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**Nottingham
City Council**

Nottingham City Council Nottingham City Health and Wellbeing Board

Date: Wednesday, 24 January 2024

Time: 1.30 pm

Place: Ground Floor Committee Room - Loxley House, Station Street, Nottingham,
NG2 3NG

Councillors are requested to attend the above meeting to transact the following business

Director for Legal and Governance

Governance Officer: Phil Wye

Direct Dial: 0115 8764637

- 1 Membership**
To note that Sally Olohan, Director of Student Experience at the University of Nottingham, has been appointed as representative for Nottingham universities.
- 2 Apologies for Absence**
- 3 Declarations of Interests**
- 4 Minutes** 3 - 10
Minutes of the meeting held on 29 November 2023, for confirmation
- 5 Minutes of the Commissioning Sub-Committee** 11 - 12
Minutes of the meeting held on 29 November 2023, for noting
- 6 Nottingham and Nottinghamshire Joint Strategic Needs Assessment: Suicide Prevention** 13 - 84
Report of the Director for Public Health, Nottingham City Council
- 7 Data Integration for Public Health** 85 - 88
Report of the Medical Director, Nottingham and Nottinghamshire Integrated Care Board
- 8 Nottingham City Place-Based Partnership Update** 89 - 96
Update from the Nottingham City Place-Based Partnership

9	Joint Health Protection Board Update Update from the Joint Health Protection Board	97 - 102
10	Board Member Updates Updates from Board Members	103 - 112
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12	Future Meeting Dates 27 March 2024	

If you need any advice on declaring an interest in any item on the agenda, please contact the Governance Officer shown above, if possible before the day of the meeting

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Nottingham City Council

Nottingham City Health and Wellbeing Board

Minutes of the meeting held at Loxley House, Nottingham on 29 November 2023 from 1.31 pm - 3.28 pm

Attendance (✓ indicates present)

Voting Members		
✓	Nottingham City Council's Portfolio Holder with a remit covering Health	Councillor Linda Woodings (Chair) Portfolio Holder for Adult Social Care & Health
✓	Nottingham City Council's Portfolio Holder with a remit covering Children's Services	Councillor Cheryl Barnard Portfolio Holder for Children, Young People & Education
✓	Two further Nottingham City Councillors	Councillor Sam Lux
✓		Councillor Sulcan Mahmood
✓	Four representatives of the NHS Nottingham and Nottinghamshire Integrated Care Board	Mohammed Shaiyan Rahman (substitute) Deputy Medical Director, Nottingham and Nottinghamshire Integrated Care Board
✓		Lucy Dadge Director for Integration, Nottingham and Nottinghamshire Integrated Care Board
✓		Dr Husein Mawji (Vice Chair) Clinical Director, Nottingham City Place-Based Partnership
✓		Michelle Tilling City Locality Director, Nottingham and Nottinghamshire Integrated Care Board
	Corporate Director for People, Nottingham City Council	Catherine Underwood
✓	Director for Adult Health and Social Care, Nottingham City Council	Sara Storey
✓	Director for Public Health, Nottingham City Council	Lucy Hubber
	Representative of the Healthwatch Nottingham and Nottinghamshire Board	Sarah Collis Chair
Non-Voting Members		
✓	Representative of the Nottingham University Hospitals NHS Trust	Tim Guyler Assistant Chief Executive
	Representative of the Nottinghamshire Healthcare NHS Foundation Trust	Jan Sensier Executive Director of Partnerships and Strategy
✓	Representative of the Nottingham CityCare Partnership	Nicola Bridge (Substitute) Director of Finance and Corporate Services
	Representative of Housing Services, Nottingham City Council	Kevin Lowry Director of Housing

✓	Representative of Nottinghamshire Police	Detective Inspector Karl Thomas (Substitute)
	Representative of the Department for Work and Pensions	Jean Sharpe
	Representative of Nottingham Universities	Annie Jennings
✓	Representative of Nottinghamshire Fire and Rescue Service	Damien West Assistant Chief Fire Officer
✓	Up to two individuals representing the interests of the Third Sector	Jules Sebelin Chief Executive, Nottingham Community and Voluntary Service Charlotte Thrussell, CEO, Disability Support Nottingham
	Chief Executive, Nottingham City Council	Mel Barrett

Colleagues, partners and others in attendance:

- Karla Banfield - Head of Commissioning
- Ana Oliva - Public Health Registrar
- Naomi Robinson - Senior Joint Commissioning Manager, Greater Nottingham Clinical Commissioning Partnership
- Rich Brady - Programme Director, Nottingham City ICP
- Zara Choudhery - Public Health Registrar
- Hannah Stovin - Senior Public Health Intelligence Manager
- Emma Coleman - Adult Safeguarding Board Manager
- Phil Wye - Governance Officer

42 Membership

The Board noted the membership changes

43 Appointment of Vice Chair

Resolved to appoint Dr Husein Mawji as Vice Chair of the Committee for the remainder of the 2023-24 municipal year.

44 Apologies for Absence

Charlotte Throssel
Superintendent Kathryn Craner (sent substitute)
Kevin Lowry
Catherine Underwood
Jan Sensier
Lesley Hutchinson
Sarah Collis

45 Declarations of Interests

None.

46 Minutes

The minutes of the meeting held on 27 September 2023 were confirmed as a correct record and signed by the Chair.

47 Minutes of the Commissioning Sub-Committee

The minutes of the Commissioning Sub-Committee, held on 27 September 2023 were noted.

48 Nottingham City Safeguarding Adults Board Annual Report 2022-2023

Sara Storey, Director for Adult Health and Social Care, and Emma Coleman, Adult Safeguarding Board (SAB) Manager, presented the report providing an overview of the SAB's activity over the 2022-23 financial year including progress against the Strategic Priorities set out in the 2022-2025 Strategic Plan, Safeguarding Adults Review activity, annual data provided by Adult Social Care and information from SAB member agencies on their safeguarding activity throughout the year. The following information was highlighted:

- (a) the three strategic priorities of the SAB are Prevention, Assurance and Making Safeguarding Personal. It has three sub-groups focused on Quality Assurance, Safeguarding Adults Reviews and Training, Learning and Improvement;
- (b) there has been a national increase of 9% in the number of safeguarding concerns raised, which is the same annual growth rate as last year. In comparison, Nottingham City's data shows a 3.65% increase in adult safeguarding referrals when compared to 2021-22 which is less than the national average and goes against the decrease seen the year before. When considering Section 42 enquiries, there is a significant decrease of nearly 10% (9.45%) which goes against the national trend which shows an increase of 7%;
- (c) the most common type of reported abuse was neglect, followed by financial, physical and psychological. Physical and domestic abuse had reduced from the previous 2 years. Discriminatory abuse remains consistently low, something which has been raised nationally as an area for Safeguarding Boards to focus on;
- (d) when compared to 2021-22, there has been a small increase in NHS staff as perpetrator. It is possible this corresponds with the implementation of the SAB PiPoT (People in Positions of Trust) Guidance in Q4, and is something the Board will be seeking to explore in 2023-24;
- (e) the majority of data relates to white British citizens which does not necessarily represent the local population. The Board intends to explore better engagement with other communities and which will need more support;
- (f) all priorities have clear work programmes. Key areas that have been worked on this year include improved datasets, prevention, and implementation of a new quality assurance framework. The SAB will continue to work with all organisations and individuals to understand abuse and how to refer it.

The following points were raised during the discussion which followed:

- (g) the SAB intends to research levels of engagement with different communities in other local authority areas by reaching out through the national networks available;
- (h) the most important way to engage as fully as possible is to make people more empowered to make referrals, and recognise safeguarding concerns and abuse. The SAB is working to raise awareness and also to make the referral process simpler;
- (i) the Fire Service has challenges to engage with communities and is working with Nottingham Trent University. There may be opportunity for collaborative working.

Resolved to

- (1) note the Annual Report and Executive Summary;**
- (2) recommend any areas it would like NCSAB to focus on going forward by contacting Emma Coleman or Lesley Hutchinson.**

49 Better Care Fund (BCF) Root and Branch Review

Naomi Robinson and Karla Banfield presented the report, highlighting the following:

- (a) the Better Care Fund (BCF) was announced in June 2013 as part of the government's Spending Review. It was described as creating a national £3.8 billion pool of NHS and Local Authority monies to support an increase in the scale and pace of integration and to promote joint planning for the sustainability of local health and care economies;
- (b) Better Care Funding is aligned to Health and Wellbeing Board (HWB) areas. As such in Nottinghamshire there are two joint plans, owned and agreed by the Nottingham City and Nottinghamshire County HWBs and governed by an agreement under section 75 of the NHS Act (2006);
- (c) the BCF in Nottingham City is used under three themes: Early Help and Prevention, Proactive Care, and Discharge to Assess Services;
- (d) following the merger of 6 CCGs and the formation of the Nottingham and Nottinghamshire Integrated Care Board, a decision was made to review the BCF, in order to de-mystify it and allow shared alignment to Integrated Care Strategy strategic plans. The review was planned in three phases: a BCF Planning Template review, a Root and Branch Analysis, and Collaborative Commissioning Reviews;
- (e) the Root and Branch Analysis recommended Joint Commissioning Reviews, Collaborative Oversight of Outcomes, and Collaborative Oversight of Funding. The key recommendation is to progress identified opportunities for integration

through a collaborative commissioning review process;

- (f) phase 3 will consist of Stakeholder Workshops with each HWB, Place Based Partnerships and Providers, with sub-groups in place to progress the actions and monitor delivery.

The following points were raised during the discussion which followed:

- (g) the City and County HWBs have different priorities, so following the review sensible decisions will be made on whether to jointly commission services or not, dependent on these priorities;
- (h) the workshops will need to think about what the priorities for the city are and how the BCF programme should be shaped. This is an opportunity to think outside the box and shape priorities.

Resolved to

(1) note the BCF Root and Branch Review;

(2) agree to a developmental workshop approach for discussion outside of the H&WBB, in February 2023

50 Joint Health and Wellbeing Strategy - Delivery Update

Rich Brady, Programme Director for the Nottingham City Place Based Partnership, presented the report providing an overview of delivery progress of the four Joint Health and Wellbeing Strategy (JHWS) programmes and an overview of the work undertaken to establish an outcomes framework to allow for assessment of progress and evaluation of the effectiveness of the programmes, highlighting the following:

- (a) the Smoking and Tobacco Control, Eating and Moving for Good Health, and Severe Multiple Disadvantage (SMD) programmes are all progressing in line with delivery plan expectations;
- (b) while pace of progress of the Financial Wellbeing programme continues to be slower regarding collective actions being agreed, there is a plethora of activity being undertaken by individual partners that is contributing to the delivery of the programme. It is the view of the Programme Oversight Group that greater emphasis on collective activity will better enable the successful delivery of this programme;
- (c) in the Smoking and Tobacco Control programme, progress is good against the 4 themes. The success of the Targeted Lung Health Checks programme has enabled a range of smoking cessation support to people wanting to quit and funding is being sought for the continuation of smoking cessation support in NHS settings;
- (d) the Eating and Moving for Good Health programme is progressing well in line with its delivery plan. A Healthy Schools Team has been established and have begun engaging schools to create a Healthy School Award/Charter, and analysis of

national data is being undertaken in order to provide schools with data to support them to better understand the actions that can be taken to support healthy diet and weight management;

- (e) whilst a plan for the Financial Wellbeing programme has been produced, partners are still to agree the delivery of this plan through collective resource and actions that will have the impacts needed to meet the overarching ambition for the programme. To enhance the impact of this programme there is a need for partners to take greater shared ownership of the financial wellbeing programme through greater investment of time and resources to deliver the actions that partners have identified will have maximum impact;
- (f) a gambling related harm awareness campaign has gone live in the city including both digital and out-of-home assets. Advice provided by Financial Advisor Social Prescribing Advice Link Workers embedded in three of the City's Primary Care Networks are showing significant improvements on people's wellbeing scores, and an evaluation is underway to understand wider impact and inform a business case for continuation of support;
- (g) the SMD programme is on track to deliver against its delivery plan. The SMD partnership has now been successful in securing ongoing funding through both an extension of national funding and recurrent, local funding through the ICB Health Inequalities and Innovation Fund from 2024/25 onwards. A race equity event was held in September and attended by around 150 people;
- (h) a draft outcomes framework has been developed, which allows for the assessment of progress and evaluation of the effectiveness of each of the programmes in relation to population health outcomes. Work is underway to revise the outcomes for the SMD programme which will be incorporated into the next draft, alongside the outcomes identified as part of the Financial Wellbeing programme plan. The outcome framework will measure Nottingham's performance in comparison to nearest statistical neighbouring areas;
- (i) while the partnerships that underpin the four programmes are undertaking significant activity as detailed in the delivery updates, it is too early to assess the impact that programme activity is having on the overall delivery of the JHWS.

The Chair raised concerns about people not being able to afford attending their preventative health checks, and the digital divide and how to link up with those that do not have access to the internet.

The Chair mentioned recently proposed government policy on restricting the smoking age and restriction of vaping, seeking permission to make a response in favour on behalf of the Board.

Resolved to

- (1) note the update provided by the Nottingham City Place-Based Partnership Programme Oversight Group;**

- (2) note the challenges identified in progressing the delivery of the Financial Wellbeing programme and consider how greater shared ownership of the programme can be achieved;**
- (3) delegate authority on behalf of the Board to the Chair, Vice-Chair and Director of Public Health to provide a view to the government on its recently proposed Tobacco and Vapes bill.**

51 Director of Public Health Annual Report

Lucy Hubber, Director of Public Health, introduced her statutory Annual Public Health Report which focuses on 10 years of public health in local government, after the transfer of responsibilities from the NHS in 2013. The report celebrates some of the key public health work undertaken by the team over the past decade.

A presentation highlighting key achievements and challenges was delivered by Ana Oliva and Zara Choudhery, Public Health Registrars.

Resolved to

- (1) note the contents of the Annual Public Health Report (2023) for Nottingham;**
- (2) reflect on the lessons learnt as a result of the wide-ranging work undertaken over the past decade, and consider opportunities for building on these to further improve health and wellbeing in Nottingham moving forward**

52 Pharmaceutical Needs Assessment - Pharmacy Consolidation Application

Hannah Stovin, Senior Public Health Intelligence Manager, presented the report informing the Board of an application to consolidate onto the site at 61 Ilkeston Road, Nottingham, NG7 3GR Canning Ltd and Paul Applegate Ltd. The Health and Wellbeing Board has a statutory responsibility to consider pharmaceutical need in the city, and this application has been brought forward because it constitutes a significant change in provision.

The applicant submits that the consolidation request would not create a gap in pharmaceutical services provision because there will be no reduction in the availability of pharmaceutical services during the core hours, all NHS pharmaceutical services that are currently provided will be provided at the consolidated site, premises facilities (e.g. parking, access, translation service) will remain largely unchanged, and there are 12 other pharmacies within a 1 mile radius.

Local ward Councillors have been consulted and no concerns have been raised.

Board members commented that current customers that use the site which is to be closed should be contacted about their options for alternative pharmacies other than the consolidated site, so that they can make a meaningful choice.

Resolved to

- (1) support the proposed consolidation, noting the suitable alternative local access and raising a concern on the reduced accessibility to Site 1, and requesting that customers of the site that is to be closed be written to about their options for alternative pharmacy provision;**
- (2) delegate to the Senior Public Health Intelligence Manager to provide representation to the Nottingham & Nottinghamshire ICB.**

53 Joint Health Protection Board Update

Lucy Hubber provided a verbal update and highlighted the following:

- (a) a variant of swine flu has been identified in North Yorkshire with mild symptoms, and sources are being identified;
- (b) there has been an increase nationally of measles cases, and there is a push to increase uptake of childhood vaccination. This is a completely preventable illness so all partners should encourage uptake.

Resolved to

- (1) note the updates;**
- (2) explore whether it is possible to provide targeted data on eligibility to partners so that they can target their messaging on vaccinations;**
- (3) provide leaflets on vaccinations to Councillors so that they can distribute to citizens.**

54 Board Member Updates

The written updates were noted.

55 Work Plan

A suggestion was made to include the Race Health and Equalities report at the March meeting. With this addition, the forward plan was noted.

56 Future Meeting Dates

The future meeting dates were noted.

Nottingham City Council

Nottingham City Health and Wellbeing Board Commissioning Sub-Committee

Minutes of the meeting held at Loxley House, Nottingham on 29 November 2023 from 3.40 pm - 3.51 pm

Voting Membership

Present

Sarah Fleming (Chair)
Councillor Linda Woodings
Karla Banfield (Substitute)

Absent

Dr Dave Briggs
Roz Howie (sent substitute)

Non-Voting Membership

Present

Absent

Ailsa Barr
Sarah Collis
Lucy Hubber
Sara Storey

Colleagues, partners and others in attendance:

Alison Donaldson - Programmes and Strategy Manager
Karla Banfield - Head of Commissioning
Naomi Robinson - Joint Commissioning Manager, NHS Nottingham and Nottinghamshire Integrated Care Board
Phil Wye - Governance Officer

33 Membership

Resolved to note that Roz Howie has replaced Katy Ball as Director of Commissioning and Partnerships on the Sub-Committee

34 Apologies for Absence

Lucy Hubber
Roz Howie (sent substitute)

35 Declarations of Interests

None.

36 Minutes

As no voting member was present who has attended the previous meeting, confirmation of the minutes was deferred.

37 The Better Care Fund (BCF) Quarter 2 National Return

Naomi Robinson and Alison Donaldson presented the report which presents the Nottingham Better Care Fund quarterly reporting template for July to September 2023, which was submitted to NHS England on 31 October 2023, for formal ratification. The following information was highlighted:

- (a) Residential Admissions is the rate of permanent admissions to residential care per 100,000 population (65+). This has been reported as not on track to meet the target. The metric is linked to an ASC transformation program, which aims to enhance the independence of older people. The program only recently acquired the necessary resources for its implementation, and reviews of individuals in short-term placements have begun. The program has now entered the pilot phase, a learning and scoping phase. Due to the delay, the pilot implementation in the Hospital Discharge team has been postponed to 2023-2024, which previously did not have a defined timeline;
- (b) Reablement is the proportion of older people (65 and over) who were still at home 91 days after discharge from the hospital into reablement/rehabilitation services. The reablement team are currently experiencing challenges in meeting the demand for carers in the reablement service, which is being closely monitored. Unfortunately, this has led to some citizens being unable to access reablement and instead having to transfer directly to external providers who do not offer reablement services. A diagnostic of internal reablement service is currently underway to improve service delivery;
- (c) the quarter two return does not require any expenditure to be reported, however NHS England have advised that this will be required from quarter three onwards. Actual expenditure of the Additional Discharge Funding is reported directly to NHS England on a fortnightly basis, and the national team are currently determining which financial information to request quarterly to ensure that the information requests are proportionate.

Resolved to formally ratify the Nottingham BCF quarter two reporting template that was submitted to NHS England on 31 October 2023.

38 Future Meeting Dates

The future meeting dates were noted.

**Nottingham City Health and Wellbeing Board
24 January 2024**

Report Title:	Nottingham and Nottinghamshire Joint Strategic Needs Assessment: Suicide Prevention
Lead Board Member(s):	Lucy Hubber, Director of Public Health
Report author and contact details:	Serena Coultriss, Public Health Manager
Other colleagues who have provided input:	Helen Johnston, Consultant in Public Health Dave McDonald, Senior Public Health Manager Tammy Coles, Public Health Principal
Executive Summary:	
<p>Suicides are not inevitable. Collectively Nottingham City Health and Wellbeing Board organisations work towards reducing suicide in the local population by proactively improving population mental health and wellbeing, and by responding to known risks for suicide in the population.</p> <p>A refreshed JSNA chapter has been developed through the Nottinghamshire and Nottingham City Suicide Prevention Strategic Steering Group. The JSNA systematically describes local data and trends, along with key insight and national guidance on suicide prevention. It sets out local priorities and services to support people locally. As a needs assessment, it also highlights areas for further attention.</p> <p>In Nottingham, the most recent suicide rate is 11.2 per 100,000 people (2019-21), which is higher than both the East Midlands (10.3) and England (10.4) rates, however is not a statistically significant difference. The rate of suicide in Nottingham has decreased from 12.7 per 100,000 people in 2017-19 to 11.2 per 100,000 in 2019-21.</p> <p>The following unmet needs locally have been identified within this JSNA:</p> <ol style="list-style-type: none"> 1. Current school-based mental health support does not specifically address suicide prevention. 2. There is a need for additional work to tailor support for men to reduce risk factors and antecedents for suicidality. 3. There is a need to support health seeking behaviours in men. 4. Voluntary and community services report a need for increased skills and knowledge in how to help people experiencing self-harm and suicidality access a continuum of appropriate holistic support. 5. Ensure evidence-based approaches support social connectedness and emotional wellbeing to reduce self-harm and suicidality among LGBTQ+ young people in current school-based and community-based locations. 	

6. Further collaborative work is needed to improve access to support services for Gypsy Roma and Traveller communities.
7. Systems are needed to ensure professionals in community, healthcare, money help and other public-facing roles have up-to-date knowledge and can support access to financial advice and wellbeing and mental health support.
8. Follow-up support is commissioned after first attendance to emergency departments for suicide ideation, and not for later attendances.
9. There is a need to identify effective interventions to address the mental health needs and prevent suicide for people with long term physical health conditions.
10. Greater links and shared learning between domestic abuse and suicide prevention teams is needed.
11. There is a need to better support the needs of children and young people who are in crisis and present to the emergency department with self-harm or suicidal ideation.
12. There is a need to address online safety and suicide-related internet use.

The following knowledge gaps were identified:

- Evidence is currently limited on the effectiveness of interventions to prevent suicide and self-harm in people using substances.
- Limited understanding of the links between gender, domestic abuse and suicide (particularly sexual violence).
- Effective and appropriate links between RTSSS and Mental Healthcare provider self-harm and suicide data to inform antecedent themes and prevention action.
- Prevalence and means of self-harm, including understanding of self-harm presentations to VSCE organisations and the scale of potentially unmet need.
- Understanding gambling harm local intelligence in relation to suicide risk factors to inform targeted interventions.
- Limited understanding of approaches to reducing suicidality in people in contact with probation and youth justice services.

19 recommendations have been developed in relation to the needs in Nottingham and Nottinghamshire, aligned to the Suicide Prevention Strategy for England 2023-2028. This JSNA chapter will inform the local strategy and work programme of the Suicide Prevention Strategic Steering Group.

Recommendation(s): The Board is asked to:

- 1) To endorse the JSNA chapter on Suicide Prevention
- 2) To support the development of a local strategy for implementation of the identified recommendations

The Joint Health and Wellbeing Strategy	
Aims and Priorities	How the recommendation(s) contribute to meeting the Aims and Priorities:
Aim 1: To increase healthy life expectancy in Nottingham through addressing the wider determinants of health and enabling people to make healthy decisions	Suicide has a significant, lasting and often devastating impact – emotionally, psychologically, and economically - on individuals, families, communities and wider society. Our aim is to reduce the rate of suicide and self-harm in Nottingham City. Suicide occurs within every demographic group but certain groups are known to be at higher risk, and there is an association between suicide and socioeconomic deprivation. Our suicide prevention work focuses on promoting mental health and wellbeing, and on reducing risks and health inequalities.
Aim 2: To reduce health inequalities by having a proportionately greater focus where change is most needed	
Priority 1: Smoking and Tobacco Control	
Priority 2: Eating and Moving for Good Health	
Priority 3: Severe Multiple Disadvantage	
Priority 4: Financial Wellbeing	
How mental health and wellbeing is being championed in line with the Board’s aspiration to give equal value to mental and physical health:	
The JSNA chapter systematically describes local data and trends, insight and guidance on suicide prevention and identifies recommendations to reduce self harm and suicide locally.	

List of background papers relied upon in writing this report (not including published documents or confidential or exempt information)	
Published documents referred to in this report	Nottingham and Nottinghamshire JSNA: Suicide Prevention

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NOTTINGHAM & NOTTINGHAMSHIRE JOINT STRATEGIC NEEDS ASSESSMENT

SUICIDE PREVENTION

DECEMBER 2023

Topic information	
Topic owner	Nottingham & Nottinghamshire Suicide Prevention Strategic Steering Group
Topic author(s)	Safia Ahmed Serena Coultriss Lucy Jones David McDonald Sid Basu
Topic quality reviewed	November 2023
Topic endorsed by	Nottingham & Nottinghamshire Suicide Prevention Strategic Steering Group
Topic approved by	
Replaces version	2016
Linked JSNA topics	Self-Harm

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Executive summary

Introduction

Suicide is preventable and Nottinghamshire County Council, Nottingham City Council and local partners work towards reducing suicide in the local population by proactively improving population mental health and wellbeing, and by responding to known risks for suicide in the population.¹

The previous Joint Strategic Needs Assessment on Suicide Prevention was approved in February 2016. Seven years on, and post the coronavirus pandemic, research has shown increased psychological morbidity in UK populations.² In terms of suicide risk, systematic review research has shown that the way people seek help for suicidal behaviour has changed, with no overall rise in suicide deaths.³

A renewed understanding of local needs for those at risk of suicide is needed. Since 2019, Nottingham City and Nottinghamshire County have collected data on suspected suicide deaths (pre-Coroner's inquest) as part of a Real Time Suspected Suicide Surveillance (RTSSS) system. Insight from RTSSS provides an improved local assessment of suspected suicides, which along with nationally reported data, ensures actions to prevent suicides are based on local data and intelligence.

This executive summary contains findings in terms of unmet need, knowledge gaps, and recommendations. The full JSNA document provides the detail of who is at risk, what this tells us and what to do next.

This JSNA is owned by the Nottinghamshire and Nottingham City Suicide Prevention Strategic Steering Group. Development of the JSNA was driven by a dedicated task and finish group, consisting of stakeholders from within the owning group. This included representatives from Nottingham and Nottinghamshire Integrated Care Board mental health commissioners, Nottinghamshire County Council Public Health, Nottingham City Council Public Health, Nottinghamshire Healthcare Foundation Trust, Bassetlaw Place Based Partnership, and the voluntary sector (the Samaritans).

¹ Nottingham City and Nottinghamshire County Public Health. Nottingham City and Nottinghamshire Suicide Prevention Strategy 2019-2023. September 2019.

² Jia R, Ayling K, Chalder T, et al. Mental health in the UK during the COVID-19 pandemic: cross-sectional analyses from a community cohort study *BMJ Open* 2020;10:e040620. doi: 10.1136/bmjopen-2020-040620

³ John A, Eyles E, Webb RT et al. The impact of the COVID-19 pandemic on self-harm and suicidal behaviour: update of living systematic review [version 2; peer review: 1 approved, 2 approved with reservations]. *F1000Research* 2021, 9:1097 (<https://doi.org/10.12688/f1000research.25522.2>)

Unmet need and gaps

The following unmet needs were identified:

1. Current school-based mental health support does not specifically address suicide prevention. Evidence suggests vulnerability to suicide can be partly established early in life and that taking early intervention and school-based approaches can be preventative.⁴
2. There is a need for additional work to tailor support for men to reduce risk factors and antecedents for suicidality. These include economic adversity, alcohol and drug use, relationship stresses and lack of social connections.
3. There is a need to support health seeking behaviours in men. National data suggests that 9% of middle-aged men experiencing suicidality are not in contact with any support.⁵
4. Voluntary and community services report a need for increased skills and knowledge in how to help people experiencing self-harm and suicidality access a continuum of appropriate holistic support.
5. Ensure evidence-based approaches support social connectedness and emotional wellbeing to reduce self-harm and suicidality among LGBTQ+ young people in current school-based and community-based locations.
6. Further collaborative work is needed to improve access to support services for Gypsy Roma and Traveller communities.
7. Systems are needed to ensure professionals in community, healthcare, money help and other public-facing roles have up-to-date knowledge and can support access to financial advice and wellbeing and mental health support. This should include knowledge and pathways at a local level.
8. Follow-up support is commissioned after first attendance to emergency departments for suicide ideation, and not commissioned for later attendances. Effective follow-up care has the potential to help people who self-harm to access the right support and prevent suicide.
9. There is a need to identify effective interventions to address the mental health needs and prevent suicide for people with long term physical health conditions.
10. Greater links and shared learning between domestic abuse and suicide prevention teams is needed. National data and research highlight that women are disproportionately affected by domestic abuse suicide.⁶
11. There is a need to better support the needs of children and young people who are in crisis and present to the emergency department with self-harm or suicidal ideation. Looked after young people and those transitioning from CYP to adult services, were identified as groups of particular need.

⁴ The developmental origins of suicide mortality: A systematic review of longitudinal studies, Vidal-Ribas, Pablo; et al, *European Child & Adolescent Psychiatry*, 2022.

⁵ The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Suicide by middle-aged men. 2021. The University of Manchester.

⁶ Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England Sally McManus et al. June 07, 2022 DOI:[https://doi.org/10.1016/S2215-0366\(22\)00151-1](https://doi.org/10.1016/S2215-0366(22)00151-1)

12. There is a need to address online safety and suicide-related internet use. In the absence of local data, we look to national data which indicates a general increase in suicide-related internet use since 2011.⁶

The following knowledge gaps were identified:

- Evidence is currently limited on the effectiveness of interventions to prevent suicide and self-harm in people using substances.
- Limited understanding of the links between gender, domestic abuse and suicide (particularly sexual violence).
- Effective and appropriate links between RTSSS and Mental Healthcare provider self-harm and suicide data to inform antecedent themes and prevention action.
- Prevalence and means of self-harm, including understanding of self-harm presentations to VSCE organisations and the scale of potentially unmet need.
- Understanding gambling harm local intelligence in relation to suicide risk factors to inform targeted interventions.
- Limited understanding of approaches to reducing suicidality in people in contact with probation and youth justice services.

