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NOTICE

OF

MEETING

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Royal Borough of Windsor & Maidenhead

HEALTH AND WELLBEING BOARD

will meet on

WEDNESDAY, 15TH FEBRUARY, 2017

At 3.00 pm

in the

COUNCIL CHAMBER - TOWN HALL,

TO: MEMBERS OF THE HEALTH AND WELLBEING BOARD

COUNCILLOR DAVID COPPINGER (CHAIRMAN), DR ADRIAN HAYTER (VICE-CHAIRMAN), COUNCILLOR NATASHA AIREY AND COUNCILLOR STUART CARROLL, ALISON ALEXANDER (MANAGING DIRECTOR AND STRATEGIC DIRECTOR OF ADULTS, CHILDREN AND HEALTH SERVICES), DR LISE LLEWELLYN (STRATEGIC DIRECTOR OF PUBLIC HEALTH), DR ADRIAN HAYTER (WINDSOR, ASCOT AND MAIDENHEAD CCG CLINICAL CHAIR AND LEAD FOR WINDSOR), DR WILLIAM TONG (BRACKNELL & ASCOT CCG CLINICAL CHAIR), MIKE COPELAND (CHAIRMAN OF HEALTHWATCH WAM). ANGELA MORRIS (DEPUTY DIRECTOR ADULT SERVICES AND KEVIN JOHNSON (BETTER CARE FUND MANAGER NHS ENGLAND).

Karen Shepherd
Democratic Services Manager
Issued: 7 February 2017

Members of the Press and Public are welcome to attend Part I of this meeting. The agenda is available on the Council's web site at www.rbwm.gov.uk or contact the Panel Administrator **Wendy Binmore** 01628 796251

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AGENDA

PART I

ITEM	SUBJECT	PERSON	TIMING	PAGE NO
1.	APOLOGIES FOR ABSENCE To receive apologies for absence.			
2.	DECLARATIONS OF INTEREST To receive any Declarations of Interest.			5 - 6
3.	MINUTES To confirm the Part I minutes of the previous meeting.			7 - 16
4.	THE RBWM YEAR OF MENTAL HEALTH To receive the above paper and presentation from Cllr Stuart Carroll, Hilary Hall and Darrell Gale. a) Context and Overview – Cllr Carroll b) The Year of Mental Health Action Plan – Hilary Hall c) The DRAFT Berkshire Suicide Prevention and Self Harm Strategy / Action Plan – Darrell Gale / Hilary Hall		35 mins	17 - 140
5.	END OF LIFE CARE Partnership discussion regarding the letter from David Mowat MP – Discussion led by Hilary Hall		10 mins	141 - 142
6.	SUSTAINABILITY AND TRANSFORMATION PLAN - UPDATE ON PROGRESS To receive the above verbal update from Dr Adrian Hayter.		10 mins	
7.	DELIVERING DIFFERENTLY - UPDATE ON THE LOCAL CHANGES To receive a verbal update on Delivering Differently from Hilary Hall.			
8.	BETTER CARE FUND To receive the following update from Hilary Hall: • Update on progress • Integrated Carers Strategy Delivery Plan		20 mins	143 - 158

9.	ANY OTHER BUSINESS To discuss any other business.		5 mins	
10.	QUESTIONS FROM THE PUBLIC To receive any questions from the public.		5 mins	
11.	FUTURE MEETING DATES To note that the schedule of meetings for 2017 – 2018 are to be confirmed.			

ITEM	SUBJECT	PERSON	TIMING	PAGE NO

MEMBERS' GUIDANCE NOTE

DECLARING INTERESTS IN MEETINGS

DISCLOSABLE PECUNIARY INTERESTS (DPIs)

DPIs include:

- Any employment, office, trade, profession or vocation carried on for profit or gain.
- Any payment or provision of any other financial benefit made in respect of any expenses occurred in carrying out member duties or election expenses.
- Any contract under which goods and services are to be provided/works to be executed which has not been fully discharged.
- Any beneficial interest in land within the area of the relevant authority.
- Any license to occupy land in the area of the relevant authority for a month or longer.
- Any tenancy where the landlord is the relevant authority, and the tenant is a body in which the relevant person has a beneficial interest.
- Any beneficial interest in securities of a body where

  a) that body has a piece of business or land in the area of the relevant authority, and

  b) either (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body **or** (ii) the total nominal value of the shares of any one class belonging to the relevant person exceeds one hundredth of the total issued share capital of that class.

PREJUDICIAL INTERESTS

This is an interest which a reasonable fair minded and informed member of the public would reasonably believe is so significant that it harms or impairs your ability to judge the public interest. That is, your decision making is influenced by your interest that you are not able to impartially consider only relevant issues.

DECLARING INTERESTS

If you have not disclosed your interest in the register, you **must make** the declaration of interest at the beginning of the meeting, or as soon as you are aware that you have a DPI or Prejudicial Interest. If you have already disclosed the interest in your Register of Interests you are still required to disclose this in the meeting if it relates to the matter being discussed. A member with a DPI or Prejudicial Interest **may make representations at the start of the item but must not take part in discussion or vote at a meeting.** The term 'discussion' has been taken to mean a discussion by the members of the committee or other body determining the issue. You should notify Democratic Services before the meeting of your intention to speak. In order to avoid any accusations of taking part in the discussion or vote, you must move to the public area, having made your representations.

If you have any queries then you should obtain advice from the Legal or Democratic Services Officer before participating in the meeting.

If the interest declared has not been entered on to your Register of Interests, you must notify the Monitoring Officer in writing within the next 28 days following the meeting.

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HEALTH AND WELLBEING BOARD
MAGNET LEISURE CENTRE, HOLMANLEAZE, MAIDENHEAD SL6 8AW AT 3.00 PM

30 November 2016

PRESENT**:** Councillors David Coppinger (Chairman), Dr Adrian Hayter (Vice-Chairman) and Stuart Carroll, Alison Alexander, Dr Lise Llewellyn, Dr Adrian Hayter, Dr William Tong and Mike Copland

ALSO PRESENT: Mark Sellman, Head of Digital Transformation, Commissioning Support Unit (CSU).

Officers: Wendy Binmore and Nick Davies, Catherine Mullins and Teresa Salami-Oru

PART I

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Natasha Airey, Angela Morris, Hilary Hall, Mary Purnell and Alex Tilley. Hilary Turner has left her position with NHS England and will therefore, no longer be attending the Health and Wellbeing Board.

DECLARATIONS OF INTEREST

Cllr Carroll – Declared a personal interest as he works for a pharmaceutical company, Biogen. Cllr Carroll declared his employment in the interests of full transparency and to highlight that should for any reason during any point of the meeting, or indeed during future meetings, the HWB discussed anything directly related to Biogen's business he would abstain from the discussion and leave the room as required. Cllr Carrol confirmed he had no pecuniary interests or conflicts of interests for any of the agenda items under discussion.

Dr Adrian Hayter – Declared a personal interest as he is a member of a GP practice that is part of the Sustainability and Transformation Team affected by the Sustainability and Transformation Plan.

MINUTES

RESOLVED That: the minutes of the meeting held on 31 August 2016 were agreed and signed as a true and accurate record.

PUBLIC QUESTIONS

The Chairman explained to the Board that a question had been received via social media which read:

'I would be interested to know what is being done to monitor and address health impacts of Heathrow flight noise on residents.'

Nick Davies, Service Lead Adult Commissioning responded to the question with the following statement:

The Royal Borough of Windsor and Maidenhead has long had an interest in the developments at Heathrow Airport and have had an Aviation Forum since 2008. The Forum is committed to providing community leadership to local communities within the Royal Borough by representing local views at national and regional government on the economic, social and environmental impacts (including noise), and concerns arising from activities associated with aviation, particularly those related to Heathrow Airport.

At the last Aviation Forum on 1 November 2016, the decision by the RBWM Cabinet Prioritisation Sub-Committee on 13 October 2016 was discussed; namely to authorise the potential expenditure of £50,000, if required, to legally challenge any potential decision to expand London Heathrow Airport.

The preference expressed by government on 25 October 2016 towards Heathrow, is required to go through an NPS/consultation in 2017 before a final decision is confirmed. It remains the hope of the Council that such a decision will not happen – in order to safeguard against the significant environmental impacts such expansion would have upon Royal Borough residents, including the significant noise detriment that extra air traffic movements would bring.

It is important to note that the four Borough's considering legal action (in the event of an NPS/decision), will not have arrived at the decision making stage suddenly. A detailed dialogue has been (and will continue to be) undertaken with Government and previously with the Airports Commission over the last few years. It was hoped that the judicial review process will not have been necessary owing to the fact that expansion of the airport cannot satisfy environmental, health and other legal challenges. The Royal Borough continues to believe that Heathrow can get better without getting bigger and that there is only one viable choice in front of the government at present, which was the expansion of Gatwick airport.

The next steps for the Royal Borough will be to scrutinise the detail behind the reported evidence base (involving a further review of environmental assessments), ensuring we continue to hold government to account to protect our residents.

The Royal Borough owns two aviation monitors located in Windsor and Old Windsor to keep a log of noise from both runways. These are in addition to noise monitors sited by the airport at various locations in local communities. The results of these are often discussed with the airport at their Community Noise Forum.

All of the latest information on the Aviation Forum is on the RBWM website, with regular updates on the developments with Heathrow communicated to residents through a variety of news releases.

Other questions asked came from the public gallery of the Health and Wellbeing Board meeting. The following questions were asked with the following responses:

- **Who will be carrying out the new development at the St Mark's site?** – The estate was handed over to NHS Property Services and within the last few months, the development had been re-energised. A group was launched six weeks previously which discussed how to make the best use of the site and to see what was actually needed. The Managing Director confirmed the Borough and the CCG's would be very careful to ensure that people were constantly informed on what was happening with the site. Dr Hayter stated there would be lots of organisations working in the background but, services would be delivered to residents in a streamlined way. He wanted to make sure services were connected and simple.
- **Was there a specific place where the public could access and see what Sequins had been decided on?** – Dr Hayter confirmed that Sequins would be published on the

CCG website after Christmas 2016.

- **With STP and the CCG's, where did the voluntary sector fit in?** - the Managing Director confirmed that all services across a wide spectrum would include some voluntary sector input. STP and the CCG's were really going to start to capitalise on volunteer's expertise. Dr Hayter stated the CCG had contracted out to organisations and had discussion at the AGM on how to commission services across the voluntary sector and be more joined up. They needed to look at how voluntary organisations could partner up with other community providers to help deliver a range of services.
- **Would integrated hubs mean less GPs?** – Dr Hayter responded that no, the hubs were there to help GPs deliver better services. To help deliver things on a bigger scale such as group consultations where GP's, nurses and dieticians can all work together. Details were still to be worked out but, not to take services away from GP's but to add to them. They would also improve access to care for patients making consultations with GP's longer.
- **A lot of older people and other residents were seeing change and there was a lot of change taking place. Residents were seeing the changes as a loss. How will the Borough get across to residents that the changes were not bad or negative and that it was urgent changes that were needed?** Dr Hayter stated that the CCG's did work with patient groups that underpinned the message that the changes were positive and necessary. His patient group had been discussing the changes and had moved to telephone consultations on Mondays. The patient group had made patients aware of the changes before carrying them out. It was necessary to get patient groups to communicate those messages effectively to residents. Dr Tong commented that despite all of the different things, he asked people if there was another better way of doing things instead of it being the professionals always telling the patients.

SUSTAINABILITY AND TRANSFORMATION PLAN

Alison Alexander, Managing Director & Strategic Director of Adults, Children and Health Services and Dr Adrian Hayter gave a brief presentation on the Sustainability and Transformation Plan and highlighted the following key points:

- The STP will provide benefits to the communities and individuals will:
  - Be supported to remain as healthy, active, independent and happy.
  - Receive better coordination of heath & social care system - a 'no wrong door' approach.
  - Know who to contact if they need help and be offered care and support in their home that is well organised, only having to tell their story once.
  - Work in partnership with their care and support team to plan and manage their own care, leading to improved health, confidence and wellbeing.
  - Find it easy to navigate the urgent and emergency care system and most of their care will be easily accessed close to where they live.
  - Have confidence that the treatment they are offered is evidence based and results in high quality outcomes wherever they live - reduced variation through delivery of evidence based care and support.
  - Increase their skills and confidence to take responsibility for their own health and care in their communities.
  - Benefit from a greater use of technology, gives easier access to information & services.
  - As taxpayers, be assured that care is provided in an efficient and integrated way.
  - STP was a culmination of work that had taken place over the last two to three years through the BCF and JHWS.
  - Already acknowledged the population is independent, healthy and happy but, it needs to be better coordinated to get residents what they need so they only have to tell their story once.
  - Better use of technology.

- People's needs needed to be met through the HWB boards.

- Initiative 1: Ensuring residents had the skills, confidence and support to take responsibility for their own health and wellbeing.
  - Key local initiatives – already taking place around the Borough:
    - Detection of raised blood pressure
    - Diabetes prevention programme – programme just started within the Borough which supported healthier lifestyles.
    - Smoking cessation support for those awaiting elective procedures – real evidence post surgery that giving up smoking provides positive outcomes.
    - Obesity reduction.
    - Development of digital programmes to support healthy lifestyles.
- Initiative 2: Develop integrated decision making hubs to provide single points of access to services such as rapid response and reablement, phased by 2018.
  - Re-development of St Marks as an integrated hub for Maidenhead: Engaging with NHS PropCo regarding possibilities.
  - Potential expansion of Dedworth Medical Centre as an integrated hub for Windsor.
    - To integrate as many services within the hub as possible.
    - Want to provide the care that is actually needed.
- Imitative 3: Lay foundations for a new model of general practice provided at scale, including development of GP federations to improve resilience and capacity.
  - Drawing GPs together and working together to provide resilience.
  - Development of quality bundle for GP enhanced services – GP practices want to join together so there is a more joined up approach.
- Initiative 4: Design a support workforce that is fit for purpose across the system
  - Challenges in GPs, paramedics, nurses, non-regulated workforce domiciliary care workers.
  - Big gaps in areas so, looking to fill gaps with the right people to train and get in place.
  - Local initiatives:
    - Map current provision and gaps including use of agency
    - Establish career development track for bands 1-4 and into first registered position – lots of care staff have great potential to expand their learning.
    - Develop cross-trained Healthcare Assistants (HCAs)/Domiciliary Care Workers that operate both in hospital and community: rotational apprenticeships – some areas have difficulty recruiting and other areas don't, so joining together would help plug any gaps.
- Initiative 5: Transform the social care support market including a comprehensive capacity and demand analysis and market management.
  - Development of site to enable discharge – 'step up, step down'
- Initiative 6: Reduce clinical variation to improve outcomes and maximise value for individuals across the population.
  - Ensuring all residents get access to the same services.
- Programme of transformation enablers:
  - Working together
  - Becoming a collective system
  - Developing communities and social networks so that people have the skills and confidence to take responsibility for their own health and care in their communities.
  - Developing the workforce across our system so that it is able to deliver the new models of care – using technology and the estates.
  - Using technology to enable patients and the workforce to improve wellbeing, care, outcomes and efficiency.
  - Developing the Estate.

CONNECTED CARE - INTEROPERABILITY AND THE PATIENT PORTAL

Mark Sellman, Head of Digital Transformation for the regional Commissioning Support Unit (CSU), gave a brief presentation on the Local Digital Roadmap update. He highlighted to the Board the following key points:

- The local digital roadmap brought together health and social organisations to have a system-wide digital strategy
- Makes best use of limited resources by utilising scale, sharing best practice and reducing duplication – adopting solutions.
- Provides digital support to the Frimley Sustainability and Transformation Plan.
- Key enabler is Connected Care.
- High level vision:
    - Developing the patient portal will access Health and Social Care services online.
    - By 2017 will have a substantial number of users
    - Pulls together 18 different systems.
    - Support users that use apps
    - Patients wont need to tell their story more than once.
- Connected Care
    - Started from engagement with residents and their feedback
    - Provides a care portal that provides access to key information for health and social care professionals with the consent of the resident
    - 18 organisations across Berkshire are participating to create a holistic record.
- Connected Care Benefits:
    - There should be significant improvements to care
    - Improved patient experience
    - Increased efficiency
    - Clinical quality & improved outcomes
    - Wont replace communication between patient and health care professional.
- Patient / citizen portal:
    - Diabetes care evolving through the patient portal
    - Underpins the work on STP
    - Ahead of many areas of the country due to work ongoing for the last couple of years.
    - Patients could opt out entirely to sharing their personal details. Records would only be accessed at the point of care so a patients portal would not be activated until then.

Dr Lise Llewellyn stated the apps to access personal care information would not be live until late 2017, early 2018. One app was for new mums and there had already been some good feedback already. It was important to start using digital technology to help patients manage their conditions even if they were not connected to the portal.

CCG COMMISSIONING INTENTIONS AND OPERATING PLAN

Dr Hayter introduced his presentation and Board Members noted the following key points:

- Our commissioning Intentions – what are they?
    - How CCGs signal to providers how they were going to make changes to contracts.
    - Set out what changes they intend to make to the services they commission from providers.
    - Gave a starting point for contract negotiations
    - Provided an opportunity to discuss intentions with all stakeholder groups
    - Set the scene for the CCG Operational Plan.
- What to the Commissioning Intentions Say?

- The main headings focus on the key areas of work:
  - Urgent and emergency care – to be able to think about this with more and more demands being made of the service.
  - Integrated care – joined up services and how they were delivered in the community.
  - Mental health, learning disability and/or autism – part of a national plan and to improve care
  - Childrens and maternity services – new building in Wexham Park
  - Planned care – pharmacies and dentistry to be included.
  - Primary care – forward view in GP Practices
  - Specialised care – prevention to obesity and after care.
  - The full published document is on the CCG website at – http://www.windsorascotmaidenheadccg.nhs.uk/

- Planning Guidance for the Operational plan:
  - 2 years plan, 2 year allocations, two year contracts
  - Submissions of final plan 23/12/16 and contracts signed 23/12/16
  - Needs to be a clear link to trajectories and milestones in the STP
- Nine Must Do's:
  - Alignment of the Operational Plan to the STP
  - Financial Sustainability
  - Primary care (General Practice)
  - Urgent and emergency care
  - Referral to treatment and elective care
  - Cancer
  - Mental health
  - Learning disability
  - Improving quality
- Development of Initiatives:
  - Reviewed where there is variation in outcomes and spend
  - Considered areas where we know there are quality issues
  - Worked with clinical leads for areas to develop proposals
  - Discussed at Programme Boards
  - Discussion at BCF Boards
  - QIPP workshop to consider areas to develop further
- Examples of developments:
  - Mental health services for new mothers and children and young people
  - Improved cancer diagnosis treatment times
  - New ways of supporting people at the end of their lives
  - Seven day services – primary care and in hospitals
  - Development of GP Hubs and integrated services
  - Improved cardiology and diabetes services
  - Personal health budgets – not doing so well at working closely with Local Authority to see where working with personal budgets has worked well.
- There was a requirement to get views from the HWB so need the Board to note the plan and progress and sign off for the plan would be needed by December 2016.
- A statement was required from the HWB by 23/12/16 regarding the alignment of the HWBS and Operating Strategy.

Mike Copeland, Chairman of Healthwatch, stated it was difficult getting the information to the public and the public get confused regarding GP Out of Hours Services. There was a need to get the public to understand what services were available to patients and that required a PR campaign. Dr Hayter responded saying that A&E doctors were there 24hours but that was not necessarily the best use of resources. They needed to continually get the message out to patients. There was clear information within STP and the Patient Portal. They could use the Around the Royal Borough publication and produce a marketing plan. Alison Alexander, Managing Director & Strategic Director of Adults, Children and Health Services agreed with getting the CCG to use the Around the Royal Borough publication to get the information out to residents regarding all areas of care. The Health and Wellbeing Board agreed in principle to

the commissioning plans summary as presented

DELIVERING DIFFERENTLY - DELIVERING ADULT AND CHILDRENS SERVICES IN RBWM

Alison Alexander, Managing Director & Strategic Director of Adults, Children and Health Services gave Members a presentation on delivering adult services differently within the Royal Borough. Board Members noted the following main points:

- Meeting residents' needs as early as possible to ensure they live independent successful lives – the Borough feels it can be creative in delivering differently.
- Because our expectation of how we support residents is high, we also invest in our workforce so that we have the highest skilled workforce supporting our residents – continue to service residents and have their needs met so they can live independent healthy lives. The Borough wants to meet their needs.
- The Challenges:
    - People are living longer – the Borough is a small Local Authority
    - Needs are getting more complex – residents not as dependent on adult services till a later stage in their lives and then their needs are more complex
    - The world is more competitive – RBWM was a small Borough but with the largest number of care homes per population. That meant that residents had a choice and could have impact on the Borough as working with a broad range of care homes. The Borough needed to provide support to care homes.
    - The Borough has really good staff – but as a small Local Authority, they move onto somewhere where there were opportunities for career development
    - Retaining staff was difficult in a small unitary authority – so there were many advantages in working together
- Meeting the challenges:
    - The council was committed to constantly evolve (transform) and the focus has been on three areas:
        - Knowing our services – knowing which ones the Borough does deliver and which ones the Borough can deliver
        - Having the right people and tools – STP and commissioning intentions. Asking people to have a broader range of skills
        - Delivering differently, where necessary: Children's services approved by Cabinet in September 2016 – the Royal Borough feels it can deliver adult services and children's services differently.
- Adult services responding to change – saying to residents: what can you do for yourself and what can the people around you do for you so the Borough can target care more effectively.
    - Over four years there has been significant transformation across adult services – need to partner with another LA to deliver services.
    - Current changes include projects such as 'Each Step Together.'
    - More recently we have undertaken research and investigation into the different operating models in the country to deliver adult services.
- Conclusion of research:
    - We will enter into a partnership with Wokingham Borough Council – deliver services together. Will be overseen by three elected members.
    - Bringing our services together and buy a shareholding in the local authority trading company – Optalis Limited – Optalis was set up in 2011 and provides care at home, domiciliary care and will provide provision support and testing new ways of delivering services to residents.
    - Company overseen through a board that comprises of Elected Members from the Royal Borough and Wokingham Borough Council
        - Optalis employed around 450 people delivering services for Wokingham Borough Council
- Current Position:

- Both Councils taking proposals to Cabinet in October 2016 to form a partnership.
  - The Royal Borough will own 45% and will move over to 50% over the next two years.
  - Both Councils agreed to the partnership.
  - The ambition was to start the partnership in April 2017 with a commitment for 10 years – currently developing implementation.

- What this means for adult services staff:
  - New delivery model for adult services through Optalis, delivering £29.9m gross of services.
  - Adult services staff – circa 300 headcount TUPE to Optalis by 1 April 2017
  - Professionals delivering support services: finance, hr, ICT, data, transport etc – resource to transfer to Optalis being determined.
- Adult services to move into the partnership:
  - Physical disabilities and older people
  - Community team and people with learning difficulties
  - Windsor day car centre
  - Oakbridge Centre for adults with learning disabilities
  - Boyn Grove Day Care Centre
  - Homeside and Winston Court
  - Allenby Road
  - Short Term Support & Rehabilitation
  - Integrated mental health
  - Strategic safeguarding/DOLS
  - Contracts, Accreditation and Monitoring Team
  - Operational commissioning and brokerage
  - Business Support
  - Financial Assessment Team
  - Assisted Technology.
- Adult services not moving into the Partnership:
  - So, All adult services except for:
    - Statutory role of Director of Adult Services
    - Safeguarding Adults Board Business Unit
    - Strategic commissioning including public health.
- Fundamentally, staff will continue to deliver services to adults in the Royal Borough on behalf of the Royal Borough of Windsor and Maidenhead – with the same aims with a broader range of staff to service needs.

ANTIMICROBIAL RESISTANCE

Dr Lise Llewellyn explained to the Board that antimicrobial resistance was on the rise and highlighted the following points in order to raise awareness of the issues:

- Antimicrobial resistance was resistance to antibiotics
- During the 1900s, most deaths were due to infection
- Now, the quickest killers are cancer and heart disease
- Bugs were now becoming resistant to antibiotics
- Many infections were becoming untreatable
- The number of deaths due to infections would inevitably rise
- Increasing numbers of people are surviving cancer but, chemotherapy means the body is less able to fight infection so, if a bug is antibiotic resistant, the patient will be untreatable
- One thing that people can do to prevent antimicrobial resistance was to complete the course of antibiotics once prescribed.
- If the course isn't completed, they wont kill the bug and then the bug becomes resistant to antibiotics.

- Patients should not ask for antibiotics if they have a virus.
- All GPs and health care professionals treat people differently for a many reasons. WAM CCG prescribe more antibiotics per 1,000 but Bracknell and Ascot CCG prescribe less.
- There is a website called antibiotic guardian, people can sign up and make a pledge

Dr Hayter stated he had done work on this in GP practices and there is good information and leaflets on this which can be given to patients. An important element of this is hospitals. The south of the county are better than most areas but, there are things that could be done even better. Dr Lise Llewellyn commented there was an Antibiotic Guardian Steering Group that was looking at putting antibiotic guardians in hospitals. Dr Tong said it was about making sure the patients get the best care so there was a balance. By not prescribing antibiotics, that could cause harm when they are needed so there was a need to strike a balance. Dr Lise Llewellym agreed and said super antibiotics shouldn't be used for a simple infection and medical professionals need to ensure patients complete courses of antibiotics. Mike Copeland, Chairman of Healthwatch commented that they needed to make the public more aware of when they need to take antibiotics. There was also a need to reduce the use of antibiotics in farm animals so they are not consumed by the public.

TRANSFORMING CARE PARTNERSHIPS

Nick Davies, Service Lead Adult Commissioning provided the Board with the information relating to Transforming Care Partnerships which included the following key points:

- Transforming Care Partnerships was a national plan
- It focused on those with learning difficulties – there was no long term residency within the Borough
- It was challenging to secure community based accommodation
- The Borough had made good progress in Windsor and Maidenhead with a bid for capital funding to NHS England so the Borough can work with providers to deliver accommodation
- It will allow three people to be accommodated in the Borough and in the community.
- Confident about the final submission to secure capital funding and will make the bid work
- Property was in place by the end of 2016 and three people will be in placement by April 2017

Dr Lise Llewellyn asked if there was any plan to look at how residents with learning disability access regular health care services such as services for cancer. Could this be looked at in the next phase of work? Dr Hayter responded saying that could be taken forward within the CCG and clinical priorities for next year. Disability health checks was in there and that could probably be done better as not yet reaching everyone.

BETTER CARE FUND

Nick Davies, Service Lead Adult Commissioning wanted to reassure the Board that the Borough was progressing with key indicators and was monitoring them. A few of the highlights he wanted to share with the Board were that the Borough was hitting the target for non-elective admissions for the first time, delayed transfers of care from hospital target was being me and new figures showed that falls related NELs were exceeding targets in spite of last years successes. The Chairman stated that the Borough was required to integrate health and social care and that had started with the Better Care Fund and that was a good way to share resources and funds.

