Tameside Metropolitan Borough

ASHTON-UNDER-LYNE · AUDENSHAW · DENTON · DROYLSDEN · DUKINFIELD · HYDE · LONGDENDALE · MOSSLEY · STALYBRIDGE

HEALTH AND WELLBEING BOARD

Day: Thursday
Date: 27 June 2019
Time: 10.00 am
Place: Committee Room 1 - Tameside One

Item No.	AGENDA	Page No
1.	**APOLOGIES FOR ABSENCE**	
2.	**DECLARATIONS OF INTEREST** To receive any declarations of interest from Members of Health and Wellbeing Board.	
3.	**MINUTES** To receive the Minutes of the meeting of the Health and Wellbeing Board held on 7 March 2019	1 - 4
4.	**TAMESIDE AND GLOSSOP MENTAL HEALTH STRATEGY UPDATE** To consider the attached report of the Executive Member for Adult Social Care and Population Health / Interim Director of Commissioning.	5 - 18
5.	**SUICIDE PREVENTION STRATEGY 2019/23** To consider the attached report of the Executive Leader / Head of Mental Health & Learning Disabilities	19 - 46
6.	**SEXUAL AND REPRODUCTIVE HEALTH** To consider the attached report of the Executive Member for Adult Social Care and Population Health / Director of Public Health	47 - 58
7.	**UPDATE ON TAMESIDE & GLOSSOP PLAN AND PUBLIC SERVICE REFORM** To consider the attached report of the Executive Member for Adult Social Care and Population Health/ Director of Public Health	59 - 66
8.	**URGENT ITEMS** To consider any additional items the Chair is of the opinion shall be dealt with as a matter of urgency.	

From: Democratic Services Unit – any further information may be obtained from the reporting officer or from Michael Garraway, Democratic Services Business Manager, to whom any apologies for absence should be notified.

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HEALTH AND WELLBEING BOARD

7 March 2019

PRESENT: Councillor Warrington (Chair) – Executive Leader
Councillor Ryan – Executive Member for Children & Families
Steven Pleasant – Chief Executive Tameside MBC and Accountable Officer for Tameside and Glossop CCG
Dr Alan Dow – Chair Clinical Commissioning Group & Strategic Commissioning Board
David Swift – CCG Governing Body Member
Jane Higham – Greater Manchester Police
Phil Nelson – Greater Manchester Fire and Rescue Service
Andrew Searle – Independent Chair, Tameside Adult Safeguarding Partnership Board
Richard Hancock – Director of Children's Services
Chris Rushton – Chief Executive Active Tameside
Trish Kavanagh – Tameside and Glossop ICFT
Liz Windsor-Welsh – Chief Executive, Action Together

IN ATTENDANCE: Debbie Watson – Interim Assistant Director of Population Health
Tom Wilkinson – Assistant Director (Finance)

APOLOGIES: David Swift – Lay Member for Governance, CCG
Stephanie Butterworth – Director (Adults), Tameside MBC
Karen James – Chief Executive, Tameside and Glossop ICFT

Apologies for Absence: Councillors Cooney Tameside MBC

34 DECLARATIONS OF INTEREST

There were no declarations of interest submitted by Members of the Board.

35 MINUTES

Further to minute 27 of the meeting of the Health and Wellbeing Board held on 24 January 2019 it was reported that the NHS Tameside and Glossop Clinical Commissioning Group required adding to the detailed list of organisations across the Borough to have signed the PACT agreement.

RESOLVED
With the amendment to minute 27 as detailed above, the Minutes of the Health and Wellbeing Board held on 24 January 2019 be approved as a correct record.

36 BETTER CARE FUND - 2018/19 QUARTER 3 MONITORING REPORT

Consideration was given to a report of the Deputy Executive Leader / Director of Finance providing an update on the position of the 2018/19 Tameside Better Care Fund for the period ending 31 December 2018.

Health and Wellbeing Board Members were reminded that the Better Care Fund was introduced during 2015/16 and had continued each financial year thereafter. The funding was awarded to the economy to support the integration of health and social care to ensure resources are used more efficiently between Clinical Commissioning Groups and Local Authorities, in particular to support the reduction of avoidable hospital admissions and the facilitation of early discharge.

Members were informed an allocation of £24.4 million was included within the Section 75 funding allocation of the Strategic Commission's Integrated Commissioning Fund (ICF). The ICF 2018/19 gross expenditure total was £927.8 million which is bound by the terms within the Section 75 and associated Financial Framework agreements.

Information relating to the Disabled Facilities Grant was reported to the Board. The Disabled Facilities Grant was not included within the Better Care Fund but was required to be spent in accordance with the 2017-2019 Tameside Better Care Fund (BCF) spending plan which was approved by the Health and Wellbeing Board on 21 September 2017.

RESOLVED
That the 2018/19 Better Care Fund monitoring report be noted.

37 TAMESIDE ADULT SAFEGUARDING PARTNERSHIP ANNUAL REPORT 2017/1

Consideration was given to the report of the Independent Chair, Tameside Safeguarding Adult Safeguarding Board setting out the activity and strategic work plan of the Safeguarding Board in Tameside and its partner organisations and agencies.

In Tameside, the Tameside Safeguarding Adult Safeguarding Board oversees the strategic development and governance arrangements of Adult Safeguarding. The Board aims to ensure that the risk of abuse is minimised by preventative work and in cases where abuse has occurred or is occurring, structures within Tameside enable individuals to access safety and protection within the community and services.

The report highlighted the strategic direction of the Safeguarding Board and its partners in accordance with the duties and responsibilities set out in the Care Act 2014. There is a statutory duty for the Safeguarding Board to produce an annual report setting out the work of the Board to improve the outcomes for Adults at risk of abuse.

The Chair of the Tameside Adult Safeguarding Partnership Board reported that the Board had been successful during 17/18 in meeting their identified priorities. The Board was assured the Safeguarding Adult Framework in Tameside was fit for purpose. However, Tameside Adult Safeguarding Partnership Board acknowledged there remains further work to strengthen this agenda. As during previous years this can only be successfully achieved working in Partnership. To ensure effectiveness of the Board, the development of this agenda within existing resources would put more emphasis on the need for partnership working.

RESOLVED
That the content of the Tameside Safeguarding Adults Board Annual Report 2017/19 be noted.

38 CHILDREN AND YOUNG PEOPLE'S EMOTIONAL WELLBEING AND MENTAL HEALTH LOCAL TRANSFORMATION PLAN UPDATE

Consideration was given to a report of the Director of the Interim Director of Commissioning updating Members on the Local Transformation Plan refresh detailing the ongoing achievements realised from the onset of the original plan in 2015/16. The report also detailed a number of actions identified for 2019/20 to continue the transformation and improved outcomes for children and young people with mental health problems in line with Future in Mind and the Five Year Forward View for Mental Health published February 2016.

It was explained that in order to obtain assurance from NHS England who oversee the additional investment available to improve mental health support services to children, young people and their

parents/carers, each area was required to annually refresh the Local Transformation Plan (LTP) setting out what had been achieved and the plan for the following 12 months period.

Throughout the transformation plan, there is a focus on developing a whole-system collaborative approach to meeting the emotional health and well-being needs of children and young people. The plan has partnership involvement from a range of providers including specialist services, the third sector and the wider public sector. There is ongoing partnership work to fully implement the THRIVE model of practice with strong links to the Neighbourhood teams.

In January 2018 the Strategic Commissioning Board (SCB) agreed to prioritise investment in mental health to improve parity of esteem. Investment to support establishing a new model of mental health support in the neighbourhoods and improving support to people with ADHD and autism were included. Work was continuing to integrated all partners within the Neighbourhoods model as a mechanism to enable a whole system approach.

During the course of discussion the continuing challenges to improve services was emphasised to the Board. It was summarised as an increasing demand for Specialist CAMHS alongside the difficulty in recruiting and retaining staff with the appropriate clinical training and experience.

RESOLVED
That the progress detailed within the Children and Young People's emotional wellbeing and mental health local transformation plan be noted.

39 TOUR OF TAMESIDE 2019

Consideration was given to a report and accompanying presentation of the Assistant Director of Population Health providing information on the Tour of Tameside 2019 event.

The Tour of Tameside is an event which encompasses a number of entry points to participation enabling all areas of the community to get involved, whether running, walking, volunteering or supporting. The fundamental aim of the Tour of Tameside is to promote physical and mental health, wellbeing, togetherness and pride for the borough.

The Running Bee Foundation which is funded and supported by Sports Tours International would be organising the Tour of Tameside with all profits from the event being donated back to Tameside good causes and charities.

RESOLVED
That the content of the presentation be noted.

40 LIVING WELL: INCREASING PHYSICAL ACTIVITY IN TAMESIDE

Consideration was given to a report and presentation of the Director of Population Health updating the Health and Wellbeing Board on actions to increase physical activity levels in Tameside.

It was reported that building on existing provision and through a system wide collaboration, there was a Greater Manchester target to double the current rate of active participation, reaching the target of 75% of people active or fairly active by 2025 through the Greater Manchester Moving plan.

RESOLVED
That the report and presentation be noted.

41 HEALTH AND WELLBEING FORWARD PLAN 2018/19

The Director of Population Health submitted a report providing an outline forward plan for consideration by the Board.

RESOLVED
That the draft Forward Plan for 2018/19 be agreed.

42 DATE OF NEXT MEETING

It was noted that the next meeting of the Health and Wellbeing Board would take place on 27 June 2019.

Report to:	**Health and Wellbeing Board**
Date:	27 June 2019
Executive Member / Reporting Officer:	Councillor Wills Executive Member for Adult Social Care and Population Health Pat McKelvey, Head of Mental Health and Learning Disabilities
Subject:	**Tameside and Glossop Mental Health Strategy Update**
Report Summary:	This report provides an update on the Tameside and Glossop Mental Health Strategy for adults and older people, outlining progress against the three key priorities. These are to • Increase opportunities to keep people well in the community • Increase opportunities to get support before and during a crisis • Make effective use of secondary care. The Board will also be given a presentation on the Neighbourhood Mental Health Development. Claire Maw, the Interim Manager of the Neighbourhood Mental Health Team, will tell the Board about how mobilisation of the Neighbourhood Mental Health Team is progressing. The presentation can be found in Appendix 1.
Recommendations:	That the Health and Wellbeing Board recognises the progress towards achieving the ambitions in the mental health strategy and notes next steps.
Corporate Plan:	Links to mental health ambitions across all three life courses
Policy Implications:	None
Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)	The investment outlined in this proposal is congruent with both national and local MH Strategy and recurrent budgets are incorporated in to the CCGs financial plans including the recurrent consequences of GM Transformation funding included in this business case. It is important that the model is delivered within the budgets identified and performance is closely monitored to ensure the outcomes are in line with both qualitative and quantitative expectations. A degree of caution must be exercised regarding the planned timeline for implementation as difficulties in recruitment and retention could impede pace of development and resources must be flexed accordingly to allow for this whilst continuing pursuing the wider development.
Legal Implications: (Authorised by the Borough Solicitor)	It is important to ensure outcomes are measured to show that the fiduciary duty to the public purse is met, to focus on priorities and deliver services in effective and efficient way that demonstrates value for money. Further that the rationale behind the strategy is being applied consistently and fairly to those who require this assistance.
Risk Management:	Risks are managed by programme leads. A key risk that is being managed is workforce. The growth of new mental health services

across Greater Manchester has resulted in the lack of availability of specialist mental health staff.

Access to Information: The report is to be considered in public.

Background Information: The background papers relating to this report can be inspected by contacting Pat McKelvey, Head of Mental Health and Learning Disabilities, Commissioning.

Telephone: 07792 060411

e-mail: pat.mckelvey@nhs.net

1. INTRODUCTION

1.1 The Tameside and Glossop Mental Health Strategy was developed to meet the challenges of the Five Year Forward View for Mental Health 2016, which have been reiterated in the NHS Long Term Plan 2019.

1.2 The Strategy has three key priorities

- Increase opportunities for people to stay well in the community
- Increase opportunities to get help before/during a crisis
- Make effective use of secondary care – in-patient beds and specialist community home treatment teams.

1.3 Progress against these priorities is detailed below.

2. INCREASE OPPORTUNITIES FOR PEOPLE TO STAY WELL IN THE COMMUNITY

2.1 **The Neighbourhood Mental Health Development** – As one of four national sites we are working with the Innovation Unit the Big Lottery funded Living Well Programme to co-produce a new approach to mental health, called locally the Living Life Well Programme. At the heart of this is the neighbourhood mental health development, focused on supporting people with multi-faceted needs who have not always received coordinated support in the past.

2.2 The development includes a new Neighbourhood Mental Health Team, established by bringing together existing resources plus £1m new investment to create a multiagency team who will use asset based coaching to support people to improve their mental health. The team will rely on developing close partnerships with other support services, such as social prescribing, debt advice, housing, community groups and leisure services.

2.3 An interim team has been established to prototype the model in Hyde, with further roll out from October 2019 when Big Life Company's contract as the lead organisation commences. All neighbourhoods will be covered by March 2020.

2.4 **Delivering the Five Year Forward View for Mental Health priorities** - progress towards expanding capacity to deliver the access and waiting time standards for psychological therapy and early intervention in psychosis is continuing, with a business case going to the Strategic Commissioning Board in July 2019 for the next phase of development. This includes the ambition to embed psychological therapies into long term condition services, thereby integrating mental health with physical healthcare.

2.5 **Developing an Integrated Dementia Pathway and increasing support in the community** – a new Integrated Pathway Team Leader has been recruited to lead teams across acute and community, mental and physical health. Additional dementia practitioners are being recruited to integrate the staff into each neighbourhood.

2.6 **Integrated Perinatal/Parent Infant Mental Health Pathway** – Tameside and Glossop has a long-established parent infant mental health pathway, led by the Early Attachment Service, which has received national recognition and is being developed in other GM localities. The pathway is being refreshed in line with the new addition of the specialist Perinatal Community Mental Health Team, commissioned to work across GM.

2.7 **Neurodevelopmental provision** – additional investment has been agreed for the autism and Attention Deficit Hyperactivity Disorder (ADHD) teams to reduce waiting times and increase support. A new psychological therapy post is being established in the neighbourhood mental health team to support all therapists to make adjustments necessary for people with such conditions.

3. INCREASE OPPORTUNITIES FOR PEOPLE TO GET HELP BEFORE/DURING A CRISIS

3.1 The Neighbourhood Mental Health Team will offer easy access to support through drop-ins in each neighbourhood. These are already offered by trained staff in Minds Matter, the Step 1 service commissioned by the ICFT from Big Life Company. Embedding a mental health practitioner in the Anthony Seddon Centre has worked well too, with a mental health nurse offering drop-in and bookable appointments for two days each week. The Team will also deliver a STORM pathway, offering suicide assessment and proactive intervention.

3.2 A business case is being presented to the Strategic Commission in July to develop three elements, which will considerably enhance the local offer in line with national expectations. The three elements are

- Expansion of the Liaison Mental Health Teams that work in the Emergency Department and on the inpatient wards in the hospital
- Expansion of the capacity and interventions offered by the Home Treatment Team and integrate this with the new Safe Haven, providing community crisis services 24/7.
- Establish a new overnight Safe Haven on the hospital site providing opportunity for extended assessment, short term crisis support and intervention for people in crisis who have had a mental health assessment.

3.3 The Community Mental Health Teams support people with serious mental illness and are vital to keep people well in the community. The ideal model of care is being detailed within the Pennine Care Sustainability Programme. This programme has been established to meet the CQC requirement that Pennine Care NHS Trust delivers a sustainability plan by the autumn. Niche Consulting is working with the Trust and the five main commissioning CCGs to deliver the programme through a series of workshops at footprint and locality levels. It is anticipated that the programme will conclude in the autumn with a recommended model of care.

