NOTTINGHAM CITY COUNCIL
HEALTH SCRUTINY COMMITTEE

Date: Thursday 16 January 2020

Time: 10.00 am

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

Corporate Director for Strategy and Resources

Senior Governance Officer: Laura Wilson **Direct Dial:** 0115 876 4301

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

CITIZENS ATTENDING MEETINGS ARE ASKED TO ARRIVE AT LEAST 15 MINUTES BEFORE THE START OF THE MEETING TO BE ISSUED WITH VISITOR BADGES

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NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held at Loxley House, Station Street, Nottingham, NG2 3NG on 17 October 2019 from 10.04 am - 11.22 am

Membership

Present	Absent
Councillor Georgia Power (Chair)	Councillor Cate Woodward (Vice-Chair)
Councillor Sam Gardiner (minutes 29-31 inclusive)	Councillor Angela Kandola
Councillor Phil Jackson	Councillor Anne Peach
Councillor Maria Joannou	
Councillor Kirsty Jones	
Councillor Dave Liversidge	
Councillor AJ Matsiko (minutes 29-31 inclusive)	
Councillor Lauren O`Grady	

Colleagues, partners and others in attendance:

Ajanta Biswas	-	Healthwatch Nottingham and Nottinghamshire
Councillor Eunice Campbell-Clark	-	Portfolio Holder for Health, HR and Equalities
Lisa Kelly	-	Chief Operating Officer, Nottingham University Hospitals NHS Trust
Caroline Nolan	-	System Delivery Director, Urgent Care, Greater Nottingham Clinical Commissioning Group
Laura Wilson	-	Senior Governance Officer
Catherine Ziane-Pryor	-	Governance Officer

25 MEMBERSHIP CHANGE

The Committee noted the resignation of Councillor Merlita Bryan from the Committee.

26 APOLOGIES FOR ABSENCE

Councillor Angela Kandola – work commitments
Councillor Anne Peach – other Council business
Councillor Cate Woodward - unwell

27 DECLARATIONS OF INTEREST

None.

28 MINUTES

Subject to including Councillor AJ Matsiko in the list of absent Councillors, the minutes were confirmed as a true record and signed by the Chair.

29 PLANNING FOR WINTER PRESSURES AND EMERGENCY PATHWAYS TRANSFORMATION

Caroline Nolan, System Delivery Director, Greater Nottingham Clinical Commissioning Group, and Lisa Kelly, Chief Operating Officer, Nottingham University Hospitals (NUH) NHS Trust, were in attendance to inform the Committee of the measures in place and proposed in preparation for the predicted rise in demand for services during the winter period.

A presentation was delivered and was circulated with the agenda. The following additional information was provided:

(a) following what was believed to be the peak of patient admissions in winter 2018, intake has remained steady without reduction with an increase in demand of 8.9%, with a day in July being the busiest so far this year. Temporary additional facilities to cope with peaked winter intake (70 escalation beds) became permanently established;

(b) NUH is taking part in the emergency medicine year-long pilot with 13 other hospitals across the country, to identify the most effective treatment model that ensures that the patient experience is smooth with efficient treatments pathways, whilst hospitals ensure the most efficient use of resources. Data from pilot hospitals is gathered and analysed, and amendments issued to procedures and policies. The pilot is due to conclude at the end of March 2020;

(c) there is an aim to assess, treat and discharge the majority of patients with planned support in place, within the same day, reducing the need for inpatient care. Most patients prefer to return home and there is evidence that their recovery time can be greatly reduced if in their own familiar environment, particularly if they have issues such as dementia;

(d) patient feedback regarding waiting times, communication, and how staff behave towards patients, continue to be areas of focus to address;

(e) significantly increased demand has resulted in some 12 hour trolley waits and longer waits for inpatient beds, particularly regarding mental health and specialist department admissions;

(f) in preparation for this coming winter, NUH have attempted to predict the potential areas of highest demand and considered how best to respond. This has included:

- additional facilities on the City Hospital site for longer term inpatients preparing to be discharged;
- additional assessment beds;
- three additional critical care adult beds and four additional critical care child beds;
- further work on improving discharge processes;
- all main primary healthcare partners have been supporting NUH to engage the public and encourage and support increased self-care;
- improved use of community bed capacity with patients advancing swiftly to the next section of their care journey;

- introduction of ‘call for care’ which provides a rapid assessment within 2 hours to establish a care package;
- promoting the ‘Significant 7’ within care homes to help identify deterioration so it can be addressed at home without the need for admittance to hospital;

(g) further work is required within the City to provide high intensity bespoke care services in the community, including at home, for more complex cases;

(h) there continues to be a focus on staff health and well-being, along with morale. There is a target of 80% of staff to have received the flu jab vaccination by the end of November 2019. Uptake so far has been good and it is anticipated that the target will be exceeded;

(i) in summary, the main challenges for NUH are currently as follows:

- system demand versus capacity;
- workforce;
- patient flow;
- discharges;
- provision of the correct number and type of community care beds.

A member of the committee expressed concern that patients had been discharged from hospital with the expectation that community services would have capacity to continue care. However, as this had not been the case, the discharge could be considered as unsafe. It is understandable that with the high demand for services and restricted budgets, that maintaining patient flow is vital, but appropriate communication and adequate resources need to be in place within the community to achieve the best results for all parties.

Questions from the Committee where responded to as follows:

(j) NUH aims to provide the best possible patient care and while targets do exist and are monitored, people care is the priority. Unfortunately, with the increasing demand and pressures on resources, the organisation doesn’t get it right all the time but tries to address areas where improvements can be made;

(k) as demand consistently increases and the resources available continues to reduce, this provides a very serious challenge. Some additional funding has been secured for resources including staff, but, with a lack of qualified people available, recruitment continues to be a problem nationally;

(l) as the cost of community beds can be lower than hospital-based beds, increasing the number of community beds available is being investigated. However, Nottingham already has a high number of community beds compared to other similar cities. As people tend to recover quicker in their own home, where possible and appropriate, this is the preferred option if a care package, potentially including wraparound care, can be provided;

(m) wrap around 24-hour care can be costly in any environment but with a focus on patient outcomes, opportunities to pool resources with other healthcare providers can be mutually beneficial;

(n) how the health system operates as a whole needs to be considered, and it is vital that primary care providers, including GP surgeries and Clusters, work closely together to be as effective as possible;

(o) Primary Care doctors (GPs) and nurses are based in A&E to address the needs of some patients who present with issues which can be resolved at this level. NUH also works closely with the 111 providers to encourage use of the alternative support and advice available. It is recognised that with initial contact, the 111 Service applies an algorithm, but 75% of calls are progressed to assessment by a clinician. Some callers are directed to A&E but there remains a focus on working with citizens to first encourage access to GPs, 111 and urgent care units prior to presenting at A&E for non-emergency issues. Patients presenting at A&E are asked which health services they had accessed or tried to access prior to presenting at A&E;

(p) with regard to care transition, assessments and discussion takes place and there is thorough consideration of which services would be most appropriate to put in place. It is important that the 'home first' approach is correctly managed but with the pressure on all provider resources, this continues to be a challenge;

(q) with regard to addressing concerns raised in feedback over patient communication, specific instances have been examined and where possible improvements made or action taken;

(r) mental health is receiving a greater focus and there are plans to open crisis cafes and consultation is taking place with patients to determine what patients most need and want from a psychiatric unit;

(s) listening to staff is important and there is a cultural and leadership system in place to ensure that staff can be supported as best as is possible in their work as part of the 'Team NUH' approach. The 'Speak-up' programme also encourages staff engagement to help empower staff;

(t) staff health and wellbeing is important to ensure that staff are functioning well in what can be very difficult circumstances with the additional demands and pressures in some clinical areas. Ensuring that the basic requirements of taking appropriate breaks and maintaining hydration levels are emphasised, but also adapting processes and policies to support staff, such as extending the staff car parking period to 8am to allow staff on night shift to more easily use the facilities. Appraisals are valuable for both parties and the paperwork has been amended to ensure that staff can clearly see that it is meaningful and supportive of staff development, including into different career pathways within NUH;

(u) one element of the current pilot includes reconsideration of targets to a suite of clinically relevant measures which, it is anticipated, will better engage staff. For the duration of the pilot the previous '4 hour waiting time' target is not being applied as measures directed by the pilot are taking priority and changing as a result of ongoing real-time analysis by the central pilot team. There is no indication at this time that as a result of the pilot and increased demand, that any additional funding will be available.

Members of the Committee commented:

(v) promotion of the full range of careers and apprenticeships available with in the health service should be more strongly emphasised to local young people;

(w) additional pressures such as closure of and difficulty accessing appointments at GP surgeries do impact on A&E admissions so need to be addressed;

(x) time delays in providing care packages can result in patients returning to hospital which has a huge impact on the patient and also wider resources. These areas need to be further investigated and the fundamental issues addressed;

(y) patients presenting at A&E need to be made aware that the national waiting time targets of 4 hours maximum are not operating within NUH as a result of the pilot. Long waiting times in A&E are not helpful for patients with mental health issues, particularly where delay in community treatments may result in patients presenting with a range of physical injury in addition to continuing mental ill health.

The Chair thanked Caroline Nolan and Lisa Kelly for their update.

30 DISCUSSION WITH THE PORTFOLIO HOLDER FOR HEALTH, HR AND EQUALITIES

Due to the Portfolio Holder being required at an urgent meeting, this item was postponed to a future meeting, but Councillor Campbell-Clark briefly informed the Committee that the two major areas of concern within her remit were sexual health and substance misuse, both of which were under significant budgetary pressure.

31 HEALTH SCRUTINY COMMITTEE WORK PROGRAMME

Laura Wilson, Senior Governance Officer, presented the proposed work programme and informed the Committee that:

- the CCG has requested to attend the November meeting to present an updated pre-consultation Business Case for the National Rehabilitation Centre to detail the changes that have been made since it was considered by the Committee at the September meeting;

- the Targeted Intervention Services update scheduled for November has been removed from the work programme as this is now a ‘business as usual’ approach there is no update to provide.

Members had received an invite to visit Edwin House as part of the ‘Councillors on the front line’ programme and, given that the Inpatient Detoxification Service update (which is delivered at Edwin House) is scheduled for the November meeting, it would be appropriate for members of the Committee to accept the invite if they are available to attend.

RESOLVED to approve the updated work programme.

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HEALTH SCRUTINY COMMITTEE
16 JANUARY 2020
SUICIDE PREVENTION STRATEGY 2019-2023
REPORT OF HEAD OF LEGAL AND GOVERNANCE

1 Purpose

1.1 To receive information on the Suicide Prevention Strategy 2019-23.

2 Action required

2.1 To consider the information provided and use it to inform questioning, and make recommendations, where appropriate.

3 Background information

3.1 Following recommendations from the Parliamentary Health Select Committee, the Health Scrutiny Committee decided to review the implementation of Nottingham Suicide Prevention Plan, including how partners are working together to ensure its effectiveness in reducing suicide by Nottingham City citizens at its meeting on 22 February 2018.

3.2 Members of the Suicide Prevention Steering Group, including, Jane Bethea (Consultant in Public Health), Nick Romilly (Insight Specialist, Public Health), Ian Ridley (the Samaritans), and Pamela Dowson (Nottinghamshire Police) and Adrienne Grove (Harmless) were in attendance to present the report and respond to the Committee's questions, and provided the following information:

(a) suicide was a preventable death which nationally affected approximately 48,000 people per year, including friends and family of the person who committed suicide and those who may have witnessed or responded to the suicide;

(b) the highest risk group of the population was males aged between 35 and 69 years old;

(c) the number of suicides in Nottingham City and Nottinghamshire per year was low at between 23-25 per year, which was in line with the national trend, but still considered too many;

(d) the Local Suicide Strategy was in line with the National Suicide Strategy but an understanding of local patterns of suicide was needed to enable an effective preventative response. The Public Health Team worked closely with the Coroner and did in-depth analysis to consider which therapies work and if they were available to those in need;

(e) regional data was gathered to try and identify clusters and patterns of suicide. It was recognised that people affected by suicide were themselves at risk of suicide;

(f) 'Harmless' was a user led organisation working with those affected by self-harm (a potential indicator for suicide) and their families, and

runs the suicide prevention programme 'The Tomorrow Project'. Harmless also worked with other partner organisations including the Samaritans and the Police;

(g) how the media reported suicide was very important. A good relationship with local and national media had been established and suicides were often more sensitively reported as 'incidents';

(h) the funding period for suicide prevention training of frontline staff, provided by Harmless, had come to an end;

(i) with financial restrictions, there was concern as to the level of future funding available to support suicide prevention in Nottingham City and the escalation of risks which could occur if future adequate funding was not available;

(j) the Samaritans offered non-judgemental support on the telephone and welcomed anyone to talk to them. In addition to the telephone service, the Samaritans were also recruiting and training prison listeners amongst inmates to provide peer support;

(k) HealthWatch welcomed the suicide prevention and suicide bereavement support available, but highlighted that the current system did not cater for citizens with chaotic lifestyles and often operated with waiting lists for intervention services, which needed to be addressed.

3.3 The Nottingham City and Nottinghamshire Suicide Prevention Strategy 2019-2023 is an update of the Nottinghamshire Suicide Prevention Framework for Action 2015-2018 and the Nottingham City Suicide Prevention Strategy 2015-2018. It was developed in partnership by the Nottingham City and Nottinghamshire Suicide Prevention Steering Group, which includes members from the following organisations:

- Nottingham City Council
- Nottinghamshire County Council
- British Transport Police
- Nottinghamshire Police
- Nottingham City Clinical Commissioning Group
- Newark and Sherwood Clinical Commissioning Group
- NHS England
- Nottinghamshire Fire and Rescue Service
- Nottinghamshire Healthcare NHS Trust
- University of Nottingham
- Nottingham Trent University
- Harmless (a user led organisation that provides a range of services about self-harm and suicide prevention).

3.4 A public consultation on the draft strategy was held between 10 July and 7 August 2019, following which a refined draft was produced that takes into account feedback received as part of the consultation. The Nottingham City Health and Wellbeing Board endorsed the strategy at its meeting on 25 September 2019.

3.5 Colleagues from the Council and partner organisations will be in attendance at the meeting to present information and answer questions from the Committee.

4 List of attached information

4.1 Suicide Prevention Strategy report from Public Health, and the Suicide Prevention Strategy 2019-23.

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None.

6 Published documents referred to in compiling this report

6.1 Health Scrutiny Committee report and minutes dates 22 February 2018, and the Suicide Prevention Strategy 2019-23.

7 Wards affected

7.1 All.

8 Contact information

8.1 Laura Wilson
Senior Governance Officer
laura.wilson@nottinghamcity.gov.uk
0115 8764301

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Nottingham City and Nottinghamshire Suicide Prevention Strategy 2019-2023

Geetinder Kaur, Consultant in Public Health, Nottingham City Council

1. Background

In England, approximately one person dies every two hours as a result of suicide (1). Suicide has a significant, lasting and often devastating impact on individuals, families, communities and the wider society.

Suicide rates tend to vary over time. They reached an historical low in 2007, before increasing in the years to 2014 and reducing thereafter. It should be noted that recent figures have shown a subsequent increase, although it is not possible to say whether this reflects a change in trend. Historically, Nottingham City has had a higher rate of suicide than the England average. Although in recent years the rates in Nottingham City and Nottinghamshire have both lowered, there is significant fluctuation, and the most recent figures available from NHS Digital are again above the national average rate (see Figure 1).

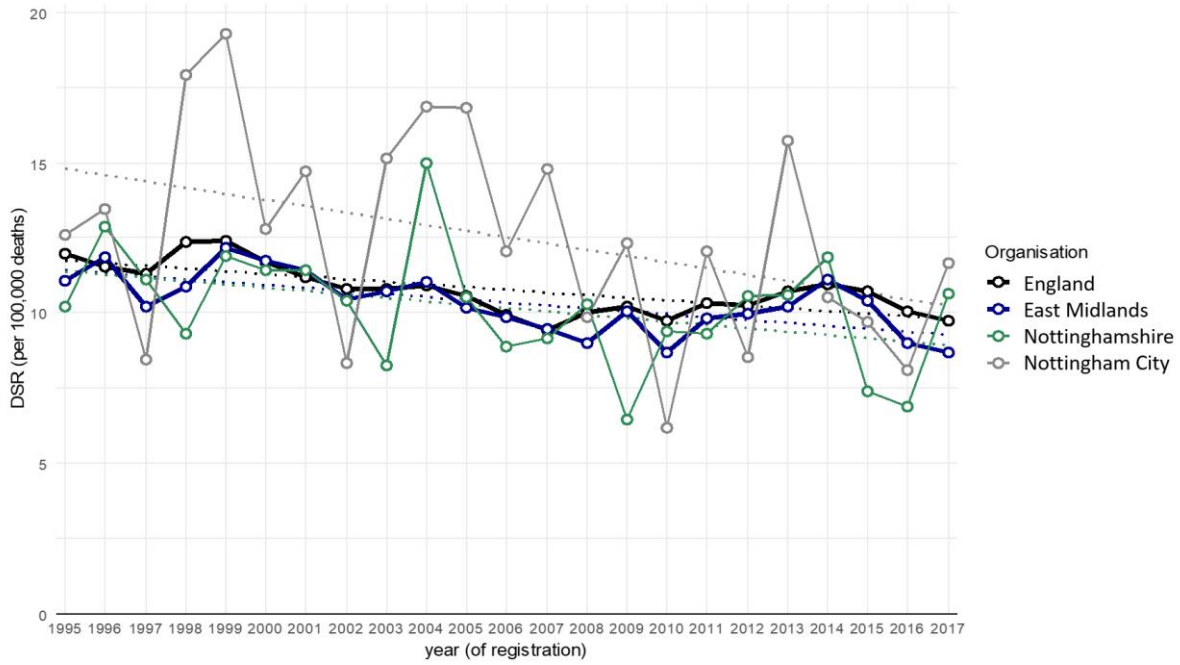

Figure 1 Trends in mortality from suicide and injury of undetermined intent in 15+yrs old (directly standardised rate per 100 000). Source: Office for National Statistics (ONS) via NHS Digital

Public Health England has published some more recent statistics of the age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population (2), displayed in Figure 2. These statistics show no statistically significant difference between the rate from suicide and undetermined injury in Nottingham compared with both England and the East Midlands in 2016-2018. The rate in East Midlands was statistically significantly lower in the East Midlands compared with England between 2015 and 2018.