AOB - ADDITIONAL INFORMATION FOR THE HWB

The Chairman stated he had received a letter from the Home Office asking the HWB to include the Police and Crime Commissioner in the HWB membership. The Chairman felt that a smaller Board was a more effective Board and he intended to keep it that way. The Chairman said he would respond to the letter explaining that and stated that the Police and Crime Commissioner would always be invited to the Board on matters which were directly linked to their role.

The Chairman had also received another letter from David Mowat MP asking the HWB to work closer with Primary Care and to support the 5 Year Forward View for General Practice. He felt the HWB already did that through joint working with the CCGs and Cllr Carroll also worked with GPs in a variety of different ways across the system so he was going to respond with words to that effect to that letter too.

FUTURE MEETING DATES

Members noted the date of the next Health and Wellbeing board meeting.

The meeting, which began at 3.00 pm, ended at 5.00 pm

CHAIRMAN…….

DATE…….....

Report Title:	Year of Mental Health Action Plan, 2017
Contains Confidential or Exempt Information?	No
Meeting and Date:	Health & Wellbeing Board 15th February 2017
Responsible Officer(s):	Hilary Hall, Head of Commissioning – Adults, Children and Health
Wards affected:	All

www.rbwm.gov.uk Royal Borough of Windsor & Maidenhead

REPORT SUMMARY

1 The report provides an overview of the Year of Mental Health Action Plan. It seeks to reflect central government recommendations and local government commitment. It also articulates the Royal Borough's vision for good population mental health through three agreed pillars: Mental health in all policies approach, Building resilience in children and young people and strengthening communities through an asset based approach.

2 The cost of delivering the plan will be met through existing budget. Over a period of three years (2017 -2020) it is envisaged that the plan will demonstrate considerable impact as evidenced through agreed performance indicators.

1. DETAILS OF RECOMMENDATION(S)

RECOMMENDATION: That Health & Wellbeing Board notes the report and:

i). Recognises the Brighter Berkshire Campaign and collaborative role played by the Royal Borough in supporting this partnership.
ii). Endorses the Royal Borough's Year of Mental Health plan.
iii). Endorses parity of esteem between mental health & physical health and the need to raise awareness and reduce stigma.

2. REASON(S) FOR RECOMMENDATION(S) AND OPTIONS CONSIDERED

2.1 The Royal Borough is working with partners across Berkshire to raise awareness of mental health issues.

2.2 In collaboration with Brighter Berkshire partners, the Royal Borough intends to:

a) Increase general awareness & reduce stigma.
b) Share best practice and integrate work streams across Berkshire.
c) Provide a communications platform for local authorities and partners to highlight their pledges and mental health strategies, including individual case studies.
d) Promote mental health across the political and health spectrum for the benefit of patients and residents.

2.3 Brighter Berkshire is a county-wide collaboration that brings together local authorities, health partners, businesses, schools and the wider community to share experiences, good practice and intelligence. The Royal Borough became a member of this partnership in 2016.

2.4 In January 2017, as part of the Charity Commission Annual Lecture, the Prime Minister described the burning injustice of mental health and the current inadequacy of treatment; suggesting that a new approach was required from government and society as a whole. The Prime Minister's mandate 'The Government's response to the Five Year Forward View for Mental Health' (January 2017) also outlined a programme of work to improve mental health services, their links to other public services and mental health prevention.

2.5 In 2014, 21,498 people had some form of mental health disorder in the Royal Borough of Windsor and Maidenhead. This is projected to rise to 22,630 by 2030 (an increase of 1,132 people)[1].

2.6 It is timely to strengthen our efforts in the area of mental health, acknowledging the importance of promoting both physical and mental health. The Royal Boroughs vision for good population mental health is built around three pillars:

a) Mental health in all policies approach.
b) Building resilience in children and young people.
c) Strengthening communities through an asset based approach

Table 1: Options

Option	Comments
Do nothing	The Royal Borough has committed to work with partners across Berkshire (Brighter Berkshire) to raise awareness of mental health issues. Doing nothing would contribute to reputational and ethical risks.
To endorse the Royal Borough's plan for the Year of Mental Health.	The Royal Borough cannot promote public health and wellbeing without including mental health. The action plan reflects central government recommendations and local government commitment. It is therefore recommended that the plan is noted and endorsed. **RECOMMENDED**

[1] RBWM JSNA, 2016

3. KEY IMPLICATIONS

Table 2: Key implications

Outcome	Unmet	Met	Exceeded	Significantly Exceeded	Date of delivery by December 2017
Demonstrable impact as a result of delivering the Year of Mental Health action plan	No impact measured by 31 December 2017	Demonstrable impacts by 31 December 2017	Demonstrable impacts by 30 November 2017	Demonstrable impacts by 31 October 2017	31 December 2017

4. FINANCIAL DETAILS / VALUE FOR MONEY

4.1 There are no financial implications – costs of delivering the action plan will be met from existing budgets.

5. LEGAL IMPLICATIONS

5.1 The council has the power to take the actions proposed; there are no known restrictions on that power.

6. RISK MANAGEMENT

Table 5: Risks

Risks	Uncontrolled Risk	Controls	Controlled Risk
Capacity for the delivery of the action plan.	Medium	Identified leads for each action in the plan Robust performance management	Low

7. POTENTIAL IMPACTS

7.1 An Equality Impact Assessment will be conducted by March 2017.

8. CONSULTATION

8.1 A summary of views have been received from Cllr Carrol, Cllr Saunders, Cllr Coppinger and the Head of HR.

9. TIMETABLE FOR IMPLEMENTATION

9.1 The timetable for implementation is at table 5.

Table 5: Timetable

Date	Details
16/1/17 – 29/12/17	Deliver action plan

10. APPENDICES

- Year of Mental Health Action Plan 2017.

11. BACKGROUND DOCUMENTS

- None.

12. CONSULTATION (MANDATORY)

Name of consultee	Post held	Date sent	Commented & returned
Hilary Hall	Head of Commissioning, ACH	31/1/17	Comments throughout – returned 03/02/2017

REPORT HISTORY

Decision type: Non-key decision and For information	**Urgency item?** No
Report Author: Teresa Salami-Oru, Service Leader/Consultant in Public Health, 01628 683505	

www.rbwm.gov.uk

Royal Borough of Windsor & Maidenhead

Royal Borough Windsor and Maidenhead

Year of Mental Health Action Plan

January 2017

“The Royal Borough of Windsor & Maidenhead is a great place to live, work, play and do business supported by a modern, dynamic and successful Council”

Our vision is underpinned by four principles:

Putting residents first
Delivering value for money
Delivering together with our partners
Equipping ourselves for the future

CONTENTS

Frequently used acronyms

FTE	Full time equivalent
RBWM	Royal Borough of Windsor and Maidenhead

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1 INTRODUCTION

1.1 The Royal Borough is working with partners across Berkshire to raise awareness of mental health issues, which remains a key priority for the Borough and formed a central part of the refreshed Joint Health & Wellbeing Strategy.

1.2 In collaboration with Brighter Berkshire partners, the Royal Borough intends to:

a) Increase general awareness & reduce stigma.
b) Share best practice and integrate work streams across Berkshire.
c) Provide a communications platform for local authorities and partners to highlight their pledges and mental health strategies, including individual case studies.
d) Promote mental health across the political and health spectrum for the benefit of patients and residents.

2 CONTEXT

2.1 Brighter Berkshire is a county-wide collaboration that brings together local authorities, health partners, businesses, schools and the wider community to share experiences, good practice and intelligence. The Royal Borough became a member of this partnership in 2016 and the Principal Member for Public Health and the Communications is a member of the Brighter Berkshire core team

2.2 In January 2017, as part of the Charity Commission Annual Lecture, the Prime Minister described the burning injustice of mental health and the current inadequacy of treatment; suggesting that a new approach was required from government and society as a whole. The Prime Minister's mandate 'The Government's response to the Five Year Forward View for Mental Health' (January 2017) also outlined a programme of work to improve mental health services, their links to other public services and mental health prevention.

2.3 National Mental Health strategies include

- **No health without mental health** (2011), a cross government mental health outcomes strategy for people of all ages sets a clear and compelling vision for improving mental health and wellbeing in England.
- **Closing the gap: priorities for essential change in mental health** (2014) aims to bridge the gap between the governments long-term ambition set out in 'no health without mental health' and shorter-term action.
- **The Five Year Forward View for Mental Health** (2016) is a report which covers care and support for all ages, this document signifies the first time there has been a strategic approach to improving mental health outcomes across the health and care system.
- **Lethal discrimination** (2013) highlights why people with mental illness are dying early and needlessly. The report highlights what needs to change.

2.4 In 2014, 21,498 people had some form of mental health disorder in the Royal Borough of Windsor and Maidenhead. This is projected to rise to 22,630 by 2030 (an increase of 1,132 people)[1]. It is timely for to strengthen our efforts in the area of mental health because:

[1] RBWM JSNA, 2016

- The number of mental health conditions (schizophrenia, bipolar affective disorder and other psychoses) did not significantly change in the Royal Borough of Windsor and Maidenhead from 2013/14 to 2014/15; however the number of people diagnosed with dementia and depression both increased over the same time period. Dementia increased from 0.6% in 2013/14 to 0.7% in 2014/15, depression rose from 4.0% to 4.8% over the same time period [1].
- In any one year, approximately 1 in 4 British adults experience at least one diagnosable mental health problem.
- 1 in 10 children aged between 5 and 16 years has a mental health condition, the equivalent of three pupils in every classroom. Many continue to have mental health problems into adulthood which is not always recognised.
- This can lead to half of all adults experiencing at least one episode of depression during their lifetime.
- Suicide is the biggest killer among young men in this country.
- People with serious mental illnesses die, on average, 20 years earlier than the rest of the population.
- One in three of 100,000 'avoidable deaths' in England each year are people with mental health problems.
- Mental health costs an estimated £26 billion a year which equates to an average of over £1,000 per employee.

3 RATIONALE

3.1 The Royal Borough cannot promote public health and wellbeing without including mental health, as mental health is acknowledged to be as important as physical health. Across the council, we have adopted an approach that clearly stipulates that there is no '*public health without mental health*'. The action plan below reflects central government recommendations and local government commitment.

4 OUR PRIORITIES – THE THREE PILLARS

4.1 Our vision for good population mental health is built around three pillars:

a) Mental health in all policies approach.
b) Building resilience in children and young people.
c) Strengthening communities through an asset based approach

Pillar 1: Mental Health in all policies approach

2.4 The mental health in all policies approach will be the legacy pillar, through which the Royal Borough will commit to undertake a mental health impact screen of selected policies, strategies and programmes which will embed cultural changes to reduce discrimination and stigma and enable parity of esteem. The Royal Borough will also ensure it has a Health and Wellbeing Board approved Suicide Prevention Strategy and will seek to ensure mental health is embedded into public health.

Table 1: Action plan – pillar 1

Key commitments	Lead
Introduce and embed mental health into Royal Borough policy through Mental	Service Leader/Consultant in Public Health

Key commitments	Lead
Health Impact Assessment Screening and or Assessment of policy, strategy or service.	(MHIS will be conducted by an SLT member and facilitated by Public Health)
Work in partnership with Brighter Berkshire stakeholders to promote mental health across the system and reduce stigma.	Principal Member for Public Health and communications
The delivery of appropriate mental health messages as part of the Joint Health & Wellbeing planned communication strategy	Public Health and Communications Team
Refresh of the Berkshire wide suicide prevention strategy	Wokingham Public Health Consultant
Development of Local Suicide prevention action plan	Service Leader/Consultant in Public Health
Planned local media engagement and reporting guidelines on suicide	Wokingham Public Health Consultant
Embedding mental health into workplace procedures	Head of Human Resources
Mental Health First Aid training for all Royal Borough managers	Public Health and Human Resources

Measuring impact		
Indicator	**Target December 2017**	**Target December 2020**
Number of Mental Health Impact Assessments conducted.	Minimum of four Mental Health Policy Impact Screens.	Minimum number of 15 completed Mental Health Impact Assessments.
Working relationship established and maintained with Brighter Berkshire partnership.	Partnership working arrangements in place	Partnership working arrangements ongoing
Mental health included in Joint Health and Wellbeing Strategy communications.	The delivery of appropriate mental health messages as part of the Joint Health and Wellbeing Strategy communication plan.	Evaluate impact of communications strategy.
Berkshire wide suicide prevention strategy completed.	Endorsed by Health and Wellbeing Board.	Review local intelligence as part of Suicide Audit for future prevention strategy.
Media engagement and reporting guidelines for suicide.	Engaged with all media organisations in the Royal Borough.	Articles raising awareness of how to avoid suicides in the Royal Borough.

Indicator	Target December 2017	Target December 2020
Workplace procedures.	A review of the categories of absence around mental health issues on iTrent. Ensure that line managers are equipped with the appropriate escalation process. Review of supervision forms, inclusion of questions around mental health e.g. 'How do you feel about your job right now'	Mental health fully embedded in workplace procedures.
Mental Health First Aid training delivered to all managers.	All managers trained in Mental Health First Aid Lite. Evaluation of Mental Health First Aid training September 2017	Mental Health First Aid training established and delivered as mandatory training for all managers. Training adapted / adjusted according to evaluation outcomes

Pillar 2: Building resilience in children and young people

2.5 Children and young people's mental health is a priority. To secure improvements in schools as envisaged by 'Future in Mind' and endorsed in the 'Five Year Forward View for Mental Health', we commit to delivering Mental Health First Aid training in all middle and secondary schools. Further to this we will raise awareness through school networks.

Table 2: Action plan – pillar 2

Key commitments	Lead
Deliver Mental Health First Aid Lite training to all senior and middle schools in the Royal Borough through Personal, Social & Health Education (PHSE) network and Head Teacher Forums by 2020	Public Health with support from Head Teachers.
Deliver full two-day Mental Health First Aid training to all senior and middle schools in the Royal Borough through PHSE network and Head Teacher Forums by 2020	Public health with support from Head Teachers
Establish a PHSE (schools) network to raise awareness of key public health messages including mental health	Public Health with support from PHSE leads
Build on development of Wellbeing	Psychology and Wellbeing service

Key commitments	Lead
Champions Programme incorporating student involvement	

Measuring impact

Indicator	Target December 2017	Target December 2020
Deliver Mental Health First Aid Lite training to all secondary (10) and middle schools (4)	One third of schools (as outlined by Prime Minister). Stretch target in RBWM all schools	Maintenance and support for all schools with continued MHFA provided
Deliver Mental Health First Aid Full 2 day training to 1/3 of all secondary and middle schools	Two schools	One third of schools
Number of schools part of the PHSE network	50%	85%
Number of messages, as part of no public health without mental health, delivered through PHSE network	Three messages delivered	Ten messages delivered
The successful roll out of the Wellbeing Champions Programme	Intervention rolled out to eight schools per year (primary and secondary).	Intervention offered to all schools. (Primary and secondary).

Pillar 3: Strengthening communities through an asset based approach

2.6 Asset mapping provides information about the strengths and resources of a community and can help to build social capital.

Table 3: Action plan – pillar 3

Key commitments	Lead
Planned strategic asset mapping overview of mental health services and development of Recovery College	Public Health in collaboration with the Community Mental health Team
Reducing stigma initiatives and increasing emotional resilience	Public Health in collaboration with library, communication and HR colleagues

Measuring impact

Indicator	Target December 2017	Target December 2020
Mental health asset map completed	Asset map completed by March 2017	Asset map part of the ongoing the Royal Borough Recovery College 'Opportunity College'

Indicator	Target December 2017	Target December 2020
		prospectus
Launch of the Recovery College and Mental health asset mapping	Launch event conducted by September 2017	All mental health services provision part of the Recovery College
Community choir to promote mental wellbeing	Choir established by December 2017	Regular timetable including performances
Provide a mental wellbeing self-evaluation toolkit to encourage residents to 'Measure your Mood' using Edinburgh Survey and associated methodologies to improve it.	Publish short Edinburgh survey in Around the Borough	Edinburgh survey available on Royal Borough website Measure response by the number of hits to website

3. Conclusion

3.1 The Royal Borough will continue to look at opportunities to promote mental health with organisations and local businesses, as we recognise the importance of the workplace for the betterment of public health and mental health for our residents.

Appendix 1: Mental Health Impact Assessment Screening Tool

CONTENTS

1. SCREENING – Initial assessment and helping you decide if you need to do a Mental Well-being Impact Assessment

This desktop MWIA screening toolkit has been designed to help people who are planning or providing policies, services, programmes or projects (collectively referred to hereafter as proposals), to begin to find out how they might make a difference through using Mental Well-being Impact Assessment (MWIA). The process is also designed to help people decide whether it is worth doing a more intensive MWIA involving a much wider range of people; screening is the *first* stage in MWIA but can also be valuable as a stand-alone short assessment. It is designed to be user-friendly and should take approximately an hour to complete. Whilst completing the form, users may identify points that they would wish to follow up or find out more about. A space for such comments has been allowed after each section.

This screening process can be used on a wide range of proposals such as:

- Strategies - Government Policies, Community Plans, Housing or Transport Policies
- Services such as Mental Health Day Services, Older People's support
- Programmes such as Healthy Schools, Healthy Weight Management, Expert Patients
- Projects such as Time banks, Community Arts

It is best done before the proposal has been finalised so that there is maximum opportunity for improvements to be made. It can be done on existing proposals if there is an opportunity or willingness to make changes to improve the rest of the delivery, or learn lessons. See appendix 1 for screening case studies.

Before you begin to undertake the MWIA screening process you will need to identify the following:

- Input from a range of key stakeholders, up to 5 people, representing a diversity of knowledge and experience of the proposal. These might include a service user, a funder, and an operational manager. Arrange for this group to meet for an hour to undertake the screening process. This shared working has proved beneficial in building a more complete picture and understanding of mental well-being needs and responses in relation to the proposal, as well as strengthening networking and ownership of the recommendations of the exercise. One person needs to take the lead for asking the questions.
- Information regarding the proposal(s) you wish to screen. This could relate to who the key stakeholders are, known information regarding the target groups' demographic profile, knowledge of what is involved with the proposal
- Clarity of the scope to influence decisions and the timescale. If there is no scope or time to influence, it might be worth re-thinking whether the proposal you have chosen is the right one!
- It is worth appointing one person as the 'scribe' to ensure records are kept of the discussion and key decisions. This role can be shared at the various stages of the process.

2. SCREENING TOOLKIT – helping to decide if you need to do a Mental Well-being Impact Assessment

Whilst completing the form, you may identify points to follow up or find out more about. A space for such comments has been allowed after each section.

Name of policy, service, programme or project (proposal):

Name of policy, service, programme or project (proposal):

At what stage is your proposal?

☐ Not yet started
☐ Short way into delivery
☐ Half way through
☐ On-going
☐ Coming to an end
☐ Other?

Name and title of person completing:

Are you the lead for this proposal – or what is your role?

Names and roles of other people involved:

1. Why do you want to look at the possible impact on mental well-being of this proposal? This is just to help you understand why you are doing this screening.

Please tick as many as are relevant to you:

☐ To find out what impact we are likely to have or are already having

☐ To find out if we should do a more developed MWIA

☐ To see if there is a way we can improve the proposal

☐ Other – please say what

2. Is there an opportunity to influence or change the ways in which the proposal is being delivered? This will be important in helping to decide whether it is worth going on to do a Rapid MQIA, as you will need to be able to influence planning or delivery.

☐ Yes

☐ Some

☐ No

☐ Unclear

Then please continue, if not, then work out what, if anything, you need to do

3. Population characteristics

Age, gender, class, race/ethnicity, disability, sexuality and physical health influence risk and protective factors for mental health and the ways in which mental health is expressed. The relative impact of population characteristics is in turn affected by wider factors. The experiences of childhood, old age, coming from a working class family, belonging to a Black or Minority Ethnic community, being gay or lesbian, living with a physical or learning disability or suffering from chronic illness vary considerably. For example, financial policy, welfare benefits, housing, education, legislation on age, racial and sexual discrimination all contribute to the mental health impact of growing old.

Please look at Table 1. Think about your proposal and the populations/ communities you are targeting and consider the ones that you think are most important (although remember this is a brief assessment so you don't need to be too detailed). One specific MWIA question is included, but you might want to think of other relevant points in relation to positive, negative or indirect impacts – please add these in.

Table 1 Population Characteristics: Risk and Protective factors for mental well-being

Population Characteristics	**MWIA Key Questions**	**Likely impact?** **Positive, negative or is it an indirect**
Age		
Early Years: Foundations for good mental health lie in pregnancy, infancy and early childhood. Parenting style and attachment are the key factors. The quality of the 'home learning environment', quality of pre-school and the amount of time in pre-school are all associated with greater 'self regulation', an attribute strongly linked to improved educational outcomes	Will this proposal enhance or diminish support for parents and families through pregnancy, childbirth and first years of life?	
Adolescence: Protective factors include: attachment to school, family and community; positive peer influence; opportunities to succeed and problem solving skills. 'Social capital' indicators (e.g. friends, support networks, valued social roles and positive views on neighbourhood) are closely related to risk and severity of emotional and behavioural disorders	Will this proposal enhance or diminish feelings of security, significance, belonging and connection in young people?	

Later Life: The key areas that influence mental health in later life are age discrimination, participation, relationships, physical health and poverty. Fear of crime and lack of transport are also consistent themes, with 'daily hassles' contributing more significantly to psychological distress than major life events	Will this proposal impact positively or adversely on the five key areas known to influence mental health in later life?	
Gender		
Gender has a significant impact on risk and protective factors for mental health and the way in which the experience of mental distress is expressed. Depression, anxiety, attempted suicide and self harm are more prevalent in women, while completed suicide, drug and alcohol abuse, crime and violence are much more prevalent among men. Women are much more vulnerable to poverty and unemployment, and are more likely to suffer domestic violence, rape and child abuse.	Will the proposal impact differently on men and on women?	
Race and Ethnicity		
Race and ethnic differences in the levels of mental well-being and prevalence of mental disorders are due to a complex combination of socio-economic factors, racism, diagnostic bias and cultural and ethnic differences and are reflected in how mental health and mental distress are presented, perceived and interpreted. Different cultures may also develop different responses for coping with psychological stressors. However a major qualitative study found that expressions of distress bore great similarity across ethnic	Will the proposal impact differentially on different ethnic groups, including refugees, asylum seekers and newly arrived Communities?	

groups, although some specific symptoms were different		
Socio-economic position and class		
Socioeconomic position (SEP) refers to the position of individuals and families, to other, measured by differences in educational qualifications, income, occupation, housing tenure or wealth. Socioeconomic position is generally analysed by quintile, for example comparing health or other outcomes of those in the poorest fifth of the population with those in the richest fifth. Socioeconomic position shapes access to material resources, to every aspect of experience in the home, neighbourhood, and workplace and is a major determinant of health inequalities. Different dimensions of SEP (education, income, occupation, prestige) may influence health through different pathways; SEP involves exposure to psychological as well as material risks and buffers, and structures our experience of dominance, hierarchy, isolation, support and inclusion. Social position also influences areas like identity and social status, which impact on well-being, for example through the effects of low-self esteem, shame, and disrespect	How will the proposal impact on people in different social positions? Will it reinforce or reduce inequalities?	
Physical Health		
Poor physical health is a significant risk factor for poor mental health; conversely, mental well-being protects physical health and improves health outcomes and recovery rates, notably for coronary heart disease, stroke and diabetes. Poor mental	Will the proposal have an impact on or take into consideration the physical health of the communities likely to be affected? Does the proposal recognise the relationship between mental health and	

health is associated with poor self management of chronic illness and a range of health damaging behaviours, including smoking, drug and alcohol abuse, unwanted pregnancy and poor diet. Stress epidemiology demonstrates the link between feelings of despair, anger, frustration, hopelessness, low self worth and higher cholesterol levels, blood pressure and susceptibility to infection. For heart disease, psychosocial factors are on a par with smoking, high blood pressure, obesity, and cholesterol problems.	physical health?	
Disability		
Life chances (notably education, employment and housing), social inclusion, support, choice, control and opportunities to be independent are the key factors influencing the mental health of people with disabilities	Will the proposal reinforce or reduce inequalities and discrimination experienced by people with disabilities?	
Sexuality and transgender		
Some studies suggest that gay, lesbian, bisexual and transgender peoples are at increased risk for some mental health problems – notably anxiety, depression, self-harm and substance misuse – and more likely to report psychological distress than their heterosexual counterparts, while being more vulnerable to certain factors that increase risk, e.g. being bullied, discrimination and verbal assault.	Will the proposal impact positively or adversely on gay men, lesbians, bisexuals and transgender peoples?	
Other population groups *(tick where appropriate)*		
Looked after children People with long term conditions People in residential settings Carers	Will the proposal have an impact or take into consideration any of the groups mentioned?	

People experiencing violence or abuse People in the criminal justice system Ex-offenders Others		
Settings		
Schools Workplace Neighbourhoods Prisons Hospitals Primary Care Others	Will the proposal have an impact on or take into consideration any of the settings mentioned?	

4. Protective factors and wider determinants that have a particular impact on mental health and well-being

There are three main factors that are thought to promote and protect mental well-being distilled from the evidence base presented in section 2 of this MWIA Toolkit:

- Enhancing control
- Increasing resilience and community assets
- Facilitating participation and promoting inclusion

Wider determinants such as our physical health and more broadly employment, housing, poverty also affect our well-being.

Please look at **Tables 2a-d**. The first table covers the wider determinants at the socio-economic/environmental level. The remaining tables cover the above three protective factors at both the individual and community/social level. Thinking about your proposal and the populations/communities it affects – consider the factors that you think are most important (although remember this is a brief assessment so you don't need to be too detailed). One specific MWIA question is included, but you might want to think of other relevant points in relation to positive or negative impacts – please add these in. Then note down any comments or recommendations that occur to you.

You are unlikely to have an impact on every protective factor – please be selective and concentrate on those that appear to be most important for your proposal and client group, and mark those that seem to be a priority impact.

2a Wider determinants at a socio-economic/environmental level

MWIA uses a framework for assessing the three protective factors *in the context of the wider determinants of mental well-being.*

The wider determinants are the factors that are determined at a structural level and impact on a population or the whole of society. There is a dynamic relationship between the wider determinants, the three protective factors and mental well-being. Mental well-being is an outcome of the circumstances and experiences of our lives: individual psychological resources, for example, confidence, self efficacy, optimism and connectedness are embedded within social structures such as our position in relation to others at work, at home, and in public spaces. Mental well-being also influences a very wide range of outcomes – health behaviour, physical health and improved recovery rates, educational attainment, employment and productivity, relationships, crime, community

cohesion, quality of life and, fewer limitations in daily living. Mental well-being may also be a factor in helping to explain why socio-economic disadvantage does not always correlate with health damaging behaviours.

