Public Document Pack

Health Overview and Scrutiny Panel

Thursday, 5th December, 2019
at 6.00 pm

PLEASE NOTE TIME OF MEETING

Conference Room 3 - Civic Centre

This meeting is open to the public

Members

Councillor Bogle (Chair)
Councillor White (Vice-Chair)
Councillor Bell
Councillor Houghton
Councillor Professor Margetts
Councillor Noon
Councillor Payne

Contacts

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PUBLIC INFORMATION

ROLE OF HEALTH OVERVIEW SCRUTINY PANEL (TERMS OF REFERENCE)

The Health Overview and Scrutiny Panel's responsibilities and terms of reference are set out within Part 3 of the Council's Constitution: Responsibility for Functions

The general role and terms of reference for the Overview and Scrutiny Management Committee, together with those for all Scrutiny Panels, are set out in Part 2 (Article 6) of the Council's Constitution, and their particular roles are set out in Part 4 (Overview and Scrutiny Procedure Rules of the Constitution.

MOBILE TELEPHONES: - Please switch your mobile telephones to silent whilst in the meeting.

USE OF SOCIAL MEDIA: - The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public.
Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so.
Details of the Council's Guidance on the recording of meetings is available on the Council's website.

PUBLIC REPRESENTATIONS
At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

SMOKING POLICY – the Council operates a no-smoking policy in all civic buildings.

The Southampton City Council Strategy (2016-2020) is a key document and sets out the four key outcomes that make up our vision.

- Southampton has strong and sustainable economic growth
- Children and young people get a good start in life
- People in Southampton live safe, healthy, independent lives
- Southampton is an attractive modern City, where people are proud to live and work

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED
Only those items listed on the attached agenda may be considered at this meeting.

RULES OF PROCEDURE
The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

QUORUM
The minimum number of appointed Members required to be in attendance to hold the meeting is 3.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.

(ii) Sponsorship

Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.

(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.

(iv) Any beneficial interest in land which is within the area of Southampton.

(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.

(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.

(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

(a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or

(b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class.

OTHER INTERESTS

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

- Any body to which they have been appointed or nominated by Southampton City Council
- Any public authority or body exercising functions of a public nature
- Any body directed to charitable purposes
- Any body whose principal purpose includes the influence of public opinion or policy

PRINCIPLES OF DECISION MAKING

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the “rationality” or “taking leave of your senses” principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, ‘live now, pay later’ and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

DATES OF MEETINGS: MUNICIPAL YEAR 2019/2020

2019	2020
27 June	27 February
29 August	23 April
24 October	
5 December	

AGENDA

1 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Panel made in accordance with Council Procedure Rule 4.3.

2 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

3 DECLARATIONS OF SCRUTINY INTEREST

Members are invited to declare any prior participation in any decision taken by a Committee, Sub-Committee, or Panel of the Council on the agenda and being scrutinised at this meeting.

4 DECLARATION OF PARTY POLITICAL WHIP

Members are invited to declare the application of any party political whip on any matter on the agenda and being scrutinised at this meeting.

5 STATEMENT FROM THE CHAIR

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

(Pages 1 - 4)

To approve and sign as a correct record the minutes of the meeting held on 24th October 2019 and to deal with any matters arising, attached.

7 HAMPSHIRE WHEELCHAIR SERVICE

(Pages 5 - 32)

Report of the Director of Quality and Integration providing an update on the Hampshire Wheelchair Service.

8 SUICIDE PREVENTION AND SOUTHAMPTON'S DRAFT 2020-23 SUICIDE PREVENTION PLAN

(Pages 33 - 80)

Report of the Interim Director of Public Health requesting that the Panel consider the draft Southampton Suicide Prevention Plan and provide feedback to inform the content of the final Plan.

9 MONITORING SCRUTINY RECOMMENDATIONS

(Pages 81 - 84)

Report of the Director, Legal and Governance enabling the Health Overview and Scrutiny Panel to monitor and track progress on recommendations made at previous meetings.

Wednesday, 27 November 2019 Director of Legal and Governance

SOUTHAMPTON CITY COUNCIL
HEALTH OVERVIEW AND SCRUTINY PANEL

MINUTES OF THE MEETING HELD ON 24 OCTOBER 2019

Present: Councillors Bogle (Chair), White (Vice-Chair), Bell, Houghton, Professor Margetts, Noon and Payne (except agnda item 11)

9. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED: that the minutes for the Panel meeting on 29 August 2019 be approved and signed as a correct record.

10. **HAMPSHIRE HOSPITALS FOUNDATION TRUST - PROPOSED ORTHOPAEDIC TRANSFORMATION**

The Panel considered the report of the Chair of the Health Overview and Scrutiny Panel requesting that the Panel review and comment on the draft service proposals for Trauma and Orthopaedic services at Hampshire Hospitals.

Alex Whitfield (Chief Executive of Hampshire Hospitals Foundation Trust (HHFT)), Dr Lara Alloway (Chief Medical Officer – HHFT), Jane Hayward (Director of Transformation and Improvement - University Hospitals Southampton (UHS)), Jacqui McAfee (Divisional Director of Operations - Trauma and Specialist Services UHS) and Peter Horne (Director of System Delivery Southampton City Clinical Commissioning Group (CCG)) were in attendance and, with the consent of the Chair, addressed the meeting.

Officers outlined the rationale for the proposed changes to orthopaedic services in Hampshire. It was explained that the changes would make the service more efficient and result in the cancelation of fewer planned orthopaedic surgical procedures whilst freeing up beds to respond to trauma cases. It was noted that the proposed changes had been drawn up with the support of national NHS experts.

The Panel heard that there were concerns that the proposals would place an increased burden on Southampton General Hospital and the local system. During the meeting it was announced that the principal stakeholders had met following the publication of the report and had agreed amendments that would see the ambulance service continuing to transport patients to Winchester. HHFT would then convey patients via private ambulance to Basingstoke if required, in line with their proposal for patients to be seen at Basingstoke. It was noted that the situation would be monitored daily by both hospital trusts and that the plan can be paused at 24 hours' notice should there be an untoward effect on the system in Southampton.

RESOLVED that the Panel

(i) considered and noted the priorities detailed within the plan, attached as Appendix 1 to the report and the modifications announced at the meeting;

(ii) requested that HHFT circulate the next scheduled update to Hampshire's Health and Adult Social Care Committee on the proposals for Trauma and Orthopaedic services to the Panel.

11. **ADULT SOCIAL CARE UPDATE**

The Panel considered the joint report of the Service Director for Adults, Housing and Communities and the Director of Quality and Integration providing an update for the Panel on the transformation journey being undertaken by Adult Social Care in Southampton

Councillor Fielker (Cabinet Member for Adult Care), Paul Juan (SCC Service Director for Adults, Housing and Communities), Stephanie Ramsey (SCC Director of Quality and Assurance) and Sharon Stewart (SCC Service Lead, Adult Social Care) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of points including:

- The Council's response to the recommendations from the Peer Challenge, including the creation of the Making Social Care Work Board.
- The focus on four key aspect of the service: Prevention and early intervention; maximising recovery and promoting independence; improving quality of life for people with care and support needs; and providing choice and control for people who have care needs;
- The priorities for a future effective service;
- The ten identified projects that are being developed for delivery over the next three years that will enhance and improve service outcomes;
- The recruitment process for the independent chair of the Local Safeguarding Adults Board;
- Concern raised about the Director of Public Health reporting to the Executive Director - Wellbeing (DASS) in the new Council structure, and the need for Public Health to have a much broader remit than Adult Social Services;
- The need to include within the performance metrics measures that reflect enablers of change;
- Opportunities to reduce costs and duplication by working with other local organisations on developing new technological solutions.

RESOLVED that:

(i) That the Panel noted the current performance in Adult Social Care and the progress being made towards improving services in line with the findings of the Local Government Association peer challenge;

(ii) That the Panel noted the Council's response to the Local Authority Data Profile: Older People's Pathway, published by the Care Quality Commission.

(iii) That the Panel noted the arrangements in place for the interim Chair of the Local Safeguarding Adults Board and steps being taken to recruit a permanent Chair;

(iv) In response to concerns raised about the Director of Public Health reporting to the Executive Director - Wellbeing (DASS) in the new Council structure, and the need for Public Health to have a much broader remit than Adult Social Services, the Panel are provided with assurance from the Chief Executive that the Director of Public Health would continue to have senior level influence across the full range of their accountabilities within the new structure;

(v) The Panel are provided with the current ratio of adult social care workers per 1,000 of the Southampton population that are aged over 65;

(vi) The enablers of change, particularly staff engagement and satisfaction, are measured and incorporated into the Adult Care performance dataset;

(vii) In recognition that most local authorities responsible for adult care services are seeking to develop technological solutions to transform how services are delivered, it is recommended that the Council explores opportunities to share the cost of research and development with other local authorities and representative organisations to improve economies of scale and reduce duplication.

NOTE: Councillor Noon explained that he worked within the Adult Social Care industry but, that there was no conflict of interest in reviewing this matter. Councillors White and Margetts declared that they were members of the Making Social Care Work Board.

12. **HAMPSHIRE AND ISLE OF WIGHT LONG TERM PLAN**

The Panel considered the report of the Senior Responsible Officer for the Hampshire and Isle of Wight Sustainability and Transformation Partnership requesting that the Panel consider the priorities detailed in the draft long term plan.

Richard Samuels (Hampshire and Isle of Wight STP Senior Responsible Officer) and James Rimmer (Managing Director, NHS Southampton City Clinical Commissioning Group) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel noted that the final version of the Plan was due to be submitted shortly. It was explained that the plan would respond to the targets included within the NHS England Long Term plan published in January 2019. The Panel discussed various matters including:

- How the plan sought to address the priorities set out in Appendix 1 of the report;
- The importance of prevention and children's health in improving long term health outcomes;
- The need for all key agencies to continue their collaborative approach to ensure that the most effective and efficient services are available.

RESOLVED that the Panel

(i) noted and considered the priorities detailed in the plan, attached as Appendix 1 to the report;

(ii) noted the collaborative development process for the Plan across the region and the timescales for the submission of the final version to Government.

13. **SOUTHAMPTON CITY FIVE YEAR HEALTH AND CARE STRATEGY 2020-2025 UPDATE**

The Panel considered the report of the Managing Director, NHS Southampton City CCG, updating the Panel of the progress being made to develop and implement the five year strategic plan.

Richard Samuels (Hampshire and Isle of Wight STP Senior Responsible Officer) and James Rimmer (Managing Director, NHS Southampton City Clinical Commissioning Group) were in attendance and, with the consent of the Chair, addressed the meeting.

The Panel discussed a number of points including:

- How the five year strategy supported the draft Hampshire and Isle of Wight Long Term Plan;
- Public engagement in the development of the strategy; and
- The importance of the Start Well work stream and focussing on the health of children and young people in Southampton.

RESOLVED that the update be noted.

14. **MONITORING SCRUTINY RECOMMENDATIONS**

The Panel considered the report of the Director, Legal and Governance enabling the Health Overview and Scrutiny Panel to monitor and track progress on recommendations made at previous meetings.

Stephanie Ramsey was in attendance and, with the consent of the Chair, addressed the meeting.

The Panel noted that information requested by the Panel in regard to Continuing Healthcare had been attached to the report as Appendix 2. The Panel expressed a desire to more fully explore the issues relating to Continuing Healthcare at a future meeting.

RESOLVED that the Panel delegated responsibility to the Scrutiny Manager, in consultation with the Panel's Chair, to commission a report for a future meeting that will enable the Panel to explore in more detail the Continuing Health Care provision within the City.

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		HAMPSHIRE WHEELCHAIR SERVICE		
DATE OF DECISION:		5 DECEMBER 2019		
REPORT OF:		DIRECTOR OF QUALITY AND INTEGRATION, NHS SOUTHAMPTON CITY CLINICAL COMMISSIONING GROUP		
CONTACT DETAILS				
AUTHOR:	**Name:**	Donna Chapman	**Tel:**	023 8029 6904
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Director	**Name:**	Stephanie Ramsey	**Tel:**	023 8029 6904
	E-mail:	stephanie.ramsey1@nhs.net		

STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY These reports provide an update on the Hampshire Wheelchair Service. It includes reports of Southampton City CCG and Millbrook Healthcare. The Hampshire Wheelchair Service is commissioned under a collaborative commissioning arrangement, by five CCGs and serves a collective population of 1,450,000. Millbrook Healthcare is the current provider of the service providing assessments, clinical/postural interventions, wheelchair equipment and repairs & maintenance.		
RECOMMENDATIONS: That the Panel		
	(i)	Notes the update.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To provide the Health Overview and Scrutiny Panel with an update on the service, as requested by the Chair in April 2019.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	Not applicable.	
DETAIL (Including consultation carried out)		
3.	Southampton City CCG previously updated the Panel on the service on 25 April 2019. This update follows on from that report and provides detail relating to activity data, service user feedback, Personal Wheelchair Budgets, future commissioning intentions, and operational and workforce information shared by Millbrook Healthcare.	
RESOURCE IMPLICATIONS		
Capital/Revenue		
4.	Not applicable.	
Property/Other		

5.	Not applicable.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
6.	Not applicable.
Other Legal Implications:	
7.	None.
RISK MANAGEMENT IMPLICATIONS	
8.	None.
POLICY FRAMEWORK IMPLICATIONS	
9.	Not applicable.

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	ALL
SUPPORTING DOCUMENTATION	
Appendices	
1.	NHS Southampton City CCG: Commissioning Update And Activity Data Set
2.	Millbrook Healthcare: Wheelchair Service Operational Update
3.	Millbrook Healthcare: Wheelchair Service Hampshire Workforce Plan
Documents In Members' Rooms	
1.	None
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out?	No
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?	No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**	
Title of Background Paper(s)	
1.	25 April report to HOSP (Item 25): http://www.southampton.gov.uk/modernGov/ieListDocuments.aspx?CId=477&MId=3787&Ver=4

Southampton City Clinical Commissioning Group

APPENDIX ONE: Hampshire Wheelchair Service update, November 2019

1. Introduction

1.1. The Hampshire Wheelchair Service is commissioned under a collaborative commissioning arrangement, by five Clinical Commissioning Groups (CCGs) and serves a collective population of 1,450,000.

1.2. The CCGs in the collaborative arrangement are:

- NHS Southampton City CCG
- NHS Portsmouth CCG
- NHS South East Hampshire CCG
- NHS Fareham and Gosport CCG
- NHS West Hampshire CCG (which leads on the contract on behalf of the collaborative)

1.3. The service is commissioned to meet the mobility needs of both children and adults and, within their mobility needs, related postural and pressure care needs.

1.4. Millbrook Healthcare is the current provider of the service providing assessments, clinical/postural interventions, wheelchair equipment and repairs & maintenance. The service provides the following equipment based on the assessment of service user needs:

- Wheelchairs, manual and/or electrically powered wheelchairs (indoor or indoor/ outdoor)
- Wheelchair accessories
- Specialist seating systems
- Pressure relieving cushions

1.5. In the financial year of 2019/20 the total value of the contract is £4,534,187.

1.6. Further information relating to the contract was provided to the Panel on 25 April 2019. This is available to view online here: http://www.southampton.gov.uk/modernGov/documents/s40153/Hampshire%20Wheelchair%20Service.pdf

1.7. This update follows on from that report and provides detail relating to activity data, service user feedback, Personal Wheelchair Budgets and our future commissioning intentions.

2. Commissioning review process for the contract

2.1. Commissioners, including quality representatives, formally meet with the provider on a monthly basis to review the service's contractual performance and quality scorecard.

2.2. The key performance indicators were comprehensively reviewed and updated in April 2019. This was to ensure full visibility, appropriate challenge, and identification of improvement actions against all elements of a patient's pathway (i.e. the clinical triage process, the assessment process, the internal ordering of equipment, the procurement and delivery of equipment from manufacturers, the handover of equipment, and the repairs and maintenance of equipment).

2.3. Commissioners also receive individualised updates for all of the service's long waiters and will scrutinise the list and identify areas for challenge at Contract Review Meetings. On a quarterly basis, in addition to these scorecards, commissioners receive narrative quality reports for review. These include patient stories, learning from incidents, learning from complaints, safeguarding report, and a joint working forum update.

