ADULT SERVICES COMMITTEE

AGENDA

Thursday 1 March 2018

at 10.00am

in Committee Room B
Civic Centre, Hartlepool

MEMBERS: ADULT SERVICES COMMITTEE

Councillors Beck, Hamilton, Hind, Loynes, McLaughlin, Richardson, and Thomas

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 To receive the Minutes and Decision Record in respect of the meeting held on 1 February 2018 *(for information as previously circulated)*

4. **BUDGET AND POLICY FRAMEWORK ITEMS**

   No items.

5. **KEY DECISIONS**

   No items.

6. **OTHER ITEMS REQUIRING DECISION**

   6.1 Suicide Prevention and Support for Men with Mental Health Issues – *Interim Director of Public Health*

7. **ITEMS FOR INFORMATION**

7.1 Raising Awareness of Adult Safeguarding – *Director of Adult and Community Based Services*

7.2 Access to Transport for People with a Disability - *Director of Adult and Community Based Services*

7.3 Strategic Financial Management Report – as at 31 December 2017 – *Director of Adult and Community Based Services and Director of Finance and Policy*

8. **ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT**

FOR INFORMATION:-

Date of next meeting – Thursday 29 March 2018 at 10.00am in the Civic Centre, Hartlepool

ADULT SERVICES COMMITTEE

MINUTES AND DECISION RECORD

1 February 2018

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Councillor: Stephen Thomas (In the Chair)

Councillors: Paul Beck, Lesley Hamilton, Brenda Loynes, Mike McLaughlin and Carl Richardson

Also present:
Frank Harrison (National Pensions Convention/Years Ahead Forum), Sue Little and Gordon and Stella Johnston

Officers: Jill Harrison, Director of Adult and Community Based Services
Jeanette Willis, Head of Strategic Commissioning – Adult Services
Angela Armstrong, Principal Democratic Services Officer

68. Apologies for Absence

Apologies for absence were received from Evelyn Leck.

69. Declarations of Interest

Councillor Stephen Thomas reiterated a personal interest as an employee of Healthwatch.

70. Minutes of the meeting held on 12 January 2018

Received.

71. Hospital Discharge Update (*Director of Adult and Community Based Services*)

Type of decision

For information.

Purpose of report

To provide the Committee with an update in relation to hospital discharges and delayed transfers of care (DToCs).

Issue(s) for consideration

The Director of Adult and Community Based Services presented the report which highlighted that during Q1 of 2017/18 there were 1,190 delayed days reported against a target of 1,279 days meaning that the target was achieved. During Q2 of 2017/18, there were 882 delayed days reported against a target of 1,037 days, evidencing further improvement against this measure. These figures combined demonstrated that in the first six months of 2017/18, the number of DToCs in Hartlepool was under target by 2443 days or 10.5%.

The main reasons for reported delays were people awaiting nursing home placement or availability, patient or family choice and people awaiting further non-acute NHS care. Further detail on the factors that had contributed to the improvement in performance was included in the report. It was highlighted that delays may increase in Q3 and Q4 linked to increased pressures over winter but recognised that performance in relation to hospital discharges had hugely improved. A number of further actions were ongoing to maintain and continue improving performance and the DToC would be closely monitored through the Better Care Fund and reported quarterly to Health and Wellbeing Board.

It was highlighted that the success of the Integrated Discharge Team was recognised in June 2017 with the team winning the Best Innovation Project award at the North East, Cumbria, Yorkshire and Humber Commissioning Awards.

The Chair concluded that this report highlighted the ongoing hard work and commitment to improve performance in hospital discharges which had been influenced by a number of initiatives introduced by the local authority and health partners. It was acknowledged that this was a significant improvement in performance and would continue to be monitored very closely in the remainder of the year, to ensure that performance was maintained and further improved performance.

Decision

That the contents of the report were noted, including the positive performance in relation to Delayed Transfers of Care and ongoing work to maintain and further improve performance.

72. Quality Ratings for Commissioned Services (*Director of Adult and Community Based Services)*

Type of decision

For information.

Purpose of report

To provide the Committee with an update on quality ratings for all other

commissioned social care services that are regulated by the Care Quality Commission (CQC).

Issue(s) for consideration

The Head of Strategic Commissioning, Adult Services presented a detailed and comprehensive report which noted that all services commissioned by the Council were subject to contract monitoring and the Quality Standards Framework. Regulated services were also required to be registered by the CQC and were subject to regular inspection, which was followed by a published rating. These services include:

- Home Care for Older People;
- Non Residential Services for Working Age Adults;
- Residential Care for People with Learning Disabilities;
- Residential Care for People with Mental Health Needs; and
- Extra Care Support.

In relation to home care for older people, the Head of Strategic Commissioning was able to confirm that the contracts for the north and south of the town had been awarded to Carewatch and Dale Care respectively and will commence from April 2018.

It was noted that since the last update, there had been a new development within the town at Whitethorn Gardens, off Seaton Lane comprising four separate buildings set in spacious grounds offering supported living accommodation for people with a range of needs.

A Member sought clarification on what was required to achieve an outstanding rating from the CQC and whether there were any homes nationally that had achieved this. The Head of Strategic Commissioning responded that there were a very small percentage of homes nationally that had been able to achieve the outstanding rating. The criteria to achieve outstanding was generally around innovation within a home and the CQC had a rigorous process in place to assess any service recommended for an outstanding rating. All care home managers within Hartlepool were very committed to the provision of an excellent service for their residents and strived to achieve an outstanding rating. It was noted that some care homes that did achieve an outstanding rating were catering solely for self funders with fee levels far in excess of local authority rates.

A discussion ensued on the care homes within Hartlepool and the Head of Strategic Commissioning responded to a number of queries and confirmed that none of the care homes within Hartlepool were Council owned. However, it was recognised that Officers, through the Local Authority's duty of care, worked closely in partnership with all providers to ensure that a good quality service was provided. A Member commented that if the care homes within Hartlepool were Council owned, there would be more accountability through Elected Members. The Director of Adult and Community Based Services confirmed that Officers had very strong links with all providers and visited services regularly and reiterated that all

providers were striving to achieve good and outstanding ratings by providing the best outcome for residents. A Member commented on the new contracts for home care for older people and the Head of Strategic Commissioning confirmed that care staff involved in the new contracts would be subject to TUPE arrangements which would provide continuity for service users.

The Chair reiterated that the new home care contracts had been awarded in line with the Unison Ethical Care Charter standards, which was extremely positive and contracts would be monitored to ensure providers were compliant. The importance of ensuring a seamless transition to the new contracts was emphasised to avoid any disruption to the provision of care. It was highlighted that the Local Authority did aspire at all times to the provision of excellent care and was encouraged that providers were continually working to achieve good or outstanding ratings at all times.

Decision

That the contents of the report were noted with further updates to be received as required.

73. Update: Care Homes for Older People (*Director of Adult and Community Based Services)*

Type of decision

For information.

Purpose of report

To provide the Committee with an update in relation to care home provision for older people.

Issue(s) for consideration

The Head of Strategic Commissioning presented a detailed and comprehensive report and highlighted that since the last report to the Committee there had been a number of developments in the following areas:

- CQC Ratings;
- Quality Standards Framework;
- Brierton Lodge – Change in Ownership;
- Rossmere Park Care Centre;
- De Bruce Court Care Home (opened on 29 January 2018);
- Former Admiral Court Care Home; and
- Support provided to the Care Home Market;
- CCG/HBC Training and Education Programme; and
- HBC Fee Negotiations.

A discussion ensued during which the Head of Strategic Commissioning provided clarification on a number of areas and it was noted that Officers had a very proactive approach and positive relationships with all providers

on a local basis as well as regionally and nationally and deal with concerns very quickly. The Head of Strategic Commissioning commented that the success of the care provision was based on the extremely positive relationship Officers had with providers and the drive and passion to maintain and further improve the service.

In relation to CQC inspections, the Director of Adult and Community Based Services indicated that new care homes were generally operational for a year before being subject to an inspection. The Director also confirmed that all homes within Hartlepool were rated good for their caring domain. During a discussion on out of borough placements, the Director highlighted that the number had reduced considerably with many out of borough placements being due to people choosing to live out of area to be close to their families, rather than being out of borough due to a lack of choice locally. It was noted that, due to an increase in the number of nursing beds, there should always be an option for someone to be supported in Hartlepool should they so wish.

It was noted that on a recent visit to Hartlepool, the High Sheriff had been very impressed with the services provided within the Centre for Independent Living and the work undertaken around dementia in the town and commended the work undertaken by the Local Authority and Healthwatch Hartlepool.

The Director of Adult and Community Based Services responded to a number of specific queries raised by members of the public

The Chair was pleased to note the report which demonstrated significant improvements over the last 3 years which the Committee wished to see continue. It was acknowledged that the care market for older people was a very fragile market where things could change rapidly. The increase in nursing bed provision within the town was highlighted as a really positive step as this enabled more people to have the choice to remain within the town. The Chair suggested that the Care Quality Commission be invited to a meeting of the Committee early in the new municipal year to discuss the developing inspection regime, particularly around the support available to care homes rated as 'requiring improvement'.

Decision

(1) The contents of the report were noted with a further update to be received in six months.
(2) That the Care Quality Commission be invited to a meeting of the Committee early in the new municipal year to discuss the developing inspection regime, particularly around the support available to care homes rated as 'requiring improvement'.

74. Any Other Items which the Chairman Considers are Urgent

The Chairman ruled that the following items of business should be considered by the Committee as a matter of urgency in accordance with the provisions of Section 100(B) (4)(b) of the Local Government Act 1972 in order that the matter could be dealt with without delay.

75. Any Other Business

The representative from the National Pensions Convention referred to the Annual Dignity Day that had been scheduled for 3 February 2018. Members were informed that this had been cancelled and would not now take place, however the Annual Dignity Day next year would be held in Hartlepool.

The meeting concluded at 11.05am

P J DEVLIN

CHIEF SOLICITOR

PUBLICATION DATE: 8 February 2018

ADULT SERVICES COMMITTEE

1 March 2018

Report of: Interim Director of Public Health

Subject: SUICIDE PREVENTION AND SUPPORT FOR MEN WITH MENTAL HEALTH ISSUES

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1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 Non-Key Decision.

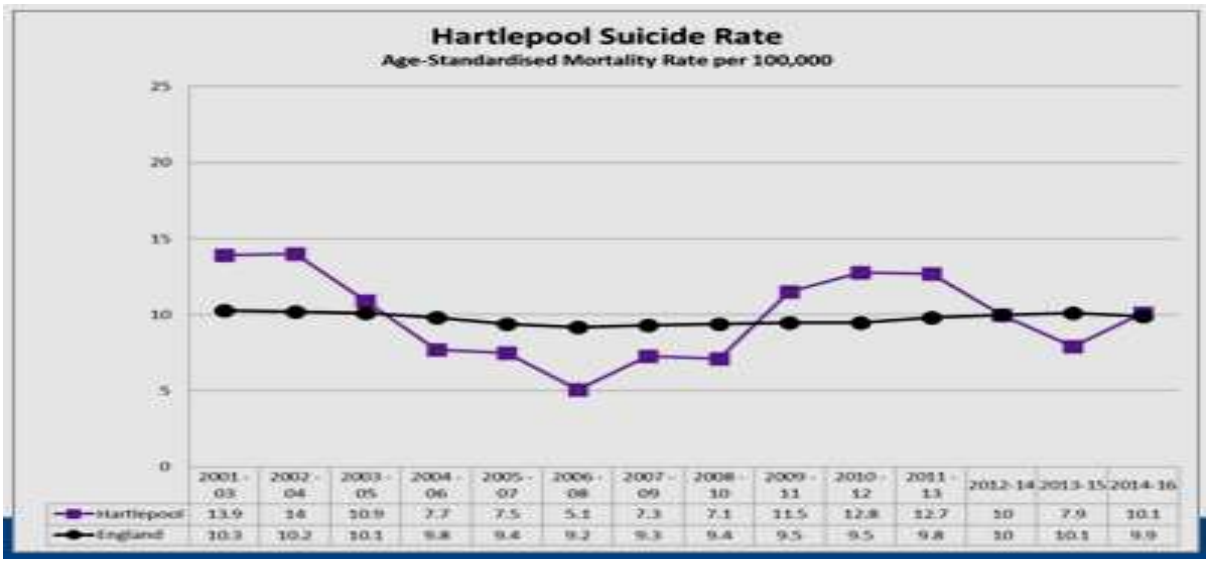
2. PURPOSE OF REPORT

2.1 This report is provided in response to a requested by the Chair of Adult Services Committee.

3. BACKGROUND

3.1 Suicide and non-fatal self-harm account for more than 4,000 deaths and 200,000 hospital presentations every year in England. Out of almost 4,700 people who died by suicide in 2013 in England – almost 3,700 (78%) of those people were men, with suicide being one of the biggest killers for men under the age of 50. This trend is reflected locally in Teesside with a higher proportion of suicide deaths also being males under 50 years of age.

3.2 Hartlepool has the lowest number and rate of suicides in Teesside. The suicide rate for Hartlepool is lower than the North East and similar to the England average. In Hartlepool, a downward trend in suicide rates has been observed in recent years.



Suicides in Teesside – 2014 to 2016

MIDDLESBROUGH	STOCKTON-ON-TEES	REDCAR & CLEVELAND	HARTLEPOOL
63 SUICIDES	**69** SUICIDES	**41** SUICIDES	**25** SUICIDES
18.3 RATE PER 100,000	**13.8** RATE PER 100,000	**11.8** RATE PER 100,000	**10.1** RATE PER 100,000
RANKED **152nd** OUT OF 152 LOCAL AUTHORITIES	RANKED **144th** OUT OF 152 LOCAL AUTHORITIES	RANKED **124th** OUT OF 152 LOCAL AUTHORITIES	RANKED **88th** OUT OF 152 LOCAL AUTHORITIES
73% MALES	**70%** MALES	**83%** MALES	**72%** MALES

NORTH EAST **11.6** RATE PER 100,000 ENGLAND **9.9** RATE PER 100,000

3.3 Factors that lead to suicide are complex but are mostly preventable. Prevention requires multi-agency action alongside efforts at an individual, family, community and local authority level. The current economic climate and the welfare reforms present significant challenges for health and wellbeing and more specifically emotional wellbeing and mental health.

3.4 To achieve success in suicide prevention it depends on several inter-connected factors: effective leadership, prioritisation of suicide prevention, targeted training, local champions, resources and the long-term survival of suicide prevention groups.

4. TACKLING THE ISSUE

4.1 Tackling suicides and mental health issues requires multi-agency action by key partners in the health and social care community, police and the voluntary and community sector.

4.2 A Tees Suicide Prevention Taskforce has been formed and chaired by Edward Kunonga, Director of Public Health for Middlesbrough Council and Interim Director of Redcar & Cleveland Borough Council. An implementation plan and accompanying action plan (Appendix 1) have been developed as the local response to the national suicide prevention strategy – Preventing Suicide in England (Appendix 2) - a cross-government outcomes strategy to save lives from suicides.

4.3 The Task Force brings together key partners, local knowledge about groups at higher risk of suicide, applying the evidence of most effective interventions and highlights resources needed to implement these plans.

4.4 The six key areas identified for action are:

- Reduce the risk of suicide in key high-risk groups;
- Tailor approaches to improve mental health in specific groups;
- Reduce access to the means of suicide;
- Provide better information and support to those bereaved or affected by suicide;
- Support the media in delivering sensitive approaches to suicide and suicidal behaviour; and
- Support research, data collection and monitoring.

4.5 There are currently two suicide prevention programmes in place commissioned on a Tees-wide basis to support the delivery of the suicide prevention action plan, these are:

- Suicide Prevention Co-ordinator; and
- Mental Health Training Hub

4.6 The four Tees Local Authorities have jointly recruited a Suicide Prevention Co-ordinator with the primary purpose of implementing the Tees Suicide Prevention Strategic Plan and accompanying action plan.

4.7 The Tees Mental Health Training Hub has been in place since 2013. The training hub is a key contributor to the delivery of the suicide prevention implementation plan – seeking opportunities to raise awareness and build capacity to prevent suicide. The main aim of the hub is to lead a cohesive approach to co-ordinate mental health related training and maintenance of the training database (trainers and participants). The hub locally co-ordinates and commissions training, supports organisations to effectively build training capacity and supports those who have been trained to utilise their knowledge and skills within their role and continue to develop. A wide range of organisations are targeted to take up training particularly those with public-facing staff including hairdressers, barbers, post offices, etc. as well as statutory and voluntary organisations. The hub is also contracted to organise,

deliver and evaluate an annual networking/updating event for those who have undertaken training and others interested in improving their knowledge of the subject.

4.8 Public Health in Hartlepool has in addition funded the Hartlepool Directory of mental health services – Beautiful Minds (Appendix 3). The directory is updated regularly and widely distributed to inform organisations and individuals on the services available to support good mental health in Hartlepool. The Directory outlines services available, their purpose, who they are aimed at and who to contact.

4.9 Although the Public Health Grant does not commission initiatives specific to men with mental health problems the grant provides £150k to Adult Social Care to support public mental health for schemes such as personal budgets. In addition, the many and varied physical activity opportunities provided by the Council's Sport and Physical Activity Team have a direct bearing on participants' mental health. The Better Health at Work Award (BHAWA) also encourages businesses to implement programmes to promote emotional health at well being for employees.

5. OTHER INFLUENCES IN SUICIDE PREVENTION

5.1 In response to a National Crisis Care Concordat there is a Cleveland wide multi agency group that work together to put in place the principles of the National Concordat to improve the system of care and support so that people in crisis because of a mental health condition, are kept safe. There is a local implementation for Hartlepool signed by a range of partners. (Appendix 4)

5.2 North East Prevention Concordat for Better Mental Health (Appendix 5)
The Prevention Concordat is a suite of documents that have been developed as practice resource to support local areas across England to put in place effective arrangements to promote good mental health and prevent mental health problems. This is in the planning stages for the North East and a Master Class was held on 24 January 2018 to raise awareness and facilitate planning and delivery of initiatives to support the prevention agenda.

5.3 Hartlepool's Mental Health Forum is a local multi agency group that meets quarterly to network, share knowledge and good practice and raise awareness of services available in the town that relate to improving emotional health and wellbeing.

5.4 Mental Health Act - In October 2017, the government announced an independent review by Professor Sir Simon Wesley into the Mental Health Act. The current mental health legislation, which is now over 30 years old, is viewed as having shortfalls and is open to misuse with high detention rates. Detentions under the act have risen year-on-year since 2010-11.

6. PROPOSALS

6.1 This report makes a proposal to launch a local marketing campaign to raise awareness on mental health issues in men in order to reduce inequalities in accessing services.

7. RISK IMPLICATIONS

7.1 There are no risk implications identified.

8. FINANCIAL CONSIDERATIONS

8.1 There are no financial implications identified.

9. LEGAL CONSIDERATIONS

9.1 There are no legal implications identified.

10. CONSULTATION

10.1 There was no requirement for consultation for this report.

11. CHILD AND FAMILY POVERTY (IMPACT ASSESSMENT FORM TO BE COMPLETED AS APPROPRIATE.)

11.1 There is no anticipated impact for child and family poverty.

12. EQUALITY AND DIVERSITY CONSIDERATIONS (IMPACT ASSESSMENT FORM TO BE COMPLETED AS APPROPRIATE.)

12.1 There is no anticipated impact for equality and diversity.

13. STAFF CONSIDERATIONS

13.1 There are no staffing implications identified.

14. ASSET MANAGEMENT CONSIDERATIONS

14.1 There are no implications for asset management identified.

15. RECOMMENDATIONS

15.1 Adult services committee is asked to:

- Note the contents of the report; and
- Approve a campaign to be launched by the Hartlepool Mental Health Forum to raise awareness on men's mental health issues and how to access services.

16. REASONS FOR RECOMMENDATIONS

16.1 Men are disproportionately affected by suicides. However findings from suicide reviews show that for the majority of cases the victims were not known to services.

17. BACKGROUND PAPERS

17.1 Tees Suicide Prevention Action Plan 2016-17-2020/21 (appendix 1)

17.2 Preventing Suicide in England: a cross government outcomes strategy to save lives (Appendix 2)

17.3 Beautiful Minds Directory of mental health services (Appendix 3)

17.4 Cleveland Declaration Statement re Crisis Care Concordat (Appendix 4)

17.5 Briefing Paper re the Prevention Concordat (Appendix 5)

18. CONTACT OFFICERS

Paul Edmondson Jones
Interim Director of Public Health, HBC
Paul.edmondson-jones@hartlepool.gov.uk

Esther Mireku
Acting Consultant in Public Health, HBC
Esther.mireku@hartlepool.gov.uk

Tees Suicide Prevention Action Plan 2016/17-2020/21

TEES SUICIDE PREVENTION TASK FORCE

HARTLEPOOL BOROUGH COUNCIL

Middlesbrough moving forward

REDCAR & CLEVELAND BOROUGH COUNCIL

Stockton-on-Tees BOROUGH COUNCIL

Tees Suicide Prevention Action Plan 2016/17-2020/21

Cross Cutting Strategies	Mental health strategy, Tees Crisis Concordat
Monitoring Board	LA Health and Wellbeing Boards (Hartlepool, Middlesbrough, Stockton-On-Tees and Redcar & Cleveland)
Chair	Edward Kunonga
Lead Officers	Tina Walker (Redcar & Cleveland); Joe Chidanyika (Middlesbrough), Carole Johnson (Hartlepool); Many Mackinnon (Stockton-On-Tees)
Implementation Date	March 2016
Review Date	March 2018

Priority 1: Sustain current funding for the TSPT group and activities

Action	Outcome	Measure	Lead	Resource	Timescales	RAG
1.1 LA leads through partnership collaboration to identify and secure annual resources	Identified funding for TSPT group to implement action plan	Committed Local Authority budgets	Tees LA Leads	In place	Annual	

Priority 2: Reduce the risk of suicide in key high-risk groups

Action	Outcome	Measure	Lead	Resource	Timescales	RAG
2.1 To re-establish access to local suicide audit data and the early alert system to identify local high risk groups and develop intervention strategies	Increased intelligence to inform local activity/ commissioning	Audit	Tees Suicide Prevention Taskforce (TSPT)	LA leads funding a suicide and drugs related deaths coordinator post for 3 years	31st August 2018	
2.2 To promote available services across all partner agencies	Appropriate and early access to services	SP Networking Events/LA Mental Health Forums	All	Via Training Hub contract	March 2018	
2.3 Explore the roll out of the GP and Primary Care Suicide Prevention awareness e-learning programme (inc. risk assessment and management)	Increased awareness of package	No. of practices completing e-learning modules	NHS England/ CCG's/PHE N/E	NHS England LA leads	March 2018	
2.4 To respond to the recommendations from the Crisis Care Concordat	Effective partnership pathways	Renewal/Sign off data sharing arrangements	CCG Crisis concordat lead	In place	March 2018	
2.5 To explore localised approach for "talking down" for a range of agencies	Increased capacity of trained responders	No's trained	Cleveland Police	Tees Crisis concordat	March 2018	
2.6 To encourage workplace policies that support mental health	Up to date policies are in place	BHAW Award	Workplace Leads	LA Public Health	March 2018	
2.7 Support national, regional and local campaigns to challenge mental health stigma and discrimination and promote mental health	Increased awareness of mental health and reducing stigma	Feedback from TSPT members	TSPT members	PHE Resources	March 2018	
2.8 To understand local need and appropriate response to self-harm and near misses	Reduction in repeats of self-harm. Increased knowledge of self-harm and local interventions. Near miss Audit.	Reduction of Repeat attendance at A&E	TEWV	All partners	March 2018	
2.9 To maintain and strengthen current Tees Training Hub to deliver suicide prevention and mental health promotion programmes	To increase mental health knowledge and skills across a range of settings. To target training to organisations most likely to come into contact with those most at risk of poor mental health To provide equitable access to training within the 4 localities. To maintain training database To host an annual networking event	As set out in contract Regular updates to TSPT	LA Public Health	£50k (Tees) annually	March 2018	

Tees Suicide Prevention Action Plan 2016/17-2020/21

Priority 3: Tailor approaches to improve mental health in specific groups

Action	Outcome	Measure	Lead	Resource	Timescales	RAG
3.1 GP practices to complete the GP audit tool to capture data regarding any potential suicide	Completed GP audit tool will improve the local information pool and identify those at risk	No's of completed audit tools	CCG's/Suicide Prevention Coordinator	CCG's/Suicide Prevention Coordinator	Annual	
3.2 To implement and support a range of preventative programmes to reduce the impact of the current economic crisis	No increase in suicides as a result of economic crisis	Evaluation of programmes	All	TSPT/LA/CCG	March 2018	
3.3 To implement and support a range of preventative programmes to support the needs of specific groups, e.g. pregnant mothers, LGBT, Asylum Seekers, etc.	No increase in suicides of targeted groups	GP Audit Tool Local intelligence (TSPT members)	All	TSPT/LA/CCG	March 2018	

Priority 4: Reduce access to the means of suicide

Action	Outcome	Measure	Lead	Resource	Timescales	RAG
4.1 To identify local hotspots, using suicide prevention audit, early alert system and local agency information e.g. Criminal Justice Service	Identification of hotspots and monitoring of numbers of deaths	Local audit/police data	TSPT/Police	Suicide coordinator	March 2018	
4.2 Adopt the National Samaritans Signage	Increased visibility of Samaritan signage	No's placed	Samaritans	LA Public Health	December 2016	
4.3 Support the ongoing work between the Samaritans, British Transport Police and Network Rail to reduce suicides on the railways	Reduced suicides on railways	Feedback to taskforce	Network Rail	Network Rail	March 2018	
4.4 Work with Pharmacy Leads to support safe prescribing and encourage the return of unused prescribed medication	Safer prescribing, reduction of self-poisoning by prescribed medications	No. of reviews No. of returned medications Local audit	Healthy Living Pharmacies	Local Pharmaceutical Committee	March 2018	
4.5 Encourage local authority planning departments and developers to include suicide in health and safety considerations when designing structures	Safer buildings Hotspot signage at identified local sites, as well as other mainstream areas to normalise signage	Reduction of near misses at hotspots	LA Leads	LA Councils	March 2018	

Priority 5: Provide better information and support to those bereaved or affected by suicide

Action	Outcome	Measure	Lead	Resource	Timescales	RAG
5.1 Raise awareness of bereavement support provision for children and young people aged 0-5 years with key partners	Timely bereavement support	Increase in the numbers seen	PH Leads	LA/CAMHS transformation investment	March 2018	
5.2 To manage performance of local support services to support those bereaved or affected by suicide	Improved health and wellbeing of clients	Number and outcome of those supported (via contract)	PH Leads	LA Public Health	March 2018	
5.3 To provide information of local, regional and national services/resources for those bereaved or affected by suicide; including how to access	Improved health and wellbeing	Networking events TSPT group	All	Partner websites, briefing papers	March 2018	

Tees Suicide Prevention Action Plan 2016/17-2020/21

Priority 6: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

Action	Outcome	Measure	Lead	Resource	Timescales	RAG
6.1 To review the taskforce communication strategy	To ensure a consistent and considered approach to respond to media stories/ campaigns	Production of a Tees communications strategy	TSPT Comms Lead	LA Comms Depts	Annual	
6.2 To promote the use of the Samaritans media guidelines for reporting suicides and self-harm	All agency communication leads will be made aware of and to follow the guidelines	Reduction in irresponsible reporting An increase in media reports with local support contact details	TSPT Comms Lead	LA Comms Depts	March 2018	
6.3 For partner agencies to provide positive promotional materials that encourage help seeking behaviour; support understanding and recognition of those at risk; how to support someone and where to go for help	Increased positive mental health attitudes in the media	Reduction in irresponsible reporting	TSPT Comms Lead	All	March 2018	

Priority 7: Support research, data collection and monitoring

Action	Outcome	Measure	Lead	Resource	Timescales	RAG
7.1 To utilise local academics to inform and learn from emerging research	To increase knowledge to support the delivery of the action plan	Roll out of pilot projects informed by research	FUSE/LA Leads	Taskforce	March 2018	
7.2 To explore existing protocol to record and learn from attempted suicides	Robust intelligence to inform delivery	Consistent recording of near misses	TEWV / Suicide/ Drugs related deaths coordinators	Taskforce	March 2018	
7.3 To identify collate and analyse real time suicides	Inform direction and delivery of taskforce action plan	Action Plan adapted according to new data	Suicide and Drugs related deaths coordinator	Taskforce	March 2018	

Preventing suicide in England

A cross-government outcomes strategy to save lives

HM Government

DH INFORMATION READER BOX

Policy	Clinical	Estates
HR / Workforce	Commissioner Development	IM & T
Management	Provider Development	Finance
Planning / Performance	Improvement and Efficiency	Social Care / Partnership Working

Document Purpose	Best Practice Guidance
Gateway Reference	17680
Title	Preventing suicide in England: A cross-government outcomes strategy to save lives
Author	HMG / DH
Publication Date	**10 September 2012**
Target Audience	PCT Cluster CEs, NHS Trust CEs, SHA Cluster CEs, Care Trust CEs, Foundation Trust CEs , Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT Cluster Chairs, NHS Trust Board Chairs, Special HA CEs, Directors of HR, Directors of Finance, Allied Health Professionals, GPs, Communications Leads, Emergency Care Leads, Directors of Children's SSs, Youth offending services, Police, NOMS and wider criminal justice system, Coroners, Royal Colleges, Transport bodies
Circulation List	Voluntary Organisations/NDPBs
Description	A new strategy intended to reduce the suicide rate and improve support for those affected by suicide. The strategy: sets out key areas for action; states what government departments will do to contribute; and brings together knowledge about groups at higher risk, effective interventions and resources to support local action.
Cross Ref	No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of all Ages
Superseded Docs	National Suicide Prevention Strategy for England
Action Required	N/A
Timing	**N/A**
Contact Details	Mental Health and Disability Division Department of Health 133-155 Waterloo Road London SE1 8UG 020 7972 1332 www.dh.gov.uk/
For Recipient's Use	

Preventing suicide in England

A cross-government outcomes strategy to save lives

Prepared by Department of Health

First published September 2012
Published to DH website, in electronic PDF format only.
www.dh.gov.uk/publications

HM Government

Ministerial Foreword

In England, one person dies every two hours as a result of suicide. When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing support and care will feel the impact.