Table 2a Wider determinants at a socio-economic and environmental level

MWIA question: How does the proposed development impact on the wider determinants?

WIDER DETRIMENTS **(often at socio-economic/environmental level)**	**Likely impact** **Positive, negative or is it an indirect impact? Select those most important**	**Comments or recommendations**
Access to quality Housing e.g. security, tenure, neighbourhood, social housing, shared ownership, affordable and appropriate		
Physical Environment e.g. access to green space, trees, natural woodland, open space, safe play space, quality of built environment		
Economic security e.g. access to secure employment (paid and unpaid), access to an adequate income, good working conditions, meaningful work and volunteering opportunities		
Good quality food e.g. affordable, accessible		
Leisure opportunities e.g. participate in arts, creativity, sport, culture		
Tackling inequalities e.g. addressing relative deprivation and poverty		
Transport access and options e.g. providing choice, affordability and accessibility		
Local democracy e.g. devolved power, voting, community panels		

Ease of access to high quality public services e.g. housing support and social care		
Access to Education e.g. schooling, training, adult literacy, hobbies		
Challenging discrimination e.g. racism, sexism, ageism, homophobia and discrimination related to disability, mental illness or faith		
Other?		

Table 2b Protective factor - Enhancing control

MWIA question: How does the proposed development impact on people's control?

PROTECTIVE FACTORS FOR ENHANCING CONTROL	**Likely impact** **Positive, negative or is it an indirect impact? Select those most important**	**Comments or recommendations**
Individual		
A sense of control e.g. setting and pursuit of goals, ability to shape own circumstances		
Belief in own capabilities and self determination, e.g. sense of purpose and meaning		
Knowledge skills and resources to make healthy choices e.g. understanding what makes us healthy and being able to make choices		
Maintaining independence e.g. support to live at home, care for self and family		
Community/organisation		

Self-help provision e.g. information advocacy, groups, advice support		
Opportunities to influence decisions e.g. at home, at work or in the community		
Opportunities for expressing views and being heard, e.g. tenants groups, public meetings		
Workplace job control e.g. participation in decision making, work-life balance		
Collective organisation and action e.g. social enterprise, commonly-led action, local involvement, trade unions		
Resources for financial control and capability e.g. adequate income, access to credit union, welfare rights, debt management		
Other?		

Table 2c Protective factor - Increasing resilience and community assets

MWIA question: How does the proposed development impact on resilience and community assets?

PROTECTIVE FACTORS FOR INCREASING RESILIENCE AND COMMUNITY ASSETS	**Likely impact** **Positive, negative or is it an indirect impact? Select those most important**	**Comments or recommendations**
Individual		
Emotional well-being e.g. self-esteem, self-worth, confidence, hopefulness, optimism, life satisfaction, enjoyment and having fun		

Ability to understand, think clearly and function socially e.g. problem solving, decision making, relationships with others, communication skills		
Have beliefs and values e.g. spirituality, religious beliefs, cultural identify		
Learning and development e.g. formal and informal education and hobbies		
Healthy lifestyle e.g. taking steps towards this by healthy eating, regular physical activity and sensible drinking		
Community/organisation		
Trust and safety e.g. belief in reliability of others and services, feeling safe where you live or work		
Social networks and relationships e.g. contact with others through family, groups, friendships, neighbours, shared interests, work		
Emotional support e.g. confiding relationships, provision of counselling support		
Shared public spaces e.g. community centre, library, faith settings, cafe, parks, playgrounds, places to stop and chat		
Sustainable local economy e.g. local skills and businesses being used to benefit local people, buying locally, using Time Banks		

Arts and creativity e.g. expression, fun laughter and play		
Other?		

Table 2d Protective factor – Facilitating participation and promoting inclusion

MWIA question: How does the proposed development impact on participation and inclusion?

PROTECTIVE FACTORS FOR PARTICIPATION AND INCLUSION	**Likely impact** **Positive, negative or is it an indirect impact? Select those most important**	**Comments or recommendations**
Individual		
Having a valued role e.g. volunteer, governor, and carer		
Sense of belonging e.g. connectedness to community, neighbourhood, family group, work team		
Feeling involved e.g. in the family, community, at work		
Community/organisation		
Activities that bring people together e.g. connecting with others through groups, clubs, events, shared interests		
Practical support e.g. childcare, employment, on discharge from services		
Ways to get involved e.g. volunteering, Time Banks, advocacy		
Accessible and acceptable services or goods e.g. easily understood affordable, user friendly,		

non-stigmatising, non-humiliating		
Cost of participating e.g. affordable, accessible		
Conflict resolution e.g. mediation, restorative justice		
Cohesive communities e.g. mutual respect, bringing communities together		
Other?		

5. Scale of impact and population

There are two more aspects to consider before determining if you will go on to do further MQIA assessment on your proposal.

A - scale of the impact on mental well-being, If known (or suspected) at this stage,

What is the duration of the likely mental health and well-being impacts of your proposal?

Please tick (this could be more than one period of time)

☐ Brief

☐ Weeks

☐ Months

☐ Years

☐ Entire Life (of the proposal)

☐ Sustained beyond the proposal

☐ Unclear

B - Scale of the population whose mental well-being is impacted.

What is the scale of the population that your proposal will impact upon?

☐ A few people

☐ A small part of the population

☐ A majority of the population

☐ The entire population

6. Having completed the screening assessment process the following sections will help you determine what to do next.

For each question in the central column, circle the appropriate answer

Favouring further appraisal	Question	Not favouring further approval
Yes/Don't know	Does your proposal affect in a negative way any of your population groups in Table 1?	*No*
Yes/Don't know	Does your proposal affect in a negative way any of the wider determinants and protective factors in Tables 2a-d?	*No*
Yes/Don't know	For some of the wider determinants and protective factors or mental well-being, are some of the impacts of your proposal unknown?	*No*
Yes/Don't know	Are the impacts likely to be over a long period of time (one year or more)	*No*
Yes/Don't know	Is there an opportunity to influence the delivery of the proposal you are screening?	*No*

If you have answered 'yes' or 'don't know' to at least two or more questions under the above question, the you are advised to consider further appraisal under the MWIA process. Use section four of this toolkit to plan and undertake your MWIA

7. Actions to think about if you don't favour further appraisal under the MWIA process

If you have answered No to at least three or more questions under the above question, then you are not in favour of further appraisal under the MWIA process and may wish to consider doing one or some of the following actions listed below.

Throughout the screening process you will have made a list of comments or action points which may relate to one or two of the other stages of MWIA. It may be useful to use one of the methods/ stages to better inform your highlighted action points. For example:

- Find out more about the project activities in relation to the mental well-being determinants – consider holding a stakeholder workshop see Section 4 of this toolkit
- Find out more about the characteristics of the population targeted by the project – consider completing a community profile see Section 4 of this toolkit
- Find out how to target population groups not using the project, and who may benefit in terms of mental well-being – consider completing a community profile and redoing the population table screening toolkit see Section 4 of this toolkit
- Develop an action plan based on your screening findings, in order to refine your project to maximise potential mental well-being and/or to reduce potential negative impacts
- Find out if there are any further opportunities to influence the proposal and / or who may be in a position to influence the proposal and seek their support for undertaking an MWIA
- Find out if you have any existing evidence of your impact on any of the components of mental well-being identified as a priority for your proposal. For example: existing monitoring data, surveys or evaluation reports. See Section 5 of this toolkit for further ideas
- Find out if you could integrate an indicator into your existing data collection to measure your impact on any of the components of mental well-being identified as a priority for your proposal? See Section 5 of this toolkit for further ideas

Appendices

Appendix 1: Screening Case Studies

Policy level – the Lancashire Local Area Agreement (LAA)

The full report for this is available on www.hiagateway.org.uk

The purpose of the MWIA was to ensure that mental health is recognised as a cross-thematic issue within the whole LAA – not just a health and social care or well-being issue, and to increase mental health awareness across the whole range of policy makers in the county. The aim was to develop a cross-thematic action plan to address community well-being with commitment and ownership across the whole LAA.

The desk top screening tool was used with each LAA thematic group which also helped to identify priority mental well-being indicators for each theme for mental well-being. We then completed the community profiling and collation of the evidence base – linking into the Joint Strategic Needs Assessment process - and organised a multi-agency

stakeholder event for each indicator. The screening process helped to prioritise which themes and indicators to work on. The first workshops were for NI 153 (working age people claiming out of work benefits) and this identified priority actions such as addressing personal development, confidence and self-esteem rather than just focusing on vocational skills when supporting people back to work; working with employers to increase their mental health awareness, skills, and how to support the mental health of employees.

Service level – Warwickshire Resource Cafés

The full report for this is available on www.hiagateway.org.uk
Warwickshire's seven resource cafés offer a service to those individuals in the community who have identified mental health problems (including common mental health problems and dual diagnosis) who are over 18 years of age. The aim is to work with service users (many of whom have been in long term institutions) to enable them to live healthily and make life changes that would both improve their mental health and their quality of life. New contracts require a move from a dependency model towards adopting a well-being focus using a self help model as well as encouraging use of Individual Budgets and Direct Payments for beneficiaries to purchase and manage their own support care.

An hour and a half meeting was organised with the resource café leads and commissioner of the services to screen all seven cafés for their potential impact on mental well-being, and to ascertain whether further appraisal of the evidence was justified. One café did not participate further. Use of the Screening Toolkit enabled each targeted population group to be systematically assessed. It was possible for each of the six cafés to identify those groups who were not currently being targeted but who could benefit from the services. These included women, some black and minority ethnic communities and young adults. Exploring the impact of the protective factors highlighted positive benefits such as promoting access to information and services, and social activities and networks. Areas that needed further work were the support needs for client groups that were in transition from dependency to self-help. All the resource cafés agreed that further investigation and understanding of their impacts was needed. A community profile and literature review were undertaken, and a successful stakeholder event was held.

Programme Level – Liverpool '08 European Capital of Culture *The full report for this is available on www.hiagateway.org.uk*

The Liverpool 08 European Capital of Culture Company was developing a wide range of programmes designed to promote culture as well as regenerate areas of Liverpool as 08 European Capital of Culture. The Company committed to commissioning the first Comprehensive MWIA as well as assisting with piloting the evolving MWIA toolkit in 2007. Sixteen projects and policies were screened to assess the effects of the programme on mental well-being. The screening toolkit was also used to decide whether a more intensive assessment should be carried out. The screening was undertaken during a short meeting with each project and policy team.

After the screening it was agreed that an intensive assessment should be done and include:

- Comprehensive profiling of the communities involved and affected

- A review of the published literature with reference to the potential impacts of the arts and culture on health and well-being

- A series of workshops for those projects identified through the screening process as having the greatest potential to impact on mental well-being. Funders, managers, people with a creative/ artistic role, and communities would be invited to join to bring a wide perspective on impacts and to pool ideas.

Eight project and policy teams participated in workshops: the Grants Programme, G-litter, Four Corners of the City, Mersey Boroughs Programme, 08 Volunteers, Chinese New Year, Commercial Partners, and the 08 Vision Document.
Project Level – Well London – Be Creative Be Well

Well London is a three year Big Lottery funded well-being programme delivered by seven partner organisations across 20 Super Output Areas (SOA) in London. One of the target areas is Broadgreen in Croydon. A project commissioned by the Arts Council (a partner in Well London) aimed to refurbish and redesign the interior of the local community resource centre to enhance and transform how the centre was used and the impact it had on community well-being.

With the design and refurbishment already underway, the MWIA screening tool helped identify the potential impacts of the refurbished centre on the mental well-being of the community and helped identify what was needed to ensure maximum impact from the investment once the refurbishment was complete. The screening highlighted key ideas and issues, for example, increasing access to the building, how decisions are made about activities, identifying organisations who may like to host activities / outreach sessions at the centre.

Appendix 2: Lambeth Expert Patients (available: www.hiagateway.org.uk)

An example of how to fill in the screening table:

Enhancing control

MWIA question: How does the Expert Patients Programme project impact on people's control?

Protective factors for the Expert Patients Project: (A six week programme for people with chronic long term conditions to enable them to maintain independent living	Likely impact Positive, negative or is it an indirect impact? Select those most important	Comments or recommendations
Individual		
Maintaining independence	*Positive and negative*	Positive – helps to develop patients' knowledge of support

		services and grants available, and how to access them. Negative – not all patients who could benefit from the programme are using it. Recommendation – need to do more work to promote the programme.
Community/Organisation		
Opportunities for expressing views/being heard	*Positive*	Views encouraged from all participants to enable people to learn from each other. Recommendation – encourage more opportunities for expressing views e.g. with GPs.

Document Name	Year of Mental Health Action Plan 2017		
Document Author	Teresa Salami-Oru, Service Leader/Consultant in Public Health		
Document owner	Hilary Hall, Head of Commissioning – Adults, Children and Health		
Accessibility	Available in other formats as required.		
File location			
Destruction date	Not applicable		
How this document was created	Version 1	January 2017	Author
	Version 2		
	Version 3		
Circulation restrictions	None		
Review date	January 2018		

Report Title:	The Berkshire Suicide Prevention Strategy
Contains Confidential or Exempt Information?	*NO - Part I*
Member reporting:	Councillor Carroll, Principal Member for Public Health and Communications
Meeting and Date:	Health & Wellbeing Board February 15th 2017
Responsible Officer(s):	Hillary Hall, Head of Commissioning Adults, Children and Health
Wards affected:	All

www.rbwm.gov.uk

Royal Borough of Windsor & Maidenhead

REPORT SUMMARY

1. The NHS Five Year Forward View for Mental Health sets a target on all NHS agencies and partners to reduce the current level of suicide by 10% by 2020. To achieve this, the Department of Health has recommended, in the National Suicide prevention Strategy, that all top tier local authorities produce suicide prevention actions plans.
2. In Berkshire, this has been coordinated by a multi-agency suicide prevention groups who have drafted a strategy which includes a Berkshire-wide action plan, and local action plans responding to the unique needs and circumstances of each of the six unitary authorities in Berkshire.
3. The action plans are reliant on multi-agency working and partners across the health and public sectors are in the process of endorsing the strategy.

1. DETAILS OF RECOMMENDATION(S)

RECOMMENDATION: That the Health & Wellbeing Board notes the report and:

i) Endorses the Berkshire Suicide Prevention Strategy; and
ii) Agrees the action plan for the Royal Borough of Windsor and Maidenhead contained within the strategy.

2. REASON(S) FOR RECOMMENDATION(S) AND OPTIONS CONSIDERED

3.1 Berkshire Authorities had not published a suicide prevention action plan at the time of the 2015 All Party Parliamentary Group inquiry into local suicide prevention plans in England. Action plans were a recommendation of the suicide prevention strategy published in 2012. Since 2015, a high-level multi-agency steering group have met in Berkshire to plan a local audit of suicides and to work together on a strategy and action plans for the local authorities. This draft strategy is the result of this work and a recommendation of the strategy is that all six local health and wellbeing boards endorse the strategy and their local action plans.

4. 3.1 The main outcomes of this strategy are to reduce suicides in Berkshire by 25% by 2020, and to provide better support for those bereaved or affected by suicide.

4.1

Table 1: Options considered

Option	**Comments**
Do nothing. This is not recommended	Councils are expected to have a suicide prevention action plan and the Secretary of State for Health has recently reiterated this desire.
Endorse the Strategy and Action plan for RBWM **This is the recommended option**	Councils can make a difference in preventing suicides through the provision and commissioning of evidence-based service sand through taking the leadership in this important public health outcome.

3. KEY IMPLICATIONS

Table 2: Key Implications

Outcome	**Unmet**	**Met**	**Exceeded**	**Significantly Exceeded**	**Date of delivery**
Reduction in suicides in Berkshire from the April 1st 2014 baseline by 31st March 2020.		10% reduction		25% reduction	31st March 2020

4. FINANCIAL DETAILS / VALUE FOR MONEY

4.1 No specific new funds are required. The local action plan will be delivered through the work of the public health team working within the constraints of the ring-fenced public health grant.

5. LEGAL IMPLICATIONS

5.1 The council has the power enshrined in the 2012 Health and Social Care Act to undertake necessary action as required to discharge its new public health duties, to improve health and protect the health of the local population.

6. RISK MANAGEMENT

None identified

7. POTENTIAL IMPACTS

7.1 An equality impact assessment screen will be undertaken on the action plan and strategy by March 2017.

7.2 The strategy follows national guidance which includes equalities issues and assesses these in relation to the evidence base regarding the risk of suicide. Some groups with protected characteristics are at increased risks of suicide, such as lesbian gay, bisexual and transgender people. .

8. CONSULTATION

8.1 The Berkshire-wide steering group is made up of stakeholders from across the area representing all sectors. They have consulted their organisations, some of whom will endorse the strategy formally. This is the first iteration of the strategy and it would be expected that with each new iteration, further organisation will be able to formally endorse it.

9. TIMETABLE FOR IMPLEMENTATION

9.1

Table 5: Implementation Table

Date	Details
1 April 2017	Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire.
1 April 2017	All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners.
20 July 2017	Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting.
15 Oct. 2017	Launch of strategy at multi-agency suicide prevention summit.

Date	Details
15 Oct. 2017	Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.

10. APPENDICES

- None.

11. BACKGROUND DOCUMENTS

- 11.1 Office for National Statistics. Suicides in the UK in 2014. London: Office for National Statistics; 2016.
- HM Government. Preventing suicide in England: A cross government strategy to save lives. London: Department of Health; 2012.
- NHS England Mental Health Taskforce. The five year forward view for mental health. NHS England; 2016.
- All-Party Parliamentary Group on Suicide and Self-Harm Prevention. Inquiry into local suicide prevention plans in England. All-Party Parliamentary Group on Suicide and Self-Harm Prevention; 2015.
- HM Government. Preventing suicide in England: Third progress report of the
- cross-government outcomes strategy to save lives. London: Department of Health; 2017.
- Public Health England (PHE). Local Suicide Prevention Planning, A Practical Resource. Public Health England; 2016.
- Draft Berkshire Suicide Prevention Strategy 2017-2020. Public Health Services for Berkshire. 2017.

12. CONSULTATION (MANDATORY)

Name of consultee	Post held	Date sent	Commented & returned
Stuart Carroll	Principal Member for Public Health and Communications	3/2/17	Comments throughout - returned 07/02/17
	Managing Director		
Hilary Hall	Head of Commissioning ACH	3/2/17	Comments throughout – returned 03/02/17

Name of consultee	Post held	Date sent	Commented & returned
	Strategic Director		
	Section 151 Officer		
	Head of HR		
	Other e.g. external		

REPORT HISTORY

Non-key decision	**Urgency item?** No
Report Author: Darrell Gale, Consultant in Public Health, Wokingham Council, 0118 908 8293	

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The Berkshire Suicide Prevention Strategy

Darrell Gale FFPH

RBWM Health & Wellbeing Board

15th February 2017

Where are we today?

- Comments on Draft Strategy were received from a range of stakeholders.
- Many regard formatting and ordering of the strategy
- Final draft (minor amendments and formatting) to be agreed by Steering Group Feb / March 2017
- Action plans at Berkshire and Unitary levels
- New National Strategy…….

Stretch Target

- Suggested by stakeholders
- To exceed the 10% reduction target in the Sustainability & Transformation Plans (STPs) and NHS 5 Year Forward View - Mental Health
- To attempt to achieve a 25% reduction from 2014 levels by 2020

Latest Statistics

- 2015 total suicide figures just published (Dec. 2016)
- Figures show an increase in numbers for Berkshire as a whole
- We will include the new figures as well as the rates from earlier data as they show the trends

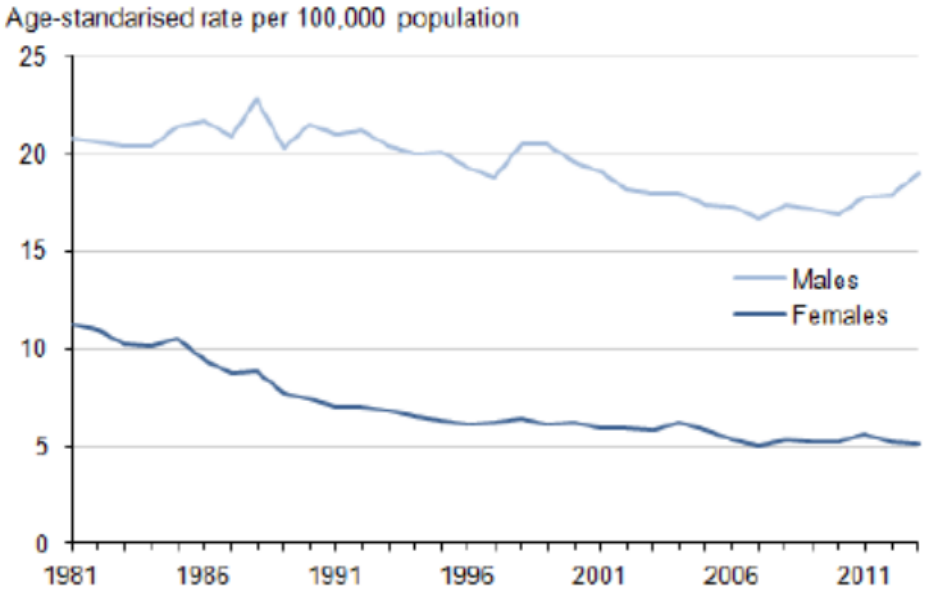
Latest Stats –Raw Data

	2014	2015	Difference
Bracknell Forest	5	10	+ 5 (+ 100%)
Reading	12	18	+ 6 (+ 50%)
Slough	15	9	- 6 (- 40%)
West Berkshire	5	6	+ 1 (+ 20%)
RBWM	11	11	-
Wokingham	6	14	+ 8 (+ 233%)
Berks Total	68	83	+ 22%
SE Total	794	756	- 5%
England Total	4882	4820	- 1%

The National Picture

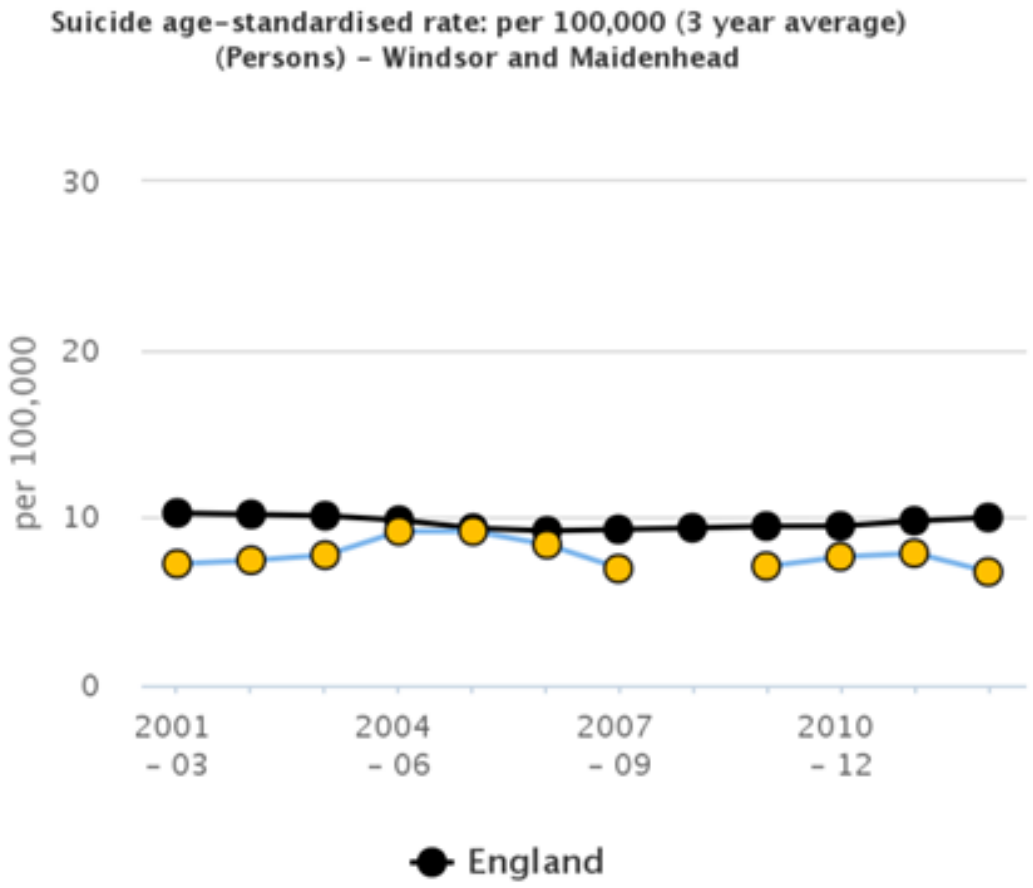
Figure 1: Age-standardised suicide rates: by sex, deaths registered in each year from 1981 to 2013

United Kingdom



Source: Office for National Statistics, Northern Ireland Statistics and Research Agency, National Records of Scotland

The Local Picture



WOKINGHAM BOROUGH COUNCIL

Over-arching Recommendations

- That the Steering Group revisit their terms of reference and membership and become known as the “Berkshire Suicide Prevention Steering Group”, with the aim of providing the governance to this strategy and its action plans.
- That organisations represented on the Berkshire Suicide Prevention Steering Group consider nominating a suicide prevention champion from within their membership.
- That all agencies represented on the Steering Group commit to an annual Action Plan of their own which can then be brought together to create a Berkshire-wide Action Plan for each year of the Strategy.
- Sign off / endorsement of this strategy by all Health & Wellbeing Boards in Berkshire.
- Launch this strategy at a multi-agency suicide prevention summit, by October 2017.
- Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat

Recommendations – High Risk Groups

- Implement the NICE guidelines on self-harm, specifically ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment.
- Evaluate the Berkshire CALMzone and recommission targeted suicide prevention work for younger and middle aged men.

Recommendations –Specific Groups

- Work to provide and commission interventions which improve the public's mental health. These may include: awareness of mental health and peer support in young people; anti-bullying campaigns in schools; addressing stigma and social isolation in older people; workplace health promotion and support with local business; working with police on mental health literacy; and addressing issues relevant to the local population.

Recommendations – Reduce access

- That local authority public health teams take the leadership for liaison with any Escalation Process in their area, and report on progress to the Steering Group.
- That the Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.
- That local authority public health teams work with other council departments such as car parks and open space services to identify local actions to prevent suicide including staff awareness training.

Recommendations – Support bereaved

- Ensure bereavement information and access to support is available to those bereaved by suicide.