Recommendations for consideration

The following recommendations have been identified and are aligned to components of the new Suicide Prevention Strategy for England (2023 to 2028):

	Recommendations	Lead(s)
	Improved Data and Evidence	
1	Improve data and intelligence sharing between partners including through the local Real Time Suspected Suicide Surveillance (RTSSS) system in order to ensure the quality of the RTSSS data and learning reviews after a suicide death has occurred and to improve the understanding of local need and gaps.	Local authority Public Health teams/ Nottinghamshire Healthcare Trust/ partners in RTSSS working group
2	Establish protocols for appropriate sharing and analysis of data on self-harm and suicide attempts among key partners working with groups at increased risk of suicidality, including mental health, domestic abuse, drug and alcohol use services to inform preventative actions.	Local authority Public Health teams/ Nottinghamshire Healthcare Trust
	Reducing access to means and high frequency locations	
3	Continue to prioritise action on reducing access to means for suicide within public places using intelligence from Real Time Suspected Suicide Surveillance (RTSSS) and through the RTSSS Working Group.	Local authority Public Health teams and partners in RTSSS working group
	Providing tailored and targeted support to target groups.	

4	Develop integrated suicide prevention approaches for children and young people (CYP) in school settings via the Whole School Approach and CYP Mental Health Transformation Programme	Local authority Public Health and Education teams/CYP Mental Health Transformation leads
5	Facilitate the development of services and support, co-produced with men, to address suicide risk factors and promote social connections in informal settings.	Local authority Public Health teams/VSCE sector
6	Develop targeted suicide prevention communications for men to support engagement in and access to support services.	Local authority Public Health teams/ Nottinghamshire Healthcare Trust
7	Work with partners (including VSCE and primary care) to better understand where people experiencing self-harm or suicide ideation come into contact with services and what further action is needed to identify and support them, particularly for those whose needs do not meet the threshold for secondary mental healthcare.	All commissioners in Local authority Public Health teams
8	Develop communication resources to support people experiencing self-harm to access the right support at the right time.	Local authority Public Health teams
9	Integrate evidence-based approaches to supporting social connectedness and emotional wellbeing for LGBTQ+ people into school and community-based approaches and services.	Local authority Public Health teams/CYP Mental Health Transformation leads
10	Partner with community champions and existing organisations to improve access to appropriate support services for people from Gypsy Roma and Traveller communities.	Local authority Public Health teams
Addressing risk factors		
11	Use learning from local pilot projects and listening events to improve access for groups who are at increased risk of not accessing self-harm and suicide prevention support such as: <ul style="list-style-type: none"> - Gypsy Roma Traveller groups - LGBTQ+ groups - Men - Those who are financially vulnerable, unemployed or people with a gambling problem - People with neurodevelopmental conditions - Young people/adults at risk of self-harm/suicide - People bereaved by suicide 	Local authority Public Health teams/CYP Mental Health Transformation leads
12	Support the community and voluntary sector to support people from at-risk groups who are experiencing self-harm and suicidality such as: men, people with financial difficulty, LGBTQ+ communities, people experiencing loneliness, and people in contact with the criminal justice system.	Local authority Public Health teams/VSCE sector

13	Work with services providing financial support/advice and wellbeing support to improve the pathways between psychosocial support and money help, promote workforce awareness of financial advice and wellbeing support, and strengthen links between financial support and mental health services.	Local authority Public Health teams
14	Identify contacts and foster links with commissioners and providers of chronic pain and cancer pathways to explore how to improve access to appropriate support services.	Local authority Public Health teams/ Nottinghamshire Healthcare trust
15	Develop links with probation, youth justice and community-based services for people in contact with criminal justice system to develop training and involvement with the Suicide Prevention Stakeholder Network and Suicide Prevention Strategic Steering Group.	Local authority Public Health teams
16	Review mechanisms for sharing learning from Domestic Homicide Reviews relating to suicide with the suicide prevention partnership and consider opportunities for links between Assurance Learning Implementation Groups (ALIG) and the Suicide Prevention Strategic Steering Group.	Local authority Public Health teams
Effective crisis support		
17	Work with the Integrated Care Board to identify support following Emergency Department attendance for every incident of suicide ideation.	Integrated Care Board
18	Work with the Integrated Care Board's Children and Young People (CYP) team to identify opportunities to promote the mental health and wellbeing and appropriate crisis support for CYP and looked-after children and ensure pathways for support are aligned to facilitate easy access for CYP.	Integrated Care Board (CYP and looked-after children's team)
Online safety:		
19	Develop an approach to promote online safety, informed by the national online excellence programme.	Local authority Public Health teams, Education and Children's social care teams.

Full JSNA report

Notable changes from previous JSNA

Real Time Surveillance for suspected suicide: (RTSSS) data collection (pre-Coroner's inquest) in Nottingham City and Nottinghamshire County has been in place since 2019, with data around sexual identity, deprivation and ethnicity consistently collected from 2022 onwards. Insight from this platform has allowed an improved local needs assessment of suspected suicide (pre-Coroner's inquest) of Nottingham City and Nottinghamshire County residents. RTSSS data is also used to highlight any potential clusters or patterns of suspected suicide deaths to inform timely strategies to help prevent suicide.

National Statistics definition of suicide: This includes all deaths from intentional self-harm for persons aged 10 years and over and deaths caused by injury or poisoning where the intent was undetermined for those aged 15 years and over.⁷

From January 2016 the National Statistics definition of suicide widened to include deaths from intentional self-harm in children aged 10 to 14 years. Deaths from an event of undetermined intent in 10- to- 14-year-olds are not included in suicide statistics. This is because for older teenagers and adults, it is assumed that the harm resulting in death is self-inflicted, however for younger children it is not clear whether this assumption is appropriate.

Research has been conducted and it was found that the inclusion of these deaths has not had a significant impact on the overall age-standardised rates.¹

Change to the Standard of Proof for suicide in England and Wales: In England and Wales, all unnatural deaths are investigated by coroners to establish the cause and circumstances of the death. The investigation, known as an inquest, compiles evidence such as post-mortem, toxicology reports, and interviews with relatives and friends. Once all the available evidence has been collected, a coroner will then determine the cause of death, and manner of death and surrounding circumstances.⁸

On 26 July 2018, as a result of a case in the High Court, the standard of proof (the evidence threshold) used by coroners to determine whether a death was caused by suicide was changed from the criminal standard of "beyond all reasonable doubt" to the civil standard of "on the balance of probabilities". This legal change has not resulted in any significant change in the reported suicide rate in England and Wales; recently observed increases in suicide among males and females in England, and females in Wales, began before the standard of proof was lowered.

Since the change, the proportion of deaths in England and Wales with an underlying cause of intentional-self harm increased, whereas the proportion coded to undetermined intent

⁷ Suicide rates in the UK Quality and Methodology Information 2019. Office for National Statistics. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/methodologies/suicideratesintheukqmi>

⁸<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/changeinthestandardofproofusedbycoronersandtheimpactonsuicidedeathregistrationsdatainenglandandwales/2020-12-08>

decreased; this indicates a change in conclusions reached by coroners, but when taken as a whole does not impact suicide statistics as both of these are included in the suicide rate.

What do we know?

1. Who is at risk and why?

Suicide is a major issue for society and a leading cause of years of life lost. Suicide can affect anyone and has a significant, lasting and often devastating impact on individuals, families, communities, and wider society.^{9 10}

Suicide is often the end point of a complex history of risk factors and distressing events. However, suicide is preventable by working towards improving population mental health and wellbeing, and by responding to known risks for suicide in the population.

1.1. National context and general trends in suicide

Nationally, a total of 15,447 deaths from suicide were registered in the three-year period of 2019-21, equating to a rate of 10.4 per 100,000 people (Figure 1).¹⁰ This is the highest rate recorded since records began in 2001-03. However, this is not statistically significant compared to the previous three-year period of 2018-20 (10.3 per 100,000). The overall trend in suicide rates has been on the rise since 2006-08, rising from 9.2 per 100,000 (2006-08) to 10.4 per 100,000 (2019-21).

Males continued to account for three-quarters of suicide deaths registered in 2021 (4,129 male deaths compared with 1,454 female deaths), as seen since the mid-1990s.¹¹ Among women, those aged 45 to 49 years had the highest age-specific suicide rate at 7.8 per 100,000 in 2021 (146 registered deaths). Among men, those aged 50 to 54 years had the highest age-specific suicide rate at 22.7 per 100,000 (456 deaths). In terms of age and suicide, small differences from year to year or between age groups are unlikely to be statistically significant.

1.2. Risk factors for suicide

Many risk factors for suicide are well established. For example, most people who end their own life experience mental illness, with depression, psychosis, personality disorder, or substance dependence often implicated.¹⁴ Among the most common risk factors identified is

⁹ Zero Suicide Alliance. ZSA Training. 2021. Available from: <https://www.zerosuicidealliance.com/training>

¹⁰ Suicide Prevention Profile. Office for Health Improvement & Disparities. Available from: <https://fingertips.phe.org.uk/suicide>

¹¹ Suicide registrations in England and Wales 2021: Statistical bulletin. Office for National Statistics (ONS). Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2021registrations>

a history of self-harm and previous suicide attempts, present in approximately 40% of people who have died by suicide.¹²

The National Centre for Social Research (2019) identified and reviewed government-funded surveys to consolidate national self-harm and suicidal behaviour survey data in terms of common findings on trends, prevalence, subgroup variations, and risk and protective factors. Seven consistent themes emerged from analyses and included:

1. Mental illness and wellbeing
2. Physical health and health behaviours (multiple chronic health conditions)
3. Relationships (social isolation, relationship breakdown or violence and abuse)
4. Acute and chronic stressors (crisis and sustained adversity)
5. Economic adversity and insecurity (debt and housing insecurity)
6. Demographics and identity
7. Formal service contact

Mental illness was consistently the strongest risk factor for suicidal thoughts, suicide attempts and self-harm (without intent) to emerge across multiple analyses. Men in midlife and non-heterosexual population groups were also associated with higher rates of suicidal thoughts and attempts compared to the general population..

The National Confidential Inquiry into Suicide and Safety in Mental Health

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) provides findings relating to those who died by suicide between 2010 and 2020 across all UK countries. The dataset includes deaths in the general population and deaths of patients in contact with mental health services. This audit of suicides is useful in establishing key groups at risk, as well as changing trajectories seen through the context of current economic and societal factors. Key findings from the most recent annual report include:¹³

General population suicide trends: The rate of suicide decreased by 6% in the UK in 2020, the first year of the COVID-19 pandemic, compared to 2019. This followed a general increase in suicide rates in 2018-19 compared to 2017.

Patient suicide trends: This relates to people in contact with mental health services within 12 months of suicide. 27% of all general population suicides were among people who had been in contact with mental health services within 12 months prior to their death (18,403 deaths in 2010-2020). The overall increase in the rate of suicide in England over the reporting period was not reflected in the rate of suicide among patients under mental health care. There has been little change over time in this key group.

Clinical and social characteristics: The majority of mental health service patients who died had a history of self-harm (64%) and had more than one mental health diagnosis (53%). There were also high proportions of those with alcohol (48%) and drug (37%) use. Nearly

¹² McManus S et al. Suicide and self-harm in Britain: researching risk and resilience. NatCen Social Research, 2019 Available from: <http://www.natcen.ac.uk/our-research/research/suicide-and-self-harm-in-britain-researching-risk-and-resilience/>

¹³ The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: UK patient and general population data, 2010-2020. 2023. University of Manchester. Available from: <https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/>



half (48%) of all patients lived alone. In 5% of cases overall, the patients were recent migrants, i.e. seeking permission to stay in the UK or resident in the UK for less than 5 years.

Clinical care: Between 2010-2020, 5,103 mental health patients died by suicide in mental health acute care settings (28% of the total deaths that occurred), including in-patients (6%), post-discharge care (14%) and crisis resolution/home treatment (13%), with an average of 464 deaths per year. The most common non-acute settings were community mental health services (14%), alcohol or drug services (13%), and older people's mental health services (8%).

Suicide-related internet use – Between 2011 and 2020, there were 73 deaths of mental health patients per year where there was evidence of suicide-related internet use, equating to 8% of all patient suicides. The number has generally been increasing since 2011 though figures for 2019-20 suggest a recent fall.

2. Size of the issue locally

This section looks at local suicide rates and how they vary over time compared to national and regional areas, along with District and City level data compared with statistically similar neighbours.

2.1. Local trends in suicide

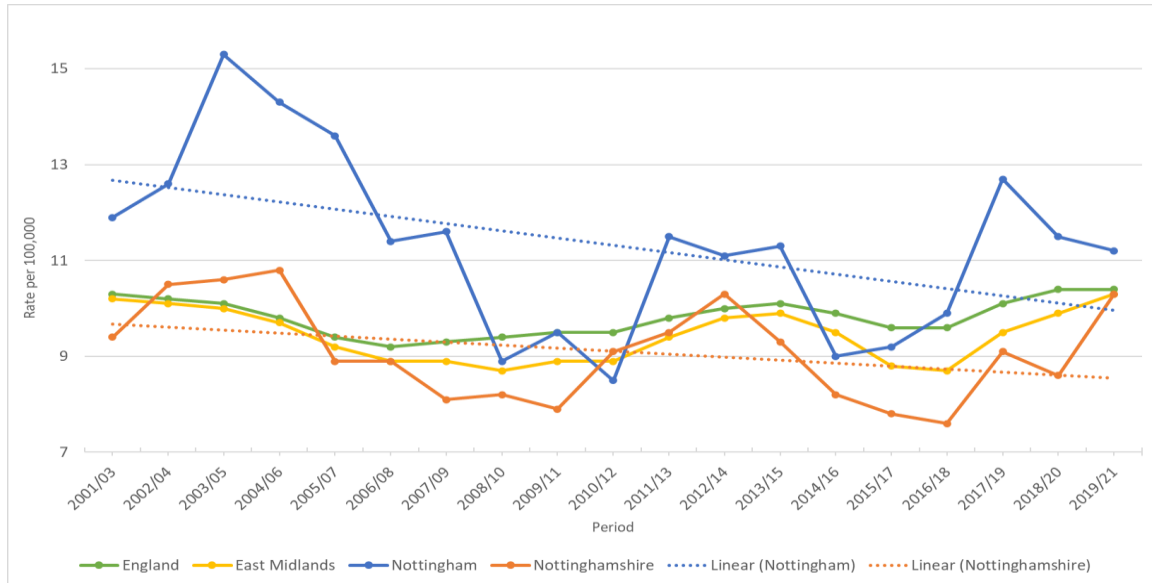
In the East-Midlands, the rate of suicide is 10.3 per 100,000 people (2019-21), which is statistically similar to the England average of 10.4. The overall trend for the region follows a similar pattern to the England average, but in more recent periods there has been a steady increase in the rate from 8.7 per 100,000 (2016-18) to 10.3 per 100,000 (2019-21) (Figure 1).³

In the latest three-year period (2019-21), Nottinghamshire's rate of 10.3 per 100,000 people is statistically similar to both the East-Midlands (10.3) and the England average (10.4). From 2012-14, the suicide rate in Nottinghamshire dropped from 10.3 to 7.6 per 100,000 in 2016-18 and has subsequently increased to 10.3 for the most recent period (2019-21). It is worth noting that the recent increase in rate from 8.6 in 2018-20 to 10.3 in 2019-21 is not significantly different.

In Nottingham, the most recent suicide rate is 11.2 per 100,000 people (2019-21), which is higher than both the East-Midlands (10.3) and England (10.4) rates, however is not a statistically significant difference. Recently in Nottingham, the rate of suicide has decreased from 12.7 per 100,000 people in 2017-19 to 11.2 per 100,000 in 2019-21.

Overall, between 2001 and 2021 the linear trend for rates of suicide in Nottinghamshire and Nottingham is following a downward trajectory.

Figure 1: Age Standardised Mortality Rate from Suicide and Injury of Undetermined Intent per 100,000 people (10+ yrs), 2001-2021



Source: OHID

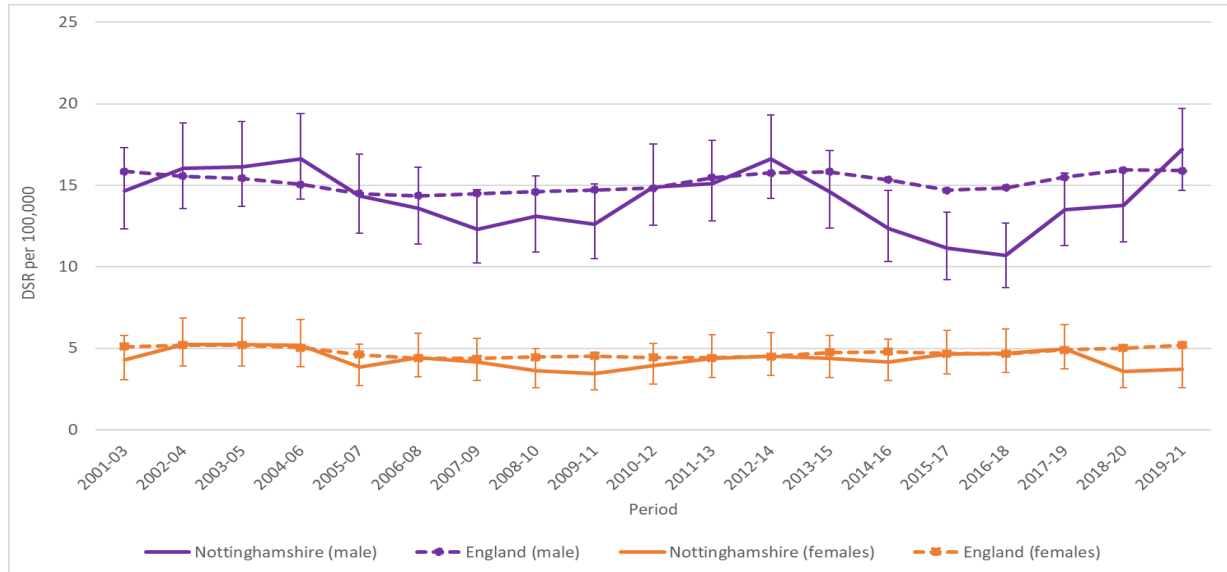
*Y axis starts from 7

** Changes in coronial context from July 2018. This legal change has not resulted in any significant change in the reported suicide rate in England and Wales.

Figure 2 shows that since 2001, suicide rates in Nottinghamshire have been significantly higher in males compared to females, mirroring national patterns. Rates in females have remained relatively stable and similar to the rates observed in England over the given time period. However, there was a notable decrease in rates among females in 2017-19 from 4.9 per 100,000 people to 3.6 in 2018-20. The rate has remained relatively constant in the recent period.

Rates among males exhibit annual variations, with a significant decrease observed from 16.6 per 100,000 people in 2012-14 to 10.7 per 100,000 people in 2016-18. However, since 2016-18 there has been a steady rise in suicide rates among males.

Figure 2: Age Standardised Mortality Rate from Suicide and Injury of Undetermined Intent per 100,000 people (10+yrs) by gender, Nottinghamshire, 2001-2021

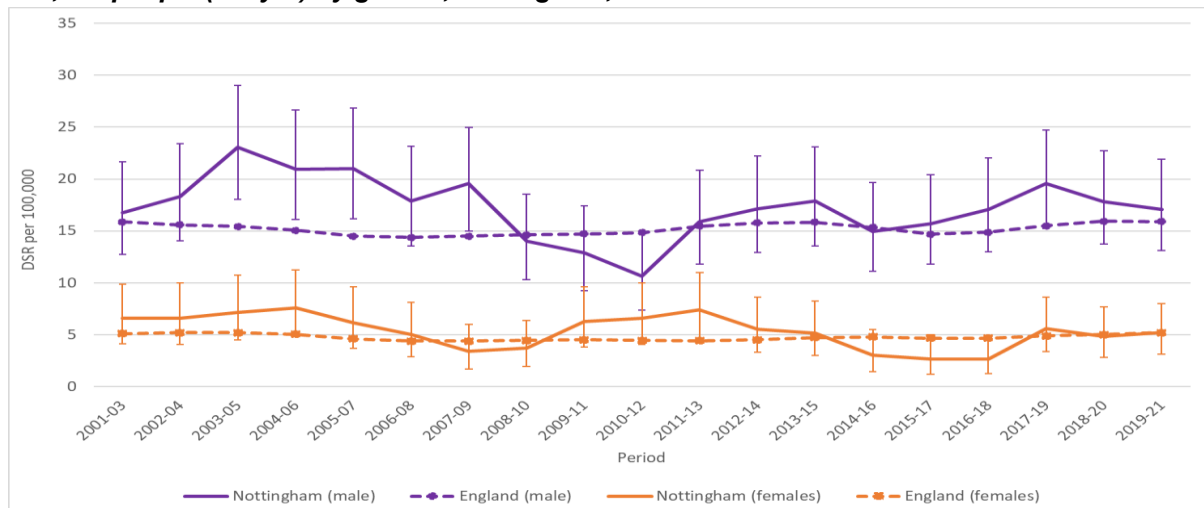


Source: OHID

Note: Directly standardised rate (DSR)

Similar to Nottinghamshire, suicide rates for males in Nottingham City have been consistently higher compared to females since 2001, mirroring national patterns. Rates in females, though varying year on year have remained statistically similar to the England average and have plateaued in more recent years. Apart from the period between 2003 and 2007, rates in males have not been significantly different from the England average. In more recent periods, suicide rates in males in Nottingham has been decreasing as shown in Figure 3 below.

Figure 3: Age Standardised Mortality Rate from Suicide and Injury of Undetermined Intent per 100,000 people (10+yrs) by gender, Nottingham, 2001-2021



Source: OHID

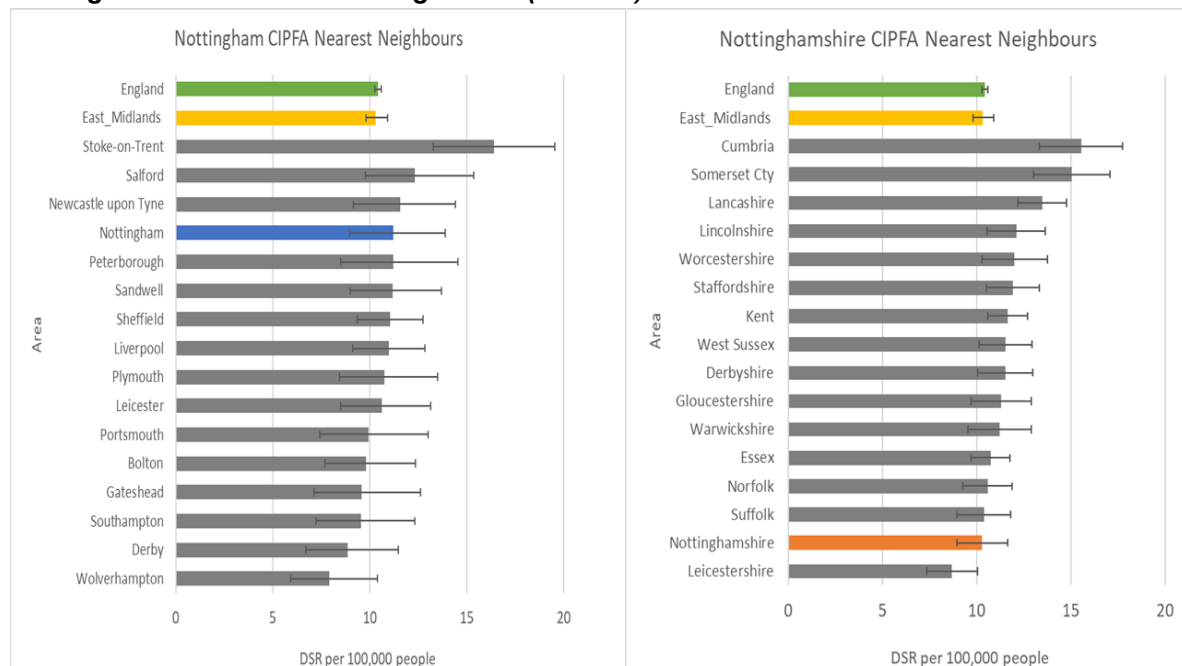
Note: Directly standardised rate (DSR)

2.1.1 Comparison to CIPFA Neighbours

For the latest three-year period (2019-21), Nottinghamshire has the second lowest rate of suicide among its Chartered Institute of Public Finance and Accountancy (CIPFA) neighbours and is also statistically significantly similar to the National and East-Midlands rates. Among CIPFA neighbours, Cumbria has the highest suicide rate of 15.5 per 100,000 people and Leicestershire the lowest rate (8.7 per 100,000 people).

For the same three-year period, Nottingham has the fourth highest suicide rate compared to its CIPFA neighbours, but this is not significantly different to either its CIPFA neighbours, England or East-Midlands averages. Among CIPFA neighbours, Stoke-on-Trent has the highest suicide rate and Wolverhampton the lowest rate (16.4 and 7.9 per 100,000 people respectively).

Figure 4: Age Standardised Suicide Rates (persons) per 100,000 people, Nottingham, Nottinghamshire and CIPFA Neighbours (2019-21)



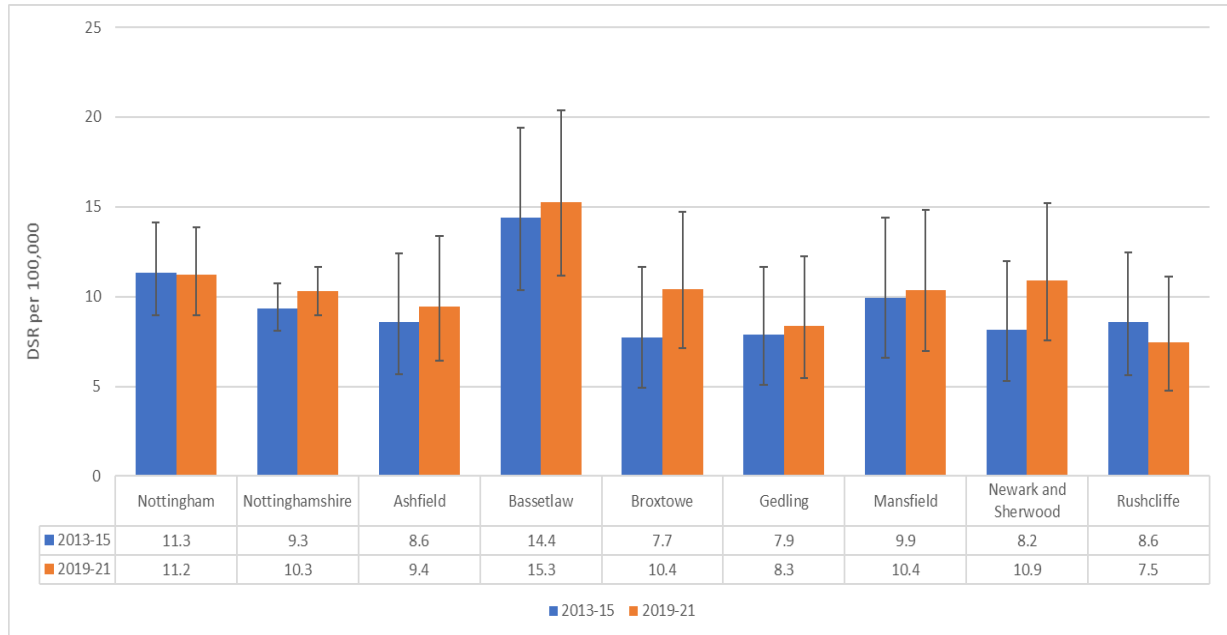
Source: OHID

Note: Directly standardised rate (DSR)

2.1.2 Suicide rates by area

Compared to the baseline year (2013-15), there has been no significant change in the suicide rates across the districts and Nottingham City as illustrated in Figure 5 below. Broxtowe and Newark & Sherwood had the highest rate change from the baseline year increasing from 7.7 to 10.4 and 8.2 to 10.9 per 100,000 people respectively (Table 1). Across the districts, Rushcliffe recorded a decrease in suicide rate from 8.6 (2013-15) to 7.5 per 100,000 people (2019-21). Due to absolute numbers being low, it is difficult to reliably detect patterns or changes over short periods of time.

Figure 5: Age Standardised Mortality Rates from Suicide and Injury of Undetermined Intent, pooled 3-year data for 2013-15 (baseline year) compared to 2019-21



Source: OHID

Note: Directly standardised rate (DSR)

Table 1: Rate change in Mortality from Suicide and Injury of Undetermined Intent, 2013-15 (baseline year) versus 2019-21.