In developing this new national all-age suicide prevention strategy for England, we have built on the successes of the earlier strategy published in 2002. Real progress has been made in reducing the already relatively low suicide rate to record low levels.

But there is no room for complacency. There are new challenges that need to be addressed. And at a time when we have economic pressures on the general population, it is particularly timely to revisit a national strategy that has demonstrated clear progress.

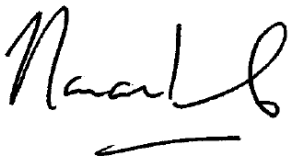
If we are to continue to prevent suicide, we also need to take specific actions, as outlined in this strategy.

This strategy supports action by bringing together knowledge about groups at higher risk of suicide, applying evidence of effective interventions and highlighting resources available. This will support local decision-making, while recognising the autonomy of local organisations to decide what works in their area.

The factors leading to someone taking their own life are complex. No one organisation is able to directly influence them all. Commitment across government, from Health, Education, Justice and the Home Office, Transport, Work and Pensions and others will be vital. We also need the support of the voluntary and statutory sectors, academic institutions and schools, businesses, industry, journalists and other media. And, perhaps above all, we must involve communities and individuals whose lives have been affected by the suicide of family, friends, neighbours or colleagues.

We have made it clear that mental and physical health have to be seen as equally important. For suicide prevention, this will mean effectively managing the mental health aspects, as well as any physical injuries, when people who have self-harmed come to A&E. It will also mean having an effective 24 hour response to mental health crises, as well as for physical health emergencies.

The strategy has been developed with the support of leading experts in the field of suicide prevention, including the members of the National Suicide Prevention Strategy Advisory Group, under the chairmanship of Professor Louis Appleby. I would like to thank all members of this group for sharing their knowledge and expertise with us. Their continued support and leadership is central to our efforts to prevent suicides in England.



Norman Lamb MP
Minister of State for Care Services

Contents

Preface

Suicide is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity. This strategy is intended to provide an approach to suicide prevention that recognises the contributions that can be made across all sectors of our society. It draws on local experience, research evidence and the expertise of the National Suicide Prevention Strategy Advisory Group, some of whom have experienced the tragedy of a suicide within their families.

In fact, one of the main changes from the previous strategy is the greater prominence of measures to support families (action 4) – those who are worried that a loved one is at risk and those who are having to cope with the aftermath of a suicide. The strategy also makes more explicit reference to the importance of primary care in preventing suicide and to the need for preventive steps for each age group.

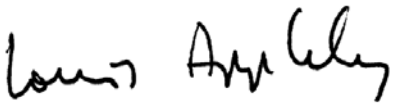
In identifying the high-risk groups who are priorities for prevention (action 1), we have selected only those whose suicide rates can be monitored – this is essential if we are to report on what the strategy achieves. However, there are also other groups for whom a tailored approach to their mental health is necessary if their risk is to be reduced (action 2). These are groups who may not be at high risk overall, such as children, or whose risk is hard to measure or monitor, such as minority ethnic communities. We have highlighted the importance of tackling certain methods of suicide (action 3) and of working with the media towards sensitive reporting in this area (action 5). We have stressed the need for timely data collection and high-quality research (action 6).

We have also had to be clear about the scope of the strategy. It is specifically about the prevention of suicide rather than the related problem of non-fatal self-harm. Although people with a history of self-harm are identified as a high risk group, we have not tried to cover the causes and care of all self-harm. Similarly, whether the law on encouraging or assisting suicide should be changed is a separate issue, outside the scope of the strategy.

No health without mental health, published in 2011, is the government's mental health strategy. An implementation framework has also been published, to set out what local organisations can do to turn the strategy into reality, what national organisations are doing to support this, and how progress will be measured and reported. This is vital, because suicide prevention starts with better mental health for all - therefore this strategy has to be read alongside that implementation framework.

The inclusion of suicide as an indicator within the Public Health Outcomes Framework will help to track national progress against our overall objective to reduce the suicide rate.

The strategy is intended to be up to date, wide-ranging and ambitious. Its publication marks the beginning of a new drive to reduce further the avoidable toll of suicide in England.



Professor Louis Appleby CBE

Department of Health, Chair of the National Suicide Prevention Strategy Advisory Group

Executive summary

1. Suicide[1] is a major issue for society and a leading cause of years of life lost. Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides and it is these that are set out in this strategy.

Objectives and areas for action

2. This strategy sets out our overall objectives:

- a reduction in the suicide rate in the general population in England; and
- better support for those bereaved or affected by suicide.

3. We have identified six key areas for action to support delivery of these objectives:

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

   2: Tailor approaches to improve mental health in specific groups

   3: Reduce access to the means of suicide

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

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

   6: Support research, data collection and monitoring.

Reduce the risk of suicide in key high-risk groups

4. We have identified the following high-risk groups who are priorities for prevention:

- young and middle-aged men
- people in the care of mental health services, including inpatients
- people with a history of self-harm
- people in contact with the criminal justice system
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

5. Those who work with men in different settings, especially primary care, need to be particularly alert to the signs of suicidal behaviour.

6. Treating mental and physical health as equally important in the context of suicide prevention will have implications for the management of care for people who self-harm, and for effective 24 hour responses to mental health crises.

7. Accessible, high-quality mental health services are fundamental to reducing the suicide risk in people of all ages with mental health problems.

8. Emergency departments and primary care have important roles in the care of people who self-harm, with a focus on good communication and follow-up.

9. Continuing to improve mental health outcomes for people in contact with the criminal justice system will contribute to suicide prevention, as will ongoing delivery of safer custody.

10. Suicide risk by occupational groups may vary nationally and even locally,

[1] Suicide is used in this document to mean a deliberate act that intentionally ends one's life.

and it is vital that the statutory sector and local agencies are alert to this, and adapt their suicide prevention interventions accordingly.

Tailor approaches to improve mental health in specific groups

11. Improving the mental health of the population as a whole is another way to reduce suicide. The measures set out in both *No health without mental health* and *Healthy Lives, Healthy People* will support a general reduction in suicides.

12. This strategy identifies the following groups for whom a tailored approach to their mental health is necessary if their suicide risk is to be reduced:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system;
- survivors of abuse or violence, including sexual abuse;
- veterans;
- people living with long-term physical health conditions;
- people with untreated depression;
- people who are especially vulnerable due to social and economic circumstances;
- people who misuse drugs or alcohol;
- lesbian, gay, bisexual and transgender people; and
- Black, Asian and minority ethnic groups and asylum seekers.

13. Children and young people have an important place in this strategy. Schools, social care and the youth justice system, as well as charities highlighting problems such as bullying, low body image and lack of self-esteem, all have an important contribution to make to suicide prevention among children and young people. Measures to help parents keep their children safe online are included in area for action 5. The call for research to support the strategy includes a focus on children and young people and self-harm.

14. Timely identification and referral of women and children experiencing abuse or violence, so that they are able to benefit from appropriate support, is of course a positive step in its own right, as well as helping to reduce suicide risk.

15. The Government is committed to improving mental health support for service and ex-service personnel through the Military Covenant.

16. In *No health without mental health* we made it clear that we expect parity of esteem between mental and physical health. Routine assessment for depression as part of personalised care planning for people with long-term conditions, can help reduce inequalities and help people to have a better quality of life.

17. Depression is one of the most important risk factors for suicide. The early identification and prompt, effective treatment of depression has a major role to play in preventing suicide across the whole population.

18. Given the links between mental ill-health and social factors like unemployment, debt, social isolation, family breakdown and bereavement, the ability of front-line agencies to identify and support (or signpost to support) people who may be at risk of developing mental health problems is important for suicide prevention.

19. Measures that reduce alcohol and drug dependence are critical to reducing suicide.

20. Staff in health and care services, education and the voluntary sector need to be aware of the higher rates of mental distress, substance misuse, suicidal behaviour or ideation and increased risks of self-harm amongst lesbian, gay and bisexual people, as well as transgender people.

21. Community initiatives can be effective in bridging the gap between statutory services and Black, Asian and minority ethnic communities, and in tackling inequalities in health and access to services.

Reduce access to the means of suicide

22. One of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide. Suicide methods most amenable to intervention are:

- hanging and strangulation in psychiatric inpatient and criminal justice settings;
- self-poisoning;
- those in high-risk locations; and
- those on the rail and underground networks.

23. Continued vigilance by mental health service providers will help to identify and remove potential ligature points. Safer cells complement care for at-risk prisoners.

24. Safe prescribing can help to restrict access to some toxic drugs.

25. Local agencies can prevent loss of life when they work together to discourage suicides at high-risk locations. Local authority planning departments and developers can include suicide in health and safety considerations when designing structures which may offer suicide opportunities.

26. British Transport Police, London Underground Limited, Network Rail, Samaritans and partners are working to reduce suicides on the rail and underground networks.

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

27. Every suicide affects families, friends, colleagues and others. Suicide can also have a profound effect on the local community. It is important to:

- provide effective and timely support for families bereaved or affected by suicide;
- have in place effective local responses to the aftermath of a suicide; and
- provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide.

28. Effective and timely emotional and practical support for families bereaved by suicide is essential to help the grieving process and support recovery. It is important the GPs are vigilant to the potential vulnerability of family members when someone takes their own life.

29. Post-suicide community-level interventions can help to prevent copycat and suicide clusters. This approach may be adapted for use in schools, workplaces, health and care settings.

30. It is important that people concerned that someone may be at risk of suicide can get information and support as soon as possible. For individuals already under the care of health or social services, family, carers and friends should know who to contact and be appropriately involved in any care planning. Help is available through many outlets across the statutory and

voluntary sector for people who are not known to services.

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

31. The media have a significant influence on behaviour and attitudes. We want to support them by:

- promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media; and
- continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services.

32. Local, regional and national newspapers and other media outlets can provide information about sources of support when reporting suicide. They can also follow the Press Complaints Commission Editors' Code of Practice and *Editors' Codebook* recommendations regarding reporting suicide.

33. The Government will continue to work with the internet industry through the UK Council for Child Internet Safety to create a safer online environment for children and young people. Recognising concern about misuse of the internet to promote suicide and suicide methods, we will be pressing to ensure that parents have the tools to ensure that their children are not accessing harmful suicide-related content online.

Support research, data collection and monitoring

34. The Department of Health will continue to support high-quality research on suicide, suicide prevention and self-harm through the National Institute for Health Research and the Policy Research Programme.

35. Reliable, timely and accurate suicide statistics are essential to suicide prevention. We will consider how to get the most out of existing data sources and options to address the current information gaps around ethnicity and sexual orientation.

36. Reflecting the continuing focus on suicide prevention, the Public Health Outcomes Framework includes the suicide rate as an indicator.

Making it happen – locally and nationally

37. Much of the planning and work to prevent suicides will be carried out locally. The strategy outlines evidence based local approaches and national actions to support these local approaches.

38. Local responsibility for coordinating and implementing work on suicide prevention will become, from April 2013, an integral part of local authorities' new responsibilities for leading on local public health and health improvement.

39. It will be for local agencies, including working through health and wellbeing boards to decide the best way to achieve the overall aim of reducing the suicide rate. Interventions and good practice examples are included to support local implementation. Many of them are already being implemented locally but local commissioners will be able to select from or adapt these suggestions based on the needs and priorities in their local area.

40. An implementation framework for *No health without mental health* has recently been published. The framework explicitly covers suicide prevention, and supports implementation of this strategy.

Introduction

1. Suicide is a major issue for society. The number of people who take their own lives in England has reduced in recent years. But still, over 4,200 people took their own life in 2010.

2. Every suicide is both an individual tragedy and a terrible loss to society. Every suicide affects a number of people directly and often many others indirectly. The impact of suicide can be devastating – economically, psychologically and spiritually – for all those affected.

3. Suicides are not inevitable. An inclusive society that avoids the marginalisation of individuals and which supports people at times of personal crisis will help to prevent suicides. Government and statutory services have a role to play. We can build individual and community resilience. We can ensure that vulnerable people in the care of health and social services and at risk of suicide are supported and kept safe from preventable harm. We can also ensure that we intervene quickly when someone is in distress or in crisis.

4. Most people who take their own lives have not been in touch with mental health services. There are many things we can do in our communities, outside hospital and care settings, to help those who think suicide is the only option.

5. Between July and October 2011, the Government held a public consultation on a new suicide prevention strategy for England. A summary of the consultation responses that were received, and the decisions that the Government has taken in the light of them is available from www.dh.gov.uk/health/category/publications/consultations/consultation-responses/

The challenge of suicide prevention

6. The likelihood of a person taking their own life depends on several factors. These include:

   - gender – males are three times as likely to take their own life as females;
   - age – people aged 35-49 now have the highest suicide rate;
   - mental illness;
   - the treatment and care they receive after making a suicide attempt;
   - physically disabling or painful illnesses including chronic pain; and
   - alcohol and drug misuse.

7. Stressful life events can also play a part. These include:

   - the loss of a job;
   - debt;
   - living alone, becoming socially excluded or isolated;
   - bereavement;
   - family breakdown and conflict including divorce and family mental health problems; and
   - imprisonment.

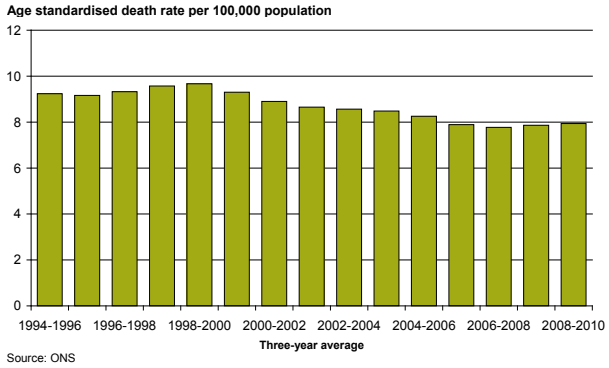
   For many people, it is the combination of factors which is important rather than one single factor. Stigma, prejudice, harassment and bullying can all contribute to increasing an individual's vulnerability to suicide.

8. Several research studies have looked at risk factors for suicide in different groups. In 2008 the Scottish Government Social Research Department undertook a Literature Review: *Risk and Protective Factors for Suicide and Suicidal Behaviour* www.scotland.gov.uk/Publications/2008/11/28141444/0. This review describes and assesses

knowledge about the societal and cultural factors associated with increased incidence of suicide (risk factors) and also the factors that promote resilience against suicidal behaviour (protective factors).

9. Suicide rates in England have been at a historical low recently and are low in comparison to those of most other European countries. In England in 2008-10, the mortality rate from suicide was 12.2 deaths per 100,000 population for males and 3.7 deaths for females.[1] The latest 15-year trend in the mortality rate from suicide and injury of undetermined intent using three-year pooled rates is shown in Figure 1.

Figure 1: Death rates from intentional self-harm and injury of undetermined intent, England 1994-2010



Source: ONS

10. The past couple of years have seen a slight increase in suicide rates, but the 2008-10 rate remains one of the lowest rates in recent years. There has been a sustained reduction in the rate of suicide in young men under the age of 35, reversing the upward trend since the problem of suicides in this group first escalated over 30 years ago. We have also seen significant reductions in inpatient suicides and self-inflicted deaths in prison. A statistical update is being published alongside this strategy document.

11. However, we know from experience that suicide rates can be volatile as new risks emerge. The recent slight increase in the suicide rate in 2008-10 demonstrates the need for continuing vigilance and why, despite relatively low rates, a new suicide prevention strategy for England is needed.

12. Previously, periods of high unemployment or severe economic problems have had an adverse effect on the mental health of the population and have been associated with higher rates of suicide.[2] Evidence is emerging of an impact of the current recession on suicides in affected countries.[3] However, suicide risk is complex and for many people it is a combination of factors, outlined above, that determines risk rather than any single factor.

13. This suicide prevention strategy can help us reduce further the rates of suicide in England and respond positively to the challenges we will face over the coming years.

Objectives and priorities

14. Our overall objectives are:

- a reduction in the suicide rate in the general population in England; and
- better support for those bereaved or affected by suicide.

15. We have identified six areas for action to support delivery of these objectives which each have a chapter of this strategy devoted to them.

16. Much of the planning and work to prevent suicides will be carried out locally. The strategy outlines a range of evidence based local approaches. National actions to support these local approaches are also detailed for each of the six areas for action.

17. Interventions and good practice examples are included to support local implementation and are not compulsory.

Many of them are already being implemented locally but local commissioners will be able to select from and adapt these suggestions based on their assessment of the needs and agreement of the priorities in their local area.

18. We should always use cost-effective evidence-based approaches which work as early as possible. This is above all in the best interests of service users - and also enables the care services to make best use of limited resources. This means getting it right first time - improving outcomes and preventing problems from getting worse to avoid the need for more expensive interventions later on.

19. We need to tackle all the factors which may increase the risk of suicide in the communities where they occur if our efforts are to be effective. Suicide prevention is most effective when it is combined as part of wider work addressing the social and other determinants of poor health, wellbeing or illness.

Outcomes strategies and making an impact

20. Cross-cutting outcomes strategies recognise that the Government can achieve more in partnership with others than it can alone, and that services can achieve more through integrated working than they can through working in isolation from one another. This new approach builds on existing joint working across central government departments, and between the Government, local government, local organisations, employers, service users and professional groups, by unlocking the creativity and innovation suppressed by a top-down approach.

21. There are two other key strategy documents that, in combination with this one, take a public health approach using general and targeted measures to improve mental health and wellbeing and reduce suicides across the whole population.

22. *Healthy Lives, Healthy People: Our strategy for public health in England* (2010) gives a new, enhanced role to local government and local partnerships in delivering improved public health outcomes. Local responsibility for coordinating and implementing work on suicide prevention will become, from April 2013, an integral part of local authorities' new responsibilities for leading on local public health and health improvement. The prompts for local councillors on suicide prevention published alongside this strategy are designed as helpful pointers for how local work on suicide prevention can be taken forward.

23. Health and wellbeing boards will support effective local partnerships and will be able to support suicide prevention as they determine local needs and assets.

24. Public Health England, the new national agency for public health, will also support local authorities, the NHS and their partners across England to achieve improved outcomes for the public's health and wellbeing, including work on suicide prevention.

25. *No health without mental health: A cross-government outcomes strategy for people of all ages* (2011) is key in supporting reductions in suicide amongst the general population as well as those under the care of mental health services. The first agreed objective of *No health without mental health* aims to ensure that more people will have good mental health. To achieve this, we need to:

    - improve the mental wellbeing of individuals, families and the population in general;

- ensure that fewer people of all ages and backgrounds develop mental health problems; and
- continue to work to reduce the national suicide rate.

26. *No health without mental health* includes new measures to develop individual resilience from birth through the life course, and build population resilience and social connectedness within communities. These too are powerful suicide prevention measures.

27. The stigma associated with mental health problems can act as a barrier to people seeking and accessing the help that they need, increasing isolation and suicide risk. The Government is supporting the national mental health anti-stigma and discrimination Time to Change programme.

28. An implementation framework for *No health without mental health* was published in July 2012. This sets out what local organisations can do to implement the mental health strategy, what work is underway nationally to support them, and how progress against the strategy's aims will be measured. The framework explicitly covers suicide prevention, and supports implementation of this new suicide prevention strategy so should be read alongside this document.

29. During the development of this suicide prevention strategy, Samaritans have been facilitating a Call to Action for Suicide Prevention in England. The Call to Action consists of national organisations from across sectors in England taking action so that fewer lives are lost to suicide and people bereaved or affected by a suicide receive the right support.

30. Member organisations have signed a declaration on suicide prevention for England; mapped existing suicide reduction and support activity in their organisations and identified priorities for joint action.

31. We are publishing separately an assessment of the impact on equalities of this strategy.

32. Our approach in this strategy is to:

- set out clear, shared objectives for suicide prevention, and key areas where action is needed;
- state what government departments will do to contribute to these objectives;
- set out how the outcomes frameworks for public health and the NHS will require reductions in the suicide rate; and
- support effective local action by bringing together knowledge about groups at higher risk of suicide, evidence around effective interventions and highlighting research available.

1. Area for action 1: Reduce the risk of suicide in key high-risk groups

1.1 Some groups of people are known to be at higher risk of suicide than the general population. We have been able to identify these groups from research and can monitor numbers from the routine data collected. In this way we identified:

- those groups that are known statistically to have an increased risk of suicide; and
- actual numbers of suicides in these groups.

1.2 In addition, evidence already exists on which to base preventative measures in these groups. We are also able to monitor the impact of preventative measures taken using existing data collections.

1.3 The groups at high risk of suicide are:

- young and middle-aged men;
- people in the care of mental health services, including inpatients;
- people with a history of self-harm;
- people in contact with the criminal justice system;
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers.

1.4 There are other groups whose risk could be high, but limits on the data available mean that their risk is hard to estimate, or else there is no way of monitoring progress as a result of suicide prevention measures.

1.5 Although the strategy focuses on groups at higher risk, it recognises that individuals may fall into two or more high-risk groups. Conversely, not all individuals in the groups will be vulnerable to suicide.

Young and middle-aged men

- Men are at three times greater risk of suicide than women. Most suicides are among men aged under 50. Men aged 35-49 are now the group with the highest suicide rate.
- Older men (over 75) also have higher rates of death by suicide, which may reflect the impact of depression, social isolation, bereavement or physical illness.
- Factors associated with suicide in men include depression, especially when it is untreated or undiagnosed; alcohol or drug misuse; unemployment; family and relationship problems including marital breakup and divorce; social isolation and low self-esteem.[45]

1.6 Men aged under 35 were a high-risk group in the 2002 strategy. Although the suicide rate in men aged under 35 has fallen we are continuing to highlight young men within the strategy because suicide is the single most frequent cause of death, and their youth means that it accounts for a large number of years of life lost. This does not mean that older men should be overlooked. Rates of suicide in men aged over 75 remain high. Different risk factors, such as loneliness and physical illness, may be important in this age group.

Effective local interventions

1.7 Findings from three mental health promotion pilot projects launched in 2006

to address the raised suicide risk in young men show that:

- multi-agency partnership is key to promoting young men's mental health;
- community locations, such as job centres and young people-friendly venues, are more successful in engaging with young men than more formal health settings such as GP surgeries;
- front-line staff feel better able to engage with young men if they receive training; and
- community outreach programmes are seen by young men as more acceptable and approachable than services provided in formal healthcare settings.

1.8 We believe that this broad-based approach has improved the identification of risk by front-line agencies and contributed to the reduction in suicides in the younger male age group. These findings can be adapted and applied to all age groups. *Reaching Out*, the evaluation report of the three projects is available at www.nmhdu.org.uk/nmhdu/en/our-work/promoting-wellbeing-and-public-mental-health/suicide-prevention-resources/

1.9 Many statutory and third sector organisations have set up regional and local initiatives and projects to support men and encourage them to contact services when they are in distress. Some of these projects take their messages out into traditional male territories, such as football and rugby clubs, leisure centres, public houses and music venues.

National action to support local approaches

1.10 Samaritans has launched a five-year campaign to address suicide in men in mid-life of lower socio-economic position. This includes research to understand why this group is at excessive risk of dying by suicide compared to other groups, stimulating debate about policy and practice to reduce suicide in this group, and encouraging men to contact Samaritans.

Helpful resources

NHS Hull has produced a short fictional film to help men in the city understand depression and its effect on their lives. 'Peter's Story' aims to encourage men, particularly in the 25–50 age group, to think and talk about issues with their mental health and wellbeing. www.peters-story.co.uk

The Men's Health Forum has published *Untold Problems: a review of the essential issues in the mental health of men and boys* and a good practice guide, *Delivering Male: Effective practice in male mental health*, setting out ways to improve men's health, including strategies to prevent suicide and encourage help-seeking.

People in the care of mental health services, including inpatients

Patient safety in the mental health services continues to improve.

