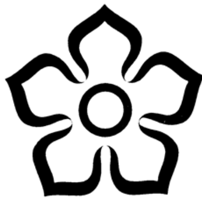

Leicester
City Council

MEETING OF THE PUBLIC HEALTH AND HEALTH INTEGRATION SCRUTINY COMMISSION

DATE: **TUESDAY, 5 NOVEMBER 2024**
TIME: **5:30 pm**
PLACE: **Meeting Rooms G.01 and G.02, Ground Floor, City Hall, 115 Charles Street, Leicester, LE1 1FZ**

Members of the Committee

Councillor Pickering (Chair)
Councillor Joel (Vice-Chair)

Councillors Bonham, Clarke, Haq, Sahu, Westley and Zaman

Members of the Committee are invited to attend the above meeting to consider the items of business listed overleaf.

For Monitoring Officer

Officer contacts:

Georgia Humby (Senior Governance Officer) and Kirsty Wootton (Governance Officer),
e-mail: committees@leicester.gov.uk
Leicester City Council, City Hall, 115 Charles Street, Leicester, LE1 1FZ

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- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

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If you have any queries about any of the above or the business to be discussed, please contact: Georgia.Humby@leiceser.gov.uk and Kirsty.Wootton@leicester.gov.uk of Governance Services. Alternatively, email committees@leicester.gov.uk, or call in at City Hall.

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PUBLIC SESSION

AGENDA

NOTE:

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1. WELCOME AND APOLOGIES FOR ABSENCE

To issue a welcome to those present, and to confirm if there are any apologies for absence.

2. DECLARATIONS OF INTERESTS

Members will be asked to declare any interests they may have in the business to be discussed.

3. MINUTES OF THE PREVIOUS MEETING — Appendix B

The minutes of the meeting of the Joint Public Health and Health Integration and Adult Social Care Commission held on 10 September 2024 have been circulated, and Members will be asked to confirm them as a correct record.

4. CHAIRS ANNOUNCEMENTS

The Chair is invited to make any announcements as they see fit.

5. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

Any questions, representations and statements of case submitted in

accordance with the Council’s procedures will be reported.

6. PETITIONS

Any petitions received in accordance with Council procedures will be reported.

7. HEALTH PROTECTION

The Director of Public Health will provide the Commission with a verbal update.

8. CRITICAL INCIDENT UPDATE

A verbal update will be provided following the critical incident that was declared by University Hospitals Leicester on 9th October 2024.

9. VACCINATIONS & SCREENINGS

A verbal update will be given on uptake and barriers to vaccinations and screening in Leicester.

10. ADULT MENTAL HEALTH — **Appendix C**

Leicestershire Partnership NHS Trust submits a joint report with Leicester City Council to the Public Health and Health Integration Scrutiny Commission on Adult Mental Health Services, including the key challenges, waiting times and partnership working.

11. LEICESTER, LEICESTERSHIRE AND SUICIDE STRATEGY — **Appendix D**

The Director of Public Health submits the draft of the Leicester, Leicestershire and Rutland Suicide Strategy 2024-2029 to update the Public Health and Health Integration Scrutiny Commission.

12. WORK PROGRAMME — **Appendix E**

Members of the Commission will be asked to consider the work programme and make suggestions for additional items as it considers necessary.

13. ANY OTHER URGENT BUSINESS

USEFUL ACRONYMS RELATING TO HEALTH

Acronym	Meaning
AEDB	Accident and Emergency Delivery Board
AHCs	Annual Health Checks
ARRS	Additional Roles Reimbursement Scheme
BCF	Better Care Fund
CAIP	Capacity and Access Improvement Payment
CAMHS	Children and Adolescents Mental Health Service
CDC	Community Diagnostic Centre
CHD	Coronary Heart Disease
CVD	Cardiovascular Disease
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DES	Directly Enhanced Service
DHSC	Department of Health and Social Care
DNA	Did Not Attend
DoSA	Diabetes for South Asians
DTOC	Delayed Transfers of Care
ECMO	Extra Corporeal Membrane Oxygenation
ED	Emergency Department
EDEN	Effective Diabetes Education Now!
EHC	Emergency Hormonal Contraception
EMAS	East Midlands Ambulance Service
EMCA	East Midlands Cancer Alliance
EMPCC	East Midlands Planned Care Centre
ENT	Ear Nose and Throat
FBC	Full Business Case
FIT	Faecal Immunochemical Test
GIRFT	Getting It Right First Time
GPAD	General Practice Appointment Dashboard
GPAU	General Practitioner Assessment Unit

GPFV	General Practice Forward View
HALO	Hospital Ambulance Liaison Officer
HCSW	Health Care Support Workers
HEEM	Health Education East Midlands
HWB	Health & Wellbeing Board
HWLL	Healthwatch Leicester and Leicestershire
ICB	Integrated Care Board
ICS	Integrated Care System
IDT	Improved discharge pathways
IMOS	Intermediate Minor Oral Surgery
IOL	Induction of Labour
ISHS	Integrated Sexual Health Service
JCVI	Joint Committee for Vaccination and Immunisation
JSNA	Joint Strategic Needs Assessment
LDA	Learning Disability and Autism
LDN	Local Dental Network
LGH	Leicester General Hospital
LLR	Leicester, Leicestershire and Rutland
LRI	Leicester Royal Infirmary
LTP	Long Term Plan
MAU	Maternity Assessment Unit
MECC	Making Every Contact Count
MDT	Multi-Disciplinary Team
MHST	Mental Health Support Team
MPRG	Major Projects Review Group
MTFP	Medium Term Financial Plan
MoC	Manager on Call
NDPP	National Diabetes Prevention Pathway
NEPTS	Non-Emergency Patient Transport Service
NICE	National Institute for Health and Care Excellence
NHP	New Hospitals Programme
NHSE	NHS England

NQB	National Quality Board
OBC	Outline Business Case
OPA	Outpatient Appointment
OPEL	Operational Pressures Escalation Levels
PAS	Private Ambulance Services
PCARP	Primary Care Access Recovery Plan
PCBC	Pre-Consultation Business Case
PCN	Primary Care Network
PICU	Paediatric Intensive Care Unit
PIFU	Patient Initiated Follow-Up
PHOF	Public Health Outcomes Framework
PPG	Patient Participation Group
PTL	Patient Tracking List
QIA	Quality Impact Assessments
QNIC	Quality Network for Inpatient CAMHS
RCR	Royal College of Radiologists
RN	Registered Nurses
RSE	Relationship and Sex Education
RTT	Referral To Treatment
SPOC	Single Point of Contact
SSP	Specialist Screening Practitioner
STI	Sexually Transmitted Infection
STP	Sustainability Transformation Plan
SLAIP	System-level Access Improvement Plan
TasP	Treatment as Prevention
UDA	Units of Dental Activity
UEC	Urgent and Emergency Care
UHL	University Hospitals of Leicester
YTD	Year To Date
5YP	5 Year Plan

Minutes of the Meeting of the
PUBLIC HEALTH AND HEALTH INTEGRATION SCRUTINY COMMISSION

Held: TUESDAY, 10 SEPTEMBER 2024 at 5:30 pm

P R E S E N T:

Councillor Pickering – Chair
Councillor Joel – Vice Chair

Councillor Bonham
Councillor Haq
Councillor Kaur Saini
Councillor Orton
Councillor Singh Sangha
Councillor Clarke
Councillor Joannou
Councillor March
Councillor Sahu
Councillor Westley

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72. WELCOME AND APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Zaman and the Deputy City Mayor for Social Care, Health and Community Safety – Cllr Russell

73. DECLARATIONS OF INTEREST

The Chair asked members of the commission to declare any interests in the proceedings for which Cllr March declared that she is an employee of Citizens Advice.

74. MINUTES OF THE PREVIOUS MEETING

The Chair noted that the minutes of meeting held on 9 July 2024 were included within the agenda pack and asked members to confirm that they could be agreed as an accurate account.

AGREED:

- Members confirmed that the minutes for the meetings on 9 July 2024 were a correct record.

75. CHAIRS ANNOUNCEMENTS

The Chair thanked the ICB for hosting a briefing session on virtual wards providing members with assurance of the process and expressed the members commendation for the expansion of virtual wards to ensure people can continue to receive care whilst returning home safely.

It was further noted that the Chair and Cllr Sahu had met with the ICB, LPT and DHU for an update on actions agreed following concerns about the number of GP mental referrals being sent back to practices for children and young people. The Chair highlighted that it was pleasing that terminology had been changed and concerns has been taken on board as health colleagues committed to work with the LMC and a number of GPs to review the PRISM form. It was noted that to allow time for these changes to be implemented, a report has been requested to be presented to the Commission in the New Year.

The Chair also highlighted that assurances are being provided through regular communication with the ICB who are monitoring GP collective action situation and ensuring details of urgent care centres are promoted. It was noted that details can be circulated to members and any issues that may arise would be shared with the Commission.

The Chair thanked Members who had expressed their interest to form the task group with the Housing Scrutiny Commission to look at services and the impact of homelessness on health, particularly those with complex needs. Members were reminded that if they wished to take in the inquiry day to contact the governance officer as soon as possible.

76. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

It was noted that none had been received.

77. PETITIONS

It was noted that none had been received.

78. HEALTH PROTECTION

The Director of Public Health gave a verbal update of the latest position of health protection, and it was noted that:

- TB had previously been mentioned as a topic of concern as rates are higher than would like in the city. There was a successful reduction of TB rates in the early 2000's but there had been an upward trend, with Leicester now having the second highest rates in the country. New

figures will be released next month, and it is suspected Leicester will be rated as having the highest rates of TB.
- Work has been ongoing across the public health team, the ICB and UK Health Security Agency (UKHSA) and a new strategy has been developed with a steering group Chaired by the Director of Public Health with a host of actions.
- University Hospitals Leicester have an amazing TB service, but it does not have the resources for managing the levels of TB in the city. A business case has been created to increase the capacity for the service.
- TB treatment is difficult and lengthy taking 6 months. Latent cases are particularly difficult to maintain treatment as patients feel healthy in themselves, yet the treatment can have side effects making them feel ill.
- Identifying and treating cases of latent TB screening is a main objective through GP practises, however funding is an issue. A case has been made to NHS England for doubling funding locally in order to reduce TB rates in the city.
- The Loughborough strain is more severe and contagious, and treatment can take up to 9 months but there are fewer cases.
- Mpox has become a global concern with a new (clade 1b) potentially more severe and contagious to affect younger people although data is not yet available. There have been cases in Europe but none in the UK to date. The UKHSA has outlined a plan should it come to the UK and is monitoring the situation.

Members were reassured that there is a strategy in place for controlling the rates of TB, but concerns were acknowledged in that Leicester was likely to have the highest rates in the country.

In response to questions and comments from Members, it was noted that:

- Public Health are hopeful that the request for additional resources for latent TB testing would be successful.
- A joint letter from the Health and Wellbeing Board, the Deputy City Mayor for Social Care, Health and Community Safety and the ICB had been sent to the UK Health Security Agency to request additional funding. The business case had been put through urgently with the hope that an outcome would be achieved before the usual time span of 6-8 weeks.
- As part of the strategy implementation to address TB there had been lots of work with health partners around screening, data analysis, communications, and a particular focus on addressing the stigma that is often associated with TB to help break down barriers for screening or treatment.
- TB requires a resource intensive treatment, so it is important to ensure the local infrastructure has the capacity to support the most vulnerable to sustain the treatment.
- There were 200 cases of TB in the city last year, and one case of the Loughborough strain; so is not comparable to covid or flu numbers but concerning and higher than other areas in the country.

- TB is usually related to patterns of migration. Leicester has high numbers of refugees and asylum seekers, as well as individuals travelling to areas of high prevalence of TB so it is vital to make sure screening, particularly latent screening, occurs.
- The TB vaccination is not as effective as vaccinations for other conditions.
- It has not been a requirement for migrants to get a latent TB test, just an active one which is not always reliable. Nationally, there needs to be a more effective screening programme.

The Commission expressed the importance of seeking additional funding and hoped the city would be successful to tackle the current rates. It was further noted that Members suggested health checks at border controls would be most effective in bringing down rates and that lessons should be learnt from previous decades with clear messaging.

As part of discussions the Chair invited the youth representative to make comments and it was noted that there are different campaigns to encourage vaccination uptake for different vaccinations and these differ dependent on targeted population. There had been lots of work in schools and communities to target vaccination campaigns.

AGREED:

- The Commission noted the report.
- The TB strategy and action plan to be added to the work programme.

79. WINTER PLANNING

The Chair asked members that the various reports all be presented, and that comments and questions be taken at the end in which members agreed.

The LLR Director of Emergency and Urgent Care presented the LLR winter planning update. It was noted that:

- Vaccination programmes are important to ensuring citizens and staff are safe during the winter and communication campaigns encourage take up to help ensure immunisation coverage. There has been a slower take up of coronavirus vaccines amongst health workers, but communication is ongoing to promote safety to staff, families and patients when vaccinated.
- The RSV vaccination programme commenced nationally in September and paediatric consultants are confident of a positive impact on children. The programme is aimed at under 2's, pregnant women, and those over 75.
- Seasonal planning is crucial and partners across health and care work collaboratively to develop and refresh plans. They have also been reviewed by clinical and operational leaders to ensure the right areas are being focussed on.
- Staff wellbeing and support has been identified to ensure resilience and

that services are equipped to serve patients.

- Communication leads have been working on joint campaigns for citizens and staff to ensure clearer messaging on the right pathways and access to services.
- There is a focus to increase capacity for urgent treatment and joining up the frailty offer. There are good services across adult social care and acute community services but are not always interlinked in the best way so will be a focus.
- There is confidence in discharging patients requiring social care in the city.
- Data indicates a clear increase in demand and activity of zero length of stay and same day access, including use of virtual wards. A focus will therefore be to ensure there is awareness of alternative services for ambulances and primary care to access for patients to be treated sooner.
- There has been an increase in investment in the voluntary and community sector for supporting individuals with mental health, learning disability or autism and evidence from last year highlights support helped alleviate individuals attending the emergency department.

The Strategic Director for Education and Social Care presented the adult social care winter plan update in which it was noted that:

- Adult Social Care services are considered to experience consistent pressures year-round and escalation plans are therefore developed and monitored throughout the year by analysing data. The service looks across the system to ensure there is a balance of care providers across care homes, domiciliary care and exit planning for all pathways at any given time.
- Hospital discharges and supported for patients who require social care support. There has been investment through the discharge grant which has allowed the reablement offer and timely discharge of patients seven days a week. A domiciliary care contract is in place and provision can be accommodated for discharged later in the day to receive required support during the evening when returning home.
- There tends to be low numbers of patients waiting for social care to be discharged at any given time - across 1,800 beds, there are usually less than 30 patients waiting for discharge.
- Leicester has an elderly population and more chance of hospital admission; therefore, there is a focus on reducing admissions.

The Heads of Service for Independent Living and Health Transfers reiterated the strengths of the discharge offer, and it was noted that double handed care has now been addressed to ensure an equitable offer for reablement. The latest data illustrated 92% patients requiring social care support were able to return home in August as opposed to a care home. Admissions avoidance was also highlighted as an area of focus with responding to falls and supporting residents to prevent calls to the East Midlands Ambulance Service. The positive work on virtual wards had also contributed to avoiding residents being admitted to hospital as well as returning home sooner and there had been an

increase in flow for the reablement offer and there was confidence in the joined-up approach across health and social care.

