicides under crisis resolution/home treatment compared to in-patients. Opiates are the main substance in self-poisoning[10].

The number of people in contact with mental health services who died from suicide increased slightly from 1,261 in 2001 to an estimate 1,333 in 2011. Part of this increase in the patient suicide in 2011 may reflect the rising numbers of people under mental health care[10].

6.5 Offenders and suicide

People at all stages within the Criminal Justice System (CJS), including people on remand and recently discharged from custody, are at higher risk of suicide. The period of greatest risk is the first week of imprisonment[46].

Reasons for the increased risk include the fact that a high proportion of offenders are young men, who are already a high suicide risk group. However, the increase in suicide risk for women prisoners is greater than for men. An estimated 90% of all prisoners have a diagnosable mental health problem (including personality disorder) and/or substance misuse problem[1].

The patterns for both rates and numbers of self-inflicted deaths in custody closely mirror each other. Prison suicides are no longer falling after a major fall in 2004-08, with about 60 deaths each year, representing a rate of 0.7 per 1,000 individuals in custody. Suicides in women prisoners are now very rare[10].

There was a considerable rise in the number of apparent suicides within two days of release from police custody, with 59 such deaths in 2013, the highest number recorded over the last nine years. Almost two-thirds were known to have mental health concerns, a higher proportion than in 2011-12, and seven had previously been detained under the Mental Health Act[10].

6.6 What are the self-harm risk factors?

Self-harm occurs in all sections of the population but is more common among people who are disadvantaged in socio-economic terms and among those who are single or divorced, live alone, are single parents or have a severe lack of social support[47]. According to NICE[48], risk factors for self-harm include a number of other 'associations' such as: life events; alcohol and drug use; mental disorder; child abuse, domestic violence and being within the criminal justice system. Within this are special groups such as young people. There are others for whom the evidence is not so well collected such as gay men, lesbians and bi-sexual people[49].

6.7 Rates of self-harm

The Department of Health estimates that self-harm represents one of the top five reasons for admissions in Accident and Emergency services[3]. There are around 200,000 episodes of self-harm that present to hospital services each year[50]. However, many people who self-harm do not seek help from health or other services and so are not recorded.

People who self-harm are at increased risk of suicide, although many people do not intend to take their own life when they self-harm[51]. At least half of people who take their own life have a history of self-harm, and one in four have been treated in hospital for self-harm in the preceding year. Suicide risk is particularly increased in those repeating self-harm and in those who have used violent/dangerous methods to self-harm[52].

The rates of self-harm are highest in girls and women with the highest incidence being among 15-19 year olds. A recent child psychiatrists and paediatricians report highlights an alarming rise in self-harm presentations to paediatric departments, particularly among girls, which in some areas exceeds 50%[53]. In men, the highest rates are in 20-29 year olds[54]. However, in a recent study of over 4000 self-harming adults in hospital, 80% had overdosed and around 15% had cut themselves. In the community, it is likely that cutting is a more common way of self-harming than taking an overdose[13].

As the majority of young people who self-harm do not present to statutory services this figure is a possible underestimation of the level of self-harm incidences. Self-harm is often carried out in secret and so will often not come to medical attention.

The Multicentre Study of Self-harm in England studied 1,177 older adults aged 60 years and over who had presented to hospital with self-harm and found that within one-year of their self-harm presentation, 1.5% of older adults had subsequently died by suicide. Their risk of suicide was 67 times greater than older adults in the general population. Men aged 75 years and over had the highest suicide rate. Also examined were older adults who re-presented to hospital with another non-fatal self-harm episode: 12.8% repeated self-harm within one-year. Risk factors for non-fatal repetition included previous self-harm, previous psychiatric treatment and age 60–74 years[55].

6.8 What are the suicide and self-harm protective factors?

There are factors which research suggests protect some people against suicide[9].

These include:

- Stable and supportive family and social networks
- Being open about feelings and able to talk about concerns
- A sense of hope for the future
- Ability to problem-solve and set goals

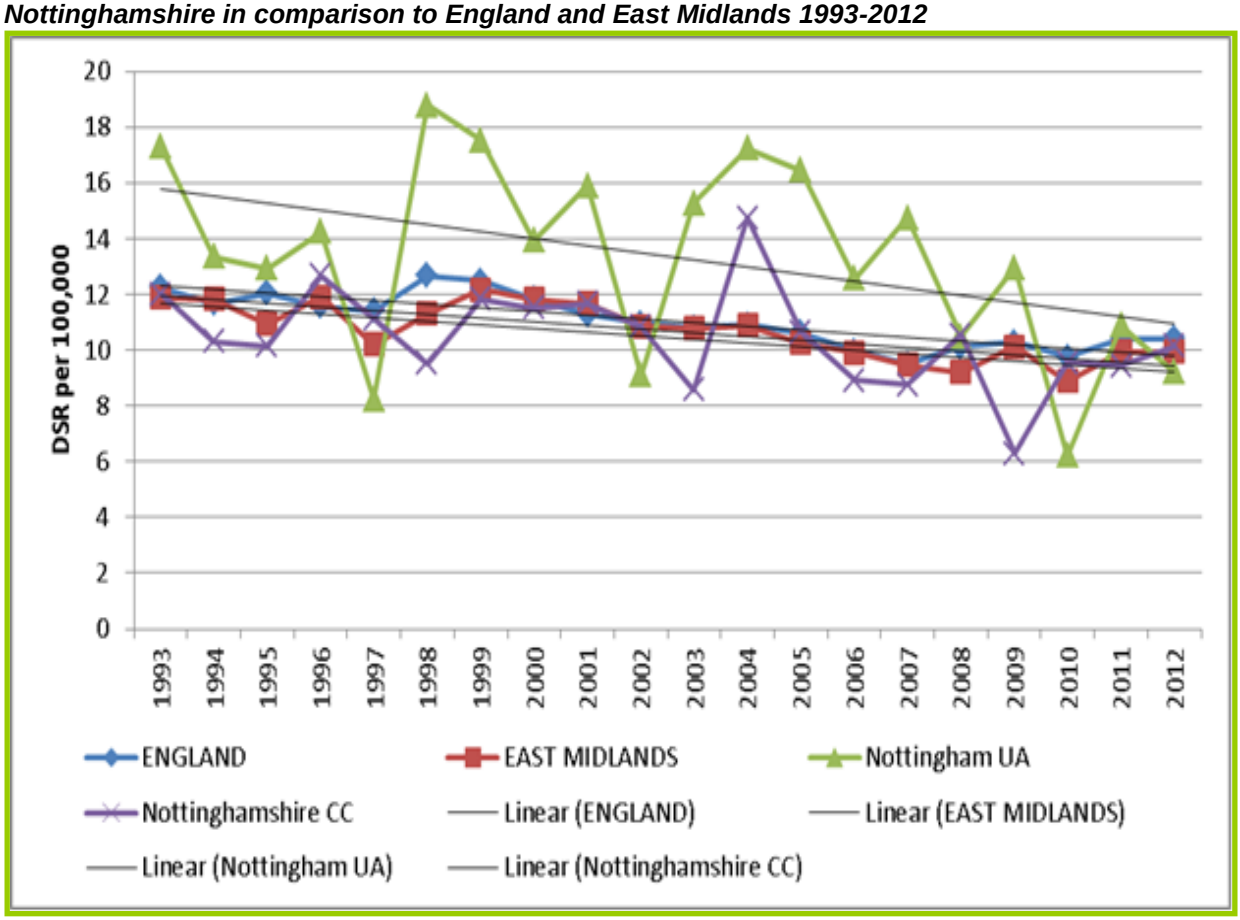
7.0: THE NOTTINGHAMSHIRE LOCAL PICTURE

This section summarises the local rates and trends in the incidence of suicide and undetermined death rate as well as particular risk factors in Nottinghamshire. Some comparisons are made against the national trends.

7.1 National and regional trends

Figure 2 below, illustrates that nationally, suicide and injury undetermined death rates are showing a downward trend. The latest (2012) data shows a reduction of 13.2% (to a rate of 10.4 per 100,000) from the 1993/4/5 baseline. The rate in the East Midlands dropped from a peak of 11.8 per 100,000 in 1999/00/01 to an average lowest rate, 9.6 per 100,000, in 2010/11/12. Nottinghamshire average mortality rate from suicide and injury undetermined death for the period 10/11/12 was slightly below the national average (Nottinghamshire: 8.2; England: 8.5 deaths per 100,000 populations).

Figure 2: Trends in mortality from suicide and injury undetermined death 15+yrs old in Nottinghamshire in comparison to England and East Midlands 1993-2012



Source: Compendium of Clinical and Health Indicators (2014)

Because annual rates for suicide can fluctuate widely from year to year, a three year rolling average is used to provide a more accurate representation of trends. **Table 2** shows these averages from 1993 to 2012. For Nottinghamshire the 1993/4/5 baseline suicide rate was 8.5 per 100,000 population, with lowest rate of 6.9 per 100,000 population in 2008/09/10 and the highest rate of 9.7 per 100,000 population in 2010/11/12.

Table 2: Directly standardised rate per 100,000 and numbers: mortality from suicide and injury undetermined death in Nottinghamshire

Authority area	3-year pooled	1993-1995	1996-1998	1999-2001	2002-2004	2005-2007	2008-2010	2010-2012 *(New definition[11])*
Nottinghamshire	Rate	8.5	8.6	9.1	8.9	7.3	6.9	9.7
	Number	199	205	213	207	184	169	191
Nottingham City	Rate	11.3	10.7	12.3	11.2	11.9	7.8	8.8
	Number	102	89	103	95	92	67	62

Source: Compendium of Clinical and Health Indicators (2014)

7.2 Local trends

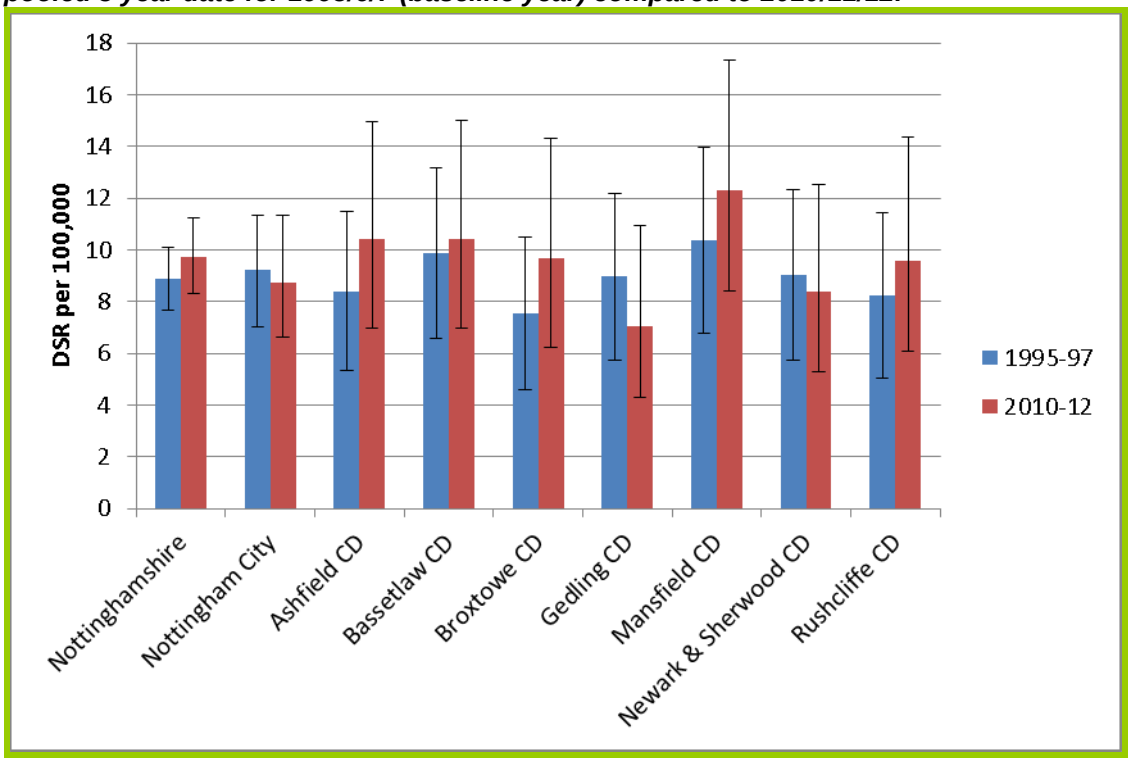
Table 3 and Figure 3 shows a slight increase in the rate of mortality from suicide and injury undetermined for Nottinghamshire County in the period 2010/11/12 compared to the 1995/6/7 baseline rate. However, as the numbers are small statistical significance is not reached.

Table 3: Percentage changed in the Directly Age Standardised Mortality from Suicide and injury undetermined death rate and number – 1995/6/7 and 2010/11/12 for all Nottinghamshire Districts

Local Area and District	1995/6/7 (baseline)		12/11/2010* New Definition		Percentage difference in DSR (baseline to current year)
	DSR per 100,000	Number	DSR per 100,000	Number	
Nottinghamshire	8.87	212	9.72	191	*-9.58%*
Nottingham City	9.21	77	8.76	62	*4.89%*
Ashfield CD	8.41	30	10.44	31	*-24.14%*
Bassetlaw CD	9.87	35	10.43	30	*-5.67%*
Broxtowe CD	7.57	26	9.68	26	*-27.87%*
Gedling CD	8.97	32	7.07	21	*21.18%*
Mansfield CD	10.37	33	12.29	33	*-18.51%*
Newark & Sherwood CD	9.04	30	8.4	26	*7.08%*
Rushcliffe CD	8.22	26	9.6	24	*-16.79%*

Source: Compendium of Clinical and Health Indicators (2014)

Figure 3: Suicide mortality and injury undetermined death rates for districts within Nottinghamshire, pooled 3 year date for 1995/6/7 (baseline year) compared to 2010/11/12.