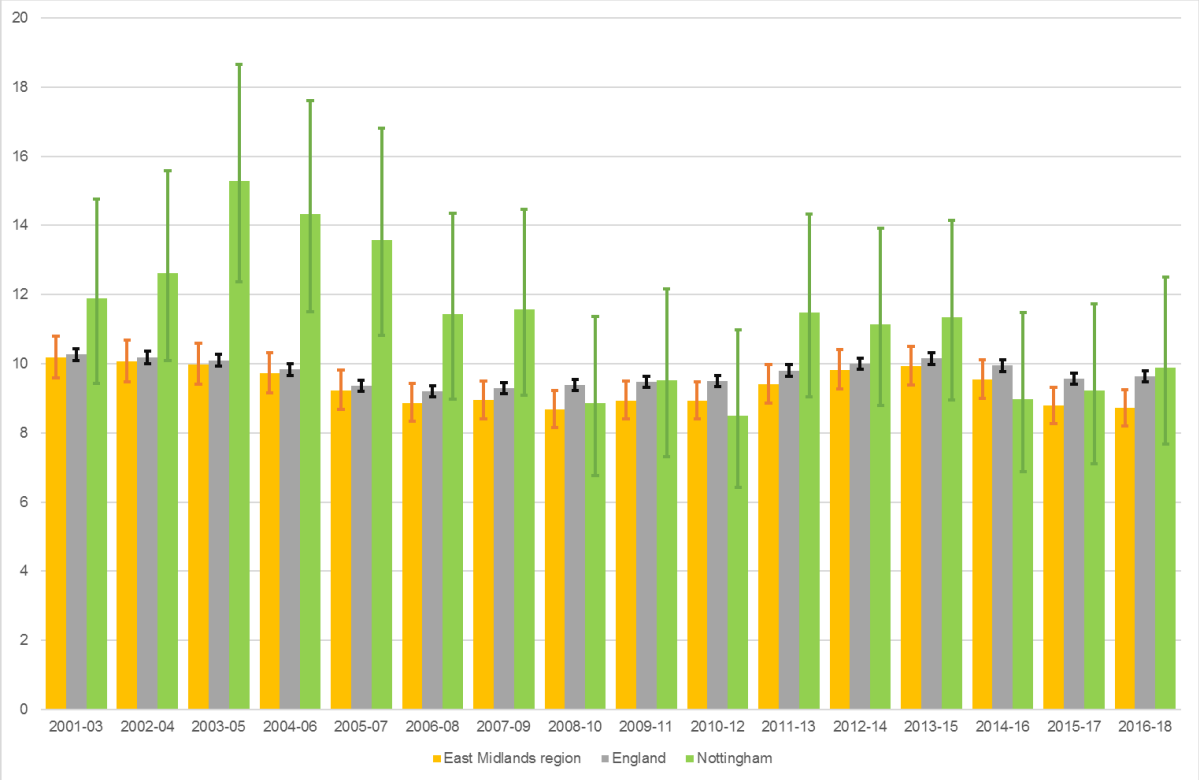

Figure 2 Age-standardised mortality rate from suicide and injury of undetermined intent per 100,000 population, with 95% upper and lower confidence intervals

There are many well-recognised risk factors and at-risk groups for suicide. There is a notable socio-economic gradient, with those in the poorest group subject to ten times the risk of suicide than those in the most affluent group (3). Men are also at significantly higher risk, accounting for around three quarters of all suicides (3,328 out of 4,451 suicides in England were males in 2017). Suicide remains the biggest killer of men under 50, and is a leading cause of death in young men. Self-harm is another recognised risk factor for suicide – the biggest single risk factor for many groups – with UK studies estimating that in the year after an act of self-harm, the risk of suicide is 30–50 times higher than in the general population. Non-fatal self-harm leading to hospital attendance is the strongest single risk factor for completed suicide. National evidence also highlights increased risk to those from ethnic minority communities (4).

Suicide prevention requires both an upstream, population and life-course approach and a targeted, risk group approach. This refreshed strategy outlines the ways in which Nottingham City Council, Nottinghamshire County Council, and their local partners aim to work towards a reduction in suicides and self-harm amongst the local population. This is in line with the national target of a 10% reduction by 2020/21, as cited by the national suicide prevention strategy for England (1), the national mental health strategy (5) and the NHS Long Term Plan (6), among others.

2. Strategy development and consultation

The Nottingham City and Nottinghamshire Suicide Prevention Strategy 2019-2023 is an update of the Nottinghamshire Suicide Prevention Framework for Action 2015-2018 and the Nottingham City Suicide Prevention Strategy 2015-2018. It was developed in partnership by the Nottingham City and Nottinghamshire Suicide Prevention Steering Group, which includes members from the following organisations:

- Nottingham City Council
- Nottinghamshire County Council

- British Transport Police
- Nottinghamshire Police
- Nottingham City Clinical Commissioning Group
- Newark and Sherwood Clinical Commissioning Group
- NHS England
- Nottinghamshire Fire and Rescue Service
- Nottinghamshire Healthcare NHS Trust
- University of Nottingham
- Nottingham Trent University
- Harmless (a user led organisation that provides a range of services about self-harm and suicide prevention).

A public consultation on the draft strategy was held between 10 July to 7 August 2019, following which a refined draft was produced that takes into account feedback received as part of the consultation. The Nottingham City Health and Wellbeing Board endorsed the strategy at its meeting on 25 September 2019.

3. Aim, priorities and governance

The overall aim of this strategy is to *reduce the rate of suicide and self-harm in the Nottingham City and Nottinghamshire population, by proactively improving the population mental health and wellbeing, and by responding to known risks for suicide in the population*. This aim will be realised by focusing on four strategic priorities:

1. At-risk groups
2. Use of data, particularly via real-time surveillance
3. Training and bereavement support
4. Staff training.

Progress against the four strategic priorities will be managed through an action plan steered by the Nottinghamshire and Nottingham City Suicide Prevention Steering Group. It is proposed that oversight is maintained by the Nottingham City and Nottinghamshire County Health and Wellbeing Boards as well as the Nottinghamshire ICS, via the ICS Mental Health and Social Care Board.

4. Current areas of focus

Nottingham City now has the ability to draw on real time local data to enable the identification of high-risk locations and high-risk groups (including young people who self-harm). The next steps will involve working with counterparts in Nottinghamshire County to coordinate how these data will be analysed, shared and utilised to target evidence-based interventions.

Nottingham City & County Councils, Greater Nottingham, Mansfield and Ashfield, Newark and Sherwood Clinical Commissioning Groups, along with Nottinghamshire Healthcare Trust and other third sector organisations are working together to develop a design for mental health sanctuaries. Mental health sanctuaries are places that people can go to be in a calm non-clinical safe space. They are for anyone experiencing an emotional or mental health crisis or anyone who is at risk of developing a crisis. Practical and emotional support is given in a warm and welcoming environment.

Funding for the bereavement pathway is currently guaranteed until March 2020. Partnership discussions are underway to secure a plan for provision from April 2020.

5. References

1. **HM Government.** *Preventing suicide in England.* London : Department of Health, 2012.

2. **Public Health England.** *Suicide rate - Notttingham.* London : Public Health England, 2019.

3. **Samaritans.** *Socioeconomic disadvantage and suicidal behaviour.* 2017.

4. **Royal College of Psychiatrists.** *Self-harm, suicide and risk: helping people who self-harm.* London : s.n., 2010.

5. **HM Government.** *No health without mental health.* London : Department of Health, 2011.

6. **National Health Service.** *NHS Long Term Plan.* 2019.

7. **Office of National Statistics.** *Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014.* s.l. : NHS Digital, 2016.

8. **National Statistics.** *Mental health of children and young people in Great Britain, 2004.* s.l. : NHS Digital, 2005. 1-4039-8637-1.

Nottingham City and Nottinghamshire

Suicide Prevention Strategy

2019-2023

Produced by Nottingham City and Nottinghamshire County Public Health, in partnership with Nottingham's Suicide Prevention Steering Group and Nottinghamshire Healthcare NHS Trust, September 2019.

THIS SUICIDE PREVENTION STRATEGY IS AN UPDATE OF THE NOTTINGHAMSHIRE SUICIDE PREVENTION FRAMEWORK FOR ACTION 2015-2018, AND THE NOTTINGHAM CITY SUICIDE PREVENTION STRATEGY 2015-2018. THIS STRATEGY WAS DEVELOPED IN PARTERSHIP BY THE NOTTINGHAMSHIRE AND NOTTINGHAM CITY SUICIDE PREVENTION STEERING GROUP. PRINCIPAL CONTRIBUTORS INCLUDE:

Organisation	**Name**
Nottinghamshire County Council	Susan March
	Catherine Pritchard
	Jane O'Brien
Nottingham City Council	Jane Bethea
	Ben Rush
	Anna Masding
British Transport Police	Mark Clements
Nottinghamshire Police	Anthony Horsnall
Nottingham City CCG	Dr Marcus Bicknell
Newark and Sherwood CCG	Karon Glynn
NHS England	Elaine Woodward
	Wendy Henson
Nottinghamshire Fire and Rescue Service	Chris Hooper
Nottinghamshire Healthcare NHS Trust	Rachel Lees
	Faye Harrison Yuill
	Marie Armstrong
University of Nottingham	Professor Ellen Townsend
	Jo Lockwood
Nottingham Trent University	Karen Slade
Harmless	Bevan Dolan

Advice when reading this document:

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

- ***Making an appointment with your GP***
- ***Telephoning the Samaritans on 08457 90 90 90***
- ***Telephoning Childline, help for young people, on 0800 1111***

If by reading and reviewing this strategy you become concerned about your own or someone else's thoughts or behaviour as a consequence of a bereavement, we advise that you speak to a trained bereavement professional:

- ***Telephone Cruse Bereavement Care on 0844 477 9400***
- ***Telephone Childline, help for young people, on 0800 1111***

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1.0 Executive Summary

In England, approximately one person dies every two hours as a result of suicide[1]. Suicide has a significant, lasting and often devastating impact - economically, psychologically and spiritually - on individuals, families, communities, and the wider society. While accurate costs are difficult to quantify, national estimates suggest that each suicide costs the economy in England around £1.67 million.[2]

The causes of suicide are complex, and no strategy can be expected to completely remove all risk. However, there is much that can be done to ensure that we reduce this risk, and ensure that support is available for those at their most vulnerable.

Suicide rates tend to vary over time. They reached an historical low in 2007, before increasing in the years to 2014. There has been an encouraging reduction in suicide rates since, and 2017 figures for the overall rate in England were at their second lowest recorded level: 14.0 per 100,000, down from 16.0 per 100,000 in 2014. It should be noted that recent figures have shown a subsequent increase, although it is not possible to say whether this reflects a change in trend. Historically, Nottingham City has had a higher rate of suicide than the England average. Although in recent years the rates in Nottingham City and Nottinghamshire have both lowered, there is significant fluctuation, and the most recent figures are again above the national average rate.

There are many well-recognised risk factors and at-risk groups for suicide. There is a notable socio-economic gradient, with those in the poorest group subject to 10 times the risk of suicide than those in the most affluent group.[3] Men are also at significantly higher risk, accounting for around three quarters of all suicides (3,328 out of 4,451 suicides in England were males in 2017). Suicide remains the biggest killer of men under 50, and is a leading cause of death in young men. Self-harm is another recognised risk factor for suicide – the biggest single risk factor for many groups – with UK studies estimating that in the year after an act of self-harm, the risk of suicide is 30–50 times higher than in the general population. Non-fatal self-harm leading to hospital attendance is the strongest single risk factor for completed suicide.

Suicide prevention goes hand in hand with addressing these risk factors, both at an upstream, population and life-course level, and at a targeted, risk group level. This strategy outlines the ways in which Nottingham City Council, Nottinghamshire County Council, and their local partners aim to work towards a reduction in suicides and self-harm amongst the local population. This is in line with the national target of a 10% reduction by 2020/21, as cited by the national suicide prevention strategy for England,[1] the national mental health strategy,[4] and the new NHS Long Term Plan,[5] among others.

Overall aim of this strategy:

To reduce the rate of suicide and self-harm in the Nottingham City and Nottinghamshire population, by proactively improving the population mental health and wellbeing, and by responding to known risks for suicide in the population.

The following priorities have been 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, paying particular attention to:

- Men, including men in contact with or in transition through the criminal justice system.
- Children and young people, including university students.
- Self-harm as a risk factor.

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.

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

2.0 Introduction

Suicide refers to the act of intentionally taking one's own life. It is a sensitive issue, as well as a highly complex one: in its contributory factors, its impact, and its very interpretation. Today, suicide is rightly seen as a serious and significant public health issue. Worldwide, across all ages, sexes and populations, suicide ranks as the tenth most common cause of death. Throughout our lifetimes, around one person in fifteen will make at least one suicide attempt.[6] While the number of people who take their own lives in England has been gradually reducing over recent years, the overall numbers are still very significant. Between the years of 2003-2013, 18,220 people in the UK took their own lives; nearly 6,000 suicides were recorded in 2017 alone. Three quarters of suicides are male, and for men aged 20-49 in England and Wales, it is the single most common cause of death.[6]

The impact of a suicide, be it completed or attempted, cannot be underestimated. Completed suicide is sadly unique in the immeasurable and long-lasting pain, suffering and loss it causes to individuals, families and communities. Psychological burden is borne not only by those at risk of or attempting suicide, but by their loved ones as well. There are also significant wider economic and societal costs associated with both attempted and completed suicide; the cost of a completed suicide in the UK has been estimated at over £1.6 million. [1,7–10]

Self-harm describes somebody intentionally damaging or injuring their own body. It is closely related to suicide, but is a distinct entity in its own right: there is often a history of self-harm in completed suicides, but not all those who self-harm will attempt suicide, and not all those who complete suicide will have a history of self-harm.[2,7,11] Some self-harm is driven by the desire to take one's own life, but self-harm can also be a way of coping with, or expressing, overwhelming emotional distress.[12,13] Both suicide and self-harm are very closely linked to mental distress. Self-harm is one of many well-recognised risk factors for suicide, although mental health disorders in general are the most common and significant risk, with up to 90% of people taking their own lives suffering from such a disorder. As well as this, there are also wider personal, social and environmental stressors, including substance abuse and genetics.[12]

Despite the size of the problem, its tragic cost, and its inherently preventable nature, efforts to address suicide are not always well-recognised or supported. There remains significant stigma, often contributing a lack of willingness to engage. For these and other reasons, preventing suicide is well acknowledged to be a complex challenge.[14]

Suicide prevention strategies are a means by which organisations and partnerships can set out their commitment and intent towards reducing suicide rates in a defined population. This strategy is intended to outline our local approach to suicide prevention. It applies to all ages and all groups. It recognises not only the

difficulties, but the opportunities that exist and the contributions that can be made across all sectors of society. The strategy draws on local experience and expertise, as well as on national policy, research evidence, and guidance.

3.0 History of the Strategy

In recent decades, suicide prevention has developed considerably as concerns around suicide rates have intensified. In England, since September 2012, there has been an integrated national Government strategy, *Preventing Suicide in England: a cross-government outcomes strategy to save lives.*[1] This built on a previous Government strategy, established in 2002, which was more limited and in particular did not acknowledge the need to operate at a cross-Government level.

In 2009, Nottinghamshire County, Bassetlaw and Nottingham City Primary Care Trusts (PCT) produced a joint suicide prevention strategy for the period 2009-2012. This placed emphasis on achieving the prior *Our Healthier Nation* target of reducing suicide by one fifth by 2010.

In 2015, Nottingham City and County Councils each produced individual but jointly-researched Suicide Prevention Strategies (2015-2018).[15,16] These strategies both included the same five priority areas for action to reduce the incidence of suicide.

This 2019-2023 strategy provides an update on the previous strategy, and drives the ongoing suicide prevention work which has been carried out across Nottingham and Nottinghamshire since 2009, while reflecting new and updated priorities and guidance.

The Nottinghamshire and Nottingham City Suicide Prevention Steering Group oversees the strategy and implementation of its associated action plan. This multi-agency steering group includes representation from Nottinghamshire County and Nottingham City Public Health, Clinical Commissioning Groups (CCGs), child and adolescent mental health services (CAMHS), health and social care, HM Coroner's Service, police, fire and ambulance services, Network Rail and third sector organisations with a remit in suicide prevention and support.

The Steering Group, and this strategy, form a part of the Nottinghamshire Integrated Care System (ICS); as such, they also sit within the ICS' Strategy (see section 4.2.3), and will report to the ICS Board through the ICS Mental Health and Social Care Board.

4.0 Policy Context

4.1 National Drivers – historical context and developments

4.1.1 National Strategy and its updates

Prior to 2012, suicide prevention initiatives in England centred on health policy and were directed through the Department of Health, including the white papers **Modernising Mental Health Service** (1998); **Saving Lives: Our Healthier Nation** (1999); and the **National Service Framework for Mental Health** (1999). The first **National Suicide Prevention Strategy for England** was produced in 2002.

Preventing suicide in England: A cross-government outcomes strategy to save lives[1] was published in 2012. This was an all-age suicide prevention strategy, building on the 2002 work. The strategy supports actions by bringing together knowledge about groups at higher risk of suicide, applying evidence of effective interventions and highlighting resources available. Crucially, it was the first to explicitly acknowledge the importance of cross-Government working, stating that

> *"Suicide is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity. This strategy is intended to provide an approach to suicide prevention that recognises contributions that can be made across all sectors of our society."*

The strategy's key objectives and action areas aimed to define what the strategy as a whole intends to achieve. These objectives and actions are outlined in Box 1:

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

Key Objectives

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

Key areas for action

Action area 1 - Reduce the risk of suicide in key high-risk groups.

Action area 2 - Tailor approaches to improve mental health in specific groups**.**

Action area 3 - Reduce access to the means of suicide.

Action area 4 - Provide better information and support to those bereaved or affected by suicide.

Action area 5 - Support the media in delivering sensitive approaches to suicide and suicidal behaviour.

Action area 6 - Support research, data collection and monitoring

The first annual report, **Preventing Suicide in England: one year on** (2014)[17] set out the developments since the launch of the 2012 national prevention strategy, and highlighted areas where more work was felt to be needed. The messages in this report were designed to help local areas focus on the most effective things that they can do to reduce suicide.

