#healthyplym

Democratic and Members Support
Chief Executive's Department
Plymouth City Council
Ballard House
Plymouth PL1 3BJ

Please ask for Amelia Boulter
T 01752 304570
E amelia.boulter@plymouth.gov.uk
www.plymouth.gov.uk/democracy
Published 23 September 2015

HEALTH AND WELLBEING BOARD

Thursday 1 October 2015
11.00 am
Warspite Room, Council House

Members:
Councillor McDonald, Chair
Councillors Mrs Bowyer and Ian Tuffin.

Statutory Co-opted Members: Strategic Director for People, NEW Devon Clinical Commissioning Group representatives, Director for Public Health, Healthwatch representative, NHS England (Vacancy).

Non-Statutory Co-opted Members: Representatives of Plymouth Community Homes, Plymouth Community Healthcare, Plymouth NHS Hospitals Trust, Devon Local Pharmaceutical Committee, University of Plymouth, Devon and Cornwall Police, Devon and Cornwall Police and Crime Commissioner and the Voluntary and Community Sector.

Members are invited to attend the above meeting to consider the items of business overleaf.

This meeting will be broadcast live to the internet and will be capable of subsequent repeated viewing. By entering the Warspite Room and during the course of the meeting members are consenting to being filmed and to the use of those recordings for webcasting.

The Council is a data controller under the Data Protection Act. Data collected during this webcast will be retained in accordance with authority's published policy.

For further information on webcasting, attending Council meetings and how to engage in the democratic process please follow this link http://www.plymouth.gov.uk/accesstomeetings

Tracey Lee
Chief Executive

HEALTH AND WELLBEING BOARD

PART I (PUBLIC COMMITTEE)

1. APOLOGIES

To receive apologies for non-attendance by Health and Wellbeing Board members.

2. DECLARATIONS OF INTEREST

The Board will be asked to make any declarations of interest in respect of items on this agenda.

3. CHAIR'S URGENT BUSINESS

To receive reports on business which, in the opinion of the Chair, should be brought forward for urgent consideration.

4. MINUTES (Pages 1 - 8)

To confirm the minutes of the meeting held on the 30 July 2015.

5. QUESTIONS FROM THE PUBLIC

To receive questions from the public in accordance with the Constitution.

Questions, of no longer than 50 words, can be submitted to the Democratic Support Unit, Plymouth City Council, Ballard House, Plymouth, PL1 3BJ, or email to democraticsupport@plymouth.gov.uk. Any questions must be received at least five clear working days before the date of the meeting.

6. CAMHS TRANSFORMATION PLAN (Pages 9 - 26)

Board members to receive a report and presentation on the CAMHS Transformation Plan.

7. ALCOHOL DASHBOARD UPDATE (Pages 27 - 40)

Board members to receive an update on the Alcohol Dashboard.

8. SUICIDE PREVENTION WORK (Pages 41 - 62)

Board members to receive a report and presentation on Suicide Prevention.

9. CHILDREN AND YOUNG PEOPLE PARTNERSHIP UPDATE

Board members to receive a verbal update on the Children and Young People's Partnership.

10. WORK PROGRAMME (Pages 63 - 66)

The Board are invited to add items to the work programme and to note the Solution Shop programme.

11. EXEMPT BUSINESS

To consider passing a resolution under Section 100A(4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item(s) of business on the grounds that it (they) involve the likely disclosure of exempt information as defined in paragraph(s) of Part 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000.

PART II (PRIVATE COMMITTEE)

AGENDA

MEMBERS OF THE PUBLIC TO NOTE

that under the law, the Panel is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

Nil.

This page is intentionally left blank

Health and Wellbeing Board

Thursday 30 July 2015

PRESENT:

Councillor McDonald, in the Chair.
Dr Paul Hardy, Vice Chair.

Chief Supt Andy Boulting - Devon and Cornwall Police, Councillor Mrs Bowyer, Carole Burgoyne - Strategic Director for People, Jerry Clough - NEW Devon CCG, Peter Edwards - Healthwatch, Tony Fuqua - Community and Voluntary Sector, Tony Hogg - Office of the Police and Crime Commissioner, Ann James - Plymouth Hospitals NHS Trust, Sarah Lees – Public Health (for Kelechi Nnoaham), Dr Richard Stephenson - Plymouth University, Sue Taylor - Devon Local Pharmaceutical Committee (for David Bearman), Councillor Tuffin and Steve Waite.

Apologies for absence: David Bearman - Devon Local Pharmaceutical Committee, Dr Caroline Gamlin - NHS England, Judith Harwood - Assistant Director for Learning and Communities, Kelechi Nnoaham - Director of Public Health and Clive Turner – Plymouth Community Healthcare.

Also in attendance: Ross Jago – Lead Officer and Amelia Boulter – Democratic Support Officer.

The meeting started at 10.00 am and finished at 11.50 am.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

1. **CONFIRMATION OF CHAIR AND VICE CHAIR**

Agreed -

1. the appointment of Councillor Sue McDonald as Chair for the municipal year 2015 – 2016;

2. the appointment of Dr Paul Hardy as the Vice-Chair of the Board for the municipal year 2015-2016.

2. **APPOINTMENT OF CO-OPTED REPRESENTATIVES**

Agreed the following co-opted representatives -

Statutory Co-opted Members

- Carole Burgoyne, Strategic Director for People, Plymouth City Council;
- Kelechi Nnoaham, Director of Public Health;

- Jerry Clough, NEW Devon
- Dr Paul Hardy, NEW Devon Clinical Commissioning Group representative;
- Peter Edwards, Healthwatch;
- Dr Caroline Gamlin, NHS England.

Non-Statutory Co-opted Members

- Tony Fuqua, Community and Voluntary Sector Representative;
- Jo Traynor, Community and Voluntary Sector Representative;
- Clive Turner, Chief Executive, Plymouth Community Homes;
- Steve Waite, Chief Executive, Plymouth Community Healthcare;
- Ann James, Chief Executive, Plymouth NHS Hospitals Trust;
- David Bearman, Chair, Devon Local Pharmaceutical Committee;
- Richard Stephenson, Dean and Pro Vice-Chancellor, Plymouth University;
- Chief Superintendent Andy Boulting, Devon and Cornwall Police;
- Tony Hogg, Devon and Cornwall Police and Crime Commissioner.

3. DECLARATIONS OF INTEREST

There were no declarations of interest made.

4. CHAIR'S URGENT BUSINESS

Tony Hogg requested Board members support for the Fair Funding Campaign which relates to the police funding formula for Devon and Cornwall Police. Devon and Cornwall Police were discriminated against in terms of funding because of the rural nature, areas of deprivation and high tourism during the summer months and the Commissioner was requesting that the Government to reconsider the current funding formula. The campaign would run until 15 September 2015 and was being supported by the Western Morning News.

5. MINUTES

Agreed that the minutes of 26 March 2015 were confirmed subject to the following change –

Regarding Minute 44 – Declarations of Business for Peter Edwards. The contract relates to Cornwall supporting victims of crime.

Regarding Minute 47 – Feedback from the Mental Health Solution Workshop. To note that Healthwatch were only involved in the planning of the solution workshop.

6. NHS SUCCESS REGIME

Jerry Clough, NEW Devon CCG provided the Board with an overview of the Success Regime. It was reported that –

(a) the Success Regime was being overseen by the 3 regulatory bodies, NHS England, Monitor and the Trust Development Authority;

(b) the Success Regime was announced on 3 June 2015 as part of Simon Steven's speech to help the NHS to recover against the backdrop of the forecast deficit for 2014/15 and 2015/16;

(c) Devon was identified as an area and follows on the from the 5 Year Forward View to tackle challenges and ensuring that the healthcare system is sustainable;

(d) external support to take forward the level of transformation identified for the significant financial challenge in the Devon and Plymouth;

(e) across the system we have a combination of financial and performance challenges which is why we are a system that would benefit from the Success Regime;

(f) we need to ensure we have the right leadership behaviours in place to tackle the challenges ahead.

The following comments were made -

(g) that it was important for the new Programme Director (when appointed) to have discussions with the Health and Wellbeing Board and the council on how the interaction of the Success Regime with local systems would happen. Making sure the system in Plymouth interacts with the Success Regime but not in a way that derails or centralises a single response but builds on what we have done locally;

(h) only one meeting taken place with the regulators from the Success Regime and the need to balance the focus on NHS and the impact and opportunity around systems but not sure how this would develop;

(i) the hospital works with two systems Plymouth, Devon and Cornwall as a provider of tertiary services and Cornwall not yet part of the Success Regime. If we plan services for the longer terms we need to look at this. The financial challenges and performance around A & E or time waiting for operation for example both locally and nationally were very significant and suggest an increased focus on the shorter term financial improvement that would get a greater focus and the skill to ensure we build on a sustainable system. This was a challenge but also a great opportunity to make it this as good as it can be for the local population;

(j) the university offer their support and would be interested in working in this area both as the largest provider of healthcare professionals and innovation that build on the productivity gap;

(k) the Community Transformation Partnership has picked up these issues and Plymouth was well sighted in the western locality certainly in terms of the services Plymouth Community Healthcare provide. The Partnership were helping shape the Success Regime for Plymouth area.

Agreed that the Health and Wellbeing Board would welcome an early discussion with the Programme Director of the Success Regime.

7. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2014/15

Sarah Lees, Public Health attended the meeting on behalf of Kelechi Nnoaham to answer the Board's questions in relation to the Director of Public Health Annual Report 2014-15. This is the first report as Director of Public Health who has responsibility to produce an independent report on the health of the local population.

The following comments were made –

(a) this report is interwoven and embedded throughout the Plymouth Plan and community safety, fear of crime and how safe people feel within their communities was well embedded;

(b) each organisation needs to make a commitment to take this back to their own organisations for wider dissemination useful;

(c) the challenge for the Health and Wellbeing Board is to ensure that messages from the report are embedded in the actions we take and our behaviours;

(d) the hospital employs 6,000 people and Kelechi helped launch the hospital's health and wellbeing strategy and the messages in this report will underpin what we are doing for a healthy workforce. The graphics within the report are excellent and should be used within with our own organisations.

8. JOINT STRATEGIC NEEDS ASSESSMENT

Sarah Lees, Public Health provided the Board with a paper on the Joint Strategic Needs Assessment. This is consideration that Kelechi has had with the JSNA Steering Group to rationalise where we are considering all things that might equate to be the same thing and to bring into the same forum in terms of the JSNA and intelligence around system performance for the integrated health and wellbeing system moving forward. The suggestion that the group would change to the Integrated System Performance and Intelligence Group (ISPIG) which would become the body responsible for producing the JSNA in a much more co-ordinated way.

The following comments were made -

(a) ISPIG membership includes representatives from across public health and social care and the local authority are charged from bringing together the JSNA with the expectation topic specific arises then other people can come in to supplement the work of the group;

(b) Healthwatch not mentioned as a member of the group and represents service users in the city as well as gathering intelligence across the city. The Terms of Reference makes no mention of ISPIG reporting back to the Health and Wellbeing Board and as a Board member not actively involved in managing healthcare need to be able to access the latest information to help me undertake my role better especially from a Healthwatch perspective;

(c) would like to see a map of the governance of the group which has the potential with this membership to take on a much wider remit of the JSNA across the region in which Plymouth resides but isn't clear how the specific focus of Plymouth would play out. When we talk about systems would welcome the move to embed this in a wider system to take a wider remit across the region;

(d) Dr Paul Hardy gave reassurance that this group was in formative stages and set to address a gap that he and Kelechi had identified. The group have met and business had changed at each meeting and asked the Board for its patience while they address the gap and to ascertain whether they need to make changes to address the broader agenda;

(e) it was suggested that the Board may find it beneficial to go through the complete process because this group fits into the overall governance structure that has been agreed to deliver the integrated commissioning budget and very detailed map of all the groups set up. Progress to date at a Solution Workshop;

(f) the document talks about health and health inequalities and 80% of police activity doesn't relate to crime but relates to issues of harm and vulnerability and will some health issues and how do we get that strongly enough reflected in this work?.

The Health and Wellbeing Board agreed the recommendations as set out in the report –

1. The production of the Joint Strategic Needs Assessment becomes the responsibility of the Integrated System Performance and Intelligence Group (ISPIG).

2. The Joint Strategic Needs Assessment Steering Group meeting planned for coming are cancelled.

3. The Director of Public Health (as Chair of the ISPIG) provides updates to the Health and Wellbeing Board on the ISPIG workplan and in particular the ongoing development of the JSNA in Plymouth.

The Health and Wellbeing Board also agreed -

4. Board directed the ISPIG group to ensure its membership of data / intelligence officers cover the entirety of the pooled budget (Community Services, Housing, Children's etc).

5. ISPIG will be considered alongside governance of the pooled budget and commissioning plans through a HWB workshop. All members asked to attend.

9. PLYMOUTH INTEGRATED COMMISSIONING BOARD (PICB) COMMISSIONING INTENTIONS

Jerry Clough, NEW Devon CCG provided the Board with a presentation on the 4 Commissioning Strategies. It was reported that -

(a) there are 4 key strategies with one system and one budget to deliver our ambition, the 4 strategies are –

- Wellbeing
- Children and Young People
- Community
- Enhanced and Specialised Care

(b) an overarching aim for a Health and Wellbeing system about improving outcomes, reduction inequalities, experience of care and the sustainability of our health and wellbeing system;

(c) a system that is driven around the citizen, family and carers, about how we access services, people allowing to care for themselves and only telling my story once was very important;

(d) there are aims for each of the 4 strategies and 4 system design groups were being created to oversee the further development of the 4 strategies;

(e) signing off the final versions would place us in a completely different strategic position to undertake the operational planning for 2016/17 based more firmly on these strategies;

(f) a group of officers recently visited Tameside to discuss the similarities and differences between the work we had done on integrated commissioning. The notable feature was the scope of our ambition and the end to end services we have in the integrated fund and 4 commissioning strategies was more than what Manchester were considering. We have undertaken some really impressive work in capturing the range of work we have into 4 strategies which will guide our commissioning work for the future.