Source: Compendium of Clinical and Health Indicators (2014)

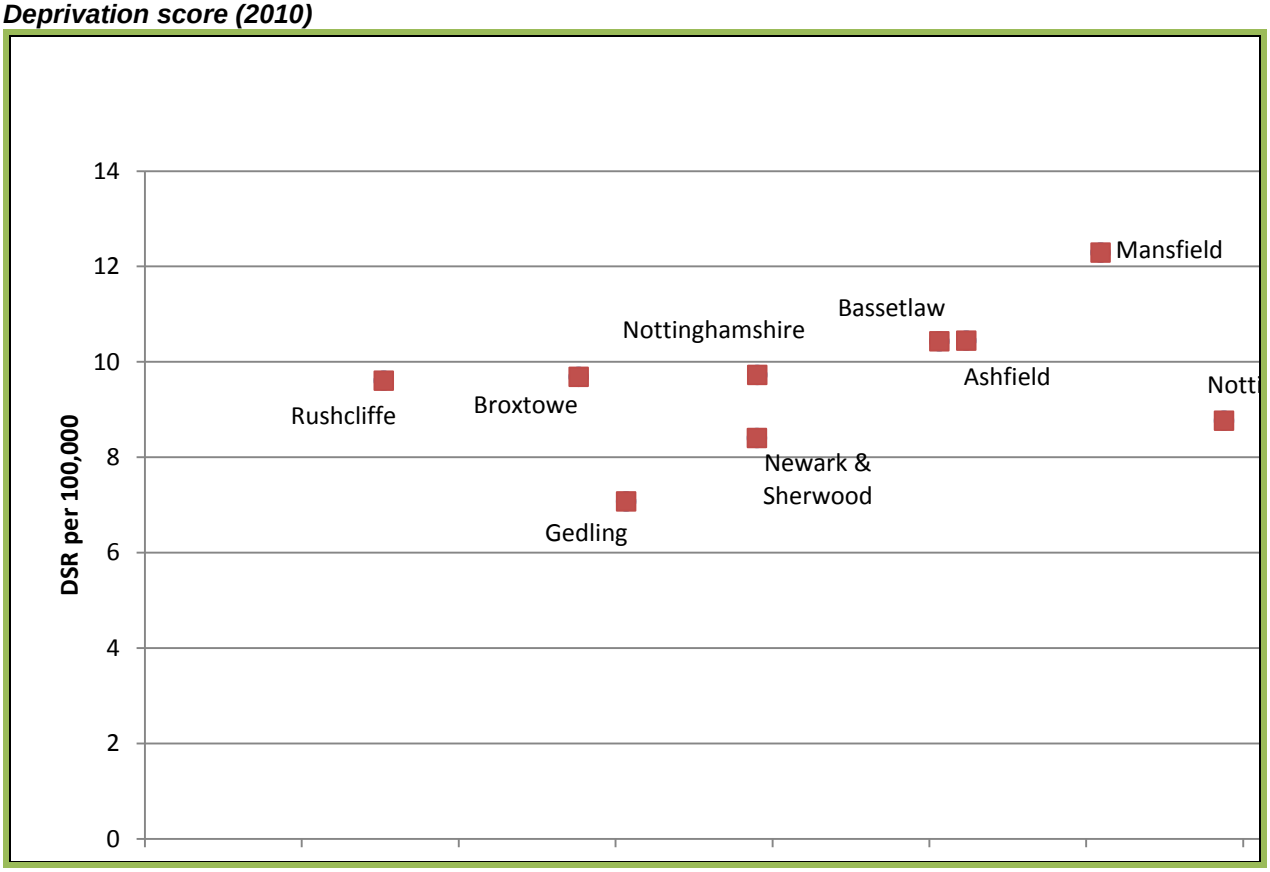
When comparing the number of road fatalities against the rate of suicide and injury undetermined deaths for Nottinghamshire for the period 2010-2012, the number of road fatalities is significantly lower for Nottinghamshire, 91 road fatalities,[33] compared to 191 suicide and injury undetermined deaths.

7.3 Suicide rate and deprivation

The Index of Multiple Deprivation score 2010 (IMD 2010) is a measure of multiple deprivation, at small area level. It is made up of seven domain indices, relating to income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services, living environment deprivation, and crime. The higher the IMD number indicates a higher level of deprivation for that area.

Research suggests that there is a strong relationship between suicide and socio-economic deprivation. **Figure 4** below shows the relationship between deprivation and suicide rate.

Figure 4: District Suicide and injury undetermined mortality rate 2010/11/12 v Indices of Multiple Deprivation score (2010)



Source: Compendium of Clinical and Health Indicators (2014)

7.4 Suicide rate and age and gender

7.4.1 Children and young people

The true number of suicides amongst young people may be understated as it can be much more difficult to reach a conclusion of suicide beyond reasonable doubt.

Local analysis of data from the Child Death Overview Panel on cases of suicide among children 2009-12 has been carried out[54]. Due to the small numbers of cases, the specific findings will not be outlined. Broad findings include:

- Recognition of two main groups of young people taking their own lives are:

  (1) Those with recognised needs and service involvement from CAMHS/other services and
  (2) A group of young people often invisible to services carrying out impulsive acts.

- The vast majority die by asphyxiation (from hanging/ligatures around neck). Overdoses were the cause of death in a minority.

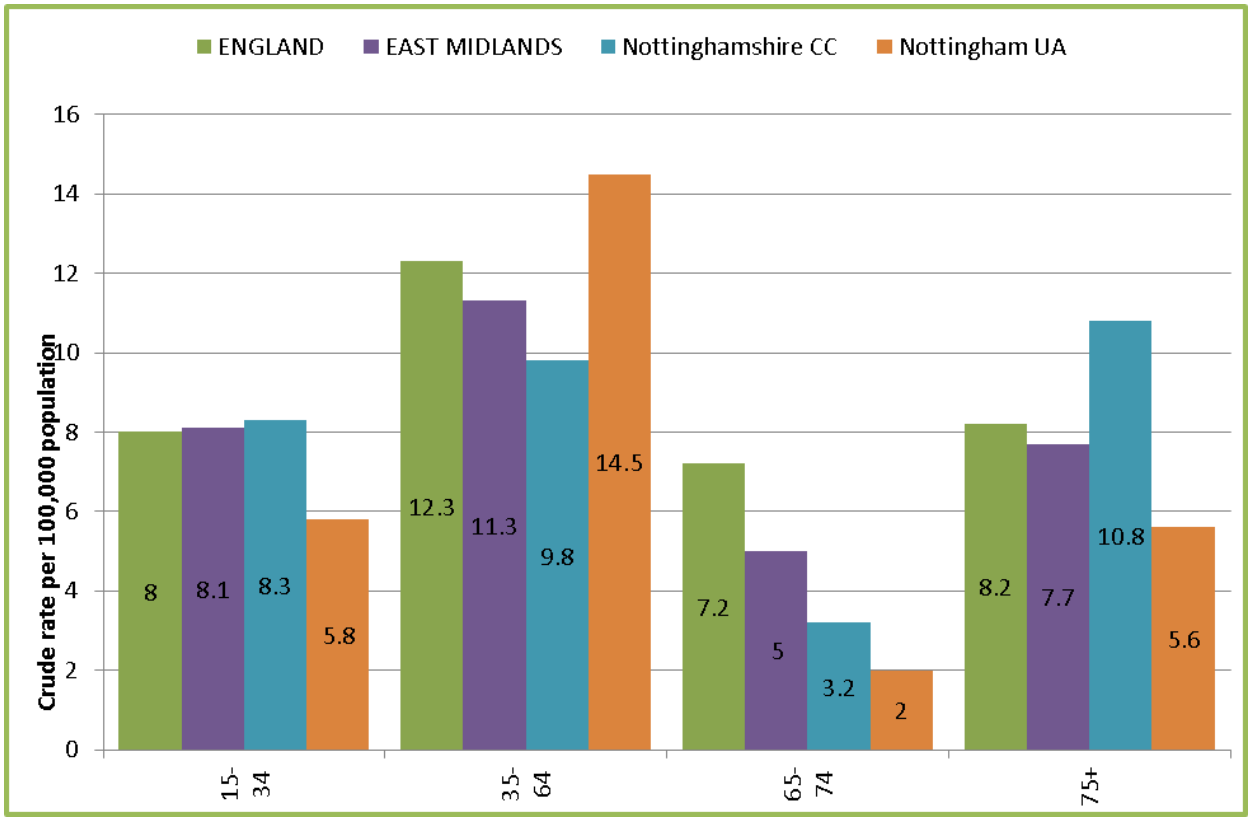
- The presence of parental mental health disorders was highlighted in a large number of cases. Domestic violence was seen in a smaller group of cases.

7.4.2 Adults

Figure 5[*]below shows for the period 2008-10 when compared to the national suicide rate that Nottinghamshire had the highest rate of suicide in the 35-64 age group whilst in the 75+ age group the suicide rate is higher when compared to the national suicide rate. Although none of these differences are statistically significant due to the small numbers.

[*] The 2010/12 suicide and injury undetermined death data by age groups is not available in line with new suicide definition[15]. Therefore, 2008/10 data is used.

Figure 5: Suicides by age bands in Nottinghamshire compared to the East Midlands and England, 2008-10

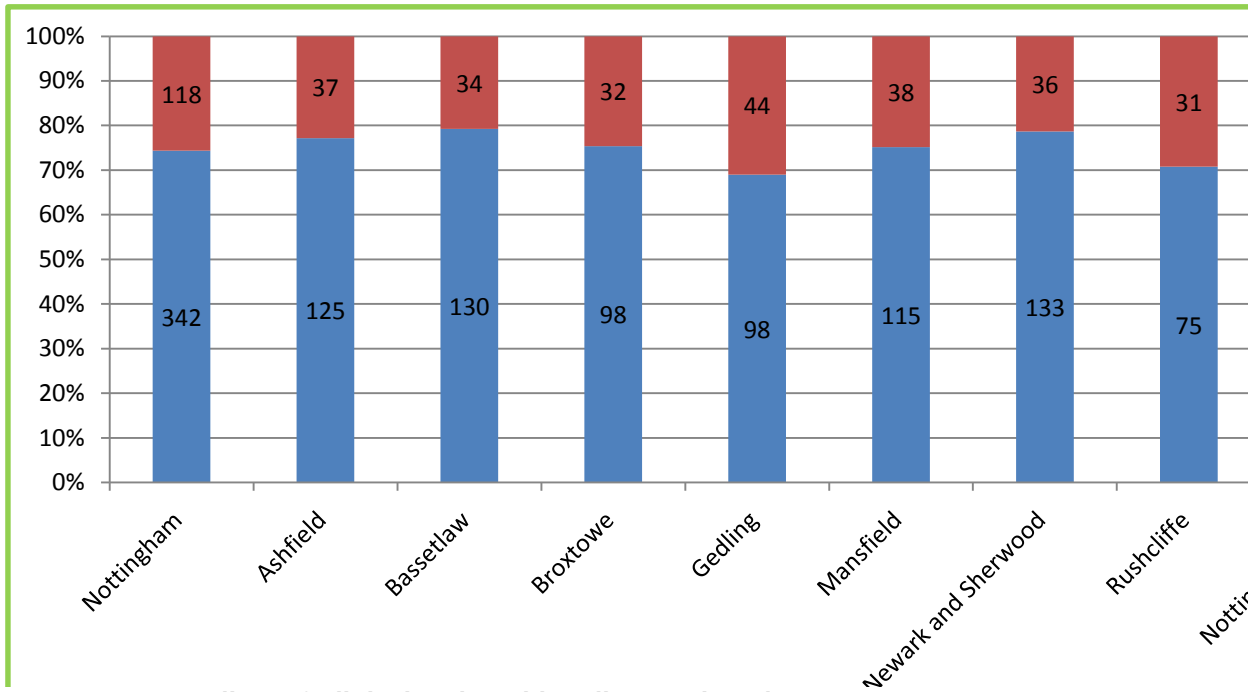


Source: Compendium of Clinical and Health Indicators (2012)

7.4.3 Gender

Figure 6 below shows that the 1997 to 2012, gender split in the suicide rate for Nottinghamshire which is in line with national suicide rates with men accounting for around three quarters of suicides. There is no significant variation in the gender split suicide rate between all the Nottinghamshire districts.

Figure 6: Proportion of Suicides (aged 15+) by Gender (1997-2012) in Nottinghamshire (number in bar indicate actual number of cases)



Source: Compendium of Clinical and Health Indicators (2014)

Table 4 overleaf shows the rate of change suicide mortality rate in the gender split from the 1995/6/7 baseline to 2010/11/12. Across all districts there has been a slight reduction with the exception of Ashfield and Mansfield districts for males. Newark and Sherwood and Broxtowe have seen a slight increase for females. Females show a more apparent decrease compared to males. However, as the numbers are small this highlights the difficulties of drawing significant conclusions and caution should be taken in interpreting this data.

Table 4: Gender number and percentage change in suicide mortality – 1995/6/7 and 2010/11/12 for Nottinghamshire Districts

Local Area and District	1995/6/7 (baseline)	2010/11/12	% change	1995/6/7 (baseline)	2010/11/12	% change
	Number	Number	(baseline to current year)	Number	Number	(baseline to current year)
	Male	Male		Female	Female	
Nottingham City	55	39	*-29.09%*	22	23	*4.55%*
Nottinghamshire	152	110	*27.63%*	60	19	*68.33%*
Ashfield CD	19	26	*36.84%*	11	5	*-54.55%*
Bassetlaw CD	26	25	*-3.85%*	9	5	*-44.44%*
Broxtowe CD	19	18	*-5.26%*	7	8	*14.29%*
Gedling CD	18	14	*-22.22%*	14	7	*-50.00%*
Mansfield CD	22	26	*18.18%*	11	7	*-36.36%*
Newark & Sherwood CD	26	19	*-26.92%*	*<5	7	*75.00%*
Rushcliffe CD	22	21	*-4.55%*	*<5	*<5	*-25.00%*
Total	**207**	**149**		**82**	**42**	

Source: Compendium of Clinical and Health Indicators (2014) *Numbers 1-5 suppressed to <5 to protect privacy

7.5 Self-harm

For the period 2010-13, the Nottinghamshire rate of hospital admissions caused by unintentional and deliberate injuries in children (aged 0 -14years) was 85.2 per 100,000 population. For the age range of 15-24, the rate was 120.4 per 100,000 per population. Both rates are better than the national averages of 103.8 per 100,000 and 130.7 per 100,000 population, respectively.

7.6 Ethnicity

The 2011 census data indicates for Nottinghamshire that the Black and Minority Ethnic (BME) population remains relatively small with 95.5% white and 4.5% from BME groups[56].