Local Area & District	2013-15		2019-21		Difference	
	DSR per 100,000	Number	DSR per 100,000	Number	Rate Change	% Change
Nottingham	11.3	85	11.2	94	-0.1	11%
Nottinghamshire	9.3	200	10.3	226	1	13%
Bassetlaw	14.4	43	15.3	47	0.9	9%
Newark & Sherwood	8.2	26	10.9	35	2.7	35%
Broxtowe	7.7	23	10.4	32	2.7	39%
Mansfield	9.9	28	10.4	30	0.5	7%
Ashfield	8.6	28	9.4	32	0.8	14%
Gedling	7.9	25	8.3	26	0.4	4%
Rushcliffe	8.6	27	7.5	24	-1.1	-11%

Source: OHID

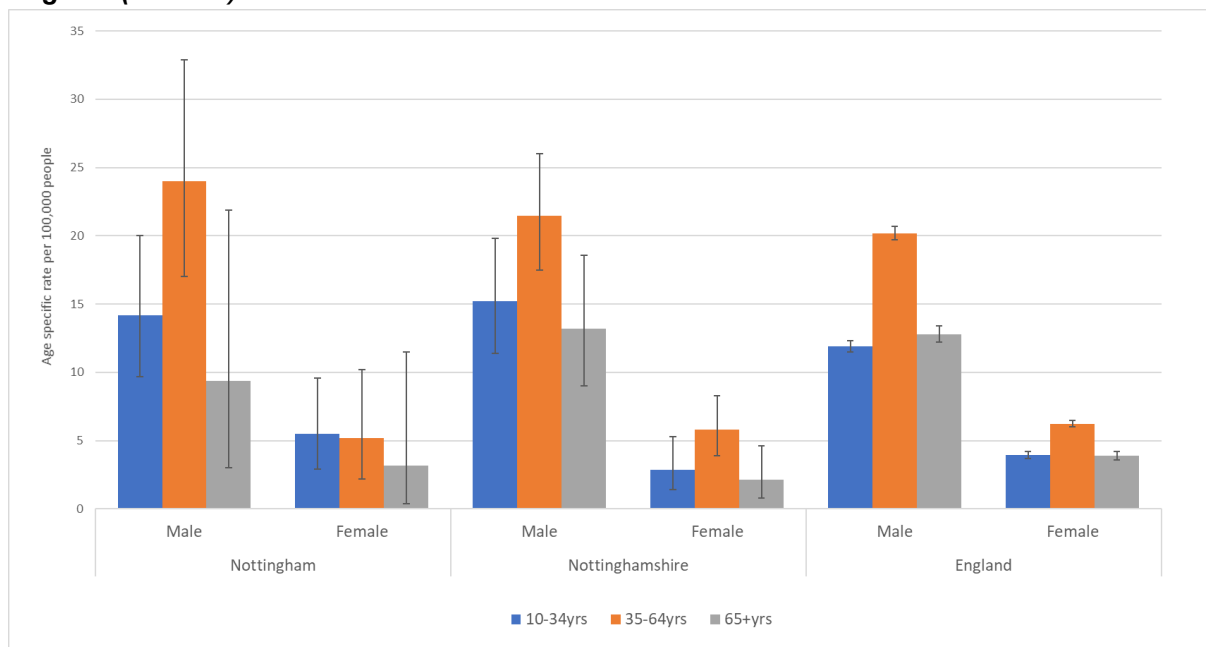
Note: Directly standardised rate (DSR)

*The darker shades indicate higher rates.

2.1.3 Age specific rates by gender

Figure 6 displays the age specific rates by gender in Nottingham, Nottinghamshire, and England. The data indicates significantly higher rates among males compared to females across all age groups except in the 10-35 and 65+ age groups in Nottingham. For both males and females, the rates are higher in age group 35-64; however, this is not statistically significant compared to other age groups in Nottingham and Nottinghamshire. Likewise, although rates are highest in males aged 35-64 in Nottingham, it is not significantly higher compared to rates in Nottinghamshire and England.

Figure 6: Age Specific Suicide Rates by Gender, Nottingham City, Nottinghamshire and England (2019-21)



Source: NHS Digital/ONS

2.2 Real Time Surveillance

This section looks at data from the Real Time Surveillance of Suspected Suicides (RTSSS) and includes general trends over time with further sub-group analysis by age, gender, ethnicity and deprivation.

The RTSSS data is comprised of data reported by Nottinghamshire Police and British Transport Police. Data is reported pre-Coroners' inquest and relates to deaths that are suspected to be suicide deaths rather than deaths that have been confirmed as a suicide by the coroner. The system supports the local response whilst there is a lag in official statistics on numbers of deaths by suicide.



There are a range of factors that may influence the numbers and patterns of reported suspected suicide deaths that the real-time surveillance system is informed of. Nationally reported data provides a more consistent measure.

Data reported by Nottinghamshire Police is collected from the next of kin at the time of death and is reliant on what next of kin are able and comfortable to share. Nottinghamshire Police made improvements to case finding methods in 2022 and some changes in rates may in part be attributed to this.

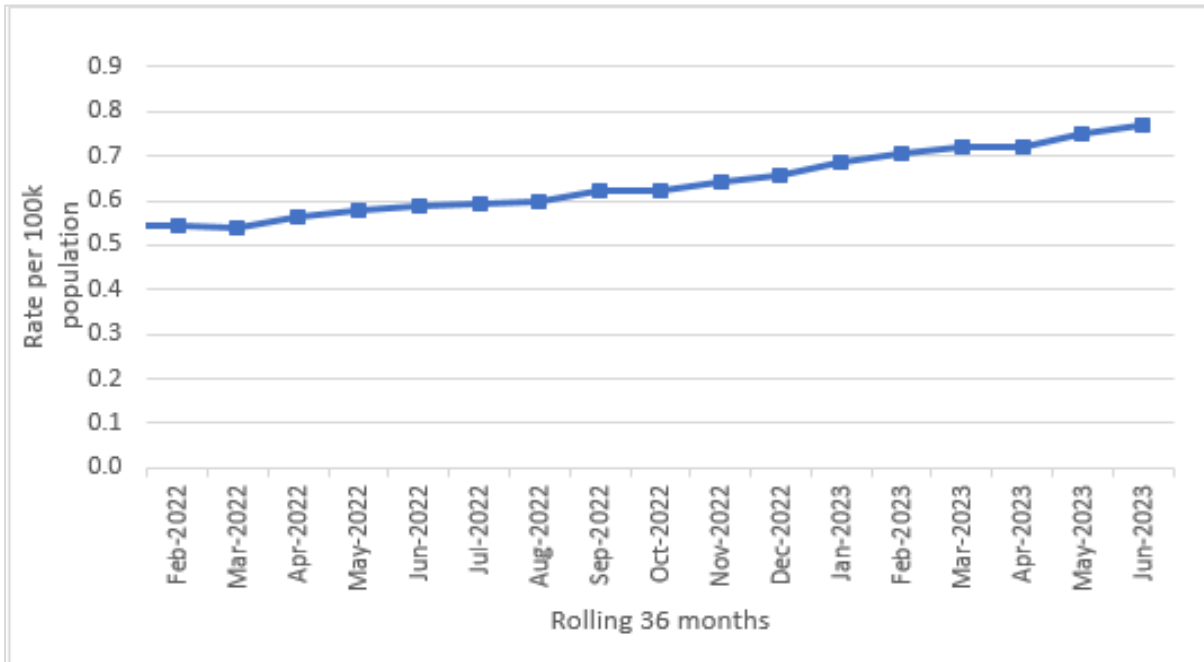
Data reported is based on the location of death rather than the location of residence. It is therefore likely that some deaths reported in the data were residents outside of Nottingham and Nottinghamshire. It is also likely that some Nottingham and Nottinghamshire residents will have died outside of the local area and will not be reflected within the data.

The time period used for RTSSS data is 1st February 2019 to 9th July 2023. This time period runs from when RTSSS data was first collected in Nottingham and Nottinghamshire, up to the most recent data submitted and available for analysis. Due to the small numbers of data at a local level, the longer time period was selected to ensure as large a dataset as possible. Even with the larger dataset this data is sensitive to changes in data collection and reporting and should be interpreted with caution.

2.2.1 Suspected suicide rates

Local suspected suicide rates were calculated on a rolling 3-year average by month with the Nottingham and Nottinghamshire RTSSS data. Figure 7 shows that the monthly rolling 3-year average for suspected suicide rate from a rate of 0.53 per 100,000 population in February 2022 to 0.73 per 100,000 population in June 2023.

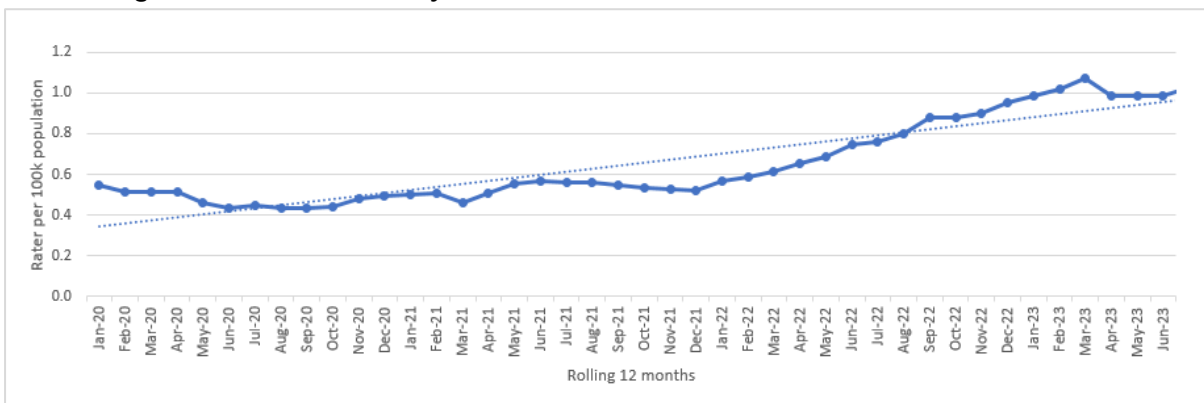
Figure 7: Suspected suicide monthly rolling 3-year average per 100,000 population for Nottingham and Nottinghamshire from February 2022 to June 2023



Source: Real Time Suspected Suicide Surveillance data

A 12-month rolling rate (Figure 8) calculated from February 2020 shows that the suspected suicide rate increases from early 2022. This is consistent with the time that the Police improved case finding methods for suicide reporting. It is not possible to deduce from this graph alone whether there was a true increase in suspected suicide in our population or whether the Police were capturing more cases due to changes made in reporting.

Figure 8: Suspected suicide 12 month rolling average per 100,000 population for Nottingham and Nottinghamshire from January 2020 to June 2023



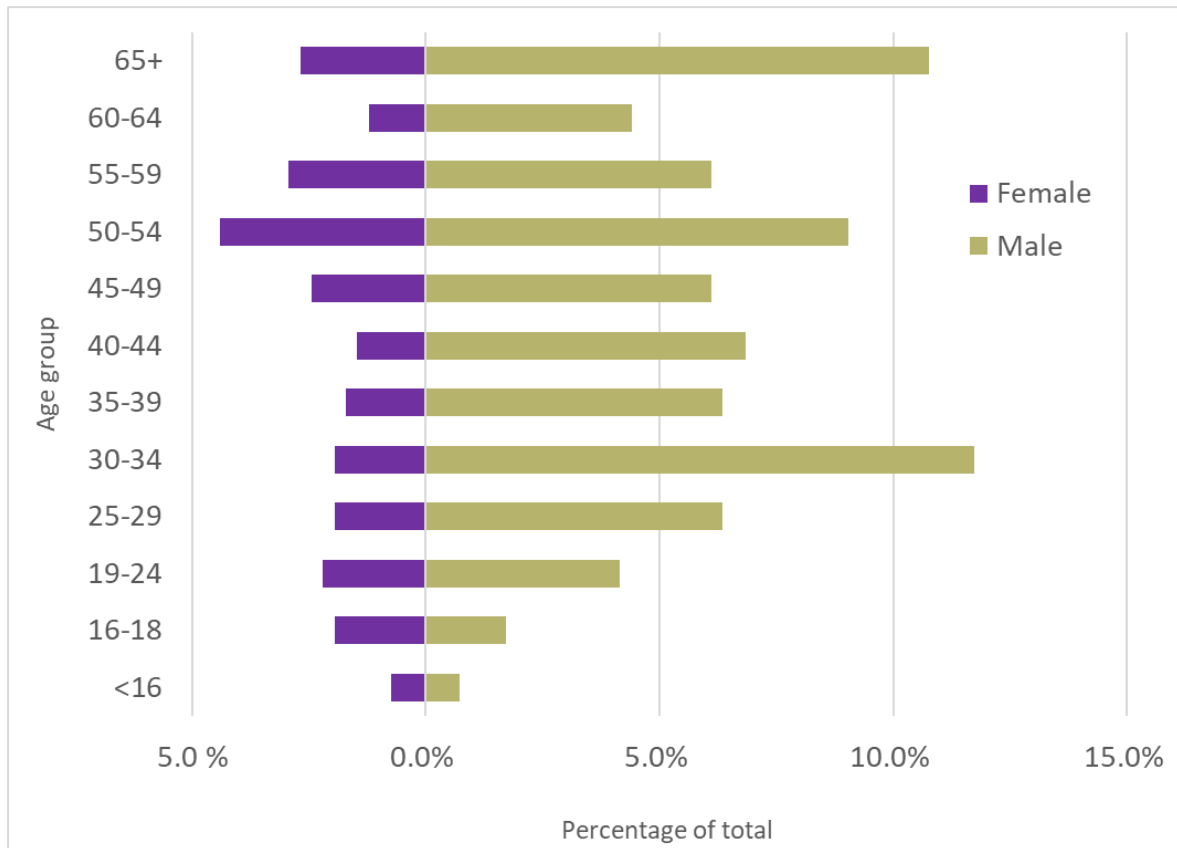
Source: Real Time Suspected Suicide Surveillance data

2.2.2 Age and Gender

RTSSS data for Nottingham City and Nottinghamshire County indicates that suspected suicide deaths of males are higher in age groups 30-34, 50-54 or 65+ years. Females

suicide deaths from RTSSS data are higher in the age group of 50-54 years (Figure 9). The proportion of male to female suspected suicides is approximately 2.9:1. The latest national data available is for 2021, which showed similar proportions of male to female suicide registrations (3:1), consistent with long term trends for male/female differences in suicides.⁴

Figure 9: Proportion of suspected suicides for Nottingham and Nottinghamshire by age and gender from February 2019 to June 2023



Source: Real Time Suspected Suicide Surveillance data

2.2.3 Ethnicity

National data on suicide rates and ethnicity is published by the Office for National Statistics (Table 2).¹⁴ Estimated suicide rates for England and Wales are highest in Mixed/Multiple and White ethnic groups and lowest in Arab, Pakistani and other Asian/Asian British ethnic groups, for both men and women.

¹⁴ Sociodemographic inequalities in suicides in England and Wales: 2011 to 2021: A population level analysis comparing the risk of dying by suicide across sociodemographic groups in adults in England and Wales. Available from: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/bulletins/sociodemographicinequalitiesinsuicidesinenglandandwales/2011to2021>

Table 2: Rates of suicide per 100,000 people by ethnicity in England and Wales, 2011 to 2021

Group	Women			Men		
	Rate per 100,000 people	Lower 95% confidence limit	Upper 95% confidence limit	Rate per 100,000 people	Lower 95% confidence limit	Upper 95% confidence limit
White	6.79	6.53	7.05	21.03	20.56	21.51
Arab	2.54	1.32	4.88	3.75	2.33	6.03
Caribbean, African, Black British and other Black	2.8	2.35	3.34	9.1	8.15	10.15
Chinese	4.8	3.69	6.26	6.6	5.12	8.51
Indian	4.21	3.6	4.94	10.78	9.75	11.92
Mixed/multiple ethnic groups	9.57	8.27	11.08	23.56	21.32	26.04
Other ethnic group	3.59	2.42	5.32	11.87	9.55	14.75
Pakistani and other Asian/Asian British	2.75	2.33	3.24	6.43	5.75	7.19

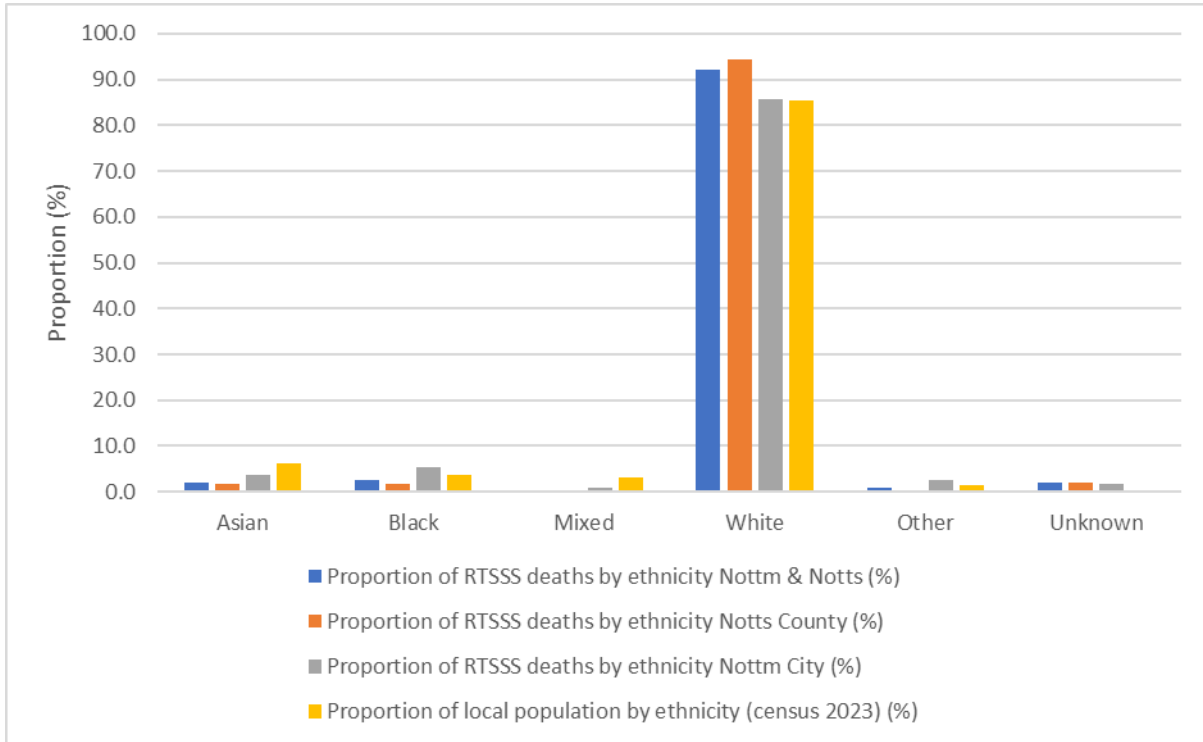
Source: 2011 Census and death registration data from the Office for National Statistics

When reviewing local data on suspected suicide deaths and ethnicity, it should be noted that the absolute numbers of suspected suicide deaths among non-White ethnic groups are low, and data should be interpreted with caution.

Within local RTSSS data (Figure 10), the highest percentage of suspected suicide deaths in Nottingham and Nottinghamshire are of people from White ethnic groups (92.1%) and this is broadly reflective of the ethnicity profile of Nottingham and Nottinghamshire combined. People from Black ethnic groups make up the second highest percentage of suspected suicide deaths in Nottingham and Nottinghamshire (2.62%), followed by people from Asian ethnic groups (2.14%). People from Mixed ethnic groups make up the lowest percentage of suspected suicide deaths (0.24%).

The population of Nottingham City is more ethnically diverse than the population of Nottinghamshire County and the population of Nottingham and Nottinghamshire combined. When looking at data for Nottingham City alone, it remains that the highest percentage of suspected suicide deaths are of people from White ethnic groups (85.6%).

Figure 10: RTSSS stated ethnicity (01/02/19-09/07/23) as % of all deaths reported, compared by LA and with Census reported ethnicity (2023), Nottingham and Nottinghamshire



Source: Real Time Suspected Suicide Surveillance data

2.2.4 Deprivation

Nationally, there is a clear link between deprivation and rates of suicide. In England the suicide rate in the most deprived 10% of areas (‘decile’) in 2017-2019 was 14.1 per 100,000, which is almost double the rate of 7.4 per 100,000 in the least deprived decile.³

The Index of Multiple Deprivation (IMD) is an overall measure of deprivation experienced by people living in an area and is calculated for 32,844 Lower layer Super Output Areas (LSOA) in England. Every such neighbourhood in England is ranked according to its level of deprivation.¹⁷

When ranking the most deprived local authorities based on IMD 2019, Nottingham ranks 10th nationally for the highest average levels of deprivation across an area, based on the population weighted ranks of all the neighbourhoods within it. Nottingham also ranks as the 15th local authority district with the highest proportion of neighbourhoods in the most deprived 10 per cent of neighbourhoods nationally on the IMD 2019.¹⁵ Nottinghamshire County is ranked 101st out of 151 Upper Tier Local Authorities in England on IMD 2019.¹⁶ At a local authority district level, Mansfield ranked 46th out of 317 Lower Tier Local Authorities

¹⁵ The English Indices of Deprivation 2019. Ministry of Housing, Communities and Local Government. Available from: https://assets.publishing.service.gov.uk/media/5d8e26f6ed915d5570c6cc55/loD2019_Statistical_Release.pdf

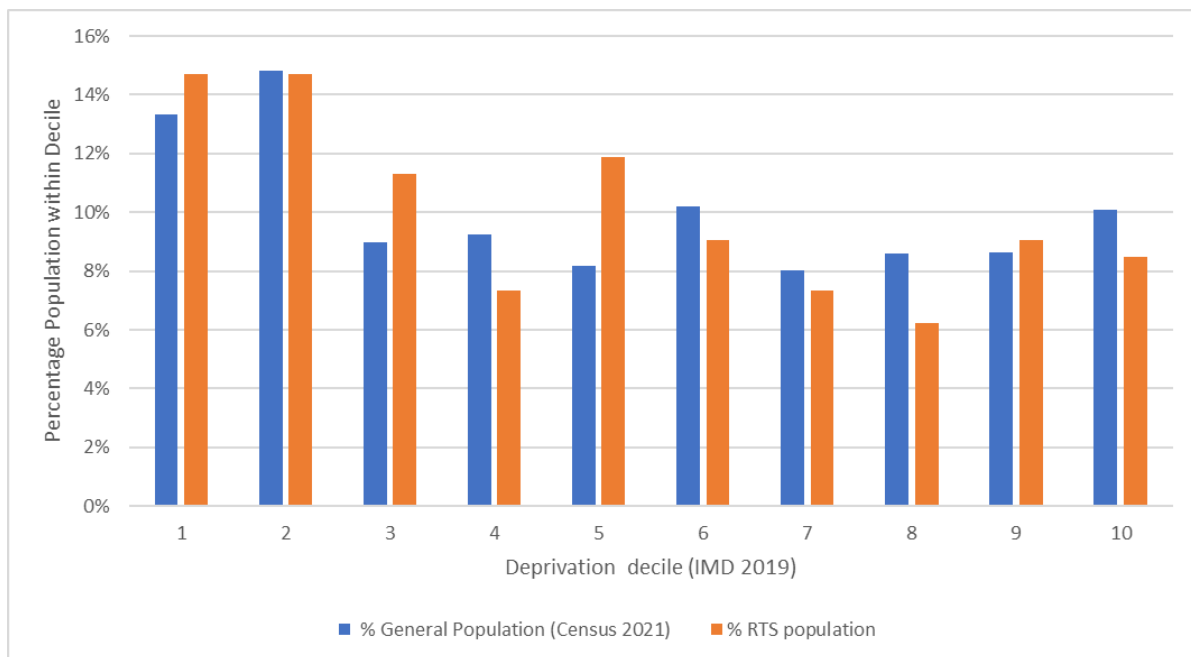
¹⁶ Indices of Deprivation (2019). Nottinghamshire Insight. Available from: <https://www.nottinghamshireinsight.org.uk/themes/deprivation-and-poverty/indices-of-deprivation-2019/>

in England (using an average score measure) putting Mansfield in the top 20% of most deprived districts in the country. In contrast, Rushcliffe was within the top 3% of least deprived Local Authority Districts in the country.

Approximately 75% of suspected suicides reported in local RTSSS data take place at a private residence. Private residence postcodes were only collected as part of RTSSS from the year 2022 onwards. For those deaths taking place within a private residence, the deprivation decile can be calculated using the postcode of that residence, based upon an assumption that the individual died in their own residence. It is not possible to include those deaths occurring in a public place as the postcode for home residence is not collected.

Figure 11 displays proportions of suspected suicides by private residence deprivation decile against Nottingham and Nottinghamshire’s population by deprivation decile, taken from Census 2021 data.

Figure 11: Proportion of suspected suicides by private residence deprivation decile, compared to Nottingham and Nottinghamshire’s population by deprivation decile, from 2022 onwards.



Source: Real Time Suspected Suicide Surveillance data

Note: The lower the decile the more deprived the area.

Deciles 6-10 show proportionately fewer suicides than the population proportion living in matching deciles based on 2021 census data. Deciles 1-5 generally show higher proportions of suicide than the population proportion living in matching deciles based on 2021 census data. This indicates that locally we see a deprivation gradient, with suicides more likely to occur in more deprived areas, consistent with national trends.

2.3 Target groups

This section summarises the national and local data and research around specific targeted at-risk groups for suicide.

2.3.1 Mental health

Established data and research shows that a previous history of mental illness such as depression, psychosis or personality disorder can increase suicide risk.^{12 13}

Local data

Locally within RTSSS data, issues with mental health and wellbeing were the most common theme identified within the narrative reports and were mentioned in over half of all narrative reports analysed. This included undiagnosed poor mental health and wellbeing including 'low mood'.

Diagnosed mental health problems can span from common mental health disorders to severe mental illness. Whilst it is clear that there is heightened risk of suicidality with diagnosed mental health disorders, the differing levels of suicide risk between mental health conditions is less clear. A common mental health disorder is a generic term that includes depression and anxiety disorders. In 2017 the prevalence of common mental health disorders in people (aged 16 years or older) was approximately 21% in Nottingham City and 12-16% in the Nottinghamshire population.¹⁷ Severe mental illness includes all patients with a diagnosis of schizophrenia, bipolar affective disorder, and other psychoses.¹⁸

The Population Health Management team at the Integrated Care Board (ICB) shared the following data at the level of the Nottingham and Nottinghamshire Integrated Care System around severe mental illness:

- 'As an ICS we have 8,880 people aged over 15 on the GP severe mental illness (SMI) register (0.8% prevalence).'
- '6,245 of these individuals have a recorded diagnosis of schizophrenia or other psychoses, and 2,635 have a recorded diagnosis of bipolar affective disorder (BPAD).'
- 'Prevalence of SMI is higher in Black and Mixed ethnic groups and in more deprived areas – the proportion of people with SMI living in the most deprived areas is more than double than in the least deprived areas.'
- 'Prevalence of GP recorded SMI is significantly higher in Nottingham City than the overall Nottingham & Nottinghamshire ICB rate.'

¹⁷ Common Mental Health Disorders. Office for Health Improvement and Disparities. Available from: <https://fingertips.phe.org.uk/profile/common-mental-disorders/data#page/1/ati/154/are/E38000132>

¹⁸ Severe Mental Illness Indicator definitions. Office for Health Improvement and Disparities. Available from <https://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness/data#page/6/gid/1938132719/pat/159/par/K02000001/ati/15/are/E92000001/iid/90581/age/1/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1>



- 'More men have a diagnosis of schizophrenia and/or other psychoses than women (58% are male), but more women have a diagnosis of bipolar affective disorder (BPAD) than men (60% are female).'
- 'Prevalence of comorbidities and long-term conditions are also higher. 69% of people on the SMI Register have other long-term conditions.'

2.3.2 Mental Healthcare Service Users

Local mental healthcare usage data was not available during the joint strategic needs assessment and is noted as a knowledge gap. Going forward, establishing a data sharing agreement between partners would facilitate a better understanding of the needs of mental health service users.

Local data

Analysis of RTSSS data fields indicate 34% of suspected suicides in the last year of data collected (October 2022 - September 2023) were known to mental health services in the six months leading up to death, 52% were not known to mental health services and in 14% of cases the information was unknown. As RTSSS data is based police reporting rather than healthcare data, there is an element of uncertainty around these figures. Nationally people known to be in contact with mental health services over years 2010 to 2020 represent around 27% of all deaths by suicide in England.¹⁹ NCISH also report that the overall increase in England in suicides over 2010 to 2020 was not reflected in the rate of suicide among patients under mental health care. There has been little change over time in this key group.

Where local views have been sought through engagement with Healthwatch, an independent consumer champion for both health and social care, local people have reported experiencing long waiting times when accessing mental health services:

- 'Significant problems around a lack of Mental Health Services for those falling between Improving Access to Psychological Therapies (IAPT) and Crisis Care.'
- 'Acknowledgment that there is a need for long waiting times for many Mental Health services to be reduced in order to prevent individuals' conditions deteriorating before they can access the support required.'