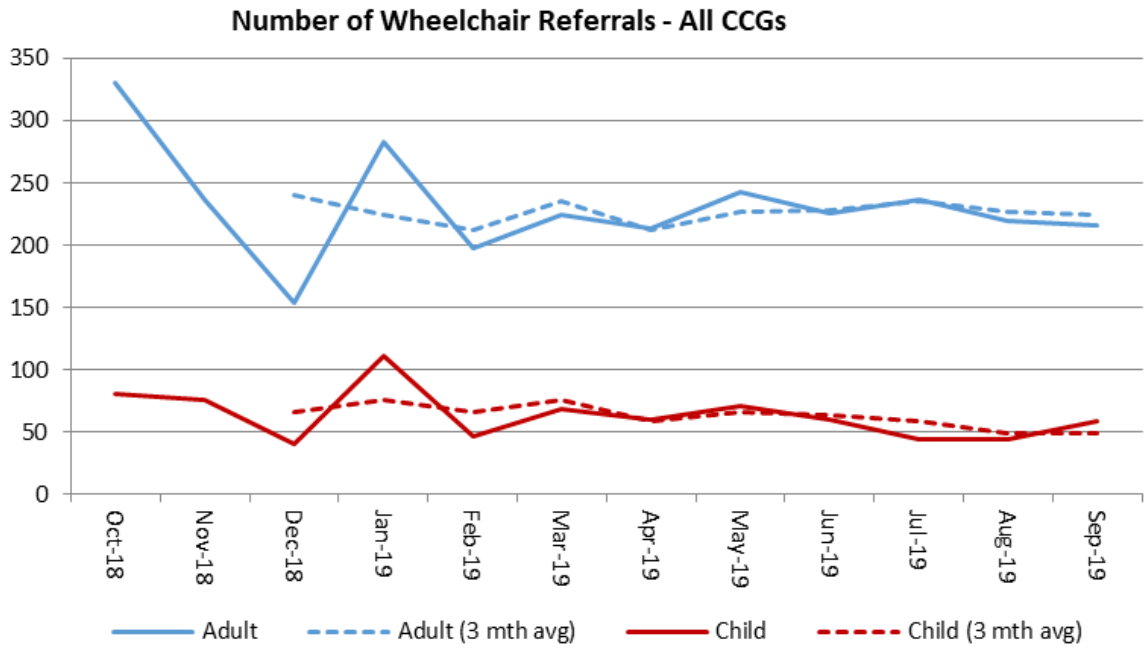
2.4. Outside of the contractual process, commissioners have instigated meetings between the provider and representatives from our two community providers for Southampton and Hampshire, Solent NHS Trust and Southern Health NHS Foundation Trust, on a monthly basis. This forum gives these providers an additional opportunity to raise any patients of concern to the provider's clinical team for appropriate action and review.

3. Activity data

3.1. This section provides a data set on the key activity areas of the service over the last 12 months for which data is available (October 2018 – September 2019). This data covers all the collaborative CCG areas.

3.2. Number of referrals:

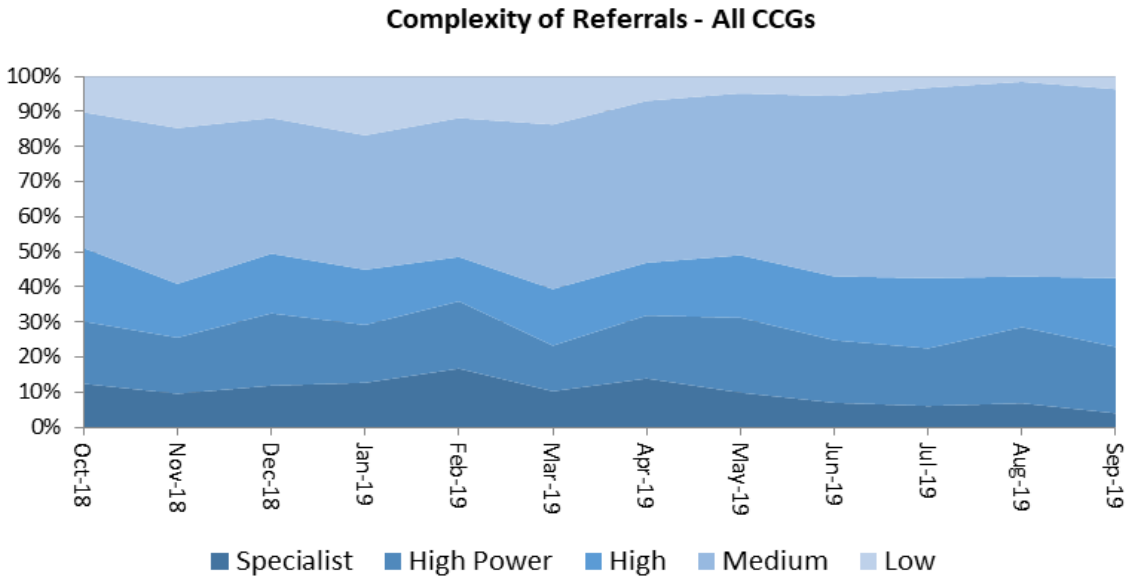
Number of Referrals - All CCGs	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Adult	330	237	154	283	198	224	213	243	226	236	219	216
Adult (3 mth avg)			240	225	212	235	212	227	227	235	227	224
Child	81	76	40	111	47	68	60	71	60	44	44	59
Child (3 mth avg)			66	76	66	75	58	66	64	58	49	49



3.2.1. The number of referrals can vary significantly in some months, which can be challenging from a staffing perspective. This position is further compounded by the national shortage in wheelchair service clinicians.

3.3. Complexity of referrals:

Complexity of Referrals - All CCGs												
	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Specialist	12%	10%	12%	13%	17%	10%	14%	10%	7%	6%	7%	4%
High Power	18%	16%	21%	16%	19%	13%	18%	21%	18%	16%	22%	19%
High	21%	15%	17%	16%	13%	16%	15%	18%	18%	20%	14%	20%
Medium	39%	44%	39%	38%	40%	47%	46%	46%	51%	54%	56%	54%
Low	10%	15%	12%	17%	12%	14%	7%	5%	6%	3%	2%	4%

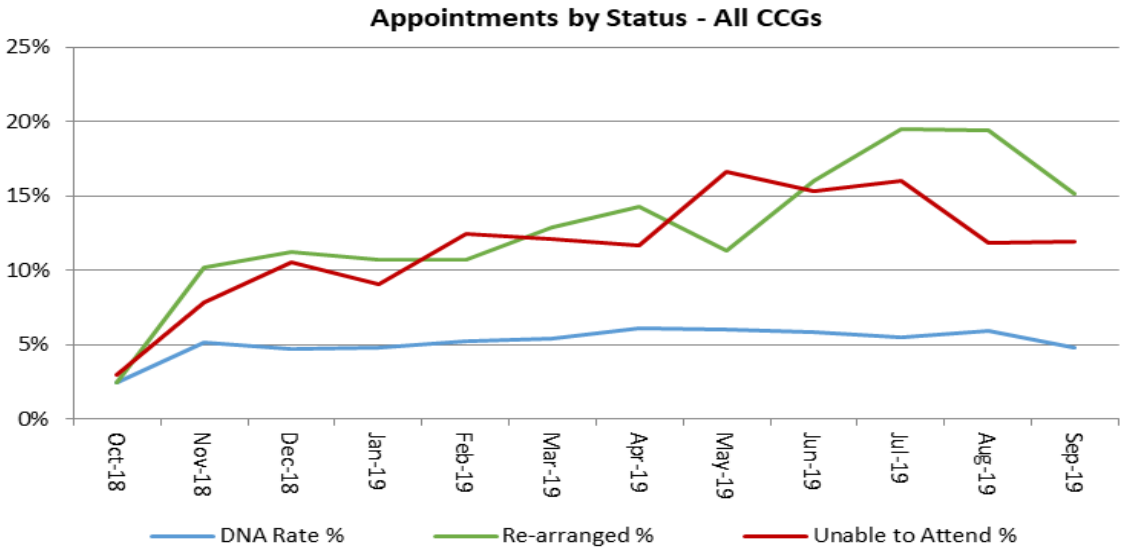


3.3.1. The charts above show that, over that past twelve months, there has been a reduction in the small number of specialist referrals but also a particular reduction in low level need referrals and a corresponding increase in the number of referrals classified as medium need. This is relevant because it demonstrates the overall increase in complexity of referrals.

3.3.2. Medium need is defined by NHS England as those who are daily users of a wheelchair, or use a chair for significant periods most days. Service users will have some postural or seating need and a physical condition that may be expected to change (e.g. weight gain / loss; some degenerative conditions). Medium need service users will require a comprehensive, holistic assessment by a skilled assessor and regular follow ups and review will be required.

3.4. Appointments by status:

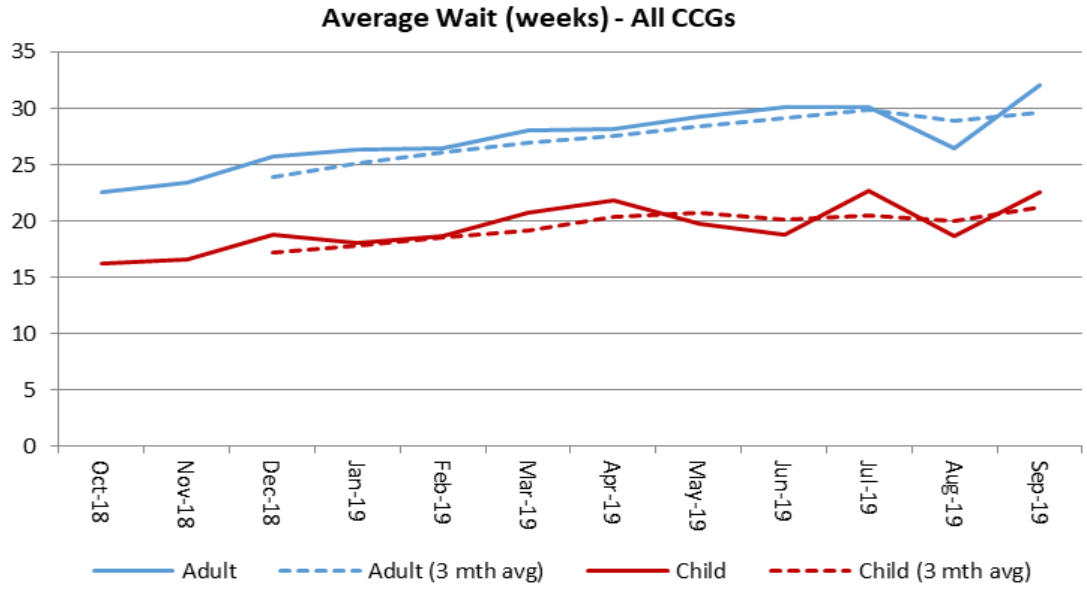
Appointments by Status - All CCGs												
	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
DNA Rate %	2%	5%	5%	5%	5%	5%	6%	6%	6%	5%	6%	5%
Re-arranged %	2%	10%	11%	11%	11%	13%	14%	11%	16%	19%	19%	15%
Unable to Attend %	3%	8%	11%	9%	12%	12%	12%	17%	15%	16%	12%	12%



3.4.1. The graph above shows the percentage of appointments that are rearranged or that clients have been unable to attend has been increasing since October 2018, although there has been a reduction over the summer of 2019. The service continues to send out appointment reminders, but we accept there will be circumstances in which attendance will be affected by unpredictable situations such as hospital admissions, service users / staff sickness, or transport issues. This will have an impact on the number of assessment and handover appointments conducted.

3.5. Average wait in weeks:

Average Wait (weeks)												
	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Adult	22.5	23.4	25.7	26.3	26.4	28	28.1	29.2	30.1	30.1	26.5	32.1
Adult (3 mth avg)			24	25	26	27	28	28	29	30	29	30
Child	16.2	16.6	18.8	18.1	18.6	20.7	21.8	19.8	18.8	22.7	18.6	22.5
Child (3 mth avg)			17	18	19	19	20	21	20	20	20	21



3.5.1. The charts above show the average wait in weeks for both adults and children. It is important to note that not all service users will be waiting for a wheelchair. Over the last twelve month period, only 44% of all referrals were for wheelchairs / seating equipment to be issued; users will also be open to the service for reviews and clinical interventions.

3.5.2. The average wait in weeks for adults has increased since October 2018 from 22.5 weeks to 32.1 weeks. For children the increase has been from 16.2 weeks to 22.5 weeks. Whilst this is by no means acceptable, it should be noted that this is a national issue, primarily linked to the challenges in recruitment and retention of clinical staff within wheelchair services. This is further discussed in Millbrook Healthcare's workforce report.

3.5.3. Commissioners have been working with Millbrook to implement a range of initiatives to address the waiting list which have included:

- Enhancing the availability of standard stock within the depot to reduce the number of handovers reliant on ordering of equipment, and promoting chair in a day opportunities
- Implementing the revised School clinic model to improve the quality of care and experience within the school environment, following feedback from the School Clinic review.
- Providing entry level wheelchair prescribing training for community referrers to allow community therapists to directly order equipment for 'low need' individuals without requiring an additional assessment within the wheelchair service
- Implementing a waiting list initiative for children's provision; providing additional capacity to complete 188 handovers
- Improving the quality of referrals received through continued engagement with professionals who refer patients to the service; improving the service's ability to triage responsively, and increasing opportunities to issue equipment at the first appointment

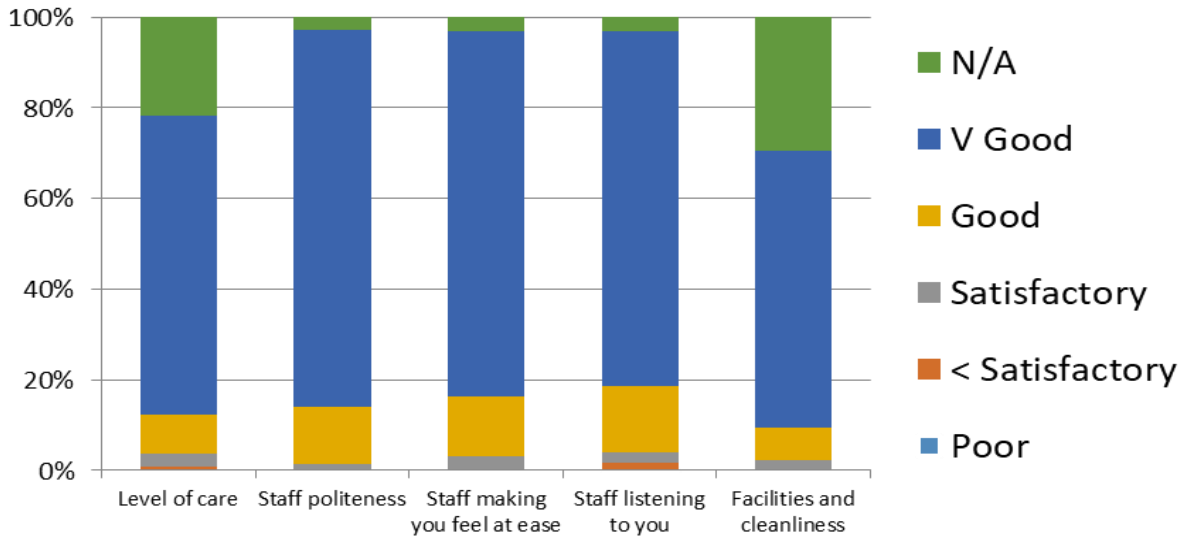
3.5.4. The staffing challenge however within the service has limited the impact of some of these initiatives on the waiting list, most notably the waiting list initiative for which there was additional investment. Finding staff with the appropriate specialist skills to deliver the additional capacity funded has been difficult.

3.5.5. The staffing challenges within the service are covered in more detail in the Workforce paper. However, one area that commissioners and the service are exploring with the community NHS Trusts is the role that community therapists can play in the direct prescription of wheelchairs with a view to reducing duplication and increasing capacity.