The Director of Public Health presented the fuel poverty and health programme, and it was noted that:

- Fuel poverty has different definitions, with England considering income and the energy performance of a property whereas Scotland and Wales identify fuel poverty is a household have to pay more that 10% of their income to keep warm. The English definition is being reviewed as it is not clear, but millions are estimated to be in fuel poverty.
- The two-year programme has been funded by the ICB and delivered in partnership by National Energy Action (NEA) and public health which is due to end this year. NEA have secured additional funding through the gas distribution network and agreed to continue with elements of the programme in Leicester next year.
- The programme was established in recognition of the cost-of-living crisis and whilst fuel prices have reduced, they remain higher than before and are expected to increase again in October. The crisis therefore remains real with thousands of city residents unable to keep warm which can have a detrimental on physical and mental health, increase frailty and risk of falls and colder homes can be associated with damp and mould which also have health risks.
- The NHS look at health inequities through the CORE20PLUS5 model. Four of the five conditions for the biggest differences in health inequality can be associated to fuel poverty and emphasises the importance of the programme to tackle inequalities in the city as Leicester generally has low income and poorer energy housing standards and high excess winter deaths.
- The programme has been based on NICE guidelines for training and issuing energy advice as well as identifying people at risk. The team consists of 5 NEA energy advisors and trainers and 2 public health officers. The programme includes providing advice for energy and maximising income as well as outreach and engagement. Education programmes are also provided in schools to inform children of the importance of health and climate change.
- Referrals were initially being made mostly in the west of the city where there are higher social housing tenants, but the programme has had a good spread of referrals across the city through council services, health partners and the voluntary and community sector. Residents supported through the programme often have ill health and therefore benefit from help and signposting to other appropriate service. Around £181k direct extra income has been generated for residents supported through the programme.
- Qualified energy advisors are undertaking outreach in communities and training other individuals to promote energy awareness and ensure the programme and impact is sustained.

The Chair invited the youth representative to make comments and it was noted that respiratory services for children in community hubs as opposed to

attendance at the emergency department received positive feedback, but families highlighted, they were unaware of the offer. A proactive approach is being undertaken this year to share information within school and neighbourhood settings.

The Commission commended the positive working relationships across health and social care to support residents, particularly the timely discharge of patients and reablement service. Members raised concerns about the impact of the withdrawal of the winter fuel payment to elderly residents' health and pressures on the health service.

In response to Members comments and questions in was noted that:

- The eBed system enables monitoring across the system of where people are for their pathway to being treated.
- Paediatric virtual wards have been designed by clinical leads to identify cases that may benefit from a virtual ward. Patients will be assessed and only those deemed low risk and safe to use a virtual ward will be provided the option to return home. A 24hour telephone line will provide support if required.
- The vaccination programme and engagement for vaccines will continue as in previous year but learning has been identified to improve the offer. For example, the roving unit has been popular in communities, but feedback of appropriate locations and times has been accounted for to have the most impact.
- It is recognised that high levels of standing charges can attribute to fuel poverty and debt even where residents have not used energy. NEA are campaigning nationally for fairer solutions as it is a concern.
- Energy advisors work to maximise income and proactive work has been underway to identify individuals who may be eligible to support to apply for pension credit as it is recognised to be underclaimed and can open access to other benefits. If cases are complicated, they may be referred on to other organisations such as citizens advice. Health also completes a checklist when discharging patients to identify patients who may be in fuel poverty and work is underway to improve advice and signposting for health contacts across the system.
- NEA have secured funding from gas networks to replicate the fuel poverty and health programme in other cities, but assurances have been provided that it will continue in Leicester to offer sustainability, although it may not include the education programme.
- The roving mobile unit can be accessed for vaccinations as an alternative to attending GP practices to provide flexibility for residents.
- Pharmacy and transport can delay discharge; a new transport provider has been commissioned and working to increase capacity over the coming weeks. Take home medication is reliant on a doctor prescribing the medication, pharmacy processing and dispensing to the ward which is being looked at for quality improvement. Patients discharged to a care home or community bed can be relocated and medication follows.
- New hubs at Leicester General Hospital and Hinckley will create 30k additional appointments for all types of therapy.

- 48% of referrals to the Leicester Energy Action programme are from deprived areas across St Matthews & Highfields North, New Parks & Stokeswood, Braunstone Park West, Kirby Frith and Eyres Monsell.
- Volunteers support patients being discharged from hospital across Leicester, Leicestershire and Rutland and further details of organisations would be shared with the Commission.
- A critical incident was declared at Leicester Hospitals throughout winter 2023-24 and unfortunately negatively impacted wait times but this did not result in the closure of the emergency department. A site visit is being arranged for members to visit the emergency department and understand the processes ahead of winter.
- Pressures are expected for winter 2024-25 as there is increased demand with a 20% higher disease burden in the city compared to pre-pandemic which is being analysed locally. Plans are in place to alleviate the strain on services with a focus on same day emergency care to ensure patients are taken to an appropriate service as opposed to waiting in the emergency department and admission avoidance through virtual wards being promoted.
- Same day care is where a patient is admitted to the right pathway on the same day as presenting to the emergency department. The proactive care model is a national programme for GPs to use population data to identify patients at risk of hospital admission and optimising their care through tests and suitable care and crisis plans. This model has been trialled over recent years and has positive results of patients being in control of their health. The challenge with expanding this model is around resources. Intermediate care is ensuring patients are supported by the appropriate pathway when discharged, for example into a specialised care home or reablement. A partnership approach is taken for all models of care, and they can be altered if circumstances require it.
- Public health data and societal changes shows that alcohol dependency has reduced in the city and although some people may present at the emergency department intoxicated there are also an alcohol liaison team and mental health liaison team to support patients.
- The health inequities hub is now in place.
- All posts have been filled to support the Leicester Energy Action programme over the last 18months and will continue. The number of complex cases being supported have been higher, and a judgement is taken on where cases may need to be referred to a separate organisation or where they can continue to be supported by the team, but all individuals referred and requiring support will receive appropriate help.
- A contract is in place with Derby for the local 111 service and looking to increase call handlers for winter to support residents. It was agreed that further information on call back times would be circulated to the Commission.
- Checks are available and being encouraged when in contact with patients at GPs and pharmacies for monitoring blood pressure, pulse and cholesterol as earlier identification is better to manage. It was

agreed that information would be circulated for Members to help promote services and checks.

Members raised concerns about lack of information provided directly to councillors about services to promote to residents and the variation of information issued by health providers. It was noted that various communication methods are used to target different audience and that information requested would be collated to share with Members. It was further agreed that the process for informing all ward councillors would be reviewed for future communications and Members input for identifying information to be shared was requested.

AGREED:

- The Commission noted the report.
- Additional information to be circulated to Members.

80. WORK PROGRAMME

The Chair requested that adult mental health be added to the work programme and be discussed at the next meeting to be considered alongside the suicide strategy.

Members were also invited to make suggestions for the work programme in which it was noted that the suicide strategy item include provision for self-harm and that an item be added for the commission to further discuss why Leicester residents are 20% sicker than they were four years ago.

The Chair reminded members that the next meeting would take place on 5 November 2024 and that the inquiry day with housing scrutiny commission would be taking place beforehand.

81. ANY OTHER URGENT BUSINESS

Councillor Haq raised concerns in relation to parking and the use of surrounding streets to avoid hospital parking charges. It was requested that joint consideration be given to improve transport services and encourage use of public transport.

AGREED:

- Communication and engagement of transport options to be reviewed and enhanced where possible.

There being no further business, the meeting closed at 19.27.

Item 10

Adult Mental Health (LPT and Leicester City Council update)

Public Health and Health Integration Scrutiny Commission

Date of meeting: 5th November 2024

Useful information

■ Ward(s) affected: City-wide

■ Report authors: Natasha Bednall (City Council), Tanya Hibbert, David Williams & Glyn Edwards (LPT), Justin Hammond (ICB)

■ Author contact details:

■ Report version number: V1

1. Summary

1.1. This paper provides an update on key challenges, waiting times and joint working to address mental health across Leicester City.

1.2. This paper provides an update from Leicester City Council and Leicestershire Partnership NHS Trust (LPT) Adult mental health services. In the October meeting an update was provided on Child & Adolescent Mental Health (CAMHS) waiting times and developments of these services. An update to members on the local learning from improving services for people with a neuro-disability or learning disability is planned for a future meeting in 2024.

1.3. Across Leicester City, Leicestershire & Rutland we have a Mental Health Partnership where local authorities, the ICB and VCS are all members and work together to. The partnership drives forward the Joint Integrated Commissioning Strategy for Adult Mental Health (2021 – 2025) and the placed based plan for mental health.

1.4. Our partnership working is supporting us to deliver connected services to our people and tackle many of the challenges we are facing.

2. Recommended actions / decision

Scrutiny Commission is asked to note:

2.1. The demand for mental health services and the actions that the City Council and LPT have taken to address the increased demand.

2.2. The engagement of the city council and LPT to support individuals into employment to support long-term recovery and well-being.

2.3. The challenges for both Leicester City Council and Leicestershire Partnership NHS Trust within their respective mental health provision.

Scrutiny Commission is asked to support:

2.4 Championing good mental health, well-being and employment through our City Council, LPT, wider public services and our voluntary and community services to support people in our city.

3. Community Mental Health Services

3.1. Leicester City Council's Adult Mental Health Service works with adults with severe and enduring mental health issues. The service conducts assessments under the Care Act, Mental Health Act assessments, Mental Capacity assessments, provision of support to people to meet eligible needs under Section 117, supporting people to be discharged from hospital, Community treatment Orders, reports to Mental Health Review Tribunals and Ministry of Justice reports (including monitoring and reviews).

3.2. The Mental Health Wellbeing & Recovery Support Service has been delivered by P3 since October 2022. Since going live, the service has supported over 1,000 people with one-off advice or ongoing Community Recovery Support. This is a preventative service which contacts people within 10 working days of referral. At times there is a waiting list for Community Recovery Support, however this is managed through regular check-in calls with people while they wait. The service also delivers peer support groups and mental health support & awareness programmes that people can access whilst waiting for 1:1 support.

3.3 Employment Support. Both the city council and LPT are supporting people with mental health needs back into employment as part of their recovery.

The LPT Employment Support Service is open to adult patients in community mental health teams, psychosis intervention and early recovery (PIER) and assertive outreach services.

The Employment Support Service team have more than nine years' experience and has helped more than 1,000 patients achieve their work or learning goals. The staff group bring a wealth of expertise and skill and the service continues to expand.

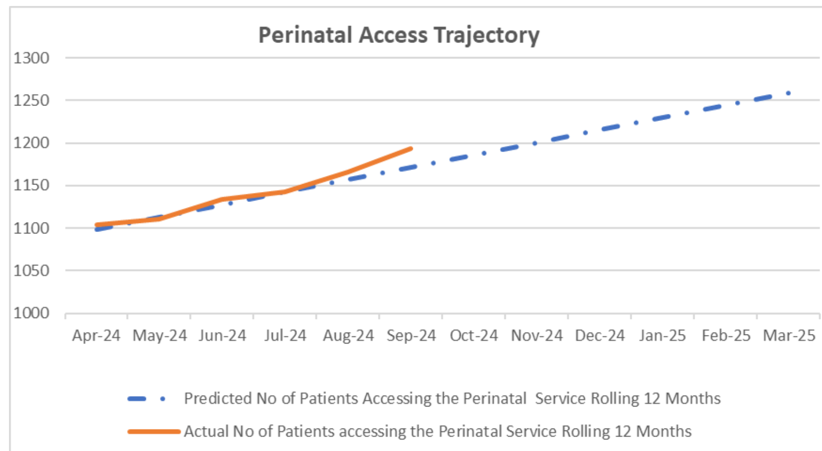
The city council does not have a specific service supporting people with mental health needs into employment, but does commission and provide various offers that people with mental health needs can get support from such as the Employment Hub. Support around obtaining and maintaining employment is also built into adult social care services such as supported living services and the Mental Health Wellbeing & Recovery Support Service detailed at 3.4 above.

3.4 Adult General Psychiatry Waiting Times This service was a key driver to changes proposed in Step up to Great Mental Health now delivering as our Better Mental Health for all Transformation programme.

- Since March 2020 services have noted an increase in referrals and increased challenges in relation to discharge. Our transformation programme focuses on ensuring early help, the first-time people contact us. The service has implemented immediate improvement actions including a caseload review project, continuous recruitment with a drive to develop attractive roles within the new neighbourhood model and maximising current clinical pathways and capacity.

3.5. Perinatal Mental Health Services has an access target which is 10% of the LLR birth rate. This equates to 1259 women accessing the service cumulatively across the 12-month financial year. All patients must be seen face-to-face or via a virtual platform on at least one occasion within 12 months to be counted as accessing the service.

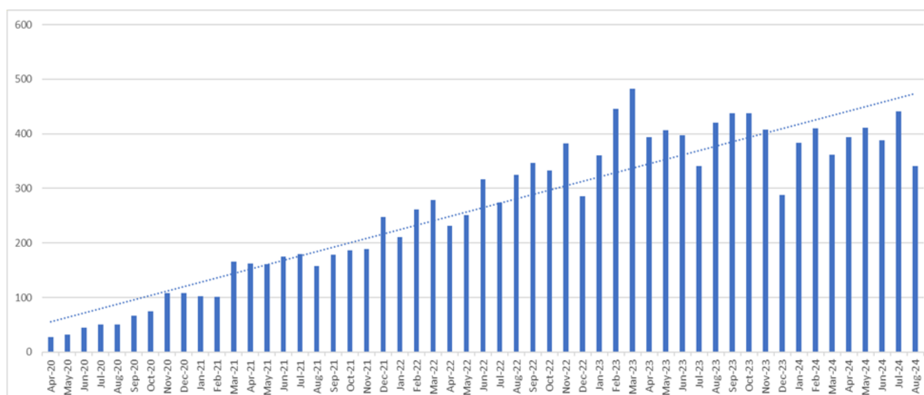
- The service has received significant investment to increase capacity and achieve long term ambitions. However, since the pandemic the service has struggled to achieve the access target.
- During 2024/25 the service put in place a trajectory which is monitored regularly in a number of forums. This is alongside weekly and monthly dashboards, capacity and demand planning, focused job plans and a number of initiatives to increase referrals and best utilise clinical time. This has proven successful and the service has remained on an upward trajectory throughout the year.



3.6. <u>ADHD Waiting Times:</u> The ADHD Service has seen a year-on-year increase in referrals received and accepted. Due to the significant increase in referrals the service has not met the 18-week referral to treatment target. Nationally, all Trusts are facing similar demand and capacity issues due to increased referral rates and additional challenges that include:

- National regulation that means the Mental Health Investment Funds cannot be used to support ADHD services.
- An increase in private companies undertaking online/ in person assessments and diagnostics for ADHD with concerns about the prescribing practices of the private sector which cause issues when the patient is referred into NHS services.
- Universal challenges with diagnostics for ADHD across all systems.
- Regional and local challenges with Right to Choose legislation in MH and impact on ADHD services
- Ongoing shortages of ADHD medication impacting on treatment waiting lists.

The graph below illustrates the increase in referrals:



3.7. Despite these challenges the ADHD service is putting in place initiatives to reduce waits including:

- Development of an Adult ADHD business case to help bridge the gap between demand and capacity.
- NHSE have developed a national ADHD Task Force to gain a better understanding of the challenges affecting those with ADHD, including access to services and rising demand
- ADHD Task and Finish group in place to identify and review agreed initiatives.
- Ongoing recruitment to vacant posts.
- Transformational work identified as part of improving the pathway to be taken forward, which includes working towards transferring annual reviews to primary care, a review of the secondary care model and review of workforce skill mix.

3.8. Adult Memory Service: LPT Memory Service provides an assessment, diagnostic and treatment service for LLR patients referred with possible dementia. Prior to the Covid-19 pandemic the service achieved 85% compliance, however, the legacy of service closure during Covid-19 is a substantial increase in waiting times and a corresponding reduction in RTT compliance.

- The service has put in place a number of initiatives to improve waiting time compliance including robust job plans, ongoing recruitment to vacant posts, caseload reviews, weekend clinics to increase capacity, pathway improvements and additional volunteer roles. Demand and capacity work has been completed and a waiting times trajectory is monitored regularly in a number of forums. The service is exploring transformative developments and are piloting a 'one stop shop' which will bring a group of clinicians together to increase efficiency, flow and patient experience.

