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NHS Nottingham City Clinical Commissioning Group

Nottingham City Council

NOTTINGHAM CITY HEALTH AND WELLBEING BOARD

Date: Wednesday, 25 September 2019

Time: 1.30 pm

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

Contact: Zena West **Direct Dial:** 0115 8764305

The Nottingham City Health and Wellbeing Board is a partnership body which brings together key local leaders to improve the health and wellbeing of the population of Nottingham and reduce health inequalities.

Members:

Voting members

Councillor Eunice Campbell-Clark (Chair)	City Council Portfolio Holder with a remit covering health
Dr Hugh Porter (Vice Chair)	NHS Nottingham City Clinical Commissioning Group representative
Councillor Cheryl Barnard	City Council Portfolio Holder with a remit covering Children's Services
Councillor Leslie Ayoola	City Councillor
Councillor Adele Williams	City Councillor
Dr Marcus Bicknell	NHS Nottingham City Clinical Commissioning Group representative
vacancy	NHS Greater Nottingham City Clinical Commissioning Partnership
vacancy	NHS Greater Nottingham Clinical Commissioning Partnership

Alison Michalska	City Council Corporate Director for Children and Adults
Catherine Underwood	City Council Director of Adult Social Care
Alison Challenger	City Council Director of Public Health
Sarah Collis	Healthwatch Nottingham representative
Samantha Travis	NHS England representative

Non-voting members

Lyn Bacon	Nottingham CityCare Partnership representative
Alison Wynne	Nottingham University Hospitals NHS Trust representative
Julie Hankin	Nottinghamshire Healthcare NHS Foundation Trust representative
Richard Holland	Nottingham City Homes representative
Matthew Healey	Nottinghamshire Police representative
vacancy	Department for Work and Pensions representative
Leslie McDonald	Representing interests of the Third Sector
Jane Todd	Representing interests of the Third Sector
Craig Parkin	Nottinghamshire Fire and Rescue Service representative
Andy Winter	Nottingham Universities representative
Ian Curryer	City Council Chief Executive

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NOTTINGHAM CITY COUNCIL

HEALTH AND WELLBEING BOARD

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 24 July 2019 from 2.07 pm - 4.45 pm

Membership
Voting Members

Present	Absent
Councillor Eunice Campbell-Clark (Chair)	Councillor Leslie Ayoola
Dr Hugh Porter (Vice Chair)	Alison Challenger
Councillor Cheryl Barnard	Samantha Travis
Dr Marcus Bicknell	Catherine Underwood
Andrea Brown	
Sarah Collis	
Alison Michalska	
Councillor Adele Williams	
Paula Child (Substitute for Catherine Underwood)	

Non-Voting Members

Present	Absent
Lyn Bacon	Tim Brown
Leslie McDonald	Ian Curryer
	Matthew Healey
Jules Sebalin (Substitute for Jane Todd)	Gill Moy
	Craig Parkin
	Hazel Johnson
	Jane Todd
	Andy Winter
	Alison Wynn

Colleagues, partners and others in attendance:

Uzmah Bhatti	-	Public Health Insight Manager
Helene Denness	-	Consultant in Public Health
Catherine Kirk	-	SRE Consultant
Richard Taylor	-	Environmental Health Officer
Ruth Taylor	-	NHS Consultant in Sexual Health

17 APOLOGIES FOR ABSENCE

Ian Curryer	- Chief Executive Officer
Hazel Johnson	- Nottinghamshire Healthcare Trust.
Jane Todd	- Nottingham CVS – Substitute sent
Catherine Underwood	- Director of Adult Social Services (Substitute sent)
Alison Wynne	- Nottingham University Hospital Trust (Substitute sent)
Marie Cann-Livingstone	- Teenage Pregnancy Specialist

Tim Guyler (as substitute) - Nottingham University Hospital Trust

18 DECLARATIONS OF INTERESTS

None.

19 SEXUAL HEALTH AND TEENAGE PREGNANCY

Helene Denness, Consultant in Public Health, introduced the topic of Sexual Health (including RSE and Teenage Pregnancy) to the Board. She summarised the complex commissioning model meaning that local authorities, CCGs and NHS England are each responsible for different services within sexual and reproductive health landscape. She went on to introduce Uzmah Bhatti, Public Health Insight Manager who presented a number of slides around sexually transmitted infections, highlighting the following points:

(a) Some STI rates in Nottingham were higher than comparators. Whilst acknowledging the gravity of this, it was highlighted that Nottingham had significantly high testing rates and positivity rates. There is a suggestion that higher testing leads to higher detection rates and the fact that Nottingham had high positivity rates meant that the right people were being tested and testing resources were being used efficiently;

(b) there has been an increase in rates of Gonorrhoea, with a small but steady increase in diagnoses in older age groups. This trend in the diversification of age groups is also seen across other STIs;

(c) there has not been a significant reduction in the instances of genital warts since 2016, further work is underway to understand this and inform any action.

Catherine Kirk, SRE Consultant presented slides to the committee focusing on Relation and Sex Education highlighting the following information:

(d) RSE Day was celebrated in late June this year in Nottingham with an aim to increase family and community engagement;

(e) there have been a number of concerns and challenges in recent months and Nottingham City Council recognises the concerns raised by some families and is leading discussion and supporting schools to enable all young people to access age appropriate RSE;

(f) The RSE Charter is currently being refreshed and updated guidance issued in light of new legislation being issued recently;

(g) Nottingham City Council recognises that it is important to work with parents around their concerns and share best practise with schools to encourage an open and frank dialogue between parents, schools and the wider community;

Helene Denness went on to present information around teenage pregnancy.

(a) To date the work to reduce teenage pregnancy rates has been effective and the rate of teenage pregnancy has been reduced by almost 65% in Nottingham since the baseline year of 1998.

(b) However, teenage pregnancy rates in Nottingham are still higher than the national average, higher than our statistical neighbours and there are still wards within Nottingham where the rate is significantly higher than the Nottingham average.

(c) Since 2012 there has not been a statistically significant reduction in the Nottingham teenage pregnancy rate.

(d) Nationally and locally, 80% of teenage conceptions are to 16 and 17 year olds with the remaining 20% to under-16 year olds.

Ruth Taylor, NHS Consultant in Sexual Health gave the Board an overview of some cases seen in the City Centre Clinic on a daily basis and the day-to-day work her colleagues performed. She emphasises the range of ages of patients as well as the range of issues they presented with.

Following questions and comments the following information was highlighted:

(h) Although there is no specific mention of work with BAME communities, a Health Equity Audit with a specific focus on access by BME service users is being conducted. The results of this audit will be shared with Board members when they are available.

(i) Demographics of patients accessing clinics are recorded but rely on self-identification of patients and not all patients wish to declare their ethnicity, therefore, there are a high number of incomplete records in terms of ethnicity.

(j) There are a number of services available where there are multi-language clinicians, most notably at the Mary Potter Centre. If committee members are aware of links that can be made into BAME and emerging communities they are asked to make officers aware so that further connections into the community can be made;

(k) There were a number of well publicised protests around RSE in schools recently. Head Teachers, the Leader of the Council, and the Deputy Leader of the Council met with religious and non-religious groups, to discuss concerns. Parents had access to the teaching materials and the community was reassured. In addition to this Councillors have signed up to the RSE charter;

(l) Commissioning pathways need to be improved to ensure that services are not duplicated and that no one falls into gaps between services. Once the PCN's and the ICP is in place, it is envisaged that better collaboration will be facilitated and will lead to more efficient commissioning of sexual health services;

(m) A targeted focus on digital education should be considered for 12-25yr olds as an effective way of further progressing access to information and education around sexual health;

RESOLVED to:

(1) Conduct a sexual health commissioning review to ascertain if and where there are any gaps

(2) Aim to protect the sexual health budget from further cuts.

(3) To consider guidance in the House of Commons Health and Social Care Committee report on Sexual Health and identity long term opportunities around integrating commissioning of services

(4) Support the RSE agenda mandatory roll-out and continue to work together to overcome challenges and resistance by addressing local people's concerns

(5) Support recommendations from the Teenage Pregnancy JSNA upon completion later this year.

20 NOTTINGHAM CITY'S MENTAL HEALTH AND WELLBEING STRATEGY 2019-2023

Helene Denness, Consultant in Public Health, introduced the report on Nottingham City's Mental Health and Wellbeing Strategy for 2019-2023 to the Board. She advised the Board that the strategy had been refreshed and builds on the work done by the previous strategy. Following brief discussion and questions, the following points were raised:

(a) There are many strategies being refreshed and rewritten at the current time and it is important that they give consistent messages to staff and to patients. This particular strategy links into and aligns with the ICS and Mental Health Strategy;

(b) The message of the Strategy is easy and simple early access, aims to reduce stigma and correct and timely support in crisis;

(c) Concerns were raised that the funding for the Time to Change programme ends at the end of August 2019, those champions currently in place are working hard to continue to offer the programme after this time but there will be no dedicated support for the programme and that there is a significant risk that the programme will not be able to run as it currently stands;

(d) There are no measurable targets within the report, no way of presenting the progress from the old strategy or project the success of the new strategy. The Board felt that this could be added to the Strategy to make it more measurable throughout its life to ensure efficiency;

(e) There is emphasis on an element of delivery by the voluntary and community sector within the strategy, and the issue of funding and support was raise. The organisations are all run independently and there is no one overarching organisation that coordinates them;

RESOLVED to:

(1) Endorse Nottingham City's Mental Health Strategy 2019 – 2023

(2) Agree to commence the process of signing up to the prevention concordat for better mental health through the Mental Health and Wellbeing Steering Group, which will coproduce an action plan.

21 DEVELOPMENT OF THE JOINT HEALTH AND WELLBEING STRATEGY

Uzmah Bhatti, Public Health Insight Manager informed the Board that work on the new Health and Wellbeing Board Strategy would be starting very soon. She asked for feedback from members on the current strategy.

The main point made by members was that it would be important to learn from the current strategy and thoroughly evaluate it. It was suggested that a refresh should focus more on how the HWB Board responds holistically to a multitude of asks across other plans through collective responsibility for services

RESOLVED for all members to feedback on the current strategy, and reflections on what to do for the next strategy via email to kate.morris2@nottinghamcity.gov.uk

22 CLINICAL SERVICES STRATEGY

Duncan Hanslow, Programme Director, Integrated Care System introduced the report summarising the work of the Clinical and Community Services Strategy which gives a framework for the future model of clinical and community health and wellbeing services across Nottingham and Nottinghamshire. This review will drive the work to develop services in terms of what will be delivered and where. The main points of the appended presentation highlighted were:

(a) The Clinical service strategy aims for the integration of care systems, looking at the whole provision, ensuring that scale and sizing is correct for the community it serves. This allows the services to be sustainable of services in a challenging funding landscape;

(b) The strategy will form a place based model of care, define standardisation and autonomy across different levels of care, enable and embed personalised care, prevention and early intervention and ensure that the ICS is responsive to changes that may emerge in the future;

(c) There are 6 main principles to the clinical model
- Care provided close to home will be effective and appropriate whilst promoting equality of access

- Prevention and Early intervention will work to maximise the health of the population making “every contact count”
- Mental health and wellbeing will be considered alongside physical health and wellbeing
- High levels of engagement and collaboration both within the ICS and with neighbouring ICS’s
- Models of care will be based on evidence and best practice, ensure pathways are aligned and will avoid unnecessary duplication
- Designed in partnership with local people and operate across the complete health care system delivering consistent outcomes for patients.

(d) A number of service reviews are taking place the ones currently prioritised are:

- Cardio Vascular Disease – Stroke
- Respiratory – COPD and asthma
- Frailty
- Children and young people
- Colorectal services
- Maternity and Neonates;

Member of the Board asked a number of questions and the raised a variety of issues. The following was highlighted:

(e) Within the published report, and the presentation there is no reference to the voluntary sector, however assurances were given that discussions were ongoing with a number of different organisations, relating to the service reviews and the strategy as a whole;

(f) The point around communication with the voluntary and community sector was made, that as there is no overarching organisation to disseminate information to the different groups, careful consideration must be given to communicating with individual groups;

RESOLVED to note the strategy and provide feedback on the strategy and its likely impact

23 PROPOSED MERGER OF NOTTINGHAM CITY AND NOTTINGHAMSHIRE CCG

Dr Hugh Porter, Clinical Chair NHS Nottingham City CCG , gave a verbal update to the Board on the proposed merger of Nottingham City and Nottinghamshire Clinical Commissioning Groups.

He highlighted the following points:

(a) Historically there has been close working across the 6 CCG’s within Nottingham and Nottinghamshire. In the last 12 months, plans have been developed to merge them into one coherent Clinical Commissioning Group.

(b) This large group would be responsible for strategic commissioning rather than the pathway commissioning;

(c) Public consultation has taken place and 68% of responders were in favour of the merger. 60% of partner organisations who responded were also in favour of the merger;

(d) There are a number of financial efficiencies to be made as a result of the merger;

Following questions and comments from the Board further information was highlighted:

(e) Concerns were raised about the size of the proposed new group and a loss of local/city based focus. This would be mitigated against by the creation of a City ICP who would be responsible for the pathway commissioning for the City;

(f) The next step will be to apply to NHS England for approval of the merger. Time scales suggest the merger would occur in April 2020 if the application to NHS England was successful;

(g) Concerns were raised about the recent history of restructure, and the potential for further workforce drain and impact on frontline staff. It was acknowledged that the recent restructures and the potential merger has been difficult on staff, however work to align staff prior to the merger is already underway to mitigate further change later in the process;

RESOLVED to note the update on the proposed Merger of Nottingham City and Nottinghamshire CCG's

24 BOARD MEMBER UPDATES

a THIRD SECTOR

Jules Sebelin advised the Board that a review of provider networks was taking place to ensure that the right communications were reaching the relevant organisations.

b HEALTHWATCH NOTTINGHAM AND NOTTINGHAMSHIRE

Sarah Collis informed the Board that upcoming key priorities are mental health for young people. This will include the development of a Healthwatch Board for Young People.

There is ongoing recruitment to ensure that the Healthwatch Board is representative of the community. Applications are particularly welcome from BAME and emerging community applicants.

c NHS GREATER NOTTINGHAM CLINICAL COMMISSIONING PARTNERSHIP

None

d NOTTINGHAM CITY COUNCIL CORPORATE DIRECTOR FOR CHILDREN AND ADULTS AND DIRECTOR OF ADULT SOCIAL SERVICES

Alison Michalska advised the Board that following a recent inspection 97.5% of schools within the Nottingham Schools Trust are rated as good.

She also informed the Board that following the announcement of her retirement at the end of 2019 her replacement as Corporate Director for People will be Catherine Underwood. A full and thorough hand over period is already underway.

e NOTTINGHAM CITY COUNCIL DIRECTOR FOR PUBLIC HEALTH

None

25 MINUTES

The minutes of the meeting held on 29 May 2019 were confirmed as a correct record and they were signed by the Chair.

26 FORWARD PLAN

There was discussion around the themed topics coming over the next 6 month with some amendments and updates made to the Plan.

RESOLVED to note the forward plan.

27 ACTION LOG

The Chair remained partners of the importance of feedback on actions taken between meetings.

28 MINUTES OF THE HEALTH AND WELLBEING BOARD COMMISSIONING SUB COMMITTEE HELD ON 29 MAY 2019 (DRAFT)

RESOLVED to note the minutes of the Health and Wellbeing Board Commissioning Sub Committee held on 29 May 2019

29 NEW JOINT STRATEGIC NEEDS ASSESSMENT CHAPTERS - AIR QUALITY AND SMOKING & TOBACCO CONTROL

RESOLVED to note the new Joint Strategic Need Assessment Chapters on Air Quality and Smoking & Tobacco Control

30 QUESTIONS FROM THE PUBLIC

None.

HEALTH AND WELLBEING BOARD

25 SEPTEMBER 2019

	Report for Information
Title:	Winter preparedness – Seasonal Flu Vaccination Planning for Nottingham City
Lead Board Member(s):	Alison Challenger, Director of Public Health
Author and contact details for further information:	Shade Agboola, Public Health Consultant Shade.agboola@nottinghamcity.gov.uk
Brief summary:	The report provides information on performance of the flu vaccination programme during the last flu season and a summary of initiatives designed to improve uptake for the forthcoming flu season.

Recommendation to the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to explore and identify ways to improve uptake amongst all eligible cohorts by considering the discussion points included in the report. Specifically, the board is asked to consider:

1. What member organizations can do to actively promote the flu vaccination programme amongst established eligible cohorts
2. How the HWBB/ICP can support the flu vaccination programme delivered in schools
3. How the HWBB/ICP can ensure that underserved groups are targeted appropriately (people who are homeless or sleep rough, people who misuse substances, asylum seekers Gypsy, traveller and Roma people, people with learning disabilities, young people leaving long-term care).