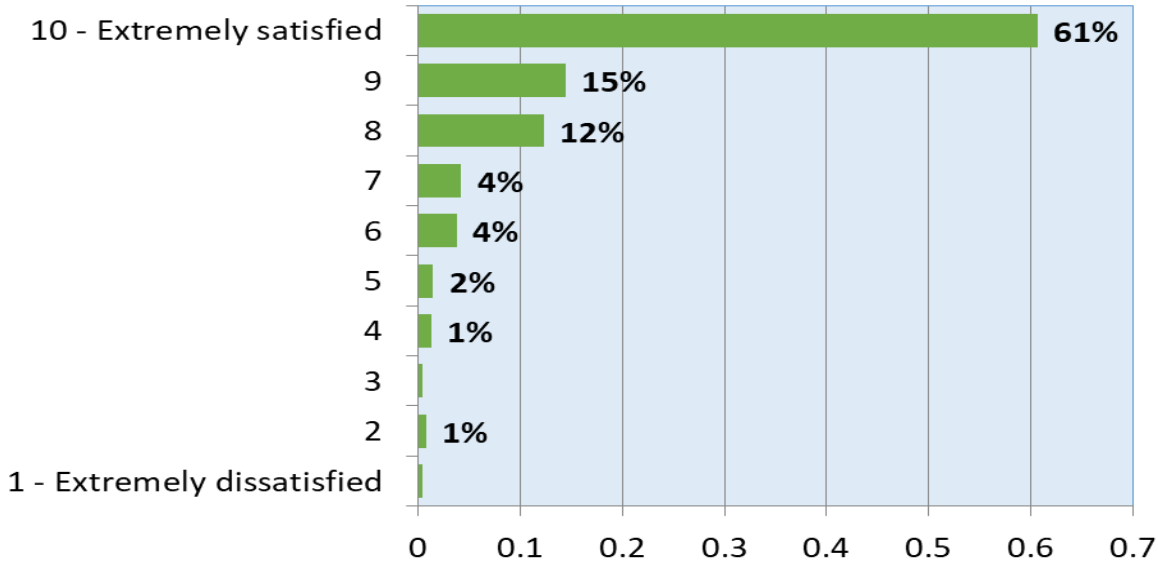
4. Service user feedback

4.1. We expect the service to continually ask for feedback from service users on their experience of the service. The following graphs provide feedback from 42 service users captured in August 2019, which is the most recent data available.

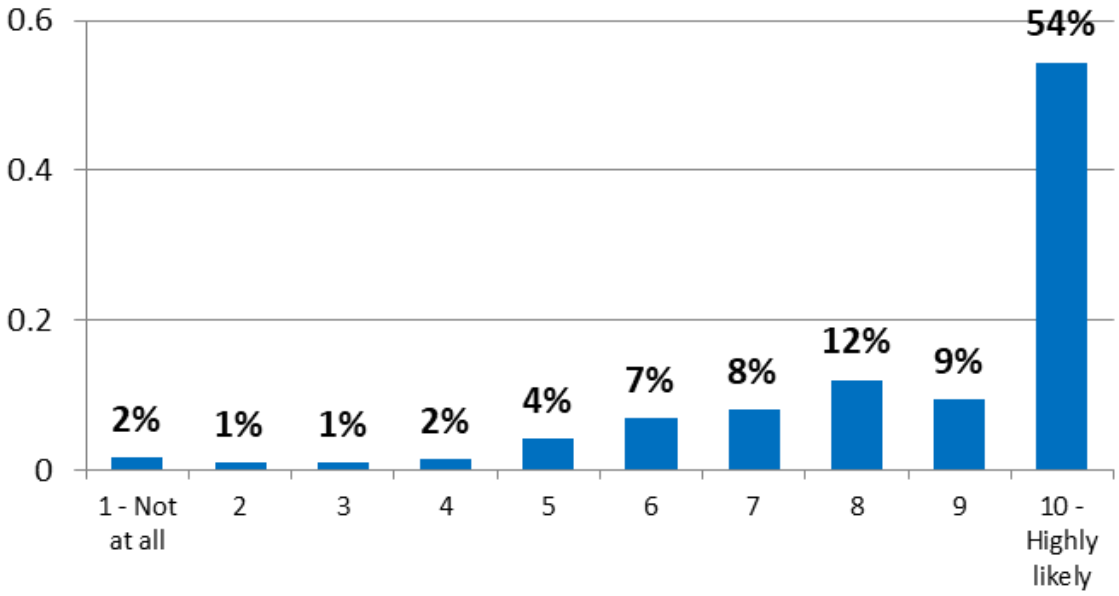
4.2. Respondent ratings:



4.3. How satisfied were you with your experience of the service?:



4.4. How likely are you to recommend our service?:



4.5. The self-reported service user experience rating of the service is ‘good’ or ‘very good’. The majority of service users completing the survey would recommend the service to others and were ‘extremely satisfied’ with their experience.

5. Personal Wheelchair Budgets

5.1. For those who may prefer a different wheelchair to that which the clinician assesses as meeting their mobility and postural needs, a voucher scheme has been in place since commencement of the service in April 2014.

5.2. In 2019 the voucher scheme was replaced by the national offer of a Personal Wheelchair Budget (PWB). PWBs were launched in April 2019.

5.3. PWBs aim to increase choice and control for people who access a Wheelchair service by providing holistic assessments that take into account wider needs and increase independence to improve health and wellbeing. PWBs will support people to identify their own health and wellbeing goals and offer an integrated approach by bringing together care and support agencies.

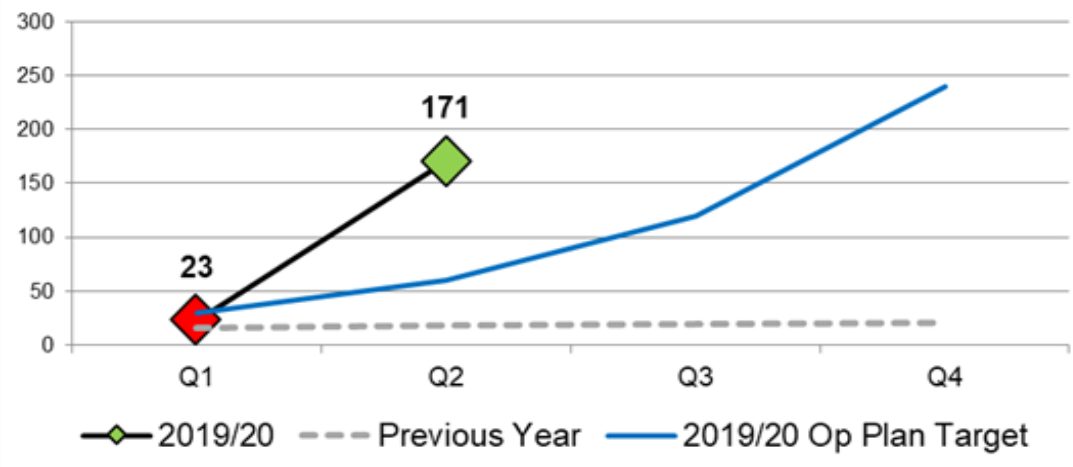
5.4. PWBs provide people a variety of options, these include:

- NHS provision of a notional budget whereby the PWB is used for a wheelchair, repairs and maintenance are provided by the NHS
- An alternative wheelchair, using the NHS provision but upgrading to an alternative model through top up by the individual.
- Additional features, NHS provision with additional features topped up by individual
- PWB, direct payment whereby the individual chooses a wheelchair outside of the NHS provision providing it meets their clinical needs.
- Third party PWB, notional or direct payment and top up by another service under joint funding i.e. social care, education, access 2 work etc.

5.5. Each CCG within the collaborative is required to report the overall number of Personal Health Budgets (PHBs) taken up each quarter to NHS England.

5.6. Quarter 2 is the first quarter that the number of Personal Wheelchair Budgets (PWBs) has been included in the overall PHB return.

5.7. The following graph demonstrates the Quarter 2 PHB return for Southampton City CCG:



5.8. Of the 171 PHBs taken up, 139 were PWBs and 32 PHBs.

6. Future commissioning intentions

6.1. The current contract with Millbrook Healthcare finishes on 31 March 2021 for Southampton City and West Hampshire CCGs. For the other CCGs in the collaborative (Portsmouth, South Eastern Hampshire, and Fareham and Gosport CCGs) on 31 March 2020.

6.2. Southampton City, West Hampshire and Isle of Wight CCGs will be commissioning a new service together, which will commence on 1 April 2021.

6.3. In preparation for this procurement, commissioners are taking into consideration the challenges within the current service and making a number of changes to the specification and contractual model. There has been extensive engagement of service users and stakeholders whose feedback has helped to develop the new service specification. A full engagement report has been published online. Between February 2019 and August 2019, 400 people provided feedback to help inform the future provision of a Wheelchair and Posture Service. 262 people completed a service user survey, 87 healthcare professionals completed a second survey and 17 focus groups were held.

6.4. A market warming event was held on 5 June 2019. The Invitation To Tender (ITT) will be published in December 2019.

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Appendix 2

Hampshire Wheelchair Service

Operational Update

18 Week Referral to Treatment (RTT) – Children

In September 2019 the service had 71 open children referrals on the waiting list. 40 open referrals on the waiting list were over 18 weeks at the end of Sept-19. All open referrals over 18 weeks were in progress and at various stages of the pathway:

- 10 referrals had appointments booked
- 10 referrals had equipment on order
- 7 referrals had recent appointments and required follow on actions
- 4 referrals were in the process of having a handover appointment booked
- 7 referrals recently had an appointment booked which had been cancelled due to the service user not attending the planned appointment
- 1 referral is due equipment to be ordered
- 1 referral is on hold as the service user is considering using the PWB process

11 of the 18 weeks plus referrals were still open due to exceptions. Exceptions are when a referral is open longer than 18 weeks for reasons that are outside of Millbrook Healthcare's (MBHC) control. Below is an example of a referral pathway that has been extended due to multiple appointment cancellations.

Case study

Referral received and triaged on 8/3/19, the service user's current chair is deemed beyond economical repair. The referral is classified as a medium complexity and a medium priority. The service user has a loan chair for the interim period and has be placed on the children's waiting list project. The Wheelchair Service made contact with the services users Dad to arrange an appointment for 22/5/19 which was then cancelled by the Dad on 21/5/19, the appointment was re-arranged for 5/6/19 and the service user was not bought into clinic for the appointment on the day. The next appointment was booked for the 5/8/19 and this was cancelled by the Dad prior to the date. Another appointment was booked for 27/8/19 and the service user and Dad attending the assessment. On completion of the assessment, the service user and Dad requested time to think about options. On the 8/11/19 the Wheelchair Service OT made contact with the Dad and confirms he would like to progress with the prescription discussed at the assessment on 27/8/19. The WCS OT has processed the prescription and the equipment order was raised on 8/11/19.

Due to the number of cancelled, missed appointments and consideration time taken, this has meant the RTT has significantly overrun the 18 week target.

Long Waiters – Adults

At the end of September 2019 the service had 345 open adult referrals and 64 referrals were long waiters. 19 of the long waiters were exceptions and all open referrals were being progressed through the referral pathway:

- 13 referrals with appointments booked
- 6 referrals had appointments cancelled by the service user
- 6 referrals were in the process of having a handover booked
- 4 referrals were in the process of having a follow on assessment booked

- 6 referrals were on hold pending contact from the service users
- 7 referrals had orders placed
- 4 referrals were pending follow on actions
- 4 referrals had attended appointments and were in the process of orders being raised
- 14 referrals were triaged and in the process of an appointment being booked

All long waiters are reviewed by the clinical team on a monthly basis and relevant actions are taken to update the service user and their pathway.

Current Projects

MBHC are working on a number of IT initiatives to support communication with our service users and below is an overview of the current project:

Implementing a text message within the services:

- The system will send an automated text message to the service user with an appointment reminder message
- The service user will have the option to cancel the appointment via text if they are unable to attend
- The system will send and automated text message to confirm when the field service engineer will be due to complete a delivery, collection or a repair
- If a service user does not have a mobile phone the system will send a message to the landline number
- This will improve communication with our service users and aim to reduce the amount of UTA's and DNA's within the service.

Service User Portal:

- The purpose of the new portal is to provide the service user with a secure system to access and view the information we hold
- On completion of phase one of the portal project, the service user will be able to login and check information about their current referral, equipment information and check any repair jobs booked
- On completion of phase two of the portal project, the service user will be able to view their open referral, book an appointment and raise a repair/collection
- This will provide the service user a new way to communication with the service and flexibly to check their open episode of care as and when is suitable for them. It is also expected to reduce the amount of inbound call into the customer service team.

HAMPSHIRE CLINICAL WORKFORCE PLAN

Annette Cairns - Clinical Director

Strategic Overview

Contents

Introduction

Nationally there is a shortage of GPs and other healthcare professionals working in primary care and community services which is putting the NHS ambitions to deliver more care out of hospitals at risk. It is recognised within the UK that we have a skill shortage of Occupational Therapists (OT) and Rehabilitation Engineers (RE). A report commissioned in 2017 by Health Education England (HEE) and The College of Occupational Therapists (COT) has highlighted vacancy rates in London for occupational therapists of up to 40% and the difficulties in filling these posts across the capital. The COT have repeatedly highlighted the need for more occupational therapists across England, where there are critical shortages of qualified specialists. In London, for example, there is a particularly acute crisis, with NHS trusts having a vacancy rate of 15.2 per cent, which rises to 17.5 per cent in social care (Kings Fund NHS workforce source). The Royal Academy of Engineering estimates that the UK will need more than a million new engineers and technicians by 2020 to meet industry demand. Engineering UK's The State of Engineering 2016 report claims that the need is far greater: the UK will need to find 182,000 people with engineering skills every year to 2022. Their data shows a current shortfall of roughly 69,000 engineers and technicians entering engineering or STEM-related employment per year.

In Millbrook we have firsthand experience of the OT and RE skill shortage, where qualified specialist OTs are the predominant skillset required to deliver the clinical aspect of the contract. We are facing a perpetual cycle in which unfilled OT and RE vacancies put pressure on staff, prompting some to leave and thereby creating even more pressure on the remaining staff. The size and complexity of this workforce challenge is such that addressing it has and will require consistent and concerted action by Millbrook Healthcare on workforce planning, pay, training, retention and job roles. Evidence and experience from high-performing health systems demonstrates that developing compassionate, inclusive leadership enables teams to deliver better care. Therefore, culture and leadership will also be examined and play an essential role in improving our retention and recruitment.

Current Issues

- Available population from which we recruit is changing, high volume of retirements nationally expected for OT's over the next few years (coupled with a shortage of people registering / completing the relevant training courses)
- National labour shortage of both Occupational Therapists (OT) and Rehabilitation Engineers(RE)
- Abundance of OT jobs currently being advertised and some are perceived as being more desirable, as there is less stress, less pressure, less accountability and responsibility within those roles and less performance management
- It has always been difficult to recruit into wheelchair services as they are not regarded as 'trendy' services to work within and they are often misunderstood even by other clinicians
- Introduction of Personal Wheelchair Budgets (PWB) has also added an extra layer of complications into the Wheelchair Service. Allowing equipment and items to be provided outside of the eligibility criteria, the service provides the assessment and

provides maintenance support, but were never funded or expected to have the capacity to do so

- The introduction of PWB adds time to every appointment as well as extra admin time and complications that need to be addressed following appointments and equipment provision
- As similar to other wheelchair services the requests for Independent Funding Requests (IFR) are continuing to rise year on year and this creates the same issues as detailed in the sentence above about PWB
- As per other wheelchair services across the UK, the complexities of the referral received by Hampshire Wheelchair Service continues to increase, which means more clinical contacts are required to complete the Referral to Treatment pathway.

Implemented changes

In direct relation to the issues we are experiencing we have implemented the following changes:

Peripatetic OT role

Within our business we have introduced a full time peripatetic OT role, whose role is to provide clinical support to the wheelchair services when required. This is primarily to cover long term absences, maternity cover and vacancies. We have employed a highly experienced band 7 specialist wheelchair OT. This role is full time in Hampshire and provides 15 contacts per week along with triage support.

