Rotherham Metropolitan Borough Council

BRIEFING	**TO:**	Health Select Commission
	DATE:	23 January 2020
	LEAD OFFICER:	Janet Spurling Governance Advisor, Assistant Chief Executive's Directorate 01709 255421
	TITLE:	Outcomes of Workshop on Suicide Prevention

1. Background

1.1 **Present**: Cllrs Keenan (Chair), Bird, Cooksey, R Elliott, Ellis, Jarvis and Walsh

1.2 **Apologies**: Cllrs Albiston and Williams

1.3 **Attendees**: Cllr Roche, Ian Atkinson - Rotherham Clinical Commissioning Group (RCCG), Ruth Fletcher-Brown - RMBC, Sharon Greensill - Rotherham Doncaster and South Humber NHS Trust (RDaSH), Lynsey Mould - RMBC, Matt Pollard - RDaSH, Glyn Shakespeare - South Yorkshire Police (SYP), Jean Summerfield - The Rotherham Foundation Trust (TRFT), Kate Tufnell - RCCG/RMBC, Andrew Wells - RMBC, and Jacqueline Wiltschinsky - RMBC.

1.4 **Purpose of the session**

1) To seek assurances regarding current activity, future plans and resources for work on suicide prevention and self-harm.

2) To scrutinise and have input into the draft action plan.

1.5 **Information**

A short presentation outlined work at both local level and at South Yorkshire and Bassetlaw Integrated Care System level on suicide prevention. Other supporting papers, including financial information and Public Health data on suicide prevalence rates and suicide prevention profiles, provided additional information and informed discussion with representatives from RMBC and partner agencies involved in this work.

The Draft Rotherham Suicide Prevention and Self-Harm Action Plan 2019-2021 was circulated in advance of the workshop to assist Members in developing their questions. Embedded within the multi-agency plan and contributing towards it is the RDaSH Suicide Prevention Action Plan 2019 – 2021.

2. Key Issues

Members went through the draft action plan in detail asking a number of questions in relation to the various workstreams and touching on broader issues in relation to the information provided. The key issues explored and responses from partners are outlined below.

2.1	**Funding** **After using quite a large sum of non-recurrent funding to date, how will this be handled in the future?** Commissioners were trying to avoid having a time-limited view and were taking an earlier opportunity to look at funding in year to see its impact and to prioritise where initiatives were doing well for small spend. NHS England were prescriptive regarding Clinical Commissioning Groups' spending sets parameters. Real time information would also advise future work. Recurrent funding for core provision was for crisis support (hospital and community) and IAPT (Improving Access to Psychological Therapies). A significant shift had been through putting in additional money above the core. Co-ordination of spending non-recurrent money was needed within the overall plan and discussion about how to move non-recurrent to recurrent if possible. Commissioning used different approaches and although some funding was non-recurrent dialogue about sustainability and how things might be done in a different way took place. For example, working with men's groups to see if they could tap in to other external monies. Future planning took place even if the money was non-recurrent at that time. **Scope to be creative whilst also meeting government priorities** Some leeway existed and regional colleagues would also advise. There would still be investment, for example support for people in crisis, but perhaps looking to do more downstream. **ICS-wide funded activity** The funding split from NHS England Suicide Prevention monies is ICS 20% and local 80%, and has funded the following activity:- • Coroners Audit • Real Time Surveillance and Bereavement Support • Working with the Media The Coroners retrospective audit involved working with the university to look at records and build up the bigger picture around people's lives and around themes. SYP have appointed a post to look at real time surveillance. Any suspected death by suicide leads to a suicide inquiry form being circulated to Public Health leads from SYP. The picture could be very complex with many people affected or involved, for example if it was a person from Rotherham with a GP in another area and whose suicide took place in a third, hence the value of good partnership working. **Locally funded activity** For year one this included the small grants scheme, training including post-vention support and targeted geographical work in central Rotherham with Rotherham United. Year two includes the Train the Trainer self-harm project on reducing stigma, which was at an early stage. Suicide prevention training had been put into practice by those who had taken the courses. The Suicide Liaison service had been added and commenced in February/March for those bereaved and/or affected by suicide, including historical cases.
2.2	**Sharing good practice across the sub-region** Two officers had links South Yorkshire-wide and in a Yorkshire and Humber peer group. Other areas looked to Rotherham and our approach to real time data surveillance. Workshops were held at Integrated Care System (ICS) level, where Rotherham had a