Local level ethnicity data with regard to cases of suicide is not currently available through existing information sources. However, national evidence highlights the increased risk to those from ethnic minority communities:

- Patterns of self-harm and suicide amongst people from minority ethnic groups continue to be different to those amongst white people. It has been reported that the highest rate of suicide in the BME groups in young black females age 16-34years[57].

- Suicide rates and classical indicators of suicide risk among inpatients committing suicide vary by ethnic group. Black African men have the highest rates of suicide compared to the White British group[58].

7.7 Suicide and mental health

The Nottinghamshire main mental health service provider is the Nottinghamshire Healthcare NHS Trust (NHCT). NHCT have a mechanism in place whereby all unexpected deaths for patients in contact with the service are reported on and examined to ascertain the circumstances and cause of the patient death. This scrutiny process aims to look at any lessons that could be learnt in order to prevent any unexpected deaths in the future.

It should be noted that only the Coroner can determine actual cause of death. Therefore the suicide and mental health data is categorised as unexpected deaths. This includes suspected suicide, and deaths from overdose of illicit substances and where NHCT are awaiting confirmation of cause of death but excludes homicides and deaths that were later confirmed by the coroner as physical/natural causes/unascertained**.**
Table 5 overleaf shows the total annual numbers of NHCT unexpected deaths for the period 2010/11/12/13.

Table 5: NHCT Nottinghamshire and Nottingham City (combined) unexpected deaths annual numbers for the periods 2010/11 2011/12 and 2012/13.

Year	Number of Unexpected deaths
2010/11	39
2011/12	47
2012/13	37
Total	**123**

Sources: NHCT Serious Untoward Incident reporting data

7.8 Methods of Suicide

The Public Health Mortality Files contain a certain level of detail on each individual case of suicide such as age, place of death, cause of death etc. Using the International Classification of Diseases version 10 code (ICD-10) attached to each case, the methods used have been analysed. Results from analysis in this section are based on this data analysis for the period 2001-2011, combined for Nottinghamshire and Nottingham City by gender.

In keeping with national findings,[59] **Table 6** below shows that the most common methods of suicide and injury undetermined are hanging for men and drug poisoning for women, 51.9% and 46.3% respectively. When analysing ICD-10 suicide only codes, hanging is the most common suicide method for men and women, 60.5% and 46.5%, respectively.

Table 6: Deaths from Suicide and Injury Underdetermined by Method and Gender - Nottinghamshire and Nottingham City - combined (2001-2012)

Suicide and Injury Underdetermined (ICD-10 X60-X84, Y10-Y34 exc Y33.9)			Suicide Only (ICD-10 X60-X84)		
	Males	Females		Males	Females
Method	**%**	**%**	**Method**	**%**	**%**
Firearms	*2.2*	*0.0*	**Firearms**	*2.9*	*0.0*
Drowning	*4.9*	*5.5*	**Drowning**	*2.4*	*2.6*
Carbon Monoxide	*6.2*	*1.1*	**Carbon Monoxide**	*7.5*	*1.9*
Other	*8.1*	*8.8*	**Other**	*6.7*	*5.2*
Jumping/Falling /Lying	*9.1*	*7.0*	**Jumping/Falling /Lying**	*8.7*	*7.1*
Drug Poisoning	*17.6*	*46.3*	**Drug Poisoning**	*11.4*	*36.8*
Hanging	*51.9*	*31.3*	**Hanging**	*60.5*	*46.5*
Total	***100.0***	***100.0***	**Total**	***100.0***	***100.0***

Source: Compendium of Clinical and Health Indicators (2014)

7.9 Offenders

7.9.1 Her Majesty's Prison (HMP)

There are three closed male national prisons operating across Nottinghamshire, HMP Whatton, Lowdham and Ranby and one local male prison, HMP Nottingham. **Table 7** gives an outline of these prisons category and operational capacity.

Table 7: Nottinghamshire HMP Prison Classification

Classification	HMP Nottingham	HMP Whatton	HMP Lowdham Grange	HMP Ranby
Category of Prison	Local prison	Closed training prison	Closed training prison	Closed training prison
Security status	Category B	Category C	Category B	Category C
Sex of prisoners	Male	Male	Male	Male
Capacity of prisoners	Increased from 550 to 1060 in April 2010	847	920	1060

Source: Ministry of Justice

Table 8 and **Table 9** shows the number of deaths from suicide and self-harm incidents within all Nottinghamshire prisons between 2005/06/06 (baseline) compared to 2008/09/10 and 2011/12/13. These suicide figures reflect those that are known and suspected as suicide, not necessarily as having a coroner's verdict as suicide.

Table 8: Number of suspected suicides in all Nottinghamshire Prisons pooled 3 year data for 2005/06/07 (baseline year) compared to 2008/09/10 and 2011/12/13.

Prison	2005/06/07 (Baseline)	2008/09/10	2011/12/13
	N=	N=	N=
HMP Nottingham	*<5	*<5	*<5
HMP Whatton	**	**	0
HMP Lowdham Grange	0	0	*<5
HMP Ranby	0	0	*<5
Total	***<5**	***<5**	***<5**

Source: NHS England ***** No available data***

Numbers 1-5 suppressed to <5 to protect privacy

Table 9: Number of self-harm incidents in all Nottinghamshire Prisons - pooled 3 year data for 2005/06/07 (baseline year) compared to 2008/09/10 and 2011/12/13.

Prison	2005/06/07 (Baseline)	2008/09/10	2011/12/13
	N=	N=	N=
HMP Nottingham	407	610	925
HMP Whatton	*	*	*
HMP Lowdham Grange	*	**132	1022
HMP Ranby	*	184	229
Total	**407**	**926**	**2,708**

Source: NHS England NB: * no data available ** Stats available for 2009/10 only

Nottinghamshire Secure Children's home – Clayfields is an inpatient unit with a capacity of 18 beds. From 2005 to 2013, there have been no suspected deaths from suicide in Clayfields.

Table 10 shows the number of self-harm incidents reported in Clayfields for the period 2008/09/10 to 2011/12/13.

Table 10: Number of self-harm incidents in Nottinghamshire Secure Children's Home– pooled 3 year data for 2005/06/07 (baseline year) compared to 2008/09/10 and 2011/12/13.

Secure Children's Homes	2005/06/07	2008/09/10	2011/12/13
	N=	N=	N=
Clayfields	Not available	231	229

NB: Data is calculated using calendar years and not financial years. *2008 is December only data.

All Nottinghamshire Prisons adhere to the Prison Service Order (PSO) 2700 Suicide and Self-Harm prevention first published in 2007 and revised in 2012[60]. The revised 2012 policy retained the Assessment, Care in custody and Teamwork (ACCT) procedures at its centre; ACCT is an individualised care planning approach for prisoners at risk of suicide or self-harm. The ACCT pathway improved cross agency information flows and integrated local Safer Custody Teams. Also reflected are long-standing areas of safer custody work such as peer supporters (Listeners and Insiders) and working with outside organisations such as the Samaritans.

The ACCT pathway aims to improve the quality of care by introducing individual/flexible care-planning, supported by improved staff training in case management and in assessing and understanding at-risk prisoners. The ACCT pathway alongside local prevention of suicide in the local prison initiatives such as the Listeners Scheme performed by prisoners for prisoners (trained by the Samaritans) who may be at risk from suicide or self-harm has had a significant impact in prevention suicides in prisons.

7.10 Where are the current gaps?

In order to set the FfA priorities and actions we needed to know what the current situation was in relation to suicide and self-harm prevention in Nottinghamshire. All key stakeholders of the Nottinghamshire and Nottingham City suicide prevention steering group were tasked with identifying current suicide prevention delivery. The delivery was then matched against the national suicide prevention strategy areas for action[1.] Gaps were identified by comparing the mapping results against national and local suicide and self-harm data. This enabled us to identify the five FfA priority areas and where we need to focus.

Box 5 overleaf outlines where the current gaps exist against the FfA priority areas.

Box 5: Summary of Nottinghamshire current service mapping gaps

Risk of suicide in key high risk groups

- Access to self-harm and suicide awareness training for frontline professionals is required
- Access to suicide prevention and early identification is not delivered across all districts of Nottinghamshire
- There is a need to offer targeted screening in high risk professional groups such as: farmers, vets, nurse and doctors
- Targeted suicide prevention programmes for specific groups such as: BME and LGBT groups

Approaches to improve mental health in specific groups

- Better support for veterans suffering with depression and/or PTSD is required

Access to the means of suicide

- Improved monitoring of means of self-harm and suicide is required in order to put in place targeted strategies and interventions

Information and support those bereaved or affected by suicide

- Improved information and access to support for those bereaved or affected by someone else's suicide is required, particularly, in primary care, prisons and social care

Sensitive media

- An agreed and joined up approach is required by all Suicide Prevention steering group stakeholders in communicating self-harm and suicide to the local media
- A local suicide communication plan is required for dealing with media on self-harm and suicide

Research, data collection and monitoring

- Improved timeliness in self-harm and suicidal behaviour data is required in order that suicide prevention and self-harm strategic outcomes can be monitored
- Self-harm and suicide awareness, prevention and intervention programmes need to be delivered in line with national and local outcome based research and best evidence to ensure effectiveness in reducing the rate of suicide and self-harm

8.0: OUR SUICIDE PREVENTION FRAMEWORK FOR ACTION PRIORITIES FOR NOTTINGHAMSHIRE

Priority 1: Identify early those groups at high risk of suicide and self-harm and support effective interventions.

To achieve this priority a multi-pronged approach is required that addresses suicide at three levels, such as:

- Whole population approach for suicide prevention

- Suicide prevention for specific groups who are more vulnerable. The identified specific groups are:

  - Men aged 35-54 years
  - Ex-armed forces men aged 24 years and younger
  - People in the care of mental health services, including inpatients
  - People with a history of self-harm, untreated depression, misuse alcohol, are facing economic difficulties, are going through divorce or separation, or have long-term physical illnesses[1]
  - Children and Young People who have experience abuse and/or neglect, especially 'looked after' children
  - People in contact with the criminal justice system (police, probation, the courts and prisons)
  - Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers
  - Young women from South Asian, Caribbean and African origin and older South Asian women
  - Older people aged 65+ experiencing social isolation and loneliness and/or depression
  - Lesbian, Gay, Bisexual and Transgender people
  - People following repeated exposure to bullying and/or cyber-bullying
  - Victims of sexual or domestic violence in adulthood

- Reduce access to means of suicide

We can make a positive impact by:

i) Whole population approach

- Embed the promotion of good mental health to existing local services
- Provide training on mental health and resilience to frontline staff including teachers, community groups, faith groups and service providers
- Develop and implement a local annual suicide prevention campaign programme that address mental health stigma and discrimination, bullying, and self-harm.

ii) Suicide prevention for specific groups

Early identification of mental health problems, provision of evidence-based targeted interventions[13,19,48,] and access to treatment[61] as quickly as possible for:

- Children and young people - work with schools, social services and justice system to identify and refer those at risk to appropriate services
- People with untreated depression and those living with long term physical health conditions- work with GPs to increase identification and referral
- Black, Asian and minority ethnic groups and asylum seekers
- Lesbian, Gay, Bisexual and Transgender groups
- People who misuse drugs or alcohol- link with local substance misuse strategy to ensure joined up approach in addressing substance misuse needs
- People recently discharged from mental health inpatient care
- People recently sentenced to prison or released from prison
- Develop tailored interventions that support young and middle aged men, those who self-harm and vulnerable adults e.g. those who have been abused and/or looked after children who are discharged from care to independent living

Assessment of suicide risk and treatment in a ***primary care setting*** should include:

- Screening for those who do access primary need to include the clear markers of suicide risk, such as: frequent consultation, multiple psychotropic drugs, and specific drug combinations such as benzodiazepines with antidepressants[62]
- Effective treatment for depression, by implementing the NICE guidance on depression[61]
- Everyone who presents with depression or anxiety should be assessed and treated and have rapid access to support and treatment, either primary care based, such as through Improving Access to Psychological Therapies (IAPT), or secondary mental health care.

Reducing patient suicide in in ***mental health care settings***[63] should include:

- The provision of specialist community mental health services such as crisis resolution home treatment teams, assertive outreach and services for people with dual diagnosis
- Implement NICE guidance on depression[61]
- Share information with criminal justice agencies
- Ensure physical safety, and reduce absconding on in-patient wards
- Create a learning culture based on multidisciplinary review.

Management of self-harm in ***emergency departments*** should include:

- Effective assessment and management of self-harm, particularly to reduce repetition of self-harm and future suicide risk[11].

iii) Reduce access to means

- Reduce access to high-lethality means of suicide in hospitals, care institutions and criminal justice settings
- Regular assessments of mental health ward areas to identify and remove potential risks
- Identify high risk suicide sites in Nottinghamshire and limit access and make them safer for example put barriers or nets, provide emergency telephone numbers, e.g. Samaritans and British Transport Police
- Work with local authority and councils in the planning departments to include suicide risk in health and safety considerations when designing multi-storey car parks, bridges and high-rise buildings
- Reduce availability of certain medicines were appropriate
- Identify further high risk medicines by undertaking medicines review in line with national prescribing guidelines.

Priority 2: Review of ***timely suicide and self-harm data and be informed by national and local evidence based research and practice*** in order to better understand the local needs

To achieve this priority we need to improve timely data capture. This will enable suicide prevention and interventions strategies will target the most at risk groups. Also, applying evidence based research and practice that will inform the local commissioning of prevention and interventions will aim to ensure effectiveness in reducing the rate of suicide and self-harm.

We can make a positive impact by:

Undertaking regular reviews of national and local suicide and self-harm trends and conducting local regular suicide audits. Sources of data used to complete the annual audit in order to gain insights and identify areas to prioritise are:

- The Coroners' Office suicide verdict data
- Public Health Mortality Files (main source)
- Compendium of Clinical and Health Indicators
- Nottinghamshire Healthcare Trust suicide audit
- Prisons (HMP): Nottingham, Whatton, Lowdham Grange and Ranby
- Police, ambulance and fire service data
- Safeguarding of Children and Adult data
- Suicide and self-harm prevention and interventions evidence based research

By working with academic experts in the field and commissioners will aim to ensure that all locally delivered self-harm and suicide interventions are aligned to evidence based research and effective outcomes.