- Waiting times have remained challenged large due to workforce issues which have resulted in a reduction in capacity. Referrals into the service have also remained high which is further impacting the team's capacity and waiting times performance.

- The system also has a Dementia Diagnosis Rate target of 66.7% by the end of the financial year. The Memory Service is working closely with ICB colleagues and has set a trajectory for improvement; however, this LLR system target is proving challenging to achieve with September performance reported at 64.8% which is a 0.1% increase on the previous month. The city performance is at 77.4%, which is over the national expectation.

3.9 **Developments within LPTs Adult Memory Psychological Therapies**

3.9.1 Cognitive Behavioural Therapy (CBT)

The service has been receiving an unprecedented number of referrals over the past two years, with referrals almost doubling. This has resulted in a 50% increase in people waiting for treatment.

The service is relatively small, with 7 Therapists and 1 Service Lead. As part of the transformation programme, CBT is working closely with Community Mental Health Teams (CMHTs) through the MDT which has resulted in an increase in referral rates. In addition, referrals from Vita Minds via MHCAP since June 2023 have been double their previous

norms. This is impacting on capacity for both assessment and treatment, in September 74% of people completed their pathway in 13 weeks, with a goal of 95%.

Actions that the service are taking to improve performance include:

- CBT input provided into the fortnightly meeting between Vita Health and MHCAP.
- Alignment with transformation developments to improve flow, efficiency and patient experience.
- Recruiting to vacancies.
- Maximising clinical capacity.

3.9.2 <u>Dynamic Psychotherapy Service (DPS)</u>

The service has experienced some challenges with achieving the 13-week waiting time target to access the service during the past year due to an increase in referrals into the service, which is impacting on the capacity for both assessment and treatment, with waits increasing. In September 66% of patients completed their pathway, with a goal of 95%.

To improve performance the service is:

- Recruiting to vacancies.
- Alignment with transformation developments to improve flow, efficiency and patient experience.
- Developing group offers to impact longest waits for treatment.

3.9.3 <u>Therapeutic Service for People with Personality Disorder (TSPPD)</u>

The service has seen a significant improvement in waits for assessment as per the table below achieving the target consistently since January 2024.

ACCESS	Target	Target Waiting Time	Target Type	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Complete Pathway Compliance rate	95%	13 weeks	Trust	90.9%	97.4%	90.9%	97.5%	100.0%	100.0%	100.0%	100.0%	96.2%	100.0%	100.0%	100.0%
Incomplete Pathway Compliance rate	95%	13 weeks	Trust	100.0%	97.7%	97.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Treatment waits are also continuing to decrease.

The service is seeing ongoing improvements and is actively engaged with the transformation programme. Improvements continue to be embedded. Immediate actions include:

- Collaborating across the system to develop a system-wide strategy for working with people with personality difficulties,
- Working more closely with locality teams to inform clinical presentation that is suitable for referral.
- Introducing shorter interventions to meet the needs of those people with a lower level of personality difficulty.

4.0. Urgent Care Mental Health Care

4.1. <u>Mental Health Central Access Point (MHCAP).</u>

The MHCAP was launched in April 2020 and provides urgent mental health support across LLR. The service is delivered in collaboration with Turning Point who provide the

initial call handling function. The service has been experiencing capacity challenges over recent months:

- The introduction of NHS 111 2 went live in April 2024 and has significantly increased the number of calls being received into the MHCAP.
- The original MHCAP call demand has remained high with this element of the service receiving on average 4600 calls a month (153 per day).
- The 111 element of the service receives on average 1000 calls per month (33 per day).
- The 111 service has significantly impacted capacity, with the numbers coming though much higher than initially anticipated from the sample dataset provided by DeMontfort Health Care. As a result, the number of calls answered has decreased and the average time from call to clinical triage has increased. Performance is being monitored through a number of forums.
- To address the capacity challenges, the service is working through ways in which to maximise capacity and are working closely with the staff to implement new ways of working.
- Incoming call patterns and lengths are unpredictable making it a challenge to match capacity to demand at any given time. However, the demand and capacity exercise is being reviewed to include the increasing 111 activity.
- Care teams are supporting with developing agreed call plans for frequent callers.
- Review of triage processes, daily oversight of activity and staffing capacity, continue to plan for routine work to move to front door in planned care.

4.2. Crisis Resolution and Home Treatment Team (CRHT)

The CRHT Team is for adults aged 18 and over who would otherwise require hospital admission to an acute mental health ward due to a crisis that impacts on their ability to cope with day-to-day activities. Providing intensive home treatment through a multi-disciplinary approach as an alternative to hospital admission, patient caseload averages 180 patients at any time and can rise to 210 at times.

The waiting time key performances indicator for the Crisis Resolution Team is 24 hours (urgent). The service has been unable to achieve the target of 95% and reported September performance of 62%.

- Referral rates have remained high, which is line with all urgent care services.
- Crisis caseload and contact demand is being reviewed as part of the Crisis MDT QI Project.
- The Crisis team support with EDP (Early Discharge Planning) to improve patient experience and outcomes.
- A post has been established to support Adult & Older persons Crisis pathway which will look at the Mental Health offer for Functional older adults referred to CRHT team.

4.3. Mental Health Urgent Care Hub

The Hub was set up in April 2020 as an alternative pathway for individuals in an urgent crisis not needing to attend an emergency department (ED). It is a 24/7 all age crisis service and on average accepts circa 300 referrals per month, which is an increase when compared with the previous year.

The service has helped to reduce urgent referrals from the Crisis team and Central Access Point who need a face-to-face assessment. The service supports the crisis team in helping to manage those in urgent need of assessment.

The key performance waiting time indicators for the MH Hub is 4 hours. The service has been challenged in achieving the 95% target, however, performance has been improving as illustrated in the table below

MHUCH 4 Hour Target	Target	Target Type	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Complete Pathway Performance	95%	Trust	78.0%	76.8%	82.9%	83.8%	79.5%	85.2%	88.5%	85.7%	87.2%	84.0%	90.4%	87.3%

Data quality audits, training and support are underway to help staff to improve data inputting, which will reflect positively on performance information reported.

4.4. The Mental Health Liaison Service (MHLS)

The MHLS provides services to adults within LLR aged 16 to 65 years. People are seen on inpatient wards at all UHL hospital sites - Leicester General Hospital, Leicester Royal Infirmary and Glenfield Hospital. The service provides outpatient clinics and a specialist Chronic Fatigue Syndrome (CFS) service. Care is provided by experienced multidisciplinary-team liaison professionals.

- The service responds to referrals within 1 hour and 24 and 48 hours. The service has struggled to achieve the performance targets of 95%.
- The clock starts as soon as someone is assessed by the ED and once declared physically fit patients are referred for assessment by the liaison team. Due to the busy nature of ED this can often result in batching referrals meaning time is lost by the liaison team as the clock is still running. To try and resolve this, we are working alongside UHL to implement an e-referral process via Nervecentre which will eliminate batching.
- A review of capacity and demand is being undertaken, which includes a deep dive into peak times of activity.
- Mandatory data quality training sessions are taking place, to improve data quality which represents performance.

5.0. Developments in our Mental Health Acute Inpatient Services.

LPT continue with their estate modernisation programme, eliminating dormitory accommodation in our inpatient units with final works being completed by the end of this year.

5.1. Developments Out of Area (OOA) Placements

LPT has seen an increase of inpatient activity which has led to use of inappropriate OOA inpatient bed placements. Inappropriate is defined as someone receiving care outside Leicester, Leicestershire and Rutland (LLR) solely due to a lack of capacity within LLR.

To support effective patient flow LPT has commissioned 5 additional beds within the LLR footprint to allow patients requiring an inpatient admission to remain within the locality. LPT will continue to work towards reducing the use of acute inpatient beds outside of the local bed base through the use of step-down beds and the efficient use of community

services. LPT is working towards further improvements as part of our Better Mental Health for All programme.

5.2. Clinically Ready for Discharge (CRFD).

CRFD rates are high for adult services and Mental Health Services for Older people (MHSOP). An improved discharge model is being implemented to support flow between LPT and external agencies including Social Care. Discharge delays to CRFD patients are most frequently due to awaiting allocation of a social worker or the availability of supported living accommodation. LPT holds weekly CFRD meetings with partners from adult social care and housing to retain oversight and identify alternative solutions to facilitate discharge. Technical solutions to ensure oversight of CRFD are being explored. Everyone is working together to reduce delays.

6.0 Challenge & transformation

Both City Council and LPT Adult Mental Health services face pressures with increased demand and challenges to ensure recruitment and retention.

We are working together with our local place plans, in our system meetings to address the challenges we face. Our community work seeks to engage locally with community groups who are commissioned by us to provide additional services, these include our community cafes and other services.

We are also seeking advice from regional colleagues in the NHS and with the East Midlands Association of Directors of Adult Social Services.

The Mental Health Collaborative has been established since winter 2022 with partners across the three local authorities to ensure partnership working is central at both system (LLR) and place (Leicester City) level. The MH Collaborative consists of three MH place-based Groups and one LLR-wide group. Collectively, the system MH Shadow Collaborative Group (MHSCG) and MH Place-based Groups form the Mental Health Collaborative for the LLR system. The Place based groups are not subordinate to the MHSCG. Membership of the MHSCG includes; H&WB Board chairs, NHS, voluntary sector partners, LA's, District Councils and Healthwatch. It's chaired by Angela Hillary, Chief Executive of LPT who is the MH Executive sponsor for LLR.

For the city, the Mental Health Partnership Board is the MH Place based group, it's a sub-group of the Health & wellbeing Board and focuses on delivery of local MH plans. The membership is broad and includes voluntary sector partners and people with lived experience of MH.

The MH Collaborative (at a system and place level) cover children, young people and adult mental health. They provide a vehicle for joint work and an increased awareness of initiatives and planned actions between partners.

Item 11a

LLR Suicide Prevention Strategy

Public Health and Health Integration Scrutiny Commission

Date of meeting: 05/11/2024

Lead director/officer: Rob Howard/Mark Wheatley

Useful information
■ Ward(s) affected: All
■ Report author: Mark Wheatley
■ Author contact details: mark.wheatley@leicester.gov.uk
■ Report version number: 1.0

1. Summary

1.1 This report is to inform, and consult, the Public Health and Health Integration Scrutiny Commission about the draft Leicester, Leicestershire, and Rutland (LLR) Suicide Prevention Strategy 2024-2029. The draft strategy is attached as Appendix A. Appendices B, C and D set out evidence of risk of death by suicide, some remarks on local data and our suicide prevention initiative, Mental Health Friendly Places.

1.2 The transfer of public health duties into local authorities means upper tier and unitary authorities have responsibility to oversee local suicide prevention activities. This is done alongside the Integrated Care Board (ICB), Police, and other statutory and voluntary sector (VCSE) organisations. It includes collecting and analysing data on deaths by suicide to inform the development of suicide prevention strategies and action plans.

1.3 The relevant local and policy includes:

National policy:

- NHS Long Term Plan 2019 and subsequent NHS Mental Health Implementation Plan 2019/20 – 2023/24.
- The National Suicide Prevention Strategy 2023-2028.
- The Labour Manifesto,[1] states the aims to reduce the lives lost to suicide, with staff trained to support people at risk and to 'reform the NHS to ensure we give mental health the same attention and focus as physical health.'

Local policy:

- Leicester Health, Care and Wellbeing Strategy 2022-2027: The LLR Suicide Prevention Strategy and Action Plan support the Healthy Minds section of the Leicester Health, Care and Wellbeing Strategy
- Leicester Mental Health Partnership Board Strategy.

2. Recommendation(s) to scrutiny:

Health Scrutiny Commission are invited to:

- Comment on the draft Leicester, Leicestershire, and Rutland (LLR) Suicide Prevention Strategy.
- Comment on consultation and next steps.

[1] Build an NHS fit for the future – The Labour Party see Build a better future for the NHS

3. Detailed report

3.1 Each death by suicide is a tragedy. Suicide risk reflects wider inequalities, with people facing adversity, such as isolation and economic challenges more likely to be affected. The impacts are long lasting and traumatic. Suicide is devastating for families, friends, neighbours, colleagues, and others. However, suicide can be preventable; lives can be saved with the right support, interventions, and preventative measures.

3.2 The current LLR Suicide Prevention Strategy, which covered the period 2020-2023, is a strong foundation for ongoing efforts. Many priorities continue to be relevant. The refreshed LLR strategy takes on board the latest local evidence and objectives set out in the new National Suicide Prevention Strategy. It will ensure the approach of Leicester City Council, and the wider LLR suicide prevention partnership, continues to be effective and responsive to emerging needs.

3.3 Leadership for suicide prevention sits with Public Health teams in local authorities. Oversight and co-ordination in Leicester, Leicestershire, and Rutland sits with the LLR Suicide Audit and Prevention Group (SAPG). This reports to local Health and Wellbeing Boards. The SAPG is made of representatives from local authorities, ICB, University Hospitals Leicester (UHL), Leicestershire Partnership Trust (LPT), Leicestershire Police, VCSE organisations, universities, and people with lived experience. This broad approach allows the partnership to address broad local priorities and specific place-based needs.

3.4 The latest National Suicide Prevention Strategy[2] was launched in September 2023, with the expectation that its objectives are reflected in local strategies and action plans.

The ambitions of the National Strategy are to:

- reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner.
- continue to improve support for people who self-harm.
- continue to improve support for people who have been bereaved by suicide.

The eight priorities for action include:

- Improving data and evidence to ensure that effective, evidence-informed, and timely interventions continue to be developed and adapted.
- Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.
- Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.
- Promoting online safety and responsible media content to reduce harm, improve support and signposting, and provide helpful messages about suicide and self-harm.
- Providing effective crisis support across sectors for those who reach crisis point.
- Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.

[2] Suicide prevention strategy for England: 2023 to 2028 - GOV.UK (www.gov.uk)

- Providing effective bereavement support to those affected by suicide.
- Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.

3.4 The refreshed local strategy has been developed based on collaboration and partnership with local stakeholders. It has been overseen by a Steering Group which consisted of local authority officers, ICB, LPT, a representative from the Suicide Lived Experience Network, Leicestershire Police and local VCSE organisations.

3.5 An important element of the development of the refreshed strategy has been engagement with professional stakeholders and people with lived experience. Evidence was gathered in focus groups held face-to-face and online, with professionals from across LLR, experts with experience from LPT Youth Advisory Board, LLR Mind, the Suicide Lived Experience Network and the LLR Survivors of Bereavement by Suicide group. Data collected were thematically analysed and the findings used for the development of the strategy.

3.6 Other reports, data and assessments were used to shape the strategy including Joint Strategic Needs Assessments (JSNAs) and HNAs on mental health, substance use and gambling harms, local Health and Wellbeing Board priorities, Child Death Overview Panel (CDOP) reports and insights, and the National Suicide Prevention Strategy (where the expectation is that this is mirrored within local strategies). It was important to stakeholders that the local strategy reflected LLR data and needs, rather than being based primarily of the national strategy.

3.7 The LLR Suicide Prevention Strategy 2024-2029 (See Appendix A below) focusses on 5 key priorities:

Supporting the system to put in place measures to help reduce suicidal ideation and suicides in <u>children and young people.</u>

Although numbers are small there is an increasing national trend for death by suicide in children and young people which we want to address locally. We want to work across the system to support partners to put measures in place to reduce suicidal ideation and behaviours.

Targeted support and resources at <u>higher risk groups and locations</u>, as identified by local and national data and evidence.

There is no single explanation of why people die by suicide. However, there are common risk factors, and higher risk groups. We will use the best available data and evidence to understand our populations and locations, putting targeted interventions in place to address risk.

Improve our local understanding of <u>self-harm</u> and support people with a history of self-harm.

People with a history of self-harm are a key high-risk group, as demonstrated by national and local data. Locally we will work to understand our self-harm rates better, especially regarding data, whilst also working with local services and people with lived experience of self-harm.