<table>
<tr><td></td><td>strong voice so it certainly happened at higher levels. Rotherham was doing a lot but also learned from other areas. RDaSH confirmed that in North Lincolnshire there had been discussion about real time data post-vention and they were looking to adopt our approach.</td></tr>
<tr><td>2.3</td><td>Primary Care – work with GPs to upskill staff on mental health
At the symposium this work had interested national colleagues as an example of good practice. A national core contract for the service existed and a GP quality contract was in place in Rotherham with all 30 practices. Discussions looked at spending area funding to improve health outcomes. This year the focus had been on mental health, dementia, learning disability and military veterans. Practices had to identify a mental health lead and have staff undertake training to be able to recognise mental health needs, which linked to care navigation. RCCG agreed to look into a case reported by a Member of HSC where this did not seem to be embedded.</td></tr>
<tr><td>2.4</td><td>Military Veterans
Support for veterans was a national issue and Rotherham mirrored national best practice. It was clarified that military veterans could be all ages, not necessarily veterans meaning older people, with some still in training. Suicide attempts from young veterans had been known here and other issues were severe mental illness, dementia and health inequalities. The work of the Military Community and Veterans Centre (MCVC) was positive and it was important to capture the learning from what they had done.</td></tr>
<tr><td>2.5</td><td>In Protected Learning Time (PLT) was there a danger of focusing too much on one group and potentially missing others as messages needed to go to anyone at risk?
PLT focus was on those at risk. “Be the One” focused on men in the age range with higher suicide prevalence. It was also important to engage women to talk to men.</td></tr>
<tr><td>2.6</td><td>Core Themes in the plan
(linked to 2016 Public Health England guidance and NHS Long Term Plan)
Reducing the number of suicides amongst people receiving mental health support from across all organisations.
- reemphasis that suicide prevention is the responsibility of all.
To improve support to those bereaved or affected by suicide.
– the child bereavement pathway was unique to SY&B and showed a real partnership approach.
People who self-harm.
Reducing suicides amongst high risk groups by reaching people where they live and work.
Emerging from the Rotherham symposium it was evident that self-awareness of partners and awareness of the wider context around suicide prevention and self-harm were both vital. The key was learning as a place, as Professor Kapur had informed the symposium that other than for self-harm the clinical evidence base was less clear for the other issues. He had agreed to act as a critical friend to review the draft plan, bringing the benefits of external input.</td></tr>
<tr><td>2.7</td><td>“Be the One” Campaign
Members watched the video for the recently launched campaign and were informed that officers had worked with a men’s group on the wording. Since the launch on 10 September the campaign had achieved a good “reach”, bettering that of some national campaigns. This encompassed web hits and returns to the web, looking at pledges and looking at social media contacts, although retweets could not be measured. Members were all encouraged to sign the pledge and to tweet. It had been suggested that the video should play on the screens in GP waiting rooms.</td></tr>
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2.8	**Governance** **It was recognised as positive that the list of partners and groups on page 4 of the plan was important for coordination and sustained coordination, plus it showed the collective responsibility. Were strong governance arrangements in place?** An annual report was presented to the Health and Wellbeing Board but recent updates had been more frequent. The Place Board had also requested brief monthly updates and Public Health supported delivery. The Mental Health and Learning Disability Transformation group receives regular updates. Health Select Commission (HSC) could pick up discussion/issues through the minutes of these meetings.
2.9	**Contacts and Information for parents/carers** **After a recent crisis situation with a young person, what was the first point of contact, as social workers seemed unsure? Could there be an information pack/card for foster carers?** Cards had been produced with a range of both local and national numbers including Papyrus and Samaritans. In cases of immediate risk people should ring 999. RDaSH confirmed that the 24:7 crisis number for Rotherham was staffed during the day and diverted in the evenings. The service were strengthening the staffing on the numbers and would do more advertising and promotion. RDaSH agreed to look into the case reported. **How do we inform bereaved parents/carers about good news stories and that things have improved since they lost their young people?** There is contact with them and opportunities to be kept informed if they wish to be, which some do and others choose not to. The key is to think of the best way to do it.
2.10	**Training** **Was there a problem with coordination between services as it was hard to believe social workers would not be aware of self-harming and suicidal ideation amongst young people who were fostered?** Some social workers had undertaken the Youth mental health first aid training which was valuable in raising their awareness. **Who was being trained on the courses? Foster carers were a potential group who would benefit from the training.** Front line training and training for parents/carers was taking place. Two people from Rotherham Parent Carers Forum had completed the Self-Harm Train the Trainer project and would be able to train other parents and carers and the general public. People could book places through RMBC Directions portal where it was advertised. Training could also be tailored. **Reassurance about training for officers from South Yorkshire Police** In cases of immediate risk or a life and death situation national best practice was followed. Call handlers were trained to risk assess calls and front line officers were trained as they will meet people in crisis through their normal everyday policing. **Was autism being addressed strategically and also within staff training?** This had been flagged with the lead officer and the understanding was that it was reflected in the strategy for children and adults, but this point would be taken back. There were still many unknowns regarding best practice. **Staff training on self-harm as some people seemed inured to it or had certain attitudes?**