Contribution to Joint Health and Wellbeing Strategy:	
Health and Wellbeing Strategy aims and outcomes	**Summary of contribution to the Strategy**
Aim: To increase healthy life expectancy in Nottingham and make us one of the healthiest big cities	Flu vaccination directly impacts on the health and wellbeing of all children and adults in Nottingham City, especially individuals in the eligible cohorts.
Aim: To reduce inequalities in health by targeting the neighbourhoods with the lowest levels of healthy life expectancy	
Outcome 1: Children and adults in Nottingham adopt and maintain healthy lifestyles	
Outcome 2: Children and adults in Nottingham will have positive mental wellbeing and those with long-term mental health problems will have good physical health	
Outcome 3: There will be a healthy culture in Nottingham in which citizens are supported and empowered to live healthy lives and manage ill health well	

Outcome 4: Nottingham's environment will be sustainable – supporting and enabling its citizens to have good health and wellbeing	

How mental health and wellbeing is being championed in line with the Board's aspiration to give equal value to mental and physical health
N/A

Background papers: *Documents which disclose important facts or matters on which the decision has been based and have been relied on to a material extent in preparing the decision. This does not include any published works e.g. previous Board reports or any exempt documents.*	None

Winter Preparedness - Seasonal Flu vaccination planning

Introduction

There are a large number of avoidable deaths each winter in England primarily due to heart and lung conditions from cold temperatures. The reasons more people die in winter are complex and interlinked with inadequate heating and poorly insulated housing and health inequalities as well as circulating infectious diseases, particularly flu and norovirus, and the extent of snow and ice.

The multiple impacts of cold weather on health, result in excess winter deaths (e.g. 567 extra deaths in Nottingham in the winter months 2012- 2015 compared with the expected average number of non-winter deaths).

This paper describes local plans to ensure that flu vaccination remains a core part of winter preparedness in Nottingham City. The paper will present an overview of commissioning and delivery arrangements and plans to ensure that performance exceeds last year's uptake. HWBB is being asked to note these plans and put forward recommendations to further increase uptake.

Seasonal Influenza (Flu)

Seasonal Flu is a common infectious viral illness spread by droplets from coughs and sneezes. Whilst it can be very unpleasant, most individuals begin to feel better within about a week. Conversely older people, those with long-term conditions such as heart and lung disease, pregnant women and young children can develop more serious symptoms requiring hospitalisation and can, in some instances, lead to death.

Groups eligible for flu vaccination are based on the advice of the Joint Committee on Vaccination and Immunisation (JCVI). The national flu immunisation programme aims to provide direct protection to those who are at higher risk of flu associated morbidity and mortality. The objective of the National Flu Programme is to minimise the health impact of flu through effective monitoring, prevention and treatment, including actively offering Flu vaccination to 100% of all those in eligible groups.

Frontline health and social care workers should be provided with flu vaccination by their employer. This should form part of the organisations' policy for the prevention of transmission of infection (flu) to help protect patients, residents, and service users.

A Flu Plan is developed each year which sets out a coordinated and evidence-based approach to planning for, and responding to, the demands of flu across England.

In 2019/20 the following are eligible for flu vaccination:

- All children aged two to ten (but not eleven years or older) on 31 August 2019
- Those aged six months to under 65 years in clinical risk groups
- Pregnant women
- Those aged 65 years and over
- Those in long-stay residential care homes
- Carers
- Close contacts of immunocompromised individuals

NHS England and NHS Improvement is responsible for commissioning all of the national immunisation programmes. Details of the national commissioning arrangements for immunisation programmes are described in NHS public health functions agreement 2016-17[1] and NHS public health functions agreement 2017-18[2].

Table 1: Delivery of the flu vaccination programme

Service Provider	Cohort
GP Practices	• Healthy Children aged 2, and 3 years • Those in an 'at risk' category (long term condition) aged 6 months -65 years • Over 65's • Pregnant women
School Aged Providers	• Children in school reception, years 1 to 6 (4-10 years of age)
Pharmacies	• Over 18's in an 'at risk' category (long term condition) • Over 65's

[1] Available at https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/02/core-serv-spec-00.pdf

[2] Available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/694130/nhs-public-functions-agreement-2018-2019.pdf

National Winter Plans

Nationally, NHS England & NHS Improvement communications team coordinates an overarching winter campaign with Public Health England.

The first phase is the Flu vaccination campaign *(Help us Help You Stay Well this Winter)* which runs throughout the month of October with aims to:

- Promote flu vaccination uptake amongst pregnant women, children aged 2-3 years, (targeting their parents), and those with long term health conditions, particularly respiratory diseases (e.g. COPD or bronchitis)
- Improve awareness of the nasal spray among parents of children aged 2-3 years
- Continue to promote reasons to get the flu vaccine amongst pregnant women

The Flu phase of this winter campaign will consist of TV, radio and online messages, Google search, social marketing, BAME targeting and accessibility activity for disabled groups.

Flu Performance in 2018/19

Nottingham City saw a decrease in flu vaccination uptake in most cohorts, although this decrease was also observed nationally. Through joint working, NHS England and Nottingham City Council, in conjunction with other stakeholders such as the CCG, worked together to ensure that all citizens eligible for flu vaccination received their offer of vaccination. It is hoped that the planned initiatives outlined below will increase uptake in 2019/20 to keep the circulation of influenza at a minimum, which in turn will reduce the pressure on our NHS services through the busy winter season. Ongoing support of the annual flu vaccination programme, by all stakeholders, is vital to ensure its success.

Flu Planning 2019/20

NHS England & NHS Improvement(NHSE/I) - Midlands are responsible for commissioning the flu vaccination programme locally and have a flu action plan which encourages all providers to increase flu vaccination uptake through various strategies (including funding midwives at NUH, funding reminder letters for 2&3 year olds and funding vaccination of all special school pupils). In line with NHSE/I PHE's winter plans, Public Health continue to work closely with NHSE/I.

Planned initiatives to improve uptake for the forthcoming flu season

- Ongoing work with AstraZeneca, the sole manufacturer of the nasal flu vaccine, designed to increase uptake in children[3]. This work includes dedicated engagement with the lowest performing practices via AstraZeneca's telephone support team, distribution of bespoke materials to schools and GP practices and joint working with the CCG.
- A "fluathon" is currently being planned for the autumn which will encourage all practices to open on a chosen weekend and invite parents with eligible children to drop in to receive the flu vaccine. This is being led by CCG and its aim is to vaccinate as many 2-3 year olds as possible in one day.
- Reminder letters will be sent to parents of 2 & 3 year olds. A reminder letter was sent out to all parents of two and three year olds in Nottingham City during the 2018/19 flu season. This reminder had a positive effect and NHSE intend to repeat this for the next flu season.
- Flu vaccine to be offered to all pregnant women who attend maternity clinics
- Flu vaccine to be offered to 'at risk' patients. NHS England & NHSI - Midlands commissioned Nottingham University Hospitals to offer flu vaccinations via their liver and kidney out-patients clinics. Flu vaccination will continue to be offered to patients attending for renal dialysis. Vaccination will be delivered by renal nurses who have received specific training in Flu vaccination.
- Training packages for health care professionals in the run up to flu season
- Maintenance of close working relationships with all stakeholders
- Monthly multi-stakeholder flu meetings
- Development of tailored comms messages to other groups and using existing channels – Care Homes, Home Care, Employee health and wellbeing and schools
- For the first time in 2019/20 patients contacting the NHS111 service will hear a 30 second long Seasonal Flu message encouraging eligible patients to schedule their flu vaccination. This National Initiative will mean that in excess of 1 million people per week contacting the 19 commissioned NHS111 services will this year hear a health promoting message. The message states: "Having your flu vaccination can help protect you against flu and help prevent the spread of flu to others. If you are pregnant, a carer, aged 65 and over or if you

[3] Small children are 'super spreaders' of flu, becoming very ill themselves and passing it on to their families and the wider community. The nasal flu vaccination is the best way of stopping the virus in its tracks.

have one of the following health conditions: a chronic respiratory disease, diabetes, heart, kidney or liver disease, immunosuppression or a chronic neurological disease, please contact your GP Practice or local pharmacy to ask about the free flu vaccination. All children aged two on or before 31 August 2019 and all three-year olds can get the vaccine free from their GP practice. Stay Well This Winter."

- Flu performance presented at Health Scrutiny July 2019
- Flu messages displayed on all Council display screens and staff comms on the intranet
- Staff survey developed and shared with staff to understand the barriers to uptake
- Reminder letters to be sent out to parents of eligible children in November
- Flu vaccination to be offered to all renal and liver outpatients

Ambitions for 2019/20 flu season

Eligible Group	**Ambition (2018/19 uptake)**
Aged 65 years and over	75% (72.4%)
Aged under 65 'at risk', including pregnant women	At least 55%. Ultimately the aim is to achieve at least a 75% uptake in these groups given their increased risk of morbidity and mortality from flu. (47.5%).
Preschool children aged 2 and 3 years	At least 50% with most practices aiming to achieve higher (44.5% in 2 year olds and 42.2% in 3 year olds)
Primary school aged children.	An average of at least 65% to be attained by every provider across all primary school years. (49.7% to year 5)

Summary

Strong joint working is vital to ensure that the uptake ambitions for the forthcoming flu season are achieved.

Discussion Points

1. What can HWBB member organizations do to actively promote the flu vaccination programme amongst established eligible cohorts?
2. How can the HWBB/ICP support the flu vaccination programme delivered in schools?

3. How can the HWBB/ICP ensure that underserved groups[4] are targeted appropriately? (people who are homeless or sleep rough, people who misuse substances, asylum seekers Gypsy, Traveller and Roma people, people with learning disabilities, young people leaving long-term care).

Report author
Shade Agboola
Consultant in Public health

[4] Adults and children from any background are 'underserved' if their social circumstances, language, culture or lifestyle (or those of their parents or carers) make it difficult to: recognise they are eligible for flu vaccination (for example, they have an undiagnosed clinical condition) access health service attend healthcare appointments.

Nottinghamshire POLICE & CRIME COMMISSIONER

NHS Newark and Sherwood Clinical Commissioning Group

NHS Mansfield and Ashfield Clinical Commissioning Group

NHS Greater Nottingham Clinical Commissioning Partnership

VRU Violence Reduction Unit Nottingham City and Nottinghamshire

Health and Wellbeing Board

25th September 2019

Natalie Baker Swift,
VRU Programme Manager

NHS Nottingham University Hospitals NHS Trust

Nottinghamshire County Council

Nottingham City Council

NOTTINGHAMSHIRE POLICE

Public Health England

FOREST

What is the purpose of the VRU?

- **VRU core function** is to offer **leadership** and, working with all relevant agencies operating locally, **strategic coordination** of the **local response** to serious violence.
- VRU activity enabled by the funding **must support a multi-agency, 'public health' approach to preventing and tackling serious violence.**
- **Mandatory products:**
  - Joint Needs Assessment
  - Violence Reduction Strategy
  - Response Plan
- **Other**
  - Community and Stakeholder Engagement Plan
  - £880,000 – March 2020

Home Office

Violence Reduction Units
Application Guidance

- ✓ **Received 20th June 2019**
- ✓ **First meeting 21st June 2019**
- ✓ **Bid Submitted 04 July 2019**
- ✓ **Funding Agreement Received 30 August 2019**

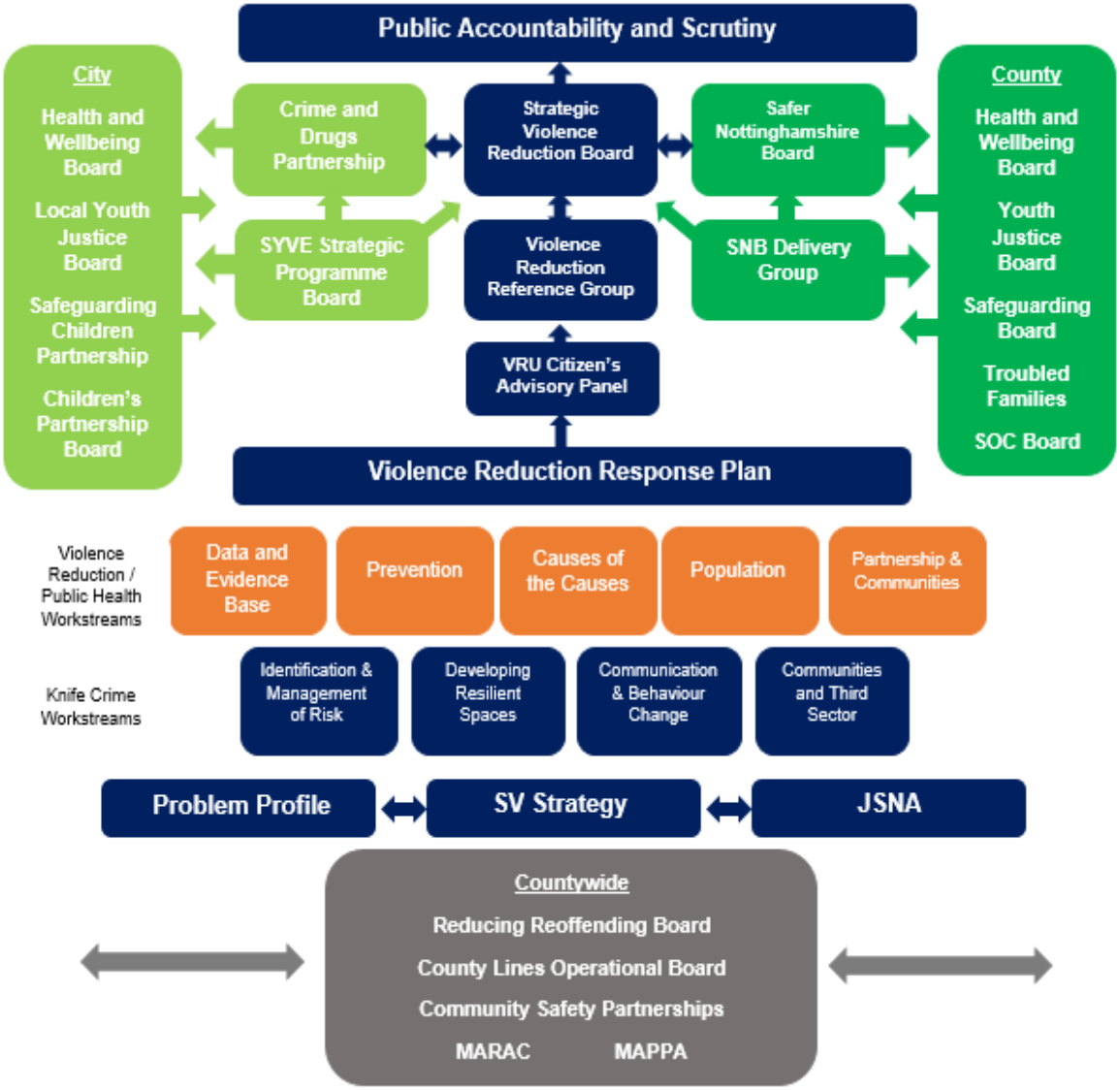
Governance

Dependent on existing multi-agency arrangements

Strategic Violence Reduction Board

Violence Reduction Stakeholder Reference Group

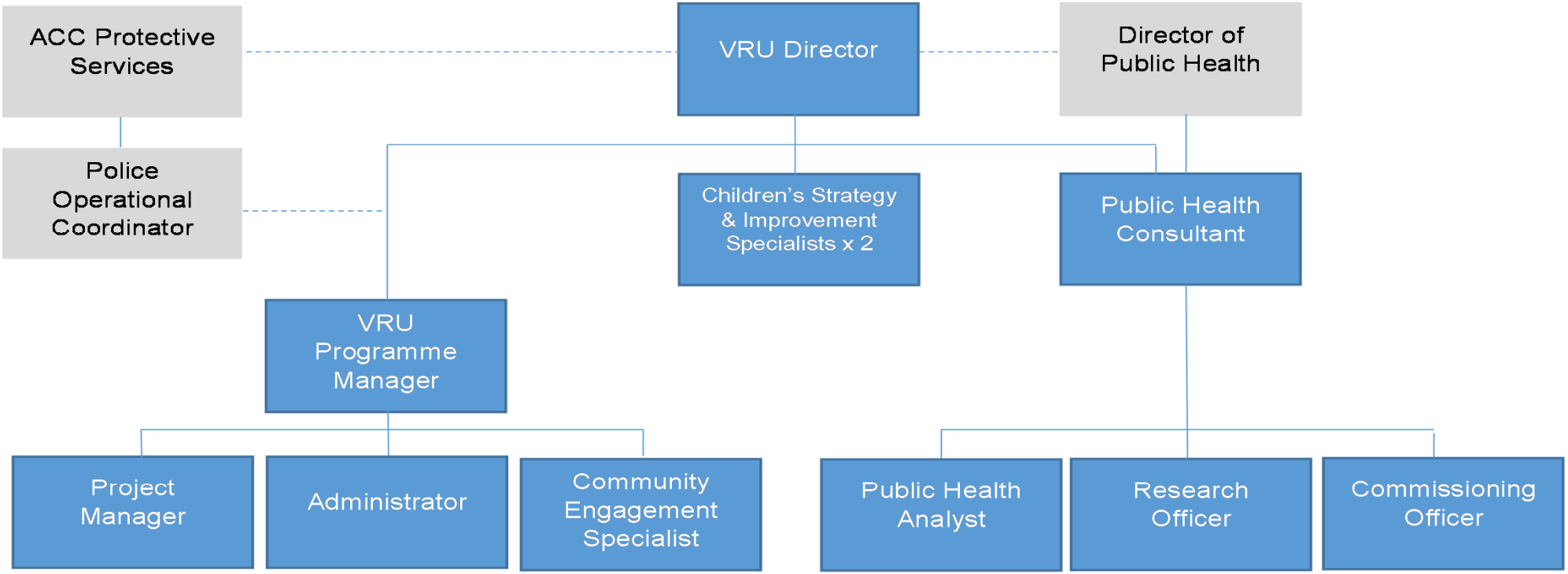
Citizens Advisory Panel



Strategic VR Board Membership

- Paddy Tipping, Police and Crime Commissioner (Chair)
- Adam Brooks, Major Trauma Surgeon Nottingham University Hospitals (Vice Chair)
- Craig Guildford, Chief Constable, Nottinghamshire Police
- Jonathan Gribbin, Director of Public Health, County Council
- Alison Challenger, Director of Public Health, City Council
- Colin Pettigrew, Corporate Director, Children's, Families and Cultural Services, County Council
- Alison Michalska, Corporate Director of Children and Families, City Council
- Amanda Sullivan, Accountable Officer, Nottinghamshire CCG
- Dr Fu-Meng Khaw, Centre Director, Public Health England East Midlands
- Chief Executive, Nottingham College
- Chief Executive, Vision West Notts College
- Chief Executive, East Midlands Ambulance Service
- Governor – HMP Nottingham

