#healthyplym

Oversight and Governance
Chief Executive's Department
Plymouth City Council
Ballard House
Plymouth PL1 3BJ

Please ask for Jamie Sheldon
T 01752 304001
E jamie.sheldon@plymouth.gov.uk
www.plymouth.gov.uk/democracy
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HEALTH AND WELLBEING BOARD

Thursday 4 October 2018
10.00 am
Warspite Room, Council House

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

Statutory Co-opted Members: Strategic Director for People, Director of Children's Services, NEW Devon Clinical Commissioning Group representatives, Director for Public Health, Healthwatch representative and NHS England.

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 webcast and available on-line after the meeting. By entering the Warspite Room, councillors are consenting to being filmed during the meeting and to the use of the recording for the webcast. For further information on attending Council meetings and how to engage in the democratic process please follow this link - Get Involved

Tracey Lee
Chief Executive

Health and Wellbeing Board

1. Appointment of a Vice Chair

The Committee will be asked to appoint a Vice Chair for the municipal year 2018/19.

2. Apologies

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

3. Declarations of Interest

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

4. Chairs urgent business

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

5. Minutes **(Pages 1 - 4)**

To confirm the minutes of the meeting held on 21 June 2018.

6. 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.

7. Chairs Report **(Pages 5 - 12)**

8. Director of Public Health Annual Report 2018 **(Pages 13 - 44)**

9. Suicide Audit and Prevention Update **(Pages 45 - 98)**

10. Prevention Concordat for Better Mental Health **(Pages 99 - 106)**

11. Integrated Care System Development **(Pages 107 - 114)**

12. Devon Wide Learning Disability Strategy **(Pages 115 - 132)**

13. Work Programme

The Board are invited to add items to the work programme.

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Health and Wellbeing Board

Thursday 21 June 2018

PRESENT:

Councillor Tuffin, in the Chair.
Councillors Mrs Bowyer and McDonald.

Craig McArdle ((Director for Integrated Commissioning), Rob Nelder (Consultant Public Health Intelligence), Anna Coles (General Manager), Neelam Bhardwaja (Services Director for Children, Young People & Families), Jacky Clift (VCS), James Brown (VCS), Professor Bridie Kent (University of Plymouth), Kathyrn Deeney (Natural Infrastructure Manager)

Apologies for absence: Ruth Harrell (Director of Public Health) (Rob Nelder substituting), David Bearman (Devon Local Pharmaceutical Committee), Alison Botham (Neelam Bhardwaja substituting), Carole Burgoyne MBE (Strategic Director for People), John Clark (Plymouth Community Homes), Nick Pennell (Health Watch) (Justin Robins substituting) and Chief Superintendent Dave Thorne (Devon and Cornwall Police).

Also in attendance: Ross Jago (Senior Panel and Partnership Adviser), Jamie Sheldon (Democratic Advisor).

The meeting started at 10:00 am and finished at11:15 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.

39. **To Note the Appointment of the Chair and Appoint a Vice Chair**

The board noted the appointment of Councillor Ian Tuffin as the Chair but chose to defer the appointment of Vice Chair to the next meeting due to attendance.

40. **Declarations of Interest**

There were no declarations of interest made in accordance with the code of conduct.

41. **Chairs urgent business**

There was two items of Chairs urgent business:

1. The chair gave his thanks to Cllr Lynda Bowyer for her hard work as chair for the last two years.

2. The chair wanted to highlight the importance of the compassionate cities end of life event that had taken place 17 May 2018 and asked for the support of the board.

42. **Minutes**

Agreed the minutes of the meeting held on the 22 March 2018.

43. **Questions from the public**

There were no questions from members of the public.

44. **CQC Action Plan Update**

Craig McArdle (Director for Integrated Commissioning) updated the board on the CQC Action Plan.

Members discussed:

(a) the difficulty in recruiting GP's;
(b) how recruitment could be assisted through the help of the university.

Members noted the update.

45. **STP Update**

Craig McArdle (Director for Integrated Commissioning) introduced the STP Update.

Members discussed:

(a) governance of the STP;
(b) the importance of mental health services being delivered locally rather than across the NEW Devon CCG geography.

Members noted the update.

46. **Strategic Integrated Commissioning Intentions next steps and feedback from Consultation**

Craig McArdle (Director for Integrated Commissioning) introduced the Strategic Integrated Commissioning Intentions next steps and feedback from consultation.

Members noted the update.

47. **Parks and Green Spaces**

Jacky Clift (Voluntary and Community Sector), Kathryn Deeney (Natural Infrastructure Manager) and James Brown (Voluntary and Community Sector) introduced the Parks and Green Spaces report.

Members noted the report and agreed to form a sub group to look at this issue.

48. **Work Programme**

The Board noted the work programme and were requested to forward it for inclusion to the Democratic Support Officer.

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HEALTH AND WELLBEING BOARD CHAIRS REPORT

THURSDAY 4TH OCTOBER 2018

1. Introduction

A Reminder of our role –

- To act as system leaders on the strategic planning and co-ordination of NHS, Public Health, Social Care, Children's and Wellbeing Services.

The key functions of the Health and Wellbeing Board are:

- To prepare Joint Strategic Needs Assessments (JSNAs and Pharmaceutical Needs Assessments) and Joint Health and Wellbeing (JHWSs)
- To promote integrated working between health, care and wellbeing
- To hold commissioners and the system to account to this end. Our agenda in future will focus on items where decisions and actions are required.

2. CQC Reviews

In August CQC published their reviews of University Hospital Plymouth and Livewell Southwest. University Hospital Plymouth, was rated as Requires Improvement overall and Livewell Southwest was rated as Good

University Hospital Plymouth:

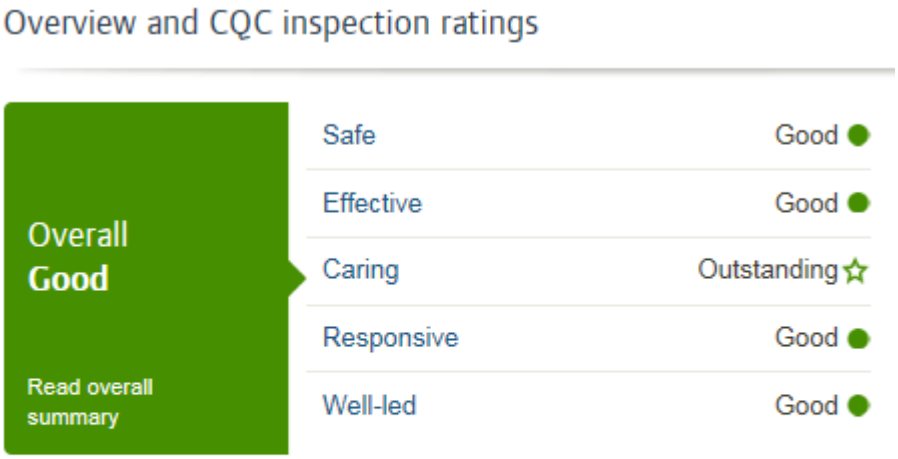
Overview and CQC inspection ratings

Overall **Requires improvement** Read overall summary	Safe	Requires improvement
	Effective	Requires improvement
	Caring	Outstanding
	Responsive	Requires improvement
	Well-led	Requires improvement

Latest inspection: 17 April 2018

Report published: 15 August 2018

Livewell Southwest:



Latest inspection: 17 April 2018

Report published: 7 August 2018

I have agreed with the Chair of Overview and Scrutiny Committee that the Reviews and resulting Action Plans will be presented to them for oversight and assurance.

Following December's Local System Review conducted by the Care Quality Commission, Plymouth as a system co-designed a system action plan to manage the improvements recommended in the final report. This plan was based around three key areas:

- Commissioning and Market Management
- Staff and Organisational Development
- System Improvement

We have seen a number of changes already deliver as a result of the Action Plan. In June, Cabinet signed off Plymouth System Health and Wellbeing Strategic Commissioning Intentions 2020 outlining a clear vision for the next two years and detailing a number of high impact changes that as a system we can expect to see.

We have started work on a Multi-Agency Workforce strategy with support from the Local Government Association to help Plymouths leaders design a system-wide, high-level integrated workforce strategy.

In May and June, Plymouths' Health and Wellbeing system undertook a Hard Reset process involving leaders of all organisations in our system meeting to discuss daily performance and agree daily actions to unblock and correct issues across our urgent care system.

As Quarter two is drawing to a close we can reflect on a period of enabling development, with plans now in place to launch the next two Health and Wellbeing Hubs in October, development of the Commissioning and Contract Approach for the Integrated Care Partnership included significant engagement with University Hospitals Plymouth and Livewell South West along with the commencement of consultation on the future model of delivery for Early Help and Targeted Support for Children, Young People, Families and their Carers

We are also pleased to announce that Plymouth has had two successful submissions from GP Practices to be lead providers for the delivery of Improved Access between October 2018 and March.

The next phase of the plan will see a significant focus on developing the Integrated Workforce Strategy and plan along with completion of the Continuing Health Care improvement actions.

Developments will continue around Risk Stratification, the Care Traffic Control Centre, the Acute Assessment Unit and two further HWB Hubs are due to launch in October. We will also see the launch of the procurement processes for the Integrated Care Partnership and Mayflower.

This steady progress has been maintained through the continued collaboration between system leaders and their organisations. As winter approaches these key relationships and close ways of working will be absolutely critical to the momentum of the plan at a time of significant pressure within our system.

3. Motion of Notice - Motor Neurone Disease

A motion was proposed at Full Council on 17th September that PCC adopt the MND charter. On adoption of it, suggestions are to publicise it via a press release and social media, raise awareness amongst colleagues via disseminating postcards, displaying posters in council buildings, keeping copies of the charter available for all staff to access, raise awareness as widely as possible with and distribute resources to partner organisations who support people with MND and their carers.

The charter's aim is to ensure that the rights of people with MND and their carers are understood and respected in order for them to access any care they need when and where they need it, have the best possible quality of life and have dignity in death (the latter ties directly in with the compassionate communities charter).

The charter has 5 specific points for action:

1. People with MND have the right to an early diagnosis and information
2. People with MND have the right to high quality care and treatments
3. People with MND have the right to be treated as individuals with dignity and respect (This would include for example, being offered the opportunity to develop and Advance Care Plan to ensure their wishes are met and appropriate end-of-life care is given in their chosen setting-this is part of the aforementioned compassionate communities charter).

People with MND have the right to maximise their quality of life. Carers of people with MND have the right to be valued, respected, listened to and well supported. Councils are being encouraged and supported to raise awareness about MND and councillors to consider the potential impact on people with MND and their carers for every decision that they make.

4. Compassionate City

St Luke's are leading on this and Abenna Gyamfuah-Assibey (Community Development Worker) is working to drive it forward.

A Compassionate City recognises that caring for one another at a time of loss and crisis is everyone's responsibility and not just that of social and health services.
It publicly encourages, supports, facilitates and celebrates care for those with life-threatening and life limiting illness, frail, chronic disability, ageing and dementia, death in childhood, grief and bereavement etc.

The Compassionate City Charter has 14 specific points for action:

1. Our **schools** will have annually reviewed policies or guidance documents for dying, death, loss and care.
2. Our **workplaces** will have annually reviewed policies or guidance documents for dying, death, loss and care.
3. Our **trade unions** will have annually reviewed policies or guidance documents for dying, death, loss and care.
4. Our **places of worship** will have at least one dedicated group for end of life care support.
5. Our city's **hospices** and **nursing homes** will have a community development program involving local area citizens in end of life care activities and programmes.
6. Our city's major **museums and art galleries** will hold annual exhibitions on the experiences of ageing, dying, death, loss or care.
7. Our city will host an **annual peacetime memorial parade** representing the major sectors of human loss outside military campaigns-cancer, motor neuron disease, AIDS, child loss, suicide survivors, animal companion loss, widowhood, industrial and vehicle accidents, the loss of emergency workers and all end of life care personnel, etc.
8. Our city will create an **incentives scheme** to celebrate and highlight the most creative compassionate organisation, event, and individual/s. the scheme will take the form of an annual award administered by a committee drawn from the end of life care sector. A 'mayor's prize' will recognise individual/s for the year who most exemplify the city's values of compassionate care.
9. Our city will publicly showcase, in print and in social media, **our local government policies,** services, funding opportunities, partnerships, and public events that address 'our compassionate concerns' with living with ageing, life-threatening and life-limiting illness, loss and bereavement, and long term caring. All end of life care-related services within the city limits will be encouraged to distribute this material or these web links including veterinarians and funeral organisations.
10. Our city will work with local social or print media to encourage an annual city-wide **short story or art competition** that helps raise awareness of ageing, dying, death, loss or caring.
11. All our compassionate policies and services, and in the policies, and in the policies and practices of our official compassionate partners and alliances, will demonstrate an understanding of how **diversity** shapes the experience of ageing, dying, death, loss and care-through ethnic, religious, gendered and sexual identity and through the social experiences of poverty, inequality, and disenfranchisement.
12. We will seek to encourage and to invite evidence that institutions for the **homeless and the imprisoned** have support plans in place for end of life care and loss and bereavement (The 4 homeless hostels in Plymouth have 55 people trained as End of Life champions and St Luke's have been running an End of Life project for the past 3 years in Dartmoor Prison to try to increase the number of prisoners having contact with EOL services and the ensure care is integrated and patient centred.)
13. Our city will establish and review these targets and goals in the first two years and thererafter will add **one more sector annually** to our action plans for a compassionate city-e.g. hospitals, further and higher education, charities, community & voluntary organizations, police & emergency services, and so on.

14. Our city will have **compassionate networks** that work together, in communities to support those who are dying or experiencing loss in emotional and practical ways.

The network outlined above will develop actions, using a public health approach to end of life care (.e. what we can do to achieve a good death for our community and grieve in a healthy way) to implement the Charter.

The charter's overall aim is to improve end of life experiences and bringing together communities (including volunteers and specialist providers e.g. local primary care teams, the health and wellbeing hubs, voluntary and statutory agencies) to ensure care is integrated and that people are cared for in a place of their choosing (usually at home). The volunteers report back any conerns or changes in the person's condition or needs (an early warning system to try to avert crisis and reduce unnecessary hospital admissions towards the end of life.

Specific aims are:

1. To raise public awareness of issues around death and dying.
2. To build emotional resilience in our city by developing and encouraging our community's ability to talk about death, dying and bereavement, giving everyone the best chance to die well and have a normal grieving process, reducing the risk of negative long term impacts on mental and physical health due to isolation, anxiety for those who are experiencing loss and bereavement.
3. To increase compassion at end of life through developing self-sustaining voluntary and informal compassionate networks of volunteer 'Compassionate Friends' to support those who are dying or experiencing loss to Make a Difference by lending a helping hand or a friendly ear; Find champions from the communities to train and help build their own informal networks by; giving them a toolkit to run compassionate friends awareness sessions and/or co-ordinating friends to work together within the communities when needed.
4. Address inequality in end of life care.

Plymouth City Council has signed up to the charter.

Thus far, the Dementia Friendly City Co-ordinator has become part of the End of Life Compassionate Network Action Group for Diversity, Homeless and Prisons, to ensure that the needs of those affected by dementia are taken into account as regards access to good end of life care, bereavement support and information for future planning.

5. LGA Consultation

Once again Local Authorities are having to take the lead in this area. The Government's Long Awaited Green Paper was once again deferred until the "Autumn"

For too long successive governments have kicked this issue into the long grass because it is seemingly too hard. The truth is it is too important not to make a decision. We have a crisis in Social Care now and it is because Central Government has shown lack of leadership.

A recent report in the Lancet has shown:

- The number of adults over 85 needing round-the-clock care is predicted to almost double to 446,000 in the next 20 years.
- The number of over-65s with the same high dependency levels will also increase by a third, to more than 1 million people, over the same period.

- In Plymouth, a total of 12,600 people over the age of 65 are predicted to have a long-term limiting illness where their day-to-day activities are restricted. This is expected to rise to 18,000 in 2035.
- Yet in despite of this growing demand we know:
- Government funding for local authorities has fallen by an estimated 49.1% in real terms from 2010-11 to 2017-18.
- And between 2010-11 and 2016-17, local authority spending on adult social care services reduced by 3.3% in real terms.
- Therefore The LGA estimates that adult social care services face a £3.5 billion funding gap by 2025, just to maintain existing standards of care

This lack of government leadership is in stark contrast to our Local Leadership:

- We have tackled the issue of funding by revising the Fairer Charging Policy and levying the Adult Social Care precept
- We have modernised services, by decommissioning in house residential homes whilst building Extra Care Homes and supporting more people at home through domiciliary care
- We have taken the leader on Integrated Health and Social Care creating a pool fund with the CCG of £460 million and integrating 174 staff with Livewell Southwest to create integrated whole person care

We have input into this important debate, and are showing leadership, we will be coming up with solutions to tackle this crisis and we will be calling on the government to do the same.

6. Proud to Care

Proud to Care Background:

The Proud to Care South West campaign initially ran during the summer and autumn of 2017 and consisted of 16 local authorities across the South West.

The campaign was developed because of the challenges across the health and social care workforce, both locally and nationally, and also because of the responsibility placed on local authorities by the Care Act to ensure quality and sufficiency of external markets.

The aims of Proud to Care South West were to:

- Establish a regional approach to raising the profile of care
- Encourage positive thinking and reaction to care and care giving
- Recognise the value and commitment of carers and care workers
- Attract and retain high calibre applicants to caring roles and care careers in the public, private, voluntary and independent sector
- Develop career pathways in care and health to attract, retain and develop high quality people in the sector

Proud to Care Ambassadors

Devon County Council led the way with Proud to Care Devon and have been running the Proud to Care Ambassador role for some time, with over 130 Ambassadors. Although this is beneficial for Devon as a whole system, it was felt that a more local approach was needed for Plymouth, and therefore Plymouth City Council, Livewell Southwest and University Hospital Plymouth worked in partnership, along with the support of Scott College, to develop the

Proud to Care Ambassador Programme in Plymouth. This was launched in June 2018 and to date over 70 workers from across health and social care in Plymouth have signed up to be a Proud to Care Ambassador. The role of the Ambassadors will be to champion working in the sector, promote career pathways to show the opportunities across the wider sector and raise the profile of care and health as well as encourage others to become an Ambassador.

Plymouth City Council, Livewell Southwest and University Hospital Plymouth continue to work in partnership to provide quarterly events for existing and new Ambassadors, which will provide updates and training to develop in their role, such as support in developing public speaking skills and learning more about career pathways in other areas of the sector, as well as offering networking opportunities amongst the group.

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PLYMOUTH CITY COUNCIL

Subject:	Director of Public Health Annual Report 2018
Committee:	Health and Wellbeing Board
Date:	4th October 2018
Cabinet Member:	Ian Tuffin
CMT Member:	Ruth Harrell, Director of Public Health
Author:	Claire Turbutt, Advanced Public Health Practitioner
Contact details:	01752 304568
Ref:	
Key Decision:	No
Part:	I

Purpose of the report:

Each year the Director of Public Health has a duty to publish an independent report on a topic of their choosing. This year's report is a review of year three of the Thrive Plymouth programme. Thrive Plymouth is the Council's 10-year programme to improve health and wellbeing and reduce health inequalities in the city. Each year of the campaign has a different focus. Year three (which ran from October 2016 to October 2017) focused on the localisation of the national 'One You' campaign within Plymouth. One You is the national Public Health England (PHE) campaign to re-engage 40 to 60 year olds with their health.

Corporate Plan:

The annual report will support the corporate plan in the following ways:

Pioneering: The report highlights how year three of the Thrive Plymouth programme encouraged innovative solutions to address the health inequalities in the city.

Growing: The report shows how the population have been encouraged make positive choices to improve their health and wellbeing. In the longer term this will lead to improved health outcomes across and a more resilient population.

Caring: The resources that supported the national PHE One You campaign gave the local Public Health Team the opportunity to secure engagement across the city, allowing residents, organisations and institutions to re-engage with their own health and make the best possible choices about their health.

Confident: Plymouth City Council was recognised nationally for its success in promoting the One You campaign locally as well as its promotion of the supporting tools and apps.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land:

None - The report has been produced by the Public Health Team in order to fulfil the mandated requirement to produce such reports.

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

None

Equality and Diversity:

Has an Equality Impact Assessment been undertaken? No

Recommendations and Reasons for recommended action:

1. Our Joint Local Plan commits us to making healthy growth a priority for our city and creating environments in our city where the healthy choice is the easy choice. We should therefore plan for health impact assessment to be considered in all our developments and strategies.

2. We should use targeted media to reach those who have not engaged with One You so far and find out what will get them engaged.

3. We should make the most of our natural environment through low cost and fun activities that will improve health outcomes.

4. We need to increase the low cost/free options for improving health and wellbeing within the city, making it easier for everyone to engage with activities on their doorstep.

Reasons:

1. Utilising the health impact assessment approach to development and strategic planning allows us to identify potential avenues for added social value that are missed if health impact is only considered at the end of the process when most decisions have already been made.

2. Public Health England has produced a wide range of well researched marketing materials. It makes sense to use these to target out population.

3. The green and blue spaces in the city already contribute towards improved health amongst our population. By making access easier for those who do not have direct access we can spread these benefits through the community.

4. A significant barrier to activity for many people is financial. By increasing the low cost/free options for physical activity/social interaction/community engagement, we will be helping those on low incomes to take advantage of the health benefits inherent.

Alternative options considered and rejected:

Not applicable

Published work / information:

None

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7
DPH Annual Report 2018	I								

Sign off:

Fin	djn1819.09	Leg	lt/30479/1605	Mon Off	lt/30479/1605	HR		Assets		IT		Strat Proc	
Originating SMT Member: Ruth Harrell													
Has the Cabinet Member(s) agreed the content of the report? Yes / No N/A (this is an independent report of the Director of Public Health). Leader and the Cabinet member for public health have been briefed.													

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Thrive PLYMOUTH

Plymouth – *A* place to Thrive

Thrive Plymouth Year Three

Director of Public Health | Annual Report 2018

ONE YOU PLYMOUTH

CONTENTS

Thrive PLYMOUTH

Plymouth – A place to thrive

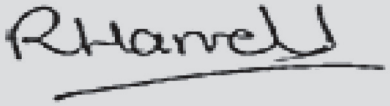
FOREWORD

Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives[1]. We want Plymouth, Britain's Ocean City, to be a place where everyone enjoys an outstanding standard of living and where health is not determined by which part of the city a person is born or lives in. This is why we launched Thrive Plymouth in 2014, to raise awareness of this issue, and work with our partners to coordinate resources from across the city with the goal of reducing the impact of health inequalities on our residents.

We have set ourselves a big challenge and in this Annual Report we look back at year three of our campaign. The national One You campaign launched by Public Health England in March 2016 presented a remarkable opportunity for Plymouth to use precisely researched marketing resources designed to re-engage seven million adults in the UK with their health and influence behaviour change nationally. Year three of Thrive Plymouth maximised the impact of this national campaign, making it meaningful and tailored for Plymouth.

Within this report I have included the stories of our partners who have engaged with Thrive Plymouth this year alongside an explanation of why the localisation of this campaign was so successful. My recommendations for the future are also included.

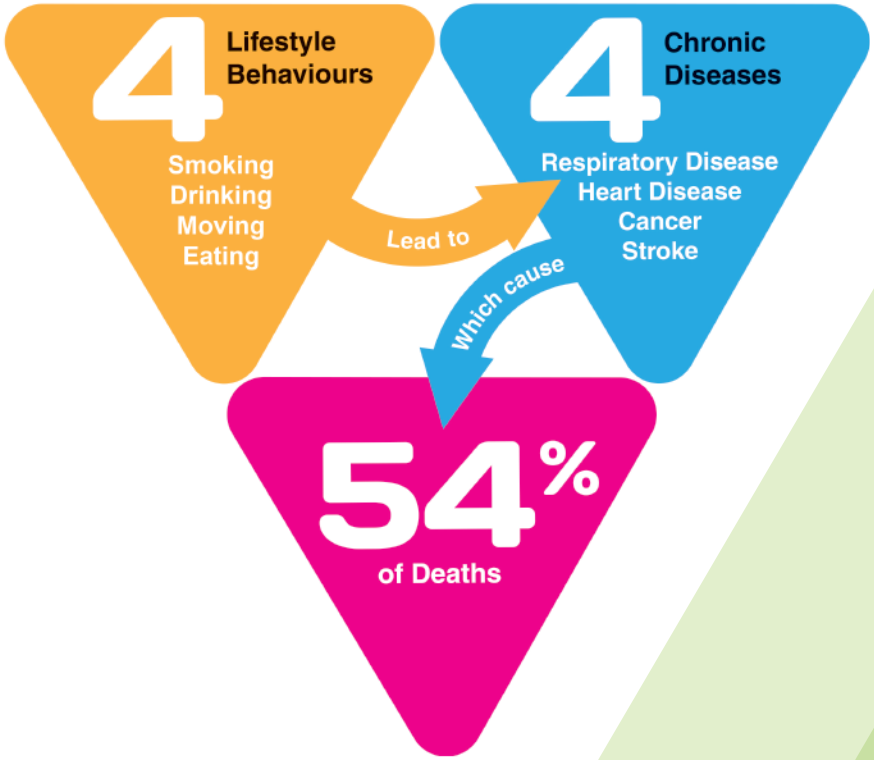
I hope you will enjoy seeing the rich selection of activity in the city this year. As we move forward with year four of Thrive Plymouth, which focuses on mental wellbeing, I want to congratulate all those who participated in year three and encourage them to continue making their contribution to reducing health inequalities. Together we can make this city a thriving community where everyone feels welcome and cared for.