In response to questions, it was reported that -

(g) each of the 4 strategies have a system design group which involves all partners interested in the strategies and welcome feedback from the Board on how partners can be represented. The system design group will be relatively larger group engaging around the future of the strategies;

(h) engagement events have been arranged to start discussions to shape the system design groups and recognising that the groups would be working in different way for each of the strategies;

(i) each commissioning strategy has an action plan for 2015-16 and some of the actions would continue into 2016-17 and form the start of the 2016-17 plan. The key elements in the action plan would be picked up by the system design group to look at how we change the system. The system design group are not 'talking shops' they will be action focused on key pieces of work and addressing any changes to put back into the system;

(j) with reference to domestic abuse and currently commissioned services across victims and perpetrators officers were looking at the needs and how we move to new commissioning when required and where do stop or commission in a different way;

(k) the wellbeing aim was ambitious but the point was to try and capture Kelechi's determination and use of employer/employee relationship to drive up health improvements;

(l) two board members are also members of Health Education England South West and we can influence this body to change the profile of education to put a focus on out of hospital care in support of the acute services. This would positively contribute to the Health Education England debate.

Agreed that a Solution Workshop to be arranged to have further discussions on shaping the Commissioning Strategies.

10. WORK PROGRAMME

Board members were invited to forward items to populate the work programme and also attached is the Solution Workshop programme which will now include the integrated commissioning strategies. The following amendments were made –

Work Programme

- Removal of the Care Act Part 2
- Suicide Prevention Work – October to site the board on the prevention work taking place in the city.
- Integrated Commissioning Board Update
- Regular update from the Children and Young People's Partnership

Peter Edwards reported that a Children and Young People Mental Health and Wellbeing Transformation plan in development and suppose to come to this board in August/September. Carole Burgoyne added this would be included as part of the update from the Children and Young People Partnership.

11. EXEMPT BUSINESS

There were no items of exempt business.

Northern, Eastern and Western Devon Clinical Commissioning Group

Developing the local CAMHS Transformation Plan

1. Introduction

1.1 Scene setting

In May this year, NHS England announced plans to develop a major service transformation programme to significantly reshape the way services for children and young people with mental health needs are commissioned and delivered across all agencies over the next 5 years. NHS England set out initial objectives of this transformation programme as:

- Developing evidence based community Eating Disorder Services for children and young people
- Rolling out the Children and Young People's Improve Access to Psychological Therapies Programme (IAPT)
- Improving access to perinatal care

An important part of this programme is the development of local Transformation Plans for each Clinical Commissioning Group (CCG) area.

Further planning guidance was published in August 2015. This guidance explains that local Transformation Plans should set out real improvements for the whole system. This should include the changes, partnerships and investment decisions that will be made to: promote good mental health and build resilience in children and young people; get serious about prevention; intervene early when problems arise; and address unacceptable variations in mental health services for children and young people.

The local Transformation Plans are to be underpinned by the input of children and young people themselves. They are also to be underpinned by partnership working across the system. This includes the completed plans being signed off by Health and Wellbeing Boards. This paper is presented to the Plymouth Health and Wellbeing Board to:

- Describe the planning requirements, including assurance processes
- Set out the scope, design features and resource framework
- Outline the local process for developing the Transformation Plan
- Propose an approach for Health and Wellbeing Board engagement and sign off

Plymouth Health and Wellbeing Board is asked to consider the planning process and agree an approach for sign off for the CAMHS Transformation Plan prior to submission to NHS England for assurance purposes.

1.2 NHS England Assurance

To ensure the local Transformation Plans are of a high standard they will be subject to an assurance process led by NHS England. There are two potential dates for assurance. The CCG is working to develop the draft plan by the first NHS England assurance window of 18th September 2015, although our intention is to then use the time to refine the plan and submit the final draft for the second assurance window on 16th October 2015.

The planning process is associated with the allocation and release of over £1.5 million funding for the CCG area. CCGs will need to evidence that the local Transformation Plan is aligned to the requirements and the plan will need to be deemed satisfactory through the assurance process before full funding is released. This assurance process is expected to be completed and associated funding released to CCGs by the first week in November 2015**.**

It is expected that Transformation Plans will become 'living documents' that local areas will wish to review and develop both 'in year' and within the mainstream organisational planning processes commencing from 2016/17 onwards.

2. Scope of the Transformation Plan

2.1 Future in mind

The context for the local Transformation Plan is set out in *Future in Mind*[1] which describes the Government's aspirations for children and young people and sets out that by 2020 for children and young people with mental health needs there will be:

- Improved crisis care, right place, right time, close to home
- Improved transparency and accountability across the system
- A better offer for the most vulnerable children and young people
- Improved public awareness, less fear, stigma and discrimination
- Timely access to clinically effective support
- More evidence based outcomes focused treatments
- More viable and accessible support
- Professionals trained in child development and mental health
- Model built around the needs of children and young people (move away from tiered model)
- Improved access for parents to evidence based programmes of intervention and support

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

2.2 Design features

Local Transformation Plans will need to span the full spectrum of service provision. They should improve perinatal care, roll out IAPT, develop evidence based eating disorder services and ensure the needs of all children, including the most vulnerable, are addressed within the plan priorities[2]. Additional national guidance has been published for eating disorders[3]. At the present time guidance is awaited for perinatal care.

CCGs will need to demonstrate that their local Transformation Plans:

- Have been designed with, and are built around the needs of, children and young people and their families;
- Are based on the mental health needs of children and young people within the local population;
- Provide evidence of effective joint working both within and across all sectors including NHS, public health, Local Authorities, social care, youth justice, education and the voluntary sector;
- Include reference to other improvement initiatives such as the Crisis Care Concordat;
- Include evidence that plans have been developed collaboratively with NHS England Specialised Commissioning and Health and Justice Commissioning teams;
- Promote collaborative commissioning approaches within and between sectors
- Clarify status within the IAPT programme
- Include the level of investment by all local partners commissioning children and young people's mental health services for the period April 2014 to March 2015;
- Include spend on services directly commissioned by NHS England on behalf of the CCG population;
- Will be published on the websites for the CCG, Local Authority and any other local partners;
- Are based on delivering evidence based practice and focused on demonstrating improved outcomes;
- Make explicit how you are promoting equality and addressing health inequalities;
- Will be monitored by multi-agency boards for delivery supported by local implementation / delivery groups to monitor progress against your plans, including risks;
- Include baseline information for April 2014-March 2015 on referrals made, accepted, and waiting times;
- Include workforce information, numbers of staff including whole time equivalents, skills and capabilities;
- Include measurable, ambitious Key Performance Indicators;
- Have been costed and are aligned to the funding allocation that will be received;
- Take into account the existing different and previous funding streams including the MH resilience funding (Parity of Esteem).

---

[2] http://www.england.nhs.uk/wp-content/uploads/2015/07/local-transformation-plans-cyp-mh-guidance.pdf

[3] http://www.england.nhs.uk/wp-content/uploads/2015/07/cyp-eating-disorders-access-waiting-time-standard-comm-guid.pdf

2.3 Resource framework

The planning process is associated with the allocation and release of funding for each CCG area, pending the plan being deemed to be satisfactory through the assurance process. The published financial detail for NHS Northern, Eastern and Western Devon CCG is described in the table below.

Extract from NHS England Funding Tables - Northern, Eastern and Western Devon CCG

Total weighted populations with SMR<75 adjustment and uplifted by ONS population growth to 2015	919,443
Shares of weighted populations	1.61%
Initial allocation of funding for eating disorders and planning in 2015/16	£481,669
Additional funding available for 2015/16 when Transformation Plan is assured	£1,205,666
Minimum recurrent uplift for 2016/17 and beyond if plans are assured	£1,687,335

The Health and Wellbeing Board will be aware that Southern Devon and Torbay CCG will also submit a local Transformation Plan and both CCGs are looking at the areas within these plans where there are benefits of working together.

3. Local arrangements

3.1 Developing the plan

The CCG Partnerships commissioning team spanning both Devon and Plymouth will be leading this process, working closely with local authority and public health colleagues, providers and other parties to develop a clear and credible local CAMHS Transformation Plan. A small planning team has been established and activities include:

- Baseline data collation, including needs, activity, workforce and views from a range of prior engagement of children and young people
- Developing the local principles and priorities for the plan including outcomes and key performance indicators
- Engaging a range of stakeholders through an event and other engagement opportunities towards the end of September to ensure views are taken into account
- Drafting the planning document and templates to ensure a quality local Transformation Plan

A summary of the NHS England requirements of Transformation Plan submissions is provided as an appendix. Summaries and full drafts of the Plan will be circulated to key stakeholders in the latter half of September 2015. The will be discussed at the CCG Governing Body on 7th October 2015 ahead of submission to NHS England on 16th October 2015.

3.2 Health and Wellbeing Board

The CCG is providing this initial information to the Health and Wellbeing Board at the meeting on 1st October 2015 and this will be followed by circulation of the draft plan for comment ahead of the final draft submission on 16th October 2015. As there is not a further Health and Wellbeing Board meeting before submission, it is requested that arrangements are put in place for sign off by the Chair for submission recognising that the plan will be a 'living document' and will continue to be updated and included in the CCG wider planning process in due course. It will also be important to discuss how the Health and Wellbeing Board will continue to engage in relation to the delivery of the CAMHS Transformation Plan and associated outcomes for children and young people.

J McNeill, Associate, 1st September 2015

Appendix 1: Summary of areas covered for the local Transformation Plan

In addition to a narrative plan, the Transformation Plan includes a series of planning templates requiring a range of information and evidence which spans:

- Leadership and development of the plan, including the partnerships in place
- Objectives and principle changes to be achieved and how the offer will look
- Progress against the national ambitions set out in 'Future in mind'
- Requirements of a structured programme of transformation support
- Self-assessment evidence in relation to:
    - Engagement and partnership
    - Transparency
    - Level of ambition
    - Addressing equality and health inequalities
    - Governance
    - Measuring outcomes
    - Finance
- Compliance and plans for Eating disorder services, including redirection of resources
- Local CAMHS priorities, financial detail and KPI's
- Assurance and sign off

NHS
South Devon and Torbay
Clinical Commissioning Group

NHS
Northern, Eastern and Western Devon
Clinical Commissioning Group

CAMHS Transformation

in

Devon, Torbay and Plymouth

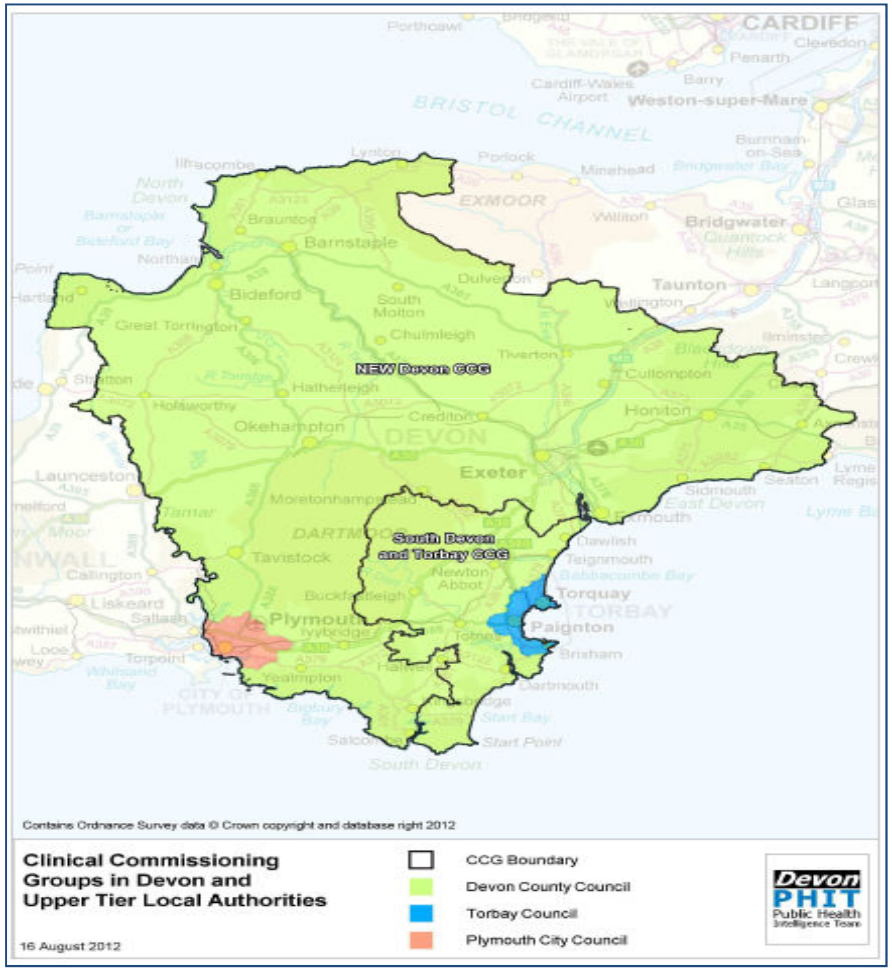
What are the messages from children and young people?