- The number of people in contact with mental health services who died by suicide has reduced from 1,253 in 2000 to an estimated 1,187 in 2010, a reduction of 66 deaths (5%)
- The number of inpatients who died by suicide reduced from 196 in 2000 to 74 in 2010, a reduction of 122 deaths (62%). The number of inpatients who died on wards by hanging or strangulation reduced by 54%
- The number of patients who refused

drug treatment who died by suicide reduced from 229 in 2000 to 141 in 2010 (38%). www.medicine.manchester.ac.uk/mentalhealth/research/suicide/

- People with severe mental illness remain at high risk of suicide, both while in inpatient units and in the community. Inpatients and people recently discharged from hospital and those who refuse treatment are at highest risk.

Effective local interventions

1.11 The provision of high-quality services that are equally accessible to all is fundamental to reducing the suicide risk in people of all ages with mental health problems.

1.12 Although much has been achieved by front-line staff to reduce suicides in people with mental health problems, they remain a group at high risk, so it is important that mental health services remain vigilant and continue to strengthen clinical practice.

1.13 The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI) checklist 'Twelve Points to a Safer Service' is based on recommendations from a national study of patient suicides and provides key guidance for mental health services. www.medicine.manchester.ac.uk/cmhr/centreforsuicideprevention/nci/saferservices

1.14 A recent research study suggested that these services changes (particularly 24 hour crisis teams, policies for people with drug and alcohol problems, and reviews after suicide) were associated with a reduction in the rate of suicide in implementing NHS Trusts.[6]

1.15 Approaches identified by the NCI which can contribute to a reduction in suicide rates include:

- improving care pathways between emergency departments, primary and secondary care, inpatient and community care, and on hospital discharge;
- ensuring that front-line staff working with high-risk groups receive training in the recognition, assessment and management of risk and fully understand their roles and responsibilities;
- regular assessments of ward areas to identify and remove potential risks, i.e. ligatures and ligature points, access to medications, access to windows and high-risk areas (gardens, bathrooms and balconies). The most common ligature points are doors and windows; the most common ligatures are belts, shoelaces, sheets and towels. Inpatient suicide using non-collapsible rails is a 'Never Event'.[7*] New kinds of ligatures and ligature points are always being found, so ward staff need to be constantly vigilant to potential risk;[8]
- improving safety in new models of care such as crisis resolution/home treatment;
- service initiatives to prevent patients going missing from inpatient wards, such as those in *Strategies to Reduce Missing Patients: A practical workbook* (National Mental Health Development Unit, 2009);
- good risk management and continuity of care. The recent judgment, Rabone vs Pennine Care NHS Foundation Trust, confirmed that NHS Trusts have a duty to protect voluntary mental health patients from the risk of suicide, and

[*] Never Events are serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

highlights the importance of risk management. Aligning care planning more closely with risk assessment and risk management is important, as is the provision of regular training and updates for staff in risk management. The Department of Health guidance on assessment and management of risk[9] emphasises that risk assessment should be an integral part of clinical assessment, not a separate activity. All service users and their carers should be given a copy of their care plan, including crisis plans and contact numbers;

- innovative approaches which may be helpful: many local services have developed ways to follow up people recently discharged from mental health inpatient units using telephone, text messaging and email, as well as letters.

Helpful resources

1.16 *No health without mental health: Delivering better mental health outcomes for people of all ages* outlines a range of evidence-based treatments and interventions to prevent people of all ages from developing mental health problems where possible, intervene early when they do, and develop and support speedy and sustained recovery. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123737

1.17 NCI provides regular reports on patient suicides and up-to-date statistical data. These reports highlight and make recommendations where clinical practice and service delivery can be improved to prevent suicide and reduce risk. www.medicine.manchester.ac.uk/suicideprevention/nci

1.18 The National Patient Safety Agency's (NPSA's) *Preventing Suicide: A toolkit for mental health services* includes measures for services to assess how well they are meeting the best practice on suicide prevention. www.nrls.npsa.nhs.uk/resources/?EntryId45=65297. The NPSA also published *Preventing suicide: A toolkit for community mental health (*2011). It focuses on improving care pathways and follow up for people who present at emergency departments following self-harm or suicidal behaviour and those who present at GP surgeries and are identified as at risk of self-harm or suicide. www.nhsconfed.org/Documents/Preventing-suicide-toolkit-for-community-mental-health.pdf

People with a history of self-harm

- There are around 200,000 episodes of self-harm that present to hospital services each year.[10] However, many people who self-harm do not seek help from health or other services and so are not recorded.
- Studies have shown that by age 15-16, 7-14% of adolescents will have self-harmed once in their life.[11]
- People who self-harm are at increased risk of suicide, although many people do not intend to take their own life when they self-harm.[12] At least half of people who take their own life have a history of self-harm, and one in four have been treated in hospital for self-harm in the preceding year. Around one in 100 people who self-harm take their own life within the following year. Risk is particularly increased in those repeating self-harm and in those who have used violent/dangerous methods of self-harm.[13]

Effective local interventions

1.19 Emergency departments have an important role in treating and managing people who have self-harmed or have made a suicide attempt. There are still problems in some places with the quality of care, assessment and follow-up of people who seek help from emergency departments after self-harming.[14] Attitudes towards and knowledge of self-harm among general hospital staff can be poor. A high proportion of people who self-harm are not given a psychological assessment. Often, follow-up and treatment are not provided, in particular for people who repeatedly self-harm. In many emergency departments, the facilities available for distressed patients could be improved.

1.20 GPs have a key role in the care of people who self-harm. Good communication between secondary and primary care is vital, as many people who present at emergency departments following an episode of self-harm consult their GP soon afterwards.[15]

1.21 Work undertaken by the London School of Economics has shown that suicide prevention education for GPs can have an impact as a population-level intervention to prevent suicide. This has the potential to be cost-effective if it leads to adequate subsequent treatment. See www2.lse.ac.uk/businessAndConsultancy/LSEEnterprise/news/2011/healthstrategy.aspx

1.22 Appropriate training on suicide and self-harm should be available for staff working in schools and colleges, emergency departments, other emergency services, primary care, care environments and the criminal and youth justice systems.

Helpful resources

1.23 Clinicians can use the NICE self-harm pathway, which summarises both short and long term self-harm guidance using a flowchart based approach: www.pathways.nice.org.uk/pathways/self-harm

1.24 NICE has developed two sets of clinical practice guidelines on self-harm for the NHS in England, Wales and Northern Ireland:

- on the short-term management and secondary prevention of self-harm in primary and secondary care (see http://publications.nice.org.uk/self-harm-cg16); and
- on the longer-term management of self-harm. It includes recommendations for the appropriate treatment for any underlying problems (including diagnosed mental health problems). It also covers the longer-term management of self-harm in a range of settings (see http://publications.nice.org.uk/self-harm-longer-term-management-cg133).

1.25 The National CAMHS Support Service produced a self-harm in children and young people handbook and an e-learning package, to provide basic knowledge and awareness of self-harm in children and young people, with advice about ways staff in children's services can respond. www.chimat.org.uk/resource/view.aspx?RID=105602

National action to support local approaches

1.26 NICE quality standards are under development on self-harm in adults and children and young people.

1.27 The Royal College of GPs will focus on strengthening training in mental health as part of the GP training programme,

both within current arrangements and as they develop the case for enhanced (four year) training.

People in contact with the criminal justice system

- People at all stages within the CJS, including people on remand and recently discharged from custody, are at high risk of suicide. The period of greatest risk is the first week of imprisonment.[16] However, recent figures suggest that risk of self-inflicted death has decreased in the first week of custody (Ministry of Justice, Safety in Custody Statistics).

- Reasons for the increased risk include the following:
  - a high proportion of offenders are young men, who are already a high suicide risk group. However, the increase in suicide risk for women prisoners is greater than for men;
  - an estimated 90% of all prisoners have a diagnosable mental health problem (including personality disorder) and/or substance misuse problems; and
  - offenders can be separated from their family and friends, whose social support may help to guard against suicidal feelings.

- The three-year average annual rate of self-inflicted deaths* by prisoners in England was 69 deaths per 100,000 prisoners in 2009-2011. This has decreased year-on-year since 2004 when it was 132 deaths per 100,000 prisoners.

Effective local interventions

1.28 Details of proposals to improve mental health outcomes for people in contact with the CJS are given in *No health without Mental Health: Delivering better mental health outcomes for people of all ages*.
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123737

National action to support local approaches

1.29 The National Offender Management Service (NOMS) has a broad, integrated and evidence-based strategy[17] for suicide prevention and self-harm management, and is committed to reducing the number of self-inflicted deaths in prison custody. The Youth Justice Board is taking a similar approach to reduce the number of self-inflicted deaths in the Young Person's Secure Estate. Each death is investigated by the Prisons and Probation Ombudsman.

1.30 The National Safer Custody Managers and Learning Team was established in 2009. The National Safer Custody Managers provide deputy directors of custody with advice on safer custody policies and other areas where they have a direct link to the delivery of safer custody. Strenuous efforts are made to learn from each death and improve understanding of and procedures for caring for prisoners at risk of suicide or self-harm.

1.31 Since the introduction of mental health in-reach services, the Integrated Drug Treatment System and Assessment, Care in Custody and Teamwork procedures into prisons there has been a reduction in self-inflicted deaths in prison custody.

* Prisoner 'self-inflicted deaths' include all deaths where it appears that a prisoner has acted specifically to take their own life. Approximately 80 per cent of these deaths receive a suicide or open verdict at inquest. The remainder receive an accidental or misadventure verdict.

1.32 The Department of Health, NOMS and University of Oxford Centre for Suicide Research are funding an analysis of all self-harm data based on incidents from 2004 to 2009. This will inform the development of more effective ways of identifying, managing and reducing the risk of those prisoners who self-harm.

1.33 The Health and Criminal Justice Transition Programme Board is overseeing a programme to provide police custody suites and criminal courts with access to liaison and diversion services by 2014. These services will be open and accessible to people of all ages, whether they have a mental health problem, learning disability, personality disorder, substance misuse issue or other vulnerability. They will provide early identification of individuals, allow the police and courts to understand as much as possible about the individual, and inform offender management and rehabilitation. For people in the criminal justice system with mental health needs, the aim is to ensure that they receive treatment in the most appropriate setting, whether in prison, secure mental health services, or in the community.

1.34 A study commissioned by the Independent Police Complaints Commission found that deaths in or following police custody, particularly those as a result of hanging, reduced significantly between 1998-99 and 2008-09. The study report identified improvements in cell design, identification of ligature points, risk assessments and Safer Detention guidance as all possibly contributing to the reduction.
www.ipcc.gov.uk/Pages/deathscustodystudy.aspx

Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers

- Some occupational groups are at particularly high suicide risk. Nurses, doctors, farmers, and other agricultural workers are at highest risk, probably because they have ready access to the means of suicide and know how to use them.

- Research[18] shows that these patterns of suicide are broadly unchanged. Among men, health professionals and agricultural workers remain the groups at highest risk of suicide. However, other occupational groups have emerged with raised risks. The highest numbers (not rates) of male suicides were among construction workers and plant and machine operatives.

- Among women, health workers, in particular doctors and nurses, remained at highest suicide risk.

1.35 This strategy maintains the focus on the highest risk occupational groups but recognises the potential vulnerability of other occupational groups.

Effective local interventions

1.36 Risk by occupational group may vary regionally and even locally. It is vital that the statutory sector and local agencies are alert to this and adapt their suicide prevention interventions and strategies accordingly. For example, GPs in rural areas, aware of the high rates of suicide in farmers and agricultural workers, will be well prepared to assess and manage depression and suicide risk.

The Practitioner Health Programme, funded by London primary care trusts, offers a free, confidential service for doctors and

dentists who live or work in the London area. www.php.nhs.uk/what-to-expect/how-can-i-access-php

MedNet is funded by the London Deanery and provides doctors and dentists working in the area with practical advice about their career, emotional support and, where appropriate, access to brief or longer-term psychotherapy. www.londondeanery.ac.uk/var/support-for-doctors/MedNet

Helpful resources

1.37 The Department for Environment, Food and Rural Affairs has a number of measures in place to support rural workers aimed at easing some of the stresses which are known to adversely affect farmers, agricultural workers and their families. These include specific support on bovine tuberculosis to the Farm Crisis Network. The Task Force on Farming Regulation aims to reduce some of the bureaucratic burden on farmers.

Rural Stress Helpline offers a confidential, non-judgemental listening service to anyone in a rural area feeling troubled, anxious, worried, stressed or needing information. Helpline 0845 094 8286 (Mon-Fri 9am-5pm); email help@ruralstresshelpline.co.uk

1.38 The Department of Health published *Maintaining high professional standards in the modern NHS* (2003) with additional guidance (2005) on handling concerns about a practitioner's health. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4103586

1.39 In 2008, The Department of Health published *Mental health and Ill health in Doctors*. This identifies a number of sources of help and recognises that many of the issues are very similar for other health professionals. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_083066

1.40 *NHS Health and Wellbeing Improvement Framework*, published in 2011, is a tool for decision makers on Boards to support them in establishing a culture that promotes staff health and wellbeing. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128691

1.41 The Police Service proactively manages staff wellbeing to try to avoid individuals becoming unwell due to mental health problems such as depression, anxiety or post-traumatic stress disorder. Police officers and staff can access services through their line management, Occupational Health Departments or often via self-referral.

2. Area for action 2: Tailor approaches to improve mental health in specific groups

2.1 As well as targeting high-risk groups, another way to reduce suicide is to improve the mental health of the population as a whole. The measures set out in both *No health without mental health* and *Healthy Lives, Healthy People* will support a general reduction in suicides by building individual and community resilience, promoting mental health and wellbeing and challenging health inequalities where they exist.

2.2 For this whole population approach to reach all those who might need it, it should include tailored measures for groups with particular vulnerabilities or problems with access to services. They are groups of people who may have higher rates of mental health problems including self-harm. These are not discrete groups, and many individuals may fall into more than one of these groups, for example, some Black and minority ethnic (BME) groups are more likely to have lower incomes or be unemployed; children and young people may also fall into several other of these groups. The groups identified are:

- children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the YJS;
- survivors of abuse or violence, including sexual abuse;
- veterans;
- people living with long-term physical health conditions;
- people with untreated depression;
- people who are especially vulnerable due to social and economic circumstances;
- people who misuse drugs or alcohol;
- lesbian, gay, bisexual and transgender people; and
- Black, Asian and minority ethnic groups and asylum seekers.

2.3 For many of these groups we do not have sufficient information about numbers of suicides or about what interventions might be helpful. The requirements for improved information and research are considered further under area for action 6.

Children and young people, including those who are vulnerable such as looked after children, care leavers and children and young people in the YJS

- The suicide rate among teenagers is below that in the general population.[19] However, young people are vulnerable to suicidal feelings. The risk is greater when they have mental health problems or behavioural disorders, misuse substances, have experienced family breakdown, abuse, neglect or mental health problems or suicide in the family. The risk may also increase when young people identify with people who have taken their own life, such as a high-profile celebrity or another young person.

- Self-harm is particularly common among young people.[20]

- Children and young people in the youth justice system experience many of the same risk factors as adults in the criminal justice system. Since January 2002, six young

people in custody in the Young Person's Secure Estate have killed themselves.

- Looked after children and care leavers are between four and five times more likely to self-harm in adulthood. They are also at five-fold increased risk of all childhood mental, emotional and behavioural problems and at six to seven-fold increased risk of conduct disorders.

Effective local interventions

2.4 The non-statutory programmes of study for Personal, Social, Health and Economic (PSHE) education provide a framework for schools to provide age–appropriate teaching on issues including sex and relationships, substance misuse and emotional and mental health. This and other school-based approaches may help all children to recognise, understand, discuss and seek help earlier for any emerging emotional and other problems.

2.5 The consensus from research is that an effective school-based suicide prevention strategy would include:

- a co-ordinated school response to people at risk and staff training;
- awareness among staff to help identify high risk signs or behaviours (depression, drugs, self-harm) and protocols on how to respond;
- signposting parents to sources of information on signs of emotional problems and risk;
- clear referral routes to specialist mental health services.

2.6 The Healthy Child Programme 0-19, led by front line health professionals, focuses on health promotion, prevention and early intervention with vulnerable families. Health visitors and their teams will identify children at high risk of emotional and behavioural problems and ensure that they and their families receive appropriate support, including referral to specialist services where needed. Preventing suicide in children and young people is closely linked to safeguarding and the work of the Local Safeguarding Children Boards. Professor Munro's review of child protection (2011) made 15 recommendations to reform the system. The review emphasised the importance of evidence-based early interventions and recommended that help is provided early to children and families in order to negate the impact of abuse and neglect and to improve the life chances of children and young people. In response, the Government is working with partners to reinforce the existing legislation and revise statutory guidance, and to understand better how to make progress on early help. Inspections of child protection services will assess local provision of early help.

2.7 Local services can develop systems for the early identification of children and young people with mental health problems in different settings, including schools. Stepped-care approaches to treatment, as outlined in NICE guidance, can be effective when delivered in settings that are appropriate and accessible for children and young people. The Department of Health's *You're Welcome* quality criteria self-assessment toolkit may be helpful in ensuring that services and settings are genuinely acceptable and accessible to children and young people.

2.8 The specialist early intervention in psychosis model of community care has achieved better outcomes than generic community mental health teams for young people aged 14–35 in the early phase of severe mental illness, achieving faster and more lasting recovery. The impact of early intervention on suicide is under investigation, but it is clear that suicide in young patients has decreased in recent years.[21]

2.9 It is particularly important that interventions for children and young people who offend, and for other vulnerable children and young people in the area, are both easily accessible and engaging. This requires outreach, flexible wraparound support and persistence, so that sessions can continue, even in the face of barriers to engagement.[22] In all forms of custodial or secure settings, including detention, continuous attention is needed to minimise a young person's sense of isolation from home and family and workers should be proactive in responding to their mental health needs. What young people in these circumstances value highly from professionals is knowing that someone will listen to them and be interested in their concerns.

Helpful resources

2.10 Stonewall's Education for All campaign, works to tackle homophobic bullying in Britain's schools, and has a lot of resources. www.stonewall.org.uk/at_school/education_for_all/default.asp

2.11 Beatbullying is a UK-wide bullying prevention charity, and has developed a large range of anti-bullying teaching resources to help raise awareness of bullying in all its forms and help children to keep safe. They are available free at: www.beatbullying.org/dox/resources/resources.html

National action to support local approaches

2.12 *No health without mental health* and *No health without mental health: Delivering better mental health outcomes for people of all ages* include local and national interventions to improve the mental health of children and young people. Interventions include effective school-based approaches to tackling violence and bullying and sexual abuse. They also cover effective approaches to identifying children who are at risk and the specific needs of looked after children and care leavers.

2.13 We are also extending access to psychological therapies for children and young people. Building on the learning from the Improving Access to Psychological Therapies (IAPT) initiative for adults, a rolling national programme with a strong focus on outcomes will seek to transform local child and adolescent mental health services, equipping them to deliver a broader range of evidence-based psychological therapies for children and young people and their families.

2.14 Additional investment will extend both the geographical reach and range of therapies offered through the Children and Young People's IAPT project. It will also support development of interactive e-learning programmes in child mental health to extend the skills and knowledge of:

- NHS clinicians;

- a wide range of people working with children and young people in universal settings including teachers, social workers, police and probation staff and faith group workers;
- school and youth counsellors working in a range of educational settings.

2.15 The new e-portal will include specific learning and professional development in relation to self-harm, suicide and risk in children and young people.

2.16 The Children and Young People's Health Outcomes Strategy will identify the health outcomes that matter most to children, young people and their families and set out how the system will contribute to their delivery. Children and young people's mental health outcomes – including those in relation to suicide and self-harm – was one of four key areas considered by the Children and Young People's Health Outcomes Forum. The Forum's report[23], published in July, and the system's response to their recommendations will be key components within a Children And Young People's Health Outcomes Strategy, which will be published in autumn 2012.

Survivors of abuse or violence, including sexual abuse

- One in four people in England has experienced some form of violence or abuse in their lifetime, and almost half of all children have been the victims of bullying. Women and children are most at risk of domestic and sexual violence.

- Violence and abuse can lead to a number of psychosocial problems associated with a heightened suicide risk, including: social isolation and exclusion; poor educational achievement; conduct, behavioural and emotional problems in children, and antisocial and risk-taking behaviours. Violence and abuse are also associated with a higher risk of mental health problems and suicidal feelings.

- Adverse and abusive experiences in childhood are associated with an increased risk of suicidal behaviour.[24]

Effective local interventions

2.17 Timely and effective assessment of all vulnerable children is crucial to speedy identification and referral to appropriate support services. Screening tools such as the Strengths and Difficulties Questionnaire (SDQ) can help to prioritise referrals to local CAMHS.

2.18 A training and support programme targeted at primary care clinicians and administrative staff improved referral to specialist domestic violence agencies and recorded identification of women experiencing domestic violence.
www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61179-3/abstract

Leicestershire Police have a Comprehensive Referral Desk (CRD) of specialist officers who deal with domestic abuse, child abuse and adults in vulnerable situations. Each report from front-line officers and other agencies is assessed and dealt with by referral onto other agencies or by providing an appropriate police response to any criminal allegations or safeguarding issues. The CRD has led to improved joint working with health and other agencies. Through partnership working, the CRD

tries to reduce the likelihood of the same individuals being in situations of threat, harm or risk in the future.

National action to support local approaches

2.19 *Call to End Violence against Women and Girls (2010),* a cross-government strategy, has been followed by two cross-government action plans – the latest of which was published in March 2012. It includes actions around preventing violence, provision of services, partnership working, justice outcomes and risk reduction. The Government's continued support for Independent Sexual Violence Advisers, Independent Domestic Violence Advisers and Multi Agency Risk Assessment Conferences aims to ensure that women and girls at highest risk of violence are identified and referred for specialist help. Data sharing between emergency departments and other agencies is being encouraged to improve the identification of violence.

Helpful resources

2.20 The RCGP has produced an e-learning resource for GPs to enable them to identify and respond to victims of domestic violence more effectively. www.elearning.rcgp.org.uk/course/view.php?id=88

2.21 Southall Black Sisters have developed a model of intervention on domestic violence amongst Black and Minority Ethnic women.[25]

Veterans

- There are five million armed forces veterans in the UK and around 180,000 serving personnel. The prevalence of mental disorders in serving and ex-service personnel is broadly the same as that in the general population. Depression and alcohol abuse are the most common mental disorders. The most recent research found that one in four veterans from the Iraq War experienced some kind of mental health problem and one in 20 had been diagnosed with post-traumatic stress disorder.

- In general, suicide rates among armed forces veterans are lower than those in the general population. There is no evidence that, as a whole, people who have served their country in armed conflict are at higher risk of suicide. An important possible exception is young armed-service leavers in their early 20s. One study suggests they may be at two or three times' greater risk of suicide than comparable groups.[26]

2.22 *No health without mental health: Delivering better mental health outcomes for people of all ages* outlines all the Government's commitments to improving mental health support for service and ex-service personnel.

People living with long-term physical health conditions

- Some long-term conditions are associated with an increased risk of suicide, e.g. epilepsy. There is also evidence that receiving a diagnosis of cancer, coronary heart disease and chronic obstructive airways disease is associated with higher suicide risk. For cancer, the risk of suicide increases by more than ten times in

the week after diagnosis.

- Physical illness is associated with an increased suicide risk.[27] Many people who live with long-term conditions - including physical illness, disability and chronic pain – will, at some time, experience periods of depression that may be undiagnosed and untreated. Disadvantage and barriers in society for disabled people can lead to feelings of hopelessness. People with one long-term condition are two to three times more likely to develop depression than the rest of the general population. People with three or more conditions are seven times more likely to have depression. Many medical treatments for long-term physical health conditions (for example, chronic pain medication, insulin treatment) also provide people with ready access to the means of suicide.

- While depression explains a substantial part of the increased suicide risk in people with physical health conditions, it does not explain all of the increase.

2.23 *No health without mental health* is clear that we expect mental health needs to be given equal consideration to physical health needs.

Effective local interventions

2.24 Support for self-management and self-care is crucial, for example, in managing chronic pain, so that people have a greater sense of choice over how their health and care needs are met, feel more confident to manage their condition on a day-to-day basis and take an active part in their care. Feeling in control of one's life is associated with increased mental wellbeing and resilience.

2.25 Routine assessment for depression as part of personalised care planning can help reduce inequalities and support people with long-term conditions to have a better quality of life and better social and working lives.

2.26 Suicide can occur in general hospitals. Providers need to be aware of this risk, and to make appropriate links between physical and mental health care.

2.27 *No health without mental health: Delivering better mental health outcomes for people of all ages* outlines a number of local approaches to improve the mental health care of people with physical health problems.

Helpful resources

2.28 The NPSA has produced suicide prevention toolkits for ambulance services, general practice, emergency departments and community mental health and mental health services. The toolkits support clinicians and managers to understand what they can do to reduce the suicides. www.nhsconfed.org/Publications/briefings/Pages/Preventing-suicide.aspx

National action to support local approaches

2.29 *Talking Therapies: A four year plan of action (*2011) sets out the Government's plans to improve access to talking therapies and expand provision for children and young people, older people and their carers, people with long-term

physical health conditions, people with medically unexplained symptoms and people with severe mental illness.

2.30 The Office for Disability Issues (ODI) is developing a new cross-government disability strategy in partnership with disabled people and their organisations. Together, they are identifying effective ways to remove the barriers that prevent disabled people, including those with mental health conditions, from fulfilling their potential and having opportunities to play a full role in society. In September we will publish a summary of responses to *Fulfilling Potential*, including current and planned actions across government. We will also outline the next steps based upon the issues and ideas disabled people have told us about. We will publish a strategy and action plan in 2013.

2.31 The Department of Health's long-term conditions model aims to improve the health and wellbeing of people with long-term conditions such as diabetes. The Department is also developing a Long Term Conditions Outcomes Strategy for publication towards the end of 2012 which will outline a vision for how Government can work with local bodies to improve outcomes for people with long-term conditions.

2.32 The Government has recently published the White Paper *Caring for our future: reforming care and support*[28], following extensive engagement with the care sector over recent months. This sets out the Government's vision for reform of care and support, with a renewed focus on high quality, personalised and joined up care, supporting people to maintain independence for as long as possible and have choice and control over how their outcomes are met.

People with untreated depression

- Depression is one of the most important risk factors for suicide and undiagnosed or untreated depression can heighten that risk. Most depression can be treated in primary care.

- Depression is now recognised as a major public health problem worldwide. In England one in six adults and one in 20 children and young people at any one time are affected by depression and related conditions, such as anxiety. Depression is the most common mental health problem in older people - some 13-16% have sufficiently severe depression to need treatment. But only a quarter (or even fewer young and older people) receive treatment, even though effective drug and psychological treatments are available.

- Untreated depression can have a major impact on quality of life and can cause other health and social care problems - for example, postnatal depression can be associated with behavioural problems in the child. There are also risks in the early stages of drug treatment when some patients feel more agitated.

- Depression, chronic and painful physical illnesses, disability, bereavement and social isolation are more common among older people.

Men aged 75 and over have the highest rate of suicide among older people. While suicide rates among older people have been decreasing in recent years, an increase in absolute numbers is expected in the coming decades, due to the increase in number of older people.

Effective local interventions

2.33 People recover more quickly from depression if it is identified early and responded to promptly, using effective and appropriate treatments.