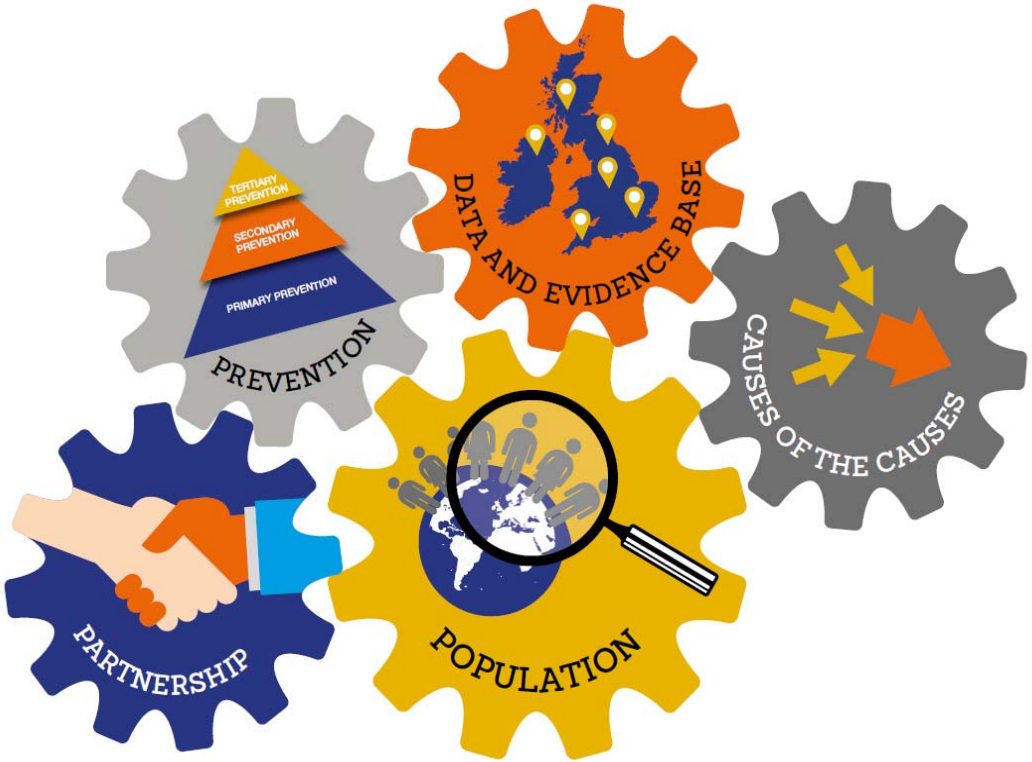
Violence Reduction Unit: Core Team



A Public Health Lens

- Affects personal health, family health and population health.
- Applying science to understand ‘Why’.
- Focus on social, behavioural and environmental factors.
- Stop the transmission of violence.
- Focus on those who are high risk.
- Reduce community susceptibility to violence and increase resistance.
- Mental health, drug use, depression and anxiety.
- Change community ‘norms’ – a counter narrative to violence.

Violence Reduction Strategy: Public Health Workstreams



Charles Ransford
University of Illinois at Chicago, USA

Gary Slutkin
University of Illinois at Chicago, USA

Rebalancing Act

A resource for Directors of Public Health, Police and Crime Commissioners, the police service and other health and justice commissioners, service providers and users.

Home Office | Public Health England

Thank you.

Any Questions/Feedback?

Natalie Baker Swift, VRU Programme Manager

natalie.baker-swift@nottinghamshire.pnn.police.uk

Integrated Care System
Nottingham & Nottinghamshire

healthwatch
Nottingham & Nottinghamshire

Long Term Plan Engagement Integrated Insights Report

Executive Summary Report

Nottingham and Nottinghamshire Integrated Care System

August 2019

1 Background

1.1 On 7 January 2019 the new Long Term Plan for the NHS was published. This plan sets out the ambitions of the NHS in England for the next ten years and received widespread support upon its publication.

1.2 Following the publication of the plan, each local area has been asked to develop their own local plan setting out how they will implement the national strategy. In Nottingham and Nottinghamshire this is being led by the Integrated Care System (ICS) in partnership with the local Clinical Commissioning Groups (CCGs), the hospital and provider Trusts and Local Authorities.

1.3 The NHS Long Term Plan was developed with a high level of engagement with clinical experts and other stakeholders, patients and the public.

1.4 To support the implementation of the Long Term Plan, each local area was asked to undertake engagement with their populations to understand what matters to local people in their health services and to inform the development of a local system plan.

1.5 Healthwatch England, the organisation that supports local Healthwatch organisations, worked closely with the NHS to coordinate a programme of national engagement. In Nottingham and Nottinghamshire we have worked in partnership with Healthwatch Nottingham and Nottinghamshire (HWNN) to undertake an extensive programme of engagement with local people. This engagement has explored some of the key themes in the NHS Long Term Plan and sought to understand what matters to people in their health and health services. This report details the findings of that engagement and sets out how we will ensure that they inform our local system plan.

1.6 We have spoken to over 1,000 people across Nottingham and Nottinghamshire in our engagement about topics such as mental health, urgent care, health prevention and more. These conversations with local people have given us a wealth of insight that will help us improve local services and deliver the national NHS Long Term Plan in a way that reflects what matters to people.

2 Our approach

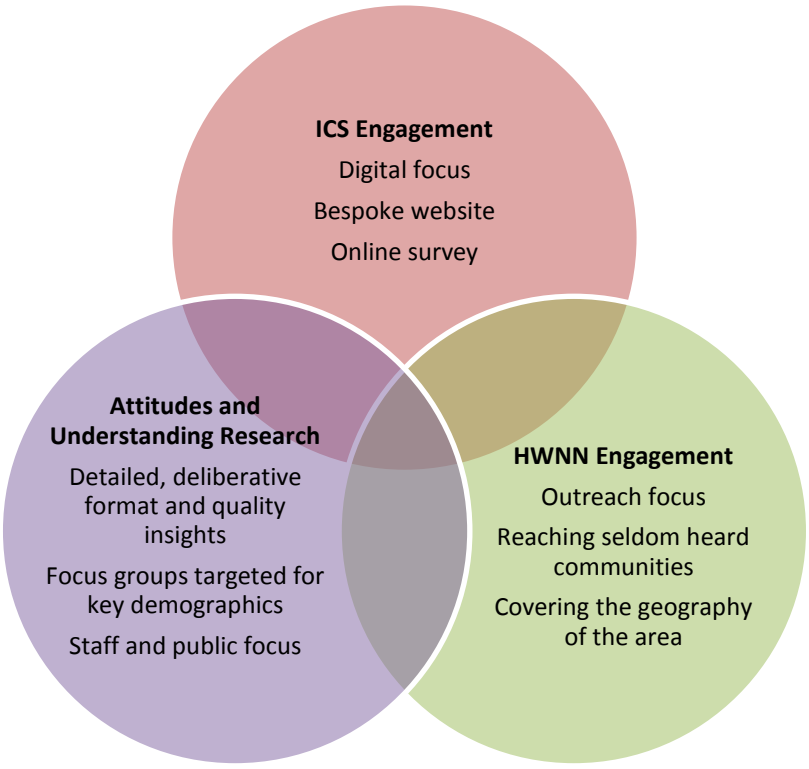
2.1 The Nottingham and Nottinghamshire ICS has worked in partnership with HWNN Nottinghamshire to deliver an extensive programme of public engagement on the NHS Long Term Plan.

2.2 Our approach includes:

a) Public engagement by the ICS communications and engagement team, through digital and face-to-face channels
b) Public engagement by HWNN through face-to-face channels
c) Understanding and Attitudes Research by social research agency Britain Thinks, delivered through a series of focus groups with staff and members of the public.

2.3 The elements above form the key parts of our engagement approach. While each element includes a different focus, the programme is underpinned by core themes and questions. This model is summarised below in figure 1.

Figure 1 – model for engagement



2.4 The core theme underpinning each element of our engagement was exploring what matters to local people, in the context of the NHS Long Term Plan ambitions. Each element focused engagement around the priorities within the NHS Long Term Plan.

2.5 Within all of our engagement we have discussed the priorities within the NHS Long Term Plan in three ways:

a) Understanding how important each priority is to people;
b) Understanding what matters most to people within each priority
c) Discussing the priorities in terms of hypothetical 'trade-offs' e.g. investment in prevention versus investment in treatment, to generate debate.

2.6 We also asked people 'What do you think is the best thing about the NHS?' to understand people's priorities without prompting or context.

2.7 We talked to a wide range of partners and stakeholders to gain input into our engagement approach. This included conversations with our engagement partner HWNN; our ICS Board members; neighbouring systems; local voluntary and community sector (VCS) partners; NHS Confederation; local MPs and Local Authorities.

2.8 Table 1 below summarises the delivery of engagement across all elements.

Table 1 – summary of engagement by approach

Focus of engagement	Engagement activity/outputs	Value added
ICS Team Engagement		
Engagement through digital channels Campaign focus	Bespoke website with 3,200 visitors over the engagement period Online survey with 405 responses Outreach engagement at 7 community events Social media reach of >70,000	High number of responses to survey across digital channels High level of engagement with campaign through digital channels Numbers reached by Long Term Plan conversation far in excess of engagement respondents
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Outreach engagement targeting seldom heard communities	Outreach engagement with 610 survey responses 40 community events attended	Reach into communities across Nottingham and Nottinghamshire Trusted engagement partner enabling the ICS to reach into communities Expertise in engagement design

Focus of engagement	Engagement activity/outputs	Value added
Attitudes and understanding Research		
In-depth research targeting professionals, heavy service users and light service users	27 tele-depth interviews with GPs; nurses; consultants; junior doctors; allied health professionals; public health professionals; social care staff 10 at-home interviews with heavy service users with complex long-term conditions 4 focus groups with light service users	In depth conversations with staff and the public enabling detailed insights to be generated Adding context and depth to the survey findings
Summary		
1015 Survey responses 47 Community events 58 in-depth interviews/focus groups participants 3,200 website visitors Social media reach of >70,000		

3 Summary of findings

3.1 There were clear and common themes that emerged from all these sources of input. The key insights drawn collectively are summarised below.

3.2 Public views about priorities and pressures within the system are strongly influenced by the national media narrative on the NHS or on personal experience of services

3.2.1 Alongside a significant amount of pride in the local NHS, there is a perception that services are under pressure. This explains the widespread public support identified for urgent and emergency care and mental health. Even those with no experience of these services rank them as important or very important.

3.2.2 The public also see their experience of one service as indicative of the whole NHS, so experiences of long waits for GP services or urgent and emergency care are interpreted as indicators of pressure across the whole system.

3.3 People mostly value having a free at the point of need healthcare model, frontline staff and the accessibility of services within the NHS

3.3.1 Both the ICS and HWNN elements of the engagement opened with the question 'What do you think is the best thing about the NHS?' This has provided useful insight into public

perceptions about the NHS, which have been reinforced in the Understanding and Attitudes Research.

3.3.2 Overwhelmingly, people value the free at the point of need model as the best thing about the NHS.

3.3.3 Where the workforce are cited as the best thing about the NHS, this is usually focused on front-line staff with compassion, dedication and helpfulness the qualities that people value.

3.3.4 Many people also cite the accessibility of services as the best thing about the NHS, in particular equity of access and fairness e.g. 'it's for everyone'.

3.3.5 It should be noted that the free at the point of need model does not, of course, apply to much of social care and therefore care needs to be taken when emphasising this strength of feeling when talking about integrated care.

3.4 There is widespread support for urgent and emergency care and mental health, which are among the system's top priorities

3.4.1 The public are highly supportive of prioritising urgent and emergency care and mental health. There is a perception among both staff and the public that more focus is needed on mental health.

3.5 While there is public support for a focus on finance and efficiency, this is not as significant as support for other areas

3.5.1 While many people rated finance and efficiency as important or very important, support for other system priorities was significantly higher. Support for focusing on finance and efficiency also needs to be considered alongside public and staff concerns about system pressures and perceptions of diminishing resources and cutbacks.

3.5.2 This can be seen in wider national research including this from the King's Fun (https://www.kingsfund.org.uk/blog/2019/05/public-and-nhs-funding) where 83% of survey respondents felt that there was a major or severe funding problem in the NHS. The majority (58%) said they would be willing to accept an increase in taxes to fund the NHS and 75% opposed means testing.

3.6 People are broadly supportive of a focus on preventative activity, with some reservations

3.6.1 There is widespread support for focusing on prevention of ill health among both staff and the public. Among the public however, there are some reservations. People still view

Treatment for health problems as a priority and would be concerned if resources were viewed to be being taken away from this area. People also highlight the limits of preventative interventions, citing that not all health problems are preventative and that people cannot always be encouraged to change their behaviour.

3.7 There are mixed and ambiguous views about personalisation, choice and control

3.7.1 In being asked to consider personalisation, choice and control in health people felt that these things were highly dependent on context. This is reinforced by previous engagement carried out by HWNN on shared decision making. Both engagement on the Long Term Plan, and previous work by HWNN highlights that people do not always understand these terms – particularly those who are not 'health literate'.

3.8 There is only lukewarm support for digital innovation in healthcare and a lack of understanding of the value of digital technology to improve access

3.8.1 Of all the areas of healthcare covered within the engagement there was the least understanding of, and support for, digital innovation to improve access. While there is a correlation between respondents age and their level of support for digital innovation in healthcare, with those over working age less likely to be supportive, it remains the least supported and least understood of all areas covered among all groups.

3.9 The public are mostly uninterested in hearing about system change

3.9.1 The public have little appetite for hearing about system change and transformation, unless it directly affects how they access care. They perceive the biggest challenges to the NHS to be difficulty accessing services, a loss of high performing services and hit-and-miss quality of care. For access to services people are mostly referring to A&E and their GP.

3.10 Staff are concerned about diminishing resources and increasing demand

3.10.1 Staff see an increasing demand for healthcare alongside diminishing resources. They highlight short-term thinking and pressure on staff as the net effects of this. Staff are interested in seeing investment in more effective and efficient ways of working.

3.10.2 Where staff are particularly interested in knowing more about system change they will be very proactive in seeking out information. For those with limited interest in these matters, they want to hear about what it means for them directly in their job and expect to hear it from their line manager or professional association.

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Long Term Plan Engagement
Integrated Insights Report

Nottingham and Nottinghamshire Integrated Care System

August 2019

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Section 2 – Our approach

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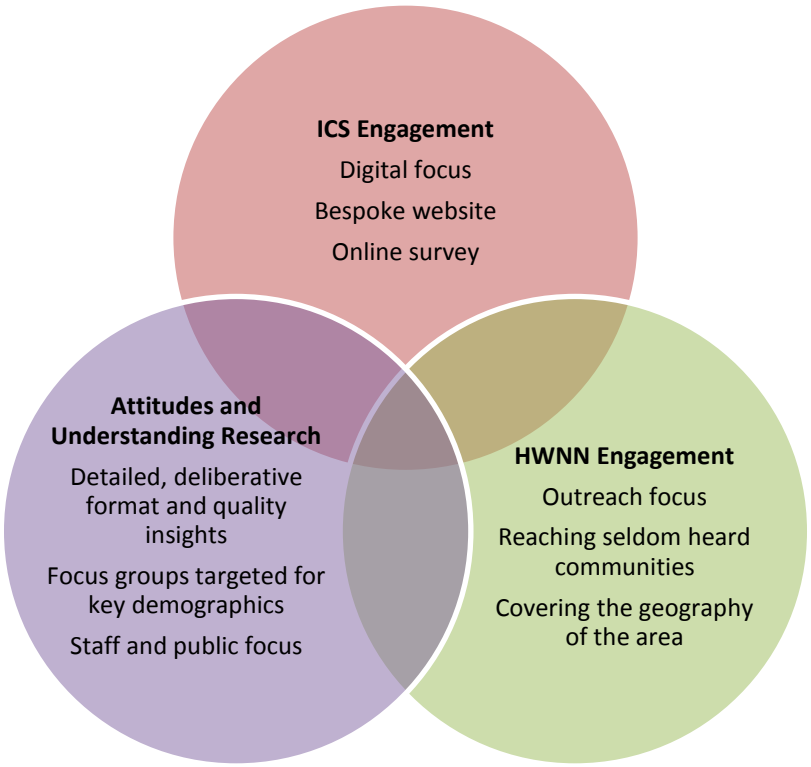

2.4 The core theme underpinning each element of our engagement was exploring what matters to local people, in the context of the NHS Long Term Plan

ambitions. Each element focused engagement around the priorities within the NHS Long Term Plan.