Recommendations – Support Media

- Liaise with local media to encourage reference to and use of guidelines for the reporting of suicide through a summit with local press and media organisations, and to provide information to professionals on the sensitive reporting of suicide. By 20 July 2017

  (BBC Berkshire have been asked to host)

Recommendations – Support Research

- Develop working relationships between individual coroners and local public health teams ensure local plans are evidence based and responsive. Coroners can be invited to become formal members of any local suicide prevention groups or networks
- Coroners can also inform the local authority or Director of Public Health if they identify particular areas of concern, e.g. locations used for suicide, possible clusters of suicide, increase in a particular method or new and emerging method of suicide.
- Refresh the Berkshire-wide Suicide Audit for deaths in the period 2014-16 to include new categories based on best practice.

Next Steps

- Format and agree final look of strategy
- Seek sign-off from other Health and Wellbeing Boards
- Deliver actions

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Public Health Services for Berkshire

Berkshire Suicide Prevention Strategy

2017-2020

DRAFT V7

Darrell Gale FFPH

Consultant in Public Health

NB: All comments in red are instructions to help guide the final drafting and formatting.

Front cover to be designed

Contents

Acknowledgements

Acknowledgements are due to a wide range of partners and colleagues whose work; encouragement and commitment to suicide prevention has enabled the development of this strategy and its action plans. In particular, we acknowledge the following:

Rutuja Kulkarni and the public health officers from Berkshire local authorities who undertook the Suicide Audit, and who did much to build the foundations of this strategy;

The suicide prevention and mental health leads from the Berkshire local authorities for preparing the local action plans;

Network Rail and British Transport Police for their support with work on railway suicides;

Helena Fahie at Public Health England South East Centre for encouragement; advice and going the extra mile;

David Colchester at the Local Criminal Justice Board for the Thames Valley and Thames Valley Police for their input on real-time surveillance;

The NHS Provider trusts in Berkshire for their input and continued support;

The seven Clinical Commissioning Groups in Berkshire for their strong partnership working;

and of course all past and present members of the Berkshire Suicide Prevention Steering Group.

Executive Summary

To be introduced by Strategic Director and finalised at the end of the final editing process.

The NHS Five Year Forward View for Mental Health sets a target on all NHS agencies and partners to reduce the current level of suicide by 10% by 2020. This is a laudable and hopefully readily achievable aim. However as discussions across the range of organisations which have contributed to this strategy have progressed, it appears to many, that this aim is not challenging enough. Zero Suicide should be our aim; as it is in the gift of the combined efforts of these organisations, and on society at large, to put in place the policies and services which protect people from mental distress, and to ease the factors which cause that distress. This strategy therefore forges ahead with a stretch target to reduce suicide by at least 25% by 2020, thus ensuring that this becomes a shared priority across organisations and areas. We recognise that a Berkshire without suicide is the true aim to work towards.

Many stakeholders have contributed to this strategy and it should now be adopted as a joint strategy by each CCG, Local Authority, and Health and Wellbeing Boards in Berkshire. It should also be reflected in other plans and strategies when they are drafted or re-written, to ensure suicide prevention becomes a pursuit common to all agencies and professions. The strategy will be formally launched once it has been endorsed by all health and wellbeing boards in Berkshire and this will give the opportunity to report back on the delivery of many of the actions detailed herein.

RECOMMENDATION
Launch this strategy at a multi-agency suicide prevention summit, by October 2017.

Recommendations

The following recommendations are the principle strategic objectives for Berkshire as a whole. These link through into more detailed action plans for Berkshire-wide work and for local authority areas. In line with the national suicide prevention strategy, the main outcomes of this strategy are to reduce suicides in Berkshire by 25% by 2020, and to provide better support for those bereaved or affected by suicide. The national strategy has identified six priority areas and the recommendations linked to these are outlined below, following those relating to the overarching aims.

Over-arching Recommendations

RECOMMENDATION
That this Steering Group revisit their terms of reference and membership and become known as the "Berkshire Suicide Prevention Steering Group", with the aim of providing the governance to this strategy and its action plans.

RECOMMENDATION
That organisations represented on the Berkshire Suicide Prevention Steering Group consider nominating a suicide prevention champion from within their membership.

RECOMMENDATION
That all agencies represented on the Steering Group commit to an annual Action Plan of their own which can then be brought together to create a Berkshire-wide Action Plan for each year of the Strategy.

RECOMMENDATION
Sign off / endorsement of this strategy by all Health & Wellbeing Boards in Berkshire.

RECOMMENDATION
Launch this strategy at a multi-agency suicide prevention summit, by October 2017.

RECOMMENDATION
Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat.

Priority Areas

1. Reduce the risk of suicide in key high-risk groups;

RECOMMENDATION
Implement the NICE guidelines on self-harm, specifically ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment.

RECOMMENDATION
Evaluate the Berkshire CALMzone and recommission targeted suicide prevention work for younger men and middle aged men.

2. Tailor approaches to improve mental health in specific groups;

RECOMMENDATION
Work to provide and commission interventions which improve the public's mental health. These may include: awareness of mental health and peer support in young people; anti-bullying campaigns in schools; addressing stigma and social isolation in older people; workplace health promotion and support with local business; working with police on mental health literacy; and addressing issues relevant to the local population.

3. Reduce access to the means of suicide;

RECOMMENDATION
That local authority public health teams take the leadership for liaison with any Escalation Process in their area, and report on progress to the Steering Group.

RECOMMENDATION
That the Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.

RECOMMENDATION
That local authority public health teams work with other council departments such as car parks and open space services to identify local actions to prevent suicide including staff awareness training.

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

RECOMMENDATION
Ensure bereavement information and access to support is available to those bereaved by suicide.

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

RECOMMENDATION
Liaise with local media to encourage reference to and use of guidelines for the reporting of suicide through a summit with local press and media organisations, and to provide information to professionals on the sensitive reporting of suicide. By 20 July 2017

6. Support research, data collection and monitoring.

RECOMMENDATION
Develop working relationships between individual coroners and local public health teams ensure local plans are evidence based and responsive. Coroners can be invited to become formal members of any local suicide prevention groups or networks

Coroners can also inform the local authority or Director of Public Health if they identify particular areas of concern, e.g. locations used for suicide, possible clusters of suicide, increase in a particular method or new and emerging method of suicide.

Refresh the Berkshire-wide Suicide Audit for deaths in the period 2014-16 to include new categories based on best practice.

Background

Suicide is a devastating event. It is an individual tragedy, a life-altering crisis for those bereaved, and a traumatic event for communities and services. The impacts are immediately and profoundly distressing. We thus need to be sure that in the Clinical Commissioning Groups (CCGs) and Local Authorities in Berkshire, an alliance of stakeholders takes preventive and ongoing action covering the main risks. The 2012 national strategy ('Preventing Suicide in England') sets us two major objectives: reducing the suicide rate in England, and giving better support to people bereaved or affected by suicide. Those objectives are thus given priority in this strategy.

Suicide is not inevitable. Preventing suicides is a complex and challenging issue, but there are effective solutions for many of the individual factors which contribute towards the risk of suicide. Suicide Prevention work is cost-effective when conducted in accordance with evidence of effectiveness, and by working in partnership. Local Government, statutory services, the third sector, local communities and families each have a role to play.

Whilst suicide causes a vast negative wellbeing impact on family, friends, colleagues, and wider contacts, they also have a huge economic impact. The average cost of a single completed suicide of a working age individual in England was estimated in 2012 to be more than £1.5 million. This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as waged and unwaged lost output, public service time and funeral costs. Non-fatal self-harm also has major – potentially avoidable - cost implications for public services, particularly A&E and acute inpatient services and psychiatric follow-up.

Suicides are not inevitable and are a major issue for society as well as being a leading cause of years of life lost. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides. Government and statutory services have a role to play in building individual and community resilience. Vulnerable people in the care of health and care services can be supported and kept safe from preventable harm. Interventions can be provided quickly when someone is in distress or in crisis and for vulnerable people in the wider community, practical measure such as debt advice services can make all the difference.

Public Health England (PHE) has recently published a guide to local suicide prevention planning (2016). In it, they identify ten things that everyone needs to know about suicide prevention. These are re-produced here in full, and with kind permission of PHE. Simple to follow and understand, these form the basis of raising awareness of suicide prevention across Berkshire services and populations.

10 Things Everyone Needs To Know About Suicide Prevention

1 Suicides take a high toll

There were 4,882 deaths from suicide registered in England in 2014 and for every person who dies at least 10 people are directly affected.

2 There are specific groups of people at higher risk of suicide

Three in four deaths by suicide are by men. The highest suicide rate in England is among men aged 45-49. People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic group living in the most affluent areas.

3 There are specific factors that increase the risk of suicide

The strongest identified predictor of suicide is previous episodes of self-harm. Mental ill-health and substance misuse also contribute to many suicides. Suicide prevention strategies must consider and link to programmes of early identification and effective management of self-harm, mental ill-health and substance misuse.

4 Preventing suicide is achievable

The delivery of a comprehensive strategy is effective in reducing deaths by suicide through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. Directors of public health and health and wellbeing boards have a central role. Their involvement is crucial in coordinating local suicide prevention efforts and making sure every area has a strategy in place.

5 Suicide is everybody's business

A whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play. Suicide prevention can also be part of work addressing the wider determinants of health and wellbeing.

6 Restricting access to the means for suicide works

This is one of the most evidenced aspects of suicide prevention and can include physical restrictions, as well as improving opportunities for intervention.

7 Supporting people bereaved by suicide is an important component of suicide prevention strategies

Compared with people bereaved through other causes, individuals bereaved by suicide have an increased risk of suicide and suicidal ideation, depression, psychiatric admission as well as poor social functioning.

8 Responsible media reporting is critical

Research shows that inappropriate reporting of suicide may lead to imitative or 'copycat' behaviour.

9 The cost of suicide justifies investment in suicide prevention work

The economic cost of each death by suicide of someone of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering.

10 Local suicide prevention strategies must be informed by evidence

Local government should consider the national evidence alongside local data and information to ensure local needs are addressed.

Strategy Aims

In 2014, the seven Berkshire CCGs and six local authority public health teams across Berkshire began work to refresh the suicide audits previously undertaken and to recommend from this a strategy for reducing suicide risk across Berkshire. This strategy is the result of a study of national research and recommendations plus recommendations of many local stakeholders from a range of organisations.

This strategy proposes co-ordinated prevention across all the elements influencing suicide, from the wider determinants of distress and escalating desperation, and poor mental health, through coordinated local preventive action spanning local authority and voluntary services, and primary and secondary care.

The overall aim of this strategy is:

- To outline how partners across the county will work to prevent suicide in Berkshire.
- To outline the governance structure for Suicide Prevention work in Berkshire.
- To make clear how the public, partners and other stakeholders can deliver the actions outlined herein.

The objectives and six priority areas to meet this aim are also drawn from the National Suicide Prevention Strategy – "Preventing Suicide in England" (DH, 2012), and are intended to be met through coordinated multi-agency actions, under the governance of the Berkshire Suicide Prevention Steering Group.

The objectives of this strategy developed from the national strategy are:

- To reduce suicides in Berkshire by 25% by 2020;
- To ensure better support is provided for those bereaved or affected by suicide.

The priority areas of this strategy drawn from the national strategy are:

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

These six priority areas have become the golden thread which runs through this strategy and the action plans which support it. These action plans are for the year 2017/18, whilst the strategy is for the years 2017-2020, taking this to the year when the overarching aim to reduce suicide by 10%, as stated in the Five Year Forward View on Mental Health and incorporated into the Sustainability and Transformation Plans produced by groups of CCGs. There are other recommendations around process and which address the overarching aims and/or a combination of the priority areas.

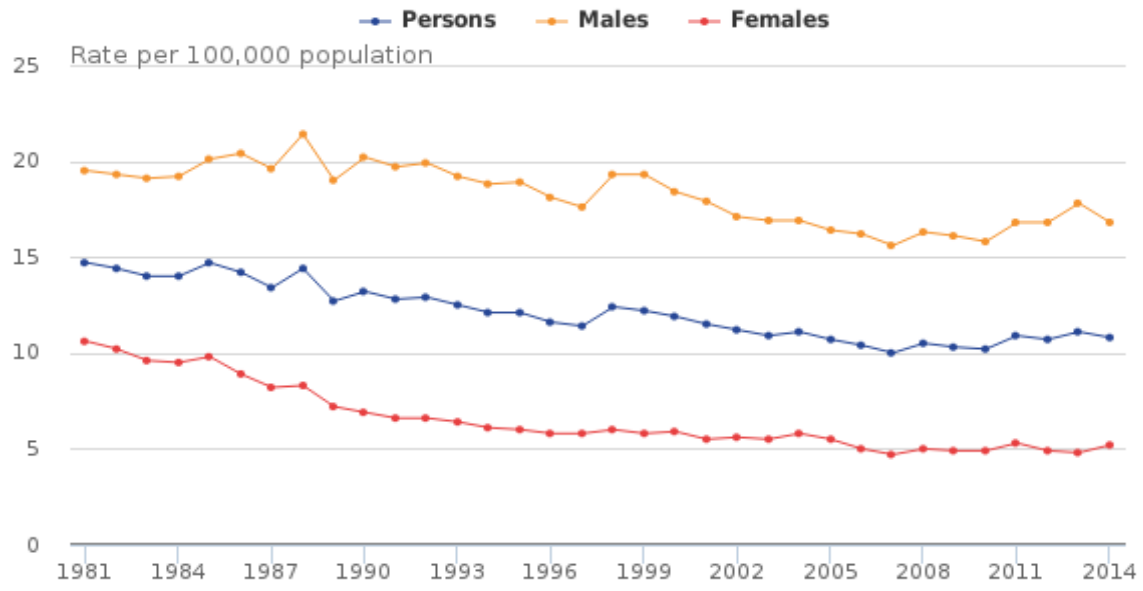
National Context

Nationally available data on suicides can help place local information on suicides in context. From the national references which include rates, trends, risk factors, suicide methods and evidence of what works to prevent suicides, a local approach for suicide prevention can be developed. This section presents the national data on suicides and is intended to be used as a guide to draw comparisons with local data and information from the Berkshire Audit.

The Office for National Statistics (ONS) provides figures on deaths by suicide, available publicly on its website at: www.ons.gov.uk. Data can be downloaded which shows numbers and rates of death by suicide per 100,000 population. Rates are important as they account for the age and size of populations, so it is more reliable when comparing suicide across age groups and areas.

Suicide is defined in England and Wales as a death with an underlying cause of intentional self-Harm and/or an injury/poisoning of undetermined intent (ICD10 codes X60-X84 - all ages and Y10-Y34 – for ages over 15 years). There is an assumption that most injuries or poisonings of undetermined intent are self-inflicted and where there is insufficient evidence to prove that the person intended to kill themselves. This assumption however is not applied to children due to the possibility that these deaths were caused by other situations – such as abuse or neglect. For this reason, data on suicides in England only include persons aged 15 years and over for deaths from injury of undetermined intent and may therefore lead to an under-reporting of deaths as a result of suicide in children.

Figure 1: Age-standardised suicide rates by sex, deaths registered between 1981 and 2014, United Kingdom



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency. 2016.

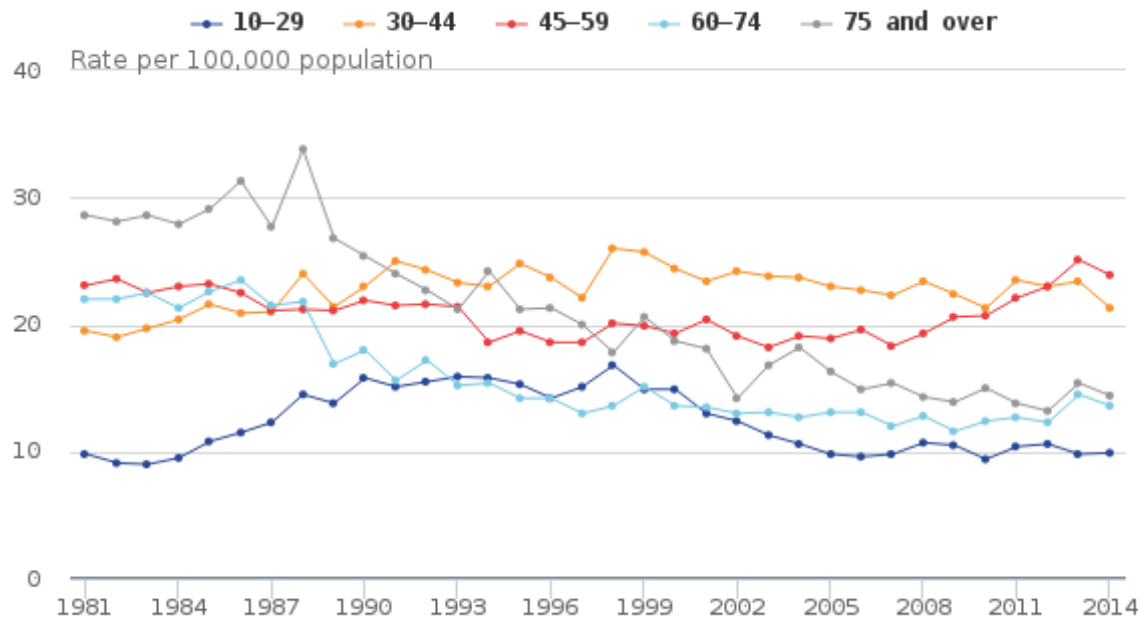
Figure 1 above shows the age standardised suicide rates for the UK since 1981. A generally downward trend in suicide rates was observed between 1981 and 2007, with a decrease from 15.6 to 10.6 deaths per 100,000 population (see figure 1). There has been a slight overall increase in suicide rates since 2007, to 10.8 per 100,000, which is part of an upward trend since 2007 for both sexes.

Suicide continues to be more than three times as common in males. The male suicide rate in 2013 was the highest since 2001. The lowest male rate since the beginning of the data series, at 16.6 per 100,000, was in 2007.

The highest suicide rate in the UK in 2014 was among men aged 45 to 59, at 23.9 deaths per 100,000, slightly lower than the record high seen in 2013. This age group also had the highest rate among women, at 7.3 deaths per 100,000 population.

Men aged 45 to 59 had the highest suicide rate in 2014 for the second year in a row with a rate of 23.9 deaths per 100,000 population. Between 2000 and 2011, the rate in this age group was the second highest, behind men aged 30 to 44. Since 2007, the rate in the 45 to 59 age group has been increasing.

Figure 2: Age-specific suicide rate, males, deaths registered between 1981 and 2014, United Kingdom

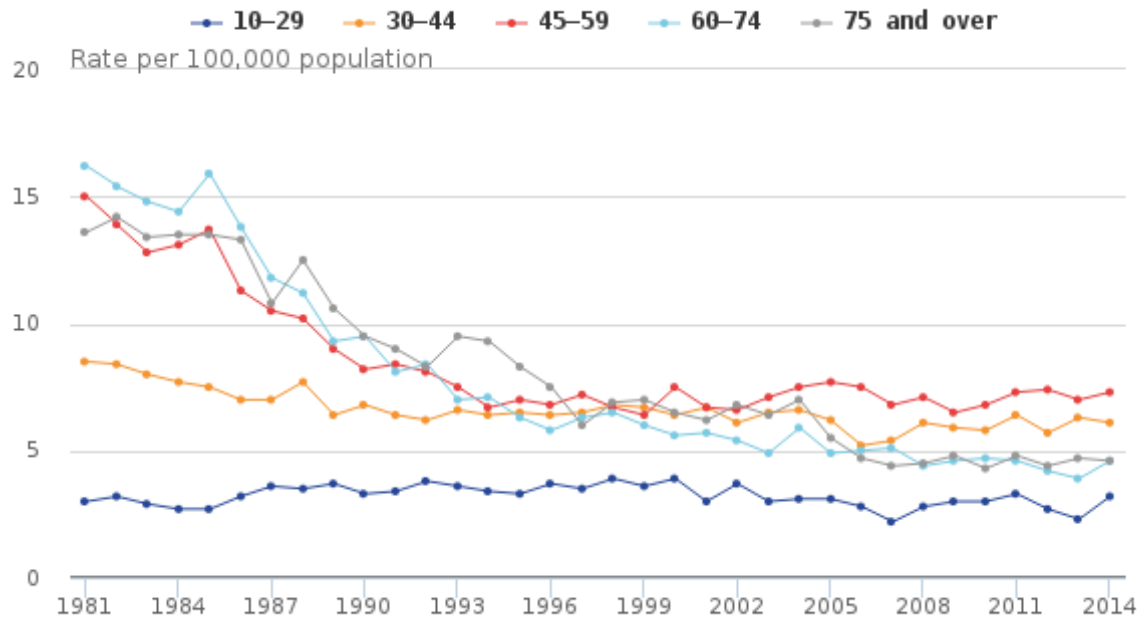


Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency. 2016.

Female rates have stayed relatively constant since 2007. In 2014, the age group with the highest suicide rate for females was 45- to 59-year-olds, with a rate of 7.3 deaths per 100,000 population (see Figure 3). This has been the case since 2003. Analysing this data by 5 year age group shows that females aged 50 to 54 have the highest suicide rate at 8.0 per 100,000 population. Between 1981 and 1994, female suicide rates decreased across all broad age groups apart from 10 to 29 year-olds. Suicide rates for

women under 60 have remained relatively constant since 2008, and for women aged 60 and over continue to show a broadly decreasing trend,showing the biggest reduction since 1981.

Figure 3: Age-specific suicide rate, females, deaths registered between 1981 and 2014, United Kingdom



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency. 2016.

A time trend analysis in England suggested that the recent recession in the UK could be an influencing factor in the increase in suicides. The study found that local areas with greater rises in unemployment had also experienced higher rises in male suicides (Barr et al 2012). A review by the Samaritans (2012) emphasised that middle-aged men in lower socioeconomic groups are at particularly high risk of suicide. They pointed to evidence that suicidal behaviour results from the interaction of complex factors such as unemployment and economic hardship, lack of close social and family relationships, the influence of a historical culture of masculinity, personal crises such as divorce, as well as a general 'dip' in subjective wellbeing among people in their midyears, compared to both younger and older people (Office for National Statistics, 2014).

Suicide in mental health inpatients had almost halved since 1997 and deaths had also fallen among prisoners. The most recent National Confidential Inquiry into Suicide and Homicide annual report (July 2013) shows a rise in overall patient suicide, probably reflecting the rise in suicide in the general population, which has been attributed to current economic difficulties. There are twice as many suicides under crisis resolution / home treatment compared to in-patients. Hanging, strangulation and suffocation account for the largest number of suicides in males, at 60% of the total. In females hanging and drug related poisoning are the joint most frequent methods, 38% *(Preventing suicide in England: 1 year on, 2014).*

Strategic Context

Local suicide prevention planning is the responsibility of local authority public health teams to deliver with clinical commissioning groups (CCGs), health and wellbeing boards and a wider network of partners. Very recent guidance to inform this strategy has been developed by Public Health England (2016) in partnership with the National Suicide Prevention Alliance.

The need to develop suicide prevention strategies and action plans at a local level and which engage with a wide network of stakeholders in reducing suicide is set out in the government's national strategy for England, Preventing Suicide in England, a cross government strategy to save lives (HM Government, 2012). It is also reinforced by the Mental Health Taskforce's report to NHS England, *The Five Year Forward View for Mental Health* (NHS England, 2016).

Two key objectives are laid out in the national suicide prevention strategy:

- to reduce the suicide rate in the general population, and
- to provide better support for those bereaved or affected by suicide.

This national strategy in turn set out six key areas for action:

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

Responsibility for suicide prevention action plans and strategy lies with local government through health and wellbeing boards. Local authorities report on the quality and success of initiatives to improve the health and wellbeing of their populations, using national indicators set out in the Public Health Outcomes Framework. Indicators relevant to suicide prevention include suicide rate, self-harm and excess mortality in adults aged under 75 years with serious mental illness

Around half of people who die by suicide have a history of self-harm, and self-harm is a sign of serious emotional distress in its own right. Mental health promotion, prevention and early intervention are essential to help reduce self-harm in the community that does not present to health services. The effective assessment and management of self-harm by NHS services where people do present with self-harm, particularly in Emergency Departments, represents a huge opportunity to reduce repetition of self-harm and future suicide risk. In June 2013, NICE published a new quality standard to improve the quality of care and support for people who self-harm. The Spending Review (2013) committed to every Emergency Department having constant access to mental health professionals and Public Health Outcomes Framework published in (2013) includes the definition of the new indicator on self-harm. This makes clear the priority given to the prevention and management of self-harm across local authority and NHS services.

Evidence Base in Suicide Prevention

The Government published its review of the suicide strategy, *"Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives"* (Department of Health, 2015). This section summaries this, the latest evidence and best practice as identified within the report.

Men and Economic Crisis

A recent study found that men in different age brackets had different suicide risks during the recent recession. Those aged between 35-44 years old experienced increased suicide rates corresponding to economic decline. The study also found the halt in the downward trend in suicide rates amongst men aged 16-34 may have begun before the 2008 economic recession (Coope, et al, 2014).

Self-Harm and Alcohol

There was a higher rate of alcohol-related deaths for those presenting at emergency departments with self-harm for both males and females. Local areas need to ensure that those presenting to hospital with self-harm should be assessed for alcohol problems to identify issues early and get treatment (Bergen, et al, 2014). This is in line with NICE guidelines. In the year following self-harm the risk of suicide is raised 49-fold in the year, this increases with age at initial self-harm (Hawton, et al).

Crisis Resolution

Crisis resolution home treatment services have a key role to play in suicide prevention. Approximately 180 suicides each are patients who are under crisis resolution home treatment services, with approximately 80 among in-patients (Hunt, et al; NCISH 2014).

Primary Care Patients

Both frequent attendance and non-attendance at GP surgeries is linked to increased risk of suicide. For young men, non-attendance is a particular risk factor (NCISH 2002-20012).

Discharge Processes

The first 3 months following discharge from a mental health inpatient episode remains a high risk, with the highest risk at 2 weeks discharge. Community Care reforms which recommend a 7 day follow up have shown positive results although progress has stalled recently (Psychiatry Online).

Self-harm in Prisons

There is an association between self-harm and suicide within the prison setting. Prevention and treatment of self-harm should be part of the suicide prevention efforts within prisons (Hawton, et al, 2014).

National Best Practice in Suicide Prevention

These case studies were reported in, *"Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives"* (Department of Health, 2015).