2.34 *No health without mental health: Delivering better mental health outcomes for people of all ages* identifies effective local approaches to treating depression and outlines some effective approaches for 'ageing well'.

Helpful resources

2.35 NICE issued updated guidance on *Depression: Management of depression in primary and secondary care* in 2009 and *Depression in Children and Young People: Identification and management in primary, community and secondary care* in 2005. NICE has also published a quality standard on depression, including with a chronic physical health problem.

2.36 Depression Alliance has produced leaflets on depression and an information pack. www.depressionalliance.org

2.37 The Staffordshire University Centre for Ageing and Mental Health has developed a set of information sheets to help health and social care providers respond to suicide risk in older clients: www.wmrdc.org.uk/mental-health/primary-care/suicide-prevention-in-elders-project-summary

2.38 The Department of Health has funded multi-centre research on suicide prevention[29] which has produced useful recommendations for services working with older people. It found that older adults who self-harm are at high risk of suicide, with men aged over 75 years at greatest risk. Use of a violent method in the first attempt is also a predictor of subsequent suicide. Alcohol dependency is also common among older adults who attempt suicide.

2.39 *Caring for our future* sets out how supporting active and inclusive communities, and encouraging people to use their skills and talents to build new friendships and connections, are central elements to the Government's new vision for care and support. The Department of Health has supported the Campaign to End Loneliness to produce a digital toolkit for health and wellbeing boards to support them in understanding, and addressing loneliness and social isolation in their communities: www.campaigntoendloneliness.org.uk/toolkit

2.40 The Department of Health, the Royal Colleges of General Practice, Nursing and Psychiatry and the British Psychological Society have developed a fact sheet on depression in older people: www.rcgp.org.uk/mentalhealth/resources.aspx

People who are especially vulnerable due to social and economic circumstances

- There are direct links between mental ill health and social factors such as unemployment and debt. Both are risk factors for suicide.
- Previous periods of high unemployment and/or severe economic problems have been accompanied by increased incidence of mental ill health and higher suicide rates.[30]
- Suicide risk is complex – we do need to be vigilant at this time of higher economic uncertainty, but it is important not to assume that an increase in suicide is inevitable.
- 34% of rough sleepers have a mental health need and 18% have a mental health need combined with a substance misuse issue (dual diagnosis).

Effective local interventions

2.41 A range of front-line agencies, including primary and secondary health and social care services, local authorities, the police and Jobcentre Plus, can identify and support (or signpost to support) vulnerable people who may be at risk of suicide. As the Government's strategy *Social Justice: Transforming Lives* also makes clear, for individuals and families facing multiple social or economic disadvantages, it is really important that these local agencies 'join up' to maximise the effectiveness of services and support. www.dwp.gov.uk/docs/social-justice-transforming-lives.pdf

2.42 Interventions that improve financial capability reduce both the likelihood of people getting into debt and the impact of debt on mental health. Local services include Citizens Advice, the Money Advice Service at: www.moneyadviceservice.org.uk and the Consumer Credit Counselling Service: www.cccs.co.uk/Home.aspx. Credit unions can provide affordable credit to and encourage saving by the most disadvantaged families.

2.43 Other useful approaches at a local level include:

- continuously improving the knowledge and confidence of front-line staff who are in regular contact with people who may be vulnerable because of social/economic circumstances. This is particularly relevant to DWP front-line businesses including Jobcentre Plus staff, people working in other advice and support agencies and front-line staff in the financial sector (banks, building societies and utility companies);
- providing public information to signpost people to information, support and useful contacts if they are in debt or at risk of getting into debt. Information can be provided in a number of different ways, for example online and accessible leaflets. A number of NHS trusts have developed information sheets for the local population on the impact of the economic crisis - these give advice on maintaining wellbeing during difficult times and offer guidance on where to go for further help; and
- developing suicide awareness and education or training programmes to teach people how to recognise and respond to the warning signs for suicide in themselves or in others. These can be delivered in a variety of settings (such as schools, colleges,

workplaces and job centres). There are several training programmes available including Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid, Safe Start and training carried out by Samaritans.

2.44 DWP has guidance in place to help their staff to manage suicide and self-harm declarations from customers safely and effectively, for themselves and the customer.

2.45 Businesses and other employers can help by investing in and supporting their staff, particularly during times of anxiety and change.

National action to support local approaches

2.46 *No health without mental health: Delivering better mental health outcomes for people of all ages* gives examples of effective national approaches to support people back into employment and improve their financial capability and to support employers to meet their business needs and statutory requirements for healthy workplaces.

2.47 The Government's Work Programme supports people who are out of work to gain and sustain paid employment. This includes providing tailored support for people with mental health conditions to work. Work Programme Prime providers and specialist service providers have pledged to improve support to people with mental health problems; an approach endorsed by voluntary and community organisations.

2.48 We are replacing a wider range of financial benefits with a single Universal Credit which will ensure that people are always better off in work. The new system will be much simpler to administer and easier for claimants to understand. It will help people to get back to work gradually and smooth over earnings fluctuations where hours of work and income can vary.

2.49 The Government is committed to preventing and reducing homelessness, and improving the lives of those people who do become homeless. The Ministerial Working Group (MWG) on Preventing and Tackling Homelessness is bringing the relevant government departments together to share information, resolve issues and avoid unintended policy consequences, with the aim of enabling communities to tackle the multifaceted issues that contribute to homelessness. The MWG produced its first report *A Vision to End Rough Sleeping: No Second Night Out* in 2011 and is working on its second report on preventing homelessness, to be published later this year. www.communities.gov.uk/publications/housing/visionendroughsleeping

People who misuse drugs or alcohol

- Many people with drug and alcohol dependence problems also have some form of mental health problem.[3132] Similarly, about half of people with mental health problems misuse alcohol and/or drugs. Dual diagnosis (co-morbidity of drug and alcohol misuse and mental ill health) is associated with increased risk of suicide and suicide attempts.

- The use of drugs or alcohol is strongly associated with suicide in the general population and in sub-groups such as young men and

people who self-harm.

- For some people, their dependence is on prescribed drugs such as tranquilisers, and they may experience agitation on withdrawal and co-morbid mental health problems which may add to their risk.
- Smoking and nicotine dependence are associated with suicidal behaviour. There is no evidence to suggest that smoking cessation increases suicide risk.

Effective local interventions

2.50 Measures that reduce alcohol and drug dependence are critical to reducing suicide. That is why the 2010 drug strategy, *Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug-free life*, put the goal of recovery at its heart. It aims to create a recovery system that is locally led and locally owned enabling prompt access to treatment, helping people to realise the goal of recovery and ensuring appropriate aftercare to help people lead fulfilling lives.

2.51 Close working between mental health teams and local NHS stop smoking services should deliver cessation treatment strategies that complement recovery. Bupropion[33] should not be used to treat people at risk of suicide and care should be taken if varenicline[34] is prescribed.

National action to support local approaches

2.52 *Reducing Demand, Restricting Supply, Building Recovery* highlights the importance of holistic support to enable people to rebuild their lives and play their full role in society. The transfer to local authorities of responsibility for commissioning treatment for dependence on drug and alcohol will help local systems to develop effective links between treatment, housing services, criminal justice bodies, training and the wider support that is needed.

2.53 The Government Alcohol Strategy (2012) is explicitly targeted at harmful drinkers, problem pubs and irresponsible shops and sets out radical plans to turn the tide against irresponsible drinking. Chapter 3 of the Alcohol Strategy sets out how local communities and services can tackle alcohol-related issues in their area.

2.54 The NICE guidelines on management of anxiety[35] and treatment and management of depression[36] state that treatment with benzodiazepine (where appropriate) should usually be for no longer than two weeks in order to prevent the development of dependence.

Lesbian, gay, bisexual and transgender people

- A review of the research literature suggests that lesbian, gay and bisexual people are at higher risk of mental disorder, suicidal ideation, substance misuse and deliberate self-harm.[37] One Danish study found the suicide risk among gay men in civil partnerships is eight times higher than in heterosexual couples and twice as high as the risk in men who have never married. However, the same study showed no statistically significant increase in suicide risk among women in civil partnerships.[38]

- Lesbian, gay and bisexual people are twice as likely as heterosexual people to self-harm. Gay and bisexual men have a particularly high prevalence of self-harm. One in ten gay and bisexual men aged 16 to 19 have attempted to take their own life in the last year.[39]
- There are indications that transgender people may have higher rates of mental health problems and higher rates of self-harm.

Effective local interventions

2.55 Staff in primary and secondary health care, social services, education and the voluntary sector need to be aware of the higher rates of mental distress, substance misuse, suicidal behaviour or ideation and increased risks of self-harm in these groups.

National action to support local approaches

2.56 PACE, the lesbian, gay, bisexual and transgender (LGBT) voluntary sector research, counselling and advocacy organisation, has published *Where to Turn*, a review of web-based mental health promotion and preventive information, support and advice services for LGBT people. www.pacehealth.org.uk/Where%20To%20Turn%20-%20Final%20Full%20Report.pdf

2.57 Local services and external partners working with LGBT groups and individuals may find the findings and conclusions in *Where to Turn* helpful when planning and delivering mental health promotion, substance misuse and other support and advice services for LGBT people.

2.58 *Working for Lesbian, Gay, Bisexual and Transgender Equality: Moving Forward* (2011) sets out specific actions that will be taken across government, including actions on health and social care issues. www.homeoffice.gov.uk/publications/equalities/lgbt-equality-publications/lgbt-action-plan?view=Binary

2.59 *Advancing transgender equality: A plan for action* (2011) sets out specific actions that will be taken across government to advance transgender equality. www.homeoffice.gov.uk/publications/equalities/lgbt-equality-publications/transgender-action-plan

Black, Asian and minority ethnic groups and asylum seekers

- The evidence on the incidence of mental health problems in Black, Asian and minority ethnic groups is complex. This term covers many different groups with very different cultural backgrounds, socioeconomic status and experiences in wider society. People from Black, Asian and minority ethnic groups often have different presentations of problems and different relationships with health services. Some Black groups have admission rates around three times higher than average, with research showing that some BME groups have high rates of severe mental illness, which may put them at high risk of suicide. The rates of mental health problems in particular migrant groups, and subsequent generations, are also sometimes higher. For example, migrant groups and their children are at two to eight times greater risk of psychosis. More recent arrivals, such as some asylum seekers and refugees, may also require mental health support following their experiences in their home countries.

- There is little evidence on suicide risks in Black, Asian and other minority ethnic groups, as information on ethnicity is currently not collected through the death registration and inquest processes. This is a major obstacle to getting reliable and accurate data on suicides and to improving the evidence base and monitoring trends.

- In 2006, *Suicide prevention for BME groups in England*, summarised the literature and identified areas for future research. The message remains that we need more and better information about prevention and risk factors among different ethnic groups.
www.nmhdu.org.uk/silo/files/executive-summary-suicide-prevention-for-bme-groups-in-england.doc

Effective local interventions

2.60 The Delivering Race Equality in Mental Health Care action plan has improved understanding of BME communities' mental health needs and their attitudes towards and beliefs about mental health and mental health services. The final report on the programme describes examples of good practice in reaching out to minority ethnic groups and demonstrates the value of community initiatives aimed at bridging the gap between statutory services and BME communities. It also shows how this community development approach, working across sectors and in partnership with communities, can be effective in tackling inequalities in health and access to services.

2.61 The Count Me In 2010 census[40] showed little change from those reported for previous years. Although the numbers of mental health inpatients overall have fallen since 2005, ethnic differences in rates of admission, detention under the Mental Health Act and seclusion have not altered materially since the inception of the Delivering Race Equality action plan in 2005.

2.62 Healthcare staff coming into contact with asylum seekers and refugees should be aware of the following:

- The prevalence of suicidal behaviour, suicide and self-harm among refugees and asylum seekers is difficult to ascertain. Official statistics are not readily available and data may come from unofficial sources such as the media and personal accounts.

- Social isolation, language barriers, racism, homophobia and legal uncertainties about the future may be experienced by asylum seekers and lead to depression. Factors such as differing cultural perceptions of mental illness and stigma associated with mental illness/suicide may then stop treatment being sought.

- Some asylum seekers could be suffering from post-traumatic stress disorder and severe depression caused by their experiences in their home countries, although it is difficult to gauge the number of people who will be affected in this way. Not all mental health and suicide prevention services may be geared to meet these needs and specialised help may be more appropriate.

National action to support local approaches

2.63 A Ministerial Working Group on Equality in Mental Health has been established to ensure that equality issues directly inform strategy implementation. Its initial priority is to tackle race inequality in particular, but it also aims to ensure that the full obligations of the Equality Act 2010 are met.

2.64 Asylum applications in the UK were at their lowest in 2010 at 17,790, excluding dependents, since a peak in 2002 of 84,130. The UK Border Agency is, however, considering whether its ability to identify individuals at risk of suicide or self-harm, and to refer them to the appropriate services, could be improved.

3. Area for action 3: Reduce access to the means of suicide

3.1 One of the most effective ways to prevent suicide is to reduce access to high-lethality means of suicide. This is because people sometimes attempt suicide on impulse, and if the means are not easily available, or if they attempt suicide and survive, the suicidal impulse may pass.[41][42]

3.2 Suicide methods most amenable to intervention are:

- hanging and strangulation in psychiatric inpatient and criminal justice settings;
- self-poisoning;
- those at high-risk locations; and
- those on the rail and underground networks.

It is also important to be vigilant and respond to new or unusual suicide methods.

3.3 The media has an important role in avoiding reporting and portraying new high-lethality methods of suicide, that may increase the number of fatal suicide attempts. The internet is a ready source of detailed information concerning the use of lethal suicide methods (see area for action 5).

Reduce the number of suicides as a result of hanging and strangulation

- The most common method of suicide for men and women is hanging and strangulation.[43] Hanging and strangulation also continues to be the most common method of suicide among mental health inpatients and prisoners.

Effective local interventions

3.4 Inpatient suicides as a whole have reduced since 2004: the removal of non-collapsible fittings has resulted in no inpatient suicides as a result of hanging from non-collapsible bed or shower curtain rails, and the total number of deaths by hanging has fallen by more than half. Inpatient suicide using non-collapsible rails is a 'Never Event'*.

3.5 Paragraphs 1.11-1.15 outline approaches which will help mental health service providers to reduce suicide risk.

3.6 Hanging accounts for over 90% of self-inflicted deaths in custody. In prison, access to certain methods will be severely restricted and this may contribute to the choice of hanging as a method. Safer cells are one example of facilities that can be used in the care of prisoners. Safer cells are designed to make the act of suicide or self-harm by ligaturing as difficult as possible, mainly by reducing ligature points. The design also takes account of the need to create not only a safer and robust environment, but also a more normalising one. However, no cell can be considered totally 'safe'. Safer cells can complement (but not replace) a regime providing care for at-risk prisoners and can reduce risks associated with impulsive acts.

* Never events are serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

National action to support local approaches

3.7 A recent Department of Health study[44] found that people choose hanging as a method of suicide because they mistakenly think it is quick, tidy and effective. These findings have important implications for suicide prevention work and the National Suicide Prevention Strategy Advisory Group will consider how best to respond to these findings.

Reduce the number of suicides as a result of self-poisoning

- Self-poisoning accounts for approximately a quarter of all suicide deaths in England. It is the second most common method of suicide in both men and women and was, until 2008, the most common method among women.

3.8 Significant progress has been made in reducing access to medications associated with suicide attempts, including:

- the phased withdrawal of co-proxamol, a prescription-only painkiller that was associated with 300–400 fatal deliberate or accidental drug overdoses a year in England and Wales alone. This reduced deaths from this cause, without evidence of a significant increase in deaths due to poisoning with other analgesics;[45] and

- the introduction in 1998 of legislation to limit the size of packs of paracetamol, salicyates and their compounds sold over the counter, supported by guidance on best practice in the sale of pain relief medication (MHRA, 2009). Restricting the availability of these medicines has led to a reduction in both deliberate and accidental overdoses.[46]

3.9 However, a substantial number of deaths still occur from paracetamol overdose. The MHRA has established an expert working group of the Commission on Human Medicines to review current guidelines for the management of paracetamol overdose.

3.10 Further consideration needs to be given to the prescribing of some toxic drugs, where safer alternative medicines are available.[47]

3.11 The National Institute for Health and Clinical Excellence (NICE) will be developing a quality standard on safe prescribing, as part of a library of approximately 170 NHS Quality Standards covering a wide range of diseases and conditions.

Reduce the number of suicides at high-risk locations

- Jumping from a high place is an important method of suicide to address. Suicides by jumping almost inevitably occur in public places, have a very high fatality rate and are extremely traumatic for witnesses and people living and working in the surrounding area. Jumps also tend to attract media attention, which can lead to copycat suicides. All the world's most notorious suicide locations are jumping sites.

- Locations that offer easily accessible means of suicide include vehicle and pedestrian bridges, viaducts, high-rise hotels, multi-storey car parks and other high buildings, and cliffs.

3.12 Most areas have sites and structures that lend themselves to suicide attempts.

Suicide risk can be reduced by limiting access to these sites and making them safer.[48]

3.13 Evidence suggests that loss of life can be prevented when local agencies work together to discourage suicides at high-risk locations, including sites that temporarily become suicide hot-spots following a suicide death.

Examples of effective local interventions

3.14 Effective approaches to reducing suicides at high-risk locations or from jumping include:

- preventative measures – for example barriers or nets on bridges, including motorway bridges, from which suicidal jumps have been made, and providing emergency telephone numbers, e.g. Samaritans;
- working with local authority planning departments and developers to include suicide risk in health and safety considerations when designing multi-storey car parks, bridges and high-rise buildings that may offer suicide opportunities;
- In care and hospital settings, environmental assessments should include assessing the risk of vulnerable patients accessing opening windows or balconies (see guidance in NHS Estates Health Technical Memorandum No 55 *Windows*); and
- working with local and regional media outlets to encourage responsible media reporting on suicide methods and locations (see area for action 5).

Helpful resources

3.15 *Guidance on Action to be Taken at Suicide Hotspots* (2006) supports local suicide prevention work, enabling responsible authorities to identify local places (for example bridges, cliffs, railway stations) where people who are thinking about suicide may be tempted to go. It identifies a number of evidence-based interventions that have proved effective. www.nmhdu.org.uk/nmhdu/en/our-work/promoting-wellbeing-and-public-mental-health/suicide-prevention-resources/

3.16 Work undertaken by the London School of Economics and the Institute of Psychiatry on behalf of the Department of Health includes a cost benefit analysis of bridge safety measures for suicide prevention, which would potentially also apply to other suicide hot-spots. See www2.lse.ac.uk/businessAndConsultancy/LSEEnterprise/news/2011/healthstrategy.aspx

3.17 *Falls from windows* provides HSE guidance to help organisations manage the risks of people using care services falling from windows or balconies. http://www.hse.gov.uk/healthservices/falls-windows.htm

Reduce the number of suicides on the rail and underground networks

- Suicide by jumping or lying in front of trains and other moving vehicles is similarly an important method to address. While suicide rates have been falling generally, suicide deaths on the railway network have increased slightly, to about 210 people a year in England, Scotland and Wales. Most (about 80%) are men and most are in the 15–44 age range. The RSSB and the British Transport Police collect extensive information on railway deaths and incidents, including suicides and

attempted suicides.

Examples of effective local interventions

3.18 The British Transport Police (BTP) and London Underground Limited (LUL) have worked closely with local services to reduce risk at transport-related suicide hotspots. LUL has provided staff training to help them identify people who may be considering suicide and engage with them in the hope that they can persuade them not to. This approach has helped reduce incidence of suicide at one London Underground station close to a psychiatric inpatient unit. The training is currently being rolled out across the London Underground network.

3.19 The British Transport Police recognises that suicide attempts provide an opportunity for interventions aimed at preventing an individual from repeating their attempt at a later date, with the aim to reduce the number of fatalities on the railway. BTP has developed a suicide prevention plan, which is completed for every "determined" attempt at suicide. It is a comprehensive record of information about the individual and the incident, supported by a menu of potential actions which could be taken according to the information available, in order to minimise the risk that the individual poses. In particular, it captures the contact details of any friends, relatives or any individuals who have assisted in reducing the person's risk of suicide (e.g. social worker, doctor, and psychiatrist) for future reference and to enable follow up enquiries regarding the individual's progress/wellbeing.

National approaches to support local actions

3.20 Samaritans and Network Rail have established a joint, five-year training, communications and outreach programme. Through joint working with partners including train operators and the British Transport Police, they aim to reduce suicides on the national rail network by 20%. The project was launched in January 2010 and is initially focused on those stations most affected by suicide.
www.samaritans.org.uk/support_samaritans/corporate_suppporters/network_rail/about_the_partnership.aspx

Respond to new methods of suicide

Effective local interventions

3.21 As well as understanding commonly used means of suicide, it is important to be vigilant and respond to new or unusual suicide methods and locations. Local services and external agencies may need to devise ways to ensure that they are provided promptly with information about the circumstances and methods of suicides either by the police following initial investigation of the death or through the coroner's office following the police report to the coroner.

National approaches to support local actions

3.22 The Government will work with the National Suicide Prevention Strategy Advisory Group to take a lead in identifying, monitoring and responding to new methods of suicide when they emerge.

4. Area for action 4: Provide better information and support to those bereaved or affected by suicide

4.1 To provide better information and support for those bereaved or affected by suicide we need to:

- provide support that is effective and timely;
- have in place effective local responses to the aftermath of a suicide; and
- provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide.

Provide effective and timely support for families bereaved or affected by suicide

- Family and friends bereaved by a suicide are at increased risk of mental health and emotional problems and may be at higher risk of suicide themselves.[49]
- Suicide can also have a profound effect on the local community. We know from studies that, in addition to immediate family and friends, many others will be affected in some way.[5051] They include neighbours, school friends and work colleagues, but also people whose work brings them into contact with suicide – emergency and rescue workers, healthcare professionals, teachers, the police, faith leaders and witnesses to the incident.
- There may be a risk of copycat suicides in a community, particularly among young people, if another young person or a high-profile celebrity dies by suicide.

Effective local interventions

4.2 Effective and timely emotional and practical support for families bereaved or affected by suicide is essential to help the grieving process, prevent further or longer-term emotional distress and support recovery. There is some evidence that referral to specialist bereavement counselling and other bereavement support can be helpful for people who actively seek it[52], although evidence for efficacy of interventions is currently limited[53]. It is important that GPs are vigilant to the potential vulnerability of family members when someone takes their own life.

4.3 Guidance that mental health trusts will have in place on how to deal with the suicide of a patient under the care of the mental health services may include information on preparing for the inquest and dealing with the family, carers and friends of the deceased, including the impact of the suicide and the inquest on the family. The need to be sensitive in their dealings with the family will continue if the clinical team have to attend an inquest.

Helpful resources

4.4 The Department of Health has recently reviewed and updated *Help is at Hand: A resource for people bereaved by suicide and other sudden, traumatic death*. This provides advice and information for anyone directly affected by suicide. It also has advice for people in contact with

those bereaved through suicide, either because of their work or because they are part of the same community. See www.nmhdu.org.uk/nmhdu/en/our-work/promoting-wellbeing-and-public-mental-health/suicide-prevention-resources/ or order from www.orderline.dh.gov.uk

4.5 This useful resource could be publicised more widely. A recent evaluation has shown that it is well received but that access to it can be a problem.[54] The Department of Health will continue to work with partners to get the document to people at the right time.

4.6 The Government has recently published the *Guide to Coroners and Inquests and Charter for Coroner Services* which has been provided to all coroners' courts. It will ensure that people have accessible, concise information on the processes and standards in a coroner inquiry, and setting out the standards in a single document will also improve consistency across the coroner system.
www.justice.gov.uk/downloads/burials-and-coroners/guide-charter-coroner.pdf

4.7 INQUEST, a charity which provides advice and support to bereaved people on the inquest process, has developed *The Inquest Handbook: A guide for bereaved families, friends and their advisors*. This booklet includes specialist sections dealing with deaths in police or prison custody and when detained under the Mental Health Act 1983.

4.8 There are other sources of support, information and advice that may be helpful both for people directly affected by suicide and also for use when training and supporting staff whose work brings them into contact with suicide. They include:

- *The Road Ahead… A guide to dealing with the impact of suicide*, published by Mental Health Matters. www.mentalhealthmatters.com
- Healthtalkonline, a website where people can share experiences of ill health and bereavement, including bereavement by suicide. www.healthtalkonline.org
- If U Care Share, a website and campaign organisation with links to sources of support. www.ifucareshare.co.uk
- Winston's Wish, bereavement support for children and young people. www.winstonswish.org.uk/
- Cruse Bereavement Care. www.crusebereavementcare.org.uk
- Survivors of Bereavement by Suicide, a self-help organisation to meet the needs and break the isolation of those bereaved by the suicide of a close relative or friend. www.uk-sobs.org.uk/
- The Compassionate Friends, support for bereaved parents and their families after a child dies. www.tcf.org.uk/

National action to support local approaches

4.9 The Independent Advisory Panel on Deaths in Custody held a listening day in September 2011 for those whose family member had died whilst detained under the Mental Health Act.

4.10 As a result of what they heard, the Panel recommended to the Ministerial Board on Deaths in Custody that Trusts with responsibility for detained patients should have procedures in place for ensuring good quality family liaison with bereaved families, and to signpost them for support and advice. Policies on investigation should be explained to families to ensure they are offered an opportunity to be involved and receive ongoing information. Trusts should also keep families informed of actions taken

to learn from their relative's death including any changes as a result of the investigation or inquest.

4.11 This good practice, particularly following the judgment in *Rabone vs Penine Care NHS Foundation Trust*, is equally applicable where a voluntary patient in contact with mental health services takes their own life.

4.12 The Department of Health recently made a grant to Survivors of Bereavement by Suicide to enable the organisation to forge productive relationships with other suicide prevention organisations so that they can continue to support bereaved families and friends in the future.

Have in place effective local responses to the aftermath of a suicide

- Suicide can have devastating effects on a community. There is emerging evidence that post-suicide interventions at community level can help to prevent copycat and suicide clusters and ensure support is available. This approach may be adapted for use in schools, colleges and universities, workplaces, prisons, mental health and other care services, drug and alcohol services and residential care homes.

4.13 Samaritans has successfully piloted a Step by Step post-suicide intervention service for schools, and is now offering this service across the UK. Samaritans branches work with schools and local authorities, offering practical support, guidance and information on the impact of suicide on school communities, and ways to promote recovery and prevent suicide clusters. This approach could also be used in other settings. www.samaritans.org

4.14 Publicity about suicide, and in particular detailed descriptions of the suicide method, may lead to copycat suicide attempts. Area for action 5 describes ways to work with the media to raise awareness of this risk and promote responsible reporting and portrayal of suicides.

Provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide

4.15 If families, friends and colleagues become concerned that someone may be at risk of suicide it is important that they can get information and support as soon as possible.

4.16 Recent qualitative research[55] indicates that there are very significant difficulties for family members and friends recognising and responding to a suicidal crisis. Signs and communications of suicidal crisis are rarely clear: they are often oblique, ambiguous and difficult to interpret. Even when it is clear to relatives and friends that something is seriously wrong, they may be afraid to intervene for fear of saying or doing `the wrong thing' and damaging relationships or even raising suicide risks. The answer is not simply to give people information about warning signs, because the blocks to awareness and intervention may be emotional rather than factual in nature. Efforts to support families and friends to play a role in preventing suicide should highlight the ambiguous nature of warning signs and should focus on helping people to acknowledge and overcome their fears about intervening.