2.3.3 Self-Harm

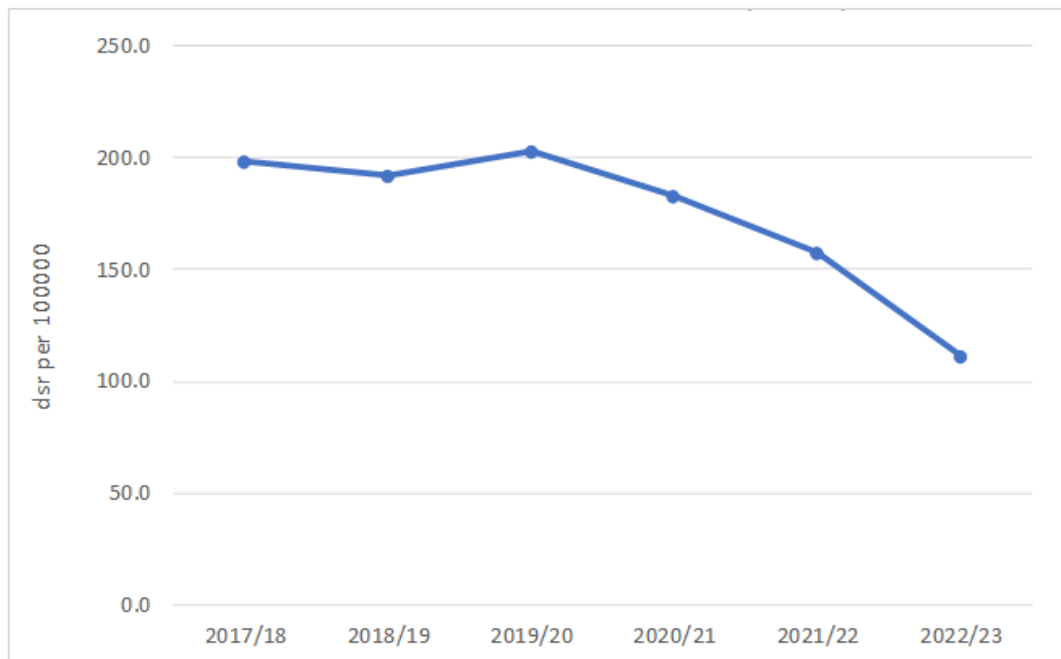
Self-harm as an antecedent for suicide has been increasingly recognised from data and research. Among the most common risk factors for suicide identified is a history of self-harm and previous suicide attempts, present in approximately 40% of people who have died by suicide. Self-harm requiring emergency hospital treatment has been found to be present in about 15% of those who take their own life.⁸

¹⁹ The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Annual report 2022 Available from: <https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/>

Trends in emergency admissions for intentional self-harm

As part of the Mental Health Covid Impact Assessment for Nottinghamshire County Council, hospital admissions data for intentional self-harm was explored to assess any changes in trends over the COVID19 pandemic. Data included pre-pandemic years to post pandemic years (2017-2023) for Nottinghamshire County residents.

Figure 12: Directly standardised rate of Emergency Hospital Admissions for Intentional Self-harm, for Nottinghamshire County residents, over time between years 2017 to 2023.



Source: Hospital Episode Statistics (HES), NHS Digital

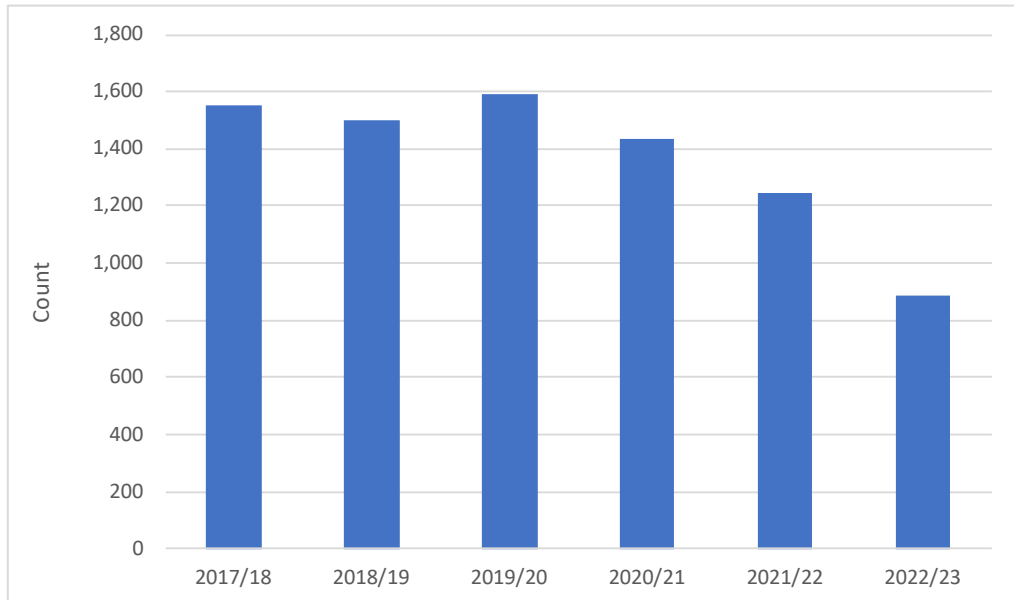
Note: Directly Standardised Rate (DSR)

Figure 12 shows the direct standardised rate of Emergency Hospital Admissions for intentional self-harm remained stable in pre-pandemic years at around 198.8 to 202.8 per 100,000 people (2017-2020). There were then notable decreases year-on-year for the subsequent 3 years; with emergency admissions for intentional self-harm for the year 2022/23 being almost 50% of 2019/20 values, at 111.7 per 100,000 people. This decrease is consistent with the start of the COVID-19 pandemic and appears to have persisted well into recovery phases (2022/2023 data).

Figure 13 highlights counts of Emergency Hospital Admissions for Intentional Self-harm for Nottinghamshire County residents. This reiterates that admissions for intentional self-harm had a sustained fall from 1,590 in 2019/2020 to 888 in 2022/2023, constituting a drop of 40%. In terms of benchmarking, Nottingham City and Nottinghamshire County are in line

with England and regional averages on emergency admissions for intentional self-harm for the latest data available (2021/22).²⁰

Figure 13: Counts of Emergency Hospital Admissions for Intentional Self-harm, for Nottinghamshire County residents, over time between years 2017 to 2023.



Source: Hospital Episode Statistics (HES), NHS Digital

Demographic Analyses

Further subgroup analysis by age, sex, district, ethnicity, deprivation, and provider trust indicated a general trend of reducing admission rates and count data over time. Patterns between categories within subgroup analysis also remained similar over time.

Local stakeholder input

On review of this data, the JSNA task and finish group noted that local voluntary and community sector organisations were reporting increases in people presenting with self-harm to their organisations for the time period this data covered. There were suggestions that there could be unmet demand in relation to people who intentionally self-harm accessing the right support. In addition, the Task and Finish group reported that follow-up support for intentional self-harm is currently provided at emergency departments after first attendance only, and not for later attendances, constituting a potential service gap.

²⁰ Suicide Prevention Profile. Office for Health Improvement & Disparities. Available from: <https://fingertips.phe.org.uk/search/self%20harm#page/3/gid/1/ati/501/iid/21001/age/1/sex/4/cat/-1/ctp/-1/yr/1/cid/4/tbm/1/page-options/car-do-0>

2.3.4 Men in mid-life

A 2021 report by National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) used national mortality data of men aged 40-54 who had died by suicide in 2017.²¹ Key findings included:

- **Suicide in men is complex and multi-layered**: There is often a combination of longstanding and recent risks for suicide therefore attributing suicide deaths to single causes will make prevention less effective. Vital roles in suicide prevention exist particularly for primary care, A&E, the justice system, and mental health services.
- **Service contact**: Rates of contact with services among middle-aged men were higher than expected (91% had been in contact with at least one frontline service or agency). Middle-aged men who seek help for their mental health sometimes remain untreated – in particular, psychological therapies suited to their needs should be offered.
- **Risk factors**: Economic adversity, alcohol and drug misuse, and relationship stresses are common antecedents of suicide in men in mid-life. More than half of the middle-aged men who died had a physical health condition. Many of the men were affected by bereavement.
- **Role of the Voluntary/Community Sector**: 9% of middle-aged men experiencing suicidality appear to be out of contact with any support. There are several examples of local and national third sector initiatives aiming to reach this group.
- **Online safety**: Suicide methods were often obtained via the internet – online safety should be part of any prevention plan for men at risk of suicide.

2.3.5 Gambling

Summary of the key issues in relation to suicide and gambling

There is a growing evidence base linking gambling related harm and suicidality. The Office for Health Improvement and Disparities (OHID) estimates there are up to 496 gambling-related suicides every year in England which suggests that experience of a gambling problem can be a significant driver of suicidal behaviours and thoughts.²²

Gambling is a legal activity that is participated in by half of the UK population.²³ Gambling can harm physical and mental health, relationships, finances, employment, and education. Gambling-related harms are the negative consequences of gambling on the health and wellbeing of individuals, families, communities, and society with suicide being the greatest harm. Individuals experiencing a gambling problem are a key risk group for experiencing suicidality. According to Public Health England, a person with a gambling problem is 19.3

²¹ The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Suicide by middle-aged men. 2021. The University of Manchester. Available from: <https://sites.manchester.ac.uk/ncish/reports/suicide-by-middle-aged-men/>

²² Office for Health Improvement and Disparities (2023). *The economic and social cost of harms associated with gambling in England. The economic cost of gambling-related harm in England: evidence update 2023 (publishing.service.gov.uk)*

²³ National Audit Office (2020). *Gambling regulation: problem gambling and protecting vulnerable people. Gambling regulation: problem gambling and protecting vulnerable people - National Audit Office (NAO) report*

times and 9.6 times more likely to die by suicide compared to the general population in younger (20-49 years) and older (50-64 years) age groups respectively.²⁴ A recent cross-sectional research study found a link between suicide attempts in 16-24 year olds and excessive gambling, even after adjustment for other factors.²⁵ The researchers conclude that young people and young adults experiencing gambling problems should be considered at risk for suicidality.

There are a range of factors which increase the likelihood of suicidality for people with a gambling problem. Research has highlighted gambling type, gambling severity, social relationships, quality of life and comorbidities as important factors which influence the risk of suicide. Women with gambling problems are at a higher risk of dying by suicide compared to their male counterparts, with identified factors such as social isolation, relationship breakdown, trauma and socio-economic stress having a greater impact on this group.²⁶

The UK Government recently published the [Gambling White Paper](#) setting out a legislative framework to reduce gambling-related harms. The new [National Suicide Prevention Strategy](#) has highlighted that experiencing a gambling problem is a significant risk factor for suicidality which needs to be addressed through early intervention and tailored support.

Estimated prevalence rates of gambling

There is limited availability of local data sources to understand the prevalence of gambling in Nottingham and Nottinghamshire. The Gambling Commission national survey data (2020) was applied to Nottingham and Nottinghamshire population data to provide estimated gambling prevalence.

In Nottinghamshire (see table 3), almost 35% of people aged 16 or over have gambled in the last four weeks. Within this cohort, 6,300 individuals are at a moderate risk of a gambling problem where signs of gambling-related harms are demonstrated but the individual falls below the screening tool threshold for a gambling problem. 2,111 individuals are estimated as having a gambling problem (defined as having a PGSI score of 4 or above). The 35-44 age group has the highest prevalence of gambling problems, while prevalence of moderate risk gambling is highest for 16-24 year olds.

In Nottingham (see table 4), almost 40% of people aged 16 or over have gambled in the last four weeks. There are 3,447 individuals at moderate risk of a gambling problem, while 1,050 individuals are estimated to have a gambling problem. Similar to Nottinghamshire, the 35-44 age group has the highest prevalence of gambling problems in the city and the 16-24 age group is the highest for moderate risk gambling.

²⁴ Public Health England (2021). *Harms associated with Gambling*. [Harms associated with gambling: an abbreviated systematic review \(publishing.service.gov.uk\)](#)

²⁵ Wardle, H. (2021) *Suicidality and gambling among young adults in Great Britain: results from a cross-sectional online survey*. The Lancet. [https://doi.org/10.1016/S2468-2667\(20\)30232-2](https://doi.org/10.1016/S2468-2667(20)30232-2)

²⁶ Marionneau, V. and Nikkinen, J. (2022) *Gambling-related suicides and suicidality: A systematic review of qualitative evidence*. National Library of Medicine. <https://doi.org/10.3389/fpsy.2022.980303>.

This data has important caveats to consider. The figures outlined are likely to be an underestimate because individuals can hide gambling behaviours and not disclose gambling problems due to factors such as guilt and shame. The figures are not a direct measure of local prevalence rate because the methodology involves applying national data to the local population which provides an estimate. The Gambling Commission data was incomplete for people aged 65 and over, which limits understanding of prevalence numbers for this cohort. Finally, the data is extracted from a survey which provides a snapshot of prevalence.

Table 3: Estimated prevalence of gambling participation and gambling problems among people aged 16 and over in Nottinghamshire

Metric		M	F	16-24	25-34	35-44	45-54	55-64	65+	All 16+
People surveyed	%	47.8	52.2	10.1	14.4	16.2	18.9	16.9	23.6	100
	n	1,915	2,092	403	577	651	754	677	945	4,007
Gambling in last 4 weeks	%	44.5	39.6	31.2	39.0	45.8	48.4	46.5	39.1	34.9
	n	149,217	140,266	26,151	39,899	46,218	54,419	52,927	68,906	288,520
Moderate risk of a gambling problem	%	1.3	0.6	2.2	1.5	1.1	0.7	0.9	0.0	0.9
	n	4,359	2,125	1,844	1,535	1,110	787	1,024	0	6,300
Gambling problem (PGSI ≥4) ²⁷	%	0.6	0.03*	0.5	0.2	0.8	0.2	0.4	0.0	0.3
	n	2,012	99*	419	205	807	225	455	0	2,111

*Not officially reported in survey data. Calculated by subtracting number who are male from total age 16+

Source: 2020 Gambling Commission national data applied to ONS 2021 Census Population Statistics.

²⁷ The Problem Gambling Severity Index is a standardised, screening tool for a gambling problem.

Table 4: Estimated prevalence of gambling participation and gambling problems among people aged 16 and over in Nottingham

Metric		M	F	16-24	25-34	35-44	45-54	55-64	65+	All 16+
People surveyed	%	47.8	52.2	10.1	14.4	16.2	18.9	16.9	23.6	100
	n	1,915	2,092	403	577	651	754	677	945	4,007
Gambling in last 4 weeks	%	44.5	39.6	31.2	39.0	45.8	48.4	46.5	39.1	39.9
	n	62,148	53,454	23,422	22,173	17,334	17,011	14,152	15,288	109,380
Moderate risk of a gambling problem	%	1.3	0.6	2.2	1.5	1.1	0.7	0.9	0.0	1.3
	n	1,816	800	1,652	862	418	253	261	0	3,447
Gambling problem (PGSI ≥4)	%	0.6	0.1 ²⁸	0.5	0.2	0.8	0.2	0.4	0.0	0.4
	n	838	212	402	139	311	76	122	0	1,050

Not officially reported in survey data. Calculated by subtracting number who are male from total age 16+

Source: 2020 Gambling Commission national data applied to ONS mid-2020 population estimates.

2.3.6 Financial wellbeing

Nationally reported data

According to the NCISH Annual report for 2023, there were 373 deaths per year between 2016 and 2020 in mental healthcare patients who had experienced recent economic adversity such as serious financial problems and loss of job, benefits or housing. The number increased over this five-year period.

The increases in the cost of living mean there is a potential for increased numbers of patients and the wider population experiencing economic adversity. The NCISH report recommends training for frontline staff on the risks associated with the loss of jobs, benefits and housing, among other issues, and information to signpost patients to sources of financial support and advice.²⁹

Research

There is evidence further linking financial stress, unemployment, and suicide in a recent systematic review and meta-analysis which reported significantly elevated suicide risks following financial stress (23 studies) and unemployment (43 studies).³⁰ After controlling for physical and mental health, financial stress and unemployment remained weakly associated with suicide, suggesting financial wellbeing is more significant as a factor when combined with other risk factors.

²⁹ Annual report 2023: UK patient and general population data 2010-2020. March 2023 Available from <https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/>

³⁰ **Financial stress, unemployment, and suicide—A meta-analysis**, Roelfs, David J. and Shor, Eran, Crisis: The Journal of Crisis Intervention and Suicide Prevention, 2023.

Local data

Issues relating to work/employment and finances were mentioned in 15% of all narrative reports analysed within the RTSSS dataset. Mentions relating to work/employment encompass a range of experiences such as loss of job, recent retirement, being off work due to mental or physical ill-health, bullying, stress and issues relating to self-employment.

2.3.7 Those in contact with the criminal justice system

There are four closed male national prisons operating across Nottingham and Nottinghamshire:³¹

- Lowdham Grange is a privately run male prison in Lowdham, Nottingham.
- Nottingham Prison is a men's prison in the Sherwood area of Nottingham.
- Ranby is a men's prison in Retford, Nottinghamshire.
- Whatton is a prison in Nottingham for men convicted of a sex offence.

National data

The current national dataset reports up to 2019. Between 2008 and 2019, 677 deaths were reported as suicide in prison custody according to the Office for National Statistics (ONS) death registrations database. This equates to around 56 deaths a year.³²

Of the 677 deaths in prison custody between 2008 to 2019, the large majority were male deaths, accounting for 97% (657 deaths) compared with 20 female deaths. The risk of suicide was 3.9 times higher between 2008 and 2019 in the male prison population, compared with the general male population.

Local data

It is important to note that the Real Time Surveillance for suspected suicides was set up from 2019. There are no overlapping reporting periods with national data. Suspected suicides reported in RTSSS data show that 2% of male suicides in Nottingham and Nottinghamshire occurred in prison. This equates to seven people dying by suicide. There was no pattern to suicides that highlighted a particular prison within Nottingham and Nottinghamshire.

2.3.8 Multimorbidity

Nationally reported data

According to the NCISH Annual report for 2022, the number of mental healthcare patients with a comorbid physical illness has been increasing since 2014, accounting for 25% of all patient suicides in 2009-2019 overall. The risk profile of these patients is not the same as for patients generally; they are older, common risk factors such as self-harm or alcohol/drug misuse are less often present, and a higher proportion are women.³³

³¹ Office for National Statistics (ONS), released 26 January 2023, ONS website, article, [Drug-related deaths and suicide in prison custody in England and Wales: 2008 to 2019](#)

³² Office for National Statistics (ONS), released 26 January 2023, ONS website, article, Drug-related deaths and suicide in prison custody in England and Wales: 2008 to 2019

³³ The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Annual report 2022. Available from: <https://sites.manchester.ac.uk/ncish/reports/annual-report-2022/>

Research

Multimorbidity is classed as the presence of multiple chronic health conditions and confers additional risk of suicide.^{34 35}

In a large sample of UK adults, physical multimorbidity was associated with significantly higher odds for suicidal ideation and suicide attempts (more than six-fold for four health conditions). Researchers found cognitive problems and disability explained the largest proportion between multimorbidity and suicidal ideation. Pain and cognitive problems explained the largest proportion between multimorbidity and suicide attempts.

Local data

Within suspected suicides reported in RTSSS data, health conditions were mentioned in 15% of narrative reports analysed, covering a range of health conditions that are not specified in all cases. Where information or indication of the health condition is provided, the most common health condition mentioned related to a cancer diagnosis with experiencing physical pain being the second most commonly cited health condition within the narrative reports.

2.3.9 Children and Young people

National Data

A report drawing on data from the National Child Mortality Database (NCMD) identified common characteristics of children and young people who die by suicide as well as factors associated with these deaths. The 'Suicide in Children and Young People' report drew key findings from deaths that occurred or were reviewed by a child death overview panel between 1st April 2019 and 31st March 2020 and found that:³⁶

- Child suicide is not limited to certain groups; rates of suicide were similar across all areas, and regions in England, including urban and rural environments, and across deprived and affluent neighbourhoods.
- 62% of children or young people reviewed had suffered a significant personal loss in their life prior to their death, this includes bereavement and "living losses" such as loss of friendships and routine due to moving home or school or other close relationship breakdown.
- Over one third of the children and young people reviewed had never been in contact with mental health services. This suggests that mental health needs or risks were not identified prior to the child or young person's death.
- 16% of children or young people reviewed had a confirmed diagnosis of a neurodevelopmental condition at the time of their death. For example, autism

³⁴ The association of physical multimorbidity with suicidal ideation and suicide attempts in England: A mediation analysis of influential factors, Smith, L., et al., The International journal of social psychiatry, 2023. 69(3): p. 523-531.

³⁵ Identification of Risk Factors for Suicide and Insights for Developing Suicide Prevention Technologies: A Systematic Review and Meta-Analysis, Jha, S., G. Chan, and R. Orji, Human Behavior & Emerging Technologies, 2023: p. 1-18.

³⁶ Suicide in Children and Young People. NCMD Programme. Available from: <https://www.ncmd.info/publications/child-suicide-report/>

spectrum disorder or attention deficit hyperactivity disorder. This appears higher than found in the general population.

- Almost a quarter of children and young people reviewed had experienced bullying either face to face or cyber bullying. The majority of reported bullying occurred in school, highlighting the need for clear anti-bullying policies in schools.

Local engagement

Local stakeholders have highlighted inappropriately met or unmet needs of young people who are in crisis, with some children and young people (CYP) experiencing long waits on physical health wards whilst appropriate provision was sought. Looked after young people and those transitioning from CYP to adult services, were identified as an area of particular need.

Research

Suicide prevention efforts generally target acute precipitants of suicide, though emerging evidence suggests that vulnerability to suicide is partly established early in life before acute precipitants can be identified. A systematic review of longitudinal studies published in 2022 found evidence consistently supported the link between sociodemographic, obstetric, parental and child developmental factors to higher risk of suicide death later in life.³⁷

- Sociodemographic: young maternal age at birth, low parental education, and higher birth order
- Obstetric: low birth weight
- Parental: exposure to parental death by external causes
- Child developmental factors: exposure to emotional adversity

Researchers stated additional research into how early life factors interact with acute precipitants and increase vulnerability to suicide.

2.3.10 LGBTQ+ communities

Nationally reported data

According to the NCISH Annual report for 2023, there were 223 deaths by mental healthcare patients who identified as lesbian, gay, or bisexual and 37 patients within a trans group, an average of 49 deaths per year (between 2016 and 2020). In general LGBT patients were younger than other patients and a high proportion had experienced childhood abuse.²⁵

Research

Within the last few years larger pieces of research, such as systematic reviews, have been published around the risk of suicidality and self-harm in the LGBTQ+ community.

In 2022, the International Review of Psychiatry journal published a systematic review and meta-analysis which quantified the risk of suicidality in LGBTQ+ people compared to their

³⁷ The developmental origins of suicide mortality: A systematic review of longitudinal studies, Vidal-Ribas, Pablo; et al. , European Child & Adolescent Psychiatry, 2022.

cisgender or heterosexual peers.³⁸ Researchers reported that the LGBTQ+ people had over four times the risk of attempting suicide over cisgender/heterosexual groups. The reported statistics were statistically significant however the overall quality of evidence included within the systematic review ranged from low to moderate.

Another systematic review aimed to elicit risk and protective factors for suicide attempts among sexual minority youth.³⁹ The identified risk factors associated with suicide attempts were:

- early coming out
- being unaccepted by family
- dissatisfaction with sexual minority friendships
- loneliness and bullying
- physical abuse and/or sexual abuse.

The identified protective factors for suicide attempts were:

- feeling safe at school
- teacher support
- anti-bullying policy
- other adult support.

Similar risk factors around victimisation, bullying (including cyber-bullying) and mental health difficulties, were highlighted in research looking at the risk profile of LGBTQ+ young people with self-harm, suicidal ideation or suicidal behaviour.⁴⁰ Considering this research, it seems clear that risk and protective factors for suicide attempts in the LGBTQ+ community stem directly from the environments in which youth grow up: family, school, and the internet.

Local data

Information around sexuality was only regularly collected in RTSSS data from 2022. Any inference from analysis is precluded due to high levels of 'unknown' status being reported.

2.3.11 Gypsy Roma and Traveller communities

In the 2021 census, 0.3% of population identified as 'Gypsy, Roma or Irish Traveller', however these figures are thought to be an underrepresentation, with estimates of up to 300,000 Gypsy or Traveller people and up to 200,000 Roma people living in the UK.⁴¹

In the UK, these communities are recognised to have some of the poorest life outcomes with severe health inequalities. When considering mental health in these communities there are reported to be even larger disparities.⁴² Suicide risk in the Gypsy, Roma or Traveller

³⁸ Self-harm and suicidality among LGBTIQ people: a systematic review and meta-analysis. Marchi, M et al. 2022. *International Review of Psychiatry* 34(3-4), pp. 240-256

³⁹ A systematic review of the factors associated with suicide attempts among sexual-minority youth. Wang, X. X et al. 2023. *European Journal of Psychiatry* 37(2), pp. 72-83

⁴⁰ A systematic review and meta-analysis of victimisation and mental health prevalence among LGBTQ+ young people with experiences of self-harm and suicide. Williams, A. Jess et al. 2021. *PLoS ONE [Electronic Resource]* 16(1), pp. e0245268

⁴¹ <https://www.ethnicity-facts-figures.service.gov.uk/summaries/gypsy-roma-irish-traveller>

⁴² Parry et al. Health status of Gypsies and Travellers in England. *J Epidemiology Community Health*. 2007 Mar;61(3):198-204. doi: 10.1136/jech.2006.045997.

communities has been reported to be 6.6 times higher than the general population's risk of suicide.

National data

At present mortality data published by the ONS does not include the ethnicity of the deceased, there are no official data on deaths by suicide among the Gypsy, Roma and Traveller individuals in England and Wales.⁴³

Research

Nottinghamshire County council's public health team undertook a literature review in 2023 on suicide risk and the barriers to receiving suicide prevention support in the Gypsy, Roma and Traveller communities in the UK. The findings were:

- **Lack of data:** An understanding of risk, cause, and prevention of suicide in the Gypsy, Roma and Traveller community is greatly hampered by the absence of systemic data monitoring of these populations by health authorities.⁴⁴
- **Discrimination:** A survey targeting the Gypsy, Roma and Traveller communities by the Traveller Movement charity highlighted high levels of direct discrimination related to ethnicity (91% reported by 214 community members).²³ Current suicide prevention and health services can also indirectly discriminate through digital exclusion and reliance on patient literacy.
- **Barriers to healthcare access:** Systematic review research and engagement with Gypsy, Roma and Traveller communities highlights digital exclusion and difficulty in registration with primary care, particularly when online registration is required and where proof of identity or proof of fixed address is essential.⁴⁵
- **Culture:** In the Traveller Movement Policy Briefing, three patterns of suicide were identified as being closely linked to Travellers. These included bereavement suicides, where 40% of those who died by suicide had recently lost someone close to them to suicide. This also included 'violent suicide' following domestic feuding and thirdly, shamed suicide which occurred after disclosure of an alleged criminal act or awaiting a trial for a criminal act.²³

2.3.12 Domestic abuse

Nationally reported data

The majority of people who died by suicide between 2009 and 2019 with a history of domestic violence were female, according to NCISH data.²⁹ This group was more often younger, single or divorced, living alone and unemployed than other women. Self-harm, previous alcohol or drug misuse and personality disorder diagnosis were more common in this group, potentially reflecting previous trauma or abuse.

⁴³ <https://wp-main.travellermovement.org.uk/wp-content/uploads/2021/09/Mental-Health-and-Suicide-among-GRT-communities-in-England-Briefing-2019.pdf>

⁴⁴ Millan, M. and Smith, D., 2019. A comparative sociology of Gypsy Traveller health in the UK. *International journal of environmental research and public health*, 16(3), p.379.

⁴⁵ Gypsy, Roma and Traveller access to and engagement with health services: a systematic review | *European Journal of Public Health* | Oxford Academic (oup.com)

Research

Intimate partner violence (IPV) is strongly associated with self-harm and suicidality.⁴⁶ Furthermore there is a disproportionate impact on women which is exacerbated by experiences of multiple unmet needs and poverty. Findings included:

- Over a quarter (27%) of women report experience of IPV in their lifetimes
- Women who have experienced IPV are three times more likely to have made a suicide attempt in the past year compared to women who have not experienced IPV
- Sexual IPV is ten times more common in women than men and is an IPV type particularly associated with self-harm and suicidality
- IPV often occurs in a context of poverty and multiple unmet needs, trapping women with fewer resources for escape.

Local data

A small number of RTSSS narrative reports mentioned domestic abuse. It is important to note that not all narrative reports where domestic abuse is mentioned have had police involvement or convictions related to domestic abuse and it appears that in some cases the information has been disclosed by the next of kin, family members or friends.

Domestic Homicide Reviews (DHRs) can also be instructed where a suicide is deemed to have resulted from ongoing domestic abuse. The percentage of DHRs in Nottinghamshire County that are identified as survivor suicides are 27% and perpetrator suicides are 13%. (These figures exclude Gedling district data which was unavailable).

2.3.13 Relationship breakdown

Local data

Within suspected suicides reported in RTSSS data, intimate partner relationships were the fourth most common theme identified within narrative reports and encompass a range of issues such as divorce, separation and arguments between partners.

Research

Stressful life events increase the risk of subsequently reported suicidal ideation and behaviours, based on systematic review and meta-analysis data.⁴⁷ Researchers reported after a stressful life event, there was a 37% significantly higher odds of reported suicidal ideation and behaviours combined, and a 45% significantly increased risk for suicidal ideation. The association is stronger in males, young adults, and studies with shorter term follow-up. These findings suggest that the experience of stressful life events should be incorporated into clinical suicide risk assessments and suicide interventions could include a component on developing resilience and adaptive coping to stressful life events.