Providing effective bereavement support to those affected by suicide.

Every suicide can have a profound and traumatic effect on those close to the individual, as well as the wider community. This puts people experiencing suicide bereavement at risk themselves. We will continue to develop and deliver the local suicide bereavement offer and ensure lived experience voice is captured and used.

Leadership - Work with system partners and communities to support their role within suicide prevention.

Suicide is everybody's business. We will work with key organisations, partners and the community to ensure suicide is considered a priority and everyone has an appreciation of their role within suicide prevention. Working as system leaders, we will act collectively to drive change across LLR.

3.8 The key priorities are underpinned and driven by the guiding principles. The guiding principles are key concepts and ideas which crosscut all the priorities and were key themes that arose from the engagement activities and literature reviews:

- **Co-production and collaboration**
- **Learn from past stories**
- **Data driven**
- **Normalising conversations**
- **Settings-based approach**
- **Trauma informed practice**

3.9 The next steps will be to consult stakeholders about the draft strategy and to act on areas which need amending. Consultation will be face-to-face and online. A version of the online questionnaire is attached in Appendix B below. It covers the priority actions, is open to people, including people with lived experience.

Appendix A: Draft LLR Suicide Prevention Strategy

Y0389 Suicide Prevention 05_V_Pag

Appendix B: LLR Suicide Prevention Strategy Questionnaire

LLR Suicide Prevention Strategy

Appendix C: Evidence of risk of death by suicide

Death by suicide is a complex issue, for which there are common risk factors, and people at higher risk. The national strategy focuses on at risk groups including:

- **Children and young people:**

- Although numbers are low, the national trend is increasing. In 2019 the World Health Organisation found suicide to be the fourth leading cause of death in young people, both sexes combined, aged 15-29 years.[3]
    - Studies found that up to 54% of young people who died by suicide had a history of previous self-harm.
    - Antecedents to death by suicide in young people include academic pressures, bullying (including cyber bullying), bereavement, physical health conditions, family problems, social isolation and abuse or neglect.[4]
- **Middle aged men:**
    - Men are three times more likely to die by suicide than women.[5]
    - Associated factors include living in the most deprived areas, unemployment, and financial hardship.
- **People with a history of self-harm:**
    - Evidence shows that the risk of suicide among those who have self-harmed is much greater than that in the general population, with the risk elevated in the year following an episode of self-harm.[6]
- **People in contact with mental health services:**
    - 26% of all people who died by suicide (2011-2021) had recent contact with mental health services (12 months prior to their death).[7]
- **People in contact with the justice system:**
    - People in contact with the justice system have higher rates of suicide and self-harm behaviour than the general population.[8]
- **People with autism:**
    - It is estimated that around 1 in 7 people (more than 15% of people in the UK) are neurodivergent, meaning that the brain functions, learns and processes information differently. Evidence suggests suicide could be one of the leading causes of early death for people with autism; those diagnosed with autism and no other learning disability are 9 times more likely to die by suicide.[9]
- **Pregnant women and new mothers:**
    - Suicide is the leading cause of direct maternal death in the first year following having a child.[10]
- **People bereaved by suicide:**

[3] World Health Organization, 2019. Suicide worldwide in 2019: Global Health Estimates [Online]. Available at https://www.who.int/publications/i/item/978924002664

[4] C Rodway, S-G Tham, S Ibrahim, et al. Suicide in children and young people in England: a consecutive case series. The Lancet Psychiatry, Volume 3, Issue 8, 751 – 759

[5] Department of Health and Social Care, Suicide Prevention Strategy for England: 2023 to 2028 https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028

[6] Chan, M.K., Bhatti, H., Meader, N., Stockton, S., Evans, J., O'Connor, R.C., Kapur, N. and Kendall, T., 2016. Predicting suicide following self-harm: systematic review of risk factors and risk scales. The British Journal of Psychiatry, 209(4), pp.277-283.

[7] National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report 2024. https://sites.manchester.ac.uk/ncish/reports/annual-report-2024/

[8] See Department of Health and Social Care, Suicide Prevention Strategy for England: 2023 to 2028 https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england-2023-to-2028

[9] Hirvikoski, T. et al. (2015). Premature mortality in autism spectrum disorder. The British Journal of Psychiatry, 207(5).

[10] MBRRACE-UK https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2023/MBRRACE-UK_Maternal_Compiled_Report_2023.pdf

- It is well documented that bereavement due to suicide is different to other forms of loss, including other forms of traumatic or sudden death. Research has shown that bereavement by suicide is associated with suicide risk and poorer mental health.[11]
- Evidence suggests family, friends and acquaintances who are bereaved by suicide may have a risk of dying by suicide that is up to 3 times higher than the general population.

Other risk factors and high-risk groups include:

- People who misuse alcohol and drugs.
- People experiencing problem gambling:
  - Data suggests between 4-11% of suicides in the UK are gambling related.[12]
- Access to means, such as firearms and pesticides, which can largely be driven by specific occupational groups e.g. veterinary works and those within the agricultural sector.
- Armed forces personal and the veteran community.
- Female nurses.
- Financial instability and hardship, including unemployment.
- Relationship breakdown.
- Domestic abuse.
- Trauma:
  - Whether acute (such as accidents or violence) or chronic (such as ongoing abuse), significantly increases suicide risk. Individuals who have experienced trauma may struggle with emotional pain, hopelessness, and suicidal thoughts.
  - Childhood abuse, sexual trauma, and combat-related trauma are all associated with increased suicide risk.

The following findings concern UK deaths by suicide which have been reviewed in the **National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)** 2024 annual report[13]:

- 26% of all people who died by suicide had recent contact with mental health services (12 months prior to their death).
- Of those in contact with clinical care, who died by suicide, 48% of lived alone, 47% had alcohol misuse, 63% had a history of self-harm, and 54% had a diagnosis of mental illness.
- Highest risk of suicide for those accessing acute mental health care settings was 1-2 weeks following discharge.
- The report highlighted people with autism and ADHD as emerging at risk groups; 32 deaths per year in autistic people and 15 in people with ADHD in the UK.
- There were 11 deaths per year for in-patients under 35, and 9 deaths per year in students aged 18-21 under mental health care.

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[11] Pitman, A., Osborn, D., King, M. and Erlangsen, A., 2014. Effects of suicide bereavement on mental health and suicide risk. The Lancet Psychiatry, 1(1), pp.86-94.

[12] Gambling with Lives. Gambling-Suicidal Ideation, attempts and completed suicides data review. 2022. https://www.gamblingwithlives.org/wp-content/uploads/2022/01/Gambling-Suicidal-Ideation-and-Completed-Suicides.pdf

[13] National Confidential Inquiry into Suicide and Safety in Mental Health. Annual Report 2024. https://sites.manchester.ac.uk/ncish/reports/annual-report-2024/

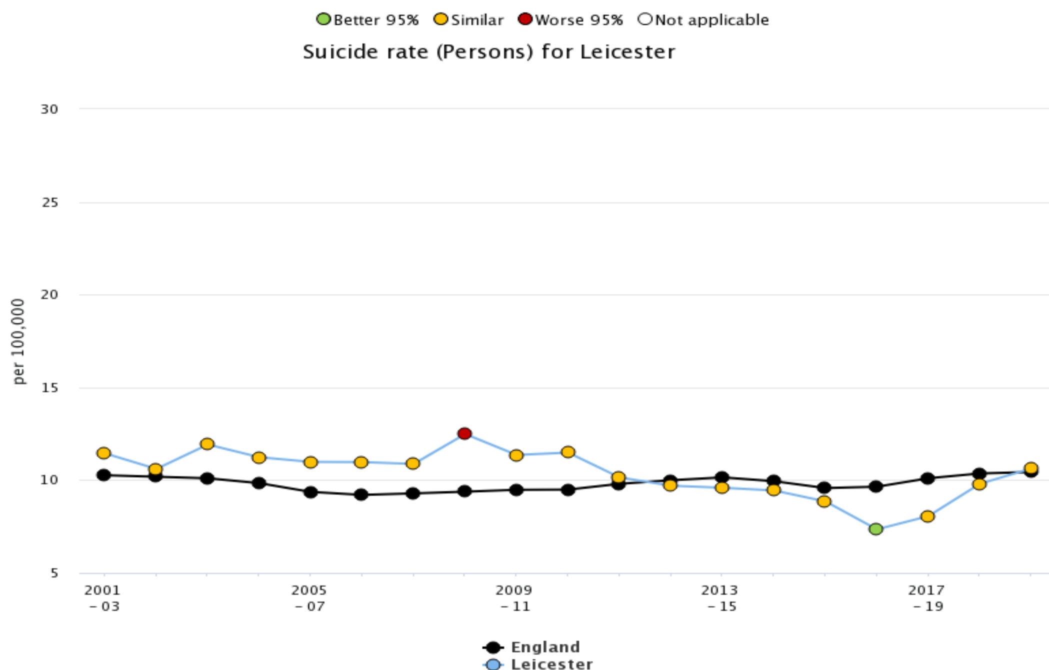
- There were 354 deaths per year in public locations by patients who were generally younger and more acutely unwell.

Appendix D: Suicide in Leicester

Information on death by suicide in Leicester, Leicestershire, and Rutland is underpinned by a mature Real Time Suspected Suicide Surveillance (RTSSS) data and three-year rolling average trends, currently monitored by Office for National Statistics (ONS). RTSSS closely matches the ONS data.

Figure 1 shows the trend in the rate of death by suicide for Leicester since 2001. The suicide rate for all persons in Leicester was 10.6 per 100,000 population for 2019 – 2021. This rate is not significantly different to the national average suicide rate of 10.4 per 100,000 population. The suicide rate in Leicester has not been significantly different to the national average since 2001-3, other than in 2008-10 and 2016-18.

Figure 1: Suicide rate (Persons) Leicester Source: ONS



Nationally, almost 75% of deaths by suicide are by men; and this is mirrored locally. In Leicester, the median (the middle number in an ordered list of numbers) age of people dying by suspected suicide is 42 years for men and 38 for women.

Analysis of RTSSS data for 2023 shows that 42% of people who died by suicide in LLR had a history of self-harm and 41.2% had previously attempted suicide. Other risk factors highlight the complexity of factors underpinning death by suicide:

- **Marital Status**
  - Between 2018 and 2023, 62.9% of Leicester deaths by suspected suicide occurred in single people.
- **Unemployment**
  - In Leicester with 54.8% of people who died by suspected suicide were unemployed.

- The majority of the unemployed that died by suspected suicide were unemployed for more than 3 years.

- **Financial situation**
    - Based on 2023 RTSSSD data, 29.7% of deaths by suspected suicide in Leicester were experiencing financial difficulty.

Appendix E: Mental Health Friendly Places

Mental Health Friendly Places contribute to the LLR suicide prevention strategy by raising awareness about mental wellbeing, promoting resilience to mental illness, and improving access to wellbeing support in Leicester neighbourhoods. A Suicide Prevention Programme Officer (SPPO) coordinates and manages this initiative; recruiting organisations to become MHFPs, developing training offers, listening to local people, learning about their needs, developing supportive networks and evaluating impact.

The ethos underpinning MHFPs is in line with NICE Guidance on Community Engagement[14]. This provides advice on ways to draw on local knowledge, to bring together people in communities to plan, design, develop, deliver, and evaluate action to protect health.

This community development approach aligns with emerging integrated care programme in which the LLR Mental Health Collaborative prioritises placed based approaches. It also supports delivery of the local and national suicide prevention strategies and the need to tackle health inequalities.

In practice the MHFPs initiative encourages people with an interest in supporting local mental wellbeing to access free training and sign up as a Mental Health Friendly Place. The training aims to help people to have safe conversations about mental health and signpost people experiencing adversity in their lives to access local support. In this way, MHFPs encourage openness about everyday adversity which impact on mental health, such as money worries, relationship breakdown, poor housing, insecure employment, and isolation.

Currently there are 23 MHFPs[15] across Leicester. They are situated in areas where the risks of poor mental health are high, such as Belgrave, Braunstone, Highfields, New Parks. Feedback from the MHFPs show that most are having daily conversations with people about their mental health; this includes service users and colleagues, staff members and managers. About a fifth have more conversations about mental health since becoming MHFPs, with most staff feeling confident about having safe conversations about people's mental wellbeing since receiving the training on offer. MHFPs also report being more connected to other local services and projects which are supportive of mental wellbeing.

One MHFP offers this case study:

[14] See Overview | Community engagement: improving health and wellbeing and reducing health inequalities | Guidance | NICE

[15] Two Queens Art Gallery and Studio, P3 Charity, Jamila's Legacy CIC, The Peepul Centre, The Conservation Volunteers (TCV), Shama Women's Centre, Saffron Acres, The Centre Project, African Caribbean Centre, One Roof (homeless support), Team Hub CIC, Turning Point Leicester, Eyres Monsell Club for Children and Young People, LLR Mind, B Inspired, Trade Sexual Health. Working towards MHFP status include Iskcon, MHM Community Connectors, ZamZam, Soft Touch Arts, South Asian Health Action, Peace of Green CIC, Age UK

‘we have had someone visit us a few times over the last few months, and on one visit to us, our staff who have done the e-learning and the Mental Health Aware training, started noticing some of the signs that he may be experiencing a very difficult time, and that things might be more serious than he was letting on. Our staff were able to navigate a chat with him, asking him direct questions whilst also listening to him, being able to offer direct support in simply being available to chat, and ready to signpost him to other support and help.

Just under a week later, he came back in and seemed a lot better in himself. He told us that, whilst he hadn't at that point been feeling like he was thinking about "doing anything", he said "I have done before though", and that on his last visit, he had been "very low". He thanked the staff member for listening and making him 'feel welcome', and said he appreciated that we didn't make him feel embarrassed or judged when he had started crying a bit. He stated that it made him realise that coming to our project was something he really looked forward to, and that "lots of places just don't make the time to get to know people".

He now comes to our project nearly every week and is training to be a Buddy Team Mentor to welcome new people who come to the project, showing them around the site and where the tea and coffee is etc, and always lets other people know if they have anything they want to talk about, they should find one of the team for a chat.’

4. Financial, legal, equalities, climate emergency and other implications

4.1 Financial Implications

This report is to inform, and consult, the Scrutiny Committee about the draft Leicester, Leicestershire, and Rutland (LLR) Suicide Prevention Strategy, and has no direct financial implications.

Signed: Yogesh Patel
Dated: 22-10-2024

4.2 Legal Implications

This report is to inform, and consult, the Scrutiny Committee about the draft Leicester, Leicestershire, and Rutland (LLR) Suicide Prevention Strategy 2024-2029.

Consultation is already being considered and therefore I have not considered when a consultation is required. However key principles in relation to consultation must be considered, namely:
a) The consultation must take place when the proposals are at a formative stage.
b) Sufficient reasons must be given for the proposal “to permit of intelligent consideration and response”.
c) Adequate time must be given to respond.
d) The results must be conscientiously taken into account when finalising the decision.

Any consultees will be those who are liable to be affected by the proposals if they are implemented, including individuals, groups, contractors and the public as a whole. It should include those likely to support the proposals, as well as those likely to object.

The report notes that the work is undertaken collaboratively with Leicestershire County Council and Rutland County Council. Consideration should be given to formalising this collaboration with a collaboration/joint working agreement setting out what each authority does towards the strategy. Legal Commercial can support this drafting if required.

Signed: A Powers
Dated: 28.10.2024

4.3 Equalities Implications

Under the Equality Act 2010, public authorities have a Public Sector Equality Duty (PSED) which means that, in carrying out their functions, they have a statutory duty to pay due regard to the need to eliminate unlawful discrimination, harassment and victimisation, to advance equality of opportunity between people who share a protected characteristic and those who don't and to foster good relations between people who share a protected characteristic and those who don't.

Protected Characteristics under the Equality Act 2010 are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation.