Priority 3: Access effective support for those ***bereaved or affected by suicide***

Suicide can also have a profound effect on the local community. We know from studies that, in addition to immediate family and friends, many others will be affected in some way[64,65]. They include neighbours, school friends and work colleagues, but also people

whose work brings them into contact with suicide – emergency and rescue workers, healthcare professionals, teachers, the police, faith leaders and witnesses to the incident. It is important we:

- Collate local information on available support for those bereaved or affected by suicide
- Provide effective and timely support for families bereaved and other people affected by suicide e.g. friends and colleagues
- Have in place effective local responses procedure to deal with the aftermath of a suicide
- Provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide

We can make a positive impact by:

- Developing local responses to the aftermath of suicide
- Developing easily accessible information on mental health and wellbeing services
- Working with third sector organisations to provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide

Priority 4: ***Engage with media personnel*** to agree on sensitive approaches to reporting suicide and suicidal behaviour

The media have a significant influence on behaviour and attitudes. There is evidence to suggest that the reporting of suicide in the media can increase the rate of suicide, particularly amongst young people who may already be at risk[66,67]. It is apparent that the media have a role to play in suicide prevention, by limiting certain aspects of reporting, providing details of local support organisations and helplines and by portraying suicide in ways which may discourage imitation.

We can make a positive impact by:

- Developing a local suicide prevention communication plan that promotes responsible reporting of suicide in the media
- Ensuring details of local support organisations and helplines are included with any coverage of suicide deaths
- Promoting responsible reporting and portrayal of suicide and suicidal behaviour in the media
- Continuing to support the internet industry to remove content that encourage suicide and provide ready access to suicide prevention services.

Priority 5: Improve the understanding and care for people at risk of suicide and self-harm through ***training of frontline staff*** to deal with at risk of suicide and self-harm behaviour.

Early identification of those at risk of suicide and self-harm is important in supporting people to access the right intervention.

We can make a positive impact by:

- Raising awareness of suicide and self-harm prevention identification and interventions through training of all health and social care professional, criminal justice and emergency frontline staff
- Training in self-harm for frontline and general hospital workers to address negative attitudes and knowledge gaps that have major negative effects on the experience of people who self-harm and can be a major impediment to their care
- Training of psychiatric staff in psychosocial assessment and in effective brief psychological interventions.

9.0: MONITORING OUTCOMES

The overall aim of this FfA is to reduce the rate of suicide and self-harm in the Nottinghamshire population. By improving the mental health and wellbeing of the population of Nottinghamshire by effectively preventing mental health conditions and ensuring appropriate access and delivery of mental health and social care services can support the reduction in the local rates of suicide and self-harm.

Measuring suicide and self-harm preventions outcomes is complex due to the level, types and complexity of mental health problems. Also, suicide and self-harm data has its limitations as mental health problems can go under diagnosed or under reported. Also, mortality data, such as suicide data lacks timeliness and does not capture the prevalence of mental illness, or the disability it causes.

Therefore, in order to monitor this FfA progress and outcomes we will be looking at a number of key indicators. These indicators are found and incorporated into:

- The national outcome framework: the Public Health Outcomes Framework, which has a specific indicator to monitor a range of mental health outcomes,
- The Department of Health (DH), No Health without Mental Health dashboard (December, 2013)[68] brings together a number of indicators for a wide range of sources to reflect progress against the national mental health strategy. There is specific indicator on reducing the number of suicide related deaths. Nationally, data and benchmarking against these indicators is in the process of being developed
- The No Health without Mental Health, Nottinghamshire's Mental Health Framework for Action 2014-2017

The priorities of this FfA are also linked with other local strategies and drivers, outlined in **Appendix B.**

10.0: TAKING THE NOTTINGHAMSHIRE SUICIDE PREVENTION FRAMEWORK FOR ACTION FORWARD

10.1 Leadership

To realise the aims of the Nottinghamshire Suicide Prevention FfA and in order to see real improvement in Nottinghamshire we need Suicide Prevention leaders and champions at all levels across the public, private and voluntary sectors.

Those of particular note are:

- Councillors and officers of Nottinghamshire County Council have already committed to prioritise mental health by signing up to the ***Mental Health Challenge***[69]. The Mental Health Challenge is a new concept where local councils through a mental health leadership role help in the promotion of good mental health in their communities and to ensure people with mental health conditions have better, more fulfilling lives. Member champions for mental health can also help to raise awareness about mental health in Nottinghamshire.

- ***Senior leaders,*** including commissioners and mental health clinical leads, from NHS Nottingham West, Nottingham North and East, Mansfield and Ashfield, Newark and Sherwood, Rushcliffe and Bassetlaw Clinical Commissioning Groups, Nottinghamshire County Adult and Children's Social Care and research leads from University of Nottinghamshire

- ***Service providers*** including Nottinghamshire Healthcare NHS Trust, Nottingham University Hospitals, Sherwood Forest Hospital Trust, Doncaster and Bassetlaw Hospital Trust, Nottinghamshire County Council and, Nottinghamshire Police and the voluntary sector.

There is a need to agree a clear way forward to ensure the FfA is implemented, including the development and delivery of detailed action plans for each of the five FfA priorities. Further strategic work will include ensuring that children's, adults and older people's suicide and self-harm prevention work is linked to this FfA with agreed suitable targets for assessing progress.

10.2 Governance

The FfA is owned by the Nottinghamshire Health and Wellbeing Board and steered by the Public Health Suicide Prevention lead. Implementation and progress of this FfA will be monitored by the Health and Wellbeing Implementation Group (HWIG). The Nottinghamshire Integrated Commissioning Group (ICG) for Mental Health, Learning Disability and Autism will be responsible for overseeing the implementation of this FfA and the quarterly progress reporting to the HWIG.

The Nottinghamshire and Nottingham City Suicide Prevention Steering group comprising of key stakeholders will continue to deliver against this FfA key actions.

The overarching leadership for each of the five FfA priorities will be developed and consist of the most appropriate suicide and self-harm prevention leaders and champions.

10.3 Action plans

A detailed action plan will be developed by the Nottinghamshire and Nottingham City Suicide Prevention Steering group following the consultation on the FfA. Working groups will be set up to achieve each of the five priorities in this FfA.

10.4 Equality Impact Assessment

An equality impact assessment (EIA) is an assessment to ensure that policies do not discriminate and that where possible, equality is promoted. A full equality impact assessment of this FfA will be undertaken in accordance with the Nottinghamshire County Council Equality and Diversity Policy. Further equality impact assessment will be undertaken on the action plans resulting from this FfA.

Appendix A: Preventing suicide in England: A cross-government outcomes strategy to save lives 2012[1]

The strategy is not a one-off document but an on-going, co-ordinated set of evolving activities. It seeks to be comprehensive, specific, evidence-based, and subject to evaluation. For these reasons, when identifying high-risk groups as priorities for prevention, it selects only those for whom suicide rates can be monitored. The Strategy recognises however, that there are other groups for whom a tailored approach to their mental health is necessary if their risk of suicide is be reduced. These approaches are illustrated among the 6 Goals below.

Goal 1: Reduce the risk of suicide in key high-risk groups
The following high-risk groups are priorities for prevention:

• young and middle-aged men
• people in the care of mental health services, including inpatients
• people with a history of self-harm
• people in contact with the criminal justice system
• specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers

Goal 2: Tailor approaches to improve mental health in specific groups
Improving the mental health of the population as a whole is another way to reduce suicide. The measures set out in both *No health without mental health* and *Healthy Lives, Healthy People* will support a general reduction in suicides.

The strategy identifies the following groups for whom a tailored approach to their mental health is necessary if their suicide risk is to be reduced:

• Children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system
• Survivors of abuse or violence, including sexual abuse
• Veterans
• People living with long-term physical health conditions
• People with untreated depression
• People who are especially vulnerable due to social and economic circumstances
• People who misuse drugs or alcohol
• Lesbian, gay, bisexual and transgender people and Black, Asian and minority ethnic groups and asylum seekers

Goal 3: Reduce access to the means of suicide
One of the most effective ways to prevent suicide is to reduce access to high lethality means of suicide. Suicide methods most amenable to intervention are:

• Hanging and strangulation in psychiatric inpatient and criminal justice settings
• Self-poisoning
• Those in high-risk locations; and
• Those on the rail and underground network

Continued vigilance by mental health service providers will help to identify and remove

potential ligature points. Safer cells complement care for at-risk prisoners.

Safe prescribing can help to restrict access to some toxic drugs.

Local agencies can prevent loss of life when they work together to discourage suicides at high-risk locations. Local authority planning departments and developers can include suicide in health and safety considerations when designing structures.

Goal 4: Provide better information and support to those bereaved or those affected by suicide

Effective and timely emotional and practical support for families bereaved by suicide is essential to help the grieving process and support recovery. It is important that GPs are vigilant to the potential vulnerability of family members when someone takes their own life.

Post-suicide community-level interventions can help to prevent copycat and suicide clusters. This approach may be adapted for use in schools, workplaces and health and care settings.

It is important that people concerned that someone may be at risk of suicide can get information and support as soon as possible.

Goal 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

The media have a significant influence on behaviour and attitudes. The government wants to support them by:

• promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media; and
• continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services

Local, regional and national newspapers and other media outlets can provide information about sources of support when reporting suicide. They can also follow the Press Complaints Commission Editors' Code of Practice and *Editors' Codebook* recommendations regarding reporting suicide.

The Government will continue to work with the internet industry through the UK Council for Child Internet Safety to create a safer online environment for children and young people. Recognising concern about misuse of the internet to promote suicide and suicide methods, they will be pressing to ensure that parents have the tools to ensure that children are not accessing harmful suicide-related content online.

Goal 6: Support research, data collection and monitoring

The Department of Health will continue to support high-quality research on suicide, suicide prevention and self-harm through the National Institute for Health Research and the Policy Research Programme.

Reliable, timely and accurate suicide statistics are essential to suicide prevention. The Department will consider how to get the most out of existing data sources and options to address the current information gaps around ethnicity and sexual orientation.

Reflecting the continuing focus on suicide prevention, the Public Health Outcomes Strategy includes the suicide rate as an indicator.

Appendix B: Local Policy Drivers

Key local documents

- No health without mental health, Nottinghamshire's Mental Health Framework for Action 2014-2017[5]
- Nottinghamshire Suicide Prevention Framework for Action 2015-2018 (this document)
- Nottinghamshire Joint Strategic Needs Assessment (JSNA)
- Nottinghamshire Health and Wellbeing Strategy 2014/16
- Nottinghamshire Children and Young People Strategic Plan
- The Mental Health and Emotional Well-being of Children and Young People in Nottinghamshire – Health Needs Assessment 2013
- Nottinghamshire Children and Young People Mental Health and Emotional Wellbeing Strategy 2014-16
- Nottinghamshire Workplace Health Strategy 2014-2017 (draft)

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Final version – NOTTINGHAMSHIRE AND NOTTINGHAM CITY SUICIDE PREVENTION ACTION PLAN: 2016-2018

Background:

This action plan has been developed by allocating actions against each priority of the Nottinghamshire County Suicide Prevention Framework for Action (FfA) and the Nottingham City Suicide Prevention Strategy (2015-2018), targeting all ages at increased risk of suicide and/or self-harm.

Prevention of mental health problems by building mental resilience and intervention that aim to improve mental health crisis care is being progressed via the Nottingham City Mental Health and Wellbeing Strategy (2014-2017), the No Health without Mental Health Nottinghamshire's Mental Health FfA 2014-2017 and the Crisis Care Concordat Action Plan. Although the Suicide Prevention Steering Group does have the responsibility for taking forward the Suicide Prevention actions forward the steering groups role is to feedback on the effectiveness of these actions developments in relation to suicide and self-harm prevention, intervention and post-vention.

Contents

Actions	Progress	Led by	Outcomes	RAG

Priority 1: Identify early those groups at high risk of suicide and self-harm and support effective interventions				
A: For people at high risk of suicide				
A.1: Young and middle-aged men				
Actions	**Progress**	**Responsibility**	**Outcomes**	**RAG**
Develop health promotion initiatives which are targeted at men and delivered in locations frequented by men (job centres, youth centres, sports venues, music venues, pubs and clubs	Raise Mental Health Awareness through Men's Health Forums Men in Sheds Project delivered in Nottingham, Blidworth, Daybrook, Worksop, Collingham, Stapleford to bring older men together to put their practical skills to good use and encourage them to be more socially active.	**PH** – Alison Challenger (City) Jonathan Gribbin (County) **Councils (City and County)** Communication lead – Abby Jakeman **MH awareness providers** – Harmless – Caroline Harroe (City) Kaleidoscope – Claire Dale (County) **IAPT providers** – City and County (incl. Bassetlaw) **Men in Sheds** – Age UK	More men are able to talk about their problems Reduce loneliness by encouraging men to be more socially active Men's health forum awareness shared https://www.menshealthforum.org.uk/sites/default/files/pdf/how_to_mh_v4.1_lr web_0.pdf Increased access to IAPT interventions and treatment for depression 2017/18 Suicide Prevention Delivery plan – targeted approach for men aged 35-64 years	
A.2: People in the care of mental health services, including inpatients				
Provide risk assessment and management as part of routine clinical assessment and care planning provided by front line staff working with high risk groups	NHCT 'Sign up to Safety Plan' in place http://www.nottinghamshirehealthcare.nhs.uk/sign-up-to-safety NHCT_Sign up to Safety - FINAL.docx NHCT staff have access to Connecting to People training as recommended by NICE Guidance	**NHCT SP Oversight group-** Caroline Carston	Preventing suicide: a toolkit for mental health services http://www.nrls.npsa.nhs.uk/resources/?entryid45=65297 is in place and implemented Programme of audit against standards is undertaken with findings and recommendations shared and implemented Clinical services place priority for suicide prevention and monitoring on: -In-patients under non-routine observations - In-patients who are assessed to be at high risk or who are detained and in the first seven days of admission - In-patients who are at high risk and who are sufficiently recovered to allow home leave but whose home circumstances lack support (particularly those who live alone) - Recently discharged patients who are high risk or who were recently detained - Patients who become non-compliant or who miss service contact while under enhanced CPA - All discharged in-patients who have severe mental illness or a recent (less than three months) history of deliberate self-harm should be followed up within one week - NHCT have a Strategic Suicide Group in place, with an ambition of zero suicide quality improvement	
Improve care pathways between key services: - Emergency departments - Primary Care - Secondary Care - Inpatient care - Community care - On hospital discharge	Pathway development being undertaken by the Crisis Concordat – Working Party Crisis Concordat Task and Finish Actio	**CCG –**Jade Akers (County) **Katherine** Biddulph (City) BBC Bassetlaw) **NHCT** **NUH** **SHFT** **DBFT**		