2.5 Central to our approach are a number of 'trade-off' questions. These questions are designed to generate debate and challenge assumptions around some of the core elements of the Long Term Plan – for example digital innovation or personalisation. Our trade-off questions ask people to consider how important a potential priority area is, when considered in direct competition with a competing priority. For example, people are asked to rank the importance of preventing ill health versus the importance of treating ill health. These trade-offs are hypothetical and intended to generate debate.

2.6 Within all of our engagement we have discussed the priorities within the NHS Long Term Plan in three ways:

a) Understanding how important each priority is to people;
b) Understanding what matters most to people within each priority
c) Discussing the priorities in terms of hypothetical 'trade-offs' e.g. investment in prevention versus investment in treatment, to generate debate.

2.7 We also asked people 'What do you think is the best thing about the NHS?' to understand people's priorities without prompting or context.

2.8 The following areas were discussed as priorities within the NHS Long term Plan:

- Urgent and emergency care
- Mental health
- Finances and efficiency
- Prevention
- Digital innovation
- Personalisation
- Children and young people's health
- Supporting our workforce
- Major health conditions.

2.9 We talked to a wide range of partners and stakeholders to gain input into our engagement approach. This included conversations with our engagement partner HWNN; our ICS Board members; neighbouring systems; local voluntary and community sector (VCS) partners; NHS Confederation; local MPs and Local Authorities.

ICS Team engagement

2.10 The ICS Team engagement focused on engagement through digital channels.

2.11 A bespoke website was developed to support the engagement with a campaign run over three months, focusing on local activity linked to the priorities within the Long Term Plan. The campaign drove traffic to the website, which contained news articles and case studies of local interest.

2.12 The survey developed to generate feedback was housed within the website. It was developed in partnership with HWNN, who focused on outreach activity to promote the survey and generate responses.

2.13 The ICS Team also attended local community events to promote the survey and gather feedback. Detail of those events can be seen in the appendix.

HWNN engagement

2.14 HWNN engagement focused on engagement through face-to-face channels and aimed to reach as broadly across the ICS area as possible. This included targeted engagement with:

- Carers
- Parents of young children
- People with long-term conditions
- Homeless people
- People experiencing mental health issues.

2.15 HWNN particularly focused on reaching communities that are seldom heard and people experiencing health problems or likely to experience poor health outcomes. Over 25% of respondents to the HWNN engagement identified themselves as carers and over half identified as having a disability.

2.16 Additional focus group discussions were held by HWNN targeting older people and people who are LGBT. Detail of all of these face-to-face events can be seen in the Appendix 2.

Understanding and Attitudes Research

2.17 The ICS commissioned social research agency Britain Thinks to undertake research on attitudes towards and understanding of the priorities within the NHS Long Term Plan, with a focus on what matters to local people.

2.18 The Understanding and Attitudes Research was structured around the same priority areas and key trade-off questions as the ICS and HWNN engagement. It included three key target groups:

a) Health and care professionals
b) Heavy service users
c) Light service users

2.19 A mix of telephone interviews, face-to-face interviews and focus group were deployed across the research. These methods aimed to generate in-depth, meaningful insight and add more context and understanding to the survey results.

2.20 The findings of the engagement will inform the development of our local system plan. We have a broad programme of local stakeholder engagement planned to share the findings of our engagement; discuss how to reflect those findings in our local system plan; and share our local system plan as it develops, gaining input along the way.

2.21 Table 1 below summarises the delivery of engagement across all elements.

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Section 3 – Summary of findings

3.1 There were clear and common themes that emerged from all these sources of input. The key insights drawn collectively are summarised below.

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Section 4 – Detailed findings

What matters to people in Nottingham and Nottinghamshire?

4.1 Within the survey used in the HWNN and ICS engagement, the first question that was asked was 'What do you think is the best thing about the NHS. Responses against this question are shown below in table 2.

Table 2 – 'What do you think is the best thing about the NHS?'

Theme	% of responses	No. of responses*
Free at the point of need	46%	468
Staff/workforce	18%	182
Accessibility	16%	159
High quality services	9%	96
Variety of services	4%	44

**combined data across HWNN and ICS engagement*

4.2 Of the 807 people who responded to the question the majority (47%) cited free at the point of need healthcare as the best thing about the NHS. Staff and workforce (18%) and accessibility (16%) were the next most common responses.

4.3 HWNN note that a general theme within the responses to this question was that people felt secure knowing that the NHS was in place and that they were reassured they would receive a good standard of care from staff. A high level of trust in healthcare professionals was identified across all engagement approaches, with HWNN and Britain Thinks stating that many people trust professionals to make decisions about their care and treatment.

4.4 Britain Thinks identified a high level of pride in the local and national NHS in the Understanding and Attitudes Research, particularly in comparison to the health systems in other countries.

"My neighbour collapsed on a bank holiday – they said you'll wait a while, and then the ambulance was there within 3 minutes. You can't do better than that."

4.5 Within responses highlighting accessibility as the best thing about the NHS, it is often the principles of fairness and equity of provision that are highlighted as most important. Within the Understanding and Attitudes Research, light service users tended to prioritise reducing waiting times for A&E and their GP as the most important things to address.

Top local priorities for health and care

4.6 The survey used within the HWNN and ICS engagement explained that three areas were being considered as priorities for health and care locally:

- Mental health - Improving mental health services and treating mental ill health as important as physical health
- Urgent and emergency care - Making sure that emergency services such as A&E are quick and easy to access
- Finances - Making sure taxpayers' money is used as efficiently as possible and that we stick to our budgets.

Our Understanding and Attitudes Research also used these areas to prompt discussions about people's priorities for health and care.

4.7 Responses to this question within the survey are shown below in table 3.

Table 3 – 'Please tell us how important each of the following are to you'

Theme	% of responses rating as very important	% of responses rating as important	% of responses rating as important or very important	No. of responses rating as important or very important*
Urgent and emergency care	79%	19%	98%	806
Mental health	70%	24%	94%	772
Finance and efficiency	50%	33%	84%	688

**combined data across HWNN and ICS engagement*

4.8 Most people who responded to this question felt that urgent and emergency care (98%) and mental health (94%) were either important or very important. Our Understanding and Attitudes Research highlights that the national media narrative is highly influential in people's views of local health services. It is therefore expected that areas receiving significant media attention are thought to be important.

"I do know that A&E is at crisis point. It's all over social media, people put up their experiences, on the news there are people being left in hallways. People who have died at home because ambulances aren't able to get to them."

4.9 People who have had personal experience of mental health services highlighted confusing referrals, long waiting times and a particular struggle for young peoples' services and support for carers.

4.10 Finance and efficiency was seen as important or very important by 84% of respondents to the question. While this demonstrates public support for this area as a priority it should be noted that other priorities (see below) were more widely supported. It should also be noted that both staff and the public perceive that the system is under pressure and that resources are diminishing – so a focus on further reducing budgets or making further efficiencies will be seen as unwelcome and unpopular.

4.11 It is worth noting the gap between these three areas in the proportion of people who rated them as *very important*. While urgent and emergency care and mental health were rated as very important by 79% and 70% of respondents respectively, finance and efficiency was rated as very important by 50%. This highlights that finance and efficiency is seen as less of a priority than other areas.

Other priorities for health and care

4.12 The survey then explained that the local health and care system had a further set of other priorities for focus over the next five years and asked people how important they thought these areas are:

- Preventing ill health - More action on the things that create poor health such as smoking, alcohol and unhealthy eating
- Children and young people's health - More action on services for children and young people including mental health services, maternity services and treating illnesses
- Major health conditions - Better care for the major health conditions in our society such as cancer, diabetes and stroke - for example faster diagnosis and better treatment
- Supporting our workforce - Making sure we have the right number of doctors, nurses and social care workers in the right places and that they have the right skills to provide what people need
- Digital innovation in healthcare - Using things like Skype for appointments to help you get better access to your GP.

Again, these were used as prompts in our Understanding and Attitudes Research for discussions around priorities.

4.13 Responses to this question within the survey are shown below in table 4.

Table 4 – 'Please tell us how important each of the following are to you'

Theme	% of responses rating as very important	% of responses rating as important	% of responses rating as important or very important	No. of responses rating as important or very important*
Supporting our workforce	79%	20%	99%	805
Major health conditions	72%	28%	99%	783
Children and young people's health	64%	34%	98%	753
Preventing ill health	48%	48%	95%	702
Digital innovation in healthcare	31%	43%	55%	444

**combined data across HWNN and ICS engagement*

4.14 All the listed priority areas were overwhelmingly seen as important or very important, with the exception of digital innovation in healthcare (55%). Digital innovation was also the least supported area within the trade-off questions. Considering the areas ranked as *very important* by people, workforce (79%) and major health conditions (72%) have much more public support than the other areas. Less than half of respondents thought that preventing ill health or digital innovation are very important.

4.15 Beyond using Skype for appointments the public struggle to see other areas where digital technology can improve access. There is also some suspicion in investing in what is seen to be new as there is a perception that existing services are under-resourced. People are also concerned about those that are not comfortable using digital technology and the risk of system failures, or perceptions that existing or previous digital services have not performed well.

4.16 There is a correlation between the age of respondents and their level of support for digital innovation in healthcare. Of respondents of working age, 59% rated digital innovation as important or very important. For non-working age respondents this fell to 46%.

> *"Some people haven't got internet. The people who use services the most – the elderly, young children. So investing in [Skype appointments] might not work"*

4.17 Among the public, the prioritisation of support for the workforce is interpreted to mean either more front-line staff or staff being able to spend more time with patients.

"Nursing staff and GPs are worth their weight in gold"

4.18 Children and young people's services and treatment for major health conditions were seen as strengths of the local area's health services, with the exception of mental health.

4.19 Preventing ill health was viewed positively by both staff and the public, although comments within the survey used by HWNN and the ICS and discussions within the Understanding and Attitudes Research indicate some reservations about focusing on prevention at the detriment of treatment. The limits of public health campaigns, in particular, are seen as caveats in prioritising prevention.

"Everybody already knows all that. Everybody knows how to live a healthy life, it's whether you choose to or not, it's up to the individual. Yes they should still advertise walking and quitting smoking and all that. But nobody wants it shoved in their face 24/7."

Choices about health and care investment

4.20 The survey used by HWNN and the ICS asked people which they felt was more important for the local health and care system to deal with, out of a series of two opposing choices. People were asked which was more important to focus on between:

Preventing people becoming ill - Keeping people fit and well so they are less likely to become ill	**OR**	***Treating people when they become ill*** - Making sure that people who become ill have the best possible treatment
Choice and control - Letting people manage their own health and wellbeing and choice of treatment	**OR**	***The best possible care and treatment without having to choose*** - Doctors and other health professionals deciding what is best for people and making sure it is provided
Investing in digital technology for healthcare - Using things like Skype for appointments to help people get better access to their GP	**OR**	***Investing in buildings and equipment for healthcare*** - Investing in the buildings and equipment used at locations where people go to for urgent healthcare

These hypothetical trade-offs were also used to stimulate debate in our Understanding and Attitudes Research.

4.21 HWNN and the ICS collected the data for this question in different ways. Within the HWNN survey, these questions were formatted as multiple-choice with respondents able to choose either of the trade-off choices or a neutral answer. Within the ICS survey, respondents were able to use a manual sliding scale of 0-100 to indicate *how much more important* they felt one choice was than another.

4.22 Tables 5 – 7 below show the responses for the ICS and HWNN surveys separately. Within the ICS survey results, the number and proportion of respondents showing a ***strong*** preference for one choice within a trade-off question are shown within the table. A 'strong' preference is one where the response is at least 75% towards one choice. The HWNN results show the proportion of people selecting one option or another. The number of responses shown against each option within the Healthwatch results is therefore higher than the ICS results, which only includes response at each end of a sliding scale.

Table 5 – Preventing people becoming ill or treating people when they become ill

	HWNN data		**ICS data**	
Which is more important to you?	**% of responses selecting this option**	**No. of responses**	**% of responses stating a *strong* preference**	**No. of responses**
Preventing people becoming ill	40%	243	27%	108
Treating people when they become ill	39%	237	26%	104

4.23 Presenting a choice between prevention and treatment generated a similar numbers of strong responses for each option.

Table 6 – Choice and control or the best possible care and treatment without having to choose

	HWNN data		ICS data	
Which is more important to you?	**% of responses selecting this option**	**No. of responses**	**% of responses stating a *strong* preference**	**No. of responses**
Choice and control	30%	182	21%	87
The best possible care without having to choose	40%	246	25%	101

4.24 There were slightly more strong responses for the best possible care without having to choose compared to strong responses for choice and control in healthcare.

4.25 The Understanding and Attitudes Research highlighted some important nuances in perceptions of choice and control. Both light and heavy service users are satisfied with their current level of choice and control. However, people who are working and have families express a desire for more choice in terms of flexibility of appointments. Social care staff are more likely than NHS staff to view choice and control positively, and highlight the benefits it can bring for older people and those with long-term conditions.

4.26 A previous HWNN project engaged with people who do not traditionally engage with shared decision making and discussions around choice and control. It found that these participants were in favour of shared decision making in health as long as a number of conditions were met, including having the confidence and time to ask questions about choices; having trust in healthcare professionals; understanding the language being used; having the mental capacity to make a choice, understanding the benefits and risks and being listened to.

Table 7 – Investing in digital technology for healthcare or investing in buildings and equipment for healthcare

	HWNN data		ICS data	
Which is more important to you?	**% of responses selecting this option**	**No. of responses**	**% of responses stating a *strong* preference**	**No. of responses**
Investing in digital technology	10%	63	12%	47

Investing in buildings and equipment	61%	371	32%	128

4.27 There is limited public and staff support for investing in digital innovation versus other areas. This gap is starker when people are asked to choose between investment in digital innovation and investment in buildings and equipment. As highlighted, people struggle to identify areas where digital technology could improve access.

Section 5 – Key lessons learned and next steps

5.1 The key lessons learned through our engagement on the Long Term Plan are:

- People value a free at the point of need model for healthcare as the best thing about the NHS and plans should reassure people that this will be protected for the future
- The public are supportive of prioritising mental health services and urgent and emergency care.
- People feel that we should prioritise supporting our workforce and view front-line staff as one of the best things about the NHS.
- People are concerned about pressure on services and would like to see improvements in waiting times for access.
- People recognise finance and efficiency as important, but also view services as under pressure and under-funded. It will be important to reassure people that decisions on investment and disinvestment are robust and underpinned by long-term thinking.
- The public are supportive of action to prevent ill health, but see this as less as a priority than other areas and need reassurance that treating ill health will not be deprioritised
- Digital innovation to improve services was the least supported of all potential priority areas discussed and there is work to do to take the public with us if we wish to accelerate the use of digital technology in health services.
- Support for choice and control is dependent on context and this area merits further engagement.

5.2 A wide programme of engagement with key bodies, forums and organisations across the local health and care system is planned. This work will help us in feeding the findings of our Long Term Plan engagement into our local system plan.

5.3 We recognise that further engagement will be required within specific areas of our local plan and this will be carried out within our Integrated Care Providers, who will be tasked with implementing the plan.

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Appendix 1 – What Matters to You Survey

What matters to you in health and care?

Make sure your voice is heard

In January the NHS launched its Long Term Plan, which sets out its ambition to make sure everyone has the best start in life, receives world class care for major health problems and gets the support they need to age well.

To help us deliver the aims of the Long Term Plan locally, we'd like your views to help shape our local plan.

Whether it's your opinion on the plan's priorities, or how you and your family get health advice, support and services – please join the conversation. You're at the heart of everything we do, so we want to make sure your voice is heard.

You can give us your feedback through this short survey.

Completing the survey

For each question please tick clearly inside the box that is closest to your views using a black or blue pen. Don't worry if you make a mistake; simply cross out the mistake and put a tick in the correct box. Please do not write your name or address anywhere on the survey. All information will be kept strictly confidential and in accordance with the Data Protection Act 1998 and associated protocols.

This survey is available to complete here or by visiting our website:

https://nottswhatmatterstoyou.co.uk/

Please return this form either by email to julie.andrews12@nhs.net

or by post to:

Freepost RTGE-CRAT-BABH

NHS Mansfield & Ashfield CCG

Birch House

Mansfield

NG21 0HJ

Please call 0115 804 3925 if you require:

- Any further information
- Support to complete this survey
- Copies of the information and survey in different languages and formats

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Q1. What do you think is the best thing about the NHS?

Our top priorities for health and care in Nottingham and Nottinghamshire

We believe that the biggest challenges for health and care in Nottingham and Nottinghamshire over the next 5 years are **mental health**; **urgent and emergency care** and **finance and efficiency**.

We want to know if you agree or disagree that these should be our top priorities.

Q2. Please tell us how important each of the following are to you

	Not important at all	Not very important	Neither unimportant or important	Important	Very important
Mental health - Improving mental health services and treating mental ill health as important as physical health	☐	☐	☐	☐	☐
Urgent and emergency care - Making sure that emergency services such as A&E are quick and easy to access	☐	☐	☐	☐	☐
Finance and efficiency - Making sure taxpayers' money is used as efficiently as possible and that we stick to our budgets	☐	☐	☐	☐	☐
Please tell us more about any areas you feel strongly about					

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Our priorities for health and care in Nottingham and Nottinghamshire

The following is a list of other areas we may want to prioritise over the next 5 years.