The second report, **Preventing suicide in England: two years on** (2015)[18] highlighted work that was being conducted to prevent suicides and set out priorities for the following year. It noted in particular the rise in suicides among prisoners and younger age groups, despite a gradually decreasing trend overall.

The third progress report for the national strategy, **Preventing suicide in England: Third progress report of the cross-government outcomes strategy to save lives** (2017)[19] articulated a commitment to strengthen the Government's response to suicide, and provided some response to the Health Select Committee interim report on suicide prevention. It specifically pledged to "put in place a more robust implementation programme to deliver the aims of the National Strategy", particularly at the local level, by committing every area to produce a multi-agency suicide prevention plan. This Progress report highlighted, as a priority for renewed focus, patients who are commonly identified as being at higher risk of suicide by ensuring safe treatment in community settings and investing in liaison mental health services in acute hospitals. There was also a new focus on support for bereaved families as well as on education and young people's mental health. It

added a commitment to the national strategy to reduce the rate of suicides by 10% by 2020/21 nationally, as compared to 2016/17 levels.

The third progress report highlighted several specific high-risk groups, although this was in the context of priority groups and groups of interest, rather than an objective list of highest risk. The highlighted groups included:

- Young and middle-aged men
- People in the care of mental health services
- People in contact with the criminal justice system
- Specific occupational groups (doctors, nurses, veterinary workers, farmers and agricultural workers)
- People with a history of self-harm

The fourth and most recent progress report, **Preventing suicide in England: Fourth progress report of the cross government outcomes strategy to save lives,**[20] was published in January 2019. This reaffirmed the importance of suicide prevention as a national priority, including within the new NHS Long Term Plan ,[5] also published in early 2019. It noted the recently-announced national investment in suicide prevention, the importance of local multi-agency suicide prevention groups, and the overall reductions in suicides, such that the last two years have seen the biggest reduction in England in the past decade. It also noted the establishment of the new National Suicide Prevention Strategy Delivery Group. The following priority areas were outlined:

- Working in partnership with local government to embed their local suicide prevention plans in every community
- Delivering the ambition for zero suicide in mental health inpatients and improving safety across mental health wards and extending this to whole community approaches
- Addressing the highest risk groups including middle-aged men and other vulnerable groups such as people with autism and learning disabilities, and people who have experienced trauma by sexual assault and abuse
- Tackling the societal drivers of suicide such as indebtedness, gambling addiction and substance misuse and the impact of harmful suicide and self-harm content online
- Addressing increasing suicides and self-harming in young people
- Improving support for those bereaved by suicide

4.1.2 Health Select Committee Inquiry and Government response

The House of Commons Health Select Committee (HSC) conducted an inquiry into suicide prevention in England during late 2016 and early 2017. In anticipation of

the publication of the Government's Third Progress Report, the HSC published an interim report in December 2016, **Suicide Prevention: Interim Report, Fourth report of Session 2016-17.**[21] The HSC hoped that this would allow the Government to "take (its findings) into account before drawing its final conclusions". The Interim Report highlighted five areas it believed ought to be key to the Government's considerations:

1. *Implementation*. A clear implementation programme underpinned by external scrutiny.

2. *Services to support people who are vulnerable to suicide.* This would include wider support for public mental health and wellbeing; identification of and targeted support for at-risk groups; early intervention services; access to help in non-clinical settings; improvements to both primary and secondary care; and services for those bereaved by suicide.

3. *Consensus statement on sharing information with families.* This relates to better training of professionals to ensure that opportunities to involve families or friends in a patient's recovery are maximised where appropriate.

4. *Data*. Timely and consistent data are needed to enable swift responses to suspected suicides and to identify possible clusters, in order to prevent further suicides.

5. *Media*. Media guidelines relating to the reporting of suicide are being widely ignored; greater attention must be paid to dealing with breaches by the media, at national and local level. Consideration should also be given to what changes should be made to restrict access to potentially harmful internet sites and content.

Following the publication of the third progress report,[19] the HSC published its full inquiry report in March of 2017, **Suicide prevention. Sixth Report of Session 2016–17.**[22] This responded to the Government's recently updated Strategy, commenting as follows:

> *"The Government's recent focus on suicide prevention and mental health is welcome and necessary. Whilst the Government recognised our work in their progress report, we were disappointed that our concerns were not fully addressed nor were all of our recommendations taken on board… We consider that there are further steps which could be taken to reduce suicide."*

The inquiry voiced particular disappointment that its recommendation of all discharged inpatients receiving follow-up care within three days was not adopted. The Interim Report's five key areas for consideration were re-stated, and a further two were added:

6. *Self-harm.* the HSC welcomed the Third Progress report's inclusion of self-harm prevention and recommended that "all patients who present with self-harm must receive a psychosocial assessment in accordance with NICE guidelines" and that "patients who present at A&E with self-harm should have a safety plan, co-produced by the patient and clinician, and properly communicated and followed up."

7. *Support for those bereaved by suicide.* The HSC further emphasised this area, deeming it appropriate to be incorporated into the renewed Strategy, and recommending that "ensuring high quality support for all those bereaved by suicide should be included in all local authorities' suicide prevention plans", and which should abide by basic standards.

While the Inquiry report made clear that the Strategy could be improved in many areas, it also highlighted that its key issue was "not with the strategy itself, but with ensuring effective and consistent implementation across the country", and to this effect recommended a national implementation board be created.

The HSC also raised concerns that the **Information Sharing and Suicide Prevention Consensus Statement**[23] had not been promoted well and was being underused. This Statement was developed in 2014 to encourage sharing of information about those at risk of suicide between healthcare professionals and a patient's family members and friends.

The **Government Response to the Health Select Committee's Inquiry into Suicide Prevention**[2] was published in July 2017 and contained specific responses to all recommendations. While it rejected the suggestion of a national implementation board, it did announce other governance arrangements, including creating an "Inter-Ministerial Group for Mental Health", creating a cross-Whitehall Director General/Director level group to oversee the full Government mental health portfolio, and establishing a National Suicide Prevention Strategy Delivery Group.

4.1.3 NHS Long Term Plan

The NHS Long Term Plan,[5] published in 2019, contains a number of ambitions around mental health and suicide reduction. In particular, it calls for:

- A new approach to young adult mental health services, including services for the student population, services focusing on suicide

reduction, improving access to psychological therapies, and highlighting groups of students with specific vulnerabilities.

- Provision of a single point of access and timely, universal mental health crisis care for everyone within the next 10 years. This is to include post-crisis support for families and staff who are bereaved by suicide.
- A continuation of the reduction in suicide rates to meet the target 10% reduction by 2020/21.
- Keeping suicide reduction as an NHS priority over the next 10 years.
- Developing a new Mental Health Safety Improvement Programme, focusing on suicide prevention and reduction for mental health inpatients.

4.1.4 Targets and Outcomes frameworks

From April 2013, Public Health England (PHE) became the national agency for public health in a role designed to support local authorities, the NHS, and partners across England. It was assigned a national leadership role to support local areas to help improve outcomes in public health, including mental health and suicide prevention. From this point on, suicide was included as an indicator within the **Public Health Outcomes Framework: Improving outcomes and supporting transparency**,[24] which set out an overarching view for public health. The outcomes framework supports the overall national strategic objective of reducing the suicide rate, and it includes indicators designed to help to track progress against this.

4.1.5 Wider mental health strategies

The Department of Health report **No health without mental health: A cross-government outcomes strategy for people of all ages**,[4] published in 2011, covered suicide and was key in supporting reductions in suicide amongst the general population, as well as those under the care of mental health services. The first agreed objective aimed to ensure that more people will have good mental health. The subsequent 2012 prevention strategy drew heavily on this report.

Healthy Lives, Healthy People: Our strategy for public health in England (2011)[9] gave a new, enhanced role to local government and local partnerships in delivering improved public health outcomes. This document outlines that the local responsibility for coordinating and implementing strategic direction for suicide prevention from April 2013, became an integral part of local authorities' new responsibilities for leading on local public health and health improvement. The prompts for local councillors on suicide prevention published alongside this

strategy are designed as helpful pointers for how local work on suicide prevention can be taken forward**.**

The 2013 **Annual Report of the Chief Medical Officer: Public Mental Health Priorities: Investing in the evidence** was published in 2014. This report included a focus on the epidemiology of public mental health and the quality of the evidence base, 'horizon scanning' of innovation in science and technology, the economic case for good mental health and chapters outlining the importance of both treating mental health as equal to physical health and of focusing on the needs and safety of people with mental illness.

4.1.6 Professional bodies and evidence-based guidelines

National Institute for Health and Care Excellence (NICE) guidelines: Self-harm in over 8s: short-term management and prevention of recurrence,[25] and **Self-harm in over 8s: longer-term management**[26] – These are evidence-based clinical guidelines for professionals involved in the management of people who self-harm. The key recommendation areas across both these guidelines include:

- Improving awareness, respect, understanding and choice in the delivery of services to those who self-harm
- Offering a comprehensive psychosocial assessment of needs and risks for those who self-harm
- Coproducing care plans and risk management plans with those who self-harm
- Treating associated mental health conditions

National Institute for Health and Care Excellence (NICE) guidelines: Preventing suicide in community and custodial settings[27] – these are further evidence-based clinical guidelines for professionals, aimed at helping local services to identify and help at-risk groups and people, and to prevent suicides in places where it is currently more likely. Its key recommendation areas include:

- The formation, structure and governance of local multi-agency suicide prevention partnerships
- Multi-agency partnerships in the community
- Multi-agency partnerships specifically in residential custodian and detention settings
- Multi-agency suicide prevention strategies and action plans, in line with the national strategy recommendations
- Using data sources to gather and analyse suicide-related information
- Preventing and responding to suicide "clusters"
- Engaging in local awareness-raising
- Reducing access to methods of suicide

- Providing ongoing training
- Supporting those bereaved by suicide
- Reducing the potential harmful effects of media reporting of suicide

NICE are also developing a **Suicide Prevention Quality Standard**,[11] which is due to be published in September 2019. This standard covers means to reduce suicide and address the effects of suicide at a local level, in communities and custodial settings. In its draft form, it makes quality statements covering five areas: the organisation and operation of multi-agency suicide prevention partnerships; collaboration with local media; involvement of family and carers with at-risk patients; and bereavement support.

Public Health England (PHE) published **Local suicide prevention planning: A practice resource**[28] in 2016. This was guidance specifically developed for local suicide prevention planning. It provided guidance around establishing a local multi-agency suicide prevention group, completing a local suicide audit, and developing a local strategy and action plan which is based on the national strategy and local data. PHE has also more recently published guidance for local commissioners on how and why they can deliver support after suicide.

The report **Why children die: death in infants, children, and young people in the UK**,[29] published in 2014 by the Royal College of Paediatrics and Child Health, National Children's Bureau and the British Association for Child and Adolescent Public Health, recommends national analysis to be completed on young people's suicides. The report also calls for a concerted and sustained policy response "to the problem of violence and self-harm among Britain's young people is needed urgently to address the lack of progress in reducing deaths and injuries from these causes."

4.1.7 Other reports

The **Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis**[30] report was published by the government in February 2014. The concordat outlines a vision for health, social care and emergency services work together to deliver a high quality response when people of all ages with mental health problems including suicidal behavior, urgently need help. It contained four core principles:

- Emphasising the importance of early intervention and improving access to support before reaching crisis point
- Improving the standards, accessibility and equity of urgent and emergency access to crisis care
- Ensuring the quality of treatment and care when in crisis

- Attention towards recovery, staying well and preventing future crises

The **National Confidential Inquiry into suicide and homicide by people with mental illness: Annual reports for England, Northern Ireland, Scotland and Wales**[31] are regularly-published reports from the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). The NCISH database is a national case series of suicide, homicide and sudden unexpected death by mental health patients. The current database stands at almost 127,000 suicides in the general population, including over 33,500 patients. This is a large and internationally unique database which allows for the examination of circumstances leading up to and surrounding incidents, and for making clinical and policy recommendations that will improve safety. The most recent such report is from 2018 and covers the period 2006-2016.[32] Information on all general population suicides (i.e. deaths by intentional self-harm and deaths from undetermined intent) by individuals aged 10 and over is collected from the Office for National Statistics (ONS). Comparisons are made with those identified as patient suicides, i.e. the person had been in contact with mental health services in the 12 months prior to death. The report contains the following key findings:

- Suicide rates in the general population have shown a recent downward trend.
- The highest rates during the report period (2006-2016) in England were in middle-aged people.
- Although the number of patient suicides in 2016 in England remained similar to the previous two years, patient numbers have increased, thus the rate has fallen.
- The commonest method remains hanging/strangulation, and the second-commonest remains self-poisoning.
- Suicides in the three months post discharge for inpatients has fallen since 2011, although this still accounts for 17% of all patient suicides. The highest risk was in the first two weeks after discharge, with the highest number of deaths on the third day after discharge.
- Common antecedents in young people included family problems, bereavement, bullying, physical health conditions, and self-harm. A history of self-harm was particularly common among females.

The report drew its findings together into a number of clinical messages:

1. Reducing suicide by inpatients and recently discharged patients should be emphasised.
2. Female patient risk profiles require more focus on depression treatment, self-harm care and personality disorder services.
3. Management of self-harm in mental health patients should highlight short-term risk.

4. A wide range of professionals have a role in prevention, particularly given the broad range of stressors in under-20s.
5. Suicide prevention in students requires mental health promotion on campus, risk awareness, support availability particularly during exams, and strengthened links to NHS services
6. Measures most likely to prevent patient homicides are reducing substance misuse, and maintaining treatment and contact.

The Mental Health Taskforce, launched by NHS England and formed in March 2015, is an independent body bringing together health and care leaders with service users and other experts in mental health. It published a **Five Year Forward View for Mental Health for the NHS in England**[33] in 2016, updating this with the **Five Year Forward View for Mental Health: One Year on**[34] report in 2017.

These reports made recommendations on suicide prevention and reduction, and included the objective to reduce suicides by 10% nationally by 2020/21 compared to 2016/17 levels. The Five Year Forward View for Mental Health also made recommendations at a local level, including that all local authorities have multi-agency suicide prevention plans in place by 2017, and that these plans should target high-risk locations and support high-risk groups.

NHS England broadly accepted the recommendations of the report in its response, **Implementing the Five Year Forward View For Mental Health.**[35] NHS England agreed with the Government that to support the transformation of mental health services there would be an additional investment of £1 billion per year by 2020/21, including £25 million specifically on suicide prevention.

In January 2018, the former Health Secretary Jeremy Hunt built on these developments by also announcing a zero-suicide ambition for mental health inpatients, including a new requirement for NHS mental health organisations in England to draw up detailed plans to achieve zero suicides, starting with those in inpatient settings. The plans included:

1. Asking that all suicides by mental health patients are reported and published more quickly
2. Requiring Trusts to "strengthen the package of suicide prevention measures" they have in place
3. Ensuring that there are thorough investigations after all suicide attempts, with a focus on learning from errors
4. Encouraging a "cultural shift within mental health services" so that suicides are not viewed as inevitable.

4.2 Local Drivers

4.2.1 Health and Wellbeing strategies

The priorities within both Nottingham City and Nottinghamshire County's health and wellbeing strategies[36,37] acknowledge the importance of mental health. Mental wellbeing forms one of four explicit outcome areas in Nottingham City's health and wellbeing strategy. Both strategies place an emphasis on ensuring any action to support and improve mental health is based on evidence.

4.2.2 Mental Health Trust strategy

Nottinghamshire Healthcare NHS Foundation Trust is currently developing a Trust wide suicide strategy, *Towards Zero Suicide.* This is in alignment with the Five Year Forward View for Mental Health, with the ambition of reducing suicide among mental health patients.

4.2.3 Nottingham and Nottinghamshire Integrated Care System Mental Health and Social Care Strategy (2019-2024)

Nottingham and Nottinghamshire's status as an "accelerator site" for early adoption of an Integrated Care System (ICS) has led to the development of a new ICS Mental Health Strategy in 2019. This was published in June 2019.[38] It broadly reflects and reaffirms the requirements within the Five Year Forward View and Long Term Plan, including those around suicide prevention, and incorporates the target 10% reduction in suicide rate by 2020/21. The strategy also contains a specific commitment to liaise with the Suicide Prevention Partnership to identify priority areas for support.

5.0 Definitions of suicide and self-harm

5.1 Suicide

Suicide is defined by the Oxford Dictionary of Law as *'the act of killing oneself intentionally.'* However, for a Coroner to reach a conclusion of suicide, this intent would need to be proved to the relevant standard in law. There are often difficulties in determining the intent of a person who dies. Measuring or estimating the true level of suicide can therefore be complex. For the purpose of

this strategy, the 'suicide rate', will include deaths recorded as set out by the Office of National Statistics (ONS):

"..deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent"

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

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

It should be noted that over the past decade, coroners have increasingly returned narrative verdicts.[39] These record the circumstances of a death rather than providing a 'short form' verdict such as suicide, accident, or natural causes. Prior to 2011, some narrative verdicts were coded as accidental deaths where intent was not specified, which may have led to an underestimation of suicide. In 2011 guidance was issued to coroners in England and Wales when returning narrative verdicts to provide clearer information on the intent of the deceased. This has led to changes in the coding of narrative verdicts by the ONS coding team, and some cases which would previously be coded as accidental may now be coded as possible suicide, although the impact on mortality statistics is unclear.[39] More recently, in 2018, the High Court determined that coroner's courts should move to using the civil standard of proof (i.e. on the balance of probabilities) when returning a verdict on whether the deceased died as a result of suicide.[40] This is anticipated to make it more likely that coroners will record verdicts of suicide, potentially resulting in clearer data, less stigma, and greater access to bereavement support.