2.3.14 Serving UK Armed Forces and Veterans

⁴⁶ Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England Sally McManus et al. Published: June 07, 2022 DOI: [https://doi.org/10.1016/S2215-0366\(22\)00151-1](https://doi.org/10.1016/S2215-0366(22)00151-1)

⁴⁷ Are stressful life events prospectively associated with increased suicidal ideation and behaviour? A systematic review and meta-analysis, Howarth, Emma J.; et al. , Journal of Affective Disorders, 04 01 ,2020. 266, pp. 731-742

National data

Annual summaries and trends of suicides in the UK regular armed forces were investigated from Ministry of Defence data covering 2002-2021.⁴⁸ In this period, 285 suicides occurred in the serving armed forces personnel. Suicides were male dominated (264 out of 285 suicide deaths). The report concluded suicide remains a rare event in the UK armed forces; confirmed suicides in 2021 representing less than one death per 1,000 armed forces personnel.

The UK regular armed forces have seen a declining trend in male suicide rates since the 1990s and were consistently lower than the UK general population over the last 35 years. However, in the last five years the number of army male suicides have been increasing and since 2017, the risk of suicide among army males was the same as the UK general population for the first time since the mid 1990's.

Research

A cohort study exploring suicide after leaving the UK Armed Forces (1996-2018) concluded that as a cohort, veterans are at no greater risk of suicide than the general population.⁴⁹ There are associated factors within this cohort that increases risk, such as age, where veterans under the age of 25 are at a two to four times greater risk than the same age group within the general population. Veterans over the age of 35 are at a lower risk than the same age group within the general population.

2.3.15 Alcohol and substance use

Nationally reported data

Alcohol and drugs are common antecedents of suicide. According to the 2019 NCISH annual report, in 2017 there were 866 suicides by mental healthcare patients who had a history of alcohol or drug misuse. This was 57% of all mental healthcare suicides and only a minority were in contact with specialist substance misuse services.⁵⁰

Local data

Alcohol and drug use were the second most common theme identified within RTSSS narrative reports (34% of all narrative reports analysed), with alcohol use being more commonly cited than drug use.

Alcohol use included long-term use, alcohol use immediately prior to the time of death, and evidence of alcohol use at the location/time of death. Where drug use is mentioned within the narrative report this includes ongoing problems with drug use including Class A drug use, drug use that might be considered 'recreational' and evidence of drug use at the location/time of death.

⁴⁸ Suicides in the UK regular armed forces: Annual summary and trends over time (Ministry of Defence) https://assets.publishing.service.gov.uk/media/6241903be90e075f142546aa/20220331_UK_AF_Suicides.pdf

⁴⁹ Suicide after leaving the UK Armed Forces 1996–2018: A cohort study. Cathryn Rodway August 8, 2023 <https://doi.org/10.1371/journal.pmed.1004273>

⁵⁰ The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Annual report 2019. Available from: <https://sites.manchester.ac.uk/ncish/reports/annual-report-2019-england-northern-ireland-scotland-and-wales/>

3. Targets and performance

The Nottingham City and Nottinghamshire Suicide Prevention Strategy for 2019-2023 sets out the high-level priorities and objectives for delivery across the partnership. The areas of significant progress made by local authority public health teams and local partners against the strategy priorities have been summarised in table 5.

Nottingham City and Nottinghamshire Suicide Prevention Strategy 2019-2023

The overall aim of the strategy was to reduce the rate of suicide and self-harm in the Nottingham City and Nottinghamshire population, by proactively improving the population's mental health and wellbeing, and by responding to known risks for suicide in the population. The following priorities were identified as the local key areas for action:

- **Priority 1: At-risk groups:** Identify early those in groups at risk of suicide, and ensure they have access to evidence-based interventions.
- **Priority 2: Use of data:** Collect and review suicide and self-harm data in a timely manner, using it to inform local practice, particularly via real-time surveillance.
- **Priority 3: Bereavement support:** Ensure the availability of prompt bereavement support for those affected by suicide.
- **Priority 4: Staff training:** Provide effective training for frontline staff to recognise and respond to suicide risks, integrating current research into practice.
- **Priority 5: Media:** Foster close engagement with media personnel to ensure that suicide and suicidal behaviour are reported with sensible, sensitive approaches.

Table 5: Summary of progress against the Nottingham City and Nottinghamshire Suicide Prevention Strategy 2019-2023

Priority	Areas of significant progress
Identifying and addressing at-risk groups	<p>Findings of evidence reviews on at-risk groups regularly fed back to Nottingham and Nottinghamshire Suicide Prevention strategy group for wider stakeholder input and alignment of new priorities.</p> <p>Development and implementation of Wave 4 pilots targeted towards men and older boys, parents/carers of CYP who self-harm, LGBTQ+ groups, Gypsy Roma Traveller communities, those experiencing relationship breakdown, and people with bereavement through suicide.</p>
Sensible use of local data	<p>Local RTSSS response process map and guide developed to support a consistent and systematic approach in identifying and responding to concerns in RTSSS data.</p> <p>RTSSS Working Group has regular attendance of key partners ensuring a robust multi-agency approach, including, to respond to suspected suicide deaths in public places and implementation of local Suicide Cluster Response Plan Guidance.</p>

Bereavement support	An evaluation was undertaken in 2020/21 which highlighted areas of good practice and provided evidence of interventions that can reduce the suicide risk of people bereaved by suicide.
Staff training	Development and circulation of a suicide prevention primary care and pharmacy resource pack. Bespoke and tailored training is being developed for organisations who work with particular at-risk groups (including males, those experiencing relationship breakdown and bereavement services).
Working with the media	Development of a close working relationship with the Samaritans, who produce responsible media reporting guidance including sharing findings of an audit into how suicide was reported in local media.

The NHS England Wave 4 funding for suicide prevention activity has contributed to the delivery of this strategy. An evaluation of the impact of the local Wave 4 programme activity is being commissioned and will be completed in early 2024.

4. Current activity, service provision and assets

4.1 Assets

4.1.1 Partnership Working

Suicide Prevention Strategic Steering Group

The Suicide Prevention Strategic Steering Group (SPSSG) is responsible for the development and implementation of a suicide prevention strategy and action plan across Nottinghamshire and Nottingham City. Membership includes representatives from Public Health, Adult Social Care, Nottinghamshire ICB, Nottinghamshire Healthcare NHS Foundation Trust, Police, and local universities.

Real Time Suspected Suicide Surveillance (RTSSS)

As part of the Nottingham City and Nottinghamshire County suicide prevention strategic plan, Real Time Suspected Suicide Surveillance (RTSSS) was established in 2019. The RTSSS is collated with real time Police and British Transport Police intelligence and coroner reports. Public health teams from Nottinghamshire County and Nottingham City have oversight of the data and response. A multi-agency Nottingham and Nottinghamshire Real Time Surveillance Working Group (RTSSS Working Group) is in place with responsibility for the ongoing monitoring of RTSSS data processes, analysis of data and information to identify risks, patterns and trends, and to make recommendations for and implement timely action to respond to identified suicide risks. Membership includes representatives from public health Nottinghamshire Police, British Transport Police, Network Rail, Highways, the [NHS LeDeR programme](#), Tomorrow Project local bereavement services, Integrated Care Board and Nottinghamshire Healthcare NHS Foundation Trust.



Since its inception, RTSSS has facilitated responsive postvention and cluster response, as well as providing insights to identify and target interventions for high-risk groups.

Stakeholder Network

The Network consists of approximately 250 members and brings together representatives from a broad range of organisations and groups who work with people across Nottingham and Nottinghamshire. The role of the network is to help shape local suicide prevention work, share good practice, and foster links with other professionals.

Wave 4 Suicide Prevention Funding

In 2020, the Nottingham and Nottinghamshire Suicide Prevention Strategic Strategy Group successfully secured NHS England Wave 4 Suicide Prevention Funding. Since 2021, local Wave 4 funding has supported the following activities:

- Commissioned pilot projects to support high-risk groups (including males, self-harm parents and carers group, children and young people, and people with history of self-harm).
- Development of a local recognisable suicide prevention brand and communications campaign.
- Commissioned suicide prevention, self-harm prevention and suicide bereavement training for front line professionals across the system.
- Small grants (up to £500) allocated to pilot projects to prevent suicide within identified at-risk groups. Due to low uptake, plans are now in place to increase the grant allocation and improve engagement.

Suicide Prevention Charter Task & Finish Group

The aim of the group is to plan, co-ordinate and support the development of a Nottingham and Nottinghamshire suicide prevention charter by people with lived experiences. This group will be responsible for delivering engagement activities with individuals with lived experiences, capturing the outputs from these activities, consulting with the Suicide Prevention Strategic Steering Group and informing the new suicide prevention strategy.

4.1.2 Resources to promote good mental health for all

National resources

Better Health - Every Mind Matters: This campaign aims to improve people's mental health, by directing them to free, practical tips and advice.

[Better mental health for all](#)⁵¹: This report focuses on what can be done individually and collectively to enhance the mental health of individuals, families, and communities by using a public health approach.

⁵¹ Mental Health Foundation (2022) *Better Mental Health For All A public health approach to mental health improvement*. Available at: [MHF-better-mental-health-for-all.pdf](#) (mentalhealth.org.uk)

Prevention Concordat for Better Mental Health: The Concordat focus is on evidence-based planning to reducing health inequalities and address the social determinants of health.

Local resources

There are range of evidence-based interventions, assets and public health initiatives in Nottinghamshire and Nottingham that contribute to mental wellbeing, such as:

- Initiatives to reduce domestic abuse.
- Interventions to reduce drugs, alcohol, and gambling related harm.
- Interventions supporting people experiencing severe multiple disadvantage.
- Tackling Loneliness Collaborative: Campaigns and work to end loneliness and isolation.
- Workplace wellbeing initiatives: In 2023, a workplace mental wellbeing project for Nottingham City employers of all sizes and sectors was initiated to build on the success of the Time to Change social movement and campaign.
- Nottingham Better Mental Health Collaborative: In 2021, Nottingham City Local Authority along with system-wide partners, committed to the Prevention Concordat for Better Mental Health for All. Nottingham's Collaborative for Better Mental Health was subsequently established, with the aim to work in partnership to focus on what matters to people and improve mental health services and support and people's lives.

4.1.3 Mental Health Transformation

The [NHS Long Term Plan](#) (2019) outlined plans to improve and widen access to care for children and adults needing mental health support implemented through a series of transformation programmes delivered up to March 2024. Each transformation area has a multi-partner steering group from across the Integrated Care System (ICS). The transformation programmes are as follows:

- Specialist Community Perinatal Mental Health: Expansion of specialist community perinatal mental health teams, increasing access to evidence-based psychological therapies and extending the period of care from 12 to 24 months.
- Children and Young People's (CYP) Mental Health: Expansion and transformation of specialist community services, including expansion of Mental Health Support Teams in schools; Expansion of specialist community Eating Disorder Services and implementation of Avoidant Restrictive Food Intake Disorder (AFRID) pathway; 24/7 mental health crisis provision for CYP. Nottingham City and Nottinghamshire County partners have committed to using the [Thrive Framework](#)⁵² model to support its CYP mental health transformation.
- Adult Severe Mental Illnesses (SMI) Community Care: Transform and enhance community services with the aim of developing enhanced primary care based

⁵² Thrive (2019) Thrive Framework for system change. Available at: [THRIVE-Framework-for-system-change-2019.pdf](https://www.thriveframework.org/) (implementingthrive.org)

integrated support to help manage fluctuating needs. This includes the transformation of Adult Eating Disorder Services.

- Adult Common Mental Illnesses (NHS Talking Therapies): Expand service availability to meet the local demand and national targets for people entering treatment; maintain waiting times and recovery rates.
- Mental Health Crisis Care and Liaison: Maintain coverage of 24/7 Adult Crisis Resolution and Home Treatment (CRHTs); commission a range of complementary and alternative crisis services (including VCSE/Local Authority provided services); develop a model with EMAS to improve the ambulance response to mental health; maintain 24/7 mental health liaison services within acute hospitals; eliminate all out of area placements (OAPs).
- Therapeutic Acute Mental Health Inpatient Care: Therapeutic approach to improve outcomes and experience from inpatient care and reduce length of stay. Eliminate all inappropriate adult acute out of area placements (OAPs).
- Suicide Reduction and Bereavement Support: Develop and implement multi-agency suicide prevention plans, to reduce suicides for people in contact with mental health services; deliver suicide bereavement support services.

4.1.4 Suicide Prevention Training

National

Samaritans: The charity promotes a better understanding in society of suicide, suicidal behaviour and the value of expressing feelings which may otherwise lead to suicide or impaired emotional health. They provide training to organisations on a range of suicide prevention approaches, in addition to engaging with the media and rail networks.

[Zero Suicide Alliance](#) provide suicide prevention training for the general population, as well as university students, veterans, taxi drivers and men in prison.

Local

Primary Care: Plans are currently progressing to develop and deliver a one-off training session on self-harm to primary care through their practice learning time.

Nottinghamshire Healthcare NHS Foundation Trust delivers suicide awareness and response training for its mental health staff.

Harmless is commissioned to provide mental health awareness, suicide prevention awareness, self-harm awareness and suicide bereavement training to frontline workers (including within the voluntary and community sector) across the system. The training is free to people living or working within Nottingham and Nottinghamshire (note: mental health awareness training is not currently commissioned for people living/working in Nottingham City).

4.2 Service Provision

4.2.1 Nottinghamshire Healthcare NHS Foundation Trust (NHCFT)



[Nottinghamshire Healthcare Foundation Trust](#) (NHCFT) provides community, outpatient, day and inpatient services for all ages of the population for people with mental health problems. These services are delivered in line with the NICE stepped-care model for managing common mental health disorders. The stepped-care model is used to organise provision based on scale of severity and complexity of need, with recommendations for complex and severe mental health disorders focused on specialist mental health services. Access to support in a mental health crisis is available in both Nottingham and Nottinghamshire.

NHCFT services include:

- Acute Mental Health Inpatient Care
- Psychiatric Intensive Care Inpatient Facilities
- S136 Places of Safety
- Community Mental Health Services.
- Mental Health Crisis Services
- A&E Liaison Services
- Psychology And Psychotherapy
- Day Care services
- Recovery College

The Trust-wide suicide prevention strategy (Towards Zero Suicide Strategy 2020-2023) was written in consultation with key stakeholders and sets out our aims for reducing the incidence of suicide across the Trust whilst providing meaningful, effective, and compassionate care. In line with the strategy, NHCFT has developed suicide awareness and response training for its staff. NHCFT have a mechanism in place whereby all unexpected deaths for patients in contact with the service are reported 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 to prevent any unexpected deaths in the future. This work is in addition to the RTSSS led by public health leads for all local suspected suicides. The training offer, strategic development and suicide response is led by the Trust-wide Clinical Lead for Suicide Prevention.

4.2.2 Crisis Resolution and Home Treatment (CRHT)

The CRHT provides a 24 hour, 7 days a week crisis resolution service, offering assessment to adults (18-65 years of age) with severe mental illness. The multidisciplinary team provide short-term home treatment and support to facilitate crisis recovery at home and reduce the need for hospital admission.

4.2.3 Talking Therapies

[NHS Nottingham and Nottinghamshire Talking Therapies](#) is a free and confidential NHS treatment service designed to help with common mental health problems such as stress, anxiety, and depression. Therapeutic approaches include Cognitive behavioural therapy (CBT), Guided self-help, Counselling for depression, Eye Movement and Desensitisation

and Reprocessing (EMDR), Talking therapies for couples, Dynamic interpersonal therapy, as well as employment support.

4.2.4 Primary Care

The Additional Roles Reimbursement Scheme (ARRS) was introduced in England in 2019 with the aim to expand general practice capacity and widen their offer. The scheme aligned with the [NHS Long Term Plan](#) and [NHS Mental Health Implementation Plan 2019/20 – 2023/24](#)⁵³, which set out new and integrated modes of primary and community mental health care. As a result, Primary Care Networks (PCNs) had the option to select and fund Mental Health Practitioners to meet the needs of their local population. Mental health practitioners help to bridge the gap between adults whose needs cannot be met by local talking therapies, but who may not need ongoing care from secondary mental health services.

4.2.5 Children and Young People Mental Health

Nottinghamshire Child and Adolescent Mental Health Services (CAMHS) are for people up to 18 years old and include the following services provided by Nottinghamshire Healthcare:

- Community CAMHS:
 - Looked After and Adoption Team
 - Crisis Resolution Home Treatment Team
 - Developmental Neuropsychiatry and Tourette's Clinic
 - Eating Disorder Team
 - Intellectual Disability Team
 - Paediatric Liaison Team
 - Head 2 Head is an assertive outreach team for young people who: present symptoms that could indicate early onset psychosis; are on an order within the criminal justice system and have co-morbid mental health or learning difficulties; are experiencing mental health difficulties and have co-morbid substance use needs (dual diagnosis); have harmful sexual behaviour as well as mental health difficulties and/or a learning disability.
- The Lookout Adolescent Unit
- Music therapy

A targeted CAMHS service in Nottingham City is provided by Nottingham City Council.

4.2.6 CAMHS Crisis Resolution and Home Treatment

The [CAMHS CRHT](#) provides intensive home treatment for young people who have acute psychiatric/psychological problems or whose mental health is getting worse and who are at high risk of experiencing an acute psychiatric crisis. When young people are admitted to a psychiatric hospital, the CRHT can facilitate the transition to home.

4.2.7 Mental Health Support Teams

⁵³ NHS (2019), *NHS Mental Health Implementation Plan 2019/20 – 2023/24*. Available at: [NHS Long Term Plan » NHS Mental Health Implementation Plan 2019/20 – 2023/24](#)



From 2019, local NHS commissioners initiated the roll out of [Mental Health Support Teams](#) (MHSTs) in over 100 schools across Nottingham and Nottinghamshire. The MHSTs aim to deliver evidence-based interventions for mild to moderate mental health issues, support the development of a [whole school approach](#)⁵⁴ to mental health and help children and young people access the right support by providing timely advice to educational staff.

4.2.8 Be U Notts

Since April 2022 [Be U Notts](#) has delivered a free mental health and emotional wellbeing service to Children and Young People with low to mild emotional needs in Nottingham City and Nottinghamshire County.

4.2.9 Student Mental Health Services

The two universities and three further education colleges in Nottingham and Nottinghamshire have differing models but all offer some form of mental health support or coaching, in addition to links with external provision. There is an opportunity within the Further Education and Higher Education network to map mental health provision to develop an understanding of met and unmet need for students.

4.2.10 NottAlone

[NottAlone](#) is the first point of contact for children and young people, parents, carers and professionals seeking mental health information, including self-harm and suicidal thoughts.

4.2.11 HMP Whatton, Lowdham Grange, Ranby and Nottingham Prisons

All Nottinghamshire Prisons adhere to the Prison Service Order Suicide and Self-Harm Prevention and the Assessment, Care in Custody and Teamwork (ACCT) procedures. ACCT is an individualised care planning and cross agency approach for prisoners at risk of suicide or self-harm. ACCT also aims to improve staff training in case management and in assessing and understanding at-risk prisoners.

4.2.12 Harmless and The Tomorrow Project

[Harmless](#) is commissioned by the ICB to deliver The Tomorrow Project. The Tomorrow Project provides confidential support to people bereaved by suicide via self-referral. A referral mechanism has also been established with local police and regional railway operators to promote awareness of The Tomorrow Project where appropriate, and to facilitate self-referrals. Harmless also provides self-harm and suicide crisis support to the local population.

4.2.13 Text SHOUT

[Text SHOUT](#) is a national service that has also been commissioned locally to provide 24 hours a day and seven-days a week confidential support from a trained volunteer via text.

⁵⁴ PHE (2015), *Promoting children and young people's mental health and wellbeing*. Available at: Promoting children and young people's mental health and wellbeing - GOV.UK (www.gov.uk)



The service is intended to help with: anxiety and stress, depression or sadness, suicidal thoughts, self-harm, panic attacks, loneliness or isolation, abuse and bullying.

4.2.14 Crisis Line

[Crisis Line](#) is available to anyone in [mental health crisis](#) at anytime, anywhere across Nottingham and Nottinghamshire. It's open to people of all ages who need urgent mental health support. Local health workers operate the line and can provide access to mental health profession and signpost to other relevant services.

4.2.15 Nottinghamshire Crisis Sanctuaries

The Crisis Sanctuaries provide support, information, and guidance to people over 18 years old experiencing mental health issues or in a mental health crisis. Crisis Intervention Workers can provide recovery-focused crisis support and community referral as appropriate. The Sanctuaries are delivered through a partnership of three VSCE organisations: Framework, Turning Point and Mind. People can attend in person by dropping into the one of the sanctuary sites at Chilwell, Mansfield, Worksop or Nottingham City. Phone and video call options are also available.

4.3 Activity

4.3.1 Rail companies

In partnership with Network Rail, the Samaritans deliver a Managing Suicidal Contact course to rail staff on how to identify, approach and support a person potentially experiencing suicidality. Samaritans also provides Trauma Support Training to managers to assist staff recovery post-incident support and a 24hour post-incident call-out service at stations delivered by volunteers. Samaritans also works with the media and has developed a [range of guidance](#), including reporting on suicides and self-harm, clusters and rail suicides.

5. Local Views

5.1 Healthwatch Nottingham and Nottinghamshire

Healthwatch is the independent consumer champion for both health and social care. The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality.⁵⁵

At the beginning of the planning process for the Joint Strategic Needs Assessment (JSNA), Healthwatch Nottingham and Nottinghamshire were presented with the Nottinghamshire County JSNA: Project Initiation Document (PID) to consider ways in which relevant patient experience and evidence could be included. Healthwatch Nottingham and Nottinghamshire liaised with the Population Health Management team at the Integrated Care Board (ICB) to

⁵⁵ Healthwatch 2023. Available from: <https://www.healthwatch.co.uk/our-history-and-functions>

share local views of mental health service use (including barriers around access), as well as data at the level of Nottingham and Nottinghamshire ICS, used earlier in this report.

Healthwatch also shared that a service evaluation of the Specialist Mental Health services provided and commissioned by Nottinghamshire Healthcare NHS Foundation Report was being undertaken at the time of engagement. This was due to be published out of the timeframe for inclusion within the JSNA. The service evaluation will be shared once available and will feature into development of the local strategy for Nottingham and Nottinghamshire in 2024.

5.2 Suicide Prevention Stakeholder network

The Suicide Prevention Stakeholder network was set up by Nottinghamshire County Council Public health team and consists of over two hundred organisations that work within suicide prevention.

On the 17th of October 2023, the overall findings of the Joint Strategic Needs Assessment were shared in a presentation to virtual attendees at the Suicide Prevention Stakeholder network event, held on MS Teams by Nottinghamshire County Council Public health. The presentation was subsequently shared through email to the network for those who could not attend. Opportunities to feedback on findings were invited via email, or directly at the stakeholder network event.

6. Evidence of what works

6.1 National strategy and guidance context

6.1.1 Suicide prevention

The [Suicide prevention in England: 5-year cross-sector strategy](#) is the national suicide prevention strategy published in September 2023. It highlights the role of national government, NHS, local government VSCE sector, employers and individuals in suicide prevention. The strategy has key objectives and action areas, outlined as follows:

Key objectives:

- Reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner.
- Improve support for people who have self-harmed.
- Improve support for people bereaved by suicide.

Eight key areas for actions:

- Improve data and evidence to ensure that effective, evidence-informed and timely interventions continue to be adapted.

- Provide tailored, targeted support to priority groups, including those at higher risk. At a national level, this includes:
 - Children and young people
 - Middle-aged men
 - People who have self-harmed
 - People in contact with mental health services
 - People in contact with the justice system
 - Autistic people
 - Pregnant women and new mothers
- Address common risk factors linked to suicide at a population level by providing early intervention and tailored support. These are:
 - Physical illness
 - Financial difficulty and economic adversity
 - Gambling
 - Alcohol and drug misuse
 - Social isolation and loneliness
 - Domestic abuse
- Promote online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.
- Provide effective crisis support across sectors for those who reach crisis point.
- Reduce access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.
- Provide effective bereavement support to those affected by suicide.
- Make suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

The [NCISH Safer Services toolkit](#) provides comprehensive evidence based guidance for self-harm and safety practices in mental health services and primary care. Ten key themes emerged from a UK study of clinicians' views on good practice in mental health services and secondary care services provide a best practice framework:

- Safer wards
- Early follow-up
- No out-of-area admissions
- 24-hour crisis teams
- Family involvement
- Guidance on depression
- Personalised risk management
- Outreach teams
- Low staff turnover
- Reducing alcohol and drug misuse

NCISH toolkit also provides recommendations for:



- Psychosocial assessment for self-harm
- Safer prescribing
- Diagnosis and treatment of mental health problems especially depression in primary care
- Additional measures for men with mental ill-health
- Children and young people

[Aiming for Zero Suicides' – Centre for Mental Health report \(2015\)](#) ⁵⁶: Commissioned by the East of England Strategic Clinical Network, the Centre for Mental Health has published an evaluation report on a whole-system approach to suicide prevention being piloted in four local areas in the East of England. The 'zero suicide' pilot programme, which looks to take suicide prevention into local communities, is based on an approach developed by Dr Ed Coffey in Detroit, Michigan.

[Suicide prevention: identifying and responding to suicide clusters \(2015, updated 2019\)](#): This PHE toolkit, based on suicide cluster research describes steps to identify and respond to suicide clusters.

[Suicide prevention: suicides in public places](#) sets out PHE's guidance for Local Authorities for reducing suicide deaths in public places. It reports that reducing access to means is one of the most effective methods of preventing suicide and sets out four main steps:

- Identify locations and prioritise based on frequency.
- Plan and take action at priority locations.
- Apply the same thinking to similar locations.
- Evaluate and reflect.

PHE guidance also identifies four areas of action to eliminate suicides at frequently used locations:

- Restrict access to the site and the means of suicide.
- Increase opportunity and capacity for human intervention.
- Increase opportunities for help seeking by the suicidal individual.
- Change the public image of the site; dispel its reputation as a 'suicide site'.

[Suicide-safer universities \(2018\)](#): Developed by Universities UK, the document provides guidance to universities on developing a suicide prevention strategy covering the following areas:

- Steps to prevent student suicide.
- Intervening when students get into difficulties.
- Best practice for responding to student suicides.
- Case studies on approaches to suicide prevention through partnership working.
- Checklist highlighting steps university leaders can take to make their communities safe.

Online safety

⁵⁶ Centre for Mental Health (2015), *Aiming for Zero Suicides*. Available at: [Aiming for 'zero suicides' – Centre for Mental Health](#)

The Samaritans completed research into [how social media users experience self-harm and suicide content](#), which has informed their [online excellence programme](#).⁵⁷ The research report acknowledged that the internet can be valuable to some for accessing information and support, for others experiencing self-harm and suicidal feelings it can present a risk, by glorifying and promoting self-harm and suicide. Many of the key research recommendations are beyond the scope of local organisations and are informing the online safety bill. However, the following recommendations provide opportunities at local level:

When signposting individuals to appropriate support, platforms should include:

- Information about local services.
- Options for live chat and messaging services.
- The option for someone to contact you.
- Platforms should also consider ways to make signposting to support more visible to users across their site.

6.1.2 Mental Health

The strategic direction for mental health in England is described in the [NHS Long Term Plan](#) (LTP) published in 2019; the 10 year plan includes measures to improve access for mental health services for adults and children. The [NHS Mental Health Implementation Plan](#) (2019/20 – 2023/24) consolidated LTP ambitions and actions, building on the Five Year Forward View for Mental Health Plan. In addition to a commitment to advancing mental health equality, the Plan outlined a Suicide Reduction and Bereavement Support programme to:

- Deliver against multi-agency suicide prevention plans, working towards a national 10% reduction in suicides by 2020/21
- Work closely with mental health providers to ensure plans are in place for a ‘zero suicide’ ambition for mental health inpatients.
- Cover every local area in the country.
- Have suicide bereavement support services providing timely and appropriate support to families and staff.

The Implementation Plan identified that other mental health service improvements outlined in the LTP would further support their suicide reduction plan such as:

- 24/7 crisis care for all ages available via 111.
- integrated community models for severe mental illness which will include meeting needs for those who self-harm and with co-morbid substance use.

⁵⁷ Samaritans (2023), How social media users experience self-harm and suicide content.

- improving the therapeutic environment in inpatient settings

[Prevention Concordat for Better Mental Health](#) was published in 2017 and refreshed in 2022, in recognition of the long-standing inequalities highlighted by the COVID-19 pandemic. The concordat takes a prevention-focused approach to improving the public's mental health, addressing wider social determinants of health and tackling health inequalities.

6.1.3 Clinical guidelines and quality standards

The National Institute for Health and Care Excellence (NICE) issues clinical guidelines and quality standards drawn from the best available evidence. Key points are highlighted below.

[Suicide Prevention \(2019\)](#) NICE Quality Standard 189:

- Multi-agency suicide prevention partnerships have a strategic suicide prevention group and clear governance and accountability structures.
- Multi-agency suicide prevention partnerships reduce access to suicides based on local information.
- Multi-agency suicide prevention partnerships have a local media plan.
- Adults presenting with suicidal thoughts or plans discuss whether they would like their family, carers or friends to be involved in their care and are made aware of the limits of confidentiality.
- People bereaved or affected by a suspected suicide are given information and offered tailored support.

[Preventing suicide in community and custodial settings](#) (2018)⁵⁸, NICE Guideline 105: This guideline includes recommendations on partnerships, strategies and action plans, which largely reflect general overarching national suicide prevention approaches, with specific advice for some custodial settings.