National Clinical Team

We have employed a team of highly experienced OT's/Clinical Scientists to form a National Clinical Team (NCT). The remit of this team is to provide support with complex clinical cases and supervisions and to also focus on quality and clinical governance. Within Hampshire all four members of the NCT are carrying caseloads as well as training/supporting the clinical team and the commissioners as required. This provides approximately 20 – 30 contacts per month.

ACE Rehabilitation

We have employed the services of ACE rehabilitation to provide rehabilitation engineering support to the contract. ACE have a skill base of trained rehabilitation engineers that can provide the necessary technical support to the clinical team and our service users. This support provides 3 contacts per week for complex service users, these appointments often take longer.

Recare

Recare are an external rehabilitation and mobility specialist assessment provider who are currently providing support to the contract with the handover of low level equipment to our service users. Recare are a long standing partner of Millbrook Healthcare and the Hampshire Wheelchair Service. Their support provides between 10 – 20 contacts per week.

Locum support

We have two locum specialist wheelchair OT currently working within the Hampshire contract, covering 21 contacts per week between them.

Two additional locums have also been secured:

- A wheelchair experienced band 7 Physiotherapist, who will start in January until the end of March. This role will support the contract 5 days per week, 3 days in clinic and 2 days working from home to complete notes and support triage/ duty tasks. This will provide between 12 – 15 contacts per week
- A wheelchair experienced band 7 Occupational Therapist who is available for one day per week. Providing between 3 -4 contact per week

Supplier support

We have approached our suppliers and Sunrise Medical have agreed to offer support via two of their therapists, who will be supported by our own clinical staff. This will equate to 6 clinical days per month in the contract and 36 contacts per month.

Staffing improvements

We have introduced changes to the existing clinical staffing responsibility with the focus on maximising clinical facing time by bringing in clinical non-qualified lower bands (OT Assistant s & OT Technical Instructor) to support the higher band OTs. This has created approximately 10% extra time.

We have also employed a medical secretary which enables the OTs to dictate their clinical notes, this reduces the time required to complete their notes by approximately 30%.

The introduction of the new clinical rota has been redesigned to maximise the capacity within the clinical team. This approach provides approximately 15% extra time per therapist per week.

Remote Triage Therapy Team

We have introduced a remote triage therapy team across our business to support wheelchair services, this will include the Hampshire contract. The triage team are made up of qualified band 7 wheelchair specialist OT's, who work from home and complete the triaging for specific contracts. These roles have been relatively easier to recruit into as we offer a flexible working approach to fit around family or other commitments. The triage team live all over the UK, primarily in the north of England. Each clinician spends regular scheduled time within the service centres they are assigned to, in order to complete clinical practice, training and attend team meetings. They triage on average 15 referrals per day and based on the Hampshire referral intake rate the required number of triage therapists is 1.15 FTE.

Additional clinical staffing options we have or are considering:

- Introduction of a new staffing model
- Therapy support from other contracts
- Supplier support
- Explored locum options
- Further individual locum support
- Tier 2 sponsorship

Workforce planning

Objective

A clinical workforce of sufficient numbers, with the right skills able to meet required quality standards and the flexible challenges of the contracts and the organisation.

Where do we want to be within the next 12 months?

- Better analysis of workforce data, metrics and benchmarking across all clinical workforce activities
- A properly designed and highly developed workforce plan that reflects demand, commissioning, workforce design and supply factors
- Maximise new job roles and design to service user and service needs and demands
- Overhaul of the clinical model to future proof against further staff skill shortages

Currently underway/review

- Workforce planning function enhanced by training and networking
- Better metrics for translating themes and trends into clear workforce data (top down)
- Granular work with services on detailed needs (bottom up)
- Established benchmarking group
- Established workforce committee
- Demand and capacity modelling with future projection
- Apprenticeship scheme

Key measures

Vacancy, turnover and temporary staffing/ locum's metrics

IMPROVEMENT EXAMPLE

A new workforce strategy currently being aligned with the introduction of new company values, following purchase by Cairngorms.

Recruitment and retention

Objective

Recruit and retain staff with the right skills at the right time to fulfil the Organisation's workforce plan.

Where do we want to be within the next 12 months?

- An employer of choice driven by service user needs and service requirements
- 'Best in class' for Hampshire wheelchair service
- International recruitment to fill voids
- Greatly reduced usage of locums
- Ability to recruit and retain staff

Currently underway/ review

- Strategic recruitment using social media/demographics
- Employer branding – adverts, website and positive Hampshire WCS campaign
- Lead times reduced from 60.8 days to recruit to 45 days
- Tier 2 recruitment strategy
- Flexible working options
- Scoping the introduction of other skillsets to fill the vacancies e.g. Registered Nurse
- Recruit into apprenticeship schemes
- Internal development via our 'Grow Your Own' programme
- Improved terms and conditions
- Introduction of Access Recruitment system
    - Internal head hunting facility; CV search tool, strategic recruitment using media / demographics
    - Improving the 'candidates journey' – introducing a new careers website, focusing on employer branding, adverts and positive Hampshire WCS campaign
    - Review of KPI's in respect of filling roles and reduction in lead time in filling vacancies

Key measures

Vacancy, turnover and temporary staffing metrics

IMPROVEMENT EXAMPLE

New recruitment system introduced across the business which improves the candidate experience through, better quality website, slicker on boarding process and the use of talent pool function.

Pay and reward

Objective

Pay and reward strategies that enable Millbrook to become an employer of choice in times of skill shortage and financial restraint, reflecting service needs.

Where do we want to be within the next 12 months?

- To become an employer of choice – affordable and flexible pay utilising AFC freedoms that matches recruitment and service needs
- Robust use of scheduling to maximise clinical resource and offer recognition and reward scheme

- Flexible use of imaginative benefits – such as
- Access to NHS pension for clinical staff

Currently underway/review

- Enhanced clinical staffing function ensuring robust scheduling
- Opt in to the NHS Pension scheme
- Develop a new approach to pay with local flexibility
- Recruitment and retention premia (RPP)
- Loan contributions & 'Golden Hellos' to attract staff
- Flexible benefits toolkit for clinical staff

Key measures

Vacancy, turnover and locum staffing/ staff survey metrics

IMPROVEMENT EXAMPLE

Retention strategy for the clinical team has been agreed by the board and has been offered.

Learning and development

Objective

To train and develop the clinical and non-clinical workforce to acquire the skills their roles require and to manage and lead their teams.

Where do we want to be within the next 12 months?

- Provider of first class training
- Maximising external funding sources
- Comprehensive and contemporary induction, management and leadership programmes
- Systematic and embedded appraisal scheme
- Development of talent management through succession planning, coaches and metrics

Currently underway/review

- Single management of L&D staff and resources
- E-Learning system revamp of corporate induction
- Comprehensive leadership framework and programmes
- L&D framework to provide profession specific support and guidance
- High quality training for qualified and non-qualified clinical staff groups
- New appraisal system linked to supervisions and personal development
- Established 'Grow Your Own' scheme

Key measures

Staff survey and retention metrics; appraisal / supervision feedback

IMPROVEMENT EXAMPLE

A training matrix has been developed with the input of the Clinical Leads and the National Clinical Team, this covers both clinically qualified and non-clinically qualified staff.

Engagement

Objective

A workforce that is fully engaged at all levels via majority staff survey return and an engaged staff.

Where do we want to be within the next 12 months?

- An engaged and supported workforce who feel involved in the Organisation's development
- An engaged and supported work on a local, regional and national level
- A clear consultation and negotiation framework that reflects service needs
- Staff survey engagement scores to be at > 90%

Currently underway/review

- Open engagement between staff groups and Board/management (coffee and conversations)
- Staff survey 2020 50% +
- New staff partnership engagement strategy
- Enhanced clinical engagement
- Enhanced intranet and extended use of social media
- Improved internal communication

Key Measures

Staff survey engagement metrics; staff engagement

IMPROVEMENT EXAMPLE

A series of staff open forums are being delivered in order to improve communication across the business, along with an improved internal communication strategy led by our new communication manager.

Health & Wellbeing

Objective

A fit and healthy workforce to deliver the wheelchair services, who are supported through a comprehensive Health and Wellbeing strategy.

Where do we want to be within the next 12 months?

- 4 pillar Health & Wellbeing strategy covering physical, mental, financial and family health & wellbeing
- Overall sickness absence <3% with the UK average being 2.6%
- Flu uptake increased to 55% and continuing to rise to 75% in line with the ambitions of the World Health Organisation
- Delivery of a range of Health and Wellbeing measures (e.g. CBT and alternative therapies)via multiple routes i.e. OH and HR Business Partners
- Proactive range of preventative measures and health education around smoking, alcohol, exercise etc.
- Strength and resilience built into the clinical workforce

Currently underway/review

- Remodelled OH service focusing on health and wellbeing
- Trained mental health first aiders across the business
- Promotion of resilience and measures to tackle stress
- Better company utilisation of Perkbox to offer a new suite of services to staff

Key measures

Sickness absence metrics and data; staff survey metrics

IMPROVEMENT EXAMPLE

A new Perkbox package available since September 2019 to promote financial, physical and emotional wellbeing of all of our staff.

Potential and current workforce projects

- Grow our own Rehabilitation Engineers and Occupational Therapists scheme
    - 2 RE Tech's currently on the scheme being sponsored through college and then if suitable on to university
    - 1 OT TA currently being sponsored through a part time degree course to qualify as an OT
- Scope the possibility of recruiting an additional OT peripatetic role into the business
- Explore the introduction of an RE peripatetic role into the business
- Work collaboratively with the commissioners to examine the feasibility of introducing a rotational post into the service
- Securing a Masters student to rotate into the contract
- Offering weekend work for wheelchair specialist OT
- Clinical staff retention scheme
- Review the Clinical Workforce Strategy to address specific issues and roles, responsibilities, skills and capabilities needed for more effective workforce planning
- Linking with the National Wheelchair Managers Forum, Institute of Physics and Engineering in Medicine and Postural and Mobility Group on the subject of staffing shortage for OT's and RE's?

DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		SUICIDE PREVENTION AND SOUTHAMPTON'S DRAFT 2020-23 SUICIDE PREVENTION PLAN		
DATE OF DECISION:		5 DECEMBER 2019		
REPORT OF:		INTERIM DIRECTOR OF PUBLIC HEALTH		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Amy McCullough, Consultant in Public Health**	**Tel:**	**023 8083 2640**
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STATEMENT OF CONFIDENTIALITY

Not applicable

BRIEF SUMMARY

Local Authorities in England have a statutory duty to take appropriate steps to improve the health of the people who live and work in their areas. Public Health functions include responsibility for co-ordinating and implementing work on suicide prevention, with Public Health teams being well placed to co-ordinate efforts to address many of the risk factors for suicide. This paper outlines the key development and achievements in suicide prevention in Southampton since the Panel last considered suicide prevention in June 2017, and presents the draft Southampton's Suicide Prevention Plan (2020-23) for comment.

RECOMMENDATIONS: That the Panel

	(i)	Consider the developments and achievements that have been made in suicide prevention since the Panel last reviewed the suicide prevention work programme in June 2017.
	(ii)	Consider the draft Southampton Suicide Prevention Plan (2020-23) and provide feedback to inform the content of the final Plan.

REASONS FOR REPORT RECOMMENDATIONS

1.	The Health Overview and Scrutiny Panel (HOSP) is provided with the opportunity to scrutinise developments in suicide prevention up until the present. In 2017 HOSP noted the report that was tabled and asked that further updates be brought to the Panel in due course.
2.	HOSP is provided with the opportunity to inform future suicide prevention activity by considering and providing feedback on the draft Southampton Suicide Prevention Plan (2020-23). The House of Commons Health Committee (2017) recommends that there should be scrutiny of local suicide prevention plans.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
3.	Not applicable
DETAIL (Including consultation carried out)	
Background information on suicide	
4.	In 2018 there were 6,507 suicides registered in the UK, an age-standardised rate of 11.2 deaths per 100,000 population. This latest rate is significantly higher than that in 2017 and represents the first increase since 2013. Prior to 2013, the increase in suicides (from 2008) is thought to be linked with austerity. However, when looking at suicide rates over the last two decades, there does continue to be a general decrease over time from a rate of 10.3 deaths per 100,000 population in 2001-03 to 9.6 in 2016-18.
5.	In Southampton, the suicide rate has fallen in recent years from 15 deaths per 100,000 in 2012-14 to 12.7 in 2016-18. However, Southampton continues to have a significantly higher rate of suicides than the national (9.6 deaths per 100,000) and South East (9.2 deaths per 100,000) average. Southampton's suicide rate is also the third highest when compared to 15 similar Local Authorities (using the CIFA nearest neighbour definition)[1]. Translated into numbers of deaths by suicide, we know that around 26 residents in Southampton take their own life by suicide each year (based upon 2016-18 data). This number is subject to small year on year variability, and in the period 2001 to 2018 was highest in 2012-14 when there was an average of 29 deaths per year by suicide.
6.	Public Health works with the coroner's office to undertake suicide audits to gather intelligence on deaths by suicide. For the two year period 2017-2018, 38 deaths by suicide were audited. Of the 38 deaths by suicide: • 71% (27) were male, and 28% (11) female. • The highest proportion of deaths took place in men aged 51-60 years. • 90% were White British (for 5% ethnicity is unknown). • 52% were known to mental health services (48% were not), and 31% had been in contact with their GP in the 4 weeks prior to taking their life. • 47% were known to have previously attempted to take their life by suicide, and 23% were known to have a history of self-harm. • Hanging was the most frequent method of suicide (55%), with most people taking their own life at home. The next most frequent methods are overdose/poisoning (16%), injuries (10%), suffocation (5%), falling from a height (3%) and by being hit by a train/life taken on the tracks (2%). • 42% of those that died were employed, 29% unemployed, 13% retired, 13% had a long-term disability which meant they could not work, and 2% "other". • Mental health problems (65%), relationship problems such as separation (52%), physical health problems (52%), job problems (28%), history of contact with the criminal justice system (28%), financial issues

[1] Public Health England suicide prevention profile: https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

	(26%), adverse childhood experiences (26%), and being a victim of abuse (21%) were the most common recorded “life event” risk factors.
7.	In relation to risk factors for suicide, according to the Public Health Outcomes Framework (2019), Southampton has a higher than the national average prevalence of recorded depression in those aged 18 years and over, and higher prevalence of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers for all ages. Southampton also has a higher than national average levels of unemployment, and a higher than average percentage of people living alone. In relation to children and young people, Southampton has higher than national average levels of looked after children, care leavers, and children in the youth justice system.
Developments and achievements that have been made in suicide prevention	
8.	**STP Suicide Prevention:** The Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP), which coordinates health and care across Hampshire, Southampton, Portsmouth and the Isle of Wight, has been awarded £468,000 “wave 2” transformation funding from NHS England for local suicide prevention. This funding forms part of the commitment set out in the NHS Long Term Plan (2019) to reduce suicide rates and self-harm and will support local work on suicide prevention. The funding will be used to focus on four key areas across the STP: to improve the support available in primary care; improve care for people who self-harm; provide training and support in workplaces and in relation to debt (for those in and out of work); and ensure that people bereaved by suicide are able to gain the support they need. Informed by learning from wave 1 sites, some of the funding has been used to employ an STP Suicide Prevention Programme Manager (recruited by Southampton City Council) to support delivery of the programme. See Appendix 1 for further information on the STP Suicide Prevention Programme.
9.	**Mental Health Anti-Stigma:** Public Health has built upon a strong legacy of mental health anti-stigma work by being awarded (through a joint bid with Solent Mind) Time to Change Funding for a joint Southampton and Portsmouth Time to Change Hub. The Hub has been operational since June 2019, and aims to build a social movement across Southampton, breaking down stigma attached to mental health by changing the way people think and act about mental health problems. Key activities include organising and having presence at both mental health and large city events that have good public reach (i.e. in 2020 this will include Mela, Pride), working with schools and colleges, and developing and supporting the work of Time to Change Champions (local residents with lived experience of mental health). Southampton City Council continues to take action in relation to its own Time to Change Pledge; to promote good mental health in the workplace. Public Health also coordinates a *Southampton Anti-Stigma Partnership*, where communication leads from partner organisations come together to develop and deliver joint mental health communications, campaigns and events.
10.	**Children and young people’s mental health:** Public Health conducted a needs assessment on the mental health and wellbeing needs of children and young people in the schools setting in 2018, which informed the content of Southampton’s Children and Young People’s Local Transformation Plan (led by Southampton CCG). This led to a number of actions such as membership of the