U Can Cope

The U Can Cope film and online resources were designed for people in distress and those trying to support them, to instil hope, promote appropriate self-help and inform people regarding useful strategies and how they can access help and support. They have been endorsed by the International Association of Suicide Prevention: www.connectingwithpeople.org/ucancope

Social Media

Emerging findings from the research study on Understanding the role of social media in the aftermath of youth suicides (COSMOS), commissioned in support of the suicide prevention strategy, are that:

- Suicidal tweeters show a high degree of reciprocal connectivity (i.e. they follow each other), when compared with other studies of the connectivity of Twitter users, suggesting a community of interest.
- A retweet graph shows that users who post suicidal statements are connected to users who are not, suggesting a potential for information cascade and possibly contagion of suicidal statements.
- The reaction on Twitter to the Hayley Cropper Coronation Street suicide storyline was mostly information/support and debate about the morality of assisted dying, rather than statements of suicidal feelings.
- Tweets about actual youth suicide cases are far more numerous than newspaper reports and far more numerous than tweets about young people dying in road traffic accidents. This suggests that suicide is especially newsworthy in social media. In newspapers there is no significant difference between the two types of death, in terms of number of reports per case.

Nottinghamshire Healthcare NHS Trust and Connecting with People

Nottinghamshire Healthcare NHS Trust is implementing an innovative approach to suicide prevention to improve both patient care and clinical governance. The Trust has developed a team of in-house trainers to deliver suicide and self-harm awareness and response training across the Trust. They are also piloting a web-based App to help to consistently record individual assessments. The App is integrated securely within the NHS system and is based on peer-reviewed clinical tools.

Other Trusts are also involved in the pilot of the App in partnership with the social enterprise *Connecting with People*. The approach being taken:

- Is evidence based and uses peer reviewed clinical tools. It combines compassion with sound clinical governance.

- Is proactive, emphasising safe triage and the co-creation of immediate safety plans for all patients with suicidal thoughts, irrespective of risk. It documents evidence on level of risk and actions agreed to mitigate the risks.
- Has been developed by healthcare practitioners, third sector organisations and service users, for delivery to health and social care practitioners in primary and secondary care and in third sector organisations.

It is an example of how the third sector can work effectively in partnership with the NHS to improve patient care in specialist areas, forming part of the RCPsych OnSite training.

Safety Collaboratives in Mental Health

The South West of England has had a safety collaborative in Mental Health since 2010. This work spread across the South of England in 2013. It involves the majority of Mental Health Trusts in the region. Work streams include getting medicines right, improving physical health care and delivering safe and reliable care. This includes reducing absence without leave from inpatient units and reducing suicides.

North Essex Partnership University NHS Foundation Trust and Samaritans

Three Samaritans branches together with the North Essex Partnership University Foundation Trust have signed a partnership agreement to develop a range of opportunities for patients and staff to benefit from the knowledge, experience and complementary services offered by Samaritans in support of emotional wellbeing and suicide prevention. This will include:

- NHS staff organising for a patient (with their consent) to receive a call from Samaritans.
- Training for non-clinical NHS staff on handling challenging contacts, suicide awareness and emotional well-being.
- Establishing referral pathways between Samaritans and GPs in the area.
- Samaritans presence in Emergency Departments.

This partnership is an example of how the voluntary sector and NHS can deliver better support to people by working together more closely.

Healthtalk Online for parents whose child is self-harming

Drawing on research with families, this website enables parents to see and hear parents and other family members of young people who self-harm share their personal stories on film. The films cover issues such as why young people self-harm, discovering that a young person is self-harming, how they helped their young person, living with self-harm, support and treatment, and what helped them cope. www.healthtalk.org/peoples-experiences/mental-health/self-harm-parents-experiences/topics

Staying safe if you're not sure life's worth living

A new online resource developed by the Royal College of Psychiatrists, Connecting with People, Samaritans, Grassroots Suicide Prevention, State of Mind, leading academics, people with lived experience and their carers.

Staying safe if you're not sure life's worth living includes practical, compassionate advice and many useful links for people in distress:

www.connectingwithpeople.org/StayingSafe .

Local Context

In Berkshire, the trends in suicides broadly reflect the national trends, and the results from the most recent local suicide audit, carried out in 2015, are shown below.

Of note:

- more males completed suicide than females
- 70% of the deaths recorded between 2007-2014 were in age group 30-59 years
- The percentage of deaths among the unemployed rose from 13% in 2007 to 38% in 2014
- The most common method for suicide was hanging/strangulation.

Local Suicide Audit Results

During 2015, Public Health Teams in Berkshire undertook an audit of suicide and undetermined deaths during the 2012-2014 period. This audit provides an analysis of the most recent audit and includes comparative data from previous audits. The audit defined suicide as a death where the coroner has given a verdict of suicide (based on evidence that the intent was to cause death or take own life) or where an open verdict was reached in a death from injury or poisoning. The definition comprises suicides and open verdicts coded as ICD10 X60-X84 and Y10-YY34.

Data for the audit was collected from Berkshire Coroner Office case notes for people who died from suicide or undetermined injuries during 2012-2014. The audit only includes Berkshire residents who died in the County. It is important to note that there can be a substantial delay between the date of death and the date of registration for suspected suicides, so it is likely that not all deaths from 2014 were included in this audit.

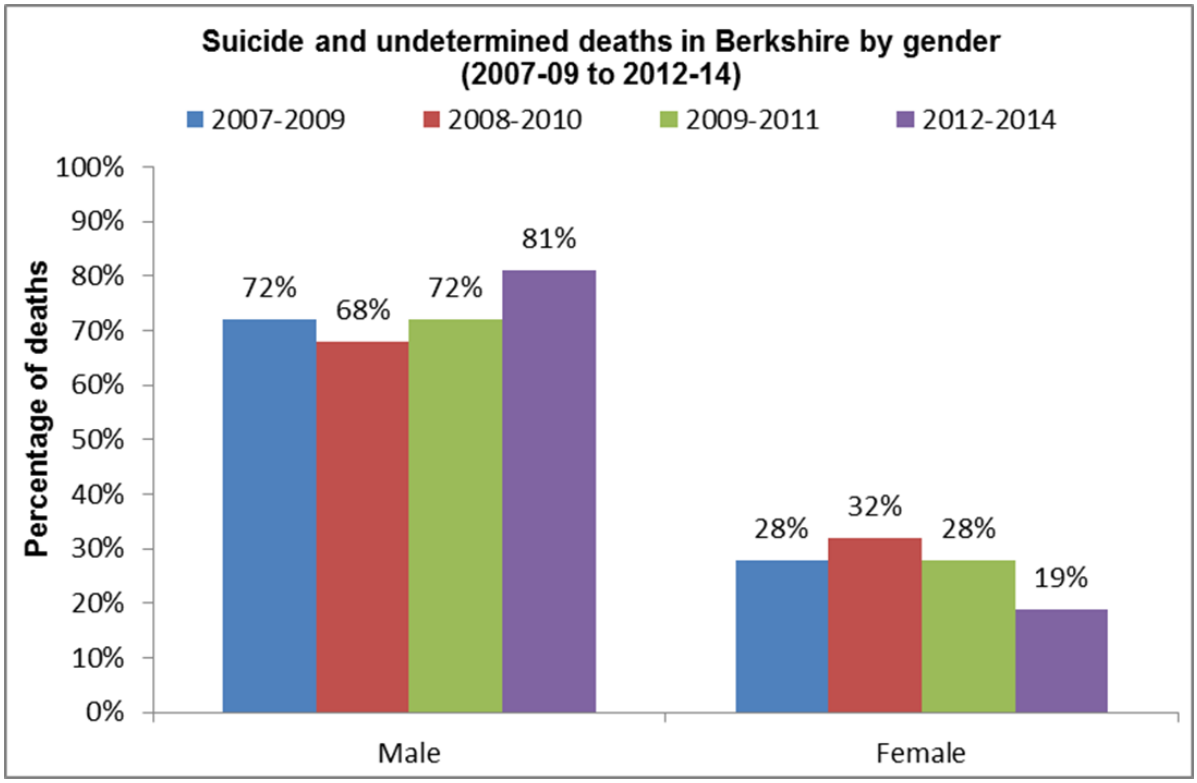
The analysis of suicide data is based on small numbers and is likely to show differences over time or between different groups that are due to random occurrence. However, the analysis of this data can give some indication as to local patterns in suicide deaths. Data from the audit is presented as averages over a three year period to reduce some of the random variations that occur when analysing small numbers. For confidentiality reasons, figures under 5% have been supressed and data is shown at a Berkshire level, rather than by individual local authorities.

120 deaths were included in the Berkshire suicide audit for 2012-14. 70% of these were classified as suicide by the coroner and the other 30% were undetermined deaths / open verdicts.

Gender

Data from all recent audits show that males have a higher suicide rate compared to women in Berkshire. This is consistent with national figures.

Figure 4: Suicide and undetermined deaths in Berkshire by gender (2007-09 to 2012-14)



Age

70% of the deaths recorded in 2012-14 were for people aged 30-59.

Age group	2012-2014
10-19	*
20-29	13%
30-39	23%
40-49	23%
50-59	24%
60-69	*
70-79	*
80-89	7%

Ethnicity

The majority of people dying from suicide or an undetermined death in Berkshire are White-British. This is largely representative of Berkshire's population. In 2011, 73% of Berkshire's population were from a White-British background, ranging from 35% in Slough to 80% in West Berkshire. The majority of deaths from other ethnic groups (Asian/Asian-British and White-Other) were Slough residents and this also reflects the Borough's population profile. It is important to note that 15% of the cases included in the 2015 audit did not have an ethnic origin recorded in the audit. This is a higher proportion than the previous audit and will therefore have affected the validity of the analysis for 2012-2014 data.

Ethnicity	2007-2009	2008-2010	2009-2011	2012-2014
White-British	77%	75%	77%	61%
White-Other	10%	15%	13%	13%
Asian/Asian-British	<5%	<5%	<5%	12%
Black/Black-British	<5%	<5%	<5%	0%
Not Known	<5%	<5%	<5%	15%

Diurnal and Seasonal Variation

The following tables illustrate the day of the week and seasons in which deaths from suicide occurred in Berkshire during 2007-2011 and 2012-2014.

Day of the week	2007-2009	2008-2010	2009-2011	2012-2014
Monday	19%	21%	21%	20%
Tuesday	16%	17%	17%	13%
Wednesday	16%	11%	10%	9%
Thursday	10%	10%	15%	16%
Friday	8%	9%	7%	14%
Saturday	19%	14%	15%	13%
Sunday	14%	17%	15%	13%

The data shows a relatively even spread across the whole week, with no particularly 'common' day.

Season	2007-2009	2008-2010	2009-2011	2012-2014
Winter (Dec-Feb)	24%	23%	27%	28%
Spring (Mar-May)	29%	30%	27%	31%
Summer (Jun-Aug)	25%	21%	21%	21%
Autumn (Sept-Nov)	21%	26%	28%	18%

Figure 5: Suicide and undetermined deaths in Berkshire by day of week (2007-09 to 2012-14)

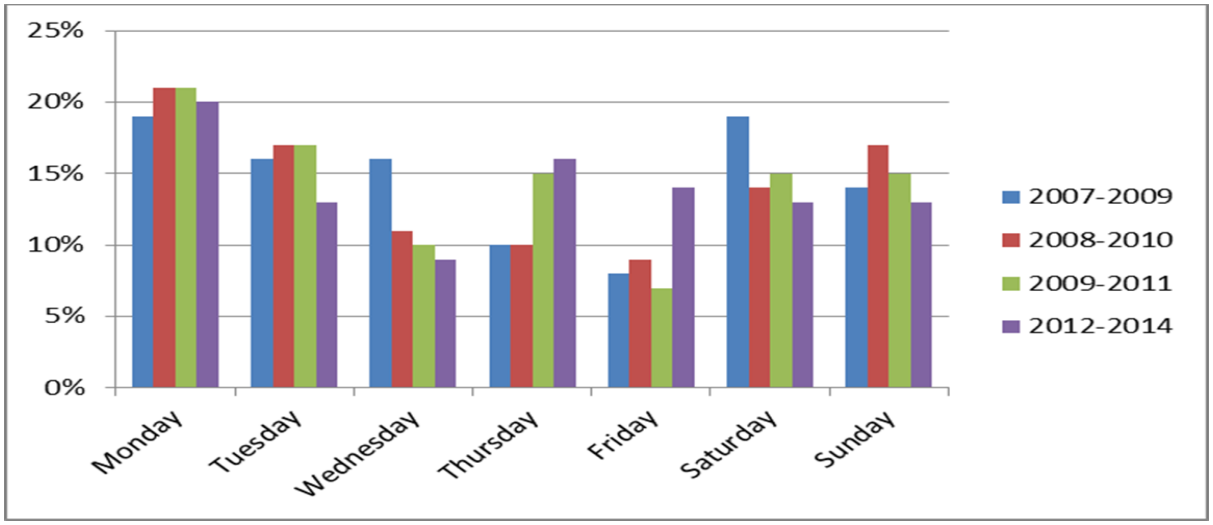
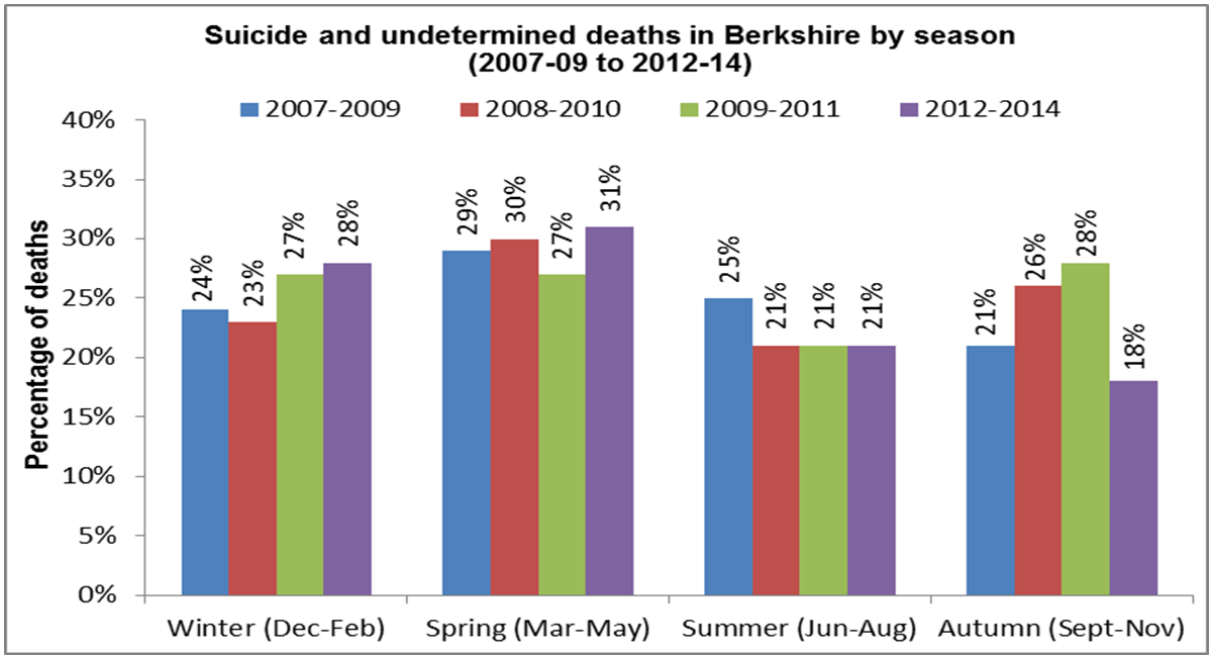


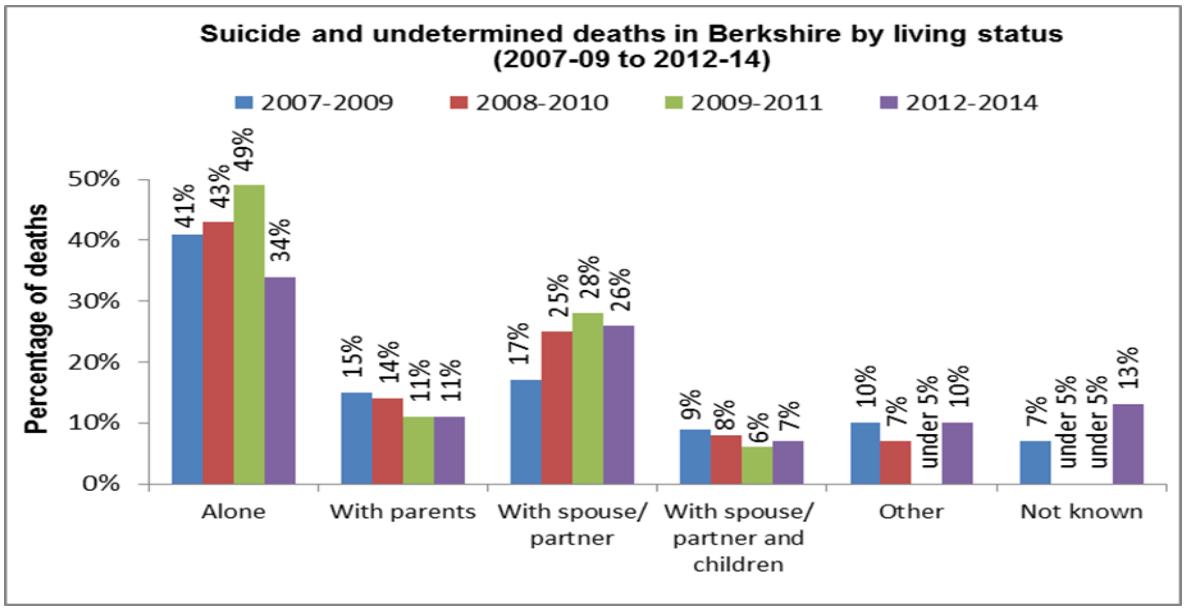
Figure 6: Suicide and undetermined deaths in Berkshire by season (2007-09 to 2012-14)



Marital and Living Status

Recent data from the Office for National Statistics shows that 13% of usual residents in England and Wales were living on their own in 2011. The table below indicates that those living alone in Berkshire are therefore over-represented in suicide deaths. This percentage has reduced from 49% in 2009-2011 to 34% in 2012-2014, however it is still the main living status recorded. It is important to note that the number of people with a living status not recorded or not known is higher in 2012-2014 (13%), which makes comparisons of data difficult.

Figure 7: Suicide and undetermined deaths in Berkshire by living status (2007-09 to 2012-14)



The table below shows that there were more deaths from single people in the two audit periods, ranging from 39% to 45%.

Marital status	2007-2009	2008-2010	2009-2011	2012-2014
Single	45%	39%	39%	40%
Married	23%	29%	30%	29%
Divorced	14%	13%	13%	8%
Separated	10%	7%	7%	<5%
Widowed	4%	6%	7%	<5%
Co-habiting	<5%	<5%	5%	10%
Not stated	<5%	<5%	<5%	6%

Employment Status

Some studies have indicated that there is a strong independent association between suicide and individuals who are unemployed (Lewis and Sloggert, 1998). Unemployment in the Thames Valley is low, although there has been some fluctuation between 2007 and 2014. The lowest level of unemployment during this time was 3.4% in Jul-07 to Jun-08, with the highest rate of 6.1% in Apr-09 to Mar-10.

Data from the 2012-2014 Berkshire audit shows that 38% of people dying from suicide and undetermined deaths were unemployed. This is an over-representation of the population, considering that only 4-5% of people were unemployed during that time period. This is also a notable increase on the figures from 2007-2011, which ranged from 11%-14%. This change may be down to a random occurrence, due to small numbers.

Employment status	2007-2009	2008-2010	2009-2011	2012-2014
Full Time	46%	51%	55%	36%
Part Time	5%	<5%	<5%	<5%
Unemployed	13%	11%	14%	38%
Student	6%	6%	<5%	<5%
Retired	18%	17%	17%	11%
Long-term illness/ disability benefits	<5%	<5%	<5%	<5%
Housewife/husband	<5%	<5%	<5%	<5%
Not known	8%	5%	<5%	12%

Suicide Note

The table below shows the proportion of deaths where a suicide note was left.

Left a suicide note?	2007-2009	2008-2010	2009-2011	2012-2014
Yes	29%	32%	40%	36%
No	71%	68%	60%	54%
Not known	0%	0%	0%	10%

Housing Status

A large number of the cases included in the 2012-2014 audit did not capture the housing status for people, which means that the data cannot be presented in this analysis.

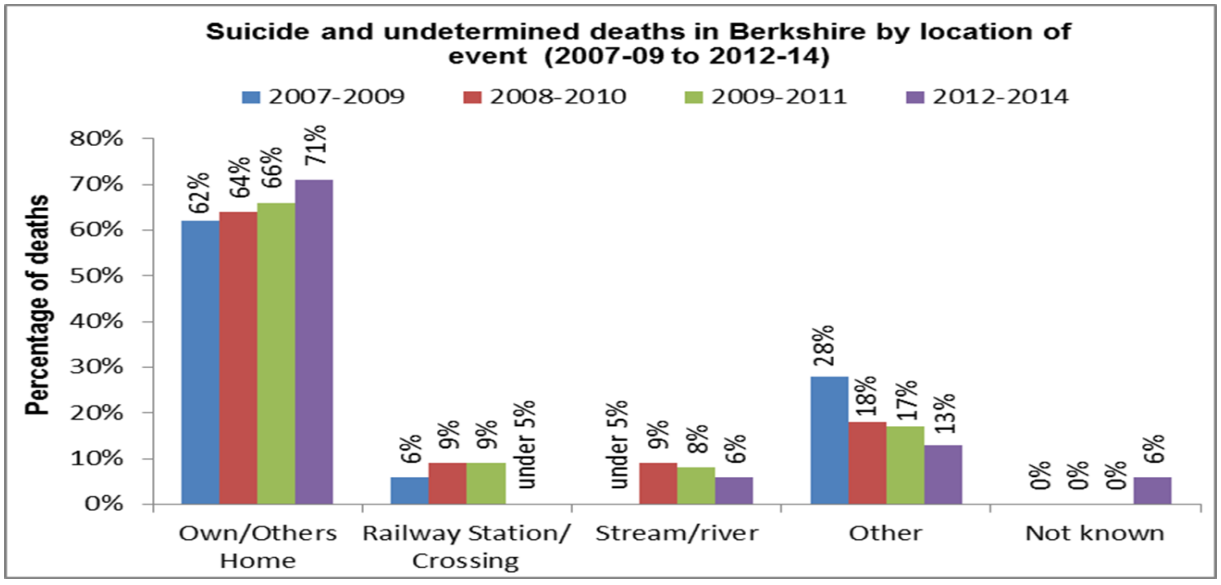
Housing status	2007-2009	2008-2010	2009-2011	2012-2014
Owner/Occupier	46%	46%	52%	35% of these cases did not have a housing status recorded and therefore this data cannot be presented
Privately Renting	41%	33%	25%	
Council House/ Housing Association	5%	9%	11%	
With Parents	<5%	<5%	<5%	
Supervised Hostel	<5%	<5%	<5%	
Unsupervised Hostel	<5%	<5%	<5%	
Other	<5%	<5%	<5%	
Not Known	<5%	<5%	<5%	

Location of event

The majority of deaths identified in the local audits took place in the person's own home or another person's home. This proportion has continued to increase from 62% in 2007-2009 to 71% in 2012-2014.

Location of event	2007-2009	2008-2010	2009-2011	2012-2014
Own/Others Home	62%	64%	66%	71%
Railway Station/ Crossing	6%	9%	9%	<5%
Stream/river	<5%	9%	8%	6%
Other	28%	18%	17%	13%
Not known	0%	0%	0%	6%

Figure 8: Suicide and undetermined deaths in Berkshire by location of event (2007-09 to 2012-14)



Methods Used

Suicide methods can be classified as either 'active' or 'passive'. Active methods are quick and effective allowing little time for reconsideration. Such methods are hanging, shooting, jumping in front of a train or from a height. Among the general population hanging, strangulation and suffocation has been identified as the most common cause of suicide for men. Passive methods are less violent and allow some time for reconsideration or intervention (e.g. self-poisoning, carbon monoxide). Hanging/strangulation has been the most common cause of death over 2007-2014.

Methods used	**2007-2009**	**2008-2010**	**2009-2011**	**2012-2014**
Hanging / Strangulation	54%	47%	48%	49%
Carbon Monoxide Poisoning	8%	<5%	<5%	<5%
Jumping / laying before a train	6%	9%	9%	<5%
Jumping from a height	11%	11%	8%	<5%
Self-Poisoning	10%	9%	12%	0%
Drowning	<5%	7%	7%	6%
Other	7%	12%	14%	38%
Not known	0%	0%	0%	<5%

Alcohol and drugs taken at time of death

The audit of people dying from suicide and undetermined deaths during 2012-14 identified whether alcohol or prescribed drugs were detectable in the deceased. This data was not collected in the previous audit. The tables below show that at least 36% of people who died in 2012-14 had taken alcohol prior to their death and at least 42% had taken prescribed drugs, and outlines those drugs that were implicated in suicide deaths.

Alcohol present?	**2012-2014**	
At intoxicating level	23%	
At non-intoxicating level	13%	
No alcohol detected	54%	
Not known	11%	
Prescribed drugs present?	**2012-2014**	
At fatal level	14%	
At intoxicating level	8%	
At therapeutic level	20%	
No prescribed drugs detected	43%	
Not known	16%	
Drugs implicated	**Male**	**Female**
Antidepressants	✓	✓
Paracetamol	✓	
Coproxomal or similar	✓	✓
Benzodiazepine	✓	
Other hypnotic		
Anti-psychotic	✓	✓

Other substances implicated in suicide deaths in 2012-14 were:

Other substances	Male	Female
Amphetamines	✓	✓
Ecstasy	✓	
Crack/Cocaine	✓	
Ketamine	✓	
Heroin	✓	✓
Opiates	✓	
Methadone	✓	✓

Personal, Social and Health Factors associated with deaths from suicide

The following factors were identified from records at the Coroner's Office as being associated with suicide:

Factor identified	2007-2009	2008-2010	2009-2011	2012-2014
Relationship problems	14%	6%	<5%	29%
Financial problems	9%	6%	<5%	24%
Depression	25%	42%	51%	67%
Low self esteem	<5%	<5%	<5%	Not collected
Other Mental health Issues	8%	8%	<5%	Not collected
Pending Police Investigation	<5%	<5%	<5%	12%
Family bereavement	<5%	<5%	<5%	12%
Physical Health	8%	<5%	<5%	33%
Job related	<5%	<5%	<5%	17%
Not Stated	15%	13%	20%	-

Local Governance Structures

In order to facilitate the production of this strategy and to steer the Berkshire-wide audit of suicides, a strategic group was convened with representatives from organisations across county. This worked under the identity of the Berkshire Suicide Risk & Self Harm Reduction / Prevention Steering Group. During 2015/16 as key staff changed, the group has lost some of its membership and had become less strategic. The original terms of reference state that the group:

> "*will provide public health leadership and advice to support a joint approach to achieve real change in the prevention of suicides and self- harm through actions taken by member organisations. It will facilitate the bringing together of clinicians, professionals and organisations, with the patient's voice, to deliver surveillance data to support projects / programmes to prevent suicides and offer support to those who are bereaved*."

