Report to:	**STRATEGIC COMMISSIONING BOARD**
Date:	28 November 2018
Reporting Member / Officer of Strategic Commissioning Board	Sarah Dobson, Assistant Director Policy, Performance and Communications.
Subject:	**DELIVERING EXCELLENCE, COMPASSIONATE, COST EFFECTIVE CARE – IN-FOCUS REPORT**
Report Summary:	In-focus – a more detailed review of performance across a number of measures in a thematic area. This report provides the Strategic Commissioning Board (SCB) with an in-focus report on suicide and self-harm prevention.
Recommendations:	The Strategic Commissioning Board are asked to note the content of the report.

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

Budget Allocation (if Investment Decision)	n/a
CCG or TMBC Budget Allocation	n/a
Integrated Commissioning Fund Section – s75, Aligned, In-Collaboration	£34.957m S75 £0.752m Aligned
Decision Body – SCB Executive Cabinet, CCG Governing Body	SCB
Value For money Implications – e.g. Savings Deliverable, Expenditure Avoidance, Benchmark	n/a
Additional Comments The report is for information only. Investment in Mental Health Services totals £35.709m across the Strategic Commission in 2018-19 (£29.800m CCG; £5.909m Council). Further growth is expected in future years in line with the NHS Five Year Forward View.	

Legal Implications: (Authorised by the Borough Solicitor)	The purpose of the report is to undertake deep dives into difficult issues to determine how best to allocate resources to deliver better outcomes and value for money. This may require consideration of resources to manage transition to early intervention work.
How do proposals align with Health & Wellbeing Strategy?	Should provide a check & balance and assurances as to whether meeting strategy.
How do proposals align with Locality Plan?	Should provide check & balance and assurances as to whether meeting plan.
How do proposals align with the Commissioning	Should provide check & balance and assurances as to whether meeting strategy

Strategy?	
Recommendations / views of the Health and Care Advisory Group:	This section is not applicable as this report is not received by the professional reference group.
Public and Patient Implications:	Patients' views are not specifically sought as part of this report.
Quality Implications:	As above.
How do the proposals help to reduce health inequalities?	This will help us to understand the impact we are making to reduce health inequalities.
What are the Equality and Diversity implications?	None.
What are the safeguarding implications?	None reported related to the report as described in report.
What are the Information Governance implications? Has a privacy impact assessment been conducted?	There are no Information Governance implications. No privacy impact assessment has been conducted.
Risk Management:	There are no risks associated with this report.
Access to Information:	The background papers relating to this report can be inspected by contacting the report writer Lorraine Kitching by: Telephone: 0161 342 4043 e-mail: Lorraine.kitching@tameside.gov.uk

1. INTRODUCTION

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. Suicide is often the end point of a complex history of risk factors and distressing events which prevention interventions need to address.

1.2 More than half of people who die by suicide have a history of self-harm. The intention of self-harm is more often to punish themselves, express their distress, or relieve unbearable tension. Self-harm is also an indication of the underlying mental wellbeing of a population.

1.3 Suicide rates are produced nationally at a local authority level, therefore in order to provide comparative data; the statistics within this report focus on the Tameside area and where possible provide data for Glossop.

1.4 This report details the work that is being undertaken to understand the issues that lead to suicide and the preventative action being proposed or taken to address the problems.

2. KEY STATISTICS

- In 2015-17, Tameside had the 16th highest suicide rate in England (out of 149 local authority areas). This is an improved position on 2014-16 where Tameside was ranked 10th worst.

- Suicide is more prevalent amongst males and Tameside had the 11th highest suicide rate in England (out of 149 local authority areas). This is an improved position on 2014-16 where Tameside ranked 5th worst.

- The suicide rate for men aged 35-64 years (2013-17) is 32.7 per 100,000; third worst in England.

- In 2016-17 the rate of emergency hospital admissions for intentional self-harm was 230.48 per 100,000; higher than the England average at 185.27 per 100,000.

- In Tameside, emergency hospital admissions due to intentional self-harm is far more prevalent amongst females than males (272.82 per 100,000 compared to 189.39 per 100,000).

- Hospital admissions for self-harm in young people aged 10-24 years was significantly higher than the England average.