4. MAKE EFFECTIVE USE OF SECONDARY CARE

4.1 The Safe Haven and the expanded Home Treatment Team will reduce the number of short stay admissions to the mental health wards and also support early discharge.

4.2 Efforts to promote timely discharge and reduce Delayed Transfers of Care (DTOC) through proactive inreach from the CCG and Social Care in Tameside and Derbyshire has had a very positive impact on the reducing delays.

4.3 Unlike other localities Tameside and Glossop have had very few out of area mental health hospital admissions however demand is high and therefore the Pennine Care sustainability programme will identify solutions across the footprint to ensure that no patients need to access care out of Greater Manchester.

4.4 Aiming to reduce DTOC and improve care closer to home for people with very complex dementia commissioners are investigating options to commission a specialist dementia care home/beds.

5. CONCLUSION

5.1 This paper summarises the significant progress in delivering the Mental Health Strategy for adults and older people, improving access, choice and quality of mental health support in Tameside and Glossop. The final business case against the £6m Mental Health Investment Plan agreed by the Strategic Commission in January 2018 will be considered by the Strategic Commissioning Board in July 2019. The investment was agreed in order to

improve parity of esteem for mental health vs. physical health however it is anticipated that demand will continue to rise and therefore the need to continue to transform and develop high quality effective services will be ongoing.

5.2 The delivery of the developments in line with the Mental Health Strategy has been challenging due to the demands on capacity in both commissioning and for providers, but has been mitigated through close partnership working across all sectors.

5.3 Going forward the ambition is to take a stronger focus on public mental health, the wider determinants of health, and to reducing adverse childhood experiences, ACEs, with the aim of preventing long term problems. In addition the Strategic Commission will need to take account of the outcomes from the Pennine Care Sustainability Programme.

6 RECOMMENDATIONS

6.1 As set out at the front of the report.

Appendix 1

Neighbourhood Mental Health Development Presentation

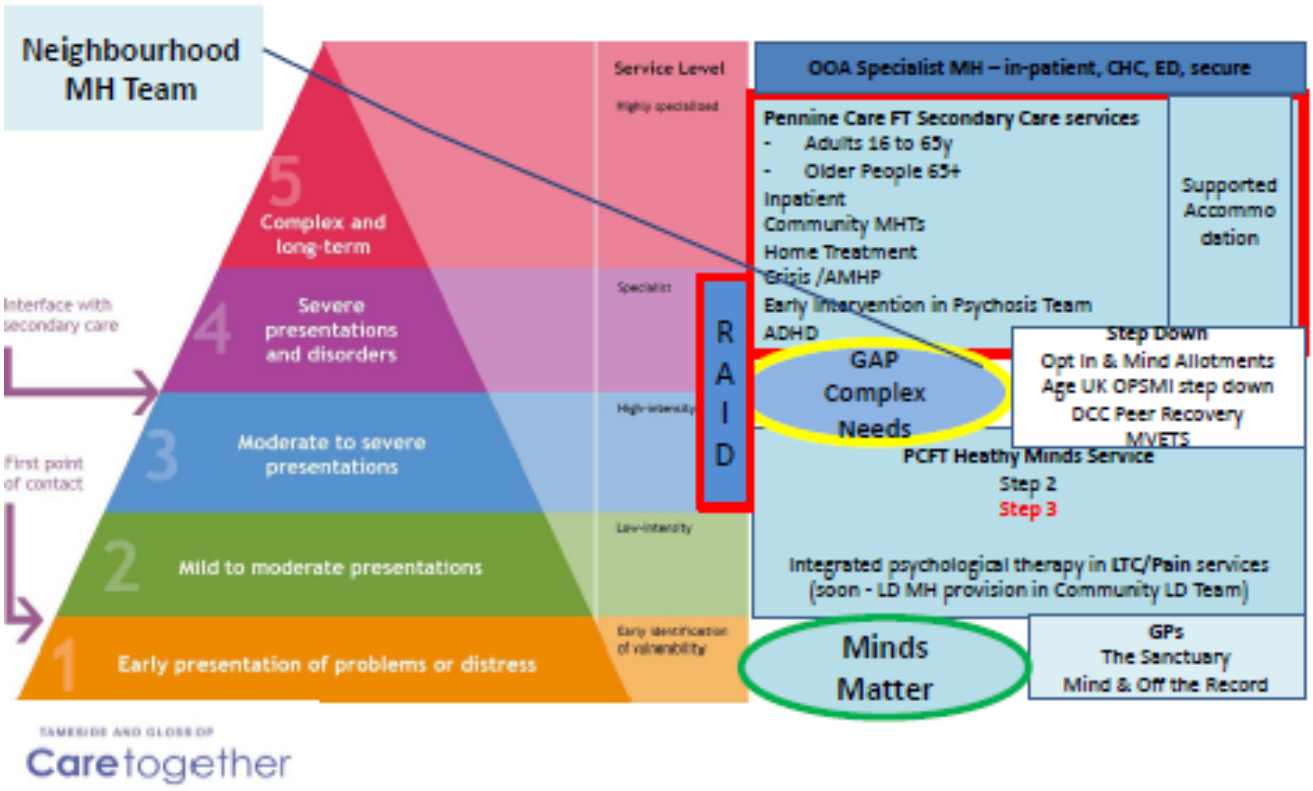
TAMESIDE AND GLOSSOP Caretogether | Innovation Unit | Living Well UK | National Lottery Funded

Living Life Well Programme

Co-producing a new model for improving mental health in our neighbourhoods

June 2019

Mental Health Commissioned Services Provision (16y +)



Types of Needs of People Within the Gap

Referrals keep being done and keep being told all I need is therapy, when done it, was advised no more therapy, also say don't meet criteria"

- The effects of childhood abuse
- Emotional instability
- Dual diagnosis (substance misuse, LD and autism)
- Young people transitioning from CAMHS
- People with complex psychological needs
- Medically unexplained symptoms
- People frequently asking for help, including GP, A&E
- People under the care of tertiary services e.g. with eating disorders

Ambition

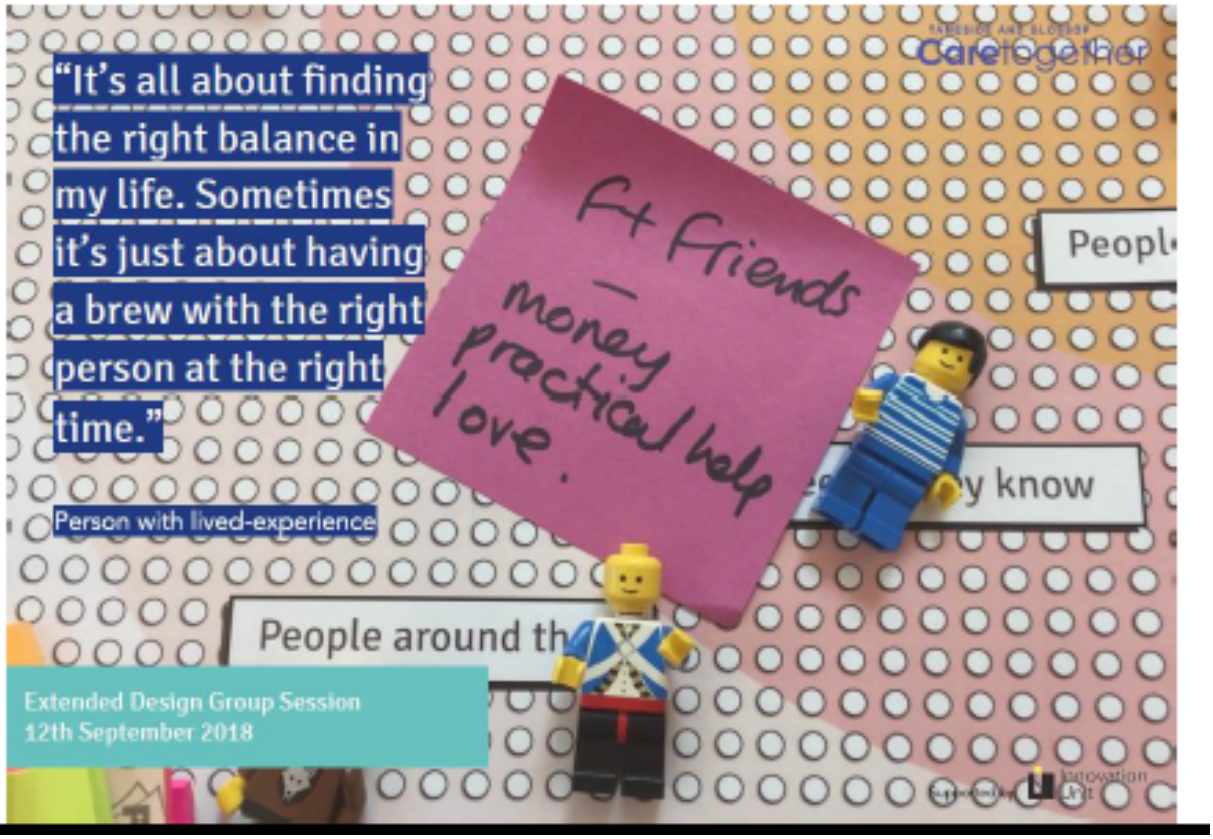
To create a new model of mental health care that will, as well as reducing problems or eliminating symptoms, focus on supporting people to get and keep well through;

- improving people's personal sense of meaning,
- close interpersonal relationships and
- social integration.