Children and young people told us that mental health is at the top of their concerns about health

Local Healthwatch 2015

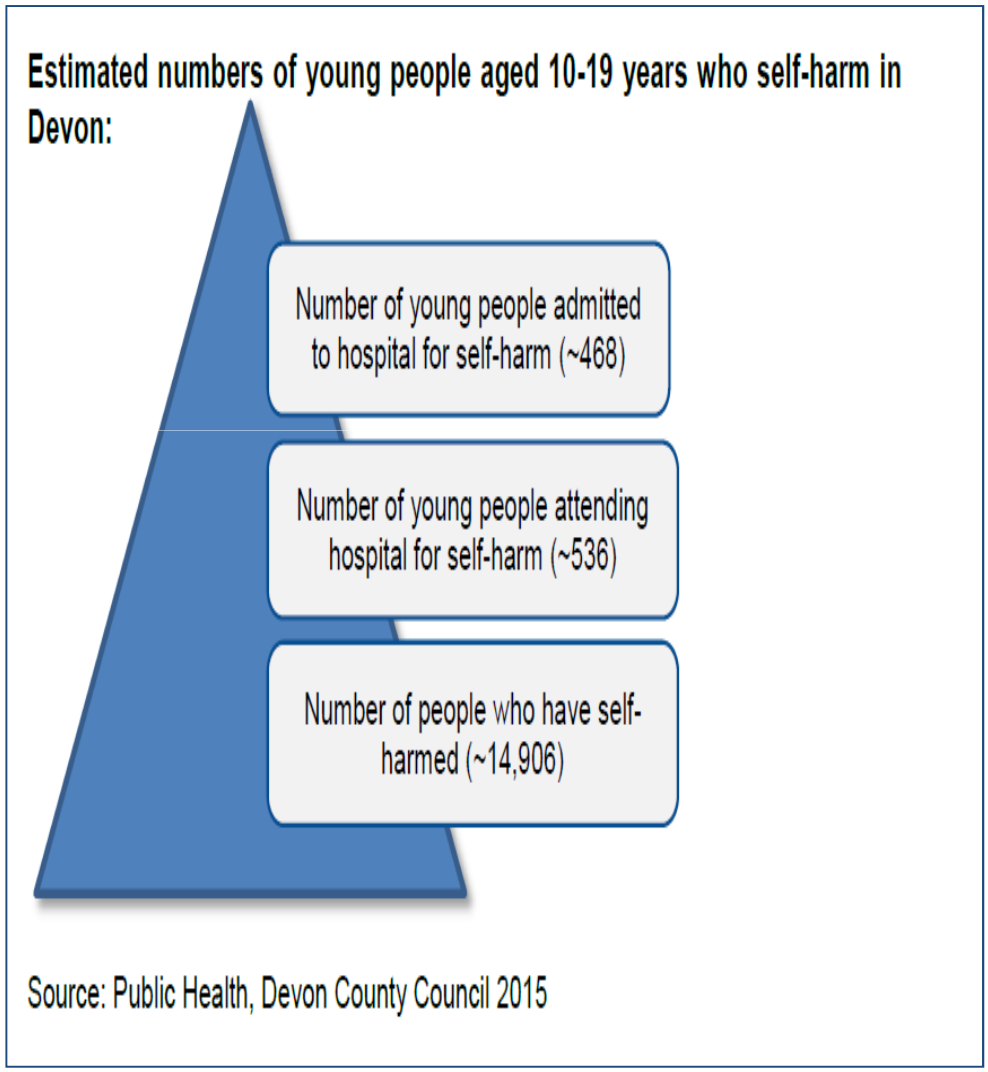
Locally there has been a vast amount of engagement to hear the voice of children and young people and those who work with them in schools, youth centres and health and social care.

What are the needs and considerations locally?



- 0-19 population of more than 200,000
- Mixed rural and urban area
- Span 2 CCGs and 3 local authority boundaries
- Range of understanding e.g. EHWB strategy, needs assessments

What are the realities for children and young people?



- 3709 referrals to CAMHS in last year
- Self harm needs assessment shows we are an outlier
- Approximately 115 young people with Eating Disorders
- New services impact - Assertive Outreach reduced admissions from 27 in August 14 to 17 in August 15

What are our successes to build on?

- CAMHS is already an important local agenda
- Strong advances already to build on
- Shared ambition for real transformation
- Nationally recognised models and good practice
- Commitment from local partners for a whole system approach

Important advances

- Place of Safety
- Crisis Response service
- Access to CAMHS
- Co-support with schools
- Eating disorder service

What else do we need to achieve?

- Make sure future models are evidence based and designed around children and families
- Work as a whole system in interests of children and young people
- See the wider workforce as a focal point for transformation
- Be clear on outcomes and use interventions that are effective and evidence based
- Ensure we use routine outcomes monitoring at an individual level
- Achieve an effective ‘two way’ reach to improve transitions to adult services

How did we reach our priorities?

- Emotional Health and Wellbeing Strategy (draft)
- Self assessment
- Future in mind priorities
- Needs assessments
- Views of young people
- Sharing best practice
- Whole system conversation

What do we consider our main priorities?

Early intervention

- Working with partners and peers
- Early intervention with support at Tier 1 and 2
- Working with adult providers for all age pathways

Crisis response

- Implement requirement of MH Crisis Concordaat
- Timely front door response in acute crisis 24/7
- Assertive outreach over extended hours

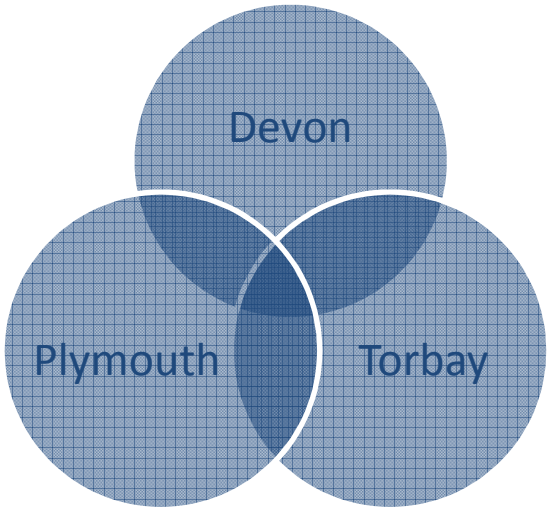
Children in care

- Remodelling CiC pathway
- Enhanced, evidence based therapeutic interventions
- Multiagency support for children on the edge of care

Specific services

- Embed self harm evidence pathway
- Extending Eating disorders model across Devon and Plymouth in line with evidence base

What are our governance plans?



CCG's
Integrated CYP providers
Public Health
Local Authorities
Specialist Commissioning
Clinical leads

- Establish a Single System wide Governance Group to oversee the development and implementation of the CAMHS Transformation plan
- Responsible for wider networking and engagement with stakeholders involved with CAMHS
- Sub group of Children Alliance in Devon; and CAMHS redesign board in Torbay; and CYP System Design Group in Plymouth
- Continue to learn from and build on engagement of children and young people at the centre of transformation

What should children and young people be able to expect?

- Access in a timely way
- Choice over how receive support
- Control over services received
- Integrated support
- Services in line with best practice
- Involved in planning
- Opportunity to influence
- Delivery of *Future in mind*

Extract from Finance Templates

	NEW Devon CCG	South Devon and Torbay CCG
Total weighted populations with SMR<75 adjustment and uplifted by ONS population growth to 2015	919,443	301,074
Shares of weighted populations	1.61%	0.53%
Initial allocation of funding for eating disorders and planning in 2015/16	£481,669	£157,724
Additional funding available for 2015/16 when Transformation Plan is assured	£1,205,666	£394,798
Minimum recurrent uplift for 2016/17 and beyond if plans are assured	£1,687,335	£552,522

This page is intentionally left blank

HEALTH AND WELLBEING BOARD

1 October 2015

Author: Laura Juett

Job Title: Senior Public Health Commissioning and Policy Officer

Department: Office for the Director of Public Health

Date: 21st September 2015

1.0 Introduction

The Alcohol Dashboard is the agreed mechanism for reporting the position and progress of the overall objectives in the Strategic Alcohol Plan. This report updates the Alcohol Dashboard and provides details of the revised Strategic Alcohol Implementation Plan.

Promote Responsibility, Minimise Harm, A Strategic Alcohol Plan for Plymouth 2013-18 was published in August 2013. This defines the first whole systems approach to addressing alcohol in the city.

The Plan defines a coherent and shared strategic approach to tackling alcohol related harm whilst at the same time contributing toward Plymouth's ambition of being 'one of Europe's finest, most vibrant waterfront cities where an outstanding quality of life can be enjoyed by everyone.'

The overall ambition of the Plan is to reduce alcohol related harm in Plymouth.

Specifically the strategy aims to;

- Change attitudes towards alcohol
- Provide support for children, young people and parents in need
- Support individual need
- Create a safer more vibrant Plymouth

In doing so we are seeking to

- Reduce the rate of alcohol attributable hospital admissions
- Reduce levels of harmful drinking by adults and young people
- Reduce alcohol related violence
- Reduce alcohol related anti-social behaviour
- Reduce the number of children affected by parental alcohol misuse

2.0 Update of the reporting framework – the Alcohol Dashboard

The Alcohol Dashboard reports on each of the above indicators. A full update of the Dashboard is shown in Appendix 1 and a summary of main points is provided below.

2.1 Alcohol related admissions to hospital (broad and narrow)

This indicator provides a measure of the burden of health harms and the impact of alcohol related disease and injury at Derriford Hospital. It does not count number of people admitted but rather uses alcohol attributable fractions to calculate the estimated number of admission episodes. These indicators do not include attendances at the Emergency Department that do not lead to admission to hospital.

In 2013/14 the admission rate (broad) was 2,290 per 100,000 population - a slight reduction from 2012/13 when the rate was 2,298. This equates to 5,437 admission episodes. The rate in Plymouth is higher than the England average. It is in the middle of its ONS comparator group areas.

In 2013/14 the admission rate (narrow) was 665 per 100,000 a slight reduction from the 2012/13 rate of 708 per 100,000. This is higher than the England average but the gap between England and Plymouth has narrowed in the last year.

2.2 Levels of harmful drinking

It is notoriously difficult to accurately measure consumption levels. The 2013 Health Survey for England reported that

- 15 per cent of men and 20 per cent of women did not drink any alcohol in the last

- 63 per cent of men and 64 per cent of women drank at levels indicating lower risk of harm *(up to 21 units per week for men and up to 14 units a week for women).* **This equates to an estimated 136,952 people in Plymouth**

- 18 per cent of men and 13 per cent of women drank at an increased risk of harm *(between 21 and 50 units per week for men and 14-35 units per week for women).* **This equates to an estimated 33,362 people in Plymouth.**

- 5 per cent of men and 3 per cent of women drank at higher risk levels (*more than 50 units per week for men and more than 35 units per week for women).* **This equates to an estimated 8,601 people in Plymouth**

The Plymouth 2014 Wellbeing Survey was sent to 6,327 over 18 year olds (r. 1,647) and asked a series of questions about drinking behaviours. 23% of respondents reported they have never drunk alcohol. A further 27% reported that they drink monthly or less. 11% of respondents reported that they drink alcohol on 4 or more occasions a week

The Schools Health Related Behaviour Survey 2014 was carried out in 15 secondary schools with responses from 3,749 pupils in Year 8 (12/13 years) and Year 10 (ages 14-15). 45% of pupils responding to the survey have never drunk alcohol. 25% reported that they usually get/buy alcohol from a friend or relative and 24% reported that they usually get it from their parents/carers

2.3 Alcohol related violence – assaults not reported to the police
This data is captured at the Emergency Department at Derriford Hospital and records assaults not reported to the police – a high proportion of which are alcohol related. Between September 2014 and August 2015 there were between 47 and 97 assaults recorded a month. The ARID database is currently being installed in the Emergency Department to improve intelligence on the location of assaults.

2.4 Alcohol related violence – local measure
This measure is based on violence offences recorded by the police, excluding any domestic abuse offences. It includes 3 offence groups, violence with injury, violence without injury and public order where there has been an incident where one or more people's behaviour has caused alarm or distress to others. A new 'alcohol related flag' has been recorded for violent crimes since April 2014. The definition of an alcohol related offence is '*the victim or offender was under the influence of alcohol or the location indicates it was'.*

The level of **all** violence offences (non-domestic abuse) recorded by the police has been rising since the beginning of 2015. The recent rise is not in the most serious crimes but in those with no or minor injuries and in youth/family related offences. This rise is in line with national data and that seen in cities similar to Plymouth. Alcohol related violence has not seen the same rise during this timeframe.

2.5 Alcohol related anti-social behaviour (proxy measure)
This measure combines two datasets – anti-social behaviour (ASB) incidents recorded by the police as street drinking (either with or without rowdy behaviour) and non-notifiable offences recorded by the police which are relating to drunk behaviour, failure to comply with police direction/designated area and breaches of drink banning order.

Between 2011 and 2014 there was a significant reduction in the number of alcohol related ASB cases. There has been an increase in number of cases per month between January 2015 and

August 2015 to an average of 65 cases a month. Rates of ASB are higher in the City Centre, Devonport and Mutley neighbourhoods.

2.6 Children affected by parental alcohol misuse

Parental alcohol misuse can lead to poor outcomes for children. Between August 2014 and August 2015 there were an average of 421 child protection cases a month and of those 48 where parental alcohol misuse was a classification. This is an overall reduction in the number of children with a child protection plan due to parental alcohol misuse compared to 2013/14**.**

A further indicator is being developed to enhance local understanding of the scale and impact of parental alcohol misuse. This will record the number of cases where parental alcohol misuse is identified through continuing assessment for families that are below the level of child protection.

3.0 2015/16 Implementation Plan

A review of the current Implementation Plan focusing on how we escalate our efforts in reducing alcohol related harm has recently taken place. Two clear themes have emerged from these discussions.

Narrative and key messages

There is a need to articulate a clearer definition of the city's vision re alcohol. We need to develop our narrative around key issues such as the role of alcohol in growth and economic development, the role of alcohol in the evening and night time economy and our messages to Plymouth resident's re sensible/acceptable levels of drinking.

Key to this is having a cost benefit analysis of alcohol in Plymouth. This will provide a better understanding of the value of alcohol to the city and the costs in terms of impact on individuals, families, communities and public services. This in turn will allow us to shape our vision and narrative and inform our conversations with various audiences.

Leadership and influence

As well as clearer messages there are opportunities for more visible leadership around alcohol. This includes a number of conversations to ensure strategic coherence re alcohol across key policy and service areas in the city. These conversations will themselves further shape and refine our key messages and on-going narrative.

Key audiences for conversations are

- Local politicians and leaders
- Key strategic partners – in particular Plymouth University and Plymouth Hospitals NHS Trust
- The public
- National politicians and policy makers

Next Steps

- Public Health will lead work on a cost benefit analysis of alcohol in Plymouth. This will require input from a number of partners including the Police, Plymouth City Council Economic Development and Public Protection Services. This will be completed by November 2015.