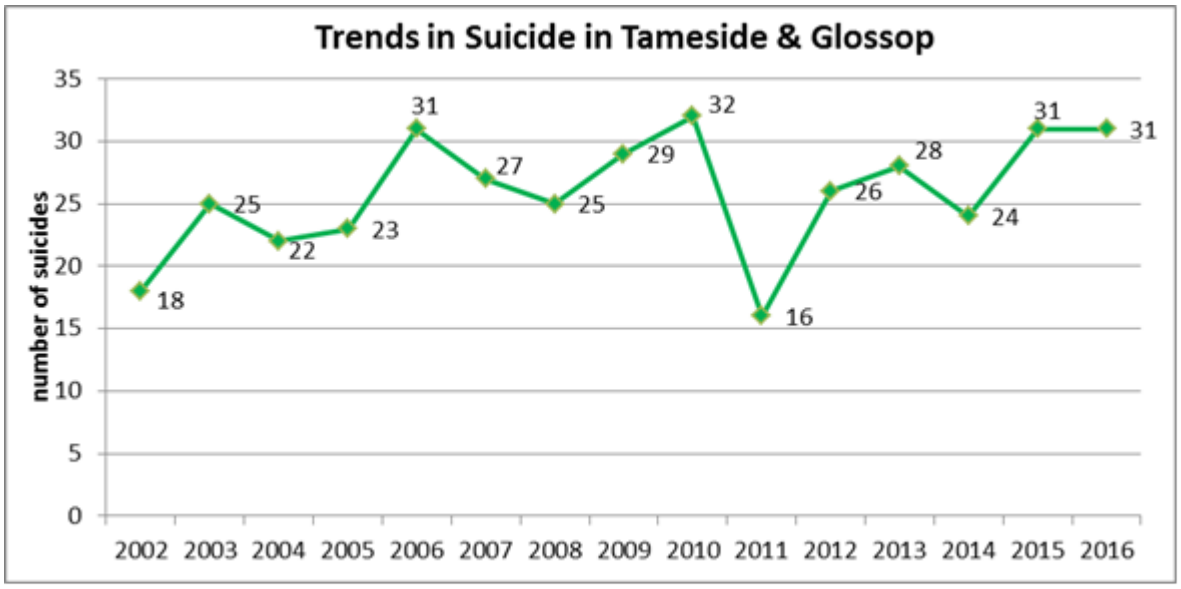
- Three-quarters of all people who end their own lives are not in contact with mental health services.

- Approximately 12% (23,832) of the population are registered with depression. Over the last five years the prevalence of depression has been increasing year on year.

- Just over 2,100 people have a serious mental health condition in Tameside and Glossop.

2.1 Figure 1 shows the number of suicides that have occurred in Tameside and Glossop between 2002 and 2016.

Figure 1: Trends in suicide in Tameside & Glossop



Source: Primary Care Mortality Data (NHS Digital)

3. NATIONAL PRIORITES FOR TACKLING SUICIDE

3.1 In February 2016 the independent Mental Health Taskforce published its Five Year Forward View which set out the current state of mental health services in England and made recommendations for specific services areas; one of which was suicide prevention.

3.2 The report recognised that suicide prevention is a complex public health challenge and requires closed working between different NHS and partner organisations in order to develop plans to tackle the issue.

3.3 To support this, the Government refreshed the National Suicide Prevention Strategy in January 2017 with a focus on the need for effective targeting of suicide prevention for high risk groups such as middle aged men and those who self-harm.

3.4 Last month the Government announced £2 million in funding for Zero Suicide Alliance (ZSA) over the next two years. As part of their work they will develop a digital suicide prevention resource and explore the use of data analytics to predict suicide risk.

3.5 The Public Health Research Programme are currently in the process of commissioning research to identify which interventions, aimed at those people with a high risk of suicide, are effective in reducing the number of suicides that take place.

4. LOCAL RESPONSE - SUICIDE AUDIT AND PREVENTION STRATEGY

4.1 Work has already been undertaken to understand the issues and factors that lead to suicide and self-harm in Tameside. A suicide audit for Tameside covering the period 2013-2017 was undertaken in July 2018 and has been presented to the Health and Wellbeing Board. This audit identifies the groups that are known to be at higher risk of suicide than the general population in Tameside; these groups are:

- young and middle-aged men;
- people in the care of mental health services, including in-patients;
- people with a history of self-harm;

- people in contact with the criminal justice system;
- people in lower skilled, manual occupations

4.2 The audit also identifies key factors that are known to be associated with increased risk of suicide in Tameside, these include:

- prior mental health issue such as depression and anxiety;
- relationship breakdown;
- loss of job;
- chronic pain or disability;
- longstanding issues with drugs and or alcohol;
- financial issues/debt.