Effective local interventions

4.17 If individuals are already being cared for by mental health, primary care or social services it is critical that family, carers and friends know how to contact the services and are appropriately involved in any care planning. Any concerns they raise should be considered carefully and responded to in a timely and appropriate way.

4.18 The NHS Future Forum reported how people often find care systems difficult to navigate, and that having a person to help coordinate their care made a significant difference to both their experience and the effectiveness of their care. The Government wants everyone with a care plan to be allocated a named professional who has an overview of their case and is responsible for answering any questions they or their family might have. *Caring for our future* sets out how we hope this can become standard practice.

4.19 There are clearly times when mental health service practitioners, in dealing with a person at risk of suicide, may need to inform the family about aspects of risk to help keep the patient safe. The Department of Health is working with a wide range of professional bodies to raise the profile of this issue and to try to reach a consensus view on confidentiality and suicide prevention.

4.20 For individuals who are not known to services help is still available through many outlets. A list of services and contacts is being published alongside the strategy. Contact details and further information about other organisations is available in *Help is at Hand*: www.nmhdu.org.uk/nmhdu/en/our-work/promoting-wellbeing-and-public-mental-health/suicide-prevention-resources/

National action to support local approaches

4.21 Samaritans has a partnership with the social networking site Facebook in the UK. Friends who are concerned about an individual will be able to tell Samaritans through the Facebook help centre. Facebook will then put Samaritans in touch with the distressed friend to offer their expert support. The Samaritans' Facebook page also has advice on how to support vulnerable friends, such as how to spot when someone is distressed and how to start a difficult conversation.

4.22 Some individuals are more likely to come into contact with people at higher risk of suicide as a result of their work, for example, staff in job centres, the police and emergency departments (see paragraph 2.38).

5. Area for action 5: Support the media in delivering sensitive approaches to suicide and suicidal behaviour

5.1 There are two key aspects to supporting the media in delivering sensitive approaches to suicide and suicidal behaviour:

- promoting the responsible reporting and portrayal of suicide and suicidal behaviour in the media; and
- continuing to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services.

Promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media

- The media have a significant influence on behaviour and attitudes. There is already compelling evidence that media reporting and portrayals of suicide can lead to copycat behaviour, especially among young people and those already at risk.[5657]

Effective local interventions

5.2 Local services and agencies may wish to work with local and regional newspapers and other media outlets to encourage them to provide information about sources of support and helplines when reporting suicide and suicidal behaviour. Working with local media is particularly important where there is a specific location for suicide causing concern.

National action to support local approaches

5.3 In 2006 the Press Complaints Commission (PCC) added a clause to the Editors' Code of Practice explicitly recommending that the media avoid excessively detailed reporting of suicide methods. The 2009 edition of the PCC *Editors' Codebook* highlights the distress that can be caused by:

- insensitive and inappropriate graphic illustrations accompanying media reports of suicide;
- use of photographs taken from social networking sites without relatives' consent; and
- the re-publication of photographs of people who have died by suicide when reporting other suicide deaths in the same area.

5.4 It also commends the inclusion of details of local support organisations and helplines with any coverage of suicide deaths. www.pcc.org.uk/cop/practice.html

5.5 A number of other organisations and agencies, most notably Samaritans, have developed helpful guidance for the media on the reporting of and portrayal of suicide. www.samaritans.org/media_centre/media_guidelines.aspx

5.6 Samaritans plays a key role in monitoring media coverage of suicide, looking at examples of both poor and excessive reporting of suicide in the UK in national, regional and local media. It works closely with the media and regulators to support sensitive reporting

of suicide in line with its media guidelines and undertakes proactive training and outreach with the media.

5.7 The portrayal of suicide behaviour in TV programmes and film and advertising is also an important consideration. In regulating television programming and film, both Ofcom and the British Board of Film Classification take account of the risk of imitative behaviour which could encourage suicide. Advertising is subject to the Advertising Standards Authority's advertising codes, which contain a range of regulatory controls regarding the content of advertisements. We intend to consult with the regulators to ensure that their rules and guidelines remain robust and continue to provide suitable protections.

5.8 The Government is supporting the Time to Change anti-stigma and discrimination social marketing programme. The programme's media engagement work in 2012-13 will: provide an advisory service to broadcast media; pro-actively engage TV drama and news producers, scriptwriters and commissioners; hold seminars to improve the reporting and representation of people with mental health problems; and aim to secure board-level support from media companies. www.time-to-change.org.uk

Continue to support the internet industry to remove content that encourages suicide and provide ready access to suicide prevention services

- There is growing concern about misuse of the internet to promote suicide and suicide methods.[58] In particular, there has been widespread condemnation of internet sites that could help and encourage vulnerable people – particularly young people – to take their own lives. In 2005-7 there was evidence that internet use may have contributed to at least 1-2% of suicides, particularly in relation to the use of relatively unusual, highly lethal methods.

- The internet also provides an opportunity to reach out to vulnerable individuals who would otherwise be reluctant to seek information, help or support from other agencies. The internet can develop and expand the availability of sources of support to vulnerable people online and can also encourage major organisations that provide content in the most popular parts of the internet (such as social networking sites; search engine providers; and online news media outlets) to develop responsible practices which reduce the availability of harmful content and promote sources of support.

National action to support local approaches

5.9 *Safer Children in a Digital World*, the report of the Byron Review (2008), identified some confusion about the application of the law to the encouragement of suicide online. The relevant provisions of the law have since been simplified and modernised to make clear that the law applies to online as well as offline actions. The new provisions came into force on 1 February 2010.[59]

5.10 Under section 2(1) of the Suicide Act 1961 (as amended by section 59 of the Coroners and Justice Act 2009) it is an offence to do an act capable of encouraging or assisting the suicide or

attempted suicide of another person with the intention to so encourage or assist. The person committing the offence need not know the other person or even be able to identify them. So the author of a website promoting suicide and suicide methods may commit an offence if the website encourages or assists the suicide or attempted suicide of one or more of their readers, and the author intends that the website will so encourage or assist. They may be prosecuted whether or not a suicide or attempted suicide takes place. Similarly, any person making a posting to an online chat room or a social networking site which intentionally encourages another person to commit or attempt to commit suicide may be guilty of an offence.

5.11 The Director of Public Prosecutions has issued a Policy for Prosecutors in respect of Cases of Encouraging or Assisting Suicide which sets out guidance to prosecutors on how to apply the law in force. The policy also provides information on the relevant evidential and public interest stages which must be considered in cases of assisted suicide. The policy is available on the CPS website.

5.12 Content providers are free to make their own policies on the publication of harmful or inappropriate material. We expect that the updated law on promoting suicide should make it easier for content providers to identify and take down any content based in England and Wales that contains potentially illegal material. However, potentially illegal material that is hosted by providers outside the UK will not be covered by these arrangements.

5.13 The Government works with the internet industry and content providers through the UK Council for Child Internet Safety (UKCCIS) to create a safer online environment for children and young people through industry self-regulation, improving e-safety education and raising public awareness.

5.14 The Government will continue to work through UKCCIS to promote active choice on domestic broadband connections and on new internet-enabled devices – prompting consumers to choose which content they wish to be able to access – enabling consumers, should they so choose, to restrict access to the most common content and sites which promote suicide. We will promote the use of default filters on public wifi networks, which could help to prevent children using public wifi from accessing adult content. Technical solutions will not offer the complete solution and UKCCIS is also working to develop greater internet safety and education tools for parents and children. We will be pressing for greater transparency from industry on their responses to the public's reporting of harmful and inappropriate content. Over the summer period, we will be seeking the views of industry, children's charities and parents on the best ways to keep children safe online.

5.15 Implemented effectively, these measures will reassure parents that they have the tools to ensure that their children are not accessing harmful suicide-related content online.

5.16 Samaritans and others have worked with search engines and social media sites to ensure that ready access is provided to trusted suicide prevention and support services. PAPYRUS, a voluntary organisation for the prevention of young suicide, has developed a leaflet *Action for Safety on the Internet*, which offers

basic advice and sources of help for anyone who wishes their child to take a safe and responsible approach to the internet; and has concerns that a young person is depressed or suicidal. www.papyrus-uk.org

5.17 See section 4.20 for a joint initiative by Facebook and Samaritans.

6. Area for action 6: Support research, data collection and monitoring

6.1 To support research, data collection and monitoring we need to:

- build on the existing research evidence and other relevant sources of data on suicide and suicide prevention;
- expand and improve the systematic collection of and access to data on suicides; and
- monitor progress against the objectives of the national suicide prevention strategy.

- Reliable, timely and accurate suicide statistics are the cornerstone of any suicide prevention strategy and of tremendous public health importance.
- Research is essential to suicide prevention. Research studies enhance our understanding of the statistical data provided by ONS to inform strategies and interventions; highlight trends and changes in patterns; identify key factors in suicide risk and enhance our understanding of risk groups; evaluate and develop interventions to reflect changing needs and priorities, and develop the evidence base on what works in suicide prevention.
- A wealth of data is already collected by different agencies in the course of their routine work, but only limited information is collected centrally or easily accessible and available to researchers or public health specialists.

Build on the existing research evidence and other relevant sources of data on suicide and suicide prevention

6.2 There is a range of existing research evidence and other relevant sources of data which are useful to inform local and regional strategies and interventions to prevent suicide. A brief description of and links to the key information sources is included in the statistical update being published alongside this strategy.

6.3 Nationally, the Government will work with the Devolved Administrations in the UK to share national and international evidence from research studies on suicide prevention and effective interventions, and identify gaps in current knowledge.

6.4 The Department of Health, through the National Institute for Health Research (NIHR) and the Policy Research Programme (PRP), has invested significantly in mental health research and will continue to support high-quality research on suicide, suicide prevention and self-harm.

6.5 A five-year NIHR programme grant to generate research evidence to underpin the implementation and evaluation of the 2002 Suicide Prevention Strategy is due to report during 2012.

6.6 The NIHR has approved a five-year programme grant on suicide prevention starting 1 April 2012. This new programme will collect and analyse data on suicide and self-harm as related to the recession; develop interventions to reduce the impact of the recession on suicides; evaluate different forms of risk

assessment following self-harm; review the literature and develop guidelines on the management of episodes of self-harm where individuals have made advance decisions on treatment; develop resources for parents of young people who self-harm; evaluate whether the use of some specific new methods of suicide is increasing; and identify medicines associated with high fatality in overdose.

6.7 The PRP will fund up to £1.5 million for new suicide prevention research to contribute to the delivery of policy.

Expand and improve the systematic collection of and access to data on suicides

6.8 The information in the national mortality statistics produced by ONS is useful for identifying national trends, but does not allow more detailed analysis. Preventative interventions and monitoring would be enhanced if more comprehensive information was more easily accessible. Additional information may be held in coroners' records and records from GPs or secondary care and mental health services, but it is not routinely or systematically reported.

6.9 Public Health England is establishing an evidence and intelligence function. This will include the role currently performed by public health observatories, and will include gathering information on suicide prevention activities and data on suicide and self-harm in order to publish the data to support the Public Health Outcomes Framework.

6.10 Scotland is currently establishing a Scottish Suicide Information Database (ScotSID) to improve the quality of information available on suicides in Scotland. The first national report is available at: www.isdscotland.org/Health-Topics/Public-Health/Publications/2011-12-20/2011-12-20-Suicide-Report.pdf?45182436705

6.11 The Department of Health will work with the National Suicide Prevention Strategy Advisory Group to consider how we can get the most out of the existing data sources in England and address the issues raised in paragraph 6.8. This will include considering options to address the current information gaps around ethnicity and sexual orientation, and will seek to learn from the Scottish experience in establishing ScotSID.

6.12 At a local level, coroners may work with health services and partner organisations and agencies to provide data that will give an early indication of emerging patterns, such as clusters or particular patterns of suicides, before data are compiled by the ONS.

6.13 At a national level the Department of Health will work with the Ministry of Justice and coroners to consider what access to coroners' records may be achievable for bona fide researchers, subject to relevant data protection and confidentiality safeguards and bearing in mind coroners' statutory duties.

6.14 The varying detail given by coroners in narrative verdicts and the increasing use of multi-category verdicts means that, in some cases, ONS find it difficult to classify intent accurately. ONS is confident that the overall picture of current suicide trends shown by national and regional statistics is reliable at present.[60] However, the variation in practice by different coroners means that local figures could be less reliable. Also,

if the rise in narrative verdicts continues at the same rate, the accurate reporting of injury and poisoning deaths may be affected in the future. ONS is working with coroners and others concerned to ensure that they are able to classify these narrative and multi-category verdicts accurately in order to monitor trends and draw comparisons over time.

6.15 In the light of this, ONS made changes to the processing of narrative verdicts for all deaths registered from 2011 onwards, and the work with coroners will not have an impact until later in that year. Accordingly, ONS will be able to look at data for 2011 when it has the annual dataset in summer 2012 to assess the impact of these changes.

6.16 The Government is reforming the coroner system under Part 1 of the Coroners and Justice Act 2009. These reforms, which involve the establishment of the Chief Coroner, will help to bring about much greater consistency of practice between coroner areas and improved services to the bereaved, as well as helping to speed up the investigation and inquest process.

6.17 National monitoring statistics depend on the data generated by the coroners' reporting system so it will be important to bear in mind the continuity of data and information when making these changes.

Monitor progress

6.18 The Government is committed to a new focus on outcomes that matter to people and their families both at national and local level. Three outcome frameworks have been developed: for the NHS, public health and adult social care. Together, these provide a comprehensive and coherent approach to tracking national progress against a range of critical outcomes.

6.19 Reflecting the continuing focus on suicide prevention, the Public Health Outcomes Framework (January 2012) includes the suicide rate as an indicator. Two other indicators with direct relevance to suicide prevention are self-harm and excess under 75 mortality in adults with serious mental illness. The indicator on excess mortality is also contained in the NHS Outcomes Framework.

6.20 *No health without mental health: Delivering better mental health outcomes for people of all ages* gives examples of outcomes and indicators for consideration by the NHS Commissioning Board and local commissioners; these include the rates of inpatient suicides.

6.21 The National Suicide Prevention Strategy Advisory Group will meet regularly to assess progress on the shared areas for action and objectives outlined in the strategy.

6.22 An update on progress in the implementation of the final strategy will be published annually online. This will summarise developments at national level, identify relevant research studies and their findings, and report detailed statistical information on suicides by gender, age, method and location.

7. Making it happen locally and nationally

7.1 A key message of this strategy is that there are many sectors, groups and individuals who can help to reduce suicide. Each priority area for action, set out in chapters 1 to 6, contains suggested local and national activities to help deliver change.

7.2 This chapter describes some of the broader context, systems and bodies, such as public health and primary care, which will support several of the areas for action.

7.3 *No health without mental health* outlines the proposed reforms to the public health, health and social care systems and how the new architecture and approach will affect planning and delivery of improved public health and mental health outcomes. It also describes cross-government actions to support the delivery of the mental health strategy. Many have direct relevance to suicide prevention; for example, the work on employment being undertaken across government and the Ministerial Working Group on Preventing and Tackling Homelessness.

7.4 An implementation framework for *No health without mental health* was published in July 2012. This sets out what local organisations can do to implement the strategy, what work is underway nationally to support them, and how progress against the strategy's aims will be measured. The implementation framework explicitly covers suicide prevention, and will support local agencies in implementing this strategy.

Public Health

7.5 Public Health England (PHE) is the new national agency for public health (from April 2013) and will support local authorities, the NHS and their partners across England to achieve improved outcomes for the public's health and wellbeing.

7.6 PHE will take a leadership role across public health services, providing expertise and support to local areas to help improve outcomes in public health and reduce health inequalities, including on mental health and suicide prevention.

7.7 An effective local public health approach is fundamental to suicide prevention. This will depend on effective partnerships across all sectors including health, social care, education, the environment, housing, employment, the police and criminal justice system, transport and the voluntary sector.

7.8 New health and wellbeing boards (HWBs) will be able to support suicide prevention as they bring together local councillors, Clinical Commissioning Groups (CCGs), directors of public health (DsPH), adult social services and children's services, local Healthwatch and, where appropriate, wider partners (such as the Police and the Local Safeguarding Children Board) and community organisations.

7.9 HWBs will assess the local community's health and wellbeing needs and assets. Improvements in population health and wellbeing, including mental health, will reduce the risks of suicide. Specific

approaches to suicide prevention could feature in an effective local health and wellbeing approach. For example, many of the locations used for suicide are under the control of local authorities and they can act to reduce this risk.

7.10 DsPH can play a key part in developing local public health approaches and in nurturing and maintaining links across the NHS and local government. They will be appointed jointly by local authorities and Public Health England. This will place many DsPH in a unique position to contribute to taking forward the suicide prevention strategy.

7.11 Some areas have established regional or sub-regional multi agency suicide prevention groups to co-ordinate activities to reduce suicides. In many cases these groups also support more localised groups or networks of suicide prevention activists. These groups could help support DsPH and health and wellbeing boards in developing assessments and strategies.

Primary care services

7.12 Most general practices will have a patient who dies by suicide only once every few years. However, GPs can make a big difference to overall suicide rates. General practices will see a lot of people with many of the known factors for higher risk of suicide, for example long-term physical health problems, self-harming, drug and alcohol misuse and mental health problems. They are the first point of contact for many people who are experiencing distress or suicidal thoughts and who may be vulnerable to suicide. GPs are also the key gatekeepers to specialist services.

7.13 Primary care staff may also be the first point of contact for people who are bereaved or affected by the suicide of family members, friends and colleagues.

7.14 Health visitors, midwives and other community staff may be in contact with children, young people and families and be the first to be aware of mental health problems or other difficulties developing. They can therefore provide direct support and also refer speedily to other services.

Commissioning reforms

7.15 The NHS Commissioning Board (NHS CB) will be committed to improving outcomes in mental health. Through its role in commissioning primary care, specialised services, prison health, military health and some specific public health services, the NHSCB will have a vital contribution to make in realising the aims of *No health without mental health* and this strategy.

7.16 The NHS CB will also have an important role in providing national leadership for driving up the quality of care across health commissioning. The Board could do this, for example, by publishing commissioning guidance and model care pathways, based on the evidence-based quality standards that it has asked NICE to develop.

7.17 NICE quality standards, defining high quality care, are relevant to both local authorities and CCGs in their commissioning roles. Existing quality standards relevant to suicide prevention include alcohol

dependence and depression in adults. Others are under development including: depression in children and young people; self-harm in adults; self-harm in vulnerable groups, children and young people; antenatal and postnatal mental health; long-term care of people with co-morbidities and or complex needs and safe prescribing. For the full list of topics referred to NICE see www.nice.org.uk/guidance/qualitystandards/QualityStandardsLibrary.jsp

7.18 Clinical Commissioning Groups will become responsible for commissioning the majority of healthcare services. In considering CCGs' applications for establishment, the NHS CB will assess whether a CCG has the capacity and capability to commission improved outcomes for the people who need support for mental health.

7.19 The National Offender Management Service (NOMS) is an executive agency of the Ministry of Justice, and brings together HM Prison Service and the Probation Service. It commissions and delivers offender management services in custody and the community as well as managing those offenders who receive hospital and restriction orders unders sections 37 and 41 of the Mental Health Act 1983. The prison population contains a high proportion of very vulnerable individuals, many of whom have experienced negative life events that we know increase the likelihood of them harming themselves such as drug and alcohol misuse, family background and relationship problems, social disadvantage or isolation, previous sexual or physical abuse, and mental health problems.

7.20 The Youth Justice Board (YJB) oversees the youth justice system in England and Wales. The YJB works to prevent offending and reoffending by young people, and to ensure that those held in custody are safe and secure.

Coroners

7.21 Suspected suicide deaths will always be reported to a coroner, who will certify the death after an inquest. Coroners have an important role in establishing via inquest proceedings the who, how and where of these deaths. The coroner's office will be able to help bereaved families to find support from local and national organisations.

7.22 The Government is reforming the coroner system under Part 1 of the Coroners and Justice Act 2009. These reforms include establishing a Chief Coroner who, for the first time, will be responsible for providing national leadership to coroners in England and Wales. He will also play a key role in setting new national standards and developing a new statutory framework for coroners including rules and regulations, guidance and practice directions within which coroners will operate. Coroners will be under a duty to inform the Chief Coroner of any investigations lasting more than a year and the Chief Coroner will be under a duty to include a summary of these in an annual report. This will help to bring about much greater consistency of practice between coroner areas and improved service to the bereaved, as well as helping to speed up the investigation and inquest process.

Central support for delivering the strategy

7.23 The Cabinet Sub-Committee on Public Health oversees the implementation of *No health without mental health*, while the Cabinet Committee on Social Justice ensures effective cross-government action to address the social causes and consequences of mental health problems. The suicide prevention strategy is a key component of *No health without mental health.*

7.24 The National Suicide Prevention Strategy Advisory Group (NSPSAG) provides leadership and support for suicide prevention initiatives including advice on monitoring and analysing trends in suicide. Membership includes senior academic researchers, voluntary sector representatives (Samaritans and PAPYRUS), representatives from NOMS, Department of Health, public health, offender health care, professional bodies such as the Royal College of Psychiatrists and a coroner. It also includes people (often family members) with direct experience of bereavement by suicide. This group will continue to provide leadership for implementation of this strategy.

7.25 The Ministerial Council on Deaths in Custody is jointly funded by the Home Office, UK Border Agency, the Ministry of Justice and the Department of Health. The Council's remit covers deaths in prisons, in or following police custody and in immigration detention; the deaths of residents in approved premises; and the deaths of those detained under the Mental Health Act.
http://iapdeathsincustody.independent.gov.uk

Links across the UK and Republic of Ireland

7.26 This strategy relates to England only, as the majority of issues involved are the responsibility of the Devolved Administrations. Suicide prevention strategies have now been established in Scotland, Wales and Northern Ireland, as well as in the Republic of Ireland. Strong links have been maintained between the nations, and these links should continue to ensure a co-ordinated approach to suicide prevention, where necessary, across the UK and Ireland.

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Hartlepool's
Beautiful Minds
celebrating good mental health

Mental Health Directory

2017

HARTLEPOOL
BOROUGH COUNCIL

What is this booklet about?

Most people will experience mental health problems at some point in their life. Hartlepool's Beautiful Minds is a partnership project comprised of a range of organisations working across Hartlepool that deliver mental health services. The project is dedicated to promoting good mental health. This booklet is designed to give residents of Hartlepool knowledge of mental health services that can offer support and advice as well as ways to self help.

Contents:

Hospital of God in the Community

The Bridge—Dementia Advice & Support

Live Well with Dementia

The Bridge
Unit 1, Gemini Centre
Villiers Street
Hartlepool, TS24 7SA

Phone: (01429) 868587 Email: thebridge@hospitalofgod.org.uk
Website: www.hospitalofgod.org.uk

Who the Service is for:

The Bridge is part of the Hospital of God charity of dementia care and support services in Hartlepool. It provides advice and support for people who have dementia (or who are concerned about their memory), their carers, friends and families. It is for people of any age with dementia.

Getting the Service:

The Bridge is a town centre open access service. You can visit, phone or email to make an appointment to see one of our dementia advisers. Alternatively we may be able to visit you at home or at another location if travel is a problem.

Description of Service:

The Bridge provides a one-stop shop for advice and support. The advice service is free of charge and will help you to understand dementia and live well with dementia. We have information on dementia and we will help you to use our computers to get more information through the internet. We work closely with social workers, memory clinics and nursing colleagues and we can help you obtain the care package you need.

The Hospital of God also provides day care, community pastimes, carer support services and memory cafes.

Call in and see us—we are here to help

Creative Support

Creative Café

Unit 17, The Gemini Centre

Villiers Street

Hartlepool, TS24 7SA

Phone & Fax: (01429) 262918

Description of Service:

Creative Café is an inclusive and welcoming café in the centre of Hartlepool run by Creative Support. The focus is on delivering an inclusive, vibrant and unique hub that is open to everyone. The Café is used by a number of community groups that use the space to deliver closed and open sessions for individuals to access for a range of support.

Creative Café also offers a range of low cost activities too, such as baking, art, social afternoons and volunteering opportunities.

Creative Café is a designated "Safe Place" with the Cleveland Police 'Safer Places Scheme' and a five star gold rated food hygiene kitchen.

Contact the café or pop into our venue to pick up more information.

‘HART’

(Hartlepool Action Recovery Team)

Drug & Alcohol Treatment Services

Location of Services:

Whitby Street
Hartlepool
TS24 7AB
Phone: (01429) 285000

Description of Service:

A commissioned clinical service through Addaction, which offers a substitute prescribing service for those with substance misuse issues including initiation, titration, stabilisation and reduction regimes, BBV (Blood Bourne Virus)

vaccinations and counselling.

Linked to that service we have:-

- The James Cook University Hospital Hepatitis team providing a fort-nightly Hepatitis C treatment clinic supporting clients testing positive for Hepatitis C.
- A midwife from Hartlepool Hospital who provides a weekly pre and post natal clinic.

A Psychosocial recovery support element, which was recently brought in-house is now provided by Hartlepool Borough Council. We offer a NBPS (Neurological, Biological, Psychological, Sociological) model.

Continued .....

‘HART’

(Hartlepool Action Recovery Team)

Drug & Alcohol Treatment Services

Description of Service: (continued)

The team provide a wide range of evidence based, needs led, interventions on drop in, 1-1 and group work basis, including:

- Assessment
- NBPS Structured Group Work Programme
- 12-Week Intensive Community Recovery Programme
- DRR (Drug Rehabilitation Requirement) and ATR (Alcohol Treatment Requirement) support groups.
- Preparation for Residential Rehabilitation and Detoxification
- CRAFT (Community Reinforcement and Family Training) / Family Intervention

- HART Young People’s Service offer a range of services for young people up to the age of 18 yrs. The service provides support around substance misuse treatment, prevention and early interventions.

- HART support young people in achieving the recovery goals using structured care planning and we support young people to make informed decisions and stop them making decisions they may later regret.

- We also provide harm reduction advice and education to schools, youth projects or any other young person related service in Hartlepool.

Incontrol-able CIC
Supporting Disabled People in Hartlepool through our Information, Advice and Guidance services

Centre for Independent Living
Burbank Street
Hartlepool, TS24 7NY
Phone: (01429) 401742 Email: info@incontrol-able.co.uk
Website: **www.incontrol-able.co.uk**

Who the Service is for:
Incontrol-able CIC is the only nationally recognised Disabled People's User Led Organisation (DPULO) across Teesside. Our Management Board is made up of 75% of Disabled People, making us 'Experts by Experience' that is person centred and promotes independence through our services and projects.

Getting the Service:
Incontrol-able CIC provides **FREE** services to Disabled and Older People who live in Hartlepool. We deliver projects and services that provide individuals with Information, Advice and Guidance.

We are based at the Centre for Independent Living and can be contacted via telephone,

Description of Service:

We have two main projects that we deliver.