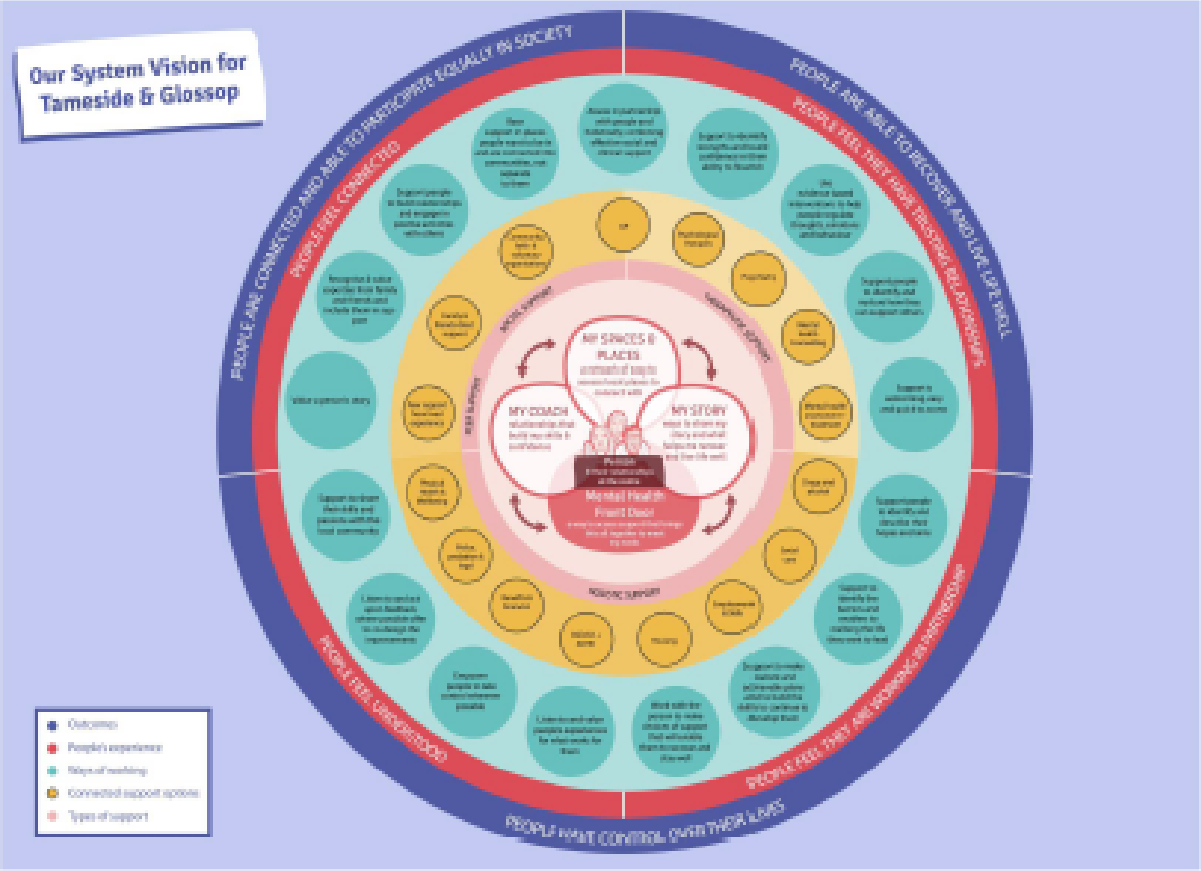
The Collaborative

Lots of People are Helping

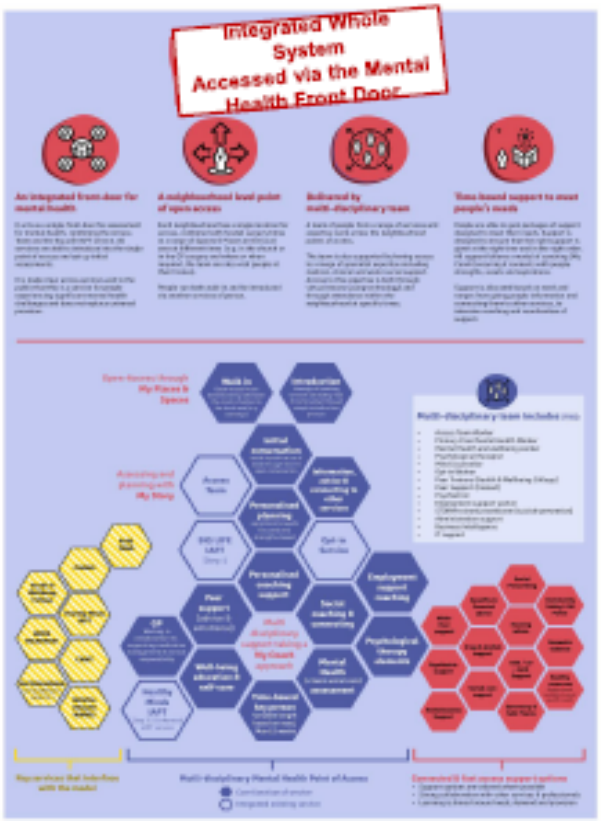
Collaborating to design and



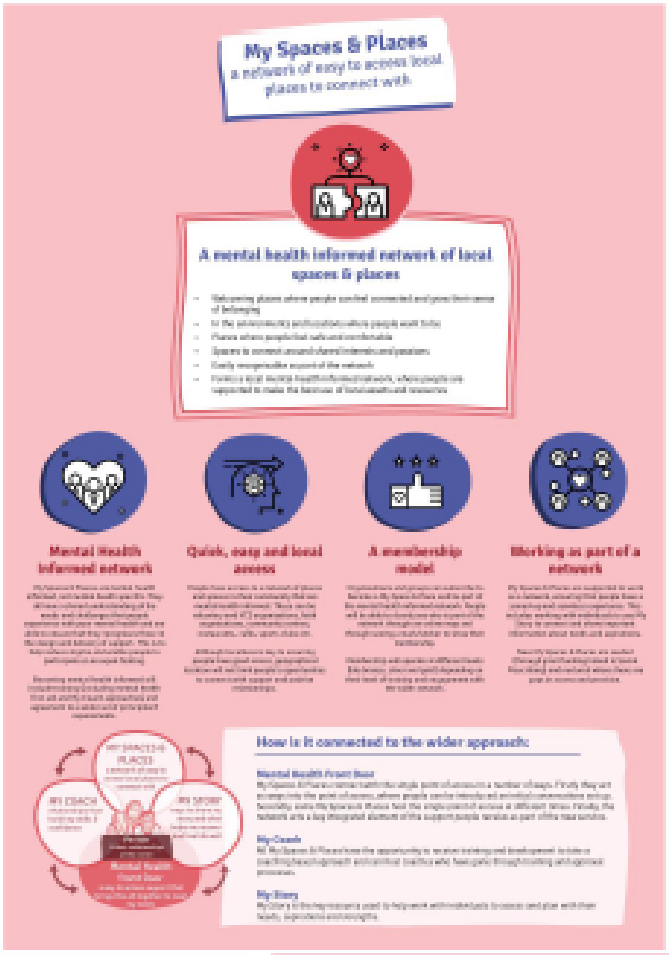
The Vision

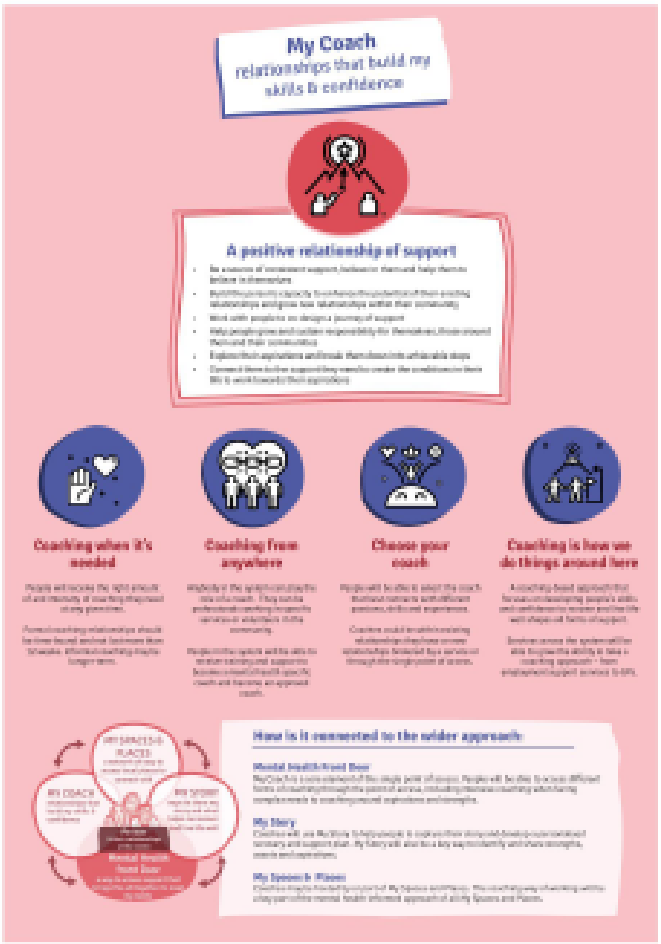


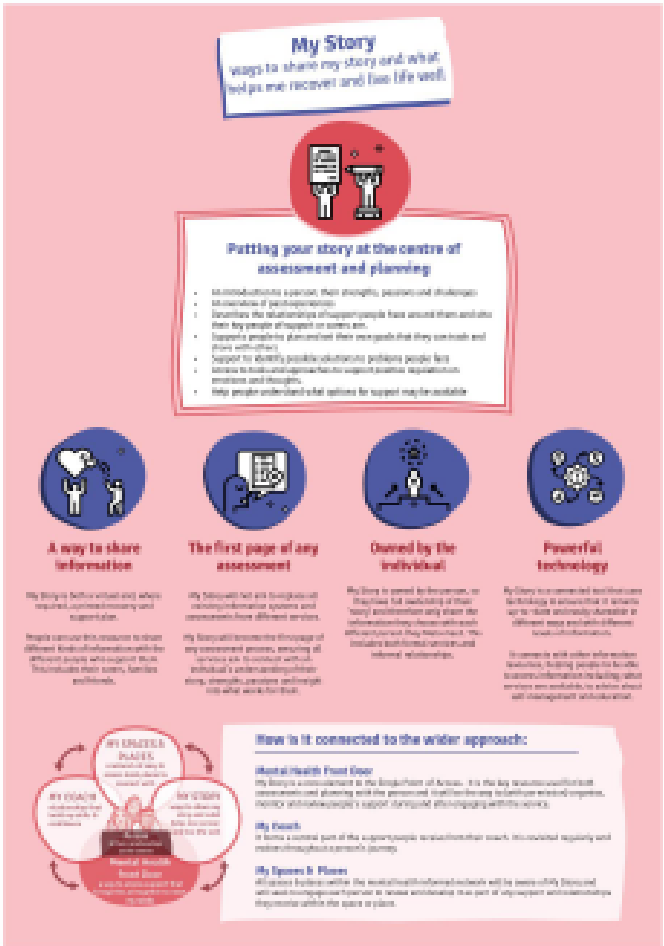
The Model



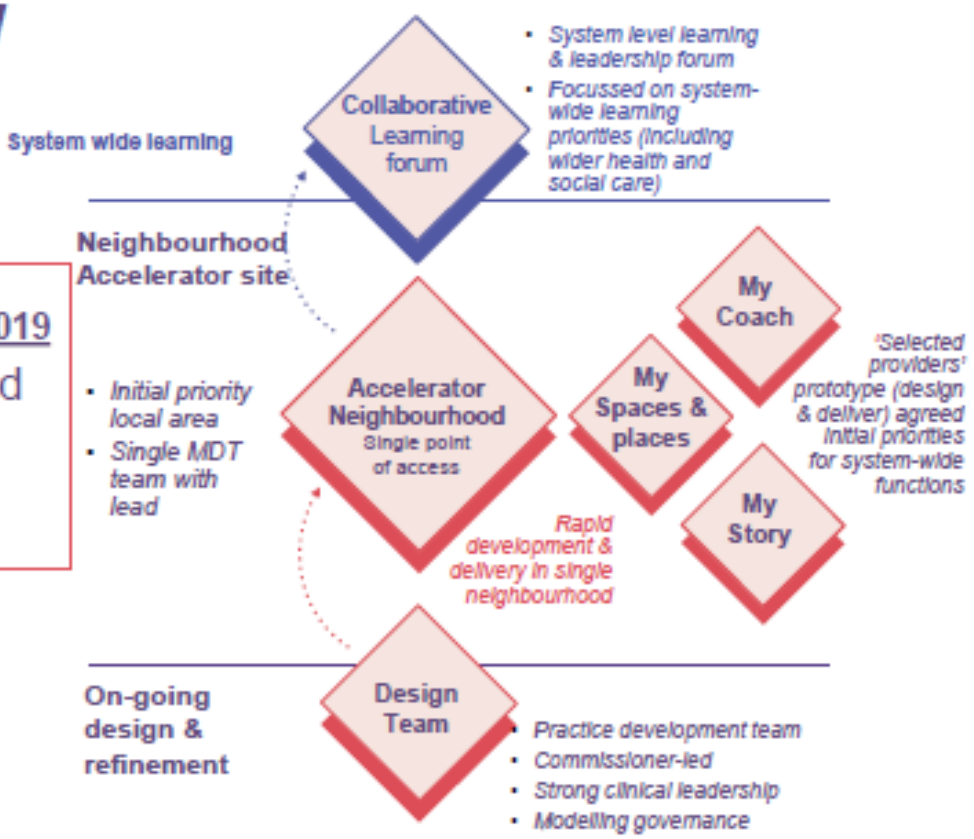
The Model


My Spaces & Places
a network of easy to access local places to connect with
A mental health informed network of local spaces & places
Mental Health Informed network
Quick, easy and local access
A membership model
Working as part of a network
How is it connected to the wider approach:
Mental Health Front Door
My Coach
My Story


My Coach
relationships that build my skills & confidence
A positive relationship of support
Coaching when it's needed
Coaching from anywhere
Choose your coach
Coaching is how we do things around here
How is it connected to the wider approach:
Mental Health Front Door
My Story
My Spaces & Places


My Story
ways to share my story and what helps me recover and live life well
Putting your story at the centre of assessment and planning
A way to share information
The first page of any assessment
Owned by the individual
Powerful technology
How is it connected to the wider approach:
Mental Health Front Door
My Coach
My Spaces & Places

NOW

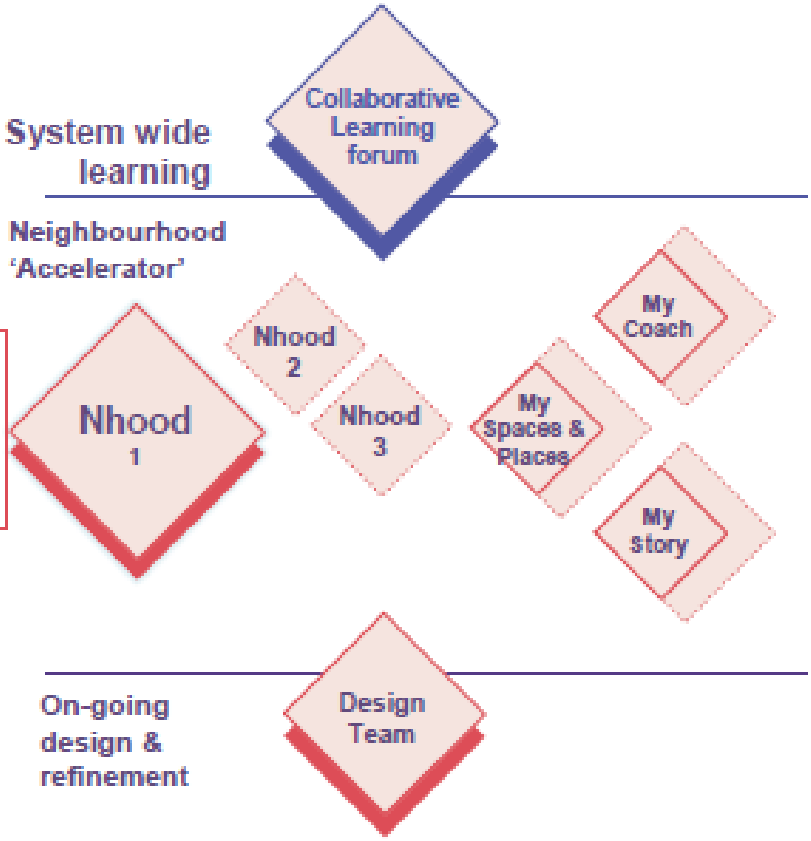


April 2019 – Oct 2019

Neighbourhood **Accelerator - HYDE**

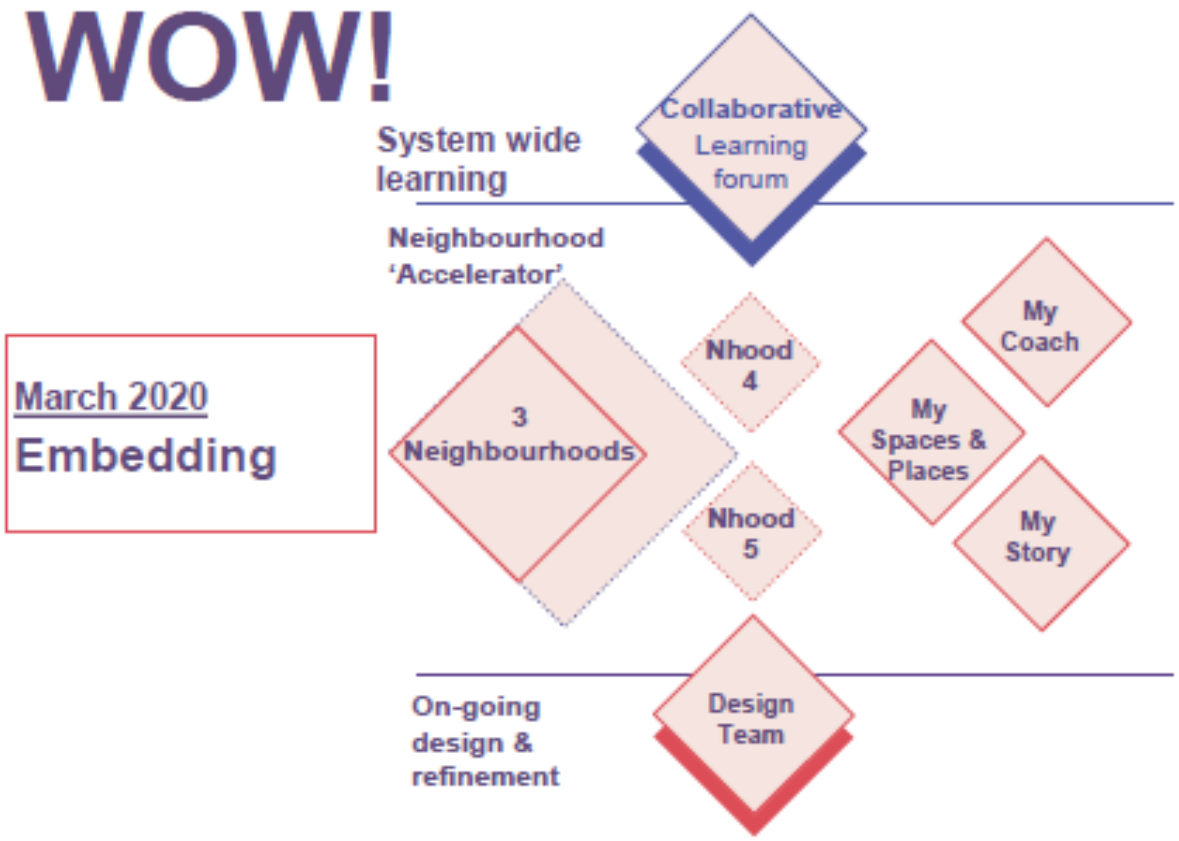
- *Initial priority local area*
- *Single MDT team with lead*

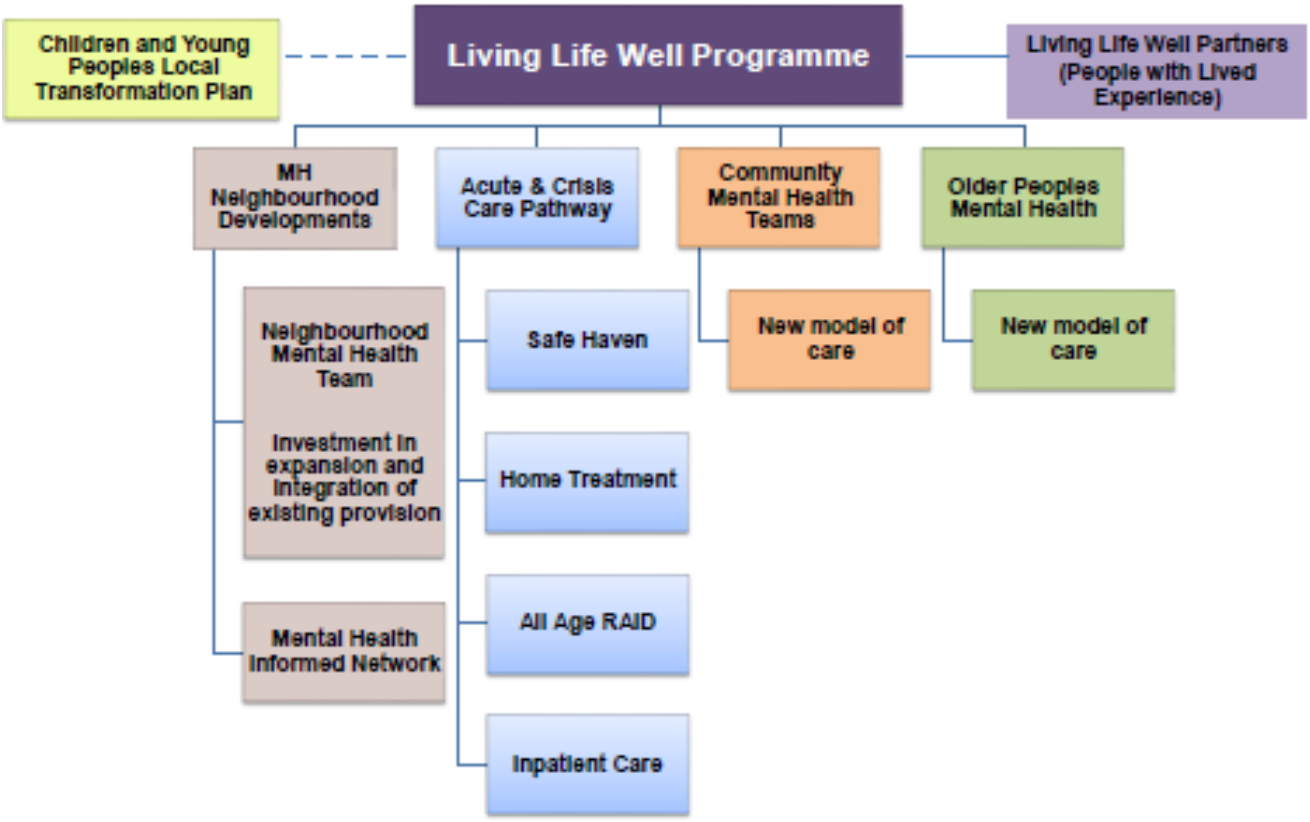
NEXT



Oct 19– Jan 20

Review & Expand


WOW!
System wide learning
Collaborative Learning forum
Neighbourhood 'Accelerator'
March 2020
Embedding
3 Neighbourhoods
Nhood 4
Nhood 5
My Coach
My Spaces & Places
My Story
On-going design & refinement
Design Team