- Public Health will lead work to develop and collate a series of info graphics and narratives to improve communications and inform conversations.

- The Alcohol Programme Board will use the outputs from the cost benefit analysis work and other key intelligence sources to refine a vision and key messages (Alcohol Programme Board meeting 10th December 2015).

- Alcohol Programme Board members will define and lead a series of strategic conversations.

- The Alcohol Programme Board will define an approach to engagement and conversations with Plymouth residents.

- The implementation of the current Strategic Alcohol Plan will continue to be led by the Alcohol Programme Board and Accountable Leads.

This page is intentionally left blank

Alcohol-related admissions to hospital
i) Alcohol-related conditions (broad)

Definition

Admission episodes for alcohol-related conditions (primary diagnosis or any secondary diagnosis) all ages, directly age-standardised rate per 100,000 population. Does not include attendance at Emergency Departments that do not lead to hospital admission.

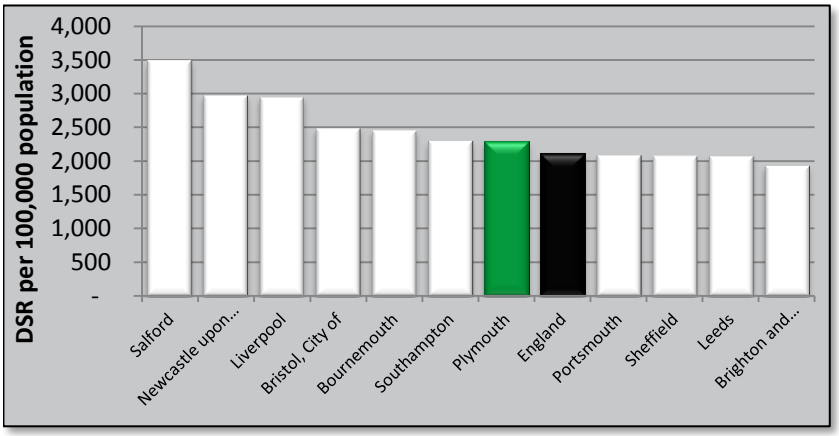
Description

Alcohol-related hospital admission episodes are used to understand and illustrate the impact of alcohol on the health of a population.

Admission episodes are calculated by applying alcohol-attributable fractions (AAF) to all admissions. AAFs calculate what proportion of a health condition is alcohol related. There are 20 conditions that are wholly attributable and have an AAF of 1such as alcoholic liver disease. There are 32 conditions that are partially attributable - that have an AFF of less than 1. These include cardiac arrhythmias, a number of cancers, falls and self-harm.

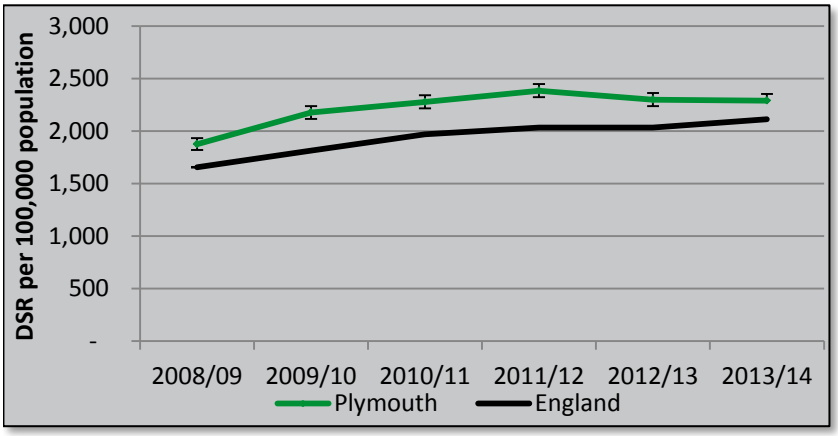
In this way the indicator is not a number of actual people or a number of actual admissions but an estimated number of admissions calculated by adding up all of the alcohol attributable fractions that have been identified.

Alcohol-related admissions to hospital (broad) - 2013/14



The 2013/14 rate of admission episodes (broad) was 2,290 per 100,000 population - a slight reduction from 2012/13 when the rate was 2,298. Plymouth is higher than the England average. It sits in the middle of its ONS comparator group areas.

Alcohol-related admissions to hospital (broad) for Plymouth



Over the last six years admission episodes to hospital (broad) have been higher than the England average. The gap between England and Plymouth has narrowed in the last year.

Interpretation

As far as possible this tells that whole story of hospital admission episodes and goes some way to describe the total burden of alcohol health harms. People are admitted to hospital for the more obvious reasons such as alcoholic liver disease and pancreatitis but also for a range of other conditions where alcohol has played a part such as cancer of the oesophagus, high blood pressure, self-harm and assault. For 2013/14 this equates to 5,437 admission episodes in Plymouth although by definition we know that the number of people admitted is higher than the number of admission episodes.

Alcohol-related admissions to hospital
ii) Alcohol-related conditions (narrow)

Definition

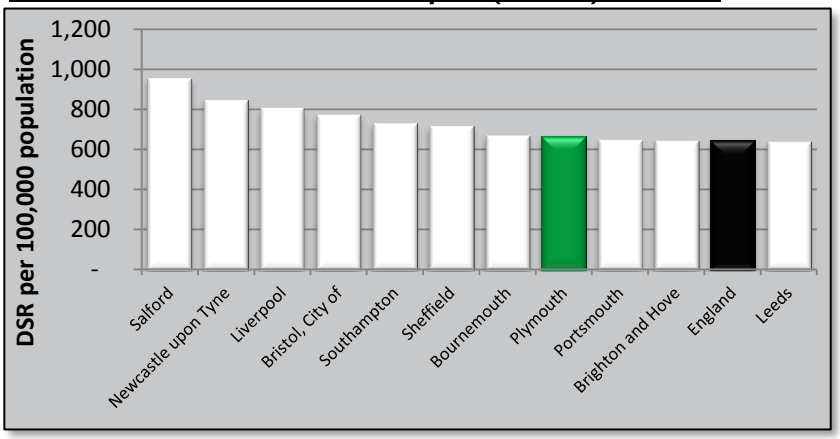
Admission episodes for alcohol-related conditions (primary diagnosis or any secondary diagnosis with an external cause) all ages, directly age-standardised rate per 100,000 population. Does not include attendance at Emergency Departments that do not lead to hospital admission.

Description

This is a subset of alcohol related admissions (broad) measure.

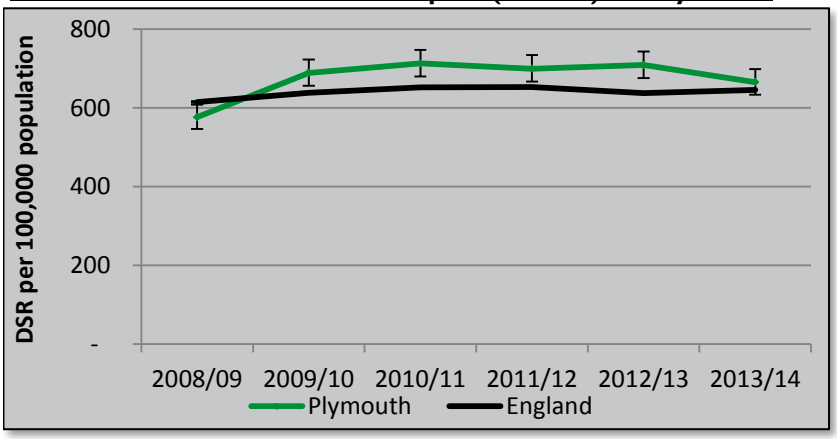
The same methodology using the alcohol attributable fractions is applied but only to admissions where the primary diagnosis has an alcohol attributable fraction and admissions where the primary diagnosis does not have an alcohol attributable fraction but the secondary diagnosis does and is an external cause – such as alcoholic poisoning, assaults and falls.

Alcohol-related admissions to hospital (narrow) - 2013/14



The 2013/14 admission rate (narrow) was 665 per 100,000 a slight reduction from the 2012/13 rate of 708 per 100,000. The Plymouth rate is slightly is higher than the England average but not statistically significant. Compared to ONS comparator group local authorities Plymouth is the fourth lowest out of eleven.

Alcohol-related admissions to hospital (narrow) for Plymouth



Over the last five years admission episodes to hospital (narrow) have been higher than the England average. The gap between England and Plymouth has narrowed since last year.

Interpretation

This provides a narrower measure of alcohol harm and contains a larger proportion of acute conditions.

It is easier to achieve a notable impact with these more acute conditions in a short period of time than it is to achieve a similar impact on chronic conditions which may take several years.

For 2013/14 this equates to 1,640 admission episodes in Plymouth although by definition we know that the number of people admitted is higher than the admission episodes.

Consumption levels
Levels of harmful drinking

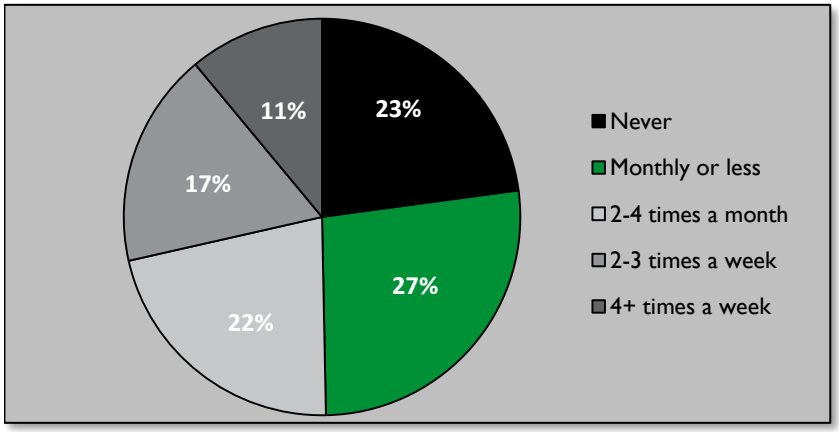
Definition

It is notoriously difficult to accurately report alcohol consumption. There is evidence that people frequent report lower levels of use than data for alcohol sales indicates.

Description

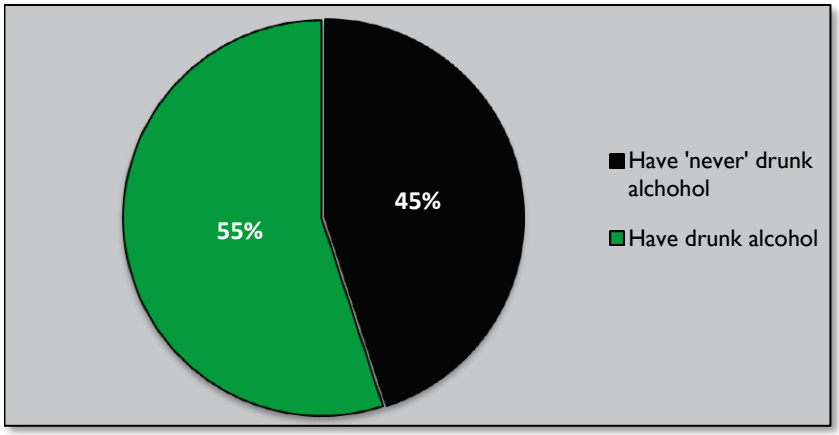
The 2013 Health Survey for England monitors trends in the nations health. In 2013 a total of 8,795 adults were interviewed as part of the survey that included questions about drinking behaviours and patterns.
The 2014 Wellbeing Survey was sent to 6,327 people (r.1,647) and asked a series of questions about drinking behaviours
The Schools Health Related Behaviour Survey 2014 was carried out in 15 secondary schools with responses from 3,749 pupils in Year 8 (12/13 years) and Year 10 (ages 14-15)

How often Plymouth residents have a drink containing alcohol



The Plymouth 2014 Health and Wellbeing Survey shows that
23% of respondents reported that they have never drunk alcohol.
A further 27% reported that they drink monthly or less.
11% of respondents reported that they drink alcohol on 4 or more occasions a week.

The percentage of pupils that have tried alcohol



The 2014 Schools Health Related Behaviour Survey

45% of pupils responding to the survey have never drunk alcohol.

25% reported that they usually get/buy alcohol from a friend or relative and 24% reported that they usually get alcohol from their parents/carers.

Interpretation

The 2013 Health Survey for England reported that
15% of men and 20% of women did not drink any alcohol in the last year
63% of men and 64% of women drank at levels indicating lower risk of harm *(up to 21 units per week for men and up to 14 units a week for women).* **This equates to an estimated 136,952 people in Plymouth**
18% of men and 13% of women drank at an increased risk of harm *(between 21 and 50 units per week for men and 14-35 units per week for women).* **This equates to an estimated 33,362 people in Plymouth.**
5% of men and 3% of women drank at higher risk levels (*more than 50 units per week for men and more than 35 units per week for women).* **This equates to an estimated 8,601 people in Plymouth**
The Plymouth 2014 Wellbeing Survey (1,647 respondents) indicated that over 50% of respondents either never drink or drink monthly or less. 11% drink on four or more occasions. Further editions of the survey will allow recording of trends in consumption over time and provide a measure of progress in this area.
The Schools Health Related Behaviour Survey 2014 reported that 45% of year 8 and 10 have never used alcohol. 24% who have used alcohol usually get it from their parents/carers. This survey will be repeated every two years and will allow recording of trends in drinking behaviours over time.