Ruth Harrell
Director of Public Health,
Plymouth City Council

1 THRIVE PLYMOUTH

Thrive Plymouth is the city's ten year programme to get everyone working together to improve health and wellbeing in Plymouth and reduce health inequalities between different people and different communities.



OUR APPROACHES

Population prevention
recognises that small changes in a large number of people can lead to a significant difference in the amount of ill health and premature death across the population. We therefore support everyone, no matter the size of their risk, to make small positive changes.

Common risk factor
recognises that although single unhealthy behaviours can lead to many different diseases, often these risk factors cluster, because they are associated with underlying social determinants of health. Understanding how these behaviours affect each other and tackling these underlying causes is therefore more efficient and effective.

Changing the context
of choice recognises that people do not make decisions in a vacuum; they are influenced by people, places, advertising, street design and many other factors. Many people know how to improve their health and if it was easier to do so, would. We therefore focus on making the healthy choice the easy choice.

OUR VISION
for Plymouth
of happy, healt
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OUR RATIONALE

is that if everyone who lives, works and plays in Plymouth has the opportunity, encouragement and support to make positive changes to their lifestyle, this would add up to a large difference across the population.

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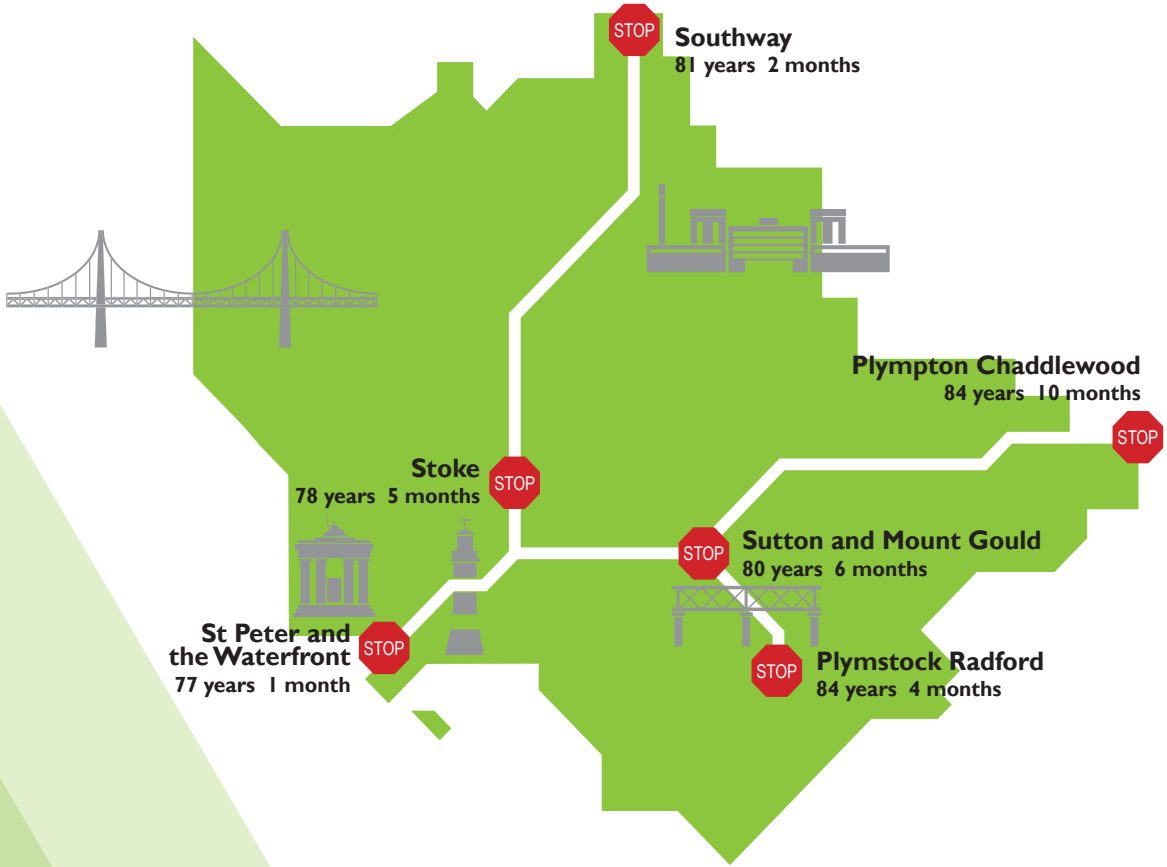
OUR WEBSITE

More information is available on our website www.plymouth.gov.uk/publichealth/thriveplymouth

Why is this important?

Health inequalities mean that some people live more painful, shorter lives than others and we think this is unacceptable. One way of measuring health inequalities is by comparing differences in life expectancy. We have created a bus route which shows that for every mile you travel from the suburbs to the city centre life expectancy drops considerably.



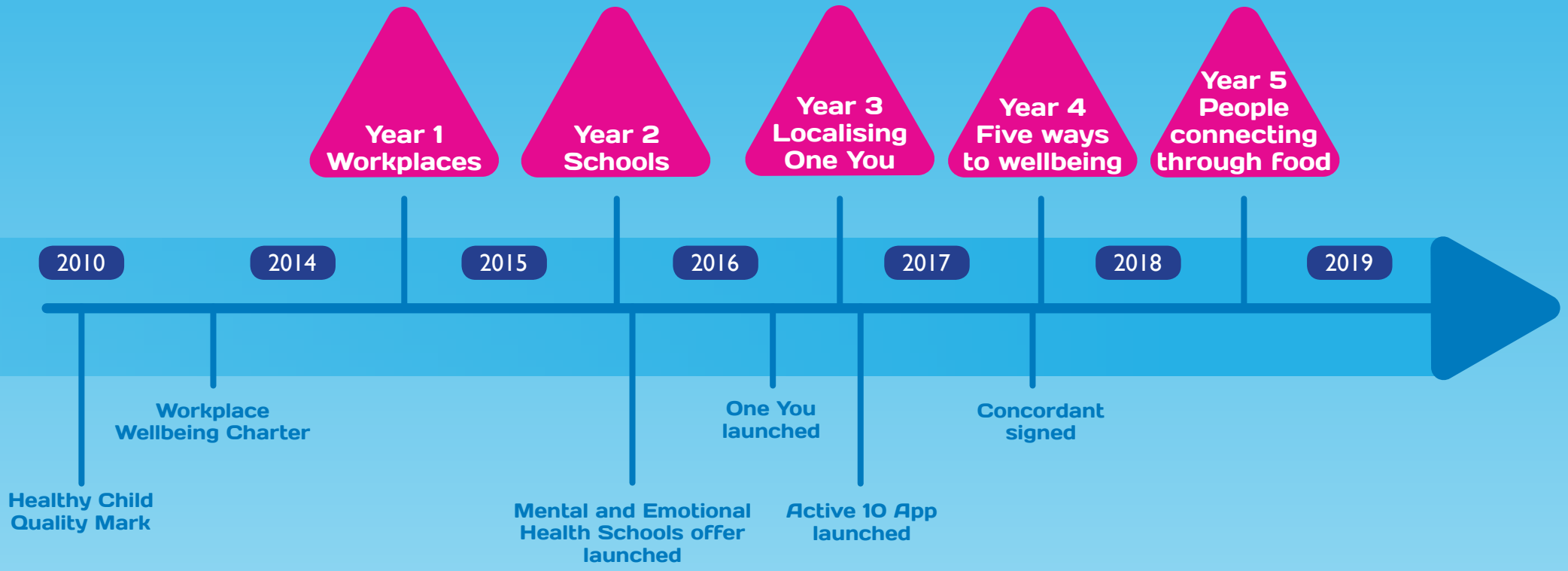
Plymouth's life expectancy bus route 2014 -16

Wards just a few miles apart can have life expectancy values varying by years. Travelling the seven miles south from the Southway ward, each mile closer to the St Peter and the Waterfront ward represents seven months of life expectancy lost. Travelling west to the same location from Plympton Chaddlewood, each mile represents over one year of life expectancy lost.

2 A TIMELINE OF THRIVE PLYMOUTH SO FAR

We think of Thrive Plymouth's annual campaigns like launching a ship each year. We put our efforts into getting the right resources together, making sure the messages are right and then organising the efforts of the institutions, teams and people in the city so that those messages and resources spread as far through the community as possible.

In our first year we focused on workplaces and the workplace wellbeing charter, in the second on schools and the healthy child quality mark, and for the third year, as you will read, we focused on adult health using the national resources of the One You campaign to re-engage adults with their health. Since then, we launched year four in October 2017 which focuses on mental wellbeing and the five ways to wellbeing. We are looking forward to year five, which will focus on the ways we can use food to engage with our community and is currently being developed with partners.



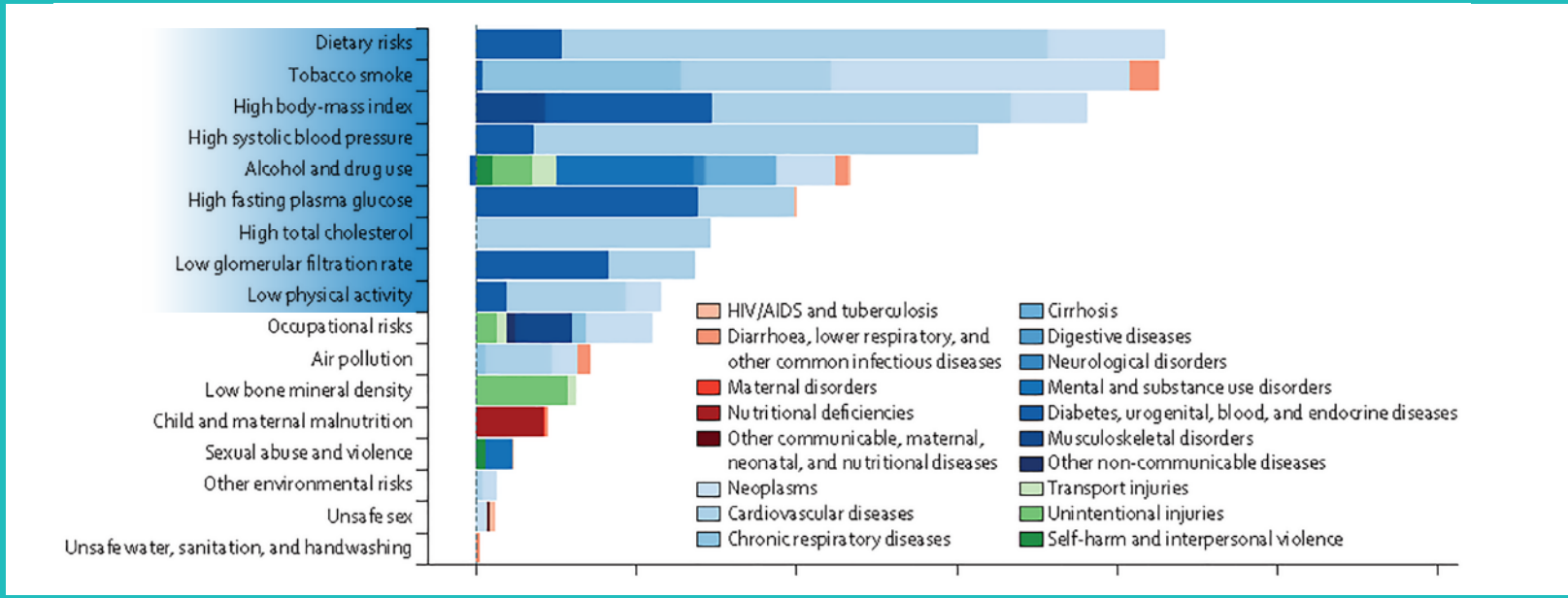
3 ONE YOU NATIONAL CAMPAIGN

Many adults can expect to live into their mid-80s, and many people believe gradual decline in physical and mental health is an inevitable part of ageing. Yet so much of how we age is down to lifestyle and that represents a real opportunity for change. Our lifestyles can be unhealthier than we think. Without even knowing it, by the time we reach our 40s and 50s, many of us will have dramatically increased our risk of contracting diseases like cancer and heart disease, and increased our risk of suffering a stroke. Whether we're eating too much of the wrong things too often, or drinking more than we should, or continuing to smoke despite everything we know, or not being sufficiently active, all these things can add up to have a huge influence on our health.

The good news is that making small changes can improve health right away. It's never too late to start. And that's where One You comes in, an exciting behaviour change programme to help adults fight back and kick those unhealthy habits out of our lives.

One You was launched nationally by Public Health England (PHE) in March 2016 with the goal of getting one million adults between 40 and 60 years old re-engaged with their own health. They did this through a campaign which used cutting edge marketing approaches to health promotion including the creation of an online lifestyle quiz. The 'How Are You?' quiz gives a score out of 10 for health and then gives lifestyle advice specific to the person completing the quiz. The goal of the campaign was to get people doing more physical activity, eating better, going smokefree, drinking less alcohol, sleeping better, stressing less and checking themselves for the symptoms of disease.

Disability adjusted years (DALYs) attributed to level 2 risk factors in 2013 in England for both sexes combined



TO SUPPORT THE CAMPAIGN PHE CREATED A RANGE OF SMART PHONE APPS THAT CAN HELP PEOPLE TO LIVE HEALTHIER LIFESTYLES.

1 Did you know? You don't have to go to the gym or wear Lycra to feel the benefits of exercise. Walking counts too. Active10s are 10 minutes of continuous walking, which can get your heart pumping and can make you feel more energetic, as well as lowering your risk of serious illnesses like heart disease and type 2 diabetes.

2 Did you know? We don't have to stop enjoying our family favourite recipes to reduce salt, sugar and fat in our food, finding tasty and healthier alternatives is easy. It's often cheaper (not to mention tastier) to make your own!

3 Did you know? If you stay smoke free for 28 days you're more likely to stay smokefree. Cravings usually only last a few minutes so they can be beaten. If you time one of them you'll know how long you need to keep busy until it goes away.

4 Did you know? There's a lot you can do to cut down on drinking. Don't feel you have to have an alcoholic drink in a round, order a soft drink. Try a smaller glass or a lower strength drink, or add a mixer.

CONTEXT

Our health system is geared to treating people when they are ill. We need to be equally focussed on prevention. 70% of how well we age, and many adult diseases, are linked to lifestyle factors that could, in the main, be prevented. Many adults believe that a gradual deterioration in physical and mental health is an inevitable sign of aging. But by moving more, eating better, quitting smoking, drinking less, stressing less and checking ourselves we could all make major improvements to our long term health.

KEY BEHAVIOURS THAT WE WILL INFLUENCE

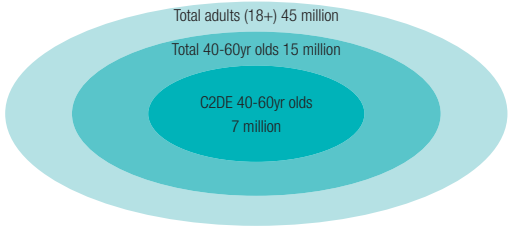
- Moving more
- Smokefree
- Drinking less
- Eating well
- Checking yourself
- Stressing less
- Sleeping better

REINVENTING ADULT HEALTH

40% of audience visit facebook daily, 8/10 most shared content are quizzes, only 4% of audience downloaded a health app

TARGET AUDIENCE

Our core audience is the 7m 40-60 year old C2DEs living in England, although we recognise that there will be a much larger adult audience that overhears campaign comms.

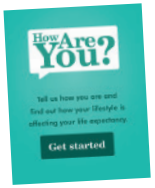


Key insight:

TO VALUE YOUR HEALTH, YOU HAVE TO VALUE YOURSELF

ONE YOU

We believe there is a once in a generation opportunity to reinvent and re-launch adult health to energise and engage one million adults in One You. We are creating an adult to adult voice that advocates living well, engaging and supporting real people to make real changes throughout the year.

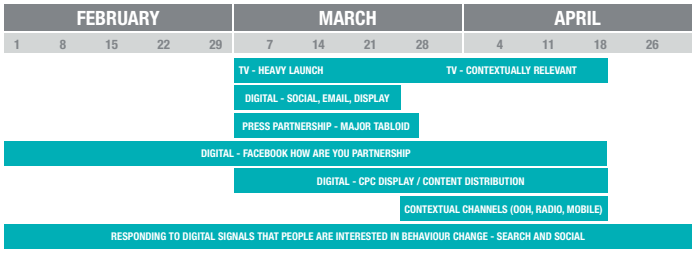


DIGITAL ENGAGEMENT – THE HOW ARE YOU? TOOL

A health related marketing 'quiz' (NOT a medical or clinical diagnostic tool) that starts a conversation about an individual's health, lets people know how they're doing and drives to product(s) they can use to change behaviours.

From | Public Health England

LIVING WELL - OPTIMAL PLAN



A versatile brand to use in a range of settings

4 THRIVE PLYMOUTH YEAR THREE

The behaviours

Of the seven behaviours identified within the One You campaign which impact on health, four are the same as Thrive Plymouth, smoking, eating, drinking and moving, and two others support our ability to make and sustain positive changes (sleeping better, stressing less). As the initial focus of the One You campaign was on these same four behaviours although the One You campaign is aimed at the 40 to 60 years old age group we felt their messaging was also appropriate for Plymouth. We decided to use the third year of Thrive Plymouth to localise One You within the city. The third year launched in November 2016 at Plymouth University.

The launch of year 3

▼ *Thrive Plymouth November 2016 launch event*

During year three of Thrive Plymouth (2016-17) we set ourselves the following goals:

Engagement	To engage 20 organisations in the city by November 2017 150 people to complete Livewell Southwest training courses by November 2017
'How Are You?' quiz	To increase the number of people completing the 'How Are You?' quiz in the city
Geographic coverage	To plan events throughout the whole city using national marketing
Gender balance	To improve the ratio of men using the 'How Are You?' quiz (September 2016 1:3)
Behaviours	To use all seven behaviours throughout the city
Events	To plan a full calendar of events throughout the city To count the number of events using resources branded as One You or One You Plymouth in the city

See page 19

See page 12

The year in brief

We had an amazing year, meeting and exceeding our goals with over 3,000 people in the city completing the 'How Are You?' quiz.

80 New Home New You

360 people received training

3 LARGE SCALE EVENTS

52 organisations joined the Thrive Plymouth Network

23 PCC Health Champions

See page 16

12 ACTIVE 10 Events

11 Working Links staff

20 local events branded as ONE YOU

25 briefing events took place

See page 22

5 WHY OUR APPROACH WAS SUCCESSFUL

We got partners engaged early

We were involved early in the design of the One You campaign; Plymouth City Council is part of a national reference group including 20 local authorities across England which helps Public Health England plan and design their future campaigns. Our participation in this group allowed us enough time to plan for the national launch event in March 2016.

This early engagement gave us time to strengthen our links with a group of organisations in the city who were ready to put their resources towards launching One You successfully. Working as a partnership, a range of organisations from across the city joined with Council teams to plan for the Thrive Plymouth launch of One You. See Livewell Southwest and I Love Life pages.

On the day of the national launch of One You many businesses and services in the city encouraged their staff, clients and customers to take the How Are You Quiz.

Individual Challenges	Organisational Challenges	Population Challenges
Search for How Are You online and take the quiz. Sign up to receive email updates about events and projects you can get involved in.	Spread the One You message through your organisation. Hold a competition to see who can improve their 'How are you?' (HAY) score the most. Use the quiz to measure the health of your workforce.	Let's make it easier to be healthy. Our Joint Local Plan commits us to making healthy growth a priority for our city and creating environments in our city where the healthy choice is the easy choice. We should therefore plan for health impact assessment to be considered in all our developments and strategies.

Livewell Southwest

One You Plymouth is the local health improvement service commissioned by the Council. As One You was launched nationally the local health improvement service had the opportunity to rebrand and decided that aligning with the national PHE brand would be beneficial to the local population.

In 2016 Livewell Southwest was working closely with Plymouth City Council, Plymouth Community Homes and the Herald. It was decided that there would be a local launch of One You through the Herald on the same day as the national publicity. During this time the Livewell Southwest Health Improvement service rebranded to One You Plymouth and established a new website and interactive tools. As a result we were the local provider with the most 'How Are You?' quiz referrals during the launch, 400 more than the next most successful provider.

For the Thrive Plymouth launch event in October 2016 the health improvement service was officially launched as One You Plymouth and all the lifestyles interventions were delivered under the One You Plymouth banner.

Using the national brand at a local level allows the local activity to be endorsed by a nationally recognised brand. The apps and digital tools devised by PHE are very useful for Plymouth residents and allow us to effectively engage with evidence based applications. One You Plymouth has recently joined with PHE to publicise NHS Health Checks and this has increased local take up.

Livewell SW Video

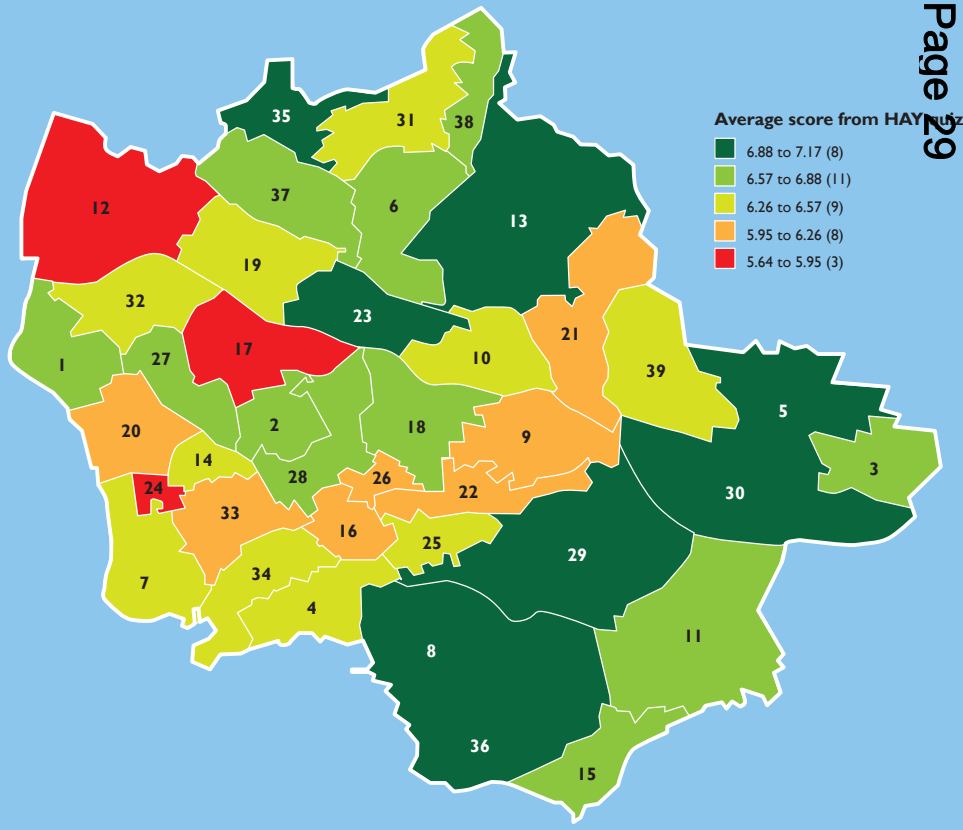
1 Barne Barton
2 Beacon Park
3 Chaddlewood
4 City Centre
5 Colebrook, Newnham and Ridgeway
6 Derriford West and Crownhill
7 Devonport
8 East End
9 Efford
10 Eggbuckland
11 Elburton and Dunstone
12 Ernesettle
13 Estover, Glenholt and Derriford East
14 Ford
15 Goosewell
16 Greenbank and University
17 Ham and Pennycross
18 Higher Compton and Mannamead
19 Honicknowle
20 Keyham
21 Leighham and Mainstone
22 Lipson and Laira
23 Manadon and Widey
24 Morice Town
25 Mount Gould
26 Mutley
27 North Prospect and Weston Mill
28 Peverell and Hartley
29 Plymstock and Radford
30 Plympton St Maurice and Yealmpstone
31 Southway
32 St Budeaux and Kings Tamerton
33 Stoke
34 Stonehouse
35 Tamerton Foliot
36 Turnchapel, Hooe and Oreston
37 Whitleigh
38 Widewell
39 Woodford

'How Are You?' quiz results for Plymouth

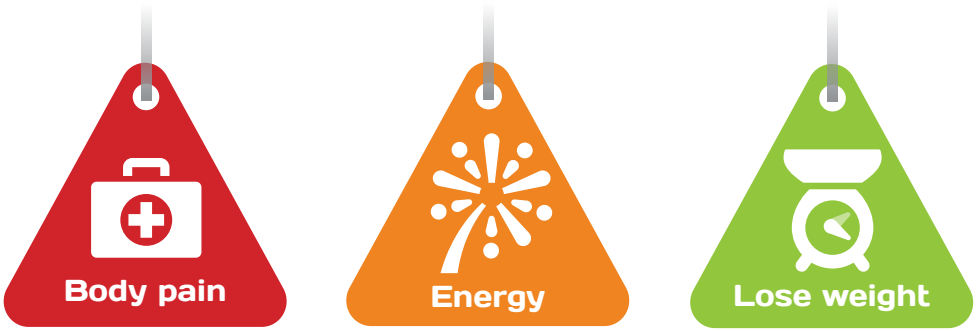
2,329 Plymouth residents completed the quiz in the three months following its launch.