The report invites Comment on the draft Leicester, Leicestershire, and Rutland (LLR) Suicide Prevention Strategy. There is no single explanation of why people die by suicide, however, there are common risk factors, and higher risk groups. Every area is different, with its own community strengths and challenges. Understanding our data and populations is crucial so that we can respond to needs, which could be different across the three areas.

Having a coordinated response to deliver support for those affected by suicide will have a positive impact on people from across all protected characteristics. Suicide risks reflect wider inequalities as there are differences in suicide rates and it is important to take into account equalities considerations and the diversity of the city.

Whilst the proposed strategy is a strategic overarching document setting out priority areas, equality considerations should be embedded throughout with partners, and once an action plan has been agreed, it will be used to monitor delivery and track progress. Consultation/engagement with key stakeholders needs to be accessible, fair and proportionate and targeted to the relevant group(s).

Signed: Surinder Singh
Dated: 21 October 2024

4.4 Climate Emergency Implications

There are no significant climate emergency implications directly associated with this report.

Signed: Aidan Davis, Sustainability Officer, Ext 37 2284
Dated: 18 October 2024

Item 11b

START A CONVERSATION

Leicester, Leicestershire and Rutland

SUICIDE PREVENTION STRATEGY

2024-2029

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Foreword

Foreword to be added here

Introduction

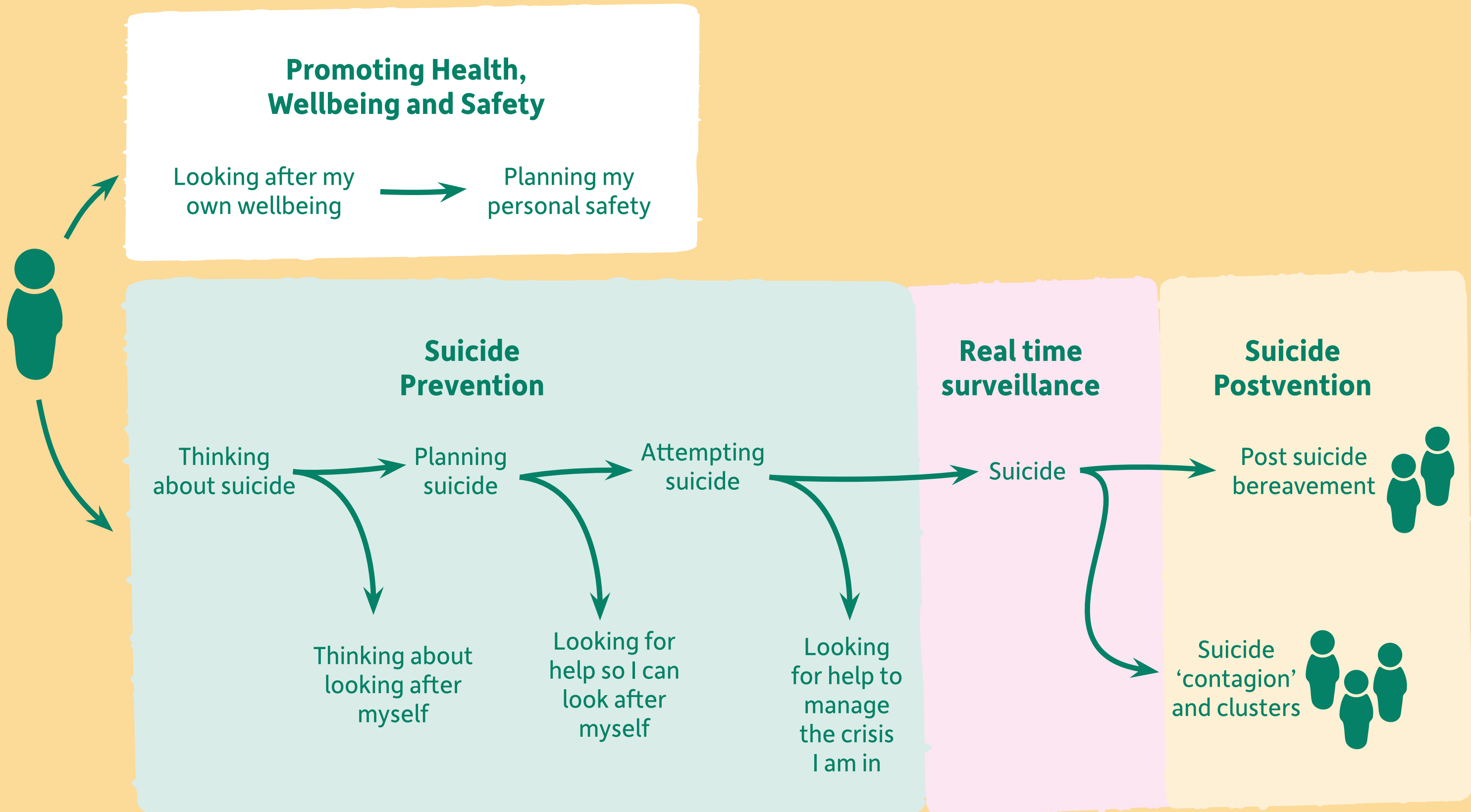
Welcome to the refreshed Leicester, Leicestershire, and Rutland (LLR) Suicide Prevention Strategy 2024-2029. We have worked hard to refresh our strategy through extensive engagement, consultation, and collaboration. By listening to those with lived experience, stakeholders and partners, and using the best available data, we've created a strategy which aims to fit the needs of those who are experiencing suicidal thoughts, and those impacted by suicide, whilst also aiming to stop people from reaching a point where they feel suicide is their only option.

This strategy covers LLR – a diverse area with a population of more than 1.1 million people. Every area is different, with its own community strengths and challenges. Understanding our data and populations is crucial so that we can respond to needs, which could be different across the three areas. However, we work in partnership to harness these strengths and tackle the challenges together.

We have aimed to align our LLR strategy with the National Suicide Prevention Strategy where possible, but ensure our principles and priorities are based on what is needed locally. While suicide is a hugely complex issue, it is one that we believe can be reduced through our joint efforts and collective action. Suicide is not inevitable.

Suicide prevention can mean many different things – covering various interventions, points in people's lives, stages of deteriorating mental health, and crisis points. There are opportunities to prevent poor mental health and opportunities to support those at key points in their life where risk is higher, such as unemployment and financial hardship.

The diagram below sums up the prevention pathway for suicide, clearly demonstrating the touch points where suicide could be prevented, and interventions put in place. Ultimately, we want to prevent suicide at the earliest possible opportunity and stop people going into crisis or having suicidal thoughts. Our strategy aims to capture prevention at all points along the continuum but noting that we are adopting a Public Health approach by understanding our data and populations, and aiming for early interventions where possible, with local services working together to address need.



NHSE Midlands Mental Health Team Suicide Prevention Forum 2024

WHO ARE WE?

We are the LLR Suicide Audit and Prevention Group, a partnership of local authorities, NHS organisations, Leicestershire Police, lived experience and local voluntary and community sector organisations who work together on suicide prevention.

Our previous strategy had 9 priorities

Target support at key High-Risk Groups and at High-Risk Settings	**Protect people with a history of self-harm**	**Preventing suicide in public places**
Support Primary Care to Prevent Suicide	**Engage with Private Sector to Enhance Their Efforts to Prevent Suicide**	**Support Provision of Enhanced Suicide Awareness Training**
Better use of media to manage messages about suicide	**Raise awareness with better data and better use of data**	**Provide a coordinated mental wellbeing approach to COVID-19**

What has been achieved since the previous strategy

Significant progress has been made across these priorities including the commissioning of the LLR Self-Harm service, expansion of the Suicide Bereavement Service and establishment of the LLR Lived Experience Network (for those who have experienced or live with suicidal thoughts, people who have attempted suicide, people living with or in relationships with those who have suicidal thoughts, and those bereaved by suicide). We have continued work on expanding our 'Start a Conversation' website and campaign, launching our new bespoke eLearning, supported by the lived experience network.

We have also worked together to improve our data and evidence, using this to drive service development. Since the previous strategy, we have also established Mental Health Friendly Places. A Mental Health Friendly Place is a public-facing organisation or community space (such as a shop or library) in Leicester, Leicestershire or Rutland that has received training, resources and support to confidently have conversations around low-level mental health and wellbeing. Greater understanding of our data has also led to important developments around high-risk locations, where community responses to local suicides are being utilised, linked to Mental Health Friendly Places, to support hyper local interventions.

However, with the launch of the strategy during the height of the COVID-19 pandemic, there were some elements that we were not able to fully address, which we are open and transparent about. We have used our learning from the previous strategy, to refresh and develop our next strategy iteration based on it being ambitious, but realistic.

Since the launch of the previous strategy, external factors beyond our control (such as the pandemic and cost of living crisis),have likely adversely affected people's mental health and financial stability, both of which are known risk factors for suicide.[1]

KEY ACHIEVEMENTS

Development of the LLR self-harm service

Expansion of the tomorrow project, supporting those bereaved by suicide

Establishment of Mental Health Friendly Places

Lived Experience Network

Establishment of the Lived Experience Network

Production of adult and children's mental health COVID-19 resources

START A CONVERSATION

Start a Conversation eLearning, website revamp and various events and conferences

Established key working group on communications and media, high risk locations and data, which are driving our work in a targeted and evidence-based manner

Ongoing collaboration with Leicestershire Police on the Real Time Suspects Suicide Data

How was this strategy developed?

This strategy has been informed by a wide range of data, both nationally and locally, as well as academic and expert literature, and importantly though engagement of those with lived experience. The mission, principles and priorities were driven by local Joint Strategic Needs Assessments (JSNA) and Health Needs Assessments on mental health, gambling harms, and substance use, as well as by local Health and Wellbeing Board Priorities, Child Death Overview Panel insight and recommendations on suicide, and the Leicester, Leicestershire and Rutland Integrated Care Board (ICB) 5-year plan. The strategy was also developed in line with the National Suicide Prevention Strategy.

A Health Needs Assessment was undertaken, examining our Real Time Suspected Suicide Surveillance Data (RTSSSD) from 2018-2023, as well as exploring our Office for National Statistics (ONS) data. Suicide data often doesn't show the full picture due to time lags, sensitivity and difficulties with reporting, so other sources, such as academic journals, were used to triangulate the findings, as well as explore **intersectionality** where appropriate. Literature was also systematically reviewed to determine the most recent and possible options for preventative activities and interventions.

Intersectionality is a way of understanding how different parts of a person's identity, such as their gender or ethnicity, overlap and combine to shape their experiences in the world.

Engagement with people who have lived experience, and with stakeholders working within suicide and mental health was very important to our strategy development. Focus groups and workshops were held to gather expert voice and were analysed to bring out common themes and areas, which have been translated into our Guiding Principles and Priorities.

The work has been overseen by the LLR Suicide Audit and Prevention Group (SAPG), but developed by a steering group comprising of local authorities, Leicestershire Police, LLR ICB, Leicestershire Partnership NHS Trust, various VCSE organisations and our Lived Experience Network. This strategy is a culmination of collaboration.

National context, drivers and data

National Suicide Prevention Strategy

Suicide prevention is an important public health priority nationally, as well as locally, with suicide rates presenting a significant challenge. In England, suicide rates are 10.3 per 100,000 population, which from 2020-2022 equated to 15,415 deaths.[2] The World Health Organisation estimate that for every suicide, there are in turn 20 non-fatal attempts, which equates to 16 million attempts annually (globally).[3] In response, the National Suicide Prevention Strategy 2023-2028[4] has set forth a comprehensive plan to reduce these rates.

The ambitions set out by the national strategy are:

Reduce the suicide rate over the next 5 years – with initial reductions observed within half this time or sooner

Continue to improve support for people who self-harm

Continue to improve support for people who have been bereaved by suicide

The national strategy also sets out 8 priorities for action

1. **Tailored, targeted support to priority groups, including those at higher risk, to ensure there is bespoke action and that interventions are effective and accessible for everyone.**
2. **Improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted.**
3. **Addressing common risk factors linked to suicide at a population level to provide early intervention and tailored support.**
4. **Promoting online safety and responsible media content to reduce harms, improve support and signposting, and provide helpful messages about suicide and self-harm.**
5. **Making suicide everybody's business so that we can maximise our collective impact and support to prevent suicides.**
6. **Reducing access to means and methods of suicide where this is appropriate and necessary as an intervention to prevent suicides.**
7. **Providing effective bereavement support to those affected by suicide.**
8. **Providing effective crisis support across sectors for those who reach crisis point.**

Our strategy aligns closely with the National Suicide Prevention Strategy4, which underscores a multi-faceted approach to preventing suicide risk. This includes targeting support towards at-risk groups, promoting mental health education, and ensuring timely and effective interventions. Evidence from key academic literature supports these initiatives, highlighting the effectiveness of early intervention, community-based programs, and improved access to mental health services.

Risk Factors and Higher Risk Groups

There is no single explanation of why people die by suicide – suicide is complex. However, there are common risk factors, and higher risk groups. The national strategy focuses on at risk groups including:

Children and young people

- Although numbers are low, there is an increasing national trend which is concerning. In 2019 the World Health Organisation found suicide to be the fourth leading cause of death for young people, both sexes combined, aged 15-29 years.[5]
- Some studies have found that up to 54% of suicides in young people had a history of previous self-harm.[6]
- Antecedents to children and young people's suicides are varied including: academic pressures, bullying (including cyber bullying), bereavement, physical health conditions, family problems, social isolation and abuse or neglect.[6]

Middle aged men

- Men are three times more likely to die by suicide than women.[4]
- Particularly linked to this group are factors around living in the most deprived areas, unemployment and/or financial hardship and difficulties.

People with a history of self-harm

- Evidence shows that the risk of suicide among those who have self-harmed is much greater than that of the general population, with the risk elevated by between 30 to 100-fold in the year following an episode of self-harm.[7]

People in contact with mental health services

- 26% of all people who died by suicide (2011-2021) had recent contact with mental health services (12 months prior to their death).[8]

People in contact with the justice system

- People in contact with the justice system have higher rates of suicide and self-harm behaviour than the general population.[4]

Autistic people

- It is estimated that around 1 in 7 people (more than 15% of people in the UK) are neurodivergent, meaning that the brain functions, learns and processes information differently. Evidence suggest that suicide could be one of the leading causes of early death in autistic people, with those diagnosed with autism and no other learning disability being over 9 times more likely to die by suicide.[9]
- We also need to be conscious of the estimated large numbers of people who are undiagnosed, and the impact this may have on their health and wellbeing, as well as acknowledgment of the lengthy waiting times people often experience before receiving a clinical assessment. This is also prevalent in other **neurodiversity** conditions, such as ADHD.

What do we mean by neurodiversity? People's brains all work in different ways. We all think, speak, feel, act and experience the world differently. Neurodiversity is a term that covers a range of conditions including autism, ADHD, dyslexia, dyspraxia, dyscalculia and Tourette's Syndrome. Neurodiversity encourages acceptance of these differences and conditions, recognising that everyone has unique strengths and challenges.

Pregnant women and new mothers

- Suicide is the leading cause of direct maternal death in the first year following having a child.[10]

Those who have been bereaved by suicide

- It is well documented that bereavement due to suicide is different to other forms of loss, including other forms of traumatic or sudden death. Research has shown that bereavement by suicide is associated with suicide risk and poorer mental health.[11,12]
- Evidence suggests family, friends and acquaintances who are bereaved by suicide may have a risk of dying by suicide that is up to 3 times higher than the general population.