Alcohol related violence

i) Assaults not reported to the police

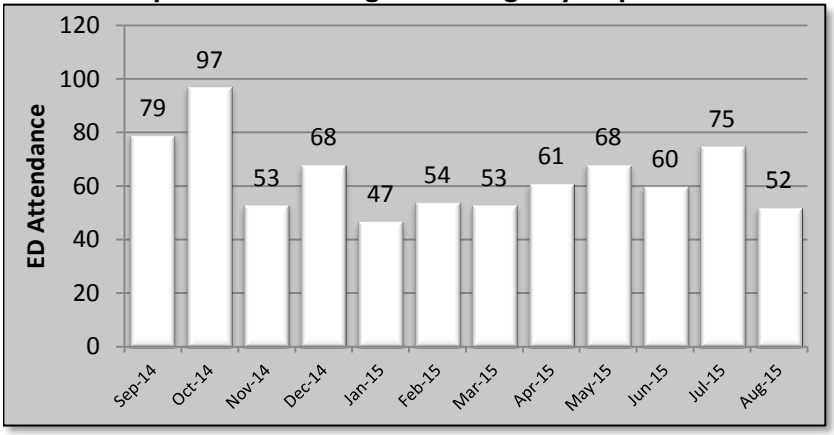
Definition

Hospital Emergency Department assault data - this is sometimes referred to as the Cardiff Model or ARID data. The College of Emergency Medicine recommends a minimum dataset to include time of assault, assault type and location of assault.

Description

Emergency Departments (EDs) can contribute to violence prevention by working with local partners to collect anonymised data about precise location of violence, weapon use, assailants and day/time of violence. A significant number of violent offences which result in hospital treatment are not reported to the police. Information about location and time of assaults, which can easily be collected in EDs can help police and local authorities target their resources much more effectively.

Number of patients attending the Emergency Department because of assaults



Between September 2014 and August 2015 the Emergency Department at Derriford Hospital saw an average of 64 assaults a month. This peaked in October with 97 assaults.

Interpretation

The ARID database is currently being installed at Derriford Hospital Emergency Department. This will improve intelligence around the location of assaults and support improved targeting of response and resources. The data will also be compatible with that collected in other Emergency Departments and Minor Injuries Units in the Peninsula and will contribute to police-force wide intelligence

Alcohol related violence
ii) Alcohol-related violence (local measure)

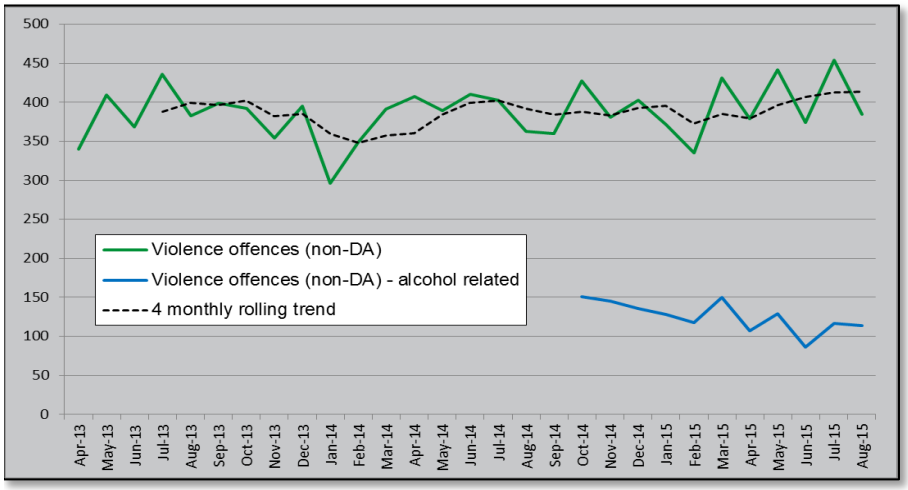
Definition

This measure is based on violence offences recorded by the police, excluding any domestic abuse offences. It includes 3 offence groups: violence with injury, violence without injury and public order offences.
A new 'alcohol related flag' has been recorded for violent crimes since April 2014 and there is a high level of confidence in the data from Oct 2014.

Description

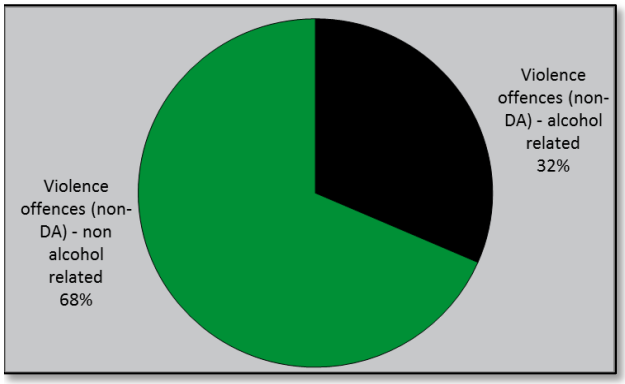
To provide context the overall violence offences (non-DA) trend has been provided for last two and a half years. The graph shows the monthly levels which tend to vary and then the rolling 4 month trend line. The graph also shows 11 months of alcohol related violence data.
The pie charts show the % of violence which is recorded as alcohol related and the types of offences making up the alcohol related violence.

Plymouth Violence offences (excl. domestic abuse) monthly trend (April 2013 to August 2015)

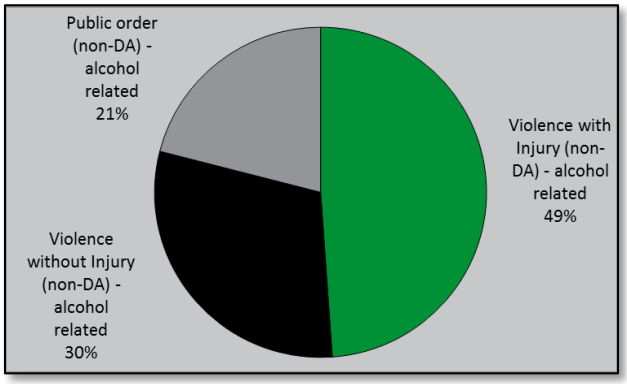


The level of **all** violence offences (non-DA) recorded by the police has been rising since the beginning of 2015. The recent rise is not in the most serious crimes but in those with no or minor injuries and in youth/family related offences. This rise is in line with national data and that seen in cities similar to Plymouth. Alcohol related violence has not seen the same rise during this timeframe.

Oct 2014 to Aug 2015 - Violence offences By alcohol and non-alcohol related



Oct 2014 to Aug 2015 - Alcohol related Violence offences by type



Interpretation

The first pie chart shows that for the 11 month period Oct 2014 to August 2015 32% of all reported offences for violence were recorded as alcohol related. The second pie chart shows the breakdown of alcohol related violence offences from October 2014 to August 2015, where 49% were violence with injury, 30% violence without injury and 21% public order offences.

Alcohol related Anti-Social Behaviour

Issued alcohol related ASB

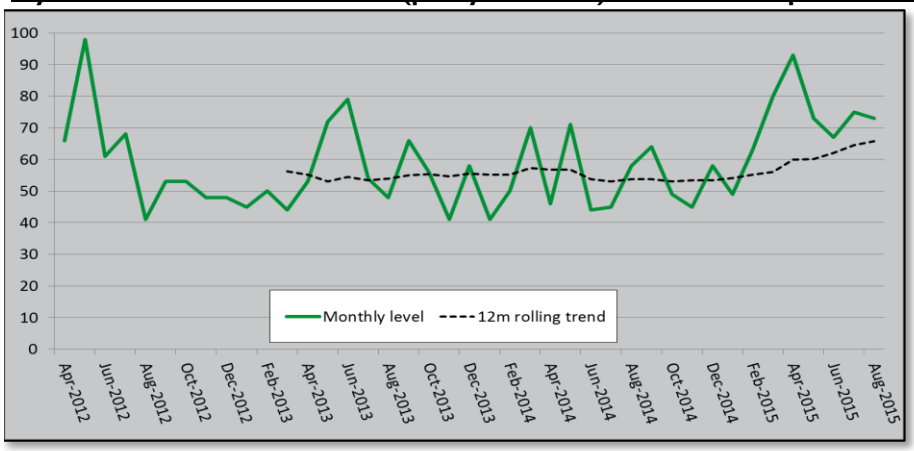
Definition

This is a proxy measure being used until fuller alcohol-related ASB information is available. Two data sets are combined to give these figures – ASB incidents recorded by the police as street drinking (either with or without rowdy behaviour) and non-notifiable offences [1] recorded by the police which are relating to drunk behaviour, failure to comply with police direction/designated area and breaches of drink banning order.

Description

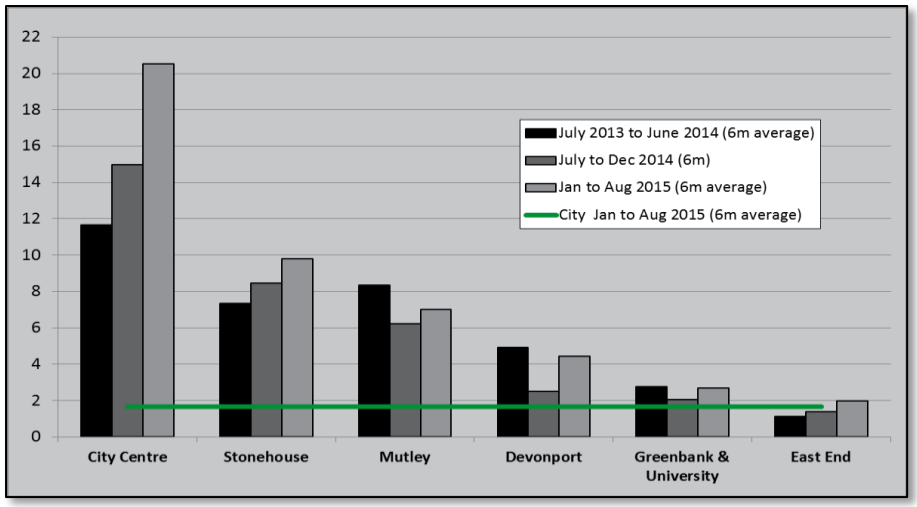
This proxy measure provides a city trend and highlights which neighbourhoods have higher rates of alcohol-related ASB or increasing trend. The aim is to move towards a fuller measure which would cover all alcohol-related ASB recorded by the police and other agencies.

Plymouth Alcohol related ASB (proxy measure) Trend from April 2012 to August 2015



Alcohol related ASB (proxy measure) has seen significant trend down from average of over 80 a month in 2011 to around 55 a month for 2013 and 2014, with slight increase in 2015 to average of 65 a month. This proxy measure is likely to be only a small part of the actual alcohol related ASB for the city but gives an indication of longer term trends.

Plymouth Alcohol related ASB (proxy measure) per 1,000 population Jan to Aug 2015 (average 6 months) compared to previous 6 months for top 6 neighbourhoods against City average



Alcohol related ASB (proxy measure) has risen from a rate of 1.24 per 1,000 population for the City up to December 2014 to 1.67 for period to August 2015. There are 6 of the 39 neighbourhoods which are above this city average rate, with all 6 neighbourhoods showing increased rate for latest period.

Interpretation

The trend for recorded alcohol related anti-social behaviour incidents (proxy measure) has increased over the last 12 months. Rates of alcohol related anti-social behaviour are highest in the City Centre, Stonehouse and Mutley areas.

[1] Non-notifiable crimes are crimes that are recorded by the police but do not have to be notified to the Home Office and therefore do not get included in the national crime statistics

Children affected by parental alcohol misuse

Parent(s) alcohol misuse

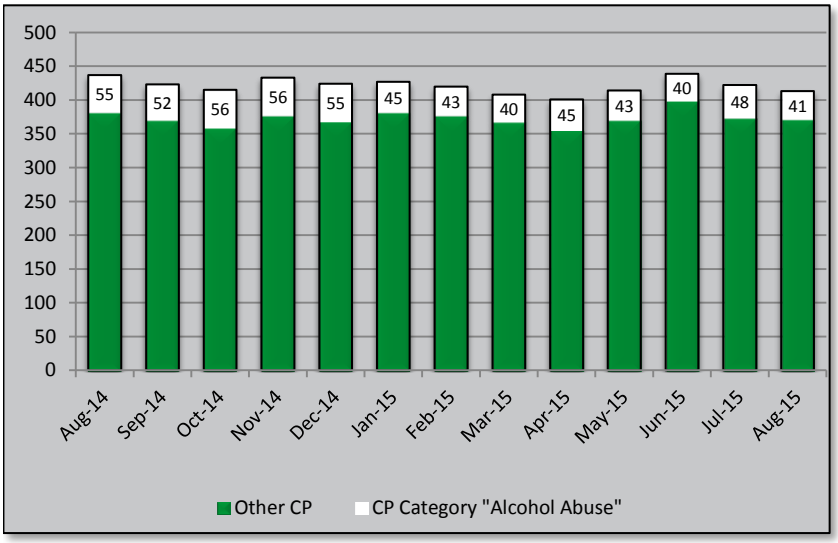
Definition

The number of children with a Child Protection Plan where parental alcohol misuse has been identified as one of the parental classifications presented as a proportion of the total number child protection cases.

Description

Parental alcohol misuse can lead to poor outcomes for children. The prevalence of parental alcohol misuse is not widely understood. There is currently no national recording or reporting of parental alcohol misuse.

Number of children with a CP plan with parental alcohol misuse



The number of children with a child protection plan due to parental alcohol misuse has remained fairly static throughout 2014/2015. This shows that on average (Aug14 - Aug15) there were 421 cases a month and of those 48 where parental alcohol misuse was a classification. This is an overall reduction in the number of children with a child protection plan due to parental alcohol misuse compared to 2013/14

Interpretation

Parental alcohol misuse was a classification in 11% of child protection cases between August 2014 and August 2015. For the first 5 months of 2015/16 there was on average 43.4 child protection cases where alcohol misuse is present which is a around 10 less case per month compared to the first 5 months of 2014/15.
A further indicator is currently being developed. This will record the number of cases where parental alcohol misuse is identified through continuing assessment for families that are below the level of child protection.
Additionally the Health Visitor Caseload Survey is undertaken every two years and records a series of health need factors from over 13,000 families with children under 5 years across Plymouth. In 2014 parental alcohol misuse was recorded in 262 families.