Public Health England (2016) suggests that the membership of suicide prevention partnerships is made up of representative working with adults, children and young people. The following diagram suggests the range of partners who may be included.

The Berkshire Steering Group will need to own this strategy, and the membership should be updated to ensure a closer fit with the groups suggested above. The membership of the current group as at December 2016 is detailed in Appendix 8.

RECOMMENDATION

That the Berkshire Steering Group re-visits their terms of reference and membership and become known as the "Berkshire Suicide Prevention Steering Group", with the aim of providing the governance to this strategy and its action plans.

There are other groups for whom this strategy and its action plans are an important issue, and these include commissioning boards in the East Berkshire and West Berkshire Confederations of CCGs; Health and Wellbeing Boards; Health Overview and Scrutiny Committees; Adult Safeguarding Boards; and Community Safety Partnerships. In order to get full endorsement of this strategy and for organisations to commit to their action plans, the terms of reference should ensure that the links to these other structures are robust and transparent.

Members of the Steering Group could be asked to act as suicide prevention champions. These are individuals who get involved in specific pieces of suicide prevention work – and might include people who have been bereaved by suicide or those with a special interest or expertise. They can be pivotal in raising issues regarding suicide awareness locally, and drive forward the action plans of their agencies. A specific initiative to engage the elected members of councils as Mental Health Champions may provide an opportunity for them to also speak out on suicide prevention. Details of this initiative are available here: http://www.mentalhealthchallenge.org.uk/the-challenge/

RECOMMENDATION
That organisations represented on the Berkshire Suicide Prevention Steering Group consider nominating a suicide prevention champion from within their membership.

Monitoring & Evaluation and Progress

This is a pan-Berkshire and multi-agency Strategy and the action plans for this strategy which are overseen by the Berkshire Suicide Prevention Steering Group are set out below.

Individual Borough action plans for each of the six Berkshire Unitary Authorities are also included and are set out in appendices 2-7. These give a more local set of priorities and respond to the particular geographical issues, population structures and general health needs of the Authorities.

Other agencies which are part of the Steering Group may have their own action plans and an objective of this strategy is to bring these into one combined action plan as far as possible and to share openly the actions plans of all agencies in order to learn from one another; to avoid un-necessary duplication of effort or resources; and to encourage co-production of outcomes.

Links to Other Local Strategies

This is the first comprehensive Berkshire-Wide Suicide Prevention Strategy and action plans have been produced for the year 2017-18. One of the objectives is to ensure that this strategy, its aims and objectives are shared and upheld in the strategies, action plans and objectives of all those groups across Berkshire who are committed to improving health outcomes, promoting wellbeing, removing the stigma associated with mental health and preventing suicides.

Local Joint Health and Wellbeing Strategies and their action plans should endorse this Strategy and Health and Wellbeing Boards are key to the governance of this Strategy and the Steering Group. Through tightly-knit joined up thinking, organisations, individual and communities across Berkshire can come together to make the progress necessary to reduce suicides in our populations.

RECOMMENDATION

That all agencies represented on the Steering Group commit to an annual Action Plan of their own which can then be brought together to create a Berkshire-wide Action Plan for each year of the Strategy.

Local Best Practice in Suicide Prevention

Thames Valley Suicide Prevention and Intervention Network (SPIN) CALMzone

The Campaign Against Living Miserably (CALM) was originally a Department of Health helpline project on suicide prevention particularly targeting younger men using marketing methodology and images to specifically engage with this audience on issues surrounding mental distress and social alienation. The resources produced directed men to a special helpline, and latterly to web-based resources. In 2000, a partnership of six areas in the North-west of England commissioned this work for young men in Merseyside, which continued when CALM transferred into a national charity. There is a local CALMzone Coordinator who promotes CALM across Merseyside in collaboration with the local community – pubs and clubs, venues and universities, sports teams and clubs – to encourage them to join and promote the campaign.

In 2015, the local authorities across the Thames Valley through SPIN funded a Thames Valley CALMzone, and employed a coordinator undertaking similar promotions as in Merseyside. CALM have provided local commissioners with anonymised reports on numbers and trends of calls and web chats across the Thames Valley. As well as providing funding to support the helpline, the commissioners ensure CALM has an up-to-date local database of agencies which local callers can be referred to. Berkshire local authorities have continued to fund the helpline until June 2017, although the local coordinator post is no longer funded.

RECOMMENDATION
Evaluate the Berkshire CALMzone and recommission targeted suicide prevention work for younger men and middle aged men.

Real Time Suicide (and near fatal self-harm) Surveillance

It is important to have a real time overview of self-inflicted deaths/suspected suicides and near fatal self-harm in order to provide timely support for those bereaved and affected, pick up community risks of contagion or suicide clusters and identify public places where suicides/incidents of near fatal self-harm appear to occur with increasing frequency. All of these activities contribute to suicide reduction and prevention in line with national and local strategy. Thames Valley Police (TVP) and the Thames Valley Suicide Prevention and Intervention Network (SPIN), supported by funding from the Thames Valley Strategic Clinical Network are collaborating to build on the supportive signposting for people bereaved by suicide work and develop a robust real time surveillance process.

In simple terms this process is as follows:

- TVP identifies and collates suspected suicides on the Gen 19 sudden death form.
- Coroner's officers send Gen 19s of suspected suicides to a central TVP email for monitoring.
- Details of the incidents in real time are thereby collated and are available for analysis, reporting and provide the ability to respond.

- Details of families who consent to 'Supportive Signposting' are sent to a central NHS England suicide bereavement address.
- Supportive literature and referral signposting links to organisations and charities are provided to relatives.

RECOMMENDATION
Ensure bereavement information and access to support is available to those bereaved by suicide.

Further data is being collated from the following sources;

- NHS England monitor the strategic executive information system database for suspected suicides and near fatal self-harm.
- Links are being established with British Transport Police to monitor suspected suicides and near fatal attempts on the railways
- Links are being established with prisons to monitor prison suspected suicides and near fatal attempts.
- Links are to be established with the general hospital psychiatric liaison services to monitor incidents of near fatal self-harm.

All of this information will be reviewed by the TVP and SPIN leads and figures and concerns will be communicated to local public health suicide prevention leads for consideration within the local multi-agency suicide prevention action groups. A hub of SPIN comprising TVP, public health, NHS and the University of Oxford Department of Psychiatry Centre for Suicide Research has been established to maintain oversight of the regional prevalence of suicide with the aim of collaborating where indicated, in order to respond to issues that concern the whole geography, for example contagion and clusters.

Berkshire Healthcare Foundation NHS Trust (BHFT) Zero Suicide Programme

Reducing suicide for BHFT means early identification of people who may be at risk of taking their own lives and putting into place crisis plans so that patients and carers know what to do in a crisis. This can only be achieved by the early identification of individuals who are particularly at risk of suicidal thoughts and behaviours. The key objective of the BHFT Zero Suicide programme is to develop a culture of zero suicide where patients, families and carers feel supported to manage illness when in crisis.

By March 2018:

- BHFT staff will have received suicide prevention training and feel confidence in their practice. In the event of a suicide occurring, they will feel they had done everything in their power to avoid that outcome.
- BHFT will have risk management and safety plans which patients and carers recognise, understand, and consider being valid and useful.
- BHFT will have the evidence to demonstrate the same.
- BHFT will have identified local and national resources aimed at helping people who feel suicidal.

Benefits to be realised through the Zero Suicide programme are as follows:

- Staff have confidence in their practice and ability to work with patients in crisis.
- Patients and carers will know what to do in a crisis.
- Potential reduction in suicide.
- Potential for reduction in waste (via QI methodology) as patients become more able to cope with periods of crisis.
- Staff will feel more supported by the organisation to do their work effectively (including less exposed to criticism).
- Staff will have access to a broader range of resources that can assist them in their work.

Through 2016 – 2018 BHFT will be running targeted promotional campaigns to raise awareness with key at risk groups and provide signposting to local resources.

Areas of High Frequency

Due to their geography, design or operational use, there are places which present easier access to the means of suicide than others. This could be as a result of their isolation from staff operating their functions; because they are more generally isolated from crowds and the general public: or because life-threatening hazards exist which are generally mitigated by normal operation. They may have become known as places where suicides have occurred previously, either via media reports, or word of mouth.

The Railway Network

The railway network, mostly operated by Network Rail, is in places associated with higher frequencies of suicides, injurious attempts at suicide and suicide attempts and other incidents of people in hazardous positions which do not cause physical injury. The rail network in Berkshire includes a section of the main Great Western Railway routes from London to Wales and the South West, as well as sections of suburban rail lines and minor branch lines. The Great Western lines feature high-speed trains, and is presently being electrified by means of overhead cables. Most of the suburban rail lines are electrified using a third rail system. As well as a high volume of passenger trains, most local lines also feature freight trains operating throughout the day and night.

On average there are 255 suicides on the network per annum. Rail staff particularly drivers, are likely to be severely traumatised by these events and some may never return to work and therefore might need to access support services because of that. Network Rail operates a comprehensive programme of suicide prevention, working to reduce the potential for suicides to occur on the rail network and the industry sees its potential as going beyond that by seeking to do all it can to prevent suicides in its neighbouring communities. In 2015 Network Rail, together with British Transport Police, and The Samaritans agreed a process whereby any location that experienced three suspected suicide or injurious attempt incidents (or a combination of the two) would be subject of an escalation process. This would mean that enhanced working would be taken by all three parties in order to prevent further incidents at that that location. In Berkshire, there are locations where this process has been enacted. Actions taken at these locations include engineering solutions, such as the replacement of crossing with overbridges; or the fencing off of platforms on non-stopping fast lines; and the placement of Samaritans posters across the location.

RECOMMENDATION
That local authority public health teams take the leadership for liaison with any "Escalation Process" in their area, and report on progress to the Steering Group.

The Motorway and Roads Network

Most motorways and trunk roads (the strategic road network) are the operational responsibility of Highways England, with most other roads being the responsibility of local authorities, whilst some roads and byways are in private ownership. In Berkshire, the main London to South Wales Motorway, the M4 passes through the length of the county through all of the six unitary authorities and is managed by Highways England,

whilst the adjoining A329(M) motorway is the responsibility of Wokingham Borough Council. The speed of traffic on these roads and other major roads together with their overbridges provide places which can give access to the means of suicide. In 2013, the Highways Agency Traffic Officer Service attended 293 of 652 suicide/attempted suicide incidents on the strategic road network. Between April 2013 and December 2014, there were over 1,500 incidents which were brought to the attention of a Traffic Officer (Sutherland, 2015). Definitions in this area are not clear, but this does seem to indicate an increase in the reporting of road network incidents, if not in the number of incidents themselves.

RECOMMENDATION
That the Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.

Car Parks and Tall Buildings

Berkshire towns feature a number of multi-storey car parks of which some in the management or ownership of the Local Authorities. There are also many other tall buildings both residential and commercial, and together these locations can sometimes provide an access route to a means of jumping from a height.

The Horsham branch of The Samaritans is working with a local shopping centre and car park where suicides have occurred. They offer sessions for the car park attendants who are generally the first on the scene. They also have an arrangement with the shopping centre to call Samaritans if there is an incident, either to support the staff involved or to support shoppers/shop workers more generally if the incident was widely witnessed. (Sutherland, 2015). This is a simple intervention in which suicide prevention training could be incorporated.

Local Authority Settings

Local authorities may be responsible as owners, operators or managers of other facilities and locations where suicides may take place. This may be because of their isolation or due to their inclusion of specific means of suicide within them. Generally the local authorities in Berkshire look after many hectares of open space; parkland; and woodland, some of which may be managed as part of the highways network; but with most likely to be part of an open spaces portfolio. There is also significant waterside public realm managed or owned by the authorities. The risks at these sites include strong, tall trees as a means of hanging; access to water features such as lakes, rivers and canals which pose a risk of drowning; and dense undergrowth which could allow a person to die through neglect and exposure. Council staff and contractors may have an enhanced role to play in identifying suicide risks and in supporting people who appear to be in distress

RECOMMENDATION
That local authority public health teams work with other council departments such as car parks and open space services to identify local actions to prevent suicide including staff awareness training.

Mental Health Crisis Care Concordat

The Mental Health Crisis Care Concordat is a national agreement between 22 national agencies involved in the care and support of people in crisis and includes health, policing, social care, housing, local government and the third sector. It sets out how these agencies will work together better to make sure that people get the help they need when they are having a mental health crisis. Local areas have submitted declarations and developed action plans for the improvement of local mental health crisis care for their areas.

The Concordat focuses on four main areas:

- Access to support before crisis point – making sure people with mental health problems can access help 24 hours a day and are taken seriously.
- Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- Quality of treatment and care when in crisis – people are treated with dignity and respect, in a therapeutic environment.
- Recovery and staying well – preventing future crises by ensuring that people are referred to appropriate services.

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. This strategy includes and reflects some of the key messages and recommendations from the concordat, aiming to reinforce a commitment by partners to work together in preventing and managing crises.

The local Crisis Care Concordat has, common to this strategy, been set at Berkshire-wide level, and has a comprehensive action plan, and certain actions include specific suicide prevention actions. These relate to the work of British Transport Police and the escalation process and staff training issues. They are more detailed than the recommendations and actions set out in this strategy, but there is strategic fit. There is a need to ensure full reference to this strategy in the Crisis Care Concordat action plans, and for further synergies to be explored.

RECOMMENDATION
Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat.

Gap Analysis and Emergent Berkshire-Wide Concerns

A gap analysis was undertaken by members of the Steering Group to identify the areas of the National Strategy which were not seen to be adequately addressed across Berkshire, taking into account the results of the local Suicide audit and the demography of the six unitary authorities. Some emergent concerns have also been captured which reflect discussion on the audit findings.

High Risk Groups

This strategy recognises that individuals may fall into two or more high-risk groups. Conversely, not all individuals in the group will be vulnerable to suicide. Other risk factors, such as loneliness, social circumstances and physical illness, must also be considered within the wider context or risk (Preventing suicide in England, Department of Health, 2012).

Berkshire is home to the University of Reading and other higher and further education establishments. Although the risk of suicide in the student population locally has not been established, recent ONS data (ONS, 2012) has shown a substantial increase nationally in both male and female suicides in the student population from 2007-2011.

Carers and people with long-term conditions have been highlighted as a local population at particular risk and this has been reinforced by the investigations into domestic homicides where a partner had subsequently taken their own life or attempted to. Adult Social Care and Public Health Outcomes Frameworks record measures of carer social interaction and that of people receiving care which give an insight into the vulnerabilities of these groups, and these are highlighted in the PHE Suicide Prevention Profiles. Not all people with a long-term health condition will be captured within these data, however; and the impact of symptoms such as chronic pain and reduced mobility, and access to certain medicines make this a group with heightened risk and access to means of suicide.

Berkshire no longer contains a prison. People in the criminal justice system will be imprisoned in neighbouring counties, which could make access visits more difficult for family and friends leading to increased isolation for the imprisoned.

Self-Harm continues to be an important risk factor for suicide and growing evidence to support using self-harm as an outcome measure for suicide prevention work with evidence showing that hospital presentation following self-harm is a clear risk factor for suicide (Hawton et al. 2012). There are around 200,000 episodes of self-harm that present to hospital services each year in England, although the true scale of the problem is not known as many people who self-harm do not attend A&E, or seek help from health or other services. Around 50% of people who die by suicide had a history of self-harm, in many cases with an episode shortly before their death, and around 15% of those who die by suicide have carried out an act of self-harm leading to presentation at hospital in the year before their death (PHE 2016).

The table below shows the rates of self-harm and suicide in the six authorities in Berkshire from the PHE Suicide Prevention Profiles (PHE, 2016A). All authorities have lower rates than England, although there is quite some variation across the authorities. It is important to ensure implementation of the NICE standards and pathways CG16 and CG133 for managing patients who self-harm.

Indicator	Period	England	SE England	Bracknell Forest	Reading	Slough	West Berkshire	Windsor & Maidenhead	Wokingham
Hospital stays for Self-Harm	2014-15	191.4	193.1	118.3	130.0	162.2	127.0	150.6	91.1
Suicide Rate persons	2013-15	10.1	10.2	8.1	11.0	8.8	7.0	7.1	6.0
Suicide rate (male)	2013-15	15.8	15.9	*	19.0	14.8	*	*	*
Suicide rate (female)	2013-15	4.7	4.8	*	*	*	*	*	*

Source: PHE Prevention Profiles. 2016

RECOMMENDATION
Implement the NICE guidelines on self-harm, specifically ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment.

Tailor approaches to improve mental health in specific groups

Work on detailed Mental Health Strategies is underway across the Berkshire East and Berkshire West health systems. It will be important to ensure a good strategic fit between this strategy and those that are developed. Mental health and wellbeing promotion will remain important objectives of both strategies.

RECOMMENDATION
Work to provide and commission interventions which improve the public's mental health. These may include: awareness of mental health and peer support in young people; anti-bullying campaigns in schools; addressing stigma and social isolation in older people; workplace health promotion and support with local business; working with police on mental health literacy; and addressing issues relevant to the local population.

Support research, data collection and monitoring

With real-time surveillance giving information on suicides and many near fatal self-harm events, there is concern that not all events will be recorded, for instance those attempted suicides which occur on the highways network.

There is further analysis of Coroner's case notes that is recommended as good practice, such as the last contact with a GP which have not been captured in the last local audit. A new audit should be run with this new category for deaths in the period 2014-16, beginning as soon as practicable. This can then be appraised alongside data received through real-time surveillance; gaps identified and protocols and policies put in place to

ensure that data can be confidentially shared for the purposes of identifying trends and clusters in order to take appropriate preventative actions.

RECOMMENDATION

Develop working relationships between individual coroners and local public health teams ensure local plans are evidence based and responsive. Coroners can be invited to become formal members of any local suicide prevention groups or networks

Coroners can also inform the local authority or Director of Public Health if they identify particular areas of concern, e.g. locations used for suicide, possible clusters of suicide, increase in a particular method or new and emerging method of suicide.

Refresh the Berkshire-wide Suicide Audit for deaths in the period 2014-16 to include new categories based on best practice.

Berkshire-Wide Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:	Delivery Lead
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire.	1 April 2017	Lead Consultant Mental Health
		All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners.	1 April 2017	Local PH Mental Health Leads
		Launch of strategy at multi-agency suicide prevention summit.	15 Oct. 2017	Strategic DPH
		Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	15 Oct. 2017	Local PH Mental Health Leads
		Develop Berkshire-wide information sharing protocols to best utilise real time surveillance of suicides and near misses, in order to respond promptly to local trends and risks to reduce risk of clusters, and inform future service delivery.	30 July 2017	Lead Consultant Mental Health
		The Steering Group revisit their terms of reference and membership and become known as the "Berkshire Suicide Prevention Steering Group", with the aim of providing the governance to this strategy and its action plans.	1 April 2017	Steering Group Members
		Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat.	1 April 2017	Lead Consultant Mental Health
National Strategy				
1. Reduce the risk of suicide in key high-risk groups	Men	Evaluate the Berkshire-Wide CALMzone initiative and agree Berkshire-wide commissioning of specific support services for men for future years. To include future commissioning of CALMzone for younger men; and services for middle aged men and older men.	15 Oct. 2017	Lead Consultant Mental Health
	People who self-harm	Ensure agencies have plans to Implement the NICE guidelines on self-harm	15 Oct. 2017	Lead Consultant Mental Health
	People who misuse substances	Ensure local strategies and contracts for DAAT services include suicide prevention objectives.	Ongoing work	Local PH Mental Health Leads

	People in mental health care	Support BHFT in its Zero Suicide Approach	Ongoing work	Steering Group Members
	People in contact with the criminal justice system	Through Community Safety Partnerships, identify local actions to prevent suicide in those in contact with the criminal justice system.	30 July 2017	Local PH Mental Health Leads
	Occupational groups	Ensure local health trusts and providers can demonstrate actions to prevent suicide and promote metal wellbeing amongst their staff.	30 July 2017	Steering Group Members
		Identify particular local action plans for those in agricultural / land-based industries.	30 July 2017	Local PH Mental Health Leads
2. Tailor approaches to improve mental health in specific groups	Community based approaches	For the Steering Group to assess community-based interventions which may be best delivered at scale across the county.	Ongoing work	Steering Group Members
	Suicide prevention training	Coordinate a database on evidence based suicide prevention training programmes and providers across the county.	Ongoing work	Steering Group Members
	People vulnerable due to economic circumstances	For the Steering Group to solicit data from each LA on key indicators that may highlight risk: e.g. number of homelessness presentations.	Ongoing work	Steering Group Members
	Pregnant women and those who have given birth in last year	To undertake a needs assessment of this group in relation to suicide prevention.	30 July 2017	Local PH Mental Health Leads
	Children and young people	Through LSCBs, identify local actions to prevent suicide in children and young people.	30 July 2017	Local PH Mental Health Leads
3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work.	Ongoing work	Steering Group Members
		Investigate suicides on council owned land and properties, and agree a local action plan.	15 Oct. 2017	Local PH Mental Health Leads
		Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work	Local PH Mental Health Leads

		The Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.	1 April 2017	Lead Consultant Mental Health
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources).	Ongoing work	Steering Group Members
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide	20 July 2017 20 July 2017 Ongoing work 1 Sept 2017 1 April 2017	Lead Consultant Mental Health Local PH Mental Health Leads Local PH Mental Health Leads Local PH Mental Health Leads Local PH Mental Health Leads
6. Support research, data collection and monitoring		Refresh Berkshire-wide suicide audit to include deaths during 2014-2016 to include data on GP consultations. To update data on the JSNA summary on suicide.	30 July 2017 As per JSNA timetable	Local PH Mental Health Leads Local PH Mental Health Leads

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To be checked and formatted

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Samaritans. Men, Suicide and Society: Why disadvantaged men in mid-life die by suicide. Ewell; The Samaritans; 2012.

Sutherlands, R. PACTS: 26th Westminster Lecture for Samaritans on 'Working together to reduce suicide in transport'. 2015.

Preventing Suicide in England: 1 year on. 2014.

Appendix 1: Resources available

These need adding to and amending

Factsheet on managing suicide risk in Primary Care
http://www.connectingwithpeople.org/sites/default/files/SuicideMitigationInPrimaryCareFactsheet_0612.pdf

A free booklet on debt advice is available from:
http://www.moneysavingexpert.com/credit-cards/mental-health-guide#collect

Guide for health and social care workers to support people with debt and mental health problems written by the Royal College of Psychiatrists and Rethink Mental Illness:
http://www.rcpsych.ac.uk/pdf/FinalDemandcf.pdf

Primary Care Guidance on Debt and Mental Health from the Royal College of GPs and Royal College of Psychiatrists, due to be updated shortly:
http://www.rcgp.org.uk/clinical/clinical-resources/~/media/Files/CIRC/Mental%20health%20forum/Mental%20Health%20Page%20Sept%202013/PCMHF-Guidance-Debt-Mental-Health-Factsheet-2009.ashx

Leeds Bereavement Forum has produced a short document with details of local and national support services available.
http://www.leeds.gov.uk/docs/Bereavement%20leaflet%202013.pdf

Grassroots Suicide Prevention Brighton & Hove Suicide Prevention Strategy Group provides an excellent website full of practical suicide prevention expertise.
http://prevent-suicide.org.uk/suicide_safer_brighton_and_hove.html

RAID service saves money as well as improving the health and well-being of its patients.
http://www.bsmhft.nhs.uk/our-services/rapid-assessment-interface-and-discharge-raid/

NHS Cornwall and Isles of Scilly, in partnership with Outlook South West
http://www.outlooksw.co.uk/suicide-liaison-service

Children and Young People's Mental Health Coalition Resilience and Results:
http://www.cypmhc.org.uk/resources/resilience_results/

State of Mind is a Rugby League mental health and wellbeing initiative which aims to raise awareness and tackle stigma. The organisation aims to reach men who may not normally contact health and social care services, and signpost them to where support is available. A round of Rugby League fixtures is dedicated to State of Mind, which maximises the publicity. The focus is on promoting player welfare and resilience in local communities. Super League players act as ambassadors reaching fans and amateur players through presentations, meetings and social networking, with positive messages being specially commissioned and tweeted. Films with specific themes are available at www.stateofmindrugby.com

Samaritans Media Reporting Guidance:
http://www.samaritans.org/media-centre/media-guidelines-reporting-suicide

Appendix 2: Bracknell Forest Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	1 April 2017 1 April 2017 15 Oct. 2017 15 Oct. 2017
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men People in mental health care Occupational Groups Carers (including young carers) Socially isolated	Promotion of CALM to a wider audience Support BHFT in its Zero Suicide Approach Work with local Carers' support groups to highlight Mental Wellbeing issues and risk factors Multi agencies approach to identify individuals and sign posting for support/ local befriending service/ other services Increase local befriender 's awareness of Mental Wellbeing issues and Risk factors	1 June 2017 Ongoing work
2. Tailor approaches to improve mental health in specific groups	Community based approaches People vulnerable due to economic circumstances	Work with local Domestic Abuse Forum and Executive Group to provide support and information on suicide prevention To share local Suicide Prevention strategy/action plans/supporting materials with IAPT/Job Centre and other employment support agencies Increase agencies awareness of Mental Wellbeing issues and Risk factors	

3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources).	Ongoing work
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide.	20 July 2017 20 July 2017 Ongoing work 10 Sept. 2017 1 April 2017
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide.	As per JSNA timetable

Appendix 3: Royal Borough of Windsor and Maidenhead Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies. Establish a multi-agency steering group: terms of reference to be agreed. Group will also be responsible for reviewing communication between primary and secondary care including risk assessment and escalation protocols	1 April 2017 1 April 2017 15 Oct. 2017 15 Oct. 2017 Locally determined
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men Carers; The unemployed; Those who misuse substances Persons with a mental health diagnoses.	Build on existing local voluntary and community group programmes e.g. men in sheds. Promotion of Calm Support BHFT in its Zero Suicide Approach Ensure clarity for the dual diagnosis referral pathway with reference to Drug & Alcohol Service providers. Ensure adequate arrangements are in place for follow-up after discharge from secondary care Consider strengths and issues arising from the Berkshire crisis concordat relating to the Royal Borough of Windsor and Maidenhead.	Ongoing work Locally determined Ongoing work Ongoing work Ongoing work
2. Tailor approaches to improve mental health in specific groups		Map evidence of coverage by sector/organisation of self-harm and suicide prevention training.	Ongoing work

		Explore opportunities to deliver MHFA training to high risk group leads. Explore funding opportunities with HEE for Suicide prevention & Self Harm training.	
3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources). Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide. Map existing bereavement support and pathways.	Ongoing work Locally determined Ongoing work
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide.	20 July 2017 20 July 2017 Ongoing work 10 Sept. 2017 1 April 2017