5.2 Self-harm

Self-harm is most frequently defined as intentional *"self-poisoning or self-injury, irrespective of the apparent purpose of the act'.*[13,25]

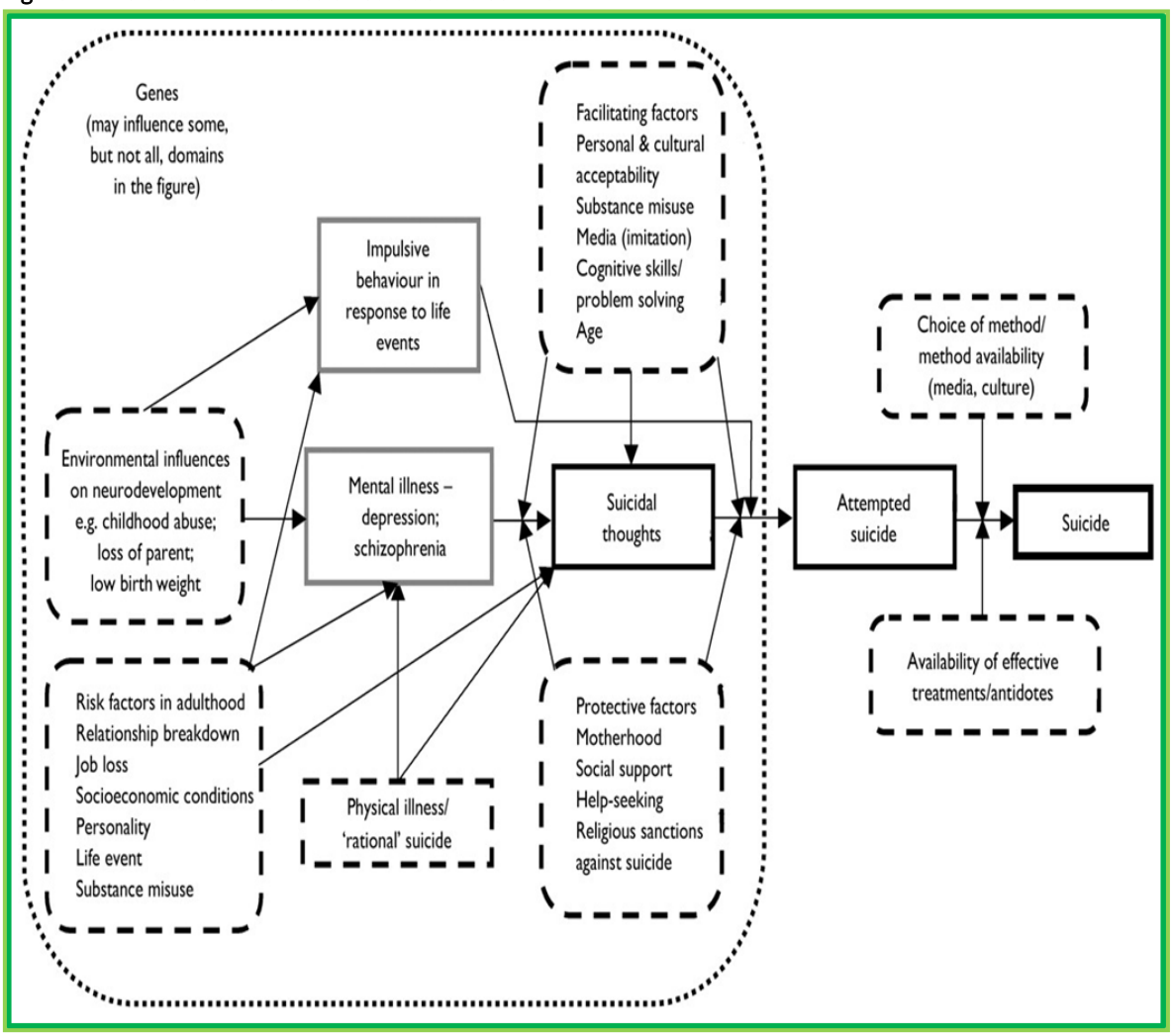
The term self-harm focuses on those acts of harm that are an expression of personal distress and where the person directly intends to injure him/herself. It is important also to acknowledge that for some people, especially those who have been abused as children, acts of self-harm occur seemingly out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

6.0 Factors associated with suicide

6.1 Risk factors for suicide and self-harm

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

Figure 1: Life course influences on suicide and self-harm.[41]



Some groups of people are known to be at higher risk of suicide than the general population. Groups at high risk of suicide[1] are:

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

Table 1 below shows the estimated increased risk for the high risk of suicide groups compared with that of the general population. The highest risk of suicide group are patients up to 4 weeks following discharge from a psychiatric hospital, with an estimated increased risk of 100-200 times.

Table 1: Increased risk for groups at higher risk compared to the general population. Source: Adapted from information on Mental Health Specialist Library website at www.library.nhs.uk/mentalhealth

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

6.2 Other factors associated with suicide and self-harm

Suicide and self-harm is often precipitated by recent adverse events across the life course. These include relationship breakdowns, conflicts, legal problems, financial concerns, interpersonal losses, traumatic events. There is also research into the links between suicide and terminal and/or chronic illness.

The following points are also important in terms of suicide prevention:[42]

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

- Suicide in ***older people*** is strongly associated with depression.
- A follow-up study of patients at a general hospital, reported a 0.7% risk of adults dying by suicide in the year following self-harm, a 1.7% risk within five years and 2.4% at ten years. The ***risk was far higher in men than in women.***
- ***More men die from suicide than women***, but suicidal thoughts and self-harm are more common in women.

Groups who have more frequent thoughts of suicide are:

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

6.3 Mental health services and suicide

The 2017 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness report[43] has shown that mental health patient suicides have fallen in recent years in England, with a downward trend in the number of suicides by patients recently discharged from hospital, and in those who were non-adherent with drug treatment in the month before death: both highlighted as significant groups of concern. While inpatient suicides have likewise fallen, the trend has slowed. These trends are despite an overall increase in the number of people under mental health care.

The report also noted that the commonest method of suicide by patients in the UK is hanging, with the next most common method being self-poisoning. Opiates and opiate-containing compounds remain the main type of drug taken in fatal overdose, including both prescribed and illicit drugs.

6.4 Offenders and suicide

People at all stages within the Criminal Justice System, including people on remand and recently discharged from custody, are at higher risk of suicide. The period of greatest risk is the first week of imprisonment.[44] Reasons for this increased risk include the fact that a high proportion of offenders are young men, who are already a high suicide risk group, although the increase in suicide risk for women prisoners is greater than for men. An estimated 90% of all prisoners have

a diagnosable mental health problem (including personality disorder) and/or substance misuse problem[1].

The patterns for both rates and numbers of self-inflicted deaths in custody closely mirror each other. Prison suicides are no longer falling after a major fall in 2004-08, with about 60 deaths each year, nationally, representing a rate of 0.7 per 1,000 individuals in custody. Suicides in women prisoners are rare[43].

6.5 Risk factors specific to self-harm

Self-harm occurs in all sections of the population but is more common among people who are disadvantaged in socio-economic terms and among those who are single or divorced, live alone, are single parents or have a severe lack of social support.[45] According to NICE, risk factors for self-harm include a number of other 'associations' such as: life events; alcohol and drug use; mental disorder; child abuse, domestic violence and being within the criminal justice system. Within this are special groups such as young people. There are others for whom the evidence is not so well collected such as gay men, lesbians and bi-sexual people.[18]

6.6 Rates of self-harm

The Department of Health estimates that self-harm represents one of the top five reasons for admissions in Accident and Emergency services.[46] There are around 200,000 episodes of self-harm that present to hospital services each year,[47] although many people who self-harm do not seek help from health or other services, and so are not captured by this.

People who self-harm are at increased risk of suicide, although many people do not intend to take their own life when they self-harm.[48] At least half of people who take their own life have a history of self-harm, and one in four have been treated in hospital for self-harm in the preceding year. Suicide risk is particularly increased in those repeating self-harm and in those who have used violent/dangerous methods to self-harm.[49]

The rates of self-harm are highest in girls and women with the highest incidence being among 15-19 year olds. There has been a recent rise in self-harm presentations to paediatric departments, particularly among girls, which in some areas exceeds 50%.[50] In men, the highest rates are in 20-29 year olds.[51] In a previous study of over 4000 self-harming adults in hospital, 80% had overdosed and around 15% had cut themselves. NICE suggests that in the community, it is likely that cutting is a more common way of self-harming than taking an overdose.[26] As the majority of young people who self-harm do not present to

statutory services, available self-harm data is a likely underestimation of the true incidence of self-harm. Self-harm is often carried out in secret and so will often not come to medical attention.

The Multicentre Study of Self-harm in England studied 1,177 older adults aged 60 years and over who had presented to hospital with self-harm and found that within one-year of their self-harm presentation, 1.5% of older adults had subsequently died by suicide. Their risk of suicide was 67 times greater than older adults in the general population. Men aged 75 years and over had the highest suicide rate. Also examined were older adults who re-presented to hospital with another non-fatal self-harm episode: 12.8% repeated self-harm within one-year. Risk factors for non-fatal repetition included previous self-harm, previous psychiatric treatment and age 60–74 years.[52]

6.7 Protective factors

There are a number of factors which research suggests protect some people against suicide.[53–55] These include:

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

7.0 Suicide rates and trends

The data cited in this strategy is taken from that most recently published by official bodies, most notably the Office of National Statistics (ONS), on suicide data. This has been analysed according to the calendar year in which the death was registered (as opposed to when it occurred), which follows the coroner's inquest verdict. Analysis is also based on the postcode of usual residence of the deceased (rather than where the death occurred). Suicide rates have been standardised for age and sex unless otherwise stated. This allows for comparisons over time and between localities, which may differ in the size and age structure of their populations.

In the UK, a coroner is able to give a conclusion of suicide for those as young as 10 years. However, rates per 100,000 are provided by the ONS only for ages 15 years and over when the suicide bulletin is released. This is due to a number of factors, including the known subjectivity between coroners[56,57] with regards to classifying

children's deaths as suicide, and the small numbers involved in under-15 suicides leading to variable and potentially misleading rates.

7.1 National data

The fourth progress report by HM Government on Preventing Suicide in England[20] outlines that:

- There has been an encouraging reduction in suicide rates amongst men over the past four years, with the suicide rate now at its second lowest recorded level, from 16.0 in 2014 to 14.0 in 2017.

- Despite this, men remain the group at highest risk, and suicide data monitoring suggest there may be increases in these groups after 2017. Males continue to account for around three quarters of all suicides (3,328 out of 4,451 suicides were males in 2017) and suicide is the biggest killer of men under 50 and a leading cause of death in young men.

- The rate of suicide in those who are in contact with mental health services continues to reduce, although such people still account for around a third of all suicides in England, and are some of the most preventable suicides.

- Around 25 per cent of mental health patients who die by suicide have a major physical illness (accounting for 3,410 deaths between 2005 and 2013).

- About a third of people who take their own life will have seen their GP recently before their death.

- Presentations for self-harm by young girls aged 13-16 at GP practices have increased by 68 per cent from 45.9 per 10,000 in 2011 to 77.0 per 10,000 in 2014.

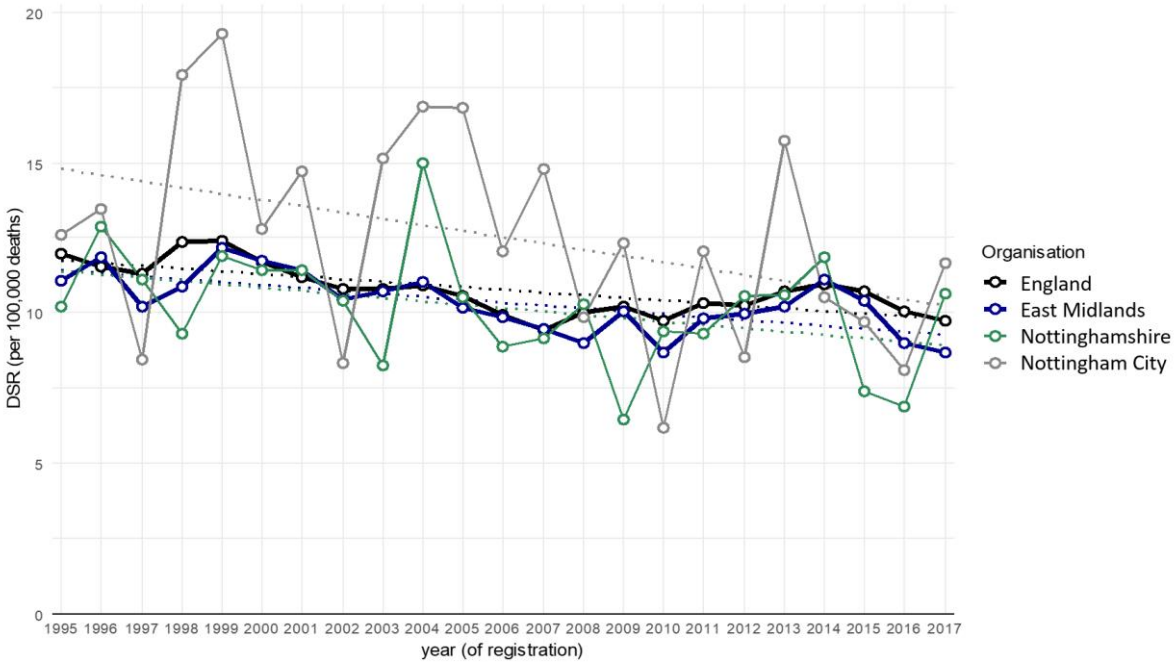
7.1.1 National and regional trends

Because annual rates for suicide can fluctuate widely from year to year, a three year rolling average is conventionally used to provide a more accurate representation of trends.

Figure 2 below, illustrates suicide and injury undetermined death rates from 1995 to 2017. It can be seen that nationally and locally, these rates are showing a gradual overall downward trend.

There are fluctuations in rates which are more extreme for smaller (i.e. local) areas, demonstrating the effect of noise (random variation) which is more pronounced with smaller numbers. Although the latest data (2017) shows both Nottingham and Nottinghamshire to be above regional and national rates, it is difficult to draw any inference from this alone, given such marked fluctuations.

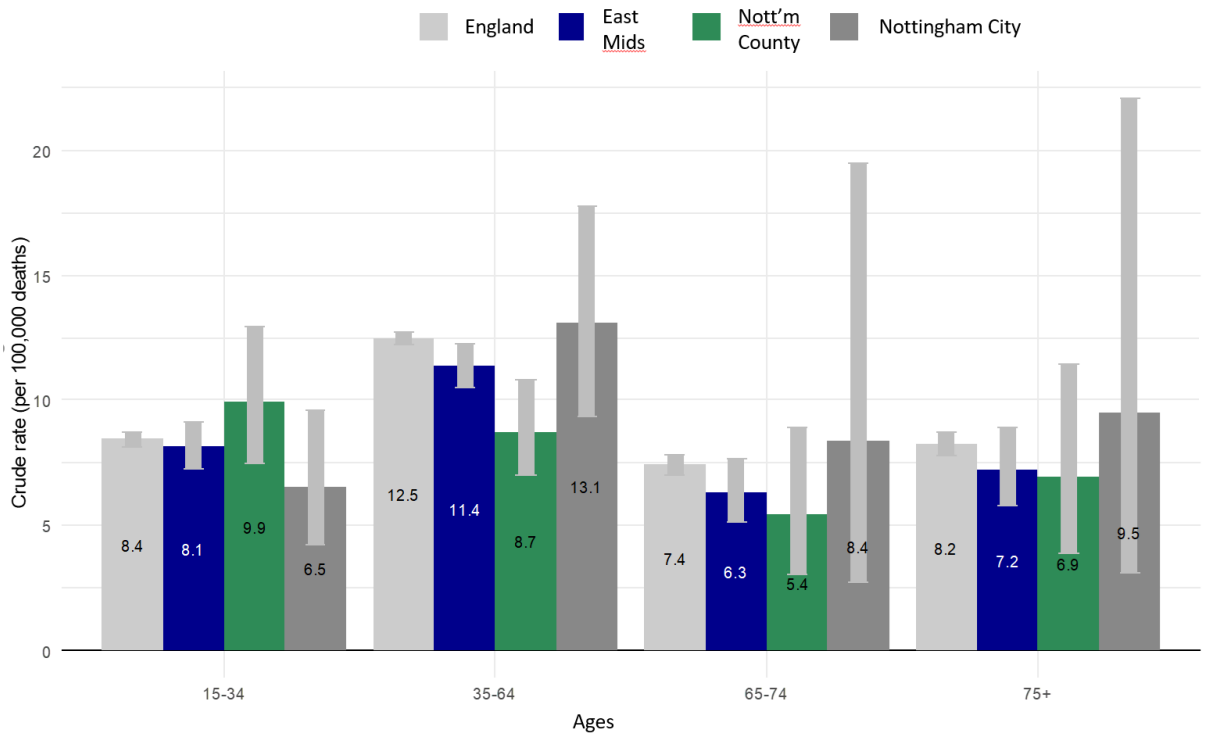
Figure 2: Trends in mortality from suicide and injury of undetermined intent in 15+yrs old (directly standardised rate per 100 000). Source: Office for National Statistics (ONS) via NHS Digital



7.1.2 Suicide rate by age and gender

Figure 3 shows the most recent suicide and injury undetermined death rates by age groups. It can be seen that local rates broadly mirror regional and national ones, and that the 35-64 age bracket remains the highest across all areas. The true number of suicides amongst young people may be understated, as it can be much more difficult to reach a conclusion of suicide beyond reasonable doubt.

Figure 3: Variation in Mortality from suicide and injury undetermined death (3 year pooled, 2015-17) by age. Source: NHS Digital



7.2 Local data

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

7.2.1 Suicide rate and deprivation

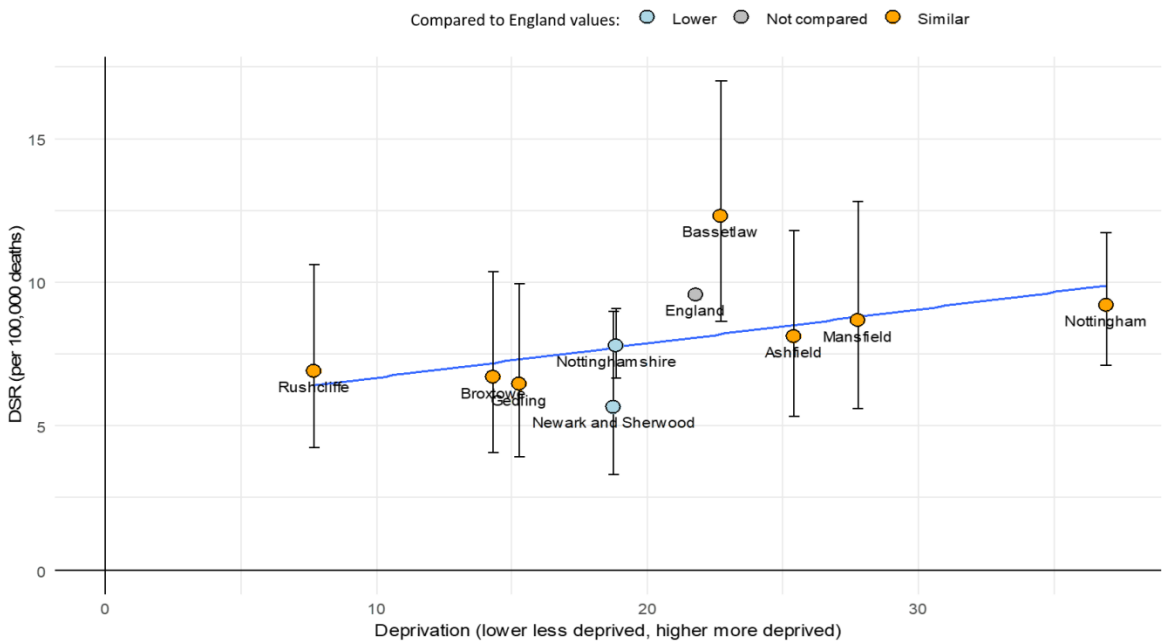
The Index of Multiple Deprivation score 2010 (IMD 2010) is a measure of multiple deprivation, at small area level. It is made up of seven domain indices, relating to income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to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

Research suggests that there is a strong relationship between suicide and socio-economic deprivation. **Figure 4** below shows the relationship between deprivation and suicide rate for Nottingham City and all Nottinghamshire districts.