This page is intentionally left blank

SUICIDE AND SUICIDE PREVENTION IN PLYMOUTH

Health and Wellbeing Board 1st October 2015

BACKGROUND

Suicide is a major issue for society and is a leading cause of years of life lost. When someone takes their own life, the effect on their family, friends and colleagues is devastating and many others involved in providing support and care also feel the impact. In England, on average, someone dies every 2 hours as a result of suicide, equating to around 5,000 deaths each year. Suicide is often the end point of a complex pattern of risk factors and distressing events and the prevention of suicide must address this complexity. The estimated overall average cost to society of a case of suicide in England is £1.45 million [at 2009 prices].[i]

A death is officially considered a suicide only when a coroner at an inquest has concluded that the person intentionally took their own life. Deaths by undetermined injury are where the coroner at inquest reaches an open or narrative verdict because the intention of the person is uncertain. Both suicide deaths and deaths by undetermined injury are considered in data analysis at national and local levels.

In recent years between 27% and 30% of people who died by suicide were known to have been in contact with mental health services in the 12 months before their death. Thus by far the majority of people who die by suicide are not known to mental health services. Self-harm is one indicator of suicide risk. Some research[ii]suggests that people who self-harm are 20 times more likely to die by suicide within eight years than those who do not self-harm.

Suicide is the commonest cause of death in men aged <35 years and is the main cause of premature death in people with mental illness. The overall trend in suicide rates in England was decreasing between 1998 until 2008, but has been rising slightly since then. Between 2011 – 2013 the three-year average suicide rate was 8.8 suicides per 100,000 general population.[iii] The majority of suicides continue to occur in adult males [79% of suicides in 2013]. Suicide rates in men aged 45-54 years have risen by 37% since 2006 and in men aged 55-64 years the rise was 29%.[iv]

Suicide is not inevitable; in fact most suicides are preventable. Prevention strategies can be effective by:

- Promoting mental and emotional wellbeing and reducing risk factors that can lead to suicidal ideation
- Providing appropriate and effective support and treatment to enable people to continue with their lives and decide not to take their own lives
- Protecting people and keeping them safe through influencing the media, culture, stigma and reducing the availability and lethality of suicide methods

NATIONAL CONTEXT

In 2012, the Coalition Government launched "Preventing suicide in England; a cross-government outcomes strategy to save lives". The overall objectives of the strategy are;

- To reduce the suicide rate in the general population in England
- To better support those bereaved or affected by suicide

The national strategy identified 6 key areas for action to support the delivery of these objectives and the key areas are;

- Reduce the risk of suicide in key high-risk groups

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

- Tailor approaches to improve mental health in specific groups

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

- Reduce access to means of suicide

- Provide better information and support to those bereaved or affected by suicide

- Support the media in delivering sensitive approaches to suicide and suicidal behaviour

- Support research, data collection and monitoring

There have been two annual reports since the launch of the strategy documenting current trends in suicide, new messages from research, progress on prevention and making further recommendations for action. The All Party Parliamentary Group Report on Local Suicide Plans in England [2015] considers 3 main elements are essential to local implementation of the national strategy;

- Carrying out a local suicide audit to build understanding of local factors
- Developing a suicide prevention action plan based on the national strategy and local data to reduce the suicide risk in the local community
- Establish a multi-agency suicide prevention group involving all key statutory agencies and voluntary organisations

Public Health England have published guidance for local authorities on the development of local action plans and recommends that local plan include

- Monitoring data, trends and hot spots
- Engaging with local media
- Working with transport to map hot spots
- Working on local priorities to improve mental health

Public Health England are piloting a "real-time" surveillance of suicides in collaboration with the police. The primary aim of the pilot is to provide information to front line local authority and NHS staff to enable them to respond to local clusters of suicides and to provide timely support to people bereaved by suicide.

National data on suicide is provided by ONS in their Annual Mortality Extract. Further data is provided in the Annual Report of the National Confidential Inquiry into suicide and homicide by people with mental illness. The Public Health Outcomes Framework includes measures for suicides and self-harm and Public Health England has recently launched a new dataset in their Suicide Prevention Profiles. This data is available down to local authority area level and a current extract is attached as Appendix 1.

Trends and learning from national context where numbers mean can be assured of evidence [small numbers in any one area make this difficult]

REGIONAL CONTEXT

Rates of suicide in the South West rates tend to be above national average for England. The age-standardised three-year average rate of suicide 2011-2013 for the South West Region was 10.1 per 100,000 general population.

In July 2014 the South West Strategic Clinical Network for Mental Health started working on bringing together a collaborative of organisations to share a vision of reducing suicides in the South West to zero by October 2018. Through collaborative working, organisations from across the region and different sectors have been working with people with lived experience of suicide to understand what improvements need to be made, identify suitable improvement projects and coming together to learn and share experience. The collaborative recognises that the vision is an aspirational one and will be hard to achieve but is worthwhile, compelling and inspiring.

LOCAL CONTEXT

Local authorities are the lead agencies for suicide prevention and the leadership responsibility most often sits with the Director of Public of Health and their team. The complexity of risk factors for suicide means however that many local agencies are required to be involved in local suicide prevention activity.

In Plymouth the Office of the Director of Public Health conducts an annual suicide audit and produces a summary as part of the Joint Strategic Needs Assessment. The latest summary for 2010-2012 is attached as Appendix 2. The general approach taken in producing the audit is that outlined in the National Institute for Mental Health in England document Suicide Audit in Primary Care Trust Localities [2006]. The audit process covers the deaths of Plymouth residents only and those aged 15 or over. The process includes identifying deaths from suicide and also open verdicts from the weekly deaths register, then visiting the coroner's office to find information. Information is also requested from GPs, mental health services and hospitals as required. A record of all deaths during the year is kept and then checked against the annual death extract data when available. The suicide audit undertaken by ODPH looks back in time and gathers information to confirm numbers, causes and other pertinent information. In the 3 year period 2011 – 2013 84 Plymouth residents died by suicide or undetermined injury. The suicide rate in Plymouth 2010 – 2012 was 10.8 deaths per 100,000 population which was above national and regional average values.

The local authority audit is not the only suicide audit that takes place. Mental health service providers and others conduct their own audits, including of attempted suicide and self-harm, which provide additional local data to inform service design and improvement and the prevention agenda.

In response to the national strategy launched in 2012, a local suicide prevention steering group was formed and convened by Public Health. This group was originally made up of those individuals and agencies who were interested in working towards a local approach for the national strategy and has developed over time into a functioning steering group with well-developed relationships. The group has developed an action plan to deliver locally appropriate actions to meet the ambitions of the national strategy. There is a focus in the group on sharing information to identify local issues and solutions where possible. As well as considering suicide data and suicide prevention, the group also consider self-harm. Current members include ODPH, Plymouth City Council Cooperative Commissioning, NEW Devon CCG, Plymouth Community Healthcare [CAMHS, Options, Mental Health Services, Training, Livewell], Police, Age Concern, CASS, Samaritans, MIND, University of Plymouth, The Zone. Plymouth Hospitals Trust and the Coroner's office are included in all of the group's correspondence but have not been able to attend group meetings in the last year. The latest action plan is attached as Appendix 3.

The make-up of the group and the action plan meet the recommendations made by Public Health England on local suicide prevention and plans. The local work as outlined above also delivers the 3 recommended elements outlined by the All Party Parliamentary Group on suicide and self-harm

APPENDICES

Appendix 1 South West Region Suicide Prevention Profile Extract

Appendix 2 Plymouth Suicide Audit Summary 2010 – 2012

Appendix 3 Plymouth Suicide Prevention Action Plan

[i] Knapp M, McDaid M and Parsonage M. PSSRU London [2011] Mental Health Promotion and Mental Illness Prevention – the economic case

[ii] Hawton and Fagg [2008] Suicide following deliberate self-harm: long-term follow-up of patients who presented to a general hospital

[iii] Dept of Health [2015] Statistical update on suicide

[iv] University of Manchester [2015] National confidential inquiry into suicide and homicide by people with mental illness. Annual Report for England, Northern Ireland, Scotland and Wales.

PUBLIC HEALTH ENGLAND - SUICIDE PREVENTION PROFILE

Compared with benchmark: Lower Similar Higher | Not compared

Data quality: Significant concerns | Some concerns | Robust

Suicide Data : South West Region – Local Authorities

Indicator	Period		England	South West region	Bath and North East Som...	Bournemouth	Bristol	Cornwall	Devon	Dorset	Gloucestershire	Isles of Scilly	North Somerset	Plymouth	Poole	Somerset	South Gloucestershire	Swindon	Torbay	Wiltshire
Suicide age-standardised rate: per 100,000 (3 year average) (Female)	2011 - 13		4.0	4.9	*	*	5.2	6.2	4.9	5.2	4.3	*	*	*	*	5.2	*	*	*	4.1
Suicide age-standardised rate: per 100,000 (3 year average) (Persons)	2011 - 13		8.8	10.1	10.2	9.6	10.0	11.7	10.4	10.2	11.5	*	9.6	11.3	8.3	9.8	7.6	9.3	11.7	8.0
Suicide age-standardised rate: per 100,000 (3 year average) (Male)	2011 - 13		13.8	15.6	15.6	14.5	14.8	17.6	16.4	15.4	19.1	*	12.6	18.7	12.1	14.9	11.4	13.9	20.5	12.2
Persons years of life lost due to suicide age-standardised rate 15-74 years: per 10,000 persons (3 year average)	2011 - 13		31.4	35.9	35.6	31.7	37.3	*	37.1	38.8	42.2	*	38.9	40.4	27.4	34.4	23.9	33.8	40.1	30.4
Female years of life lost due to suicide age-standardised 15-74 years: rate per 10,000 females (3 year average)	2011 - 13		13.4	17.1	12.6	14.8	16.5	*	17.2	18.6	15.3	*	25.2	17.0	12.5	20.7	14.2	14.7	10.6	17.4
Male years of life lost due to suicide age-standardised rate 15-74 years: per 10,000 males (3 year average)	2011 - 13		49.5	54.7	58.7	47.8	57.5	*	57.6	58.4	69.2	*	52.8	64.0	42.2	48.6	33.7	52.7	71.4	43.6
Female suicide crude rate 15-34 years: per 100,000 females (5 year average)	2009 - 13		3.30	4.57	4.57*	4.57*	4.57*	4.57*	4.57*	4.57*	4.57*	4.57*	4.57*	4.57*	4.57*	4.57*	4.57*	4.57*	4.57*	4.57*
Female suicide crude rate 35-64 years: per 100,000 females (5 year average)	2009 - 13		5.84	6.73	6.73*	6.73*	6.73*	6.73*	6.73*	6.73*	6.73*	6.73*	6.73*	6.73*	6.73*	6.73*	6.73*	6.73*	6.73*	6.73*
Female suicide crude rate 65+ years: per 100,000 females (5 year average)	2009 - 13		4.22	4.90	4.90*	4.90*	4.90*	4.90*	4.90*	4.90*	4.90*	4.90*	4.90*	4.90*	4.90*	4.90*	4.90*	4.90*	4.90*	4.90*
Male suicide crude rate 15-34 years: per 100,000 males (5 year average)	2009 - 13		12.3	14.1	13.7	12.6	13.3	15.1	12.9	17.0	18.2	*	20.0	15.3	15.0	11.0	7.2	14.4	16.2	13.4
Male suicide crude rate 35-64 years: per 100,000 males (5 year average)	2009 - 13		20.1	22.5	18.8	22.1	24.3	23.3	23.1	21.0	28.0	42.7	21.5	28.4	15.2	21.6	15.0	18.8	30.7	18.9
Male suicide crude rate 65+ years: per 100,000 males (5 year average)	2009 - 13		12.1	14.2	11.2	18.1	11.3	17.0	16.5	10.9	16.6	-	5.2	14.9	8.9	18.0	16.6	9.0	18.7	8.7

Related Risk Factors : South West Region – Local Authorities

Indicator	Period	England	South West region	Bath and North East Som...	Bournemouth	Bristol	Cornwall	Devon	Dorset	Gloucestershire	Isles of Scilly	North Somerset	Plymouth	Poole	Somerset	South Gloucestershire	Swindon	Torbay	Wiltshire
Estimated prevalence of opiates and/or crack cocaine use: rate per 1,000 aged 15 - 64	2011/12	8.4	7.7	10.7	15.2	18.0	5.6*	4.8	5.6	6.9	*	7.9	12.1	5.7	5.6	5.2	8.1	10.2	3.8
Higher risk drinking: % of people drinking at increasing or higher risk levels	2008 - 09	22.3	23.4	24.4	23.5	23.3	22.8	23.8	23.1	23.6	-	23.6	23.4	22.6	23.3	23.8	23.1	22.2	24.2
Long-term health problems or disability: % of people whose day-to-day activities are limited by their health or disability	2011	17.6	18.4	16.1	18.6	16.7	21.4	19.5	20.1	16.7	14.0	19.1	20.4	18.4	18.8	15.6	15.4	24.0	16.0
Self-reported well-being: % of people with a low satisfaction score	2013/14	5.6	5.3	4.7	5.1	9.0	4.4	4.9	4.3	4.9	*	*	5.3	5.1	4.9	*	6.5	7.7	5.3
Self-reported well-being: % of people with a low worthwhile score	2013/14	4.2	4.4	4.6	5.3	6.0	4.1	*	*	*	*	-	5.7	*	4.9	-	*	5.7	*
Self-reported well-being: % of people with a low happiness score	2013/14	9.7	9.7	8.4	11.5	11.9	11.3	8.5	9.2	8.5	*	9.4	10.2	9.3	10.1	8.4	11.7	12.8	7.9
Self-reported well-being: % of people with a high anxiety score	2013/14	20.0	19.3	23.8	18.0	21.4	20.9	18.1	20.6	18.1	*	18.6	21.3	18.2	15.8	14.9	20.9	22.1	20.7
Prisoner population: Number	Sep 2014	-	-	-	-	-	594	-	1914	1401	-	-	-	-	-	-	1179	-	-	519
Children in the youth justice system: rate per 1,000 aged 10 - 18	2013/14	7.0	6.7	8.3	6.2*	11.3	5.8	5.6	4.6	5.8	*	8.6	8.5	6.2*	7.4	7.4	9.4	8.2	4.3
Looked after children: Rate per 10,000 <18 population	2013/14	59.8	51.0*	43.8	83.5	76.8	42.7	48.4	44.0	38.7	0.0	50.9	77.0	50.9	45.1	29.9	52.1	126.4	38.2
Children leaving care: Rate per 10,000 <18 population	2013/14	26.4	27.1*	20.5	37.3	35.9	27.8	24.7	22.0	22.4	0.0	30.8	36.1	27.2	27.6	14.9	28.1	62.2	21.3
Domestic abuse incidents: rate per 1,000 population	2012/13	18.8	14.2	12.0	13.5	12.0	19.4	19.4	13.5	11.9	19.4	12.0	19.4	13.5	12.0	12.0	9.6	19.4	9.6
Relationship breakup: % of adults whose current marital status is separated or divorced	2011	11.6	12.2	10.1	13.2	10.7	13.0	12.2	12.0	11.8	11.2	12.6	13.0	12.6	12.6	11.1	12.7	14.8	11.9
Statutory homelessness: rate per 1000 households	2013/14	2.3	1.4	0.9	1.7	2.6	0.9	1.0	1.1	1.1	1.0	0.9	2.5	0.9	1.9	1.2	1.2	0.9	2.0
People living alone: % of all households occupied by a single person	2011	12.8	13.3	13.3	17.0	14.7	13.2	13.5	13.3	13.0	15.8	13.6	13.7	13.2	13.1	11.1	12.6	15.8	11.3
Older people living alone: % of households occupied by a single person aged 65 or over	2011	5.24	6.06	5.88	6.23	4.84	6.52	6.80	7.45	5.77	7.07	6.29	5.34	6.47	6.48	4.76	4.35	7.57	5.37
Unemployment: % of working age population	2013	7.4	5.8	5.0	6.9	7.8	5.9	4.8	5.7	5.5	-	5.3	9.0	4.0	4.5	5.4	6.7	7.0	5.5
long-term unemployment: % of working age population	Oct 2014	0.61	0.30	0.23	0.39	0.56	0.31	0.18	0.16	0.34	0.00	0.27	0.48	0.21	0.22	0.25	0.31	0.69	0.21