	PSHE Association for all schools and colleges in Southampton and the establishment of a CYP Emotional and Mental Health Partnership, which includes a prevention and early-intervention sub-group chaired by Public Health. Current activity includes mapping and articulating pathways for different mental health conditions, and the services and resources available, for use by young people, parents/carers and professionals.
11.	**Itchen Bridge:** Public Health, Transport (SCC), Balfour Beatty and the Samaritans have worked in partnership to install new signage at the Itchen Bridge to better signpost people with suicidal thoughts to help. The new signs have the updated free Samaritans helpline on them, and appeal to people to call them if things are getting too much for them. These replace the old signage, some of which displayed an old telephone number for the Samaritans (and callers had to be redirected). Public Health is currently reviewing the evidence base on suicide prevention measures on bridges, and the data on attempted and completed suicides from the Itchen bridge, to inform SCC discussion (including transport and infrastructure colleagues) on suicide prevention measures.
Draft Southampton Suicide Prevention Plan (2020-23)	
12.	Deaths by suicide are preventable. There are many ways in which services, communities, individuals and society as a whole can help to prevent people from taking their own life. The 5 Year Forward View for Mental Health (Independent Mental Health Taskforce for NHS England, 2016), recommends that every local area has a multi-agency suicide prevention plan in place. It states that the aim of local plans should be to reduce suicide rates by at least 10% over a three year period.
13.	The Southampton Suicide Prevention Partnership, chaired by Public Health, is in the process of refreshing Southampton's Suicide Prevention Plan. In line with national guidance, the (draft) Southampton Suicide Prevention Plan (2020-23) considers how each priority contained in the national strategy will be addressed locally. The draft Plan is being informed by the following: • Intelligence and data on suicide prevention, including suicide audit intelligence. • National suicide prevention guidance. • Learning from a national audit of 99% Local Authority Suicide Prevention Plans. • Good practice Suicide Prevention Plans from other areas. • The published evidence base. • Stakeholder engagement.
14.	The Southampton Suicide Prevention Plan will help to deliver on other key strategies, including Southampton's Health and Wellbeing Strategy (2017-25) through supporting residents to live active, safe and independent lives and through tackling inequalities, particularly in relation to deprivation and men's health. See Appendix 2 for the draft Southampton Suicide Prevention Plan (2020-23). After consideration by the HOSP the draft Plan will go to the following forums for discussion and ultimately the Health and Wellbeing Board for agreement (around March 2020); Alcohol Strategy Steering Group, Substance

	Misuse forum, Better Care Vulnerable Adults sub-group, Children and Young People's Safeguarding Board, Adult Safeguarding Board.
RESOURCE IMPLICATIONS	
Capital/Revenue	
15.	The STP suicide prevention programme is funded through NHS England "wave 2" transformation funding (£468,000). An STP Suicide Prevention Steering Group has been established, chaired by Public Health, and reporting to the STP Prevention Board. There is no specific local budget for suicide prevention; the actions rely on partners embedding suicide prevention work into their existing programmes.
Property/Other	
16.	Not applicable.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
17.	Local Authorities in England have a statutory duty to take appropriate steps to improve the health of the people who live and work in their areas.
Other Legal Implications:	
18.	Not applicable.
RISK MANAGEMENT IMPLICATIONS	
19.	There are societal, financial and reputational risks in not developing and implementing a Suicide Prevention Plan. Societal in relation to not taking action in tackling the risk factors for suicide and through a coordinated partnership approach; financial as the Local Authority would not be in a good position to take forward wider STP work or to bid for external funding, and; reputational because all Local Authorities are expected to have suicide prevention plans in place (as stated by national guidance, Department for Health and Social Care).
POLICY FRAMEWORK IMPLICATIONS	
20.	Implementation of the Suicide Prevention Plan (2020-23) will support delivery of the Council strategy, including the following: - Through supporting residents to live active, safe and independent lives (Health and Wellbeing Strategy 2017-25, and Council Strategy 2016-20); - Through tackling inequalities, particularly in relation to deprivation and men's health (Health and Wellbeing Strategy 2017-25). - Through supporting children and young people to get the best start in life (Council Strategy 2016-20).

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	

1.	STP Suicide Prevention Programme (November update).
2.	DRAFT Southampton Suicide Prevention Plan

Documents In Members' Rooms

1.	None

Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out?	Yes
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?	Not for the Plan

Other Background Documents
Other Background documents available for inspection at:

Title of Background Paper(s)		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	None	

NHS
Hampshire and Isle of Wight
Sustainability and Transformation Partnership

Suicide Prevention Programme

November 2019 update

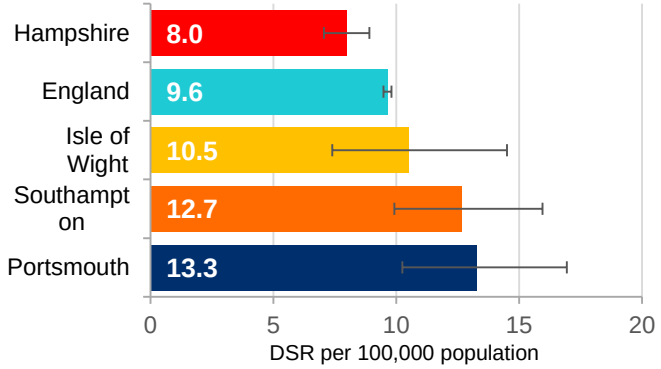
Local data – numbers over stated period

PHE Fingertips data, suicide prevention profile. Data from Office for National Statistics (based on date of registration) for 2016-18.

- Hampshire 287 (average of 96 per year)
- Isle of Wight 39 (average of 13 per year)
- Portsmouth 68 (average of 23 per year)
- Southampton 78 (average of 26 per year)

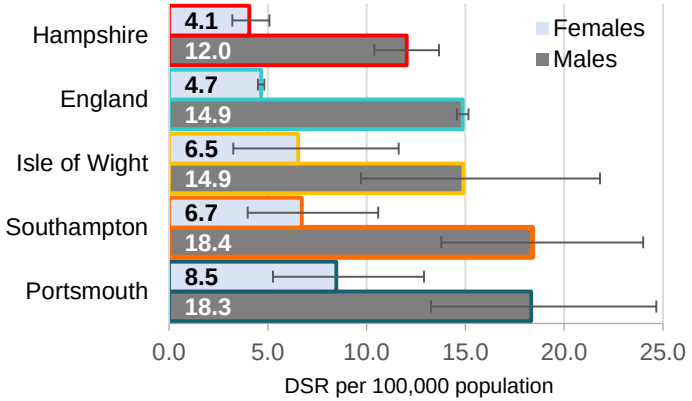
Local data – rate per 100,000

Mortality from suicide and injury undetermined - Persons DSR per 100k - HIOW STP Local Authorities: 2016-18:



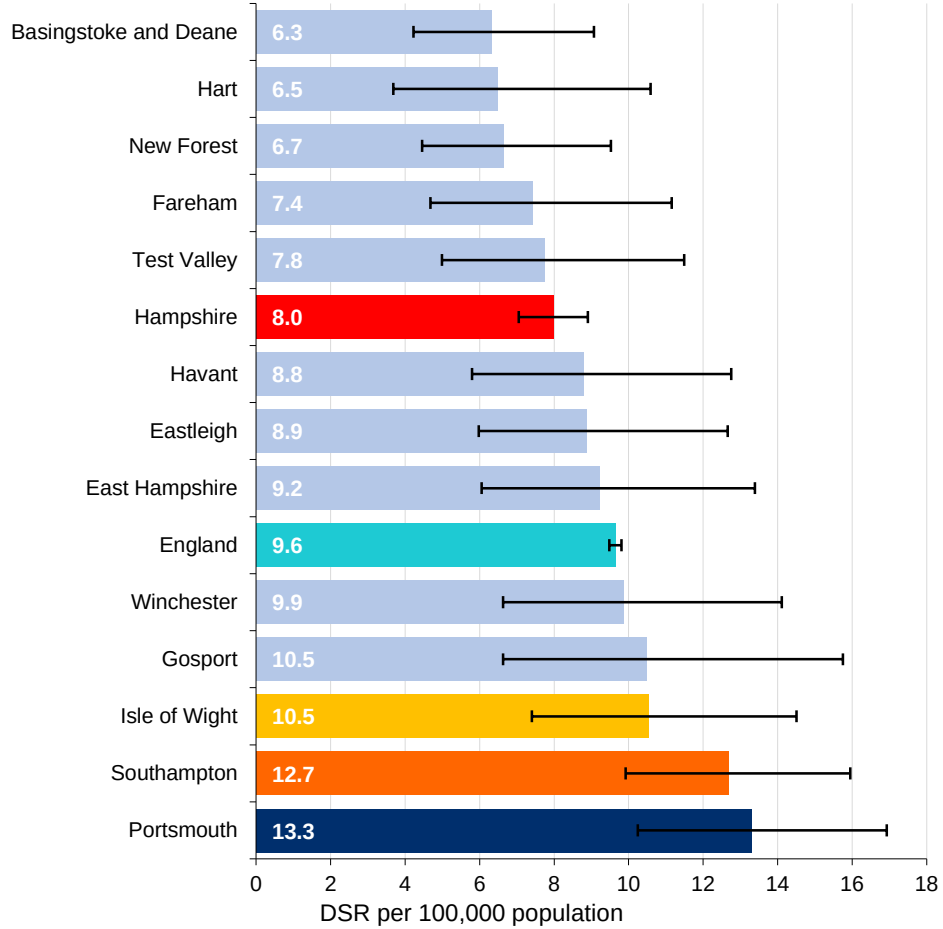
Source: Public Health England

Mortality from suicide and injury undetermined - Persons DSR per 100k - HIOW STP Local Authorities: 2016-18:



Source: Public Health England

Mortality from suicide and injury undetermined (persons) DSR per 100k HIOW STP Districts: 2016-18



Sources: Public Health England

HIoW local suicide audit analysis

Each PH team currently records and analyses suicide data in slightly different ways. The key themes from collective analysis are:

- Mental health and relationship issues were the most common recorded adverse life events.
- Illness, bereavement, addiction and financial worries (including debt) were also common antecedents to suicide.

Key lessons to be learned were identified as:

- People not in contact with ‘formal’ services.
- Poor risk assessments/note keeping (including potential precursory events) and onward sharing.
- Poor communication between and with services/agencies/partners:
  - Continued partnership approach to suicide prevention is crucial.
  - Requirement for improved cross-system communication and shared learning.
  - Referral processes and discharge protocols.
- Services, organisations and support groups require clarity on resources available to them and availability of appropriate training.
- Lack of family and carer involvement.
- Time allocation, management and follow-up with DNA/’difficult to engage’ patients.
- Inconsistent data recording and coding.
- Transition processes e.g. CAHMS to AMH.

National guidance

Suicide prevention is often only seen as an issue for MH Services, yet around two thirds of people who take their own lives aren't in contact with MH Services in the year before they die.

Evidence based risk factors:

- Men (men are three times more likely to die by suicide than women).
- People in the age group 40-44 years.
- People in the care of MH Services.
- People with a history of self-harm.
- People in contact with the Criminal Justice System.
- People bereaved or affected by suicide.
- People living in areas of higher socioeconomic deprivation.
- People who are unemployed.
- People working in least skilled occupations (e.g. construction workers).
- People with a low level of educational attainment.
- People who do not own their own home.

NHS England areas of focus

In 2012 the government published ‘Preventing Suicide in England: A Cross Government Outcomes Strategy to Save Lives’.

This strategy identified six key areas for action:

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

The Suicide Prevention National Transformation Programme was established in response to a national commitment to reduce deaths by suicide by 10%, by 2020/21. This programme includes £25m of transformation funding to support targeted local areas to reduce suicide rates and self harm.

Hampshire & IoW STP is a second wave STP and received funding of £468,000 in May 2019.

NHS England areas of focus

There are three areas of focus for the programme, based on evidence provided by NCISH (National Confidential Inquiry into Suicide and Safety in Mental Health) about the highest levels of need:

- Men (particularly those aged 35-54) – they have the highest incidence of deaths by suicide
- People who use mental health services – around one third of people who die by suicide are in contact with services
- People who have self-harmed – they are at increased risk of death by suicide.

NHS England have set the following criteria for delivery:

- Prevention beyond secondary services:
  - place-based community prevention work targeting;
  - middle-aged men; and/or
  - primary care support.
- AND/OR
- Reduction within services via quality improvement: self-harm care within acute hospitals and/or generally within mental health services. This should account for people with diagnoses of personality disorder.

HIoW approach and process

Principles informing HIoW recommendations:

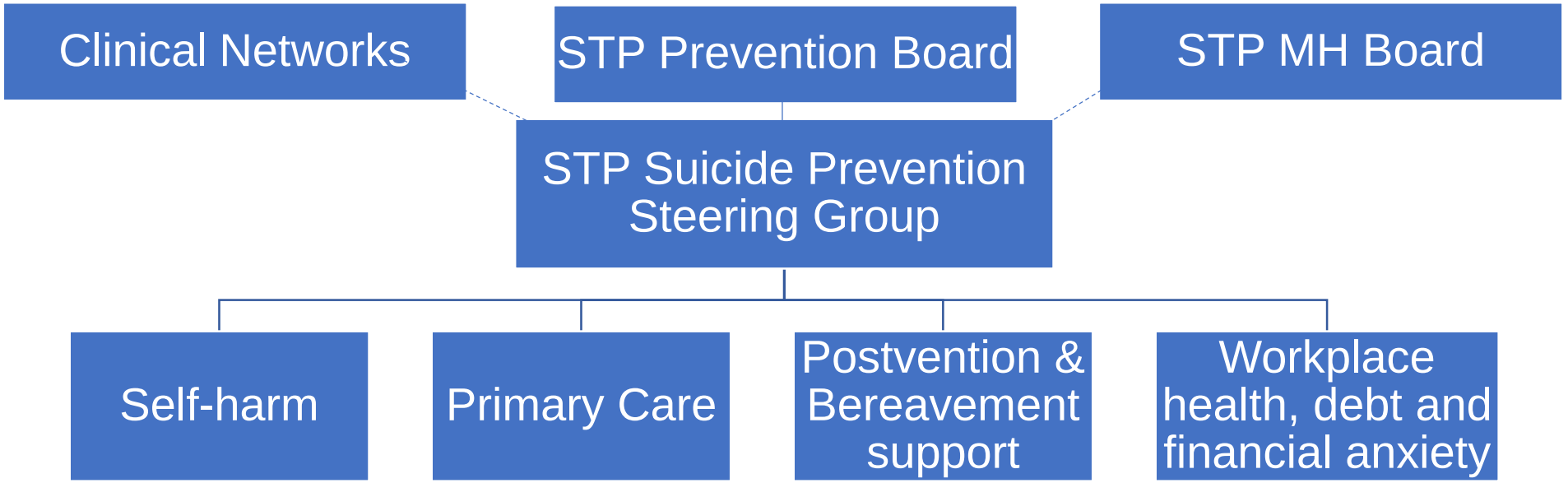
- Sustainability: beyond the initial guaranteed 12 month period of funding.
- Added value
  - Improving quality and/or equity.
  - Over and above commissioned services / ‘business as usual’ and/or increasing scalability.
  - Adding value to existing suicide prevention actions at local level.
- Early intervention and prevention
  - Promoting protective factors for suicide and/or self-harm, addressing key risk factors.
  - Consider interventions across different settings and including the wider determinants.
- Evidence based (or to inform the evidence base)
  - Informed by intelligence, published literature and/or stakeholder views.
- Universal approach with additional support for vulnerable groups.
- Life-course approach where appropriate.

HIoW approach and process

Initial scoping for each of the four priority areas for HIoW:

- Two Tasks and Finish groups delivered for each of the four priority areas.
- Task and Finish Groups attended by partners working across the system.
- Aim of Task and Finish Groups:
    - Scope unmet needs and prioritise to make recommendations for how STP suicide prevention funding should be best spent.
- Additional meetings for self-harm with service providers and commissioners.
- “Bottom up” approach.
- Triangulated recommendations with the data, intelligence and evidence base.