Q3. Please tell us how important each of the following are to you

	Not important at all	Not very important	Neither unimportant or important	Important	Very important
Preventing ill health - More action on the things that create poor health such as smoking, alcohol and unhealthy eating	☐	☐	☐	☐	☐
Children and young people's health - More action on services for children and young people including mental health services, maternity services and treating illnesses	☐	☐	☐	☐	☐
Major health conditions - Better care for the major health conditions in our society such as cancer, diabetes and stroke - for example faster diagnosis and better treatment	☐	☐	☐	☐	☐
Supporting our workforce - Making sure we have the right number of doctors, nurses and social care workers in the right places and that they have the right skills to provide what people need	☐	☐	☐	☐	☐
Digital innovation in healthcare - Using things like Skype for appointments to help you get better access to your GP	☐	☐	☐	☐	☐
Please tell us more about any areas you feel strongly about					

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Choices about health and care in Nottingham and Nottinghamshire

We want to know what matters to you in health and care. Please tell us which of the following things is more important to you.

Q4. Which is more important for the NHS and social care to deal with?

Preventing people becoming ill - Keeping people fit and well so they are less likely to become ill	**Don't know**	**Treating people when they become ill** - Making sure that people who become ill have the best possible treatment
☐	☐	☐
Please tell us why you feel this way		

Q5. Which is more important for the NHS and social care to deal with?

Choice and control - Letting people manage their own health and wellbeing and choice of treatment	**Don't know**	**The best possible care and treatment without having to choose** - Doctors and other health professionals deciding what is best for people and making sure it is provided
☐	☐	☐
Please tell us why you feel this way		

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Q6. Which is more important for the NHS and social care to deal with?

Investing in digital technology for healthcare - Using things like Skype for appointments to help people get better access to their GP	**Don't know**	**Investing in buildings and equipment for healthcare** - Investing in the buildings and equipment used at locations where people go to for urgent healthcare
☐	☐	☐
Please tell us why you feel this way		

Appendix 2 – Demographic breakdown of survey respondents

HWNN engagement

District	No.	Percent
Nottingham City	158	25.9%
Gedling	131	21.5%
Ashfield	83	13.6%
Newark and Sherwood	59	9.7%
Rushcliffe	58	9.5%
Broxtowe	39	6.4%
Mansfield	38	6.2%
Out of area	52	6.9%
Not answered	2	0.3%
Total	**610**	**100.0%**

Age Groups	No.	Percent
1 - 15	4	0.7%
16-17	11	1.8%
18-24	24	3.9%
25-34	52	8.5%
35-44	63	10.3%
45-54	95	15.6%
55-64	100	16.4%
65-74	92	15.1%
75-85	56	9.2%
85+	11	1.8%
Not answered	102	16.7%
Total	**610**	**100.0%**

Gender	No.	Percent
Female	410	67.2%
Male	181	29.7%
Non-binary	1	0.2%
Not answered	13	2.1%
Prefer not to say	5	0.8%
Total	**610**	**100.0%**

Sexuality	No.	Percent
Heterosexual	438	71.8%
Prefer not to say	68	11.1%
Not answered	32	5.2%
Bisexual	27	4.4%
Homosexual	25	4.1%
Asexual	20	3.3%
Total	**610**	**100.0%**

Ethnicity	No.	Percent
White	542	88.9%
Not answered	19	3.1%
Prefer not to say	14	2.3%
Mixed/Multiple ethnic	12	2.0%
Black	11	1.8%
Asian	7	1.1%
Other	4	0.7%
South Asian	1	0.2%
Total	**610**	**100.0%**

Religion	No.	Percent
Christian	305	50.0%
None	193	31.6%
Prefer not to say	34	5.6%
Other	30	4.9%
Not answered	28	4.6%
Buddhist	8	1.3%
Sikh	4	0.7%
Hindu	3	0.5%
Jewish	3	0.5%
Muslim	2	0.3%
Total	**610**	**100.0%**

Carers	No.	Percent
No	426	69.8%
Not answered	28	4.6%
Yes	156	25.6%
Total	**610**	**100.0%**

Illness/impairment	No.	Percent
Mental health illness	123	24.4%
Physical impairment	122	24.2%
Hearing impairment	94	18.7%
Visual impairment	58	11.5%
Other	36	7.1%
Prefer not to say	31	6.2%
Learning impairment	21	4.2%
Social/behavioural problems	19	3.8%
Total	**504**	**100.0%**

ICS engagement

What is your gender?	No.	%
Female	232	70.1%
Male	95	28.7%
Non binary	1	0.3%
Prefer not to say	3	0.9%
Total	331	

Is your gender identity the same gender you were assigned at birth?	No.	%
Yes	322	97.9%
No	2	0.6%
Prefer not to say	5	1.5%
Total	329	

Is your gender identity the same gender you were assigned at birth?	No.	%
Yes	322	97.9%
No	2	0.6%
Prefer not to say	5	1.5%
Total	329	

What is your ethnicity?	No.	%
Any other Black background	1	0.3%
Any other ethnic group (please specify)	9	2.7%
Any other mixed background	3	0.9%
Any other White background	4	1.2%
Asian or Asian British - Indian	6	1.8%
Asian or Asian British - Pakistani	4	1.2%
Black or Black British - African	1	0.3%
Black or Black British - Caribbean	1	0.3%
Gypsy or Traveller	1	0.3%
Irish	5	1.5%
Mixed - White and Asian	2	0.6%
Mixed - White and Black Caribbean	1	0.3%
White British	292	88.5%
Total	330	

What is your age?	No.	%
Under 18	3	0.9%
18-24	9	2.7%
25-34	44	13.4%
35-44	62	18.8%
45-54	86	26.1%
55-64	67	20.4%
65+	58	17.6%
Total	329	

Do you consider yourself to have a disability?	No.	%
No	254	76.5%
Prefer not to say	13	3.9%
Yes	41	12.3%
Total	332	

What is your sexual orientation?	No.	%
Bisexual	8	2.4%
Gay	12	3.6%
Heterosexual	287	87.2%
Prefer not to say	22	6.7%
Total	329	

What is your religion?	No.	%
Buddhist	6	1.8%
Christian (all denominations)	133	40.7%
Hindu	2	0.6%
Muslim	5	1.5%
None	160	48.9%
Other	18	5.5%
Sikh	3	0.9%
Total	327	

What is your marital status?	No.	%
Civil partnership	11	3.3%
Divorced	22	6.6%
Married	189	56.9%
Prefer not to say	18	5.4%
Separated	8	2.4%
Single	73	22.0%
Widowed	11	3.3%
Total	332	

Women and pregnancy - are you pregnant?	No.	%
No	285	96.0%
Yes	3	1.0%
Prefer not to say	9	3.0%
Total	297	

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Appendix 3 – Engagement Log

Date	Activity	Audience	Notes/documents
15/1/19 and ongoing	Email, face-to-face and phone exchanges with South Yorkshire ICS Comms Director to get builds and inputs. (AB and LE)	Sister ICS with adjoining geography (Bassetlaw)	Aligned approach and agreed to co-create generic questions and ensure that timings are dovetailed.
1/2/19 to 7/2/19	Email exchange with NCVS lead to get builds and input. (AB)	Nottingham City Community and Voluntary sector.	No major amends, endorsed approach.
5/2/19	Met with and shared plan with local NHS Confederation representative to get builds and input. (AB)	NHS Confederation regional rep.	No major amends, endorsed approach
15/2/19	Shared overall plan with ICS Board to alignment and agreement on approach to engagement. (AB)	ICS Board members (CEs, Chairs, Councillors).	
26/2/19	Shared summary of LTP and new GP contract and overall engagement plan with ICS Partnership Forum for alignment and specific builds on approach.	Partnership Forum members (see ToR)	
4/3/19	Nottinghamshire County Council – Adult Social Care and Public Health Committee	County Councillors with interest in ASC and Public Health	
26/3/19	Met with Prof Jonathan Tallant to discuss how to enhance levels	Professor of Philosophy,	

Date	Activity	Audience	Notes/documents
	of Trust amongst respondents to the survey to maximise engagement and response rates. Suggested amendments incorporated into survey. (AB)	Nottingham University	
29/3/19	Briefings issued to staff, stakeholders, Councillors and MPs. (AB, LE, JG, TS and others)	Staff, system partners, Councillors, MPs	
1/4/19	ICS Team engagement at 4 Seasons Shopping Centre, Mansfield	Public	
1/4 to 2/4/19	Diabetes Awareness Week activities in QMC; Oak Tree Tesco, Mansfield; Asda, Newark; Idlewells Shopping Centre, Sutton-in-Ashfield, Asda Hyson Green)	Public	https://twitter.com/MandAccg/status/1113087472974659585  Dawn Jameson, Diabetes Manager 1.jp
2/4/2019	Experian initial meeting with Amy Priest, Wellbeing Lead (KH)	Experian staff	Initial meeting to commence building ICS / CCG / Experian information channels and staff engagement opportunities around the Long Term Plan activity.
2/4/19	ICS Team Engagement with CCG Patient and Public Engagement Committee	Public	
3/4/19	ICS Team engagement at diabetes truck, Mansfield	Public	
4/4/19	ICS Team engagement as part of diabetes awareness week, Newark	Public	
4/4/19	ICS Team engagement as part of diabetes awareness week, Sutton-in-Ashfield	Public	

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Date	Activity	Audience	Notes/documents
9/04/2019	Connected with Community Gardens managers and volunteers (St Ann's allotments, Clifton Summerwood Lane Gardens and Bulwell Forest Gardens) across City to find out their additional events throughout the summer.	Volunteers and managers but to understand the visitor and footfall across the gardens to see who we can connect with.	
10/4/19	HWNN with LGBT group in Nottingham City	Public	
11/4/19	ICS Team engagement at Tesco Health Event, Ollerton	Public	
12/4/19	HWNN engagement with Citycare Patient Engagement Group	Public	
12/4/19	Coverage of Estates Strategy item from Board (11/4) includes reference to LTP Engagement and has URL	Public	https://www.nottinghampost.com/news/nottingham-news/bold-five-year-plan-upgrade-2752189 and https://westbridgfordwire.com/plans-to-improve-nottinghams-nhs-buildings/
12/4/19	HWNN engagement at Arnold Mental Health Drop-In	Public	
16/4/19	Coverage of City Council rejoining the ICS includes reference to LTP Engagement and has URL	Public	https://westbridgfordwire.com/city-council-rejoins-nottingham-and-notts-health-and-social-care-system/
16/4/19	HWNN engagement in Nottingham City	Public	
16/4/19	HWNN public engagement at 4 Seasons Shopping Centre, Mansfield	Public	

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Nottingham & Nottinghamshire

Date	Activity	Audience	Notes/documents
17/4/19	HWNN engagement with Broxtowe diabetes group	Public	
23/4/19	First Patient Impact Group meeting for the Integrated Urgent Care project.	Internal – Mid Notts and Greater Notts	Brief notes taken and agreed to hold future meetings and engagement until Governing Body ratify the latest paper. Added to engagement log here as cross-ICS work and might impact on LTP when finalised.
23/4/19	HWNN engagement with Gedling diabetes group	Public	
24/4/19	First Strategy Workshop with ICS Board, pre-circ includes initial insights from Engagement (AB)	Board Members	
26/4/19	HWNN Focus Group with Growing Bolder, older person's group in Mansfield	Public	
27/4/19	HWNN engagement with Fibromyalgia group	Public	
29/04/19	Summary of social media activity and engagements over first month of the project	Public	
1/5/19	ICS team public engagement in Ollerton	Public	
3/5/19	HWNN engagement at Bullwell Carers Group	Public	
4/5/19	HWNN public engagement in Gedling	Public	
7/5/19	HWNN Focus Group with LGBT Switchboard volunteers	Public	
7/5/19	Trent Barton engagement activity.	Trent Barton staff	https://www.facebook.com/photo.php?fbid=678305389272262&set=pcb.678305425938925&type=3&theater

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Nottingham & Nottinghamshire

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Nottingham & Nottinghamshire

Date	Activity	Audience	Notes/documents
8/5/19	ICS Team engagement at Ageing Well event, Sherwood	Public	
8/5/19	HWNN drop-in community event in Gedling	Public	
8/5/19	HWNN public engagement in Newark	Public	
9/5/19	HWNN engagement at Gedling Homes community event	Public	
9/5/19	Presented summary of engagement activities so far and initial insights from data gathered.	ICS Board Members	Details and papers here at item 9: http://www.stpnotts.org.uk/media/1737342/icsboardagendapapers20190509.pdf
9/5/19	HWNN engagement at Burton Joyce library	Public	
10/5/19	HWNN focus group with weight management group in Ashfield	Public	
10/5/09	Mention of MP engagement meeting in Alex Norris MP email newsletter	Nottingham North residents	Newsletter attached – see page 4
10/5/19	HWNN engagement with Arnold mental health group	Public	
10/5/19	HWNN public engagement in Gedling	Public	
13/5/19	HWNN engagement in Nottingham City	Public	
13/5/19	HWNN engagement with Kings Mill Hospital Patient Involvement Group	Public	
13/5/19	HWNN engagement at Talk2Us event in Newark	Public	

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Date	Activity	Audience	Notes/documents
13/5/19	HWNN engagement in Rushcliffe	Public	
13/5/19	HWNN engagement in Rushcliffe	Public	
14/5/19	HWNN engagement at Nottingham City Carers Roadshow	Public	
14/5/19	HWNN engagement at Ollerton toddler group	Public	
14/05/19	Experian Mental Health awareness week and LTP engagement	Experian staff	
14/5/19	Briefing for MPs on ICS, Long Term Plan (and CCG Merger).	Members of Parliament: Norris, Greenwood, Leslie, Coaker. Plus via their staff: Jenrick and Spencer.	
14/5/19	HWNN engagement at Emmanuel House in Nottingham City	Public	
14/5/19	ICS Team engagement at Ashfield Active AGM	Public	
15/5/19	ICS Team engagement at Kings Mill hospital	Public	
15/05/19	Trent Barton Engagement	Trent Barton engagement	
16/5/19	HWNN engagement at Arnold play group	Public	
17/5/19	HWNN engagement at Clifton	Public	

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Date	Activity	Audience	Notes/documents
	Carers Roadshow		
17/5/19	Alex Norris MP – mention of engagement meeting in Westminster in constituent newsletter	MPs	
21/5/19	Discussion with Jane Laughton, CEO, HWNN re progress and plan to finalise analysis	Stakeholder	
22/5/19	Partnership Forum – presentation on approach so far and emerging insights. Discussion on how to further propagate survey and ensure wider completion of survey.	Stakeholders	
28/5/19	ICS Team engagement	Clifton	
28/5/19	ICS Team engagement	Bulwell	
30/5/19	City Council Leadership Group	Leader, Deputy Leader, 2x Portfolio Holders, Chief Exec	
5/6/19	County Health and Wellbeing Board	Councillors and wider stakeholders. Cllrs Glynn Gilfoyle, Joyce Bosnjak and colleague from PCC v interested. Esp on Rough Sleeping and MH. Agreed to set up informal	

Date	Activity	Audience	Notes/documents
		workshop in the summer.	
19/6/19	ICS Team engagement at learning disability event	Public	
24/6/19	ICS Team engagement at LGBT event	Public	
25/6/19	Councillors and NEDs Discussion – facilitated by Chris Ham.	Councillors and NEDs. 13x Councillors 5x NEDs	
28/6/19	ICS Team engagement at school event	Public	
3/7/19	Workshop with County H&WB members	15 Councillors (County and District) and other H&WB Members (inc VCS, Police).	
8/7/19	County Adult Social Care and Public Health Committee	11 Councillors	
16/7/19	City Councillor Eunice Campbell – conversation following re-entry of City Council to ICS	City HWBB Chair	
22/7/19	ICS Board Development Session	ICS Board Members	

HEALTH AND WELLBEING BOARD

25 SEPTEMBER 2019

	Report for Resolution
Title:	Health and Wellbeing Board Commissioning Sub Committee Terms of Reference
Lead Board Member(s):	-
Author and contact details for further information:	Jane Garrard, Senior Governance Officer jane.garrard@nottinghamcity.gov.uk 0115 8764315
Brief summary:	The Health and Wellbeing Board established the Health and Wellbeing Board Commissioning Sub Committee as a commissioner-only body, bringing together commissioners from Nottingham City Council and NHS Greater Nottingham Clinical Commissioning Partnership to take strategic funding decisions delegated to it by the Board. It is proposed to amend the Terms of Reference for the Sub Committee to add an additional voting member as detailed in the attached report.

Recommendation to the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to:

a) add the Nottingham City Council Portfolio Holder with a remit covering adult social care as a voting member of the Health and Wellbeing Board Commissioning Sub Committee and amend the Health and Wellbeing Board Commissioning Sub Committee Terms of Reference accordingly.

Contribution to Joint Health and Wellbeing Strategy:	
Health and Wellbeing Strategy aims and outcomes	**Summary of contribution to the Strategy**
Aim: To increase healthy life expectancy in Nottingham and make us one of the healthiest big cities	The report relates to the governance of the Health and Wellbeing Board and its Commissioning Sub Committee, which aims to ensure that it operates appropriately so that it can carry out its role and responsibilities in relation to the Joint Health and Wellbeing Strategy.
Aim: To reduce inequalities in health by targeting the neighbourhoods with the lowest levels of healthy life expectancy	
Outcome 1: Children and adults in Nottingham adopt and maintain healthy lifestyles	
Outcome 2: Children and adults in Nottingham will have positive mental wellbeing and those with long-term mental health problems will have good physical health	
Outcome 3: There will be a healthy culture in	

Nottingham in which citizens are supported and empowered to live healthy lives and manage ill health well	
Outcome 4: Nottingham's environment will be sustainable – supporting and enabling its citizens to have good health and wellbeing	

How mental health and wellbeing is being championed in line with the Board's aspiration to give equal value to mental and physical health
The report relates to the governance of the Health and Wellbeing Board and its Commissioning Sub Committee, which aims to ensure that it operates appropriately so that it can carry out its role and responsibilities, including fulfilling the aspiration to give equal value to mental and physical health.