Over half of the population of Nottingham live in the 20% most deprived areas in the country and many risk factors for poor mental health are significantly higher in the city, such as unemployment, levels of violent crime and numbers of children in care.

Figure 4 shows variations in mortality from suicide and injury of undetermined intent for Nottingham City and County districts, plotted against deprivation scores for each area. Although there is a wide degree of uncertainty (represented by the confidence interval bars) due to the small numbers involved, a potential trend can be seen with increasing rates as deprivation increases. As shown, Bassetlaw district has the highest suicide and injury-undetermined-death mortality burden of the districts, although again, the wide confidence intervals should be noted.

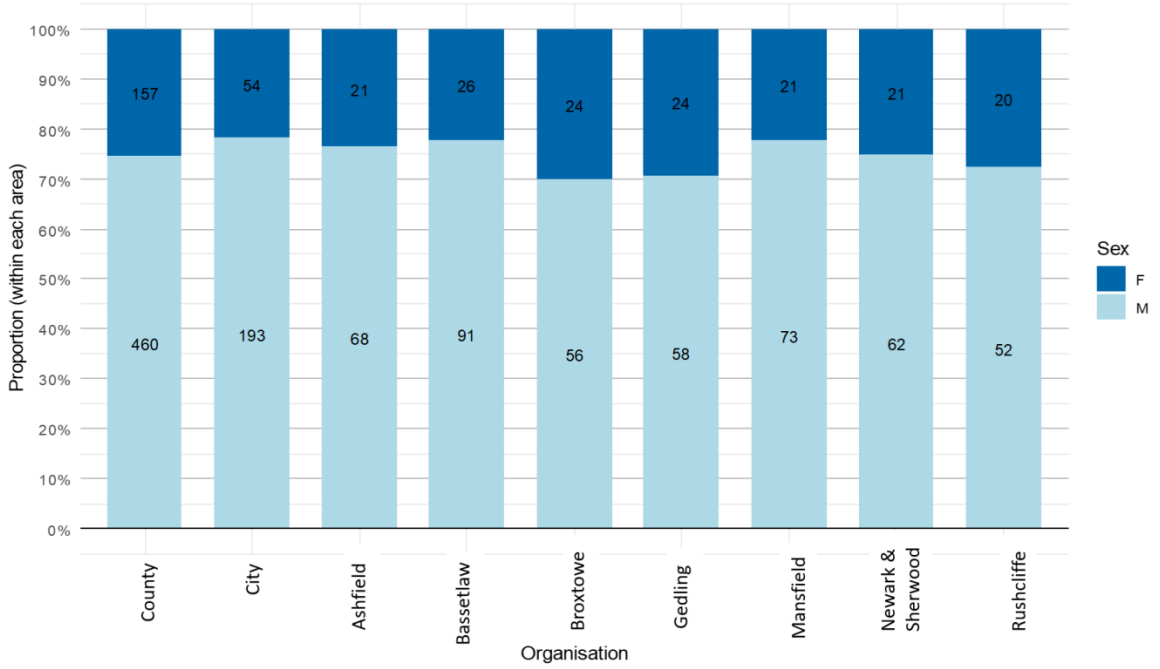
Figure 4: City and County districts variation in mortality from suicide and injury undetermined death (3 year pooled, 2015-17) with deprivation. Source: PHE suicide prevention profiles; IMD 2015 scores



7.2.2 Suicide rate and gender

Figure 5 demonstrates the gender breakdown in deaths from suicide and injury undetermined death. This is a longstanding trend with no notable difference in recent data; national suicide rates consistently place men at around three quarters of suicides.

Figure 5: Percent of deaths from suicide and injury undetermined death (2008-2017) by sex within local areas. Source: ONS mortality extracts

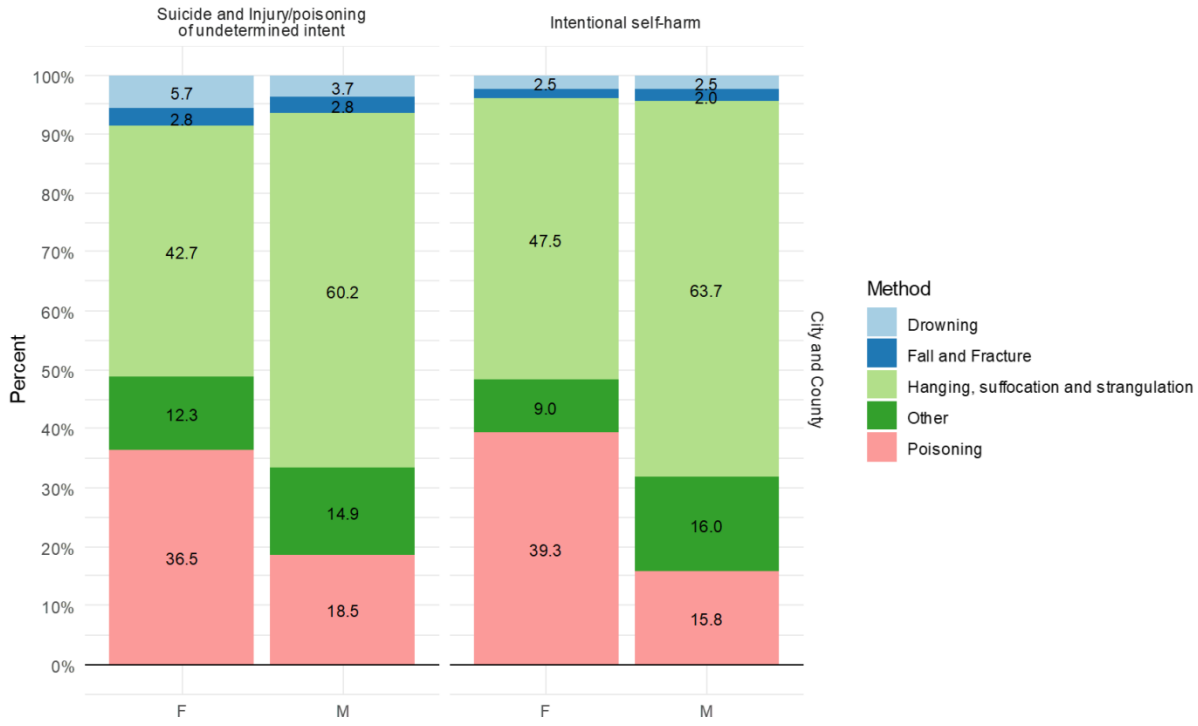


7.2.3 Methods of suicide and self-harm

Figure 6 shows a breakdown by sex and method, for both non-fatal self-harm and deaths (by suicide or injury undetermined). The combined figures for Nottingham City and Nottinghamshire County are shown. Hanging, suffocation and strangulation are by some margin the most common methods across both genders and in both self-harm and suicide. Hanging, suffocation and strangulation are more likely in males than females. Poisoning is more likely in females than males.

When older people self-harm, it should be noted that the risk of further self-harm and suicides are substantially higher. All acts of self-harm in people older than 65 years of age should be regarded as evidence of suicidal intent until proven otherwise, as the number of people in this age range who go on to complete suicide is much higher than in younger adults.[58]

Figure 6: Deaths from suicide and injury undetermined death (2008-2017) by method and sex, across Nottingham City and Nottinghamshire County combined. Source: ONS mortality extracts



7.2.4 Ethnicity

The 2011 census data indicates Nottingham City's population is 65.4% White British and 34.9% Black and Minority Ethnic (BME). Nottinghamshire's population at the time of the 2011 Census was 92.6% White British and 4.5% BME. Census averages for England were 85.4% White British and 15.2% BME.

Local level ethnicity data with regard to cases of suicide is not currently available through existing information sources. The relatively recent approach of using police-reported data via real-time surveillance holds promise for providing a clearer picture of ethnicity breakdown. As this approach develops, more detailed local analysis may well become possible.

The available national evidence highlights the existence of an increased risk to those from ethnic minority communities:

- Patterns of self-harm and suicide amongst people from minority ethnic groups continue to be different to those amongst white people. It has been reported that the highest rate of suicide in the BME groups is in young black females age 16-34 years.[13]
- Suicide rates and classical indicators of suicide risk among inpatients committing suicide vary by ethnic group. Black African men have the highest rates of suicide compared to the White British group.[13]

8.0 Progress since the previous strategy

In order to set appropriate strategic priorities and actions, it is helpful to know where progress has been made, and what the local situation is in relation to suicide and self-harm prevention. This was approached in two ways. The existing strategy was evaluated using a World Health Organisation mental health strategy evaluation tool,[59] to analyse its impact and progress against its vision. Key stakeholders of the Nottinghamshire and Nottingham City suicide prevention steering group were then consulted via a workshop exercise, using the evaluation results to help inform an exploration of areas to concentrate on within the new strategy. This has enabled the identification of new strategic priority areas.

Points of particular note in the evaluation were:

- No significant differences were found between City and County strategies.
- Appropriate collaborative working was evident in creating and implementing the strategies.
- Clear vision, values and principles were present, backed up by appropriate evidence and data.
- There was recognition of the importance of promoting good mental health in the general population, and promoting greater awareness in staff.
- There was a paucity of acknowledgement of wider principles such as human rights, social inclusion, equity with physical healthcare, and institutionalisation.
- Passive language was used throughout.
- There was an overabundance of actions, with sometimes vague or imprecise linking with some organisations and sectors.

- Some risk groups were not acknowledged, particularly severe mental illness and intellectual disabilities, although these were small in absolute terms.

Some of these points suggest areas to improve on with the refreshed strategy. These have been acted on where feasible. Certain points were not feasible to act upon, however. A wide range of risk groups exist in the research literature, and given pragmatic constraints, it is sensible to select those of greatest pertinence to the local area, and those where action is likely to have the greatest positive impact, rather than attempting to concentrate on every risk group.

9.0 Strategy aims and priorities

Suicide prevention is not the sole responsibility of any one sector of society, or of health services alone. Therefore, prevention largely necessitates a general population approach rather than service-related initiatives. For example, restriction of access to means for suicide, population approaches to prevention of depression, improved detection and management of psychiatric disorders in primary care, and voluntary agency and internet-based support.[60]

As well as targeting high-risk groups, another way to reduce suicide and self-harm is to improve the mental health of the population as a whole. A life course approach recognises that mental health problems often start in childhood, and that opportunities to promote and protect good mental health arise form pre conception through to old age. The greatest impact in suicide prevention is thus likely to result from a combination of preventative approaches directed at potential suicide determinants across the life course, which include both:

- Factors which increase the risk of suicidal behaviour in a population; for example, availability of means, knowledge and attitudes concerning the prevalence, nature and treatability of mental disorders, and media portrayal of suicidal behaviour
- Recognised high risk groups - e.g. people with recurrent depressive disorders, previous suicide attempts, people who misuse alcohol, the unemployed, people with certain co-morbid mental and personality disorders and people recently discharged from psychiatric inpatient care.

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

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

This suicide prevention strategy aims to reduce the suicide and self-harm rate in Nottingham City and Nottinghamshire. The strategy has been developed in line with national policy, including the Suicide Prevention Strategy for England and its updates. It also builds on the previous local suicide prevention strategy and existing local work.

9.1 Overall aim

The overall aim of this strategy is ***to reduce the rate of suicide and self-harm in the Nottingham City and Nottinghamshire population, by proactively improving the population mental health and wellbeing, and by responding to known risks for suicide in the population.***

This strategic ambition is consistent with the national suicide prevention strategy for England.

Although self-harm and suicide are distinct entities, the strong and close relationship between them means that both have been included in this strategy's overall aim.

9.2 Strategic priorities

Strategic suicide prevention priorities

Priority 1: At-risk groups

Identify early those in groups at risk of suicide, and ensure they have access to evidence-based interventions. Pay particular attention to:

- Men
- Men in contact with/in transition through the criminal justice system
- Students
- Children and young people
- Self-harm as a risk factor

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.

9.2.1 Priority 1: At-risk groups

This priority outlines the known risk factors for suicide. This does two things: it reveals “at-risk” groups in the population, for whom interventions can be targeted; it also shows that primary preventative measures aimed at the whole population can be effective, when they address the root causes of these risks.

Successfully meeting this priority therefore calls for a two-pronged approach that can address suicide prevention at both levels.

9.2.2 Priority 2: Use of data

To achieve this priority we need to improve timely data capture. This will enable suicide prevention and interventions strategies to target the most at risk groups, as well as to identify and respond rapidly to emerging patterns. Using data to inform local approaches, and to enable evidence based research and practice, is also a key part of this priority, and will ensure effectiveness at reducing the rate of suicide and self-harm.

9.2.3 Priority 3: Bereavement support

Suicide can have a profound effect on the local community. We know from studies that, in addition to immediate family and friends, many others will be affected in some way. They can include carers, neighbours, school friends and work colleagues, but also people whose work brings them into contact with suicide – emergency and rescue workers, other healthcare professionals, teachers, the police, faith leaders and witnesses to the incident. It is important to ensure appropriate and timely bereavement support is available for all those so affected.

9.2.4 Priority 4: Staff training

This priority area focuses on the adequate training of staff. Equipping staff to be more aware, to identify early those at risk of suicide, and how to most effectively intervene integrating current research into practice. This is important in supporting people and services.

9.2.5 Priority 5: Media

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

9.3 Monitoring Outcomes

The overall aim of this strategy is to reduce the rate of suicide and self-harm in the Nottingham and Nottinghamshire population, by proactively improving the population mental health and wellbeing, and by responding to known risks for suicide in the population.

Measuring the success of this is complex due to the levels, types and complexities of suicide and its associated risks. Data has its limitations, as mental health problems can go under diagnosed or under reported, and there is often a lack of timely data available.

In order to monitor this strategy's progress and outcomes we will be looking at a number of key national indicators:

- The national outcome framework: the Public Health Outcomes Framework, with specific indicators to monitor a range of mental health and suicide-related outcomes
- The Department of Health (DH), *No Health without Mental Health* dashboard brings together a number of indicators for a wide range of sources to reflect progress against the national mental health strategy.
- Locally, specific process and distal indicators will be developed in accordance with the strategy's Action Plan to facilitate monitoring and subsequent evaluation.

10.0 Taking the Suicide Prevention Strategy forwards

10.1 Leadership and governance

To realise the aims of the Nottingham City and Nottinghamshire County Suicide Prevention Strategy, and in order to see real improvement in the City and County population, we need suicide prevention leaders and champions at all levels across the public and voluntary sectors.

Those of particular note are:

- Councillors and officers of Nottingham City Council and Nottinghamshire County Council.
- Senior leaders, including commissioners and mental health clinical leads.
- Service providers, including NHS Trusts and the third sector.

The Health and Wellbeing Boards at both Nottingham City and Nottinghamshire County will have oversight of the suicide prevention strategy, as will the Nottinghamshire ICS, via the ICS Mental Health and Social Care Board. It will be steered by the Nottinghamshire and Nottingham City Suicide Prevention Steering Group, comprising key stakeholders who will continue to deliver against this strategy's key actions. The overarching leadership for each priority area will be developed, and will consist of the most appropriate suicide prevention leaders and champions.

10.2 Suicide Prevention Strategy action plan

An action plan has been developed as part of stakeholder consultation on the strategy, based on the five key priority areas outlined above.

Suicide Prevention Action Plan 2019-2023

Rate	Target
ICS Nottingham and Nottinghamshire - All persons suicide age-standardised rate per 100,000 population (3-year average) 2015-17	**NHS - The Five Year Forward View for Mental Health (Feb 2016) – Target reduce suicide by 10 per cent by 2020/21.**
Suicide: age-standardised rate per 100,000 population (3 year average) (all persons) is 9.6 per 100,000 population or 202 suicide deaths or roughly 68 per annum (2015-2017).	
Nottingham City - All persons suicide age-standardised rate per 100,000 population (3-year average) 2015-17	
Suicide: age-standardised rate per 100,000 population (3 year average) (all persons) is 9.2 per 100,000 population or 71 suicide deaths or roughly 23 per annum (2015-2017).	
Nottinghamshire County - All persons suicide age-standardised rate per 100,000 population (3-year average) 2015-17	
Suicide: age-standardised rate per 100,000 population (3 year average) (all persons) is 7.8 per 100,000 population or 168 suicide deaths or 56 per annum (2015-2017).	
Emergency Hospital Admissions for Intentional Self-harm: Directly age-sex standardised rate per 100,000 2014-2015 and 2016-17	
2017/18 Nottingham City rate 229.5 per 100,000 population/or 850 admissions	
2014/15 Nottinghamshire County rate 196.7 per 100,000 population/or 1,538 admissions	

At risk group/s	Rationale	Action	Responsible stakeholder	Milestones/Outcomes	RAG	Date reviewed/updated
1 All age population approaches	Universal suicide prevention approaches	1.1 Promote the *it's safe to talk about suicide* leaflet	All	• The leaflet content is advertised on Notts Help Yourself and appears at the top of the topic search. • The leaflet content is advertised on Nottingham City Ask LiON.		
				• All champions have been encouraged to increase promotion of the leaflet. Champions include Mental Health Champions, Time to Change Champions, Mental Health First Aiders and both Councils' customer service staff.		
			University of Nottingham and Nottingham Trent University	• The University of Nottingham and Nottingham Trent University are promoting the leaflet and this has been embedded into their suicide awareness training.		