Actions	Progress	Led by	Outcomes	RAG
Use the National Patient Safety Agency's (NPSA's) suicide prevention toolkits for community and emergency healthcare (ambulance service, community mental health teams, emergency departments and general practice): http://www.nhsconfed.org/Publications/briefings/Pages/Preventing-suicide.aspx	NHCT 'Sign up to Safety Plan' in place (Community Mental Health Teams) Primary Care Emergency Departments Ambulance	**NHCT** **CCG –** Clare Fox**(City)** Jade Akers **(County)** TBC (Bassetlaw) **NUH** **SHFT** **DBFT** **EMAS –** Terry Simpson	- EMAS signed up to Crisis Concordat Mental Health action plan - Ambulance staff have access to MH and SP training - Crisis MH management is available via Street Triage	
Restrict access to means (ligatures, ligature points, medications, windows, places of height) and identify/reduce risk in high risk areas (gardens, bathrooms, balconies) particularly in healthcare buildings used by high risk groups;	NHCT 'Sign up to Safety Plan' in place	**NHCT**		
Implement policies to protect voluntary mental health patients and manage risk associated with leaving the inpatient setting;	NHCT 'Sign up to Safety Plan' in place	**NHCT**		
Use the 'Twelve points to a safer service' checklist: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4058243.pdf	NHCT Twelve points to a safer service' checklist in place	**NHCT**		
Develop initiatives to prevent risk to patients missing from inpatient wards: http://www.nmhdu.org.uk/silo/files/a-strategy-to-reduce-missing-patients--a-practical-workbook.pdf	NHCT 'Sign up to Safety Plan' in place	**NHCT**		
A.3. People with a history of self-harm				
Communicate with and follow up people who seek help from emergency departments after self-harming;	- Undertaken within the CAMHS review - Pathway development being undertaken by the Crisis Concordat – Working Party - NHCT 'Sign up to Safety Plan' in place - As part of contractual requirements learning from serious incidents is included within the 6 monthly lessons learned reports for NHCT - NHCT produce a specific Suicide and Self Harm report for Contract meetings that identified themes and trends.	**PH CYP CAMHS Commissioners –** Lynn McNiven (City) Kate Allen (County) **NHCT –** Marie Armstrong **+ adult nominated person needed** **CCG Quality leads** Janine Fleming **(City)** **Quality leads for**	Quality Standards in place: NICE self-harm pathway in clinical practice: http://pathways.nice.org.uk/pathways/self-harm NICE clinical practice guidelines on the short-term management and secondary prevention of self-harm in primary and Secondary Care: http://publications.nice.org.uk/self-harm-cg16 NICE clinical practice guidelines on longer-term management of self-harm: http://publications.nice.org.uk/self-harm-longer-term-management-cg133 Referral to psychological assessment of people who self-harm as routine practice	

Actions	Progress	Led by	Outcomes	RAG
	- Primary Care do not currently produce reports identifying themes and trends however a quarterly serious incident report is submitted to the CCG's Quality Improvement Committee which highlights the number and type of serious incidents and any lessons learnt/changes to practice that have been identified - Training delivered by lead Department of Psychological Medicine Consultant on s.136 and suicide risk at Nottingham University Hospital NHS Trust, on-going teaching of medical students and suicidal patient scenario role play	**Nottinghamshire CCGs to be confirmed at Clinical Leads meeting** **CCG MH Clinical Leads–** Safiy Karim **(City)** **Quality leads for Nottinghamshire CCGs to be confirmed at Clinical Leads meeting** **Hospitals/ A & E and Paediatric Depts for NUH, SHFT, DBFT** **Harmless-** Caroline Harroe		
Improve communication and sharing of information between emergency departments, mental health services and GP practices in relation to patients who present having self-harmed	- Pathway development being undertaken by the Crisis Concordat – Working Party	Crisis Concordat partnership board and working group	Improvement in early access to self-harm interventions NHCFT National Pilot on Vanguard	
Deliver appropriate training on facts and issues behind self-harm including ways that staff can respond in:	CAMHS *Nottinghamshire* - Funding identified to provide mental health training to primary and secondary care staff and schools / colleges. To be delivered through School Health Hub (NCC) and Primary Mental Health Workers (CAMHS). Recruitment ongoing. *Nottingham City* - SHARP commissioned to provide ongoing training to universal, community, health and social care professionals. Primary Care- Asist	**ICH City and County Public Health NCC-** Lucy Peel NCC – Educational Psychologies	The Euregenas Toolkit School-based Suicide Prevention, Intervention and Postvention is in place, http://www.euregenas.eu/wp-content/uploads/2014/11/TOOLKIT-School-based-Suicide-Prevention-Intervention-and-Postvention.pdf	
A.4: People in contact with the criminal justice system				
Conduct investigations to learn from deaths in police custody to inform future prevention	- Early identification of those at risk through undertaking a pre-release risk assessment for all detainees in custody- Those being passed to another agency are also accompanied by a PER form with risks highlighted. - Undertaking regular audits of suicides following police custody- **This information is not shared to custody at this time.**	**Nottinghamshire Police –** Det Supt Robert Griffin and Insp Mark Whitaker **NHCT –** Yvonne Bird	Serious lessons learnt and recommendations implemented to further prevent suicide and self-harm in custody	

Actions	Progress	Led by	Outcomes	RAG
	NHCT Criminal Justice Liaison team offer Mental Health screening and signposting in police custody - Undertaking regular audits of suicides following police custody			
Conduct investigations to learn from deaths in prisons to inform future prevention	NHCFT have been involved in all investigations of suicide post police custody	**HMP Nottingham -**Debbie Langford **HMP Whatton** **HMP Lowdham Grange** **HMP Ranby** **NHS England –** Anthony Nichols/ Sian Harris **NHCT –** Dr Kaul Adarsh, Anna Conway	Serious lessons learnt and recommendations implemented to further prevent suicide and self-harm in custody. Mental health pathways in place from reception, on transfer across the prison system and on release back to the community. A specialist mental health teams in prisons to assess prisoners and coordinate care when mental health problems are identified, residential staff Mental health awareness in place for prison staff on how to manage prisoners with mental health issues on the wings as part of their daily routine. HMP Ranby have in place IAPT and Crisis Intervention service offered 7-days, complex case register HMP Nottingham – 5 day a week service HMP Lowdham – 5-day a week service	
Improve understanding of and procedures for identifying and supporting detained persons, at any point in the CJS, at risk of suicide or self-harm;	NHS England have commissioned a Diversion and Liaison service Provision of information/ signposting support for those in police custody with significant risk factors Robust screening and pathways in place within HMPS and SCH	**NHS England –** Anthony Nichols **NHCT –** Yvonne Bird	- Pathways in place to improve early identification and access to mental health care for people entering the CJS - Provide mental health support information and/or liaison within police custody and court settings; - Routinely monitor levels of risk amongst people detained in police custody Service commenced on the 20th of April 2015 – awaiting outcomes data from NHS England to measure the effectiveness of the service ;	
Improve cell design (reduce ligature points);	- NHCT Criminal Justice Liaison team offer Mental Health screening and signposting in police custody- Liaison teams embedded within Nottinghamshire Custody.	**Nottinghamshire Police –** Det Supt Robert Griffin and Insp Mark Whitaker **HMP Nottingham -**Debbie Langford **HMP Whatton** **HMP Lowdham Grange** **HMP Ranby**	Means of suicide and self-harm reduced in custody Improved access to Mental Health interventions Samaritans Listening Service in place across Nottinghamshire Prisons	
A.5 People in the workplace and specific occupational groups				
Ensure workplace health programme inclusive of emotional health objectives for workforces	- County has a workplace scheme in place - Improving mental health and wellbeing in the workplace is being delivered - City Public Health working with Mental Health steering Group to identify good practice in health and employment. Building health partnerships - City HWB Strategy includes focus on mental health and employment.	**PH –** Lindsay Price (County) Sharan Jones/Liz Pierce (City)	- Mental health awareness and champions are in workplaces signed up to the Workplace Health scheme - All staff know who to access support for mental health at work and/or in the community	
Workplaces develop staff emotional health policies and procedures			Workplaces signed up to the Workplace Health Scheme have policies and procedures in place to: - Support people with mental health problems to find employment - Support those in employment singed off sick due to a mental health problem to return to work	
Delivery of evidence based mental health awareness training for managers which is specific to the workplace where appropriate			- Training challenges myths, stigma and negative attitudes about self-harm and suicidality	
Target approaches at high risk workforces:			- City - Building Health Partnerships events brings together health and employment on the theme of Mental Health.	

Actions	Progress	Led by	Outcomes	RAG
- Young and middle-aged men - Young women - Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers	- City Council are part of Time to Change Alumni programme. - County Workplace Health strategy scheme has Mental Health awareness training and improving mental health and wellbeing in place , -progress as of December 2015 includes 75 workplace health champions have been trained in 'mental health community first responders and basic listening/support skills with 40 more due to be trained by March 31st 2016		-City to continue to commission local health and employment support services with strong emphasis on mental health and employment. - Provide support, information and advice for members of the workforce who are absent from work due to mental health problems - Improve the extent of emotional health support offered in workplaces with a largely male workforce - Provide practical, emotional advice and support within workplaces and accessible via line management, occupational health or self-referral; - Take a pro-active, policy led approach to valuing and supporting a diverse workforce which includes people with experience of mental health problems;	
B.1: Children and Young People				
Schools and young people's educational settings Devise and deliver school/ university based approaches to help all children/ young people to recognise, understand, discuss and seek help earlier for any emerging emotional and other problems;	Delivered by Harmless and SHARP (City) *Nottingham City* Delivered by SHARP (City). Funding identified to pilot academic resilience based programmes in schools. *Nottinghamshire* - Funding identified to commission public mental health and resilience based programmes in school and education settings. Programmes to be commissioned by March 2016.(GE) Nottm University-Bespoke Mental Health Advisory Service supports students experiencing significant mental health problems, and offers liaison with external NHS services and signposting advice. MH awareness events (preventative approach) run via the Healthy U scheme. University Counselling Service offers 1-1 counselling and workshops. Nottm Trent University- Wellbeing service provide- Referral to appropriate NHS services where there is a risk of harm plus and voluntary agency support and self-help A brief model of counselling, brief case work for a range of issues often including emerging or previously un-	**PH CYP CAMHS Commissioners –** Lynn McNiven (City) Kate Allen (County) **SHARP –** Sharon O'Love **PH City and County CYP CAMHS** Lucy Peel ICH **Harmless –** Caroline Harroe **Nottingham University**– Farah Humberstone **Nottingham Trent University-** Alison Bromberg	- The Euregenas Toolkit School-based Suicide Prevention, Intervention and Postvention is in place, http://www.euregenas.eu/wp-content/uploads/2014/11/TOOLKIT-School-based-Suicide-Prevention-Intervention-and-Postvention.pdf - Personal, Social, Health and Economic (PSHE) education framework is in place - Systems for identifying and supporting children/young people/vulnerable families where children are at risk of emotional and behavioural problems are in place - Enables young people to know of opportunities to be listened to by someone who is interested in their concerns The Primary Mental Health (PMH) Team has been established as part of Child and Adolescent Mental Health Services (CAMHS) to work with universal services in Nottinghamshire County. The team will be working together with and supporting practitioners working with children, young people and their families in relation to emotional health and well-being. The team will be providing training and consultation to empower and support the universal workforce to extend their range of skills and knowledge in mental health difficulties.	

Actions	Progress	Led by	Outcomes	RAG
	reported mental health difficulties. Mental Health Support Team who offer mentoring for diagnosed students to support their studies. Our Student Health Development Officer has a role in promoting positive mental health and suicide prevention via our web site, a range of on line, social media and paper based communication plus wellbeing events. Provision of Mental Health First Aid training to a broad range of NTU staff plus other mental health awareness training.			
Multi- agency shared approach for services that work with young people Devise systems and pathways for identifying and supporting children/young people/vulnerable families where children are at risk of emotional and behavioural problems that includes: - Children and Young Peoples Mental Health Services - Children's Social Care - Education – Schools, Colleges, Universities - Primary Care - Health Visitors - School Nurses - Voluntary services	- Undertaken within the CAMHS service review Progress monitored within the Crisis Care Concordat Action Plan *Nottinghamshire* - Local transformation plan and funding approved by NHS England, enabling delivery of new model / pathway from prevention through to crisis care (GE) *Nottingham City* - BEMH pathway piloted from December 2014, with expanded single point of access to services for children with behavioural, emotional and mental health difficulties, and wider service offer including parenting programmes and interventions. Implementation of phase two of CAMHS pathway, now part of the Future in Mind local transformation plan, will focus on the multi-agency support to children with moderate or severe mental health difficulties. NHCFT (Pathway development work undertaken)	All CCGs Working with: Nottinghamshire Healthcare NHS Foundation Trust, Nottinghamshire Police, Nottingham University Hospitals NHS Trust, Sherwood Forest Hospitals NHS Foundation Trust, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, Nottingham City & Nottinghamshire County Councils (Children's Social Care/ Children's Services)- PH City and County CYP CAMHS ICH -Lucy Peel	A shared approach that aims to: - Enable young people to know of opportunities to be listened to by someone who is interested in their concern - Provides early help to address the impact of abuse and neglect and improve life chances for children and young people is in place - Provides early intervention in psychosis model of community care; - Provides Improved Access to Psychological Therapies (IAPT) services to children and young people; - Delivers supportive interventions in settings that are appropriate and accessible for children and young people is in place- Provide emergency mental health care for children and young people - Individuals in crisis should expect that their needs can be met appropriately at all times - Responses should be on a par with responses to physical health	
To review information provided to children and young people when coming into contact with services	Progress monitored within the Crisis Care Concordat Action Plan	**NHCT**	- Easily accessible and age appropriate information about facilities - Clearly stated standards about how each service involves or informs children and young people about their care	