Background papers: *Documents which disclose important facts or matters on which the decision has been based and have been relied on to a material extent in preparing the decision. This does not include any published works e.g. previous Board reports or any exempt documents.*	None

Amendment to the Terms of Reference for the Health and Wellbeing Board Commissioning Sub Committee

The Health and Wellbeing Board Commissioning Sub Committee is a sub-committee of the Health and Wellbeing Board. It is a commissioner-only body bringing together Nottingham City Council and Greater Nottingham Clinical Commissioning Partnership to ensure timely and appropriate consideration of joint commissioning plans and pooled budgets.

The Commissioning Sub Committee currently has four voting members (two from Nottingham City Council and two from Greater Nottingham Clinical Commissioning Partnership) as detailed below.

Voting Members	Organisation
Portfolio Holder with a remit covering health	Nottingham City Council
Director of Commissioning and Procurement (Joint Chair)	Nottingham City Council
Associate Director, Joint Commissioning and Planning (Joint Chair)	Greater Nottingham Clinical Commissioning Partnership
GP Lead	Greater Nottingham Clinical Commissioning Partnership

However, while there are four voting members, Nottingham City Council and Greater Nottingham Clinical Commissioning Partnership only have one vote each which is shared between their two respective voting members.

Nottingham City Council has recently split responsibility for health and adult social care between two different councillor-held portfolios. The Portfolio Holder with responsibility for health is currently a member of the Sub Committee, but the Portfolio Holder with responsibility for adult social care is not. The Sub Committee considers issues relating to both health and social care matters and therefore it is proposed that the Nottingham City Council Portfolio Holder with responsibility for adult social care is added as a voting member. While this would result in Nottingham City Council having three voting members compared to the Clinical Commissioning Partnership's two voting members, it is important to note that each organisation will still only have one vote each which is shared between its respective voting members. Therefore the proposed amendment would not affect the balance of votes between members.

Current members of the Health and Wellbeing Board Commissioning Sub Committee have been consulted on the proposed amendment and no members have indicated that they do not support the change.

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HEALTH AND WELLBEING BOARD

25 SEPTEMBER 2019

	Report for Information
Title:	Joint Strategic Needs Assessment Annual Report
Lead Board Member(s):	Alison Challenger, Director of Public Health
Author and contact details for further information:	Shade Agboola, Public Health Consultant Shade.agboola@nottinghamcity.gov.uk Claire Novak, Insight Specialist Public Health claire.novak@nottinghamcity.gov.uk
Brief summary:	The report provides information on the progress and development of Nottingham City's Joint Strategic Needs Assessment (JSNA) for 2019/20. The JSNA evidence contributes towards improving health and wellbeing and reducing inequalities for Nottingham's citizens.

Recommendation to the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to:

note and endorse the 2019/20 workplan and the progress and development of the Joint Strategic Needs Assessment.

Contribution to Joint Health and Wellbeing Strategy:	
Health and Wellbeing Strategy aims and outcomes	**Summary of contribution to the Strategy**
Aim: To increase healthy life expectancy in Nottingham and make us one of the healthiest big cities	The JSNA directly informs Health and Wellbeing Strategy formulation and commissioning. Its contribution cuts across the strategic aims and outcomes in the Health and Wellbeing Strategy.
Aim: To reduce inequalities in health by targeting the neighbourhoods with the lowest levels of healthy life expectancy	
Outcome 1: Children and adults in Nottingham adopt and maintain healthy lifestyles	
Outcome 2: Children and adults in Nottingham will have positive mental wellbeing and those with long-term mental health problems will have good physical health	
Outcome 3: There will be a healthy culture in Nottingham in which citizens are supported and empowered to live healthy lives and	

manage ill health well	
Outcome 4: Nottingham's environment will be sustainable – supporting and enabling its citizens to have good health and wellbeing	

How mental health and wellbeing is being championed in line with the Board's aspiration to give equal value to mental and physical health
JSNA authors consider mental health impact alongside physical health. In addition, several chapters focus specifically on mental health topics.

Background papers: *Documents which disclose important facts or matters on which the decision has been based and have been relied on to a material extent in preparing the decision. This does not include any published works e.g. previous Board reports or any exempt documents.*	

NOTE: Once you have completed this report front sheet, upload the main report as a separate document via the 'Add Document' button. If you have appendices you can either include them at the end of the report or upload as separate documents. When uploading the main report and any appendices remember to include the title. Guidance on completing this front sheet and writing the main report is available from the Constitutional Services Team.

JOINT STRATEGIC NEEDS ASSESSMENT ANNUAL REPORT

1.0 Background

1.1 Nottingham City's Joint Strategic Needs Assessment (JSNA) is an assessment of the current and future health and social care needs of its citizens. The JSNA should identify the needs of citizens as well as highlight inequalities and, in doing so inform priorities, targets and commissioning decisions.

1.2 The City's JSNA is produced in collaboration with public health, social care, the Nottingham City Clinical Commissioning Group and the Crime & Drugs Partnership. There are nearly 50 individual chapters covering clinical topics such as viral hepatitis, behavioural topics such as smoking, and chapters on the wider determinants of health such as air quality.

1.3 This report provides Nottingham City's Health and Wellbeing Board with an annual update on the JSNA; including key achievements and the 2019/20 work plan.

2.0 Key Achievements

2.1 Since the last update to the Health and Wellbeing Board in September 2018, the JSNA steering group has met regularly to provide overall guidance and oversee chapter development. This has again been a challenging year with widespread organisational change affecting chapter production, capacity for authorship and owning groups, and membership of the JSNA steering group. A review of the current JSNA approach is in progress, with the aim of continuing the current high quality product and statutory function in the context of significantly reduced capacity, alongside a changing geographical and strategic context.

2.2 **Nottingham & Nottinghamshire Integrated Care System (ICS)**
City and county public health colleagues have been meeting to align JSNAs with the emerging ICS functions and geography. Work in progress includes collaborating on the production of a suite of sample ICS JSNA products. For example on the Emotional and Mental Health of Children and Young People and other population health management products.

2.3 **Author guidance documents**
Various support documents for authors have been refreshed, including chapter templates and the agreement with Nottingham CVS and Healthwatch Nottingham & Nottinghamshire. This incorporates delivery of the Armed Forces Covenant, whereby Health and Wellbeing Boards were asked to consider the health and social care needs of veterans within JSNAs. The Parliamentary Under Secretary of State for Mental Health, Inequalities and Suicide Prevention wrote to the Chairs of Health and Wellbeing Boards in November 2018.

3.0 The 2019/20 Work Plan

3.1 **Chapter and Content Development**

The JSNA steering group met in March 2019 to finalise the JSNA work plan for 2019/20. The pragmatic approach to the workplan was continued, in light of general reductions in capacity across local authority, CCG and voluntary sector organisations alongside ongoing organisational change. It is recommended that the Board endorse this approach.

3.2 Three chapters that were due for update last financial year are nearing completion. As well as completion of the outstanding chapters, up to an additional eighteen chapters will be refreshed this financial year. New chapters on Knife Crime and Noise Pollution will be produced. Further detail on the 2019/20 work plan is contained within Appendix 1.

Joint Strategic Needs Assessment Annual Report

Appendix 1: JSNA Work Plan 2019/20

Chapter	Due	Owning Group	Progress
Adult Mental Health	2020	Mental Health and Wellbeing Strategic Group	1
Adults with Multiple and Complex Needs	2019	Opportunity Nottingham Board	7
Adult Substance Misuse	2019	CDP Executive Group	4
Air Quality	2019	Nottinghamshire Health Protection Strategy Group	7
Cancer	2019	TBC – CCG/ICS changes	0
Cardiovascular Disease and Stroke	2019	TBC – CCG/ICS changes	0
Child Poverty	2020	Nottingham Financial Resilience Partnership	1
Chronic Obstructive Pulmonary Disease	2019	TBC - CCG/ICS changes	0
Demography	2019	JSNA Steering Group	7
Diabetes	2019	TBC - CCG/ICS changes	0
Excess Winter Deaths and Cold Related Harm	2018	Health and Housing Partnership Board	6
Healthy Weight	2020	Physical Activity, Diet and Obesity Strategic Group	3
Housing	2018	Health and Housing Partnership Board	6
Knife Crime/Weapon Enabled Violence	2020	CDP Executive Board	2
Life Expectancy and Healthy Life Expectancy	2020	JSNA Steering Group	2
Musculoskeletal Conditions	2019	Greater Nottingham MSK Group	2
Noise Pollution	2020	Nottinghamshire Health Protection Strategy Group	2

Physical Activity	2020	Local Delivery Pilot Leadership Board and Physical Activity, Obesity and Diet Strategic Group	2
Pregnancy	2018	Local Maternity System Steering Group	7
Smoking and Tobacco Control	2018	Strategic Tobacco Control Group	7
Tuberculosis	2020	Nottinghamshire Health Protection Strategy Group	1

Key for milestone codes

0 Not started
1 Engaging stakeholders and working towards a PID
2 PID agreed and working on a first draft
3 First draft completed and out to consultation
4 Incorporating stakeholder comments into final draft
5 Final draft completed and waiting for sign-off
6 Working on final tweaks
7 Published on Nottingham Insight

HEALTH AND WELLBEING BOARD

DAY MONTH YEAR

	Report for Resolution/ Report for Information
Title:	Nottingham City and Nottinghamshire Suicide Prevention Strategy 2019-2023
Lead Board Member(s):	Alison Challenger, Director of Public Health, Nottingham City Council
Author and contact details for further information:	Jane Bethea, Consultant in Public Health, Nottingham City Council Caroline Keenan, Insight Specialist – Public Health, Nottingham City Council
Brief summary:	The Nottingham City and Nottinghamshire Suicide Prevention Strategy has been refreshed. The Health and Wellbeing Board is asked to endorse this refreshed strategy.

Recommendation to the Health and Wellbeing Board:

The Health and Wellbeing Board is asked to:

a) Endorse the Nottingham City and Nottinghamshire Suicide Prevention Strategy 2019-2023 (Enc. 2).

Contribution to Joint Health and Wellbeing Strategy:	
Health and Wellbeing Strategy aims and outcomes	**Summary of contribution to the Strategy**
Aim: To increase healthy life expectancy in Nottingham and make us one of the healthiest big cities	Suicide prevention is vital to achieving the Health and Wellbeing Board's ambition to improve healthy life expectancy, as set out in Nottingham City's Mental Health and Wellbeing Strategy 2016-2020.
Aim: To reduce inequalities in health by targeting the neighbourhoods with the lowest levels of healthy life expectancy	
Outcome 1: Children and adults in Nottingham adopt and maintain healthy lifestyles	
Outcome 2: Children and adults in Nottingham will have positive mental wellbeing and those with long-term mental health problems will have good physical health	
Outcome 3: There will be a healthy culture in Nottingham in which citizens are supported and empowered to live healthy lives and manage ill health well	
Outcome 4: Nottingham's environment will be sustainable – supporting and enabling its citizens to have good health and wellbeing	

How mental health and wellbeing is being championed in line with the Board's aspiration to give equal value to mental and physical health
The refreshed Nottingham City and Nottinghamshire Suicide Prevention Strategy 2019-2023 aims to reduce the rate of suicide and self-harm by proactively improving the mental health and wellbeing of the population.

Background papers: *Documents which disclose important facts or matters on which the decision has been based and have been relied on to a material extent in preparing the decision. This does not include any published works e.g. previous Board reports or any exempt documents.*	None

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Nottingham City and Nottinghamshire Suicide Prevention Strategy 2019-2023

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 are again above the national average rate (see Figure 1).

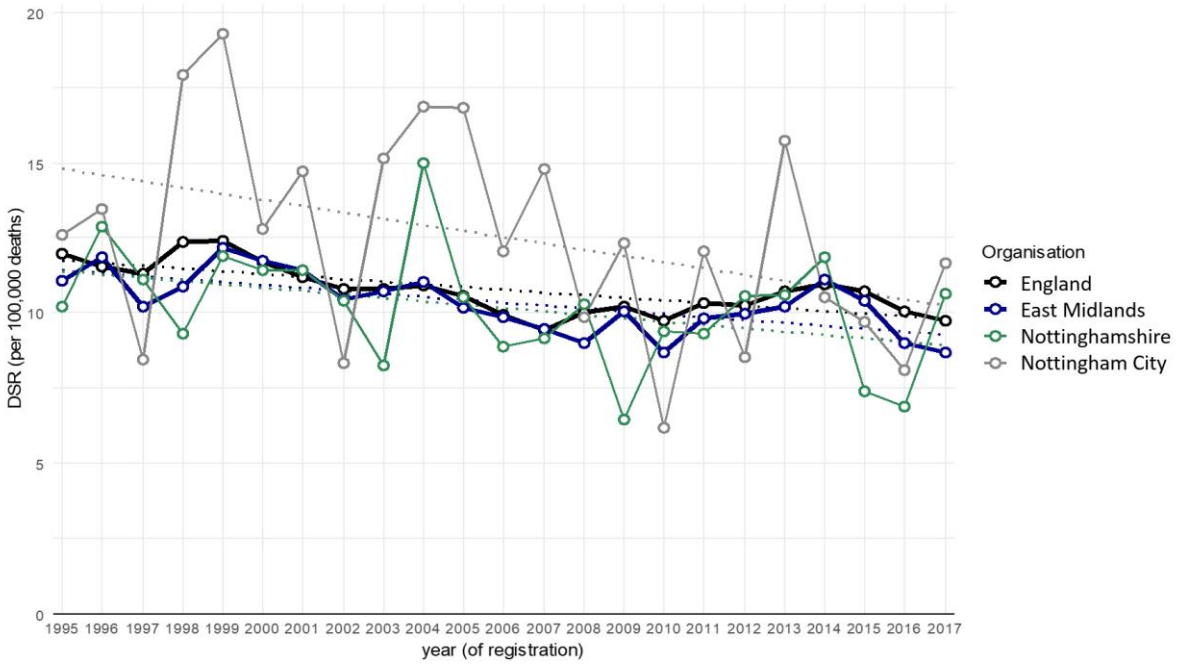

Figure 1 Trends in mortality from suicide and injury of undetermined intent in 15+yrs old (directly standardised rate per 100 000). Source: Office for National Statistics (ONS) via NHS Digital

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 (2). 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 (3).

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 (4) and the NHS Long Term Plan (5), 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 Health and Wellbeing Board is asked to endorse this refined draft strategy (Enc. 2).

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. Recommendations

The Health and Wellbeing Board is asked to:

1. Endorse Nottingham City and Nottinghamshire Suicide Prevention Strategy 2019-2023 (Enc. 2).

5. References

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

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

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

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

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

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

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

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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***

Contents

Table of Contents

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]

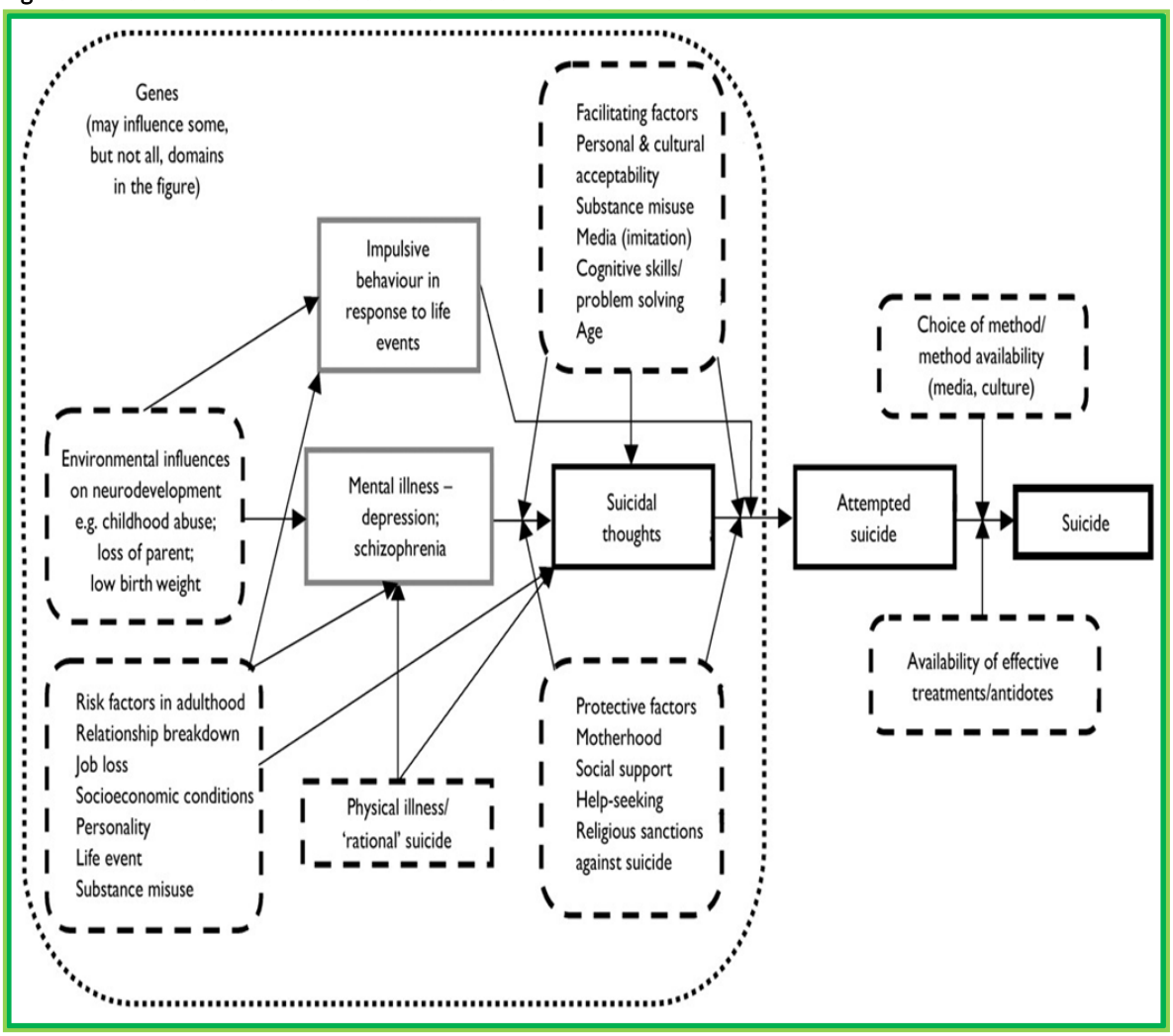
The term self-harm focuses on those acts of harm that are an expression of personal distress and where the person directly intends to injure him/herself. It is important also to acknowledge that for some people, especially those who have been abused as children, acts of self-harm occur seemingly out 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.