4.3 The key findings from the audit can be found in **Appendix 1**.

4.4 As a result of the audit, a draft Tameside Suicide and Self-Harm Prevention Strategy 2018-2023 has been developed. Further engagement with key stakeholders will take place to further refine and shape the draft strategy.

4.5 The primary focus for the first two years of the strategy is to reduce the suicide rate by 10% by 2020 with the ultimate long-term goal being to have no one taking their own life. The draft strategy sets out 8 key areas of focus to reduce the risk of suicide:

- **reducing the risk in men** – in particular middle-aged men, with a focus 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.
- **preventing and responding to self-harm** – a range of services are needed 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.
- **mental health of children and young people (and in pregnancy)** – joint working between health, social care, schools and youth services, and includes risk during pregnancy and those who have given birth during the last year. A particular focus on the increased suicide risk between 15-24 year olds.
- **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 review, and using social prescribing to enhance quality of life.
- **Improve the general mental wellbeing and resilience in the population through opportunities** – through being more physically active and socially included, access to good transport links and access to help and support early when needed.
- **Improve economic opportunities for the population** – particularly for those in long term unemployment and suffering mental health conditions.
- **tackling high frequency locations** – includes making high risk public areas safer and working with the local media organisations and groups to prevent imitative suicides.
- **bereavement support** – provision of better information and support for those bereaved or affected by suicide and supporting the media in delivering sensitive approaches to suicide and suicidal behaviour.

5.1 INTEGRATED CARE AND WELLBEING PANEL

5.1 A working group of the Integrated Care and Wellbeing Scrutiny Panel has been undertaking activity looking at suicide prevention in Tameside. The group has engaged with Public Health, Tameside and Glossop CCG, Pennine Care (Secondary Care), visited the Anthony

Seddon fund, attended a suicide prevention group and meeting and met with Dr Vinny Khunger (Primary Care). The purpose of the scrutiny review is to understand the issues surrounding suicide and the preventative activity taking place to address it.

5.2 A paper of the findings and recommendations will be drafted and presented to the joint meeting of Executive Cabinet and Overview (Audit Panel) on the 13 February 2019.

6. MENTAL HEALTH PROJECTS IN PROGRESS

6.1 In 2018/19, £23.3 million is being spent on the mental health contract with NHS Pennine Care NHS Foundation Trust to provide mental health services in the area. Additional funding support has also been given to a number of targeted initiatives to tackle mental health issues. In 2018/19 this funding stood at £2.4 million and is set to rise to £4.2 million in 2019/20 and £5 million in 2020/21.

6.2 During 2017/18, approximately £2.5 million was spent on prescribing the following types of drugs to help deal with mental health issues: hypnotics and anxiolytics, drugs used in psychoses & related disorders and antidepressant drugs.

6.3 Over the last year, as part of the targeted funding of services to improve mental health in the population, a number of projects have been established and approved for funding through the Single Commissioning Board; some of these projects are detailed below.

6.4 ***101 days for mental health project*** (£58,000 investment) – this project focussed on establishing a new model of care to better support people with multi-faceted needs who currently fall between secondary care mental health services and the psychological therapy service.

6.5 Building on this work, Tameside and Glossop have been selected by the Innovation Unit to join the **Living Well UK** programme (one of four sites nationally). This programme will enable people with mental health needs living in the area to benefit from having a say in how mental health support is designed and developed in Tameside and Glossop over the next three years. The new model will support early intervention and prevention; it will support people to stay well; ensure the delivery of high quality and sustainable services, including support for families; help reduce homelessness; get people into work and will be age friendly.

6.6 ***Early Intervention in Psychosis*** (£249,795 recurrent investment) ***& increasing access to psychological therapy*** (£270,250 recurrent investment) - investment made to increase team capacity in order to meet the national standards of 53% of people receiving NICE compliant care within 2 weeks of referral and increasing access to psychological therapy.

6.7 ***Children and Young Peoples Mental Health*** (£90,630 recurrent investment) – Increased capacity in specialist services for children and young people with a neurodevelopmental condition and those with a learning disability and/or autism. The additional capacity will enable families to be supported to promote positive behavioural approaches at home and school.