The How Are You (HAY) quiz gives a red/amber/green rating for smoking, drinking, eating and moving with green being the best result and red being the worst. After the launch event we were given access to anonymised quiz results for Plymouth residents. Using this data we were able to identify average health results for the city by electoral ward. We then compared this to the deprivation score for the wards and were able to identify patterns within the data. See map showing overall scores by ward across the city.

Map of average overall score by neighbourhoods



Reasons why people wanted to improve their health



Improving Lives Plymouth

Improving Lives Plymouth (ILP) is a local charity that supports people with disabilities and long term health conditions. They offer both practical and emotional support through a number of programmes which are free to access. They supported 17,000 people in the local community last year alone.

ILP has 50 staff and 80 volunteers who are all passionate about what they do for this local charity.

Active for All is a programme which supports adults with learning difficulties and long term health conditions to get more active and live healthier lifestyles, walking boccia, basketball to name a few. They worked with us to ensure One You was accessible to all and an easy read version of the Thrive Plymouth strategy was created as a result of their input. Improving Lives Plymouth incorporated the Thrive Plymouth framework to all the work they do.

We used media effectively

Our Thrive Plymouth year three launch event in November 2016 was held at the University of Plymouth. At this event we encouraged all organisations present to join up to our Thrive Plymouth network which was launched the following week, as a result 41 organisations joined, by the end of year three there were 52 organisations involved. We also launched a Facebook page dedicated to Thrive Plymouth.

Social media played a big part in the campaign with our partners re-posting many of our posts and using social media to advertise the events they held to support Thrive Plymouth.

Using the nationally developed resources from PHE saved us the cost and time involved in designing and printing marketing material. With the message already crafted and designed by the national team we could focus on networking and spreading the message.

Individual Challenges	Organisational Challenges	Population Challenges
Create a social media post which encourages people to search for the How Are You quiz online.	Create a newsletter article or post to social media as your organisation encouraging your staff, clients or customers to take the How Are You quiz.	Let's get as many people as possible engaged with their own health. Use targeted media to reach those who have not engaged with How Are You so far and find out what will get them engaged.

Improving Lives Video

Plymouth Herald 'I Love Life' campaign

Plymouth's local paper, the Plymouth Herald, has for a number of years run health promotion campaigns. The 'I Love Life' campaign had been running for some time before the launch of One You. This campaign was funded jointly by Public Health, Livewell Southwest, Healthwatch, and Active Devon. The 'I Love Life' steering group had produced a series of 12-page supplements which were published as part of a Herald weekend publication.

In preparation for the launch of One You the 'I Love Life' supplement for March 2016 focused on One You related messages and encouraged readers to complete the How Are You quiz online. The supplement also included articles and features on healthy lifestyles with personal stories from a group of taxi drivers who had become 'I Love Lifers' by completing the Livewell Southwest healthy lifestyles programme. It was hoped by showing the stories of people who had been successful at changing their lifestyles the readers would feel inspired to make their own changes.
The supplement was heavily branded using One You raising the likelihood of readers recognising the accompanying out of home advertising which was funded in the city to coincide with the launch.

We were pleased to find out that for all completions of the "How Are You" quiz nationally the BBC website had the highest number of referrals and the Plymouth Herald website had the second most referrals.


4 ONE YOU

Meet 12 people who want to be healthier

5

A dozen Plymouth City Council workers have signed up to The Herald's 'I Love Life campaign in the hope of making small changes that will make them fitter and happier

BECAUSE THERE'S ONLY ONE YOU


2

Help to get you started

THERE IS ONLY ONE YOU

Being healthy in middle age can double your chances of being a fit and happy pensioner

Welcome

Professor Kelechi Kinsahan, Director of Public Health for Plymouth City Council

HOW ARE YOU?

HOW HEALTHY ARE YOU? TAKE THE EASY ONLINE QUIZ AT WWW.PLYMOUTHHERALD.CO.UK/ILOVELIFE

The Green Taverners Love Life

One of Plymouth Argyle's football club supporter groups is called the Green Taverners. In January 2017 they became one of the teams of 'I Love Lifers'. They went through a 12 week programme where Livewell Southwest Wellbeing Team worked with them to 'know their numbers' which means they were weighed, measured and had their blood pressure and body fat percentage recorded. They then learnt about nutrition and physical exercise as well as receiving help and support to cut down tobacco and alcohol use. After 12 weeks they reviewed to see if the programme had helped them make any changes to their lifestyle.

▼ *Plymouth Argyle supporters*

Santa Cycles to Whitleigh

As part of the Herald's 'I Love Life' campaign Healthwatch organised and ran an outreach event in Whitleigh. A series of local elves cycled Santa miles on two stationary bikes to carry Santa all the way from the North Pole to Whitleigh in time for the annual Christmas Fayre.

▼ *Healthwatch, Santa Cycles to Whitleigh*

We ensured a wide range of activities

We held five Thrive Plymouth network events where organisations could come together to share their best practice and encourage each other. We know as a result of these network events many new projects and partnerships have been formed. We look forward to reaping the rewards as a city.

We were asked to make 25 presentations to organisations over the year, this meant an extra 361 people heard about Thrive Plymouth and One You.

There were a further twenty events where One You was represented throughout the city.

Throughout the year PHE launched a number of initiatives with accompanying apps which could help people to live healthier lives. The Active10 app encouraged people who were only doing a small amount of physical activity to increase that to 10 minutes of brisk walking per day, with the eventual goal to increase to 30minutes per day. This app caught our imagination and in the last week of March 2017 we held a week of lunchtime walks with media coverage to encourage more walking in the city. Twelve Active10 walks took place across the city, run by organisations who are members of the Thrive Plymouth network and the Plymouth Herald ran news reports on the app and the walks.

Individual Challenges

Take part in one of the many One You events that are happening city wide throughout the year.

Organisational Challenges

Run an event that will encourage your clients, customers or staff to move more, eat better, smoke less or drink safely?

Population Challenges

Let's make the most of our natural environment. Plymouth has incredible green and blue spaces available. We need to make the most of these through low cost and fun activities that will improve health outcomes.

DATAplay Event

DATAplay is an innovative Plymouth City Council project which aims to encourage more use of publicly collected data. The hope is this will provide solutions to hard-to-solve problems in Plymouth. Towards the end of 2017 we worked with the DATAplay team to run a Hackathon event. Hackathons are events where the digital community comes together and works to solve problems that are presented during the events. We presented the Thrive Plymouth message and data about health in the city to the digital community asking them to suggest/design/create solutions to encourage better lifestyles in the city. The community responded with a menu project to encourage healthy eating through redesigning menus. This project has now been run three times in the city influencing people to make healthier choices within cafés and we are hoping to get funding to continue the good work in the future.

▼ *DATAplay event Dec 2017*

St Jude's Community Hub

This new Community Hub meets every Tuesday morning in the local Church Hall. The volunteers provide an internet café, social inclusion activities and free coffee to anyone who attends. When they got involved with Thrive Plymouth they decided to train their volunteers in how to lead Walking for Health activities as part of the Active10 App launch. Two of their volunteers attended a training course provided by Livewell Southwest and now they offer a weekly walk in the local parks. 'St Jude's Walk, Talk and Tea' takes place at the same time as the Community Hub to encourage more physical as well as social activity.

▼ *Walking for Health Event*

Poole Farm

This community farm has been owned by the Council for over a year and is bringing a little bit of the countryside into town. The farm now boasts a herd of cattle, sheep, bees and chickens alongside the impressive amount of tree planting and improved wildlife habitats that have been achieved. This has all been done through an extensive volunteering programme and organised events, happening weekly throughout the city as well as proactively working with partners such as Duchy College and Plymouth Environmental Action.

In celebration of the work Poole Farm have been doing to increase low level physical activity this year, the Thrive Plymouth Summer Away Day was held at the farm in July 2017. This event was a celebration of all the work which had been carried out to encourage healthier lifestyles, especially amongst our low income residents.

▼ *Poole Farm, Volunteering Days*

PCH New Home New You

This project came about as result of conversation between Public Health and Plymouth Community Homes (PCH) about how PCH could get involved in year three of Thrive Plymouth. PCH revealed that they see approximately 600 new tenancies each year and many of these new tenants suffer from poor health and wellbeing-related outcomes.

The new tenants have several meetings with PCH Housing Officers, before their tenancy begins and then at four weeks, six months, nine months and twelve month home visits. Housing Officers are also responsive to residents needs throughout their tenancy. The start of a new tenancy is the moment that many people choose to make lifestyle changes.

Livewell Southwest trained PCH Housing Officers on how to have a health and wellbeing-related conversation with the new tenants. Staff from the council and Livewell Southwest liaised to develop and deliver a bespoke training package for the PCH Housing Officers. There was also input from the Peninsula Dental School. The package was a mixture of 'making every contact count' and 'wellbeing champion' training. Four half-day training sessions were held with the PCH staff in February and March 2017. Approximately 45 PCH Housing Officers attended these sessions. A further 55 (approximately) front-line staff have also been trained.

The opportunity was also taken to review the 'goody bag' that new tenants are given. Rather than it being simply filled with household items, they now contain signposting information to health and wellbeing-related services as well as some health-improvement-related literature.

The intervention process has now been agreed. This is based on a standard health and wellbeing 'conversation starter' form developed by Livewell Southwest.

A plan for evaluating the impact of the programme has been developed. It is based on the use of (1) the Warwick-Edinburgh mental wellbeing scale and2 the PHE How Are You (HAY) quiz. These can be administered at different points in the first year of tenancy to assess impact over time.

PCH Video

A post-graduate student studying for an Masters in Public Health at Marjons University will carry out an evaluation of the project as part of their degree.

The training has now been offered to staff from the other social housing providers in the city.

The project was officially launched on 16 October 2017.

"A new home isn't the answer to optimal wellbeing, but it can be a powerful catalyst for wider positive change. PCH and partners will provide opportunities to make that change."

We celebrated the success

Throughout the year our partners did incredible things to help Plymouth to thrive. There were so many events and projects it would not be possible to include them all in this report. To share the great news about One You we sent monthly emails to the Thrive Plymouth network encouraging and sharing good practice. We also helped our partners create case studies that could be shared online and in newsletters.

Individual Challenges

Use a One You apps and tell your friends about how it helps you live a healthier lifestyle.

Organisational Challenges

Look at your organisation and identify what environmental factors are discouraging your staff, clients or customers to be unhealthy – can you change anything?

For example encourage brisk walking during breaks or redesign the menu in your staff canteen to make healthy choices the easy choices.

Population Challenges

Let's include everyone. We need to increase the low cost/free options for improving health within the city. Making it easier for everyone to engage with activities on their doorstep.

▲ *Blue Light Day – resulted in hundreds of people living with learning difficulties and their carers learning about healthy lifestyles*

▼ *Library Case Study – resulted in a great health and wellbeing offer being available through the library*

Library Case Study Video

Working Links provided Wellbeing Champion training through Livewell Southwest

IHC lecture

Plymouth Hospitals

Derriford Hospital is the largest hospital trust in the South West. Working with Livewell Southwest. We set up a Plymouth NHS Hospitals Trust Thrive Group to manage the changes that improve the health and wellbeing of our staff. Over the past two years we've:

- launched the Derriford Centre for Health and Wellbeing
- reduced the membership fees for Staff at our Leisure Services
- reviewed our smokefree policy
- launched a range of social activities to target mental as well as physical health
- reviewed our retail catering offer across the Trust
- launched a Health Champion scheme
- run a 'Big Pinch' campaign offering boot camp activities
- revisited our Green Travel plans
- held annual staff health and wellbeing days.

Opening of Derriford Centre for Health and Wellbeing

▲ *Walking football*

As a major employer the Trust already had many of the things you would expect from a good employer: staff knowledgeable about their health, occupational health services, a gym, smoking cessation services, healthy eating options in the café, green travel plans and a commitment to the environment. Thrive Plymouth enabled us to bring this all together to encourage active, happy and healthy staff.

Nick Thomas Deputy CEO, Plymouth NHS Hospital Trust

6 CONCLUSIONS

It was a great year for engagement with Thrive Plymouth across the city. Using a national campaign locally meant we could access high quality, evidence based, free resources to encourage healthy lifestyles amongst our residents. This allowed us to spend time focusing on other aspects of behaviour such as the environment in which we make our choices. A huge amount of work has been done in Plymouth to encourage local residents to access the many smart phone apps launched this year.

▼ *Public Health team at the year four launch 2017*

7 WHAT IS THE FUTURE?

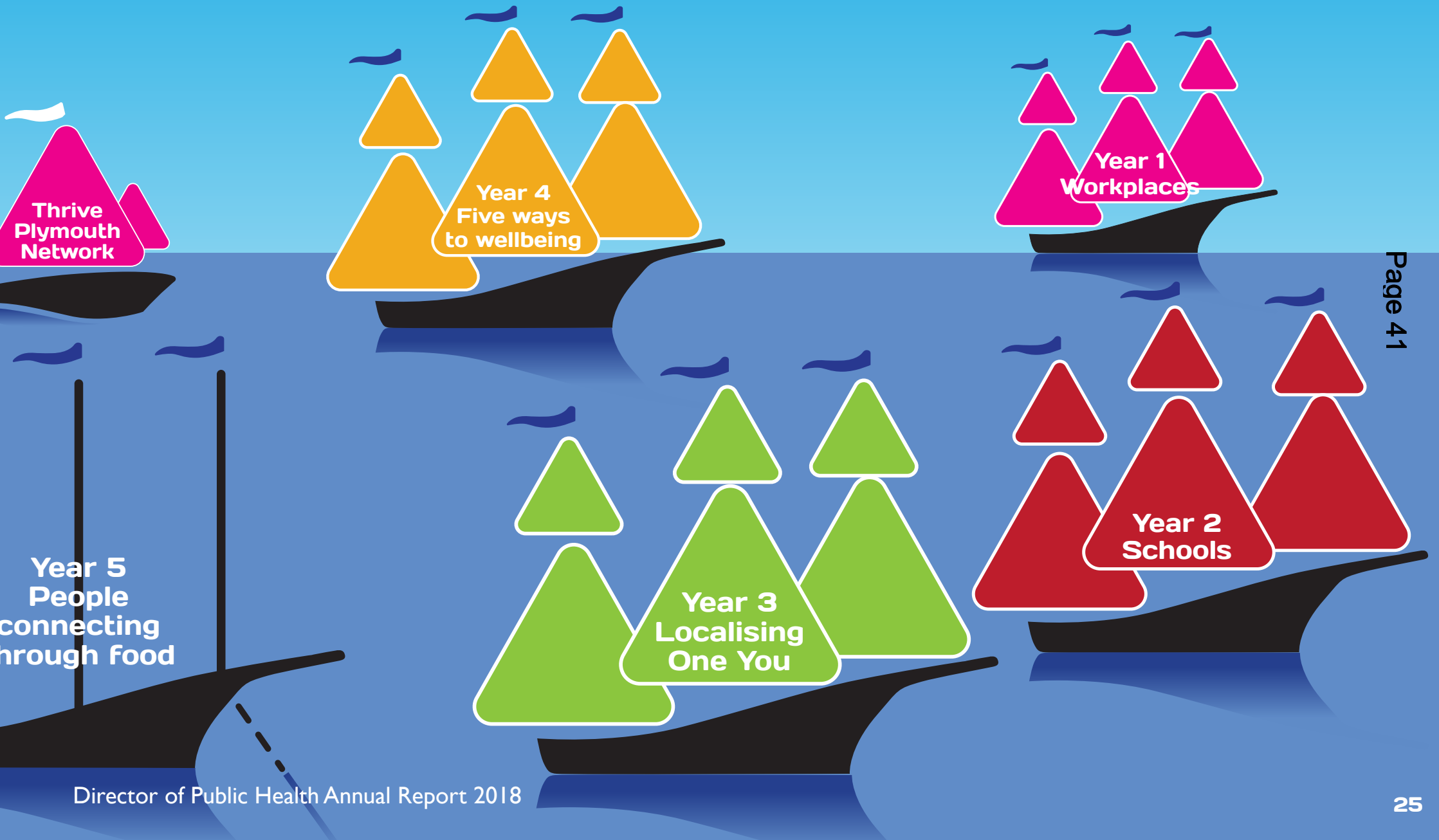
So what is the future for Thrive Plymouth? We are in the midst of year four which is focusing on mental wellbeing. The five ways to wellbeing are a really good way to get people to understand there is more to health (mental and physical) than simply what you eat, drink or do. We want to treat people as individuals, with complex and interesting lives. Understanding that how people are feeling has a massive impact on how well they can respond to stress in their lives we want to make it easier for people to feel good.

We also need to find out whether this year of the Thrive Plymouth programme has worked. There are two parts to this:

1. Finding out what the impact of the One You campaign has been; are people more engaged with their health and able to make healthier choices?
2. Tracking changes in the twenty Thrive Plymouth indicators which include both behaviour and disease rates amongst the population.

It will be some time before we are able to see any significant changes in the indicators, and we know it will be extremely difficult to be certain any changes have definitely been caused by Thrive Plymouth; however we believe we have made a good start and are heading in the right direction.

So to finish, year three allowed us to recruit over fifty organisations into our fleet of Thrive Plymouth ships and we're all heading in the same direction, towards a Plymouth were the healthy choice is the easy choice.



8 LINKS

Thrive Plymouth:

www.plymouth.gov.uk/publichealth/thriveplymouth

Plymouth's Life Expectancy Bus Route 2015-16

www.plymouth.gov.uk/publichealth/thriveplymouth/aboutthriveplymouth/healthinequalities

Global Burden of Disease:

www.healthdata.org/gbd

One You:

www.nhs.uk/oneyou

All One You Apps available from:

www.nhs.uk/oneyou/apps#HeDTm2C0SRUtJUAJ.97

Public Health England:

www.gov.uk/government/organisations/public-health-england

DATAplay:

www.plymouth.gov.uk/dataplay

9 REFERENCES

1 Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013Newton, John N et al.

2 The Lancet, Volume 386 , Issue 10010 , 2257 - 2274 www.thelancet.com Published online September 15, 2015 http://dx.doi.org/10.1016/S0140-6736(15)00195-6

Public Health
Office of the Director of Public Health
Plymouth City Council
Windsor House
Plymouth PL6 5UF

Tel: 01752 398606
odph@plymouth.gov.uk
Date: April 2018 (v1.6)

Editorial Team
Claire Turbutt, Robert Nelder and Ruth Harrell

Contributors
Claire Turbutt and the Thrive Plymouth Network

For queries relating to this document,
please contact: odph@plymouth.gov.uk

Acknowledgements
Mike Jane and Jayne Mills of Corporate Communications

Public Health
Office of the Director of Public Health
Plymouth City Council
Windsor House, Plymouth PL6 5UF
Tel: 01752 398606
odph@plymouth.gov.uk

PLYMOUTH CITY COUNCIL

Subject:	Suicide Prevention and Audit Update
Committee:	Health and Wellbeing Board
Date:	4th October 2018
Cabinet Member:	Councillor Ian Tuffin
CMT Member:	Ruth Harrell, Director of Public Health
Author:	Sarah Lees, Consultant in Public Health
Contact details	Tel: 01752 398605
Ref:	
Key Decision:	No
Part:	I

Purpose of the report:

The report provides the Health and Wellbeing Board with an update on local suicide prevention action and presents the latest citywide audit on deaths by suicide.

Local leadership for suicide prevention is the responsibility of the local authority and is provided by the Office of the Director of Public Health and through a local strategic partnership group. The Health and Wellbeing Board have previously asked to be receive occasional reports on local activity for suicide prevention and on the annual audit of deaths by suicide undertaken by the Office of the Director of Public Health. The last such report was presented to the Board in October 2015.

Recommendations:

The Health and Wellbeing Board is asked to:

- Note and accept the latest suicide audit report
- Note the progress being made by the Plymouth Suicide Prevention Strategic Partnership on delivering the annual action plan
- Support the proposal of the Plymouth Suicide Prevention Strategic Partnership to review the scope of the citywide audit and to amend it to make it locally more appropriate [in the absence of current national guidance]
- Support the Office of the Director of Public Health in exploring the adoption of an avoidable deaths approach to consider deaths by suicide alongside drug and alcohol related deaths, to widen the scope of future audits and to develop proactive and timely sharing of information and the development of shared learning.

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SUICIDE PREVENTION AND AUDIT UPDATE

Health and Wellbeing Board; 4th October 2018

SUICIDE PREVENTION

The last report to Health and Wellbeing Board on suicide prevention was in October 2015. This report provided assurance to the Board that the local system for suicide prevention was fully aligned with the national strategy and guidance.

Suicide prevention continues to be an important public health issue. In 2017 there were 5,821 deaths by suicide registered in the UK. Each one of those deaths is not only a personal tragedy, but has a major impact on the families, friends and colleagues of those who died and on society as a whole. Suicide prevention strategies can be effective by;

- Promoting mental and emotional wellbeing and reducing risk factors that led to suicidal ideation
- Providing appropriate and effective support and treatment to enable people to continue to live 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

Local leadership for suicide prevention continues to be provided by the Office of the Director of Public Health and through the Plymouth Suicide Prevention Strategic Partnership. The Partnership has been in existence since 2012 and continues to meet quarterly. The group has contributed to and approved an updated strategic statement on suicide prevention in conjunction with the strategic partnerships in Devon and Torbay. The strategic statement is provided here as Appendix 1. Each area has also adopted a locally appropriate action plan and the current action plan for Plymouth is provided here as Appendix 2. The action plan is fully aligned to the national strategy and planning guidance.

SUICIDE AUDIT UPDATE

Plymouth City Council Office of the Director of Public Health conduct a citywide audit each year into deaths by suicide and undetermined injury. This year a more in depth audit report has been produced to inform future audit and prevention activity. The latest audit report is provided here as Appendix 3.

RECOMMENDATIONS

1. The Health and Wellbeing Board is asked to note the latest suicide audit report.
2. The Health and Wellbeing Board is asked to note the progress being made by the Plymouth Suicide Prevention Strategic Partnership on delivering the annual action plan.
3. The Health and Wellbeing Board is asked to support the proposal by Plymouth Suicide Prevention Strategic Partnership to review the scope of the citywide audit and to amend it to make it locally more appropriate [in absence of new national guidance]
4. The Health and Wellbeing Board is asked to support the Office of the Director of Public Health in exploring the adoption of an avoidable deaths approach to consider deaths by suicide alongside drug and alcohol related deaths, to widen the scope of future audits and to develop proactive and timely sharing of information and the development of shared learning.

Appendix I

Devon-wide Suicide Prevention Strategic Statement

Working together to make all communities in Devon, Plymouth and Torbay suicide safer communities

Devon County Council

Torbay Council

Plymouth City Council

1 Vision

The Wider Devon Sustainability and Transformation Partnership (STP) includes the local authority areas of Devon, Torbay and Plymouth and sets out ambitious plans to improve health and transform care services. A key theme across the STP is an increased focus on prevention, and specifically prevention of mental ill-health, supported by the recent publication of the *'PHE Better Mental Health Prevention Concordat'.*

Partners across Devon, Torbay and Plymouth are committed to working to together to reduce suicides. This strategic statement gives an overview of the strategic intent across the STP area. We recognise that each local authority area has its distinct make up of population demographics, environmental and social economic factors, therefore, more detailed local implementation plans will be developed for each area, detailing how organisations will work in partnership to reduce suicide among respective populations.