HIoW governance



Postvention & bereavement support

Evidence

- Around 800,000 people a year are affected by suicide.
- People bereaved by suicide are at 65% higher risk of attempting to take their lives, and around 9% of those bereaved make a suicide attempt.

Objectives

- Real-time surveillance data allows for identification of high-risk groups, individuals and locations.
- Key partners are informed of suspected suicides in a timely way and are able to put in place appropriate postvention support.
- Everyone that would like bereavement support knows what is on offer and how to access support, and that support is available in a timely manner.
- Equity of service provision: proactive and reactive tailored support providing emotional support for next of kin and wider family, as well as wider groups affected e.g. workplaces.
- The voluntary and community sector providing consistent support across the STP geography.

Postvention & bereavement support

Status in HIoW

- Hampshire Police have instituted a real-time surveillance system, providing monthly reports to PH teams.
- There is no current universal provision of bereavement support across the STP. Hampshire Police will refer to SOBS (Survivors of Bereavement by Suicide) and Red Lipstick Foundation as well as providing Help is at Hand booklet and seeking consent to share contact details with bereavement services.
- Postvention support (within 48-72 hours) is not currently in place across the STP, but efforts are being made to ensure there is a standardised postvention protocol for suspected suicides of young people and/or of those within schools or college communities.

Solutions

- Develop and implement a timely STP-wide real-time surveillance and notification system that incorporates key partners. Create standardised operating procedures for postvention activity by key partners.
- Identify/develop central hub(s) of consistent information relating to suicide bereavement (e.g. Hub of Hope, NHS Trust websites etc.). Consistent, well communicated pathways for different people/needs (e.g. group vs. one-to-one support).
- Map and link existing provision of bereavement support, improving capacity and capability across needs.
- Linking real-time surveillance to suicide audit data collection, and wider unexpected deaths processes/data collection and analysis (e.g. drug related deaths).

Workplace health, debt & financial anxiety

Evidence

- Low-skilled male labourers are three times more likely to take their own lives than the national average. Other groups with an increased risk are nursing staff, primary teachers and agricultural workers.
- Workplace stress, job insecurity, zero-hour contracts and workplace downsizing are important risk factors.

Objectives

- Improve awareness of suicide prevention amongst targeted high-risk employers and employee groups.
- Identify key business service organisations that can multiply reach of this initiative and support the self-employed.
- Promote best-practice and provide employers with access to the skills and resources required, including crisis response plans.
- Co-produce appropriate resources and approach with key employers.
- Support workplaces to navigate approach to improving mental wellbeing and suicide prevention in the workplace (phased, low-resource approach).
- Incorporate financial literacy and access to financial advice and support, as well active sign-posting to support organisations.
- Build on available resources and existing good practice.

Workplace health, debt & financial anxiety

Status in HIoW

- A number of initiatives operate across HIoW:
  - Hampshire Step-by-Step men's mental health programme.
  - Job Centre Plus suicide prevention training for staff.
  - Southampton & Portsmouth Time to Change Hub.
  - Southampton CC Wellbeing at Work.
  - CAB collaboration with Southern Health to support people with poor mental health access CAB support.
  - MIND Workplace Wellbeing programme.
  - Samaritans work with ports.

Next steps

- Identify key target organisations and employee groups across HIoW. Identify levers across the system to help engage target audiences (including use of voluntary and community sector organisations, grassroots organisations, sports clubs etc.).
- Research best-practice employers and approaches to high-risk groups (e.g. middle-aged men) and industries.
- Work with key stakeholders e.g. Citizens Advice Bureau, MIND etc. to improve access to financial advice for key target groups.

Primary Care

Evidence

- Many people who take their own life are in contact with their GP in the months before they die, with estimates ranging from 32-66% in the month leading up to their death and 75% in the six months before.

- A Samaritans and Centre for Mental Health research paper highlights 5 key areas in need of improvement:
  - Education and training: there is a consensus that education is crucial to suicide prevention.
  - Primary Care practice and staffing: therapeutic relationships between patients and their GP needs to be a priority.
  - Emotional support for GPs; many GPs are not getting the support they need with their own emotional wellbeing, particularly following the death of a patient by suicide.
  - Effective care pathways for people who are feeling suicidal: there is little evidence of effective pathways between primary care and both clinical and social support.
  - Ease of making referrals and accessing further support: many GPs face considerable challenges referring patients on for further support. These include high thresholds for eligibility, variation in availability of services and lack of access to expert advice.

Primary Care

Solutions

- Training (suicide prevention, self-harm and bereavement support)
  - Embed suicide prevention training and a “train the trainer approach” in GP trainee training.
  - Develop and deliver local suicide prevention training for primary care clinicians; using a combination of face-to-face and webinar training (learning from the pilot of 4MH training for primary care staff in Hampshire and Southampton).
  - Promote free online training to the non-clinical workforce.
  - Focus on improved practices and actions taken (e.g. use of safety plans) as a result of training.
- Resources
  - Suicide prevention and self-harm resources: ensure that existing good quality suicide prevention and self-harm resources are easily accessible to professionals, and embedded in their processes.
  - Take learning from other areas and across the STP, e.g. Southern Health’s use of Stay Alive app and ‘Every Life Matters’ cards.
- Data quality and communications
  - ED coding of attempted suicides and self harm: potential audit of ED coding for attempted suicides and self-harm to support identification of issues and recommendations.
  - Review of communication practices between Primary & Secondary care regarding referrals, discharge etc.

Self-harm

Evidence

- 170 times greater risk of suicide (than general population) in the month after attending A&E with self-harm injury.
- 50 times greater risk of suicide (than general population) in year after attending A&E with self-harm injury.
- Approximately two thirds of self-harm injuries don't end up in A&E/Hospital.
- Nationally only c.60% of A&E self-harm attendees receive a psychosocial assessment.

Objectives

The factors behind self-harm are varied and complex, and may require different interventions depending on target demographic and stage of intervention (e.g. following A&E attendance vs. population-wide). This programme will initially focus on three priority areas:

- Post-A&E discharge to address the significantly increased risk of suicide. This will look at referral mechanisms (and recipients of referrals), best-practice interventions/therapies and how existing STP practices can be improved and strengthened.
- Prevention. An initial focus on better understanding self-harm across the STP - what A&E/Psychiatric Liaison data tells us, the prevalence of self-harm in non-A&E settings, and the core issues that lead people to self-harm, particularly for CYP. An improved understanding of self-harm pathways and underlying issues will assist in targeting interventions at those most in need and/or where biggest impact can be achieved.
- There is an abundance of resources available on self-harm and our approach will seek to maximise their use, focussing on accessibility and utility – what is available and where, what will change as a result of using these resources, how can they be embedded within everyday practice and how can we measure any impact of their use.

The programme will also be escalating some issues for national discussion, such as the potential role of algorithms that embed protective messages in social media.

Self-harm

Approach

- To be sustainable interventions must integrate with existing structures and complement wider initiatives. Scoping conversations have included CAMHs and workforce development (particularly DBT capacity across the STP), resilience training for CYP in schools (resilience being a key protective factor for self-harm and attempted suicide) and resilience training for families/carers (equipping families and carers with key proactive skills such as family communications skills, and the knowledge, skills and confidence to be able to support their child's mental heath and emotional wellbeing needs).

Status in HIoW

- Self-harm pathways are being developed by local PH teams.
- Wessex CYP MH Steering Group working on LTP, crisis care, access to mental health services and workforce development.
- HEE Workforce Development programme, HEE's competency framework and self-harm resources such as Health Talk and Health in Education Settings.
- MHSTs being established in a number of schools (not covering the whole STP).

Next steps

- Review existing self-harm data, gaps and data requirements, working with partners to address gaps in data and understanding of self-harm.
- Linking local data to self-harm pathway development work to understand intervention points and potential for value add – taking learning from other STPs and best-practice.
- Develop relationships across wider stakeholders, e.g. Ambulance service, Schools/Colleges, voluntary and community sector organisations etc. to identify partners for delivery and sustainment.
- Linking with the Primary Care programme strand on self-harm data collection and ensuring self-harm is incorporated in future PC training.

Measurement and evaluation

- There is a national commitment to reduce the number of deaths by suicide by 10%, by 2020/21. It is not possible to attribute specific interventions to a reduction in the number of suicides at an STP level.

- Each project will have a set of defined target outcomes and output measures to evaluate their impact and effectiveness.

- The programme will be incorporating a ‘Quality Improvement’ approach with PDSA cycles (Plan, Do, Study, Act) to test approaches locally before wider implementation.

- Through improvements to the real-time surveillance system, we will be reporting on suspected suicide numbers for the STP in addition to business as usual annual suicide audit reporting (based on date of registration).

Next steps

- Agree broad approach outlined above and arrangements for updates/decision making
- Develop and finalise driver diagrams
- Outline business case/options paper for each of the four programme areas, covering:
  - High-level delivery plans and milestones
  - Governance and stakeholders (incorporating local suicide prevention arrangements)
  - Ways of working across the STP
  - Stakeholders
  - Budget outline
  - Measures and evaluation
- STP Steering Group meeting – January/February 2020 (date TBC)
  - Agenda: Presentation and discussion of high-level delivery plans

VERSION 1

DRAFT SOUTHAMPTON SUICIDE PREVENTION PLAN

2020 - 2023

OWNER: SOUTHAMPTON SUICIDE PREVENTION PARTNERSHIP
BOARD RESPONSIBILITY: SOUTHAMPTON HEALTH AND WELLBEIGN BOARD
COMPILED BY: PUBLIC HEALTH SOUTHAMPTON

DRAFT SOUTHAMPTON SUICIDE PREVENTION PLAN

Death by suicide is preventable and every one suicide is one too many. It is a deeply personal tragedy, which has a long-standing effect on families, friends and communities. Nationally, there is a call to reduce deaths by suicide. The Five Year Forward View for Mental Health sets out the ambition to reduce the number of suicides in England by 10 per cent by 2020, and the NHS Long-term Plan (2019) reaffirms the commitment to make suicide prevention a priority over the next decade.

AIM

This plan **aims to reduce the number of suicides in Southampton, and ensure provision of support to those bereaved by suicide, focusing on but not limited to groups at high risk of taking their own life.**

PRIOIRTY AREAS

In line with the 2012 (updated in 2017) cross-government strategy on Suicide Prevention, we will focus on the 6 key areas for action to reduce suicide, plus an additional priority in relation to leadership:

1. Achieve city wide leadership for suicide prevention
2. Reduce the risk of suicide in key high-risk groups
3. Tailor approaches to improve mental health in specific groups
4. Reduce access to the means of suicide
5. Provide better information and support to those bereaved or affected by suicide
6. Support the media in delivering sensitive approaches to suicide and suicidal behaviours.
7. Support research, data collection and monitoring.

CONTEXT

Death by suicide refers to a deliberate act that intentionally ends one's life. Suicide is often the end point of a complex history of risk factors and distressing events. Around 26 people take their own life in Southampton each year, which is a significantly higher rate than the England and South East average. Suicide affects people across the life-course, and whilst the highest proportion of deaths are in middle aged men, nationally, suicide is a leading cause of death for young people aged 15–24 years.

NATIONAL PICTURE

According to data from the Office for National Statistics (ONS)[1] in 2018 there were 6,507 deaths by suicide registered[2] in the UK, an age-standardised rate of 11.2 deaths per 100,000 population. The 2018 rate is significantly higher than the rate in 2017 and represents the first increase since 2013.

[1]https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations

2 In England, Wales and Northern Ireland, when someone dies unexpectedly, a coroner investigates the circumstances to establish the cause of death. The investigation, referred to as an "inquest", is a process that can take months or, in some cases, years. The length of time it takes to hold an inquest creates a gap between the date of death and the date of death registration. For deaths caused by suicide, this generally means that around half of the deaths registered in a given year will have occurred in the previous year or earlier.

However, when looking at suicide rates over the last two decades, there does continue to be a general decrease over time from a rate of 10.3 deaths per 100,000 population in 2001-03 to 9.6 in 2016-18.

Three-quarters of registered deaths in 2018 were among men (4,903 deaths), which has been the case since the mid-1990s. Males aged 45 to 49 years have the highest age-specific suicide rate (27.1 deaths per 100,000 males); for females, the age group with the highest rate is also 45 to 49 years, at 9.2 deaths per 100,000.

As seen in previous years, in 2018 the most common method of suicide in the UK was hanging, accounting for 59.4% of all suicides among males and 45.0% of all suicides among females.

There is a relationship between suicide and deprivation, with suicide rates being statistically significantly higher in the most deprived areas of England.

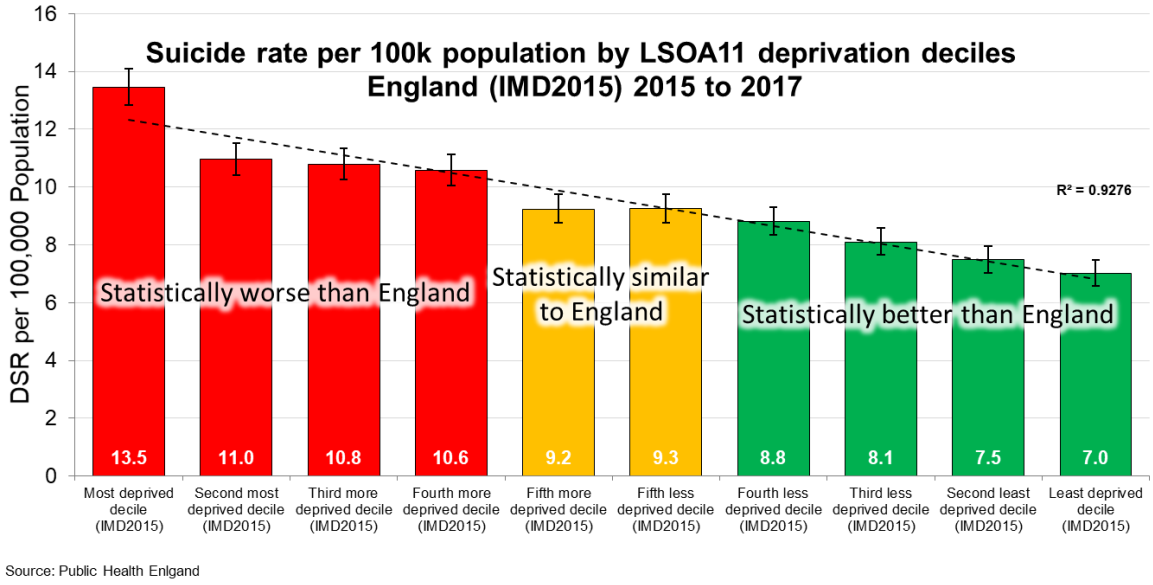


Figure 1. Differences in suicides rate for deprivation deciles in England.

LOCAL PICTURE

In Southampton, the suicide rate has fallen in recent years from 15 deaths per 100,000 in 2012-14 to 12.7 in 2016-18. However, Southampton continues to have a significantly higher rate of suicides than the national (9.6 deaths per 100,000) and South East (9.2 deaths per 100,000) average. Southampton's suicide rate is also the third highest when compared to 15 similar Local Authorities (using the CIPFA nearest neighbour definition)[3]. Translated into numbers of registered deaths by suicide, we know that around 26 residents in Southampton take their own life by suicide each year (based upon 2016-18

[3] Public Health England suicide prevention profile: https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

data). This number is subject to small year on year variability, and in the period 2001 to 2018 was highest in 2012-14 when there was an average of 29 registered deaths by suicide per year.