Children and Young Peoples Local Transformation Plan
Living Life Well Programme
Living Life Well Partners (People with Lived Experience)
MH Neighbourhood Developments
Acute & Crisis Care Pathway
Community Mental Health Teams
Older Peoples Mental Health
Neighbourhood Mental Health Team
Investment in expansion and integration of existing provision
Mental Health Informed Network
Safe Haven
Home Treatment
All Age RAID
Inpatient Care
New model of care
New model of care

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Report to: **HEALTH AND WELLBEING BOARD**

Date: 26 June 2019

Executive Member / Reporting Officer: Councillor Wills Executive Member for Adult Social Care and Population Health

Pat McKelvey, Head of Mental Health and Learning Disabilities

Jacqui Dorman, Public Health Intelligence Manager

Subject: **SUICIDE PREVENTION STRATEGY 2019/2023**

Report Summary: The number of deaths to suicide in Tameside and Glossop is significant, with 75 deaths occurring in 2015/17 alone. This strategy builds on our work to date and sets out an ambitious five year plan for reducing and ultimately eliminating suicides in Tameside and Glossop. To do this will require a co-ordinated effort so that suicide prevention becomes 'everyone's business'.

Our vision is that no-one will see suicide as a solution, and our ambition is therefore that there will be no more suicides in Tameside and Glossop.

This strategy sets out how we will go about preventing suicide in Tameside and Glossop, in line with our ambition. In order for this to be achieved, all partners in every organisation in Tameside and Glossop will need to understand and support this strategy

Recommendations: To support the strategy and its ambition and objectives.

Corporate Plan: The suicide prevention strategy sets out the strategic direction to reduce suicides in Tameside and Glossop. It directly aligns with our priority to increase healthy life expectancy and reduce inequalities.

Policy Implications: The suicide prevention strategy sets out the strategic direction to reduce suicides in Tameside and Glossop. It aligns with the direction being taken by the GM Health & Social Care partnership and the locality plan which aims to increase healthy life expectancy and reduce inequalities

Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)

Integrated Commissioning Fund Section	Section 75
Decision Required By	Strategic Commissioning Board
Organisation and Directorate	CCG
Additional Budget Allocation By 2021/22	£5.691 million (Approved at SCB on 30 January 2018)
Integrated Commissioning Fund Section	Aligned
Decision Required By	CCG Governing Body
Organisation and Directorate	CCG
Additional Budget Allocation By 2021/22	£0.100 million (Approved at CCG Governing Body on 28 March 2018)

Additional Comments

On 30 January 2018 the Strategic Commissioning Board approved an investment programme in Mental Health services by an additional recurrent value of £5.791 million by 2021/22, £5.691 million of which is within the Section 75 of the Integrated Commissioning Fund, with £0.100 million within the aligned fund. The aligned fund investment was approved at the CCG Governing Body on 28 March 2018.

Whilst this report is not specifically requesting any further additional funding, it should be acknowledged that there is a clear investment plan which sets out the level of funding available for each programme of work. The investment programme included funding to support the prevention strategy as explained in this report.

Legal Implications: (Authorised by the Borough Solicitor)

It is important to ensure that individual cases and the outcome of their inquest, which are an inevitable consequence, are taken into account when devising this type of strategy. The Coroner will require sight of and may require details of the governance and rationale behind the strategy, the policy and any procedures and processes which flow from this decision when considering this category of death. They therefore must be kept under regular review and linked to all agencies involved with inquests.

Risk Management:

This report fulfils the commitment for the delivery of a suicide prevention strategy as part of our public health statutory duties and aligns with the ambition for Greater Manchester to substantially reduce deaths from suicide

Access to Information:

The background papers relating to this report can be inspected by contacting Jacqui Dorman, Policy, performance and intelligence:

Telephone:0161 342 2119

e-mail: Jacqui.dorman@tameside.gov.uk

Tameside & Glossop Suicide Prevention Strategy 2019-2023

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Main Author/editor	Jacqui Dorman
Report of	Suicide and self-harm prevention group
On behalf of	Health and Wellbeing Board, Strategic Commissioning Board and the Mental Health and Wellbeing Strategic Group
Contributors	Pat McKelvey
Version	8.0 (Draft)
Version date	27th March 2019

1. FORWARD

1.1 In England, one person dies every two hours as a result of suicide. When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing support and care will feel the impact. Suicide is often the end point of a complex history of risk factors and distressing events; the prevention of suicide has to address this complexity.

1.2 There are marked differences in suicide rates according to social and economic circumstances, so suicide is also a marker of how fair our society is. Those who are out of work, in poor housing, and/or with a significant health issue, (particularly those who are dependent upon drugs and alcohol) are more at risk. Reducing risk requires system change to address the wider determinants of mental health in addition to high quality health and social care in its widest sense. This presents us with a considerable challenge at a time when resources are more stretched than ever.

1.3 It is clear that nationally and locally our collective goal is that ***no-one will see taking their own life as a solution***, and to this end our commitment in Tameside and Glossop is that we will do everything in our power to achieve this.

1.4 In developing our strategy we have taken inspiration from the Greater Manchester Suicide prevention strategy[1] and thus we take the opportunity here to acknowledge the excellent work of all our all colleagues working on this agenda across the region.

2. EXECUTIVE SUMMARY

2.1 The number of deaths to suicide in Tameside and Glossop is significant, with 75 deaths occurring in 2015/17 alone. The majority of suicides occur in men, with increased risk seen in those within the lowest socioeconomic groups and living in the most deprived geographical areas. Other at risk groups includes those who self-harm, children and young people and those with untreated depression. Individuals who have been bereaved by suicide, those who are isolated, and those who misuse drugs and alcohol are also at increased risk.

2.2 Less than a third of all suicides occur in individuals who are known to mental health services, thus preventing suicide requires a co-ordinated whole system approach.

2.3 This strategy builds on our work to date and sets out an ambitious five year plan for reducing and ultimately eliminating suicides in Tameside and Glossop. To do this will require a co-ordinated effort so that suicide prevention becomes ‘everyone’s business’.

2.4 We have sought direction from the Suicide Prevention Strategy for England[2] from 2012, the Five Year Forward View for Mental Health[3], and the recently published PHE resources for local Suicide Prevention Planning[4].

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[1] https://www.gmhsc.org.uk/wp-content/uploads/2018/05/GM-Suicide-Prevention-24.02.17.pdf
[2] file:///N:/Transformation/MH%20&%20LD/Suicide/GM/Preventing-Suicide-England.pdf
[3] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

2.5 In Tameside & Glossop we are aiming for Suicide Safer Communities Accreditation and have therefore based our strategy objectives in line with the 'Nine Pillars of Suicide Prevention'. These are:

1. A leadership/steering committee
2. A robust background summary of the local area to support goal setting
3. Suicide Prevention Awareness raising
4. Mental Health and Wellness promotion
5. Training for community members, lay persons and professionals
6. Suicide intervention and ongoing clinical support services.
7. Suicide bereavement support and resources
8. Evaluation measures including data collection and evaluation system
9. Capacity building/sustainability within communities

3. WHAT WE WANT TO ACHIEVE IN TAMESIDE AND GLOSSOP?

3.1 Our vision is that no-one will see suicide as a solution, and our ambition is therefore that there will be no more suicides in Tameside and Glossop.

3.2 We recognise that from the evidence that suicides are mainly preventable and avoidable. With this in mind, our strategy sets out our plan to ensure that we harness the support and contribution of all services and agencies so that we can reduce risk, proactively intervene when needed, and effectively respond to those in crisis.

3.3 Our primary focus for the first two years of our strategy (2018/19 – 2019/20) will be to meet the challenge set out within the Five Year Forward View for Mental Health i.e. to reduce the rate of suicide by 10% by 2020. Thereafter we will seek to stretch this target further.

4. WHAT IS THE PURPOSE OF THIS STRATEGY?

4.1 This strategy sets out how we will go about preventing suicide in Tameside and Glossop, in line with our ambition that there will ultimately be no more suicides. In order for this to be achieved, all partners in every organisation in Tameside and Glossop will need to understand and support this strategy.

4.2 Our strategy is intended to stimulate a social movement for change in the way we think and act in relation to suicides and suicide prevention. We aim to enhance the skills of our wider workforce in relation to assessing and managing risks and supporting those who are affected or bereaved, to reduce the stigma attached to talking about suicide and mental health more openly, and to promote suicide safer communities.

4.3 As previously stated this strategy is based primarily on the Greater Manchester suicide strategy but with a focus on the outcomes and priorities for Tameside and Glossop. It will

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4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585411/PHE_local_suicide_prevention_planning_practice_resource.pdf

also link with the priorities and strategic framework developed for Derbyshire 2018/21, as the Glossop resident population fall under the responsibility of Derbyshire County council within the local authority area of High Peak[5]. However from a registered population perspective, patients registered with a Glossop GP are the responsibility of the Tameside & Glossop Strategic Commission and therefore this strategy encompasses the Tameside resident population and the Tameside & Glossop registered population.

5. WHY WE NEED A SUICIDE PREVENTION STRATEGY?

5.1 *Key drivers*

5.1.1 Suicide is a major mental health, social, economic, and public health issue.[6] It is a major cause of early death and an indicator of underlying poor mental health at a population level and represents a devastating loss for individuals, families and communities and carries a huge financial burden.[7] The highest numbers of suicides are found in men aged 45–54 years, and in women aged under 45 years.

5.1.2 By 2020/2021 our local health and social care system faces an estimated financial deficit of £42 million to £180 million[8] indicating the need for radical transformation. The impacts of mental health on our wider health care system are considerable: we know that poor mental health worsens physical illness and raises total health care costs by at least 45%, for example, an estimated 12% - 18% of all NHS expenditure on long term conditions is linked to poor mental health and wellbeing.

5.1.3 Most importantly, this strategy recognises that suicide has a significant toll on others – i.e. estimates suggest that for every person who dies from suicide at least 10 people are directly affected.[9] Also for each case of suicide we know that there are around nine others that will have attempted suicide. Thus each suicide is an indication of a significant number of individuals who need help and support.

5.1.4 The key national driver for the development of local suicide prevention strategies and action plans was set out within the 2012 strategy for England Preventing Suicide in England, a cross government strategy to save lives[10]. The requirement for a comprehensive local suicide strategy is considered to be an effective mechanism in reducing deaths by suicide by supporting the combination of a range of interventions.

5.1.5 More latterly, the Five year forward view for Mental Health[11] set a requirement for all local areas to have Suicide Prevention plans in place by 2017.

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[5] Derbyshire self-harm and suicide prevention framework 2018/21

[6] https://www.mentalhealth.org.uk/a-to-z/s/suicide

[7] Pitman AL, Osborn DPJ, Rantell K, King MB. 2016 Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults. BMJ Open 2016 Jan 1;6(1)

[8] Greater Manchester Suicide prevention strategy 2016

[9] https://www.mentalhealth.org.uk/a-to-z/s/suicide

[10] Preventing Suicide in England: A cross government strategy to save lives (2012) https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england

[11] The five year forward view for mental health (2016)

5.1.6 A Tameside and Glossop approach that follows the Greater Manchester approach also presents an opportunity to achieve parity of access for all our residents, through a combination of a framework for action to which all boroughs can pledge their support and the potential for economies of scale when commissioning interventions for Tameside and Glossop with the whole of Greater Manchester. It will also allow us to promote the prevention of suicide as everyone's business; with key stakeholders (including the media) joining forces to support workers and residents to reduce the stigma surrounding suicide, and to take action.

5.2 Outcomes we want to achieve in Tameside and Glossop Suicide Prevention.

5.2.1 Our strategy supports us in focusing on all six areas of the national strategy in the long-term, however the outcomes we want to achieve for the whole system in the short term are [12]:

1. Reducing the risk in Men
2. Preventing and responding to self-harm
3. Improving outcomes for children and young people and women during pregnancy and postnatally
4. Treating Depression more effectively in Primary Care
5. Improving Acute Mental Health Care Settings
6. Tackling High Frequency Locations
7. Reducing Isolation and Loneliness
8. Improving Bereavement Support /Postvention

6. THE NATIONAL, REGIONAL AND LOCAL PICTURE

6.1 National

6.1.1 The recent publication of the 2016 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness7 (NCISH) shows that suicide is the biggest killer of men under 49 years and it remains the leading cause of death in people aged 15-29[13]. The majority of people (two thirds) who die by suicide are not in contact with mental health services[14] and in England one person dies as a result of suicide every 2 hours.[15]

6.1.2 For every one person who dies from suicide, at least 10 others are directly affected. In 2017, there were 4,451 deaths from suicide in England, of which 224 were in Greater Manchester and 19 were in Tameside. From 2004 to 2017 there was a 26% fall in suicide rates in men aged 30 to 34. However since 2006, suicide rates in men aged 45-59 have risen by 11%. We also know that specific groups appear to be at higher risk. The following risk factors have become more common as antecedents to suicide:[16]

[12] Appleby,L (2016) 'Priorities for Suicide Prevention action plans' in Local Suicide Prevention Planning – A Practical Resource. Public Health England.
[13] Office of National Statistics, What do we die from? (2015)
[14] HM Government Preventing suicide in England A cross-government outcomes strategy to save lives (2012)
[15] Self-harm, suicide and risk: helping people who self-harm (2010) Royal College of Psychiatrists
[16] Appleby L et al (2016) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. The University of Manchester. Commissioned by the Healthcare Quality Improvement Partnership (HQIP)

- Isolation
- Economic adversity
- Alcohol and drug misuse
- Recent self-harm

6.1.3 People in the most deprived areas are ten times more at risk of suicide than those in the most affluent group living in the most affluent area. The strongest predictor of suicide is previous episodes of self-harm with the most common antecedent to suicide being alcohol use.

6.1.4 Nationally the most common methods of suicide are hanging and strangulation (47%), self-poisoning (overdose) (21%) and jumping and multiple injuries (mainly jumping from a height or being struck by a train) (11%). Less frequent methods are drowning (4%), gas inhalation (including carbon monoxide poisoning (3%), cutting and stabbing (3%) and firearms (2%).

6.1.5 Suicides amongst those who are under the care of mental health services appears to be decreasing overall, although this picture is not uniform – with inpatient suicides falling significantly (by 60%) following the decree by government in 2003 to eliminate ligature points on inpatient mental health wards, although there are still in excess of 75 inpatient deaths each year.