At risk group/s	Rationale	Action	Responsible stakeholder	Milestones/Outcomes	RAG	Date reviewed/updated
1 All age population approaches	Universal suicide prevention approaches	1.1 Promote the *it's safe to talk about suicide* leaflet	Nottinghamshire Office of the Police and Crime Commissioner	• Opportunities to increase suicide prevention awareness in victims of sexual abuse have been explored and implemented where possible to do so.		
			Nottinghamshire Police	• The leaflet is in use by the Street Triage Service and Liaison and Diversion Service. • The leaflet is visible in Nottinghamshire Police staff and locker rooms.		
		1.2 Promote the *it's safe to talk about self-harm* leaflet	All	• The leaflet has been completed and published. • The leaflet content is advertised on Notts Help Yourself and appears at the top of the topic search. • The leaflet content is advertised on Nottingham City Ask LiON.		
		1.3 Promote the *Stay Alive* mobile phone suicide prevention app	All	• The app is being promoted on Notts Help Yourself. • The app is being promoted on Ask LiON.		
			Nottinghamshire Healthcare NHS Foundation Trust	• The app has been reviewed for use on mental health wards and in inpatient safety plans.		
	WHO Suicide Prevention Day Raise awareness of suicide in men as a high risk group	1.4 Promote support available to people with self-harm behaviour and interventions available for men with suicidal thoughts	City/County Public Health and partners	• A joint approach to promoting World Suicide Prevention Day has been developed, agreed and delivered.		
		1.5 Raise suicide prevention awareness in high	All	• The *it's safe to talk about suicide* leaflet is available in high male population locations, such as pubs and sport and leisure facilities.		

At risk group/s	Rationale	Action	Responsible stakeholder	Milestones/Outcomes	RAG	Date reviewed/updated
		male population locations				
2 Children and young people (CYP) population approaches	Promote emotional health and wellbeing in CYP to prevent mental health problems that could lead to suicide and self-harm thoughts and ideation	2.1 Mental health support teams in schools trailblazer includes self-harm prevention	City/County Public Health and CYP commissioners	• The mental health teams schools trailblazer includes self-harm prevention.		
		2.2 Develop academic resilience in schools		• The feasibility of extending academic resilience in schools to include suicide and self-harm has been reviewed and appropriate action has been taken.		
All age at-risk settings	Network Rail suicide deaths – Nottinghamshire is an escalation site	3.1 Lessons are learned from regular updates provided from real-time surveillance	British Transport Police, Network Rail, Public Health and Nottinghamshire Healthcare NHS Foundation Trust	• A nominated Public Health Analyst is receiving daily Rail Deaths Network Rail reports. • Network Rail and British Transport Police have an alert system in place when high incidence locations are identified.		
	Aspiration for Nottinghamshire Healthcare NHS Trust to adopt the Towards Zero Suicide Strategy	3.2 Nottinghamshire Healthcare NHS Trust implement Towards Zero Suicide Strategy	Nottinghamshire Healthcare NHS Trust	• The Towards Zero Suicide Strategy has been launched (expected September 2019). • Access to inpatient suicide prevention training has been improved (year 1 priority).		
4 Men in contact with the criminal justice system	Men in contact with criminal justice system are at high risk	4.1 Undertake a qualitative evaluation to review the effectiveness of the	University of Nottingham	• An offender health suicide prevention pilot project has been developed and implemented. • Finding of the pilot have been shared with the Suicide Prevention Steering Group.		

At risk group/s	Rationale	Action	Responsible stakeholder	Milestones/Outcomes	RAG	Date reviewed/updated
	of suicide at transitional points (when entering or leaving prison or police custody)	Pilot Welfare Assessment in early detection of those at risk of self-harm and suicide targeting men charged with sexual offences		• The Suicide Prevention Steering Group has considered feasible means of implementing the findings across the local criminal justice system.		
			Nottinghamshire Police	• Links with Office of the Police and Crime Commissioner and the Ministry of Justice have been made to implement findings across work with offenders.		
		4.2 Lessons are learned from regular updates provided from real-time surveillance	City/County Public Health	• The nominated Public Health Analyst shares lessons learnt with the Suicide Prevention Steering Group.		
5 University and further education college students	CYP are at increased risk of suicidal thoughts and self-harm at life pressure points such as exams, transition from school to university and college etc.	5.1 Implement 'Safe Suicide response'	Universities and further education colleges	• The University of Nottingham Suicide Prevention Task and Finish Group has developed a 'Safe Suicide response'. • The universities and further education colleges have reported progress to the Suicide Prevention Steering Group on the effectiveness of the Safe Suicide response.		
		5.2 Ensure access to the post-suicide bereavement pathway	Nottinghamshire Office of the Police and Crime Commissioner	• The opportunity to consider bereavement support within the CYP commissioned victims services has been explored.		
		5.3 Offer support to universities on the wider offer and availability of suicide prevention awareness and interventions	University of Nottingham	• The University of Nottingham draft Suicide Prevention Plan has been circulated to the Suicide Prevention Steering Group.		
			City/County Public Health	• Engagement is in place with Nottingham Trent University if any support can be offered in the development of their Suicide Prevention Plan.		

At risk group/s	Rationale	Action	Responsible stakeholder	Milestones/Outcomes	RAG	Date reviewed/updated
6 Quality review	Real-time surveillance enables the identification of hotspots, clusters and methods to ensure targeted prevention is reaching those most at risk	6.1 Replicate the Nottingham University Hospitals Emergency Department self-harm audit in Sherwood Forest Hospitals	City/County Public Health	• The feasibility of replicating the Nottingham University Hospitals' self-harm audit in Sherwood Forest Hospitals has been reviewed and appropriate action has been taken.		
		6.2 Agree criteria for identifying near suicide misses	Real-time Surveillance Working Group	• The Real-Time Surveillance Working Group has reviewed the WHO criteria for identifying and reporting mechanisms for serious near misses.		
		6.3 Suicide Prevention Steering Group to oversee the Real-Time Surveillance Working Group's plans	City/County Public Health	• The Real-Time Surveillance Working Group has reported on timely suicide data to the Suicide Prevention Steering Group. • The Suicide Prevention Steering Group has considered what lessons can be learned from these data and put mitigating action in place.		
		6.4 Suicide prevention to target any at-risk groups identified through real-time surveillance	All	• The Suicide Prevention Steering Group has received quarterly reports on suspected suicide deaths and identified hotspots. • Mitigating action has been put in place by the Suicide Prevention Steering Group to target identified at-risk groups.		
7 Bereavement support	Ensure those who are affected by a person's suicide have access to timely interventions	7.1 Secure NHS England funding bereavement support	City/County Public Health	• Funding for bereavement support has been secured. • Effective outcomes for the bereavement support pathway have been agreed and implemented.		
		7.2 Ensure CYP have access to suicide bereavement support	City/County Public Health	• Funding for all-age bereavement support has been secured across the City and County.		

At risk group/s	Rationale	Action	Responsible stakeholder	Milestones/Outcomes	RAG	Date reviewed/updated
8 Media	A skilled workforce in suicide and self-harm early identification and intervention	8.1 Review learning from the Integrated Care System South Yorkshire and Bassetlaw Media workshop and review what could be implemented locally	City/County Public Health	• The learning from the Integrated Care System South Yorkshire and Bassetlaw Media workshop has been received and reviewed. • Engagement is ongoing with local media to explore perceptions and uptake of national guidance around suicide reporting, including best practice suicide reporting tips and Media Reporting Guidelines.		
		8.2. Develop a co-ordinated plan to respond to the media in cases of suicide irresponsible reporting	City/County Public Health	• The Samaritans best practice suicide reporting tips and Media Reporting Guidelines.		
9 Training	A skilled workforce in suicide and self-harm early identification and intervention	9.1 Mapping of suicide prevention training availability across the City and County	Integrated Care System Workforce Work Stream	• A mapping exercise of suicide and self-harm training needs and provision has been undertaken. • Action is in place to address any areas of need where training is not available.		
		9.2 A Suicide Prevention Steering Group Member links with the Integrated Care System Mental Health Training Work Stream to ensure suicide and self- harm training is addressed	All	• The Suicide Prevention Steering Group has established a link with the Integrated Care System Mental Health Training Work Stream • The following best evidence training is being promoted: 1. Health Education England 60 minutes online training *We need to talk about suicide* 2. Zero Suicide Alliance 20 minute training https://www.zerosuicidealliance.com/training 3. Health Education England suicide prevention competency framework https://www.ucl.ac.uk/pals/self-harm-and-suicide-prevention-competence-framework 4. Learning from wave 1 sites including campaigns www.rcpsych.ac.uk/improving-care/nccmh/national-suicide-prevention-programme		

At risk group/s	Rationale	Action	Responsible stakeholder	Milestones/Outcomes	RAG	Date reviewed/updated
9 Training	A skilled workforce in suicide and self-harm early identification and intervention	9.3 Self-harm, suicide prevention and bereavement training is available for and accessed by teachers	City/County Public Health, CYP Commissioners	• Increase in the number of teachers who have undertaken self-harm, suicide prevention and bereavement training.		
		9.4 Increase knowledge and skills on suicide prevention within Nottinghamshire Police	Nottinghamshire Police	• Suicide prevention training is being offered to Nottinghamshire Police via e-learning.		

RAG Key

C	**Completed:** action has been successfully completed within the deadline
G	**On schedule:** action is in progress and meeting milestones
R	**Behind schedule:** action is in progress but milestones have not been met
N	**Not due to start yet.** Action is yet to commence

10.3 Equality Impact Assessment

An equality impact assessment (EIA) is an assessment to ensure that policies do not discriminate, and that where possible, equality is promoted. A full equality impact assessment of this strategy will be undertaken in accordance with the relevant local authority Equality and Diversity Policies.

11.0 Appendices

Appendix A: Local Policy Drivers

Key local documents

- Happier Healthier Lives, the Nottingham City Joint Health and Wellbeing Strategy 2016-2020
- Nottinghamshire County Council Joint Health and Wellbeing Strategy 2018 - 2022
- Nottingham City Suicide Prevention Strategy 2014-2017
- Nottinghamshire Suicide Prevention Framework for Action 2014-2017
- Nottingham City Joint Strategic Needs Assessment (JSNA) 2018
- Nottinghamshire Joint Strategic Needs Assessment (JSNA) 2016
- The Nottingham Plan 2020

- Everyone's different, everyone's equal: All-age integrated mental health and social care strategy, Nottingham and Nottinghamshire Integrated Care System, 2019

- The Nottingham City Joint Carers Strategy 2012 to 2020

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HEALTH SCRUTINY COMMITTEE
16 JANUARY 2020
YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING SERVICES
REPORT OF HEAD OF LEGAL AND GOVERNANCE

1 Purpose

1.1 To receive an update on the progress of the young people's mental health and wellbeing services.

2 Action required

2.1 To consider the information provided and use it to inform questioning, and make recommendations, where appropriate.

3 Background information

3.1 At its meeting on 13 December 2018, the Committee heard from Charlotte Reading and Lucy Anderson, both from the Greater Nottinghamshire Clinical Commissioning Partnership, Catherine Pope and Richard Glover, both from Nottinghamshire Healthcare NHS Foundation Trust, and Aileen Wilson, Head of Early Help Services on young people's mental health, and the following information was provided:

(a) all services should be working together towards a tierless and seamless system with a single point of access. Screening and assessment may identify the need for behavioural support, parenting issues, or occasionally child protection or physical health issues. There may need to be challenging but necessary conversations;

(b) following the initial assessment which usually took place within a week of referral, the length of waiting times for children and young people to receive treatment/support particularly following a mental health episode or suicide attempt would ideally be shortened. Work continued to address this, but initial contact by mental health colleagues was made within 24 hours of referral. Once the initial risk was considered to have passed, parents could be supported through a short parenting group where they were taught what indicators to look for and possible appropriate reactions. It was vital that parents didn't feel that they were on their own and they knew that support was available and that they could learn to trust their children. Advice was also now provided in hospitals;

(c) young people needed to be able to manage their own risks and challenge their perceptions. It was important that young people and their parents/carers understood and could apply coping strategies;

(d) the majority of young people entering the service were aged between 12 and 16 years old. Whilst the transition of children to adult services had been historically awkward in some areas, it should be noted that support in the form of a transition champion

was available but that the majority of young people suffering mental health difficulties did not go on to access adult services;

(e) there were local challenges in that there were different service providers in the City and the County, but there was good evidence of partnership working with the organisations working together well;

(f) there had been a lot of work with schools on prevention but also to ensure that young people could access information, help and support with mental health issues and can be referred to specialist services when needed. There had been resistance in some schools which were reluctant to escalate pupil's mental health support, but work was continuing to encourage improved engagement;

(g) although a lot of work had been done to improve young people's independent access to information and services with a web based presence, it was recognised that there could be further potential to use modern technology, including apps and social media;

(h) there remained issues around recruitment and retention of specialist staff and it was a concern that fewer people were studying mental health. However, now that adult apprenticeships had been launched, this provided alternative career paths and routes for training and gaining formal qualifications for becoming registered professionals. Careful consideration was taking place as to how career progression could be offered across services and partners to make the offer an attractive career;

(i) a pilot scheme of having a paediatric mental health specialist available to both Kings Mill and QMC hospitals to support emergency presentations proved so successful that it was proposed to continue but it hadn't been confirmed;

(j) feedback from young people and their families regarding the changes to services was being collected by each service. Focus groups had been held and young people had welcomed consistency in being able to see the same worker each time, feel uncomfortable about being reassessed at 6 weeks as this was perceived as a pressure to have recovered by then, welcome friendly environments, and responded that 94% would recommend services to friend. It was vital that young people had confidence in the services and this included consistent and quality interaction with workers, which in turn meant that workers could not be allocated too heavy a workload as they would be overstretched and quality would be affected;

(k) Hopewood opened in June 2017 and although there were a few initial teething problems, the facility was generally operating very well. The onsite school was the same as operates for patients of Nottingham University Hospitals and works to the national curriculum.

3.2 At the meeting the Committee agreed to review progress of the services in 12 months time.

3.3 Colleagues from the relevant services will be in attendance at the meeting to present the information and answer questions.

4 List of attached information

4.1 Detailed report from the relevant services.

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None.

6 Published documents referred to in compiling this report

6.1 Health Scrutiny Committee report and minutes dated 13 December 2018.

7 Wards affected

7.1 All.

8 Contact information

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Report to Nottingham City Health Scrutiny Committee
16th January 2020

CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING

Purpose of the Report

The purpose of this report is to update the Health Scrutiny Committee on Child and Adolescent Mental Health Services (CAMHS) in Nottingham including progress in implementing the local transformation plan to improve children and young people's mental health.

Context

Local areas, led by clinical commissioning groups (CCGs), have been required to have a system-wide local transformation plan (LTP) for children and young people's emotional and mental health since 2015. The development and delivery of the plan is overseen by the joint City and County Children and Young People's Mental Health Executive, membership includes representatives from CCGs, Local Authority Children's Services, Public Health, local NHS providers and NHS England and elected members.

The published LTP can be found at https://healthandcarenotts.co.uk/joint-local-transformation-plan/ .This plan, covers the period 2015 to 2021, is the fifth iteration, covering Nottingham and Nottinghamshire. The plan has been fully assured by NHS England and approved for publication by the CCGs. This is the last iteration of the plan as we move into NHS Long Term Plan implementation.

The plan is system-wide and as such covers services commissioned and provided by the two local authorities (including Public Health and Children's Services functions), local clinical commissioning groups and NHS England.

The NHS Long Term Plan 2019 outlines the following ambitions for Children and Young People's Mental Health

- Children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending.
- There will be an increase in the number of children and young people receiving evidence based community services.
- An additional 345,000 children and young people aged 0-25 will be able to access support via NHS funded mental health services and school or college-based Mental Health Support Teams.
- The new waiting time standards for eating disorders will be achieved and maintained.
- There will be a 24/7 mental health crisis provision for children and young people that combines crisis assessment, brief response and intensive home treatment functions.
- There will be a comprehensive offer for 0-25 year olds that reaches across mental health services for CYP and adults.

Service Delivery

In Nottingham City there are a number of Child and Adolescent Mental Health Services (CAMHS) which are delivered by the following providers:

- Community Specialist CAMHS provided by Nottinghamshire Healthcare NHS Foundation Trust
- Targeted CAMHS provided by Nottingham City Council

- Behavioural and Emotional Health support provided by Nottingham CityCare Partnerships
- Face to face and online counselling provided by KOOTH
- Face to face counselling provided by Base 51
- Early intervention and prevention services are provided by the SHARP team (Nottingham City Council)

Key achievements

Since the LTP was first published, there has been significant transformation undertaken to improve support for children and young people's emotional wellbeing and mental health. A summary of the developments are detailed below;

1. Promoting resilience, prevention and early intervention

Mental Health First Aid Youth:
This training is delivered in partnership with the ICS Workforce Development team. There are school staff only sessions available. Schools are offered an in-depth 2-day training course or a shorter 1-day course.
The 2-day training provides participants with:

- An in depth understanding of young people's mental health and factors that affect wellbeing
- Practical skills to spot the triggers and signs of mental health issues
- Confidence to reassure and support a young person in distress
- Enhanced interpersonal skills such as non-judgemental listening
- Knowledge to help a young person recover by guiding them to further support
- Ability to support a young person with a long term mental health issue or disability to thrive
- Tools to look after their own wellbeing

To date (Dec 19) 127 school staff have been trained.

A **Best Start Children's Public Health Service** for 0-19 year olds, with a focus on promoting emotional health and wellbeing, has been commissioned and awarded to CityCare. CityCare are working closely with the Early Help Team to enable the delivery of an integrated service model for the 0-5 year old age group from April 2020. The Strategic System Change Board, chaired by the portfolio holder for Children and Young People, Cllr Barnard, governs the delivery of this integrated model. The Board ensures that the model supports the SSBC objective linked to system change and that it is the mechanism to rollout across the city those programmes and approaches that have evaluated positively in the 4 wards.