6.8 ***Children & Young People's Emotional Wellbeing and Mental Health Local Transformation Plan*** (£931,000 in 2018/19) – the aim of the transformation plan is to improve and sustain access to children and young people's mental health provision through a whole system approach.

6.9 ***Adult Social Care & Population Health*** (£5,909,000 in 2018-19) – This investment includes Community Mental Health Teams, Supported Accommodation facilities, Community based homecare and placements in Residential and Nursing Care Homes.

This sum also includes recurrent Population Health funding of £211,000 and a non recurrent sum of £255,000 approved by the Strategic Commissioning Board on 20 March 2018. This was the year one sum of a three year programme (total £ 685,000) via the Population Health Investment Fund. The programme aims to build on the local Neighbourhood Mental Health offer to complement the current approach to social prescribing. There will be no eligibility criteria or clinical threshold with easy access via community drop in's or online self-referral. Asset based brief conversations about needs and solutions via drop-in or telephone will take place within Neighbourhoods with support into locality initiatives e.g. social prescribing, welfare and debt support, lifestyle, housing, skills and employment. The programme provides direct access to a broad offer of mental health specific social, therapy, employment, physical and mental health with access to the Health and Wellbeing College programmes.

7. CONCLUSION

- In 2015-17, Tameside had the 16th highest suicide rate (out of 149 Local Authority areas in England)
- The suicide rate for men aged 35-64 years (2013-17) is 32.7 per 100,000; third worst in England.
- Over half of suicides in Tameside (52%) are amongst those aged between 35 and 54.
- The highest proportion of suicides occur in routine occupations, which include roles such as factory workers, retail assistants, cleaners and labourers.
- A suicide audit has been completed and a draft suicide prevention strategy has been developed for the area.
- In the last 12 months investment in mental health services has been approved by the Single Commissioning Board to improve mental health in the area.
- Successful selection as one of four pilot areas for the Living Well UK programme areas will help to drive the mental health strategy forward.

8. RECOMMENDATIONS

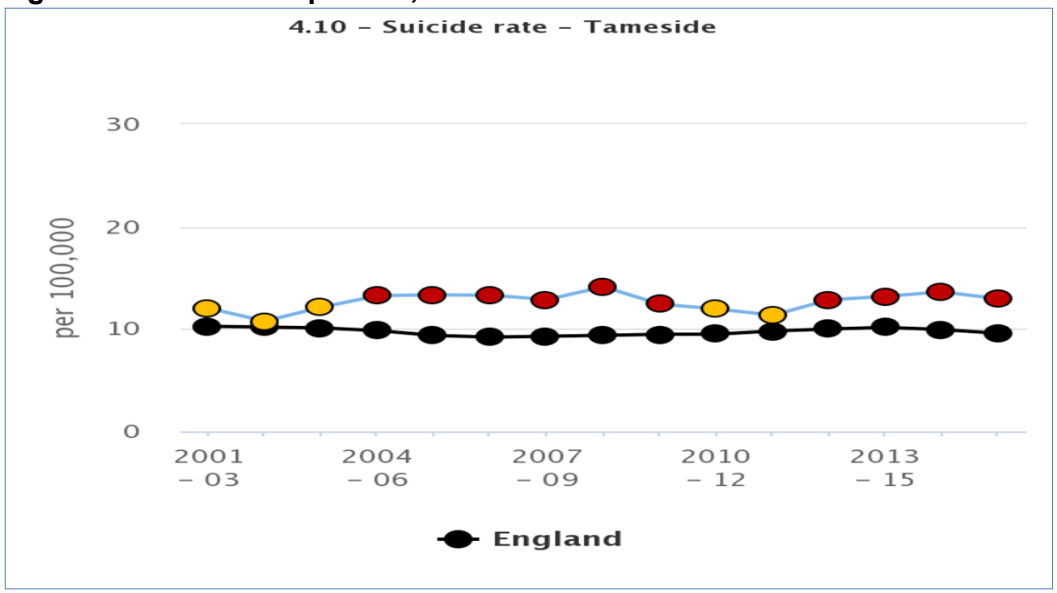
8.1 As set out on the front of the report.

APPENDIX 1

Key Findings

To note – all statistics are based on where the person was resident.

Figure 2: Suicide rate per 100,000



Source: Public Health England

Figure 1 illustrates that the suicide rate has consistently been above the England average over the last decade. Where the dots are red this means Tameside is significantly above the England average and the yellow dots signify that Tameside is not significantly different to the England average.