6.1.6 An increase in suicides under the care of crisis teams is clear from the data which is considered to be as a result of pressure on the system i.e. as a consequence of community crisis teams taking on more complex clients as a result of scarcity of inpatient beds.[17]

6.1.7 The NCISH report indicates that effective crisis teams can have an essential role in reducing suicides - a third of suicides amongst those under the care of mental health services have been discharged from hospital within the preceding 7 days. 30% of suicides in this group occur in the space between discharge and the first outpatient appointment at 7 days plus, reducing this gap to 2-3 days can reduce this to 11%[18].

6.2 Greater Manchester

6.2.1 The total population of Greater Manchester is approximately 2.8 million people. In 2017 there were 224[19] deaths by suicide in Greater Manchester. The greatest number (31) were seen in Bolton and Salford, with the lowest in Trafford (N=15) (table 1)

[17] Greater Manchester suicide audit 2017

[18] Appleby L et al (2016) National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. The University of Manchester. Commissioned by the Healthcare Quality Improvement Partnership (HQIP)

[19] ONS: Www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority

Table 1 Numbers of suicides by Borough (2017)

Local Authority	Number of Suicides
Bolton	31
Bury	13
Manchester	30
Oldham	18
Rochdale	18
Salford	31
Stockport	19
Tameside	19
Trafford	15
Wigan	30
Greater Manchester	**224**

6.3 Tameside and Glossop

6.3.1 As the Locality of Tameside and Glossop covers two local authority areas and as previously stated this Strategy covers both Tameside and Glossop, however as the public health responsibility for suicide prevention sits with the local authorities the majority of the publicly available statistics reported in this strategy are at a Tameside level only. Further work will take place with Derbyshire County Council to ensure the whole system approach is embraced equally in Glossop as in Tameside. As also previously mentioned, this strategy will link closely with the priorities for suicide prevention for Derbyshire using their Suicide prevention framework 2018/21 as a reference in the development of our suicide prevention action plans.[20]

6.3.2 Of the 4,451 deaths registered in 2017 for suicide in England, suicides in Greater Manchester constituted around 5% (n=224) of these, reflecting the significant regional and national burden of suicide within the population.

6.3.3 In 2017 there were 19 deaths registered for suicide in Tameside, this is nineteen too many and places Tameside 5th highest across Greater Manchester for numbers of suicides in 2017.Between 2015/17 there were 5 suicides across Glossop.

6.3.4 Of the 224 deaths from suicide in Greater Manchester in 2017, suicides in Tameside constituted around 8% of these, reflecting the significant local burden of suicide within our population.

[20] Derbyshire self-harm and suicide prevention framework 2018/21

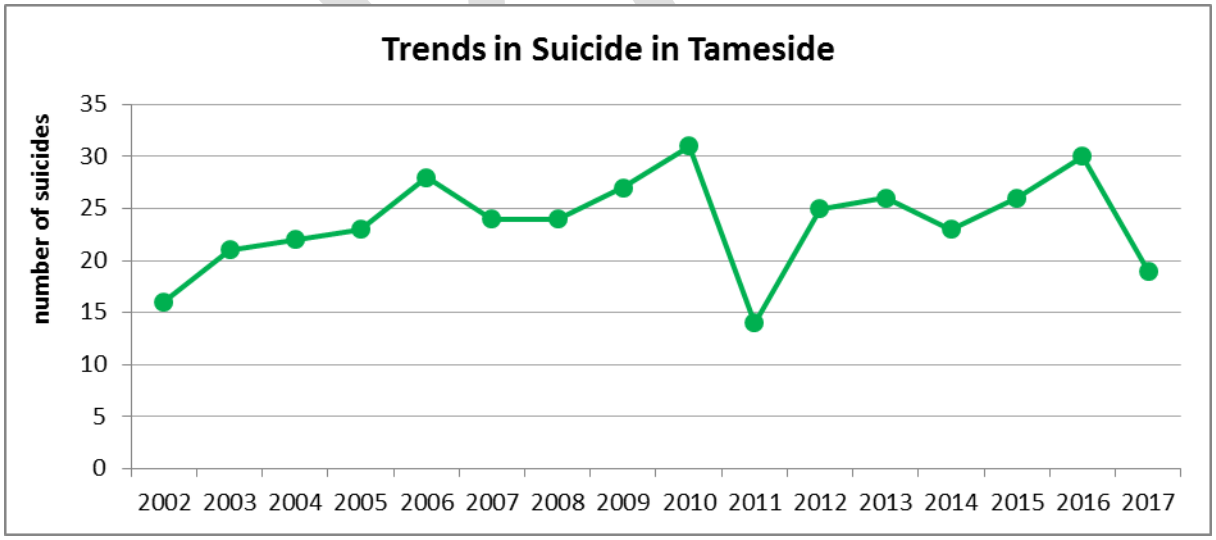
Chart 1: Rates of Suicide in Greater Manchester (2015/17)

Area	Value	Lower CI	Upper CI
England	9.6	9.4	9.7
CA-Greater Manchester	9.7	9.0	10.4
Bolton	11.9	9.5	14.6
Bury	8.0	5.7	11.0
Manchester	9.3	7.5	11.3
Oldham	8.3	6.1	11.0
Rochdale	8.4	6.2	11.2
Salford	12.3	9.6	15.4
Stockport	9.0	7.0	11.5
Tameside	12.9	10.2	16.2
Trafford	7.3	5.3	9.9
Wigan	11.2	9.0	13.6

Source: Public Health England (based on ONS source data)

6.3.5 Rates of suicide in Tameside have fluctuated somewhat but overall have been on the rise since 2002, peaking in 2010, but rising again from 2011. (Chart 2) The overall rate of suicide in Tameside between 2015/17 was 12.9 (per 100,000 residents),[21] (chart 1) making this the highest rate in Greater Manchester over the 3 year period, with significant variation between wards and different population groups.

Chart 2: Trends in suicide in Tameside 2002-2017



Source ONS

7. KEY RISKS FACTORS TO SUICIDE

7.1 Understanding the key risks in relation to suicide enables targeted approaches to those most in need of intervention. A local suicide audit suggested that Tameside fits the national and regional picture with regard to overarching demographic, social and economic factors which place residents at higher risk of suicide.

[21] Suicide prevention profiles_ PHE_ 2014/16

7.2 Men are five times more likely to die by suicide than women in Tameside,[22] three times higher on average in England[23] and people in the lowest socio-economic group and living in deprived areas appear to be more at risk of suicide than those in the most affluent groups living in the most affluent areas.[24]

7.3 Local evidence suggests that those most at risk are:

- Men
- People with prior mental health issue such as depression and anxiety
- Relationship breakdown
- Loss of job
- Chronic pain or disability
- People with longstanding issues with drugs and or alcohol
- People with financial issues/debt

These are similar to what the national evidence suggests that those most at risk nationally are:

- Men
- Individuals aged 35-49
- People with a recent history of self-harm
- People in the care of mental health services
- People in contact with the criminal justice system
- Specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers[25] and veterans.

7.4 The incidence of self-harm as a precursor to suicide has seen a steep rise, calling for better assessment of those presenting to services. In 2016/17 there were 512 hospital admissions due to self-harm in Tameside.[26] Of these, evidence suggests that patients can often present with a complex history of risk factors and events leading up to admission including:

- Untreated depression
- Unemployment
- Debt
- Relationship breakdown and bereavement including by suicide
- Drug and alcohol misuse
- Social isolation[27]

[22] A suicide audit for Tameside 2013-2016

[23] http://web.ons.gov.uk/ons/rel/subnational-health4/suicides-in-the-united-kingdom/2014-registrations/

[24] Platt, S. Inequalities and suicidal behaviour; In O'Connor, R.C. et al. International handbook of suicide prevention: research,
policy and practice. 2011

[25] Op.cit. HM Government (2012)

[26] https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide/data#page/4/gid/1938132834/pat/126/par/E47000001/ati/102/are/E08000008/iid/21001/age/1/sex/4

[27] PHE Local suicide prevention planning A practice resource (2016)

7.5 Key risk factors for the under 25s are:[28]

- Family factors such as mental illness
- Abuse and neglect, Bereavement and experience of suicide
- Bullying, Suicide-related internet use
- Academic pressures, especially related to exams
- Social isolation or withdrawal
- Physical health conditions that may have social impact
- Mental ill-health, self-harm and suicidal ideas

7.6 In contrast, certain protective factors are evident from the data on suicides, which include:

- Effective coping and problem solving skills
- Presence of reasons for living, hopefulness and optimism
- Physical activity and health
- Family connectedness
- Supportive schools and Social support
- Religious participation, Employment
- Lack of exposure to suicidal behaviour
- Traditional social values
- Access to health treatment[29]

7.7 It is reasonable to assume therefore that strategies which seek to increase these protective factors at a population level are likely to be of benefit in reducing overall risk.

8. STRATEGIC APPROACH

8.1 National Strategy

8.1.1 The Five Year forward view for Mental Health (2016) sets out the challenge to reduce suicides by 10%, and several strategies around the UK have clearly stated their intent to go much further than this – toward a zero suicide approach. This too is our ambition. We intend to adopt a focused approach to achieving this goal by targeting those deaths which are most preventable by identifying specific at-risk groups, communities or settings for action. We will use the intelligence gathered via the GM and local Suicide Audits to inform where our efforts might be best targeted in addition to national priority groups. This strategy acknowledges and builds on a substantial body of work in relation to suicide prevention in Greater Manchester and reflects the learning of a programme of sector led improvement undertaken in 2013. Our overarching objectives are aligned with the six national priorities (2012) and national refresh (2017).

[28] National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) Suicide in children and young
people. (2016)

[29] Scottish Government Social Research Risk and Protective Factors for Suicide and Suicidal Behaviour: A Literature Review
(2008)

8.1.2 The strategic priorities nationally are set out below and this strategy principally focuses on actions that support those objectives which can be delivered or supported by utilising a Greater Manchester and local approach.

8.2 National Priorities for Action

8.2.1 The National Suicide Prevention strategy of 2012 set out six priority areas for action:[30]

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

8.2.2 These six areas for action have been used as a framework for this Strategy, and to develop our overarching aims and objectives and supporting action plan.

8.2.3 The more recent national strategy refresh (January 9th 2017) stays true to these themes with an additional emphasis on

- Better and more consistent local planning and action by ensuring that every local area has a multi-agency suicide prevention plan by 2017, with agreed priorities and actions.
- Better targeting of suicide prevention and help seeking in high risk groups such as middle-aged men, those in places of custody/detention or in contact with the criminal justice system and with mental health services
- Improving data at national and local level and how this data is used to help take action and target efforts more accurately
- Improving responses to suicide
- Expanding the scope of the national strategy to include self-harm prevention in its own right.

[30] https://www.gov.uk/government/publications/suicide-prevention-strategy-for-england

9. TAMESIDE & GLOSSOP MENTAL HEALTH APPROACH

9.1 The overarching Tameside & Glossop Mental Health Approach

9.1.1 This suicide prevention strategy forms part of an overarching approach for mental health in Greater Manchester and in Tameside and Glossop. This broader strategy for GM is summarised in **Appendix 2**, and sets out the vision to improve child and adult mental health, narrow the gap in life expectancy and ensure parity of esteem with physical health. The vision also commits to shifting the focus of care toward prevention, early intervention and resilience and toward delivering a sustainable mental health system. Simplified and strengthened leadership and accountability is at its core, as is the enablement of resilient communities, the engagement of inclusive employers and close partnership working with the third sector.

9.1.2 To achieve these goals in Tameside and Glossop we intend to strengthen our mental health system, and this will be achieved through four key characteristics which run throughout our plans:

- Prevention
- Access
- Integration
- Sustainability

9.1.3 A number of 'golden threads' also run throughout our strategy, including

- Parity of Esteem
- Research deployed to inform best practice
- Using technology to provide new and innovative forms of support
- Leverage the learning from successful programmes (e.g. Troubled families)
- Workforce Development,

This Suicide Prevention strategy stays true to these principles

9.2 As one of four national sites chosen by the Innovation Unit our local Living Life Well Programme, supported by the Big Lottery Fund, will design a new model of care that ensures that people with mental health conditions will

- Have no gap between services
- Have no wrong door and no silo working
- Get swift and easy access to life changing support and interventions
- Get help in a crisis and get the right support required
- Have access to early support to prevent crises from happening
- Have less need for in-patient care
- Have access to alternatives to hospital admission

9.3 Starting with the 101 Days for Mental Health Project in summer 2018 we have co-produced a new model of care in the neighbourhoods that meets the currently unmet mental health care needs of individuals in Tameside and Glossop. We are expanding the principles of this model into our work on mental health crisis care.

9.4 All of this new development is supported by the Strategic Commissioning Board's commitment to improving the mental health of the Tameside and Glossop population by agreeing to prioritise increasing investment to improve parity of esteem.

9.5 The Board has agreed to a plan to invest £6million recurrently from 2018 until 2021 on a phased basis in order to support the following objectives:-

- Affordability;
- Development of robust business cases for each scheme;
- Phased approach to building complex services;
- Recognition of the time lag in recruitment to mental health posts.

9.6 The investment is focussed on:

- Increasing opportunities for people to stay well in the community
- Increasing opportunities to get help before/during a crisis
- Making effective use of secondary care

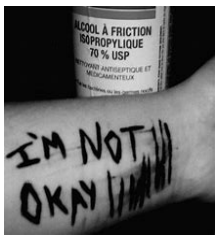
10. SUICIDE PREVENTION OUTCOMES WE WANT TO ACHIEVE

10.1 Our key priority areas for actions and outcomes for preventing suicide in Tameside and Glossop are described in the recent Public Health England resource for suicide prevention[31]. Following the completion of the Tameside and Glossop suicide audit this will be enhanced to reflect the findings. It is also important to note that this suicide prevention strategy cannot operate in isolation. As stated previously, suicide is complex and intrinsically linked to deprivation, unemployment, debt, substance misuse, social isolation and other adverse experiences people in Tameside and Glossop live with. Therefore this strategy needs to work alongside the corporate plan, (**Appendix 3**), the local poverty strategy and the health and wellbeing strategy.

1. Reducing the risk in men

We will reduce risk in men, in particular middle aged men, we will do this by focusing on economic disadvantage such as debt and or unemployment, social isolation and drugs and alcohol misuse. A focus on developing treatment and/or support settings that are more acceptable and accessible by men

[31] Appleby,L (2016) 'Priorities for Suicide Prevention action plans' in Local Suicide Prevention Planning – A Practical Resource. Public Health England



2. Preventing and responding to self- harm

- We will develop a care pathway and services for adults and young people in crisis, and psychological assessment for self-harm patients.
- Acknowledgement that support for young people will be distinct from that of adults.

3. Mental Health of Children and Young People (and parents in pregnancy and first two years of life)

We will work in partnership with health, social care, schools and youth services, including maternity and health visiting to increase awareness and training of professionals so they are able to identify those at risk of suicide and intervene where necessary.

4. Improved Care, pain management and mental health in people with long term conditions

This includes ensuring people with long term conditions are managing their condition and any pain effectively through self-care and regular condition and medicine reviews, and using social prescribing to enhance quality of life.

5. Improve the general mental wellbeing and resilience in the Tameside population through opportunities

- To be more physical active and socially included
- To learn and engage and have access to Improved employment opportunities
- To have access to good public transport links
- To have access to help and support early when needed

6. Improve Economic opportunities for the Tameside population

Including opportunities to attract good employers that offer well paid jobs, reduced unemployment, in particular in those in long term unemployment in people with mental health conditions, learning disabilities and physical health conditions

7. Tackling high frequency locations

This includes making high risk public areas safer and working with the local media organisations and groups to prevent imitative suicides

8. Bereavement Support and Media engagement

We will ensure there is better provision of information and support for those bereaved or affected by suicide and support the media in delivering sensitive *approaches to suicide and suicidal behaviour*

11. OUR OBJECTIVES

11.1 The action plan for 2019/20 to support the delivery of this strategy can be found in **Appendix 1**. The action plan will be the parameter by how we ensure the implementation of our objectives to achieve the outcomes we aspire to. The measure of success of both the strategy and action plan will be a substantive reduction in suicide in Tameside & Glossop over the course of the strategy. Below is a summary of our strategic objectives and associated 'pledges' that this strategy makes for 2019-2023.