6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide. Work with steering group members to review data about current levels of population need and service provision Work with steering group members to map areas of high risk through information on locations of deaths and attempts. Take action to reduce suicide enablers (e.g. install signage, barriers) in line with evidence base Undertake mapping relating to local suicide prevention and self-harm services.	As per JSNA timetable Locally determined Locally determined Locally determined

Appendix 4: Slough Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	1 April 2017 1 April 2017 15 Oct. 2017 15 Oct. 2017
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men People who misuse substances People in mental health care Occupational Groups	Promotion of CALM to a wider audience To partner with the drugs and alcohol team on reviewing the referral pathway for dual diagnosis. To ensure that information on how to access DAAT services and seek help are readily available for young men. Support BHFT in its Zero Suicide Approach To support SME business on the Slough Trading Estate on incorporating mental health and wellbeing in their policies and advise on how to improve staff well-being; i.e.; promote resilience training	Locally determined Ongoing work
2. Tailor approaches to improve mental health in specific groups	Community based approaches Suicide prevention training	To work with the community development team - to build community cohesion, etc. To identify and work with Housing and unemployment teams on MHFA training for staff To deliver MHFA training to managers of SME businesses in Slough To partner with NEET young people's	

		team and train staff on MHFA	
	People vulnerable due to economic circumstances Children and young people	To design a service information leaflet for new migrant arrivals and to ensure that all frontline services have an access to the leaflet. To partner with young people service to design an intergenerational programme addressing loneliness and social isolation	
3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources) To conduct a mapping of services available for those that have been bereaved by suicide Contact Samaritans SBCCG in order to identify Slough residents assessing the service and where they refer them to Contact the community mental health team to ensure all frontline staff have the information required to signpost patients to bereavement services To identify other local stakeholders and provide better information and support to those bereaved or affected by suicide	Ongoing work Locally determined
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the	20 July 2017 20 July 2017

		local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide To identify 'keywords' relating to suicide and how many hits are coming from Slough	 Ongoing work 10 Sept. 2017 1 April 2017 Ongoing work
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide.	As per JSNA timetable

Appendix 5: Reading Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies. Establish local oversight arrangements for development and delivery of Reading suicide prevention plan; including local links with Reading Mental Health Steering Group around local oversight of action plan delivery.	1 April 2017 1 April 2017 15 Oct. 2017 15 Oct. 2017 Locally determined
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men People in mental health care	Promotion of CALM to a wider audience Support BHFT in its Zero Suicide Approach	1 June 2017 Ongoing work
2. Tailor approaches to improve mental health in specific groups	Community based approaches Suicide prevention training Children and young people	Promote existing local voluntary and community group programmes e.g. via Reading Services Guide Delivery of Adult Mental Health First Aid Training Delivery of Youth Mental Health First Aid Training	

3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources) Promote effective signposting for those bereaved by suicide, e.g. via Reading Services Guide.	Ongoing work Locally determined
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide.	20 July 2017 20 July 2017 Ongoing work 10 Sept. 2017 1 April 2017
6. Support research, data collection and monitoring		Update Reading JSNA module on suicide and self-harm Work with Reading Mental Health steering group members to review data about current levels of population need and service provision Ensure local data and evidence is fed through to Berkshire level to support identification of wider trends and to share learning.	As per JSNA timetable

Appendix 6: West Berkshire Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire.	1 April 2017
		All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners.	1 April 2017
		Launch of strategy at multi-agency suicide prevention summit.	15 October 2017
		Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	15 October 2017
		Set up local quarterly meetings to review the action plan	Quarterly interval
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men	Further development of "Pie and a pint" interventions	Ongoing work
		Promotion of CALM to a wider audience	Ongoing work
	People who self-harm	Monitor levels of self-harm	
	People who misuse substances	Liaising with local substance misuse services	
	People in mental health care	Support BHFT in its Zero Suicide Approach	Ongoing work
2. Tailor approaches to improve mental health in specific groups	Community based approaches	Improve public awareness of suicide	
		Link with West Berkshire Emotional Health Academy	
	Suicide prevention training	Delivery of Adult Mental Health First Aid Training	
	Children and young people	Delivery of Youth Mental Health First Aid Training and MHFA Schools Training	

3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 October 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources) Seek views of those with lived experience on draft action plan Promotion of Newbury SOBs group	Ongoing work Locally determined Ongoing work
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide	20 July 2017 20 July 2017 Ongoing work 10 Sept. 2017 1 April 2017
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide. Develop infographics to share with public. Link to W Berks mental health strategy Link to W Berks health and wellbeing strategy	As per JSNA timetable Locally determined

Appendix 7: Wokingham Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire.	1 April 2017
		All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners.	1 April 2017
		Launch of strategy at multi-agency suicide prevention summit.	15 Oct. 2017
		Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	15 Oct. 2017
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men	Promotion of CALM to a wider audience	1 June 2017
	People in mental health care	Support BHFT in its Zero Suicide Approach	
	Occupational Groups	Awareness raising and training for local businesses on identifying early signs and how to respond.	Ongoing work
	LGBT groups	Working with local services such as TVPS.	
	Carers (including young carers) and People with LTC	Work with local carer groups to raise awareness of Mental Health risks and prevention, promote local befriending and support groups.	
	People who misuse substances	Work with the local treatment provider to ensure that risk of suicide and mental health are part of the assessment.	
2. Tailor approaches to improve mental health in specific groups	Community based approaches	Engage with local groups such as faith groups and befriending services.	
		Wellbeing work with tenants services	
	Suicide prevention training	Plan and prioritise a programme of suicide prevention training and integrate into MECC work stream.	

3. Reduce access to the means of suicide		Support Network Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources). Review the availability of support for families and communities bereaved by suicide and affected by near misses. Promote the local Wokingham SOBS group, working with them to identify gaps.	Ongoing work Locally determined Ongoing work
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide	20 July 2017 20 July 2017 Ongoing work 1 Sept. 2017 1 April 2017
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide.	As per JSNA timetable

Appendix 8: Membership of the Berkshire Suicide Prevention Steering Group as at December 2016

Angela Baker	Deputy Centre Director	PHE South East
Angus Tallini	GP	Newbury & District CCG (West)
Anthony Barrett		NHS
Belinda Dixon		RBWM
Caroline Attard		Berkshire Healthcare Foundation NHS Trust
Chris Allen		NHS
Colin Bibby		SEAP
Daren Bailey		Berkshire Healthcare Foundation NHS Trust
Darrell Gale	Consultant in Public Health	Public Health, WBC
Debbie Daly	Director of Nursing and Quality	NHS West
Eugene Jones		Berkshire Healthcare Foundation NHS Trust
Geoff Dennis		Berkshire Healthcare Foundation NHS Trust
Gillian McGregor		Reading Council
Gwen Bonner		NHS
Helen Ranasinghe		Samaritans
Helena Fahie	Public Health Support Manager	PHE South East
Jason Jongali		NHS West
Jillian Hunt		Bracknell Forest
Jo Baskerville		NHS West
Jo Greengrass		NHS
Jonathan Groenen		Thames Valley Police
Julia Wales,		Slough Council
Kate Ford		Thames Valley Police
Kate Jahangard		Reading Council
Katie Simpson	GP	NHS East
Ken Hikwa		Berkshire Healthcare Foundation NHS Trust
Kim McCall		Reading Council
Lesley Wyman	Consultant in Public Health	West Berkshire Council
Lisa McNally	Consultant in Public Health	Bracknell Forest
Lise Llewellyn	Strategic Director of Public Health	Public Health Services Berkshire
Natalie Mears	Public Health Programme Officer	RBWM
Mark Spencer		Thames Valley Police
Sally Murray		NHS West
Nadia Barakat		NHS East
Nick Davies		RBWM
Rachel Johnson	Public Health Programme Officer	West Berkshire Council
Ramesh Kukar		Slough Council of Voluntary Services
Reva Stewart		Berkshire Healthcare Foundation NHS Trust

Rukayat Akanji-Suleman	Public Health Programme Officer	Slough Council
Sarah Bellars		NHS
Sue McLaughlin		Berkshire Healthcare Foundation NHS Trust
Susanna Yeoman		Berkshire Healthcare Foundation NHS Trust
Tandra Forster		West Berkshire Council
Tanya Demonne		Royal Berkshire Hospital Foundation NHS Trust
Timothy Foley		SEAP
Tony Dwyer		Berkshire Healthcare Foundation NHS Trust
Trudi Sams		

Back Cover to be designed and add contact details of Shared Team etc.

URL of Strategy

Report Title:	Royal Borough of Windsor and Maidenhead's suicide prevention action plan
Contains Confidential or Exempt Information?	NO - Part I
Meeting and Date:	Health and Wellbeing Board - 15 February 2017
Responsible Officer(s):	Hilary Hall, Head of Commissioning - Adults, Children and Health
Wards affected:	All

www.rbwm.gov.uk
Royal Borough of Windsor & Maidenhead

REPORT SUMMARY

1. The NHS Five Year Forward View for Mental Health sets a target on all NHS agencies and partners to reduce the current level of suicide by 10% by 2020.

2. Responsibility for suicide prevention strategies and action plans at a local level lies with local government through health and wellbeing boards.

3. The borough is launching the 'Year of Mental Health', suicide prevention falls under pillar one, mental health in all policy approach.

4. The objective of this paper is to, in principle, agree to the borough's local suicide prevention action plan being collaboratively developed by a task and finish group.

1. DETAILS OF RECOMMENDATION(S)

RECOMMENDATION: That the Health and Wellbeing Board notes the report and:

i) Agree that a task and finish group, led by the Principal Member for Public Health and Communications, is established with a view to collaboratively developing the borough's suicide prevention action plan, using local data and information. Success will be measured using SMART performance indicators.

ii) Agree to set-up a local suicide prevention steering group which will oversee the delivery of the borough's suicide prevention action plan.

2. REASON(S) FOR RECOMMENDATION(S) AND OPTIONS CONSIDERED

2.1. In England, responsibility for the suicide prevention action plan and strategy lies with local government through health and wellbeing boards. Developing a suicide prevention strategy and/or action plan that is based on the national strategy and local data is one of the three recommendations from the All Party

Parliamentary Group on Suicide Prevention (APPG). The APPG recognises that continued local leadership and commitment to take action is needed to ensure England achieves the recommendation in the Five Year Forward View from Mental Health for local authorities to have multi-agency suicide prevention plans in place in 2017.

2.2. Berkshire's suicide prevention strategy, 2017-2020, supports the achievement of a reduction in suicide of 10% by 2020. This is underpinned by recommendations in the Five Year Forward View on Mental Health and articulated locally into Sustainability and Transformation Plans produced by groups of CCGs. A stretch target to achieve a 25% reduction from 2014 levels by 2020 has been proposed by the Berkshire Suicide Prevention Steering Group.

2.3. Preventing suicides is a complex and challenging issue, but there are effective solutions for many of the individual factors which contribute towards the risk of suicide. Suicide prevention work is cost-effective when conducted in partnership and based on best evidence.

2.4. It should be noted that suicide prevention leads from across Berkshire attended a PHE Suicide Prevention masterclass in December 2016. Learning from which has been used to frame the county and borough wide strategy and plan. The borough's suicide prevention action plan, 2017/18, see section 9, table 6, will use the recommended six priority areas for local action and align local and national strategy. The priority areas are as follows,

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

2.5. A task and finish group and steering group would allow the local action plan to be further developed in consultation with partners; with delivery overseen by key stakeholders. In addition, the APPG will work with local authorities and ensure that local plans are updated annually to drive improvement and ensure that the newest information and best practice are incorporated.

2.6. The process of developing the local action plan is proposed as follows:

- The Principal Member for Public Health and Communications will lead a suicide prevention task and finish group which will oversee the development of evidence based actions with SMART performance indicators.
- The action plan will use the recommended six priority areas as a framework and national & local evidence and intelligence[ii].

- Public health will work with Principal Member for Public Health and Communications to establish a local suicide prevention steering group which will oversee the delivery of the action plan.

- The action plan will be updated annually, overseen by the steering group. The steering group will function to drive forward improvements and ensure that the most up to date information and best practice are incorporated, as recommended by the APPG.

2.7. Suicide figures for Berkshire broadly reflect national trends; results from the most recent local suicide audit (2015) are as follows,

- More males completed suicide than females.
- 70% of the deaths recorded between 2007-2014 were in age group 30-59 years.
- The percentage of deaths among the unemployed rose from 13% in 2007 to 38% in 2014.
- The most common method for suicide was hanging/strangulation.

2.8. From 2013 to 2015 there were 27 suicides or deaths of undetermined intent in the Royal Borough of Windsor and Maidenhead; a rate of 7.1per 100,000[iii]. Graph 1 shows the suicide rate 2001-2003 to 2013-15. Although the borough remains lower than the England, it remains a national and local priority.

Graph 1: RBWM: Age-standardised rate per 100,000 population (3 year average), 2001-2015 [iv]

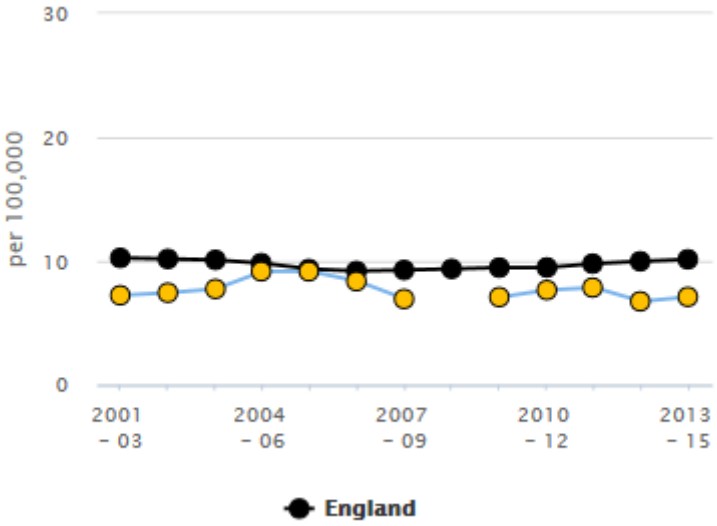

Table 1: Options

Option	Comments
Agree to a task and finish group further developing a local suicide prevention action plan that based on the six local priority areas for action and is based on local and national evidence. **RECOMMENDED**	A locally developed plan will ensure focus on, and alignment with, local need.
(2) Agree to establish a local suicide prevention steering group which will oversee the delivery of the borough's suicide prevention	A borough task and finish group will ensure delivery at a local level.

Option	Comments
action plan. **RECOMMENDED**	

3. KEY IMPLICATIONS

Table 2: Key outcomes

Outcome	Unmet	Met	Exceeded	Significantly Exceeded	Date of delivery
Task and Finish group develops evidence based actions and SMART KPIs for the local action plan	1st May 2017	1st April 2017	30th March 2017	28th February 2017	1st April 2017
Steering group set-up and overseeing implementation of action plan	31st July 2017	30th June 2017	3rd April 2017	1st May 2017	30th June 2017
All actions within the action plan completed, 2018/19 action plan developed	30th April 2018	31st March 2018	3rd January 2018	1st November 2017	31st March 2018

4 FINANCIAL DETAILS / VALUE FOR MONEY

4.1 The economic and social cost of a suicide is substantial. The average cost of suicide in someone of working age in England is estimated to be £1.67 million [v].This includes direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering of those bereaved or affected by suicide. For every person who dies by suicide at least 10 people are directly affected.

4.2 Cost implications relating to the action plan are not yet known, however it is anticipated that these will be absorbed into existing budget lines.

5. LEGAL IMPLICATIONS

5.1 The recommended combined option will bring the borough in line with national recommendations and documents, including the All Party Parliamentary Group for suicide prevention.

6. RISK MANAGEMENT

6.1 In order to ensure suicide trends go in the right direction it is imperative that the Royal Borough has a robust evidence based action plan developed in partnership.

Risks	Uncontrolled Risk	Controls	Controlled Risk
Insufficient time to develop and agree an action plan.	Medium	Establish a virtual task and finish group	Low

7. POTENTIAL IMPACTS

7.1 An Equality Impact Screen/Assessment will be conducted on the completed action plan.

8. CONSULTATION

8.1 If the recommended combined option is endorsed by the Health and Wellbeing Board the action plan will be collaboratively developed by a task and finish group, which will consist of local stakeholders and be led by the Principal Member for Public Health and Communications.

9. TIMETABLE FOR IMPLEMENTATION

9.1 The timetable for implementation is set out in table 5.

Table 5: Implementation

Date	Details
15 February 2017	Health and Wellbeing Board endorse recommendations
By 31 March 2017	Task and finish group set-up by Principal Member for Public Health and Communications and action plan in development.
By 30 June 2017	Local suicide prevention steering group established by Public Health and Principal Member for Public Health and Communications; overseeing the delivery of the borough's suicide prevention action plan.

9.1 The Royal Borough of Windsor and Maidenhead Action Plan 2017-18 (pre-Task and Finish group) which appears in the Berkshire suicide prevention strategy, 2017-2020, is at table 6. The draft actions listed for 2017-18 use the nationally available guidance, data and locally available data as well as the most recent suicide audit and Berkshire suicide prevention strategy.

Table 6: RBWM Proposed Suicide Prevention Action Plan

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale/lead	Delivery Lead
Overarching Aims		Establish a multi-agency steering group: terms of reference to be agreed. Group will also be responsible for	Locally determined	To be locally determined

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale/lead	Delivery Lead
		reviewing communication between primary and secondary care including risk assessment and escalation protocols		
National Strategy				
1. Reduce the risk of suicide in key high-risk groups	Men Carers; The unemployed; Those who misuse substances Persons with a mental health diagnoses.	Build on existing local voluntary and community group programmes e.g. men in sheds. Promotion of Calm Support BHFT in its Zero Suicide Approach Ensure clarity for the dual diagnosis referral pathway with reference to Drug & Alcohol Service providers. Ensure adequate arrangements are in place for follow-up after discharge from secondary care Consider strengths and issues arising from the Berkshire crisis concordat relating to the Royal Borough of Windsor and Maidenhead.	Ongoing work Locally determined Ongoing work Ongoing work Ongoing work	To be locally determined
2. Tailor approaches to improve mental health in specific groups		Map evidence of coverage by sector/organisation of self-harm and suicide prevention training. Deliver MHFA training to all managers in the RBWM. Explore opportunities to deliver MHFA training to high risk group leads. Explore funding opportunities with HEE for Suicide prevention & Self Harm training.	Ongoing work	To be locally determined
3. Reduce		Support Network	Ongoing work	

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale/lead	Delivery Lead
access to the means of suicide		Rail, British Transport police and The Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	15 Oct. 2017 Ongoing work	To be locally determined
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources). Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide. Map existing bereavement support and pathways.	Ongoing work Locally determined Ongoing work	
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications	20 July 2017 20 July 2017 Ongoing work 10 Sept. 2017 1 April 2017	

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale/lead	Delivery Lead
		team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide.		
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide. Work with steering group members to review data about current levels of population need and service provision Work with steering group members to map areas of high risk through information on locations of deaths and attempts. Take action to reduce suicide enablers (e.g. install signage, barriers) in line with evidence base Undertake mapping relating to local suicide prevention and self-harm services.	As per JSNA timetable Locally determined Locally determined Locally determined	

11. BACKGROUND DOCUMENTS

- 11.1 Department of Health (2012); Preventing Suicide in England: A cross-government outcomes strategy to save lives
- 11.2 HM Government (2014); Preventing suicide in England: One year on
- 11.3 HM Government (2015); Preventing suicide in England: Two years on
- 11.4 HM Government (2017): Preventing suicide in England: Third progress report
- 11.5 Berkshire Suicide Prevention Strategy 2017-2020. Not currently publicly available.

12. CONSULTATION (MANDATORY)

Name of consultee	Post held	Date sent	Commented & returned
Cllr Carroll	Principal Member	3/1/2017	Comments throughout returned 6/2/2017
Hilary Hall	Head of Commissioning ACH	31/1/2017	Comments throughout – returned 03/02/2017

REPORT HISTORY

Non-key decision	**Urgency item?** No
Report Author: Teresa Salami-Oru, Service Leader/Consultant in Public Health 01628 683505	

[i] Public Health England, (2016) local suicide prevention planning resource
[ii] Public Health England, (2016) local suicide prevention planning resource
[iii] Public Health England, (2017) Suicide Prevention Profile
[iv] Public Health England, (2017) Suicide Prevention Profile
[v] McDaid, D; Park A,L, & Bonin E (2014) Population-level suicide awareness training and intervention. Posted on September 10, 2014 in: Economics, Mental Health

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Department of Health

From David Mowat MP
Parliamentary Under Secretary of State for Community Health and Care

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

FAO Health and Wellbeing Board Chairs

Dear Chair,

14 DEC 2016

I am writing to you in your capacity as local Health and Wellbeing Board Chair to highlight the Government response to the independent Review of Choice in End of Life Care.

This document set out the Government's commitment to everyone approaching the end of life, and I ask you to consider this commitment at this important time for your local area as Sustainability and Transformation Plans (STPs) are further developed, and Clinical Commissioning Groups (CCGs) finalise Operational Plans for the coming years.

Our ambition is for everyone approaching the end of life to receive high quality care that reflects their individual needs, choices and preferences, regardless of where they live.

On 5th July, we set out plans to improve end of life care in England. Our proposals were based on a commitment to high quality, personalised end of life care that we are making to all people at, or approaching the end of life. The commitment states that everyone should be able to expect:

- honest discussions between care professionals and dying people;
- dying people making informed choices about their care;
- personalised care plans for all;
- the discussion of personalised care plans with care professionals;
- the involvement of family and carers in dying people's care;
- a key contact so dying people know who to contact at any time of day.

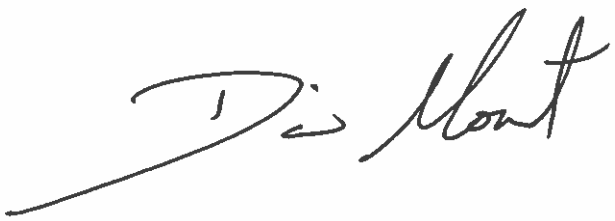
I am aware of the many priorities you have at a local level, but I am asking you to consider how you can encourage your colleagues locally to consider the importance of end of life care as local strategies and priorities are finalised.

A key element of the commitment is bringing together the NHS, social care and the voluntary sector to deliver seamless, person-centred care. Good end of life care is not the responsibility of one person or organisation: it happens because professionals and organisations work together.

There is a real opportunity over the coming years to ensure innovative ideas are put to work to deliver better outcomes for dying people. The Government fully supports the Ambitions for Palliative and End of Life Care Framework, which encourages local health leaders to develop strategies for palliative and end of life care which involve all providers and relevant stakeholders.

NHS England and the National Council for Palliative Care have launched a *Palliative and End of Life Care Knowledge Hub* bringing together resources and tools to support commissioners and providers to drive delivery of the Ambitions Framework. More information is available at: http://endoflifecareambitions.org.uk/.

In summary, I am asking you and your colleagues to consider how you can encourage action to improve end of life care, specifically through Operational Plans and STPs, to ensure everyone receives the high quality, personalised care at the end of life they deserve.