Actions	Progress	Led by	Outcomes	RAG
Criminal Justice Settings Provide accessible and engaging interventions for children and young people who offend, in their area and in custodial or secure settings;	All CYP in police custody have assessments . Developing work for assessments of CYP who have offended in the community and have not formally been in custody (eg first caution or school sanctions)	**NHS England – Anthony Nichols (L&D; healthcare in SCH)** **NHCT –** Yvonne Bird **Nottinghamshire Police –** Det Supt Robert Griffin and Insp Mark Whitaker	- Enables young people to know of opportunities to be listened to by someone who is interested in their concerns;	
B.2: Survivors of abuse or violence, including sexual abuse				
Timely, recorded assessment, identification and referral and commissioning of vulnerable children and adults Referral to and commissioning of specialist agencies	County-DVA services for adults, male and female and teenagers commissioned 2015-18. Service supports children affected by DVA PCC and CCGs undertaking a review of current Survivors of Sexual Abuse Adult Services City -Joint commissioning arrangement between CDP,CCG, PCC, NCC, and Public Health .for DSVA. SV services and DV services commissioned from April 2016	County-Public Health and PCC Commissioned. WAIS and NWA are the providers **CCG -** TBC Theodore Philips/Sandra Morrell (City) **PCC –** Nicola Wade **PH DV commissioners –** (**County)** Gill Oliver **CDP (City)**Jane Lewis **(City)** Liz Pierce	Improve access to specialist DSVA support, reduce risk of DSVA in future, improved safety, improved emotional health and wellbeing for adults, improved emotional wellbeing for children. Improve accessing to IAPT and other appropriate counselling and support	
Use the strengths and difficulties questionnaire to identify children and young people for referral to CAMHS.		**NHCT**	The SDQ is helpful for ADHD but other outcome and assessment measures may be more useful for some other presentations eg RC ADs and PHQ9 – they should never be used in isolation – there is always a need to add/enhance clinical assessment.	
Provide an appropriate police response to any criminal allegations of abuse or safeguarding issues and/or referral onto other agencies.		**Nottinghamshire Police –** Det Supt Robert Griffin **PP-** Helen Chamberlain/ Mel Bowden in Public protection	Identify police officer specialists for domestic abuse, child abuse and adults in vulnerable situations;	
B.3: Ex-military service personnel				
Improve access to mental health practitioners with specialist knowledge of the difficulties faced by veterans following active service; Improve access to general support delivered by practitioners with specialist knowledge of the difficulties faced by veterans following active service;	A review of commissioned services has commenced to ensure the inclusion of people who have specific needs County CCGs have developed a veterans' working group to identify specific issues and consider solutions Revised Mental Health JSNA chp to is including the mental health needs of veterans	**CCG -** Ciara Stuart (City) Jade Akers (County) Susan March **- PH County**	Provide early intervention and prevention for individuals with specific needs Provide better access to services for individuals who do not regularly access mental health services	

Actions	Progress	Led by	Outcomes	RAG
B.4: People living with long-term physical health conditions				
Support awareness of self-management and self-care (e.g. in managing chronic pain) to increase sense of choice/confidence/control about managing health and health needs;		**CCG (County) -** TBC **City IAPT services-** Katherine Biddulph	-Increased suicide risk and response awareness in key settings, including general hospitals is in place - Extend the local Improving Access to Psychological Therapies (IAPT) services to people with long-term physical health conditions and people with medically unexplained symptoms according to Talking Therapies: A four year plan of action (2011). - Provide routine assessment for depression as part of personalised care planning in health and care services	
Use the National Patient Safety Agency's (NPSA's) suicide prevention toolkits for community and emergency healthcare (ambulance service, community mental health teams, emergency departments and general practice): http://www.nhsconfed.org/Publications/briefings/Pages/Preventing-suicide.aspx	Crisis Care Concordat action plan	**CCG (County) -**Jade Akers **CCG (City)-** Ciara Stuart	Multi-agency approach to developing pathways to local support and opportunities for improved wellbeing as access to 24 hour crisis care not meeting demand.	
B.5: People with untreated depression				
Identify people early and provide effective and appropriate treatments based on evidence-based practice (systematic reviews and NICE guidance);	IAPT pathways in place CQUINN in place to increase uptake of IAPT in the 65+ age group Rushcliffe CCG undertaking a pilot to increase IAPT uptake in older people	**CCGs** **Primary Care** **IAPT services**	Early access to IAPT services for psychological therapies and anti-depressant prescribing	
Utilise a range of interventions for depression (self-help, social interventions, psychological therapy, medications);	Books on Prescription (BoP) in place in the City and County libraries with good uptake	**Public Health –** Alison Challenger (City) Jonathan Gribbin (County)	BoP promotes people to manage their own wellbeing	
	Social prescribing services in place Bassetlaw Delivered by Co-production in the County Health Lifestyle referral service in the City to refer as appropriate to IAPT providers. City CCG commissioning community mental health support services to complement treatment services to support the pathway Awareness raising through the Wellness in Mind MH training programme. Need further links with LAEO and connected care in the City	**Bassetlaw CCG –** TBC **Public Health (County)** Jonathan Gribbin **(City)** Alison Challenger	Promotes mental well-being by accessing activities in the community and connecting people to non-medical sources of support. IAPT target increased from 15% to 25% 2017/18	

Actions	Progress	Led by	Outcomes	RAG
Devise standardised approaches to identifying and assessing common mental health problems and use recognised depression assessment tools (e.g. PHQ 9) in response to known risk factors;	This is possibly not universally and consistently completed by all Gps and may use more subjective than objective measures.	**CCG MH clinical Leads** Dr Karim Safiy **CCG quality leads –** Janine Fleming (City CCG) **Primary Care**		
Develop initiatives to address loneliness and social isolation	County - Connecting communities through grant aid funds Pilot scheme in Mansfield/Ashfield 'Together we are better' Implement 'Together we are better' scheme across all Nottinghamshire districts Nottingham City - has a 'loneliness group' focussed on older people - Signed up to 'age friendly' city scheme - Nottingham Circle commissioned to support older people to access a network of helpers	**PH -** Susan March (County) Sharan Jones (City)	Promotes mental wellbeing and prevents mental health problems	
B.6: People facing difficult social and economic circumstances				
Develop interventions that improve independent financial capability;	Referral to relevant organisations advertised on the City and Council website giving details organisations that offer financial advice support via a central point of access City financial exclusion review and community mental health support services review both stress the importance of effective links across the advice and mental health sectors.	Staff in regular contact with people facing difficult social and economic circumstances (e.g. people working in housing associations, welfare, Jobcentre Plus, advice and support agencies and the financial sector)	Provision of public information to signpost people to information, support and useful contacts in relation to debt; Provision of public information on the impact of the economic crisis (e.g. advice on maintaining wellbeing during difficult times and guidance on where to go for further help); Pathways to financial support and guidance for people identified as emotionally distressed due to financial difficulties are in place	
B.7: People who misuse drugs and alcohol				
Provide prompt access to holistic treatment, including psychosocial support, and appropriate aftercare;	Community pathway to substance misuse recovery interventions and treatment is in place Dual Diagnosis pathways need to be agreed between NHCT and CRI City taking into account DD needs within the substance misuse	**County PH SM Commissioners -** Lindsay Price/ Tristan Snowdon-Poole **City CDP-** Ian Bentley **New Directions (ND) –** Andy Ambler	- Deliver treatment strategies that identify and respond appropriately to people suffering from mental health problems; - Effective links between treatment, housing services, welfare, employment support, criminal justice bodies, and the wider support that is needed; -Staff are appropriately trained in: - Understanding and responding to emotional distress - Supporting people to keep emotionally well and/or seek support	

Actions	Progress	Led by	Outcomes	RAG
	procurement	**NHCT –** Dave Manley	- Recognising and responding to risk of suicide or self-harm safely and effectively - Sources of support for mental health problems	
B.8: Lesbian, gay, bisexual and transgender people				
Conduct equity initiatives within mental health and other support services, involving LGBT people in the identification of issues within services that provider barriers to access.	Better links with IAPT and counselling services required to influence LGBT needs NHCFT received No 1 status from Stonewall	**PH -** Carl Neal (City) **CCG – E & D leads** **NHCT – E and D lead**	Participation in PRIDE – positive messages and engagement Welcoming services, embrace differences – information about services available Routine collection of data on sexual orientation that informs services about needs and service uptake	
B.9: Black, Asian and minority ethnic groups and asylum seekers				
Commission and design local services in response to recommendations generated through local needs assessment, qualitative research and consultation on cultural differences in understanding mental health and accessing support;	City commissioned 'STEPS BME mental health service Access to healthcare for refugees and asylum seekers through the 'Into the mainstream' project	**City CCG Mental Health Commissioners –** Simon Castle Robert Stephens (PH Coty)	Equity initiatives in place within mental health and other support services, involving people from BME groups in the identification of issues within services that provider barriers to access Accessibility protocols in place within mental health and other support services, inclusive of procedures for providing translation where necessary	
C.1: People who are recently released from custody				
Provide health and treatment services in the criminal justice system that are equal to those provided in the community (staff training, therapeutic quality, coverage rates and treatment alternatives)	NHCT 'Sign up to Safety Plan' in place Outcome achieved for NHCFT community forensic services in the criminal justice services, Transitions out of Prisons still challenge for Offender Health Services. NHSE Health & Justice commission integrated healthcare services to individuals in prison and SCH; and assessment and referral only in police custody – not any services within the community	**NHS England –** Anthony Nichols **NHCT –** Yvonne Bird		
Provide inter-agency partnerships between corrections-based and external service providers with appropriate referral systems	NHSE commission integrated healthcare and SMS services in HMP's and SCH and assessment and referral in police custody – continuity of care pathways and agreements in place along with robust Strategic Partnership Board arrangements	**NHS England –** Anthony Nichols **NHCT –** Yvonne Bird	Programmes meet the physical, practical and/or psychosocial needs of released persons	
Provide standardised risk assessment and screening to identify detained persons who are at an increased risk of drug-related post-release mortality and who would benefit from specialised programmes and support.		**NHS England –** Anthony Nichols **NHCT –** Yvonne Bird		

Actions	Progress	Led by	Outcomes	RAG
Provide comprehensive and specialist services for drug dependant people in the criminal justice system which is continued upon release	L&D services would identify, though not provide treatment for individuals - This is the responsibility of PH and PCC. In prisons, NHS E commission services to provide treatment whilst in prison/SCH, continuity of care pathways in place for release into community though LA/PCC responsible for commissioning SMS services in the community. **These services are delivered in the city and county by Framework and CRI and not NHCFT**	**NHS England –** Anthony Nichols **NHCT –** Yvonne Bird	Provision of drug or support services on first contact with the criminal justice system or when targeted as being at-risk of becoming a drug offender Provision of services for drug-dependent people while they are in police custody, pre-trial detention, prison, on release and in the community Provision of links between pre-release prison drug services and appropriate after-care	
C.2: High-risk means and locations – Samaritans and BTP				
Ensure multi-agency working to discourage suicides at high risk locations, especially following a death;	SP Steering group considering implementing the PHE's best practice guidance for identifying suicide clusters and contagion https://www.gov.uk/government/news/new-resource-to-prevent-linked-suicides-in-local-areas 24/7 emergency help-line, via email, phone, SMS or face to face. Outreach projects : festivals, school/colleges,/ universities and within the workplace if invited. close links with HMP Nottingham and Whatton supporting and training the Listeners Scheme, attendance at safer custody meetings. National and local links with Network Rail. Schools project, work in progress to have named person to develop this.(CK) NWR have ongoing project teams with different priorities and remits dependant on work required – for more urgent concerns use control.derby@networkrail.co.uk for less urgent concerns use Hayley.bull@networkrail.co.uk or lisa.bruce@networkrail.co.uk. For BTP contact use edward.carlin@btp.pnn.police.uk	**Public Health** Alison Challenger (City), Susan March (County) **Network Rail –** Carol Kingston **Samaritans –** Chris Keen **British Transport Police –** Edward Carlin **Nottinghamshire Police –** Det sup Rob Grifffin **Local Authority and Town Planners** **EMAS- Terry Simpson**	- Identify issues based on the Coroners's Suicide audit and police intelligence - Barriers or nets installed on suicide hot spot areas such as on bridges, high risk buildings and car parks including motorway bridges, where suicide has occurred; - Suicide risk in health and safety considerations included by Local Authority planning departments and developers when designing high structures that may offer suicide opportunities (railways, multi-storey car parks, bridges and high-rise buildings, structures close to facilities for particularly vulnerable people) - Hotspots identified through Coroners Audit process and police intelligence - Suicides avoided by share lessons learnt such as; NSPA	
Provide emergency telephone numbers (e.g. Samaritans) at high-risk locations;	Launch of Freecal Sep 15. New resources now available.(CK)	**Samaritans-** Chris Keen		

Actions	Progress	Led by	Outcomes	RAG
Work with pharmacies and retailers to support safe medicine management	City Trading Standards undertaking an audit on Paracetamol sales to young people-awaiting report CCG prescribing reviews	**Local authority Trading standards** **Public Health –** Liz Pierce **(City)** **CCGs**	Reduce paracetamol overdoses in young people Overdose identification of prescribed medications through Primary Care Serious lesson learnt reviews City trading standards undertook a Paracetamol sales audit in 2016	
Train rail staff training on identifying and engaging people who may be considering suicide.	Network Rail - I Journey to Recovery programme in place training train drivers and line managers on identifying those at risk and supporting those rail workers affected by someone else's suicide Learning tool for the industry already operational – access via **NWR** internal website – Managing Suicidal Contacts course run by the **Samaritans** to train industry staff and BTP officers – Operational and ongoing. **BTP/NWR** – Interventions introduction 30 minute workshop for delivery to front line industry staff – Operational and ongoing	**Nottingham Samaritans –** Chris Keen **Network Rail –** Caroline Kingston **British Transport Police –** Edward Carlin **NCC Public Health -** Susan March	2016 Nottinghamshire Rail Network – identified hotspots. Planning meeting with Network Rail, BTP, Samaritans and Nottinghamshire Public Health planned for April 2018. Prevention of rail suicides – for action within the 2017/18 Delivery Plan	