Other risk factors and high-risk groups include (but are not limited to):

- People who misuse alcohol and drugs
- People experiencing problem gambling
  - Data suggests between 4-11% of suicides in the UK are gambling related.[14]
- Access to means, such as firearms and pesticides, which can largely be driven by specific occupational groups e.g. veterinary works and those within the agricultural sector
- Armed forces personal and the veteran community
- Female nurses
- Financial instability and hardship, including unemployment
- Relationship breakdown
- Domestic abuse
- Trauma
  - Whether acute (such as accidents or violence) or chronic (such as ongoing abuse), significantly increases suicide risk. Individuals who have experienced trauma may struggle with emotional pain, hopelessness, and suicidal thoughts.[14]
  - Childhood abuse, sexual trauma, and combat-related trauma are all associated with increased suicide risk.[15,16,17]

The **National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)** 2024 annual report provided the follow findings related to people aged 10 and above who died by suicide between 2011 and 2021 within the UK[8]:

- 26% of all people who died by suicide had recent contact with mental health services (12 months prior to their death).
- Of those who died by suicide in contact with clinical care, 48% of them lived alone, 47% had alcohol misuse, 63% had a history of self-harm, and 54% had one or more mental health diagnoses

Clinical prevention should focus on these common risk factors

- Highest risk of suicide for those accessing acute mental health care settings was 1-2 weeks following discharge

Prevention should focus on ward environment and careful transition to the community

- The report picked out autistic people and patients with ADHD as an emerging group at risk, with 32 deaths per year in autistic people and 15 in those with ADHD
- There were 11 deaths per year for in-patients under 35, and 9 deaths per year in students aged 18-21 under mental health care, highlighting a clearer pathway to NHS services is needed for this cohort
- There were 354 deaths per year in public locations by patients who were generally younger and more acutely unwell

Local suicide prevention plans should address high risk locations

Leicestershire Partnership NHS Trust (LPT), in collaboration with the SAPG, have developed a trust wide plan to address the NCISH recommendations and the common themes associated between mental health services and suicide. Having an LPT Plan will support LLR residents who are in contact with local mental health services and ensure high quality of care. We are working closely to ensure this strategy and the LPT Plan are aligned and work together to address suicide, without duplicating efforts. Therefore, clinical mental health service (LPT delivered) and NCISH recommendations will remain within the LPT Plan.

By incorporating evidence-based strategies and drawing on the latest academic research, our local strategy aims to create a robust framework and action plan to ***prevent suicide and save lives***. This strategy not only supports individuals at risk but also builds a safer, more supportive community. Through collaboration with national initiatives and leveraging the insights from key literature, we are committed to making meaningful strides in suicide prevention.

KEY MESSAGES

1 Suicide is everybody's business

Local picture

KEY MESSAGES

2 Suicide can be preventable

Our data monitoring

Locally we work closely as a system, relying on the hard work of Leicestershire Police, to understand our suicide data using RTSSSD. Data is extracted from the reports completed by the officers that attend the incidents recorded as a suspected suicide. The timely data that we receive from Leicestershire Police helps with identifying emerging patterns and trends, cluster analysis and the detection of vulnerable groups, allowing for real-time surveillance of suicide that enables systems to respond early and appropriate interventions to take place to reduce suicide rates across LLR. The RTSSSD also provides more data per suicide than nationally available data, allowing us to understand our suicides more granularly.

It is important to note that each record represents a death by suspected suicide and is reported by the date the incident occurred and not the date the death was registered. This means that the data is not conclusive as each case is still subject to a Coroner's inquest. The Local Authority level analysis carried out only applies to residents of those Local Authorities that have died by suspected suicide, whereas the LLR-wide analysis includes all cases of death by suicide attended by Leicestershire Police Officers and can therefore also include residents that live outside of LLR.

We also utilise ONS data, which uses confirmed cases of suicide, after a Coroner's inquest. There are differences between the data, as some cases recorded via RTSSSD may not be deemed as a suicide by the Coroner. There is also a time delay with confirmed suicides, with this being approximately 180 days across LLR (101 days Leicester City, 264 Rutland County and 175 Leicestershire County).[18]

RTSSSD is reported as absolute numbers and/or proportions, without calculation of rates, therefore data should be interpreted with caution, and with an appreciation and understanding of the local context and wider demography of LLR. Rutland data is often suppressed (not shown), due to low numbers.

Overall numbers

Between the years of 2020-2022, there were 268 confirmed cases of suicide across LLR.[2] This equates to rates of 9.2 and 9.5 per 100,000 for Leicestershire and Leicester respectively, with the number of suicides in Rutland being too small to calculate a rate. Figure 1 shows the trends of deaths by suicide over time. It can be seen that the local rates fluctuate over time, but at present are not significantly different to the England average but have shown an increase over the last few years.

KEY MESSAGES

3 Suicide has a wide impact

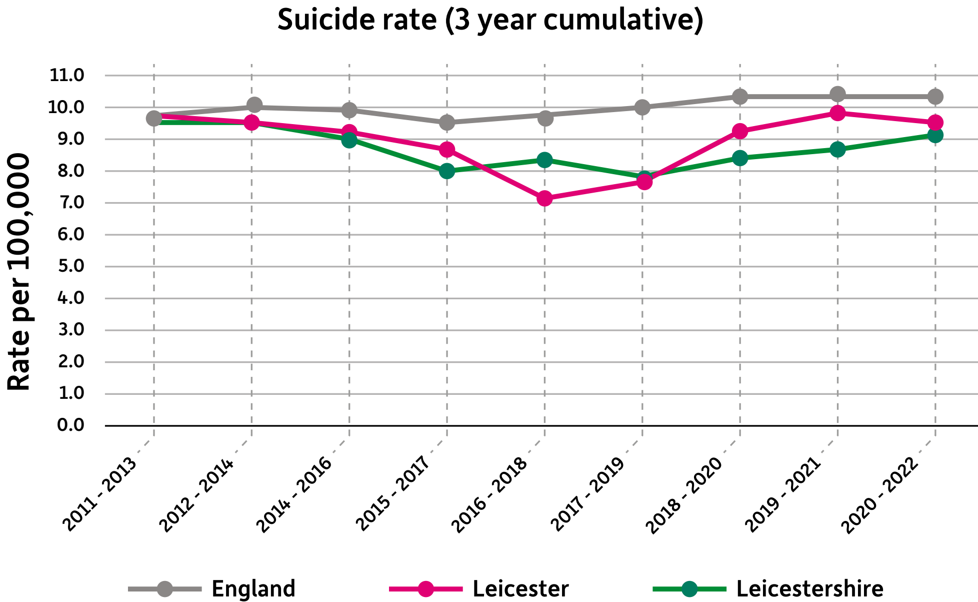


Figure 1 – Suicide rates for Leicester and Leicestershire 2011-2022

The numbers of suicides have also fluctuated over time, as demonstrated in figure 2, but have increased since 2020 (ONS). Although we cannot compare ONS data with RTSSSD, the RTSSSD also shows sequential increases. However, within 2023, a 7.8% decrease on the previous year was reported.

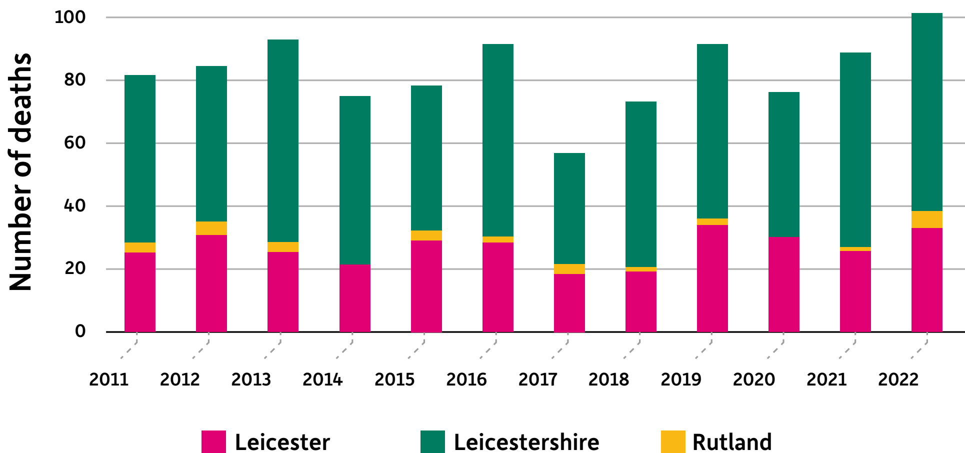


Figure 2 – Numbers of suicides within LLR 2011-2022 Source: ONS

Age

The median (the middle number in an ordered list of numbers) age of suspected suicides varies across LLR (2018-2023), likely due to the varying age demographics per place. Within Leicester, the median ages for men and women are 42 and 38 years respectively, which is younger than the Leicestershire averages at 45 years for males and 49 years for females. Ages within Rutland are again higher at 52 years for males and 57 years for females. Ages also vary across gender, as demonstrated by the RTSSSD in figure 3, with females (46 years) generally being slightly older than males overall (44 years).

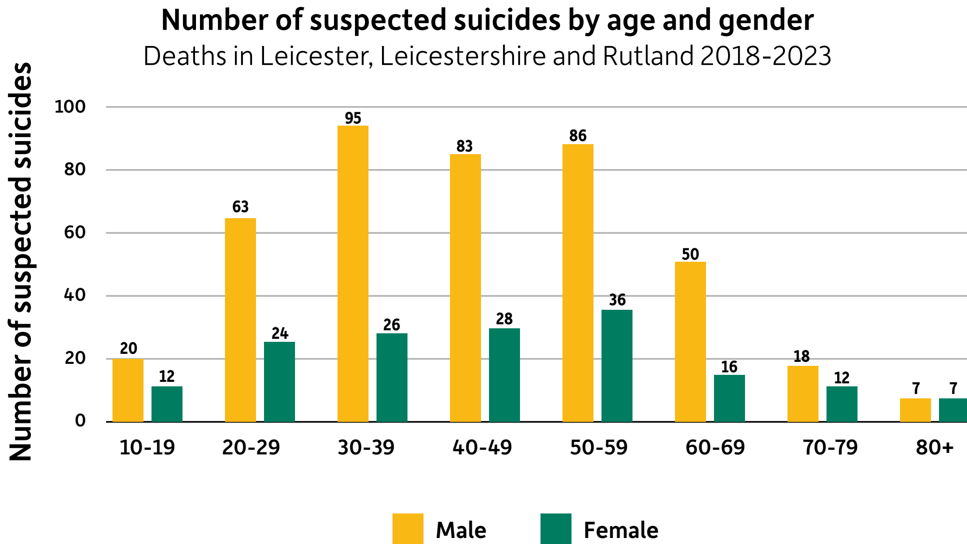


Figure 3 - Numbers of suspected suicide across LLR 2018-2023 by age category and gender

Gender

Nationally, almost 75% of suicides are by men, and this is mirrored locally, with ONS data showing 74.6% of local suicides being in males (figure 4). This can also be broken down by area (figure 5).

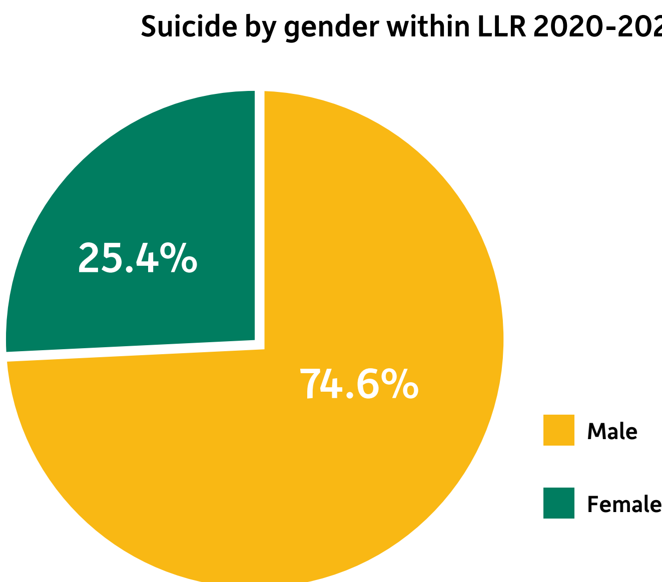


Figure 4 - Suicide by gender split 2020-2022

KEY MESSAGES

4 Some people are at higher risk of suicide

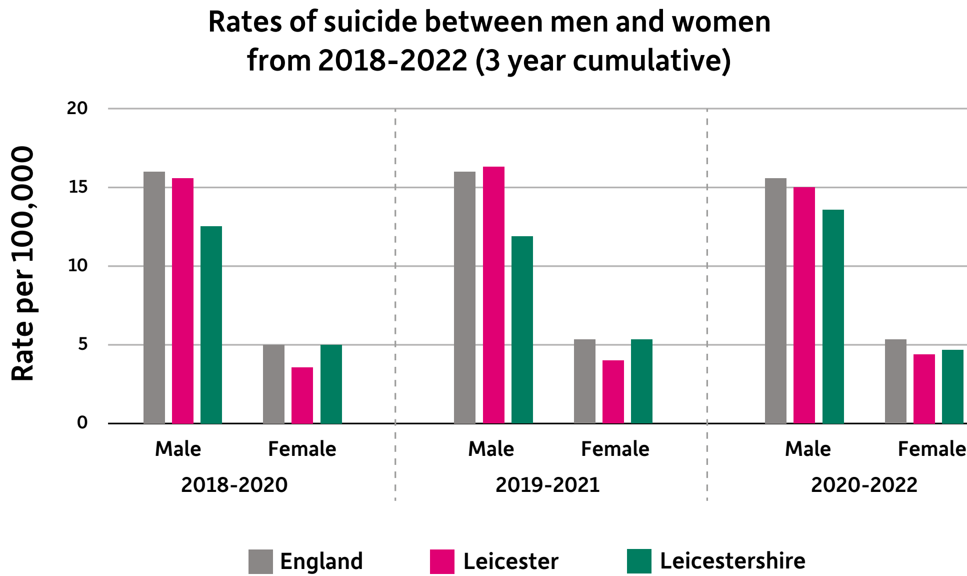


Figure 5 - Suicide rates by gender 2018-2022

Self harm and previous attempts

Self-harm and previous suicide attempt categories within the RTSSSD were only recently separated, therefore data is only available for 2023. Analysis of 2023 data shows that 42% of suspected suicides had a history of self-harm, with a similar proportion (41.2%), having a history of attempting suicide. This demonstrates the significance of the risk factors of self-harm and previous attempts in future deaths.

The Leicestershire and Rutland Adult Mental Health JSNAs estimates 40,000 people to be self-harming and/or attempting suicide per annum[19], with Rutland estimated to be 2,000.[20] Recently, both Leicester and Leicestershire have become significantly worse than the England average for intentional self-harm.

Other factors – key headlines

Other risk factors are also apparent within the RTSSSD and highlight the complexity of suicide, and the intersectionality that could be at play:

Marital Status

- Between 2018 and 2023, 51.6% of Leicestershire deaths, 62.9% of Leicester City deaths and 50% of Rutland deaths occurred in single people. Married people accounted for 18.3% in Leicester City, 26.1% in Leicestershire. 2.2% of all suspected suicides in LLR occurred in those in civil partnerships. This could demonstrate the importance of relationships as a protective factor in suicide.

Unemployment

- Employment is important, with 44.6% of suspected suicide deaths between 2018 and 2023 being in those categorised as unemployed. This is highest within Leicester City with 54.8% of deaths being in the unemployed.
- The majority of the unemployed that died by suspected suicide were unemployed for more than 3 years.