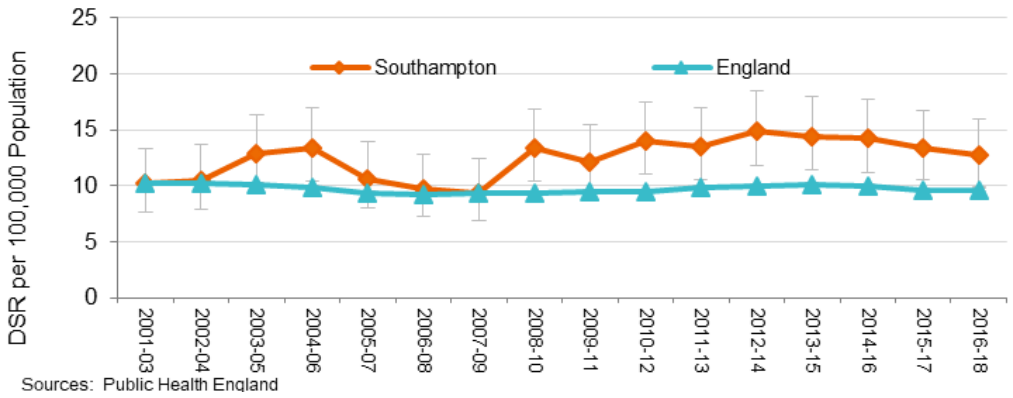


Figure 2. Southampton and England suicide rates per 100,000 from 2001-2003 to 2016-2018

The figure below shows suicide rates for Southampton, compared to the other Sustainability and Transformation Plan (STP) areas (Hampshire, Portsmouth and the Isle of Wight).

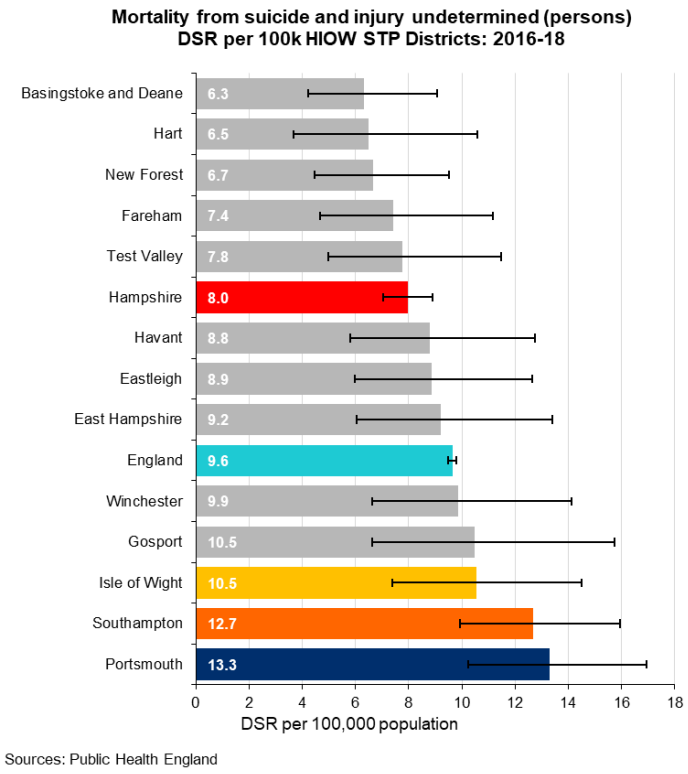


Figure 3. Suicide rate for the South East region.

Public Health works with the coroner's office to undertake suicide audits to gather intelligence on deaths by suicide. For the two year period 2017-2018, 38 deaths by suicide were audited. Of the 38 deaths by suicide:

- 71% (27) were male, and 28% (11) female.
- The highest proportion of deaths took place in men aged 51-60 years.
- 90% were White British (for 5% ethnicity is unknown).
- 52% were known to mental health services (48% were not), and 31% had been in contact with their GP in the 4 weeks prior to taking their life.
- 47% were known to have previously attempted to take their life by suicide, and 23% were known to have a history of self-harm.
- Hanging was the most frequent method of suicide (55%), with most people taking their own life at home. The next most frequent methods are overdose/poisoning (16%), injuries (10%), suffocation (5%), falling from a height (3%) and by being hit by a train/life taken on the tracks (2%).
- 42% of those that died were employed, 29% unemployed, 13% retired, and 13% had a long-term disability which meant they could not work.
- Mental health problems (65%), relationship problems such as separation (52%), physical health problems (52%), job problems (28%), history of contact with the criminal justice system (28%), financial issues (26%), adverse childhood experiences (26%), and being a victim of abuse (21%) were the most common recorded "life event" risk factors.

In relation to risk factors for suicide, according to the Public Health Outcomes Framework (2019), Southampton has a higher than the national average prevalence of recorded depression in those aged 18 years and over, and higher prevalence of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers for all ages. Southampton also has a higher than national average levels of unemployment, and a higher than average percentage of people living alone. In relation to children and young people, Southampton has higher than national average levels of looked after children, care leavers, and children in the youth justice system.

SELF-HARM

Self-harm is a concern in its own right, as well as being a risk factor for completed suicide. Not everyone that self-harms will have suicidal thoughts, whilst not everyone that dies by suicide will have self-harmed. However, we know that previous self-harm is an important predictor for suicide.

As already noted, of those deaths by suicide in 2017 and 2018 that were audited, 47% were known to have previously attempted to take their life by suicide, and 23% were known to have a history of self-harm.[4] In line with national guidance, self-harm has been identified for inclusion in this Plan as a priority for further action.

National and local Southampton data suggest levels of self-harm are increasing, although only the 'tip of the iceberg' presents to healthcare services. Young people and adolescents (especially females) have disproportionately high rates of self-harm, both nationally and in Southampton. Self-harm in adults of

[4] The local audit of Coroner's records will under-estimate the individuals that have self-harmed as it is well documented that many people who self-harm do not seek help from health or other services and so self-harm episodes are not recoded.

all ages, taken together, also represents a significant health (and healthcare) burden. Local hospital admissions for self-harm in 10-24 year olds are significantly higher in Southampton than the national average.[5]

Risk factors for self-harm include the following:

- Women - rates are two to three times higher in women than men;
- Young people - 10-13% of 15-16-year-olds have self-harmed in their lifetime;
- Mental health disorders including depression and anxiety;
- People who have or are recovering from drug and alcohol problems;
- People who are lesbian, gay, bisexual or gender reassigned;
- Socially deprived people living in urban areas;
- Women of black and South-Asian ethnicity;
- Groups including veterans, prisoners, those with learning disabilities, and those in care settings;
- Individual elements including personality traits, family experiences (being single, divorced or living alone), exposure to trauma (including bullying, abuse or adverse childhood experiences), life events, cultural beliefs, social isolation and income.

OUR APPROACH

Partnership: As a large percentage of suicidal individuals are not in contact with health or social care services, action is required beyond the health and social care system. Real partnership is required with community groups, local business and the voluntary and community sector to help identify and support people at risk of suicide and those bereaved by suicide. Key messages learned from practice and research are that suicide is preventable, that it is everyone's business, and that collaborative working is key to successful suicide prevention. This Plan has been developed by a wide range of partners to ensure that is a collaborative effort, and that action to prevent suicide is a shared responsibility across Southampton.

Prevention and early intervention: The Plan supports taking early action to prevent individuals from reaching the point of personal crisis where they feel suicidal. This requires action much earlier and across a range of settings from general practice, to schools, the workplace and community groups.

Life-course: This Plan takes a "life course" approach as advocated by the Marmot Review (2010), and aligned with the national mental health and suicide prevention strategy.

Evidence based: This Plan is informed by the evidence base. It uses national and local evidence to both identify areas of focus and specific need, and to inform the actions that will be taken to address need. This includes national guidance, published literature, and national and local intelligence, including from the local suicide audit of coroner records and real-time surveillance data from Hampshire Constabulary. The Plan has also been informed by stakeholder engagement with partners across the system, including Southampton residents with lived experience of mental health.

[5] See https://fingertips.phe.org.uk.

HOW WE WILL MEASURE SUCCESS

Ultimately, we want to see a reduction in Southampton's suicide rate. However, due to the low numbers of suicides it is difficult to show a statistically significant improvement in suicide rates across a local area and additional (proxy) measures will be used to assess the Plan's success. This includes for example, levels of self-harm and stigma in the population. See **Appendices X** for a breakdown of monitoring measures that will be used. Achieving a reduction in suicides is challenging in times of austerity as we know that higher levels of people are living with financial stress, which is a risk factor for poor mental health and wellbeing and increases suicide risk.

DELIVERY AND GOVERNANCE

Southampton Suicide Prevention Partnership (SPP) has responsibility for delivering on and monitoring progress towards the Suicide Prevention Plan. The Suicide Prevention Partnership will report to the Health and Wellbeing Board, which has overall responsibility for suicide prevention.

ACTION PLAN

ACTIONS ARE DRAFT AND REQUIRE FURTHER DISCUSSION AND AGREEMENT WITH ALL NAMED PARTNERS

AREA 1: ACHIEVE CITY-WIDE LEADERSHIP FOR SUICIDE PREVENTION

This plan has been developed by a wide range or partners to ensure this is a collaborative effort and that action to prevent suicide is a shared responsibility between stakeholders in Southampton. The Suicide Prevention Partnership (SPP) in Southampton has been in place for a number of years and will continue to work together to achieve shared outcomes.

Ref	Target Group	Action	Lead Partner	Anticipated Outcome	Timescale
1.1	All groups	Continue with regular meetings by the strategic multi-agency group; Southampton Suicide Prevention Partnership (SPP), reporting to Southampton Health and Wellbeing Board.	Public Health, SCC	Clear leadership and governance structure to enable decision-making and coordinate suicide prevention efforts.	Ongoing
1.2	All groups	Members of the SPP advocate suicide and self-harm prevention in their organisations/service areas, disseminate key messages, and take action where they are a "lead partner" in this Plan.	All partners	Co-ordinated advocacy and ownership of suicide prevention across all sectors.	Ongoing
1.3	All groups	SPP maintains and develops strong links with national, South East and Hampshire-wide mental health networks, including: - STP Suicide Prevention programme, including links with the National Collaborating Centre for Mental Health (NCCMH) and the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) - STP Mental Health Board - Wessex Clinical Networks (i.e. CYP) - PHE South East Mental Health Network	Public Health, SCC; Suicide Prevention Programme Manager; STP members	Alignment of suicide prevention outcomes, strategic support from other networks, and learning from other areas.	Ongoing

1.4	People with lived experience	Refresh the membership of the SPP to ensure that key stakeholders are represented, including people with lived experience.	Public Health, SCC Solent Mind	Improved representation of stakeholders on SPP, co-production, and engagement in delivery of actions.	2020

AREA 2: REDUCE THE RISK OF SUICIDE IN KEY HIGH-RISK GROUPS

The following groups are at higher risk of suicide in Southampton. These groups are in line with at risk groups identified by national guidance such as the national strategy report Preventing Suicide in England: Two Years On (2018):

- Men, particularly middle-aged men.
- People experiencing mental health problems, particularly depression and personality disorders – both in the care of mental health services and those not currently receiving treatment. For those in treatment, high risk periods include the first 3 months post-discharge from acute mental health services.
- People experiencing:
    - Relationship difficulties, particularly separation for men (most commonly occurring life event identified by the Southampton Suicide Audit)
    - Unemployment and financial difficulties
    - Physical health problems, particularly disability and chronic pain
    - Housing difficulties and/or social isolation
    - Bereavement, especially bereavement by suicide
- People with history of attempts of suicide or self-harm
- People formerly convicted of a crime
- People with a history of substance misuse (especially co-occurring substance misuse and mental health needs)
- People who have experienced abuse (either as victims or witnesses)

Ref	Target Group	Action	Lead Partner	Anticipated Outcome	Timescale
2.1	All target groups	Map the different services, organisations and support groups (e.g. Citizens Advice, Foodbanks, Gyms, Libraries, Men's Sheds, Relate, Street Pastors, Housing services as well as health services) that each of the at risk groups are likely to have	Public Health to utilise a Southampton Suicide Prevention Partnership meeting to complete mapping	Identification of opportunities to utilise community organisations and support groups as	2020

		frequent contact with – their "touch points" in order to identify gaps, unmet needs, and opportunities i.e. to target suicide prevention interventions.		assets in the prevention of suicide.	
2.2	All target groups	Develop and secure an improved training offer to ensure the provision of mental health, self-harm and suicide prevention training to frontline staff and "touch points" (see above) to enable them to better identify those in need of help, provide support, and signpost/refer. An example would be working with Relate and similar organisations that work with recently separated men. The above will require mapping what is currently being delivered across the city, and exploring opportunities to collaborate locally and regionally where appropriate.	Public Health to coordinate All partners to support	Improved competence and confidence in suicide prevention in front-line staff and key "touch points" in the community.	Developed and secured in 2020-21
2.3	Men, and especially those that are recently separated, socially isolated, have a disability/ pain and/or financial difficulties	Deliver public awareness mental health campaigns (including suicide prevention and self-harm messages) that target at risk groups, reduce stigma, and encourage people to seek support. These should amplify national campaigns as appropriate.	Southampton Anti-Stigma Partnership	Reduce stigma surrounding suicide, and increase help-seeking behaviour with regards to mental and emotional health.	At least one campaign each year
2.4	All groups and especially, men, CYP, LGBT and	Deliver Time to Change events that raise public awareness of mental health, tackle stigma, and encourage people to talk about mental health. Events include Mela, Pride, and sports related events.	Southampton and Portsmouth Time to Change Hub (Solent Mind)	Reduce stigma surrounding suicide, and increase help-seeking behaviour	At least two events each year for 2020-21 and 2021-22

	BME groups		Southampton Anti-Stigma Partnership	with regards to mental and emotional health.	
2.5	All groups	Promote the distribution of Life Card's* to local organisations, services and support groups, including those that are frequent "touch points" for our target and vulnerable groups. *Developed by Southern Health, credit card sized, and with vital information on the back aimed to signpost people to key tools and organisations that can offer support and advice to anyone that needs it.	TBC	TBC	TBC
2.6	Men, and especially recently separated, socially isolated, have a disability/ chronic pain and/or have financial difficulties	Gain the commitment of key employers to promote mental health and wellbeing within their organisations through a combination of: - Mental health (including suicide prevention) training; - Signing up to the Time to Change Employer Pledge; - And/or other workplace health policy and procedures that promote good mental health and wellbeing in the workplace and better identify and respond to those in need of support – aligned with the STP Suicide Prevention Programme. Occupations: Low skilled male labourers (three times more likely to take their own lives than the national average); nursing staff and primary teachers also high.	All SPP partners Southampton and Portsmouth Time to Change Hub (Solent Mind) STP Suicide Prevention Programme	Improved awareness and identification of mental health need, support, and referral amongst targeted high-risk employers and employee groups.	By 2023
2.7	Target groups: As above	Work with key stakeholders (e.g. Citizens Advice Bureau, MIND) to improve access to financial advice for key target groups.	STP Suicide Prevention Programme	Incorporation of financial literacy, access to financial advice and support,	By 2022

				and active sign-posting to support organisations amongst targeted high-risk employers, and other key organisations.	
2.8	Social isolation	Promote social prescribing as a means of improving mental health and wellbeing, including as a way of reducing social isolation. Ensure existing VCSO's/projects that support life events and address risk factors (e.g. financial advice, relationship advice) are involved.	Southampton CCG	Improved early intervention and access to protective factors.	Ongoing
2.9	All target groups	Improve identification of, and care planning with, patients with low mental health and wellbeing amongst the primary care workforce, with a focus on suicide prevention and self-harm training and making good quality resources easily available.	STP Suicide Prevention Programme	Improved identification of suicide risk and care planning for vulnerable patients in primary care.	2022
2.10	People with a history of self-harm People that could self-harm - primary prevention and early intervention	Better understand the data and pathways in relation to self-harm and identify areas for quality and service improvement, with a focus on identifying and delivering interventions that promote prevention and early intervention in the school and family settings, and interventions within the first month post ED admission for self-harm.	STP Suicide Prevention Programme	Improvements in the self-harm pathway and subsequent contribution to reducing self-harm rates	2022
2.11	People in contact with services. High risk periods;	Acute trusts have robust suicide prevention plans in place, which include: • The undertaking of psychosocial assessments for all people who present at emergency departments for self-harm.	Solent NHS Trust Southern Health	Improved clinical intervention to reduce suicide rates.	Ongoing

	first 3 months post-discharge from MH services and first month after ED	• Robust discharge planning processes for vulnerable patients (heeding the House of Common's Health Committee's recommendation that people being discharged from inpatient care should receive follow up support within 3 days of discharge, rather than the current standard of 7 days). • Compliance with NICE guidance.			
2.12	Children and young people	Promote positive mental health and wellbeing in the schools and college setting through the work of the CYPs Social and Emotional Mental Health Partnership.	CYP Social and Emotional Mental Health Partnership (chaired by the ICU)	Improved social and emotional health in CYP	Ongoing
2.13	Physical health problems, particularly disability and chronic pain	Insert CCG/ICU action on the chronic pain pathway (work on chronic pain and MH underway).	Southampton CCG	TBC	TBC
2.14	Housing difficulties	Explore how the mental health needs of those using night shelters could be better met to address unmet need.	Southern Health Society of St James Southampton ICU	TBC	TBC
2.15	Co-occurring substance misuse and MH	Requires discussion with Substance Misuse Group	Substance Misuse Steering Group	TBC	TBC
2.16	People in contact with the criminal justice system	Need to identify if action being taken elsewhere to support suicide prevention in the criminal justice system – and if there is another Plan which includes this then reference that Plan. Expectation that as well as training, there are plans in place around the pre and post release period ("through the gate" services/pathways).	TBC	TBC	TBC