The first is our Ricochet service, which loans out 'tablets/digital technology' to adults who meet our eligibility criteria, namely people with Physical Disabilities, Learning Disabilities, Autistic Spectrum Conditions and those with Long-Term Conditions who live in Hartlepool. This is a FREE service.

Our second main service is Project 65, where we loan out 'tablets/digital technology' to any individual who is a resident of Hartlepool and is aged 65 or over. We also provide support on how to use the tablet and this is also a FREE service.

All you need to do to access both services is to refer and sign up to our Loan Agreement Policy.

If you require any further information, please do not hesitate to get in touch with us on the contact details above.

Both services are supported by Hartlepool Borough Council and Northgate Public Services

Hartlepool 50+ Forum

c/o Healthwatch Hartlepool
The Orcel Centre
Wynyard Road
Hartlepool
TS25 3LB

Phone: (01429) 288146

Who the service is for:

The Forum welcomes all people aged 50+ who live in Hartlepool.

For more information:

Contact Healthwatch Hartlepool on (01429) 288146.

Description of Service:

The purpose of the Forum is to enable people age 50+ in Hartlepool to have a voice on matters which are important to them, whilst providing organisations and agencies with a mechanism to consult with people age 50+ on a range of issues that relate to planning and developing services.

Members of the 50+ Forum lobby for the rights of older people on a local, regional and national basis. The Forum has elected representatives on many groups and partnerships across Hartlepool and the North East who feed the views of older people into key decision making.

Access Service (TEWV)

Stewart House
53 Church Street
Hartlepool
TS24 7DX
Phone: (01429) 803747

Who the Service is for:

The service is for people who may require secondary mental health services such as treatment from the affective or psychosis teams or specialist services such as autism assessments. Following referral from your GP, the service will assess you and identify the most suitable service to meet your needs.

Being referred:

To be referred for assessment by the service, a referral from your GP or other health professional is required.

Following referral, an assessment will usually be arranged to take place within 2 weeks.

Description of Service:

The service provides assessments and/or short term treatment of a further two sessions for people with mental health needs that cannot be met within primary care. The aim of these assessments is to determine whether you would benefit from secondary mental health services and to signpost or refer you to an appropriate service.

Hartlepool Crisis Resolution and Intensive Home Treatment Team

Sandwell Park
Lancaster Road
Hartlepool
TS24 8LL
Phone: (01429) 285858

Who the Service is for:

The service is for adults aged 18 years+ presenting with an acute mental health need that may require admission to a mental health unit without the potential involvement of an intensive home treatment team.

Being referred:

The Crisis Team can be accessed by the following:

- Substance Misuse Services
- Primary Care Health Professionals including GPs
- Accident and Emergency Departments/Acute Hospitals
- Social Services/Emergency Duty Team
- Police/Forensic Medical Examiner working in custody suites
- Improved Access to Psychological Therapies (IAPT)
- Non Statutory Agencies
- Self referrals

Those individuals who are currently open to secondary mental health services and their respective families and/or carers can contact the team during out of hours for additional support or advice.

Description of Service:

The service provides assessment and intensive home treatment in a range of settings and offers an alternative to inpatient care. The service also responds to service users in a mental health crisis with deteriorating mental health that requires a change in management and increased support.

The Crisis Resolution and Intensive Home Treatment Team is multi disciplinary. It comprises medical, nursing, social care, occupational therapy, support and administrative staff. These are available 24 hours a day, everyday.

Hartlepool Carers

19A Lowthian Road
Hartlepool
TS24 8BH
Phone: (01429) 283095

Email: staff@hartlepoolcarers.org.uk
Website: www.hartlepoolcarers.org.uk

Who the Service is for:

Hartlepool Carers provide support and information to carers in their role. A generally accepted definition of the term carer is as follows:

"*A carer spends a significant proportion of their life providing unpaid support to family, friends or neighbours. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.*"

Being referred:

Carers can contact Hartlepool Carers directly on (01429) 283095.

Professionals and carers can refer using the referral on Hartlepool Carers website: http://www.hartlepoolcarers.org.uk

Description of Service:

Hartlepool Carers can offer support and information on issues connected with your caring role:

- Emotional support, one to one with a support worker or counsellor
- Information and guidance on local helping agencies in the Third Sector, Health and Social Care services
- Group social and peer support activities
- Advocacy service
- Hartlepool Carers Employment and Training Project

Young Carers Team offering a 'Think Family' support service accessed through your social worker or first contact, phone: (01429) 284284.

MINDskills Recovery College

Gaynor Goad, Project Manager
MINDskills Recovery College
Enterprise House
8 Yarm Road
Stockton-on-Tees, TS18 3NA
Phone: (01429) 269303

Who the Service is for:

Any person living in the Hartlepool or Stockton-on-Tees area aged 16 or over experiencing mental health, social or emotional difficulties. You can enrol yourself or someone can refer you for enrolment.

Description of Service:

This is a new service to improve mental health, develop social skills and maintain positive wellbeing. The College aims to help you to become a specialist in your own care, understand what makes you feel well so that you can use the skills learnt when you need them most.

Baby Bereavement Support Group

Christine Morton Lake
Phone: (01429) 231221
Email: bbsghartlepool@yahoo.co.uk Address: 208 York Road, Hartlepool TS26 9EB

Who the Service is for:

Grieving parents, siblings and families of babies that have been stillborn or who have died.

Description of Service:

To provide understanding and support to grieving parents, siblings, families and friends.

Healthwatch

Healthwatch Hartlepool
The ORCEL Centre, Wynyard Road, Hartlepool, TS25 3LB
Tel: (01429) 288146
Email: yoursay@healthwatchhartlepool.co.uk
Website: www.healthwatchhartlepool.co.uk

Healthwatch is the new independent consumer champion for both health and social care. It has two distinct forms - Local Healthwatch at local level and Healthwatch England at national level. The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality. Local Healthwatch will also provide or signpost people to information to help them make choices about health and care services.

Local Healthwatch will also:

- Have a seat on the local Health and Wellbeing Board ensuring that the views and experiences of patients, carers and other service users are taken into account within key local strategies such as the Joint Strategic Needs Assessment (JSNA)
- Enable people to share their views and concerns about local health and social care services and help to build a picture of where services are doing well and where they can be improved
- Be able to alert Healthwatch England or the Care Quality Commission (CQC) where appropriate, to concerns about specific care providers and other health and social care issues
- Provide people with information about their choices and what to do when things go wrong
- Give authoritative evidence based feedback to organisations responsible for commissioning or delivering local health and social care services
- Help and support Clinical Commissioning Groups (CCGs) to make sure that local services really are designed to meet citizens needs
- Be inclusive and reflect the diversity for the community it serves

Improving Access to Psychological Therapy Services (IAPT)

Alliance Psychological Services Ltd - Phone: 01642 352747
Hartlepool & East Durham Mind - Phone: 01429 269303
Insight Healthcare/Talking Therapies - Phone: 0300 555 0555
Starfish Emotional Wellbeing in Teesside - Phone: 01642 345212
Middlesbrough & Stockton MIND - Phone: 01642 218361
wecantalk.org - Phone: 01642 263121 (option 4)

Who the Service is for:

IAPT is a programme that helps people suffering from depression and anxiety disorders find the best type of therapy for them.

Being referred:

Just speak to your GP and they will put you in touch with one of your local IAPT providers or you can contact them direct. They will work with you to explore the problems you are facing and identify how best to deal with them.

Description of Service:

1 in 4 of us will experience problems with our psychological (mental) wellbeing at some point in our lives. Problems like mild depression, anxiety, stress, panicking, nervousness, isolation and loss of sleep make it hard for us to cope with our daily life. We have a team of qualified, experienced professionals and counsellors specially chosen to work alongside your local GP.

IAPT offers patients treatment combined where appropriate with medication, which traditionally has been the only treatment available. It can help patients suffering from:

- Low mood and/or depression
- Loss of interest and pleasure
- Post-traumatic stress disorder
- Poor concentration
- Sleep problems
- Anxiety
- Feelings of worthlessness, hopelessness and guilt
- Obsessive Compulsive Disorder (OCD)

Useful Contacts:

Samaritans

Phone: freephone 116 123 (24 Hour Helpline)

Website: www.samaritans.org.uk

Harbour Hartlepool Refuge

Phone: 03000 20 25 25 (24 hour)

Website: www.myharbour.org.uk

SANE (Mental Health Charity)

Phone: 0300 304 7000

Website: www.sane.org.uk

Cruse Bereavement Care

Phone: 01642 210284

Website: www.cruse.org.uk

Rethink Rethink Mental Health (Advice and Information Service)

Phone: 0300 5000 927

Website: www.rethink.org

Mental Health Matters

Website: www.mental-health-matters.com

Alcoholics Anonymous: Phone: 0800 9177 650 email: help@aamail.org
Narcotics Anonymous: Phone: 0300 999 1212
Gamblers Anonymous: Website: http://www.gamblersanonymous.org.uk/

Hartlepool's Beautiful Minds Partners

creative SUPPORT

Creative Cafe

HARTLEPOOL BOROUGH COUNCIL

healthwatch Hartlepool

Hartlepool mind For better mental health

Hartlepool Carers

HARTLEPOOL 50+Forum

Tees, Esk and Wear Valleys NHS NHS Foundation Trust

HART Hartlepool Action Recovery Team

addaction

Updated June 2017

Crisis Care Concordat
Mental Health

Hartlepool Mental Health Forum .
Declaration statement

The Hartlepool Mental Health Implementation plan on improving outcomes for people experiencing mental health crisis (December 2015-2018)

We, as partner organisations in **Hartlepool** will work together to put in place the principles of the national **Concordat** to improve the system of care and support so that people in crisis because of a mental health condition are kept safe. We will help them to find the help they need – whatever the circumstances – from whichever of our services they turn to first.

We will work together to prevent crises happening whenever possible, through intervening at an early stage.

We will make sure we meet the needs of vulnerable people in urgent situations, getting the right care at the right time from the right people to make sure of the best outcomes.

We will do our very best to make sure that all relevant public services, contractors and independent sector partners support people with a mental health problem to help them recover. Everybody who signs this declaration will work towards developing ways of sharing information to help front line staff provide better responses to people in crisis.

We are responsible for delivering this commitment in **Hartlepool** by putting in place; reviewing and regularly updating an action plan/action plans.

This declaration supports 'parity of esteem' (see the glossary) between physical and mental health care in the following ways:

- Through everyone agreeing a shared 'care pathway' to safely support, assess and manage anyone who asks any of our services in **Hartlepool** for help in a crisis. This will result in the best outcomes for people with suspected serious mental illness, provide advice and support for their carers, and make sure that services work together safely and effectively.
- Through agencies working together to improve individuals' experience (professionals, people who use crisis care services, and carers) and reduce the likelihood of harm to the health and wellbeing of patients, carers and professionals.
- By making sure there is a safe and effective service with clear and agreed policies and procedures in place for people in crisis, and that organisations can access the service and refer people to it in the same way as they would for physical health and social care services.
- By all organisations who sign this declaration working together and accepting our responsibilities to reduce the likelihood of future harm to staff, carers, patients and service users or the wider community and to support people's recovery and wellbeing.

We, the organisation listed below, support this Declaration. We are committed to working together to continue to improve crisis care for people with mental health needs in Hartlepool.

Crisis Care Concordat
Mental Health

Hartlepool Mental Health Forum .
Declaration statement

Name: DAVID STOBBS
Role: CHIEF EXECUTIVE
Signed: D Stubbs

Hartlepool Borough Council

Glossary of terms used in this declaration

Concordat	A document published by the Government. The Concordat is a shared, agreed statement, signed by senior representatives from all the organisations involved. It covers what needs to happen when people in mental-health crisis need help. It contains a set of agreements made between national organisations, each of which has a formal responsibility of some kind towards people who need help. It also contains an action plan agreed between the organisations who have signed the Concordat. Title: Mental Health Crisis Care Concordat – Improving outcomes for people experiencing mental health crisis Author: Department of Health and Concordat signatories Document purpose: Guidance Publication date: 18th February 2014 Link: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281242/36353_Mental_Health_Crisis_accessible.pdf
Mental health crisis	When people – of all ages – with mental health problems urgently need help because of their suicidal behaviour, panic attacks or extreme anxiety, psychotic episodes, or behaviour that seems out of control or irrational and likely to put the person (or other people) in danger.
Parity of esteem	Parity of esteem is when mental health is valued equally with physical health. If people become mentally unwell, the services they use will assess and treat mental health disorders or conditions on a par with physical illnesses. Further information: http://www.england.nhs.uk/ourwork/qual-clin-lead/pe

Recovery	One definition of Recovery within the context of mental health is from Dr. William Anthony: "Recovery is a deeply personal, unique process changing one's attitude, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of psychiatric disability" (Anthony, 1993) Further information http://www.imroc.org/

The Prevention Concordat – a North East briefing July 2017

The Prevention Concordat is a suite of documents that have been developed as practice resource to support local areas across England to put in place effective arrangements to promote good mental health and prevent mental health problems.

The suite of resources have been produced to support the better mental health programme and in response to the Five Year Forward View for Mental Health. Public Health England and a wide range of organisations are signed up to work through the concordat programme together, including: the Faculty of Public Health, Local Government Association, and NHS England.

The concordat is underpinned by an understanding that taking a prevention-focussed approach to improving the public's mental health is shown to make a valuable contribution to achieving a fairer and more equitable society.

The scope of the Prevention Concordat includes preventing the onset, development and deterioration of mental health problems, promoting good mental health through strengthening individuals and communities and reducing inequalities and the structural barriers to mental health.

The Prevention Concordat builds on published evidence and draws on the findings of a stocktake of prevention planning arrangements, which was led by The King's Fund as part of the programme this has been published separately as a source document.

The Prevention Concordat has been informed by stakeholder engagement events across England with a range of representatives to understand needs of local areas. This programme of engagement identified five key areas necessary for effective planning for better mental health.

The Prevention Concordat suite of documents includes:

1. **Prevention Concordat for Better Mental Health Consensus Statement**

2. **Prevention Concordat for Better Mental Health: Prevention planning resource for local areas** (PHE) is a practical guide developed to support local areas across England to put in place effective arrangements to promote good mental health and prevent mental health problems.

3. **Prevention Concordat for Better Mental Health:– Overview infographic of the prevention planning resource**

4. **Prevention Concordat for Better Mental Health – local planning resource summary**

5. **Stocktake of local strategic planning arrangements for the prevention of mental health problems: Summary report** (PHE/Kings Fund) is a high-level summary of how local areas are currently incorporating mental health promotion and prevention of mental ill-health in their planning processes. The stocktake was based primarily on a content analysis of key planning documents in 35 local areas, including a random sample of 16 areas across England and 19 areas selected as possible examples of good practice.

6. **Mental Health and Wellbeing Joint Strategic Needs Assessment Toolkit: Knowledge Guide** (PHE) complements the Mental Health Joint Strategic Needs Assessment Online Profile which is designed to support local Health & Wellbeing Boards in developing Mental Health JSNAs. It brings together nationally available data on mental health prevalence, risk and protective factors and healthcare services

7. **Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Health Problems** (PHE/London School of Economics) summarises the findings of modelling work to estimates the cost of investing in several different interventions for which there is evidence that they can help reduce the risk and/or incidence of mental health problems in individuals of different ages and/or promote good mental health and wellbeing.

8. **Barriers and Facilitators to Commissioning Cost-Effective Services for Promotion of Mental Health and Wellbeing and Prevention of Mental Health Problems** (PHE/London School of Economics) examines some of the barriers and facilitators to the implementation of actions to promote better mental health and wellbeing and prevent mental health problems.

9. **Mental Health Promotion Return on Investment Tool and tool guide** (PHE/London School of Economics) reports the Return on Investment to health and other sectors from investment in eight different interventions to promote better mental health and prevent the development of mental health problems. Results can be tailored to local settings. The guide provides users with step-by-step instructions and guidance on how to use the Mental Health promotion return on Investment Tool

10. **Psychosocial Pathways and Health Outcomes: Informing action on health inequalities** (PHE/UCL Institute of Health Equity) provides a conceptual framework that focuses on the psychosocial pathways between factors associated with social, economic and environmental conditions, psychological and psychobiological processes, health behaviours and mental and physical health outcomes.

ADULT SERVICES COMMITTEE

1 March 2018

Report of: Director of Adult and Community Based Services

Subject: RAISING AWARENESS OF ADULT SAFEGUARDING

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1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 For information.

2. PURPOSE OF REPORT

2.1 To provide an update to the Adult Services Committee on the adult safeguarding awareness campaign in February 2018 and associated local developments.

3. BACKGROUND

3.1 Hartlepool Borough Council, along with the other three Local Authorities in the Tees area and a range of statutory and non-statutory partners, is part of the Teeswide Safeguarding Adults Board (TSAB). The Teeswide Safeguarding Adults Board (TSAB) was established in order to meet the requirements of the Care Act 2014, which created a legal framework for adult safeguarding, requiring all Local Authorities to set up Safeguarding Adults Boards (SABs) for their areas.

3.2 As outlined in the TSAB Annual Report for 2016/17 and Strategic Plan for 2017/18 (which were presented to Adult Services Committee in December 2017), prevention and raising public awareness of adult safeguarding are key priorities.

3.3 In 2016/17 significant progress was made in establishing the TSAB website, which had 9,000 individual users and was viewed over 41,000 times. Use of social media had also developed with 6,900 people reached via Facebook and 170 Twitter followers. Bulletins were accessed by over 4,800 people and over 600 people were engaged through face to face events as well as footfall events in public places in each Local Authority area.

3.4 The TSAB Communications & Engagement Sub Group leads on this priority and is committed to further improving public awareness of adult safeguarding.

4. CURRENT POSITION

4.1 To further improve public awareness, TSAB developed an Adult Safeguarding Awareness Campaign which ran from 4 - 18 February 2018, focused on the question 'Do you know how to prevent adult abuse and neglect?' This was promoted in the TSAB Newsletter (attached as **Appendix 1**), which is an accessible way for staff, partners and interested parties to keep up to date with the work of the TSAB as well as a range of national and local developments linked to adult safeguarding. In the first week of the campaign, there were 1,500 hits on the TSAB website, over 600 people spoken to about adult safeguarding, 5 newspaper adverts, 3 radio interviews and 2 learning events delivered across the Tees area.

4.2 The poster developed for the campaign is attached as **Appendix 2**; this provides basic information about adults safeguarding and signposts people to resources to find out more.

People can support and join the campaign by following the Board on social media and asking others to do the same:

@TeeswideSAB *TSAB@TeeswideSAB*

4.3 Information about the campaign was shared with all Hartlepool Borough Council staff and elected members, and was promoted via the Council's social media channels, the local press and radio advertising. There was also a town centre awareness raising event in Hartlepool on 8 February where leaflets were distributed to members of the public.

4.4 An Adult Safeguarding Learning and Networking Event took place on Tuesday 6 February at the Centre for Independent Living. The event was well attended and received very positive feedback from attendees. Over 30 organisations were represented including a range of Council departments, NHS Trusts, GPs, dentists, voluntary sector services, social care providers and banks. Attendees received information on adult safeguarding processes and a wide range of preventative services. Information from the event was shared via social media by TSAB and the Council, and also features in the March edition of Hartbeat.

4.5 Feedback from the event has been overwhelmingly positive. 97.5% of attendees rating the event as excellent or good (with 62% rating it as excellent). Attendees also reported that attendance had improved their knowledge and skills in relation to adult safeguarding and 20 people volunteered to become adult safeguarding champions following the event.

4.6 The importance of prevention was a theme throughout the Learning and Networking Event, and there are many examples of how local initiatives in Hartlepool are working well to support the prevention agenda. As an example, a joint project between Trading Standards and Adult Services has supported 32 vulnerable adults who were the victim of nuisance calls over the last 5 years, by providing equipment free of charge that blocks these calls. These individuals received a total of 17,776 nuisance calls; of which 17,732 were blocked by the equipment that was provided. This has had significant benefits for the victims, reducing stress and mental health problems that are linked to being the victim of such crime, as well as preventing people falling prey to financial scams. A cost benefit analysis suggests that for every £1 spent on the scheme, the benefits have been worth £10.

4.7 Further information on work that is undertaken by the Council's Trading Standards Team (who work in partnership with adult services) is attached as **Appendix 3.**

5. RISK IMPLICATIONS

5.1 There are no risk implications identified associated with this report.

6. FINANCIAL CONSIDERATIONS

6.1 There are no financial implications identified specifically associated with this report, Hartlepool Borough Council, along with other statutory partners (Local Authorities, Clinical Commissioning Groups and Cleveland Police), makes an annual contribution to the running costs of the TSAB and the associated Business Unit. Adult Services funding supports a range of initiatives that provide advice, information and guidance; as well as services that focus on prevention and an adult safeguarding team within the Council.

7. LEGAL CONSIDERATIONS

7.1 There are no legal consideration identified associated with this report.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 There are no child and family poverty considerations identified.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 There are no equality and diversity considerations linked to this report.

10. STAFF CONSIDERATIONS

10.1 There are no staffing considerations associated with this report.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 There are no asset management considerations associated with this report.

12. RECOMMENDATION

12.1 It is recommended that members of the Adult Services Committee note the report and the positive progress being made to increase awareness of adult safeguarding, and consider how they can contribute as Elected Members to further raising awareness.

13. REASONS FOR RECOMMENDATIONS

13.1 Adult safeguarding falls within the remit of the Adult Services Committee, and the Committee has previously expressed a commitment to awareness raising, and ensuring that the public have access to information and support.

14. CONTACT OFFICER

Jill Harrison
Director of Adult & Community Based Services
Hartlepool Borough Council
jill.harrison@hartlepool.gov.uk

Newsletter: Edition Five

January 2018

Teeswide Safeguarding Adults Board

Ensuring our safeguarding arrangements act to help and protect adults

Summary of the Work of the Board

The Board last met on **13 December 2017**. The agreed and published minutes of previous meetings can be accessed here: https://www.tsab.org.uk/key-information/board-minutes/

Annual Survey

The **Board's Annual Survey 2017-18** is open until 23 March 2018. Professionals are asked to complete the survey, which can be **accessed here:** https://www.surveymonkey.co.uk/r/TSAB17-18Pro

A version of this survey is also available for members of the public and can be **accessed here:** https://www.surveymonkey.co.uk/r/TSAB17-18Pub

Adult Safeguarding Learning and Networking Event: South Tees

The Board is hosting this event on 20 March 2018 for organisations delivering health and wellbeing related services to adults in Middlesbrough and Redcar & Cleveland. The aim is to help guide professionals who are responsible for leading on adult safeguarding work in their organisations, on how to establish the policies, procedures and overall culture needed to protect adults, and to help build a 'whole community approach' to the prevention of adult abuse and neglect. Those who should apply include: Alcohol and Substance Misuse Agencies; Organisations Supporting Carers, and or Personal Assistants; Dentists Practices; GP Practices; Mental Health Service Providers.

More information can be viewed here:
https://www.tsab.org.uk/events/event/south-tees-adult-safeguarding-learning-networking-event/

Safeguarding Adults Training for Managers of Services

The course is being held on 12 -13 March and 22 - 23 March 2018 and aims to equip managers of services to be confident in their role of preventing and responding to abuse, applying the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) legislation, and managing safe services. **Those who should apply are:**

- Registered Care Home Managers and their Deputies
- Day Service Managers
- Clinical Matrons
- Safeguarding Leads in Health and Social Care Services
- Protecting Vulnerable People Unit Officers (Cleveland Police)
- Safeguarding Leads in Cleveland Fire Brigade.

More information can be viewed here:
https://www.tsab.org.uk/professionals/events-key-dates/

You Tube Channel

There is a You Tube Channel which hosts all of the video materials created by, or purchased by the Board.

This includes a **'playlist'** of all of the videos signposted on the Board's website, as well as other recommended materials that link to all of the relevant strands of adult abuse and neglect.

Anyone can **subscribe** to this Channel which is updated periodically: https://www.youtube.com/channel/UCMxNFNZsoxIc3YZEVXisx_w

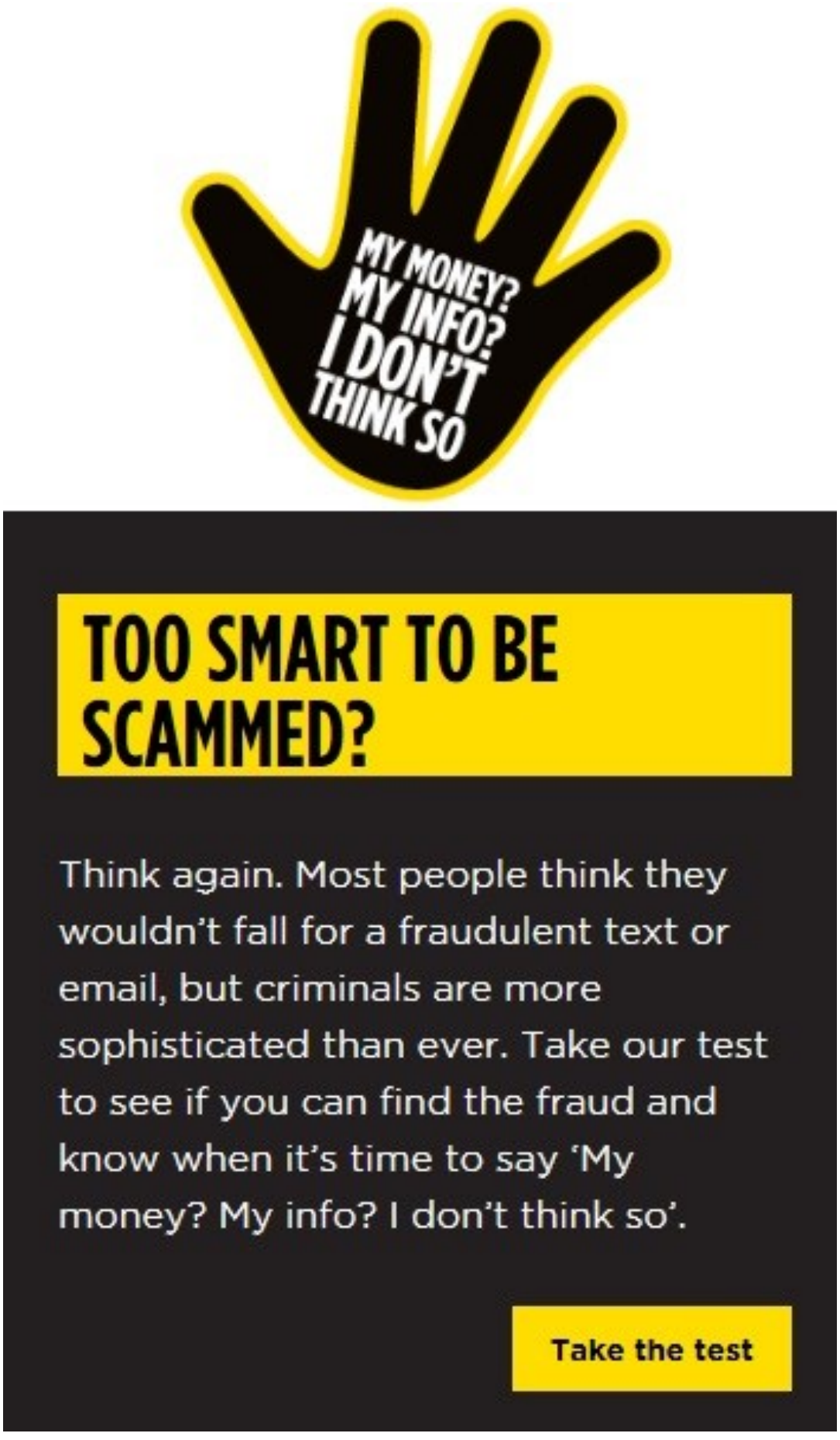
National News

Why are Loneliness and Isolation Safeguarding Issues?