In 2016, there were **29 deaths** in Wider Devon as a result of **land transport accidents**

In the same year, **115 people** died as a result of **suicide or unintentional injury**

We believe that suicide is preventable and each of these deaths could potentially have been avoided. We aim to ensure that the whole of Devon is a place where people do not consider suicide as a solution to the challenges they face. We will aspire to make Devon a place that supports people in times of personal crisis and builds individual and community resilience to improve lives.

2 Introduction

Local Health and Wellbeing Boards provide the governance for suicide prevention and leadership of suicide prevention work is the responsibility of local authority public health teams. This leadership is provided through local strategic partnerships.

Suicide is a traumatic event; the impact is felt not only by immediate family and friends, but by people in workplaces, communities and wider society. It is estimated that every suicide costs the economy £1.67 million. This estimate includes direct costs which are involvement of the emergency services, healthcare interventions and investigations carried out by the police and coroner. There are additional indirect costs attributed which include the lost opportunity to contribute productively to the economy, including paid work, voluntary activities and looking after children or parents. Arguably though, the most fundamental impact of all is the loss of the opportunity to experience all that life holds as a result of suicide. The pain and grief that suicide can have on immediate family members and friends can be immense and long lasting. These very personal impacts are known by economists as '*intangible costs*' because they are often hidden and difficult to value. It is these intangible costs that make-up approximately 70% of the total costs of suicide.

Suicide can often be the end of a complex history of risk factors and stressing events, and the risk for suicide reflects wider inequalities in social and economic circumstances. Suicide is preventable; however, the prevention approach must address the complexity of the issue. There are many effective ways in which individuals, communities and services can help to prevent suicide and this strategic statement is intended to recognise the contributions that can be made across all sectors of society.

This document sets out the local suicide prevention statement and implementation plans which are supported by national guidance. The *'Cross-Government Suicide Prevention Strategy',* published in 2012 and subsequently updated in 2015 and 2017, sets out the Government's priorities for addressing suicide and self-harm. The national strategy fits with the aim of the *'Five Year Forward View for Mental Health'* and sets the ambition to reduce the number of people who take their own lives in 2020/21 by 10% compared to 2016/17 levels.

It is acknowledged that, although there are some risk groups emerging through national trend data that require a focus for population approaches (eg middle-aged men and those with undiagnosed depression), there is great variation between local areas, therefore, the national ambition is for local delivery of suicide prevention with the target for every local area to have in place a multi-agency suicide prevention strategic partnership and action plan. To aid in this, Public Health England published "*Guidance for developing a local suicide prevention action plan"* in 2016 which provides specific guidance to Local Authorities to develop local plans and ambitions.

3 Why are we doing this?

3.1 The national picture

The most recent figures for suicide in the United Kingdom (2016 registrations) were published by the Office for National Statistics on 7th September 2017. The National Statistics definition of suicide (updated in 2016) includes all deaths from intentional self-harm for persons aged 10 and over, and deaths where the intent was undetermined for those aged 15 and over.

A reduction in suicide rates will only be achieved if prevention is prioritised by the NHS, local government, charities, British Transport Police and others, and a population approach is taken.

The headlines:

In 2016, there were **5,688** suicides among people in Great Britain. This is **202 less** than in 2015 and represents a reduction of **3.4%**.

There has been a fall in the age-standardised suicide rate for both males and females in England from 2015 to 2016. The overall suicide rate has fallen from **10.1 in 2015 to 9.5 per 100,000** people in 2016.

Suicide continues to affect more males than females. Suicide is the leading cause of death in men under 50 years old and across all broad age groups, the suicide rate for males is around **3 times** higher than for females.

The highest suicide rate is seen in middle-aged men. Males aged 40 to 44 have the highest rate at **23.7 per 100,000 people**. In females, the highest rate is seen in the 50 to 54 age group who have a rate of **8.1 per 100,000 people**.

The most common suicide method in the UK in 2016 was hanging, accounting for **59%** of male

suicides and **43%** of female suicides respectively.

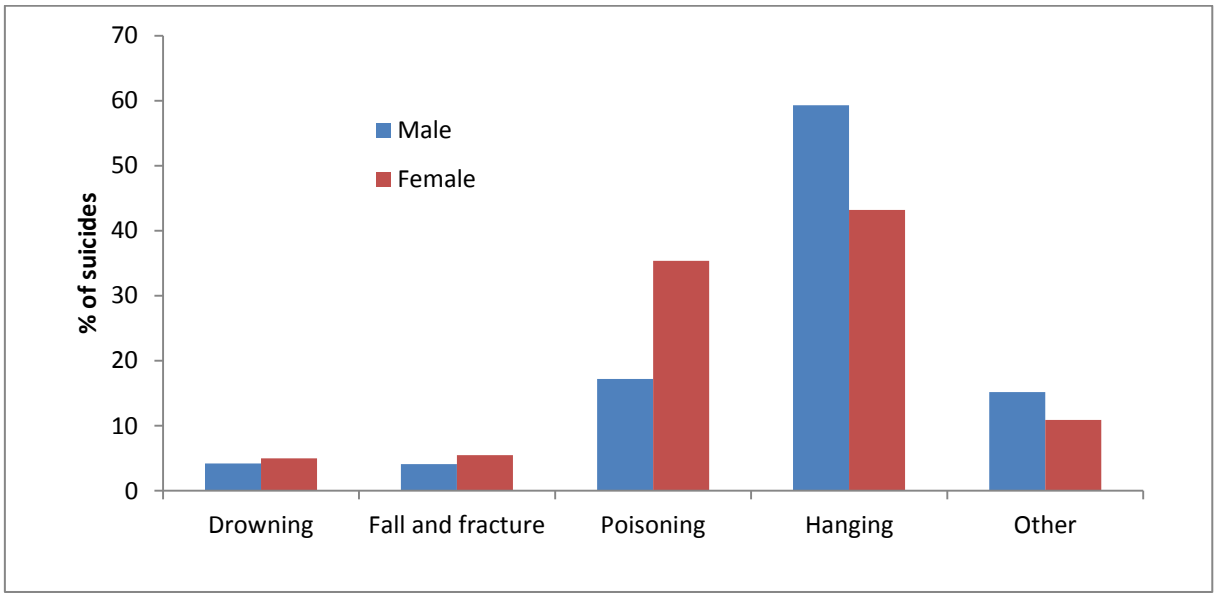

Figure 1. The proportion of suicide by method and sex, Great Britain, registered in 2016 (Office for National Statistics, National Records of Scotland)

In 2016, the South West had the highest age-standardised suicide rate for any English region at **11.2 per 100,000 people**. London has the lowest at **7.8 per 100,000 people.**

As well as gender and age, other known risk factors for suicide include self-harm, mental illness, employment status, marital status and physical ill-health.

It is estimated that the around a **third of people** who die by suicide are in current or recent contact with **mental health services**.

It is also estimated that around a **third of people** who die by suicide have had contact with their **GP** in the lead up to their death, and around a **third of people** are not known to any **health or care services.**

3.2 Local Picture

The Wider Devon STP area includes the local authority areas of Plymouth, Torbay and Devon. Each local authority area holds mortality data for its resident population, including data on deaths from suicide and undetermined injury.

Since 2014, there have been **339** deaths from suicide or unintentional injury Devon-wide *(Suicides in England and Wales by Local Authority: Office for National Statistics: 2017).* Of these, over **three-quarters** of deaths occurred in **males**.

There are suggestions that, following a peak in 2014, the directly age-standardised suicide rate is decreasing Devon-wide but there is local variation. (see Appendix 1).

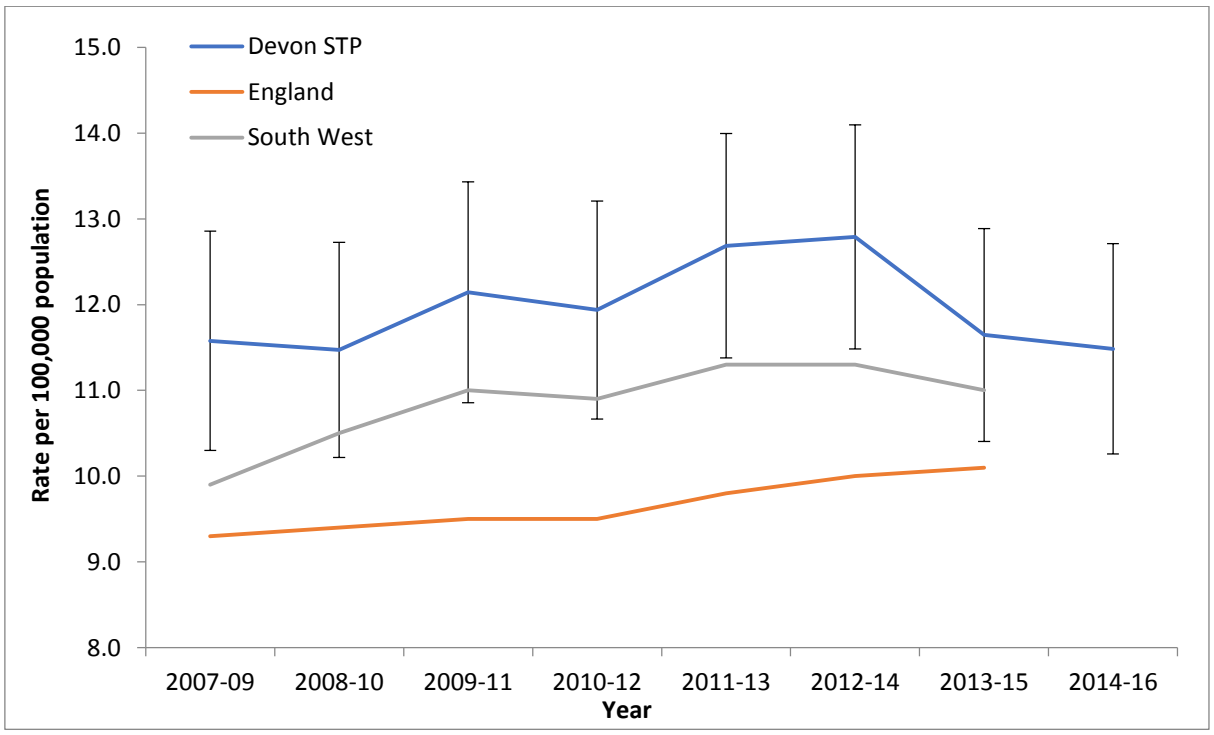

Figure 2. Trend in mortality from suicide and injury of undetermined intent Devon-wide. PHE Suicide Prevention Profiles - https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

However, presenting the overall picture may mask any trends occurring within specific risk groups.

Most deaths occur in the home (Figure 3). Deaths that are recorded as occurring in a hospital or communal establishment include those where the suicide attempt was made at home and the death occurred later in time.

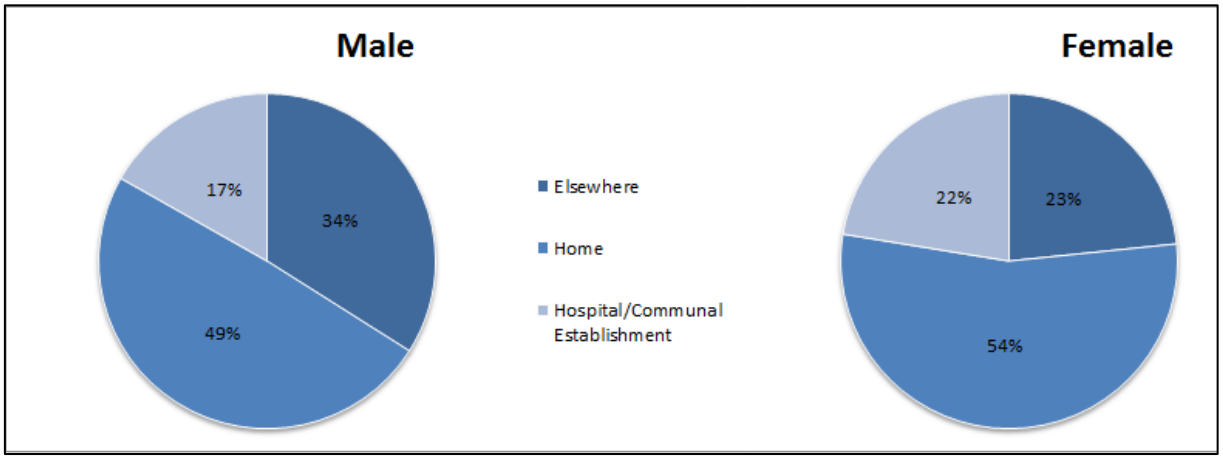

Figure 3. Place of death by gender, Devon-wide, 2014-2016 (Primary Care Mortality Database; Residents of Devon, Plymouth and Torbay)

Similarly, to the national picture the most common method of suicide Devon-wide was **hanging,** accounting for **55% of all male deaths** and **36% of female deaths**. Also reflecting the national picture, poisoning is the next most common method used, accounting for **37% of female deaths** and **16% of male deaths** (Figure 4).

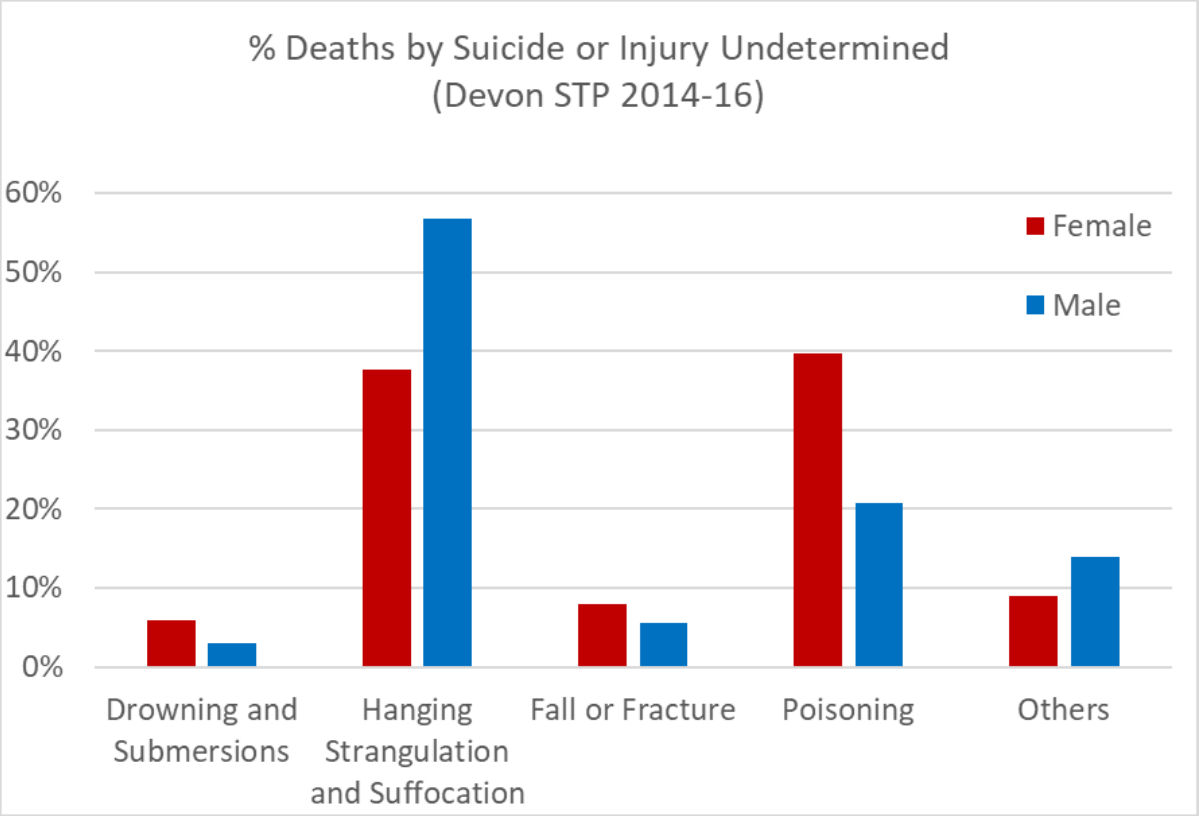

Figure 4. Method of suicide by gender, Devon-wide, 2014-2016 (Primary Care Mortality Database; Residents of Devon, Plymouth and Torbay)

The financial cost of a death by suicide is estimated at **£1.67 million** in terms of care and lost productivity. This means that the **115 suicides** Devon-wide in 2016 cost the local economy **£192 million**.

4 What is the ambition?

The aim of this strategic statement is to set a bold target for suicide prevention, based upon local, regional and national ambitions. In 2014, the South West Regional Zero Suicide Collaborative set the highly ambitious target to reduce suicides across the South West to zero by October 2018. This was followed by national publication of '*The Five Year Forward View for Mental Health*' in 2016 which sets the ambition that the number of people taking their own lives in 2020/21 will be reduced by 10% nationally compared to 2016/17 levels.

Devon-wide, we are committed to work in collaboration to reduce the number of suicides to zero. To start this process by 2020/21, we aim to reduce the number of people who take their own lives by 10% based on 2016/17 levels.

To achieve this reduction in suicide rates there needs to be a much stronger focus on suicide prevention and commitment from system leaders to make suicide prevention a priority.

"Working together to make all communities in Devon, Plymouth and Torbay suicide safer communities"

5 How do we aim to achieve this?

Suicide must be recognised as avoidable and therefore preventable. There are many effective ways that individuals, communities and services can work together to support people differently so that they do not see suicide as their only option.

Devon-wide partners will recognise the important contribution they can make and take a whole-community approach, recognising the contributions that can be made across all sectors of society. The approach will cover two tiers of action:

- **Level 1 Universal Interventions**: to build resilience and promote wellbeing at all ages for residents of Devon, Plymouth and Torbay.
- **Level 2 Targeted and vulnerable population groups:** targeted prevention of mental ill-health and early intervention for people at risk of mental health problems.

Improving the mental health of the population will support a reduction in suicide rates and this will be supported in ongoing work, at a local and strategic level, in support of the PHE Prevention Concordat for Better Mental Health.

To deliver the stated ambition, we will adopt the National Suicide Prevention Strategy which identifies seven key areas for actions. These are:

1. Reducing the risk of suicide in high risk groups
2. Tailoring approaches to improve mental health in specific groups
3. Reducing access to the means of suicide
4. Providing better information and support to those bereaved or affected by suicide
5. Supporting the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Supporting research, data collection and monitoring; and
7. Reducing rates of self-harm as a key indicator of suicide risk.

The national strategy will be implemented locally in two ways:

The **two multi-agency suicide prevention groups** will bring together the statutory and voluntary organisations necessary to support the development and implementation of the local suicide prevention implementation plans. One group will cover Devon and Torbay local authority areas and one will cover Plymouth.

There will be **localised suicide prevention implementation plans** based on the national strategy and local intelligence on suicide risk. Each local authority area (Plymouth, Torbay and Devon) will be responsible for developing and delivering their own local implementation plan that best suits the needs of their population.

6 Developing local implementation plans:

We intend to adopt the national strategy and using local data and knowledge, produce a set of local priorities for suicide prevention. The implementation plans will be developed following the steps set out below:

1. Review the national evidence base, best practice from other areas and local data to inform local priorities

2. Collate and review the current prevention activities in place and identify gaps in provision

3. Draft implementation plans with full engagement from stakeholders through the local strategic partnerships

4. Develop monitoring and evaluation plans for the suicide prevention groups.

The plans will be co-owned by a range of statutory and voluntary agencies, which will all participate by incorporating organisations' actions into the plans and working collaboratively to identify priority areas.

Once complete, the implementation plans will be made available on the local authority websites and will undergo annual review. A Devon-wide review of the data will be undertaken with sharing of best practice and, where it is appropriate, work will be undertaken on a Devon-wide level.

7 References

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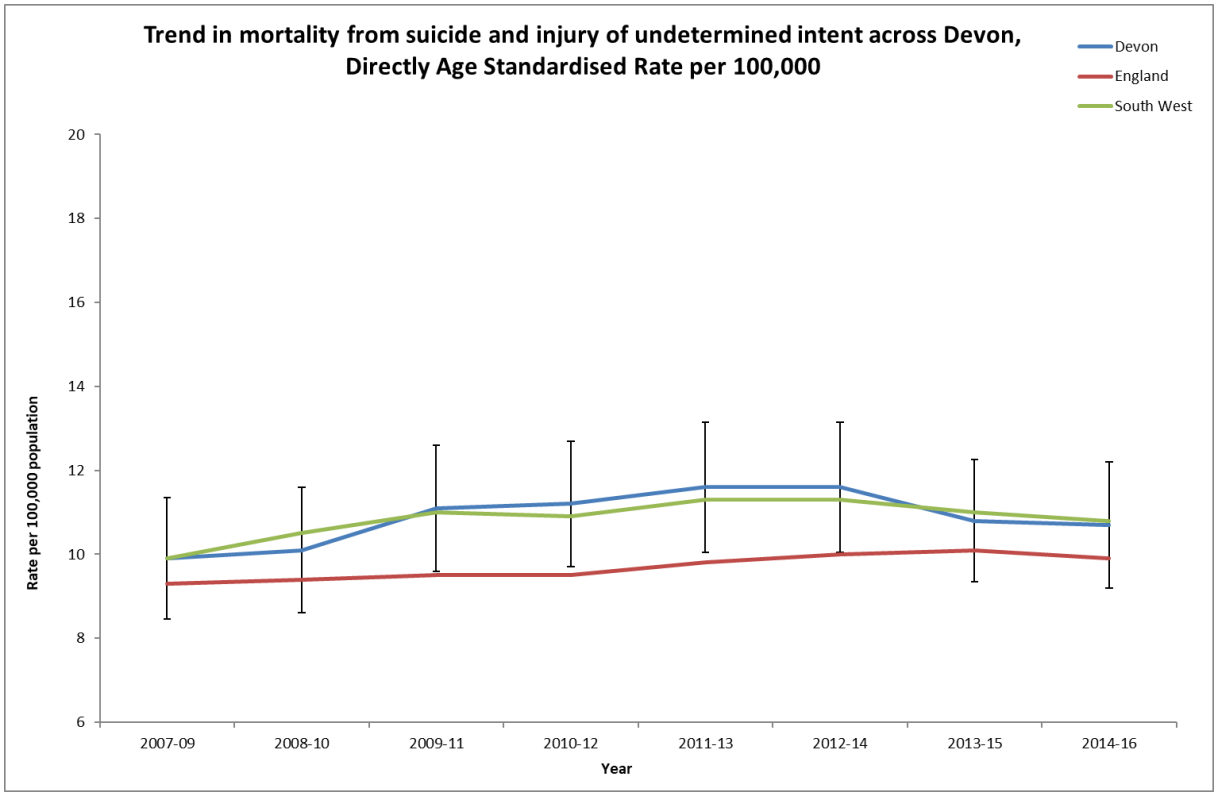
8 Glossary

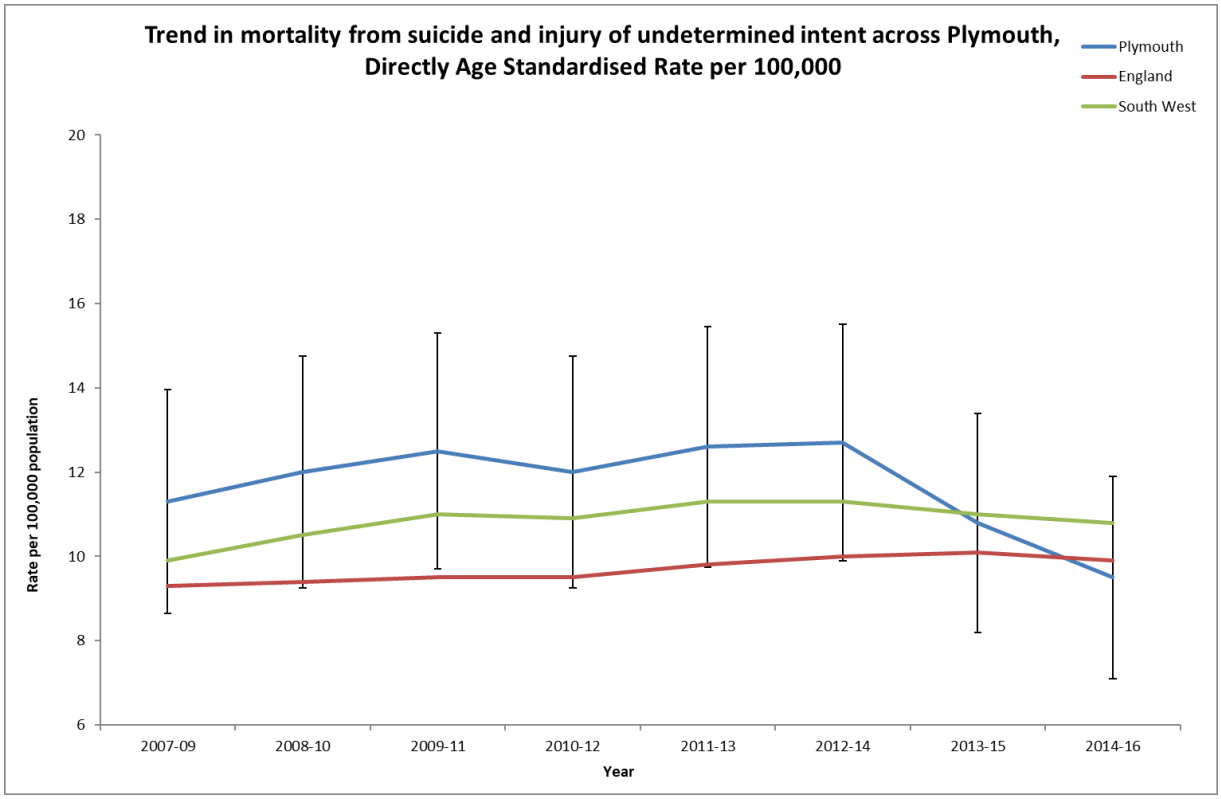
STP	Sustainable Transformation Partnership
PHE	Public Health England
LA	Local Authority
OPCC	Office of the Police and Crime Commissioner