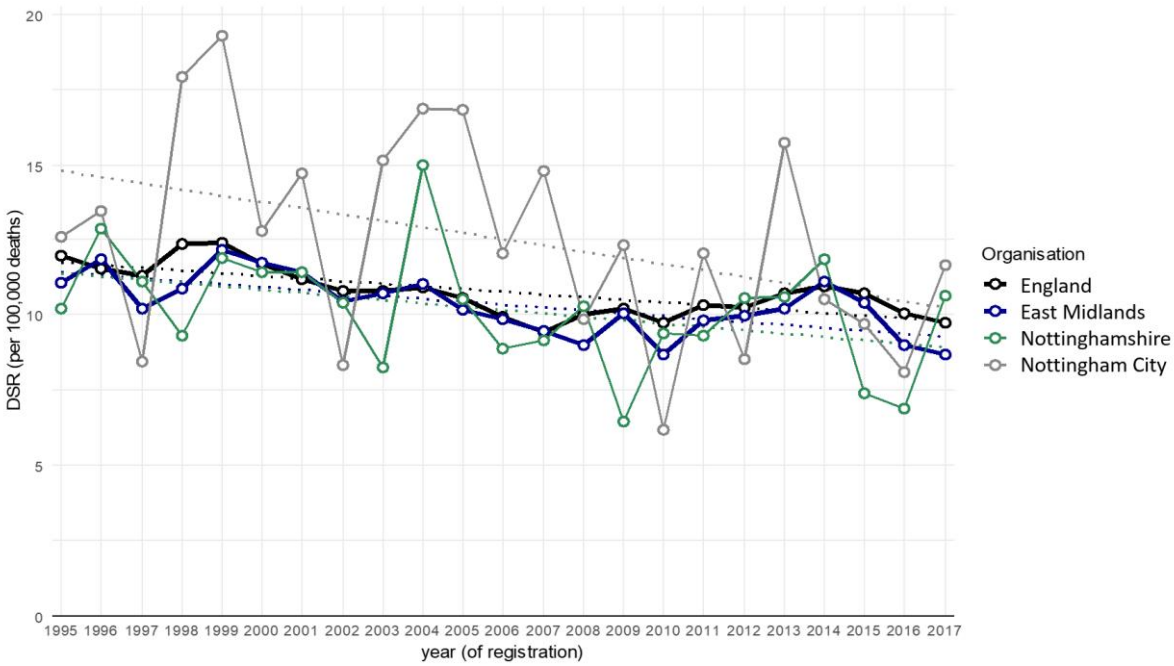
7.1.1 National and regional trends

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.

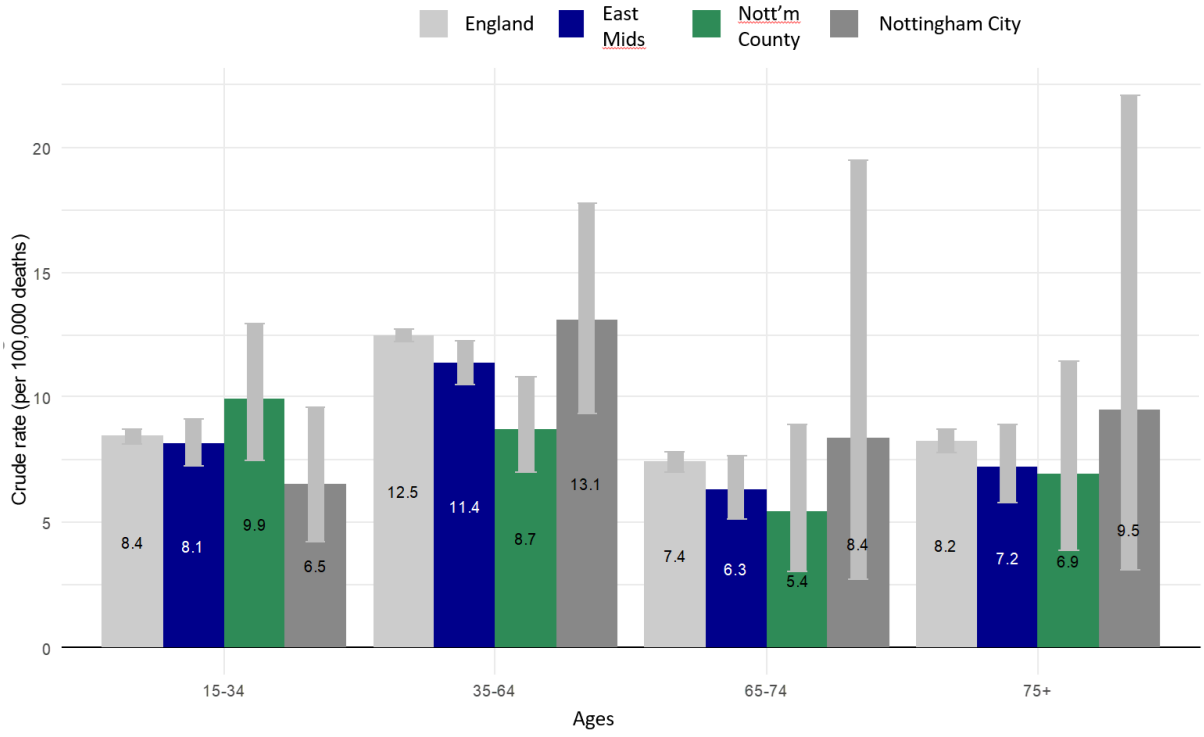
Figure 2: Trends in mortality from suicide and injury of undetermined intent in 15+yrs old (directly standardised rate per 100 000). Source: Office for National Statistics (ONS) via NHS Digital



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

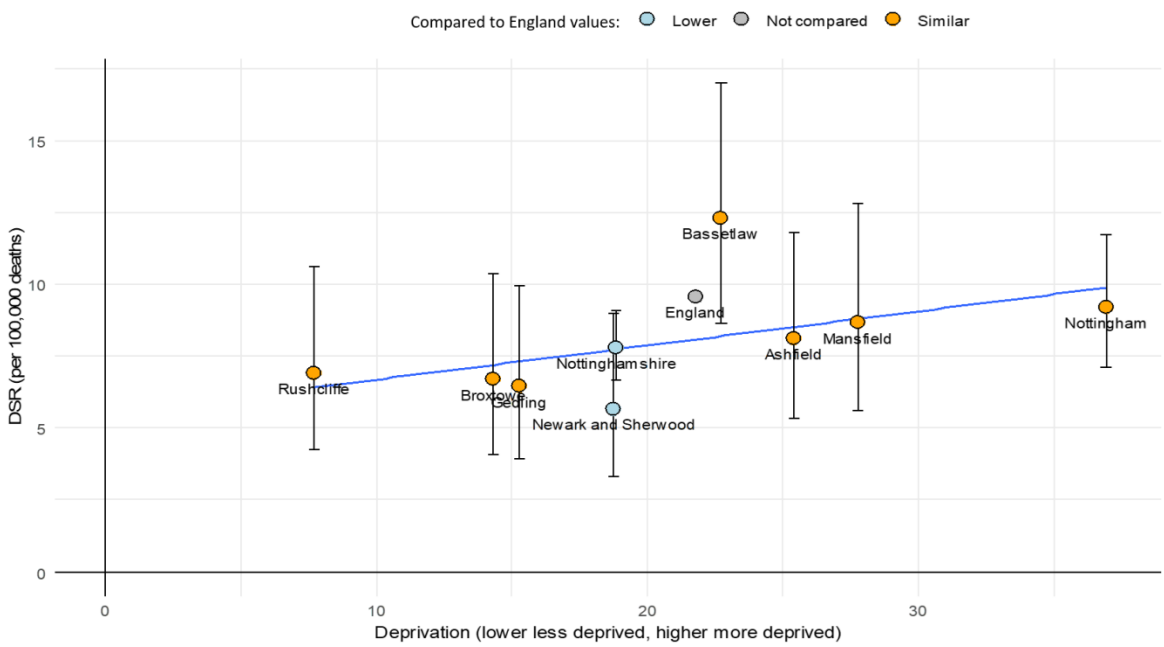
The Index of Multiple Deprivation score 2010 (IMD 2010) is a measure of multiple deprivation, at small area level. It is made up of seven domain indices, relating to income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to 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.

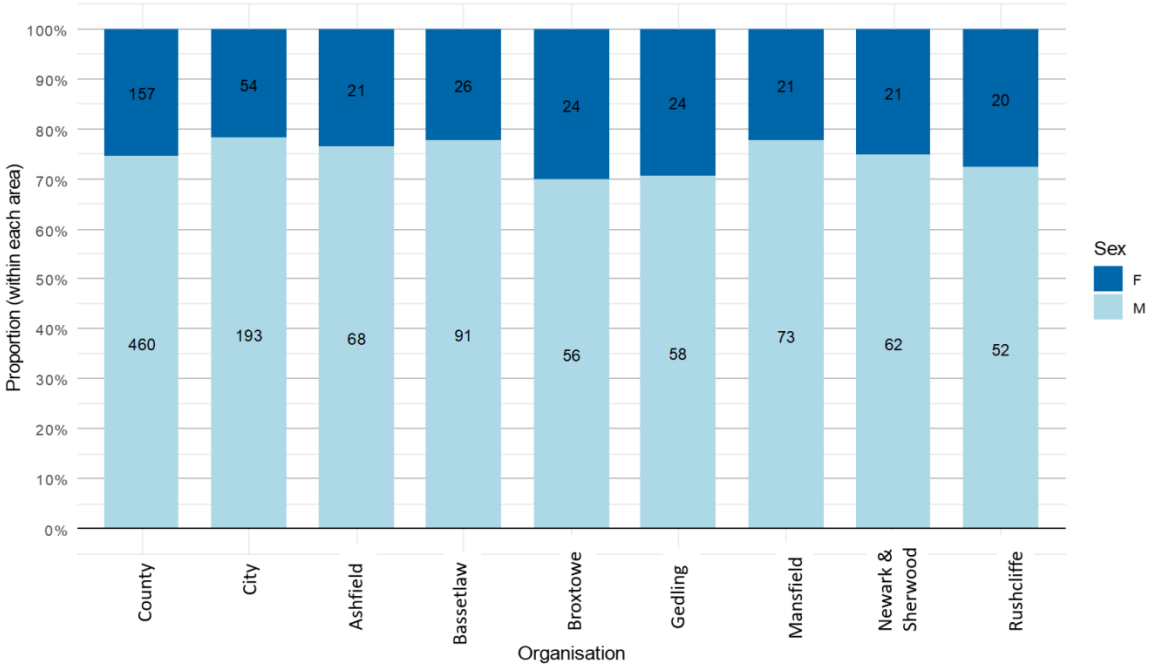
Figure 4: City and County districts variation in mortality from suicide and injury undetermined death (3 year pooled, 2015-17) with deprivation. Source: PHE suicide prevention profiles; IMD 2015 scores



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

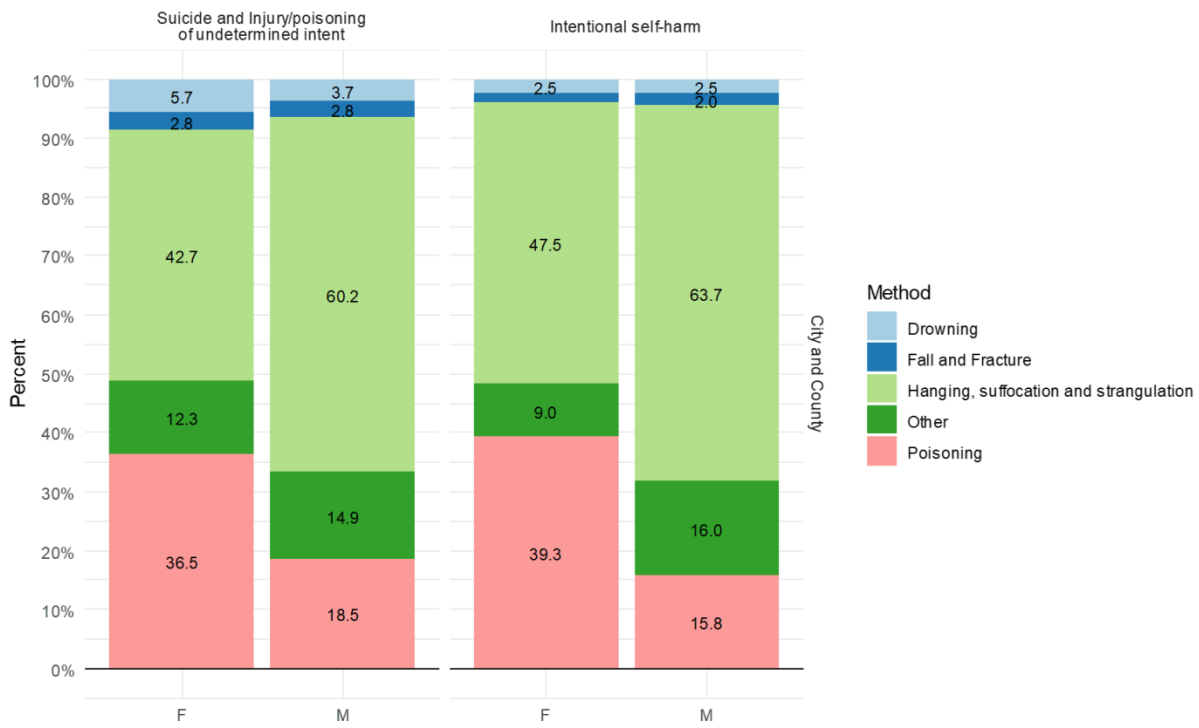


7.2.3 Methods of suicide and self-harm

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: Training and 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: Training and 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.		
3 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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Nottingham City Council

Statutory Officers Report for Health and Wellbeing Board

Corporate Director of Children's Services

September 2019

Corporate Director for People

I mentioned in my last update that I had finally succumbed to pressure from family to retire and that the recruitment campaign for the new Corporate Director was due to commence.

I am delighted to confirm the appointment of Catherine Underwood. As you will be aware, Catherine is our current Director for Adult Social Care. Catherine is enthusiastic and passionate about working in Nottingham, with a proven track record in driving improvement and delivering results that drive change. I am confident that I will be leaving the department in very safe hands.

My final day in the office will be 30th September 2019. Therefore, I would like to take this opportunity to thank you all for your support and friendship over the last six years.

Independent Inquiry into Child Sexual Abuse

On 31st July, the Independent Inquiry into Child Sexual Abuse (IICSA) published its findings into the extent of any historical institutional failures to protect children in the care of Nottingham City and Nottinghamshire County councils from sexual abuse.

There were two key recommendations, for which we will need to publish our response within six months of the publication of this report:

1. Nottingham City Council should assess the potential risk posted by current and former foster carers directly provided by the council in relation to the sexual abuse of children. They should also ensure that current and former foster carers provided by external agencies are assessed by those agencies. Any concerns which arise should be referred to the appropriate body or process, including the Disclosure and Baring Service, the local authority designated officer (LADO) or equivalent, the fostering panel and the police.

2. Nottingham City Council and its child protection partners should commission an independent, external evaluation of their practice concerning harmful sexual behaviour, including responses, prevention, assessment intervention and workforce development. An action plan should be set up to ensure that any recommendations are responded to in a timely manner and progress should be reported to City's Safeguarding Children Partnership*. We have already commissioned NSPCC to undertake this independent evaluation.*

As part of the wider cross-cutting learning from the 14 strands of the Inquiry, they will return to a number of issues that have emerged during this investigation, including but not limited to:

- Children who exhibit harmful sexual behaviour.

- The barriers to disclosure of sexual abuse by children, including those in care, and proactive steps to reduce those barriers.
- The approach to civil litigation, including the role of insurers.

We have taken the Inquiry extremely seriously and we will be considering its findings very carefully. Our biggest priorities are to make sure we are doing everything we can to protect today's children from harm and provide the best possible support for adult survivors of abuse in childhood.

Like all councils, we constantly striving to improve our services and we will redouble our efforts to do that in light of this report. We will continue to implement changes in response to lessons we have learnt through the Inquiry process.