	11 people had been trained so far (Self Harm Train the Trainer project commenced in June 2019) from partner organisations.
2.11	**Data** **In the plan pages 8 and 9 set out the local picture which was hard to understand fully, could the information be presented differently so it was clearer?** This would be taken back. However the only comparator data was the Public Health Outcomes Framework, which does have a time lag and retrospective data. Rotherham's real time data could not be compared with others. **Was there anything particular where Rotherham was different?** Following the changes to the burden of proof, in the latest data it may be that the number of recorded suicides shows an increase and this is monitored nationally. It was a complex picture and important to have the three year block of data as it varied greatly year by year. RDaSH confirmed the increased numbers due to this change and expected an increase in 2019 but added that socio-economic challenges were also a factor. Deprivation was a factor but there were anomalies and possibly different causal factors. It was positive that Rotherham has good local real time data, good work carried out in certain wards and is responsive to changes and this was reflected in the positive feedback from Professor Kapur. **Any connection to what was a borderline cluster group and CSE?** No but SYP were mindful of this. Three possible perpetrators of CSE were facing charges and another was charged on sexual offences. In terms of victims and survivors of CSE, things did not always emerge from someone's history if there was a myriad of issues but in depth information was collated for each case of suicide. SYP concurred with other partners that no-one else had as much on real time as Rotherham. **From the data regarding contact with services and death by suicide, did the findings indicate a need to increase early intervention?** Part of it was understanding when people first express needs, usually before they get to secondary care. It was important to deliver the early intervention such as through Samaritans. For some people there was still stigma attached to contacting mental health services directly so they go through other means. Samaritans can signpost people on with their consent. In terms of suicides approximately one third of patients were in primary care, a third in secondary care and a third not in contact with services. "Be the One" was part of the early intervention and prevention work. Any work on loneliness was tackling suicide prevention as part of the bigger picture. A Loneliness stakeholder event had taken place at the end of September 2019 involving all partners, with the action plan due to be launched in November.
2.12	**Schools - given the younger age range for suicides in Rotherham, was more work needed in schools?** A lot of preventative work was taking place in schools with multi-agency teams involved and good work with Educational Psychology. Relationships with schools had improved but it was important to build on this. Regarding engagement with schools the CCG confirmed that Professor Kapur was raising this at national policy level because of the impact of social media. Rotherham also had the Mental Health Trailblazer in schools.
2.13	**Evaluation of pilot projects – should evaluation afterwards be carried out by people not directly involved? This could be part of the key information to feed in when deciding budgets.** Evaluation was difficult and was mainly based on service user feedback as it was hard to do more with the resources in the system. Ward profiles had been developed if people wanted particular data and officers confirmed refreshed profiles would be coming

	out to reflect forthcoming boundary changes. The refreshed Joint Strategic Needs Assessment (JSNA) would help with ward plans.
2.14	**Small grants programme - how was this going and was it geared more towards older people?** No these were for all age groups and the grants had been one of the most successful initiatives, eliciting positive feedback and having an impact. The touring exhibition Flourish highlighted a number of positive case studies. Some groups had been awarded more than they originally requested.
2:15	**How were loneliness initiatives promoted to those at risk as these were likely to be the hardest to reach?** Methods included connectors and staff training including front line staff such as housing and police officers to deliver interventions and signpost people. MECC was now addressing loneliness as a theme. A pilot would be rolled out if successful.
2.16	**Inquests** **Why are inquests taking so long to be completed and is there any data?** National guidance is in place for Coroners and they are working to reduce the time taken for inquests. **Assurance and support for people awaiting the Coroner's verdict** Amparo are an organisation who are providing support to people through the process right up to the inquest.
3. Key Actions and Timelines	
3.1	**Conclusions** After consideration of the information provided and scrutiny of the draft plan, HSC Members were reassured about the multi-agency work taking place in Rotherham on suicide prevention and self-harm. They acknowledged the benefits of the real time data surveillance and welcomed the refreshed plan, whilst recognising that this did not represent the entirety of the work taking place on these issues. The commitment of partners was also evident from the discussion during the workshop and will be necessary to make further progress. Training and awareness raising for staff, colleagues, parents and carers continues to be a key factor and will support the achievement of the key aims within the plan. Some initiatives are still at an early stage but had already demonstrated positive impact and funding to ensure future sustainability of successful projects needs to be addressed. Scrutiny of mental health services has featured strongly in the Health Select Commission's work programme for a number of years and HSC have seen a number of improvements in recent years. After discussing the governance and reporting arrangements for suicide prevention and self-harm it was agreed any future reports to HSC would be by exception and through liaison with the Cabinet Member.
4. Recommendations	
4.1	Members made two specific recommendations in relation to the draft plan: 1. To consider presenting the information about the local picture (pages 8 and 9 of the plan) in a different way so it was clearer, as it was hard to understand fully.

	2. Future reporting to HSC would be by exception as robust governance arrangements were in place and there would be liaison between the Chair of HSC and Chair of HWBB should any major concerns or emerging issues require closer scrutiny.
4.2	The workshop also touched on broader issues and it was agreed the following points or recommendations would be taken back: 1. To ensure all foster carers and social workers have information and contact details for mental health services. 2. For foster carers to be considered as a potential cohort for youth mental health first aid training and other relevant training due to the mental health needs of many young people who were fostered. 3. For letters from RMBC in relation to finances/debt to include the phone number of counselling services, near the top of the letter not at the bottom. 4. To check that autism was being addressed both strategically and within staff training. 5. Train the trainer training/awareness raising should include a focus on LGB&T people as a specific cohort.
4.3	Partners also agreed to follow up with regard to the two issues raised by Members under points 2.3 and 2.9.