Priority 2: Review of timely suicide and self-harm data and be informed by national and local evidence based on research and best practice in order to better understand local needs.				
D.1: Improve timely suicide and self-harm data				
Undertaking regular reviews of national and local suicide and self-harm trends and conducting local regular suicide audits. Sources of data used to complete the annual audit in order to gain insights and identify areas to prioritise are: - The Coroners' Office suicide verdict data - Public Health Mortality Files (main source) - Compendium of Clinical and Health Indicators - Nottinghamshire Healthcare Trust suicide audit - Prisons (HMP): Nottingham, Whatton, Lowdham Grange and Ranby - Police, ambulance and fire service data - Safeguarding of Children and Adult data - Suicide and self-harm prevention and interventions evidence based research	Refresh of the Nottinghamshire Suicide and Self-harm JSNA chapter commenced with sign-off October 2015 Refresh of the Nottingham City Suicide and Self-harm JSNA chapter commenced with sign-off October 2015 Undertake a Coroners' Office suicide audit – draft to next SP steering group – December 2015	**PH -** Susan March (County) **PH -** Liz Pierce (City) **Nottinghamshire Police –** Det Sup Rob Griffin	Data compared with findings from previous suicide audits in order to evaluate the effectiveness of previous prevention strategies Comparison of local data and trends with national and regional data and trends Identify local risk factors, groups at risk or localities of higher incidence so that early and effective targeted support and interventions are offered Informs future prevention strategies to ensure prevention is effectiveness Have baseline data for monitoring future trends and evaluate future prevention strategies Develop a sustainable system for future data collection Able to demonstrate the full extent of suicide and self-harm amongst asylum seekers and refugees	
Assess the feasibility in implementing the PHE 'real times' reporting/ surveillance model of unexplained deaths	Public Health and Nottinghamshire Police in discussions with PHE	Susan March/Liz Pierce/Rob Griffin **NHCT/Nottinghamshire Police/Network Rail/British Transport Police/**	Identify local risk factors, groups at risk or localities of higher incidence Those bereaved or affected by someone's suicide have early access to effective advice and support Multi-agency referral arrangements for those vulnerable to suicide and self-harm.	
Sharing of lessons learnt to make service developments to prevent future suicides	NHCT developing 'Sign up to Safety' Plan CCGs developing 'Sign up to Safety' Plan in Primary Care	**CCG/NHCT/ Coroner's Office**	Coroner's office alert local services to inquest evidence that suggests areas for service development to prevent future suicides Suicide and self-harm incidents are reduced by sharing of lessons learnt Implement service delivery changes in response to the lessons learnt	
Coroner's office alert Public Health to inquest evidence that suggests patterns and suicide trends.	Scope the feasibility as part of the REAL time surveillance discussions with PHE	**Coroners Office** **PH City -** Alison Challenger **/PH County -** Susan March	Risk of copycat suicides is reduced Early Post-vention suicide processes are be put in place	

Priority 3: Access effective support for those bereaved or affected by suicide				
E.1: Early identification and access to effective support and information				
Improve identification and support offered in primary care and mental health services	Support information for those bereaved is part of the ASIST training NHCFT has developed an internal leaflet – that also signposts to Help is at Hand Healthtalkonline Survivors of Bereavement by Suicide and The Compassionate Friends.	Alison Challenger **(City Public Health)** Susan March **(County Public Health)** Caroline Harroe **(Harmless – City)** Rachael Thompson **(Kaleidoscope County)** **NHCT**	GPs and Primary Care practitioners are better aware of the potential vulnerability of family members when someone takes their own life, and how to respond; Families or those affected by someone else's suicide have improved access to practical support in primary care such as: an explanation of policies on investigation of patient suicides, opportunity to be involved and information on any actions taken as a result. Signpost information to bereavement support services in place i.e. CRUSE ?	
Coroners and services involved in suicides (e.g. Police, Pathologists) in supporting those bereaved provide accessible, concise information on the processes and standards in a Coroner Inquiry to family members	- Scope what is being delivered at the coroners office - Assess the role of police in providing information for those bereaved as part of the REAL time surveillance scoping	Ghazala Mumtaz – **Nottingham's Coroner's Office** Rob Griffin - **Nottinghamshire Police**	Good quality family liaison is offered with bereaved families with signposting to appropriate information and support Provide appropriate information, on bereavement through suicide, to bereaved families eg Help is at Hand service	
E.2: Those who are concerned about someone who may be at risk of suicide				
Deliver community awareness which enables families and friends to play a role in preventing suicide:	Support information for those bereaved is part of the ASIST training	Alison Challenger **(City Public Health)** Susan March **(County Public Health)** Caroline Harroe **(Harmless – City)**	Community better informed on the ambiguous nature of warning signs and focus on helping people to acknowledge and overcome their fears about intervening; **Form April 2017 there will be no commissioned by Public Health Suicide Prevention awareness and training services**	
Promote The Samaritans' Facebook page (advice on how to support vulnerable friends, how to spot when someone is distressed, how to start a difficult conversation & a mechanism for asking Samaritans to contact someone who is cause for concern) www.facebook.com/samaritanscharity	Network Rail - I Journey to Recovery programme in place training train drivers and line managers on identifying those at risk and supporting those rail workers affected by someone else's suicide	**Nottingham Samaritans –** Chris Keen **Network Rail –** Caroline Kingston **British Transport Police –** Edward Carlin	Advice on how to support vulnerable friends, how to spot when someone is distressed, how to start a difficult conversation and a mechanism for asking Samaritans to contact someone who is cause for concern) and alert app is in place	
Mental Health services provide information to family, carers and friends of people being cared for by mental health services on how to contact services at all times including when concerned or in a crisis;		**NHCT**	Involve family, carers and friends of people being cared for by mental health services in care planning;	
Mental Health services allocate a named professional to everyone with a care plan, to hold an overview of the case and take responsibility for answering any questions they or their family might have		**NHCT**	Respond to concerns of family, carers and friends of people being cared for by mental health services in a timely and appropriate way	

Priority 4: Engage with media personnel to agree on sensitive approaches to reporting suicide and suicidal behaviour				
F.1: Promote responsible reporting in the media				
Implement Samaritans guidance for the media on the reporting of suicide: www.samaritans.org/media _centre/media_guidelines.aspx	City and County Council Communications teams work closely with the local media offering advise on responsible reporting	**City Council –** Steve Thorn **County Council –** Abby Jakeman **Samaritans -** Chris Keen	- Local/regional newspapers and other media outlets provide information about sources of support and helplines when reporting suicide and suicidal behaviour - Avoids insensitive and inappropriate graphic illustrations accompanying media reports of suicide; - Avoids use of photographs taken from social networking sites without relatives' consent; - Avoids the re-publication of photographs of people who have died by suicide when reporting other suicide deaths Details of local support organisations and helplines are included with any coverage of suicide deaths	
Develop a local suicide prevention communication plan that promotes responsible reporting of suicide in the media and ensures effective local responses to the aftermath of a suicide			- Local media are alerted to examples of both poor and excessive reporting of suicide - The publication of harmful or inappropriate material with reference to the updated laws on promoting suicide are challenged - The internet is utilised to reach out and offer support to vulnerable individuals - The internet industry to remove content that encourage suicide and provide ready access to suicide prevention services.	
Ensure agreements are in place for joint working and especially sensitive reporting when there is any evidence that a cluster of suicides may be occurring or when a specific location for suicide is causing concern;	To be addressed through REAL time surveillance	Alison Challenger **(City Public Health)** Susan March **(County Public Health)**	Work in accordance with the Editors' Code of Practice recommendations on a avoiding excessively detailed reporting of suicide methods as endorsed by the Press Complaints Commission PCC: www.pcc.org.uk/cop/practice.html	

Priority 5: Improve the understanding and care for people at risk of suicide and self-harm through training of frontline staff to deal with those at risk of suicide and self-harm behaviour				
F.1: Raise awareness and improved access to Suicide Prevention training				
Commission mental health and suicide prevention awareness and training package	ASIST and MHFA training providers in place in both the City and County	Alison Challenger **(City Public Health)** Susan March **(County Public Health**) **Harmless –** Caroline Harroe **(City) commissioned by city PH** **CCG MH Clinical Leads–** Safiy Karim **(City)** **Quality leads for Nottinghamshire CCGs to be confirmed at Clinical Leads meeting**	From 2017 there will no commissioned Suicide Education services commissioned by Public Health - Ensure improved identification and access to early interventions - Training challenge myths, stigma and negative attitudes about self-harm and suicidality. - Improves attitudes towards, and knowledge of, self-harm amongst general hospital, primary care, mental health, emergency and criminal justice staff, staff in job centres, CAB - Able to recognise and respond to warning signs for suicide in self or others delivered in a variety of settings and targeted to where people are more likely to encounter those who are at risk - Frontline staff are trained to engage conversations in mental health and emotional wellbeing, self-harm, assessing and managing risk - Accessing appropriate information/self-help/ support for mental health and wellbeing	
Deliver community level awareness and training for local people on how to support vulnerable friends	Assessing the feasibility of implementing a 2 hour session on suicide awareness for GPS to increase uptake i.e. Connecting with People http://www.connectingwithpeople.org/		Improved knowledge and skills on how to spot when someone is distressed, how to start a difficult conversation, how to signpost confidently etc.	
Untreated depression Ensure that GPs and other practice staff are appropriately trained in mental health awareness; working with emotional health, signposting with confidence to appropriate support, suicide risk assessment and response.			- Training/information focussed specifically on common mental health problems, amongst staff in any helping role, to increase awareness, recognition and recommendations for support; - Improve access to information/resources for wellbeing and common mental health problems for staff in any helping role to provide to patients; - GP trained in writing of post-suicide serious case reviews	
Social Circumstances Deliver training for front-line staff who are in regular contact with people facing difficult social and economic circumstances (e.g. people working in housing associations, welfare, Jobcentre Plus, advice and support agencies and the financial sector):			- Improved understanding and responding to emotional distress - Supporting people to keep well and/or seek support - Recognising and responding to risk safely and effectively - Sources of support with financial difficulties - Support in a crisis	
Lesbian and Gay, Bisexual and transgender people Promote awareness of the higher rates of mental distress, substance misuse, suicidal behaviour or ideation and increased risks of self-harm in these groups, alongside training in offering support, amongst staff in primary and secondary health care, social services, education and the voluntary sector;			- Provide accessible, evidence based mental health promotion and information on available support and advice services	
BME Communities Adopt community development approaches, working across sectors and in partnership with communities, to tackle inequalities in health and access to services;			Awareness raised amongst healthcare staff coming into contact with BME, asylum seekers and refugees	

Actions	Progress	Led by	Outcomes	RAG
Develop a health promotion programme for suicide and self-harm prevention campaigns targeted at the most at risk groups (outlined in Priority 1 actions)	City and County Campaigns undertaken in 2015: May – MH awareness week September – World Suicide Prevention day October – World MH awareness day November – World Stress awareness day	Alison Challenger **(City Public Health)** Susan March **(County Public Health)** Caroline Roe **(Harmless – City)** Rachael Thompson **(Kaleidoscope County)**	- Improved community awareness on the signs of suicide and self-harm - Reduce stigma and discrimination - More people able to promote TALK techniques (Tell, Ask, Listen and Keep Safe) - Review and undertake annual awareness campaigns in 2016,17 & 18	
Victims and Survivors of Abuse Promote appropriate forms of support and knowledge of referral to specialist agencies for victims of abuse IRIS (Identification and Referral to Improve Safety) across the County for health and social care professional in contact with DV.	Access to specialist DVA services via Nottingham and Nottinghamshire Domestic and Sexual Abuse 24 hour Freephone helpline 0808 800 0340 Nottingham City CCG, Mansfield and Ashfield CCG and Nottingham West CCG all commission IRIS in General Practice	**PH County –** Nick Romilly **City -**Jane Lewis **PCC –** Nicola Wade	Helpline outcome – increased awareness and access to specialist DVA services IRIS outcome – increased identification and referral between GP and Specialist DVA services.	
Prisons/Custody Provide regularly updated training on risk assessment and management for staff in contact with detained persons.	Nottinghamshire Police have access to the ASIST training Need to input what is available for prisons	**Nottinghamshire Police –** Det Supt Robert Griffin and Insp Mark Whitaker **HMP Nottingham -**Debbie Langford **HMP Whatton** **HMP Lowdham Grange** **HMP Ranby**	- Improved awareness and early detection on the signs of suicide and self-harm - Reduce stigma and discrimination - More people able to promote TALK techniques (Tell, Ask, Listen and Keep Safe)	
Ensure that all stakeholders (police custody, pre-trial detention, prison, on release and in the community, detained persons, families and carers**)** are trained in: - Awareness of the risks of acute drug-related post-release mortality and the acute risks associated with decreased tolerance - Awareness of approaches to drug use prevention and overdose prevention - Awareness of recognising and responding to overdose	NHS E provide educational workshop sessions on suicide/self harm prevention to stakeholders – most recently November 2015.	**NHS England –** Anthony Nichols/Sian Harris **NHCT –** Yvonne Bird **– CJL team** **NHCT -** Anna Conway **(Prisons)**	- Drug related overdoses in the criminal justice system are avoided/reduced	
Veterans Train staff, who may encounter veterans in distress or seeking support	Kaleidoscope Plus commissioned to provide ASIST training across the County for 18 mths. Forces in the Community to provide SP training for approx. 60 people, 250 in MH First Aid and seeking funding to increase capacity. Forces in the Community working	**NHCT –** Dave Manley **Forces in the Community -** Rick Harrington **NCC – Community Engagement Lead –** Neil Bettison	- Increased awareness of emotional health difficulties faced by veterans following active service - Signposting and referring confidently to specialist veterans services	

Actions	Progress	Led by	Outcomes	RAG
	with Police to provide a support group for veterans engaged with police/judicial system.(RH)			
Long term conditions (LTC) Mental health awareness training to include awareness on the increased risk of LTC and mental health and impact on mental health increased risk of developing LTCs.	Being addressed through the City Mental Health strategy and Nottinghamshire Mental Health FfA MHFA training providers in place in both the City and County Raise awareness with JSNA authors to ensure MH included. City HWBB reports all ask for consideration of the mental health aspects of the report	Alison Challenger **(City Public Health)** Susan March **(County Public Health)**	- Increased awareness - Screening and pathways in place for access to both physical and mental health interventions and treatment - Health improvement programmes (i.e. smoking cessation, weight management, diet and exercise, substance misuse in place to reduce LTCs for those with a mental health problem	