While loneliness and social isolation are separate issues, there is a strong link and interplay between them.

Emotional vulnerability due to loneliness and social isolation may increase the risk of scams and other forms of abuse. Loneliness is identified as one of main indicators of social well-being, and can therefore be a ‘tipping point’ for an individual being referred to health and social care services.

Conversely a protective factor against adult abuse and harm is having numerous, strong relationships with people of varying social status. By taking a proactive approach in tackling loneliness, organisations can help prevent adult abuse and neglect. **More information on this subject can be found here**: https://www.campaigntoendloneliness.org/



Take Five to Stop Fraud

Are you too smart to be scammed?

Take the test and find out:
https://takefive-stopfraud.org.uk/takethetest/

Take Five To Stop Fraud is part of a national campaign from Financial Fraud Action UK and the UK Government, backed by the banking industry coming together to tackle fraud.

More information is available via this online guide:
https://takefive-stopfraud.org.uk/advice/

National News

Modern Slavery Awareness & Victim Identification Guidance

This guidance provides clear and up to date information on the key facts, and help for public sector workers who may not routinely come across modern slavery, to recognise the signs and respond appropriately so that more victims get help and perpetrators are brought to justice:

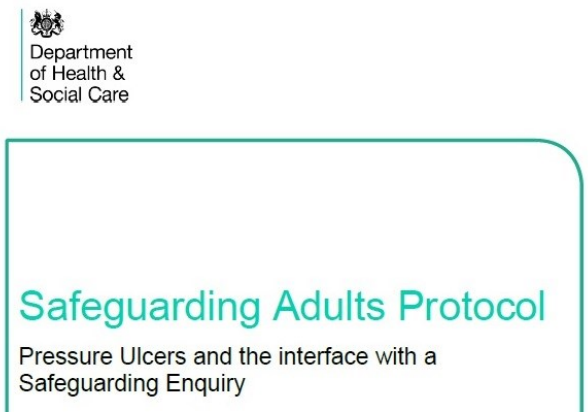
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/655504/6.3920_HO_Modern_Slavery_Awareness_Booklet_web.pdf

Royal College of General Practitioners: Safeguarding Adults at Risk of Harm Toolkit

The Safeguarding Adults at Risk of Harm Toolkit provides information, templates and handy guides. This assists in developing the knowledge of, and use of relevant legislation when promoting good care for adults at risk of harm, or those lacking the capacity to make relevant decisions.

The toolkit can be used by any general practice in the UK:
http://www.rcgp.org.uk/clinical-and-research/toolkits/safeguarding-adults-at-risk-of-harm-toolkit.aspx

Pressure Ulcers and the interface with a Safeguarding Enquiry



This guidance aims to assist practitioners and managers across health and care organisations in providing caring, speedy and appropriate responses to individuals at risk of developing pressure ulcers. “This is a real opportunity to improve the lives of individuals and their families in a way that has the potential to significantly improve the quality of life for a great many people”. **Lyn Romeo, Chief Social Worker for Adults**:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/675192/CSW_ulcer_protocol_guidance.pdf

Domestic Violence and Abuse: Help from Department of Work & Pensions (DWP)

This guide provides information for victims of domestic violence and abuse about the services and support offered by the DWP. This includes special conditions for:

- Housing Benefit
- Jobseeker’s Allowance
- Employment and Support Allowance
- Universal Credit
- The benefit cap
- Removal of the spare room subsidy
- Discretionary Housing Payments
- Migrant partner support
- Child maintenance.

https://www.gov.uk/government/publications/domestic-violence-and-abuse-help-from-dwp

Local News

Awareness Campaign

The Board is delivering an awareness campaign between 4 and 18 February 2018 which is designed to: **"improve the profile of adult abuse related issues across Tees, and in doing so act to help and protect adults".** The campaign has the following key elements:

Radio

There will be a radio advert **"Terry's Story"** running throughout the day over the two weeks on Smooth Radio and Community Voice FM (CVFM), which is a station transmitting to the BME communities in central Middlesbrough.

There will also be a series of live interviews on CVFM with professional guests who have a link to the work of the Board, discussing a number of key issues and providing information to members of the public.

Newspapers

There will be adverts and a news article in the printed and online newspapers of **The Evening Gazette** (first week), and **Hartlepool Mail** (both weeks).

Social Media and Online

All of the above agencies will be delivering digital adverts and direct messages to their followers and subscribers over the period of the campaign, and the Board will also be using Twitter, Facebook and You Tube to promote the key campaign themes:

- **Protecting adults from abuse and neglect**
- **Preventing adult abuse and neglect** (including finding support in your local area).

Events

There will be a 'footfall' activity in prominent locations in each of the four Boroughs during the first week of the campaign, where leaflets will be handed out to members of the public:

Monday: Cleveland Centre, Middlesbrough
Wednesday: The Market, High Street, Stockton-on-Tees
Thursday: Central Community Hub (Library), Hartlepool
Friday: The Market, High Street, Redcar.

Support and Join the Campaign - Three Simple Steps:

1. Follow and support the Board via Social Media and ask your organisation to do the same:

@TeeswideSAB/ TSAB@TeeswideSAB

2. Use this Newsletter as the basis of a conversation, or as a briefing session in a team meeting, and think about the key message of the campaign: **Do you know how to prevent adult abuse and neglect**?" and what more you can do to help achieve this, including links to relevant training: https://www.tsab.org.uk/professionals/training-resources/

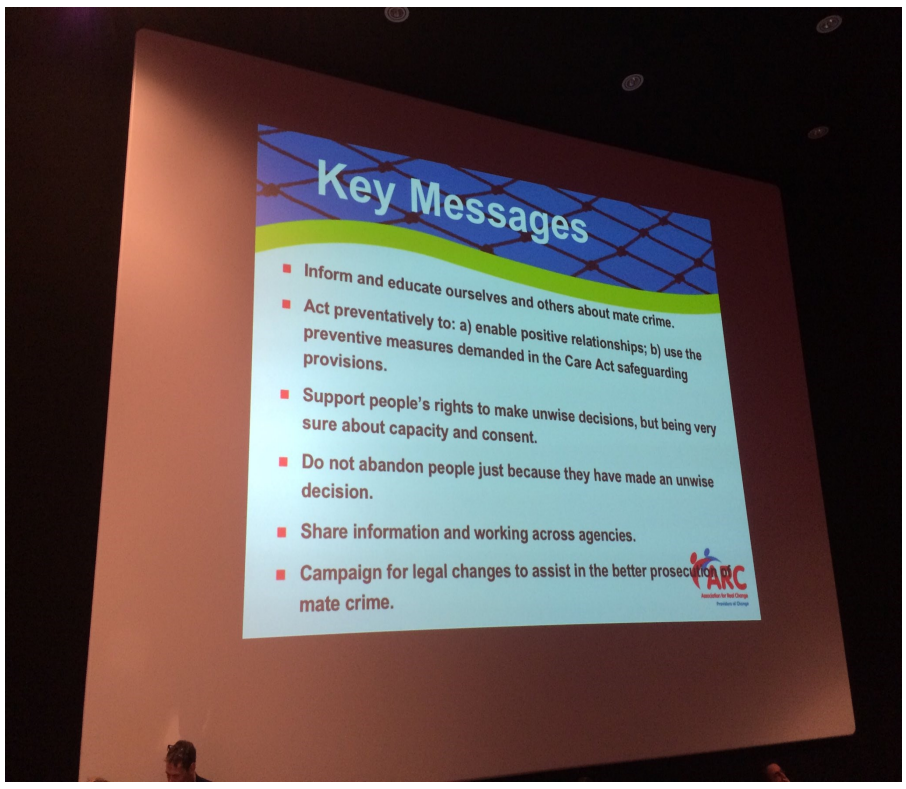
3. Encourage others to follow steps 1 & 2.

Local News

Regional Mate Crime Conference: 22 January 2018

This event was jointly delivered by the South Tyneside Safeguarding Adults Board and Community Safety Partnership, the Northumbria Police and Crime Commissioner, and Sunderland University. This date was chosen as this was the 10th Anniversary of the death of **Brent Martin** who was the victim of a mate crime related murder in Sunderland, and as such was designed to "test the temperature" in assessing the progress made in tackling this issue.

Rod Landman from the Association for Real Change (ARC) outlined these key messages:



- Inform and educate ourselves and others about mate crime.
- Act preventatively to:
  - Enable positive relationships
  - Use the preventative measures demanded in the Care Act safeguarding provisions.
- Support people's rights to make unwise decisions, but being very sure about capacity and consent
- Do not abandon people just because they have made an unwise decision
- Share information and working across agencies
- Campaign for legal changes to assist in the better prosecution of mate crime.

See back page for further information.

The **campaign #WhoRYa** was launched in January 2018 and includes a bespoke video resource **"Think Before You Link"** which provides advice about online safety, specifically for adult's with a learning disability. This can be **viewed here:**
https://www.youtube.com/watch?v=reEF95RLQgc

A documentary about the campaign can also be **viewed here:**
https://www.youtube.com/watch?v=9Vrs2Qnqjtk

(Above: Extract from the "Think Before You Link" Video)

Halo House

The Halo Project have now opened their new six-bedroom specialist refuge. This provision is DCLG (Department of Communities and Local Government) funded and supported by the six Tees Valley & Durham local authorities. They can accept victims of abuse from the BME community and there is also provision for women with no recourse to public funds.

The Halo House is located within Tees Valley and if you need any further information or to make a referral, please get in touch on: **01642 683045**.
http://www.haloproject.org.uk/halo-house-bme-specialist-refuge-W21page-88-

Teeswide Safe Place Scheme

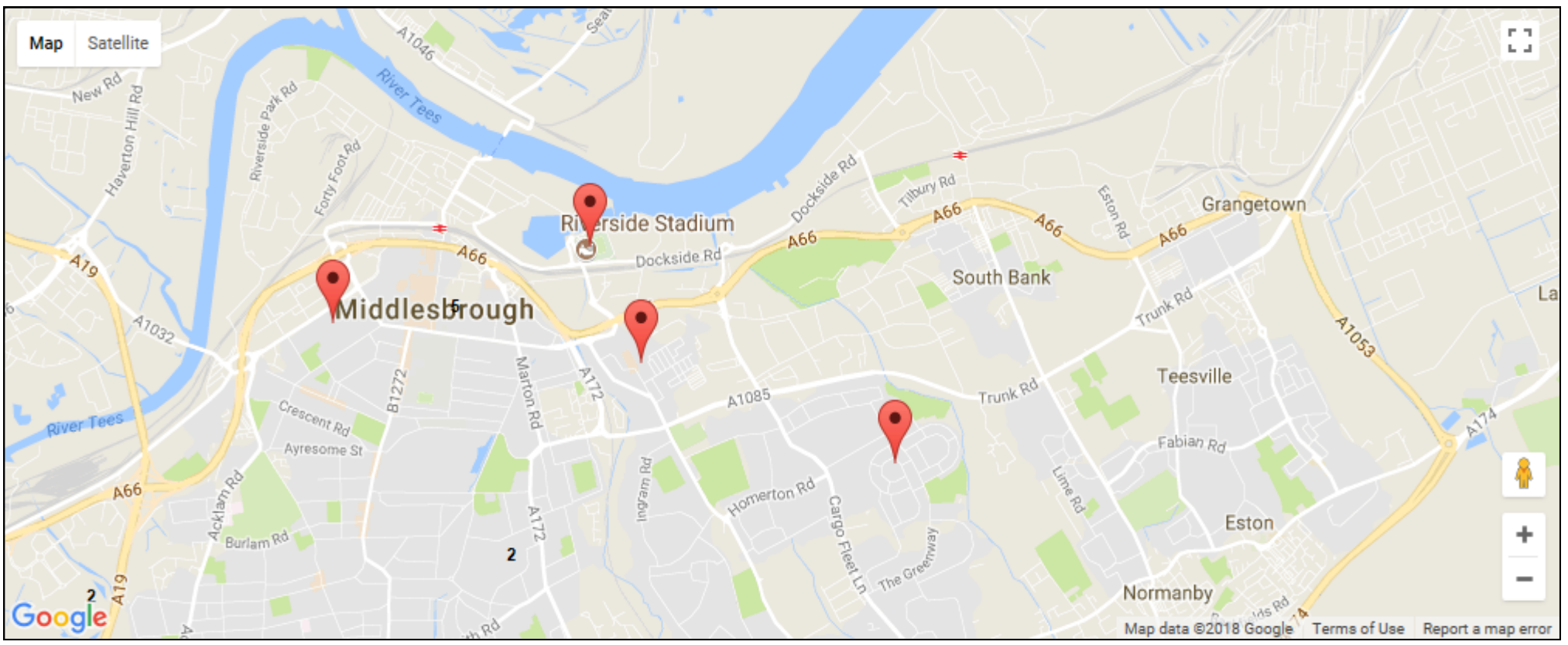
The Teeswide Safe Place Scheme aims to create and develop a network of safe places in key community locations throughout each Tees Borough, for anyone who feels vulnerable, threatened or anxious due to real or perceived behaviour of others around them.

The scheme promotes the well-being and independence of adults, and in doing so provides a balance between encouraging adults to make informed choices about their well-being, whilst providing a network to support this. Many who benefit from the scheme will never actively use the locations, although the existence of them allows people to feel safer and plan how to be more actively engaged within their local communities. Examples of how the scheme has helped people:

- A phone call to home
- Help with directions and providing reassurance
- Helping to support someone who had suffered from verbal abuse.

Agencies are asked to help promote and publicise the scheme.

An interactive map of all the Teeswide Safe Place locations can be found on this webpage: https://www.tsab.org.uk/find-support-in-your-area/safe-place-scheme/ which can also be found by using this QR TAG:



Adult Carers Support Service

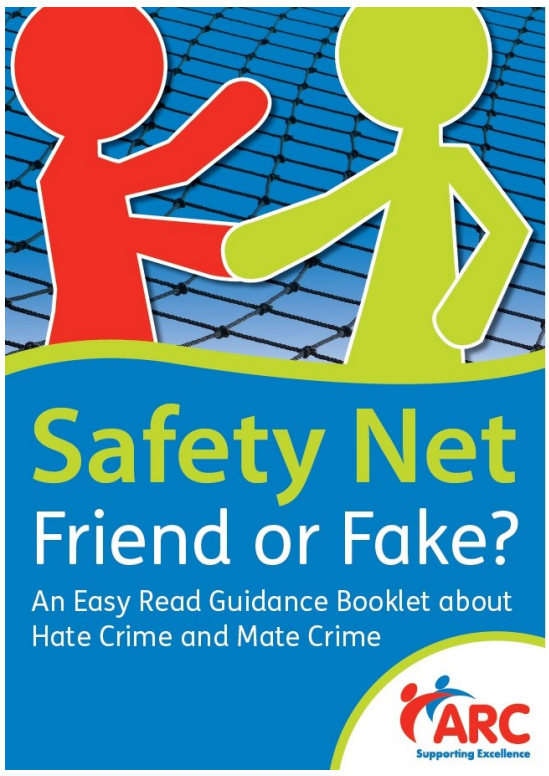
Stockton-on-Tees BOROUGH COUNCIL

From 1 January 2018 the Adult Carers' Support Service is provided by Stockton-on-Tees Borough Council and located within Adult Services. The Service will continue to be open to all Carers who are 18 years of age or above who reside in the Borough, or live outside the Borough but the person they care for lives in Stockton-on-Tees.

If you would like further information or wish to refer Carers, please contact the Adult Carers' Support Service by telephone on **01642 524494** or by email: carerssupport@stockton.gov.uk.

Primary Prevention/Early Help Information

Hate And Mate Crime Guidance Booklet



The ARC Safety Net Projects **Friend or Fake Booklet** is a useful resource outlining some of the key messages linked to hate and mate crime:
http://arcuk.org.uk/safetynet/files/2012/08/Friend-or-Fake-Booklet.pdf

There is also a short film (13 minutes) produced by Shoot Your Mouth Off (SYMO) and developed by members of the South Tyneside Community Safety Partnership.

It is based on a real life case study and is suitable for a number of different audiences in raising awareness of learning disability hate and mate crime:
https://www.youtube.com/watch?v=2N0OmDIoGVI

Stay Safe and Warm

Cleveland Fire Brigade works with a number of partners to raise the awareness of dangers faced by people who struggle to keep warm. There is no criteria other than you or someone you know is at risk of the effects of cold, either long or short term. For instance: if a boiler breaks down and parts are on order; or when a heating system has been condemned and the resident is unable to pay for replacement or repairs; and some people simply cannot afford to have the heating on, or their existing heating supply is inadequate and fails to heat their property.

Stay Safe & Warm is available to anyone in need. It is free and there's no means testing or age restrictions. If you or someone you know could benefit from this service, please contact: **01429 874063**
http://www.clevelandfire.gov.uk/safety/community-safety/warm/

Portable heaters · Thermal blankets · Torches · Wind-up lanterns · Flasks

Find Support in Your Area

The Board's website also maps relevant support services by strand of abuse and by each individual Borough across Tees. This is reviewed and updated periodically, although it is not intended to be a definitive source of information for all service providers:
https://www.tsab.org.uk/find-support-in-your-area/

Your Comments

If you have any **suggestions** for these Newsletters:
https://www.tsab.org.uk/your-comments/
01642 527263

Do you know how to prevent adult abuse and neglect?

I look out for the vulnerable and lonely people I know

I have a wide network of support and help

I know how to avoid financial scams

I am part of a support group for carers

I know how to report adult abuse and neglect

There are lots of ways to help prevent adult abuse and neglect.

For more information visit the website

www.tsab.org.uk

Teeswide Safeguarding Adults Board

Trading Standards Update

Scams in general cover a very broad range of activities employing a raft of methods to get the subject to send money to them. The more popular scams are fake prize draws, lotteries, phishing scams, romance scams, the Microsoft Scam and courier fraud to name a few.

Doorstep scams include a variety of activities ranging from "Nottingham Knockers" which are individuals purporting to be rehabilitating offenders selling cleaning products, traders offering unnecessary and over priced home improvements, fish sellers and distraction burglars.

In addition to the financial impact on the victim, there can be physical and mental effects on people:

- 3 months following the incident, 10% of victims have unexplained admissions to hospital
- Older victims decline in health faster than non victim peers, 40% of victims report a change in their quality of life & confidence
- In the 2 years following an incident, the victims are almost 2.5 times more likely to be in residential care homes or have died

*Figures obtained from Operational Liberal, a National Intelligence Unit focussing on Doorstep Crime and distraction Burglary operated by Leicestershire Police.

Trading Standards are a small mainly reactive team so when complaints are received about this criminality, they will respond to each and every complaint. Regrettably however reporting is very low so in an attempt to improve this and reduce the possibility of Hartlepool residents falling for any type of scam, a number of projects are currently underway.

1. Banking Protocol – If a bank believes that a customer is being subjected to a doorstep scam incident and have been brought to the bank by the trader, they can take them to one side and call the police using the 999 emergency number. Cleveland Police are dedicated to this service and will provide a uniformed officer at the earliest opportunity. In addition to this, the banks have been provided with a simplified Welfare Referral form if they believe the customer requires other assistance not covered by the Protocol, concerns for capacity or self neglect for example.

2. Training Carers – Contact has been made with care agencies in the town to offer them the chance of a short training session to raise awareness of scams and give them a contact for reporting. The training has been delivered to a number of carers and resulted in justified complaints being received.

3. Royal Mail – Working with the sorting office to train postal workers on how to identify potential victims to allow the information to be referred through to Trading Standards for support to be provided.

4. No Cold Calling Zones (NCCZs) – Allows a resident to request their street to become a zone where cold callers are not permitted. Once consultation is complete, the zone is identified by a sign attached to a lamppost.

5. Call Blockers – If a person has fallen for a telephone based scam, they can be provided with a call blocker that prevents them.

6. Memo Cams – If a person has fallen for a doorstep scam, they can be loaned a camera that captures all callers that come to their door. This reassures the subject and gives the home owner the confidence to remain in their homes.

7. Talks – the trading standards team have attended lunch clubs and resident meetings to raise awareness.

8. Educational materials can be provided as well as very useful information.

ADULT SERVICES COMMITTEE

1 March 2018

Report of: Director of Adult and Community Based Services

Subject: ACCESS TO TRANPSORT FOR PEOPLE WITH A DISABILTY

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1. TYPE OF DECISION/APPLICABLE CATEGORY

1.1 For information.

2. PURPOSE OF REPORT

2.1 To provide an update to the Adult Services Committee on the review of access to transport for people with a disability.

3. BACKGROUND

3.1 Hartlepool Borough Council is committed to supporting local citizens through effective consultation. Transport and access to transport within the Borough is regarded as one of the top three priorities when consulting with adults with a disability.

3.2 The Equality Act 2010 came into force in October 2010 and most transport is covered by the rules on services to the public in Equality Act Part 3.

3.3 The Disability Rights Commission (DRC) issued a statutory Code of Practice on provision and use of transport vehicles in 2006 which sets out in some detail how the DRC saw the transport rules working under the former Disability Discrimination Act 1995 (DDA).

3.4 Although the DDA has now been superseded by the Equality Act 2010, it has been referred to in past cases and is still helpful.

3.5 The Council's Audit and Governance Committee conducted a review of access to transport for people with a disability, following a referral from Adult Services Committee and the outcome was reported back to Adult Services Committee in July 2017.

3.6 The Adult Services Committee response to the findings included a request for the Council's passenger transport section to provide a further update to members. Jayne Brown, Passenger Transport Team Manager is in attendance to provide an update via a short presentation.

4. UPDATE ON ACTION PLAN

4.1 An update on the action plan presented to Committee on 27 July 2017 is attached as **Appendix 1**.

5. RISK IMPLICATIONS

5.1 There are no risk implications identified associated with this report.

6. FINANCIAL CONSIDERATIONS

6.1 There are no financial implications identified associated with this report.

7. LEGAL CONSIDERATIONS

7.1 There are no legal consideration identified associated with this report.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 There are no child and family poverty considerations identified.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 Hartlepool Borough Council is required to work within the principles of the Equality Act and where it procures, provides or promotes transportation within the Borough it must consider the impact of its services for people with a disability ensuring equality of access to transport as prescribed within the Disability Rights Commission Code of Practice.

10. STAFF CONSIDERATIONS

10.1 There are no staffing considerations associated with this report.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 There are no asset management considerations associated with this report.

12. RECOMMENDATION

12.1 It is recommended that the Adult Services Committee note the report, the update provided via a presentation and the updated action plan.

13. REASONS FOR RECOMMENDATIONS

13.1 The review by the Audit and Governance Committee highlighted concerns regarding access to transport for adults with a disability. The Adult Services Committee requested updates on progress to address these concerns.

14. BACKGROUND PAPERS

Adult Services Committee, Agenda and Minutes 27 July 2017
www.hartlepool.gov.uk/meetings/meeting/3605/adult_services_committee

15. CONTACT OFFICERS

Neil Harrison
Head of Service
Adult and Community Based Services
Hartlepool Borough Council
neil.harrison_1@hartlepool.gov.uk
Tel 01429 52 3751

Jayne Brown
Passenger Transport Team Manager
Hartlepool Borough Council
jayne.brown@hartlepool.gov.uk
Tel 01429 52 3526

AUDIT AND GOVERNANCE SCRUTINY ENQUIRY ACTION PLAN

NAME OF COMMITTEE: Adult Services Committee - Update March 2018

NAME OF SCRUTINY ENQUIRY: Access to Transport for People with a Disability

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION[+]	FINANCIAL / OTHER IMPLICATIONS	UPDATE
(a) That a mapping exercise be undertaken to explore the viability of a travel membership club for people with disabilities to access, as and when required, with a detailed exploration of the following areas:-	(a) A number of discussions have been held with local providers who expressed an interest. • A consortium of local businesses were considering the option of developing and investing in a scheme to support local citizens, however following due diligence concluded that there was little evidence to suggest it would be successful or cost neutral. • A private provider with experience of providing transport for adults with disabilities has expressed interest in purchasing a vehicle to set up an alternative travel service. • Community Travel Clubs - Clubs can be established in geographical areas by a number of community groups, Transport Champions, Parish Councils etc to consider the travel needs of individuals within their community. The travel club determines the needs of its members and the Local Authority can provide the service	Previous 'Dial a Ride' running costs in excess of £250,000 per annum to operate. Cost to run service is unknown, a provider is willing to contribute towards set up costs. Costs of journeys will vary depending on the needs of each group; the charge is made up of proportional costs of the vehicle, driver and fuel. Several community travel clubs are operating via Passenger transport none of which are subsidised routes. No cost to	**March 2018** A private provider continues to provide a community travel club, having purchased a wheelchair accessible vehicle. The service is open to all ages and provides door to door transport for people with a disability or health problem. The service can be used for short journeys such as shopping, visiting friends, attending health appointments and social occasions.