APPENDIX 1

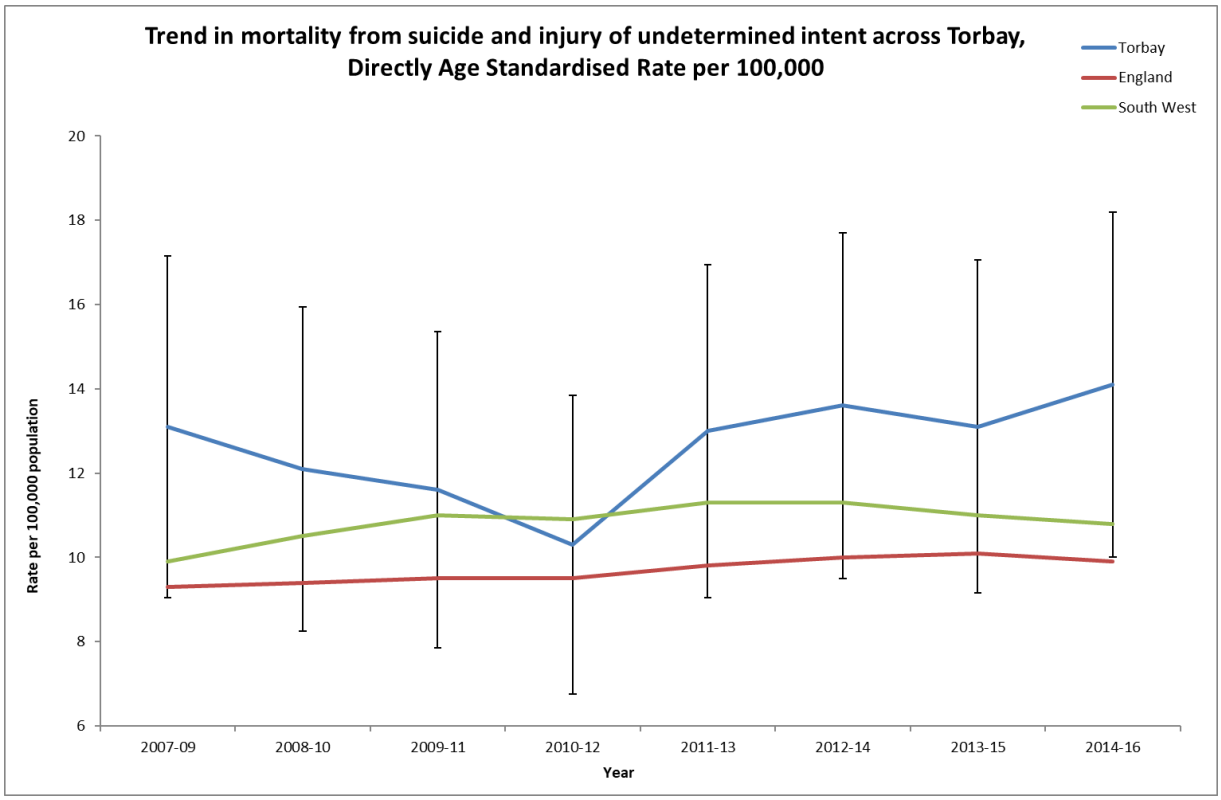
Public Health England – Suicide Prevention Profiles

https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide





APPENDIX 1


Trend in mortality from suicide and injury of undetermined intent across Torbay, Directly Age Standardised Rate per 100,000
Torbay
England
South West
Rate per 100,000 population
20
18
16
14
12
10
8
6
2007-09
2008-10
2009-11
2010-12
2011-13
2012-14
2013-15
2014-16
Year

Appendix 2

PLYMOUTH SUICIDE PREVENTION STRATEGIC PARTNERSHIP ACTION PLAN 2018-2019

Local Areas should *aim* to tackle all seven areas of the national strategy alongside the eight priorities for coordinated whole system working.

1.	Seven Areas if the National Strategy	2.	Eight priorities for coordinated whole system working
1.1	**Reduce the risk of suicide in key high-risk groups.**	2.1	**Reducing risk in men** - especially in middle age and with a focus on lifestyle factors and the treatment/settings men are prepared to use.
1.2	**Tailor approaches to improve mental health in specific groups.**	2.2	**Preventing and responding to self harm** – with a range of services for people in crisis and access to psychosocial assessment.
1.3	**Reduce access to the means of suicide.**	2.3	**Mental health of children and young people** – with joint working and plans to address suicide risk in 15-19 year olds.
1.4	**Provide better information and support to those bereaved or affected by suicide.**	2.4	**Treatment of depression in primary care** – with safe prescribing of painkillers and antidepressants.
1.5	**Support the media in delivering sensitive approaches to suicide and suicidal behaviour.**	2.5	**Acute mental health care** – with safer wards and safe discharge, adequate bed numbers and no out of are admissions.
1.6	**Support research, data collection and monitoring**	2.6	**Tackling high frequency locations** – including working with local media to prevent imitative suicides
1.7	**Reducing rates of self-harm as a key indicator of suicide risk**	2.7	**Reducing isolation** – for example through community based support, transport links and working with the third sector.
		2.8	**Bereavement support** – especially for people bereaved by suicide.

Appendix 2

Action	Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
		Start Date	End Date				
1. Reduce the risk of suicide in key high-risk groups. Men, specific occupational groups, people; who self harm, misuse drugs and alcohol, in the care of mental health services, in contact with the criminal justice system. ➢ **Priority Action 2.1: Reducing risk in men** - especially in middle age and with a focus on: economic factors such as debt; social isolation; drugs and alcohol; developing treatment and support settings that men are prepared to use.							
1.1	Deliver 'Men's Peer Support groups' in community based settings to reduce the impact of social isolation. Facilitated by experienced mental health practitioner. Focus on early intervention.	Provide signposting information to support services for high risk individuals [Enable seamless access to Recovery College provision to support the development of self-management skills and self-confidence]		Ongoing		Plymouth & District Mind	Service Providers	Ongoing initiative
1.2	Deliver in-school 'Life is a Rollercoaster' courses to young people at risk of, or currently, self-harming	Increased self-awareness of how to manage negative thoughts and coping behaviours.	01/09/17	2021		Plymouth & District Mind	The Zone (Progeny)	Ongoing initiative
1.3	Suicide Training of Risk Management (STORM) conducted with all clinical mental health staff.	Mandatory for all mental health staff. Data reviewed on a regular basis.		Ongoing		Paul O'Shea	All staff within Livewell SW	Ongoing initiative.

1.4	Through the incident and Serious Incident Requiring Investigation (SIRI) processes all incident of suspected suicides and serious self-harm are reviewed in line with National and Local guidance. Action plans created and shared throughout LSW.	Regular reporting via the Safety and Quality Group. All SIRI reports are reviewed by the CCG before closing to the organisation.		Ongoing		Nicky Varker and Graham Burton	Livewell SW staff. External Providers e.g. Harbour, Care Agencies. CCG.	SIRI panels run each month for attended by Senior staff from the Organisation and some external agencies.
1.5	Applied Suicide Intervention Skills Training (ASIST) and SafeTALK training offered to internal and external staff and agencies prioritising those in contact with high-risk groups.	Number of courses delivered in Applied Suicide Intervention Skills Training (ASIST) Number of people trained in Applied Suicide Intervention Skills Training (ASIST) Number of courses delivered in SafeTALK Number of people trained in SafeTALK		Ongoing		Jan Potter Cathryn Keeble	Livewell SW, Public Health	Priority Groups for 18/19 Blue Light services, Debt advice services, Wellbeing Hub services, substance misuse services, homeless services, sports clubs, court services, coroners officers, church and faith groups, PCC Bereavement Service, Youth services, Universities and Colleges

Appendix 2

1.6	Early intervention activities with offenders and the wider community at Magistrates' Court [primarily offenders or at risk of offending]	Specialist Court advice and support Supported sign-posting to local specialist agencies located in the community		Ongoing [subject to funding]		CASS+	Links to all partners across sectors	Priority group low level/non-statutory offenders but work with a wider range client group including Family cases, Tribunals and drop-in's. Strong model of easy access support to complex and vulnerable clients
1.7	Insight [EIP Psychosis] developed to work with people aged up to 65 years.		01/04/17	Ongoing		The Zone	Livewell SW	NICE compliant service with access to employability services, welfare advice etc.
1.8	Men's mental health promotion through local sports clubs	Resources available and promoted – Time to Change, SafeTALK, 5 ways to wellbeing	01/06/18	31/12/18		Public Health	PAFC Community Trust, Plymouth Albion, Raiders	Identify links to sports clubs for circulation and support. Resources provided by Public Health and online
1.9	Ensure Recovery Devon "Letter of Hope" available in service and community settings used by high risk groups	Availability in wide range of settings. Numbers of letters supplied	01/06/18	31/12/18		Public Health	Partnership members Wellbeing Hubs	Agreement from Recovery Devon to use "Letter of Hope" and print a Plymouth branded version

Appendix 2

Action	Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
		Start Date	End Date				
2. Tailor approaches to improve mental health in specific groups. Community based programmes, suicide prevention training, people who are vulnerable due to economic circumstances, pregnant women and those who have given birth in the last year, children and young people, survivors of abuse, veterans, people with long term physical health conditions, LGBT, BME groups and asylum seekers. ➢ **Priority Action 2.2: Preventing and responding to self harm** – with a range of services for adults and young people in crisis and access to psychosocial assessment for self-harm patients. ➢ **Priority Action 2.3: Mental health of children and young people** – with joint working between health & social care, schools & youth justice, and plans to address drastic increase in suicide risk in 15-19 year olds.							
2.1	Deliver weekly 'Mums Connect' peer support group (for mums in the perinatal period at risk of or currently experiencing mental health issues).	Provide signposting information to support services for high risk individuals		Ongoing		Plymouth & District Mind	Livewell Public Health	Ongoing initiative
2.2	Deliver in-school 'Life is a Rollercoaster' courses to young people at risk of, or currently, self-harming	Increased self-awareness of how to manage negative thoughts and coping behaviours.	01/09/17	2021		Plymouth & District Mind	The Zone (Progeny) Schools	Ongoing initiative
2.3	Maintain level of provision offered through Recovery College activities to promote mental wellbeing and recovery.	Information sharing through steering group to include numbers of high risk individuals who present at the Recovery College		Ongoing		Plymouth & District Mind	Service Providers	Ongoing initiative

3.3	Develop co-located service delivery in GP surgeries. Specialist mental health practitioner to offer tailored support for high risk patients in a surgery setting.	Access to training and specialist knowledge for GPs and nurse practitioners.	01/04/17	31/03/19		Plymouth & District Mind	GPs in Plymouth	Ongoing initiative
3.4	Progeny provision of whole school training in mental health to 26 secondary schools in Plymouth	Bespoke action plan for each school with training roll-out including ASIST and SafeTALK. Development of improved pathways for specific at risk groups	01/09/17	01/07/19		The Zone	School Mental Health Leads PCC Mind Young Devon CAMHS Beacon Medical Group	Additional funding in 17/18 from HEE re needs of most vulnerable CYP for additional schools training and training in Primary Care and CVSE
3.5	Review outputs from CYP worksho to identify top 5 actions for CYP system on suicide and self-harm prevention then add to action plan	Clarified and agreed priority actions relating to CYP		01/01/19		Public Health	CYP Partnership members	Refer back to CYP Emotional Health and Wellbeing group for agreement and to Safeguarding Board lead. Work needed to consult with CYP on final plan.
3.6	Promote 5 ways to wellbeing as whole population approach to mental health improvement	Increased awareness of 5 ways to wellbeing Number of partners using 5 ways to wellbeing with clients	10/10/17	16/10/18		Public Health	Partnership members Thrive Plymouth network	Focus for Thrive Plymouth Year 4 and will continue. Need to develop CYP appropriate materials for 5 ways to wellbeing. Targeted work for 16-24 year olds and those supporting them

Appendix 2

Action		Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
			Start Date	End Date				
3. Reduce access to the means of suicide.								
3.1	Tamar Bridge and Torpoint Ferry Joint Committee to review and where reasonable implement prevention measures on ongoing basis.	1] Samaritans signage has installed on the bridge 2017.		Complete		Tamar Bridge and Torpoint Ferry Joint Committee	Samaritans Public Health [PCC and CC] Police, Fire, Ambulance and Coastguard Services STORM	
		2] Bespoke STORM suicide intervention training for employees, contractors and emergency services		Ongoing				To date Tamar Crossings have trained 124 people. Initial and refresher training will be offered to all employees, relevant contractors and emergency services responding to the bridge on a routine basis.
		3] Intelligent CCTV cameras installed across the bridge structure to assist control room with identifying potential concerns for welfare and		Installation complete Learning phase ongoing				Learning phase programmed to help identify potential concern for welfare behaviours

		to aid quicker intervention 4] Review of concern for welfare multi-agency response plan 5] Investigate feasibility of raising pedestrian parapets including consultation with emergency services to ensure engineered changes considered in risk assessments and safe working methods if rescue required		In progress In progress				Review by Tamar Crossings with Police, Fire, Ambulance and Coastguard. Will be distributed to emergency responders for comment. Table top exercise to test plan in 2018 Information on attempts to climb bridge structure and numbers of people attending bridge in distress to be collected and analysed by Tamar Crossings. Data will be shared with Public Health, strategic group and other partners on ongoing basis
3.2	Ligature audits for LSW for inpatient units.	Ongoing annual programme	Current	Ongoing		Modern Matrons	Livewell SW staff	
3.3	Ligature and suicide prevention policy implemented on site	Ongoing review programme and learning	April 17	Ongoing		The Zone	Livewell SW	Policy reviewed May 2017
3.4	Monitoring and response to planning applications for high buildings, multi-storey car parks, public place developments to	Number of responses provided Modifications achieved and prevention measures built in	April 17	Ongoing		Public Health	PCC Planning Department	This is now done as routine. Some evidence of impact on modification to existing buildings to meet guidance.

	recommend compliance with PHE guidance							
3.5	Create working relationship with Highways to enable prevention to be embedded relating to road network and car parks	Opportunities for improvements identified and delivered Training to relevant staff delivered	01/05/ 18	31/12/18		Public Health	PCC Highways PCC Car Parks Commercial car park operators	

Appendix 2

Action	Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
		Start Date	End Date				
4. Provide better information and support to those bereaved or affected by suicide. ➢ **Priority Action 2.8: Bereavement support** – especially for people bereaved by suicide.							
4.1 Duty of candour applied to all suicides. Signposted to support agencies. Support given by clinical teams involved.	All duty of Candour applied. Support given to all affected.		Ongoing		Nicky Varker via SIRI group.	Bereavement support services and information	Copies of Help is at Hand to be available and provided to bereaved.
4.2 Promote availability of complex bereavement service as well as Cruse, Life Beyond Loss etc	Seek uptake data from service providers.	01/07/18	Review Spring 19		Public Health	Partnership members	Promote through Wellbeing Hubs network and all partnership services.
4.3 Provide Bereavement care and support training for staff in primary and secondary care mental health teams with focus on suicide	At least one member of staff from each team trained to support those bereaved, affected or at risk of bereavement where suicidal ideation a known risk factor	May 17	March 18		The Zone	Livewell SW	UPDATE REPORT REQUIRED ON PROGRESS AND CURRENT STATUS
4.4 Make the Help is at Hand leaflet readily available for bereaved families	Leaflet available in variety of locations; numbers of leaflets provided	From May 18			Public Health	Coroners Office Livewell SW Police Funeral Directors Bereavement Service [PCC]	Stock of leaflets ordered and available for circulation.

4.5	Establish website presence for Suicide Prevention Partnership to promote work of partnership and to provide links to local support services	Web presence to share action plan, audit reports etc Links to partners websites and sources of support Link to new website being developed to service Wellbeing Hubs	01/07/18	31/12/18		Public Health	Partnership members PCC DELT	

Appendix 2

Action	Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
		Start Date	End Date				
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour. ➢ **Priority Action 2.6: Tackling high frequency locations** – including working with local media to prevent imitative suicides							
5.1	Continue to work with local media re reporting of suicide and attempted suicides and in not highlighting high-risk locations – with reference to Samaritans Media Guidelines and Editors Code of Practice.	Monitor compliance of local reporting with media guidelines and provide challenge and support where non-compliance found. DPH to write to new Editor of The Herald.	Current	Ongoing		Public Health PCC Comms Team	Livewell SW Comms Team NEW Devon CCG Comms Team Partnership members	Too early to tell if initiative to date has had any substantial impact. Some more positive mental health reporting recently especially around mens' mental health
5.2	Support local media to report general mental health and illness in positive way	DPH to write to new Editor of The Herald. Examples of positive reporting	12/05/18	Ongoing		Public Health	PCC Comms Team Livewell SW Comms Team	Initiate contact with new Editor for Mental Health Awareness week
5.3	Prepare draft media statements in advance in relation to client cohorts to ensure appropriate information provided to the media in timely way specific for client group/known risks or contributory factors	Outcome more sensitive reporting and more informed about specific client groups and suspected or known conditions e.g. psychosis, depression	01/05/18	Ongoing		The Zone Livewell SW UHP Trust	Partnership members for other client groups Public Health	Pre-prepared statements to be co-produced and shared by service providers.

Appendix 2

Action		Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
			Start Date	End Date				
6. Support research, data collection and monitoring								
6.1	Support the collection and dissemination of local information on suicide and self-harm	Regular updates by all members at Strategic Partnership meetings	Current	Ongoing		Strategic Partnership members		Confidential data sharing at Partnership meetings.
6.2	Use range of data to produce Plymouth Suicide Audits	• Update at each Partnership meeting • Annual publication of audit summary • Presentation of annual audit summary to Health and Wellbeing Board	Current	Ongoing		Public Health	Coroners Office, Livewell SW GP Practices UHP NHS Trust	Annual update and short report will also go to Safeguarding Board.
6.3	Use PHE Suicide Prevention Profile for routine monitoring	Update report to Partnership meetings when profile updated or annually	Current	Ongoing		Public Health	Public Health England [PHE]	Available at https://fingertips.phe.org.uk/
6.4	Work to align suicide audit reports across Devon STP and coordinate format and publication dates	3 PH teams to work to common framework to produce short form annual summary	1/06/18	31/12/18		Public Health	Devon CC PH Torbay PH	Will enable a STP wide view and update as well as local authority area reports.
6.5	New life course Mental Health Needs Assessment for Plymouth	Published and available on JSNA website	1/4/18	31/10/18		Public Health	NEW Devon CCG Livewell SW	Last report dated 2012 so updated assessment of need required

Appendix 2

Action	Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
		Start Date	End Date				
7. Reducing rates of self-harm as a key indicator of suicide risk ➢ **Priority Action 2.2: Preventing and responding to self-harm** – with a range of services for adults and young people in crisis and access to psychosocial assessment for self-harm patients.							
7.1	Review current service provision for people who self-harm to ensure compliance with NICE standards and pathways	Compliance with CG 16 and CG 133	1/09/18	31/12/18		Public Health	Livewell SW UHP NHS Trust The Zone	Limited audit to review compliance. Review training need of staff in A+E, MIU etc
7.2	Undertake an all age needs assessment for self-harm	Completed needs assessment with recommendations to inform future action plans	1/8/18	31/12/18		Public Health	Partnership members	Aim to include focus group work especially with CYP
7.3	Contribute to Public Health England Local Knowledge Intelligence Service review of Self Harm in the South West	Comparative report and explanation of regional data on self-harm admission rates	1/6/18	30/9/18		Public Health	PHE LKIS	Regional project to understand high rates of self-harm across whole of SW region. Local data and information provided. Awaiting final report.

Appendix 2

Action	Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
		Start Date	End Date				
8. Primary & Secondary Care ➢ **Priority Action 2.4: Treatment of depression in primary care** – with safe prescribing of painkillers and antidepressants. ➢ **Priority Action 2.5: Acute mental health care** – with safer wards and safe discharge, adequate bed numbers and no out of area admissions.							
	Primary Care						
8.1	Increase access to IAPT	Nationally set trajectories for increased access	Current	Ongoing		Lin Walton NEW Devon CCG	Livewell SW	Extension of offer to those with long term conditions.
8.2	Review advice to Primary Care on safe prescribing of anti-depressants and pain medication especially relating to high risk groups	Compliance with best practice	01/07/18	31/12/18		Public Health NEW Devon CCG Meds Opt Team	LMC LPC	Build on existing work with pain medications
8.3	Review policies for controlled drugs and protocols for returning unused meds. Raise awareness with first responders and palliative care teams. Provide guidance for families/public	Returns of unused medications and safe disposal	01/07/18	31/12/18		Public Health NEW Devon CCG Meds Opt Team	LMC LPC Livewell SW First Responders	CDLIN NHSE

Appendix 2

	Secondary Care							
8.4	Discharge follow up within 48hrs	Services monitored - % achieved	Current	Ongoing		NEW Devon CCG	Livewell SW UHP NHS Trust	
8.5	Daily monitoring of bed numbers	Number of available beds	Current	Ongoing		Lin Walton NEW Devon CCG	Livewell SW	Overall bed numbers are adequate though male female bed ratio maybe a problem
8.6	Out of area acute admissions	No inappropriate out of area admission	Current	Ongoing		Lin Walton NEW Devon CCG	Livewell SW	Occasional out of area admissions are required for clinical reasons eg family working on the wards
8.7	PICU – Psychiatric intensive care beds	Achieve max use of 4 PICU beds	Current	Ongoing		Lin Walton NEW Devon CCG	Livewell SW	There is currently no PICU unit in Devon. DPT are building one and this will provide 4 beds for the Plymouth area

Appendix 2

Action	Milestones / Outcomes	Timescales		Status (RAG)	Leads	Key Partners	Comments e.g. resources
		Start Date	End Date				
9. Isolation ➢ **Priority Action 2.7: Reducing isolation** – for example through community based support, transport links and working with the third sector.							
9.1	Increased provision of social prescribing through GP practices, Wellbeing Hubs and IAPT	Numbers of people supported through social prescribing programmes Numbers of people supported through Wellbeing Hubs	10/1/18	09/07/19		Public Health PCC Strategic Commissioners	CVSE Wellbeing Hub Network	Review ASCOF scores for social contact for service users and carers. Additional funding for Wolseley Trust through successful DH funding bid is enabling provision in more practices
9.2	Reconfigured EI service to use evidence based group activities	Reduction in those excluded from mainstream activities	April 17	Ongoing		The Zone [Icebreak] [Insight]	Livewell SW	UPDATE REPORT NEEDED

PLYMOUTH SUICIDE AUDIT REPORT

Deaths registered 2014 to 2016

Appendix 3

Author: Office of the Director of Public Health, Plymouth City Council

Date: September 2018 (v1.0) DRAFT

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

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Office of the Director of Public Health
Plymouth City Council
Windsor House
Plymouth
PL6 5UF
Tel: 01752 307346
odph@plymouth.gov.uk

Date: September 2018 (v1.0)

Prepared by: Moira Maconachie, Simon Hoad and Vikki West.

For queries relating to this document please contact: odph@plymouth.gov.uk

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Contents

Introduction: Purpose and focus

This report provides an overview of the deaths of Plymouth residents by suicide and undetermined injury. It updates the information provided in the previous Plymouth Suicide Audit Summary (2013-2015)[1] and also provides additional information about contact with local health and wellbeing services. The data presented refers to the deaths of residents (10 years and older) registered during calendar years 2014, 2015 and 2016. 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 and the coroner has reached a conclusion (previously referred to as a verdict). Deaths of Plymouth residents are included in this audit whether they died in Plymouth or elsewhere in the UK.