Related Service Contracts : South West Region – Local Authorities

Indicator	Period	England	South West region	Bath and North East Som...	Bournemouth	Bristol	Cornwall	Devon	Dorset	Gloucestershire	Isles of Scilly	North Somerset	Plymouth	Poole	Somerset	South Gloucestershire	Swindon	Torbay	Wiltshire
Emergency Hospital Admissions for Intentional Self-Harm: Directly age-sex standardised rate per 100,000	2013/14	203.2	-	271.9	329.7	286.0	244.5*	235.7	245.9	283.0	*	244.0	199.8	242.5	272.5	182.7	299.0	259.2	245.3
Adults in treatment at specialist drug misuse services: rate per 1000 population	2013/14	5.0	4.6	6.0	8.6	10.5	3.6*	2.7	4.0	3.7	*	4.9	8.1	2.9	3.1	3.8	4.2	7.2	2.2
Adults in treatment at specialist alcohol misuse services: rate per 1000 population	2013/14	2.3	1.7	2.6	1.8	1.6	2.1*	2.2	2.1	1.3	*	1.4	2.1	1.4	0.7	0.8	2.5	4.5	1.2
Successful completion of drug treatment - opiate users: % who do not re-present within 6 months	2013	7.8	8.5	7.7	6.5	8.7	10.6*	9.5	12.1	5.7	*	9.5	7.2	15.3	10.1	9.3	5.0	8.4	6.1
Successful completion of drug treatment - non-opiate users: % who do not re-present within 6 months	2013	37.7	37.6	33.7	34.2	47.8	40.0*	46.0	43.5	24.8	*	44.7	28.9	39.8	35.3	29.7	36.3	35.0	23.0
Successful completion of treatment for alcohol: % who do not re-present within 6 months	2013	42.5	47.7	48.7	38.2	50.8	49.4*	55.5	48.2	32.4	*	73.1	40.0	40.7	47.0	48.4	48.4	51.9	36.2
Social care mental health clients receiving services during the year: Rate per 100,000 population	2013/14	384	499*	174	194	171	2331	868	139	98	0	132	95	303	397	256	379	452	78

This page is intentionally left blank

PLYMOUTH SUICIDE AUDIT – SUMMARY

Deaths registered 2010 to 2012

Authors: Moira Maconachie and Simon Hoad

Date: July 2014

This profile is produced as part of Plymouth's Joint Strategic Needs Assessment.

For further information please contact

Office of the Director of Public Health
Plymouth City Council
Windsor House
Plymouth PL6 5UF
odph@plymouth.gov.uk

Date: July 2014 v1.0

Plymouth suicide audit reports present data for deaths registered in a particular calendar year, enabling comparisons with national ONS data which is also presented by year of registration. Death by suicide or undetermined injury is a rare event in Plymouth and the numbers of deaths fluctuate from year to year.

Plymouth Suicide Audit – Summary

Based on deaths registered in 2010, 2011 and 2012

Deaths by suicide and undetermined injury

Purpose and focus

This report provides an overview of deaths by suicide and undetermined injury among Plymouth residents. It updates the information provided in the previous Plymouth Suicide Audit Summary (2009-2011).[1] Local suicide audits are undertaken to support suicide prevention initiatives in the city.

Deaths of Plymouth residents are included in this audit whether they died in Plymouth or elsewhere in the UK. The data presented refers to the deaths of adult residents (15 years and older) registered during calendar years 2010, 2011 and 2012. However, not all of these deaths will have occurred during these three years as deaths by suicide and undetermined injury are registered only after an inquest has taken place.

Definition of suicide and undetermined injury

A death is officially considered a suicide only when a coroner at an inquest has concluded that the person intentionally took their own life. Deaths by undetermined injury are where the coroner at inquest reaches an open or narrative verdict because the intention of the person is uncertain. Only open and narrative verdicts which are considered deaths by undetermined injury are included in the suicide audit.

Estimated cost

The estimated overall average cost to society per case of suicide (whole population) in England (at 2009 prices) was £1.45m.[2]

Audit process and data sources

Deaths included in this audit have been checked and verified using the Annual Mortality Extract for Plymouth from the Office of National Statistics. Deaths from suicide are confirmed using the ICD10 codes X60-X84 ('intentional self-harm') and deaths from undetermined injury are identified using ICD10 codes Y10-Y34, excluding Y33.9 ('event of undetermined intent').[3]

The local suicide audit process involves monitoring all deaths where the coroner has given a verdict of suicide, an open or a narrative verdict. During the year information is collected from the Coroner's Office, from the Register of Weekly Deaths, and from the monthly Primary Care Mortality Database. The trend data for this report is drawn from the Public Health Outcomes Framework (June 2014 download) and the rates provided are for all ages. In line with national guidance, the local suicide audit process seeks further information about the deceased's contact with local health care services prior to their death.

Number of deaths 2010-2012

- 80 deaths in total: 68 Plymouth residents died by suicide and 12 residents died by undetermined injury (UI)
- More deaths were registered in 2012 than in 2011 or 2010 (33 deaths compared to 24 in 2011 and 23 in 2010)
- An average of 2 or 3 deaths every month
- 10 non-residents died by suicide/UI in Plymouth (they are not included in this audit)

Average rates

- The average number of deaths per year from 2001 to 2012 is 25
- The directly age-standardised death rate for the period 2010-2012 is 10.8 deaths per 100,000 population (above the rate for England of 8.5 deaths per 100,000 population)

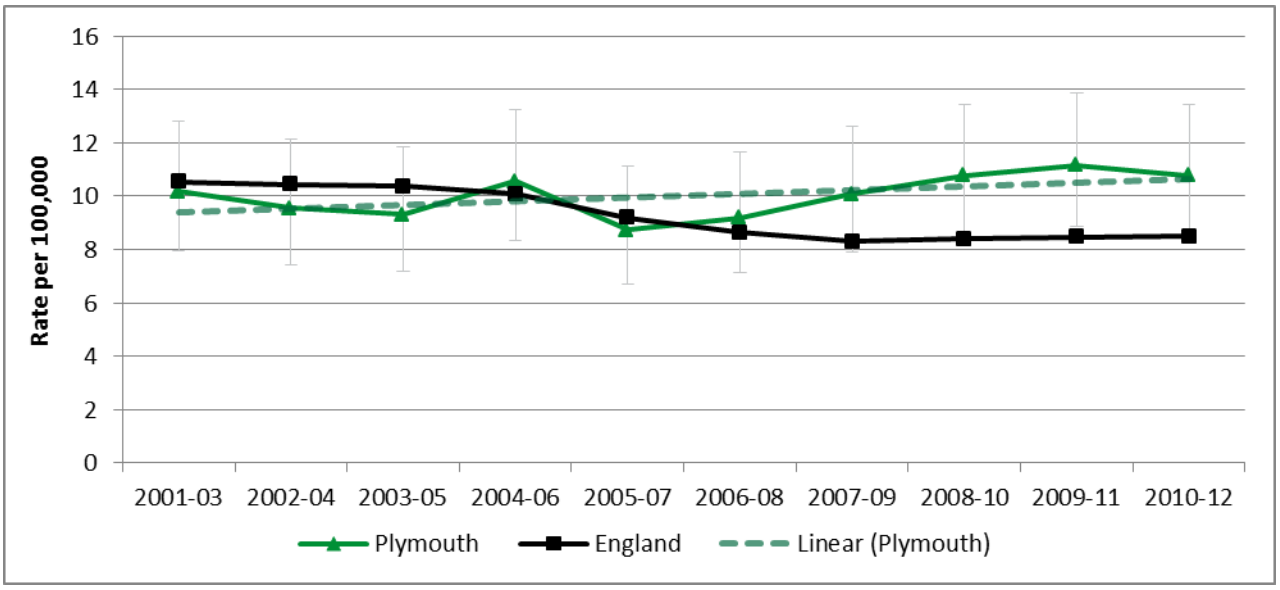
Gender differences

- 63 men and 17 women died (three times as many men than women died)
- 14 of the 17 women died by suicide (3 UI deaths)
- 54 of the 63 men died by suicide (9 UI deaths)

Place of birth

42 people who died were born in Plymouth, 31 were born elsewhere in the UK, and 7 were born outside the UK

Trends in mortality from suicide and undetermined injury, England & Plymouth 2001-2012



Source: Public Health Outcomes Framework (June 2014 download)

Age groups

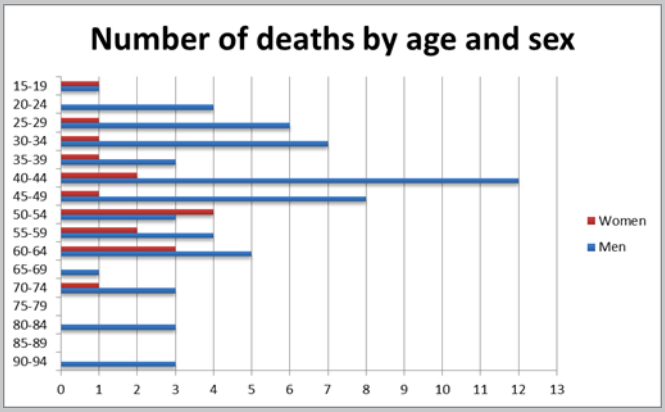
- The youngest person who died was 17 years old and the oldest was 93 years old
- 2 people who died were younger than 20 years old
- 3 people who died were over the age of 90
- More than half of all deaths occurred between the ages of 40 and 64 (44 of the 80 deaths)
- Deaths among men occurred across the life course (highest among 40 year olds)
- All the women who died were younger than 75

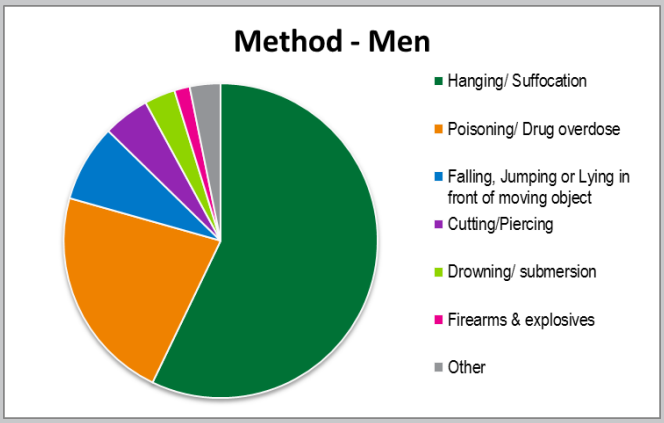
Method

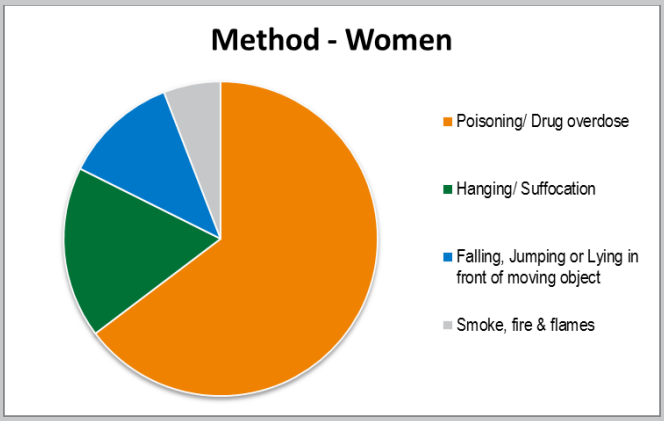
- Hanging/suffocation is the most common method (39 of the 80 deaths) followed by poisoning /drug overdose (25 of the 80 deaths)
- 36 men died by hanging/suffocation; 14 by poisoning/drug overdose; 5 by falling, jumping or lying in front of a moving object; 3 by cutting/ piercing; 2 by drowning/ submersion; one by firearms; and, 2 by other means
- 11 women died by poisoning/drug overdose; 3 by hanging/suffocation; 2 by falling, jumping or lying in front of a moving object; and, one by smoke, fire and flames