Strategic Objectives

11.2 Our strategic objectives are described against the Suicide Safer Communities Accreditation '*Nine Pillars of Suicide Prevention*'. These are

1. A leadership/steering committee
2. A robust background summary of the local area to support goal setting
3. Suicide Prevention Awareness raising
4. Mental Health and Wellness promotion
5. Training for community members, lay persons and professionals
6. Suicide intervention and ongoing clinical support services.
7. Suicide bereavement support and resources
8. Evaluation measures including data collection and evaluation system
9. Capacity building/sustainability within communities

11.3 **Pillar 1: A leadership/steering committee**

(a) Securing high level political support for suicide prevention, with support from local political mental health champions within Tameside and Glossop
(b) We will establish an executive chair and review the Terms of Reference for the Tameside & Glossop Suicide and Self Harm Prevention Group
(c) The Group is responsible for developing and delivering this Strategy and be held to account by the Tameside and Glossop Mental Health Strategy Steering Group. The

Group will also provide and annual update to the Tameside Health and Well-being Board

(d) Membership of the group will include people with lived experience, voluntary sector groups, health providers, blue light services and commissioners.

11.4 **Pillar 2: A robust background summary of the local area to support goal setting**

(a) This Strategy is based on the Tameside audit of suicides registered between 2013 and 2017
(b) We will redo the audit every 5 years and share learning across Greater Manchester and support the production of a GM annual audit
(c) We will use the audit process to identify high risk locations and or new and emerging means of suicide and put in place plans to reduce related risks.
(d) We will support and attend the annual suicide prevention conference for Greater Manchester to share learning, good practice and strengthen links between agencies

11.5 **Pillar 3: Suicide Prevention Awareness raising**

(a) We will work to develop and deliver the Greater Manchester Suicide Prevention Campaign 2019 and deliver a local boost to the campaign
(b) In partnership with Greater Manchester and Public Health England, we will look at the potential for a social marketing initiative that will stimulate a social movement for change with regard to eliminating the stigma associated with suicide and self-harm.
(c) We will review the learning from other localities and work with local residents to design a campaign to target men in particular
(d) We will work with colleagues in the media to agree standards of reporting of suicide and maximise opportunities to signpost and raise awareness
(e) We will work together to develop a World Suicide Prevention Day
(f) Being open, receptive and supportive of social movements that improve public awareness of suicide prevention through campaigns or social media platforms

11.6 **Pillar 4: Mental Health and Wellness promotion**

(a) We will embrace Public Health England's new 3-year mental health campaign in 2019.
(b) Working with colleagues in schools to raise awareness of emotional wellbeing amongst young people
(c) Working with the GM Parent Infant Mental Health Programme to promote mental well-being of parents in pregnancy and beyond
(d) Promoting mental health in our workplaces and amongst our staff, especially those in higher risk occupations, and promote approaches that reduce stigma
(e) We will work with local faith group leaders to share knowledge and understanding of suicide in relation to culture and faith.

11.7 **Pillar 5: Training for community members, lay persons and professionals**

(a) We will develop a Training Ladder and establish a rolling programme of training at all levels, monitoring the uptake each year

(b) We will support staff groups who wish to develop their knowledge skills and confidence such as primary care practitioners and pharmacies, and in management of risks in primary care
(c) We will work with primary care professionals such as GPs and practice nurses to better understand risk by utilising models such as the five Ps psychological assessment tool.[32]
(d) Working with the community and voluntary sector by supporting collaboration such as a voluntary sector Health and Wellbeing Alliance in Tameside and Glossop

11.8 **Pillar 6: Suicide intervention and ongoing clinical support services**

(a) We will ask Pennine Care to demonstrate its work toward the elimination of suicides in in-patient and community mental health care services through reporting on a bi-annual audit of quality improvement in Tameside and Glossop services in relation to the 10 ways to improve patient safety, listed below,:[33]

- Safer wards (e.g. prescribing, eliminating ligature points)
- Early follow up on discharge (within 2-3 days)
- No out of area admissions
- 24 hour crisis teams (sign up to the crisis care concordat)
- Family involvement in 'learning lessons'
- Guidance on depression
- Personalised risk management
- Outreach teams
- Low staff turnover
- Dual Diagnosis support (i.e. Alcohol and Drugs)

(b) Our neighbourhood mental health Minds Matter service will offer swift and easy access to people wanting support and advice regarding their mental health across all five neighbourhoods
(c) We will develop a STORM pathway within our Minds Matter service; ensuring people identified with high risk of suicide are offered comprehensive support
(d) We will improve crisis services including establishing a mental health observation and assessment room and increasing the capacity of the Home Treatment Team support people at home in place of a hospital admission
(e) Review the management of depression in primary care and scope the potential for a minimum/optimal standard for risk assessment tools in primary care
(f) We will establish an All-Age RAID service at Tameside Hospital, including a service for vulnerable children and young people, working in partnership with the GM CYP Crisis developments
(g) We will review of Parent Infant Mental Health Pathway following the roll out of the new GM Perinatal Community Mental Health team in order to strengthen further comprehensive support to both parents in pregnancy and the two years following birth.
(h) We will finalise our review of Psychological Therapies with the goal of continuing to improve access to and waiting times for psychological therapy. This includes IAPT for long term conditions.

[32] https://www.psychologytools.com/worksheet/friendly-formulation/
[33] Appleby,L et al (2016) Making Mental Health Care Safer: Key findings from the National Confidential Inquiry into Suicides and Homicides. Manchester University.

(i) We will review local self-harm care pathways against NICE guidance (CG133) and complete a self-harm audit to enable us to better understand the reasons behind self-harm and to assess outcomes against evidenced standards.
(j) We will establish a process for triangulating serious incidents in our mental health services and publishing outcomes.
(k) We will seek to standardise post-incident reviews in line with Greater Manchester
(l) We recognise the need to build on access to information online and through other means. Greater Manchester are developing an online resource so we will build into our online resources locally including the Life in Tameside and Glossop website.

11.9 **Pillar 7: Suicide bereavement support and resources**

(a) We will develop a Suicide Bereavement Pathway with people with lived experience including consideration of need for group based and 1-1 interventions. This will include

- The GM wide suicide bereavement service and associated website
- support offered to families by Pennine Care teams following a suicide of patient

11.10 **Pillar 8: Evaluation measures including data collection and evaluation system**

(a) A SMART Action Plan for 2019/20 is included in **Appendix 1**, the populated version will be updated each year
(b) We will agree key data and develop a bi-annual review of this to track our progress and use the learning to improve our understanding, our communications, our strategy and our services
(c) We will support the GM approach to the use of 'Real-Time Data' in maximising our response to suicides.
(d) We will develop our processes across Tameside and Glossop to foster a culture of learning from suicide attempts and the avoidance of a blame culture

11.11 **Pillar 9: Capacity building/sustainability within communities**

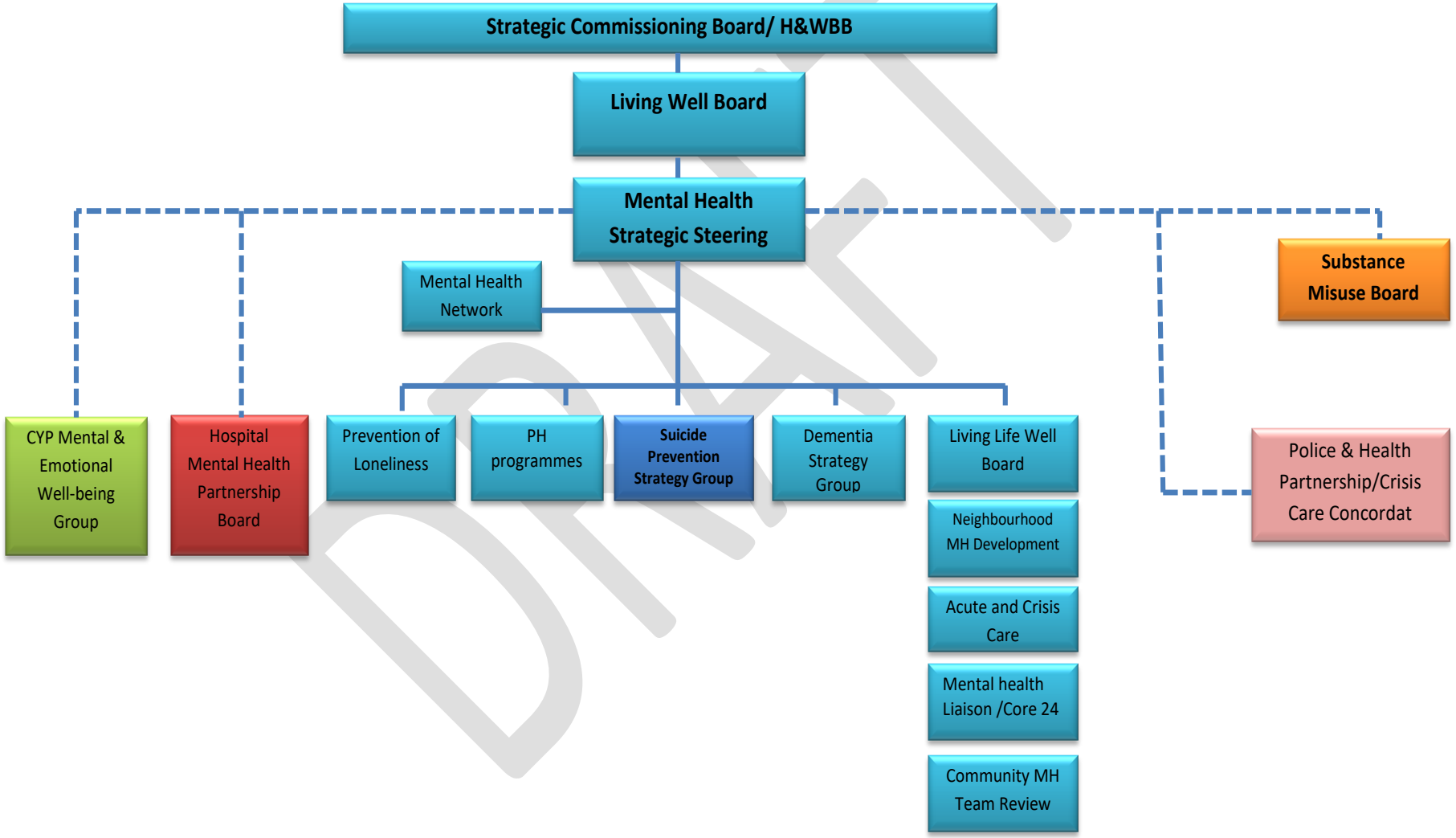
(a) We will consult with community and voluntary sector colleagues about the needs of specific groups such as LGBT, Asylum seekers, those with a Long-term condition, drugs and alcohol treatment clients and individuals in contact with the justice system to identify options for improving outcomes in these groups

12. GOVERNANCE INFRASTRUCTURE

12.1 The strategy will be delivered by the Tameside & Glossop Suicide and Self Harm Prevention Group which will identify partners to deliver progress against each work stream. The suicide prevention work stream is closely aligned to the mental health and wellbeing 'Living Life Well' programme of work, the Locality Plan and the One Corporate Plan (**Appendix 3**).

12.2 A programme management approach will be utilised to focus on delivery and measurement of impact during 2018/19 and 2019/20 which will form the basis of the work of the Suicide and Self-Harm Prevention Group.

Tameside and Glossop Mental Health Strategy Governance



APPENDIX 1: Suicide Prevention Action Plan 2019/20

Number	Objective	Action	By Whom	Timescale
1	To further develop and establish a strong suicide prevention strategy group	a) We will secure a permanent chair to the group, review the membership and terms of reference. b) The group will send regular reports and strategy implementation updates to the Mental Health Strategic Steering Group	Suicide prevention strategic group	June 1st 2019
2	To produce regular reports and briefings to the suicide prevention group, mental health steering group and Health & Wellbeing Board	a) A local suicide audit for Tameside & Glossop will be produced every 5 years and we will contribute to the annual GM audit b) We will produce regular briefings to the suicide prevention group regarding the 'Real time' data provision provides via GM	Jacqui Dorman Jacqui Dorman	April 1st 2022 December 31st 2019
3	To increase suicide prevention awareness	a) We will support and deliver locally the GM and national suicide prevention campaigns b) In partnership with GM we will develop and deliver a social marketing initiative to stimulate a social movement around self-harm and suicide to reduce stigma c) In partnership with GM we will work with local our local media to agree standards for reporting of suicides	Communication team Tameside & Glossop Suicide prevention strategy group	a) Spring and Autumn 2019 b) December 31st 2020 c) April 1st 2020

4	To promote mental health and wellness and improve population resilience	a) We will encourage schools to sign up to the 'mentally health schools' programme and school staff will be encouraged to take up the 'zero suicide alliance' e-learning module. We will capture the take up of the e-learning as part of the overall monitoring of take-up of suicide prevention training. b) A directory of mental health and suicide prevention support and services will be established and maintained through the 'Life in Tameside & Glossop' Web portal c) We will communicate and promote the services and support available to residents who need help relating to suicide risk area such as debt and money advice, housing, relationships and criminal justice etc. d) We will undertake a focused piece of work within the Living Life Well Programme with men to understand how best to reach them to promote mental wellbeing.	Charlotte Lee (population health) Jacqui Dorman and Arianne Whitley Jacqui Dorman and Communications Team Arrianne Whitley	a) December 31st 2019 b) September 30th 2019 c) March 31st 2020 d) December 31st 2019
5	To skill up our whole workforce on suicide prevention to help them to be confident to ask/support others	a) We will develop a comprehensive mental health and suicide prevention training ladder that covers the needs of the whole workforce. b) We will identify the training resources needed and develop/ commission an annual rolling programme	a) Pam Watt and Vicky Broadbent b) Pam Watt and Vicky Broadbent	a) June 30th 2019 b) August 31st 2019
6	To increase support for people at risk of suicide	a) We will develop an overnight 'safe haven' for people assessed as requiring immediate support b) We will establish a STORM Pathway within our neighbourhood mental health development for people assessed as needing on-going support. c) We will continue work with GM to develop and roll out the new GM Suicide Bereavement Service and, when operational, review if there are any unmet needs in Tameside and Glossop.	Pat McKelvey and Hayley McGowan	December 31st 2019

7	To ensure coherence across the system	a) We will undertake an audit on self-harm and from this identify any actions within this strategy. b) We will work with the leads for the Children and Young Peoples Emotional and Mental Health Locality Transformation Plan to ensure coherence with this Strategy	Jacqui Dorman Kristy Nuttall	a) 31st October 2019 b) 31st July 2019
8	To improve access to Suicide bereavement support and resources	a) We will scope bereavement support options locally with a view to implement a local offer in line with SOBs standards b) We will implement the Greater Manchester suicide bereavement offer across Tameside & Glossop c) We will develop a bereavement pathway in relation to the 'real time' GM data to ensure people who need support are signposted to appropriate services and interventions	Suicide prevention strategy group Jacqui Dorman and Pat McKelvey	a) 31st December 2019 b) June 30th 2019 c) 1st April 2020
9	To evaluate and learn from suicides	a) We will ensure that we learn from suicide and episodes of self-harm through an annual review of serious case reviews, CDOP reports and coroner's reports ensuring recommendations from the review are being implemented. This will also be part of the suicide audit process. b) we will complete a bi-annual review of the GM real-time data and report to the suicide prevention group	Suicide prevention group Jacqui Dorman	31st December 2020 31st December 2020
10	To increase capacity building and sustainability within communities	We will work with all our voluntary sector organisations to identify at risk groups within our communities to ensure that suicide prevention is embedded within our high risk populations and that these populations are aware of the help and support available	Suicide prevention group and Action Together	31st December 2020

APPENDIX 2

Appendix 1 – Greater Manchester Mental Health Strategy.