Figure 3: Suicide: age-standardised rate per 100,000 (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

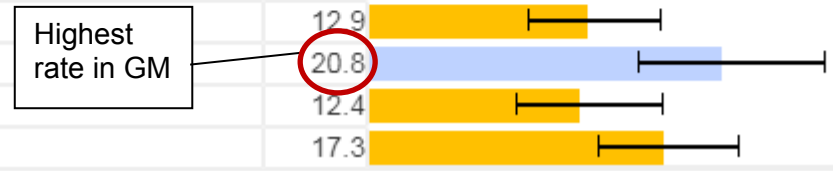
Highest rate in GM

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

The suicide rate for Tameside and Glossop was 12.6 per 100,000 population slightly lower than the Tameside only figure (12.9). The blue bar for Tameside indicates that the suicide rate is significantly higher than the England average.

Figure 4: Suicide: age-standardised rate per 100,000 population – male (2015-17)

Area	Value	Lower CI	Upper CI
England	14.7	14.4	15.0
CA-Greater Manchester	15.3	14.0	16.6
Bolton	18.6	14.4	23.7
Bury	12.7	8.5	18.1
Manchester	15.0	11.7	18.8
Oldham	12.8	9.0	17.7
Rochdale	14.4	10.2	19.7
Salford	19.0	14.4	24.7
Stockport	12.9	9.4	17.2
Tameside	20.8	15.8	26.9
Trafford	12.4	8.6	17.3
Wigan	17.3	13.5	21.9



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

The male suicide rate for Tameside and Glossop was 22.0 per 100,000 population higher than the Tameside only figure (20.8). The male suicide rate for Tameside and Glossop was the highest amongst the Greater Manchester CCG areas. The blue bar indicates that the suicide rate for males in Tameside is significantly higher than the England average.

Figure 5: Suicide: age-standardised rate per 100,000 population – female (2015-17)

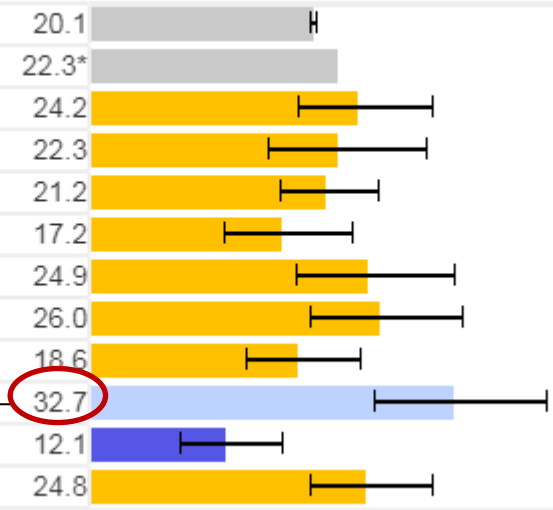
Area	Value	Lower CI	Upper CI
England	4.7	4.5	4.8
CA-Greater Manchester	4.4	3.7	5.1
Bolton	5.3	3.2	8.1
Bury	*	-	-
Manchester	3.9	2.4	6.0
Oldham	3.8	1.9	6.7
Rochdale	*	-	-
Salford	5.7	3.3	9.1
Stockport	5.6	3.5	8.5
Tameside	5.3	3.0	8.6
Trafford	*	-	-
Wigan	5.3	3.4	8.0

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

There is no available data for Tameside and Glossop for the female suicide rate. The suicide rate for females in 2015-17 for Tameside is 5.3 and is not significantly different to the England average.

Figure 6: Suicide crude rate 35-64 years: per 100,000 – male (2013-17)

Area	Value	Lower CI	Upper CI
England	20.1	19.8	20.5
CA-Greater Manchester	22.3*	-	-
Bolton	24.2	18.6	30.9
Bury	22.3	15.9	30.3
Manchester	21.2	17.1	26.1
Oldham	17.2	12.0	23.8
Rochdale	24.9	18.5	32.9
Salford	26.0	19.7	33.6
Stockport	18.6	14.0	24.4
Tameside	32.7	25.5	41.2
Trafford	12.1	8.0	17.5
Wigan	24.8	19.7	30.9



Source: Office for National Statistics (ONS), original mortality data

The suicide crude rate for males (2013-17) for the age group 35-64 years is 32.7 significantly higher than the England average. Tameside is the only Greater Manchester authority with a figure significantly higher than the England average.