KEY MESSAGES

5 Mental health is as important as physical health

Employment status of suspected suicides 2018-2023
Percentage of total suicides per area

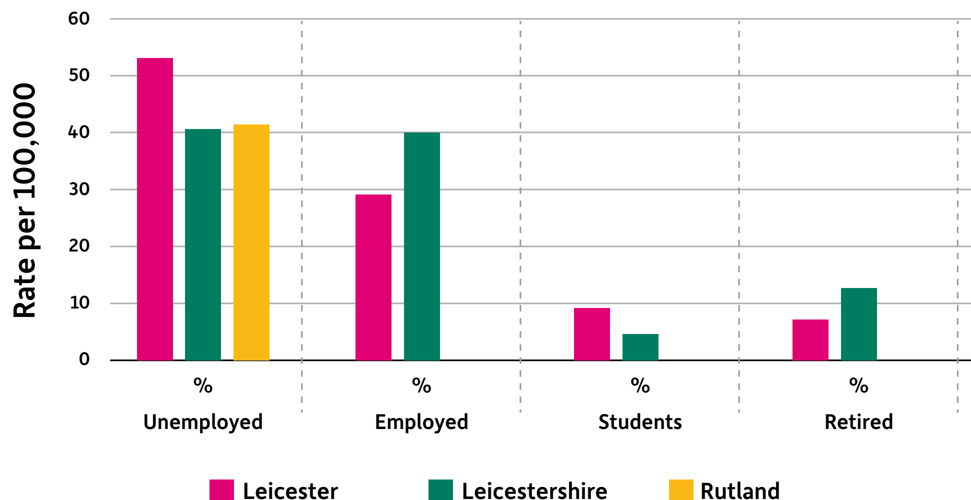


Figure 6 - Suspected suicides by employment status, per area

Financial situation

- Based on 2023 RTSSSD data, 28.6% of suspected suicides were experiencing financial difficulty across LLR. The proportions were higher in Leicester City residents (29.7%) compared to Leicestershire residents (26.7%).

Mental Health Services

- Our local RTSSSD shows higher values than national in those suicides who were in contact with mental health services prior to their death. Nationally 26% of all suicides were in contact with mental health services, however within Leicestershire this value is 43.3%, 46.2% in Leicester and 41.7% in Rutland.
- This could show the importance of local mental health services understanding and committing to their role around suicide prevention, which the new LPT strategy aims to do. However, the higher proportion could also be due to the success of local services reaching more people, therefore more exploration of this data needs to be undertaken for a more thorough understanding.

Suicide Audit and Prevention Group

This is a **system**-wide strategy, which is overseen and delivered by the LLR Suicide Audit and Prevention Group (SAPG). The SAPG draws on expertise from the public, private and voluntary sectors. It works as a multi-agency group and as a wider network. The SAPG is responsible for suicide prevention activity development and implementation.

Core membership of the SAPG and associated sub-groups strives to include:

- Voluntary sector organisations with an interest in mental health, supporting people at risk of suicide and those bereaved by suicide
- Public Health, (Leicester City Council, Leicestershire and Rutland County Councils)
- Leicester, Leicestershire and Rutland Integrated Care Board
- Local Authority commissioners of mental health services (Adult Social Care)
- Safeguarding experts
- Secondary care
- Military and Veterans representatives
- Mental Health Providers (Leicestershire Partnership NHS Trust)
- Criminal Justice System, including Leicestershire Police and Probation
- Services and local prisons
- Emergency services (East Midlands Ambulance Service)
- Universities (University of Leicester, De Montfort University, Loughborough University)
- District councils
- Other local authority services such as education psychology and business intelligence
- British Transport Police

System includes all the organisations (statutory, public and voluntary), settings and resources which are devoted to promoting, sustaining or restoring health, as well as preventing ill health. A system works together to address challenges and help improve the health of the population and the individual.

KEY MESSAGES

6 Early intervention is vital

Our Suicide Prevention Approach 2024-2029

Mission

There is no acceptable number of suicides, and we believe that suicide does not have to be inevitable. That being said, we do need to be realistic about what can be achieved with the challenges that we face and the resources that we have. We also acknowledge circumstances out with our control which have severe and devasting effects, such as pandemics and austerity measures. We cannot put a number or target on suicide reduction due to this but strive on our mission to "**prevent suicide and save lives**".

Key messages

From reading this strategy, there are several key messages we want people to remember and share where they can. We need to raise the profile of suicide prevention, and reduce the stigma attached to suicide, and more widely around mental health. We want people to talk about their mental health and not be afraid to reach out for help. Some of these are local key messages, whilst others reflect the messages within the national strategy:

1 Suicide is everybody's business

We challenge attitudes to suicide by improving knowledge of suicide risk behaviour and the signs of mental illness. We will work together to maximise our collective impact and support, to prevent suicides within LLR, intervening as early as possible. Everyone should feel confident and have the skills to help prevent suicide.

2 Suicide can be preventable

Suicides are not inevitable. We need to build individual and community resilience and support those at higher risk. Suicide rates can be influenced by external factors outside of our control; however, it is important to be accountable and deliver actions to mitigate circumstances where possible and reduce suicides.

3 Suicide has a wide impact

Over the last three years, on average 90 people died per year from suicide in Leicester, Leicestershire and Rutland. The reverberations from suicide are felt far and wide, impacting on individuals, families and communities, with an estimated 10 people intimately affected by every suicide. The impacts are also financial, including costs of care, loss of productivity and earnings and are felt by local businesses, individuals and communities.

4 Some people are at higher risk of suicide

Suicide risk is higher in particular groups – men are 3 times more likely to die by suicide than women. It is important to target and tailor resources at our local higher risk groups, and that individual needs and experiences are considered in the design and delivery of local services. Those bereaved by suicide are also at higher risk.

5 Mental health is as important as physical health

We must reduce stigma surrounding suicide and mental health, increasing the value put on positive mental health, so people feel able to seek help – through the routes that work best for them. This includes raising awareness that no suicide is inevitable.

6 Early intervention is vital

Although providing support to those in crisis or having suicidal thoughts is essential, we need to act as early as possible to stop people from reaching this point.

Our Suicide Prevention Approach 2024-2029

Plan on a page

Guiding principles

Co-Production and Collaboration
Learn from past stories
Data driven
Normalising conversations
Settings-based approach
Trauma Informed Practice and Care

Our mission from this strategy is to prevent suicide and save lives across Leicester, Leicestershire and Rutland

Key Priorities

Children and Young People
High Risk Groups and Locations
Self-Harm
Bereavement
Leadership

Key Messages

Suicide is everybody's business
Suicide can be preventable
Suicide has a wide impact
Some people are at higher risk of suicide
Mental health is as important as physical health
Early intervention is vital

Guiding Principles

Our strategy was developed through research, insight and engagement. During the process key themes kept arising, which we felt as a partnership should guide our work. Rather than being priorities, these are principles which should underpin our work, and help us deliver on our priorities, and ultimately achieve our mission to prevent suicide and save lives. Although not mentioned explicitly, upskilling individuals and organisations is crucial in our delivery and will form key aspects within our actions to deliver the priorities.

Co-Production and Collaboration

Meaningful and authentic lived experience involvement will underpin everything we do and will be viewed as an essential part of delivering effective services and interventions.

Learn from past stories

We will seek to understand our local suicides and the intersectionality of factors, using this to inform our future work.

Data driven

Our work will be driven by our understanding of local data, and the current and emerging evidence base to reduce suicides. We will target our work using data and evidence, ensuring we reach those that need help the most.

Normalising conversations

We will strive to reduce stigma and taboo around suicide and mental health and encourage people to Start a Conversation. This will be instrumental to all of our work and our priority areas. We will work with local media on aspects of mental health and suicide, ensuring stories are portrayed sensitively and safely, in line with current guidance, and challenge inappropriate reporting and conversations where necessary.

Settings-based approach

We will adopt a settings-based approach to integrate suicide prevention activity into local communities, organisations and sectors, emphasising education, awareness and training, with a strong focus on early intervention, and local leadership.

Trauma Informed Practice and Care

We will work to adopt a Trauma Informed Approach in our interactions, delivery and commissioning: understanding past experiences and the needs of the people we serve, including being sensitive to any trauma they may have experienced. By offering support early and being thoughtful in how we provide care, we can help improve lives.

Trauma Informed Practice (TIP) is an approach that recognises and responds to the impact of trauma on an individual. It involves recognising, understanding and responding to the effects of all types of trauma in a way that emphasises safety, trust and empowerment, whilst avoiding traumatisation.

Key Priorities

Our priorities reflect areas which are most important to our stakeholders and those with lived experience, whilst also being data driven. Our priorities are areas which we believe we can directly have an impact on. When devising this strategy, a conscious effort has been made to ensure it is ambitious but also realistic. Our priorities will be driven by our guiding principles.

A robust action plan will bring partners together to ensure our priorities are achieved. We will strengthen approaches through leadership, effective training, proper use of communications and media, and supporting others to take accountability and understand their role in relation to suicide prevention and the priorities below.

Our priorities are:

Supporting the system to put in place measures to help reduce suicidal ideation and suicides in children and young people

Although numbers are small, the national increasing trend is a concern locally. Early interventions, and person-centred support for younger populations can lead to improved mental health and wellbeing, improved resilience and the ability to self-help, both now and into their adult lives. We want to build on the recommendations from the LLR Child Death Overview Panel, and work across the system to support partners to put measures in place to reduce suicidal ideation and behaviours. We want to understand the local system and ensure that suicide becomes everybody's businesses.

We want to normalise conversations around mental health from an early age and equip partners with tools and expertise around building resilience in our children and young people, as well as supporting other factors such as bullying, including cyber bullying, and educating young people on signs and symptoms of poor mental health and where to get help.

Targeted support and resources at higher risk groups and locations, as identified by local and national data and evidence

Suicide, and the reasons behind are extremely complex, numerous and interlinked. However, by using national data, our RTSSSD and academic literature we can continue to understand the risk factors, higher risk groups and high-risk locations. We will identify and target high risk groups and risk factors, which may include, but are not limited to:

- Middle-aged men
- People in contact with mental health services
- People with substance use challenges
- Autistic people
- Unemployed
- Those in financial hardship
- People experiencing problem gambling
- Those with access to means, such as particular job sectors
- Veterans and those in the armed forces
- Impact of rurality, especially around loneliness and isolation
- Those within the agricultural and farming industries
- Care leavers

We will improve our data utilisation and understanding, taking into account intersectionality of factors that contribute to suicide. We will learn from past stories and put this learning into practice, targeting those higher risk groups, addressing risk factors and working with other organisations to expand our reach. Using a settings-based approach will be crucial to any intervention development and delivery. By working with different settings to strengthen community action, develop skills and knowledge (through training) and create supportive environments, we aim to have a larger impact.

By understanding where local suicides occur, we will continue our work on high-risk locations, aiming to put prevention plans in place. In the County, through our work on Health in All Policies we will work with planning colleagues on highway design, ensuring suicide is factored in through health impact assessments of planning policy and local design.

Improve our local understanding of self-harm and support people with a history of self-harm

People with a history of self-harm are a key high-risk group, as demonstrated by national and local data. Locally we will work to understand our self-harm rates better, especially regarding data, whilst also working with local services and people with lived experience of self-harm.

Ultimately, we aim to improve the support on offer to people with a history of self-harm, across all age groups, ensuring their needs are met within a timely manner.

Providing effective bereavement support to those affected by suicide

Every suicide can have a profound and traumatic effect on those close to the individual, as well as the wider community. This puts people experiencing suicide bereavement at risk themselves.

We will continue to develop and deliver the local suicide bereavement offer and ensure lived experience voice is captured and used. We will work on national guidance around how best to support those bereaved by suicide including providing effective and timely support and providing effective local responses to the aftermath of suicide.

Leadership - Work with system partners and communities to support their role within suicide prevention.

We will work with key organisations, partners and the community to ensure suicide is considered a priority and everyone has an appreciation of their role within suicide prevention. Working as system leaders, we will act collectively to drive change across LLR.

It is crucial to work with our system partners and communities to understand their influences to supporting suicide prevention. We will guide them and provide access to resources and further support, such as training and communications and ensure they are engaged with our Start a Conversation campaign.

The whole is greater than the sum of its part, therefore working collaboratively is key for us achieving our aim of ‘preventing suicides and saving lives’.

How will we monitor and measure success?

A robust action plan will be developed and refreshed annually, to provide tangible and measurable actions. There will also be annual progress reports. Overall numbers of suicides will continue to be monitored and actions put in place to address new and emerging trends.

The action plan will be overseen by the SAPG and discussed as a standing agenda item. Progress against the strategy will also be reported to the relevant Health and Wellbeing Boards and place-based Mental Health meetings and collaboratives.

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Thank you to all partners involved in the creation of this strategy and who work together locally to prevent suicide and save lives.

Thank you to all others who have contributed to the strategy and whose voice has helped shape it.

Have your say on our draft Suicide Prevention Strategy 2024-2029

Suicide is not inevitable, it can be preventable when early risk factors are identified. The strategy describes how organisations (such as councils, voluntary sector organisations, the police and NHS) plan to work together across Leicester, Leicestershire and Rutland (LLR) to prevent suicide over the next 5 years.

The draft Suicide Prevention Strategy 2024-2029 sets out a shared vision and priorities with the overall aim of reducing the number and rates of suicide deaths across LLR, which have remained at same levels over recent years.

The strategy was built on available data, evidence of best practice, intelligence and input from a wide range of stakeholders and people with lived experience.

Suicide prevention is a shared responsibility and requires meaningful partnerships between organisations and communities. In short, suicide prevention is everyone's business.

That is why we want to hear your views on the draft Suicide Prevention Strategy for Leicester, Leicestershire and Rutland. Your views will be used to inform the final version of the strategy, and the corresponding action plan which will detail how the priorities will be achieved.

Please read the supporting information provided before completing the survey. *Link to have your say page*

Thank you for sharing your views, they are important to us.

Do not use the back button on your browser/device as you may lose your response. Use the buttons below to navigate the survey.

Please note: Your responses to the main part of the survey (including your comments) may be released to the general public in full under the Freedom of Information Act 2000. Any responses to the questions in the 'About you' section of the questionnaire will be held securely and will not be subject to release under Freedom of Information legislation, nor passed on to any third party. To find out more about how, why and what information we use please visit https://www.leicestershire.gov.uk/about-the-council/data-protection-and-privacy

Please be aware that the theme of this strategy and survey is an emotive one and includes information on suicide and self-harm. Please prioritise your own wellbeing whilst completing this survey. Please take care of yourself and seek help if you need it.

If you feel that you require support, please consider visiting the Start a Conversation website which provides a wealth of information on matters relating to topics discussed in this survey. This includes providing contact details for sources of mental health support. Details will be provided once you click submit to this survey.

(Note: if leaving the survey during completion, you will not be able to save your progress).

Q1 In what role are you responding to this consultation?

- ○ Leicester, Leicestershire or Rutland resident
- ○ Interested member of the public
- ○ Leicester City, Leicestershire County or Rutland County Council employee
- ○ Representative of another public sector organisation (e.g. district/borough/parish council, health, police etc.)
- ○ Representative of a voluntary sector organisation, charity or community group
- ○ Representative of a business or private sector organisation
- ○ Representative of a school or other educational establishment
- ○ Elected Member or councillor (e.g. city, county, district or parish/town)
- ○ Other (please specify)

If 'Other', please specify

Q2 If you are responding as a representative of a business or organisation, please provide the following information: *Routed if they tick representative or business (options 4~7) in Q1*

Your name:

Organisation name:

This information may be subject to disclosure under the Freedom of Information Act 2000

Q3 Are you providing your organisation's official response to the consultation? *Routed if they tick representative or business (options 4~7) in Q1*

- Yes
- No

Q4 Which council do you work for? *Routed if they tick 'LLR council employee' (option 3) in Q1*

- Leicester City Council
- Leicestershire County Council
- Rutland County Council

Q5 In which area is your organisation based? *Routed if they tick representative of organisation business (option 3~8) in Q1*

- Blaby district
- Charnwood borough
- Harborough district
- Hinckley & Bosworth borough
- Melton borough
- North West Leicestershire district
- Oadby & Wigston borough
- Leicester City
- Rutland
- Outside of Leicester, Leicestershire and Rutland
- Prefer not to say

Q6 Which area do you live in? *Routed if they tick 'LLR resident' or 'Interested member of the public' (option 1) in Q1*

- Blaby district
- Charnwood borough
- Harborough district
- Hinckley & Bosworth borough
- Melton borough
- North West Leicestershire district
- Oadby & Wigston borough
- Leicester City
- Rutland
- Outside of Leicester, Leicestershire and Rutland
- Prefer not to say

Your experience

Please be aware that the theme of this strategy and survey is an emotive one and includes information on suicide and self-harm. Please prioritise your own wellbeing whilst completing this survey. Please take care of yourself and seek help if you need it.