Place of death

- 52 people died at home and 11 died elsewhere in the city
- 11 had their place of death noted as Derriford Hospital
- 6 Plymouth residents died outside the city





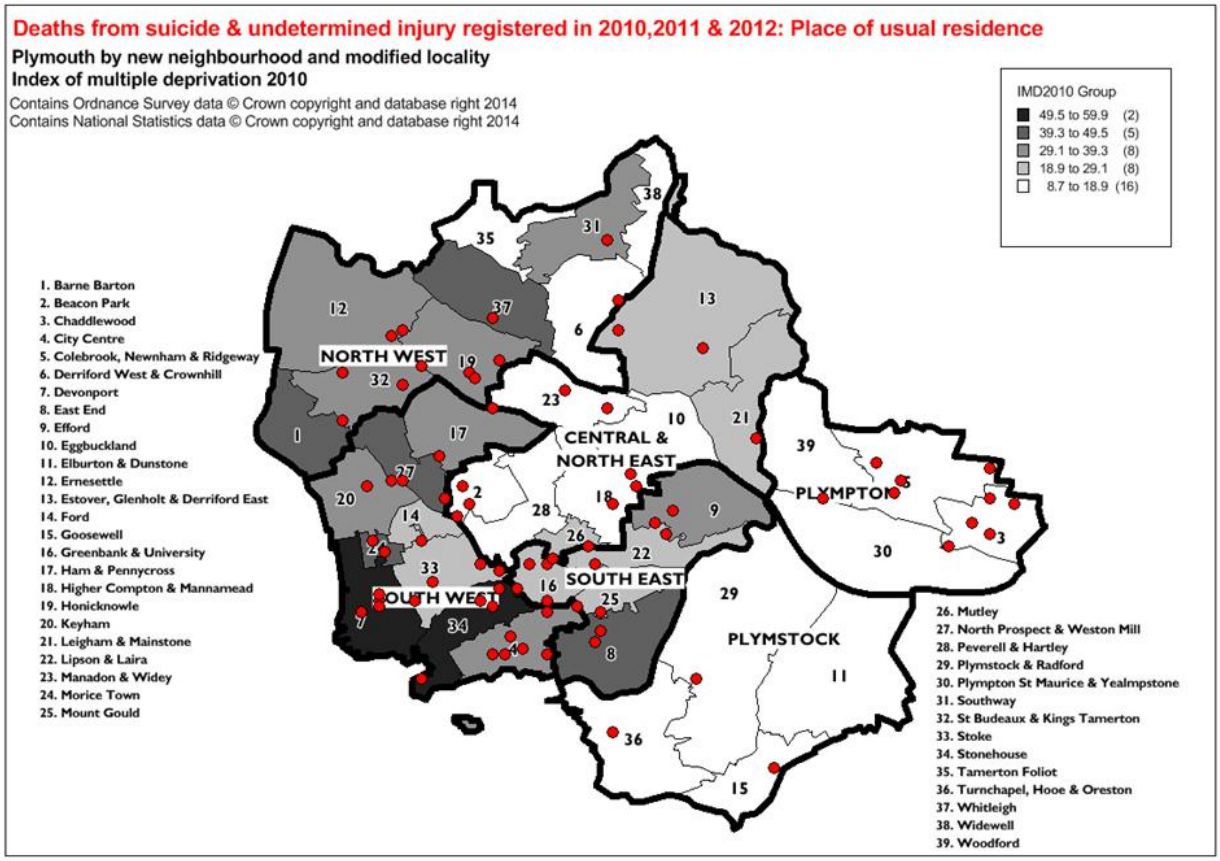


Source: Office for National Statistics

Map of where they lived

Death by suicide/UI is an issue across the city

- All six localities in the city had at least one resident die by suicide/UI (ranging from 27 deaths in the South West locality to 3 deaths in the Plymstock locality)
- 'St Peter & the Waterfront' ward had the highest number of residents die by suicide/UI (10 deaths)
- 'City Centre' and 'Stoke' neighbourhoods had the highest number of residents die by suicide/UI (6 deaths in each neighbourhood)



Source: Office for National Statistics

References

1. Maconachie, M (2012) Plymouth Suicide Audit - Summary (deaths registered in 2009, 2010 & 2011). Plymouth: Plymouth Public Health, NHS Devon, Plymouth & Torbay.
2. Knapp, M., McDaid, M. & Parsonage, M (eds) (2011) Mental Health Promotion and Mental Illness Prevention: The economic case. London: PSSRU, London School of Economics & Political Science.
3. World Health Organisation (2010) International Statistical Classification of Diseases and Related Health Problems, 10th Revision. Geneva: WHO.

Acknowledgements

The Public Health Team wishes to thank the following agencies and individuals for supporting the local suicide audit process: the Coroner's Office, General Practitioners, Graham Burton, Clinical Risk Advisor (Plymouth Community Healthcare CIC) and Justin Whyatt (Plymouth Hospitals NHS Trust.

PLYMOUTH SUICIDE PREVENTION ACTION PLAN

Action		Milestones and Outcomes	Timescales		Status	Leads	Key Partners	Action Progress/Comments
			Start Date	End Date				
Reduce the risk of suicide in key high-risk groups								
1	Identify all groups and service providers working with high risk groups	• Draft list of groups to be worked up by Public Health for discussion at Steering Group • Service providers in contact with groups identified by Steering Group	01/07/15	22/09/15 22/09/15		Public Health Steering Group	Service Providers	 To conclude at Meeting on 22/09/15
2	Identify clear pathways of referral and support including information (POD)	• Signposting leaflet from Livewell Team • Links to key websites • Sense check of POD and links		31/08/15		Livewell Team PCC POD & Livewell		Completed and on website
3	Safeguarding improvement through information sharing	• Information and intelligence sharing through Steering Group • Steering Group to design shared risk management procedure and risk notification process • Use Suicide Audit data where possible to improve local planning via Steering Group	22/09/15	Ongoing function 30/11/15 Ongoing function		Steering Group Members Public Health and Steering Group		 Volunteers needed

4	Raise awareness with service providers and those likely to come into contact with high risk groups	• Provide information to enable signposting to support services for known high risk individuals • Access to training to raise awareness of issues and confidence in talking about them	30/11/15	15/12/15		Public Health Livewell	Service Providers	
5	Target ASIST, STORM and Mental Health First Aid training at those likely to come into contact with high risk groups	• Access to training to raise awareness of issues and confidence in talking about them		Ongoing function		Livewell Team Training Providers		Additional funding from successful HEE bid with other LA's in Peninsula will deliver 2 people trained in SafeTalk and 1 further trainer in ASIST

Action		Milestones and Outcomes	Timescales		Status	Leads	Key Partners	Action Progress/Comments
			Start Date	End Date				
Tailor approaches to improve mental health in specific groups								
1	Promote mental wellbeing and emotional resilience in all settings including schools, older people settings and non-mental health settings	• MHFA Youth • MHFA in the Workplace • 5 ways to wellbeing • "Beyond Fed Up" – development of resilience course		Ongoing function		Public Health Livewell Team		Full details of training programme on Livewell webpages. Update report at December steering group on activity levels to date.
2	Work with Community Covenant Group to promote wellbeing for service Veterans and families	• Familiarisation with 5 ways to wellbeing • Pathways to include signposting • Explore potential for MHFA for armed forces, veterans, families, reservists	01/07/15	31/12/15		Public Health	Community Covenant Members Veterans Forum	Information provided to Covenant members July for sharing in their networks. Update on MHFA Armed Forces.
3	Maintain and develop local POD and Livewell websites and ensure fully connected to each other and to relevant national websites and resources (e.g.CALM)	• Develop separate page on Livewell site for suicide prevention • Livewell and POD teams to review websites and connectivity	01/07/15	30/09/15		PCC POD Livewell Team		

Action		Milestones and Outcomes	Timescales		Status	Leads	Key Partners	Action Progress/Comments
			Start Date	End Date				
Reduce access to the means of suicide								
1	Reviews by mental health service providers of safety in their services and premises	• Map requirements in place for ensuring safety • CQC reports reviewed • Activity within contracts reviewed		28/02/16		Service providers		
2	People in contact with criminal justice system	• Reduce number of people held in custody suites rather than Place of Safety • Review pathway for people awaiting trial, leaving custody		15/12/15		PCH D & C Police CASS Probation		Update on POS use December 2015 Pathway review to begin in 2016
3	Work with PCC Planning on dissemination of latest guidance on new and existing building safety	• How build suicide prevention considerations into system • Monitoring of implementation of recommendations in new build projects	01/07/15	30/08/15		Public Health		Guidance provided and work on standard responses being made to new applications for tall buildings etc now being finalized. PHE due to publish guidance in next 3 months based on work done by Exeter University.
4	Identify means of sharing information on near misses and attempted suicide to gather intelligence	• Develop Steering Group information sharing to include near miss intelligence • Focus on where near misses occur and on means	05/08/15	22/09/15		Steering Group members		Volunteers to work on this from group membership

5	Review of signage and information available at high risk locations	• Identify high risk locations • Review provision of signage • Link with National Rail work and campaigns	1/10/15	30/11/15		Public Health		Samaritans partnership with Network Rail continuing until 2020

Action		Milestones and Outcomes	Timescales		Status	Leads	Key Partners	Action Progress/Comments
			Start Date	End Date				
Provide better information and support to those bereaved or affected by suicide								
1	Adapt and adopt first responders protocol from Gloucestershire so appropriate for Plymouth	• Review and adapt protocol • Make available to local first responders • Links to signposting	01/01/16	31/03/16		Livewell		Any other similar to consider. PH to work alongside Livewell
2	Review prioritised access to Plymouth Options for high risk groups	• Review with commissioners how build into contracts requirement to provide support for dealing with traumatic loss	01/01/16	31/03/16		PCH/CCG		
3	Define options for supporting the development of SOBS provision in Plymouth area	• Liaison with neighbouring areas to consider sustainable group • Potential business case development	01/01/16	31/03/16		Public Health CCG PCH		Potential business case

Action		Milestones and Outcomes	Timescales		Status	Leads	Key Partners	Action Progress/Comments
			Start Date	End Date				
Support the media in delivering sensitive approaches to suicide and suicidal behavior								
1	DPH write to editors of local media (written and broadcast) making them aware of guidance and protocols for suicide and self-harm	• Local media following best practice	01/10/15	31/10/15		Public Health	PCC/PCH /CCG Comms Teams	
2	Regular review of reporting in local media and raising of concerns	• Ongoing review of reporting with quarterly report to Steering Group		Ongoing function		Public Health		All steering group members can bring items to meeting for review
3	Establish links with and between PCC/CCG/PCH communications teams and local media	• Workshop with media and communications focus to share best practice • Promote local mental health awareness training to media and comms	01/01/16	31/03/16		Public Health	PCC/PCH /CCG Comms Teams Local Media	Share idea to see if welcome
4	Develop consistent agreed messaging and communications content to respond to current reports	• Steering Group agree consistent messaging and press statements		22/09/15		Public Health		Agree at September meeting. All members to bring standard response ideas

Action		Milestones and Outcomes	Timescales		Status	Leads	Key Partners	Action Progress/Comments
			Start Date	End Date				
Support research, data collection and monitoring								
1	Conduct analysis of local self-harm data to provide intelligence to inform local services and service development		01/01/16	22/03/16		Public Health	PHNT MH Service Providers 1y and 2y care	Consider at March meeting Consider model of analysis used in Bristol
2	Conduct evidence review of effective intervention programmes for those who have self-harmed		01/01/16	22/03/16		Public Health		Consider at March meeting
3	Support the local suicide audit process and the dissemination of the annual update	• Update at each Steering Group • Annual publication of audit summary		Ongoing function		Steering Group	Coroners Office	
4	Review of public health suicide intelligence and audit reporting	• Review with neighbouring areas to maximize local intelligence	01/01/16	22/03/16		Public Health	Devon and Torbay PH Teams	
5	Use PHE Suicide Prevention Profile to form a Plymouth dashboard for routine monitoring at Steering group	• Update report to Steering Group when profile updated • Quarterly examination of one element of profile	15/12/15	Ongoing		Public Health		

HEALTH AND WELLBEING BOARD

Work Programme 2015 - 2016

PLYMOUTH CITY COUNCIL

Date of meeting	Agenda item	Reason for consideration	Responsible
30 July 2015	NHS Success Regime Update	To inform the Health and Wellbeing Board of the programme.	Jerry Clough
	Public Health Annual Report	Report from the Director of Public Health	Kelechi Nnoaham
	Plymouth Integrated Commissioning Board Commissioning Intentions	To consider alignment against the Plymouth Plan	Jerry Clough / Carole Burgoyne
	JSNA Steering Group	Discussion on the reconfiguration of the steering group	Kelechi Nnoaham / Rob Nelder
1October 2015	Plymouth Integrated Commissioning Board Commissioning Intentions	Standing Item – (if required)	Jerry Clough / Carole Burgoyne
	Alcohol Dashboard Update		Kelechi Nnoaham / Laura Juett
	Suicide Prevention		Sarah Lees
	CAMHS Transformation Plan		Paul O'Sullivan
	Children and Young People's Partnership Update		Judith Harwood
28 January 2016	Plymouth Integrated Commissioning Board Commissioning Intentions	Standing Item – (if required)	Jerry Clough / Carole Burgoyne
	Psychoactive Substances		
	Adult Safeguarding		
	Health Weight Programme		Julie Frier

Date of meeting	Agenda item	Reason for consideration	Responsible
24 March 2016	Plymouth Integrated Commissioning Board Commissioning Intentions	Standing Item – (if required)	Jerry Clough / Carole Burgoyne

SOLUTION SHOP

2015 - 2016

Date	Topic	Reason	Lead Board Member
tbc	Mental Health	Identified by Board	Tbc
tbc	Primary Care Services	Identified by Board	Tbc
tbc	How to work within reduced funding – setting priorities	Identified by Board	Tbc

This page is intentionally left blank