Death by suicide or undetermined injury is a rare event in Plymouth and the numbers fluctuate from year to year. Suicide audit reports for Plymouth present data for deaths registered in particular calendar years averaged for three year periods. This enables direct comparisons to be made with national mortality data which is also presented by year of registration.

Our suicide audits are undertaken to monitor local trends and to compare these with national data. Our audit also supports suicide prevention initiatives in the city. The Plymouth Suicide Prevention Strategic Partnership is a multi-agency group led by Plymouth City Council which has responsibility for suicide prevention in the city. Information from the suicide audit process is provided to meetings of the partnership and suicide audit reports are discussed with and distributed to members of the group.

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 life. Deaths that are 'undetermined' are where the coroner at inquest reaches an open or narrative conclusion because the intention of the person is uncertain. Only open and narrative conclusions which are considered deaths by undetermined injury (UI) are included in the suicide audit.

Audit process and data sources

The local suicide audit process involves monitoring all deaths where the coroner has given a conclusion of suicide, or an open or a narrative conclusion. During the year information is collected from weekly death registrations, from the Primary Care Mortality Database, and from HM Coroners Office in Plymouth:

- Deaths included in this audit have been checked and verified using the Annual Mortality Extract for Plymouth from NHS Digital. Deaths from suicide are confirmed using the International Classification of Diseases (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').[2]

- Information on the trend in mortality rates is drawn from the Public Health Outcomes Framework (PHOF). [3]
- In line with national guidance on suicide audits published by the National Institute for Mental Health in England in 2006,[4] the local suicide audit process requests information about the deceased's contact with local health and wellbeing services prior to their death. The service information has been drawn together and collated for this audit report.

This report provides a city-wide overview of deaths by suicide and undetermined injury whether or not the deceased person had been in contact with local services. An overview is by definition limited in scope.

Detailed investigations into the circumstances of individual deaths are undertaken by appropriate services in the city. The coroner's inquest is the most important investigation that takes place and establishes whether or not the person intended to take their life. Other investigations may also take place if the deceased was in contact with local health and wellbeing services:

- In primary care services, a general practice may undertake a Serious Event Audit (SEA) if one of their patients dies by suicide/UI.
- In mental health services, a Serious Incident Requiring Investigation (SIRI) is undertaken for every patient death by suicide/UI.

Reports of the SEA and the SIRI investigations are not shared with the public health team and therefore are not directly considered in our suicide audit process.

Outline of the report

In preparing this audit we have drawn on six sources of information: the register of weekly deaths, official mortality data and the coroner files, as well as requests for information from local NHS services: including primary care, mental health and hospital services. The report is divided into three sections with each section presenting information drawn from particular sources:

- **Section One** presents summary information drawn from official statistics: the register of deaths in Plymouth and mortality data (this information is the basis for previous Plymouth Suicide Audit Data Summary reports).
- **Section Two** draws together information provided by primary care, mental health and hospital services.
- **Section Three** presents a range of contextual information drawn from coroner records.

Section One: Information drawn from official statistics

Official statistics provide information about the number of deaths and the mortality rates for death by suicide/UI (making it possible to compare Plymouth with England and our neighbours). Demographic information including the sex and age of the deceased, and details about where the deceased were born and the place of their death are also given. The post-codes of where they lived in the city are shown on a map which reveals that suicide is a concern across the city.

(1) Numbers

(a) Total deaths: 2014-16

A total of 64 deaths by suicide/UI were registered in the years 2014, 2015 and 2016. The majority of deaths were by suicide:

- 56 residents died by suicide
- 8 residents died by undetermined injury

Fewer deaths were registered in 2016 than in 2015 or in 2014:

- 19 deaths were registered in 2016
- 21 deaths were registered in 2015
- 24 deaths were registered in 2014

Over the three year period, the average number of deaths is one to 2 deaths a month.

9 non-residents died by suicide in Plymouth (this information is drawn from the inquest conclusions noted in weekly death registrations). Non-resident deaths are not discussed in our audit as they would be included in the audit undertaken for the place where they lived.

(b) Number of deaths by sex and age group: 2014-16

More than four times as many male than female deaths by suicide/UI were registered in the three year period:

- 52 males died (47 by suicide and 5 by UI)
- 12 females died (9 by suicide and 3 by UI)

Most of those who died (38 of the 64 deaths) were between 35 and 59 years old. In addition:

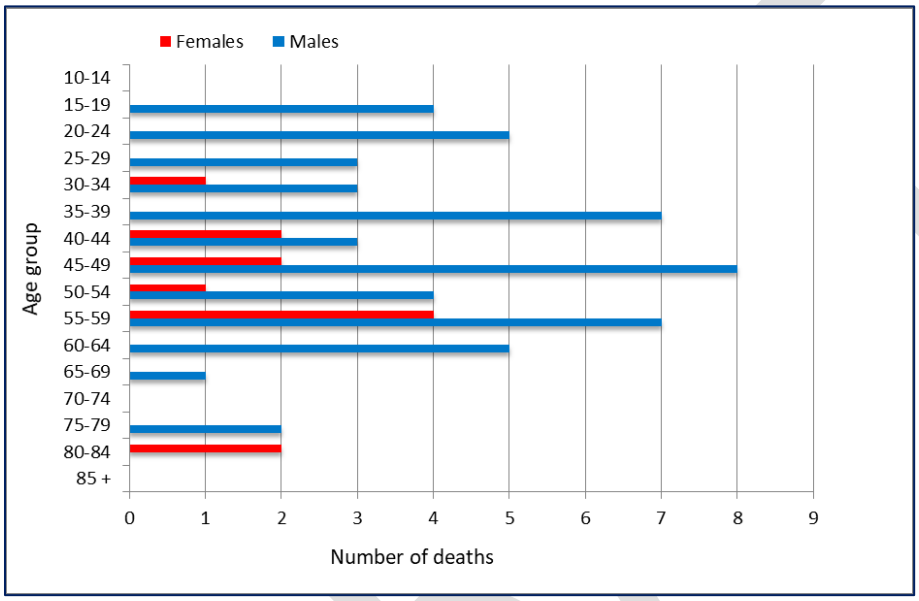
- The youngest person who died was 16 years old
- The oldest who died was 82 years old

- 9 people who died were younger than 25 years old
- 4 people who died were older than 75 years old

The chart below shows that number of deaths varies by sex and age group and reveals the following differences:

- Deaths among males are highest between the ages of 45 and 59 (19 of the 52 male deaths)
- All the females who died were over the age of 30

Number of deaths by age group and sex



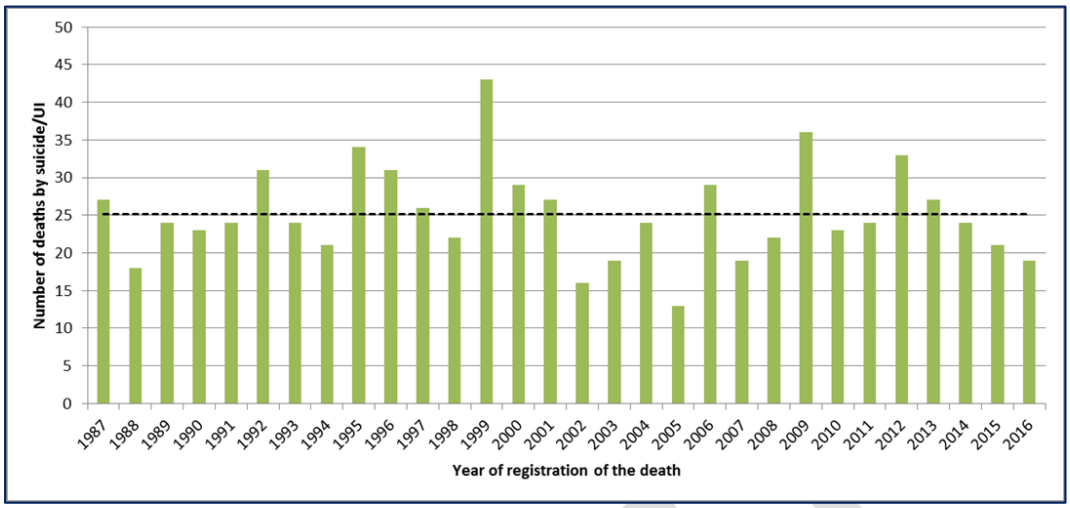
(c) Trend in the number of deaths: 1987-2016

A total of 753 deaths of residents by suicide/UI have been registered over the past 30 years. Calculating the long-term averages for the city reveals:

- Around 25 deaths each year
- Around 2 deaths a month

The figure on the following page shows the number of deaths registered for each year. The number of deaths ranges from a high of 43 deaths in 1999 to a low of 13 deaths in 2005. The black dotted line indicates the long term average of 25 deaths.

Trend in numbers of deaths by suicide/UI: 1987-2016



Source: Annual Death Extracts, ONS and NHS Digital.

(2) Mortality rates

Official mortality rates are given for the number of deaths for three year periods (expressed as the number of deaths per 100,000 of the relevant population). Statistical methods are used to control for variations in population structure by age to produce standardised rates enabling us to compare rates for different areas.

(a) Mortality rates for Plymouth and England: 2014-16

For deaths by suicide/UI, the directly age-standardised mortality rate (DASR) for Plymouth is in line with England for persons, for males, and for females:

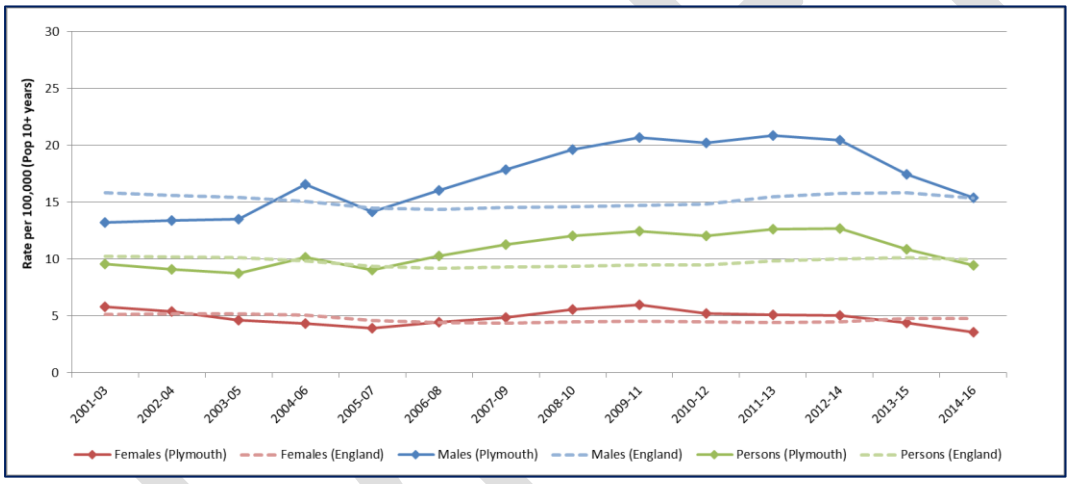
- The DASR for Plymouth **persons** is 9.5 deaths which is in line with the rate for England of 9.9 deaths per 100,000 population
- The DASR for Plymouth **males** is 15.4 deaths which is in line with the rate for England of 15.3 deaths per 100,000 population
- The DASR for Plymouth **females** is 3.6 deaths which is in line with the rate for England of 4.8 deaths per 100,000 population

(b) Trend in mortality rates for Plymouth and England: 2001-2016

The DASR for Plymouth deaths by suicide/UI has varied over the past 15 years for persons and the pattern differs for males and females. The rates are shown in the figure below which compares the DASR for Plymouth persons (green line), males (blue line) and females (red line) with those for England (the dotted lines in the same colours):

- The DASR for Plymouth **persons** is below England until 2007-09 when it rises above England and stays above to 2012-14. It falls in line with England for the period 2013-15 and remains in line with England to 2014-16.
- The DASR for Plymouth **males** follows a similar pattern to that for persons (which is expected as males comprise the majority of all deaths). It is above England from 2007-09 until 2012-14 and is in line with England from 2013-15.
- The DASR for Plymouth **females** follows a different pattern – it remains in line with England for the past 15 years.

Trend in mortality from suicide/UI, England and Plymouth: 2001-03 to 2014-16



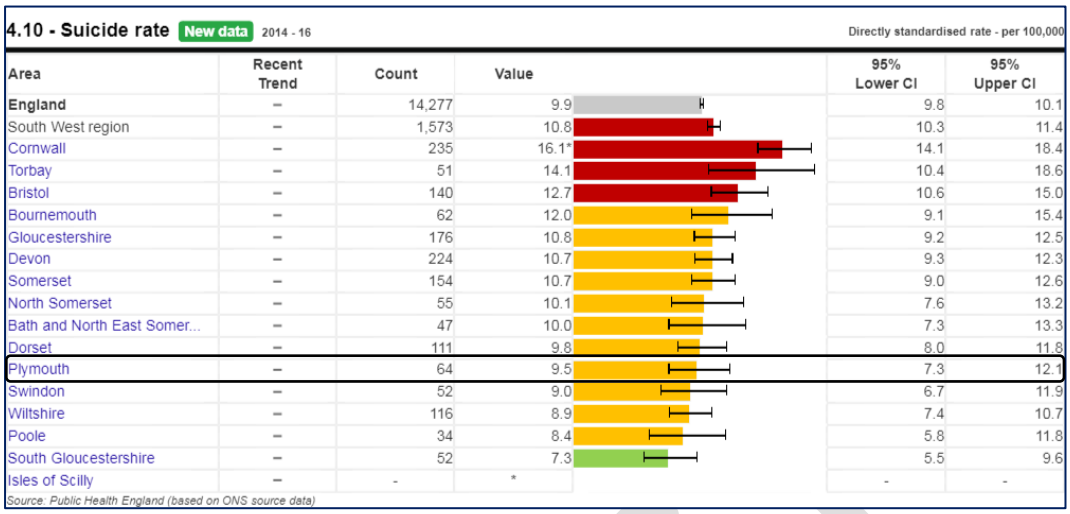
Source: PHOF (November 2017 download)

(c) Mortality rates: Plymouth ranked within the South West region

The England mortality rate for suicide/UI is 9.9 per 100,000 population for 2014-16. The rates per 100,000 population for the nine regions in England range from a high of 11.6 (North East) to a low of 8.7 (London). The South West region is ranked third highest in England (below the North East and the North West regions).

Plymouth is ranked 11th out of 15 when the DASR for Plymouth persons is compared to our neighbours in the South West region. The rates in the South West region range from a high of 16.1 (Cornwall & the Isles of Scilly) to a low of 7.3 (South Gloucestershire). Plymouth's rate of 9.5 is fourth from bottom (the lowest rate). Rates for the South West region are presented in the figure on the following page.

Mortality rate from suicide/UI, South West region and Plymouth: 2014-16



4.10 - Suicide rate New data 2014 - 16 — Directly standardised rate - per 100,000

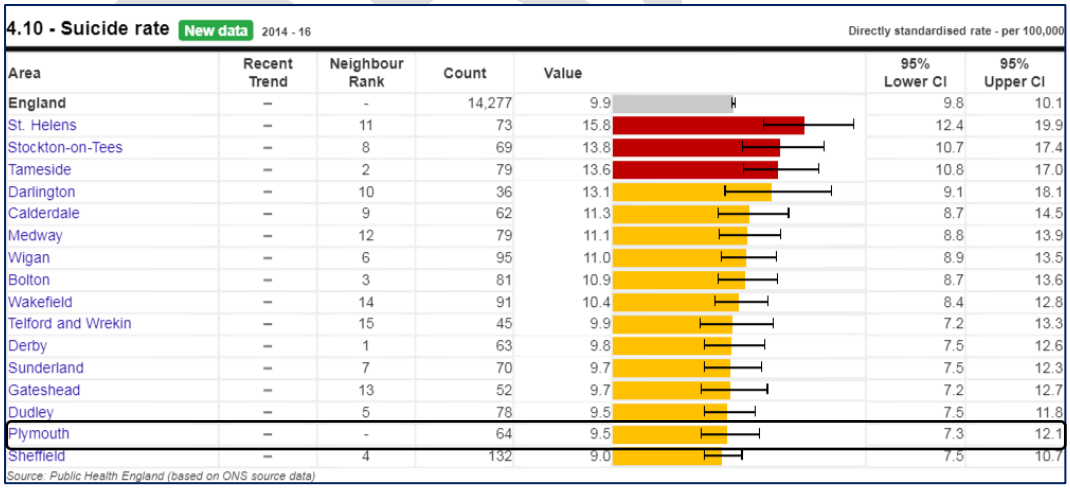
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	14,277	9.9	9.8	10.1
South West region	–	1,573	10.8	10.3	11.4
Cornwall	–	235	16.1*	14.1	18.4
Torbay	–	51	14.1	10.4	18.6
Bristol	–	140	12.7	10.6	15.0
Bournemouth	–	62	12.0	9.1	15.4
Gloucestershire	–	176	10.8	9.2	12.5
Devon	–	224	10.7	9.3	12.3
Somerset	–	154	10.7	9.0	12.6
North Somerset	–	55	10.1	7.6	13.2
Bath and North East Somer...	–	47	10.0	7.3	13.3
Dorset	–	111	9.8	8.0	11.8
Plymouth	–	64	9.5	7.3	12.1
Swindon	–	52	9.0	6.7	11.9
Wiltshire	–	116	8.9	7.4	10.7
Poole	–	34	8.4	5.8	11.8
South Gloucestershire	–	52	7.3	5.5	9.6
Isles of Scilly	–	-	*	-	-

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

(d) Mortality rates: Plymouth ranked within the CIPRA group

Plymouth is ranked 15th out of 16 when the DASR for persons is compared to neighbours in our CIPRA group (a set of local authorities considered most similar to Plymouth). The rates per 100,000 population in the CIPRA group range from a high of 15.8 (St. Helens) to a low of 9.0 (Sheffield). Plymouth's rate of 9.5 is second from bottom (the lowest rate). Rates for the CIPRA group are presented in the figure below.

Mortality rate from suicide/UI, CIPRA group and Plymouth: 2014-16



4.10 - Suicide rate New data 2014 - 16 — Directly standardised rate - per 100,000

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	14,277	9.9	9.8	10.1
St. Helens	–	11	73	15.8	12.4	19.9
Stockton-on-Tees	–	8	69	13.8	10.7	17.4
Tameside	–	2	79	13.6	10.8	17.0
Darlington	–	10	36	13.1	9.1	18.1
Calderdale	–	9	62	11.3	8.7	14.5
Medway	–	12	79	11.1	8.8	13.9
Wigan	–	6	95	11.0	8.9	13.5
Bolton	–	3	81	10.9	8.7	13.6
Wakefield	–	14	91	10.4	8.4	12.8
Telford and Wrekin	–	15	45	9.9	7.2	13.3
Derby	–	1	63	9.8	7.5	12.6
Sunderland	–	7	70	9.7	7.5	12.3
Gateshead	–	13	52	9.7	7.2	12.7
Dudley	–	5	78	9.5	7.5	11.8
Plymouth	–	-	64	9.5	7.3	12.1
Sheffield	–	4	132	9.0	7.5	10.7

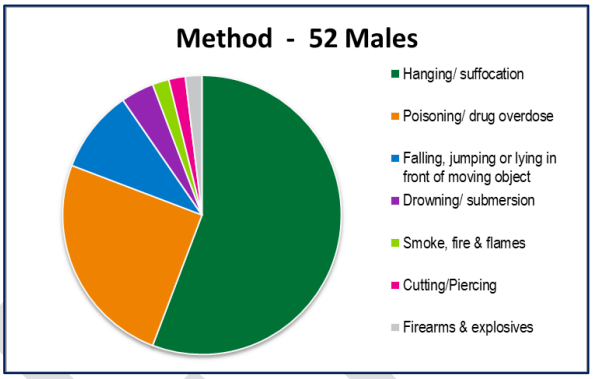
Source: Public Health England (based on ONS source data)

(3) Methods

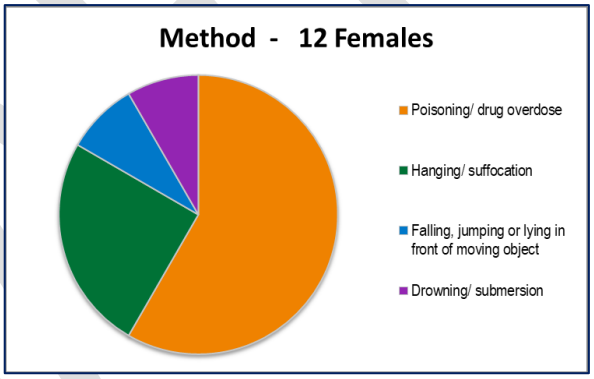
Hanging/suffocation is the most common method overall (32 of the 64 deaths) followed by poisoning/drug overdose (20 deaths). Other methods include death by falling, jumping or lying in front of a moving object (6 deaths), by drowning/submersion (3 deaths), and one death each for deaths by cutting/piercing, by firearms, and by smoke, fire and flames.

There are differences in the methods used by males and females. These are shown in the adjacent charts:

- The majority of **males** died by hanging/suffocation (29 deaths) and poisoning/drug overdose (13 deaths).



- Most **females** died by poisoning/drug overdose (7 deaths) followed by hanging/suffocation.



(4) Places

(a) Where they were born

The majority of the deceased (56 of the 64 residents) were born in the UK:

- 26 were born in Plymouth
- 30 were born elsewhere in the UK

8 of the deceased were born outside the UK.

(b) Where they died

The majority of the deceased (50 of the 64 residents) died in Plymouth:

- 35 died at home
- 8 died elsewhere in the city
- 7 had their place of death noted as Derriford Hospital (the injuries leading to death would have been initiated prior to reaching hospital, either at home or elsewhere in the city).

14 residents died by suicide/UI outside the city.

(c) Where they lived in the city

Death by suicide/UI is a concern across the city with the majority of electoral wards in the city and the majority of neighbourhoods in the city having at least one death by suicide/UI registered in the three year period.

- **Electoral wards:** 19 out of the 20 wards in the city had at least one resident die by suicide/UI.

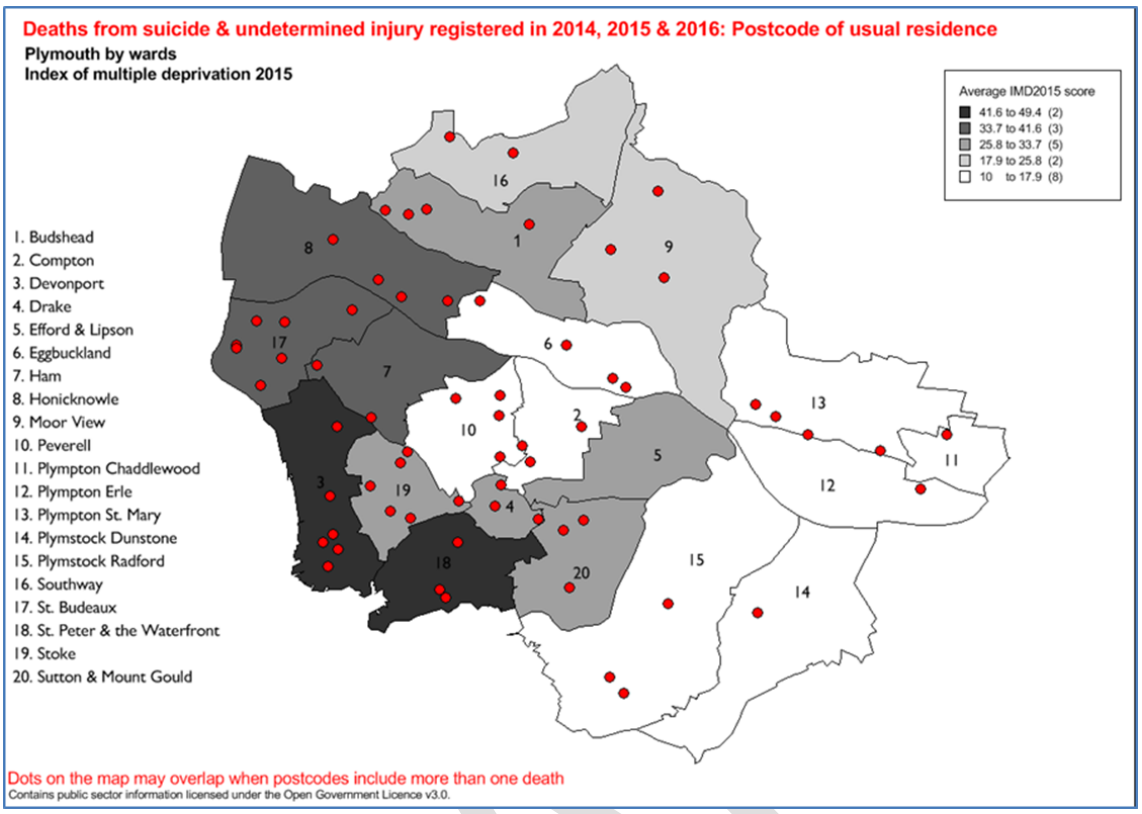
The number of deaths registered is highest in St Budeaux ward (7 deaths) followed by Devonport ward and Stoke ward. No deaths were registered for residents of Efford & Lipson ward.