DAVID MOWAT

Better Care Fund Board – Q3 16/17 performance update

(inc Month 8 16/17 CSU data and RBWM data to end December 2016)

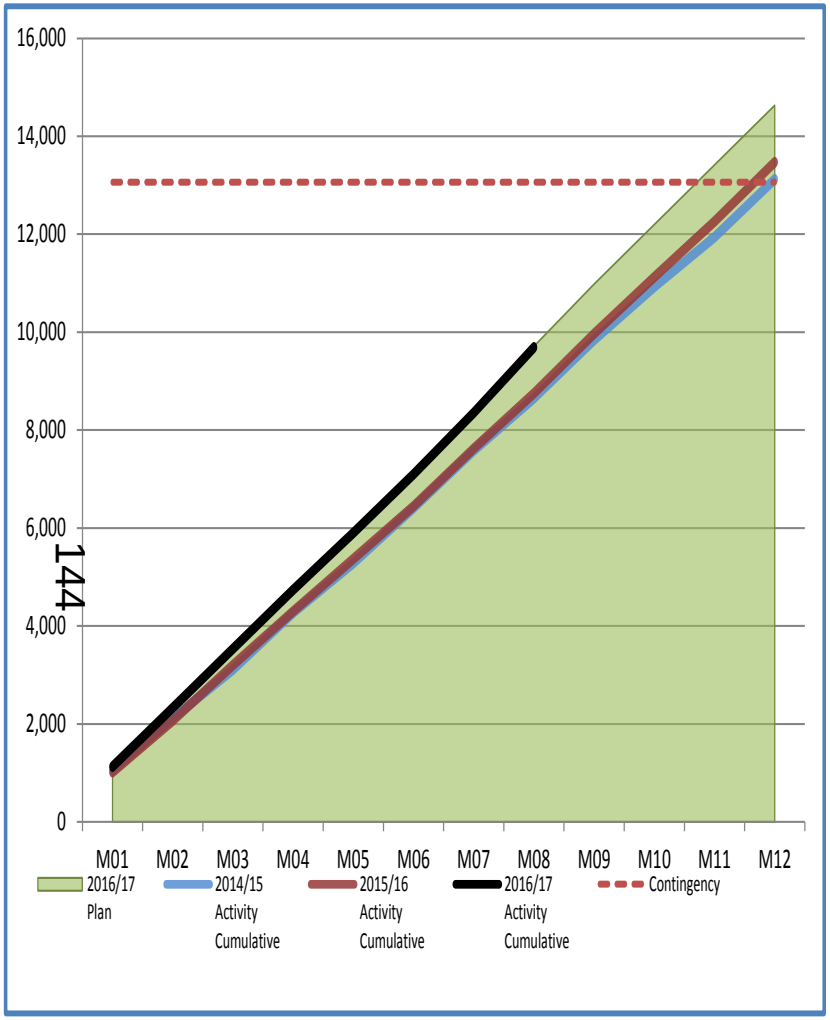
Slide	Summary of Performance against national BCF metrics 16/17	

2
3
4
	- Overall NEL admissions
	  - Falls related NELs
	  - 0-4 year old NELs	

5	- DTOCs	
6 -7	- Care Home placements	
8	- Patients still at home 91 days after STSR referral/support	
9	- Service User metric	
10 - ??	- Carers strategy update	

Report collated by Marianne Hiley, Better Care Fund Manager

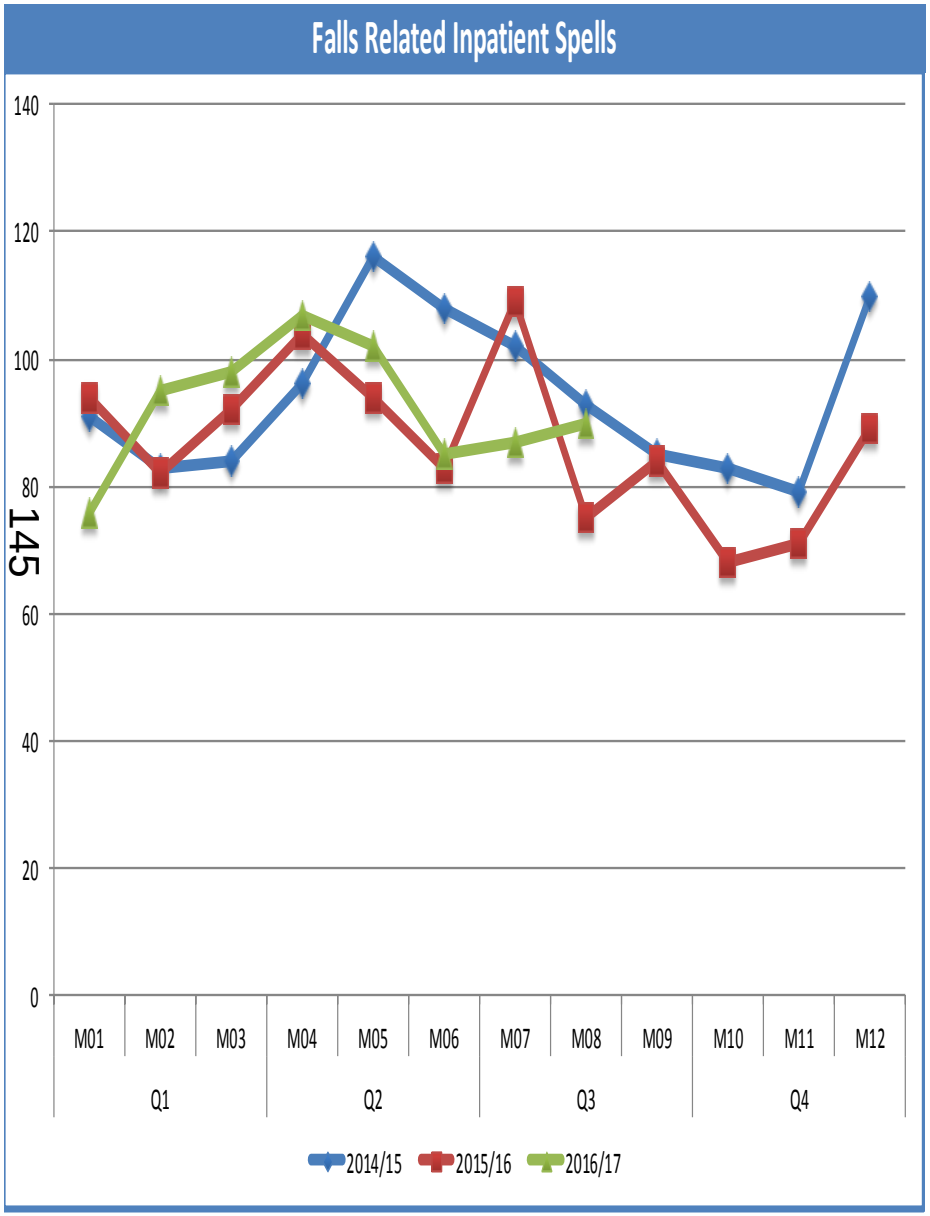
NEAs - RBWM performance to Month 8 2016/17



Key points:

- NEL admissions still under BCF target performance, but only by small margin.
- £600K performance fund will be needed to offset acute care requirements.
- Continuing containment of NEL admissions from care homes through close working across multi disciplinary teams.
- Programme of targeted GP practice visits to review NELs, referrals and other key performance criteria practice by practice.
- Intensification of identification and treatment of patients with high blood pressure/atrial fibrillation to reduce high levels of NEL admissions.
- Unexpected increase in 0-4yr old admissions across all localities in Thames Valley – best practice networking across Clinical Commissioning Groups.

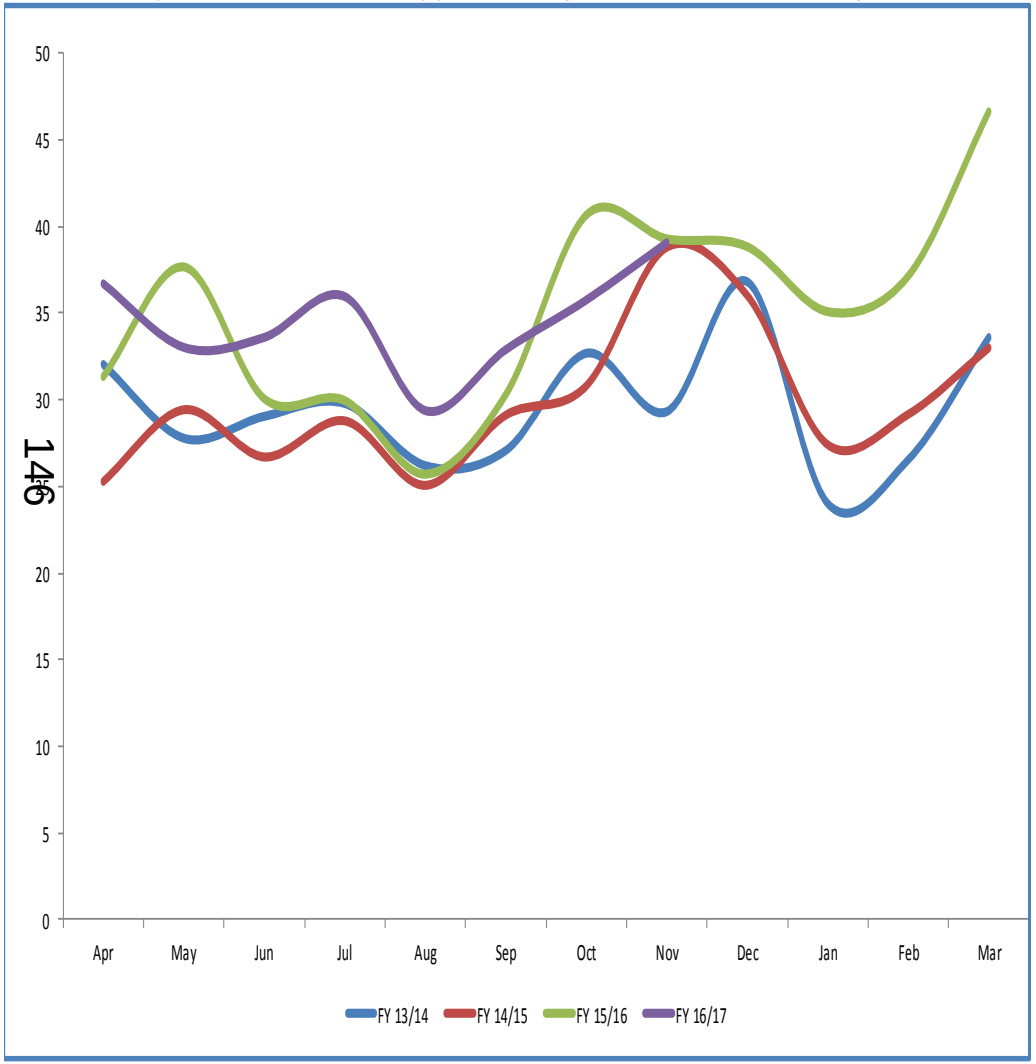
Falls related NEL admission – to Month 8 2016/17 Year on year comparison



Key points:

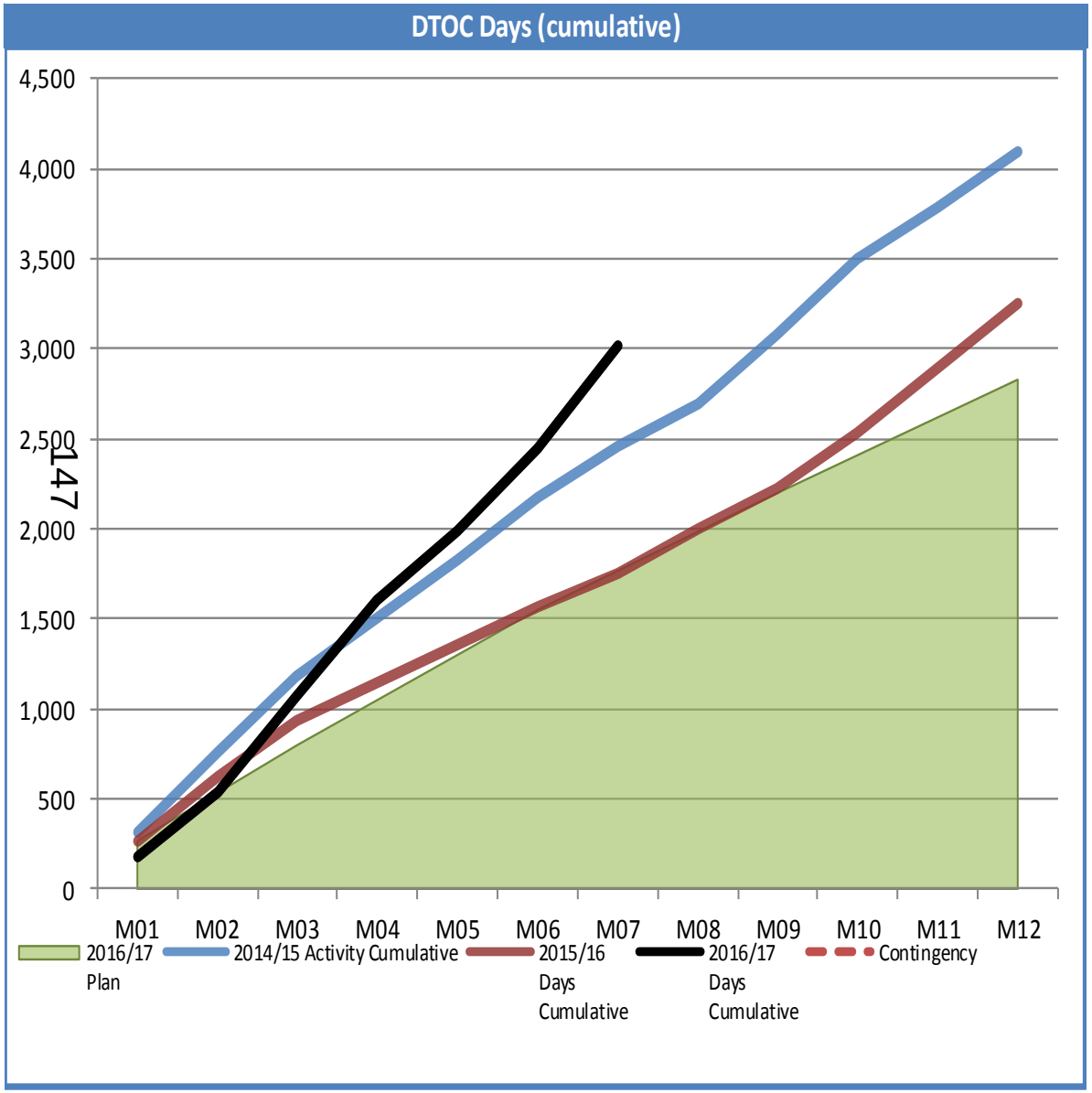
- Parameters for falls data analysis changed from last year – graph reflects revised performance using consistent measures across previous years.
- Review of all falls related pathways to improve appropriate referrals and use of all services available.
- BCF investment in OT and physio in Keep Safe Stay Well services to deliver sustained benefits to residents at risk.
- Promote use of assistive technology for residents with dementia.
- Pilot multifactorial assessment approach to case finding at Cedars practice – for intensive review and promotion cross all practices
- Public Health - Fit for Life Week – promotion of increased physical activity.

Note: this graph reflects data to Month 8 2016/17



- Unexpected increase in 0-4 year old admissions across all GP practices.
- Addressed through intensive programme of parent education, and programme of leaflets, identification of frequent flyers and joint discussion with Health visitors and GPs.
- Additional follow up campaign to promote flu immunisation which has had low take up across the region in spite of public health promotion.
- Hotline advice for GPs direct to paediatrics consultant trialled at Wexham – helpful reassurance and education, but not significantly impacting NELs.

Delayed Transfers of Care - performance against BCF 2016/17 target



Key points:

Significant pressure on all discharges nationally.

Local initiatives:

Alamac daily report – improved analysis/ definition of delays to manage patient flow.

1) patients newly agreed as ready for discharge.
2) Patients in assessment phase.
3) Patients ready to transfer.
4) Patients where agreed transfer date has been exceeded.

Frailty Unit pilot in Wexham to avoid admission / longer LOS

Discharge to assess – trial model with CHC patients moved to temporary care home bed in Slough.

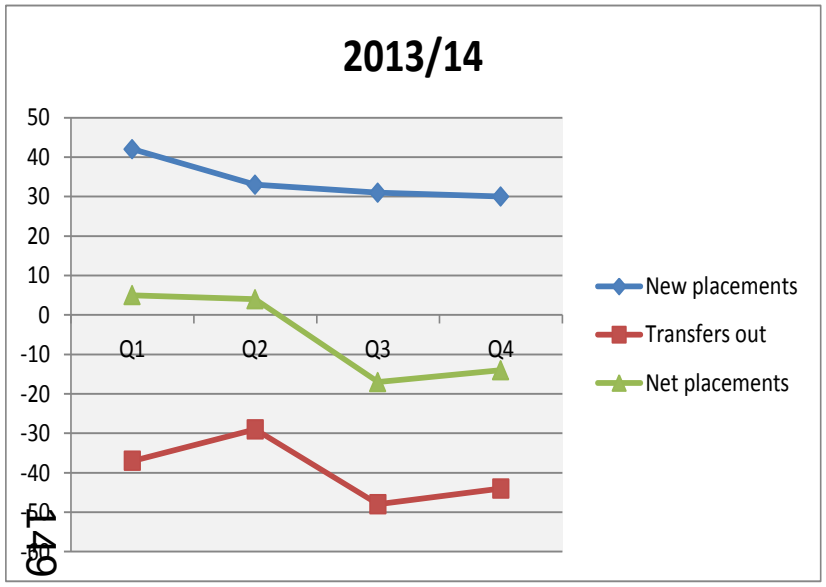
New placement in Residential and nursing homes – RBWM 2016/17 performance including data to end December 2016

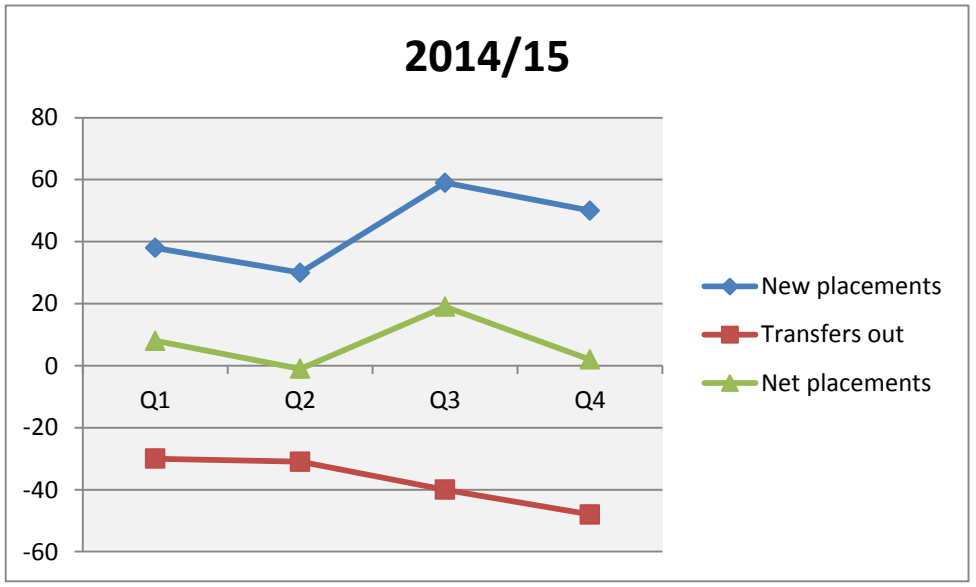
Nursing & Residential					
2016/17	Q1	Q2	Q3	Q4	Total
New placements	**37**	**52**	**45**	**3**	**137**
Transfers out	-39	-46	-47	-11	-143
Net placements	-2	6	-2	-8	-6

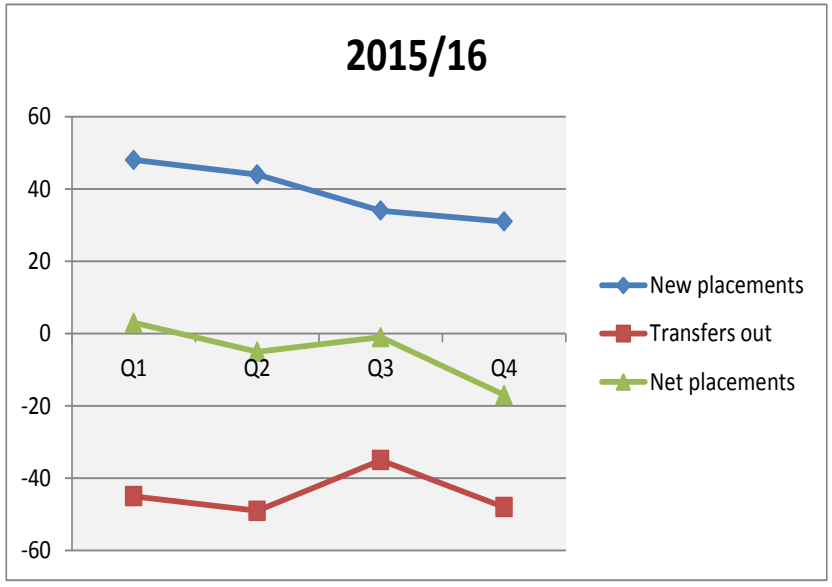
Target for 2016/17 – new placements – 160

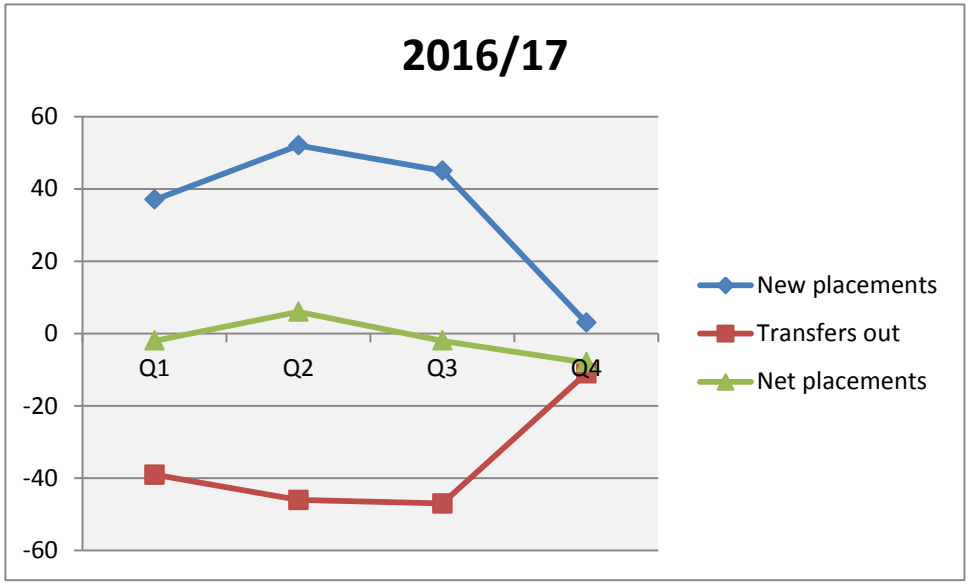
Target is still challenging but achievable

Care Home placements (nursing + residential) – year by year analysis



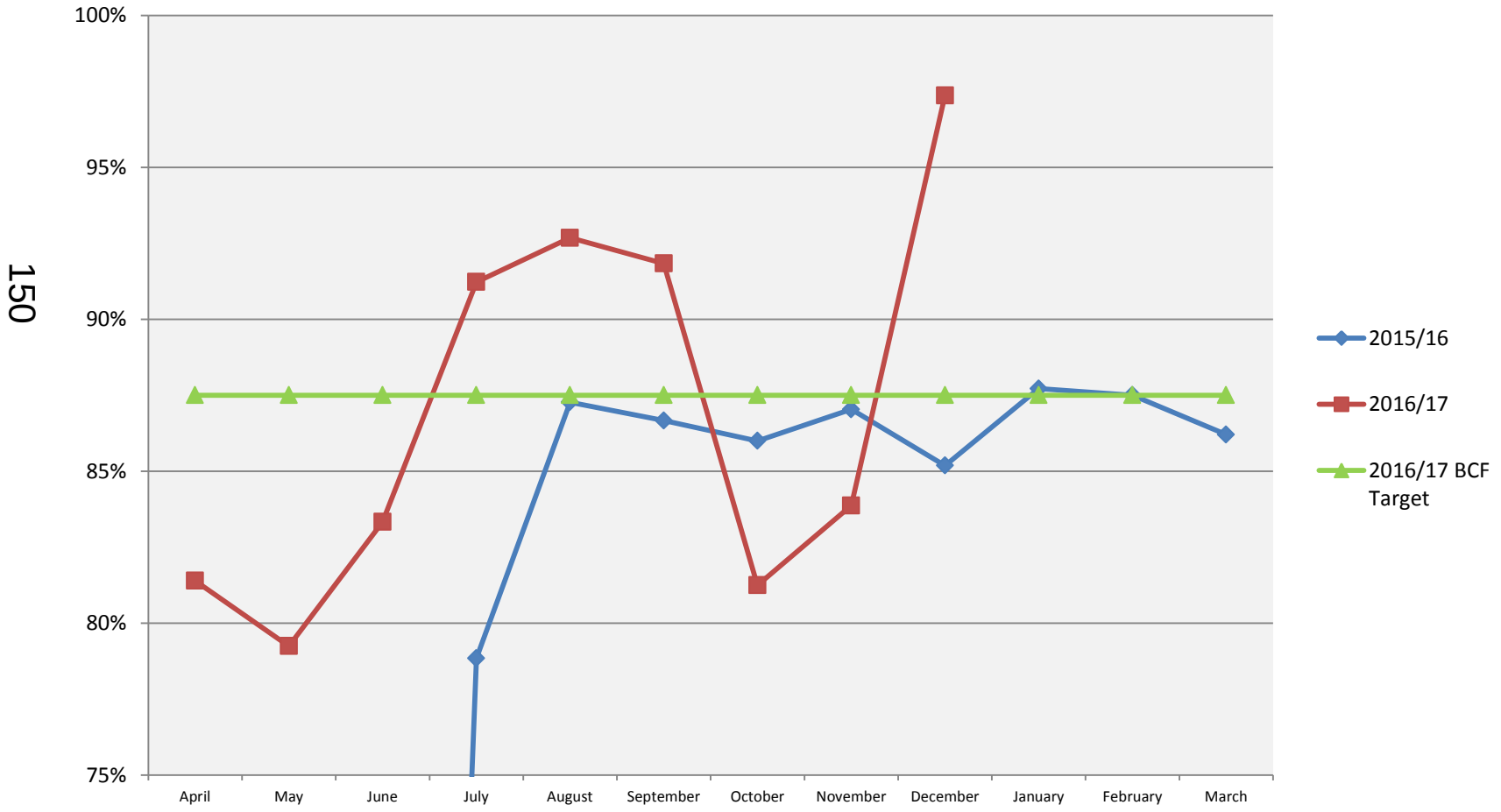






NI 125 % - proportion of adults (65+) who are at home 91 days after discharge

The data below shows the proportion of people who are at home 91 days after discharge from hospital from April 2015 onwards.. This figure excludes those residents who have passed away (RIP) which significantly improves our performance. BCF Performance Target Rate for the year is 87.5%. To ensure we have timely updates, the current months figure is looking up the exit status of referrals received 3 months ago.



Service User metric

- Successful bid for innovation funding from NHSE in December 2015 for £19K to trial model that combined service user feedback and service provider perspectives.

- Six survey questions + free text box for additional information – hand held app, easy to complete,

- Trialled with Short Term Support and Rehabilitation team – iterative improvements to the questions and recording to reflect :
  - First time or returning service user, type of package.
  - First introduction, mid term review, end of package.

- Well received by both service users and staff – has provided recognition of good service and opportunities for continuous improvement, particularly in importance of timely communications with residents. Extended beyond pilot stage to all STS&R. Business case under consideration for extending application to other service areas in Royal Borough of Windsor and Maidenhead.

- Further adaptation of the model being trialled for carer feedback at Runnymede practice as part of innovation project for RBWM and Surrey residents.

Spotlight on Carers – FB!

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Royal Borough of Windsor & Maidenhead

Integrated Carers Strategy and Delivery Plan

Carers Strategy Delivery Plan

www.rbwm.gov.uk
Royal Borough of Windsor & Maidenhead

- The Carers Partnership Board (CPB) brings together carers, local providers and local commissioners to deliver the Strategy plan
- Within the Delivery Plan, the term 'Carer' is used to encompass carers of any age, ethnicity etc.
- The revised Delivery Plan reflects the Carers' pathway, summarised below. It recognises that support is needed in the right format when it is needed by Carers.

Carers Strategy Delivery Plan

www.rbwm.gov.uk
Royal Borough of Windsor & Maidenhead

The following seven statements set the direction for implementing the Integrated Carers Strategy Delivery Plan:

1. I know I am a carer, and I'm confident that when I need information, guidance or support I can access it in a timely way
2. I access the services that are appropriate to my needs as a carer
3. I am confident that the Carers Assessment process works effectively to meet my needs as a carer
4. I can access a break from my caring responsibilities that helps me sustain my caring role
5. I access services that promote my health and wellbeing
6. I am able to maximise my educational and employment opportunities whilst being a carer, or having cared for someone
7. I am confident that my experience as a carer is valued and used to shape future services

Achievements to date

www.rbwm.gov.uk
Royal Borough of Windsor & Maidenhead

Key achievements to date for the Carers Partnership Board include:

- A broad and engaged membership
- Increased use of social media to target and support carers
- Targeted training courses for carers based on need and demand
- Chest clinic at Wexham – pilot to identify and support carers
- Review of Carers Assessment processes and documents
- Continuing promotion of carer identification at GP practices – e.g. promotional evening events with PPGs
- Specific project work on Direct Payments for carers to support their caring role
- Working with key providers to ensuring commissioned services deliver in line with local needs and demands
- Joining up support services for Young Carers and adult carers

Further information

www.rbwm.gov.uk
Royal Borough of Windsor & Maidenhead

Nick Davies

Chair, Carers Partnership Board

Service Lead – Adult Commissioning, RBWM

Fiona Betts

Lead for Carers

Commissioning Manager, RBWM

Any questions?

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