Appendix 4

Nottinghamshire County and Nottingham City Suicide and Self-harm Prevention Priority Actions - 2017/18

Rate	Target
All persons suicide age-standardised rate per 100,000 population (3 year average) 2013-15.	**NHS - The Five Year Forward View for Mental Health (Feb 2016) – Target reduce suicide by 10 per cent by 2020/21.**
Nottingham City rate 11.3 per 100,000 population or 85 suicide deaths/ or average of 28 suicide deaths per annum.	**10% reduction in suicide by 2020/21 – reduction of 2 suicide deaths per annum/or 8 suicide deaths by 2020/21**
Nottinghamshire County rate 9.3 per 100,000 population or 200 suicide deaths/ or average of 66 suicide deaths per annum.	**10% reduction in suicide by 2020/21 – reduction of 7 suicide deaths per annum/or 20 deaths by 2020/21**
Emergency Hospital Admissions for Intentional Self-harm: Directly age-sex standardised rate per 100,000 2014-2015	
Nottingham City rate 225.2 per 100,000 population/or 786 admissions	
Nottinghamshire County rate 175.3 per 100,000 population/or 1,383 admissions	

At risk group	Rationale	Actions	Led by	Progress/Outcomes	RAG
1. Males aged 35-64 years	From 2010-2014 (City and County combined) 58% of all suicide deaths occurred in the males aged 35-64 years. This rate is over twice as high of any other age group	1.1. Undertake a HEA of IAPT services to ascertain if men are accessing support	City CCG David Johns	- City IAPT report completed – uptake of men accessing IAPT services is	▶
		1.2. CCGs to review current contracts to ascertain if they are targeting at risk men	City and County Mental Health CCG commissioners		⬢
		1.3. CCGs to raise suicide awareness within primary care GPs	Dr Nick Page	Rushcliffe CCG offering GP Primary Care in Suicide Prevention training using the Connect Safe-tool	▶
		1.4. Employment links to DWP	Nottinghamshire D2N2 City employment – local business	- targeting and supporting those with mental health problems to get back to employment	▶
		1.5. Debt advice	Citizens Advice	- Promote access to Citizens Advice Bureau as part of the MECC approach	▶
		1.6. Marketing campaign targeting areas men go – i.e. promote State of Mind Sport at sporting venues, workplaces, benefits, housing associations, hostels, pubs, University and Colleges	City and Counties Samaritans leads	- Promote Samaritans literature - Public Health Workplace Health Schemes promoting mental resilience and ways to maintain good mental health	▶
		1.7. Population awareness – how to talk to someone who is suicidal?	CGL/Samaritans	- CGL Suicide toolkit - Samaritans offer 24/7 confidential emotional support,	▶
			Notts HC Trust	- C-SSRS Training Resources.pptx	▶
			Harmless	ASIST Suicide Prevention Training Review training programmes and outcomes Dec 2017 meeting	▶
		1.8. Implement a programme of awareness campaigns targeting men i.e. Campaign Against Living Miserably (CALM) awareness and National Suicide Prevention awareness campaigns such as 'It's okay to Talk'	Public Health	Vets – Mind Matter Initiatives https://www.rcvs.org.uk/news-and-views/news/mind-matters-initiative-new-veterinary-mental-health-and/ Permission give for the 'It safe to Talk' leaflet develop by Exeter University to be implemented in City and County	▲
		1.9. Promote Time to Change campaigns to tackle mental health stigma	Public Health and Councils	- Time to Change campaigns are supported and shared - Each council signed up a Time for Change champion - County HWB refresh to be launched early 2018. Mental health champion to be confirmed	▲
		1.10 Effectiveness review of criminal justice pathways in identifying and accessing mental health interventions for offenders/prisoners at risk of self-harm and suicide	HMP Ranby, Lowdham, Whatton and Nottingham prisons (Safety Leads)	- Prison pathways in place, following the 'ACCT' procedures. - Monitoring and support offered for those prisoners at risk - Automatic mental health referrals are activated when a prisoner is identified as being at risk	▶
			CGL & Samaritans Samaritans	CGL Suicide toolkit, Samaritans listener scheme	▶
		1.11 Linked to Crisis Concordat CCGs - ensure good access to mental health crisis care	Clare Fox – City CCG	- Crisis Concordat operational across City and County - Working to a joint action plan that includes Suicide	▶
2. All ages	Preventing and responding to Self-harm	2.1. County Self-harm JSNA chapter to identify areas of CCG commissioning priorities	Jane O'Brien (County Public Health)	- Progressing – in the process of writing up	▲
		2.2. City and County Suicide JSNA chapter to identify areas of CCG commissioning priorities	Susan March (County Public Health) Jane Bethea (City Public Health)	- County Suicide Prevention JSNA completed 2016 - City Suicide Prevention JSNA works has commenced	▲

		2.3. CCG to review effectiveness of the Liaison Psychiatry services to ensure those who self-harm and assessed and referred appropriately	CCG	- CCG to provide update for March 2018 meeting	
	Improved identification in primary care of those at risk of suicide and self-harm	2.4 Improve access to suicide awareness training in primary care	CCGs and Public Health	- Limited training resource funding available - Promote free training – MindEd, C-SSRS, Samaritans,	
		2.5. Access the feasibility on implementation of the Safetool in primary care	Dr Nick Page – Rushcliffe CCG	- Rushcliffe CCG secured funding for Safetool training – GP uptake of the training low.	
3. Quality review	Review means hotspot and methods to ensure targeted prevention is reaching those most at risk	3.1. Review all suicide deaths – CCG undertake serious case reviews and quality visits	CCG quality and safety leads	- Process in place in CCG to review all suicide deaths and ongoing - Review monthly – in-depth report. - Indicated spike of suicide deaths in October 2016.	
		3.2. Review 2013/14 coroner data on means and location	Nick Romilly (City Public Health) Susan March (County Public Health)	- Public Health (City and County) met with Coroner in May 2017 - Outcomes – Coroner office agreed to send inquest transcripts on suicide deaths to PH for review with the aim to receiving timely suicide data	
		3.3. Nottinghamshire Public Health work with Network Rail, BTP and Samaritans to reduce rail deaths on Nottinghamshire Rail.	Public Health(Susan March – County/Nick Romilly – City)	- 2016 -Overall, 11 railway locations out of the 27 saw either a suspected suicide or an injurious attempt. - 2016 – 10 suspected suicide across Nottinghamshire County Rail Network. - BTP to provide County Public Health with daily suspected suicide and/or injurious attempts – delay due to Public Health gaining access to a secure email address - Six month contact to be set up to review data and share what work has been undertaken from both the LA and the Rail Industry - Suicide trend data to be reviewed to assess Samaritan signage - Mental Health awareness days to be held at stations and could be linked in with LA's and CCG's - Network Rail to check access to the right departments/people in relation to when changes of use are made buildings/ properties near rail stations and assets - 6 months follow-up once Nottinghamshire have had the opportunity to review the BTP data with their CCG's and Health Trusts to review and consider other actions that may need to be undertaken	
		3.4. Set up data group with PH, EMAS			
		3.5. Implement Derbyshire data processes on suicide and self-harm	Public Health(Susan March – County/Nick Romilly – City)	- Share cross county border suicide death information with Derbys/Leicester/Lincolnshire visa versa. E.g person lives in Nottinghamshire but death occurs outside of the city/ county - Inform relevant services of suicide death that occurs outside of Nottingham City and County	
4. Bereavement support	Ensure those who are affected by a person's suicide have access to timely interventions	4.1 Review lessons learnt from the Tomorrow Project and feed into CCG commissioners	Harmless	- Harmlessness Tomorrow Project Pilot implemented across City and County - Pilot targeting those recently bereaved by suicide – offering early intervention and support	
			Samaritans	- Offer support and information materials for those affected by suicide	
	Guidelines in place to encourage health professionals to share information about someone at risk of suicide with family members and friends	4.2. Assess the feasibility for Nottingham and Nottinghamshire implementing the Information Sharing and Suicide Prevention Consensus Statement			

	Completed – work has been successfully completed to deadline		**On schedule** – work has started and is meeting milestones
	Happening but behind schedule – work has started, activity is not meeting milestones, but is expected to by the deadline if adjustments are made		**Behind or not happening** – work has not started when scheduled or has started but activity is not meeting or unlikely to meet its milestones
	No information received		

Nottinghamshire County Council

Report to Health Scrutiny Committee

9 January 2018

Agenda Item: 7

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To consider the Health Scrutiny Committee's work programme.

Information and Advice

2. The Health Scrutiny Committee is responsible for scrutinising substantial variations and developments of service made by NHS organisations, and reviewing other issues impacting on services provided by trusts which are accessed by County residents.

3. The work programme is attached at Appendix 1 for the Committee to consider, amend if necessary, and agree.

4. The work programme of the Committee continues to be developed. Emerging health service changes (such as substantial variations and developments of service) will be included as they arise.

5. Members may also wish to suggest and consider subjects which might be appropriate for scrutiny review by way of a study group or for inclusion on the agenda of the committee.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Considers and agrees the content of the draft work programme.

2) Suggests and considers possible subjects for review.

Councillor Keith Girling
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2017/18

Subject Title	**Brief Summary of agenda item**	Scrutiny/Briefing/Update	Lead Officer	External Contact/Organisation
13 June 2017				
Health Inequalities	Update on ongoing work to address health inequalities in the County	Scrutiny	Martin Gately	Barbara Brady, Public Health NCC
Introduction to Health Scrutiny	An introduction to health service issues and the operation of health scrutiny	Scrutiny	Martin Gately	Brenda Cook Health Scrutiny Expert (Centre for Public Scrutiny)
25 July 2017				
Public Health Briefing	Introduction to Public Health issues	Initial Briefing	Martin Gately	Barbara Brady, Public Health NCC
Bassetlaw Hospital Services (Update)	An update on children's services and recruitment issues.	Scrutiny	Martin Gately	TBC
Sherwood Forest Hospitals Performance Update	The latest performance information from Sherwood Forest Hospitals Trust.	Scrutiny	Martin Gately	Dr Andy Haynes, Medical Director, Richard Mitchell, Chief Executive
IVF Substantial Variation	Update on re-consultation/Further action taken by the commissioners	Scrutiny	Martin Gately	Dr Amanda Sullivan, Sherwood Forest CCG/Lucy Dadge
10 October 2017				
Bassetlaw Hospital (Including Children's Services)	Update on the latest position	Scrutiny	Martin Gately	TBC
Chatsworth Ward, Mansfield Community	Initial briefing on changes at Chatsworth Ward which provides specialised neuro-rehabilitation services	Scrutiny	Martin Gately	Lucy Dadge/Sally Dore Mansfield and Ashfield CCG

Hospital variation of service				
East Midlands Ambulance Service	Latest Performance Information (Particularly in relation to ambulances delayed when dropping patients off at A&E).	Scrutiny	Martin Gately	Annette McFarlane, Service Delivery Manager (Nottingham Division)
Nottingham University Hospitals – Winter Planning	Initial briefing on winter pressures and winter plans.	Scrutiny	Martin Gately	TBC
Sherwood Forest Hospitals – Winter Planning	Initial briefing on winter pressures and winter planning	Scrutiny	Martin Gately	TBC
21 November 2017				
Bassetlaw Hospitals – Winter Planning	Initial briefing on winter pressures and winter planning	Scrutiny	Martin Gately	TBC
Primary Care 24	Latest performance information	Scrutiny	Martin Gately	Dr Amanda Sullivan, Chief Officer, Mansfield and Ashfield/Newark and Sherwood CCG
Chatsworth Ward Neuro-Rehabilitation Ward	Further consideration of this service change.	Scrutiny	Martin Gately	Lucy Dadge, Chief Commissioning Officer, Ashfield/Newark and Sherwood CCG
Newark Hospital Urgent Treatment Centre	Briefing on the transition to Urgent Treatment Centre taking place from early 2018, with the intention that Newark Hospital becomes a centre of excellence across a broad range of diagnostics.	Scrutiny	Martin Gately	Lucy Dadge, Chief Commissioning Officer, Ashfield/Newark and Sherwood CCG

9 January 2018				
Local Pharmaceutical Council	Initial Briefing on the work of the LPC.	Scrutiny	Martin Gately	Nick Hunter, Local Pharmaceutical Council.
Obesity Services	Initial Briefing	Scrutiny	Martin Gately	TBC
Suicide Prevention Plans	A preliminary examination of Suicide Prevention Plans further to a general request from the Parliamentary Health Select Committee.	Scrutiny	Martin Gately	Susan March, Senior Public Health and Commissioning Manager
13 February 2018				
Sherwood Forest Hospitals/NUH Partnership	Update on the working relationship between Sherwood Forest Hospitals and NUH	Scrutiny	Martin Gately	TBC
STP Governance	Initial briefing on STP governance issues	Scrutiny	Martin Gately	TBC
27 March 2018				
Nottingham Treatment Centre Procurement	Progress Report on the results of the procurement	Scrutiny	Martin Gately	Maxine Bunn, Director of Contracting TBC
GP Services Access	Initial briefing on issues with accessing GP services (particularly in rural areas)	Scrutiny	Martin Gately	TBC
NUH Maternity Services	Initial briefing	Scrutiny	Martin Gately	TBC
8 May 2018				
Bassetlaw Children's Ward	Further consideration	Scrutiny	Martin Gately	TBC
Dementia in Hospital	Initial briefing/commencement of a review	Scrutiny	Martin Gately	TBC
Winter Planning Update	Further update on actions arising from last winter.	Scrutiny	Martin Gately	TBC

4 July 2018				
Hospital Meals	Initial briefing	Scrutiny	Martin Gately	TBC
Services at Rampton Hospital	Initial briefing	Scrutiny		
To be scheduled				
Community Pharmacy Issues Update				Liz Gundel, Pharmacy Lead, NHS England
Healthcare Trust Mid and North Notts Services				
Never Events				
Substance Misuse				

Potential Topics for Scrutiny:

TBC

Recruitment (especially GPs)

Rushcliffe CCG Pilots Update

Former Joint Health Committee Issues

STP
Implementation and Evaluation of services decommissioned from NUH (TBC)
Community CAMHS
Transforming care for people with learning disabilities/autism
Emergency Care
Winter Pressures
Congenital Heart Disease Services
Progress/Evaluation of implementation changes to mental health services
Defence National Rehabilitation Centre
East Midlands Ambulance Service