- **Neighbourhoods:** 33 out of the 39 neighbourhoods in the city had at least one resident die by suicide/UI.

The number of deaths registered is highest in Barne Barton neighbourhood (5 deaths) followed by Devonport neighbourhood and Stoke neighbourhood. No deaths were registered for residents of six neighbourhoods: Efford, Goosewell, Ham & Pennycross, Leigham & Mainstone, and Lipson.

The map on the following page shows the post-code of the usual residence for those who died in the three year period.

Postcode of usual residence for deaths by suicide/UI registered 2014-16



Section Two: Information received from local NHS health and wellbeing services

Additional information about residents whose deaths were registered in the three year period was requested from primary care, mental health, and hospital services in the city. The information sought from these services asks whether and when the person had been in contact with the service and the reasons for the contact. The focus is on the period 12 months prior to death and information for this period is presented in this section.

Some information from local services is available for 50 residents who had been in contact with one or more local services in the 12 months prior to death. It reveals the following:

- 40 residents were in contact with primary care services
- 29 residents were in contact with local hospital services
- 16 residents were in contact with mental health services

Information received from local services for the period 12 months prior to death is discussed, first, by following each person's record across the three services and, then, by focusing separately on each service and summarising the information they provided.

(1) Focus on each person and their contacts with services

The information available for the 50 residents includes details of the date of their last contact with one or more of the three services in the 12 months prior to their death. Following each person's record made it possible to find out how many services were contacted:

- **One service:** 26 people were in contact with only one service. The majority of them (18 of the 26) had contact only with primary care services.
- **Two services:** 13 people had been in contact with two services. The majority of them (9 of the 13) were in contact with both primary care and hospital services.
- **Three services:** 11 people had been in contact with all three services in the 12 months prior to their death.

Comparing the dates for their last contact with any of the services made it possible to identify which service they had contacted most recently prior to their death:

- 30 people were most recently in contact with primary care services
- 12 people were most recently in contact with mental health services
- 9 people were most recently in contact with hospital services

(Please note that one person was in contact with two services on the same day, so the total number of most recent contacts listed above is 51 rather than 50.)

(2) Focus on each service

(a) Information from primary care

If a death by suicide/UI was confirmed and it was possible to identify the person and their general practice (GP), a letter was sent to the GP asking them to complete the section of the national guidance questionnaire on 'Information relating to contact with Primary Care'.

No request for information was sent if the person who had died could not be identified by name. In some cases, for example, where residents died out of the city no death registration information and no coroner information would be available. In addition, some residents who died may not have been registered with a GP in the city.

Some information was received from primary care for 45 residents, 40 of whom had been in contact with their GP in the 12 months prior to death. Not all questionnaires were completed fully (where information is not available, it is noted).

Information for the 40 residents who had been in contact with their GP in the 12 months prior to death is summarised below giving details of the date of last contact, who they were seen by, and the reason noted for the appointment. Lastly, any lessons learned that may help prevent future suicides are collated.

Date of most recent contact prior to death

The date of the most recent contact is given as the number of days prior to death and refers to the most recent contact with any member of the primary care team (the appointment may have been with a medical doctor or another member of the primary care team):

- 23 people were seen within 30 days of their death, and 10 of the 23 people were seen within seven days of their death.
- 28 people had their most recent appointment with a medical doctor and the remaining 12 were seen by another member of the primary care team.

Most recent contact with primary care services

Number of days prior to death	Count
Up to 7	10
8 to 30	13
31 to 90	7
91 to year	10
Total	40

Reasons noted for last contacts

The reasons noted on the questionnaire for their last appointments included three options: physical health, mental health, or both physical and mental health. Information is available for their last appointment with a medical doctor and also for their last appointment with another member of the primary care team:

- **Last contact with a medical doctor**: Contact for physical health is as common as for mental health in the reasons noted for their last appointment with a medical doctor (17 people were seen for their physical health, 16 people were seen for their mental health, and 5 people were seen for both their physical and mental health. No information is available for 2 people.)

- **Last contact with another member of the primary care team**: Contact for physical health is the primary reason noted for their last appointment with another member of the primary care team (21 people were seen for their physical health, 9 people were seen for their mental health, and 2 people were seen for both their physical and mental health. No information is available for 8 people).

In the 12 months prior to their death, a total of 23 people were seen for their mental health or for both their mental and physical health. During this period, 14 people were diagnosed with a mental illness. Depressive Illness is the most common current or ongoing mental health diagnosis noted. A history of self-harm is noted for 9 of the 40 people, and 4 people were known to have made a previous attempt to take their life.

Lessons learned that might help prevent suicides in future

Comments made in response to the question about whether there are lessons to be learned are grouped into general themes (grouping comments into themes is repeated through the report). Most GP comments were brief and general.

The six main themes identified from the comments highlight:

- Personal relationships (for example, breakdown of relationships)
- Bereavement
- Medication (for example, problems due to changes in prescriptions, also access to medications as a means)
- Fear an illness had returned (physical ill health)
- Long-term mental health problems
- Issues to do with referrals, and patients missing appointments

(b) Information from local mental health services

Mental health records identified that 33 of the residents included in the audit had some contact with mental health services during their lifetime, and 16 of the 33 residents were in contact with mental health services in the 12 months prior to death.

The proportion of persons in contact with mental health services in Plymouth in the 12 months prior to death is 25% (16 out of 64). This proportion is in line with national data for England. In their Annual Report (2017),[5] the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness notes that 27% of general population suicide deaths (occurring in the period 2005 to 2015) were 'patient deaths' in that the person had been in contact with mental health services in the 12 months prior to death.

Information for the 16 residents who had been in contact with mental health services in the 12 months prior to death is summarised below giving details of the date of their last contact, common diagnoses, and inpatient information. Lastly, any lessons learned that may help prevent future suicides are collated.

Date of last contact prior to death

The date of last contact is given as the number of days prior to death and refers to the most recent contact with mental health services:

- 12 of the 16 residents were seen within 30 days of their death, and 5 of the 12 were seen within seven days of their death
- 10 of the 16 residents were on the caseload when they had their last appointment

Most recent contact with mental health services

Number of days prior to death	Count
Up to 7	5
8 to 30	7
31 to year	4
Total	16

Reasons noted for last the contact

The most common diagnoses (9 of the 16 residents) are Depressive Illness and Bipolar Affective Disorder. A history of self-harm is noted for 5 of the 16 residents. No one was known to have a history of violence, 2 were known to have a history of alcohol misuse and one to have a history of drug misuse.

Most of the residents in touch with mental health services in the 12 months prior to death (10 out of 16) had previously been admitted as inpatients (psychiatric). 5 of the 10 people had an admission within 12 months prior to their death, and none of the admissions occurred within 30 days of death.

Lessons learned that might help prevent suicides in future

Issues raised in response to the question about whether there are lessons to be learned have been grouped into general themes. The issues collated below were identified from comments included in the action plans made following investigations undertaken by mental health services.

The five main themes identified from the comments highlight:

- Patient behaviour (for example, missing appointments and not taking medication as directed)
- Medications (for example, improving liaison between primary and secondary care concerning medications)
- Service provision (for example, increasing provision of specialist services for children and young people over weekends)
- Staff issues (for example, improved supervision, case-load management and risk assessments)
- Information (for example, sharing and passing on information appropriately to teams, services and agencies)

(c) Information from local hospital services

Hospital records identified information for 29 residents included in the audit who had attended the Emergency Department (ED) or had been admitted to hospital in the 12 months prior to their death. This number excludes residents whose attendance at hospital in the days before their death was solely due to the events that subsequently would lead to them dying from their injuries (and where they had not attended on any other occasion in the 12 months prior to death).

Information for the 29 residents who had been in contact with hospital services in the 12 months prior to death is summarised below giving details of the number and times they had contact, the date of the last contact, and the reason noted for the contact.

Number and type of contact

Information is given separately for attendances at the Emergency Department only, for admissions into hospital only, and for both attendances and admissions in the 12 months prior to death:

- **Emergency Department only:** 9 residents had attended the ED without being admitted into hospital (all 9 attended only once).
- **Admission to hospital only:** 8 residents had attended as inpatients only (4 had attended more than once).

- **Attended ED and had been admitted to hospital**: 12 residents had attended both the ED and as inpatients (7 had attended either the ED or as inpatients more than once).

Date of last contact prior to death

The date of the last contact is given as the number of days prior to death and refers to the most recent contact (irrespective of whether it was attendance at the Emergency Department or as an inpatient):

- 5 people were seen within 30 days of their death
- 15 had their last contact more than 181 days prior to their death

Most recent contact with hospital services

Days prior to death	Count
Up to 30	5
31 to 90	0
91 to 180	9
181 to year	15
Total	29

Of the 29 persons, 12 were most recently seen in the Emergency Department, 11 were seen as admissions into hospital, and 6 were seen in the Emergency Department and admitted on the same day.

Reasons noted for last the contact

The reasons noted for their last contact are given below in terms of the type of attendance at hospital:

- The majority of those who had attended the Emergency Department only attended for their physical health (7 of the 9 people).
- Almost all those who were admitted as inpatients only were in hospital for their physical health (7 of the 8 people, and no information is available for the other person).
- Half of those who attended both the Emergency Department and were admitted into hospital did so for their physical health (6 of the 12 people). Reasons noted for the other 6 people included mental health/psychological, self-poisoning, and dementia.

Section Three: Information drawn from coroner records

There are local coroner records for 54 of the 64 residents included in the audit. These residents died within the boundaries of the coroner service for Plymouth, Torbay and South Devon.

Information drawn from the coroner files for the 54 residents is summarised below giving further demographic details and the health and well-being concerns mentioned. The main focus is on our notes concerning the social context which offer a broader perspective on suicide and suicide prevention.

(1) Relationship and employment status

- **Relationship status**: 21 of the 54 residents were married or cohabiting at the time of their death, 11 were separated, divorced or widowed, and 19 were single.

Relationship status	Count
Single	19
Married/cohabiting	21
Separated/Divorced/Widowed	11
No information	3
Total	54

- **Employment status:** 29 of the 54 residents were employed at the time of their death, 15 were unemployed and 7 were retired.

Employment status	Count
Employed	29
Unemployed/off sick	15
Retired	7
Not yet economically active	2
No information	1
Total	54

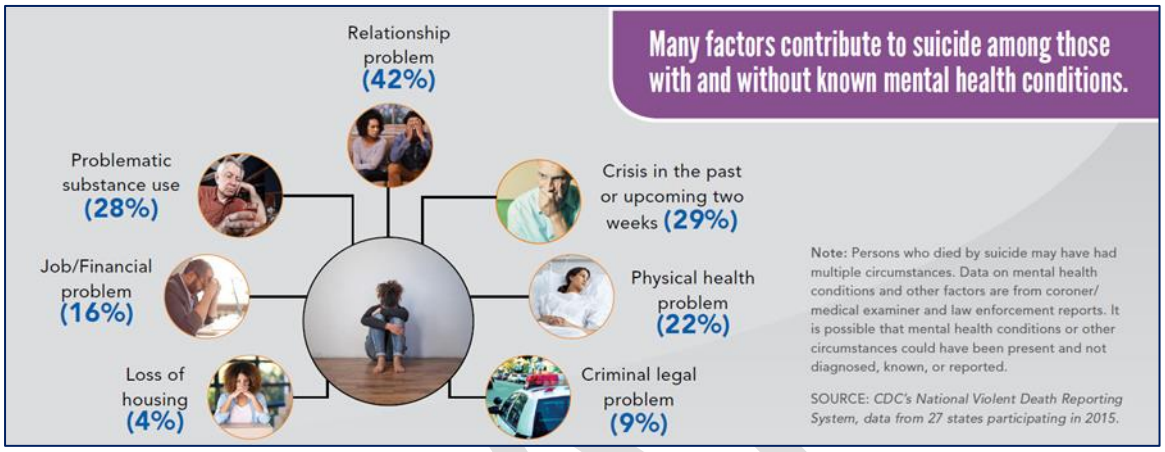
(2) Health and wellbeing concerns

The three health and wellbeing concerns most frequently noted are listed below. The categories overlap and all have been mentioned previously in this report:

- Depression
- Physical health problems
- Mental health problems

(3) Notes on social context and factors contributing to suicide

Notes were taken on the social context mentioned in coroner records. The framework chosen to help arrange our notes is taken from the Centers for Disease Control and Prevention (CDC) in the United States.[6] The broad factors identified as contributing to suicide are illustrated in the diagram below. These factors include: Relationship problem; Crisis in the past or upcoming two weeks; Problematic substance use; Physical health problem; Job/Financial problem; Criminal legal problem; and, Loss of housing.



Source: CDC 2018

The categories in the framework have been amended for the purpose of this audit, and may be further refined in future audits. Our notes on the social context are collated below.

The most common contributing factors are listed first, followed by other contributing factors that were noted less often:

Most common 'contributing factors'

- Personal relationship issues (for example, breakdown of relationships and lack of access to children following separation)
- Immediate crisis (for example, diagnosis of illness or suspected return of illness, unexpected redundancy and threatened loss of benefits, relationship problems and arguments)
- Criminal Justice history (for example, interviewed and awaiting trial)
- Bereavement (for example, death of a family member or friend)
- Living arrangements (for example, insecure housing and social isolation)

Other 'contributing factors'

- Adverse childhood experiences (for example, abused when younger)
- Job issues (for example, insecure work and unemployment)
- Financial issues (for example, debt and loss of income)
- Suicide, experience of (for example, suicide of a family member or friend)
- Access to means (for example, access to medication)
- Welfare system (for example, changes to welfare benefits)
- Substance misuse (for example, drugs and alcohol)

Conclusion

This report provides a city-wide overview of deaths by suicide/UI in Plymouth and covers deaths registered over a three year period (2014-16). Mapping their place of residence shows that the 64 residents included in this audit lived in different areas of the city and that suicide prevention is a concern across the city.

In concluding the report we ask: first, whether the audit process was successful in obtaining additional information and, second, whether the range and type of additional information collected is appropriate and timely enough.

Scope of the local suicide audit process

Official mortality data is available for all 64 residents included in the audit. Some additional information was available for the majority of the deceased from coroner records and from local NHS services. No additional information was available for 7 of the 64 residents. Overall, the local audit process has been successful in accessing additional information about the Plymouth residents who died by suicide/UI.

The scope of the additional information is currently limited to three NHS services. It is possible that other local services could be included in future (for example, substance misuse services).

An inclusive audit process for 'avoidable deaths'

The public health team is exploring whether an 'avoidable deaths' approach would be preferable for the city. This inclusive approach would consider suicide deaths alongside drug-related and alcohol-related deaths in the city and would share relevant information across services available to residents in Plymouth. It would seek to assess the wider social factors that contribute to suicides and other deaths in the city.

Sources cited

1. Maconachie M & Hoad S (2016) Plymouth Suicide Audit Summary (deaths registered in 2013, 2014 & 2015). Plymouth City Council: Office of the Director of Public Health.

2. World Health Organisation (2010) International Statistical Classification of Diseases and Related Health Problems (10th Revision). Geneva: WHO.

3. Public Health Outcomes Framework indicator 4.10 - Suicide rate

4. National Institute for Mental Health in England (2006) Suicide audit in Primary Care Trust localities: a tool to support population based audit of suicides and open verdicts. Leeds: National Institute for Mental Health in England.

5. The National Confidential Inquiry into Suicide and Homicide (2017) Annual Report 2017. Manchester: University of Manchester.

6. Centers for Disease Control and Prevention (2018) Suicide rates rose across the US from 1999 to 2016. Vital Signs, June: www.cdc.gov/vitalsigns/suicide

PLYMOUTH CITY COUNCIL

Subject:	Prevention Concordat for Better Mental Health
Committee:	Health and Wellbeing Board
Date:	4th October 2018
Cabinet Member:	Ian Tuffin
CMT Member:	Ruth Harrell, Director of Public Health
Author:	Sarah Lees, Consultant in Public Health
Contact details:	01752 398605
Ref:	
Key Decision:	No
Part:	I

Purpose of the report:

This report brings to the attention of the Health and Wellbeing Board the Prevention Concordat for Better Mental Health. It outlines the background to the development of the Concordat, its aims and ambitions. The Prevention Concordat aims to encourage and enable cross-sector action to promote public mental health approaches – in promoting good mental health and wellbeing and in preventing mental health problems.

The report identifies the type of resources that have been developed to support the concordat and the 5 areas for collaborative action. The report includes the consensus statement developed to enable organisations to sign up to commit to work together through national and local action to prevent mental health problems and promote good mental health. The report presents the opportunity to the Health and Wellbeing Board to sign the consensus statement in support of the Prevention Concordat.

The report then identifies the existing local mechanisms through which the Prevention Concordat can be delivered and summarises some of the existing work that contributes to the aims and ambition of the concordat.

Recommendations for action:

1. The Health and Wellbeing Board and its constituent members sign the Prevention Concordat consensus statement to set a clear direction to the local health and social care system and the constituent parts that all should work towards a tangible increase in the promotion of mental health and wellbeing and the prevention of mental illness.
2. The Health and Wellbeing Board confirm their support for the Public Health team to continue to provide system leadership for the promotion of mental health and wellbeing and the prevention of mental illness.
3. The Health and Wellbeing Board confirm that the existing multi-agency groups and networks should be the basis for taking forward the Prevention Concordat.

4. The Health and Wellbeing Board ask that Public Health oversee the development of a local strategy and action plan for increasing work to promote mental health and wellbeing and prevent mental illness across the system, building on the good work already in place.
5. The Health and Wellbeing Board to receive an update on progress in 12 months' time.

PREVENTION CONCORDAT FOR BETTER MENTAL HEALTH

Health and Wellbeing Board: 4th October 2018

BACKGROUND TO THE PREVENTION CONCORDAT

The Five Year Forward View for Mental Health [2016] identified that a step change was needed to prevent mental health problems and to highlight the importance of prevention alongside improving care and treatment services for mental health. A recommendation of the report was for Public Health England to bring together resources to support a Prevention Concordat, which would facilitate national and local action in preventing mental health problems and promoting good mental health.

The Prevention Concordat is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health makes a valuable contribution to achieving a fairer and more equitable society. It promotes evidence based planning and commissioning to increase the impact on reducing health inequalities. The Concordat is intended to provide a focus for cross-sector action to deliver a real and noticeable increase in the adoption of public mental health approaches across;

- Local authorities
- The NHS
- Public, private and voluntary and social enterprise sector organisations
- Educational settings
- Employers

It acknowledges the active role played by people with lived experience of mental health problems and promotes relevant evidence based interventions and best practice.

A public mental health approach is described as "the art and science of improving mental health and preventing mental illness through the organised efforts and informed choices of society, public and private organisations, communities and individuals". It recognises that mental wellbeing is profoundly important to quality of life and peoples' capacity to cope with life's ups and downs. It is also demonstrated to be protective against physical illness, social inequalities and unhealthy lifestyles. The public mental health approach aims to prevent the onset, development and escalation of mental health problems through the promotion of good mental health and wellbeing; through the strengthening of individuals and communities and by reducing inequalities.

A suite of resources are available to help local areas put in place effective prevention planning arrangements. The resources include;

- Prevention Planning arrangements
- Joint Strategic Needs Assessment for mental health
- Evidence of effectiveness reviews
- Return on Investment data – the economic case for investment in mental health promotion and cost effective commissioning for mental health

The concordat identifies 5 areas for collective action;

1. Needs and assets assessment – effective use of data and intelligence
2. Partnership and alignment – to undertake joint and aligned work
3. Translating need into deliverable commitments
4. Define success outcomes
5. Leadership and accountability

Appendix 1 is an infographic presentation of the Prevention Concordat.

THE CONCORDAT CONSENSUS STATEMENT

The following consensus statement describes the shared commitment of organisations that sign the statement and commit to work together via the Prevention Concordat for Better Mental Health, through local and national action, to prevent mental health problems and promote good mental health.

The undersigned organisations agree that;

1. To transform the health system, we must increase the focus on prevention and the wider determinants of mental health. We recognise the need for a shift towards prevention-focused leadership and action throughout the mental health system; and into the wider system. In turn, this will impact positively on the NHS and social care system by enabling early help through the use of upstream interventions.
2. There must be joint cross-sectoral action to deliver an increased focus on the prevention of mental health problems and the promotion of good mental health at local level. This should draw on the expertise of people with lived experience of mental health problems, and the wider community, to identify solutions and promote equality.
3. We will promote a prevention-focused approach towards improving the public's mental health, as all our organisations have a role to play.
4. We will work collaboratively across organisational boundaries and disciplines to secure place-based improvements that are tailored to local needs and assets, in turn increasing sustainability and the effective use of limited resources.
5. We will build the capacity and capability across our workforce to prevent mental health problems and promote good mental health, as outlined in the Public Mental Health Leadership and Workforce Development Framework Call to Action.
6. We believe local areas will benefit from adopting the Prevention Concordat for Better Mental Health.
7. We are committed to supporting local authorities, policy makers, NHS clinical commissioning groups and other commissioners, service providers, employers and the voluntary and community sector to adopt this Concordat and its approach.

This Concordat statement was co-produced and signed by;

- Association of the Directors of Public Health
- Association of Mental Health Providers
- Centre for Mental Health
- Children and Young People's Mental Health Coalition

- Department of Health
- Faculty of Public Health
- Local Government Association
- Mental Health Commissioners Network
- Mental Health Foundation
- National Survivor User Network
- NHS England
- Public Health England

The Concordat has been signed and endorsed by;

Statutory Organisations and Professional Bodies

- Care Quality Commission
- Health Education England
- NHS Digital
- NHS Improvement
- Royal College of Nurses
- Royal College of Pscychiatrists

Wider organisations and bodies

- Age UK
- British Dietetic Association
- British Islamic Medical Association
- British Institute of Learning Disabilities
- Catholic Bishops Conference of England and Wales
- Citizens Advice
- Cruse Bereavement Care
- Diabetes UK
- Homeless Link
- Housing Associations Charitable Trust
- Maternity Action
- Men's Health Forum
- METRO Charity
- MIND
- Muslim Council of Britain
- NACRO
- National Development Team for Inclusion

- National Suicide Prevention Alliance
- Network Rail
- National LGBT Partnership
- National Voices
- Rethink
- Samaritans
- Street Games
- Student Minds
- Young Minds
- Young People's Health Partnership
- Youth Access

As of March 2018, local authorities and local health and wellbeing boards have been invited to sign up to the Prevention Concordat and to its approach.

CURRENT LOCAL SYSTEM FOR PREVENTION AND PROMOTION

Currently leadership for public mental health is provided by Plymouth City Council's Public Health team. There are various existing fora and multi-agency groups which are part of the mental health system and within which a prevention and promotion approach are advocated. The current groups are;

- Plymouth Mental Health Programme Board
- Plymouth Suicide Prevention Strategic Partnership Group
- Plymouth Emotional Health and Wellbeing of Children and Young People Group
- Plymouth Mental Health Network

Through these groups there is already a good amount of work that is being done to promote mental health and wellbeing. They also provide an existing framework through which local prevention plans could be produced and adopted, to deliver the aims and ambitions of the Prevention Concordat.

Current local work to promote mental health and wellbeing and prevent mental health problems includes;

- Thrive Plymouth Year 4; 5 Ways to Wellbeing [Connect, Learn, Be Active, Notice, Give] – population approach to improving mental wellbeing and raising awareness of mental health
- Mental Health and Suicide Prevention Training provision – commissioned from Livewell Southwest as part of integrated health improvement service. Training to increase understanding and build capacity within local system
- Social Prescribing Programme – connecting people with social solutions to existing problems or to problems developing

- Workplace Wellbeing Charter – supporting businesses to improve the health of their workforce and consider mental health and wellbeing as an essential element of this
- Schools approach to emotional health and wellbeing of children and young people and the Healthy Child Programme
- Plymouth City Council signed up to the Local Government Mental Health Challenge and Time to Change Pledge – Councilor mental health champion appointed; consideration of mental health in all decisions; programme of training for managers; stress resilience and management in the workplace.
- Plymouth Mental Health Network 16+ Group – working to share expertise and resource on promoting mental wellbeing to young people in educational settings

RECOMMENDATIONS FOR ACTION

1. The Health and Wellbeing Board and its constituent members sign the Prevention Concordat consensus statement to set a clear direction for the local health and care system and the constituent parts that all should work towards a tangible increase in the promotion of mental health and wellbeing and the prevention of mental illness.
2. The Health and Wellbeing Board confirm their support for the Public Health Team to continue to provide system leadership for the promotion of mental health and wellbeing and the prevention of mental illness
3. The Health and Wellbeing Board confirm that the existing multi-agency groups and networks should be the basis for taking forward the Prevention Concordat
4. The Health and Wellbeing Board ask that Public Health oversee the development of a local strategy and action plan for increasing work to promote mental health and wellbeing and prevent mental illness across the system, building on the good work already in place.
5. The Health and Wellbeing Board to receive an update on progress in a year's time.