AREA 3: TAILOR APPROACHES TO SUPPORT IMPROVEMENTS IN MENTAL HEALTH IN SPECIFIC GROUPS

As identified by national guidance, the following groups may need tailored approaches to support improvements in resilience and contribute to improved mental health and wellbeing:

- Looked after children and/or care leavers;
- Military veterans;
- People who are lesbian, gay, bisexual or gender reassigned;
- Black and Minority Ethnic groups and asylum seekers (men of Eastern European backgrounds were found especially at risk by the Suicide Audit);
- Those with complex (and often multiple) needs;

Ref	Target Group	Action	Lead Partner	Anticipated Outcome	Timescale
3.1	Adults Those with complex needs i.e. MH, substance misuse, rough sleeping	Ensure SPP representation at the Vulnerable Adults Group of Better Care Southampton; to ensure suicide prevention is aligned with other work and embedded as appropriate.	Public Health SSJ Confirm who is on both the SCC and Vulnerable Adults Group.	Improved partnership working in relation to vulnerable adults and subsequent work on co-occurring conditions.	2020 and ongoing
3.2	All age groups Target groups: LGBT, BME, Veterans (ex), young offenders, bereavement support services.	Identify individuals/groups/organisations that can help engage with those identified as requiring tailored support (i.e. LGBT, BME groups, those with learning disabilities) and ensure they are aware of the pathways, services and resources in place so that they can best support individuals.	CYP Social and Emotional Mental Health Partnership sub-group (work on pathways, services and resources underway and likely to be promoted through Wessex Healthier Together)	Improved awareness of pathways, services and resources by professionals and in turn residents. Community groups/organisations identified and included in implementing the Suicide Prevention Action Plan.	2020

	Vulnerable CYP	Using the suicide audit, real time surveillance and other available data, complete a "deep dive" on the characteristics (including risk and protective factors) of CYP up to and including 25 year olds that have taken their own life by suicide; to inform the work of the CYP Wessex Clinical Network on vulnerable CYP (including identification of unmet need and interventions).	Public Health	Improved knowledge about the characteristics of CYP to inform Wessex CYP Clinical Network decision-making on unmet needs and interventions; which will seek to improve MH in vulnerable groups.	2020
3.3	All vulnerable groups	Commissioned services recognise and put in place measures to support the specific needs of at risk and/or potentially vulnerable groups in need of additional support. Needs to be more specific. Work with ICU/CCG.	NHS Solent Southern Health Southampton CCG	Improved early intervention for specific vulnerable groups	Ongoing

AREA 4: REDUCE ACCESS TO THE MEANS OF SUICIDE

This refers to reducing or restricting access to lethal means individuals use to attempt suicide is an important part of a comprehensive approach to suicide prevention.

Ref	Target Group	Action	Lead partner	Anticipated outcome	Timescale
4.1	Adults Those experiencing chronic pain	Promote safe prescribing of painkillers and antidepressants, including through promoting NICE guidelines on the appropriate use of drug treatments for depression.	Public Health Southampton CCG	Safer prescribing and reduced fatal suicide attempts	Ongoing
4.3	All age groups	Include suicide risk in building design considerations for: - SCC major refurbishments and upgrading of social housing stock - SCC corporate assets - Acute MH Trust settings	Housing, SCC Southern Health Hampshire Police	Suicide risk embedded in SCC housing stock (where major refurbishments and upgrading)	2019

		- Custody settings			
4.4	All age groups	Work with planning and developers to include suicide risk in new building design considerations, especially in relation to multi-storey car parks, bridges and high rise buildings that may offer suicide opportunities.	Planning, SCC and other partners as required	Suicide risk embedded in building design of major new infrastructure	2019
4.5	All age groups	Review suicide prevention measures at high-frequency locations (for attempted and completed suicides) and make recommendations.	Public Health, Planning and Infrastructure and Transport, SCC Hampshire Police and emergency services	Suicide prevention measures in place at specific high-risk locations	2021
4.6		Discuss with Network Rail – include an action they will own in relation to suicide prevention using the rail network.		Suicide prevention measures in place in relation to the rail infrastructure and network rail staff (i.e. suicide prevention training).	2021 and ongoing

AREA 5: PROVIDE BETTER INFORMATION AND SUPPORT TO THOSE BEREAVED OR AFFECTED BY SUICIDE

The provision of timely information and support to those bereaved or affected by suicide such as families, friends, colleagues and peers, is important in supporting people through the different stages of bereavement and in preventing future mental ill health. We know that death of a family member or friend by suicide is a risk factor for suicide in the bereaved.

Ref	Target Group	Action	Lead partner	Anticipated outcome	Timescale
The following actions are embedded in the STP Suicide Prevention Programme and so will be led by the STP work-stream on bereavement support and postvention, though the SPP will play an active role in informing the programme and supporting the delivery of solutions in the Southampton system:					
5.1	Families bereaved by	Strengthen effective referral to bereavement support/services by emergency services that	Public Health Hampshire Police	Strengthened pathways and referral	2022

	suicide or a death of undetermined intent	attend the death and those in contact with the families soon after bereavement from suicide occurs (i.e. Coroner's Office), so that referrals are appropriate and timely.	NHS South Central Ambulance Service (SCAS) Coroner's Office Bereavement services	to bereavement support services. Standardise approach to supporting those bereaved by suicide	
5.2	Families bereaved by suicide or a death of undetermined intent	Promote the distribution of the "Help is at Hand"* booklet or zcard by local organisations, services and support groups, including the first responders, Coroners, Funeral Directors and education settings. *A national bereavement support resource developed by those with lived experience of bereavement in partnership with Public Health England.	Public Health Hampshire Police Coroner's Office NHS Solent Southern Health Southampton General Southampton CCG (including primary care) British Transport Police Network Rail Voluntary sector partners	Information about bereavement support services more accessible	2021
5.3	Families bereaved by suicide or a death of undetermined intent	Develop and implement a Real-Time Suicide Surveillance System to 1. Enable a timely response by partners to ensure family/carers/friends are appropriately supported after a death by suicide (i.e. within 48 hours), 2. Enable system learning by partners to inform future prevention work and 3. Enable early identification of any 'clustering' to inform prevention work.	Public Health Hampshire Police Southern Health NHS Solent Education settings	Implementation of real-time suicide surveillance	2022
5.4	Families bereaved by suicide or a death of undetermined intent	Review the current bereavement support offer to families in Southampton, determine how best needs can be met, and work with services to strengthen the provision of suicide-specific bereavement support.	Public Health Bereavement support services	Strengthened suicide specific bereavement support	2023

5.5	Families bereaved by suicide or a death of undetermined intent	Build awareness raising on suicide-specific bereavement into core mental health and suicide prevention training for front line staff.	Southampton CCG (primary care)	More informed and competent workforce	2023
Out of scope of the STP programme					
5.6	Families bereaved by suicide or a death of undetermined intent	Develop a prevention and postvention protocol with Southampton schools and colleges; to ensure they know how to respond effectively in the event of a suicide and to reduce further suicides.	Public Health Schools and colleges		2023
5.7	All groups Families affected by a suicide attempt	Ensure those affected by an attempted suicide are signposted to resources, tools and organisations where they can seek further support.	Southampton General Southern Health Solent NHS Trust	Strengthen support, reduce risk of future attempts Learn from attempted suicides	Ongoing

AREA 6: SUPPORT THE MEDIA IN DELIVERING SENSITIVE APPROACHES TO SUICIDE AND SUICIDAL BEHAVIOURS

There is a proven link between certain types of media reporting of suicide and increases in suicide rates. This objective aims to promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media and reduce the risk of additional suicides

Ref	Target Group	Action	Lead partner	Anticipated outcome	Timescale
6.1	All age groups	Promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media, including by encouraging use of the Samaritans guidance on responsible reporting, and challenging the publication of harmful or inappropriate material with reference to the updated laws on promoting suicide.	Anti-stigma partnership SCC comms	Reduce stigma around suicide	Ongoing

6.2	All age groups	Work with local media to encourage inclusion of positive stories (i.e. hope and recovery) and signposting of national helplines and local services for people that are affected by local campaigns and coverage of deaths by suicide or undetermined intent.	SCC Comms Samaritans	Establish a direct approach/contact with local media Increase in help-seeking behaviour	Ongoing

AREA 7: SUPPORT RESEARCH, DATA COLLECTION AND MONITORING

It is important to build on the existing research evidence and other relevant sources of data on suicide and suicide prevention.

Ref	Target Group	Action	Lead partner	Anticipated outcome	Timescale
7.1	All age groups	In relation to the Suicide Audit: - Ensure suicide data is recorded consistency across the STP so that it can be better analysed at the STP footprint. - Explore what further risk and protective factors can be included in relation to CYP and families (i.e. parents of children), in discussion with the CYP Wessex Clinical Network. - Continue to include findings of all serious incident reviews.	Public Health Coroner's Office	Audit to inform Suicide Prevention Plan refresh.	2021
7.2	All age groups	Circulate the key findings of the suicide audit to Partners to encourage learning from suicides locally.	Public Health CCG SPP	Learning from suicide audit inform practice.	Ongoing
7.6	Children and young people	Include a section in the Year 7 Survey (with schools) or Youth Forum Survey, which will collect information on the status and views of children and young people in relation to mental health, social and emotional wellbeing – to support identification of need and preventative activities.	Public Health SCC	Identification of need and preventative activities.	2021
7.7	All age groups	Establish links with regional and leading universities on suicide and self-harm	Public Health	Strengthen academic and research links.	Ongoing

		prevention to strengthen research links and academic input to the Partnership.	Academic partners		
7.8	All age groups	Conduct “deep dives” where there is an opportunity to inform strategic and commissioning decision-making (could be in relation to self-harm, attempted suicides and/or completed suicides).	Public Health Academic partners Samaritans	Learning on suicidal thoughts and risk factors can help inform suicide prevention	Ongoing

SOUTHAMPTON SUICIDE PREVENTION PARTNERSHIP MEMBERSHIP

Public Health, SCC
Southern Health
Steps 2 Well-being
CCG/ICU
Southampton Solent University
University of Southampton
Solent Mind
Samaritans
British Transport Police
Hampshire Police
Society of Saint James
Red Lipstick Foundation
Survivors of Bereavement by Suicide (SOBS)
GP clinical lead for Southampton CCG
Community engagement officer, SCC/CCG

The Partnership is working with Solent Mind to ensure that the Plan is informed by Southampton residents with lived experience of mental health.

APPENDICES TO BE DEVELOPED:

- Monitoring measures and outcomes
- Case studies of good practice in Southampton.

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DECISION-MAKER:		HEALTH OVERVIEW AND SCRUTINY PANEL		
SUBJECT:		MONITORING SCRUTINY RECOMMENDATIONS		
DATE OF DECISION:		5 DECEMBER 2019		
REPORT OF:		DIRECTOR - LEGAL AND GOVERNANCE		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Mark Pirnie**	**Tel:**	**023 8083 3886**
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STATEMENT OF CONFIDENTIALITY		
None		
BRIEF SUMMARY		
This item enables the Health Overview and Scrutiny Panel to monitor and track progress on recommendations made at previous meetings.		
RECOMMENDATIONS:		
	(i)	That the Panel considers the responses to recommendations from previous meetings and provides feedback.
REASONS FOR REPORT RECOMMENDATIONS		
1.	To assist the Panel in assessing the impact and consequence of recommendations made at previous meetings.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
2.	None.	
DETAIL (Including consultation carried out)		
3.	Appendix 1 of the report sets out the recommendations made at previous meetings of the Health Overview and Scrutiny Panel. It also contains summaries of any action taken in response to the recommendations.	
4.	The progress status for each recommendation is indicated and if the Health Overview and Scrutiny Panel confirms acceptance of the items marked as completed they will be removed from the list. In cases where action on the recommendation is outstanding or the Panel does not accept the matter has been adequately completed, it will be kept on the list and reported back to the next meeting. It will remain on the list until such time as the Panel accepts the recommendation as completed. Rejected recommendations will only be removed from the list after being reported to the Health Overview and Scrutiny Panel.	
RESOURCE IMPLICATIONS		
Capital/Revenue		
5.	None.	

Property/Other		
6.	None.	
LEGAL IMPLICATIONS		
Statutory power to undertake proposals in the report:		
7.	The duty for local authorities to undertake health scrutiny is set out in National Health Service Act 2006. The duty to undertake overview and scrutiny is set out in Part 1A Section 9 of the Local Government Act 2000.	
Other Legal Implications:		
8.	None	
RISK MANAGEMENT IMPLICATIONS		
9.	None.	
POLICY FRAMEWORK IMPLICATIONS		
10.	None	
KEY DECISION	No	
WARDS/COMMUNITIES AFFECTED:	None directly as a result of this report	
SUPPORTING DOCUMENTATION		
Appendices		
1.	Monitoring Scrutiny Recommendations – 5 December 2019	
Documents In Members' Rooms		
1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out?		No
Data Protection Impact Assessment		
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out?		No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**		
Title of Background Paper(s)	Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)	
1.	None	

Health Overview and Scrutiny Panel (HOSP)

Scrutiny Monitoring – 5 December 2019

Date	Title	Action proposed	Action Taken	Progress Status
24/10/19	HHFT – Proposed Orthopaedic Transformation	1) That Hampshire Hospitals Foundation Trust ensure that the next scheduled update to Hampshire's Health and Adult Social Care Committee on the proposals for Trauma and Orthopaedic services is circulated to the Panel.	Agreed. The Hampshire Health and Adult Social Care Committee is expecting this item to return to the Committee on 4 March 2020.	
24/10/19	Adult Social Care Update	1) That, in response to concerns raised about the Director of Public Health reporting to the Executive Director – Wellbeing in the new Council structure, and the need for Public Health to have a much broader remit than Adult Social Services, the Panel are provided with assurance from the Chief Executive that the Director of Public Health would continue to have senior level influence across the full range of their accountabilities within the new structure.	Responses from the Chief Executive and Deputy Chief Executive circulated to the Panel on 12/11/19.	Complete
		2) That the Panel are provided with the current ratio of adult social care workers per 1,000 of the Southampton population that are aged over 65. (Paragraph 61 Peer Review)	The current ratio of social workers per 1,000 of the Southampton population aged over 65 is 2. The council's draft budget for 2020/21 contains a proposal to employ additional social workers.	Complete
		3) That the enablers of change, particularly staff engagement and satisfaction, are measured and incorporated into the Adult Care performance dataset.	The Adult Care performance dataset is being reviewed by the Adult Social Care Improvement Board with a view to measuring and reporting on enablers of change, including staff engagement and satisfaction. These measures will reported to Panel as part of the next Adult Care performance update during 2020/21.	
		4) In recognition that most local authorities responsible for adult care services are seeking to develop technological solutions to transform how services are delivered, it is recommended that the Council explores opportunities to share the cost of research and development with other local authorities and representative organisations to improve economies of scale and reduce duplication.	Opportunities to collaborate with other local authorities and representative organisations will be identified and pursued, wherever feasible, through the Adult Social Care Improvement Programme. Panel will be appraised of progress as part of the next Adult Care performance update during 2020/21.	

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