Figure 7: Suicide crude rate 65+ years: per 100,000 – male (2013-17)

Area	Value	Lower CI	Upper CI
England	12.4	11.9	12.9
CA-Greater Manchester	12.1*	-	-
Bolton	9.2	4.4	17.0
Bury	13.3	6.4	24.5
Manchester	11.8	6.3	20.2
Oldham	11.1	5.1	21.1
Rochdale	10.3	4.4	20.3
Salford	11.2	5.1	21.2
Stockport	11.8	6.6	19.5
Tameside	17.1	9.6	28.2
Trafford	18.2	10.4	29.5
Wigan	9.5	5.0	16.2

Source: Office for National Statistics (ONS), original mortality data

The suicide crude rate for males (2013-17) aged 65+ is 17.1 and not significantly different from the England average.

Figure 8: Emergency Hospital Admissions for Intentional Self-Harm: Directly age-sex standardised rate per 100,000 (2016-17)

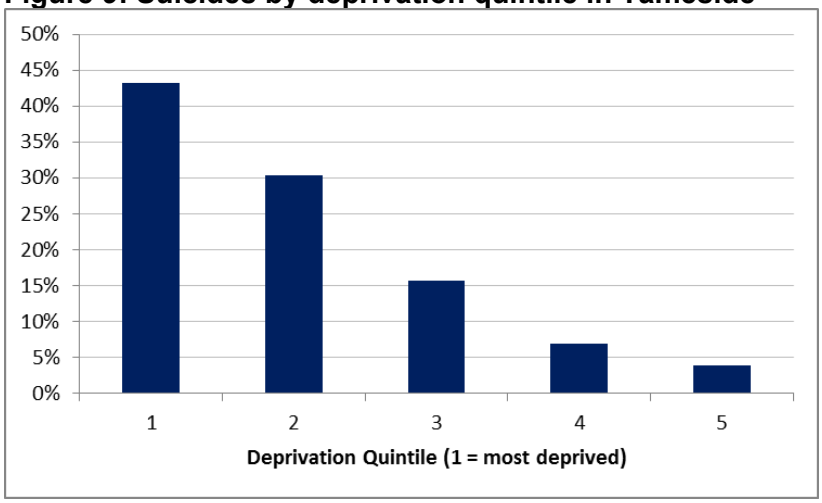
2.10ii - Emergency Hospital Admissions for Intentional Self-Harm 2016/17 — Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	103,723	185.3	184.1	186.4
CA-Greater Manchester	–	5,952	207.1	201.8	212.5
Bolton	–	639	225.4	208.1	243.6
Bury	–	350	188.6	169.3	209.5
Manchester	–	1,059	185.7	173.7	198.2
Oldham	–	393	165.7	149.6	183.0
Rochdale	–	362	164.9	148.3	182.9
Salford	–	871	343.3	320.4	367.4
Stockport	–	539	192.2	176.3	209.2
Tameside	–	512	230.5	210.9	251.4
Trafford	–	348	153.9	138.0	171.1
Wigan	–	879	276.6	258.6	295.6

Source: Hospital Episode Statistics (HES), NHS Digital, for the respective financial year, England. Hospital Episode Statistics (HES) Copyright © 2017, Re-used with the permission of NHS Digital. All rights reserved. Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to Public Health England Local Authority estimates of resident population, Office for National Statistics (ONS) Unrounded mid-year population estimates produced by ONS and supplied to the Public Health England. Analysis uses the single year of age grouped into quinary age bands, by sex.

The number of emergency hospital admissions for intentional self-harm per 100,000 population is 230.5 in Tameside which is significantly higher than the England average. The highest rate in Greater Manchester was in Salford at 343.3.