Appendix I

Public Health England

Prevention Concordat for Better Mental Health: Prevention planning resource for local areas

Why? The case for action:

- **1 in 10** children experience a mental health problem
- **1 in 6** adults have had a common mental health problem in the last week
- **1 in 5** adults has considered taking their life at one point
- **9 in 10** people with mental health problems experience stigma and discrimination

Good mental health is a vital asset for **dealing with** the different **stresses** (physical and mental) and problems in life

Good mental health is associated with better **physical health, increased productivity** in education and at work and **better relationships** at home and in our community

What good looks like:
A five domain framework for local action

Needs and asset assessment - effective use of data and intelligence
- analyse quantitative and qualitative data
- analyse and understand key risk and protective factors
- engage with the community to map useful and available assets
- agree the priority areas

Partnership and alignment
- form a local multi-agency mental health prevention group
- establish opportunities to bring mental health professionals from wider networks together
- involve members of the community with lived experiences in the planning
- pool resources together and share benefits

Translating need into deliverable commitments
- modify existing plans to Include mental health
- determine the approach that best meets local need
- provide varying approaches in the action plan
- ensure a community centred approach to delivery
- reinforce actions with existing and new Partnership plans
- use the human rights-based approach
- regularly invite feedback

Defining success outcomes
- map out who the interventions work with and why, as well as recognising inputs and outputs
- identify 5-10 measures from already available data sources which most closely resemble what success looks like
- develop a measurement, evaluation and improvement strategy to:
  a) identify the impact
  b) highlight areas for development

Leadership and accountability
- delegate a leader
- work is linked and aligned to other strategic priorities
- develop a clear accountability structure

Consider How to support mental health across:

Whole population approaches
- strengthening individuals eg mental health literacy
- strengthening communities and healthy places eg housing, social networks
- addressing wider determinants eg mentally healthy policy

Life course approaches
- family, children and young people
- working age
- older people

Targeted prevention approaches
- groups facing higher risk eg criminal justice
- individuals with signs and symptoms eg suicidal behaviour
- people with mental health problems eg recovery

PHE publications gateway number: 2017209

PLYMOUTH CITY COUNCIL

Subject:	Integrated Care System Development
Committee:	Health and Wellbeing Board
Date:	4th October 2018
Cabinet Member:	Cllr Ian Tuffin
CMT Member:	Carole Burgoyne, Strategic Director for People
Author:	Dr Sonja Manton, Director of Strategy, NEW Devon and South Devon & Torbay CCGs
Contact details	Tel: 01752 306850 email: carole.burgoynembe@plymouth.gov.uk
Ref:	
Key Decision:	No
Part:	I

Purpose of the report:

This paper has been developed to create the opportunity for discussion and contribution from partners, stakeholders and communities as we work together on strengthening our existing partnership arrangements in designing and developing the next stage of our health and care integration journey.

Health and Wellbeing Board members will note previous updates and discussions on partnership working across Devon, Plymouth and Torbay as part of the Sustainability and Transformation Partnership (STP) and the emerging Integrated Care System (ICS) in Devon.

The purpose of this discussion paper is to:

(i) Highlight the two-year STP report which has been recently published, providing the opportunity to reflect on the progress across Devon, Plymouth and Torbay over the past two years against our shared ambition

(ii) Update on recent national developments in relation to Integrated Care Systems and local work on developing a strategy for our system

(iii) Invite members to consider how they can be involved in the system development and design work over the Autumn in relation to the emerging ICS in Devon

Corporate Plan

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

N/A

Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

N/A

Equality and Diversity

Has an Equality Impact Assessment been undertaken? No – N/A

Recommendations and Reasons for recommended action:

(i) The Health and Wellbeing Board note the update.

Alternative options considered and rejected:

Published work / information:

http://www.devonstp.org.uk/about-the-stp/plan/stp-two-year-report-05-07-2018_page_01/

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7

Integrated Care System Development
A discussion paper

1. Introduction

This paper has been developed to create the opportunity for discussion and contribution from partners, stakeholders and communities as we work together on strengthening our existing partnership arrangements in designing and developing the next stage of our health and care integration journey.
Health and Wellbeing Board members will note previous updates and discussions on partnership working across Devon, Plymouth and Torbay as part of the Sustainability and Transformation Partnership (STP) and the emerging Integrated Care System (ICS) in Devon.

The purpose of this discussion paper is to:

(i) Highlight the two-year STP report which has been recently published, providing the opportunity to reflect on the progress across Devon, Plymouth and Torbay over the past two years against our shared ambition
(ii) Update on recent national developments in relation to Integrated Care Systems and local work on developing a strategy for our system
(iii) Invite members to consider how they can be involved in the system development and design work over the Autumn in relation to the emerging ICS in Devon

An ICS is not the creation of a new organisation, but rather a strengthening of partnership working with health and care organisations working more closely together than ever before to the benefit of our population. The NHS Constitution and Local Authority Constitution will remain at the heart at everything we do, meaning anyone can receive high-quality NHS care, free at the point of access, whenever they need it. People will still see a GP when they need it and there will still be hospital care. Health and care delivery models are becoming more aligned and this will mean services are increasingly organised around the needs of individuals and not organisational boundaries. There is no change to legislation, statute or constitutions. The role of the Health and Wellbeing Boards will remain and options on governance of these strengthened integrated arrangements will need to be explored.

2. The Sustainability and Transformation Partnership in Devon

Since December 2016, partners in the health and care system across Devon have been working with a shared purpose to create a clinically and financially sustainable health and care system that will improve the health, wellbeing and care of the population

Our four strategic priorities are:

- Enable more people to be health and stay healthy
- Enhance self-care and community resilience
- Integrate and improve community services and care in people's homes
- Deliver modern, safe and sustainable services

It remains an ambition in Devon to move towards fully integrating health and care services, organised around needs of individuals. Our aspirations for the Devon system are emerging from the STP process and are built on solid foundations of collaborative working and integration. We have recently reflected on our progress over the past two years (published in the two-year STP report[1] in July 2018) and used this as an opportunity to reflect on our strategy for our system, as we consider what the future of integrated care in Devon needs focus on.

[1] http://www.devonstp.org.uk/wp-content/uploads/2018/07/STP-two-year-report-05.07.2018.pdf

3. Integrated Care Systems – national thinking

ICSs are those in which commissioners, NHS providers and Local Authorities, working closely with GP networks and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they work together for the benefit of local populations and improved outcomes.

Nationally, there is emergent thinking about how integrated care systems are agile in their ability to join up care provision and commissioning at both very local level in neighbourhoods and towns, place and at wider system levels.

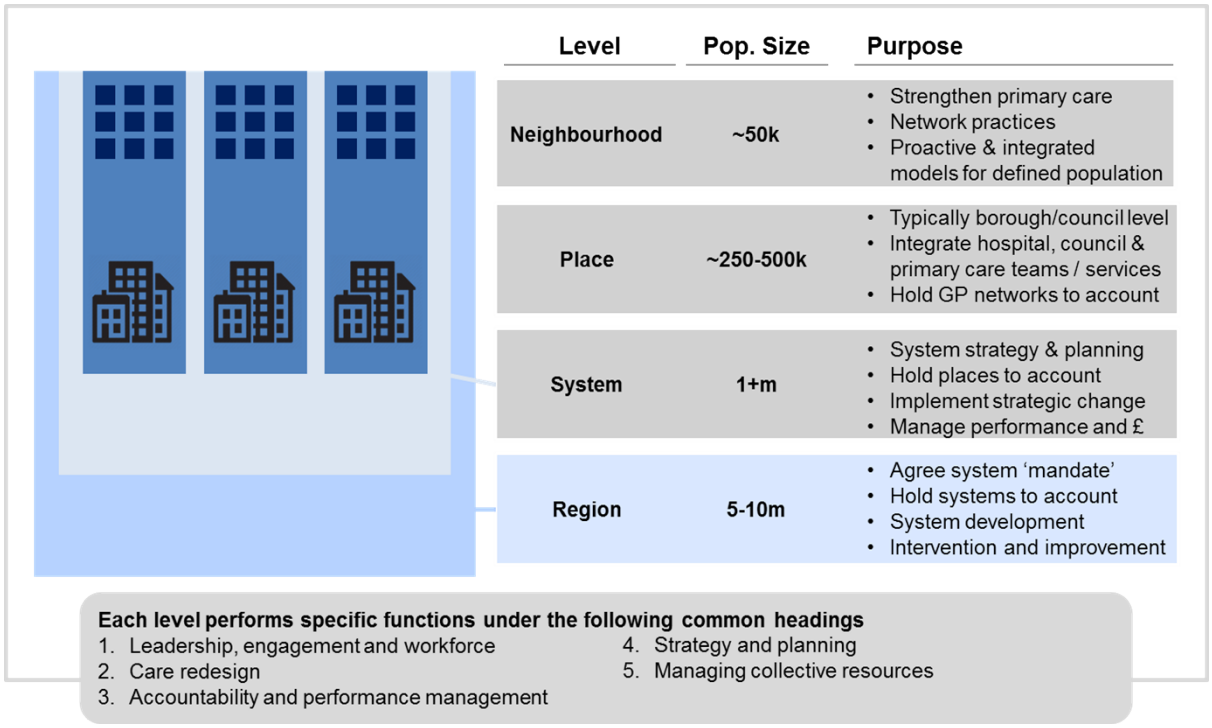


Figure 1 – Slide from presentation to STP Leads (June 2018)

From the emerging national framework in Figure 1, there is a strong emphasis of focusing the clinical and professional integration of care and how people experience care at a very local level (neighbourhood) and primary care is at the core of this. There are further opportunities from integrating networks of primary care and community health and social care services with hospitals and wider local authority functions at "place" and at system level opportunity to strategically plan for meeting the needs of populations, and deploying collective resources to meet these, addressing inequalities and ensuring efficiency and effectiveness in management and operational processes. The role of commissioning in integrated care systems is still evolving but will inevitably have to be able to operate effectively at all levels to maximise the benefits to our population and have a focus on primary care as a cornerstone of our care system.

Our experiences tell us that working together and integrating care at a very local level is important because it means we can be responsive to local needs, deliver rapidly to meet local and national priorities, ensuring that local voices are heard in developing ways of working and caring for people, leading to strong ownership of outcomes and good use of local assets and resources.

It is our ambition and intent that the benefits that we have reaped from working together locally, such as delivering innovative changes at pace to enhance care for the local population, are supported and enhanced with the advantages of being part of a wider Devon system and the resilience, sharing of good practice, and economies of scale that this has to offer. Historically, we have drawn much strength from our diversity, particularly in primary care, which has been able to develop local responses to specific issues. We want to build on this strength going forward, developing our local multi-agency delivery teams in parallel to designing our future ICS commissioning arrangements at scale.

A core element of the emerging approach is the development of integrated strategic commissioning, which can act across health and social care, and take on delegated commissioning from NHS England for primary care and increasingly specialised commissioning. The three Local Authorities (Devon County Council, Plymouth City Council and Torbay Council) have been active in approach to date; sharing elements of commissioning, collaborating in our shared geographies and delegating significant investment into joint commissioning arrangements with each CCG through section 75 agreements/ risk share agreements. A future strategic commissioner will need to recognise these existing joint arrangements, and align them with our other clinical commissioning arrangements.

NHS England have advised us to continue to act as a system and work through the arrangements and possibility for taking on more of the regulatory functions from next year, subject to having a single local NHS commissioning body in place. NEW Devon CCG and South Devon and Torbay CCG have been working on aligning their resources and executive teams to ensure that local health commissioning is more consistent and there is a sound basis to become both more integrated with Local Authorities and to take on enhanced responsibilities from NHS England. The two CCGs have been operating with boards in common since autumn 2017 and a joint executive structure since April 2018. By the end of the summer, the CCGs' workforce will have been more formally aligned in a single structure to support this executive team and the CCGs are working through a formal process of applying to become one CCG from April 2019.

4. Developing the Devon System

To effectively evolve our current partnership arrangements to meet the needs of our population for the future, partners, stakeholders and communities are involved in system design and development work to create a high performing and sustainable integrated care system. Recent work by system partners (including representatives from NHS, Local Authorities, Public health, Primary care, Clinical and Professional leads and other system stakeholders) has led to the development of a draft ICS strategy on a page as set out in Appendix 1. Further work, as part of the overall system design and development plan, is needed to widen participation, engagement and dialogue with communities in these developments, and design the operating model for the integrated care system, including development at neighbourhood and place level. Members of the Health and Wellbeing are invited to discuss involvement in this design work over the coming months, in particular partnership working with the other two health and wellbeing boards in the Devon system to support the development of the integrated care system.

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Purpose	*Together, building thriving lives, support and services for everyone*				
Ambitious Goals	A world class system that makes the best use of our resources to achieve great outcomes for everyone	Eliminate inequalities in opportunity, access and experience and improve outcomes for everyone in Devon	Collaborate to connect all people to build thriving, resilient and resourceful communities to prevent the causes and consequences of ill-health	Provide outstanding services that work with people to live their lives to the max	Inspire people to join and stay in our workforce that is achieving excellence, innovation, ambition and joy in work

Integrated Care System Core Work

Strategic Themes	Enable more people to be and stay healthy	Enhance self care and community resilience	Integrate and improve community services and care in people's homes	Deliver modern, safe and sustainable services

System Design Criteria **"We are creating an ICS that can……..**	…make clear decisions so that resources can be mobilized to meet the needs of the people of Devon;"	…be agile and adaptable"	…exercise good governance "	…operate and encourage innovation at neighbourhood, place and system level whilst embracing complexity"	…deliver involvement and influence at every level"	…be digitally enabled"
	Improve performance; jointly risk enable; reduce inequality; drive prevention and put the system first	In order to operate dynamically and evolve to meet future needs	So that there is engagement; transparency; easily understood decision making; public and democratic accountability; shared risk and mutual support and innovation	In order to maximize the benefits of local and system working for optimal outcomes	In order to support self care; effective collaboration built on trust and ownership and enable co-design and co-production	In order to drive change and innovation; offer more flexible service; allow staff to deliver care at the top of their skill set; address capacity shortfalls and improve quality and safety of care by sharing information that empowers the citizen

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PLYMOUTH CITY COUNCIL

Subject: Devon Wide Learning Disability Strategy

Committee: Health and Wellbeing Board

Date: 4th October 2018

Cabinet Member: Cllr Ian Tuffin

CMT Member: Carole Burgoyne

Author: STP Learning Disability Leadership Team

Contact details: Becky Armstrong - 01752 398708, email: rebeccaarmstrong2@nhs.net

Ref:

Key Decision: No

Part: I

Purpose of the report:

The Health and Wellbeing Board are invited to endorse the adoption of the draft Devon Learning Disability Strategy as it has been developed in partnership with users, carers and key stakeholders and is consistent with the Plymouth Corporate Plan ambitions as well as the Plymouth City Council Integrated Commissioning Strategies.

Corporate Plan:

The strategy is consistent with the values and aims of the Plymouth plan as well as with the integrated Commissioning Strategies

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Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land:

The strategy aims to ensure that resources are used as efficiently and effectively as possible and that care and support is provided as close to the individuals home as possible. A workforce plan supports the recruitment and retention

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Other Implications: e.g. Child Poverty, Community Safety, Health and Safety and Risk Management:

N/A

Equality and Diversity:

Has an Equality Impact Assessment been undertaken? Yes

Recommendations and Reasons for recommended action:

To endorse the strategic direction of the draft Devon Learning Disability Strategy.

Alternative options considered and rejected: N/A

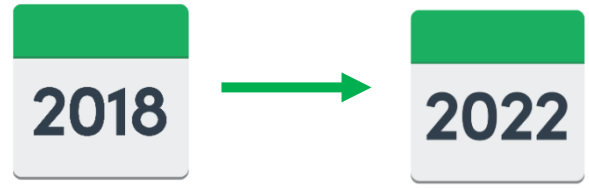
Published work / information:
N/A

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7
Sustainability and Transformation Partnership Learning Disability and Autism Mandate	X								

Easy Read Summary (About the plan)

A plan to help people Live Well with a Learning Disability in Devon



A plan to help people Live Well with a Learning Disability in Devon 2018 – 2022.

Easy read summary.

This strategy (plan) is about how we will work to improve the lives of people with a learning disability and their carers in Devon.

This Strategy (plan) is for people with learning disabilities who live in Devon, including Plymouth and Torbay.

People have told us they want to be as independent as possible.

We want people with learning disabilities to have the same opportunities as everyone else and to lead meaningful lives in their community.

	**Important things we will be working on.**
	**Community Life** Working to make sure people are able to use and enjoy their communities.
	**Housing** Working to make sure people can live in their own homes where possible and supporting people to be as independent as possible.
	**Employment – having a paid job** We will create more employment opportunities for people with a learning disability and help them to learn the skills to have a job.
 	**Health inequalities** Working to make sure people with learning disabilities can access the healthcare they need.

Preparing young people for life as an adult
Making sure people are supported to be as independent as possible. This includes travel training, cooking and the skills to have a job.

Support for people with complex needs
We will reduce the number of people with learning disabilities who go into inpatient settings outside Devon.

We will work with local housing providers to provide housing and care options.

Keeping people safe
We will commission (buy) services that provide kind and compassionate care that helps to keep people safe.

Make sure Carers are able to care
We will involve families and carers in the health and care support for people with learning disabilities and help them to plan for when they are not around.

	**Checking how we are getting on**
	Each local authority and Clinical Commissioning Group in Devon will monitor how things are and report to the Health and Wellbeing Boards.
	The Learning Disability Partnership Boards will also have an important role in the monitoring of any local action plans, making sure people who have a learning disability and their families and/or carers and involved.

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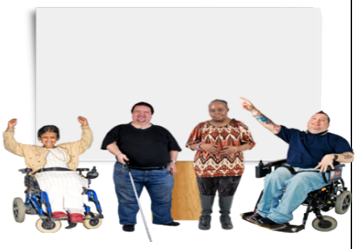
	Introduction – Learning Disability and Autism Services
	At the moment, there are too many people with learning disabilities in inpatient care, placed away from where they live and often outside Devon.
	People have to fit into services rather than services being built around them and too many people with learning disabilities are placed in long-term residential care.
	**Our vision is to create a place where children and adults with a learning disability live in the community of their choice, with the people they want, and with the right support.**
	We will develop a new model of care for people with learning disabilities and/or autism that provide them with a choice of local housing, care and support.
	Nationally cost pressures for the public purse for people with LD/Autism are as great as for older peoples support

	Individually designed services funded through personal budgets and high-quality, short-term care and support when it is needed.
	We want people with disabilities to have the same opportunities as everyone else and lead meaningful lives within their communities
	What matters to people and how they can achieve their potential will drive all we do
	We want to improve support for people with learning disabilities and/or Autism in Devon so that care promotes independence, utilises short term, community based support and is cost effective
	**Addressing Health Inequalities** - In order to help address health inequalities more people with a learning disability need to be registered on their GP learning disability register – opening up the opportunity for them to access more support and benefit from an Annual Health Check
	Increase the number of individuals with a learning disability on the GP learning disability register receiving an Annual Health Check (AHC), resulting in a Health Action Plan (HAP).

	Promote MENCAP's campaign 'Don't Miss Out' for People With Learning Disabilities (PWLD) to identify themselves to their GP teams in order to benefit from the Annual Health Checks.
	We will work to make sure that people with learning disabilities are given the right amount of medicine. We will promote the STOMP Programme (Stop The Overmedication of People).
	Ensure that Additional Information (AI) is added to individuals' Summary Care Records (SCR) to help improve quality of care
	Involve people in decisions about their care, including supporting the roll-out of the Quality Checker Programme.
	Promote NHS screening services and increase the numbers of People With Learning Disabilities (PWLD) accessing NHS screening programmes
	Develop a comprehensive plan to increase the uptake of Annual Health Checks and Health Action Plans (HAPs) amongst 14-17 year-olds

	**Promoting citizenship and optimising independence -** We are refreshing our policy for adults with disabilities in Devon. It will set out our high level approach to how we will support people with a learning disability in Devon, and it will be underpinned by local action plans.
	It will set out the key areas of work that we will undertake to improve the lives and wellbeing of adults who have a learning disability and/or autism.
	Refresh our approach for adults with learning disabilities across Devon including Torbay and Plymouth
	Develop a new model of care for people with learning disabilities.
	Enhance employability amongst those accessing our core services with a disability.
	Planning transition for children and young people to support them to develop independent life skills so they can lead fulfilling lives as adults.

	Develop a market that can adapt to change and provide cost effective solutions to support people to be independent citizens.
	Increase housing options for people with a learning disability, autism, or both to enable access to the right accommodation with personalised care and support provided to offer sustainable solutions.
	Transforming Care Partnership (TCP) – The TCP plan aims to ensure more people with complex needs and behaviours that challenge our systems are living in their own home, having choice over who is supporting them and playing an important part in the community with less people being admitted to hospital.
	Continue to deliver Care and Treatment Reviews (CTR) and Individual Service Design/Support Plans, to reduce the number of inpatient beds
	Continue to ensure Blue Light calls are used appropriately, prior to admission to hospital for children and to develop a dynamic risk register for those at risk of admission.

	Develop Community Forensic service to support people in the community that are at risk of offending.
	Ensure support is available in the community to prevent admissions to inpatient units.
	Review current commissioning arrangements and look at alternative ways of commissioning residential and supported living care.
	Develop training plans to assist Children's services in areas such as Positive Behavioural Support, admission avoidance and service development.
	Purchase and execution of six properties to support ten individuals discharge from hospital
	Implement Dual Use Accommodation as a step down from out of area placements and to avoid unnecessary admissions to hospital.
	To develop plans to identify future bed capacity and appropriate models of care.

	Autism - Our objective is that Individuals with autism are able to access mainstream services and can be referred for a timely specialist diagnostic assessment and personalised follow up support.
	To co-produce a diagnostic and post diagnostic pathway that provides a consistent approach / offer across the STP footprint and provide an analysis of how existing spend could be redirected.
	Improve data collection and needs analysis that will improve commissioning intelligence and identify gaps in health and social care support in wider Devon
	Improve access to advice & guidance for people with autism, with particular reference to parents of people with autism.
	Ability to access mainstream services
	Increase opportunities for support in employment that meets the needs of people with autism & increase paid employment in Devon for people with autism.

	Workforce - Our workforce will deliver care in a positive and practical way ensuring that individuals, their family and carers are involved in the care planning and develop plans that meet their needs and support their preferences.
	Improved awareness, knowledge and skills in supporting those with LD and/or Autism will become mainstreamed across services and not solely the domain of 'specialists'.
	Establish a broad programme of education, training, support and development to up-skill the workforce
 Support	Develop education and support networks for individuals, families and carers
	Address the challenges of workforce development, recruitment and retention by linking with relevant organisations
	Provide an easy guide that enables workforce providers to map the level of education and training required by their workers.

	Develop Individual Service Design (ISD) roles that enable tailored care to meet complex needs.
	Support and promote the 'Treat me well' campaign (Mencap 2018).
	Support and promote the process for learning from deaths of those with an LD/Autism through the Devon LeDer programme and will actively seek further reviewers to be trained from our current workforce.

Glossary	Meaning
AHC	Annual Health Check
HAP	Health Action Plan
STOMP	Stop The Overmedication of People
AL	Additional Information
SCR	Summary Care Records
PWLD	People With Learning Disabilities
TCP	Transforming Care Partnership
CTR	Care and Treatment Review
STP	Sustainability and Transformation Partnership
ISD	Individual Service Design
Blue Light call	A collaborative conference call which helps to problem solve using effective decision making based on good knowledge and evidence. This is used when a person may be at risk of being admitted. A large proportion of potential admissions can be averted using this approach.
Dual Use Accommodation	This is a capital programme which involves developing three units of accommodation to provide a local and stable environment, to enable people to either step down from hospital or step up in times of crisis.
Devon LeDer programme	Learning Disabilities Mortality Review aims to make improvements to the lives of people with learning disabilities. It clarifies any potentially adjustable reasons associated with a person's death, and works to ensure that these are not repeated elsewhere.