[Self-harm: assessment, management and preventing recurrence](#) (2022), NICE Guidelines 225⁵⁹. The guideline includes those with a mental health problem, neurodevelopmental disorder or learning disability and applies to all sectors that work with people who have self-harmed including recommendations on:

- Information and support; consent and confidentiality
- Safeguarding
- Involving family members and carers
- Psychosocial assessment and care by mental health professionals
- Risk assessment tools and scales; assessment and care by healthcare professionals and social care practitioners; assessment and care by professionals from other sectors
- Admission to and discharge from hospital; initial aftercare after an episode of self-harm; interventions for self-harm

⁵⁸ National Institute for Health and Care Excellence (2018), *Preventing suicide in community and custodial settings*. Available at: [Preventing suicide in community and custodial settings \(nice.org.uk\)](https://www.nice.org.uk).

⁵⁹ National Institute for Health and Care Excellence (2022), *Self-harm: assessment, management and preventing recurrence*.

- Supporting people to be safe after self-harm; safer prescribing and dispensing; training and supervision

[Depression in adults: treatment and management \(2022\)](#), NICE Guidelines 222 ⁶⁰. This guideline provides recommendations for adults for: first-line treatment for less and more severe depression; relapse prevention, further-line treatment, treatment options for chronic depression, depression with personality disorder or psychotic depression and the “matched care model”.

[Depression in children and young people: identification and management \(2019\)](#) ⁶¹, NICE guideline 134. This guidance provides recommendations on: psychological therapies for mild and moderate to severe depression; care for all children and young people with depression; the stepped-care model; detection, risk profiling and referral; recognition; transfer to adult services.

[Depression in adults with a chronic physical health problem: recognition and management. \(2009\)](#) ⁶² NICE clinical guideline 91. This outlines recommended care for all people with depression, as well as application of the stepped-care model.

6.1.4 Local level strategy

Key Nottinghamshire County and Nottingham City documents related to suicide prevention include:

[ICS Mental Health \(COVID-19\) \(July 2020\)](#)

[Nottingham and Nottinghamshire Integrated Care System Mental Health and Social Care Strategy \(2019-2024\)](#)

[Nottingham Director of Public Health \(Annual Report 2021\) - Tackling Severe Multiple Disadvantage](#)

[Nottingham Joint Health and Wellbeing Strategy \(2022 – 2025\)](#)

[Nottingham Mental Health and Wellbeing Strategy \(2019 – 2023\)](#)

[Nottinghamshire Guide to Championing Suicide & Self-harm Prevention & Mental health \(2022\)](#)

[Nottinghamshire Joint Health Wellbeing Strategy 2022-2026](#)

Nottinghamshire JSNA Chapters:

⁶⁰ National Institute for Health and Care Excellence (2022), *Depression in adults: treatment and management*.

⁶¹ National Institute for Health and Care Excellence (2019), *Depression in children and young people: identification and management*.

⁶² National Institute for Health and Care Excellence (2009), *Depression in adults with a chronic physical health problem: recognition and management*.

[Domestic Abuse \(2019\)](#)

[Emotional and Mental Health of Children and Young People \(2021\)](#)

[Mental Health - Adults and Older People \(2017\)](#)

[Self-Harm \(2019\)](#)

[Nottinghamshire Mental Health Promotion Action Plan \(2022-25\)](#)

6.1.5 Research evidence

Community based and clinical suicide prevention interventions.

A literature search of CINAHL, EMBASE, Epistemonikos, Medline, Public Health Database (ProQuest), PsycINFO, Social Policy & Practice and TripPro was completed to find the best available evidence relating to the question: What interventions are effective in preventing suicide? The following key search terms were used: suicide prevention, suicidal, suicide risk, prevent, intervention, program, community mental health, primary care, primary health care, general practice, GP, accident and emergency, emergency department, post hospital, post discharge, psychotherapy, psychological therapy, serious mental illness, mental illness, mental disorder, systematic review, United Kingdom. The search was conducted between the 12th and 16th June 2023.

The search included interventions conducted in the community; schools; primary care; clinical settings; and online. The results included UK and international publications of systematic review evidence, case studies and primary research.

Effective suicide prevention interventions

Although there is evidence that suicide prevention interventions can be effective in preventing suicidal behaviour, it is not always possible to determine which specific approaches are creating a difference.⁶³ Also, some approaches may work for some groups at-risk, but not others. Research and evaluation of suicide-related interventions provide useful insights. Combining this knowledge with an understanding of local determinants of suicidal behaviour, helps us understand the need and ways we can address it.⁶⁴

Some population level and community-based interventions have a consistent evidence base and are listed below.

- Training primary care physicians in depression recognition
- Educating young people on depression and suicidal behaviour
- Active outreach to psychiatric patients after discharge or a suicidal crisis

⁶³ Effectiveness of suicide prevention interventions: A systematic review and meta-analysis, Hofstra, E., et al., General hospital psychiatry, 2020. 63: p. 127-140

⁶⁴ Effective Programs on Suicide Prevention: Combination of Review of Systematic Reviews with Expert Opinions, Fakhari, A., et al., International journal of preventive medicine, 2022. 13: p. 39.

- Interventions that reduce access to lethal means

Suicide Prevention and Awareness training

Suicide prevention and awareness training provides people with skills to identify early warning signs of suicidality, how to engage in conversation and signpost people to appropriate support and services. Due to the wide variation in training between providers, the effectiveness of this approach remains unclear.⁶⁵ Where effectiveness is apparent, it diminishes with time, eventually reaching pre-test levels.⁶⁶ Directly educating young people about depression and suicide, was found to be more effective than suicide prevention and awareness training for the same population. There is some evidence for exploring training for railway staff and rail commuters.⁶⁷

Public Awareness

Suicide prevention media campaigns may improve awareness of suicide, but their effectiveness as a means of changing suicide related behaviour is less clear. One systematic review identified found that:

- Campaign exposure may improve knowledge and awareness of suicide.
- Campaign materials can improve attitudes to suicide, although there were some exceptions. In this context attitudes were described as precursors to behaviour change.
- Research on the impact of media campaigns on help-seeking behaviour was inconclusive.

Rigorous evaluation is recommended when embarking on a media campaign, with consideration given to the messaging and target audience; measuring knowledge, attitudes, behavioural intentions, and actual behaviours.⁶⁸ These evaluations should aim to explore the messaging contained within campaigns, to understand which do and do not work well. They should also consider the reach of the campaign, to ascertain if it is having the desired effect.

Means Restriction

Means restriction aims to reduce suicide by limiting public access to lethal methods⁶⁹. Reducing access to poisons and medications (especially common and lethal methods) can reduce death by suicide and was not associated with an increase suicide by other means.⁷⁰

⁶⁵ Gatekeeper training for suicidal behaviors: A systematic review, Yonemoto, N., et al., *Journal of Affective Disorders*, 2019. 246: p. 506-514.

⁶⁶ Evaluating the Longitudinal Efficacy of SafeTALK Suicide Prevention Gatekeeper Training in a General Community Sample, Holmes, G., et al., *Suicide & life-threatening behavior*, 2021. 51(5): p. 844-853.

⁶⁷ Intervening to prevent suicide at railway locations: findings from a qualitative study with front-line staff and rail commuters, Katsampa, D., et al., *BJPsych open*, 2022. 8(2): p. e62.

⁶⁸ Suicide Prevention Media Campaigns: A Systematic Literature Review, Pirkis, J., et al., *Health communication*, 2019. 34(4): p. 402-414.

⁶⁹ Public Health England (2015) *Preventing suicides in public places*. Available at: [Preventing suicides in public places \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk)

⁷⁰ Universal interventions for suicide prevention in high-income Organisation for Economic Co-operation and Development (OECD) member countries: a systematic review, Ishimo, M.-C., et al., *Injury prevention: journal of the International Society for Child and Adolescent Injury Prevention*, 2021. 27(2): p. 184-193.

Strategies to restricting access to poison and medication included “banning or withdrawing them from the market, reducing concentration, limiting the quantity sold, and allowing access for only a specific occupation or medical condition”⁷¹.

The use of barriers such as fencing as a method of restricting access to sites used for suicide by jumping may be a cost-effective approach to suicide reduction.

There was limited research related to means restriction and suicide by road traffic⁷².

Interventions to reduce rail deaths may be effective, but where multiple approaches were implemented simultaneously it was not clear which particular approaches made an impact.⁷³

⁷⁴ A small-scale study found that physical barriers and bystander interruptions, including frontline staff or commuters may prevent rail deaths.⁷⁵ ⁷⁶ The study recommended clear help points, visibility of station staff and suicide prevention training for the public to facilitate bystander interventions.

Social and Peer Support

In this context social support interventions are described as providing social support, enhancing social connectedness or tackling feelings of loneliness. Social support can prevent suicide in people with a high suicide risk.⁷⁷ A scoping review identified a range of peer-based interventions targeting suicide prevention, such as:

- One-to-one interventions delivered by lay people or professionals, via email, text, face-to-face or telephone.
- Face-to-face group interventions which met regularly and often engaged in an activity.
- Online groups providing opportunities for conversation.

However, research into the use of peer support for suicide prevention lacked methodological rigour and more rigorous evaluation methods are recommended to identify effective approaches.⁷⁸

Suicide Surveillance

Real time suspected suicide surveillance (RTSSS) allows for rapid data-driven postvention responses. In particular, RTSSS is proven to support access to timely and effective services

⁷¹ Association Between Means Restriction of Poison and Method-Specific Suicide Rates: A Systematic Review, Lim, J.S., et al., JAMA health forum, 2021. 2(10): p. e213042.

⁷² Means restriction for the prevention of suicide on roads, Okolie, C., et al., The Cochrane database of systematic reviews, 2020. 9: p. CD013738.

⁷³ Intervening to prevent suicide at railway locations: findings from a qualitative study with front-line staff and rail commuters, Katsampa, D., et al., BJPsych open, 2022. 8(2): p. e62.

⁷⁴ Intervening to prevent suicide at railway locations: findings from a qualitative study with front-line staff and rail commuters, Katsampa, D., et al., BJPsych open, 2022. 8(2): p. e62.

⁷⁵ Railway suicide in the Netherlands lower than expected: Are preventive measures effective?, van Houwelingen, C.A.J., et al., Crisis: The Journal of Crisis Intervention and Suicide Prevention, 2021.

⁷⁶ Intervening to prevent suicide at railway locations: findings from a qualitative study with front-line staff and rail commuters, Katsampa, D., et al., BJPsych open, 2022. 8(2): p. e62.

⁷⁷ Methods and efficacy of social support interventions in preventing suicide: a systematic review and meta-analysis, Hou, X., et al., Evidence-based mental health, 2022. 25(1): p. 29-35.

⁷⁸ Peer-based interventions targeting suicide prevention: A scoping review, Bowersox, N.W., et al., American journal of community psychology, 2021. 68(1-2): p. 232-248.

for those bereaved by suicide.⁷⁹ People bereaved by suicide are at an increased risk of suicide behaviour, consequently RTSSS approaches have the potential to prevent further deaths by suicide. Further research and evaluation are needed to understand the impact of other actions taken in response to RTSSS.

Riskassessment by health professionals

A high proportion of people are in contact with healthcare services in the year leading up to death by suicide. Consequently, interactions between patients and healthcare providers present an opportunity to identify and support those at risk. Risk assessment tools have regularly been used to predict self-harm and suicide behaviour, however there is now strong evidence that such tools are ineffective predictors⁸⁰. Healthcare providers may instead benefit from specialist and soft-skills training to support conversations about mental health and the development of collaborative personalised safety plans with patients.^{81 82 83}

Primary care

Primary care healthcare providers are often the first point of contact for people seeking help for suicidal ideation. There is evidence that the development of the following in primary care settings can prevent suicide^{84 85}:

- Training and educating healthcare providers to raise awareness of suicide.
- Screening for suicide risk and/or mood disturbance.
- Managing depression symptoms and mental disorders, through collaborative treatment form multidisciplinary teams.
- Managing suicide attempts and at-risk cases, for example through follow-up monitoring and [Brief Contact Interventions](#) (BCIs)⁸⁶ of people attempting suicide. BCI make use of phone calls, letters, postcards, or text messages to maintain scheduled long-term contact with a service user.

⁷⁹ Real-Time Suicide Surveillance: Comparison of International Surveillance Systems and Recommended Best Practice, Benson, R., et al., Archives of suicide research: official journal of the International Academy for Suicide Research, 2022: p. 1-27

⁸⁰ Suicide risk assessment in UK mental health services: a national mixed-methods study, Graney, J., et al., The Lancet Psychiatry, 2020. 7(12): p. 1046-1053.

⁸¹ Effective suicide prevention strategies in primary healthcare settings: a systematic review, Azizi, H., et al., Middle East Current Psychiatry, 2022. 29(1): p. 101.

⁸² The Effectiveness of the Safety Planning Intervention for Adults Experiencing Suicide-Related Distress: A Systematic Review, Ferguson, M., et al., Archives of suicide research: official journal of the International Academy for Suicide Research, 2022. 26(3): p. 1022-1045.

⁸³ Safety planning-type interventions for suicide prevention: Meta-analysis, Nuij, C., et al., The British Journal of Psychiatry, 2021. 219(2): p. 419-426.

⁸⁴ Effective suicide prevention strategies in primary healthcare settings: a systematic review, Azizi, H., et al., Middle East Current Psychiatry, 2022. 29(1): p. 101.

⁸⁵ Suicide interventions in primary care: A selective review of the evidence, Dueweke, A.R. and A.J. Bridges, Families, systems & health: the journal of collaborative family healthcare, 2018. 36(3): p. 289-302

⁸⁶ Milner A, Spittal MJ, Kapur N, Witt K, Pirkis J, Carter G (2016) Mechanisms of brief contact interventions in clinical populations: a systematic review. BMC Psychiatry 16:1–10

Again, it should be noted that risk assessments, are not reliable predictors of suicide behaviour,⁸⁷ A systematic review identified barriers to young adults (18-26 years of age) in raising and addressing suicide ideation. Unique to this group, was the finding that young people expected GP's to initiate conversations about suicide.⁸⁸

Emergency Department (ED)

Recent research demonstrated a significant decrease in suicide behaviours through the use of continuous quality improvement methods to identify and implement improvements, such as the use of collaborative safety plans.⁸⁹

In paediatric ED settings there is some evidence that family-based and motivational interviewing interventions may reduce suicidal ideation and risk in children and adolescents; however further research is needed⁹⁰.

Brief psychological interventions for people attending ED or following a suicide attempt may reduce suicide behaviours⁹¹.

The use of combined safety-planning and telephone follow-up post hospital admission for a suicide attempt was recently piloted. This preliminary study shows promise, and the approach warrants further exploration^{92 93}.

Caring Contacts makes use of periodic personalised texts to enquire about former patients' well-being without expectation of response. This approach may facilitate engagement with health services and have a protective effect⁹⁴.

Psychological therapies

Studies into the effectiveness of psychosocial and psychological interventions (such as cognitive-behavioural therapy, dialectical behaviour therapy and psychodynamic

⁸⁷ Suicide risk assessment in UK mental health services: a national mixed-methods study, Graney, J., et al., *The Lancet Psychiatry*, 2020. 7(12): p. 1046-1053.

⁸⁸ Raising Suicide in Medical Appointments-Barriers and Facilitators Experienced by Young Adults and GPs: A Mixed-Methods Systematic Review, Osborne, D., et al., *Int J Environ Res Public Health*, 2023. 20(1).

⁸⁹ Effect of an Emergency Department Process Improvement Package on Suicide Prevention: The ED-SAFE 2 Cluster Randomized Clinical Trial, Boudreaux, E.D., et al., *JAMA Psychiatry*, 2023.

⁹⁰ A rapid review of emergency department interventions for children and young people presenting with suicidal ideation, Virk, F., J. Waine, and C. Berry, *BJPsych open*, 2022. 8(2): p. e56.

⁹¹ Effectiveness of brief psychological interventions for suicidal presentations: a systematic review, McCabe, R., et al., *BMC psychiatry*, 2018. 18(1): p. 120.

⁹² Association of Suicide Prevention Interventions With Subsequent Suicide Attempts, Linkage to Follow-up Care, and Depression Symptoms for Acute Care Settings: A Systematic Review and Meta-analysis, Doupnik, S.K., et al., *JAMA psychiatry*, 2020. 77(10): p. 1021-1030.

⁹³ SAFETEL: a pilot randomised controlled trial to assess the feasibility and acceptability of a safety planning and telephone follow-up intervention to reduce suicidal behaviour, O'Connor, R.C., et al., *Pilot and feasibility studies*, 2022. 8(1): p. 156

⁹⁴ Caring contacts for suicide prevention: A systematic review and meta-analysis, Skopp, N.A., et al., *Psychological services*, 2023. 20(1): p. 74-83.

psychotherapies) on suicide and self-harm behaviours were contradictory and inconclusive.

95 96

Digital interventions

There is some support for the use of digital interventions in the reduction of suicide and self-harm, with the strongest evidence for iCBT (internet-based Cognitive Behavioural Therapy).^{97 98} Further research is needed to understand the implementation and impact of this intervention.

Population sub-groups

A literature search of CINAHL, EMBASE, Epistemonikos, Medline, Public Health Database (ProQuest), PsycINFO, Social Policy & Practice and TripPro was completed to find the best available evidence relating to the question: What interventions are effective in preventing suicide? The following key search terms were used: suicide prevention, suicidal, prevent, intervention, program, at risk, risk group, men, LGBTQ, gender diverse, substance use, financial, unemployed, systematic review, review, United Kingdom and UK. The search was conducted between the 9th and 14th June 2023.

The results included UK and international publications of systematic review evidence, case studies and primary research.

Older adults

Some evidence supports physical activity and the use of collaborative care for depression management and reduction of suicide ideation. Collaborative care is the use of multidisciplinary teams working jointly.⁹⁹

Children and young people

Psycho-educational interventions delivered in clinical, community and educational settings may reduce suicidal ideation and behaviour in young people.^{100 101} It is recommended that interventions are coproduced and are acceptable to young people. These interventions show some signs of mid-to-long term effects, have the potential to reach a wide audience and may

⁹⁵ A systematic review and meta-analysis of psychosocial interventions aiming to reduce risks of suicide and self-harm in psychiatric inpatients, Yiu, H.W., S. Rowe, and L. Wood, *Psychiatry research*, 2021. 305: p. 114175

⁹⁶ The effectiveness of psychoanalytic/psychodynamic psychotherapy for reducing suicide attempts and self-harm: systematic review and meta-analysis, Briggs, S., et al., *British Journal of Psychiatry*, 2019. 214(6): p. 320-328.

⁹⁷ Effectiveness of internet-based cognitive behavioral therapy for suicide: a systematic review and meta-analysis of RCTs, Yu, T., et al., *Psychology, Health & Medicine*, 2022. 27(10): p. 2186-2203.

⁹⁸ Internet-Based Cognitive Behavioral Therapy to Reduce Suicidal Ideation: A Systematic Review and Meta-analysis, Buscher, R., et al., *JAMA network open*, 2020. 3(4): p. e203933.

⁹⁹ Prevention of suicidal behavior in older people: A systematic review of reviews, Laflamme, L., et al., *PLoS ONE*, 2022. 17(1): p. 1-14.

¹⁰⁰ A Systematic Review of School-Based Suicide Prevention Interventions for Adolescents, and Intervention and Contextual Factors in Prevention, Walsh, E.H., M.P. Herring, and J. McMahon, *Prevention science : the official journal of the Society for Prevention Research*, 2023. 24(2): p. 365-381.

¹⁰¹ Research Review: The effect of school-based suicide prevention on suicidal ideation and suicide attempts and the role of intervention and contextual factors among adolescents: a meta-analysis and meta-regression, Walsh, E.H., J. McMahon, and M.P. Herring, *Journal of child psychology and psychiatry, and allied disciplines*, 2022. 63(8): p. 836-845.

help identify and address suicide risk factors.^{102 103104} Lack of input from school staff and young people in the development of the programme is a limiting factor in the intervention's effectiveness.

The use of psychosocial approaches and Dialectical Behaviour Therapy for Adolescents (DBT-A) may reduce suicide risk.^{105 106} Further research and evaluation of suicide prevention programmes is needed in this area.

Men

Interventions have been developed to address some of the barriers to health seeking behaviour amongst men.¹⁰⁷ For example, campaigns to destigmatise mental illness, increase awareness and health seeking-behaviours, promoting talking to others and coping strategies have been implemented in various forms across the UK. However, studies and evaluation of these types of approaches have not been robust enough to draw conclusion on their effectiveness.^{108 109} Coproducing services with men, developing targeted communications promoting social connections and delivering interventions in informal settings did show some promise.¹¹⁰

Another potential intervention included offering psychosocial and practical support to men with financial difficulties and at risk of suicide. The intervention showed a reduction in depression and suicide ideation, in addition to increased financial self-efficacy.¹¹¹

Misdiagnosed or unidentified depression are barriers to health-seeking in men. Training GPs to identify and support depression/suicidality in men is one opportunity to address this.¹¹²

LGBTQ+

¹⁰² Effectiveness of school-based preventive programs in suicidal thoughts and behaviors: A meta-analysis, Gijzen, M.W.M., et al., *Journal of Affective Disorders*, 2022. 298(Part A): p. 408-420.

¹⁰³ The effects of educational interventions on suicide: A systematic review and meta-analysis, Pistone, I., et al., *The International journal of social psychiatry*, 2019. 65(5): p. 399-412.

¹⁰⁴ The effects of interventions preventing self-harm and suicide in children and adolescents: an overview of systematic reviews, Morken, I.S., et al., *F1000Research*, 2019. 8: p. 890.

¹⁰⁵ Suicide in young people: screening, risk assessment, and intervention, Hughes, J.L., et al., *BMJ (Clinical research ed.)*, 2023. **381**: p. e070630

¹⁰⁶ Adapted Dialectical Behavior Therapy for Adolescents with a High Risk of Suicide in a Community Clinic: A Pragmatic Randomized Controlled Trial, Santamarina-Perez, P., et al., *Suicide & life-threatening behavior*, 2020. 50(3): p. 652-667.

¹⁰⁷ Barriers to help-seeking in suicidal men: A systematic literature review. Jones LJ, Iqbal Z, Airey ND, Brown SR, Burbidge F *International Journal of Psychiatry*. 2019 Dec 27;4(2):1-5.

¹⁰⁸ Kayikci S et al. Suicide Prevention Campaign in Barnet: Evaluation Report 2021-22. London Borough of Barnet, 2022

¹⁰⁹ A rapid review to determine the suicide risk of separated men and the effectiveness of targeted suicide prevention interventions, King, Kylie; Krysinska, Karolina and Nicholas, Angela, *Advances in Mental Health*, 2022. 20(3), pp. 184-199

¹¹⁰ Men and suicide prevention: a scoping review, Struszczyk, S., P.M. Galdas, and P.A. Tiffin, *Journal of mental health (Abingdon, England)*, 2019. 28(1): p. 80-88.

¹¹¹ Preventing male suicide through a psychosocial intervention that provides psychological support and tackles financial difficulties: a mixed method evaluation, Jackson, J., et al., *BMC psychiatry*, 2022. 22(1): p. 333.

¹¹² Men and suicide prevention: a scoping review, Struszczyk, S., P.M. Galdas, and P.A. Tiffin, *Journal of mental health (Abingdon, England)*, 2019. 28(1): p. 80-88.

The evidence reviewed predominately identified research for children and young people. School based approaches promoting safe community, connectedness and acceptance may address suicide behaviour for LGBTQ+ young people^{113 114} The limited evidence in these areas warrants further exploration.

Substance Use

Evidence is currently limited on the effectiveness of interventions to prevent suicide and self-harm in people using substances ¹¹⁵. Further research is needed in this field.

Finance and unemployment

Unemployment benefits, employment protection legislation, higher minimum wage and active labour market programmes may reduce suicide at the population level, however the evidence for financial-focused suicide prevention interventions is inconclusive.¹¹⁶ A pilot programme using brief psychosocial interventions for people presenting with self-harm or acute distress to emergency departments due to financial difficulties, showed some early potential. ¹¹⁷

In contact with the criminal justice system

The evidence search did not identify robust and strong evidence for approaches for reducing suicidality in people in contact with criminal justice system.¹¹⁸ It is worth noting that the term “in contact with the criminal justice system” encompasses a broad spectrum of experiences and interactions.

7. What is on the horizon?

7.1 Resourcing for the Suicide prevention strategy for England: 2023 to 2028

The new national Suicide Prevention strategy and action plan (see section 6.1.2) sets out over 100 actions across sectors, agencies, and the general public, in promoting suicide prevention as everybody's business. The government has made resource commitments that are expected over the coming months, including:

- Establishing a new nationwide near real-time suspected suicide surveillance system will improve the early detection of and timely action to address changes in suicide rates or trends (expected to launch November 2023)

¹¹³ Systematic Review of Interventions to Reduce Suicide Risk in Transgender and Gender Diverse Youth, Christensen, J.A., et al., Child psychiatry and human development, 2023.

¹¹⁴ The roles of school in supporting LGBTQ+ youth: A systematic review and ecological framework for understanding risk for suicide-related thoughts and behaviors, Marraccini, M.E., et al., Journal of school psychology, 2022. 91: p. 27-49.

¹¹⁵ Psychosocial Interventions for Reducing Suicidal Behaviour and Alcohol Consumption in Patients With Alcohol Problems: A Systematic Review of Randomized Controlled Trials, Hurzeler, T., et al., Alcohol & Alcoholism, 2021. 56(1): p. 17-27.

¹¹⁶ The Role of Unemployment, Financial Hardship, and Economic Recession on Suicidal Behaviors and Interventions to Mitigate Their Impact: A Review, Mathieu, S., et al., Frontiers in public health, 2022. 10: p. 907052.

¹¹⁷ The help for people with money, employment or housing problems (HOPE) intervention: pilot randomised trial with mixed methods feasibility research, Barnes, M.C., et al., Pilot and feasibility studies, 2018. 4: p. 172

¹¹⁸ Interventions to reduce suicidal thoughts and behaviours among people in contact with the criminal justice system: A global systematic review, Carter, A., et al., eClinicalMedicine, 2022. 44: p. 101266.



- A £10 million Suicide Prevention Grant Fund is to support Voluntary Community Sector organisations to deliver suicide prevention activity.
- NHSE is taking forward improvements to the mental health crisis support offer, supported by an investment of £150 million. This includes procuring specialised mental health ambulances and investing in a range of infrastructure schemes, including alternatives to A&E, crisis cafés, and new and refurbished mental health assessment and liaison spaces.
- Funding the government's proposed Online Safety Bill which will introduce legislation to tackle harmful online suicide and self-harm content.

7.2 Suicide and self-harm service

The Integrated Care Board is commissioning a new integrated, all age suicide and self-harm service across Nottingham and Nottinghamshire aiming to provide timely, evidence-based support for people experiencing suicidal ideation, self-harm or have been bereaved by suicide.

Learning from the wave 4 programme and wider stakeholder engagement has been incorporated into the new service model including a greater emphasis on community engagement and development, understanding the role and support for parent/carers and improving communications and awareness of the service. The new service will commence in April 2024.

7.3 Wave 4 programme delivery

The Wave 4 suicide prevention programme concludes in October 2024. For the final year of the programme work will focus on:

- Completion of a series of engagement and training pilots being delivered on behalf of the programme by Harmless focussing on organisations and groups who work with and support men, LGBTQ+ communities, Gypsy Roma Traveller communities and those working in suicide bereavement and relationship breakdown.
- Development and delivery of a listening project focussing on higher risk groups of men, people with neurodevelopmental conditions, young people and young adults at risk of self-harm, people experiencing financial vulnerability (including from gambling harm) and suicide bereavement. Findings from the listening event will inform future commissioning decisions, provide qualitative evidence to identify gaps in suicide prevention work and inform the Nottingham and Nottinghamshire Suicide Prevention strategy.
- Development of targeted communication campaigns and a small community grants programme focussing on the higher risk groups and antecedents to suicide listed above.
- Continuation of training delivered via the Wave 4 Framework Agreement to continue to upskill and increase confidence across a range of groups and organisations who support those who may experience suicidality.
- Evaluation of the Wave 4 suicide prevention programme in its totality.

The work outlined above aims to identify learning and the needs of these at-risk groups and areas of concern to be shared across the system. This will influence key partners, wider stakeholders and will be incorporated into future suicide prevention activity by the Suicide Prevention Stakeholder Steering Group.

7.4 NHS 111

From April 2024, 111 option 2 will go live and will be promoted as the first contact number for anyone in a mental health crisis. Calls will be diverted to a local Crisis hub for support, advice, triage and linked into CAMHS and AMH Crisis teams for further support. This will be a 24/7 offer.

7.5 Expected activity and provision for Children and Young People

Crisis Support and Complex Needs: A group will be established to review crisis support in children and young people on a complex needs pathway. The group will consist of partners including representatives from acute, health and social care. It will review feedback, embed services within pathways, and focusing on aligning crisis support following presentation at an emergency department.

Self-Harm Working Group: This group will review and streamline self-harm provision pathways.

Mental Health Champions will be embedded in local hospitals to:

- ensure that mental health has the same focus within acute settings as physical health.
- provide oversight of young people with complex needs attending acute settings
- support appropriate discharge.
- work with system partners to improve pathways.