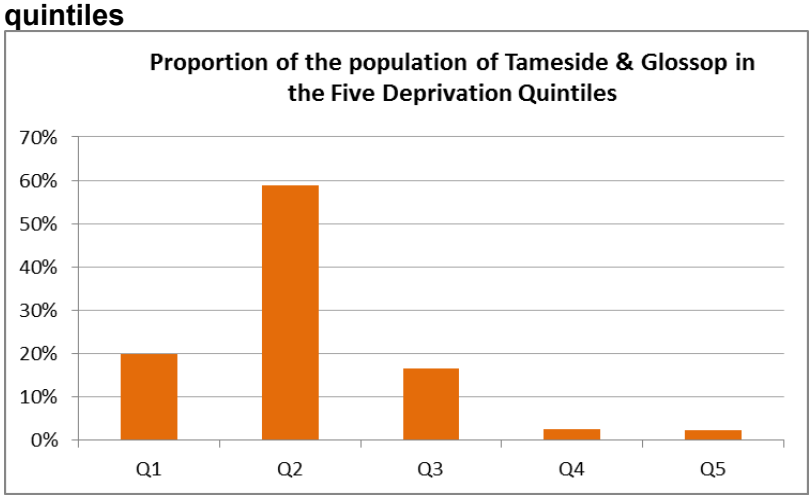
Figure 9: Suicides by deprivation quintile in Tameside



Source: Primary Care Mortality Data (NHS Digital)

Deprivation quintiles represent the level of deprivation our population live in. Deprivation quintile 1 represents the most deprived and deprivation quintile 5 represents the most affluent. The chart above illustrates that significantly more suicides occur in the most deprived quintile and the least in the more affluent. Figure 9 shows the proportion of suicides between 2013-16 in Tameside and the deprivation quintile they were resident in.

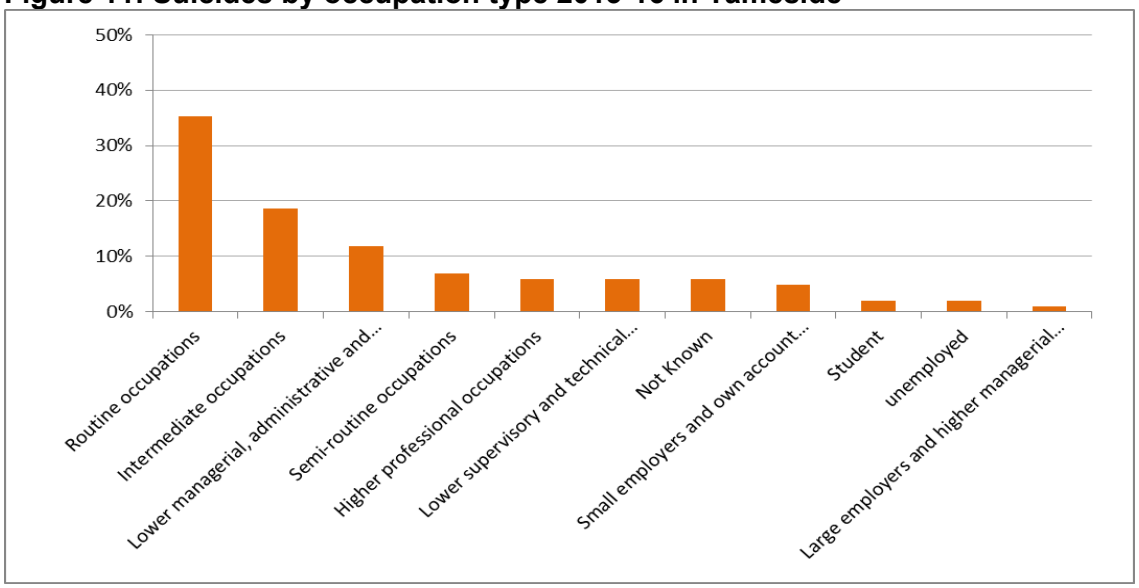
Figure 10: Proportion of the population of Tameside & Glossop in the five deprivation quintiles



Source: Primary Care Mortality Data (NHS Digital)

Almost 60% of Tameside and Glossop's population lives in quintile 2.

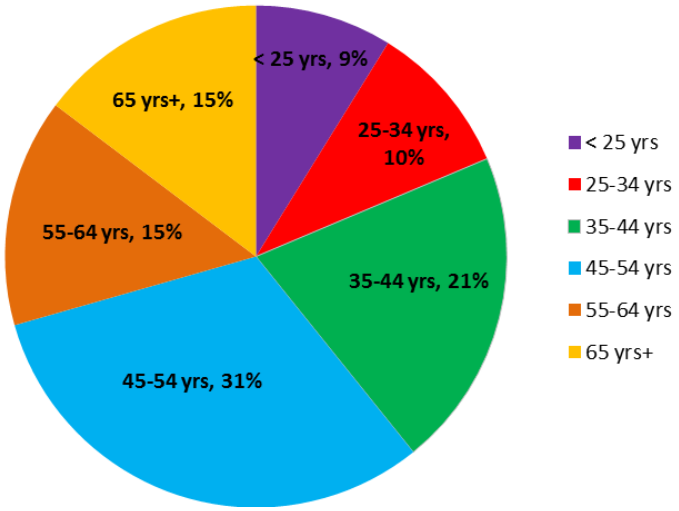
Figure 11: Suicides by occupation type 2013-16 in Tameside