Compelling Vision

Strategic Plan on a Page

CHARACTERISTICS TO UNDERPIN VISION	
PREVENTION	Place based and person centred life course approach improving outcomes, population health and health inequalities through initiatives such as health and work.
ACCESS	Responsive and clear access arrangements connecting people to the support they need at the right time
INTEGRATION	Parity of mental health and physical illness through collaborative and mature cross-sector working across public sector bodies & voluntary organisations
SUSTAINABILITY	Ensure the best spend of the GM funding through improving financial and clinical sustainability by changing contracts, incentives, integrating and improving IT & investing in new workforce roles

MENTAL HEALTH AND WELLBEING STRATEGY

STRATEGIC GOLDEN THREADS	PREVENTION	ACCESS	INTEGRATION	SUSTAINABILITY
Parity of Esteem	Early Years: Children & Family	Single Point of Access and Care Co-ordination	Integrated place based commissioning & contracting aligned to place based reform	System leadership
Research Deployed to Inform Best Practice	Improve Mental Wellbeing	IAPT Services of Consistent High Quality for GM	Vertical & horizontal integration across community, primary & acute care	Working practices
Technology providing new innovative forms of support	Building Capacity for Self care	Improving Support for Carers and Parents at Risk	Whole person integrated vertical care pathway across a horizontal integration of care	Programme prioritsation
Leverage Successful Programmes e.g. Troubled Families	Suicide Prevention	Introduce 24/7 Mental Health and 7 Day Community Provision for CYP	A strong partnership with the community and voluntary sector	Pooling of mental health budgets
Prepare the Workforce for Integrated Joined Up System	Early intervention	Ensure consistent 24/7 Mental Health and 7 Day Community Provision for adults including crisis concordat	Asset-based approach and devolution estate managed centrally	Provider Landscape Redesign
	Targeted public health campaigns	Consistent Standards and Protocols for Step Up and Step Down	Integrated monitoring, standards and KPIs	Payment and incentives
	Supporting vulnerable people	Self-sufficiency in GM Provision (out of area placements)	Integrated data sharing	Regulation reform
	Workplace and employment support	Eating Disorders for Children and Young People		New investment streams
		Consistent ADHD services for all age groups		

Priorities Identified for Years 1 and 2

The Strategic Initiatives

CASE FOR CHANGE **PRIORITY POPULATION GROUPS** **STRATEGIC INITIATIVES**

APPENDIX 3

Tameside Metropolitan Borough

Transforming Tameside & Glossop
Our People - Our Place - Our Plan
For everyone every day

NHS Tameside and Glossop Clinical Commissioning Group

Starting Well

Living Well

Ageing Well

Great Place
Vibrant Economy

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Report to: **HEALTH AND WELLBEING BOARD**

Date: 27 June 2019

Reporting Officer: Pamela Watt

Subject: **SEXUAL AND REPRODUCTIVE HEALTH**

Report Summary: Sexuality and sexual relationships form a significant part of our lives and good sexual and reproductive health is about being confident and comfortable with ourselves and having access to the information and services that enable us to make informed choices that help keep us safe and well. Sexual and reproductive health is about wellbeing, not just services: it is a social issue, not just a medical one. Sexual and reproductive health is not just a medical issue, but extends to the social, with poor sexual and reproductive health impacting not only on an individual's wellbeing but that of their family and friends. It is also relevant across the life course.

There is a complex commissioning landscape for sexual and reproductive health services, however strong strategic leadership is provided through the Greater Manchester Health & Social Care Partnership, and there are many examples of collaborative commissioning across GM local authorities.

The paper proposes a process for developing a whole system partnership framework for action that aims to deliver a sexual and reproductive vision for Tameside.

Recommendations: Health and Wellbeing Board members are asked to:

- Note the content of the paper and presentation.
- Comment on the proposed vision and process for delivery, i.e. a Framework for Action.
- Discuss how best the whole system can contribute and work towards good sexual and reproductive health and wellbeing.

Corporate Plan: Sexual and Reproductive Health links to several of the outcomes within the Corporate Plan:

- Starting well/living well
  - Number of 16-19 year olds in employment or education
  - Promote whole system approach and improve wellbeing and resilience
  - Increase median resident earnings
  - Increase the working age population in employment
  - Increase the number of people earning more than the living wage
  - Working age population with at least level 3 skills
- Living well/ageing well
  - Reduce victims of domestic abuse
  - Increase access, choice and control in emotional and

mental self-care and wellbeing

- Improve the wellbeing for our population

Policy Implications:	The provision of sexual health services is a mandatory function of the Council, with poor sexual and reproductive health effecting both health and social outcomes for individuals and their families, as well as specific population groups. However, delivering an effective sexual and reproductive health system based on proactive and informed choice and aspiration needs the support of the whole system, and new ways of commissioning and providing need to be explored.
Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)	There are no direct financial implications arising from the report, however Health and Wellbeing Board members should note the value of current investment by the Tameside and Glossop Strategic Commission. The 2019/20 budget value is £ 2.207 million. Members are reminded to consider this level of current investment in the context of the vision as outlined in the presentation. Clearly an improvement in related preventative measures will increase the value of this current investment and reduce demand on health service provision.
Legal Implications: (Authorised by the Borough Solicitor)	Where the Council is required to deliver a function, failure to do so in a rational reasonable way will attract the potential for successful challenge in the courts/tribunals or with regulatory watchdog bodies such as the Equalities Commission and the Local Government Social Care Ombudsman. Delivery must include evidence of value for money, fulfilment of the Council's fiduciary duty to the taxpayer, together with compliance with it's Equality Act duties.
Risk Management:	Effective implementation of a whole systems approach to delivering the sexual and reproductive health vision will reduce the risk of poor sexual and reproductive health outcomes, such as unintended pregnancy and poor wellbeing for our population and associated cost implications
Background Information:	The background papers relating to this report can be inspected by contacting Pamela Watt. Telephone: 07970887830 e-mail: pamela.watt@tameside.gov.uk

1. INTRODUCTION

1.1 The formal definition of sexual health is as follows:

"…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."[1]

1.2 However, the focus can often settle on detection and treatment of disease, such as Sexually Transmitted Infections (STIs). This can be seen within the outcomes data often used to define sexual health – see section 2 and Appendix 1.

1.3 Sexuality and sexual relationships form a significant part of our lives and good sexual health is about being confident and comfortable with ourselves and having access to the information and services that enable us to make informed choices that help keep us safe and well. Sexual and reproductive health is about wellbeing, not just services: it is a social issue, not just a medical one.

1.4 Sexual and reproductive health is relevant not just for young people, but for people of all ages across the life-course.

1.5 Note that within this report the term sexual and reproductive health is used rather than just sexual health. The two issues are closely connected and Tameside's specialist service is an integrated service that addresses both issues.

2. DATA AND OUTCOMES

2.1 Below is a selection of the main indicators for sexual and reproductive health (for more detail – see Appendix 1):

	Tameside	England	Statistical comparison to England	Recent Trend
New STI diagnoses (excluding chlamydia in under 25s)/100,000 (2018)	742	851	Better	No significant change
HIV late diagnosis (%) (2015-17)	50	41.4	Not measured	-
Under 25s repeat abortions (%) (2017)	28.7	26.7	Similar	No significant change
Total prescribed LARC (excluding injections) rate/1,000 (2017)	42.4	47.4	Lower	-
Under 18s conceptions rate/1,000 (2017)	22.7	17.8	Worse	Getting better
Under 18s conceptions leading to abortions (%) (2017)	56.6	52	Similar	Increasing

[1] WHO, 2006a. Defining sexual health: Report of a technical consultation on sexual health, 28-31 January 2002. Geneva, World Health Organisation.

3. WHOLE SYSTEM THINKING

3.1 There are the direct financial and medical implications of poor sexual and reproductive health related to treatment of disease and potentially severe health complications when left untreated. But in addition, the social and personal impact of poor sexual and reproductive health can be immense; for example:

- Impact of unintended pregnancy, for all ages
- Abortions, including repeat abortions
- Long term impact resulting from e.g. child sexual abuse, rape
- Reduced confidence when not in control of sexual and reproductive health decisions; e.g.:
  - when to start sexual relationships
  - unequal power dynamics within relationships.

3.2 So investing in sexual health ensures the long term wellbeing of our local population and a strategic, planned approach that encompasses the whole system is needed. This will help transform sexual and reproductive health away from identification and treatment of disease into a proactive, empowering system that encourages informed choices that keep people safe and well.

3.3 Indeed, it has been calculated that for every £1 spent on contraceptive services there is a return on investment of £9 across the public sector[2].

3.4 This work is already in progress with an update presented to the Strategic Commissioning Board in December 2018. This paper suggests a Framework to shape our approach over the next three years.

4. COMMISSIONING LANDSCAPE

4.1 There is a complex commissioning landscape for sexual and reproductive health as set out below:

[2] ADPH, LGA, English HIV and SH Commissioners' Group (2019) APPG Enquiry on Contraception.

Local Authorities	CCG	NHS England
Community contraception, including: • Long acting reversible (LARC) contraception in general practice • Emergency hormonal contraception (EHC) in pharmacy	Abortion services	HIV treatment and care including pre and post prophylaxis
Community STI diagnosis and treatment, including the National Chlamydia Screening Programme (NCSP)	Vasectomy and sterilisation services	Contraception provided under the GP contract
Targeted sexual and reproductive health promotion, including free condom schemes	Gynaecology services	Cervical screening
HIV prevention	Psychosexual services (non sexual health element)	Opportunistic promotion and testing of STIs
Sexual health aspects of psychosexual counselling		Sexual health in prisons
Specialist sexual health services: including young people's sexual health services, outreach, and sexual and reproductive health promotion services in schools, colleges and pharmacies.		Sexual assault in referral centres (SARC)

4.2 Local Authority responsibilities are led by Population Health and forms one of the largest budget portfolios for Population Health. The responsibilities outlined above are managed via several contracts.

4.3 However, it should be noted that Tameside is closely linked to other Great Manchester (GM) Local Authorities via the GM Sexual Health Network that sits within the GM Health & Social Care Partnership and involves many partnership groups looking at all aspects of sexual and reproductive health. A GM strategy is been discussed and progressed within the relevant GM governance structures and drives the strategic ambition across GM.

4.4 Tameside also collaboratively commissions many sexual and reproductive health contracts with other GM Local Authorities. This includes our largest sexual and reproductive health contract for specialist sexual health services, which is jointly commissioned across Tameside, Stockport and Trafford and is provided by Manchester University NHS Foundation Trust.

4.5 The Department for Health and Social Care recently conducted a national review of sexual and reproductive health commissioning. The review findings[3] (published 9 June 2019) stated that local authorities take an active and efficient approach to commissioning services. It was confirmed that they would continue to lead on this important work, with the recommendation that the NHS work much more closely with local authorities on public health, so that commissioning is more joined-up and prevention is embedded into a wider range of health services.

[3] https://www.gov.uk/government/news/government-review-confirms-local-authorities-will-continue-to-commission-public-health-services

5. WHERE DO WE WANT TO BE?

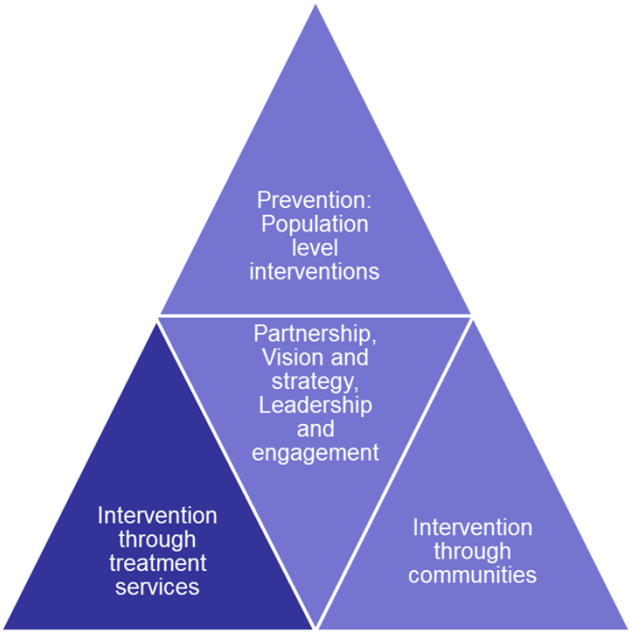
5.1 The Public Sector reform principles inform our approach - provision should be designed around people's needs and expectations; and be relatable to personal experiences.

- A new relationship between public services and citizens, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services. Do with, not to.
- An asset based approach that recognises and builds on the strengths of individuals, families and our communities rather than focussing on the deficits.
- Behaviour change in our communities that builds independence and supports residents to be in control
- A place based approach that redefines services and places individuals, families, communities at the heart
- A stronger prioritisation of wellbeing, prevention and early intervention
- An evidence led understanding of risk and impact to ensure the right intervention at the right time
- An approach that supports the development of new investment and resourcing models, enabling collaboration with a wide range of organisations.

5.2 Evidence[4] tells us what this should mean in practice:

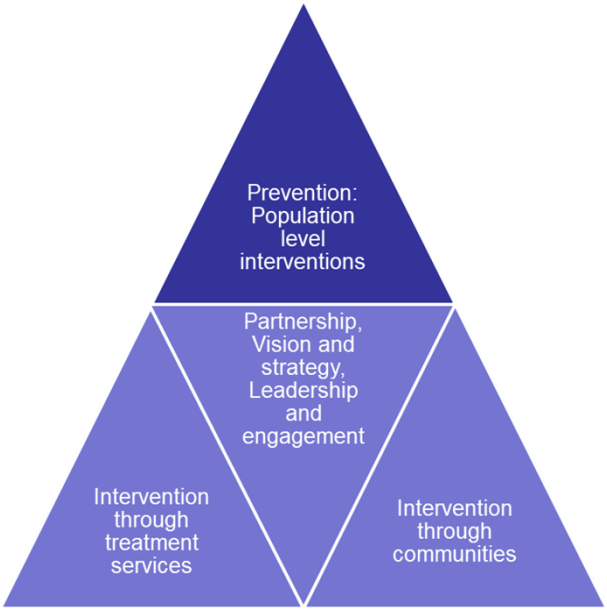
- Information that helps people to make informed decisions about relationships, sex and sexual health
- Preventative interventions that build personal resilience and self-esteem
- Rapid access to confidential, open-access, integrated sexual health services in a range of settings, accessible at convenient times
- Early, accurate and effective diagnosis and treatment of STIs, including HIV, combined with the notification of partners who may be at risk
- Joined-up provision that enables seamless patient journeys across a range of sexual health and other services – this will include community gynaecology, antenatal and HIV treatment and care services in primary, secondary and community settings.

5.4 The current focus of our attention and resources is reactive:



[4] Department of Health (2013) A Framework for Sexual Health Improvement in England, Department of Health.

5.5 However, where the focus should be is as follows:



5.6 So a proposed vision could be:

> *Tameside residents of all ages are able to express themselves, be confident, have choice and take control of decisions about their sexual and reproductive lives. This includes having effective access to good and reliable information and access to services in a way that effectively meets their needs.*

5.7 Examples of current intervention programmes that do take an integrated, collaborative, preventative and evidence approach are the recently developed Relationship and Sex Education resource for schools and Youthink, which is a youth sexual and reproductive health outreach programme.