We are already taking steps to provide 'trauma-informed training' for relevant staff which helps to ensure that survivors of abuse get the appropriate help in accessing the support they need. We are also involving survivors in helping us to shape this and other changes to ensure our policies and services are fit for purpose.

For more information about historical child abuse, including how to get help if you, or someone you know, is affected by abuse please click here or call 0300 131 0300. If you contact us you will be listened to, taken seriously and given the support you need.

The full report can be found here.

Violence Reduction Unit

The Office of the Police and Crime Commissioner have recently been notified of a funding allocation to support the partnership to establish a Violence Reduction Unit (VRU) for the Nottinghamshire area. Nottinghamshire's VRU will be a small, coordinating hub that will build on the exciting work that is already taking place in the City and County to reduce violence. Central government are keen for all VRUs to utilise a public health approach to identifying and tackling the causes of violence in our communities and will encourage all partners to work together with our communities to take a systemic, evidence-based approach to this issue.

Colleagues from both local authorities and Nottinghamshire Police are being seconded into the Unit to support this work and to ensure that this supports existing activity and to avoid duplication. The VRU is likely to get up and running in September 2019, so watch this space for more information over the next few months.

Our Exam Results

August is a busy time in our secondary academies and local Colleges. You will have seen lots of smiley, jumping youngsters waving pieces of paper in the local news. It is right to celebrate the hard work of all our youngsters. It is also important to recognise the hard work from their teachers and support staff.

Early analysis of this year's GCSE and A Level results indicate a mixed picture of improvements in some areas, but not in others.

Also, a huge congratulations to our Children in Care – provisional results show a 20% increase in the number of children getting 5 or more GCSE's. Thank you to all of our staff and Foster Carers who have supported them.

Alison Michalska
Corporate Director for Children and Adults
(September 2019)

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Health and Wellbeing Board Forward Plan 2019/20 WORKING DOCUMENT

Submissions for the Forward Plan should be made at the earliest opportunity through Kate Morris, Nottingham City Council Constitutional Services Team Kate.morris2@nottinghamcity.gov.uk

Date of meeting	Agenda Item	Lead
November 2019 (27/11/2019)	**Themed Discussion – Health Protection**	Helene Denness
	Winter Preparedness	Nancy Cordy, Rachael Harding, Lyn Bacon
	Primary Care Networks - Update	
	Population Health Management	Maria Principe
January 2020 (29/01/2020)	**Themed Discussion – 1st Draft of Health and Wellbeing Strategy 2020 onwards**	Uzmah Bhatti
March 2020 (25/03/2020)	**Themed Discussion – Sign off and Launch of Health and Wellbeing Strategy 2020 onwards**	Uzmah Bhatti
	Violence Prevention	Alison Challenger

NB: In addition to the items listed above, all ordinary Health and Wellbeing Board meeting agendas will normally include the following items:

- Minutes of the last meeting
- Board Forward Plan
- Board Member Updates
- New Joint Strategic Needs Assessment (JSNA) Chapters
- Minutes of any HWB Commissioning Sub Committee meetings that have taken place since the previous meeting
- Citizen questions

Suggested items to be scheduled:

- Children's health and wellbeing
- Domestic and sexual violence services
- Delayed Transfers of Care
- Joint CCG/ NCC update on the NHS Long Term Plan
- Health in all policies policy
- Air Quality

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Health and Wellbeing Board Action Log

Meeting and Issue	Agreed Actions	Updates received on progress
28 November 2018 Reducing Alcohol Harm	All Board Members were asked to: • Sign the Alcohol Declaration • Identify alcohol champions within their organisation • Consider how to embed Identification and Brief Advice (IBA) in their organisation	CCG has signed the declaration, appointed an alcohol champion and is working towards embedding IBA in their organisation. NCC confirmed declaration signed, alcohol Champion appointed and IBA embedded as part of HiAP work. NUH Signed. Consultant medical champion identified. [Dr Steve Ryder] Screening for alcohol introduced in all in-patients at NUH. IBA training by area given and being delivered. ED-bid for prevention hub in ED successful which will also embed screening and IBA in ED Notts Fire and Rescue Declaration has been signed and returned. Alcohol champions have been identified and notified to Caroline Keenan (Tracey Straw and Robyn Ellis) Working ongoing regarding IBA in Service.
28 November 2018 Autism	All Board Members were asked to: • support engagement on the themes within the Autism Strategic Framework within their organisation • identify autism champions within their organisation	CCG has appointed an autism champion NUH Autism awareness and autism champion training delivered (approx. 250 staff). Training was funded by NUH charity and this funding has ended and training concluded. Awaiting outcome of national consultation to inform next steps for future training. Autism champion identified (Giles Matsell, Head of Equality and Diversity) Notts Fire and Rescue

Meeting and Issue	Agreed Actions	Updates received on progress
		Autism champion identified (Rebecca Harding)
30 January 2019 Mental Health	All Board Members were asked to consider: • signing the Time to Change Employer Pledge to demonstrate their commitment to changing how people think and act about mental health in the workplace and ensuring employees with mental health problems are supported • identifying mental health champions within their organisation • ensuring that their workforce has access to mental health training • how their organisation could take the impact of past traumatic experiences on mental health into account when reviewing its working practices and supporting its workforce The Mental Health Sub Group was asked to review the issues raised during the discussion and bring back proposals for actions that Board Members can take to make a difference to improving mental health a future Board meeting.	CCG has signed the Time to Change Employer Pledge and are reviewing the opportunity to train staff on Mental Health First Aid. NUH have established a Mental Health Shared Governance Council. This group has agreed that the pledge should be signed and have provisionally registered to obtain the information to do this. Work is underway to determine our approach to identify, train and support mental health champions within the organisation. This approach will need to be embedded appropriately as part of our wider organisational response and strategy to mental health. Various training is available to all staff (and training for managers) including stress awareness and mindfulness. Training is continually monitored and reviewed. Notts Fire and Rescue Mental health champions trained and structure within Service to support mental health of employees, including around PTS. Processes and support embedded within Service. Wellbeing Strategy being revised which encompasses Mental Health. Time to Change Employer Pledge signed.
27 March 2019 Smoking in Nottingham City	All Board Members were asked to: Smoking in Pregnancy • Support the LoveBump Campaign across their organisations • Support the achievement of the Council	CCG has confirmed completion of 1-6 - The majority of the actions are supported through the approach taken across the system, including through the ICS prevention workstream. The CCG are considering staff policies and the opportunity to introduce vaping. NUH Smoking in Pregnancy

Meeting and Issue	Agreed Actions	Updates received on progress
	Plan commitment to reduce smoking rates of pregnant women at the time of delivery • Ensure the NHS long term plan commitment to provide pregnant women and their partners with a new NHS stop smoking pathway including support, is designed alongside non-NHS funded services <u>Smoking Cessation</u> • To create awareness about smoking cessation service (Stub-it) • Encourage citizens who smoke to seek support via their GP's especially if they are in one of the target groups for the service • Support referral of patients who are smokers in target groups to the new service <u>Implementation of the NICE guidance supporting cessation in secondary care (PH48)</u> • Support continued implementation of PH48 in NUH • Review current policies and ensure that provision is made for staff, patients, and families who wish to vape on site • Support staff in the delivery of brief advice through completion of the "very Brief Advice Training Module" by the National Centre for Smoking Cessation Training (NCSCT)	The smokefree team at NUH is providing a regular training session at the maternity / maternity support worker forums. Materials relating to Love Bump have been disseminated to midwives. Smoking Cessation The Smokefree advisers based at NUH routinely offer information to smokers about how to access the stop smoking service in the community. Implementation of the NICE guidance supporting cessation in secondary care (PH48) NUH now have a smokefree lead in post since April whose role is to support the continued implementation of ph48 across NUH. The current smokefree policy is under review and agreement has been established from the management board that staff, patients and visitors can vape on site. Funding is also being sought to support NUH staff wishing to quit smoking to access Stop smoking medications. A training pathway for VBA for staff across NUH is currently being developed. Vaping and E-cigarettes Current policy is being updated and will include recognition that e-cigarettes are 95% less harmful than cigarettes. <u>Notts Fire and Rescue</u> Smoking Champion identified (Alastair Bramley-Little). Service promotes smoking cessation and referrals for support through Safe & Well visits. 'No Smoking' policy adopted at Service sites

Meeting and Issue	Agreed Actions	Updates received on progress
	<u>Vaping and E-cigarettes</u> • Review current smoking cessation policies in organisations • Consider expanding current policy to include recognition that e-cigarettes are 95% less harmful than cigarettes • Support staff, patients, and clients who wish to vape by considering the provision of dedicated vaping locations/areas on site	
29th May 2019 Obesity	• Commit to the Nottingham City Council objective of reducing childhood obesity by 10% by 2023 • Encourage conversations with citizens on moving and eating for good health and, where appropriate, refer citizens to one of the weight management services available in Nottingham City • Support exploration of a new, systems approach to eating and moving for good health in Nottingham City; and • Sign-up to the Physical Activity and Nutrition Declaration, which has previously been endorsed by the Health and Wellbeing Board.	

JSNA Chapter – Severe Multiple Disadvantage

Topic information	
Topic title	Severe Multiple Disadvantage (Multiple Needs)
Topic owner	Jane Bethea
Topic author(s)	Grant Everitt and Karan Kaur
Topic endorsed by	Opportunity Nottingham Board July 2019
Current version	September 2019
Replaces version	n/a
Linked JSNA topics	Children in care (2017), Children and young people substance misuse (2016), Emotional and mental health needs of children and young people aged 0 to 18 (2015), Alcohol (2015), Homelessness (2017), Life expectancy and healthy life expectancy (2018), Adult mental health (2016)

Executive summary

Introduction

Severe Multiple Disadvantage (SMD) refers to people with two or more of the following issues: mental health issues, homelessness, offending and substance misuse. SMD can include other sources of disadvantage, for instance poor physical health, and for women, domestic and sexual abuse - and for Black, Asian and Minority Ethnic (BAME) people, community isolation. Nottingham has the 8th highest prevalence of SMD in England - currently it is estimated that over 5,000 of the City's citizens experience SMD.

SMD mainly originates in adverse childhood experiences, approximately 85% of people facing SMD have experienced childhood trauma. This effects mental health, which can lead to issues such as homelessness, substance misuse and offending. Services working with people facing SMD struggle to meet needs, because they are mainly set up to deal with single issues. The consequence for people facing SMD is their *other* issues prevent them successfully engaging with single issue treatment or support. For example substance misuse may lead to exclusion from a mental health service. Instead they tend to end up at "blue light services": e.g. A&E, Ambulance calls outs, arrests and custody. The economic cost of this "siloed" and unconnected approach is high - one source estimates across England it is £10.1 billion a year.

Unmet needs and gaps

Given the nature of multiple disadvantage there is not sufficient cross sector collaboration and coordination between mental health, housing, criminal justice and substance misuse services – as well as social care and the Department of Work and Pensions (DWP). This lack of coordination and collaboration exists at all levels from ground level staff to strategy and commissioning. Part of this lack of collaboration is a lack of data sharing which causes

people facing SMD to have to keep repeating their story and this contributes further to their alienation from services.

As SMD is primarily a consequence of trauma, a mental health response is central to meeting needs but often people facing SMD cannot get access to the mental health services they need especially psychological intervention. Nor is there sufficient psychological understanding of people facing SMD from the wider workforce.

Where SMD results in homelessness, appropriate housing solutions are not often available. Hostel provision has limited success especially for people facing SMD whose needs are most acute. Housing First has a good evidence base as an alternative but there is not enough provision.

Citizens facing the most acute SMD can benefit from specialist support from a dedicated SMD service. Opportunity Nottingham aims to provide this until 2022 but after this a replacement will need to be found. Evidence suggests people facing SMD must be involved in developing their own solutions to the disadvantages they face. This includes individually through strength based approaches and collectively through ensuring the system is service user led or informed.

Recommendations for consideration by commissioners

The following measures for consideration by commissioners have the potential to reduce both the incidence of SMD and its negative impact. They build on the five Opportunity Nottingham System Challenges for Nottingham City – available here: http://www.opportunitynottingham.co.uk/latest-news/news/system-change-challenge-join-in/

1. **Once Opportunity Nottingham ends in 2022, continue to respond to multiple and complex needs by building on its legacy through considering developing a jointly commissioned specific SMD Service.**
   This service will work with people facing SMD who have the greatest level of need and will build on the success and learning of Opportunity Nottingham and the Fulfilling Lives programme. Evidence therefore suggests it should be a multi-disciplinary team containing as a minimum the following elements:
   - A team of Coordinators/Navigators
   - Mental health specialists able to provide psychological interventions and support Psychologically Informed Environments (PIE)
   - A Lived Experience Team that includes staff to support Expert Citizens and Peer Mentors, and focuses on connecting people to positive social networks
   - Gender and Culturally specific elements – which may include posts hosted by specialist agencies
   - A Practice Development Unit – to promote good practice and collaboration more widely
   - A Social Worker working as a “trusted assessor” to support access to care services

2. **Ensure the “system works as one” through development of a strategic “Board” responsible for reducing SMD beyond the end of Opportunity Nottingham in 2022.**
   This SMD “Board” should oversee service provision and continued system change. This is needed because resolving SMD involves different sectors (principally: mental

health, homelessness, substance misuse and criminal justice, but also other sectors such as the DWP and Probation). SMD will only be reduced if senior representatives from these sectors collaborate to ensure a unified approach. Therefore, the highest priority must be given to ensuring genuine and consistent representation from all sectors, with time allowed for this by individual organisations. The Integrated Care System and other strategic initiatives should be used to lever support from all sectors. The Board would oversee implementation of point one above but also ensure coordination of the wider number of people facing SMD, who will benefit from a coordinated approach but whose needs would not be sufficiently high to qualify for the new SMD service as described in point one above.

3. **Increase over time the number of Housing First Units in Nottingham to 200 as part of the legacy to support SMD once Opportunity Nottingham ends.** This figure is based on evidence from Homeless Link that Housing First is suitable for approximately 10% of people facing multiple exclusion homelessness. So, 200 units would be sufficient for approximately 10% of the Nottingham SMD 3/4 cohort. To ensure this is a successful initiative it will need to be linked to the wider housing strategy, especially housing supply and be backed by tenancy support operating at a low resident to worker ratio.

4. **Understand the centrality of addressing mental health issues to enable people to move away from SMD. This will be underpinned by the wider goal of ensuring Nottingham becomes a city where the wider workforce apply a psychologically informed approach.**

   This will include:

   a) All services working with people facing SMD taking a psychologically informed (sometimes referred to as trauma informed) approach. This should not only include any specific SMD services, but also single issue services that work with people facing SMD including; homelessness services, substance misuse services and the DWP. The use of a psychologically informed approach should be monitored through use of an appropriate tool, such as the PIZAZZ or the Homeless and Inclusion Health standards for commissioners and service providers (Pathway, 2018).
   b) Mental health specialists should be included as part of a multi-disciplinary approach in any service substantially working with people facing SMD. This includes substance misuse services and the Rough Sleeper Outreach Team
   c) The recommendations from the CCG funded research by Sheffield Hallam University: Understanding the Mental Health Needs of Homeless People in Nottingham (2018) should be implemented.

5. **Ensure flexibility in the way we work with people facing SMD by providing gender and culturally responsive support in recognition of the diverse forms multiple disadvantage takes.**

   Evidence suggests the mainstream definition of SMD (mental health, homelessness, offending and substance use), can lead to some group's disadvantages being overlooked, including women and BAME people. Therefore, services need to be gender and culturally responsive and commissioners should monitor this. Additionally, gender and culturally specific services able to work with people facing SMD service should be considered.

6. **Support the long-term wellbeing and independence of service users by challenging stigma and by building on their strengths, skills and positive networks.**
   Ensure that positive outcomes are sustained by commissioning services that take a strength based approach, focus on skills development and enable supportive positive networks. Without such emphasis, people facing SMD will not be able to build their own resilience and the costly and ineffective "revolving door" experience will be in danger of continuing.

7. **Minimise the likelihood of SMD occurring by recognising the origins of SMD mainly begin in early life, and by equipping services for children to respond.**
   Eighty five percent of people facing SMD have early life trauma and adverse childhood experience. The best long term solution therefore is early intervention through better services supporting children and young people. These should respond to ACE's and trauma and identify and support young people at risk of moving into the SMD group.

8. **Ensure the system works as one and tackles stigma through a "no wrong door" approach, by continuing the work of Opportunity Nottingham to increase data sharing**. This involves supporting systems to improve data sharing (where consent is given) that prevents constant retelling of stories and enables more efficient interagency working, speeding up delivery of services. The inclusion of "Facts about Me" (a form to record hopes and aspirations) will also contribute to tackling stigma and focussing on strengths.

9. **Develop a service user led system, whereby people facing SMD are able to directly have a significant say in how services should be working.** This includes ensuring participation is meaningful, is supported with time and resources and is backed by a widely accepted participation standard for Nottingham City.

10. **Ensure the Criminal Justice system is fully engaged in and trained to reduce SMD, recognising that people facing SMD can present anywhere.** In economic terms it is in the criminal justice system where a positive approach to reducing SMD will make the biggest difference - this is where the greatest cost savings will be made. The previous nine measures listed above if implemented, will reduce offending. Where it does occur and a prison sentence is given, "Through the Gate Support" (meeting prisoners at the point of discharge) is also an essential component of any coordinated support network for people facing SMD.