Source: Primary Care Mortality Data (NHS Digital)

Figure 11 illustrates the proportion of suicides by occupation group (Standard Occupational Classification). It illustrates that the highest proportion of suicides occur in routine occupations, which include roles such as factory workers, retail assistants, cleaners and labourers. These occupations tend to be low paid and not secure. The 2nd highest occupation categories are intermediate and include roles such as plumbers, joiners, mechanics and train drivers. The third highest occupation of lower managerial and administrative includes roles such as computer technicians, engineers, social workers and nurses.

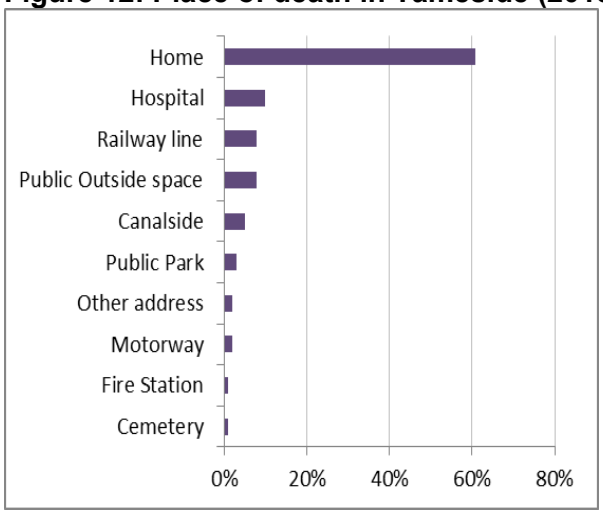
Figure 12: Suicides by age bands 2013-16 in Tameside



Source: Primary Care Mortality Data (NHS Digital)

Almost a third of suicides in Tameside (31%) were amongst those aged 45-54 year olds and 21% were amongst 35-44 year olds.

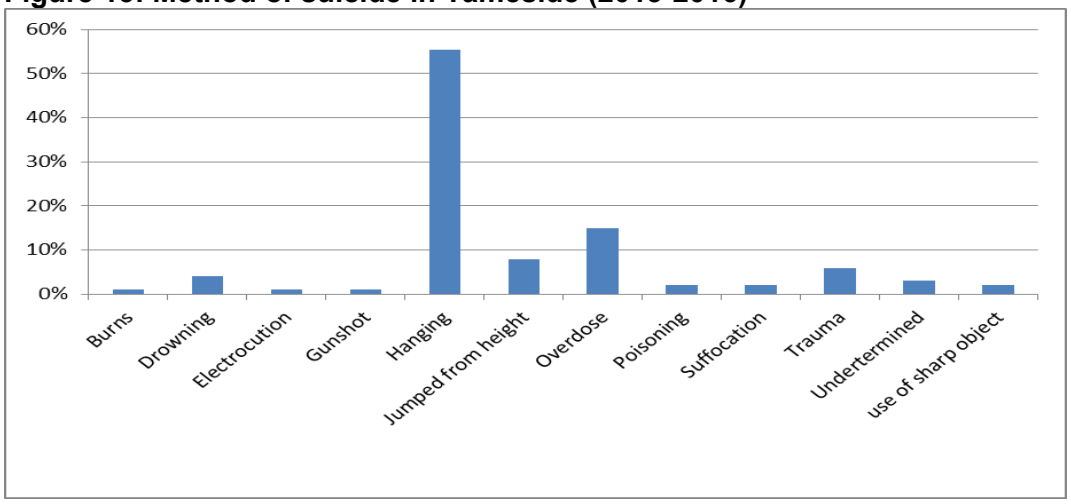
Figure 12: Place of death in Tameside (2013-16)



Source: Primary Care Mortality Data (NHS Digital)

Just over 60% of suicides in Tameside occurred in the person's own home.

Figure 13: Method of suicide in Tameside (2013-2016)



Source: Primary Care Mortality Data (NHS Digital)

Over 50% of suicides were caused by hanging.