6. HOW ARE WE GOING TO GET THERE?

6.1 Amongst this complex commissioning landscape, and based on recommendations from the Department of Health & Social Care review, there is a need for partners to come together in a more joined up way to develop a Framework for Action.

6.2 Therefore, a partnership workshop is being planned in July to begin this process. The proposed key issues for discussion are:

- Vision
- Principles
- Priorities and outcomes
- Enablers
- Actions
- Next steps

6.3 The following paragraphs give examples of potential priorities and outcomes to initiate discussion during the workshop.

6.4 Short term priorities – what we can achieve in year 1:

- Organised marketing of services and campaigns, online appointments, online kits
- Public/patient engagement via existing services and media routes

- Increase ordering of online test kits
- Consultation of National Chlamydia Screening Programme (NCSP) – summer 2019
- Develop new vision for specialist sexual and reproductive health provision (ready for procurement process beginning summer 2020)
- Develop neighbourhood model for primary care LARC provision

6.5 Medium term priorities – what can we do in year 2:

- Further roll out of SRE programme - Statutory RSE will be mandatory in all secondary schools in the UK from September 2020.
- Support roll out of Greater Manchester offer – the online/digital offer; HIV treatment & care; Primary care model
- Procurement of specialist sexual and reproductive health provision (contract ends 31st March 2021; procurement to start summer 2020)

6.6 Long term priorities – what can we do in year 3:

- Implement a primary care neighbourhood model for sexual and reproductive health
- Develop more community provision by specialist services
- Deliver a planned, whole system approach to improve knowledge and uptake of appropriate digital offers that help improve self-care.

6.7 An initial focus could be to move less complex activity from the specialist clinic based integrated sexual and reproductive health services to more primary care and prevention services offered by GPs & Pharmacies. Subsequently, the focus could move to improving self-help, early identification and people taking responsibility for their own health.

6.8 Proposed outcomes - how will we know we have made a difference?

- Improved whole system sexual and reproductive health promotion and disease prevention interventions
- Improved patient journey and satisfaction
- A workforce that can deliver modern, integrated sexual health services.
- Reduced number of under-18 conceptions.
- Reduced number of unintended conceptions/ToP (all ages).
- Reduced transmission and prevalence of (undiagnosed) HIV and sexually transmitted infections.
- Improved diagnosis, treatment and social care for people living with HIV, including reducing stigma.

6.9 The outcome of the workshop and consultations will be shared at a subsequent Health & Wellbeing Board.

7. CONCLUSION

7.1 Sexual and reproductive health is a complex subject that encompasses many issues and services with a range of commissioners and providers involved, locally, regionally and nationally.

7.2 We need to develop a clear local vision and plans for implementation, whilst also influencing the strong Greater Manchester strategy and commissioning directions. Local development could progress through a Framework for Action developed with partners that covers the whole system and life course.

8. RECOMMENDATIONS

8.1 As set out on the front of the report.

APPENDIX 1

Public Health England Fingertips data – Sexual and Reproductive Health Profiles (2019)

Compared with benchmark: Better Similar Worse Lower Similar Higher Not compared

Recent trends: – Could not be calculated; No significant change; Increasing / Getting worse; Increasing / Getting better; Decreasing / Getting worse; Decreasing / Getting better; Increasing

Indicator	Period	Tameside			Region	England			
		Recent trend	Count	Value	Value	Value	Worst/ lowest	Range	Best/ Highest
Syphilis diagnostic rate / 100,000	2018	↑	19	8.5	12.0	13.1	157.4		2.5
Gonorrhoea diagnostic rate / 100,000	2018	↑	211	94.1	81.2	98.5	870.9		17.7
Chlamydia detection rate / 100,000 aged 15-24 <1900 1900 to <2300 ≥2300	2018	↓	407	1,641	2148	1975	1,054		5,757
Chlamydia proportion aged 15-24 screened	2018	↓	4,260	17.2%	19.6%	19.6%	9.4%		48.7%
New STI diagnoses (exc chlamydia aged <25) / 100,000	2018	→	1,057	742	775	851	3,823		380
HIV testing coverage, total (%)	2018	↑	3,328	51.1%	53.0%	64.5%	29.0%		84.8%
HIV late diagnosis (%) <25% 25% to 50% ≥50%	2015 - 17	–	18	50.0%	44.2%	41.1%	68.6%		16.7%
New HIV diagnosis rate / 100,000 aged 15+	2017	→	11	6.0	7.7	8.7	44.6		0.0
HIV diagnosed prevalence rate / 1,000 aged 15-59 <2 2 to 5 ≥5	2017	↑	244	1.87	1.85	2.32	14.65		0.39
Population vaccination coverage - HPV vaccination coverage for one dose (females 12-13 years old) <80% 80% to 90% ≥90%	2017/18	–	1,280	93.8%	87.2%	86.9%	67.8%		95.3%
Under 25s repeat abortions (%)	2017	→	114	28.7%	27.5%	26.7%	39.0%		13.9%
Abortions under 10 weeks (%)	2017	→	810	83.1%	80.5%	76.6%	66.6%		86.7%
Total prescribed LARC excluding injections rate / 1,000	2017	–	1,766	42.4	44.8	47.4	7.0		85.8
Under 18s conception rate / 1,000	2017	↓	83	22.7	21.9	17.8	43.8		6.1
Under 18s conceptions leading to abortion (%)	2017	↑	47	56.6%	51.9%	52.0%	27.8%		81.0%
Violent crime (including sexual violence) - rate of sexual offences per 1,000 population	2017/18	↑	591	2.6	2.7	2.4	0.8		5.3

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Report to:	**Health and Wellbeing Board**
Date:	Thursday, 27 June 2019
Reporting Officer:	Councillor Wills Executive Member for Adult Social Care and Population Health Sarah Dobson, Assistant Director of Policy and Communication
Subject:	**UPDATE ON TAMESIDE & GLOSSOP PLAN AND PUBLIC SERVICE REFORM**
Report Summary:	This report provides an update on the Tameside & Glossop 'Our People – Our Place – Our Plan' and progress made to drive public service reform and transformation to the next level across Tameside & Glossop.
Recommendations:	Health and Wellbeing Board Members are asked to note the content of this update report and discuss the role of the Health and Wellbeing Board in delivering Public Service Reform.
Corporate Plan:	This report relates directly to the adoption and implementation of the Tameside & Glossop 'Our People-Our Place-Our Plan'
Policy Implications:	'Our People-Our Place-Our Plan' is a key underpinning policy document and sets the framework for policy and strategy making in Tameside & Glossop. Public service reform will define how we engage with our communities and therefore influence policy decisions.
Financial Implications: (Authorised by the statutory Section 151 Officer & Chief Finance Officer)	There are no direct financial implications arising from the report at this stage. However, Members are reminded that the annual revenue budgets of Tameside Council and the Tameside and Glossop Clinical Commissioning Group are reported as a single budget of the Strategic Commission which is referred to as the Integrated Commissioning Fund (ICF). Revenue budgets are currently reported and monitored within the fund by the respective services and directorates of each organisation. An analysis will be carried out to allocate current year service and directorate budgets within the ICF to the Corporate Plan priorities. This will provide an awareness of the current levels of investment against each priority and support the option to facilitate a review to ensure service reform and transformation is delivered across the economy.
Legal Implications: (Authorised by the Borough Solicitor)	Creation of a Public Service Reform Board (Reform Board) highlighted at 2.5 of the report would of course require separate governance to comply with legal framework within which required to operate. At all times members must be mindful of the fiduciary duty to the public purse and any reform and transformation programme must deliver both this and outcomes which are of proven benefit to the public in a fair and rationale way to avoid successful challenge.
Risk Management:	Failure to deliver priorities in an efficient and effective way, will

leave the Council and CCG at risk of not delivering a balanced budget as required by law and at risk of legal action or complaints to Local Government and Health Ombudsman.

Background Information: The background papers relating to this report can be inspected by contacting Jody Smith

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1 BACKGROUND

1.1 Tameside & Glossop's 'Our People – Our Place – Our Plan' (Appendix 1) was approved for formal adoption by TMBC Executive Cabinet in February 2019. The plan outlines the aims and aspirations for Tameside & Glossop, its people and how we commit to work for everyone, every day.

1.2 The plan is structured by life course – Starting Well, Living Well and Ageing Well, underpinned by the idea of ensuring that Tameside & Glossop is a Great Place, and has a Vibrant Economy. Within each life course sits an identified set of goals that set out what we want to achieve for people in the area throughout their life.

1.3 The plan is supported by a list of public service reform principles that define the ways of working to achieve those goals. Public Service Reform (PSR) has been established as a model of current and future service delivery across Greater Manchester. Identifying an asset based collaborative approach towards building community resilience and reducing reliance on public services, PSR prioritises wellbeing, prevention and early intervention. The PSR principles have been adopted locally and will redefine our relationship with residents – doing with, not to.

2. PUBLIC SERVICE REFORM

2.1 An event took place on 10 May with system leaders from across Tameside and Glossop to discuss driving public service reform and transformation to the next level. Organisations represented included:

- Tameside & Glossop Strategic Commission
- Tameside & Glossop Integrated Care NHS Foundation Trust
- Action Together
- Department for Work & Pensions
- Jigsaw Housing
- Greater Manchester Police
- Greater Manchester Fire & Rescue Service
- Derbyshire County Council

2.2 A key focus of the event was how organisations can best work together to deliver on the priorities and outcomes identified within 'Our People-Our Place-Our Plan' – at an individual, organisational, place and regional level. The following tables detail the outputs from the event - Table 1: Where we are now and Table 2: The shifts we need to make to move forward.

Table 1: Where we are now

Organisation	Clear understanding of our organisational responsibilities to Glossop/Derbyshire residents Joint bidding with other housing associations We have a wider view of our role Good customer intelligence and data
Place	Children & Young People Neighbourhood Learning Circles Provide decent housing Community based projects run/funded through neighbourhood plans Setting up the MASH – Multi Agency Safeguarding Hub
Region	Increased physical presence of system leaders Public engagement (public engagement networks, conferences, the role of the third sector)

	Disability Employment Advisors in GP surgeries Co-location of some services i.e. Tameside One Reduce areas/local teams working in isolation Prevention – youth engagement, community engagement, education

Table 2: The shifts we need to make

Individual	My identity – I'm not just an organisational leader Perceptions of me Time needed to make a difference Investing in relationships Staff retention Attractive strategies Get a better understanding of the other sectors to appreciate links, overlaps etc.
Organisation	The need to address the issues on the ground Who are our enablers? Relationships Creating the time needed Knowing the capacity of our workforce Dialogue with Place Recognising and respecting each other's pressures and regulatory requirements Breaking down individual resistance to change
Place	The need to address the issues on the ground We need to 'let go' of things e.g. leaders, organisations do not have all the answers on their own. Be part of it but not all of it. Permissions Agreeing ambitions collaboratively Consistency In partnership with… The narrative is single and unifying The communication is open and honest Opportunities to meet and build a network Team development opportunities Requires risk and vulnerability Boundaries – Where do we overlap? Where do we clash?
Region	Safety How do we understand and measure success? Dream big The system looking after itself – hard to get, easy to lose Clear purpose Do we have misaligned incentives? Always ask 'what's the alternative?' Collaboration is key Financial management

2.3 The following leadership behaviours were also identified as key to the success of implementing and delivering 'Our People-Our Place-Our Plan':

- Be visible
- Be present
- Be generous
- Understand the problem together
- Use language that we all understand
- Listen to each other and ourselves
- Committing our resources collaboratively
- Challenge ourselves and each other
- Deal with the problem not the consequences
- Bottom up, top down and sideways – collaborate

- Build relationships with trust
- Take the time getting perspective and understanding
- Create a unified, positive and optimistic narrative
- Develop a single version of the truth
- All conversations should be authentic and 'break through'
- Get to know 'people' first and 'job role' second

2.4 A commitment was made by attendees at the event to adopt 'Our People - Our Place - Our Plan' as the plan for Tameside & Glossop.

2.5 In order to strategically drive forward 'Our People-Our Place-Our Plan' it was acknowledged that it would be beneficial to create a Public Service Reform Board (Reform Board). Establishment of a Reform Board for Tameside & Glossop would enable a cross-organisational mechanism for strategic direction across a wide range of issues and help to mitigate duplication of effort.

3 RECOMMENDATIONS

3.1 As stated on the report cover

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Tameside Metropolitan Borough

Transforming Tameside & Glossop

Our People - Our Place - Our Plan

For everyone every day

NHS Tameside and Glossop Clinical Commissioning Group

Starting Well

Living Well

Ageing Well

Every best start in life where children are ready to learn and encouraged to thrive and develop

- Reduce rate of smoking at time of delivery
- Reduce the number of children born with low birth weight
- Improve school readiness
- Children attending 'Good' and 'Outstanding' Early Years settings
- Take up nursery at 2yrs
- Promote good parent infant mental health

Aspiration and hope through learning and moving with confidence from childhood to adulthood

- Reading / writing / maths at Key Stage 2
- Attainment 8 and Progress 8 at Key Stage 4
- Young people going onto higher education
- Children attending 'Good' and 'Outstanding' schools
- Number of 16-19 year olds in employment or educated
- Proportion of children with good reading skills
- Promote and whole system approach and improving wellbeing and resilience

Resilient families and supportive networks to protect and grow our young people

- Early Help Intervention
- Reduce the number of first time entrants into Youth Justice
- Increased levels of fostering and adoption
- Improve the quality of social care practice
- Improve the placement stability for our looked after children
- Reduce the impact of adverse childhood experiences

Opportunities for people to fulfil their potential through work, skills and enterprise

- Increase median resident earnings
- Increase the working age population in employment
- Increase the number of people earning above the Living Wage
- Increase number of enterprises / business start ups
- Working age population with at least Level 3 skills
- Increase the number of good quality apprenticeships delivered

Modern infrastructure and a sustainable environment that works for all generations and future generations

- Improve air quality
- Increase the number of net additional dwellings
- Increase the number of affordable homes
- Digital inclusion - average download speeds
- Reduce tonnes of waste sent to landfill and increase the proportion recycled
- Increase journeys by sustainable transport / non-car
- Increase access to public transport

Nurturing our communities and having pride in our people, our place and our shared heritage

- Increase participation in cultural events
- Reduce victims of domestic abuse
- Reduce the number of rough sleepers / homelessness
- Improve satisfaction with local community
- Victims of crime / fear of crime
- Reduce levels of anti social behaviour
- Increase access, choice and control in emotional and mental self-care and wellbeing

Longer and healthier lives with good mental health through better choices and reducing inequalities

- Increase physical and mental healthy life expectancy
- Improve the wellbeing for our population
- Smoking prevalence
- Increase levels of physical activity
- 'Good' and 'Outstanding' GPs practices
- Reduce drug and alcohol related harm

Independence and actvitiy in older age, and diginity and choice at end of life

- Increase the number of people helped to live at home
- Reduce hopsital admissions due to falls
- Increase levels of self-care / social prescribing
- 'Good' and 'Outstanding' social care settings
- Prevention support outside the care system

Great Place
Vibrant Economy

Delivering the vision, aims and priorities of the Corporate Plan will be supported by a number of enablers and ways of working:

A **new relationship** between public services and citizens, communities and businesses that enables shared decision making, democratic accountability and voice, genuine co-production and joint delivery of services. Do with, not to.

An **asset based approach** that recognises and builds on the strengths of individuals, families and our communities rather than focussing on the deficits.

Behaviour change in our communities that builds independence and supports residents to be in control

A **place based approach that redefines services** and places individuals, families, communities at the heart

A stronger prioritisation of **well being, prevention and early intervention**

An **evidence led** understanding of risk and impact to ensure the right intervention at the right time

An approach that supports the development of **new investment and resourcing models**, enabling collaboration with a wide range of organisations.