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION[+]	FINANCIAL / OTHER IMPLICATIONS	UPDATE
	required The Council's Passenger Transport Service has a variety of vehicles available to support a Community Travel Club scheme, ranging from 67 seat coaches, 33 seat buses and 17 seat minibuses, including vehicles suitable for those using mobility aids. These vehicles would potentially be available to travel clubs outside of school travel times, evenings and weekends. Transport provision would be flexible and delivered on a demand lead basis across a varied geographical area. The cost of each journey will be predetermined and shared between the patrons using the service. There is interest from a provider operating a patient transport service in Durham (NHS - transport) which has a number of vehicles and volunteer drivers. The provider is interested in exploring options to extend into Hartlepool.	the Council Service is funded through a contract with Durham CCG an Durham CC (public health grant)	**March 2018** Presentation to Committee from Jayne Brown, Passenger Transport Team Manager
(i) Identification of the actual number of people affected;	(i) Information provided from a number of sources, no definitive list of the number of people reliant on a wheelchair. • Office for National Statistics (2011 census) - 1.9% of the UK population uses a wheelchair (Hartlepool = 1,757). • Number of people claiming Severe Disablement Allowance (SDA) in Hartlepool = 480. • North Tees and Hartlepool NHS Trust has 3,709 adults and 452 children registered with	A definitive number of people cannot be predicted.	(i) Estimates suggest that over 1000 people in Hartlepool may not have access to a vehicle

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION[+]	FINANCIAL / OTHER IMPLICATIONS	UPDATE
	wheelchair services (Hartlepool = 1,387).		
(ii) Membership fees for those wishing to access the service (exploring whether it could be funded from direct payments, independent living / mobility payments);	(ii) An adult meets the eligibility criteria if their needs arise from or are related to a physical or mental impairment or illness; as a result of those needs the adult is unable to achieve two or more of the outcomes specified below and as a consequence there is, or is likely to be, a significant impact on the adult's well-being. The specified outcomes are— • managing and maintaining nutrition; • maintaining personal hygiene; • managing toilet needs; • being appropriately clothed; • being able to make use of the adult's home safely; • maintaining a habitable home environment; • developing and maintaining family or other personal relationships; • accessing and engaging in work, training, education or volunteering; • making use of necessary facilities or services in the local community including public transport, and recreational facilities or services; and • carrying out any caring responsibilities the adult has for a child.	(ii) Adult services currently have a service level agreement with HBC passenger transport to provide wheelchair accessible vehicles to people using its day services. The cost to support on average 61 people with a learning / physical disability is circa £240,000 per annum. The service has access to 5 vehicles and on average 14 spaces are allocated to people who are reliant on a wheelchair. If the buses were only utilised for wheelchair users this would equate to a daily cost of £40.18, however the bus is also used by people who do not require a wheelchair and has been set at £10 per day, or £18 per day for those who require a passenger assistant.	(ii) The SLA is still in place supporting people with a learning / physical disability. The journey and route times have improved since moving into the new Centre for Independent Living
(iii) Funding from Ward Member Budgets, the CCG and NTHFT to help towards	(iii) Head of Service to work in partnership with prospective organisations to pull together a bid to pump prime the running of a service.	(iii) Potential to pump prime a new service, cannot guarantee bid would be successful and would not create sustainability in the long term	**March 2018** (iii) DCLG bid submitted in January 2017 was unsuccessful

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION[+]	FINANCIAL / OTHER IMPLICATIONS	UPDATE
the running of the service; and (iv) The use of volunteer drivers	(iv)Meeting held with 'Supportive', which has 150 volunteer drivers in Durham. Subsidised service funded by public health and Durham CCG, provider is keen to expand into Hartlepool.	To develop a scheme in Hartlepool would require initial pump priming and a campaign to recruit and increase the number of volunteer drivers. The service in Durham is subsidised through Health and Children's services supporting Looked after Children and supervised family contact and Hospital and GP appointments	(iv) 'Supportive' continue to show an interest in further developing their volunteer driving scheme, at present they have 7 drivers from the Hartlepool area.
(b) That the potential of accessing / expanding existing Charity run schemes in the region be explored	RSVP (Retired and Senior Volunteer Programme) runs many driving schemes across the UK which provide free or low-cost door-to-door service for older or more vulnerable people NEAS - Ambulance Car Service Drivers (ACS) are volunteers who use their own vehicles to help with the transportation of patients to and from hospitals and clinics, thereby leaving ambulances free for emergencies and for patients too ill to travel by car. Over 150 volunteers helping out throughout the North East.	Cost is subject to individual requirements. Currently looking for any Ambulance Car Service volunteers in the Teesside, Darlington, Middlesbrough and Stockton-on-Tees areas and Hartlepool Volunteers are not paid for their time, however they do receive out of pocket expenses for their mileage.	**March 2018** Presentation to Committee on existing scheme supporting North Tees & Hartlepool NHS Trust
(c) (I) A request is made to provide a hospital shuttle bus	(I) Contact made with Brian Christelow, facilities manager at NT&HFT.	The service is funded by the Hartlepool and Stockton on Tees Clinical commissioning Group (CCG)	**March 2018** Presentation to Committee on the Hospital to Home service

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION[+]	FINANCIAL / OTHER IMPLICATIONS	UPDATE
that is wheelchair accessible and can be used at all times including peak periods; and (ii) Explore whether this service could be included in a wider partnership scheme, such as the travel club	(i) Highlighted the recommendations in the report and proposal that a WAV be considered when procuring hospital transport (ii) Scheme already runs alongside the NEAS passenger transport service and volunteer ACS driver's scheme.		**March 2018** Presentation to Committee on the Hospital to Home service **March 2018** It is understood that the service is under review and looking to reduce the number of journeys between North Tees and Hartlepool Hospitals
(c) Examine whether a pre-bookable service could be put in place to provide transport to GP / hospital / dental appointments which is co-ordinated and booked by the health service, when appointments are made;	(d) Meeting held with Tracie Jacobs (H&ST CCG) and John Davison (CEO) of ' Supportive' who operate a Health Appointment Car Scheme (HACS) across Durham The provider is keen to expand into Stockton and Hartlepool.	Service is reliant on funding, and is subsidised by grants from Durham CCG and Durham County Council Further work required to identify the level of subsidy required.	There was previously a GP pre bookable transport service but the GPs gave notice on this as it was deemed to be too time consuming. Hospital Trusts are now able to make the bookings with NEAS online, for follow up outpatients' appointments and planned admissions. There are no investment

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION[+]	FINANCIAL / OTHER IMPLICATIONS	UPDATE
			opportunities at this time from the CCG, above and beyond the PTS service which is commissioned.
(d) In relation to the Patient Transport Service, ensure that the assessment criteria includes arrangements for carers to travel with patients and that this is implemented on all journeys when needed;	(e) Discussed and shared the report with CCG and NT&HFT	Awaiting feedback re future plans linked to conveyance.	There is a process to assess the requirement of an escort to accompany the patient on the journey. If a patient has a requirement for a carer, then this is considered and authorised where appropriate. The report shared previously shared, which includes the eligibility criteria is attached as **Appendix 2.**
(e) Explore the potential of any financially viable options for drivers and taxi companies to provide wheelchair accessible transport along with the potential of any available	(f) Discussion with local Transport Provider willing to provide a WAV. Provider has produced estimated costs of running a service. Provider agreed to await the outcome of further work to ascertain future demand.	(f) Initial discussions suggest an incentive of £2-£3 per journey may be sufficient to encourage Taxi Companies to provide WAV. Using the Severe Disablement Allowance SDA figure of 480 people, with an average of 6 journeys per week at £3, it would equate to around £449,000 in subsidies.	**March 2018** A private provider continues to provide a community travel club, having purchased a wheelchair accessible vehicle.

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION[+]	FINANCIAL / OTHER IMPLICATIONS	UPDATE
funding streams			

Good Health - Everybody's business

Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Introduction to Patient Transport Services

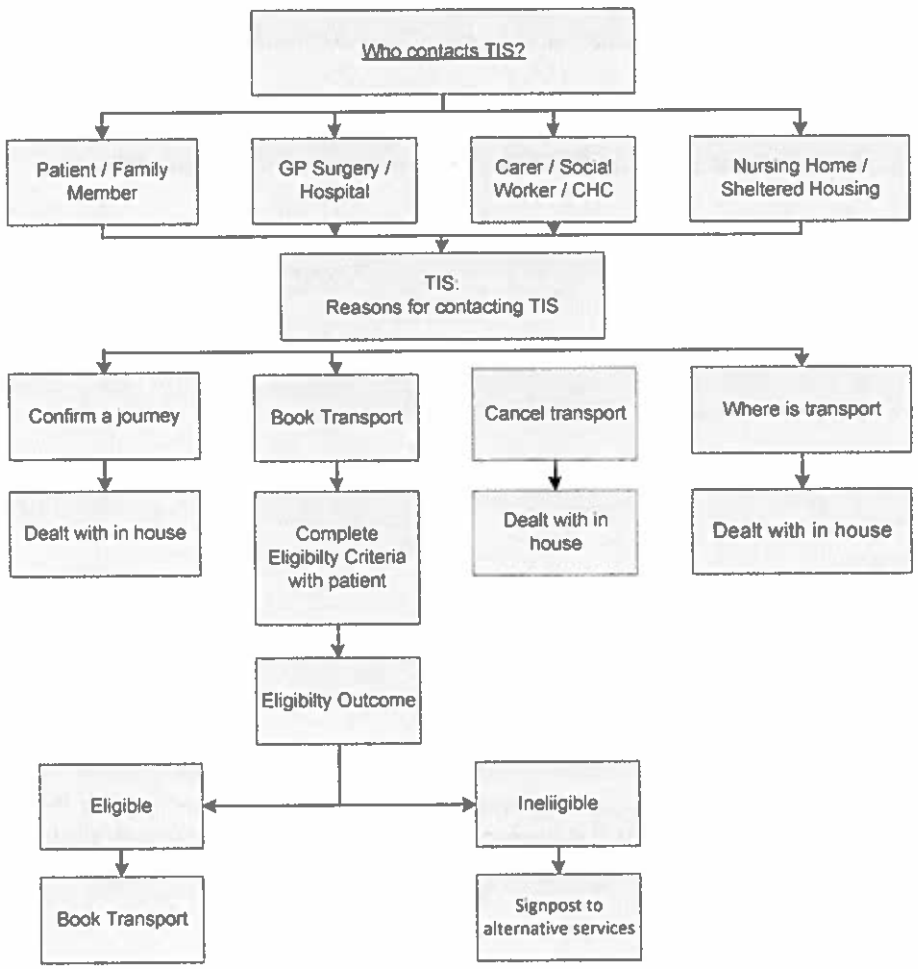
Patient Transport Services (PTS) provide pre-planned, non-emergency transport for patients travelling to a hospital or treatment centre. Transport is provided for patients who have a medical condition that would prevent them from travelling to their appointment by any other means, or who require the skills of an ambulance crew assistant during the journey.

In 2007 the Department of Health published guidance around appropriate use of NHS funded PTS. The purpose of this document was to provide criteria for establishing which patients were eligible for non-emergency patient transport services. The Teesside area was one of the first to implement the criteria. This was not consistent across the North East, which produced something of a post code lottery when it came to receiving PTS. Due to this and what was acknowledged to be an unsustainable increase in demand on local PTS provision, the north east Clinical Commissioning Groups (CCGs) collectively agreed in 2014 that it was time to implement a consistent, region wide criteria for determining patient eligibility.

The new criteria were implemented on the 20th October 2014 and since this date, the criteria have been asked for every booking.

Transport Information Service (TIS) deliver a Teeswide booking service for patients requesting NHS Patient Transport Services, and assess all patients contacting the service. A series of eligibility criterion is applied on each occasion a transport request is made to determine the suitability of patients requiring transport. Answers provided by the patient to the eligibility questions, establish their medical and mobility needs for the service. Transport is booked according to the outcome of the assessment.

Process Map



PTS Criteria

The following eligibility criteria are applied on each occasion a patient requests Patient Transport Services. A patient is required to score 31 points or over to become eligible for patient transport:

Eligibility Criteria for transport:

Is the patient's appointment for radiotherapy, chemotherapy or renal dialysis?

Yes	[50]
No	[0]

Is the patient registered blind?

Yes	[50]
No	[0]

Is the patient's journey for an inter-hospital transfer or hospital discharge?

Yes	[50]
No	[0]

Does treatment prevent the patient from making their own way home safely?

Yes	[50]
No	[0]

Is the patient able to use their own transport?

Yes	[0]
No	[0]

Can the patient drive comfortably to the hospital/clinic?

Yes	[Ineligible]
No	[0]

Is the patient able to use public transport to attend the hospital/clinic?

Yes	[Ineligible]
No	[0]

Does the patient have friends or family who could take them to the hospital/clinic?

Yes	[Ineligible]
No	[0]

At this time how does the patient normally travel to do their shopping and other general outings?

Done by someone else	[10]
Walk	[7]
Mobility Scooter	[7]
Community Transport	[2]
Other- Car, Taxi, Private Hire	[Ineligible]

At this time how does the patient move around their own home?

Confined to a bed	[31]
Only with a carer/parent	[18]
In a wheelchair	[7]
Using a Zimmer frame	[6]
Using a walking stick or crutches	[5]
Walking	[4]

At this time how far can the patient move outside of their home?

Nowhere	[31]
Into the street	[8]
Around the local area	[5]
To a main town	[0]

Given what you have told us about how the patient moves in and around their home, does the patient need support with getting from the hospital entrance to the relevant department/clinic?

Yes [10]
No [0]

Does the patient have any sight or hearing impairment which prevents them finding their own way?
Yes [31]
No [0]

Is the patient in regular contact with any mental health services?
Yes [31]
No [0]

Does the patient require Oxygen from our staff en route to hospital /clinic?
Yes [31]
No [0]

Eligibility for Escort: Score required 10

Is the patient 16 years or under?
Yes [10]
No [0]

At this time do any of the following apply when requesting escorts to travel with the patient?
Has a severe communication/learning difficulty? [10]
Requires an escort from a nursing or residential home? [10]
First referral cancer appointment? [10]
[None of the above] [0]

Patients who receive an ineligible decision, are provided with information for alternative means to get to their appointment. Contact numbers and information for voluntary services, shuttle buses, help with their travel costs and wheelchair accessible taxis, are provided to the patient.

NHS organisations work to ensure that users can get into hospital sights safely and conveniently. Consideration is given to the needs of people with disabilities, and Blue Badge holders, and disabled parking spaces are provided at the hospital sights.

Patients who are deemed ineligible for patient transport may also appeal against the decision. Appeals are actioned by the Patient Transport Appeals Team (PTAT) an independent service to maintain neutrality. During an appeal further information is gathered from the patient, and consideration is given to other contributing factors such as, the distance a patient is required to travel to their appointment, assistance requirements from the ambulance crew and how their medical condition prevents them from using other forms of transport to take them to their appointment. A patients GP practice may also be contacted with the patients' permission.

Below are the number of appeals and complaints

Hartlepool & Stockton CCG Appeals - 1 April 2015 to 31 March 2016	
Total number of Stockton patients requesting PTAT to appeal an ineligible decision	87
Total number of Hartlepool patients requesting PTAT to appeal an ineligible decision	98
Total number of appeals	185

Stockton Patient Appeals - 1 April 2015 to 31 March 2016			
Number of appeals decision overturned	Reason for overturning decision	Number of appeals decision upheld	Reason for upholding decision
61	Distance 43	26	Can Use Taxi 21
	Escorts 4		Escort 1
	Other 14		Cost Issue 2
			Other 2

Hartlepool Patient Appeals - 1 April 2015 to 31 March 2016			
Number of appeals decision overturned	Reason for overturning decision	Number of appeals decision upheld	Reason for upholding decision
66	Distance 36	32	Can Use Taxi 20
	Other 29		Escort 5
	Treatment 1		Cost Issue 1
			Other 6

TIS have not received any complaints regarding transport bookings for patients who have a disability during the period 1 April 2015 to 31 March 2016.

ADULT SERVICES COMMITTEE REPORT

1 March 2018

Report of: Director of Adult and Community Based Services and Director of Finance and Policy

Subject: STRATEGIC FINANCIAL MANAGEMENT REPORT – AS AT 31 DECEMBER 2017

1. TYPE OF DECISION/APPLICABLE CATEGORY

For information.

2. PURPOSE OF REPORT

2.1 The purpose of the report is to inform the Adult Services Committee regarding the 2017/18 forecast General Fund Outturn, the 2017/18 Capital Programme Monitoring and to provide details for the specific budget areas that the Committee is responsible for.

3. BACKGROUND AND FINANCIAL OUTLOOK

3.1 As detailed in the Medium Term Financial Strategy (MTFS) report submitted to Finance and Policy Committee on 22 November 2017, the Government will implement further cuts in funding for Councils up to 2019/20. Over the years covered by the MTFS (2017/18 to 2019/20) this means a further grant cut of £9.8m. The Council set a balanced budget for 2017/18, which includes the use of one off reserves. After reflecting the impact of inflation and legislative changes the Council faces continuing funding deficits for the next two years as detailed in the MTFS update report to Finance and Policy Committee on 12 February 2018.

3.2 In view of the ongoing financial challenges the Corporate Management Team will continue to adopt robust budget management arrangements during 2017/18 and as detailed in section 5 it is becoming increasingly difficult to manage the annual budget. This position will need to be managed carefully over the remainder of the financial year, particularly over the winter period where some services face their highest demand and therefore cost of providing services.

4. REPORTING ARRANGEMENTS 2017/18

4.1 The availability and reporting of accurate and up to date financial information is increasingly important as future budget cuts are implemented and one-off resources are used up.

4.2 The Finance and Policy Committee will continue to receive regular reports which will provide a comprehensive analysis of departmental and corporate forecast outturns, including an explanation of the significant budget variances. This will enable the Committee to approve a strategy for addressing the financial issues and challenges facing the Council.

4.3 To enable a wider number of Members to understand the financial position of the Council and their service specific areas each Policy Committee will receive a separate report providing:

- a brief summary of the overall financial position of the Council as reported to the Finance and Policy Committee;
- the specific budget areas for their Committee; and
- the total departmental budget where this is split across more than one Committee. This information will ensure Members can see the whole position for the departmental budget.

5. SUMMARY OF OVERALL COUNCIL FINANCIAL POSITION

5.1 An updated assessment of the forecast 2017/18 outturn has been completed and a net over spend of £0.124m is anticipated, which is lower than previous forecast of £0.250m. The 2017/18 outturn has been prepared to reflect expenditure incurred to date and forecast to be incurred in the rest of the financial year. As Members will be aware from previous years significant elements of the Council's budget are demand led and affected by expenditure over the winter months, including care costs in relation to older people and winter maintenance. The forecasts need to be considered in the context of the complexity of managing a gross General Fund budget of £260m and a net budget of £73m.

Forecast overspend / (under spend) 2017/18

2016/17 Actual Outturn £'000		2017/18 Latest Forecast - Overspend/ (Under spend) £'000
1,502	Departmental budgets outturn	2,254
0	Departmental reserve usage	(1,400)
(1,240)	Corporate budgets outturn	(730)
262	Net Forecast overspend	**124**

5.2 The majority of the forecast overspend relates to continuing costs in relation to Looked after Children, including the cost of care proceedings.

5.3 In order to address the forecast 2017/18 over spend of £0.124m Departments are working on eliminating the deficit by identifying 'discretionary spending' which can be stopped or delayed and capitalising existing revenue spending. If this is not possible this will need to be funded from the Unearmarked General Fund Reserve.

6. 2017/18 FORECAST GENERAL FUND OUTTURN – ADULT SERVICES COMMITTEE

6.1 The Adult Services Committee has responsibility for services managed by the Director of Adult and Community Based Services. Budgets are managed at a Departmental level and therefore a summary of the Departmental position is provided below. The table sets out the overall budget position for the Department broken down by Committee, together with a brief comment on the reasons for the forecast outturn.

Budgets Managed by the Director of Adult and Community Based Services

2016/17 Outturn £'000		Latest Forecast - Overspend/ (Underspend) £'000
(313)	Adult Committee	(600)
0	Departmental Reserves - Adult Services	600
1,641	Children's Committee	2,577
0	Child and Adult Services - Salary Abatement and One-Off Income	(600)
0	Departmental Reserves - Children's Services	123
1,328	**Sub Total - Child & Adult Services**	2,100
	Planned use of Departmental Reserves	
0	Children's Services	(1,400)
0	**Sub Total - Planned use of Departmental Reserves**	(1,400)
1,328	**Net Overspend - Child & Adult Services**	**700**

6.2 Further details of the specific budget areas this Committee is responsible for are provided in **Appendix A**.

6.3 Appendix A shows a nil forecast outturn variance for Adult Services, however it should be noted that there are overspends within commissioning budgets for older people (£300k) and mental health (£150k) and also in relation to Deprivation of Liberty Safeguards (DoLS) (£110k). These overspends are being funded in the current year from non recurrent Improved Better Care Fund grant that supports the protection of social care, which replaces planned use of reserves to balance the budget.

6.4 The MTFS Report considered by Finance and Policy Committee on 22 November 2017 advised Members that short term funding had been provided by the Government in recognition of the significant financial challenges facing adult social care. However, there is no funding commitment beyond 2019/20 and the Government has indicated they will be consulting on a number of options regarding long term funding arrangements for social care in due course.

7. CAPITAL MONITORING 2017/18

7.1 The 2017/18 MTFS set out planned capital expenditure for the period 2017/18 to 2020/21.

7.2 Expenditure against budget to 31 December 2017 for this Committee is summarised in the table below and further details are provided in **Appendix B**.

Department	BUDGET		EXPENDITURE IN CURRENT YEAR				
	A	B	C	D	E	F	G
						C+D+E	F-B
	2017/18 and Future Years Budget	2017/18 Budget	2017/18 Actual at 31/12/2017	2017/18 Expenditure Remaining	Expenditure Rephased to 2018/19	2017/18 Total Expenditure	2017/18 Variance from budget
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Adult Services	510	510	15	495	0	510	0
Total Capital Expenditure	**510**	**510**	**15**	**495**	**0**	**510**	0

8. CONCLUSION

8.1 An updated assessment of the forecast 2017/18 budget outturn has been prepared, reflecting expenditure to date and forecast over the remainder of the year. As detailed in Section 5 a 2017/18 General Fund revenue budget over spend of £0.124m is forecast. This mainly reflects Children's Services pressures and potential Regeneration and Neighbourhoods income shortfalls and Waste Disposal costs. To address the forecast deficit the following options continue to be explored:

- identify 'discretionary spending' which can be stopped, or delayed;
- reserves review has been completed. One off funding may need to be allocated to offset the overspend;
- capitalise existing revenue spending.

If this is not possible the deficit will need to be funded from the Unearmarked General Fund Reserve.

9. RECOMMENDATIONS

9.1 It is recommended that Members note the report.

10. REASONS FOR RECOMMENDATIONS

10.1 To ensure that the Adult Services Committee has up to date information on the forecast 2017/18 General Fund Revenue budget outturn and Capital Programme.

11. BACKGROUND PAPERS

Strategic Financial Management Report – as at 31 December 2017 to Finance and Policy Committee 18.02.18
Strategic Financial Management Report – as at 30 September 2017 to Finance and Policy Committee 22.11.17
Medium Term Financial Strategy 2017/18 to 2019/20 report to Finance and Policy Committee 18.02.18.

12. CONTACT OFFICERS

Jill Harrison
Director of Adult and Community Based Services
jill.harrison@hartlepool.gov.uk
01429 523911

Chris Little
Director of Finance and Policy
Chris.little@hartlepool.gov.uk
01429 523003

7.3
APPENDIX 1

ADULT SERVICES

REVENUE FINANCIAL MONITORING REPORT FOR FINANCIAL YEAR 2017/18 AS AT 31 DECEMBER 2017

Approved 2017/2018 Budget £'000	Description of Service Area	December Projected Outturn Adverse/ (Favourable) Latest Forecast £'000	Director's Explanation of Variance
Adult Committee			
0	Carers & Assistive Technology	(19)	
3,233	Commissioning & Adults General	0	
1,465	Commissioning-Mental Health	0	Budget pressures have previously been identified in this area and are funded in the current year from one-off iBCF Grant (c£150k).
9,881	Commissioning-Older People	0	Planned demand management reductions from the review of the Resource Allocation System and Direct Payment contingencies and maximising NHS income have been reflected in the budget however they will take time to be achieved. Current pressures in this area total c£300k and will be funded in the current year from the 'one-off' iBCF grant allocated for Protection of Adult Social Care.
8,074	Commissioning-Working Age Adult	0	A number of high cost packages have now ended resulting in savings being made from this area to partly offset the budgeted use of reserves required to balance the budget. Planned demand management reductions will be closely monitored during the year and may not all be achieved until 2018/19.
221	Complaints & Public Information	41	
325	Departmental Running Costs	38	
639	Direct Care & Support Team	39	Increased demand for Telecare Equipment.
425	LD & Transition Social Work	0	
2,850	Locality & Safeguarding Teams	0	Salary underspends arising from incremental drift and vacancies have been transferred towards the departmental salary abatement target. The costs of DoLS, which includes an overspend arising from unbudgeted costs from the High Court Judgement, is being funded in the current year from the one-off iBCF grant allocated for Protection of Adult Social Care.
727	Mental Health Services	(39)	
439	OT & Disability Equipment	0	
266	Workforce Planning & Dev	(30)	
1,169	Working Age Adult Day Services	(30)	
(125)	Departmental Reserves required to fund shortfall in 2016/17 savings.	0	The iBCF grant is contributing in the current year towards this budget pressure.
0	Improved Better Care Fund - 'One-Off' element	(600)	This relates to the 'one-off' element of the Improved Better Care Fund which is being used for a range of initiatives. The majority of this (c£400k) is being used for capital developments within care homes to deliver improved care environments that have demonstrable benefits for residents. Owing to the nature of this spend the funding will need to slip into 2018/19.
29,589	**Adult Committee Sub Total**	**(600)**	
Creation of Reserves			
0	Improved Better Care Fund - 'One-Off' element	600	This relates to the 'one-off' element of the Improved Better Care Fund which is being used for a range of initiatives. The majority of this (c£400k) is being used for capital developments within care homes to deliver improved care environments that have demonstrable benefits for residents. Owing to the nature of this spend the funding will need to slip into 2018/19.
29,589	**Child & Adults Total - Net of Reserves**	**0**	

ADULT SERVICES
PLANNED USE OF RESERVES

The above figures include the 2017/2018 approved budget along with the planned use of Departmental Reserves created in previous years.
The details below provide a breakdown of these reserves

Approved 2017/2018 Budget £'000	Description of Service Area	Planned Usage 2017/2018 £'000	Variance Over/ (Under) £'000	Director's Explanation of Variance
Adult Committee				
125	Departmental Reserves to Fund 16/17 Savings Shortfall	0	(125)	Use of the iBCF grant allocated towards the Protection of Adult Social Care, demand management savings and review of existing budgets has reduced the demand on this reserve in 2017/18; it is anticipated further savings will be achieved over the next couple of years to eliminate the requirement to use this reserve to balance the budget.
55	Demand Management - Adults (Modern Apprentices)	0	(55)	The costs of employing apprentices will be funded from within the overall outturn.
140	Deprivation of Liberty Safeguards (DoLS)	0	(140)	DoLS to be funded from overall outturn to protect the value of the reserve
31	Care Bill Implementation	0	(31)	The costs are to be funded from the overall outturn to protect the value of the reserve which will enable the post to be funded in 2018/19.
351	**Adult Committee Total**	**0**	**(351)**	

7.3
APPENDIX 2

ADULT SERVICES

CAPITAL MONITORING REPORT PERIOD ENDING 31 DECEMBER 2017

Project Code	Scheme Title	BUDGET A: 2017/18 and Future Years Budget £'000	BUDGET B: 2017/18 Budget £'000	EXPENDITURE IN CURRENT YEAR C: 2017/18 Actual 31/12/2017 £'000	D: 2017/18 Expenditure Remaining £'000	E: Expenditure Rephased into 2018/19 £'000	F: (C+D+E) 2017/18 Total Expenditure £'000	G: (F-B) 2017/18 Variance from Budget £'000	Type of Financing	2017/18 COMMENTS
Adult Committee										
7234	Chronically Sick and Disabled Persons Adaptations	297	297	6	291	0	297	0	MIX	
8108	Centre for Independent Living - New Build	213	213	9	204	0	213	0	MIX	Actual spend relates to landscaping work.
	Adult Committee Total	**510**	**510**	**15**	**495**	**0**	**510**	**0**		

Key

RCCO	Revenue Contribution towards Capital	GRANT	Grant Funded
MIX	Combination of Funding Types	CAP REC	Capital Receipt
UCPB	Unsupported Corporate Prudential Borrowing	UDPB	Unsupported Departmental Prudential Borrowing
SCE	Supported Capital Expenditure (Revenue)	SPB	Supported Prudential Borrowing