Evidence, recorded through case studies, is already suggesting that the integrated model is enabling families to receive the right support, at the right time by the right person. This is partly facilitated through new joint 'early support liaison meetings'. This will impact positively on the health and wellbeing of both the child/children and their parent or carer.

The **New Forest Parenting Programme** (NFPP*)* is an evidenced based parenting programme for children and young people whose symptoms and behaviours are associated to ADHD, up to the age of 12 years (however it can be adapted for teenagers too). From April 2020 this provision will be delivered as part of the Behavioural Emotional Health service.

Targeted CAMHS and SHARP
Targeted CAMHS has **Universal Services CAMHS Practitioners** who work directly with schools and universal services around children and young people. These roles offers support and training to staff in schools/services, to help them to gain confidence in working with mental health needs, and prevents them referring to CAMHS when this is not required.

Targeted CAMHS also have **Early Intervention Practitioners on SPA** who assist with screening referrals, and offer telephone based assessments, and guided self-help to children, young people and their parents/carers**.**

Targeted CAMHS have also been developing their links with local schools to offer support such as an initiative called **Time4Me**, where young people can access direct monthly support in their secondary school from a consistent CAMHS professional. There is also a project for primary schools called **'Amazing Me'** which provides early Intervention to promote Emotional Wellbeing in primary schools. **All primary schools in the City** have a CAMHS link worker who makes contact termly with a designated point of contact within the school. Primary Schools are encouraged to use this, and it has been embedded into 'The Routes to Inclusion' for schools to be included as part of good practice.

Additionally, in **September 2019** Targeted City CAMHS have also recruited to the **Mental Health Support Team in Schools** which comprises of a service manager, 3 CBT trained supervisors, 8 Education/Mental Health practitioners and 2 CBT recruit to train posts. To date, 39 schools in the City will be allocated MHST support.

Next Steps is a joint partnership venture between Targeted CAMHS and NSPCC Childline developing ways Targeted CAMHS can help children and young people achieve their next steps and goals following their support from CAMHS.

The SHARP team is commissioned to provide early intervention and prevention activities to support children and young people, professionals, families and carers where there are behavioural, emotional or mental health needs for children and young people in Nottingham City to reduce self-harming behaviours in children and young people as achieved through the following:

- SHARP currently offers monthly self-harm clinics to **26 City secondary schools, Nottingham College and Confetti College, as well as alternative education provision.** Approximately **83% of young people seen between 2019/2019 have received support from universal Services and not required input from Targeted/Specialist MH Services.**
- The SHARP team will deliver assemblies in secondary schools from January 2020, raising awareness about emotional well-being support available in the City. The team also delivers various children and young people's workshops on 'Exam Stress-Less', "Riding the Waves" (self-harm awareness).
- The team runs the Trans4Me group which supports young people who identify as transgender/non-binary and the SHARP4Parents which offers support to parent/carers. This takes place 9 times a year at various venues across the City.
- SHARP currently deliver up to **15 training sessions per month** across the City, available to all front line professionals who work with CYP affected by self-harm.
- SHARP also deliver telephone and face to face professional consultation
- Additional interventions include parent/child mediation to support CYP who identify as gender variant

- SHARP are committed to supporting City SPA by offering a weekly rota to complete self-harm follow up appointments and joint protocols.

Throughout 2019 Nottingham City Council (Targeted CAMHS and the SHARP team) have undertaken the following participation work:

- Teens 4 Change came together to support each other, undertake projects and consulted to co-design Targeted CAMHS to fit their needs, develop a mental health passport, website development and team communications.
- Launch of the CAMHS Newsletter to help better communicate and tackle the misconceptions of CAMHS, to promote mental health and wellbeing using an anti-stigmatising approach.
- In **2018/2019** Targeted City CAMHS became one of the trailblazer sites around the country to work with **Young Minds** on their Amplified project. Young Minds attended a CAMHS team day in early 2018 to identify strengths in participation and funded some of CAMHS participation events as detailed below:
- CAMHS engaged CYP and families through various platforms including Splendour and Pride, Riverside festival, and world awareness days. Parents are invited to open-door sessions pre-assessment, and Parents In Mind group to participate in service development.
- Throughout **2018/19** CAMHS and SHARP ensured promotion of services through attending and speaking at local and national conferences, and ensure their presence at secondary schools to promote emotional well-being a reduce stigma.

Kooth is commissioned to provide online and face-to-face counselling. The service has recently recruited 5 Ambassadors, who are young people attending Nottingham Free School. They have taken part in a number of training sessions with Kooth in order for them to support their peers at school and facilitate discussions around emotional wellbeing and mental health. The Ambassadors will also be working with Kooth to develop their website and ensure the content is young people friendly as well as acting as peer mentor on the Kooth discussion forums.

Base 51

Base 51 is commissioned to provide face to face counselling services and access to wider health support such as sexual health. The service delivers drop-in sessions and over. Base 51 also provides targeted projects and open access services to young people that aim to create a holistic approach to wellbeing.

In 2020, local providers in Nottingham are working with NHS Improvement to further improve data quality in relation to children and young people's emotional health and wellbeing reporting.

Behavioural and Emotional Health Team

In Nottingham City, the Behavioural and Emotional Health (BEH) team has been operational for 5 years and delivers a package of support to children and young people with behavioural, emotional, or mental health needs and their parents/carers. The service provides early intervention approaches to managing behaviour, these include;

- Information gathering to inform diagnostic assessment (ADHD and ASD)
- Multi-disciplinary assessment of needs and provision of package of care (evidence based workshop, 1:1) both pre and post diagnostic
- Plan for transition to adulthood and/or adult services.

As a result of these interventions children, young people and their parents/carers are supported with the confidence and techniques to manage challenging behaviour, supporting

improved outcomes for children and young people. The Nottingham City BEH pathway is delivered within an integrated system which includes BEH, Targeted CAMHS and Community CAMHS as part of an integrated single point of access and are supported by integrated strategies, policies and procedures. If a diagnostic assessment is required a direct referral to the specialist team is made. The service also accesses consultation and advice from Educational Psychology, Clinical Psychology and Community Paediatrics.

From April 2020, there will be a change in provider from Nottingham CityCare Partnership to Nottingham City Council.

MH:2K Project

- Embedding the learning from consultation, engagement and communication has been a key focus in the last 6 months. Analysis of large scale engagement programme (MH: 2K) with children and young people undertaken during 2017/18 and 2018/19 told us that young people want better mental health support in school, adults to have a better understanding of mental health issues and clear information on where they can get support that is easily accessible. A 'Findings and Recommendations' report has been produced and informed the detailed delivery plan for 2019/20 and the latest iteration of the Transformation Plan.

- The MH2K project has now been extended until March 2020 and recruitment is underway for a further 19 Citizen Researchers have been recruited. The group have developed a short film tackling stigma and leaflets and posters with information about where young people can get help with their mental health. These resources will be shared with 1,000 young people across the City and County at roadshows planned from January 2020.

2. Improving access to effective support

The NHS Long Term Plan outlines targets for increasing the number of children and young people who will be able to access help via an NHS funded service.

Children and young people will have increased access to support via the Mental Health Support Teams in Schools and can also access support digitally and face to face via Kooth.

Targeted CAMHS Single Point of Access (SPA) works alongside the Nottingham City Multi-Agency Safeguarding Hub (MASH). This model has ensured that cases remain at a Targeted CAMHS or universal level, only escalating to specialist community CAMHS when required. Regular case consultation with Specialist Community CAMHS takes place within the SPA, enabling transition of cases between services and improving access. Targeted and Community CAMHS managers meet monthly to oversee processes and continue to develop joint working.

Targeted CAMHS Single Point of Access (SPA) works alongside the Nottingham City Multi-Agency Safeguarding Hub (MASH). This model has ensured that over the last 4 years 95% of cases remain at a Targeted CAMHS or universal level, only escalating to specialist community CAMHS when required. There is a clinician from the Specialist Community CAMHS team co-located within the SPA with the aim to improve access to specialist community CAMHS and further develop joint working.

Joint work is taking place to support integration between Targeted and Specialist CAMHS to ensure services are streamlined and children and young people can access the service which best meet their needs.

Early Intervention in Psychosis (EIP)
The national target for this service is for 53% of young people referred to EIP should receive NICE concordant treatment within 2 weeks. In Nottingham and Nottinghamshire young people are assessed and treated within the Head to Head Service, which provides NICE compliant treatment for psychosis, bipolar disorder and schizophrenia. Head to Head is a specialist team within Specialist CAMHS, It should be noted that whilst psychosis can affect all ages, it is rare in young people and is not ordinarily apparent until older teenage years. During 2019/20 Nottinghamshire Healthcare Foundation Trust has met the access and waiting time standard. Due to small numbers we are unable to include exact figures due to data protection. In January 2020, work will begin to benchmark the service against EIP guidelines.

Transition
Transition between CAMHS and adult mental health services has been recognised as a priority both locally and nationally. A national Commissioning for Quality and Innovation (CQUIN) was agreed as part of the NHS contract for 2017-2019.

Data collected as part of the evaluation of the CQUIN work indicates that there has been a significant improvement in the transition process over the two year period, not only in the relationships that have been built between CAMHS and adult services but in the number of young people who have been involved in their transition process and the number who have a clear transition plan in place. Young people who completed pre and post transition questionnaires also indicated a positive increase in the experience of transition for young people. Further work to improve transitions will take place as part of the 0-25 work which has been identified as a priority.

3. Care for the most vulnerable
An early priority has been to consider the mental health support to young people with learning disabilities, in line with the national programme '**transforming care for children and young people with Autistic Spectrum Disorder or Learning Disability, and challenging behaviour/mental health needs**'. A risk register for children and young people at risk of admission to an inpatient mental health bed has been put in place within CAMHS and the Care and Treatment Review process has been implemented. During 2019/20 an independent review was undertaken around provision of services and pathways for children and young people with learning disabilities and/or autism. The report and recommendations will be published in February 2020 and will be overseen by the Children and young people's Transforming Care steering group.

Within Targeted CAMHS there have been a number of developments during 2018/19 in order to improve care for the most vulnerable: This includes

- Continuing pilot of **Time Limited Adolescent Psychodynamic Psychotherapy (TAPP)** to support adolescents who require more in depth assessment and therapy for more complex or trauma history presentations such as attachment disorders and emotional dysregulation. It is hoped that in two years' time this will be embedded.
- **Sel**f-harm joint-protocol ensures Targeted CAMHS and the SHARP team respond jointly, alongside social care colleagues, within 48 hours when there are serious concerns about a child/young people's self-harm or suicidal behaviours.
- **Animal assisted therapy** – the service has a trained and qualified therapy dog working with children and young people who need more support to feel comfortable to develop therapeutic relationships that have additional needs making accessing talking therapy more difficult

- **Since 2018 a Systemic Family practitioner is currently employed within CAMHS after successfully completing the CYP IAPT SFP training at Manchester University**. This provision is now embedded within CAMHS provision to deliver family/relational systemic therapy.
- **Targeted CAMHS are committed to embedding early intervention provision and developing the range of therapeutic interventions for children under 5**. To this end there have been initial meetings in mid-2019 which will continue through 2020, with potential partners such as **Small Steps Big Changes. The focus of the meetings is to explore** at the development of collaborative perinatal and infant mental health teams of which CAMHS would be a part of.

There is a commitment to ensuring that young people requiring inpatient mental health provision are cared for as close to home as possible, with as short a length of stay as possible. Commissioners are therefore working with Specialised Commissioning through the regional collaborative commissioning group, both to influence the bed types required locally by our young people, but also to ensure that as we enhance our community CAMHS Crisis provision, we have the right skill mix to provide support to young people with evidence based approaches in relation to the particular types of presentations that young people are being admitted with. Part of this work includes improving the pathway between community and inpatient services, particularly for young people with social care needs as well as mental health needs.

4. Accountability and transparency

CCGs within this Nottingham and Nottinghamshire are committed to achieving the mental health investment standards detailed in the NHS Long Term Plan. There has been an increased spend on children and young people's mental health since 16/17, with year on year increase in investment across the ICS footprint.

Improving data quality and availability continues to be a priority and is a requirement that all NHS commissioned services, including non-NHS providers flow data for key national metrics in the Mental Health Services Data Set (MHSDS). CAMHS at Nottinghamshire Healthcare NHS Foundation Trust have been able to flow data through the MHSDS since 2016/17 and work has continued to ensure that data reported locally reflects data reported from the MHSDS. All providers are now able to flow data to the MHSDS and there is ongoing work to ensure that this data is reflected accurately in national reporting. It is expected that MHSDS reporting will be accurate for all providers by quarter 4 2019/20.

Performance against this standard is not currently meeting the required level. A 2018/19 one off data collection showed an ICS performance at 25.3% against a 2018/19 target of 32%. Performance is set to improve by the end of 2019/20.

5. Developing the Workforce

Nottinghamshire is part of the CYP-IAPT (Improving Access to Psychological Therapy) programme (Oxford and Reading Collaborative) and continue to engage with the training provided. Since 2015 members of CAMHS staff at Nottinghamshire Healthcare NHS Foundation Trust (NHFT) participated in a range of training including Cognitive Behavioural Therapy (CBT), Systemic Family Practice and Interpersonal Psychotherapy for Adolescents. Team Leads have also accessed Transformational Leadership training.

NHFT have also recruited to new "recruit to train" CBT and Children and Young People's Wellbeing Practitioner (CYPWP) posts, initially funded by Health Education England, which aims to address the national workforce challenges. Staff who have been accepted into service on these temporary contracts have been offered permanent posts within the service.

The role of the CYPWP within CAMHS is an exciting development, offering low-intensity, evidence-based, short term interventions for children and young people with mild mental health difficulties. There is work currently underway to convert training posts into permanent positions within the service.

Nottinghamshire have successfully implemented Mental Health Support Teams (MHST), in the county which are a new service designed to help meet the mental health needs of children and young people in education settings. They are made up of senior clinicians, CBT therapists and Educational Mental Health Practitioners (EMHPs). The aim of these teams is to work with the mental health supports that already exist, to implement a whole-system approach to increase access and improve outcomes for children and young people. In Nottinghamshire there are two MHSTs covering Rushcliffe and Gedling, where staff have recently completed evidence-based training programmes and the team is now fully operational.
This year we have successfully expanded the offer to include a further team in Mansfield and Ashfield, and two teams in Nottingham City which will be delivered by Nottingham city council.

Working in partnership with Health Education England, throughout **2019/19** Targeted CAMHs has successfully appointed a number of **CYP IAPT Recruit to Train posts**, including CBT practitioners, Children's Well Being Practitioners and Emotional Health & Well Being practitioners. These post holders attend University of Reading to complete Post Graduate Diplomas in their clinical field, whilst attending placement within Targeted City CAMHS.

Additionally, in **September 2019** Targeted City CAMHS have also recruited to the **Mental Health Support Team in Schools** which comprises of a service manager, 3 CBT trained supervisors, 8 Education/Mental Health practitioners and 2 CBT recruit to train posts. To date, 39 schools in the City will be allocated MHST support, with 16 new staff forming part of the service from September 2020.

There are a further **2 CYP IAPT Recruit to Train Parent Therapist posts** currently being recruited to, who will deliver evidenced based parenting interventions including Webster Stratton Incredible Years, and "Helping the Non-Compliant Child", which are aimed at children from the ages of 3-12 who may be exhibiting conduct and behaviour difficulties. One of the CAMHS managers is attending Reading University to complete a post graduate qualification in Supervision in order to support the trainee's clinical work.

70% of the **Targeted CAMHS** workforce are trained in specific evidenced based therapies. The offer includes; Interpersonal Psychotherapy for adolescents (IPT-A), Systemic Family Practice (SFP), Enhanced Evidence Based Practice (EEBP) and a pilot of Time Limited Adolescent Psychodynamic Psychotherapy (TAPP).

Priorities and Actions for 2020
The following section outlines priorities and actions for 2020:

- **Improving access to support around mental and emotional health for more children and young people through the rollout of Mental Support Teams in Schools.**

Funding has been secured for two Mental Health Support Teams covering approximately 40 schools in Nottingham City. This will result in 16 new NHS trained staff working with schools to support children and young people with mild to moderate mental health issues. Schools covered by an MHST will also have the opportunity to participate in Mental Health and

Schools Link workshops, which will support the rollout of a whole school approach to mental health and well-being. These teams will

In addition to this selected schools with Nottingham have been invited to take part in the Mental Health Services and Schools Link Programme. The programme will take place over the next 4 years and work to ensure that all schools across Nottingham City feel more confident and capable to support young people within their schools with their emotional health and wellbeing. As part of the workshops the CASCADE framework will be used which allows an audit of improvement to be undertaken. The CASCADE framework can be found on the Anna Freud National Centre for Children and Families website

- **Improving transition and increasing the support available to young adults through developing a comprehensive 0-25 service**

A workshop is being held in January 2020 and all Nottingham partners are invited to participate, the workshop will focus on identifying best practice in relation to transition, share learning from other areas and provide an opportunity for partners to jointly plan improvements.

- **Increasing access to support for Looked After Children and Care Leavers via a responsive and dedicated service**

Since April 2018, the **You Know Your Mind Project** has been operating across Nottinghamshire County and Nottingham City, supporting looked after children aged 0-17 and care leavers aged 18-25 who are experiencing poor or deteriorating mental health.

Through a 'Different Conversation', the child or young person is empowered to determine what they think will genuinely improve their mental health outcomes and make every day a 'good day'. By offering children and young people the choice and control over their mental health support.

The ongoing design and delivery of the project has been informed by a local Participation Group of children and young people, as well as local 'You Know Your Mind' events to encourage young people to try new, positive activities that promote positive mental health outcomes.

Evaluations undertaken with children and young people accessing the project have told us the project:

- Increases access to positive activities that children and young people readily engage with, which in turn can have a significant impact on their quality of life, as well as supporting them to develop their confidence and & self-esteem.
- Encourages young people to engage in new hobbies and explore new interests, which has had a positive impact on issues such as alcohol /substance misuse, youth offending and self-harming behaviour .Children & young people have reported "having something to look forward to" through their self-identified support arrangements, which often allow them to build positive friendships with like-minded peers

The project is funded until April 2020, health and social care commissioners are working together to further evaluate the impact of the project, with a view to inform commissioning plans for April 2020.