7.6 Other relevant national strategy and guidance

Updated guidance on suicide cluster responses

In the [Suicide Prevention Strategy for England: 2023-2028](#), OHID committed to updating guidance for local suicide prevention partnerships on suicide clusters and contagion. This will support effective local responses where there may be more suicides than expected in a particular area, or a suspected link between suicides. The publication is expected by 2024.

Guidance for Local Authorities on suicide prevention action plans

In the [Suicide Prevention Strategy for England: 2023-2028](#), OHID committed to refreshing local suicide prevention plan guidance by the end of 2024. The updated guidance will support the development of local plans in line with national priorities, including guidance on providing bespoke support to demographic group and communities of concern.

Major Conditions Strategy

In 2023 the government committed to major conditions strategy which will include mental ill health, along with five other physical health groups of conditions. At the time of writing, it is understood that the major conditions strategy will replace the 'No Health Without Mental health' a cross government health outcomes strategy for all ages. The Department for Health and Social Care (DHSC) published an [interim case for change and strategic framework](#) ¹¹⁹ in August 2023, with the full strategy expected in 2024.

What does this tell us?

8. Unmet needs and service gaps

Unmet needs were identified by reflecting on the information presented by this JSNA on local population trends and at-risk groups, local service provision and assets, and by considering the evidence base of what works in suicide prevention. The following unmet needs were identified:

1. Current school-based mental health support does not specifically address suicide prevention. Evidence suggests vulnerability to suicide can be partly established early in life and that taking early intervention and school-based approaches can be preventative.¹²⁰ The Whole School Approach and Children and Young People (CYP) Mental Health Transformation Programme provides an opportunity to integrate suicide prevention within existing emotional wellbeing approaches.
2. There is a need for additional work to tailor support for men to reduce risk factors and antecedents for suicidality. These include economic adversity, alcohol and drug use, relationship stresses and lack of social connections. Current provision exists to support men addressing crisis, self-harm and suicide prevention but could go further to address additional risk factors and antecedents for suicidality.
3. There is a need to support health seeking behaviours in men. National data suggests that 9% of middle-aged men experiencing suicidality are not in contact with any support.¹²¹ Currently there is not a year-round targeted communications strategy to support men to engage with appropriate services and support.

¹¹⁹ Department of Health and Social Care (2023), *Major conditions strategy: case for change and our strategic framework*. Available at: Major conditions strategy: case for change and our strategic framework - GOV.UK (www.gov.uk)

¹²⁰ The developmental origins of suicide mortality: A systematic review of longitudinal studies, Vidal-Ribas, Pablo; et al. , *European Child & Adolescent Psychiatry*, 2022.

¹²¹ The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Suicide by middle-aged men. 2021. The University of Manchester.

4. Voluntary and community services report a need for increased skills and knowledge in how to help people experiencing self-harm and suicidality access a continuum of appropriate holistic support. Voluntary and community sector providers have reported an increase of self-harm presentations to their services, during the same period that hospital admissions for intentional self-harm have decreased.
5. Ensure evidence-based approaches support social connectedness and emotional wellbeing to reduce self-harm and suicidality among LGBTQ+ young people in current school-based and community-based locations. A Wave 4 funded pilot project has been established to explore engagement and crisis support for LGBTQ+ people. CAMHS has engaged with local LGBTQ+ groups to identify and implement ways to support LGBTQ+ young people. There is currently an opportunity address the risk factors of suicidality for LGBTQ+, such as loneliness, bullying and abuse via whole school approaches and CYP mental health transformation. These are promising developments, which would be bolstered by greater links between the CYP Mental Health Transformation Programme, Nottinghamshire Healthcare trust and local authority Public Health.
6. Further collaborative work is needed to improve access to support services for Gypsy Roma and Traveller communities. Evidence suggested that roles embedded in the community are best placed to support Gypsy Roma Traveller groups. There is an opportunity to collaborate with existing Community Champions and other community assets.
7. Systems are needed to ensure professionals in community, healthcare, money help and other public-facing roles have up-to-date knowledge and can support access to financial advice and wellbeing and mental health support. This should include knowledge and pathways at a local level. National and local intelligence suggests that financial adversity is a risk factor for suicide.¹²² The rising cost of living is likely to add additional risk and requires timely support to be implemented. Feedback from stakeholders acknowledges challenges for both citizens and professionals in identifying what financial support is available and where to access it.
8. Follow-up support is commissioned after first attendance to emergency departments for suicide ideation, and not for later attendances. Intentional self-harm requiring emergency hospital treatment has been found to be present in about 15% of those who take their own life.¹²³ Effective follow-up care has the potential to help people who self-harm to access the right support and prevent suicide.
9. There is a need to identify effective interventions to address the mental health needs and prevent suicide for people with long term physical health conditions. National data shows that people with long-term and chronic physical illness may be an at-risk group for low mental wellbeing and suicidality.¹²⁴ Local intelligence identified cancer diagnosis and chronic pain as the most cited physical health condition within RTSSS data. Some links exist between physical health and mental health services. However, more needs to be done to support and understand patient's needs.

¹²² Annual report 2023: UK patient and general population data 2010-2020. March 2023 Available from <https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/>

¹²³ McManus S et al. Suicide and self-harm in Britain: researching risk and resilience. NatCen Social Research, 2019 Available from: <https://nspa.org.uk/resource/suicide-and-self-harm-in-britain-researching-risk-and-resilience-using-uk-surveys-data-and-analysis/>

¹²⁴ The association of physical multimorbidity with suicidal ideation and suicide attempts in England: A mediation analysis of influential factors, Smith, L., et al., The International journal of social psychiatry, 2023. 69(3): p. 523-531.

10. Greater links and shared learning between domestic abuse and suicide prevention teams is needed. National data and research highlight that women are disproportionately affected by domestic abuse suicide.^{125 126} This group characteristically have multiple unmet needs with fewer resources to escape and seek help.
11. There is a need to better support the needs of children and young people who are in crisis and present to the emergency department with self-harm or suicidal ideation. Local stakeholders have highlighted inappropriately met or unmet needs of young people who are in crisis or emotionally dysregulated, with some CYP experiencing long waits on physical health wards whilst appropriate provision was sought. Looked after young people and those transitioning from CYP to adult services, were identified as groups of particular need.
12. There is a need to address online safety and suicide-related internet use. In the absence of local data, we look to national data which indicates a general increase in suicide-related internet use since 2011. Evidence of suicide-related internet use was evidenced in 8% of the suicides in people who were in contact with mental health services over the past year.¹²⁷

The following knowledge gaps were identified:

- Evidence is currently limited on the effectiveness of interventions to prevent suicide and self-harm in people using substances.
- Limited understanding of the links between gender, domestic abuse and suicide (particularly sexual violence).
- Effective and appropriate links between RTSSS and Mental Healthcare provider self-harm and suicide data to inform antecedent themes and prevention action.
- Prevalence and means of self-harm, including understanding of self-harm presentations to VSCE organisations and the scale of potentially unmet need.
- Understanding gambling harm local intelligence in relation to suicide risk factors to inform targeted interventions.
- Limited understanding of approaches to reducing suicidality in people in contact with probation and youth justice services.

What should we do next?

10. Recommendations for consideration

¹²⁵ The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Annual report 2022. Available from: <https://sites.manchester.ac.uk/ncish/reports/annual-report-2022/>

¹²⁶ Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England Sally McManus et al. June 07, 2022 DOI: [https://doi.org/10.1016/S2215-0366\(22\)00151-1](https://doi.org/10.1016/S2215-0366(22)00151-1)

¹²⁷ The National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report: UK patient and general population data, 2010-2020. 2023. University of Manchester. Available from: <https://sites.manchester.ac.uk/ncish/reports/annual-report-2023/>

The following recommendations have been formulated based on the unmet needs and knowledge gaps identified in section 9 and are aligned to components of the new Suicide Prevention Strategy for England (2023 to 2028):

	Recommendations	Lead(s)
	Improved Data and Evidence	
1	Improve data and intelligence sharing between partners including through the local Real Time Suspected Suicide Surveillance (RTSSS) system in order to ensure the quality of the RTSSS data and learning reviews after a suicide death has occurred and to improve the understanding of local need and gaps.	Local authority Public Health teams/ Nottinghamshire Healthcare Trust/ partners in RTSSS working group
2	Establish protocols for appropriate sharing and analysis of data on self-harm and suicide attempts among key partners working with groups at increased risk of suicidality, including mental health, domestic abuse, drug and alcohol use services to inform preventative actions.	Local authority Public Health teams/ Nottinghamshire Healthcare Trust
	Reducing access to means and high frequency locations	
3	Continue to prioritise action on reducing access to means for suicide within public places using intelligence from Real Time Suspected Suicide Surveillance (RTSSS) and through the RTSSS Working Group.	Local authority Public Health teams and partners in RTSSS working group
	Providing tailored and targeted support to target groups.	
4	Develop integrated suicide prevention approaches for children and young people (CYP) in school settings via the Whole School Approach and CYP Mental Health Transformation Programme	Local authority Public Health and Education teams/CYP Mental Health Transformation leads
5	Facilitate the development of services and support, co-produced with men, to address suicide risk factors and promote social connections in informal settings.	Local authority Public Health teams/VSCE sector
6	Develop targeted suicide prevention communications for men to support engagement in and access to support services.	Local authority Public Health teams/ Nottinghamshire Healthcare Trust
7	Work with partners (including VSCE and primary care) to better understand where people experiencing self-harm or suicide ideation come into contact with services and what further action is needed to identify and support them, particularly for those whose needs do not meet the threshold for secondary mental healthcare.	All commissioners in Local authority Public Health teams

8	Develop communication resources to support people experiencing self-harm to access the right support at the right time.	Local authority Public Health teams
9	Integrate evidence-based approaches to supporting social connectedness and emotional wellbeing for LGBTQ+ people into school and community-based approaches and services.	Local authority Public Health teams/CYP Mental Health Transformation leads
10	Partner with community champions and existing organisations to improve access to appropriate support services for people from Gypsy Roma and Traveller communities.	Local authority Public Health teams
Addressing risk factors		
11	Use learning from local pilot projects and listening events to improve access for groups who are at increased risk of not accessing self-harm and suicide prevention support such as: <ul style="list-style-type: none"> - Gypsy Roma Traveller groups - LGBTQ+ groups - Men - Those who are financially vulnerable, unemployed or people with a gambling problem - People with neurodevelopmental conditions - Young people/adults at risk of self-harm/suicide - People bereaved by suicide 	Local authority Public Health teams/CYP Mental Health Transformation leads
12	Support the community and voluntary sector to support people from at-risk groups who are experiencing self-harm and suicidality such as: men, people with financial difficulty, LGBTQ+ communities, people experiencing loneliness, and people in contact with the criminal justice system.	Local authority Public Health teams/VSCE sector
13	Work with services providing financial support/advice and wellbeing support to improve the pathways between psychosocial support and money help, promote workforce awareness of financial advice and wellbeing support, and strengthen links between financial support and mental health services.	Local authority Public Health teams
14	Identify contacts and foster links with commissioners and providers of chronic pain and cancer pathways to explore how to improve access to appropriate support services.	Local authority Public Health teams/ Nottinghamshire Healthcare trust
15	Develop links with probation, youth justice and community-based services for people in contact with criminal justice system to develop training and involvement with the Suicide Prevention Stakeholder Network and Suicide Prevention Strategic Steering Group.	Local authority Public Health teams
16	Review mechanisms for sharing learning from Domestic Homicide Reviews relating to suicide with the suicide prevention partnership and consider opportunities for links between Assurance Learning Implementation Groups (ALIG) and the Suicide Prevention Strategic Steering Group.	Local authority Public Health teams
Effective crisis support		



17	Work with the Integrated Care Board to identify support following Emergency Department attendance for every incident of suicide ideation.	Integrated Care Board
18	Work with the Integrated Care Board's Children and Young People (CYP) team to identify opportunities to promote the mental health and wellbeing and appropriate crisis support for CYP and looked-after children and ensure pathways for support are aligned to facilitate easy access for CYP.	Integrated Care Board (CYP and looked-after children's team)
Online safety:		
19	Develop an approach to promote online safety, informed by the national online excellence programme.	Local authority Public Health teams, Education and Children's social care teams.

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References

Bookmarked

Appendix

None

**Nottingham City Health and Wellbeing Board
24 January 2024**

Report Title:	Data Integration for Population Health
Lead Board Member(s):	Dave Briggs, Medical Director, Nottingham and Nottinghamshire Integrated Care Board
Report author and contact details:	Maria Principe, Nottingham and Nottinghamshire ICB
Other colleagues who have provided input:	

Executive Summary:

In the evolving landscape of health and care data, the role of integrated population data has become pivotal in driving informed decisions and strategies. At the heart of this transformation is the need to integrate and harness the power of data in innovative ways to deliver the population health agenda. This paper delves into the approach the ICB is adopting into integrated population health data, and how it aims to use it systematically to deliver both the strategic population health agenda, while operationally delivering improved outcomes for our citizens. This paper will give stakeholders within the system insight into the goals, and envisioned outcomes that underline SAIU's (System Analytics Intelligence Units) commitment to elevating the standards of data-driven health and care solutions.

Background:

In recent years, the quantity and quality of individual patient data has seen a significant increase. While the regulatory landscape has been instrumental in upholding patient data privacy and confidentiality, it has also inadvertently made it more challenging to utilise this data to its fullest potential for broader health and care management objectives, particularly as the recent Planning Guidance on Population Health Intelligence and insights highlights the pressing need to integrate and leverage this data.

In the past, the System Analytics Intelligence Unit's (SAIU) Data Management Team, previously aligned with the CCG, secured permissions from data custodians to collect and utilise data primarily for first hand use (patient/service user focus). This led to the establishment of the GPRCC (GP Repository for Clinical Care). GPRCC serves as a central hub where data from diverse sources such as GPs, community centres, acute care facilities, and Local Authority systems amalgamates. This consolidated data is then streamlined into a warehouse managed by the Data Management Team, with eHealthscope and the systems PowerBI dashboards acting as the user interface for GPRCC.

This approach provided profound insights into direct patient care. However, with the

shift towards more population health management approaches, it was quickly identified that a gap in which integrated data for secondary use purposes was needed. This integration was not just about compiling data, but also about linking data sets together to gain a more complete picture to help the system model, predict and stratify patient and citizen data enabling the system to align our strategies with the current and projected needs of both individuals and the broader community.

An integrated Data Approach

By championing the integration of data within our system, we acknowledge the following steps were a necessity.

1. Expanding GPRCC to be used for secondary use purposes

To bring the vision of integrated population health data to fruition, our first step was to engage proactively with GPs and other service providers and gain authority from them as data owners to use data for primary and secondary use purposes. This required forging collaborative relationships, persuading data owners and their patients and citizens of the benefits of us having access to this system. Accessing data for secondary use purposes enabled us to understand health trends, vulnerabilities, and opportunities in the community. This approach provided us with intelligence to steer health care strategies, promoting a tailored and holistic approach to health and wellbeing.

*Its important to note that all data stored in the GPRCC pseudonymised

2. Implementation of Section 251 to enable GPRCC data to be linked

Securing the Section 251 provided the Nottingham and Nottinghamshire healthcare ecosystem with an unprecedented advantage. We are now equipped to interlink all data within GPRCC, thus offering a panoramic view of our population's interaction with the healthcare infrastructure. Historically, our understanding of healthcare touchpoints was fragmented. Using the illustrative case of the Urgent Care Department, in the past, we had a count of 150 individuals. However, with linked data enabled by Section 251, we can discern the comprehensive patient journey, tracing steps from initial calls to 111, visits to the WIC, or even details of a medicine reviews. This multi-layered data offers richer insights and a tangible understanding of the patient journey, making healthcare intervention more strategic and impactful.

3. Enabling integrated population data to be accessible

In our commitment to fostering a data-driven healthcare culture, we are pioneering the creation of an accessible population health data warehouse. This platform, holding pseudonymised and interlinked data, enables analysts to truly analyse trends, impacts and monitor outcomes. Available to all 'authorised' system analysts, it promises a unified view of the patient journey, moving away from traditionally siloed insights to one that is truly integrated no longer restricted by a limited data viewpoint enabling and supporting true collaboration.

Conclusion Summary

Recommendation(s):

- Acknowledgment of Progress: Members are urged to take cognizance of the significant strides made in the realm of integrated data management and the transformation it promises to bring within the broader healthcare landscape.
- Support for Integrated Data Strategy: We solicit the continuous backing of all members to reinforce our integrated approach towards intelligence sharing and utilization. A cohesive, collaborative stance will be instrumental in optimising the potential of our data-driven interventions.
- Future Endeavours: As we continue to innovate and expand our data capabilities, it is crucial for members to remain engaged, providing feedback and strategic input, ensuring our approach aligns with the evolving needs of our community.

The Joint Health and Wellbeing Strategy

Aims and Priorities	How the recommendation(s) contribute to meeting the Aims and Priorities:
Aim 1: To increase healthy life expectancy in Nottingham through addressing the wider determinants of health and enabling people to make healthy decisions	The current health and care environment has many diverse challenges; rapidly evolving data streams, challenging regulations, and an overarching need to pivot towards an integrated, population health-focused strategy are obstacles that intelligence leads have to overcome on a daily basis. The ICS's commitment to this vision is evidenced by its dedicated approach to harnessing the power of integrated population health data. The System Analytics Intelligence Unit (SAIU) has been pivotal in orchestrating these data-driven initiatives, curating a strategic roadmap defined by rigorous collaboration with stakeholders, the implementation of the Section 251, and the creation of an accessible data warehouse. As the system advances on this trajectory, it is evident that our health and care strategies, informed by these sophisticated data mechanisms, are geared towards not only enhancing
Aim 2: To reduce health inequalities by having a proportionately greater focus where change is most needed	
Priority 1: Smoking and Tobacco Control	
Priority 2: Eating and Moving for Good Health	
Priority 3: Severe Multiple Disadvantage	
Priority 4: Financial Wellbeing	

	system efficiencies but also enriching the outcomes for the residents of Nottingham and Nottinghamshire.
<p>How mental health and wellbeing is being championed in line with the Board's aspiration to give equal value to mental and physical health:</p>	

<p>List of background papers relied upon in writing this report (not including published documents or confidential or exempt information)</p>	
<p>Published documents referred to in this report</p>	

**Nottingham City Health and Wellbeing Board
24 January 2024**

Report Title:	Update on the Nottingham City Place-Based Partnership (PBP)
Lead Board Member(s):	Dr Husein Mawji, Vice Chair, Nottingham City Health and Wellbeing Board and Clinical Director, Nottingham City Place-Based Partnership Mel Barrett, Chief Executive, Nottingham City Council and Lead, Nottingham City Place-Based Partnership Lucy Hubber, Director of Public Health, Nottingham City Council
Report author and contact details:	Rich Brady, Programme Director, Nottingham City Place-Based Partnership rich.brady@nhs.net
Other colleagues who have provided input:	
Executive Summary:	
<p>This paper provides an update on the work of the Nottingham City PBP. Detailed within this update is a summary of the reviews undertaken of the PBP Strategic Plan and the NHS Joint Forward Plan to inform the future work programme of the PBP. There is also an update on the ICB's Health Inequalities and Innovation Fund, from which funding had been identified for four PBP sponsored programmes and projects.</p>	
Recommendation(s): The Board is asked to:	
Note the update from the Nottingham City Place-Based Partnership.	

The Joint Health and Wellbeing Strategy	
Aims and Priorities	How the recommendation(s) contribute to meeting the Aims and Priorities:
Aim 1: To increase healthy life expectancy in Nottingham through addressing the wider determinants of health and enabling people to make healthy decisions	The Nottingham City Place-Based Partnership (PBP) is discharged responsibility for the oversight of the delivery of the Joint Health and Wellbeing Strategy (JHWS) 2022 – 2025.

Aim 2: To reduce health inequalities by having a proportionately greater focus where change is most needed	
Priority 1: Smoking and Tobacco Control	
Priority 2: Eating and Moving for Good Health	
Priority 3: Severe Multiple Disadvantage	
Priority 4: Financial Wellbeing	
<p>How mental health and wellbeing is being championed in line with the Board’s aspiration to give equal value to mental and physical health:</p> <p>The Place-Based Partnership has a programme focussed on supporting Nottingham citizens to better access preventative support to improve mental health and wellbeing. This programme is aligned with the programmes being delivered as part of the Joint Health and Wellbeing Strategy 2022 – 2025.</p>	

List of background papers relied upon in writing this report (not including published documents or confidential or exempt information)	Nottingham City PBP Strategic Plan 2023 – 2025
Published documents referred to in this report	Nottingham and Nottinghamshire NHS Joint Forward Plan 2023 – 2027

Update on the Nottingham City Place-Based Partnership (PBP)

Introduction

1. This paper provides an update on the work of the Nottingham City PBP. Detailed within this update is a summary of the reviews undertaken of the PBP Strategic Plan and the NHS Joint Forward Plan to inform the future work programme of the PBP. There is also an update on the ICB's Health Inequalities and Innovation Fund, from which funding had been identified for four PBP sponsored programmes and projects.

Place-Based Partnership Strategic Plan: Six-month review

2. In April 2023, the PBP Executive Team agreed the Nottingham City PBP Strategic Plan. The plan, inclusive of the series of partnership programmes overseen by the PBP, set out six strategic objectives over the next two years to support the partnership to mature to become an integral part of the health and care system infrastructure. At the 15 December meeting, the PBP Executive Team reviewed progress made against the strategic objectives set in the PBP Strategic Plan 2022-2025.
3. The six strategic objectives are:
 - a) Accelerate integrated working in neighbourhoods.
 - b) Build trust with communities.
 - c) Better evidence partnership activity.
 - d) Formalise governance and reporting.
 - e) Test methods of accountability and assurance.
 - f) Continue partnership programme delivery.
4. Since the publication of the Strategic Plan, the constituent partners of the Nottingham City PBP have collectively faced substantial operational and financial pressures – the health and care landscape has changed significantly in the past six months. While this has, at times, limited the ability for partners to engage in partnership activity, progress has still been made within the partnership programmes and across all six strategic objectives.
 - a. In its role to oversee the delivery of the Joint Health and Wellbeing Strategy, and in its wider programmes, the PBP has transformed the way in which partners in the City work together to support preventative approaches to improving health and wellbeing and reducing health inequalities.

- b. Through the **Serve Multiple Disadvantage (SMD)** programme the PBP has designed and delivered a unique, place-based model that is providing preventative support to approximately 200 people a year. In addition, a multi-disciplinary team (MDT) provides a central coordination function for statutory and non-statutory services working with people experiencing SMD, making more efficient use of partner resources. The model also works to build more effective partnerships (e.g. through the development of pathways, operational processes, and planning and commissioning). The programme has demonstrated significant financial savings to the NHS, local government and criminal justice service and following attracting over £5m in national government funding, has secured just under £1.5m in recurrent funding from the ICB (subject to evaluation), providing a platform for investment from other system partners.
- c. Through the **Smoking & Tobacco Control (STC)** programme the PBP has supported the assembly of a multi-agency STC Alliance, represented by a range of public sector organisations across the ICS. In the past six months, in addition to increasing referral rates to smoking cessation services by 65% in the City, there has also been a seizure of just over 4000 illegal cigarettes (street value £14,409) and 4930 illegal vapes. The programme is successfully coordinating activity across the City and County to achieve the ambition of smoking rates reducing to 5% or under by 2035.
- d. Through the **Eating & Moving for Good Health (EMGH)** programme the PBP has supported the assembly of a multi-agency EMGH Alliance in the City that is helping to coordinate a range of activity between partners. In addition to a 35% increase in referrals to weight management services, partners are working with schools to better target interventions to support children who are living with obesity or are overweight. Five of the eight Primary Care Networks (PCN) are also being supported to deliver 'healthy lifestyle' projects.
- e. Through the **Financial Wellbeing (FW)** programme the PBP has aligned advice centres with PCNs, with financial advisor social prescribing link workers embedded within three PCNs, to date providing support to 249 people. The PBP has coordinated a range of training and support programmes to support the FW of citizens and staff working in partner organisations. The PBP has also supported a gambling related harm awareness campaign running until the end of 2023, with a range of assets shared between partners, backed by advertisements across the city.
- f. Through the **Mental Health (MH)** programme the PBP has coordinated partners to take preventative approaches to reduce the impact of poor

mental health and wellbeing, including the design of a mental wellbeing service, connecting wider support services in the city. The programme is guided by a 'Prevention Concordat', recognised as an 'exemplar' by The Office for Health Improvement and Disparities. The programme is supported by the Nottingham City Collaborative for Better Mental Health, a collaborative bringing together voluntary sector partners and people with lived experience of mental health issues. The Collaborative holds regular listening events, each attended by approximately 100 people.

- g. Through the **Race Health Inequalities (RHI)** programme the PBP has worked with community leaders to develop a race health inequalities maturity matrix. Over 30 organisations in Nottingham and Nottinghamshire are now being supported to address structures and process that contribute to the exacerbation of health inequalities experienced in minority ethnic communities. In May 2023, the PBP hosted Nottingham's first ever Race Health Inequalities Summit attended by over 200 people across the partnership alongside community representatives in Nottingham to discuss health inequalities that disproportionately impact minority communities in Nottingham. The programme is now supporting NUH and Donna Ockenden to improve representation of minority ethnic communities in the maternity review.
- h. Through the PBP Executive Team and its suite of executive led programmes, the PBP has built a genuine partnership in the City, with strong relationships facilitating improved integration both within and outside the PBP programmes. For example, through the **Primary and Secondary Care Interface programme**, the PBP has been successful in improving relationship between secondary and primary care clinicians, improving relationships, strengthening pathways, communication and reducing duplication.
- i. In its role to support PCN delivery, the PBP established the **Thriving General Practice (TGP)** programme, bringing together the 46 general practices in the city to agree a vision and deliver a programme focused on six areas of transformation to support general practice resilience and sustainability. This has included the successful launch of urgent 'on-the-day hub' in Nottingham City East (NCE) PCN, offering additional capacity for urgent same day care. The hub is based in St Ann's Valley Centre and is a collaboration between the general practices in NCE PCN, Nottingham City General Practice Alliance, CityCare and the ICB, using existing resource – no additional commissioned service has been required to deliver this.

- j. The TGP Estates workshop held in September has unlocked key estates resource across the City both for general practice and the on-the-day hub. Long standing and inscrutable estates issues have been resolved to make better use of public estate to support sustainable services. This work has recently been noted as an exemplar by the ICB Primary Care Strategy Delivery Group and other areas are now looking to adopt the approach.
 - k. In 2023 the PBP was a finalist at the Local Government Chronical Awards, with its delivery approach shortlisted for the public health award. The PBP was also a finalist at the Health Service Journal Awards, nominated for the NHS race equality award for the RHI programme's work on the maturity matrix.
5. Despite the challenging circumstances that system partners face, there is strong evidence that the PBP is continuing to deliver positive outcomes for the population, the partnership and the system. While the Executive Team reaffirmed their commitment to the strategic plan, partners agreed the need assess success measures, and a development session has been scheduled in February to assess and reaffirm the PBP's work programme going forward.

Supporting the delivery of the NHS Joint Forward Plan / ICB Operating Model

6. In line with ambition in the PBP's strategic plan, for the partnership to play a greater role in supporting the delivery of system priorities, the PBP Executive Team has undertaken a review of activity that supports delivery of the NHS Joint Forward Plan (JFP). The review has shown that there is significant alignment across the PBP programmes with the priorities set in the JFP, particularly in line with the prevention ambitions.
7. The JFP states an ambition for PBPs to play a leadership role in leading partnership approaches to long-term condition management and frailty. The Executive Team noted that the constituent parts of the PBP are well positioned to be able to support this ambition, however the extent to which the PBP could effectively deliver this priority would be dependent on the resource available to the partnership, including that provided by the ICB.
8. In March 2023, NHS England communicated a requirement for ICB's to reduce their running costs by 20% by 1 April 2024, with an additional 10% by April 2025, a total of 30%. In response to this, the Nottingham and Nottinghamshire ICB has been undertaking a review of its functions, structures, and ways of working to inform a new operating model that will meet the requirements set by NHS England.

9. An announcement on the future operating model is yet to be made and therefore it is not yet clear the extent to which this will impact resource currently aligned to the PBP from the ICB. The PBP Executive Team noted the importance of understanding the impact of the future operating model in assessing the PBP's ability to align other resources from the partnership to support the delivery of the JFP. An announcement is expected ahead of the scheduled development session in February.

Funding for health inequalities programmes and projects

10. On 3 August 2023, the PBP received notification that four business cases submitted to ICB's Strategic Planning and Integration Committee had been successful in securing funding via the ICB's 'Health Inequalities and Innovation Fund'.