(Note: if leaving the survey during completion, you will not be able to save your progress).

Q7 In the last 12 months have you accessed formal support for your mental health (e.g. from NHS mental health services)? *Not routed (asked of all)*

- Yes
- No
- Prefer not to say

Lived or living experience of suicide
This includes people who have experienced or currently live with suicidal thoughts, people who have attempted suicide, people living with or are in relationships with those who have suicidal thoughts or those that have attempted suicide, and those bereaved by suicide.

Q8 Based on the description above, do you have lived or living experience of suicide? *Not routed (asked of all)*

- Yes
- No
- Prefer not to say

Our draft strategy

Our Guiding Principles

Our strategy has six Guiding Principles which will flow through all areas of work.

1. **Co-production and collaboration** - Meaningful and authentic lived experience involvement will underpin everything we do and will be viewed as an essential part of delivering effective services and interventions.

2. **Learn from past stories** - We will seek to understand our local suicides and the intersectionality of factors, using this to inform our future work.

3. **Data driven** - Our work will be driven by our understanding of local data, and the current and emerging evidence base to reduce suicides. We will target our work using data and evidence, ensuring we reach those that need help the most.

4. **Normalising conversations** - We will strive to reduce stigma and taboo around suicide and mental health and encourage people to Start a Conversation. This will be instrumental to all of our work and our priority areas. We will work with local media on aspects of mental health and suicide, ensuring stories are portrayed sensitively and safely, in line with current guidance, and challenge inappropriate reporting and conversations where necessary.

5. **Settings-based approach** - We will adopt a settings-based approach to integrate suicide prevention activity into local communities, organisations and sectors, emphasising education, awareness and training, with a strong focus on early intervention, and local leadership.

6. **Trauma Informed Practice and Care** - We will work to adopt a Trauma Informed Approach in our interactions, delivery and commissioning: understanding past experiences and the needs of the people we serve, including being sensitive to any trauma they may have experienced. By offering support early and being thoughtful in how we provide care, we can help improve lives.

Full details about our Guiding Principles can be found in the supporting information. Please refer to this detail when answering the following questions.

Q9 Overall, to what extent do you agree or disagree with our Guiding Principles?

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
○	○	○	○	○	○

Why do you say this? Is there anything else we should consider within our Guiding Principles?

Our strategic priorities

We would like your views on our five strategic priorities. We will focus on achieving these priorities over the next five years.

1. Supporting the system to put in place measures to help reduce suicidal ideation and suicides in **children and young people**

2. Targeted support and resources at **higher risk groups and locations**, as identified by local and national data and evidence

3. Improve our local **understanding of self-harm** and support people with a history of self-harm

4. Providing effective **bereavement** support to those affected by suicide

5. **Leadership** - Work with system partners and communities to support their role within suicide prevention.

Full detail about our strategic priorities can be found in the supporting information. Please refer to this detail when answering the following questions.

Priority 1

Although numbers are small there is an increasing national trend for death by suicide in children and young people which we want to address locally. We want to work across the system to support partners to put measures in place to reduce suicidal ideation and behaviours.

Priority 1: Supporting the system to put in place measures to help reduce suicidal ideation and suicides in **children and young people**

Q10 To what extent do you agree or disagree with this priority?

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
○	○	○	○	○	○

Why do you say this? Is there anything else we should consider about this priority?

Priority 2

There is no single explanation of why people die by suicide – suicide is complex. However, there are common risk factors, and higher risk groups. We will use the best available data and evidence to understand our populations and locations, putting targeted interventions in place to address risk.

Priority 2: Targeted support and resources at higher risk groups and locations, as identified by local and national data and evidence

Q11 To what extent do you agree or disagree with this priority?

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
○	○	○	○	○	○

Why do you say this? Is there anything else we should consider about this priority?

Priority 3

People with a history of self-harm are a key high risk group, as demonstrated by national and local data. Locally we will work to understand our self-harm rates better, especially regarding data, whilst also working with local services and people with lived experience of self-harm.

Priority 3: Improve our local understanding of self-harm and support people with a history of self-harm

Q12 To what extent do you agree or disagree with this priority?

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
○	○	○	○	○	○

Why do you say this? Is there anything else we should consider about this priority?

Priority 4

Every suicide can have a profound and traumatic effect on those close to the individual, as well as the wider community. This puts people experiencing suicide bereavement at risk themselves. We will continue to develop and deliver the local suicide bereavement offer and ensure lived experience voice is captured and used.

Priority 4: Providing effective bereavement support to those affected by suicide

Q13 To what extent do you agree or disagree with this priority?

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
○	○	○	○	○	○

Why do you say this? Is there anything else we should consider about this priority?

Priority 5

Suicide is everybody's business. We will work with key organisations, partners and the community to ensure suicide is considered a priority and everyone has an appreciation of their role within suicide prevention. Working as system leaders, we will act collectively to drive change across LLR.

Priority 5: Leadership - Work with system partners and communities to support their role within suicide prevention.

Q14 To what extent do you agree or disagree with this priority?

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
○	○	○	○	○	○

Why do you say this? Is there anything else we should consider about this priority?

Overall feedback on our draft Suicide Prevention Strategy 2024-29

Q15 Overall, to what extent do you agree or disagree with our draft Suicide Prevention Strategy 2024-29?

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don't know
○	○	○	○	○	○

Why do you say this?

Q16 What else, if anything, should we consider within our draft Suicide Prevention Strategy 2024-29? Do you have any views about what we could do to deliver this?

Characters remaining: left

Q17 Do you have any other comments or suggestions about our draft Suicide Prevention Strategy 2024-29?

Characters remaining: left

Further information

Q18 Thinking about the views and experiences you have shared in this survey, in which local area do they primarily relate to? *Not routed (asked of all)*

- Leicester City
- Leicestershire County
- Rutland County
- Across Leicester, Leicestershire and Rutland

About you

Questions routed for residents, public and LLR council employees

Leicester, Leicestershire and Rutland councils are committed to ensuring that their services, policies, and practices are free from discrimination and prejudice, address the needs of all sections of the community and promote and advance equality of opportunity.

Many people face discrimination in society because of their personal circumstances and for this reason we have decided to ask these monitoring questions.

We would therefore be grateful if you would answer the following questions. You are under no obligation to provide the information requested, but it would help us greatly if you did.

Q19 What is your gender?

- Male
- Female
- I use another term

Q20 Is the gender you identify with the same as your sex registered at birth?

- Yes
- No

Q21 What was your age on your last birthday? Please enter your answer in numbers not words.

Q22 What is your full postcode?
This will allow us to gather geographical information about your area. It will not identify your house.

Q23 Are you a parent or carer of a young person aged 17 or under?

- ◯ Yes
- ◯ No

If yes, what are the ages of the children in your care? Please tick all applicable.

- ☐ 0-4
- ☐ 5-10
- ☐ 11-15
- ☐ 16-17

Q24 Are you a carer of a person aged 18 or over?

- ◯ Yes
- ◯ No

Q25 Do you have a long-standing illness, disability or infirmity?

- ◯ Yes
- ◯ No

Q26 What is your ethnic group?

- ◯ White
- ◯ Mixed
- ◯ Asian or Asian British
- ◯ Black or Black British
- ◯ Other ethnic group

Q27 What is your religion?

- ◯ No religion
- ◯ Christian (all denominations)
- ◯ Buddhist
- ◯ Hindu
- ◯ Jewish
- ◯ Muslim
- ◯ Sikh
- ◯ Any other religion

Q28 What is your sexual orientation?

- ◯ Bi
- ◯ Gay or Lesbian
- ◯ Straight/ Heterosexual
- ◯ I use another term

Thank you for your assistance. Your views are important to us.

When the consultation closes on **20 December** we will refine the strategy based on the responses we have received. The strategy will then be presented in **Spring 2025**.

Please click the 'Submit button' to send your response.

Data Protection: Personal data supplied on this form will be held on computer and will be used in accordance with current Data Protection Legislation. The information you provide will be used for statistical analysis, management, planning and the provision of services by the county council and its partners. Leicester City Council, Leicestershire County Council and Rutland County Council will not share any personal information collected in this survey with its partners. We do not ask participants to identify themselves. There may be occasions where identification is possible from the information in the responses or accidentally disclosed information in free text boxes. We will treat this information as personal data and will not disclose it with our partners and anonymise it when possible. The information will be held in accordance with the council's records management and retention policy.

Information which is not in the 'About you' section of the questionnaire may be subject to disclosure under the Freedom of Information Act 2000.

Public Health & Health Integration Scrutiny Committee

Work Programme 2024 – 2025

Meeting Date	Item	Recommendations / Actions	Progress
9 July 2024	Health Protection Update	Draft TB Strategy and Action Plan, screening and food plan to be added to the work programme.	Added to the work programme.
	Health Overview	Site visit to be arranged to UHL Emergency Department.	Dates being identified.
		Work to be shared with commission in future on GP access contact system when developed.	Added to work programme.
	ICB 5-Year Forward Plan: Pledge 1 – Improving Health Equity & Pledge 2 Preventing Illness	Members to be informed to contact the Deputy City Mayor if aware of issues where residents are unable to register at a GP.	
		Work programme to be revised to bring vaccinations and screening forward.	Revised on the work programme.
		Report to be circulated to Members for ICB priorities for 2024-25 following it discussion at its own Board in August. Separate briefing session to be considered to discuss pledge monitoring dashboard.	Report circulated.
		Separate briefing session to be arranged to discuss dashboard	Dates being identified.

Meeting Date	Item	Recommendations / Actions	Progress
10 September 2024	Health Protection Update	TB Action Plan to added to the work programme.	Updated on the work programme.
	Winter Planning	Fuel poverty and health programme to consider environmental impacts.	
		Details of volunteer groups to support patients returning home/community to be circulated.	
		Communications to be shared with members on how to get vaccines, details of the roving unit, 111 service, blood pressure and cholesterol checks for promoting. The internal process for sharing health messages to ward councillors to also be reviewed.	Shared with officers to share with members.
		Consideration to be given to use of medical jargon in communication to ensure clear for members of the public to understand.	Noted and shared with all health partners for future reports.
		Information to be shared on 111 call back numbers and waiting times.	
	Work Programme	Adult mental health and health status of Leicester residents to be added to the work programme.	Added to the work programme.
		Self-harm and suicide prevention to be incorporated into suicide strategy discussion.	Shared with health colleagues to incorporate within report.
	AOB		

Meeting Date	Item	Recommendations / Actions	Progress
		Consideration to be given to transport links and how this is communicated to staff to prevent parking on side streets to avoid parking charges.	
5 November 2024	Health Protection Update Critical Incident Update Vaccinations & Screening Adult Mental Health LLR Suicide Strategy		
21 January 2025	*Suggested items tbc:* *Health Protection Update* *Budget* *GP Access* *CYP Mental Health Referral Update* *Smoking & Vaping*		

Meeting Date	Item	Recommendations / Actions	Progress
4 March 2025	*Suggested items tbc:* *Health Protection Update* *Health Research* *Long Term Conditions* *Health & Wellbeing Strategy & Health & Wellbeing Survey*		
29 April 2025	*Suggested items tbc:* *Health Protection Update* *Oral Health* *Sexual Health*		

Forward Plan Items (suggested)

Topic	Detail	Proposed Date
Update on UHL Finances **UHL**	The Chair has requested a briefing note.	
ICB 5 Year Forward Plan – Pledges **ICB**	Pledge 1 – Improving Health Equity Pledge 2 – Preventing Illness	9 July 2024 9 July 2024

Drug and alcohol services **Public Health**	Agreed at the Joint Public Health & Health Integration and Adult Social Care Scrutiny Meeting on 30 November 2023 that the item to remain on the work programme.	
Maternity CQC Inspection **UHL**	Item discussed at the Commission on 7 November. Requested item to remain on the work programme for further updates on the improvement plan. The Chair has requested a briefing note.	
UHL Reconfiguration **UHL**	Item discussed at the Commission on 7 November. Requested item to remain on the work programme for further updates. Update to be provided at Leicester, Leicestershire & Rutland Joint Health Scrutiny Committee on 27 November 2024.	
Death by Suicide **Public Health & LPT**	Agreed at the Joint Adult Social Care and Public Health and Health Integration Meeting on 30 November that the item be listed on the work programme. Leicestershire County Council leading suicide strategy to be shared with commission.	
Workforce – Health Apprenticeships **ICB**	Agreed at the Joint Adult Social Care and Public Health and Health Integration Meeting on 30 November that the item remain on the work programme and there be particular tracking of apprentices. Leicester, Leicestershire & Rutland Joint Health Scrutiny Committee requested a briefing note. Item to be discussed at Leicester, Leicestershire & Rutland Joint Health Scrutiny Committee 17 March 2025.	

Local Patient Satisfaction Survey **ICB**	Agreed at the meeting on 12 December the commission be updated in 2024 with results of local patient satisfaction survey and also information on inequalities plans being drawn up by practices. Information to be provided to Leicester, Leicestershire & Rutland Health Scrutiny Committee – 17 July 2024.	
Virtual Wards **UHL**	Agreed at the meeting on 6 February that the item be added to the work programme. Agreed at the meeting on 16 April that health partners would host a briefing session for Members. Briefing session provided to Members.	
Elective Care **UHL**	Agreed at the meeting on 6 February that the item to remain on the work programme for future updates and monitoring of waiting lists. The Chair has requested a briefing note.	
CYP Mental Health **ICB**	Agreed update will be provided to Commission on agreed actions from informal scrutiny meeting in the new municipal year. Chair and Cllr Sahu received a briefing update in July and agreed for a report to be shared with the Commission in January 2025.	
GP Access **ICB**	Commission requested item be added to breakdown for an update on GP access following communications regarding how residents can make appointments and a poll that indicated Leicester residents have most difficulty accessing. Update to be provided to Leicester, Leicestershire & Rutland Joint Health Scrutiny Committee – 17 July 2024.	

Emergency Department **ICB / UHL**	The Commission requested at the meeting on 16 April 2024 item to discuss processes and targets in the emergency department to better understand experience for patients.	
Corporate Complaints **ICB**	To be discussed at Leicester, Leicestershire & Rutland Joint Health Scrutiny – 27 November 2024.	
Transforming Care – Learning Disabilities and Autism Update	Discussed at Leicester, Leicestershire & Rutland Joint Health Scrutiny – 17 July 2024.	
Pharmaceutical Issues	To be discussed at Leicester, Leicestershire & Rutland Joint Health Scrutiny – 27 November 2024.	
Women's Health	To be discussed at Leicester, Leicestershire & Rutland Joint Health Scrutiny – 27 November 2024.	
Digital Strategy	To be discussed at Leicester, Leicestershire & Rutland Joint Health Scrutiny – date tbc.	
Healthy food provision action plan	The Commission raised concerns at the meeting on 9 July 2024 about healthy food options and it was highlighted that an action plan is being renewed and could be shared at a future meeting.	
GP Vulnerable Patient Flagging System	The Commission were informed at the meeting on 9 July 2024 that work is underway and further details could be shared when developed.	

TB Strategy & Action Plan	The Commission were informed at the meeting on 9 July 2024 of the development of a new strategy and action plan and agreed to be added to the work programme. Further highlighted at meeting on 10 September and asked to be added to the work programme for an update on the action plan.	
Health Status of Residents	The Commission requested to further discuss the health status of Leicester residents at the meeting on 10 September where it was highlighted that the population is 20% sicker than prior to the pandemic. Darzi Review circulated to Members; further discussion to be arranged.	
Fertility Policy	To be discussed at Leicester, Leicestershire & Rutland Joint Health Scrutiny – 27 November 2024.	
Water fluoridation	To be discussed at Leicester, Leicestershire & Rutland Joint Health Scrutiny – 27 November 2024.	