- **Reviewing and piloting delivery models in relation to urgent and crisis care, to ensure it is consistent with regional and national models of best practice**

There is currently a 24/7 CAMHS crisis pilot operating in Nottingham. The current pilot will be used to test new ways of working in order to provide 24/7 care to children and young people experiencing a crisis. This pilot will be used to support providers and commissioners with future planning to ensure models of care for 24/7 provision are in place by 2023/4. The pilot consists of overnight provision of a CAMHS Crisis clinician and support worker. The aim is to review the level of need and demand overnight and scope the future requirements of the service. The aim is to ensure that young people have equitable access to urgent mental health care 24/7 and ensure a service which provides a more comprehensive level of support to those at risk of psychiatric admission is in place.

- **Achieve the 2020/21 target of 95% of children and young people with eating disorders accessing treatment within 1 week for urgent cases and 4 weeks for routine cases**

Further service development has been undertaken with the CAMHS Eating Disorder Service and CAMHS Crisis and Home Treatment Service to ensure the crisis response and out of hours offer for children and young people with an eating disorder is effective and equitable. In 2019, the CAMHS Eating Disorder Service introduced the **same day 'assess and treat'** model to ensure that they achieve the **access and waiting time standard** The service has now increased their staffing capacity and made significant improvements in its performance against the 2020 waiting time standards.

Nottingham have also secured short term funding to improve access to services for children and young people with Avoidant Restrictive Food Intake Disorder (ARFID) pilot. Avoidant Restrictive Food Intake Disorder, more commonly known as ARFID, is one of the 'feeding and eating disorders', together with anorexia nervosa, bulimia nervosa, binge eating disorder, rumination disorder and pica. It is a condition characterised by a person avoiding certain foods, types of food, or mealtimes, having restricted intake in terms of overall amount eaten, or a combination of these features. Someone might be avoiding and/or restricting their intake for several different reasons. The most common are the following:

  - Sensory-based avoidance or restriction of intake
  - Concerns about the consequences of eating
  - Low interest in eating

The project will work to; map existing service provision for CYP with avoidant restrictive food intake across and identify gaps in service, identify potential partnerships and referral pathways and understand the impact of ARFID and current pathways on CYP and families. This will help inform future service planning.

- Work will continue to support and embed the **Small Steps Big Changes** programme in Nottingham City through universal maternal mental health screening, preparing for parenthood and building adult capacity and capability to improve child development outcomes. Over 1500 children have now benefited from the Small Steps at Home Programme delivered by the paid peer workforce of Family Mentors supporting all outcomes including social and emotional mental health. The Big Little Moments Campaign http://www.smallstepsbigchanges.org.uk/biglittlemoments was launched across the City in February 2019 focusing on social, emotional and speech and language development, a focussed social media campaign is underway in the four wards and will continue until March 2020. The Programme continues to support the FNP ADAPT programme in the City Baby Buddy App has now hit over 1700 downloads The Programme is working with Women's Aid to support the rollout of the Change that Lasts project including, 'ask me' and 'trusted professional'
  The Programme is investing in additional multiagency workforce training to deliver Triple P tip sheets, parenting programmes and discussion groups through 2019-

2020. The Small Steps Big Changes programme has identified infant, maternal and paternal mental health as one of its key focus areas for 2019 onwards and is currently exploring options for future test and learn and service design.

- Work will continue to align the **Best Start Children's Public Health Service** and Nottingham City's internal **Early Help Services for 0-5 year olds** in order to deliver an efficient and effective integrated service model that promotes emotional health and wellbeing.

- City schools will continue to be supported to achieve the **Emotional Health and Wellbeing Charter**

- Continue to offer **Mental Health First Aid training** to the children's workforce

Conclusion

Significant work has been undertaken to improve the mental health and wellbeing of children and young people in the city. However, there is further work to do to ensure that services are accessible and meeting the needs of children and young people. There are a number of priorities including increasing the numbers of children and young people who are able to access CAMHS and ensuring that the CAMHS Eating Disorders Standards are met and maintained. In addition, it is important that Targeted and Specialist CAMHS are fully integrated to ensure that children and young people are supported as quickly and effectively as possible and the 24/7 crisis model of support develops.

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HEALTH SCRUTINY COMMITTEE
16 JANUARY 2020
THE NATIONAL REHABILITATION CENTRE – PUBLIC CONSULTATION
REPORT OF HEAD OF LEGAL AND GOVERNANCE

1 Purpose

1.1 To receive information on the formal public consultation proposals in relation to the National Rehabilitation Centre (NRC).

2 Action required

2.1 To consider the public consultation proposals and provide feedback.

3 Background information

3.1 At its meeting on 12 September 2019 the Committee considered information on the proposals for the introduction of the NRC.

3.2 It was provided with the following information:

(a) planning permission had been granted on land donated to the NHS for a regional rehabilitation clinical facility and national research and innovation hub. It was proposed that the facility consist of 63 single and multi-bed rooms to act as a regional clinical service;
(b) NHS patients would have access to the state of the art Ministry of Defence facilities which would be located next to the site of the proposed regional centre;
(c) the 6 CCG's within Nottingham had been working alongside Nottingham University Hospitals Trust in the review to develop plans, working towards establishing services and considering how they would link with local services and fit with local populations;
(d) this development would give the opportunity to deliver more capacity to services and strengthen the overarching national strategy for rehabilitation;
(e) the facility would link with the regional trauma unit at Queens Medical Centre and provide services where there was currently a gap. It would provide targeted and intensive rehabilitation which would not only improve patient outcomes but would reduce the amount of time patients were in hospital;
(f) the current rehabilitation service was based at Linden Lodge at Nottingham City Hospital and consisted of 24 rehabilitation beds. There were additional secondary facilities that provided other aspects of rehabilitation but these were based across a number of different sites. The rehabilitation centre would ensure that services were based at one site;
(g) referral criteria were yet to be confirmed but would rely on the need for patients to be able to cope with, and benefit from, the intensive rehabilitation that would be offered at the centre;

(h) referral would take place through a single point and would be reviewed by experts through the East Midlands Trauma Network. Programmes of rehabilitation would be tailored to suit each individual patient;

(i) the centre would aim to deliver a net increase of 39 specialist beds across the East Midlands Region, and it was estimated that the centre would treat up to 800 patients a year. Individual stays at the centre would not be time limited;

(j) the aim was for the centre to be cost neutral for commissioning and to provide services within current budgets, achieved by system wide reviews of currently commissioned services and transfer of current services/activities. It was projected that this would lead to a reduction in the cost of ongoing care, release acute trauma beds more quickly, and would attract central funding;

(k) following a review by the Clinical Senate there had been a number of recommendations. The referral criteria would need to ensure equality across patient groups and conditions, there needed to be consideration of workforce planning, discharge planning process must be considered and interface with the community ensured. There needed to be more consideration of the cost/benefit relative to potential capacity gap in the system;

(l) following engagement with patient groups the following points were raised:

- quality of care was important, as was access to care all in one place;
- concerns were raised about losing access to personal connections;
- most people were willing to increase travel time to reach better services;

(m) there would also be a focus on mental health rehabilitation for patients built into the physical rehabilitation programmes. This supported the NHS Long Term Plan;

(n) an impact analysis had been conducted. It found that travel would be impacted significantly. On average, patients would need to travel further and travel time would increase from 20 minutes to 39 minutes. Those using public transport would be greatest impacted with an average regional travel time of 2 hours;

(o) key benefits would include improved patient outcomes, minimised waiting times, access to state of the art equipment, vocational rehabilitation, longer term savings in community and social care and research opportunities including integration with military education and training;

(p) concerns were raised about the significant impact on travel time for Nottingham City patients. Travel time to the new facility would impact everyone, but especially those using public transport. This would impact out-patients as well as families visiting in-patients, both in terms of travel time and cost. Consideration was being given to whether it was possible to subsidise travel in any way;

(q) there were early stage discussions with local transport companies looking the possibility of adding new routes to the infrastructure to help with transport times and accessibility of the site. The number one bus already served the site from Nottingham city centre;

(r) the site of the facility had been predetermined by the donation of land to the NHS. It was beneficial to be sited close to the MoD rehabilitation

centre as it allowed access to the state of the art facilities not currently available to NHS patients. It also allowed better education, training and research;

(s) the commissioning of the services would be subject to all of the proper processes and would be open competition. Nottingham University Hospitals Trusts would have to bid alongside other trusts if they wished to deliver the service;

(t) a centralised, regional facility combined with a National Research centre would allow for the opportunity to increase bed count, offer the opportunity for efficiency savings, as well as help to shape the national strategy for rehabilitation which were not things that could occur if the local services were retained;

(u) there was a need for further engagement with patient groups, service users and the public. Healthwatch could facilitate with this engagement to feed into the business case;

3.3 The Committee indicated that it would be interested in hearing future developments on this project, so colleagues from the CCG are attending the meeting to update the Committee on the proposals for formal public consultation.

4 List of attached information

4.1 Briefing note from the CCG.

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None.

6 Published documents referred to in compiling this report

6.1 Health Scrutiny report and minutes dated 12 September 2019.

7 Wards affected

7.1 All.

8 Contact information

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National Rehabilitation Centre – Update to the Nottingham City Health Scrutiny Committee

January 2020

Briefing

Purpose and background

We have been updating the Committee on our proposals for establishing a National Rehabilitation Centre (NRC) at the Stanford Hall Estate, which hosts the Defence Medical Rehabilitation Centre (DMRC), over recent months.

We are now in a position to formally notify the Committee of our intention to launch a full public consultation on our proposals in March 2020. This briefing outlines what we will present on our consultation plans at the Committee meeting in January 2020.

Focus of presentation

This section provides a summary of the plans we will present to the committee for discussion.

Our approach to the consultation

We will draw on three core areas of support to ensure our consultation meets its objectives. Each of these areas brings a specific benefit to the consultation:

1. Expertise on best practice - Consultation Institute
2. Ability to reach seldom heard communities across Nottingham and Nottinghamshire - Healthwatch
3. Expertise in the management of public consultation – Agency.

We will facilitate feedback and discussion on our proposals through a range of engagement activity, including a survey; a series of public events and invitations to key stakeholders to provide direct written responses.

We have also commissioned Healthwatch Nottingham and Nottinghamshire (HWNN) to deliver targeted engagement with vulnerable and seldom heard groups. This engagement is directly informed by an independent Equality Impact Assessment (EIA) carried out on our proposals.

Engagement to date

An extensive programme of patient, staff and clinical engagement has informed the development of our proposals and our approach to our proposed consultation. This includes two phases of focus groups with patients, fortnightly staff meetings and discussions with clinical bodies.

Options and timescales for a potential public consultation

We intend to undertake a one-option consultation for a period of 6 weeks commencing on March 9 2020, seeking feedback on a detailed proposal for the development of services at the National Rehabilitation Centre. Our proposal will be detailed in a Consultation Document.

HEALTH SCRUTINY COMMITTEE
16 JANUARY 2020
TREATMENT CENTRE MOBILISATION
REPORT OF HEAD OF LEGAL AND GOVERNANCE

1 Purpose

1.1 To receive a written update on the transition of providers for the Treatment Centre.

2 Action required

2.1 To consider the written update provided and whether there is a need for any further updates or recommendations.

3 Background information

3.1 The Committee has considered the proposals for the procurement of a provider for the Treatment Centre on a number of occasions over the last two years.

3.2 The latest update was at the meeting on 13 June 2019, when Lucy Dadge, Director of Commissioning at Nottingham City Clinical Commissioning Group (CCG), gave a verbal report on the change of contract for the operation of the Nottingham Treatment Centre from Circle Healthcare to the Nottingham University Hospitals Trust (NUH), and provided the Committee with the following information:

(a) the contract procurement process was subject to significant legal proceedings that were not fully concluded, but it had reached the stage where it was lawful to award the contract to NUH. The CCG was fully committed to working with both the new and departing provider and was confident that an effective handover would be achieved within the two months available, with the change taking effect from 29 July 2019. This included ensuring that the existing staff were engaged in the transition to the new provider, that the IT system transfer was managed effectively, and that the right equipment was in place, so there was no disruption to the continuity of appointments or to patient safety;

(b) it was not proposed to make any changes to the current staffing, roles or terms of employment as part of the process, and staff were being kept fully informed. The provision of support services (such as cleaning and café staff) would be discussed between the providers, but some of these services were supplied to the Centre by NUH already. NUH would need to bring the new contract in line with its other core services, but it would consider continuing any existing, positive measures in the workplace that improved staff satisfaction and wellbeing. The primary focus of the CCG was on patient wellbeing, but it would discuss with the new provider measures for how staff satisfaction could improve outcomes for patients;

(c) the award of the contract to a new provider did not change the expected outcomes for patients, which were set by the CCG, though NUH could choose to deliver them in a different way. There would be a strong focus on the continuity and maintenance of the standards of outcomes for patients, particularly at the point of transition. The contract transfer would go ahead in the context of difficult relationships in an intensive period, but the set handover date provided a strong point of focus and full measures were in place to ensure that there were no issues for patient safety;

(d) if any bedding-in measures were required on a temporary basis, such as meeting existing appointments at an alternative delivery centre, there would be a requirement for strong and effective communication. However, no services would stop as part of the transition process. The CCG was fully committed to ensuring that effective medical provision was in place up to and across the handover date, and that the right skills and competencies were deployed to ensure success in an evolving healthcare environment;

(e) the ultimate legal fees relating to the procurement for the Centre provider would be published when the process was fully concluded. The CCG had ensured that the necessary resources were available to ensure that the transition was successful. A specialist IT team had been put in place to ensure that all patient records were transferred accurately and successfully. The new and outgoing providers were in discussion relating to the current medical equipment present in the Centre. It was hoped as much of it as possible would remain in place, to minimise disruption. All costs relating to the management and operation of the Centre would be met by the new provider through the contracted tariff awarded to it by the CCG;

(f) the current procurement process for the Nottingham Treatment Centre had been long and difficult. A general consultation was underway on the award of NHS contracts, and this was an active policy area on a national level. As such, it remained to be seen what the overall context would be when the new contract came to an end in five years' time.

3.3 The Committee resolved to receive a written update on the transition of providers from the CCG within 4 to 6 months, which is attached to this report.

4 List of attached information

4.1 Written update on the Treatment Centre mobilisation from the CCG.

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None.

6 Published documents referred to in compiling this report

6.1 Health Scrutiny Committee reports and minutes dated:

23 November 2017
24 May 2018
19 July 2018
13 June 2019

7 Wards affected

7.1 All.

8 Contact information

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Update on the transfer of the Treatment Centre to Nottingham University Hospitals NHS Trust

Introduction

Briefing submitted for assurance on behalf of the Nottingham and Nottinghamshire CCGs

Mobilisation

Nottingham University Hospitals (NUH) is now coming to the end of the initial 3-month mobilisation phase. All services previously delivered by Circle have transferred and are now being delivered wholly by NUH. As part of the mobilisation, over 500 staff transferred from employment with Circle to NUH.

Previously 50% of the medical workforce was employed through ad hoc arrangements by Circle. NUH is gradually replacing these with substantive appointments and has made progress in dermatology, anaesthetics and gastroenterology.

As well as staff, the mobilisation included the migration of all IT systems, patient appointment (which have been transferred to NUH operating system). This involved a data transfer of 44,642 existing patient bookings for outpatient appointments and surgery.

Other services that have now also been moved to NUH include the pharmacy contract (which transferred from the end of October).

Patient appointments

In-patient activity was paused in August and recommenced with overnight stay patients in September.

Throughout the whole mobilisation phase just over 2,000 patients had their appointment date and time rescheduled. Each patient was received an individual letter about these changes.

Currently patients having major joint replacements have not been treated at the Treatment Centre but have been transferred to the elective orthopaedic unit at Nottingham City Hospital primarily due to need to ensure that safe out of hours cover is in place.

Apart from elective orthopaedic joints there have been no other significant changes in activity in the first three months.

Current status

NUH is now moving to the transformation phase of the work to improve services.

The CCG anticipates moving into a new phase of the contract in December when we will begin monitoring the transformation plan as mobilisation will be fully complete.

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HEALTH SCRUTINY COMMITTEE
16 JANUARY 2020
WORK PROGRAMME
REPORT OF HEAD OF LEGAL AND GOVERNANCE

1 Purpose

1.1 To consider the Committee's work programme for 2019/20.

2 Action required

2.1 To discuss the work programme for the remainder of the municipal year and make any necessary amendments.

3 Background information

3.1 The Committee is responsible for setting and managing its own work programme.

3.2 In setting the work programme, the Committee should aim for an outcome-focussed work programme that has clear priorities and a clear link to its roles and responsibilities.

3.3 The work programme needs to be flexible so that issues which arise as the year progresses can be considered appropriately.

3.4 Where there are a number of potential items that could be scrutinised in a given year, consideration of what represents the highest priority or area of risk will assist with work programme planning.

3.5 Changes and/or additions to the work programme will need to take account of the resources available to the Committee.

4 List of attached information

4.1 Health Scrutiny 2019/20 Work Programme.

5 Background papers, other than published works or those disclosing exempt or confidential information

5.1 None.

6 Published documents referred to in compiling this report

6.1 Health Scrutiny reports and minutes.

7 Wards affected

7.1 All.

8 Contact information

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Health Scrutiny Committee Work Programme 2019-20

DATE	ITEMS
13 February 2020	**Homecare Services Model** To update the Committee on the implementation of the Homecare Services Model **Safeguarding Adults Board 18-19 Annual Report** To consider the annual report **Healthwatch Annual Report** To consider the annual report **Inpatient Detoxification Services** A written update on the effects of the implementation of the new contract **Work Programme** To agree the work programme for the remainder of the municipal year
12 March 2020	**Discussion with the Portfolio Holder for Adult Care and Local Transport (with a focus on the Adult Care remit) – Councillor Adele Williams** To discuss the priorities and focus for the Portfolio, Council Plan priorities, budget pressures and challenges **Gluten Free Food Prescriptions** To update the Committee on the effects of the implementation of the changes **Over the Counter Medication Prescriptions** To update the Committee on the effects of the implementation of the changes **Work Programme 2020/21 Development** To discuss the work programme for 2019/20

DATE	ITEMS
16 April 2020	**Discussion with the Portfolio Holder for Health, HR and Equalities (with a focus on the Health remit) – Councillor Eunice Campbell-Clark** To discuss the priorities and focus for the Portfolio, Council Plan priorities, budget pressures and challenges **CityCare Provision of Out of Hospital Community Services Contract** To review the provision of services by Nottingham CityCare Partnership under the Out of Hospital Community Services contract