11. The business cases that were approved for funding were:

Scheme	Overview
Severe and Multiple Disadvantage Infrastructure and Delivery Model	Just under £1.5m in recurrent funding has been awarded to allow the continuation of specialist support to people experiencing severe multiple disadvantage in the City. Support is currently funded through the joint Department for Levelling Up, Housing and Communities and The National Lottery Community Fund's 'Changing Futures' programme, led by the Nottingham City Place-Based Partnership
Family Mentor Programme	Just over £200,000 in recurrent funding has been secured to allow the continuation of the Family Mentor service, which is delivered by Small Steps Big Changes. Supporting families from pregnancy up to their child's 4 th birthday, the service is delivered by a highly trained paid peer workforce who have experience of parenting via local voluntary and community sector providers.
Improve Uptake for Childhood Vaccinations and Immunisations across Nottingham City	£120,000 in recurrent funding has been secured to develop and deliver a community-based model to increase the uptake of childhood vaccinations in the City. A targeted approach will be taken to engage with communities where immunisations and vaccination rates are known to be low. This will be led through a partnership approach between the NHS, public health and community and voluntary sector partners.
Co-designed Community Hypertension Case Finding	Building on Nottingham and Nottinghamshire's status as a Core20PLUS5 Accelerator site, £50,000 has been secured to support co-design and delivery of an asset-based approach to community hypertension case finding. Initiatives will be built through co-design; however, it is anticipated these will include blood pressure/health checks

	within community venues and will be delivered in partnership with local GP practices and pharmacies
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12. On 1 December 2023, the PBP received notification from the ICB that, following a decision taken at the 22 November ICB Board meeting to develop a financial recovery plan, a decision was taken to halt spending on any schemes funded through the Health Inequalities and Innovation Fund (HIIF) for 23/24.

13. As of 11 January 2024, a decision has not yet been taken as to whether the HIIF will continue as planned from 24/25 onwards. If a decision is taken to reduce or withdraw HIIF for 24/25 this will have a significant impact on delivery of the four PBP sponsored programmes and projects. In addition to identifying unallocated spend in 23/24, programme and project leads are undertaking impact assessments for 24/25 to identify risks, issues and wider implications to delivery, if this decision is to be taken.

Nottingham City Health and Wellbeing Board
24 January 2023

Report Title:	Update from the Health Protection Board
Lead Board Member(s):	Lucy Hubber, Director of Public Health
Report author and contact details:	Lucy Hubber, Director of Public Health Lucy.hubber@nottinghamcity.gov.uk
Other colleagues who have provided input:	Liz Pierce, Consultant in Public Health Marie Cann-Livingstone, Senior Public Health Manager Tracey Lamming, Public Health Principal
Executive Summary: This report is provided to the Board to provide an update on the statutory responsibilities to assure adequate protection of the health of the local population.	
Does this report contain any information that is exempt from publication? No	
Recommendation(s): The Board is asked to: Note the report	

The Joint Health and Wellbeing Strategy	
Aims and Priorities	How the recommendation(s) contribute to meeting the Aims and Priorities:
Aim 1: To increase healthy life expectancy in Nottingham through addressing the wider determinants of health and enabling people to make healthy decisions	Providing assurance on adequate services to protect the health of population contributes to increasing healthy life expectancy.
Aim 2: To reduce health inequalities by having a proportionately greater focus where change is most needed	
Priority 1: Smoking and Tobacco Control	
Priority 2: Eating and Moving for Good Health	

Priority 3: Severe Multiple Disadvantage	
Priority 4: Financial Wellbeing	
How mental health and wellbeing is being championed in line with the Board's aspiration to give equal value to mental and physical health:	

List of background papers relied upon in writing this report:	Attendance, presentations and draft minutes of the Health Protection Board.
Published documents referred to in this report:	N/A

Background

The statutory assurance role at local level for health protection sits with local government through the Director of Public Health and is exercised through the Health Protection Board, reporting to the Health and Wellbeing Board (HWBB). For Nottingham and Nottinghamshire there is a joint Health Protection Board, chaired in annual rotation by a Director of Public Health. The Terms of Reference are attached for reference.

The purpose of the Health Protection Board is to:

1. Provide suitable assurance regarding outcomes and arrangements for the protection of the health of the population to Nottingham City HWBB and Nottinghamshire County HWBB.
2. Provide system challenge.
3. Facilitate information sharing and collaborative working between stakeholders.
4. Ensure health protection opportunities for early intervention are maximised.
5. Make recommendations for action where opportunities for improvement are identified.

Update from meeting held on 18 December 2023

Screening

As reported from previous meetings, screening programmes were back to business as usual (BAU) activity, with some maintained COVID-19 measures.

- Screening for aortic aneurysm at NUH was described as a high performing service, based on uptake for 2022/23. Of positive note was uptake for men living in the most deprived three deciles as it was the third highest in England for this cohort. Work was taking place to encourage higher uptake in Gypsy, Roma and Traveller communities.
- NUH were performing well with their diabetic eye screening programme and uptake had increased. To improve on this further, NUH had appointed a patient engagement officer to carry out community engagement and targeted work with practices who had high 'did not attend' (DNA) numbers.
- There were currently no performance concerns with the bowel cancer screening programme. Work was taking place at NUH, through a phased approach, to age-extend the programme to 54+ as of November 2023 and then to phase in those age 50 and 52 from April 2024.
- The NHS antenatal and new-born screening programme had no performance concerns locally. NUH were carrying out a late-booking audit with a view to engaging the community champions in work to encourage earlier booking onto maternity care.

The meeting received a separate report on breast screening services. It was reported that following the return to BAU and timed appointments, NUH had seen an improvement in uptake with coverage catching up with the nationally acceptable threshold of 70%. It was reported that initiatives to increase uptake and reduce health inequalities included working with the ICB to identify the protected characteristics of patients being called for screening so that reasonable adjustments could be planned and offered. Other initiatives to increase uptake included text messaging, extended hours and longer appointments where needed. Going forward NUH would be working with the Public Health team at the City Council to further develop their community outreach.

Immunisation and vaccinations

It was reported that delegation of vaccination services to ICBs had been delayed and was now expected to occur in April 2025. Other key points to note were:

- The long-awaited National Immunisation Strategy had been released on 13 December 2023.
- The new provider of the school-aged immunisation service (SAIS), Intrahealth, was carrying out their programme of influenza (flu) vaccinations in schools.
- A new provider of Child Health Information Services (CHIS) for Nottingham and Nottinghamshire, South Central West NHS CSU, commenced on 1 December 2023 were planning to work closely with primary care to increase uptake and decrease inequalities.

- The Nottingham City MMR Plan was submitted to NHSE Midlands in October 2023. An MMR working had been set up to develop, and deliver on, a detailed action plan. In 2022/23, uptake of one dose of MMR as measured at two years old was 84.9% in Nottingham City, as compared to the England average of 89.3%. Uptake of two doses, measured at five years old in Nottingham City was 75.1%, as compared to the England average of 84.5%.
- The HPV one-dose schedule (instead of the previous two doses) commenced in September 2023. It was hoped that locally, this would increase the number of young people who were fully immunised thus enabling finite resources to be used for targeting low-uptake cohorts.
- The new shingles immunisation schedule commenced in September 2023.

Influenza and Covid-19 vaccinations

A verbal report indicated that flu vaccine uptake so far was lower than in previous years and was lower in Nottingham City than in Nottinghamshire. Local uptake data of flu and Covid-19 vaccinations would not be released officially until the season ended and data had been verified.

However, the national data for the current season showed that flu vaccination uptake had been declining year-on-year since 2021/22 with poor uptake in the at-risk and pregnancy population. Table 1 shows flu uptake nationally, as at 31 December 2023, and compared with the same point in the last two years, indicating a lower level of protection from flu than is desirable.

Table 1 – National flu vaccination uptake data year-on-year as at the end of week 52 each year (31 December)

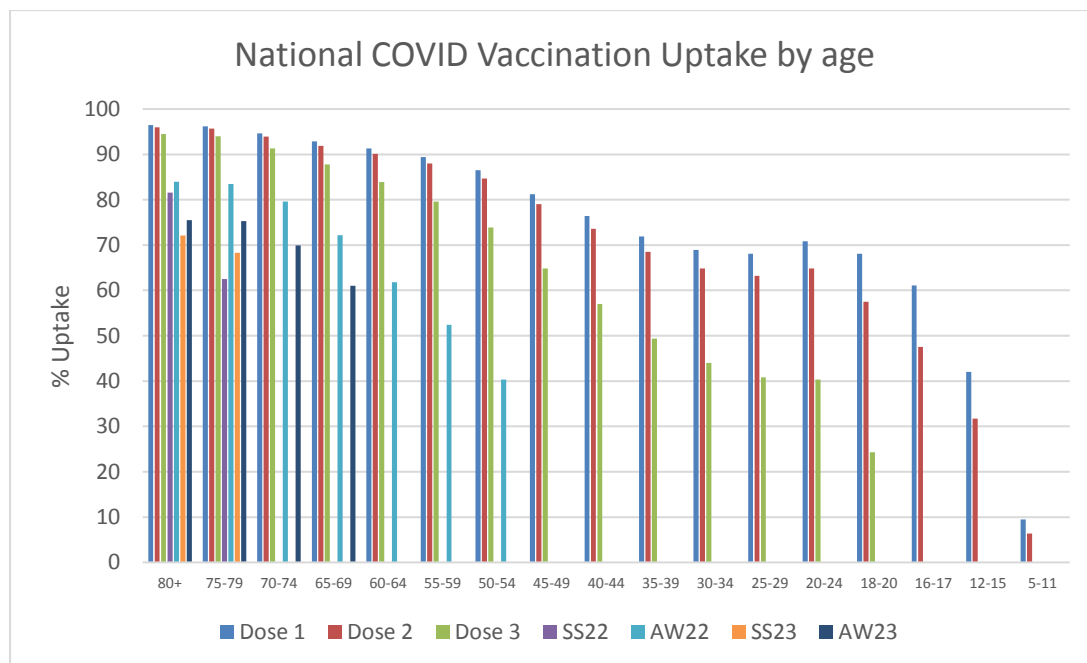
In-year as of 31 December	Flu vaccination age				
	2 years old	3 years old	Under 65 - at risk	Pregnant	65 and over
23/24	42.9	43.0	40.1	30.7	76.9
22/23	39.6	41.9	46.1	33.0	78.3
21/22	46.5	48.9	49.0	37.0	81.3

Source: UKHSA

Locally, a flu pilot had taken place with two- and three-year-olds, delivering the vaccination in nurseries. It was reported that this was being evaluated and that the results and lessons learned would be shared with partners.

Regarding Covid-19 vaccinations, the national data for the current campaign showed that there were fewer people being vaccinated with each campaign. As of, 13 December 2023, 55% of the eligible population of over-65s nationally had received the Autumn Covid-19 booster vaccination. Uptake was lower in more deprived populations and in communities of Black or Pakistani heritage. Table 2 details uptake nationally for each vaccination and booster campaign through to Autumn/Winter 2023 (AW23) by age as of 31 December 2023.

Table 2 – Covid-19 vaccination uptake by vaccination and / or booster campaign aggregated by age as of 31 December 2023



Source: UKHSA

UKHSA Health Protection Team update

It was reported that, despite the measles case reported nationally, none had been recorded in Nottingham or Nottinghamshire and numbers of scarlet fever cases remained lower than at the same point in 2022.

An updated version of the East Midlands Outbreak Management Plan was presented that reflected updated guidance and organisational roles and responsibilities. The plan had been submitted to the LHRPs across the East Midlands for sign-off.

Sexual health

The meeting received a report which discussed the lower-than-average rates of new STI diagnoses including syphilis and gonorrhoea, with no significant change being noticed since the pandemic. The report also highlighted the good work that NUH was going prescribing long-acting reversible contraceptives. Challenges were acknowledged regarding late diagnosis of HIV as well as with Chlamydia screening rates in 15-24s, and STI testing more generally. The low uptake of HPV vaccination among young people was also noted as a concern.

It was agreed that the priorities for 2024 were to:

- Increase early diagnosis of HIV.
- Improve ethnicity coding to allow for targeting to decrease health inequalities.
- Increase health promotion, outreach and co-production.

Next meeting

The next meeting of the Board was scheduled for 4 March 2024 and would include:

- A presentation on the health aspects of private sector housing.
- A report on antimicrobial resistance.
- Aiming for zero tolerance for HCAs.
- TB in Nottingham and Nottinghamshire.

Nottingham City Health and Wellbeing Board
Wednesday 24 January 2024

Report Title:	Integrated Care Strategy for Nottingham and Nottinghamshire 2023-2027: March 2024 Review
Lead Board Member(s):	Lucy Hubber, Director of Public Health, Nottingham City Council
Report author and contact details:	Sarah Fleming, Programme Director for System Development, NHS Nottingham and Nottinghamshire ICB Joanna Cooper, Assistant Director of Strategy, NHS Nottingham and Nottinghamshire
Other colleagues who have provided input:	
Executive Summary:	<p>In line with guidance from the Department of Health and Social Care (DHSC), at its meeting on 13 March 2023, the Integrated Care Partnership (ICP) approved Nottingham and Nottinghamshire's Integrated Care Strategy. Subsequent work has focussed on implementation and refining measures to monitor the impact of the strategy to assure the Partnership that the right conditions for success have been established and embedded.</p> <p>At its 6 October meeting, the ICP agreed a light touch review of the Integrated Care Strategy at the end of this first year. The ICP will consider this at their 22 March 2024 meeting.</p>
Recommendations:	<p>This paper provides partners with progress since the last meeting as well as outlining an approach to reviewing and refreshing the strategy by March 2024. The Board is asked to:</p> <ol style="list-style-type: none"> 1. Discuss progress with delivery of the strategy through the City and County Joint Health and Wellbeing Strategies and NHS Joint Forward Plan. 2. Note the approach for the review of the Integrated Care Strategy and the refresh of the NHS Joint Forward Plan. 3. Agree to delegate to the Chair and Director of Public Health responsibility for engagement with partners on the review of the Integrated Care Strategy and refresh of the NHS Joint Forward Plan. 4. Agree to schedule an item at the 27 March meeting to consider any amendments to the Integrated Care Strategy and the NHS Joint Forward Plan, including consideration of a statement of support by the Board on the NHS Joint Forward Plan.

The Joint Health and Wellbeing Strategy

Aims and Priorities	How the recommendation(s) contribute to meeting the Aims and Priorities:
Aim 1: To increase healthy life expectancy in Nottingham through addressing the wider determinants of health and enabling people to make healthy decisions	The Integrated Care Strategy should be based on the assessed needs of the population and the three ambitions focus on addressing inequalities.
Aim 2: To reduce health inequalities by having a proportionately greater focus where change is most needed	
Priority 1: Smoking and Tobacco Control	
Priority 2: Eating and Moving for Good Health	
Priority 3: Severe Multiple Disadvantage	
Priority 4: Financial Wellbeing	
How mental health and wellbeing is being championed in line with the Board's aspiration to give equal value to mental and physical health: The Integrated Care Strategy builds on the JHWS ambition	
List of background papers relied upon in writing this report (not including published documents or confidential or exempt information)	
Published documents referred to in this report	The Strategy is launched and can be found on the ICS website: https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/Integrated-Care-Strategy-2023_27.pdf

Integrated Care Strategy for Nottingham and Nottinghamshire 2023-2027: March 2024 review

Introduction and context

1. In line with guidance from the Department of Health and Social Care (DHSC), at its meeting on 13 March 2023, the Integrated Care Partnership (ICP) approved the Nottingham and Nottinghamshire's Integrated Care Strategy. The strategy has been launched and can be found on the ICS website:
https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/Integrated-Care-Strategy-2023_27.pdf
2. The ICP agreed that a light touch review of the Integrated Care Strategy should be undertaken at the end of 2023/24 to consider delivery of the Strategy at the end of this first year. The ICP will consider this at their 22 March 2024 meeting.

Delivering the Integrated Care Strategy

3. The Integrated Care Strategy is being delivered by the Nottingham City and Nottinghamshire County Health and Wellbeing Boards through the implementation of their Joint Local Health and Wellbeing Strategies, and by NHS partners through delivery of the NHS Joint Forward Plan.
4. For Nottingham City, the Health and Wellbeing Board has established arrangements for the delivery of its Health and Wellbeing Strategy (<https://www.nottinghamcity.gov.uk/media/gd0fxokf/nottingham-city-joint-health-and-wellbeing-strategy-2022-25.pdf>) to be coordinated through the Nottingham City Place Based Partnership, with the Health and Wellbeing Board retaining its oversight role. The Place Based Partnership has well developed programme plans for smoking and tobacco control; eating and moving for good health; and addressing severe multiple disadvantage¹ priorities, which are all on track in terms of delivery. A programme plan for delivery of the financial wellbeing priority is expected to be published ahead of the November meeting of the Health and Wellbeing Board. In July 2023, the Nottingham City Health and Wellbeing Board also endorsed a five-year strategy on gambling related harm, with themes of regulation, knowledge and awareness, and support pathways.
5. For Nottinghamshire County, the Health and Wellbeing Board continues to deliver a range of workshops, Covid Impact Assessments, Joint Strategic Needs Assessments (JSNAs), and papers to support the evidence base and implementation of the Nottinghamshire Joint Health and Wellbeing Strategy (<https://www.nottinghamshire.gov.uk/media/4350014/nottinghamshirejointhealthwellbeingstrategy2022-2026.pdf>). A monthly Joint Health and Wellbeing

¹ Severe Multiple Disadvantage (SMD) refers to people with two or more of the following issues: mental health issues, homelessness, offending and substance misuse. SMD can include other sources of disadvantage, for instance poor physical health, domestic/sexual abuse, community isolation, undiagnosed brain injuries, autism and learning disabilities.

Strategy Steering Group has been set up as an 'engine room' to support joined up delivery across the three Place Based Partnerships (Bassetlaw, Mid-Nottinghamshire and South Nottinghamshire), and other partner organisations. The Health and Wellbeing Board also now utilises a Joint Health and Wellbeing Strategy outcomes dashboard to inform its work and this approach will continue to evolve over the next year. During this financial year, Nottinghamshire County Council has allocated an additional circa. £1 million of in-year funding from public health grant reserves to strengthen impact within a range of programmes that will contribute to delivery of the Joint Health and Wellbeing Strategy. These include increasing support for those with the greatest need (e.g. those experiencing SMD and those who are homeless), weight management, community support through Community Friendly Nottinghamshire, alcohol use, and tobacco. The Health and Wellbeing Board commenced a review in December 2023 to consider how it can increase its effectiveness in improving health and wellbeing and reducing health inequalities.

6. In July 2023, a report was taken to the Nottinghamshire Health and Wellbeing Board proposing a review of the Board to support the delivery of the Joint Health and Wellbeing Strategy, which members endorsed, agreeing that there was a timely opportunity to review how the Board could deliver its responsibilities most effectively in the current health and care context. The review commenced in December 2023.
7. The Nottingham and Nottinghamshire Smoking and Tobacco Control Alliance has launched a smoking and tobacco control vision document and delivery plan, which can be found here: <https://www.mynottinghamnews.co.uk/wp-content/uploads/2023/05/43.114-Smoking-and-Tobacco-Control-Vision.pdf>. Tobacco control is a priority for both the Nottingham City and Nottinghamshire County Health and Wellbeing Boards, and the vision document sets out a collective ambition to see smoking among adults in Nottingham and Nottinghamshire reduced to 5% or lower by 2035 and support progress to a smoke free generation. A number of task and finish groups will develop and deliver priority actions in the areas of smoking cessation; illicit tobacco; smokefree environments; and prevention for children and young people.
8. On 13 July 2023, the Integrated Care Board approved the initial NHS Joint Forward Plan, which can be found here: https://healthandcarenotts.co.uk/wp-content/uploads/2021/05/J15562-Joint-Forward-Plan_v6-090823.pdf. The Joint Forward Plan for the local NHS sets out the five-year response to the Integrated Care Strategy as well as how the NHS Mandate will be delivered. As part of its development, the Joint Forward Plan was considered by the Nottingham City and Nottinghamshire County Health and Wellbeing Boards, and both confirmed that the plan will contribute to the delivery of their Health and Wellbeing Strategies. Currently, work is underway with NHS partners to

confirm the delivery and oversight mechanisms for the lifetime of the plan, and from March 2024, the plan will be reviewed and refreshed on an annual basis.

Impact of the Integrated Care Strategy

9. Key areas of progress made in the first six months since the Integrated Care Strategy was approved include:
 - a) Supporting children and young people to have the best start in life with their health, development, education and preparation for adulthood. A recent OFSTED inspection of children's services found that Nottingham City Council continues to make good progress against an action plan to improve its Children's Services department.
 - b) Supporting frail and/or older people with underlying conditions to stay well, remain independent and avoid unnecessary admissions to hospital in the short term. Partners are working together to jointly develop the same day emergency care pathway to prevent hospital admissions and keep people at home.
 - c) Ensuring that all health and care staff understand the building blocks of health and health inequalities, work is underway in Adult Social Care in Nottingham City Council and Nottinghamshire County Council to embed strengths-based conversations and championing preventive approaches for citizens. This will help staff to find out what is important to people accessing services and identify what support they feel they need to make positive changes in their life. Initial discussions are taking place to consider how Making Every Contact Count (MECC), personalisation and strength-based approaches can be coordinated across the Partnership to improve outcomes for adult social care service users.
 - d) Establishing clinical priorities for the next 24 months to support children, young people and adults with the greatest needs. The clinical priorities include COPD; Stroke; Heart Failure; Cancer; Dementia; Delirium and Confusion; Pneumonia; Cellulitis; Sepsis; Falls and injuries; MSK; Maternity; CYP; Mental Health. Each will be supported by a Population Health Management approach that includes detailed analysis and an in-depth review with recommendations approved through different levels of clinical leadership. Improvements in care quality, effectiveness and clinical outcomes for local people will be tracked as this work progresses.
 - e) Focusing and investing in prevention priorities such as a new Integrated Wellbeing Service in Nottingham City. The service has been developed to support Nottingham's citizens to receive personalised help to live healthier lives and support people living with SMD.
 - f) The Partnership being selected as a Scaling People Services Vanguard for the Midlands, attracting external funding to the system. This will

support the partnership to test and develop a single health and care recruitment hub to better support our staff and teams.

- g) The initial stage of the Better Care Fund (BCF) review being completed. The output will inform commissioning decisions and has identified potential areas to scale up collaborative commissioning including prevention, urgent care, mental health and Children and Young People.
 - h) Adding social value as major institutions in our area. The Partnership has been chosen as one of ten NHS England Pathfinders for Care Leavers. A project is underway to support 250 young people into work by January 2024.
10. A more detailed update, mapped to the Integrated Care Strategy's 14 priorities, will be presented to the Integrated Care Partnership at its March 2024 meeting.
 11. A monitoring and evaluation framework is being developed to align with the delivery of the Joint Health and Wellbeing Strategies and NHS Joint Forward Plan. It proposes using a mixed methods (quantitative and qualitative) approach and that will be supported by the developing Integrated Care System outcomes framework. Governance for the framework is being confirmed and will align with existing accountability.

Healthy Life Expectancy Targets

12. At the time of approving the Nottingham and Nottinghamshire Integrated Care Strategy, the Integrated Care Partnership agreed that the system Healthy Life Expectancy (HLE) and Life Expectancy targets should be revisited and refreshed. The Partnership remain committed to progressing this work.
13. Early results are anticipated by early 2024 to support Partnership discussions on setting the level of ambition for HLE. The usual measure for HLE uses surveys to assess health states and cannot be replicated locally. Analysts from the ICB and Public Health are developing alternative measures which can be monitored using local data.

Refresh of the Strategy for March 2024

14. An annual refresh of the Strategy and NHS Joint Forward Plan (JFP) is planned for March 2024.
15. There has been no further national guidance published on the Integrated Care Strategy.
16. NHS England published planning guidance on the NHS Joint Forward Plan on 22 December: <https://www.england.nhs.uk/long-read/guidance-on-updating-the-joint-forward-plan-for-2024-25/>. Key points of note from the guidance are:
 - a) The three principles for the development of JFPs remain:
 - *Principle 1: Fully aligned with the wider system partnership's ambitions.*

- *Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.*
 - *Principle 3: Delivery focused, including specific objectives, trajectories and milestones as appropriate.*
- b) Systems continue to have flexibility to determine the scope and structure of the JFP. It is anticipated that plans continue to reflect the priorities set out in 2023/24.
 - c) Health and Wellbeing Boards must be involved in revising the NHS JFP and confirm that it continues to take proper account of the Joint Health and Wellbeing Strategies (JHWBS).
 - d) The guidance again reiterates that the ICB and partner trusts are responsible for the development of the NHS JFP. Systems are encouraged to use the JFP as a shared delivery plan for the Integrated Care Strategy and JHWBS.
 - e) Should there be any significant revisions to the NHS JFP, there is a statutory duty for the ICB and partner trusts to consult with partners, including the Integrated Care Partnership and NHS England.
 - f) Previous local patient and public engagement exercises and subsequent action should inform the JFP. ICBs and their partner trusts must include a summary of the views expressed by anyone they have a duty to consult and explain how they have taken them into account.
17. The Integrated Care Partnership will need to consider any changes in their wider context including new or changed policies or guidance and be transparent and inclusive about the timing of the refresh and the opportunities to be involved.
 18. At the end of this first year of delivery, the Integrated Care Partnership will review and reconfirm the Integrated Care Strategy at their 22 March 2024 meeting. Feedback on the strategic priorities is welcome by 1 March 2024 in order that comments are reflected in the final version of the document.

Recommendations:

19. The Board is asked to:

1. **Discuss** progress with delivery of the strategy through the City and County Joint Health and Wellbeing Strategies and NHS Joint Forward Plan.
2. **Note** the approach for the review of the Integrated Care Strategy and the refresh of the NHS Joint Forward Plan.
3. **Agree to delegate** to the Chair and Director of Public Health

responsibility for engagement with partners on the review of the Integrated Care Strategy and refresh of the NHS Joint Forward Plan.

4. **Agree** to schedule an item at the 27 March meeting to consider any amendments to the Integrated Care Strategy and the NHS Joint Forward Plan, including consideration of a statement of support by the Board on the NHS Joint Forward Plan.

DRAFT

**Statutory Officers Report for Health and Wellbeing Board
Corporate Director of People
January 2024**

Childrens Integrated Services:

On 12th January 2024, Ofsted published the report of their third Monitoring Visit of Nottingham City Council's Children's Services, conducted on the 22nd and 23rd of November 2023.

The visit evaluated the support to Care Leavers aged 18-25. Inspectors focused on:

- Quality and sustainability of accommodation
- Employment, education and training
- Care leavers with specific needs.

The report can be found at: [Nottingham City Council - Open - Find an Inspection Report - Ofsted](#)

This is the third Ofsted Monitoring visit, following the authority's inadequate assessment in July 2022. Inspectors commented after the first two visits that senior leaders had taken swift action after identifying things which needed to change, that staff morale was better and there were clear improvements with the speed of response to support children in the first instance.

They recorded 'tangible improvements' in fieldwork practice through a 'committed and stable leadership team', and that children build strong relationships with their social workers.

In the report from this third Monitoring Visit, inspectors have noted:

- Senior leaders have built on the improvements of previous inspections amid challenging conditions for the council as a whole. They have invited external scrutiny and worked with staff and care leavers to refocus Children's Services
- Step changes and service modifications are helping young people and their families as they move out of care – with especially strong support for vulnerable and disabled individuals
- Personal advisers working with young people build strong, positive relationships to maximise help and support
- Quality assurance and auditing processes have been strengthened
- The council has developed effective working arrangements with its own housing team and private providers

Inspectors have noted some further areas for improvement, including more permanent recruitment to move away from agency staffing and ensure the current pace of change is maintained.

They also mentioned the need for consistency with personal advisors because some care leavers reported they found it hard when new people started, plus the need to update plans more quickly when young people's circumstances have changed.

**Nottingham City Health and Wellbeing Board
Work Plan 2023-24**

Recurring Agenda Items	Lead Officer
Joint Strategic Needs Assessment – New Chapters	Dana Sumilo (NCC)
Joint Health and Wellbeing Strategy – Delivery Update (July, November and March)	Rich Brady (PBP)
Nottingham City Place-Based Partnership Update (May, September and January)	Rich Brady (PBP)
Pharmaceutical Needs Assessment (May, September and January)	Hannah Stovin (NCC)
Joint Health Protection Board Update	Lucy Hubber (NCC)
Board Member Updates	All Board Members
Work Plan	Governance Services (NCC)

Meeting Date	Agenda Item	Lead Officer
Wednesday 24 January 2024 1.30pm	Data Integration for Population Health	Dr Dave Briggs (ICB)
	Suicide Prevention JSNA Chapter	Helen Johnston (NCC)
Wednesday 27 March 2024 1.30pm	Adult Mental Health JSNA Chapter	Helen Johnston (NCC)
	Asylum Seeker and Refugee Health Needs Assessment	Helen Johnston (NCC)
	Race Health and Equalities	
	Integrated Care Strategy	Jeanette Swan/Joanna Cooper (ICB)
	NHS Joint Forward Plan	Jeanette Swan/Joanna Cooper (ICB)

	Development of next Health and Wellbeing Strategy	Lucy Hubber
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Potential items to be scheduled	Neurodiversity	
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Annual Reports	Month of Reporting
Public Health – Annual Report	May
Joint Health and Wellbeing Strategy – Annual Performance Review	May
Joint Strategic Needs Assessment – Annual Report	September
Safeguarding Adults Board – Annual Report	January

Items for the Board’s work plan should be forwarded to Governance Services, Nottingham City Council, constitutional.services@nottinghamcity.gov.uk.

Authors **MUST** discuss their proposed reports (and any supporting presentation) with Lucy Hubber (Director for Public Health, Nottingham City Council, lucy.hubber@nottinghamcity.gov.uk) before submitting the report to a Board meeting. Reports and their recommendations must be produced in the form of a formal, written document, headed by a standard cover sheet (which is available from Governance Services). Presentations to help illustrate reports must be no more than 10 minutes in length.